East Lancashire Hospitals
NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

Safe | Personal | Effective

TRUST BOARD (OPEN SESSION) AGENDA

11 March 2026 at 09.30

Boardroom, Trust Headquarters, Royal Blackburn Teaching Hospital

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
09.30	TB/2026/027	**Chairs Welcome and Apologies for Absence**	Chair	v	Information
09.32	TB/2026/028	**Register of Board Directors Interests**	Chair	v	Information
09.35	TB/2026/029	**Register of Interests**	Interim Director of Corporate Governance	✓	Information
09.40	TB/2026/030	**Minutes of the Previous Meeting**	Chair	✓	Approve
09.45	TB/2026/031	**Action Tracker and Matters Arising**	Chair	✓	Discussion
09.50	TB/2026/032	**Patient Story**	Chief Nurse	✓	Information
10.00	TB/2026/033	**Chair's Report**	Chair	✓	Information
10.10	TB/2026/034	**Chief Executive's Report**	Chief Executive	✓	Information
FORMULATING STRATEGY					
10.25	TB/2026/035	**Provider Collaboration Board Strategic Update**	Chief Executive	✓	Information
ENSURING ACCOUNTABILITY					
10.30	TB/2026/036	**Integrated Performance Report**	Executive Directors	✓	Assurance
10.50	TB/2026/037	**Financial Performance Report – Month 10**	Director of Finance	✓	Assurance
11.20	TB/2026/038	**East Lancashire Hospitals NHS Trust Improvement Plan (RSP Exit Criteria)**	Director of Service Development & Improvement	✓	Assurance
COMFORT BREAK 11.30 – 11.40					
11.40	TB/2026/039	**Maternity and Neonatal Services Update**	Chief Nurse/ Medical Director	✓	Assurance
11.55	TB/2026/040	**Antimicrobial Stewardship Report**	Medical Director	✓	Assurance
12.05	TB/2026/041	**Patient Safety Incident Response Assurance Report**	Medical Director	✓	Assurance
COMMITTEE REPORTS					
12.10	TB/2026/042	**Triple A Reports from Quality Committee**	Committee Chair		Assurance

		a) January 2026 b) February 2026		✓ ✓	
12.15	TB/2026/043	**Triple A Reports from Finance & Performance Committee** a) January 2026 b) February 2026	Committee Chair	✓ ✓	Assurance
12.20	TB/2026/044	**Triple A Reports from People & Culture Committee** a) February 2026 b) March 2026	Committee Chair	✓ ✓	Assurance
12.25	TB/2026/045	**Triple A Report from Audit and Risk Committee** a) January 2026	Committee Chair	✓	Assurance
12.30	TB/2026/046	**Triple A Report from Trust Charitable Funds Committee** a) February 2026	Committee Chair	✓	Assurance
CLOSING MATTERS					
12.35	TB/2026/047	**Message from the Board**	Chair	v	Information
12.40	TB/2026/048	**Any Other Business**	Chair	v	Information
12.45	TB/2026/049	**Date and Time of Next Meeting** 13 May 2026 at 9.30am, Boardroom, Trust HQ	Chair	v	Information

East Lancashire Hospitals NHS Trust
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TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/029
Report Title:	Register of Board Directors Interests		
Author:	Kea Ingham, Corporate Governance Manager		
Lead Director:	Susan Giles, Interim Director of Corporate Governance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**To Note**
				✓
Executive Summary:	It is a statutory requirement for the Trust to maintain and publish a Register of Interests for the Board of Directors. This is in line with the Trust's commitment to ensuring openness and transparency in its decision making. The Register has been updated with the Declarations of Interest for new Board members.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board is asked to note the updated Register of Interests.			

Previously Considered by:	
Date:	
Outcome:	

Register of Board of Directors' Interests

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust	Potentially a material conflict of interest might arise. If service areas where family members worked were being discussed Mrs Atkinson would make a declaration and the Chair would consider the circumstances and may ask Mrs Atkinson to withdraw from the discussion.	07.08.2025
Professor Shahedal Bari Non-Executive Director	• Consultant at Morecambe Bay University Hospitals.	Potentially a material conflict could arise in connection with Prof. Bari's role at MBUH. If discussions were taking place where this was an issue Prof. Bari would declare an interest and the Chair would consider the circumstances and may ask Prof. Bari to withdraw from the discussion	03.09.2025
Sallie Bridgen Non-Executive Director	• Non-Executive Director of Syncora (part of the Calico Group) • Spouse is a Non-Executive Director at Blackpool Teaching Hospitals (BTH) • Self-employed - Sallie Bridgen Consultancy • Associate - Housing Diversity Network, Ruby Star Associates	A material conflict of interest does not exist as this role is not connected to the Trust.	01.07.2025
Simon Featherstone Non-Executive Director	• Positive nil declaration	N/A	02.09.2025

Register of Board of Directors' Interests

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Susan Giles Interim Director of Corporate Governance / Company Secretary	• Director of Board Matters Ltd. • Chair of Hearings Panels for Social Care Wales • Non-Executive Director Immigration Advice Authority • Joint Audit Committee Member of Cumbria Police, Fire & Crime Commissioner • Trustee of North West Cancer Research • Trustee of Thrive Social Housing • Independent Remuneration Panel Member Wigan Council • Independent Standards Person York and North Yorkshire Combined Authority	A material conflict of interest does not exist as Mrs Giles does not have other consultancy clients within the East Lancashire area; and the other roles are not connected to the Trust.	22.08.2025
Sharon Gilligan Chief Operating Officer and Deputy Chief Executive	• Positive nil declaration	N/A	07.08.2025
Julian Hobbs Executive Medical Director	• Board Member of Advancing Quality Alliance	Potentially a conflict could arise in connection with this if the Trust were to commission AQuA to undertake any reviews on behalf of the Trust. If discussions were taking place where this was an issue Dr Hobbs would declare an interest and the Chair would consider the circumstances and may ask Dr Hobbs to withdraw from the discussion	10.02.2025

Register of Board of Directors' Interests

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Martin Hodgson Chief Executive	• Spouse is the Group Delivery Officer at Liverpool University Hospital NHS Foundation Trust.	A material conflict of interest does not exist as LUFT is within a different ICB region.	08.08.2025
Andrew Ireland Non-Executive Director	• Pro Vice-Chancellor (Students and Teaching) and Head of Burnley Campus at the University of Lancashire.	No material conflict is envisaged, it is a constitutional requirement for the Trust to have a Non-Executive Director from the University of Lancashire.	04.04.2026
Amin Kamaluddin Non-Executive Director	• Non-Executive Director at Morecambe Bay University Hospitals • Director of Expertus Beauty Limited • Director of SK Growth Limited • Trustee at The Kokni Muslim Association	Potentially a material conflict may arise in connection with Mr Kamaluddin's role at UMBH. If discussions were taking place which would impact both UMBH and ELHT, Mr Kamaluddin would declare an interest and the Chair would consider the circumstances and may ask Mr Kamaluddin to withdraw from the discussion.	02.03.2026
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust	A material conflict of interest does not exist as Oxford Health NHS Foundation Trust is within a different ICB region.	07.08.2025

Register of Board of Directors' Interests

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Peter Murphy Chief Nurse	• Positive nil declaration	N/A	08.08.2025
Miriat Naiga Non-Executive Director	• Substantive post is at Astrazeneca	A material conflict of interest does not exist as Ms Naiga is not in a role which makes decisions connected to the NHS.	03.03.2026
Dr Neil Pease Interim Chief People Officer	• Director of Star Bay View Ltd • Chief People Officer at Lancashire Teaching Foundation Trust Hospitals (LTH)	Potentially a material conflict may arise in connection with Dr Pease's role at LTH. If discussions were taking place where this was an issue Dr Pease would declare an interest and the Chair would consider the circumstances and may ask Dr Pease to withdraw from the discussion.	20.08.2025
Catherine Randall Non-Executive Director	• Executive Director Derian House Lead for Clinical Services • Independent Chair at Blackburn Church of England • Honorary Professor at the University of Central Lancashire • Spouse is a GP in Blackburn with Darwen	Potentially a material conflict may arise in connection with Mrs Randall's role at Derian House. If discussions were taking place regarding children's hospice services Mrs Randall would declare an interest and the Chair would consider the circumstances	07.08.2025

Register of Board of Directors' Interests

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
		and may ask Mrs Randall to withdraw from the discussion.	
Liz Sedgley Non-Executive Director	• Self Employed Accountant Liz Sedgley FCCA Accountancy and Management Consultancy • Governor at Nelson and Colne Colleges Group	A material conflict of interest does not exist as the roles are not connected to the Trust.	08.08.2025
Sam Simpson Executive Director of Finance	• Positive nil declaration	N/A	05.03.2025
Mike Thomas Chair	• Chair of Lancashire Teaching Hospitals • Chair of Making Space • Chair of Lancashire & South Cumbria Provider Collaborative Board • Member of NHS England North West People Board	Potentially a material conflict may arise in connection with Prof. Thomas' role at LTH. If discussions were taking place which would impact both LTH and ELTH Prof. Thomas would declare an interest and the SID and/or Vice-Chair would consider the circumstances and may ask Professor Thomas to withdraw from the discussion.	02/03/2026
Shelley Wright Executive Director of Communications and Engagement	• Positive nil declaration	N/A	13.11.2024

Register of Board of Directors' Interests

BOARD MEETING (PUBLIC SESSION)

14 January 2026 9.30AM

BOARDROOM, TRUST HQ

MINUTES

PRESENT

Professor M Thomas	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
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Dr 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 S Giles	Interim Director of Corporate Governance / Company Secretary	
Mr M Greatrex	Interim Deputy Director of Finance	For S Simpson
Mr M Maher	Clinical Director, Obstetrics and Gynaecology	Item: TB/2026/012
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2026/012
Mrs Z Tidman	Senior Correspondent, Health Service Journal	Observer
Mrs A Vicary	Improvement Director, NHS England	Observer

APOLOGIES

Mrs S Bridgen	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
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	✓	✓	✓	✓	✓		
Prof M Thomas						✓	
Mrs S Bridgen	✓	✓	✓	**A**	**A**	**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	✓	✓	✓	✓	✓		
Prof S Bari			✓	✓	✓	✓	
Mr S Featherston			✓	✓	✓	✓	
Dr J Hobbs				✓	✓	✓	
Mr M Hodgson	✓	✓	✓	✓	✓	✓	
Mrs S Simpson	✓	✓	✓	**D**	✓	**D**	
Mrs S Gilligan	✓	✓	✓	✓	✓	✓	
Mr P Murphy	✓	✓	✓	✓	**D**	✓	
Mrs K Quinn	**A**	**A**					
Mr M Ireland	✓	✓					
Mrs K Atkinson	✓	✓	**D**	✓	✓	✓	
Mr T McDonald	✓	**D**	✓	**D**	✓	✓	
Miss S Wright	✓	✓	✓	✓	✓	✓	
Mr S Islam	✓	✓	✓				
Dr N Pease			✓	✓	✓	✓	

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

TB/2025/138 CHAIRMAN'S WELCOME AND APOLOGIES

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

Professor Thomas extended his formal thanks to the former Chair, Shazad Sarwar, who had recently left the Trust, acknowledging their contribution and service to the organisation during

their tenure. He also expressed appreciation to Professor Graham Baldwin whose term had come to an end at the start of January and Khalil Rehman whose term would come to an end at the start of February.

For the purposes of the minutes, it was requested that formal appreciation be recorded for all colleagues across the wider Trust and the community for their efforts during an exceptionally pressured period.

TB/2026/001 DECLARATIONS OF INTEREST

There were no additional declarations of interest raised.

TB/2026/002 MINUTES OF THE PREVIOUS MEETING

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

The minutes of the meeting held on the 12 November 2025 were approved as a true and accurate record.

TB/2026/003 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.

Directors noted the position of the action matrix.

TB/202506/005 PATIENT STORY

Directors were referred to the patient story which highlighted the importance of effective communication within the Trust. The patient story can be viewed here.

Directors received and noted the patient story.

TB/2026/006 CHAIR'S REPORT

The chair referred directors to the previously circulated written report, summarising key activities undertaken during the previous month. and invited any questions.

It was noted that the board would continue to refine how it worked collectively over the coming months. The intention was for Committee Chairs to take a more prominent role in presenting committee papers to the Board, with executive directors being called upon for detailed or operational clarification where required. This approach was intended to reduce

duplication of discussions already held at sub-committee level. The chair requested that all board papers were routinely taken as read and that questions relevant to board assurance should be raised during the meeting, with any operational or non-assurance matters discussed with the appropriate colleagues outside the meeting.

Directors received and noted the report provided by the chair.

TB/2026/007 CHIEF EXECUTIVE'S REPORT

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

At a national level, updates were provided on the development of Neighbourhood Health Centres, national concerns around flu infection rates, recent industrial action taken by resident doctors, the rollout of an NHS maternity signal system, the launch of an artificial intelligence based forecasting tool to address A&E bottlenecks, the ongoing rollout of online access to GP surgeries and the unveiling of England's first Men's Health Strategy.

At a regional level, updates were provided on recent quality visits by the Integrated Care Board (ICB) to urgent and emergency care (UEC) services across Lancashire and South Cumbria (LSC, the implementation of a mobile cervical screening service to reach areas with historically low uptake, new prescribing guidelines for antibiotics, the renewal of the ICBs partnership agreement with the local Voluntary, Community, Faith and Social Enterprise (VCFSE) sector.

At a Trust level, updates were provided on the Trust's financial recovery plan, winter pressures, a recent visit by the NHS North West Regional Director, Louise Shepherd, the medium-term planning process, the introduction of new learning disability and autism training, the final response rate of the most recent staff survey and a record donation of £2m to ELHT&Me by the Kay Family Foundation. Updates were also provided on flu vaccination rates, the recent receipt of a £1m grant to boost the Trust's safety and infrastructure and the continuing development of a single pathology service across LSC.

The board was informed that national announcements regarding the development of advanced foundation trusts, effective from 2026, aligned with the Trust's long-term aspirations.

It was highlighted that the Trust had declared Operational Pressures Escalation Levels (OPEL) Level 4 for the first time in its history following sustained high demand over a three-week

period. It was noted that Trust staff had responded positively to the pressures and had successfully maintained performance standards for both UEC and elective activity.

It was confirmed that the organisation was continuing to work towards delivery of its financial plan for 2025-26 and that the Trust had submitted the first phase of its medium-term plan in December, with two further submissions due over the coming months. Directors were advised that discussions with commissioning colleagues were ongoing, particularly around ensuring that activity levels were appropriately funded under new operational targets.

Responding to queries as to whether current uptake levels for flu vaccines were considered satisfactory, it was explained that although the Trust had met its internal improvement target, national vaccination rates in general had continued to trend downwards due to post-pandemic fatigue. It was suggested that consideration should be given to raising awareness around the alternative routes for vaccination, such as GP practices and pharmacies to further boost uptake.

The board welcomed the introduction of the mobile cervical screening service and discussed the potential for engagement with further education colleges to promote awareness among younger women.

Responding to a request for clarification on the response from system partners following the Trust's recent declaration of OPEL 4 status, it was reported that reported that local partners, including primary care and ambulance services, had engaged actively in the incident management process, with the declaration also bringing a sharper focus to internal and system responses. Assurances were provided that patient safety had been maintained during this period and Directors were advised that a review was planned later in the day to determine whether the Trust could formally step down from OPEL 4 status. The importance of integrated working across the LSC system to address underlying demand pressures, including initiatives such as neighbourhood-based care was emphasised. It was also noted that positive feedback continued to be received regarding the quality of care being provided to patients in UEC areas despite the immense pressures being seen.

ACTION: The Chief Operating Officer was asked to inform the Company Secretary when the Trust is out of OPEL 4, who would in turn inform the Non-Executive Directors.
WHO: Chief Operating Officer/Company Secretary
WHEN: When the Trust exits OPEL 4

The board was informed that mortality rates in the organisation continued to decrease and there had been no recent incidences of harm recorded. It was highlighted that a new dashboard had been developed to facilitate closer monitoring of the reliability of care being delivered in the organisation, as well as its effectiveness, going forward.

Directors received the report and noted its contents.

TB/2026/008 PROVIDER COLLABORATION BOARD STRATEGIC UPDATE

The board received an update on recent discussions at the most recent meeting of the Provider Collaborative Board (PCB). The report was taken as read, with a number of key areas highlighted.

It was reported that urogynaecology services across LSC had previously been an area of significant concern, particularly regarding long outpatient waiting times of 65 weeks or more. It was confirmed that this was not an issue at the Trust and that substantial mutual aid had been offered to other organisations experiencing pressure. Directors observed that discussions at the PCB had focused on service transformation aligned with the ten-year plan, as the continued high levels of activity would require a sustainable long-term solution.

It was highlighted that there had been a system-wide commitment among acute providers to transition to a single Electronic Patient Record (EPR) by 2030, with a refreshed Memorandum of Understanding (MOU) now signed by all participating organisations. Assurances were provided was given that due process would be followed throughout the programme's development.

In response to a query raised regarding whether the PCB intended to undertake a strategic review of all services, or a focus on selected areas, it was confirmed that a broader review would form part of the commissioning intentions for the year and that the PCB would play a key role in shaping, informing, and influencing the ongoing clinical configuration work across LSC. It was further noted that the ICB would be developing a clinical configuration strategy, informed by the five-year commissioning and neighbourhood plan, which would also be reflected in the Trust's own strategic planning processes.

Directors received the report and noted its contents.

TB/2026/009 FINANCIAL PERFORMANCE REPORT – MONTH 8

Directors received an overview of the Trust's financial performance as of month eight (M8), which highlighted the following key points:

- The Trust was £3.2m off plan in M8 and £13.4m off plan year-to-date (YTD).
- The Trust's Waste Reduction Programme (WRP) delivery continued to be the primary contributor to the variance, being £3m behind plan in-month. YTD WRP delivery totalled £25.5m, representing a £9m shortfall against plan.
- The Trust had been informed that Deficit Support Funding (DSF) for Months 8 and 9 would not be awarded, creating a £3.6m in-month impact.
- Additional cost pressures of £0.5m had arisen due to recent bouts of industrial action.
- The Trust's Workforce establishment increased by 54 Whole-Time Equivalents (WTEs) during the month.
- Cash levels were reported as having fallen by £15m compared to the previous month.
- Capital expenditure remained ahead of plan by £3.4m, largely due to leasing arrangements.

Directors discussed the significant cash risk to the Trust arising from the continuing absence of DSF. It was confirmed that the application to draw down the equivalent of the lost DSF for Months 8-10 had been approved, with partial funding had been received in January. It was noted that this additional cash support would need to be repaid should DSF be reinstated later in the financial year.

The additional following risks were highlighted:

- Delivery of the Trust's WRP and recovery of the current slippage.
- Operational pressures, with activity levels exceeding commissioning assumptions, contributing to the Trust's financial position and its forecast for year-end.
- The potential opportunity to earn back lost DSF, which was noted to be largely dependent on system-level decisions that were out of the Trust's control.

Responding to a request for clarification regarding the additional funding provided to the Trust in the absence of DSF, it was confirmed that this would still attract interest charges, with the full financial impact yet to be fully calculated. Directors were informed that additional income would be received to offset recent industrial action pressures, which would be reflected in the Trust's Month 9 (M9) position.

In recognition of importance of WRP delivery, Professor Thomas requested that weekly meetings were arranged with the chairs of the Finance and Performance Committee (FPC) and Audit and Risk Committee (ARC), along with relevant executives to receive updates on the progress being made and to provide strengthened oversight.

ACTION: Weekly oversight meetings will be arranged for Professor Thomas with the chairs of the FPC and ARC and relevant executive colleagues until financial year end with a focus on oversight of risks and assurance of mitigating actions.
WHO: Executive Manager
WHEN: January 2026

Directors were advised that updates made to divisional WRP plans and cross cutting savings schemes had been reviewed with executive teams and the Trust's Project Management Office (PMO), with a further review scheduled through the Financial Improvement Group (FIG).

Directors went on to discuss the likelihood of achieving the full-year target and noted that although system partners recognised operational pressures, the Trust would ultimately be held to its agreed plan. It was acknowledged that any financial shortfall would carry forward into the next financial year. It was also noted that little to no assurance had been provided at the December meeting of the FPC regarding the WRP mitigations being developed, and that a further update had been requested for the next meeting at the end of the month.
The board expressed thanks to all staff involved in preparing and managing both current and forthcoming financial plans.
Directors noted the financial report.

TB/2025/010 INTEGRATED PERFORMANCE REPORT (IPR)
Directors were referred to the previously circulated IPR and noted that operational pressures continued to be significant.

a) Safe
Directors were informed that the Trust's Venous Thromboembolysm (VTE) position had continued to improve, with only a 3% gap remaining to achieving the required target.

No significant concerns were raised within the Infection Prevention and Control (IPC) section of the report, although it was noted that work was ongoing to enhance IPC training and review the function across the Trust.

b) Caring
Directors were referred to the safe section of the report and were advised that three wards had breached safe staffing standards in December. It was confirmed that twice-daily safety meetings continued to monitor workforce levels, supported by strengthened benchmarking

across the organisation. Assurances were provided that staffing establishments were appropriate for the Trust's current case-mix of patients.

c) Effective

The board noted that mortality indicators had improved and that the Trust's Summary Hospital-level Mortality Indicator (SHMI) performance had continued to reduce. It was highlighted that further analysis had showed that outcomes in sepsis, fractured neck of femur and stroke had either improved or remained stable and below national averages.

d) Responsive

Directors received a summary of the Trust's most recently updated performance figures, it was noted that key performance standards for December had remained on or ahead of trajectory.

- Cancer performance for November exceeded the revised trajectory, with the Faster Diagnosis Standard achieved.
- The 62-day cancer standard also remained above trajectory.
- The Trust achieved the national requirement of no patients waiting 65 weeks by 21 December.
- Overall waiting lists continued to fall, reducing to 52,680 against a trajectory of 53,683, representing a significant improvement from the previous year.
- Referral to Treatment (RTT) performance at the end of December was 62.4%, slightly ahead of trajectory, with ambitions to reach 65% by the end of March 2026.
- A&E four-hour performance was ahead of trajectory, although it was noted that 12-hour performance required further improvement.
- Ambulance turnaround times continued to perform better than both the regional average and the Trust's performance in previous years.

e) Well-led

The board received an update on appraisal compliance. It was highlighted that historically the Trust had not achieved the 90% target, with work underway to introduce new approaches and further assurance to be provided through the internal audit plan for 2026-27. Directors were advised that following recent organisational changes, the opportunity was being taken to review approaches to supervision and appraisals. Improvements in resuscitation training compliance were noted, with further detail scheduled for discussion at the next meeting of the People and Culture Committee (PCC).

Responding to queries raised regarding the data provided around the number of falls occurring in the organisation, it was confirmed that this remained within normal variation, with the Harm Free Care Directorate implementing interventions as and when required.

Addressing a further query raised around VTE assessment rates and whether any data was available to indicate whether ensuing treatments were successful, it was confirmed that a request had already been made to colleagues to include additional information around correct prescription treatment and outcomes in future reports.

In response to a request for clarification regarding the timeline of the external review by the Advancing Quality Alliance (AQuA) into the Trust's mortality figures, it was explained that this had been delayed at the behest of NHSE colleagues to facilitate the inclusion of additional datasets, and that the initial outcomes were expected to be produced in April 2026. It was confirmed that these would be presented to the Quality Committee (QC) for consideration.
ACTION: The outcomes of the AQuA review into the Trust's mortality performance will be presented to the Quality Committee at its meeting in April 2026.
WHO: Executive Medical Director.
WHEN: April 2026.

It was also requested that an update was provided to the QC around new coding arrangements once they had been given sufficient time to be embedded, who will in turn provide assurance to the Board.
ACTION: An update will be provided to the Quality Committee on new coding arrangements.
WHO: Executive Medical Director.
WHEN: October 2026.

Directors were informed that there had been a significant rise in the volume of incidents being escalated to the Trust's Freedom to Speak Up (FTSU) service and that associated mandatory training compliance levels remained relatively low. It was requested that consideration was given as to how this could be addressed with an update to People & Culture Committee.
ACTION: People & Culture Committee to receive a report as to how low FTSU mandatory training figures can be addressed.
WHO: Interim Chief People Officer.
WHEN: March 2026.

A query was raised regarding indicators that were inconsistently achieving their targets. It was explained that executive leads were expected to review their respective indicators regularly, and that this was the first year of the revised reporting format, with some colleagues still familiarising themselves with the approach. The expectation remained that clear action plans should be in place where performance was not meeting target, and that subcommittees examined any areas of concern as appropriate. Following further discussion, it was agreed that if performance in specific areas had been inconsistent for an extended period, this should be clearly reflected in subcommittee reporting. It was further agreed for this issue to be addressed at the next cycle of committee meetings.

ACTION: Action plans to address areas of ongoing inconsistent operational performance will be provided to the board committees.
WHO: Chief Operating Officer.
WHEN: March 2026.

Directors were informed that further work was being undertaken to strengthen performance scorecards, ensure alignment with the IPR, and improve links with the Board Assurance Framework (BAF). It was confirmed that a review of committee effectiveness was scheduled for year end and would feed into this work.

In response to a question raised regarding whether the nursing red-flag indicators were reported to the QC it was confirmed that these were submitted on a monthly basis, alongside safe staffing reports. It was also confirmed that performance relating to bed occupancy was reported on a regular basis to both the FPC and QC.

Directors went on to discuss the indicators that did not have defined targets and clarification was provided that these were monitored for trend analysis where no national standard existed. It was requested that clearer presentation of such indicators was provided in future reports, including whether alternative baselines could be applied. Improvements were also suggested regarding labelling and categorisation to ensure transparency.

ACTION: Future iterations of the IPR will be revised to more clearly indicate which performance metrics do not have a national baseline figure.
WHO: Chief Operating Officer.
WHEN: February 2026.

Directors confirmed that they were content to accept the IPR. It was agreed that relevant financial metrics had been considered and discussed in sufficient detail earlier in the meeting.

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

TB/2026/011 EAST LANCASHIRE HOSPITALS NHS TRUST IMPROVEMENT PLAN

The Board received an update on the East Lancashire Improvement Plan, which outlined progress against the Trust's legal undertakings and associated exit criteria. It was highlighted that:

- Criterion 3 remained closely aligned to planning submissions and reflected the Trust's position at the point of submission.
- Revised dates had been requested for Criteria 1 and 3 to ensure alignment with commissioning intentions and the national planning timetable.
- A detailed review of planning arrangements linked to Criterion 3 had recently taken place at the most recent meeting of the Improvement and Assurance Group (IAG).
- Good progress had been made across Criteria 3, 4 and 5.

The Board was advised of key next steps, including a transition to a single, consolidated Improvement Plan and ensuring that the Improvement Plan remained closely aligned to the organisation's forward strategy and accurately reflected the requirements stemming from this. **Directors received the report and noted its contents.**

TB/2026/012 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson and Mr Maher joined the meeting for this item.

The Board received an update on maternity and neonatal services. The report had been circulated in advance and was taken as read.

It was noted that induction-of-labour rate had significantly reduced compared with the 24-month average, which was attributed to targeted improvement work. Directors were advised that third and fourth-degree perineal tear rates had also returned to normal levels following sustained improvement work. It was reported that elective caesarean-section rates had not reduced but work continued to ensure procedures took place at the clinically appropriate time. It was also confirmed that the new national Submit a Perinatal Event Notification (SPEN) system was in operation would feed into the National Early Warning Score (NEWS2) system. Directors noted that a report detailing a five-year perinatal mortality review had recently been considered by the Quality Committee, following concerns raised in previous neonatal mortality analysis and had provided a good level of assurance.

The board was informed that a quality assurance visit by the Local Maternity and Neonatal System (LMNS) had taken place the previous day and that all ten safety actions associated with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year Seven had been formally signed off. It was agreed that a note from the board to pass on formal congratulations would be passed to the teams involved outside the meeting.

ACTION: The formal thanks of the board will be passed onto maternity and neonatal colleagues for their efforts in successfully meeting the requirements for all CNST MIS safety actions for Year Seven.

WHO: Interim Director of Corporate Governance.

WHEN: March 2026.

The following progress on Safety Actions 4, 5 and 9 was highlighted:

Safety Action 4 – It was confirmed that the Trust's neonatal unit did meet the British Association of Perinatal Medicine (BAPM) requirements for medical staffing' as per the report provided within the September 2025 trust board update and in the report provided at the current meeting. Directors were reminded the neonatal unit did not currently meet BAPM requirements for neonatal nurse staffing as per the reports provided at the November 2025 meeting of the trust board report and the current report and that work was underway to ensure that this target would be reached. It was highlighted that an action plan had also been provided in November 2025 report, which was also provided to LMNS and the North West Operational Delivery Network (ODN) to demonstrate compliance against the relevant CNST asks.

Safety Action 5 – It was confirmed that the Q3+Q4 bi-annual midwifery staffing report would be presented at the March meeting of the board. It was noted that this would fall outside of the CNST reporting year as was anticipated.

Safety Action 9 – Directors were referred to the details in the report regarding the progress made progress against the Maternity and Neonatal Culture Improvement Plan. The board's support of this plan was acknowledged.

An update was provided on the development of a maternity and neonatal shadow board to strengthen service user involvement, and it was confirmed that the associated terms of reference (TOR) were currently being drafted. Diversity and inclusivity were identified as core principles, which was intended to result in better representation.

In response to queries raised around the rate of recorded stillbirths in the Trust, it was explained that numbers had remained consistent year-on-year, with national trends also

suggesting stabilisation. It was noted that there generally higher rates of congenital abnormalities locally and that, if these cases were excluded, the Trust's stillbirth rate demonstrated a clear downward trend. It was suggested that presentation of the data within the Integrated Performance Report would benefit from additional narrative in future iterations.

A question was raised regarding neonatal mortality, and it was reiterated that the report presented at the most recent meeting of the Quality Committee had provided good assurance around this area. Responding to further concerns raised about the operational impact of elective caesarean section activity on theatre capacity, it was confirmed that the associated risks had been clearly captured on the Trust's Corporate Risk Register (CRR). Directors were advised that a temporary solution was in place until mid-month and that a longer-term solution was currently being finalised. It was noted that theatre lifecycle works would have an impact on this and that the associated costs were being actively worked through. Further updates were expected at upcoming sub-committees.

ACTION: An update on the operational impact of caesarean section activity on theatre capacity will be provided at the next meetings of the FPC and QC.
WHO: Chief Operating Officer.
WHEN: February 2026.

Addressing a query raised regarding ethnic differences observed in third and fourth-degree tear rates, it was noted that national data indicated a higher baseline risk in certain ethnic groups and that the Trust was incorporating this into its prevention work, including translation projects to improve informed decision-making.

The maternity and neonatal teams were recognised as exemplars of effective multidisciplinary working and culture, with the processes implemented following the merger of both teams enabling responsive decision-making and effective transformation work. These were highlighted as potential models for wider organisational learning going forward.

Members went on to discuss how lessons learned from the top five injury categories were disseminated to clinical teams. It was reported that claims, complaints, and incident data were triangulated biannually and cascaded through governance structures. It was acknowledged that transparency in sharing learning from claims could be improved.

Directors confirmed that they were content to receive and endorse the report and were assured by the activity taking place to deliver safe, personal, and effective care in the Trust's maternity and neonatal services.

TB/2026/013 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

The board received the PSIRA Report, which had been circulated in advance, and agreed to take it as read. It was noted that the report provided a good level of assurance regarding the management of patient safety incidents across the Trust.

It was reported that two Never Events had occurred, both of which related to checklist processes. It was confirmed that a review of all applicable alerts had been undertaken to identify any that could lead to further Never Events, and that broad organisational learning was in progress and relevant actions being implemented. Directors were advised that there had also been two breaches of the Trust's duty of candour policy and that changes had already been implemented to ensure that these issues did not recur. All harm levels were reported as remaining below national averages. It was highlighted that a new Standard Operating Procedure (SOP) for the management of patient safety incidents had been introduced, received into the Trust and was now being progressed through the appropriate governance routes.

Directors received and noted the report.

TB/2026/014 CORPORATE RISK REGISTER REPORT

Directors noted that the CRR report had been withdrawn prior to the meeting due to inaccuracies with specific risk ratings.

TB/2026/015 BOARD ASSURANCE FRAMEWORK (BAF)

The board received an update on the BAF. It was confirmed that all Board committees had reviewed the BAF and that work continued to align its risks to the delivery of the Trust's strategies. Directors were advised that future iterations of the BAF would be presented in a new format, recently approved by the ARC, which was intended to improve clarity, particularly in identifying any assurance gaps.

Directors went on to discuss whether current risk scores and associated mitigating actions provided sufficient assurance. It was noted that the executive team reviewed BAF risks closely and considered the current scores to be an accurate reflection of the position, although it was acknowledged that risk scores had not changed despite the frequent addition of additional actions, raising questions around their ultimate effectiveness. It was requested that an

exercise was undertaken to review any actions taken and how these had impacted on BAF risk scores at the meeting of the board in April 2026.

ACTION: A full review of the BAF risks, including actions and their effectiveness, will take place at the board strategy session taking place in April 2026.

WHO: Interim Director of Corporate Governance

WHEN: April 2026.

It was pointed out that BAF risks were complex and strategic, and therefore significant score movement was not always expected, but it was recognised that it was appropriate for the board to reflect on whether its attention continued to be focused on the most appropriate areas.

Directors received and noted the BAF.

TB/2026/016 EDUCATION RESEARCH AND INNOVATION COMMITTEE TERMS OF REFERENCE

The draft TOR for the Education, Research and Innovation Committee were presented for approval.

Responding to a query raised regarding the proposed membership of the Committee, specifically the inclusion of three Non-Executive Directors, it was explained that the structure reflected established governance practice, recognising the authority of the board. It was also pointed out that committees seldom exercised formal voting procedures in practice and that any changes to membership would need to be applied consistently across all board sub-committees.

In response to a further query raised as to whether the committee represented a long-term priority for the organisation, it was confirmed that such a committee was common within NHS trusts and not be required to meet as frequently as other sub-committees. It was also noted that education-related matters were currently receiving limited attention through existing committee structures, prompting the development of a new forum to give these areas greater consideration

Directors approved the establishment of Education, Research and Innovation Committee and approved the draft TOR provided.

TB/2026/017 RISK MANAGEMENT STRATEGY

Directors noted that the Trust's revised Risk Management Strategy had been presented, and approved, at the most recent meeting of the ARC.

Directors confirmed that they were content to endorse the Trust's Risk Management Strategy.

TB/2026/018 TRIPLE A REPORTS FROM QUALITY COMMITTEE

The reports were presented to the board for information. There were no specific items escalated for discussion.

Directors noted the report.

TB/2026/019 TRIPLE A REPORTS FROM FINANCE AND PERFORMANCE COMMITTEE

The reports were presented to the board for information. There were no specific items escalated for discussion.

Directors noted the report.

TB/2026/020 TRIPLE A REPORTS FROM PEOPLE AND CULTURE COMMITTEE

The reports were presented to the board for information. It was highlighted that a staff story had been presented at the most recent meeting of the Committee from two Trust colleagues that had detailed their experiences of racism in the organisation. Directors noted that separate report had also outlined the impact to the Trust and the wider care sector following the introduction of the Immigration Act.

It was suggested that the staff story referred to should be circulated to the rest of the board to raise awareness of the issues raised.

ACTION: The staff story presented at the December meeting of the PCC will be circulated to the board after the meeting.

WHO: Interim Director of Corporate Governance.

WHEN: January 2026.

Directors noted the report.

TB/2026/021 TRIPLE A REPORT FROM AUDIT AND RISK COMMITTEE

The report was presented to the board for information. Directors were informed that while there had been clear recognition of the work done to improve the Trust's Head of Internal Audit

Opinion rating at the most recent meeting of the Committee, serious concerns had also been raised how far off trajectory the organisation remained. It was noted that the next meeting had been moved to a later date in January to provide internal audit colleagues with more time to complete the work required.

Directors noted the report.

TB/2026/022 TRIPLE A REPORT FROM TRUST CHARITABLE FUNDS COMMITTEE

The report was presented to the board for information. It was noted that the ELHT&ME annual accounts and annual report would be considered by the board, meeting as a trustee, later in the day for formal sign-off and approval.

Directors noted the report.

TB/2026/024 MESSAGE FROM THE BOARD

The board reflected on the importance of the agenda items discussed reflecting the quadruple aims of the organisation: maintaining quality, operational performance, workforce issues and finances. It was agreed that the discussions held had reflected each of these areas appropriately and the thanks of the board was also extended to colleagues in the Trust for their continuing efforts in managing them.

TB/2026/025 ANY OTHER BUSINESS

There were no matters of other business.

TB/2026/026 DATE AND TIME OF NEXT MEETING

Wednesday, 11 March 2026 at 09:30, Trust HQ Boardroom.

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.	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~~ April 2026	G	The trust has met with the GIRFT litigation team and have had subsequent discussions with the Trust solicitors. A review of all cases is currently being undertaken with them for maternity, and neonates as well as for the last two years of other claims to make ensure the Trust is not an outlier and that any themes and learning are understood and implemented. The outcomes of this review will be presented to the Quality Committee at its meeting in April 2026.
2.	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	April 2026	G	An external review of coding and mortality is underway with a view to being able to use electronic systems to improve compliance with care bundles. The Trust's internal business intelligence team are

							developing a patient safety and patient flow dashboard to compliment this work.
3.	January 2025	TB/2026/007: Chair's Report	The Chief Operating Officer was asked to inform the Company Secretary when the Trust is out of OPEL 4, who would in turn inform the Non-Executive Directors.	Chief Operating Officer/ Company Secretary	March 2026	**B**	Complete: Email sent to NEDs informing them that the Trust had exited OPEL 4.
4.	January 2026	TB/2026/009: Financial Performance Report – Month 8	Weekly oversight meetings will be arranged for the chair with the chairs of the FPC and ARC and relevant executive colleagues for the next 10 weeks to focus on oversight of the risks and assurance of mitigating actions.	Executive Manager	January 2026	**R**	Meetings are being arranged with the relevant committee Chairs.
5.	January 2026	TB/2025/010: Integrated Performance Report (IPR)	The outcomes of the AQuA review into the Trust's mortality performance will be presented to the Quality Committee at its meeting in April 2026.	Executive Medical Director.	April 2026	**G**	This action will be addressed as part of action 2 above.
6.	January 2026	TB/2025/010: Integrated Performance Report (IPR)	An update on the new coding arrangements to be provided to the Quality Committee who will then provide assurance to the Board.	Executive Medical Director.	October 2026	**G**	Not yet due.
7.	January 2026	TB/2025/010: Integrated Performance Report (IPR)	People & Culture Committee to receive a report as to how low FTSU mandatory training figures can be addressed, with an update to People & Culture Committee.	Interim Chief People Officer.	~~March 2026~~ April / May 2026	**A**	All mandatory training is currently being reviewed in terms of requirements eligibility and how this is recorded. An update on this, including Freedom to Speak Up mandatory training will be provided as part of the next general Freedom to Speak Up report provided to the People and Culture Committee and to the board.

8.	January 2026	TB/2025/010: Integrated Performance Report (IPR)	Action plans to address areas of ongoing inconsistent operational performance will be provided to the board committees.	Chief Operating Officer.	March 2026	**B**	Updates on any areas of inconsistent performance will continue to be reported through meetings of the board sub-committees as required.
9.	January 2026	TB/2025/010: Integrated Performance Report (IPR)	Future iterations of the IPR will be revised to more clearly indicate which performance metrics do not have a national baseline figure.	Chief Operating Officer.	March 2026	**A**	This work is in progress and is expected to be implemented in IPRs from May onwards.
10.	January 2026	TB/2026/012: Maternity and Neonatal Services Update	The formal thanks of the board will be passed onto maternity and neonatal colleagues for their efforts in successfully meeting the requirements for all CNST MIS safety actions for Year Seven.	Interim Director of Corporate Governance.	March 2026	**B**	Complete. Letter from the Chair sent to maternity and neonatal depts.
11.	January 2026	TB/2026/012: Maternity and Neonatal Services Update	An update on the operational impact of caesarean section activity on theatre capacity will be provided at the next meetings of the FPC and QC	Chief Operating Officer.	February 2026	**B**	Complete.
12.	January 2026	TB/2026/015: Board Assurance Framework (BAF)	A full review of the BAF risks, including actions and their effectiveness, will take place at the board strategy session taking place in April 2026.	Interim Director of Corporate Governance	April 2026	**G**	Not yet due.
13.	January 2026	TB/2026/020: Triple A Reports from People and Culture Committee	The staff story presented at the December meeting of the PCC will be circulated to the board after the meeting.	Interim Director of Corporate Governance.	March 2026	**B**	Complete.

TRUST BOARD REPORT

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/032
Report Title:	Reaffirming the purpose of the patient story at Board		
Author:	Susan Giles, Interim Director for Corporate Governance		
Lead Director:	Pete Murphy, Chief Nurse		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
				✓
Executive Summary:	The purpose of this paper is to reaffirm for the Board the rationale and intent behind the presentation of patient stories at the start of Board meetings.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board is asked to note: • that all patient stories presented at Board have already been considered by the patient experience team ensuring dissemination of any learning; and • the purpose of the patient story is not to discuss an individual case but to remind the Board of its purpose, to triangulate soft intelligence with hard data and to remind the Board that the patient is at the heart of all Board decisions.			

Previously Considered by:	
Date:	
Outcome:	

Purpose of Patient Stories at Board

1. Purpose

The purpose of this paper is to reaffirm for the Board the rationale and intent behind the presentation of patient stories at the start of Board meetings.

As an established practice, there is a risk that patient stories could become routine. Reaffirming their purpose helps ensure they continue to be used to triangulate intelligence and prompt reflection rather than passive listening.

2. Context

The Board operates within a complex environment of performance oversight, financial stewardship, workforce challenges and regulatory compliance. While these responsibilities are essential, they can risk becoming detached from the lived experience of patients and families.

Patient stories are therefore a deliberate governance tool designed to:

- Bring the patient voice directly into the Boardroom;
- Ground the Board in its core purpose from the very beginning of the agenda; and
- Reinforce that every decision must be patient-centred.

The *Insightful Board* highlights the importance of Boards drawing on both “hard” data and “soft intelligence” to gain a rounded understanding of organisational performance and culture. Patient stories are a key component of this soft intelligence.

It is important to emphasise that patient stories presented to the Board are not brought for case review or operational discussion.

All patient stories presented at Board will have already been reviewed via patient experience and quality governance routes to ensure learning points are discussed, where appropriate actions identified, and learning disseminated across the Trust.

By the time a story is shared at Board, the purpose is strategic reflection on system-level themes and cultural insight.

3. Hearing the Patient Voice

Quantitative performance data cannot fully capture how care feels to receive.

Patient stories highlight lived experience particularly in relation to compassion, dignity and communication, and can reveal unintended consequences of systems and processes

The Care Quality Commission emphasises that well-led organisations actively seek out and respond to the experiences of people using services. The NHS England Well-Led Framework similarly expects Boards to demonstrate how patient insight informs improvement and culture. Patient stories are one mechanism for Board’s to hear the patient voice.

4. Grounding the Board

Board discussions often focus on strategy, risk, performance trajectories and financial sustainability. These are necessary and appropriate areas of oversight.

Beginning each Board meeting with a patient story serves to:

- Anchor discussions in real-world impact;
- Provide a human context for performance data;
- Encourage reflective, compassionate leadership; and
- Reinforce collective accountability for quality of care

It is a visible reminder that behind every metric is a patient, and behind every decision is a potential impact on a patient or family.

5. Supporting Patient-Centred Decision-Making

The Board's statutory responsibility includes ensuring the delivery of safe, effective and person-centred care.

Patient stories help to reinforce that:

- Quality is not solely the absence of harm but the presence of dignity, compassion and good communication;
- Strategic decisions must consider patient experience alongside finance and performance; and
- Cultural tone is set at Board level.

They support the Board in maintaining a clear line of sight between governance and the patient experience.

6. Conclusion

The Board is asked to note:

- that all patient stories presented at Board have already been considered by the patient experience team ensuring dissemination of any learning; and
- the purpose of the patient story is not to discuss an individual case but to remind the Board of its purpose, to triangulate soft intelligence with hard data and to remind the Board that the patient is at the heart of all Board decisions.

TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/033
Report Title:	Chair's Report		
Author:	Professor Mike Thomas, Chair		
Lead Director:	Professor Mike Thomas, 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 since the last Board meeting.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to: • Note the appointment of new Non-Executive Directors; • Note the appointment of Amin Kamaluddin as a second Vice-Chair; • Approve the appointment of Simon Featherstone as Senior Independent Director; • Note the proposed changes in chairing and NED membership of Board Committees; and • Note the division of responsibilities between the Chair and CEO.			

Previously Considered by:	
Date:	
Outcome:	

Chair's Report

Changes to Board

On behalf of the Board I would like to thank Khalil Rehman, whose term came to an end 7th February, for his contributions during his time with the Trust. I'm sure Board colleagues will join me in wishing Khalil all the best for the future.

The Chief Executive will report on the impending retirement of Sam Simpson, Director of Finance and plans to appoint Sam's successor. However, I would also like to take the opportunity to thank Sam for her years of long service to the NHS and more latterly to the Trust. I wish Sam all the best in her retirement.

I'm delighted to welcome three Non-Executive Directors to the Board. Professor Andrew Ireland is our University appointed Non-Executive Director from University of Central Lancashire. He is joined by Miriat Naiga and Amin Kamaluddin. All three NEDs bring a wealth of experience and enthusiasm with the. Their appointments strengthen the Board skill set particularly in the areas of financial governance, digital transformation and our close working relationship with the university. No doubt colleagues will join me in welcoming them to the Board.

Our Board Development programme, which had been paused to allow for changes to the Non-Executive Directors, will now recommence on 8th April and provide an opportunity to get to know our new NED colleagues better.

Vice-Chair arrangements

Following the departure of Mr Rehman from the Trust, I have reviewed the Vice-Chair arrangements. Sallie Bridgen will be remaining as Vice-Chair and will take a lead portfolio role with an internal focus. I am also appointing Amin Kamaluddin as second Vice-Chair. Amin will take a lead portfolio role with an external focus. For clarity Sallie would act as Chair in my absence. The role description for Vice-Chair is appended to this paper (Appendix 1).

Senior Independent Director

The Board needs to appoint a new Senior Independent Director (SID). I would like to propose the appointment of Simon Featherstone as SID. The role of SID is not a requirement for NHS Trusts but is in line with best practice. The role description for SID is appended to this report for information (Appendix 2).

Changes to Committees/Lead NED roles

Considering the changes in Non-Executive Directors and in line with the principles of good governance, the Company Secretary and I have reviewed the skill set of the NEDs against the remit of each Board Committee. This has resulted in a number of proposed changes which I have appended to this paper (Appendix 3).

In addition, Simon Featherstone will be NED lead for Maternity to sit alongside his role as Chair of Quality Committee and Sallie Bridgen will be NED lead for Freedom to Speak Up to sit alongside her role as Chair of People & Culture Committee. There will only be lead NED roles where required by legislation or regulation all other lead NED roles will cease.

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

Medium Term Planning
The Trust submitted its second draft of the Medium-Term Plan (MTP) on 11th February 2026. The Chief Executive and I, together with members of the Executive Team, attended an MTP meeting with NHSE Region on 27th February 2026 and received excellent feedback. On behalf of the Board, I want to extend my sincere thanks to every member of staff involved in the submission. I recognise a significant amount of work went into pulling the plan together.

Use of Emergency Powers and Urgent Decisions
The Trust Standing Orders make provision for matter usually reserved to the Board to be to be approved by the Chair and Chief Executive, having consulted with two Non-Executive Directors, in the event of an emergency or when an urgent decision is required. The exercising of such powers must be reported at the next formal public meeting of the Board for formal ratification.

The Board is asked to ratify the following uses of this provision:

- 4th February 2026 – Cash application to NHS England (approved following consultation with Liz Sedgley, Simon Featherstone and Khalil Rehman)
- 25th February 2026 - Entering a new contract for provision of utilities with Water Plus (approved following consultation with Liz Sedgley, Simon Featherstone, Andrew Ireland and Sallie Bridgen)

Meetings attended during December

- Improvement & Assurance Group meetings held in February 2025 and March 2026
- Chaired Lancashire & South Cumbria Provider Collaborative Board
- Chaired Extraordinary Board meetings held on 5th and 11th February 2026.
- Board Strategy Session February 2026

Appendix 1

Role of the Vice Chair

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

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

Qualifying Criteria:

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

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

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

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

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

Key Duties:

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

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

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

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

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

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

Appendix 2

Role of the Senior Independent Director

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

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

Qualifying Criteria:

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

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

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

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

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

Key Duties:

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

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

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

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

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

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

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

Appendix 3

Board Committee Chair and Non-Executive Director Membership

Committee membership from 1st April 2026

	Chair	Members
Audit Committee (5 times per year)	Liz Sedgley	(All Committee Chairs) Sallie Bridgen Simon Featherstone Amin Kamaluddin Miriat Naiga
Remuneration Committee (at least twice a year)	Sallie Bridgen	All NEDs
Quality Committee (monthly)	Simon Featherstone	Sallie Bridgen Catherine Randall Shahedal Bari
Finance & Performance Committee (monthly)	Amin Kamaluddin	Liz Sedgley Simon Featherstone
People & Culture Committee (bi-monthly from April 2026)	Sallie Bridgen	Amin Kamaluddin Liz Sedgley
Education, Research & Innovation Committee (bi-monthly from May 2026)	Sallie Bridgen	Miriat Naiga Andrew Ireland
Data, Digital & Technology Committee (bi-monthly)	Miriat Naiga	Shahedal Bari Andrew Ireland
Charitable Funds Committee (quarterly)	Andrew Ireland	Amin Kamaluddin Catherine Randall

Appendix 4

Division of Responsibilities between the Chair and Chief Executive

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

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

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

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

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

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

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

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

Mike Thomas	**Martin Hodgson**
Chair	**Chief Executive**
Date:	**Date:**

Annex 1

Division of responsibilities

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

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

TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/034
Report Title:	Chief Executive's Report		
Author:	Shelley Wright, Executive Director of Communications Sam Thomas, Head of Communications Sally Davies, Communications Specialist		
Lead Director:	Martin Hodgson, Chief Executive		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	This report provides national, regional and Trust-specific updates across the NHS and wider health and social care system which are material to the delivery of organisational aims and the provision of safe, personal and effective care to patients. It includes information about ongoing 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 Board:	The Board is asked to note the contents of the report.			

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

National cancer plan published

A new National Cancer Plan for England has been published by the Department of Health and Social Care and NHS England, setting out a decade-long programme to improve cancer outcomes.

The plan was released on 4 February 2026 with the aim to make England a global leader in cancer care. The strategy establishes a core ambition: that 75% of people diagnosed with cancer will survive for at least five years by 2035, a target backed by widespread changes across prevention, diagnosis, treatment and research.

It also sets several interim milestones, including meeting all cancer waiting time targets by 2029 and rolling out national lung screening by 2030.

Key elements of the plan include:

- A drive to speed up diagnosis
- Growth planned in robotic surgery, advanced radiotherapy, and new technologies
- Prevention measures including tougher smoking and vaping regulations, food-health targets and enhancements to major screening programmes
- Digital transformation, including a unified cancer patient record accessible via the NHS app
- Research investment targeted at early detection, personalised treatments, paediatric and rare cancers, and next-generation diagnostic technologies.

The plan sets out a long-term, system-wide transformation programme designed to redefine cancer care over the next decade.

£200 million for local cancer care to reduce screening inequalities

A new £200 million Neighbourhood Early Diagnosis Fund has been announced to help reduce cancer screening inequalities in deprived and underserved areas. Over the next three years, local health services will work with communities to increase screening uptake and support earlier diagnosis.

The investment forms part of the National Cancer Plan, which aims to improve cancer survival and address longstanding gaps between different parts of the country. Earlier diagnosis remains key, with progress in survival having slowed over the last decade.

The scheme is expected to help tackle postcode variation by ensuring more patients receive timely checks and potentially life-saving treatment sooner.

Women attending first NHS mammogram hits 10-year high

Hundreds of thousands more women attended NHS breast screening last year and thousands more cancers were diagnosed early in England.

In 2024/25, 1.94 million women aged 50 to 70 attended screening within six months of invitation – up nearly 200,000 (193,745) from 1.75 million the previous year.

As a result, nearly 20,000 cancers (19,291) were detected – 9 cases in every 1,000 women screened – which is up almost 16% on the previous year, when 16,677 cancers were diagnosed through NHS breast screening.

This means thousands more women were able to access treatment earlier, when there are more options available and treatment is more likely to be effective.

AI and robotic pilot to spot lung cancer sooner

A pilot has been launched using AI and robotic technology to help detect lung cancer earlier with fewer invasive tests. AI software rapidly analyses scans to identify nodules most likely to be cancerous, and a robotic camera then guides biopsy tools with greater precision.

The pilot sits alongside plans to expand lung cancer screening so all eligible people are invited for checks within five years, supporting efforts to reduce inequalities in cancer outcomes.

Robotic bronchoscopy can reach nodules as small as 6mm and enables quicker, more accurate biopsies. For many patients, this could replace weeks of repeat scans with a single half-hour procedure.

More than 1.5 million people have attended an NHS lung health check since 2021, identifying cancers at earlier stages. Screening expansion will see 1.4 million invitations next year, with the programme expected to diagnose up to 50,000 cancers by 2035.

Waiting lists falling to lowest on recent records

The NHS delivered more elective activity in 2025 than any other year in its history, helping cut the waiting list to its lowest level since February 2023.

Over 18.4 million treatments and operations were delivered in 2025, up from 18 million in 2024, as the waiting list dropped to 7.29 million.

Latest data shows there were 1.43 million treatments delivered in December – an increase of 91,775 on last year.

Specialist teams deployed through the Further Faster 20 (FF20) programme helped cut backlogs and increase activity in trusts serving communities with high levels of economic inactivity, including ELHT. Thousands of patients have already benefitted, with learning from the programme expected to be shared more widely across the NHS.

The progress came despite the NHS's busiest ever year, with 27.8 million A&E attendances in 2025 – up by over 367,000 on 2024, with 2.33 million attendances in December alone.

Life-saving Jess's Rule to be advertised in every GP surgery

Jess's Rule is being rolled out to all 6,170 GP practices in England as part of a national patient safety initiative.

Jess's Rule prompts GPs to take a "fresh eyes" approach if, after three appointments, they have not been able to provide a substantiated diagnosis or if symptoms have escalated. The initiative, introduced in 2025 and named in memory of Jessica Brady, supports earlier identification of serious illness.

The campaign follows years of work by Jessica's parents to improve patient safety and reduce preventable harm. Displaying the posters in consultation rooms is expected to reinforce clinical vigilance and help avoid missed warning signs.

AI notetaking to free up more face-to-face care

The NHS is supporting the use of new AI notetaking tools to help clinicians spend more time with patients. A national registry of 19 suppliers has been launched, offering technology that captures clinician–patient conversations and produces real-time clinical summaries while meeting data protection and safety standards.

The tools, known as ambient voice technologies, can save 2–3 minutes per consultation, helping free up additional capacity. The registry follows national guidance encouraging NHS organisations to adopt safe and evidence-based AI notetaking solutions.

NHS Excellence Awards launched

The NHS Excellence Awards 2026 were launched in January to showcase work that is delivering tangible benefits for patients and communities.

Run by and for the NHS, the awards highlight projects that align with the ambitions of the 10-Year Health Plan and are free to enter, with finalists also receiving free tickets to the national ceremony.

There are 10 award categories covering areas such as digital innovation, sustainable healthcare, leadership, quality improvement and partnership working.

It is the first year of a new national programme designed to recognise outstanding innovation and improvement across health and care services. The Trust plans to enter nine categories.

New Bill prioritising UK medical graduates for NHS training

The government has introduced new legislation designed to prioritise UK medical graduates for foundation training places, and to prioritise UK medical graduates and other doctors with significant NHS experience for specialty training places, as part of efforts to strengthen the domestic medical workforce.

The Medical Training (Prioritisation) Bill was formally set out in the House of Commons on 27 January 2026, outlining changes that will affect training recruitment from the 2026 intake onwards.

NHS England has highlighted that prioritisation will help reduce the use of “placeholder” offers in the Foundation Programme and ease pressure on specialty training recruitment, where applicant numbers have almost tripled in recent years.

The Medical Training (Prioritisation) Bill must go through the full parliamentary process before it becomes an Act.

New pay deal for Agenda for Change colleagues

The government has confirmed a 3.3% consolidated pay rise for all NHS colleagues on Agenda for Change contracts for 2026/27, following the full acceptance of Pay Review Body recommendations. It applies to more than 1.4 million staff across the country.

Alongside the increase, the Department of Health and Social Care will begin discussions with unions and employers on structural reforms to the pay system. These include raising pay for lower bands and improving graduate-level salaries, with some additional increases to be backdated to 1 April 2026 once agreed.

Separate work is also planned to review Band 5 nursing roles, supported by additional funding, as part of wider efforts to ensure roles are aligned correctly within the job evaluation framework.

BMA ballot

Resident doctors in England have voted in favour of continuing industrial action. This means further strikes could take place over the next six months. It multiple previous ballots and continues a national dispute over pay levels and the availability of training posts.

3. **Regional Updates**

Pathology single service update

Work is progressing on the creation of a single, unified pathology service for Lancashire and South Cumbria, bringing together laboratory services from four acute NHS trusts into one coordinated network.

A formal consultation process is currently taking place as the system prepares to bring staff and services together from April 2026.

Under plans being progressed, Lancashire Teaching Hospitals would become the host organisation for the new Lancashire and South Cumbria Pathology Service, operating under a Lead Provider model.

In preparation for the transition, roadshows have been held with pathology teams across the partner trusts, offering staff the opportunity to hear about the forthcoming changes, ask questions, and understand what the move to a single service will mean for them.

Launch of 24/7 thrombectomy service for Lancashire and South Cumbria

A round-the-clock mechanical thrombectomy service has now gone live for patients across Lancashire and South Cumbria, marking a major milestone in regional stroke care.

The service began operating from Monday 2 February 2026 at Lancashire Teaching Hospitals, who are commissioned to provide this treatment for the entire region. The service previously ran between 8am and 10pm, seven days a week.

Thrombectomy is a minimally invasive procedure to remove a blood clot from an artery in the brain, restoring blood flow and reducing stroke-related disability. Timely access to thrombectomy significantly improves patient outcomes, reducing long-term disability and mortality.

Work to increase uptake of cervical screening in Asian community

Pendle West Primary Care Network (PCN) has been working with volunteer group Pendle West Community Health Champions to address the issue of low uptake of cervical screening within the local Asian community.

The number of women who have cervical screening in Lancashire and South Cumbria has been steadily increasing in recent years – although it remains some way short of the national target.

While the ambition is to achieve the benchmark of 80 per cent, some places are well below that figure: uptake in Blackburn with Darwen is 63.1 per cent, and in the Pendle West area particularly, only 52 per cent of 25-50-year-olds (national average is 66 per cent) attend when invited.

However, the reality is even starker when the figures are broken down by ethnicity: national research indicates that only 31 per cent of ethnic minority women attend cervical screenings - the risk of cervical cancer is also higher for Asian women.

The PCN held sessions with Pendle West Community Health Champions, answering questions about the issues and discussing what could be done to address them.

Further development of One LSC

Work continues with all Trusts in the system around One LSC and ensuring it is providing the best value services.

This included the transfer of around 1,000 Estates and Facilities colleagues from Lancashire Teaching Hospitals (LTH) into One LSC on March 1, 2026. One LSC is a shared service run by the NHS for the NHS, bringing together several corporate and operational support teams across five NHS provider trusts in Lancashire and South Cumbria. Bringing teams together is part of a significant shift toward system-level working, reducing duplication and standardising support across all five trusts.

Three East Lancashire health centres to be renovated and reconfigured in 2026

Three health centres in East Lancashire are benefiting from major investment projects during 2026.

Funding from the Department of Health and Social Care, totalling around £8 million, is being utilised to improve and refurbish Barbara Castle Way Health Centre in Blackburn, St Peter's Centre in Burnley, and Acorn Primary Health Care Centre in Accrington.

The investment supports the ambitions of the Government's 10-year Plan for the NHS, to create health centres that provide more services to meet the needs of the local community.

Local elections

Local elections across East Lancashire — including Blackburn with Darwen, Burnley, Hyndburn and Pendle — are set to proceed in May 2026.

These elections had previously been earmarked for cancellation due to the ongoing local government reorganisation (LGR) planned for Lancashire. Councils had raised concerns about capacity and cost during the reorganisation period, prompting initial requests for postponements.

The reinstated election timetable triggers the pre-election period on March 30, during which public sector organisations — including ELHT — must operate under stricter rules designed to maintain political neutrality.

During this period:

- No publicity will be issued that could influence voting or appear to favour any political party or candidate
- No announcements, campaigns, consultations or major service changes will begin that could be seen as politically sensitive

These measures ensure fairness for all candidates and protect public bodies from accusations of political influence during an active democratic process.

Consultation on Local Government Reorganisation in Lancashire

The Government has launched a consultation on proposals for Local Government Reorganisation (LGR) in Lancashire that will help determine the future shape of local government across the county.

This marks the most significant change to local government in Lancashire in over 50 years.

Across Lancashire there are currently 15 councils, including the County Council, two unitary councils and 12 district councils. The Government asked for proposals that would replace these with fewer, unitary authorities, and five different options have now been put forward.

The consultation is open to all residents, businesses, voluntary groups, and local organisations.

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:

- Indemnity letter for Project Agreement between the Trust and Consort relating to the removal of RAAC and reroofing/building works.
- Indemnity letter for Project Agreement between the Trust and Consort relating to theatre lifecycle works.

Changes to the Executive Team

The Trust's Executive Director of Finance (DoF) Sam Simpson will retire from the Trust on April 31, 2026. I'm sure the Board will join me in offering sincere thanks to Sam for her 31 years of dedicated service to the NHS, and for the significant contribution she has made to the Trust during her tenure. Her leadership has been instrumental in strengthening our financial governance, and her work in negotiating the 2026/27 contract with commissioners stands us in good stead as we move into a new financial year. On behalf of the Trust, I wish Sam every happiness in her retirement.

The Remuneration Committee have approved the recruitment and selection process for a new DoF. The recruitment process has commenced, and I expect to be able to appoint to this position by the end of April. Discussions are underway with the NHS England Regional Director of Finance regarding the Interim DoF arrangement and I hope to be able to verbally confirm arrangements to the Board when we meet.

Planning for 2026-27

The Trust submitted a full and compliant plan to NHS England on February 12, 2026. The plan covers our commitments on finance, workforce, activity and performance for the next three years as well as complimentary assurance metrics for North West Ambulance Service's operations. In addition, a full Delivery Plan covering the next five years was included and has been developed in parallel to our new Trust Strategy over the same period. The highlights of this include our current operating environment, key planning assumptions and our approach to delivery of standards.

Positive feedback about the plan was received during an assurance meeting with colleagues from NHS England North West on February 27, 2026, and it is expected that the plan will be formally accepted in March, for implementation on April 1.

National Summit on Corridor Care

The Trust was included in a national event designed to focus on corridor care and provision hosted by NHS England and colleagues from the Corridor Care Coalition on February 16, 2026. A number of colleagues from the Executive Team joined the Chair of the Trust and members of more than 30 other Trusts from a number of regions of England for the seminar.

The group heard about the impact of corridor care on patients and their families, as well as colleagues operating in these environments, and agreed everything possible must be done to reduce the amount of corridor care provided, with a view to eradicating it completely as soon as possible. This is most noticeable in the Emergency Department in Royal Blackburn Teaching Hospital, but in truth the pressure and demand on services also impacts on all wards and community teams.

The Trust has already enacted a multi-professional group as part of an Urgent and Emergency Care Programme which includes a range of workstreams being managed by colleagues from across all divisions and this progress will be reported regularly to Board and NHS England national and regional teams. The team is also working on a 10 Point Plan which can be clearly and succinctly shared as a marker of our intentions to eradicate corridor care and how we will achieve this in a the timeframe agreed.

Winter pressures and the Trust's response

Demand on Trust services continued to rise sharply throughout the winter period, with the Emergency Department at Royal Blackburn Teaching Hospital seeing around 60 additional patients per day compared with the same time last year. This sustained pressure has contributed to crowded waiting areas, longer waits for admission and some patients being cared for in escalation spaces, including the corridors.

As a result, on 12 January, the Trust declared OPEL Level 4, implementing business continuity measures in response to severe site pressures. Thanks to significant collective effort, the Trust de-escalated on 15 January. However, system wide pressures remained extremely high and the Trust escalated again to OPEL Level 4 on 29 January and stepped down on 4 February.

Despite these significant challenges, teams across the Trust have worked tirelessly to maintain safety and improve the experience of patients using services and a wide range of mitigating actions were implemented. These included opening and risk-assessing additional patient spaces, securing extra staffing, community services in-reaching into the department to identify patients they could support from home and pharmacy colleagues supporting the discharge lounge to speed up transfers from ward areas, helping create capacity.

Throughout this period, the Trust has continued to work closely with partner organisations — including local councils, the Integrated Care Board and Age UK — to ensure patients receive the best possible care and support.

Frailty Same Day Emergency Care

A Frailty Same Day Emergency Care (SDEC) service was launched in February to support pressures and improve the experience of older patients arriving at hospital with acute frailty needs.

Previously known as OPRA, the service offers rapid assessment, treatment and support for people aged 65 and over. Its core aim is to help patients return home on the same day wherever clinically appropriate, reducing the risk of long hospital stays and maintaining mobility and independence.

Frailty SDEC provides same-day diagnostics, treatment and comprehensive geriatric assessments, and focuses on the whole person — medically, socially and functionally, supporting many people who attend following a fall and ensuring safe discharge with community follow-up in place.

In its first 10 days, the unit saw 73 patients, including 24 direct ambulance referrals, with 70 patients either returning home the same day or moving safely into community rehabilitation. Average time spent in the unit was just three hours and 27 minutes, reflecting a streamlined and efficient pathway.

Early feedback from families has been extremely positive, praising the speed, communication and patient-centred approach of the service.

New Medical Decision Unit

The Trust also introduced a new Medical Decision Unit (MDU) which is already delivering improvements to patient care, within a month of opening and introducing a dedicated space to support smoother patient flow and relieve pressure across the site on December 1.

In its first two weeks alone, the MDU treated 266 patients, with 65% discharged directly home — demonstrating early success in providing timely assessment, avoiding unnecessary admissions, and improving patient experience.

Operating 24 hours a day, seven days a week, the MDU continues to focus on reducing delays, minimising corridor care, enhancing safety, and improving the working environment for colleagues. Above all, it supports admission avoidance by ensuring patients receive rapid clinical decisions and the right care, in the right place, at the right time.

Audit of emergency care patients

As part of ongoing work to support pressures across the Trust and ensure everything possible is being done to deliver safe, personal and effective care, an audit was recently undertaken by the Getting It Right First Time (GIRFT) team.

They worked alongside Trust colleagues to review patients and identify opportunities to improve flow into and through urgent care, the emergency department and wider hospital. This included reviewing opportunities for non-conveyance and travelling to the hospital site.

In total, 180 patients attending the Emergency Department were randomly selected over a 24 hour period. Data collected included time of arrival, what they came to hospital for, whether ED was the most appropriate place for treatment, whether they were correctly streamed and where they were finally treated.

Initial results showed:

- 18% had an emergency that required them to attend an ED for an initial assessment
- Only 9% of patients, once assessed, required an emergency doctor

The Trust is now investigating the results to see what improvements can be made, which will not only support urgent and emergency care but most importantly give patients a better experience.

ELHT bed census

In January, the Trust completed a comprehensive bed census designed to give a detailed picture of patient flow, delays and improvement opportunities across urgent and emergency care pathways.

The census forms an important part of the Trust's improvement work and helped to create a real sense of an organisation-wide effort to understand the challenges and find impactful solutions to the pressures in urgent and emergency care.

The census exercise included a full review of all beds, ED admissions and ward-based assessments, an audit of all ED admission referrals, looking to identify any avoidable admissions, potential suitability for same-day emergency care, gaps in existing pathways and variation in decision-making.

The data is now being analysed alongside other improvement initiatives to ensure decisions for 2026/27 are based on detailed evidence from across the organisation with an aim to improve flow, reduce delays and strengthen patient experience.

Violence Against Colleagues

The Trust has experienced an increase in reports of violent, aggressive and abusive behaviour from a small number of patients and visitors across our sites – particularly in Urgent and Emergency Care pathways.

There is a zero-tolerance policy to all forms of aggressions and abuse at ELHT, as the Trust is fully committed to protecting the wellbeing of staff and maintaining a secure environment for patients. A round table is planned with partner organisations to identify opportunities to strengthen the support available and a communications campaign including posters in key areas has been implemented.

Colleagues who have been impacted by violent or aggressive behaviour are being supported to recover and all teams have been reminded of the importance of reporting incidents and speaking up about behaviour which is not acceptable in a timely way.

ELHT Among the Best at Reducing Waiting Lists Fastest

In 2025 the Trust saw its waiting lists fall by 18.5% which is the biggest waiting list reduction in the region, with patients waiting over 52 weeks for treatment reducing from 4,228 two years ago to 652.

The Trust was specifically acknowledged by Regional Director Louise Shepherd, who praised ELHT for consistently ranking in the top five nationally for theatre productivity.

National statistics released in February show that elective activity has helped cut the national waiting list to its lowest level since February 2023. This milestone has been achieved despite demand across emergency services and the busiest winter ever for the NHS.

In the North West, between December 2024 and December 2025, the elective waiting list came down by over 36,590 (falling from 1.04 million to 1.01 million). The improvements relate to non-emergency treatment such as hip and knee replacements, cataract surgery and other planned operations known as elective care.

The Trust has also been recognised in a national report by NHS England's Further Faster 20 (FF20) programme as one of 10 trusts in the North West to cut waiting lists three times faster than the national average.

ELHT was specifically mentioned for showcasing its use of AI-enabled ambient dictation during pre-operative assessment, which is predicted to deliver a 14% increase in productivity for pre-assessment nurses. The aim is that this, in turn, will lead to shorter waits for patients and reduced surgery cancellations, giving patients greater certainty that their surgery will go ahead.

T&O teams deliver record surgical day and launch ground-breaking day-case pathway

The Trauma and Orthopaedic theatre teams are delivering exceptional care to patients with some of their most productive days ever.

They recently completed a record seven cases across two theatres before 5pm. These included four hip fractures, one wrist manipulation under anaesthesia (MUA) and two Incision and Drainage (I&D) procedures.

This efficiency has a real impact: prompt hip fracture treatment reduces morbidity and timely I&D procedures support earlier discharge, helping patients return home sooner to recover.

The Team has also carried out its first day-case partial knee replacement surgery at Burnley General Teaching Hospital.

The development follows extensive collaboration between orthopaedic, anaesthetic and physiotherapy teams at the Trust, who have designed a safe and efficient pathway focused on patient confidence, safety and independence.

The first patient to undergo the procedure was discharged around six hours after surgery and reported a positive recovery experience.

The approach uses a short-acting spinal anaesthetic to support a smoother recovery, combined with early physiotherapy to help patients regain movement. A follow-up call the next day provides additional reassurance and support once patients are back home.

Surgical hub recognised for excellence in clinical and operational standards

The Elective Surgical Hub at Burnley General Teaching Hospital has been officially accredited by NHS England's Getting It Right First Time (GIRFT) programme, recognising its commitment to delivering outstanding clinical care and highly efficient operational practice.

The accreditation scheme—developed in partnership with the Royal College of Surgeons of England (RCS) and supported by the Royal College of Anaesthetists—evaluates surgical hubs against a comprehensive framework of national standards.

During their assessment visit, the GIRFT team reviewed the hub's performance across five key areas: the patient pathway, workforce and training, clinical governance and outcomes, facilities and ring-fencing, and utilisation and productivity

There was further good news for the Theatre teams as the Trust Board has approved the purchase of a third surgical robot. The Trust has the strongest robotic surgical capability in Lancashire and South Cumbria and this additional capability will help realise the Trust's aim to broaden the range of surgical procedures delivered to meet growing patient needs and become a centre of excellence.

Creating one clear strategy for the future

Work is underway to bring all our existing plans together into one clear, refreshed organisational strategy for the Trust. Built around five themes — quality and safety, value, people, performance and health equity — the new approach aims to be simpler and easier for everyone to adopt.

As part of this refresh, the Trust is reviewing and updating the content to make sure it reflects the latest guidance. This includes the new national 10 year health plan, as well as regional best practice frameworks and expectations across the system. The Trust also wants to ensure the strategy meets the needs of the local population, so it properly supports communities.

As part of the development, conversations have already taken place with divisional management boards, place partners and the patient participation panel. Together, this will help the Trust build a strategy that truly reflects the people who deliver and use its services.

Cost saving and waste-reduction headlines

At the end of month 10 and with two months of 2025-26 remaining, the Trust had delivered a record level of savings, with £4.8m achieved in January and £34m year-to-date – the highest level of in-year savings in ELHT's history.

All teams and divisions are now accelerating existing plans and continuing to seek final, safe opportunities to reduce spend without impacting the quality and safety of patient care.

Ongoing activity to reduce spend includes:

- A temporary freeze on non-essential spend, which now includes all corporate non-pay expenditure
- Ward stock top-ups have been reduced to cut waste
- Team job planning has now been adopted by 85% of directorates, improving visibility of capacity and reducing inefficiencies
- Over 1,600 cost-saving and waste reduction ideas from colleagues since January 2025.

Embedding sustainability into purchasing decisions

The Trust's Procurement Team has integrated seven core sustainability principles into all purchasing decisions, covering energy use, carbon emissions, waste reduction, recycled content, hazardous substances, packaging, and end-of-life recycling.

Suppliers are now required to demonstrate their environmental performance, enabling the Trust to make responsible, evidence-based choices.

This approach not only reduces the organisation's environmental impact, but also supports long-term cost efficiency, encourages innovation within supply chains and strengthens the Trust's contribution to national NHS sustainability goals.

Progressing plans for Accrington Victoria

The Trust continues to work with partners to keep the former Accrington Victoria Hospital site secure and to progress plans for its future.

The site has experienced some challenges with break-ins and was temporarily occupied by travellers in recent weeks, causing community concern. As a result, the Trust has strengthened security measures including adding tonnes of soil to the entrances to prevent egress happening again and continues to work closely with the Police and local authority to protect the building and reassure local residents.

The Strategic Group, chaired by Hyndburn and Haslingden MP Sarah Smith, continues to meet regularly and remains fully committed to driving forward a long-term solution that reflects community priorities. This follows last year's engagement programme, which gathered around 1,500 local views and showed strong support for regenerating the site with a mix of health and community spaces.

The Trust, alongside partners, is now focused on developing these ideas into tangible next steps.

In addition, collaborative work to successfully transfer services from Accrington Victoria Hospital to Accrington Acorn Primary Health Care Centre has received a Public/Private Sector Collaboration Award for Healthcare at the Operational Public-Private Partnerships (PPP) Awards.

The project involved reconfiguring Accrington Acorn Community Health Centre to ensured continuity of Primary Care, Outpatients, Minor Injuries, and X-ray services locally.

Staff survey results imminent

The results of the 2025 National Staff survey are expected to be published on March 12, 2026.

The NHS Staff Survey is one of the largest workforce surveys in the world, sent to over 1.3 million NHS colleagues around the country.

At ELHT, responses increased by over 1,000 from the previous year to a total of 5,275 (43%), supported by the transfer of colleagues from One LSC. It followed an internal campaign encouraging colleagues to 'unmute themselves'.

The survey is aligned with the NHS People Promise and aims to provide a snapshot of staff experiences, including engagement, morale, health and wellbeing, and perceptions of management and workplace culture. Results are used to inform local improvements.

Supporting colleagues during Ramadan and Eid

The Trust is once again supporting Muslim colleagues throughout Ramadan and the celebration of Eid, ensuring everyone feels valued, understood and able to observe their faith comfortably at work.

To help colleagues and managers, guidance has been published, offering practical information for Muslim colleagues, line managers and anyone working alongside fasting staff. This includes advice on flexible break arrangements, supporting wellbeing during fasting hours, and fostering understanding across teams.

The Muslim staff network also hosted an open discussion on Teams Brief to improve understanding of what colleagues need and do during this time.

Throughout Ramadan, the Spiritual Care Centre is hosting Isha and Taraweeh prayers, providing a welcoming space for worship on site.

Colleagues of all backgrounds were also invited to take part in the “I’m not a Muslim but I will fast for one day” challenge, creating an opportunity to experience fasting, learn more about Ramadan and share an iftar meal together.

These activities highlight the Trust’s commitment to inclusion, bringing people from different faiths and cultures together and strengthening the sense of community across our organisation as colleagues prepare to celebrate Eid.

ELHT Pharmacy Research Group champions research integration

The Trust has launched a Pharmacy Research Group to strengthen research capability across the pharmacy workforce and embed research as a core part of clinical practice. Meeting quarterly, the group focuses on developing staff skills, raising awareness of research activity, creating educational opportunities and evaluating the impact of research on pharmacy services.

The group is already delivering results, with several pharmacists completing Associate Principal Investigator (API) Scheme applications, team members securing personal research awards from major funders including NIHR and Pharmacy Research UK, and—significantly—the first pharmacist acting as Principal Investigator for a Trust-hosted dermatology study.

Clinical Nurse Specialist wins NCUK Hero Award.

Neuroendocrine (NET) Clinical Nurse Specialist, Erin Bolton has won a Neuroendocrine Cancer UK (NCUK) Hero Award.

Erin was nominated for the public-voting awards by one of her patients who described her as her ‘advocate and lifeline’, the patient said Erin is ‘not just a nurse – she’s the reason I have a chance’.

The hero award is about recognising those who go above and beyond and Erin’s patient said she was the strength that reminded her to keep going when she couldn’t, saying she was her rock, her champion and greatest source of hope.

Blackburn Birth Centre nominated for a 1V Health Award

Blackburn Birth Centre has been named a finalist in the 1V Awards ‘Health Award’ category, recognising its outstanding contribution to the health and wellbeing of the local community.

This nomination recognises Blackburn Birth Centre's commitment to supporting local families and celebrates the dedication of our midwives and colleagues who provide safe, personal and effective care during one of life’s most important moments.

The 1V awards celebrate exceptional volunteers, community groups and local organisations making a real difference to health and community spirit in Blackburn with Darwen.

Chaplaincy Counselling service rated ‘outstanding’ in 2025

In 2025, 89% of colleagues who received counselling from the Chaplaincy Staff Counselling Service rated their therapy as ‘outstanding’ and 97% of colleagues said the counselling supported them to continue in work.

During the year, the Service accepted 177 referrals and delivered 1,412 hours of one-to-one counselling with 72% of those in person and 28% via Teams.

Patients take on Olympic-style challenge to support stroke rehabilitation

Patients on Marsden Ward at Pendle Community Hospital have taken part in their own week-long Olympic-style games to boost rehabilitation, coinciding with the opening of the 2026 Winter Olympics.

The event began with a torch procession around the ward and continued with daily therapy-led activities designed to encourage movement, build confidence and reduce isolation. Participation was extremely high, with 91% of patients joining in each day. Staff reported significant rehabilitation progress, including patients standing or taking supported steps for the first time since their stroke and several no longer needing hoist transfers or specialist seating.

The week concluded with a celebratory medal ceremony accompanied by a local brass band and attended by Paralympic gold medallist Gregg Stevenson.

ENDS

TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/035
Report Title:	Provider Collaborative Board Update		
Author:	Susan Giles, Interim Director of Corporate Governance		
Lead Director:	Martin Hodgson, Chief Executive		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
	✓			
Executive Summary:	This report provides an overview from the discussions at Provider Collaborative Board meetings held on 15 January 2026 and 12 February 2026.			
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:	

Provider Collaboration Board (PCB) Update

Summary of discussion 15 January 2026

1 MIAA review of the Provider Collaborative

The review provides an independent assessment of how effectively the Lancashire and South Cumbria (LSC) Provider Collaborative is operating, drawing on interviews with senior leaders, comparisons with other collaboratives, and analysis of governance, performance, and financial context. It concludes that the Collaborative has established a strong foundation built on trust and shared purpose, with credible governance structures and early successes in areas such as shared corporate services and pathology. However, it also finds that the Collaborative is still transitioning from building structures to delivering measurable impact, and that governance—while well designed—is not yet applied consistently. Leaders express a clear desire to simplify arrangements, increase pace, focus on fewer high-impact priorities, and better demonstrate financial and clinical value.

The review highlights that the Collaborative's purpose remains sound, but its model is less streamlined than those seen in comparable regions, and some programmes may be better led by other system partners such as the ICB. It identifies the need for clearer definition of the PCB–ICB relationship, stronger evidence of value for money, and a leadership culture that remains collaborative while becoming more decisive on difficult system issues. Recommendations include refocusing on core priorities, simplifying governance, strengthening decision-making and accountability, improving value-for-money evidence, and ensuring alignment with wider ICS objectives. Chief Executives and the Collaborative's Managing Director will now consider these recommendations before presenting them to the PCB for further discussion.

2 Finance and Planning Update

All Trusts and the ICB submitted their initial medium-term plans to NHS England in December 2025, with further iterations due in early 2026. The first draft was shaped collaboratively through the System Planning Group, although acute providers were not yet able to produce fully compliant or triangulated plans. Despite this, there is strong joint working across Lancashire and South Cumbria to resolve gaps and move toward an aligned final submission. Alongside this, significant work is underway to use benchmarking data to identify opportunities to manage demand differently, improve efficiency, and reduce costs, followed by further collaboration with ICB colleagues to explore commissioning changes that could support these improvements.

3 Provider Collaborative financial situation

The Provider Collaborative is forecasting a small favourable year-end position, with month 9 showing a £0.07m improvement against plan and a projected final outturn of £3.61m against a £3.71m annual plan. This reflects active in-year management of financial pressures through vacancy controls and budget realignment. Planning for the next financial year has already begun, with a focus on permanently removing vacant posts to help absorb cost pressures and pay awards within the existing financial envelope. A refreshed financial update will be brought forward at the end of quarter 4 for review.

4 ICB draft operating model

The ICB is undertaking major financial savings, supported by a voluntary redundancy programme that will see a substantial number of staff leave by the end of March 2026. Alongside this, a

session is planned with Chief Executives to set out the organisation's future vision and its renewed role as a strategic commissioner. Recruitment to the new Executive team is progressing, with shortlisted candidates now identified and appreciation expressed to colleagues who contributed to the selection process.

5 ICB service change protocol

The system is introducing a consistent, formalised approach to service change to ensure compliance with NHSE guidance and the ICB's legal duties around public engagement and consultation. This will be supported by a clear policy, a standard operating procedure, and defined roles and responsibilities, with the service change initiation proforma becoming a routine part of business-as-usual for both commissioners and providers.

Although NHSE guidance has existed for years, this is the first time the system has had a fully localised policy, and completing the proforma will allow proposed changes to be reviewed and ensure the right commissioning, communications, and engagement support is deployed. The process will require clear distinction between temporary and permanent changes, and CEOs were encouraged to compile all planned changes for 2025–26 and 2026–27 and meet with the ICB to work through the process in detail so that any implications for the pace of change are fully understood.

6 Managing Director's Report

In October 2025, NHS Trusts in Lancashire and South Cumbria declared an in-month deficit of £4.2m, bringing the year-to-date deficit to £65.6m. Trusts set a cumulative planned deficit of £27.4m and as such there was an adverse reported position of £38.2m. This adverse variance continues to be associated with the Waste Reduction Programme, which was £38.5m behind plan to the end of September 2025.

National updates have been provided on:

- Better care funds – allocations
- NHS allocations
- Standard contract update
- Tariff consultation
- National schedule of reference costs
- Strategic Commissioning framework
- Advanced Foundation Trust programme
- NHS technical bulletin.

Regional updates:

- LSC organisations were successful in bidding for regional funds. £4.4m has been allocated to reduce waiting lists. This follows the confirmation of the successful bid for advanced voice technology (AVT)
- (£2.8m). Teams are currently mobilising solutions with a procurement exercise underway for AVT.

Clinical change programme:

- The vascular pre consultation business case (PCBC) is being scrutinised by the ICB. Once complete it will enter a 12-week review by the clinical senate to be followed by a review by NHS England. Should this be supported, then consultation could progress in March 2026.

- The proposed change for Orthodontics is under review by the Health and Scrutiny Committees. It is understood that a requirement for consultation may be supported, resulting in a potential mobilisation date in quarter 3 of 2026.

Elective care and diagnostics:

- The long waits for elective care continue to see improvement, however, despite mutual aid, there remains some risk to the delivery of the 65-week target by 21 December. Trusts are working through their revised trajectories following the confirmation of the additional RTT monies from the Regional Transformation Fund.
- Performance on the DM01 standard remains static, however there are a range of movements by individual providers highlighted in the report.

7 Provider Collaborative Benefits report

- One LSC – 86% of schemes (£33.77m) are assessed as implemented or fully developed.
- Collaborative portfolios – within the reporting period, benefits released have remained stable at £4.6m.

Summary of discussion 12 February 2026

8 Faith Covenant update

The Faith Covenant sets out a shared commitment between Lancashire's faith and belief communities and public sector organisations to ensure coordinated, place-based engagement that supports wellbeing throughout life. It establishes principles for collaboration, recognising the important role faith groups play in creating healthier, more connected neighbourhoods.

Public bodies have pledged to build trusting relationships with all faith groups, involve them meaningfully in consultation and co-design, maintain transparent commissioning processes, provide resources for engagement, and share training opportunities.

The Covenant aims to strengthen relationships between leaders, deepen mutual understanding, improve partnership working, increase support for local faith-based groups, enhance engagement with minority communities, and ultimately contribute to better health and wellbeing outcomes.

9 Neighbourhood development update

Neighbourhood health development across Lancashire and South Cumbria is progressing through three connected strands: the national NHIPP programme, wider NHS neighbourhood integration, and alignment with Health and Wellbeing Boards.

The NHIPP work focuses on improving outcomes for adults with long-term conditions in deprived areas, with Blackburn with Darwen and Morecambe Bay acting as early implementers. Alongside this, neighbourhood integration is being shaped around six core components—such as population health management, MDT working, intermediate care and modern primary care—with new national requirements from April 2026 to improve access, better understand high-needs cohorts and reduce avoidable admissions.

Health and Wellbeing Boards will bring these elements together into strategic and operational plans by September 2026, supported by extensive engagement across partners and key enablers including the ICB operating model, LSC 2030 priorities, the Better Care Fund, digital

and estates planning, and innovation support. Current work is centred on agreeing the neighbourhood health framework, confirming governance, securing resources, defining delivery workstreams and setting out the 2026/27 requirements.

10 Finance and planning update

All Trusts and the ICB are preparing to submit their Medium-Term Plan on 11 February 2025, supported by strong partnership working across Lancashire and South Cumbria. However, there remains a commissioning financial pressure linked to delivering constitutional standards, and further collective action is needed to address this. CEOs agreed a set of actions on 9 February, including reviewing collaborative programmes and aligning capacity with ICB priorities to accelerate key transformation work. NHS England will meet with the ICB, PCB and individual Trusts on 26 February to review the final submissions.

11 MIAA response

MIAA has reviewed the Provider Collaborative's arrangements, focusing on governance, information quality, value for money, benchmarking and alignment with wider system strategy, and an action plan has now been agreed in response to their recommendations. The Collaborative is moving ahead with a targeted set of improvements designed to strengthen governance, enhance system impact and ensure closer alignment with ICS and ICB priorities, with most actions expected to be completed in time for the April business cycle.

This includes narrowing the portfolio to a small number of high-impact programmes for 2026–27, simplifying governance by streamlining committees and clarifying approval routes, and improving value-for-money evidence through an annual Value Statement and ongoing benchmarking. Work is also underway to formalise a collaboration protocol with the ICB, embed system-first accountability through updated Terms of Reference and leadership development, and continue maturing the Professional Working Groups and their workplans for the year ahead.

12 Updates from the ICB

A large number of staff are due to leave the ICB through voluntary redundancy by the end of March, creating challenges around reduced capacity, loss of organisational knowledge and the human impact of managing such a significant transition—something Trusts were asked to remain mindful of. At the same time, the system is still awaiting national guidance on several important areas, including ICB finances and neighbourhood working, which will shape how the organisation moves forward during this period of change.

13 Managing Director's Report

Lancashire and South Cumbria NHS Trusts reported a £6 million in-month deficit in December 2025, bringing the year-to-date deficit to £149.7 million—£47.3 million worse than planned—largely due to the Waste Reduction Programme falling £53.7 million behind target.

National updates have been issued on business rules and contract documentation, while key service change programmes continue to progress: the vascular pre-consultation business case is undergoing ICB scrutiny before a 12-week Clinical Senate review, and potential consultation could begin in March 2026; proposed orthodontic changes are being reviewed by Health and Scrutiny Committees, with consultation likely and mobilisation expected in late 2026. Elective care 52-week waits are improving following additional RTT funding, though diagnostics performance remains challenging.

14 Provider Collaborative Benefits report

An updated assessment of the One LSC benefits programme shows continued progress, with £8.3m of Waste Reduction Programme savings delivered so far this year and a forecast total of £19.41m by year-end.

Reported benefits across the Clinical and Clinical Support portfolios have risen to £6.9m, though the level of associated risk has also increased to £3.2m, partly offset by £1.1m of mitigations already secured.

The Provider Collaborative Board noted the year-to-date financial position, the risks and mitigations linked to One LSC delivery, the progress being made across clinical portfolios—particularly efforts to move amber-rated schemes into delivery—and the need for further work to ensure outpatient productivity schemes translate into tangible provider-level benefits

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TRUST BOARD REPORT

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/036
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** • **Caring** • **Effective**			
Key Issues/Areas of Concern:	The Board are directed towards the following issues of concern: **Urgent and Emergency Care** • Urgent and Emergency Care remains under sustained pressure, with 12hour time in department performance at 17.02%, broadly aligned to trajectory, alongside exceptionally high attendances through January. • Rising ambulance handover delays were driven by the volume of patients attending UEC and persistent demand on bed capacity impacting flow, leading to extended waits and increased time to offload ambulances. **Finance:** • At month 10, the Trust is reporting an in-month deficit of £3.64m, against a planned deficit of £2.52m; £1.12m behind the plan. • The year-to-date (YTD) position is a £54.17m deficit against a planned deficit of £38.73m; £15.4m behind plan (excluding the DSF). • In month WRP delivered £4.8m against the WRP Delivery plan, therefore £1.7m adverse to plan (£1.2m adverse to PFR plan) • The WRP has delivered £33.9m YTD against a plan of £47.4m; £13.5m behind the WRP Delivery plan. (£14.3m adverse to the PFR plan). **Nursing/Midwifery Staffing:** • Overall RN fill rate for January 2026 for Days: 91.25% • Overall RN fill rates for January 2026 Nights: 97.37% • 23 areas fell below 905 fill rate for January 2026 (↑3).			
Action Required by the Committee:	Directors are requested to note the attached report for assurance.			

Previously Considered by:	
Date:	
Outcome:	

Integrated Performance Report

Published: February 2026

Safe | Personal | Effective

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Contents

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How to read an SPC Chart

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

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

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

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

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

Summary

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The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
32% of our metrics are consistently achieving target
25% of our metrics are inconsistently achieving target
11% of our metrics are not achieving target, however 2 of these are showing special cause improvement.
32% 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	Avg fill care staff (night), A&E 4hr, DM01, Turnover, RTT % >52wks, RTT < 18wks treatment, <18wks for 1st appt	31d cancer, Vacancy, Variance to capital programme, WRP	VTE	Cancelled on day ops, Emg avg LOS, % handovers >30 mins, Handovers > 45 mins, Income run rate, Avg arrival to handover
Common cause	Avg fill RN (day), Inpatient F&F, Canc on day not rebooked, Appraisal (consultant & other medical), 28d cancer, 62d cancer, Safeguarding children training	Community F&F, Maternity F&F, MRSA, Over 12hr TiD % (type 1), BPPC x 2, Variance to planned performance	Wards <90% RN day fill, Appraisal (AFC)	Crude Mortality rate, In hospital deaths, Stillbirths, Bed Occupancy, Maximum arrival to handover, C diff, E coli, Pseudomonas, Klebsiella, % occupied 7+, 14+ & 21+, Emergency readmissions rate, Employee expenses run rate
Special cause concern	Avg fill care staff (day), Avg fill RN (night), Complaints, Outpatient F&F, Agency spend	CHPPD, Nursing red flags, BPPC x 2, Liquidity days	A&E F&F, IG training, Sickness	A&E Attendances, Other operating run rate

SAFE - Summary Scorecard

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METRIC	LATEST DATE	VALUE	TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	JAN 26	91.28	90.00	L	P
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	JAN 26	110.27	90.00	H	P
AVERAGE FILL RATE REGISTERED NURSES (DAY)	JAN 26	90.42	90.00		P
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	JAN 26	97.37	90.00	L	P
MRSA	JAN 26	0.00	0.00		?
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	JAN 26	91.78	95.00	H	F
CARE HOURS PER PATIENT DAY (CHPPD)	JAN 26	7.52	8.00	L	?
NATIONAL NURSING RED FLAGS	JAN-26	2.00	0.00	H	?
WARDS <90% REGISTERED NURSE (DAY) FILL RATE	JAN-26	21.00	0.00		F

METRIC	LATEST DATE	VALUE	VARIATION
REGISTERED NURSE AGENCY SPEND	JAN 26	88659.54	L
REGISTERED NURSE BANK SPEND	JAN 26	824349.94	L
MEDICATION ERRORS CAUSING LOW HARM AND ABOVE	JAN 26	38.00	L
SLIPS TRIPS AND FALLS CAUSING LOW HARM AND ABOVE	JAN 26	67.00	L

Alert

During January 2026 overall Nurse staffing was achieved at trajectory for RN and Care Support workers.
23 clinical areas were below the fill rate of 90% for the month of January 2026 during day shifts. Of which 3 ward fell below 80% fill rate, this relates to unexpected unavailability and movement of co-ordinators to support the Emergency Department.
1 of the 23 clinical areas were below the fill rate of 90% for the month of January 2026 during night shifts in the Family Care Division. These were all due to unexpected unavailability to the Antenatal ward.
Nursing red flags for January 2026 was 2, due to delays in recognition of abnormal vital signs and delays in administration of medications. There were no patient harm as a result for this but could result in poor patient experience.
Midwifery National NICE red flags for January 2026 was 2.
There has been an increase in reported pressure ulcer incidents, rising from 51 in December to 70 in January. Moisture Associated Skin Damage also increased from 54 in December to 74 in January. This period coincided with unpresented system pressure, including prolonged waits in the Emergency Department and corridor care, which are recognised contributory risk factors for skin damaged due to delayed assessment, reposition and reduced access to appropriate equipment.

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.
Monthly audit results for Assessment and Documentation of Pressure Ulcers remain below the expected target compliance range of 70–85%. January compliance was 48%, indicating continued improvement is required. The Pressure Ulcer Steering Group continues to oversee this risk and has reinforced expectations with clinical teams regarding the completion of all risk assessments within four hours of admission, alongside timely care planning and documentation.
Since April 2025, 569 pressure ulcer incidents have developed under the care of ELHT. Of these, 87 (15.3%) have been confirmed as lapses in care following review. Themes identified include incomplete risk assessments, delays in repositioning, and documentation gaps. Targeted actions and focused support are being implemented in areas of concern.

Assurance

The overall percentage fill rate for RNs for days was 90.42% and nights was 97.37%. The overall percentage fill rate for CSW for days was 97.37% and nights was 110.27%.
Compliance with mandatory training remains relatively strong but has shown a slight dip: Pressure Ulcer e-learning: 88.9%, MASD e-learning: 87.9%
This continues to be monitored through the Pressure Ulcer Steering Group, with additional focus on improving uptake to support sustained knowledge and prevention practice.

SAFE - Infection Control

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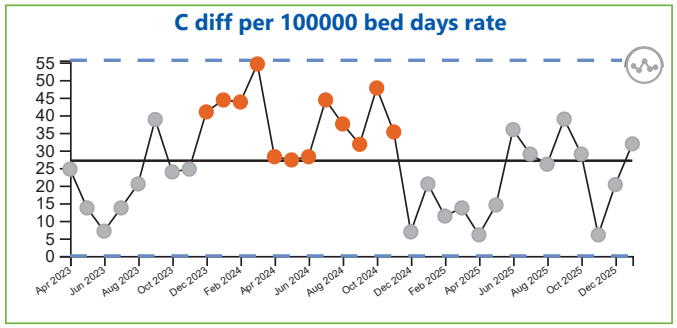

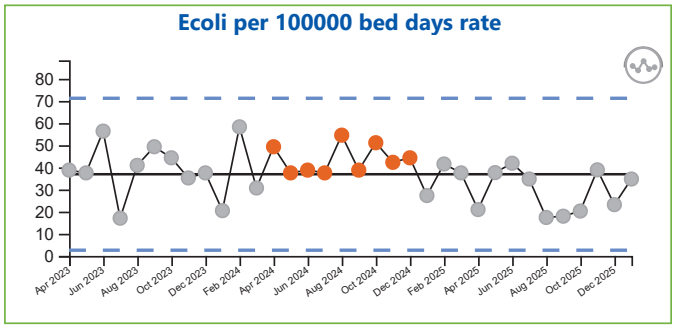

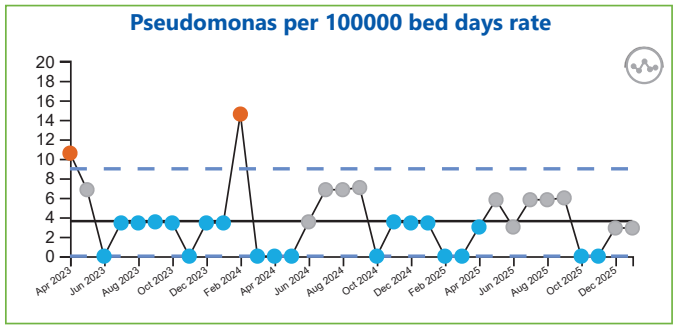

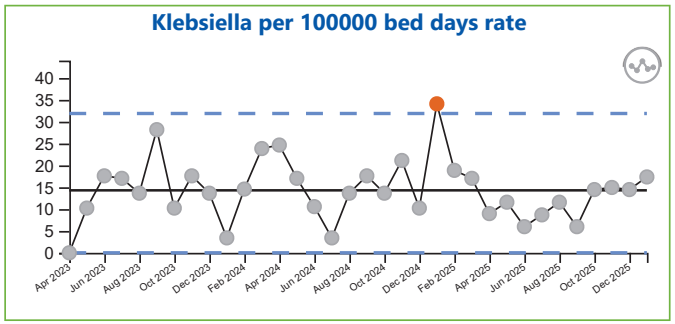

C diff		
In month	YTD	Same time last year
11	81	89
E coli		
In month	YTD	Same time last year
(Blank)	65	122
Klebsiella		
In month	YTD	Same time last year
(Blank)	23	48
Pseudomonas		
In month	YTD	Same time last year
(Blank)	10	10
MRSA		
In month	YTD	Same time last year
0	2	2

Safe | Personal | Effective

SAFE - Staffing

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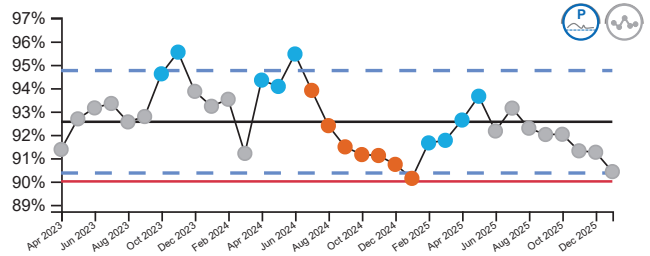
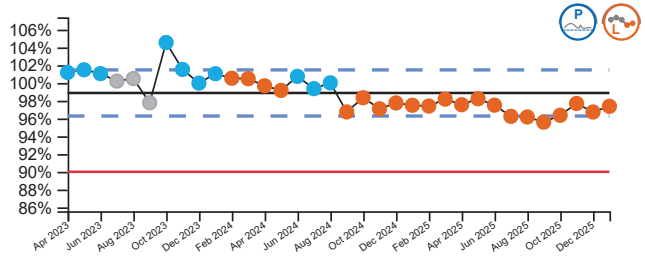
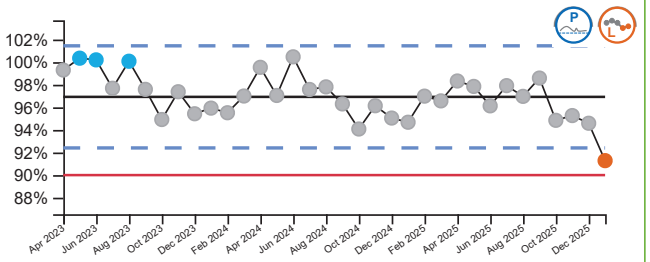
Average fill rate registered nurses (day)



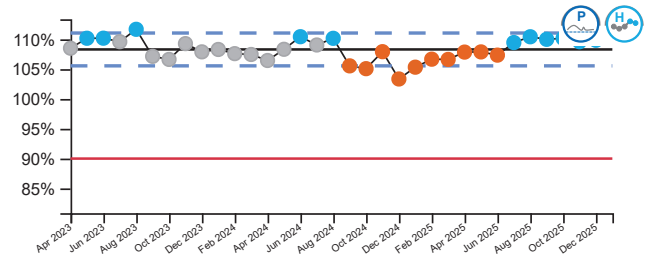
Average fill rate registered nurses (night)



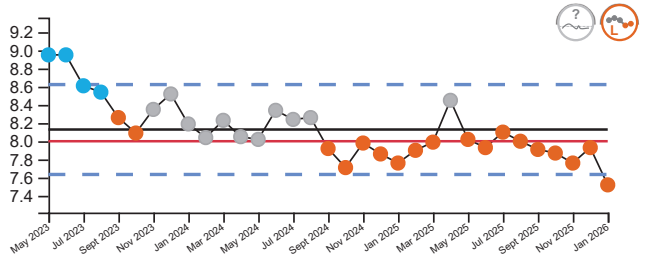
Average fill rate registered care staff (day)



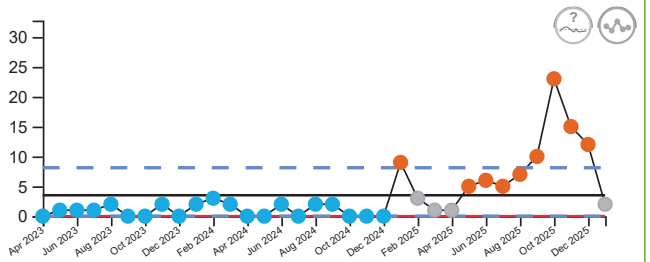
Average fill rate registered care staff (night)



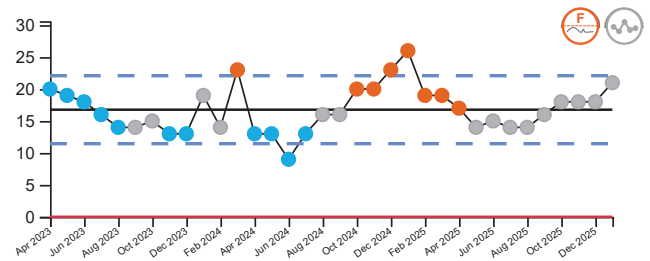
Care hours per patient day (CHPPD)



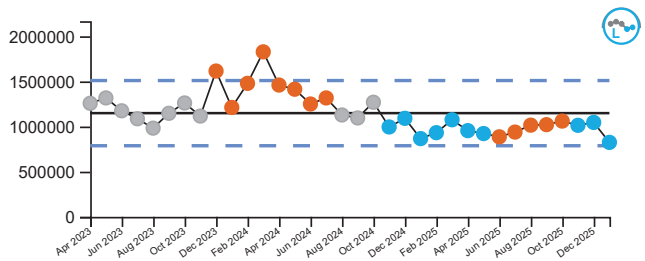
National nursing red flags



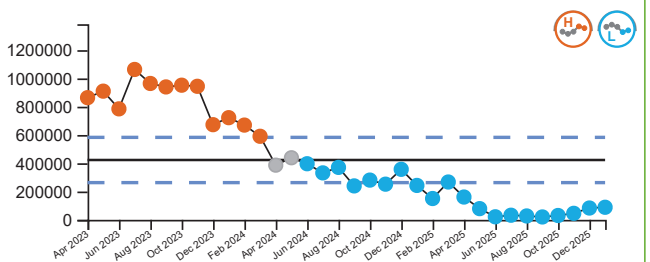
Wards <90% registered nurse (day) fill rate



Registered nurse bank spend



Registered nurse agency spend



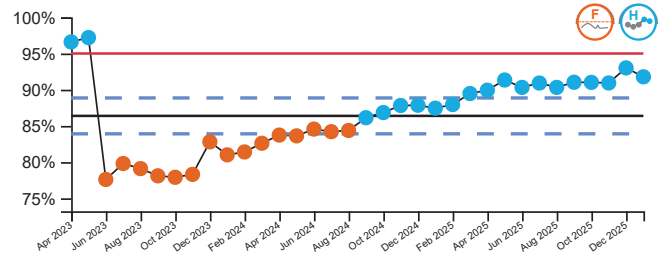
SAFE - Incidents and Pressure Ulcers

East Lancashire Hospitals NHS Trust
A University Teaching Trust

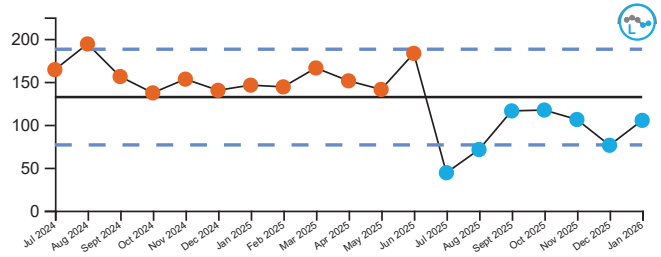
	Never events	Serious incidents reported to PSIRF	Medication errors moderate harm and above	Slips trips falls moderate harm or above
In month >	1	4	0	3
YTD >	4	31	16	26

CAS alerts - Non-compliance
0

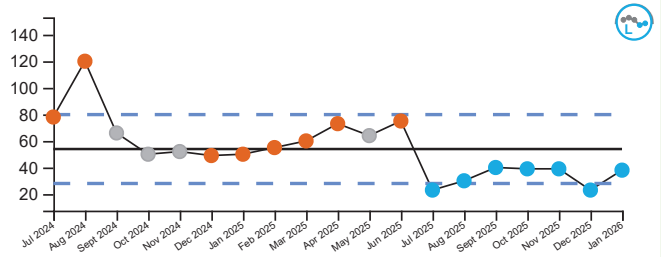
Patients risk assessed for Venous Thromboembolism



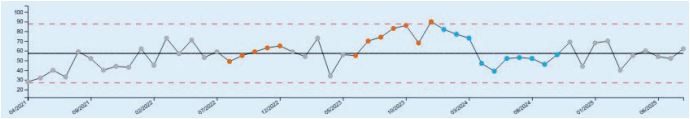
Medication errors causing low harm and above



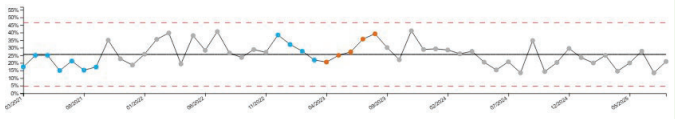
Medication errors causing low harm and above



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.

Safe | Personal | Effective

8

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 26	66.91	90.00	L	F
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 26	95.56	90.00		?
COMPLAINTS RATE PER 1000 CONTACTS	JAN 26	0.31	0.40	H	P
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 26	95.34	90.00		P
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 26	91.04	90.00		?
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 26	94.85	90.00	L	P

Alert

The A&E FFT score has declined to 66.91%, significantly below the 90% target and the November 2025 national average of 77%. This downward trend in variation indicates high operational pressure and extended wait times.
While the current rate of 0.31 remains below the 0.40 target. The Customer Relations Team is closely monitoring complaint trajectories and implementing targeted measures to enhance the end-to-end management process. These interventions are designed to ensure timely analysis and robust resolution.

Advise

Maternity FFT performance has improved to 91.04%, now exceeding the 90% target. This follows a period where scores were marginally below target (89.63%). The current variation suggests that while the target is met, consistency remains a focus for ongoing patient experience initiatives.
Complaint themes and points of origin continue to be reviewed by Customer Relations Teams to enable timely analysis and corrective action.

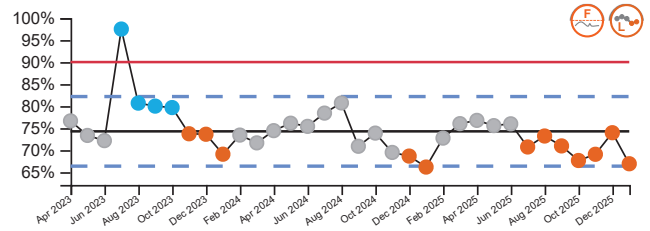
Assurance

Performance across Inpatient (95.34%), Outpatient (94.85%), and Community Care (95.56%) continues to consistently exceed the 90% target.
Sustained performance in these three areas indicates that processes are stable and statistically capable of meeting required standards reliably over time.
Notably, Community Care has seen an increase from the previously reported 92.59% to 95.56%.

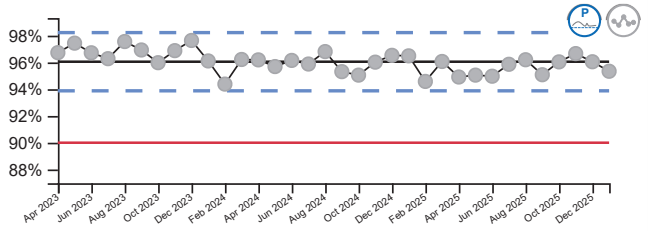
CARING - Feedback

East Lancashire Hospitals NHS Trust
A University Teaching Trust

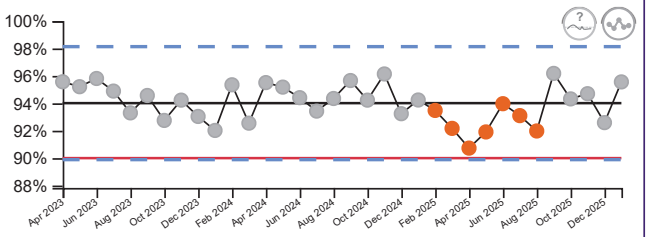
A&E Friends and Family % describing their experience as good or very good



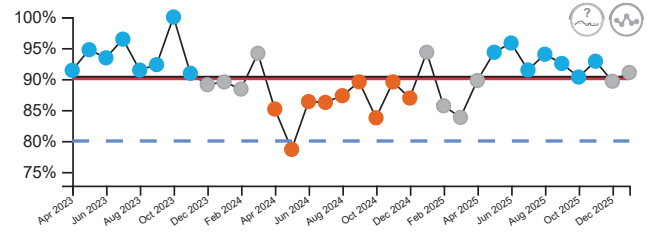
Inpatient Friends and Family % describing their experience as good or very good



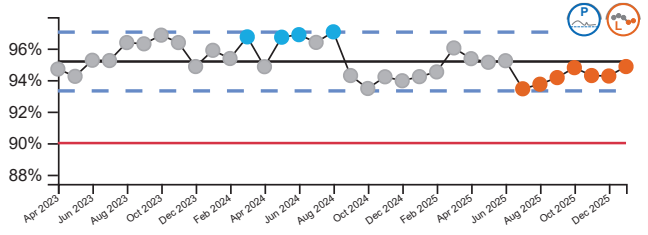
Community Friends and Family % describing their experience as good or very good



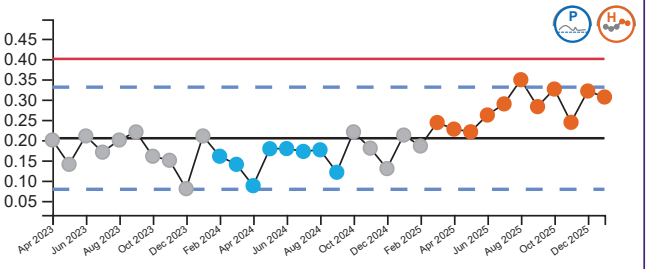
Maternity Friends and Family % describing their experience as good or very good



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	JAN 26	163.00	
CRUDE MORTALITY RATE	JAN 26	3.45	
STILLBIRTHS	JAN 26	3.00	

METRIC	LATEST DATE	VALUE
MATERNAL DEATHS	JAN 26	0.00
SHMI	SEPT 25	1.21
HOSPITAL STANDARDISED MORTALITY RATIO	OCT 25	105.00

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 1.21, which is above expected. As expected the decrease seen over the last 12 months related to the elimination of uncoded data has now plateaued, and this month there has been a slight increase. Current HSMR+ is 105.0, which is within expected, as it also was for the previous month. This also has increased slightly against 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 represents a 12 month rolling period.
Work continues to improve the throughput of SJR reviews, with some improvement. The administration post has been filled, and additional reviewers continue to come forward and be trained, although there have been retirements of experienced reviewers. In particular, acute medicine has provided additional review time. Throughput does, however, remain below target. Work continues to incorporate local directorate mortality review processes.

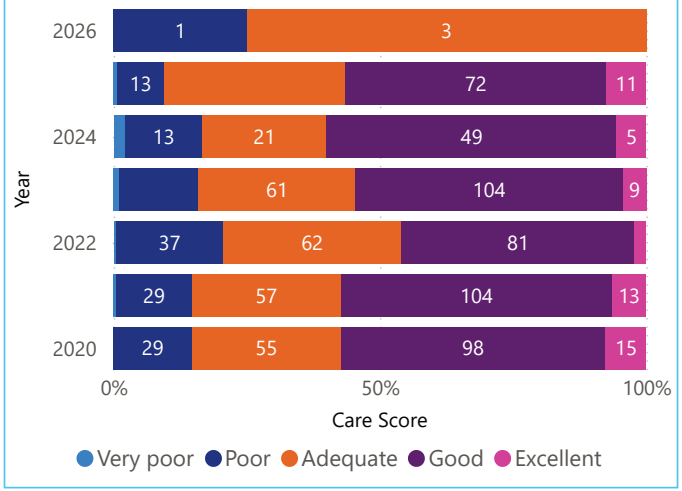
Assurance

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

EFFECTIVE - Mortality

East Lancashire Hospitals NHS Trust
A University Teaching Trust

SJR Stage 1 Completed by Year and Overall Score



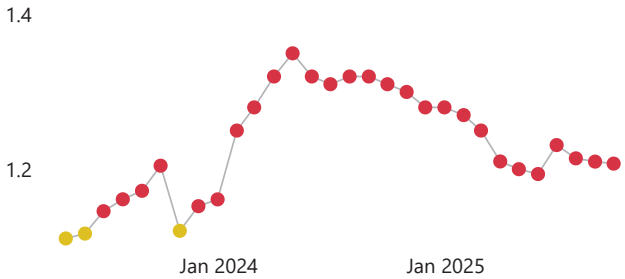
SHMI and HSMR Series

Below expected levels
Within expected levels
Higher than expected levels

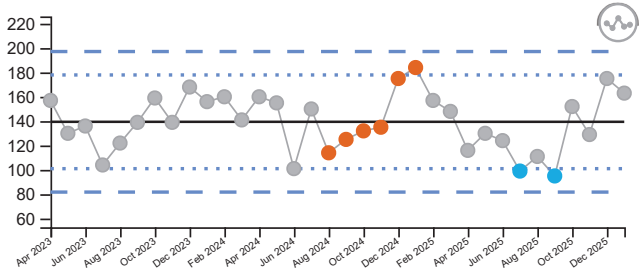
Learning Disability Mortality Reviews

No deaths reported in January 2026. 3 mortality reviews were completed this month. 1 outstanding review to be completed at mortality meeting on the 25th February.

SHMI



In Hospital Deaths



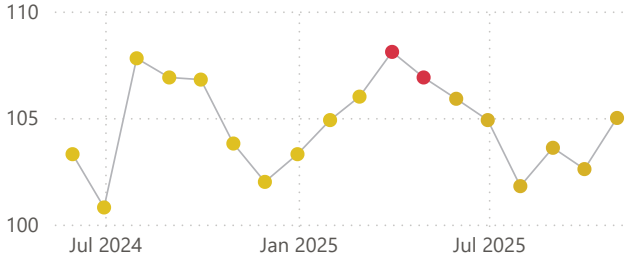
Stillbirths

In month	YTD	Same time last year
3	24	25

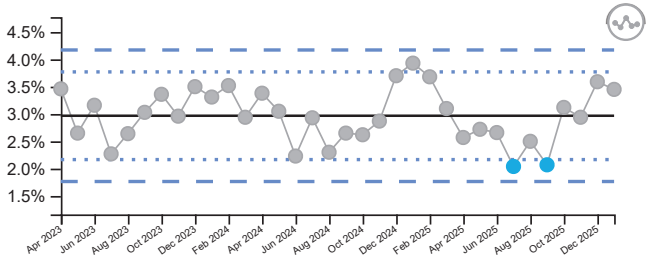
Maternal deaths

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
University Teaching Trust

METRIC	LATEST DATE	VALUE	MONTHLY TRAJECTORY	YEAR END TARGET	VARIATION	ASSURANCE
28D GENERAL FDS	DEC 2025	79.00	76.00	80.00		
62D GENERAL STANDARD	DEC 2025	75.10	73.00	75.00		
A&E 4 HR PERFORMANCE	JAN 2026	77.44	75.00	78.00		
DM01 % OVER 6 WEEKS	JAN 2026	1.75	5.00	5.00		
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	JAN 2026	1.00	0.00	0.00		
RTT ONGOING % OVER 52 WEEKS	JAN 2026	1.31	1.80	1.00		
RTT ONGOING % UNDER 18 WEEKS	JAN 2026	63.74	61.20	62.20		

METRIC	LATEST DATE	VALUE	MONTHLY TRAJECTORY	YEAR END TARGET	VARIATION	ASSURANCE
OVER 12 HOURS IN DEPARTMENT %	JAN 2026	17.02	17.20	15.20		

METRIC	LATEST DATE	VALUE	VARIATION
A&E ATTENDANCES	JAN 26	24861.00	
BED OCCUPANCY G&A	JAN 26	95.11	
CANCELLED ON DAY OPERATIONS	JAN 26	51.00	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	JAN 26	10.26	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	JAN 26	304.00	
% HANDOVERS > 30 MINUTES	JAN 26	37.61	
AMBULANCE HANDOVERS >45 MINUTES	JAN 26	521.00	

METRIC	LATEST DATE	VALUE	VARIATION
MAX ARRIVAL TO HANDOVER TIME	JAN 26	352	
AVERAGE ARRIVAL TO HANDOVER	JAN 26	35	

METRIC	LATEST DATE	VALUE
RTT ONGOING	JAN 26	51484.00
RTT OVER 52 WEEKS	JAN 26	676.00
RTT OVER 65 WEEKS	JAN 26	0.00

Alert

12-hour time in department performance was 17.02% against a trajectory of 17.20%. January activity remained extremely challenging, with 24,861 attendances, an increase of 552 from December, and the Trust declared OPEL 4 from 12th – 15th January and from 30th Jan – 4th February due to system pressures and escalation needs, to maintain patient safety. To drive improvement in patient flow, corridor care reduction and departmental throughput, the UEC Transformation Programme Board has been established, chaired by the CEO with Executive, Clinical and Operational leadership. It will meet bi-weekly and focus on key improvement domains including:

- Length of Stay
- Clinical Operating Standards
- Weekend Discharge
- Job Planning / 7-day Working
- Virtual Ward

Ambulance Handovers

Pressures in UEC directly impacted ambulance handover performance with 3,244 attendances (avg. 105/day). 30 min handovers increased by 19.57% from December

· 45 min handovers rose to 521, an increase of 417 compared to December; longest was 352 minutes

· Average handover time was 00:35:27 against a 00:30:48 trajectory; previous year 00:34:56

· NWAS average was 00:37:37, demonstrating system-wide pressures

Joint work between ELHT and NWAS continued to support safe patient management.

Advise

On-the-day cancelled operations totalled 51 in January, largely due to sickness. All patients were rebooked within 28 days. No cancellations occurred because of bed capacity pressures, despite the use of surgical day-case areas for escalation.

Bed occupancy remained high at 95.11%, reflecting significant demand for acute beds.

Assurance

RTT, Diagnostics and Cancer performance remain strong, with the Trust consistently meeting or outperforming trajectory across all key assurance metrics. Long waits continue to reduce; the Trust is utilising national sprint funding in Q4 to support further reductions. Both 28day and 62day cancer standards are above trajectory,

4Hr - Above trajectory

Readmission Rates – December readmission rate was **12.69%** (previous year was 12.1%)

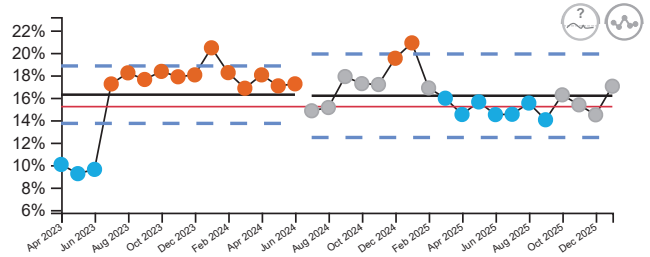
Emergency readmissions remain within normal statistical variation, with no indication of special cause change. The Trust has seen a recent reduction in both the number and rate of readmissions, and although December shows a rise, this is a return to the expected seasonal position.

When compared across the ICB, ELHT continues to sit favourably and below both regional and national averages.

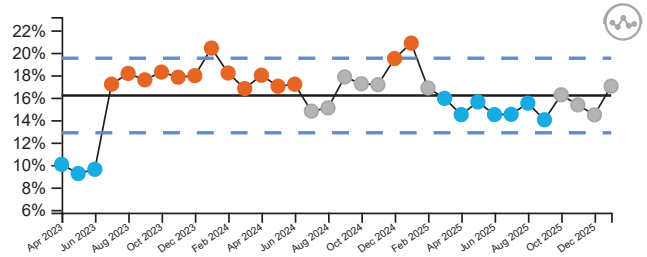
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

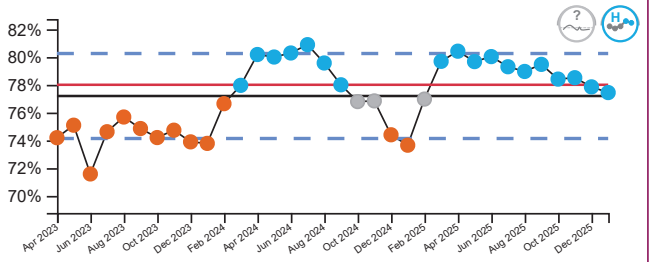
Over 12 hours in department % (type 1)



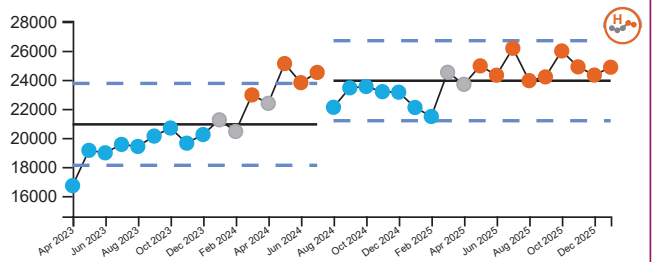
Over 12 hours in department %



A&E 4hr Performance (Trust)



A&E Attendances



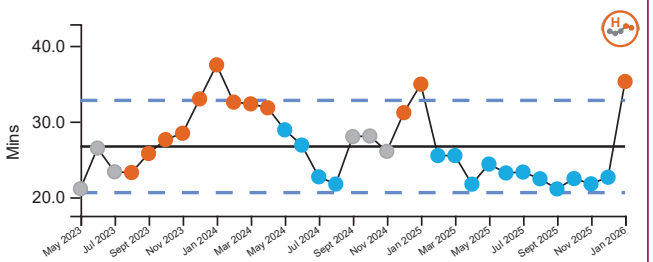
Average arrival to handover time (mins) (latest month)

35

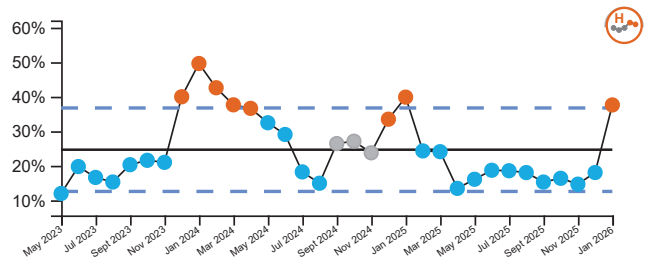
Maximum arrival to handover time (mins) (latest month)

352

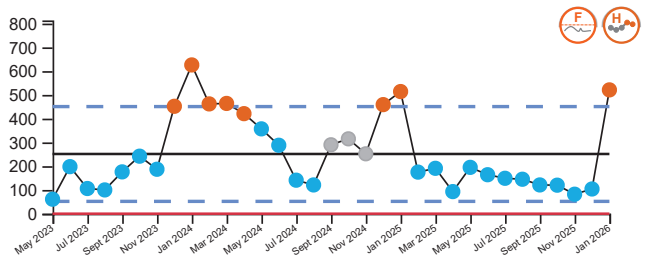
Average arrival to handover



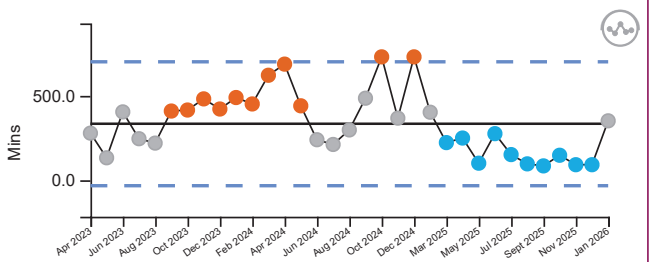
% handovers > 30 minutes



Ambulance Handovers >45 minutes



Max arrival to handover time

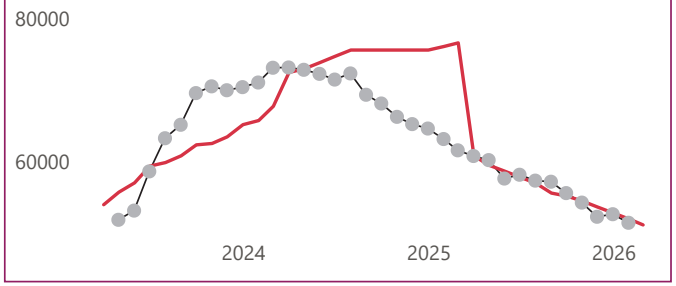


Safe | Personal | Effective

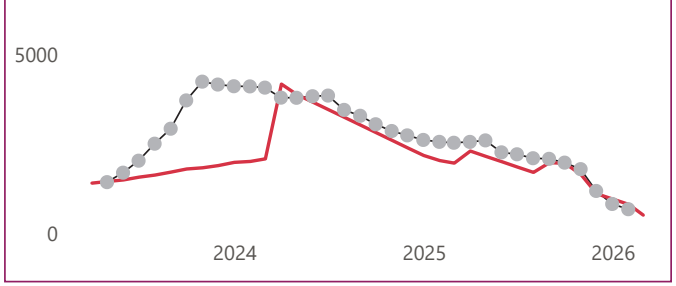
RESPONSIVE - RTT and Diagnostics

East Lancashire Hospitals NHS Trust
A University Teaching Trust

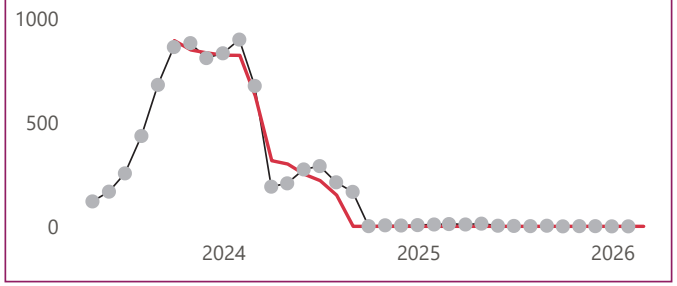
RTT Ongoing



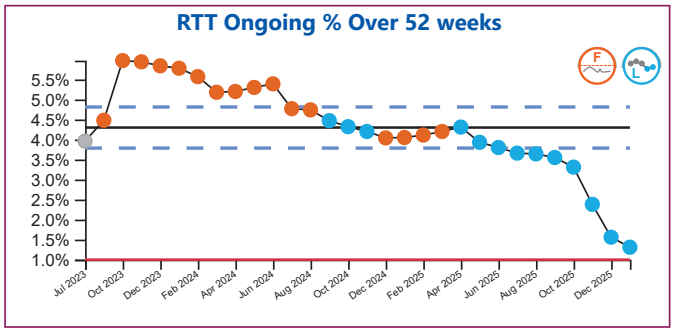
RTT Over 52 Weeks



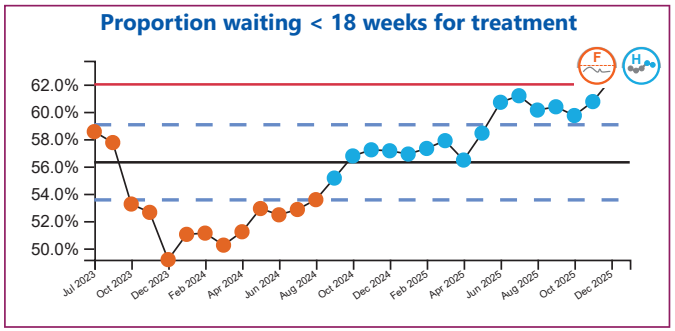
RTT Over 65 Weeks



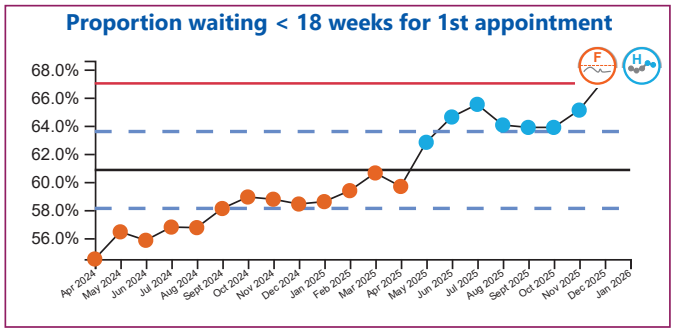
RTT Ongoing % Over 52 weeks



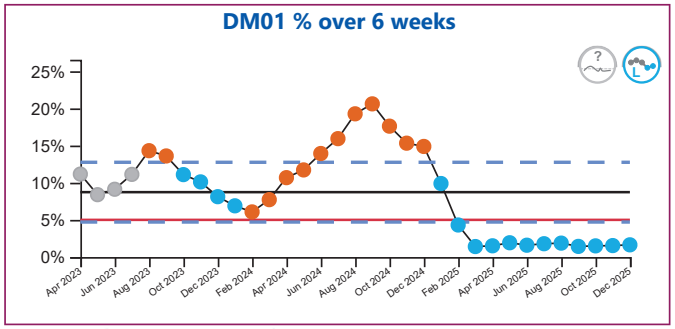
Proportion waiting < 18 weeks for treatment



Proportion waiting < 18 weeks for 1st appointment



DM01 % over 6 weeks

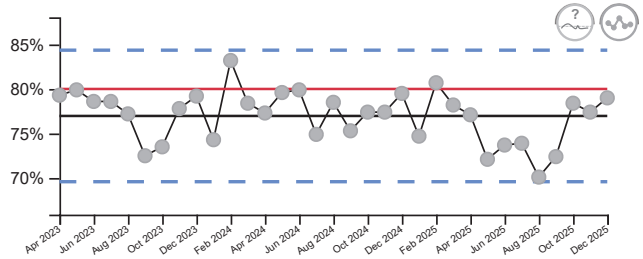


Safe | Personal | Effective

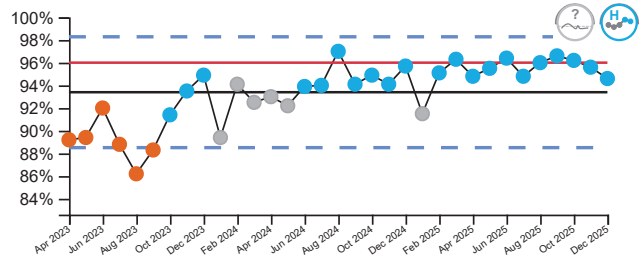
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

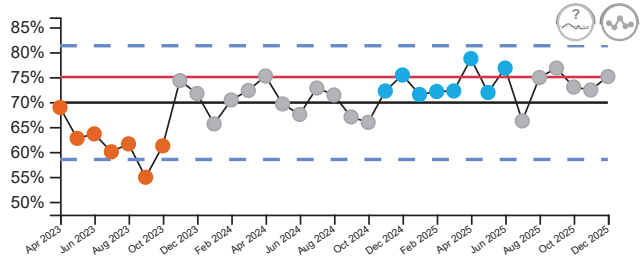
28d General FDS



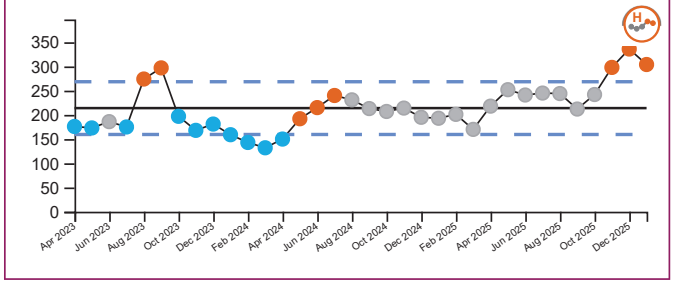
31d General treatment standard



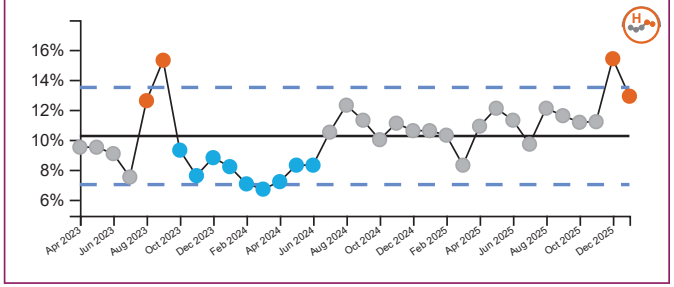
62d General Standard



Patients over 62 days (urgent GP referral)



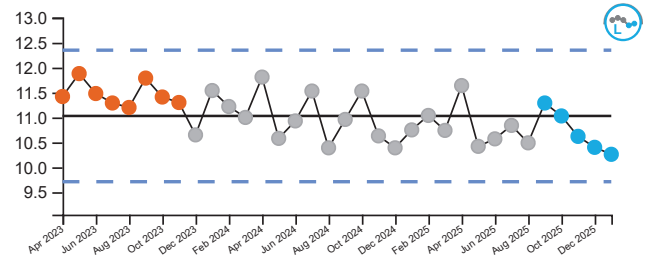
Waiting over 62 days (urgent GP referral)



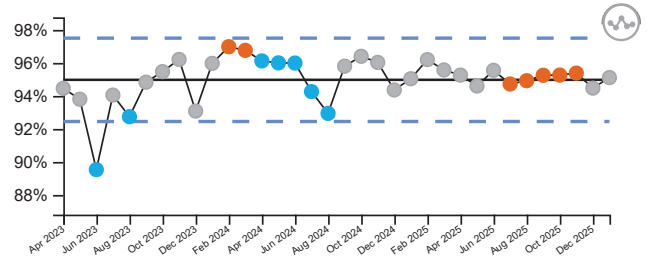
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

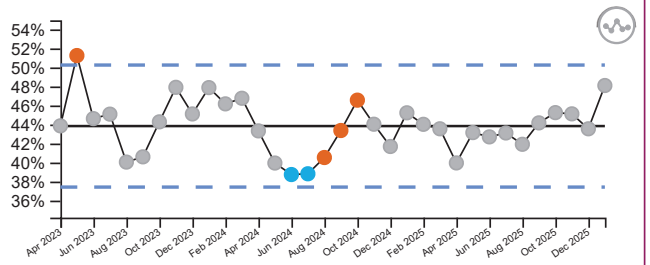
Emergency average length of stay (excl 0 and 1 days)



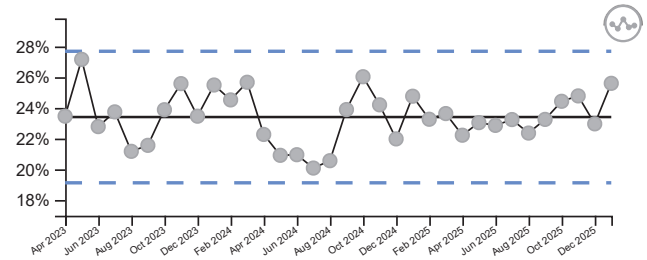
Bed occupancy G&A



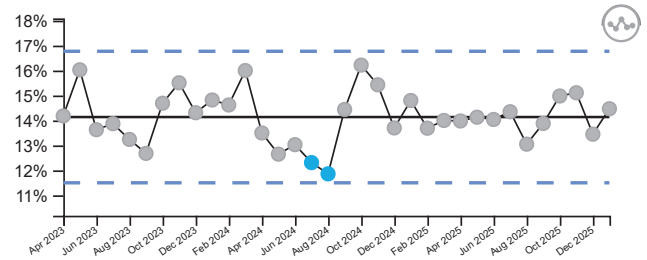
% Beds occupied by Long-Stay Patients 7+ days



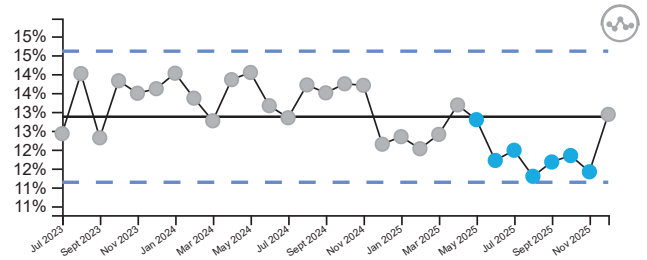
% Beds occupied by Long-stay patients: 14+ days

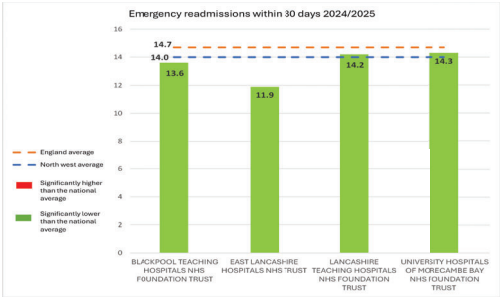


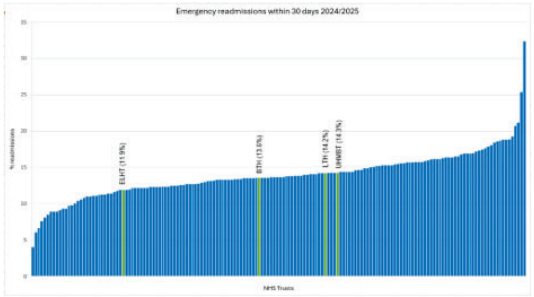
% Beds occupied by Long-stay patients 21+ days



Emergency readmissions rate - prev disch month







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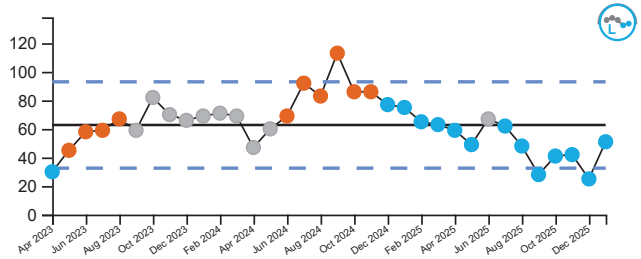
RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

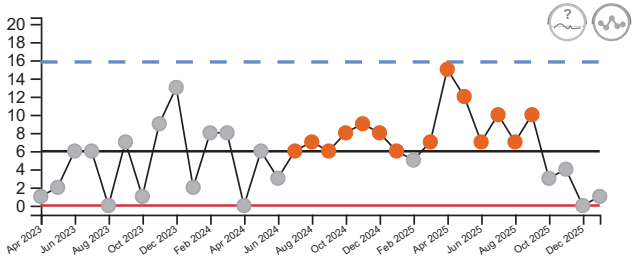
Cancelled on day operations



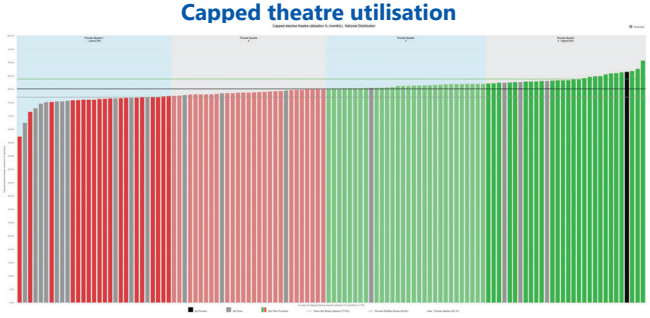
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



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WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	JAN 26	78.00	90.00		F
APPRAISAL (CONSULTANT)	JAN 26	98.00	90.00		P
APPRIASAL (OTHER MEDICAL)	JAN 26	98.00	90.00		P
INFORMATION GOVERNANCE TRAINING	JAN 26	90.00	95.00	L	F
SAFEGUARDING CHILDREN L1	JAN 26	95.00	90.00		P
SICKNESS	JAN 26	7.23	4.50	H	F
TURNOVER	JAN 26	6.53	12.00	L	P
VACANCY	JAN 26	3.60	5.00	L	?

Alert

Information Governance training remains behind the required 95%, at 9%. Lead Executive overseeing compliance and querying reporting.
Sickness absence continues to deteriorate, 7.23% (7.32% in December). Excluding OneLSC, this is 7.08%.
34% of sickness absence is a result of anxiety/stress/depression, alongside an short-term absence due to cold, cough, flu remaining an issue (12% of all absence).
Non-medical appraisal sits at 78%, behind the target of 90%. A rapid improvement week, focussing on appraisal took place week commencing 9 February 2026, aimed at improving compliance.

Advise

Job planning – live, pending or at sign-off stage: Consultants 84%, Non-Consultant grade 79%.
Team job planning completed in December. Individual job planning ongoing, consistency panels for all Directorates being arranged by end of May.

Assurance

Appraisal compliance for medics remains above the 90% target – 98% for Consultants (96% in December), 98% for other grades (97%).

WELL LED - HR

East Lancashire Hospitals NHS Trust
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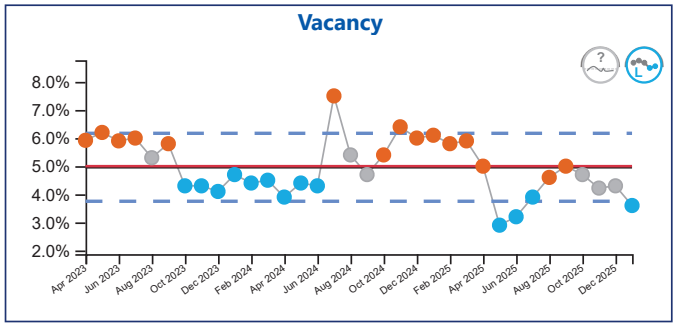

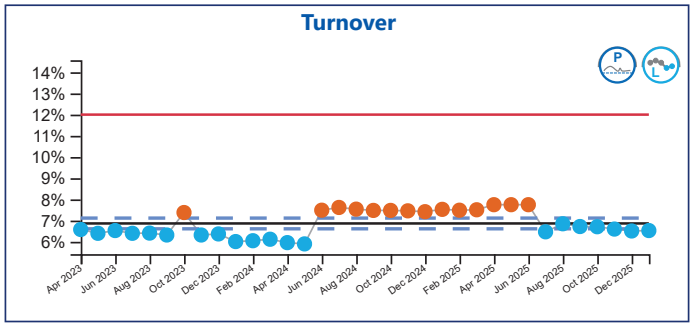

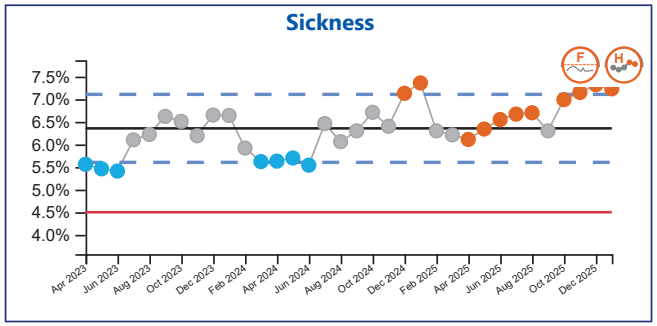

Freedom to Speak Up Cases by Elements

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
25/26 Q2	3	40	25	37	64
25/26 Q3	8	26	15	36	60

Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	167	28
Complete	13	11
Due Soon	65	37
In Progress	74	22
No Current Job Plan	2	8
Not Started	58	17
Referred Back	2	1
Uploaded	0	0
Total	**381**	**124**

WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
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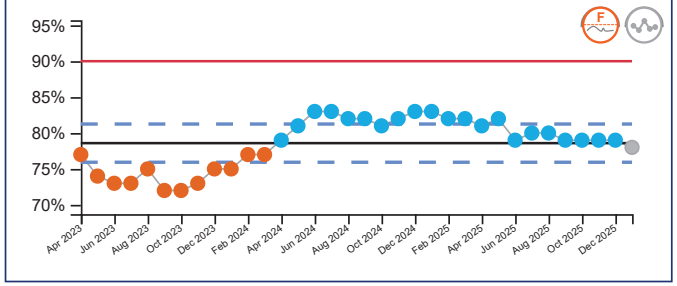
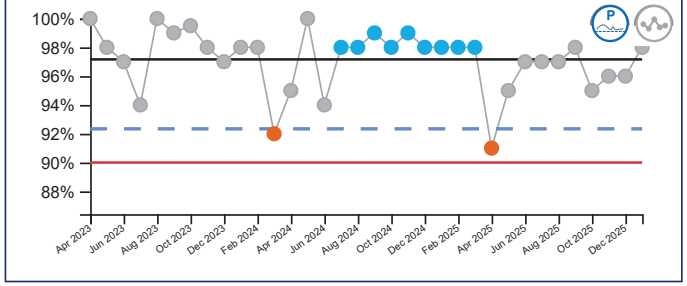
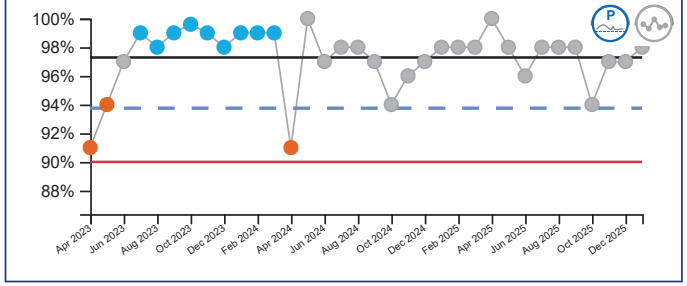
Appraisal (agenda for change)



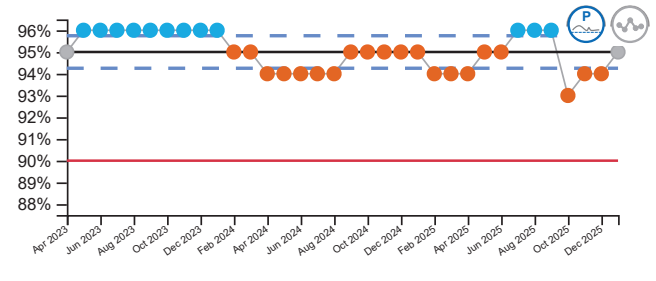
Appraisal (consultant)



Appriasal (other medical)

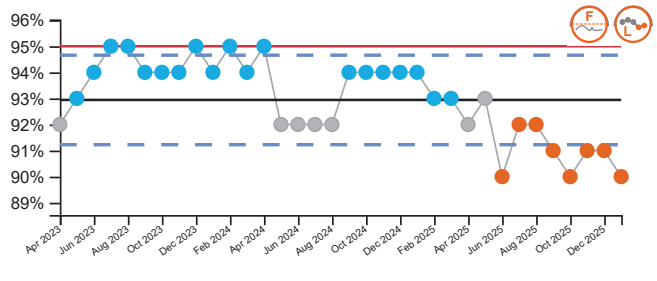


Safeguarding Children L1



Module	Target	Compliance
Basic Life Support	90.00	0.86
Conflict Resolution L1	90.00	0.96
Equality, Diversity and Human Rights	90.00	0.95
Health, Safety and Welfare	90.00	0.95
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.88
Prevent	90.00	0.95
Safeguarding Adults L1	90.00	0.95
Safeguarding Adults L2	90.00	0.94
Safeguarding Adults L3	90.00	0.94
Safeguarding Children L1	90.00	0.95
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	0.94
Freedom to Speak Up	95.00	0.88
Information governance training	95.00	0.90
Safer Handling L1	95.00	0.95
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	TARGET	VARIATION	ASSURANCE
AGENCY SPEND AS PROPORTION PAY BILL (£M)	JAN 26	0.77	1.20		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	JAN 26	89.30	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	JAN 26	85.30	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	JAN 26	54.10	95.00		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	JAN 26	90.00	95.00		
LIQUIDITY DAYS	JAN 26	-30.40	-21.50		
VARIANCE TO CAPITAL PROGRAMME (£M)	JAN 26	5.11	0.00		
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	JAN 26	-3.64	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	JAN 26	1.70	0.00		

METRIC	LATEST DATE	VALUE	TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	JAN 26	47.48		
INCOME RUN RATE (£M)	JAN 26	67.71		
OTHER OPERATING EXPENSES RUN RATE (£M)	JAN 26	21.65		

Note: The three run rate indicators above do not currently have a target set

Alert

Cash Risk and DSF Conditions: The Trust faces a critical cash risk associated with DSF being withheld due to under performance against the financial plan. Immediate focus on cost reduction and delivery of WRP is needed to maintain our cash balance. The Trust have made a cash application approved by the board.
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 is based on the risk adjusted revenue position. The cash balance increased by £3.8m to £13.8m in January, 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 Waste Reduction Programme (WRP) of £60.8m. The risk adjusted forecast is £53.3m (excluding DSF).
The Trust is reporting a deficit of £3.64m for M10, £1.12m behind the planned position. This is the deficit excluding £3.6m of DSF.
The year-to-date position, excluding £26.1m of DSF, is a £54.17m deficit, £15.44m behind the planned position of £38.7m.
WRP Delivery: The Trust achieved £4.8m WRP in Month 10 against a reprofiled plan of £6.5m. Cumulatively the Trust has delivered £33.9m of savings which is £13.5m adverse to the reprofiled plan. The WRP delivered £4.8m in month, a variance of £1.7m to the WRP Delivery plan of £6.5m. Year to date, the WRP delivered is £33.9m against the original plan of £47.4m, a variance of £13.5m.
Workforce Spend: Pay spend decreased in M09 v M08 by £1.9m.
Cash: The cash balance at the end of January was £13.8m, an increase of £3.8m compared to £10m at the end of December.
Capital: The 2025-26 capital plan is £47.6m. While the year to date spend at M10 of £19.9m is £5.5m ahead of plan, the Trust is still forecasting not to exceed the annual plan.

WELL LED - Finance

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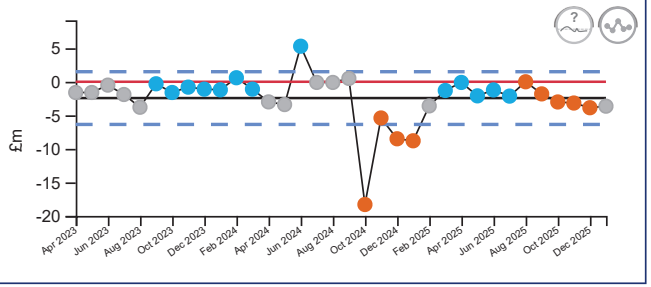
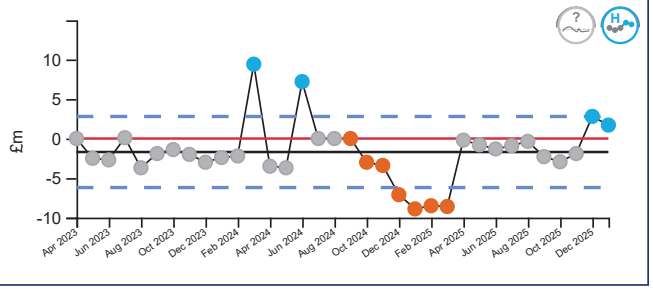
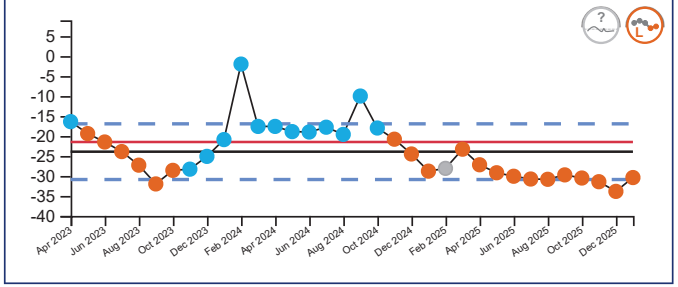
Variance to planned financial performance (deficit) (£m)



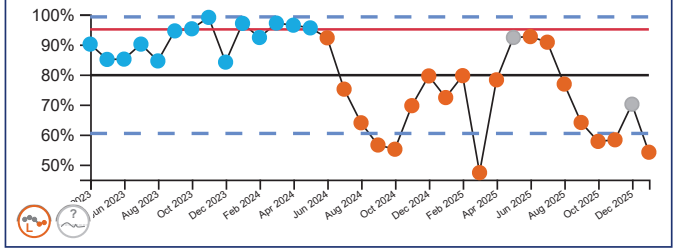
WRP achieved - variance to plan (£m)



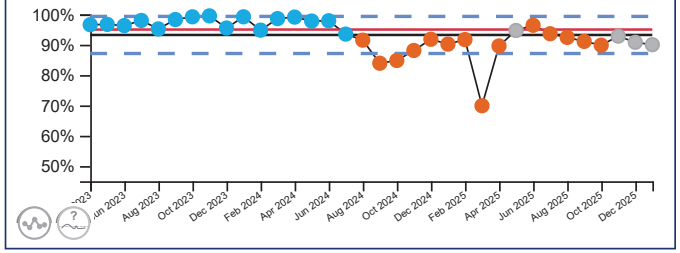
Liquidity days



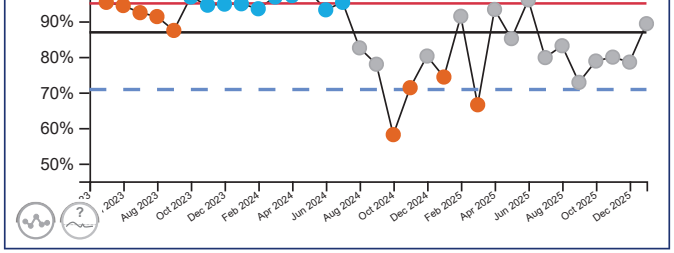
Better Payment Practice Code (BPPC) Non NHS No of Invoices



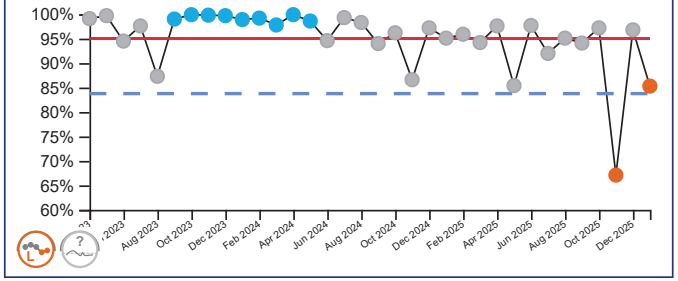
Better Payment Practice Code (BPPC) Non NHS Value of Invoices



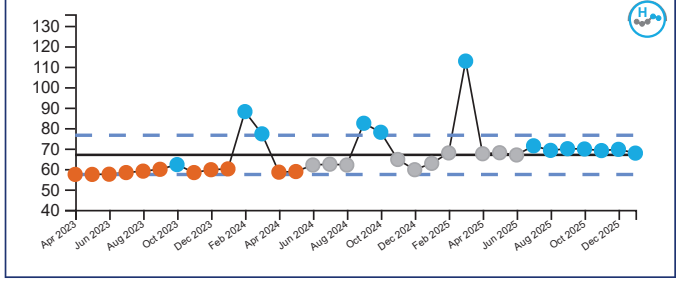
Better Payment Practice Code (BPPC) NHS No of Invoices



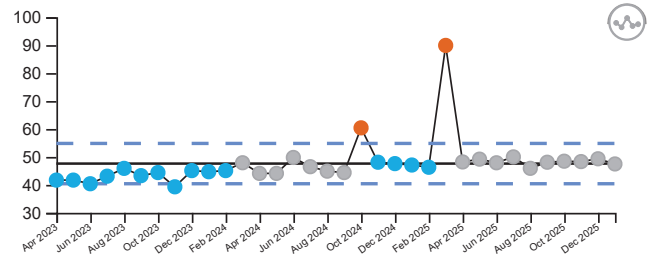
Better Payment Practice Code (BPPC) NHS Value of Invoices



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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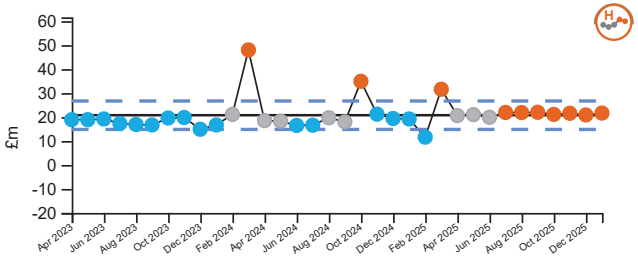
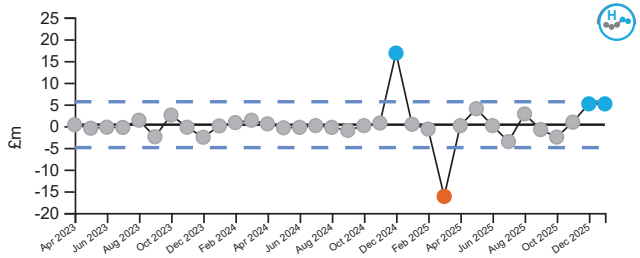
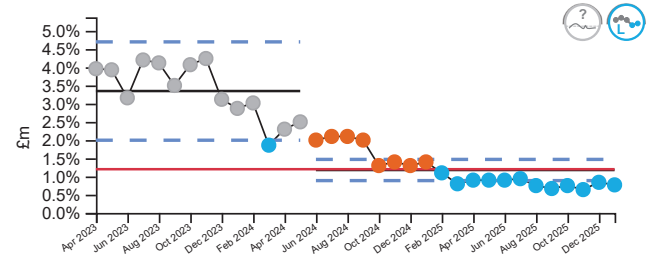
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion pay bill (£m)



East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/037
Report Title:	Financial Performance Report Month 10 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**
		X		

Executive Summary:

At month 10, the Trust is reporting an in-month deficit of £3.64m, against a planned deficit of £2.52m; £1.12m behind the plan.

The M10 Actual position came in £1.2m better than the forecasted M10 position.

Following the NHSE Forecast Outurn Protocol, the Trust has revised the forecast outturn for 2025/26 to a £10m deficit to the break-even plan, agreed at an Extraordinary Trust Board on the 5th of February 2026.

The year-to-date (YTD) position is a £54.17m deficit against a planned deficit of £38.73m; £15.44m behind plan (includes the original WRP plan and excludes the DSF).

The WRP delivered £4.8m in month which is £1.7m behind the revised plan (£1.2m adverse to the original PFR plan) although.

The WRP has delivered £33.9m YTD which is £13.5m behind the revised plan; however, this is £14.3m adverse to the original PFR YTD plan.

Key Metrics
Agency spend of £365k, is £24k higher than M9 although £144k better than plan and represents a 57% reduction on 2024/25 run rate.

Bank spend reduced against last month and was £2,995k, which is £551k favourable to plan, this represents a 34% reduction on 2024/25 run rate.

The cash balance at the end of January was £13.8m, an increase of £3.8m compared to the M9 cash position.

The annual 2025/26 capital plan is now £47.6m. The plan fluctuates as centrally held PDC funding becomes available and bids are approved. At M10, spend is £19.9m, £5.8m ahead of plan.

Paid WTE have decreased by 78 WTE from Month 9 to 9,610. The reduction is driven by the fact there was no further industrial action in M10.

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; however the Trust has revised the forecast outturn for 2025/26 to a £10m deficit against the break-even 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 with a minimum delivery in line with the Trust's forecast "most likely" of £42.9m and delivery of the One LSC Estates & Procurement Transformation Programme . • Cash flow forecasting is signalling cash will continue to be a significant challenge in the absence of DSF despite the Trust receiving some cash support in January. A further application for cash support in March was not approved by NHSE NW on the basis that the LSC system plan will be delivered, so DSF would be paid. Receipt of the full DSF allocation would require the Trust to repay the cash support received in January. Should DSF be withheld this would lead to significant cash flow challenges. • For the Capital Programme, PDC must be spent in the year of draw down and will impact upon the Trust's cash balance which as mentioned above is negatively affected by the withholding of DSF, under-delivery of WRP and in year operational pressures. This may cause a risk to the internally funded programme that may need to be curtailed. • Divisional pressures to be contained within the agreed budgets/ plan although these have stabilised. • 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.
Action Required by the Committee:	Note the content of the report.

Previously Considered by:	Finance and Performance Committee
Date:	23rd February 2026
Outcome:	Noted

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M10 Financial Performance Trust Board

11th March 2026

Month 10 Key Headlines

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Summary of Financial Position

- In month **deficit of £3.64m**, against **deficit plan of £2.52m,** therefore **£1.12m behind the plan**.
- **The M10 Actual position came in £1.2m better than the forecasted M10 position,** linked primarily to income around Paeds HDU (WRP) and ERF income.
- YTD **deficit of £54.17m** against; **deficit plan of £38.73m,** therefore **£15.44m behind plan** (excluding the DSF).
- In line with the Forecast Outurn Protocol, the Trust has revised the forecast outturn for 2025/26 to **a £10m deficit to the break-even plan**, agreed at an Extraordinary Trust Board on the 5th of February 2026.
- **Key risks** to the FOT are delivery of the "most likely" **WRP** £42.95m and delivery of the One LSC Estates & Procurement Transformation Programme
- In month **WRP delivered £4.8m** against the WRP Delivery plan, therefore **£1.7m adverse to plan** (£1.2m adverse to PFR plan)
- YTD **WRP delivered £33.9m** against the WRP Delivery plan, therefore **£13.5m behind plan**. (£14.3m adverse to PFR YTD plan)
- **Cash balance** at the end of January was **£13.8m**, an increase of £3.8m compared to M9 cash position of £10m.
- **Capital** plan 2025/26 is **£47.6m**. At M10, spend is **£19.9m**, £5.8m ahead of plan.
- Paid/worked WTE have decreased by **78 WTE** from Month 9 to **9,610 WTE**
- One of the biggest drivers of the Trust's financial position is the level of activity undertaken in excess of the funding within the block element of the contract. In part this was offset in the plan by the DSF, although withholding the DSF does impact on cash. This drives pay and non-pay costs, impacting on the ability to deliver the WRP as planned. This is a key factor in the planning for 2026/27.

M10 FPR Plan vs Actual

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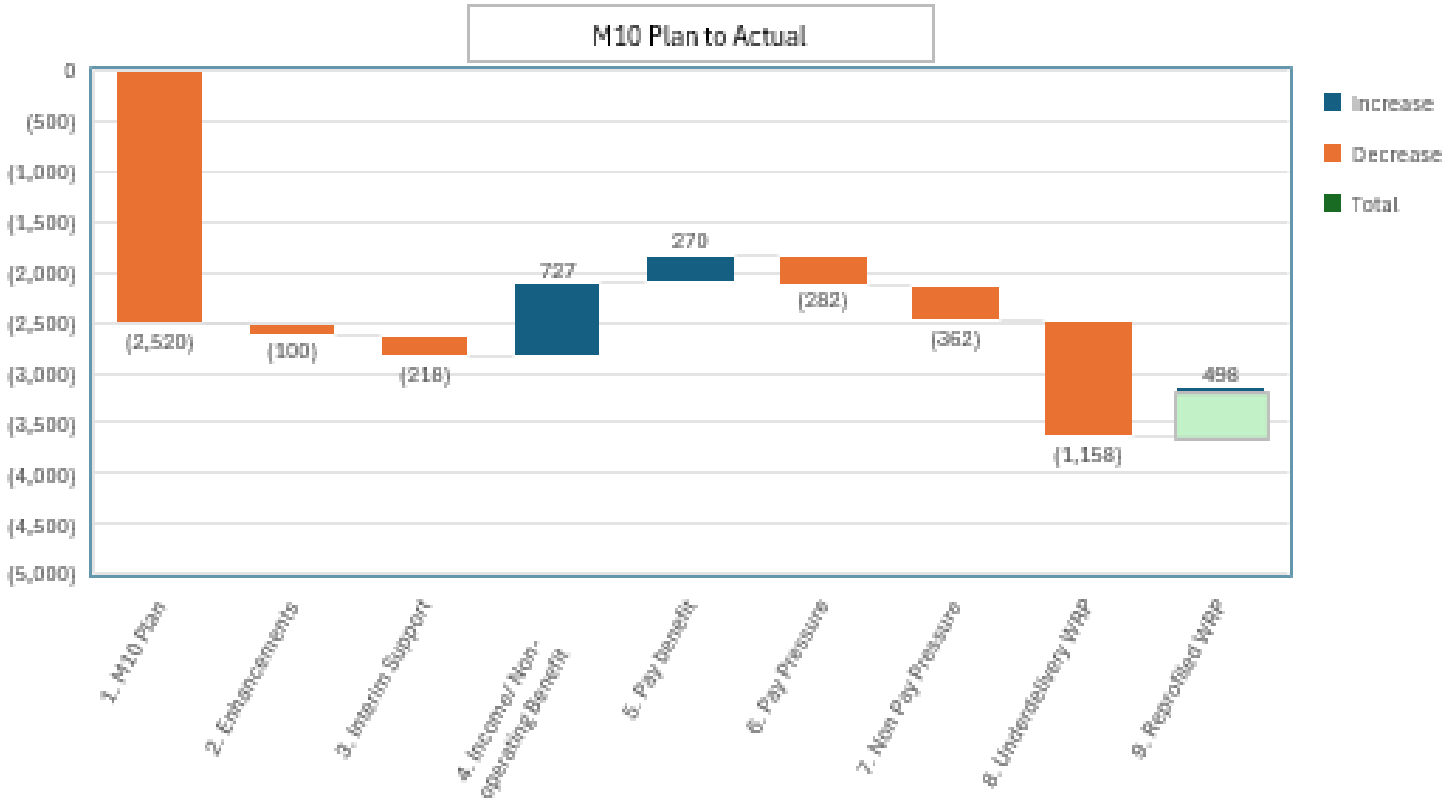
Monthly Actuals	Current Month Plan £000	Current Month Actual £000	Variance to Plan £000
Operating Income: Patient Care	63,870	63,991	121
Other Operating Income	3,891	3,716	(175)
Total Income	**67,761**	**67,707**	**(54)**
Substantive	(41,100)	(43,235)	(2,135)
Variable Pay: Overtime	(43)	(42)	0
Variable Pay: WLI / Extras	(355)	(665)	(310)
Variable Pay: Bank	(3,546)	(2,995)	551
Variable Pay: Agency	(509)	(365)	144
Other Staff Costs	(192)	(178)	14
Total Pay	**(45,745)**	**(47,480)**	**(1,735)**
Supplies & Services Clinical	(3,694)	(5,117)	(1,423)
Drugs	(4,486)	(4,769)	(283)
Other Non Pay	(11,131)	(11,760)	(629)
Total Non Pay	**(19,311)**	**(21,645)**	**(2,334)**
Total Expenditure	**(65,056)**	**(69,125)**	**(4,069)**
Net Expenditure	**2,705**	**(1,418)**	**(4,123)**
Non Operating Movements	(436)	(435)	1
Operating Surplus (Deficit)	**2,269**	**(1,853)**	**(4,122)**
Other Non Operating Movements	(1,179)	(1,513)	(334)
Adjusted Financial Performance Surplus (Deficit)	**1,090**	**(3,366)**	**(4,456)**
Deficit support Funding	(3,610)	(277)	3,333
Adjusted Financial Performance Surplus (Deficit) Excluding DSF	**(2,520)**	**(3,643)**	**(1,123)**

	£m	R	NR
Income Plan	67.8		
DSF	-3.3		x
Offset (HCD/Clear)	1.1	x	
Donation (Offset in Non-Operating)	0.4		x
PFI Pressure	-0.7		x
ERF	1.4	x	
Other various	0.1		x
WRP Delivered	1.0		x
Income Actual	67.7		

	£m	R	NR
Pay Plan	45.8		
Bank Holiday Pressure	0.10	x	
Pension pressure	0.13	x	
Benefit in month	-0.27		x
Other Pay Pressures	0.12		x
Underdelivery WRP	1.60	x	
Pay Actual	47.48		

	£m	R	NR
Non-Pay Plan	19.3		
Offset by Income	1.1	x	
Recovery Support	0.2	x	
Consumables	0.3	x	x
Other Various Pressures	0.2		x
Underdelivery WRP	0.5	x	
Non-Pay Actual	21.6		

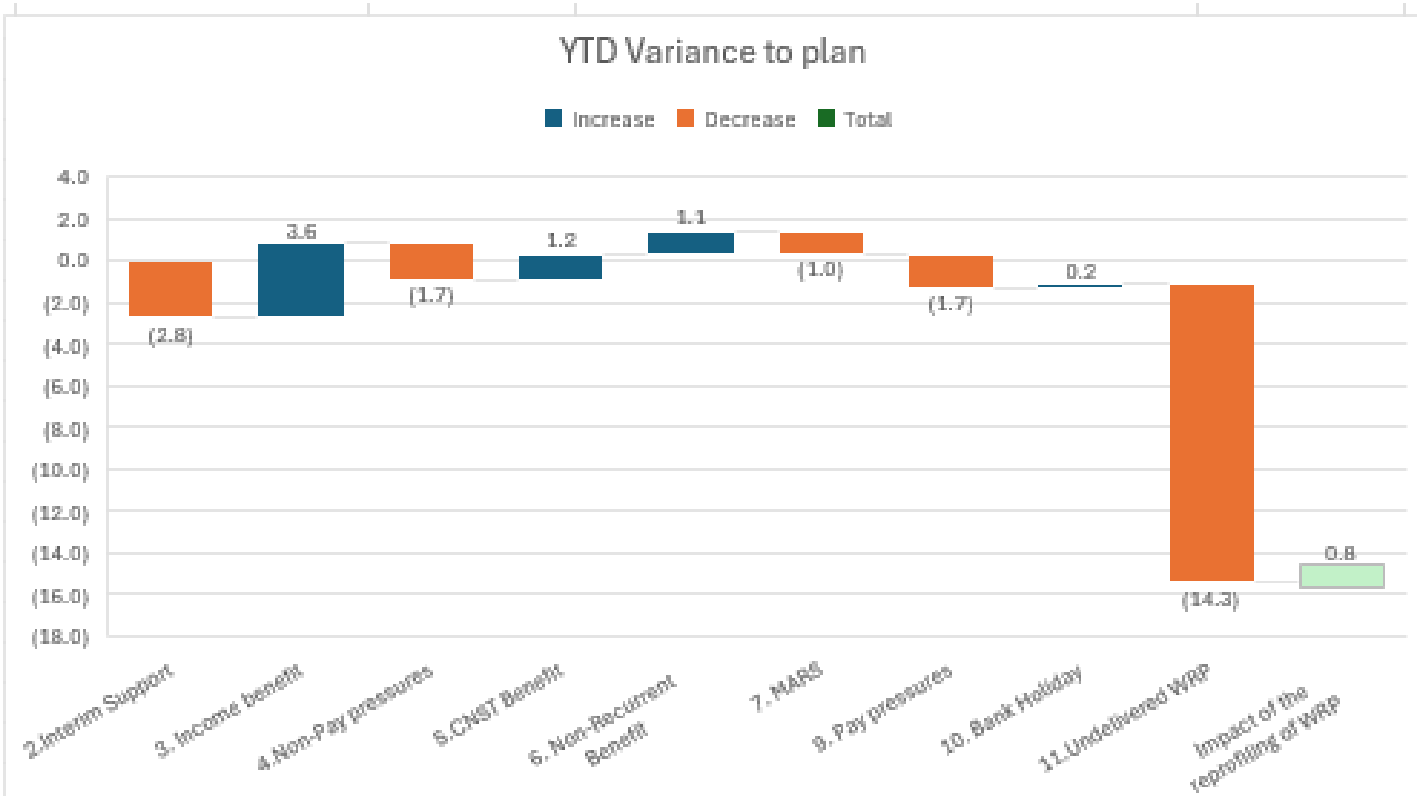
Drivers of Variance in M10



1. M10 Plan £2.52m Deficit
2. Bank Holiday Enhancements Pressure : £0.1m
3. Trust Financial Recovery Team: £0.2m
4. Income Benefit : £0.7m including ERF
5. Pay Benefit: £0.3m favourable, relates to overpayment in M9
6. Pay Pressures: £0.3m including pension opt-in
7. Non-Pay pressures: £0.4m, majority increase in consumable linked to increase in activity net of Grip and Control reductions
8. Undelivered WRP: £1.2m pay and non-pay
9. M10 Actual £3.6m Deficit

*Impact of reprofiled WRP £0.5m

Drivers of variance YTD



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1. **YTD Plan** £38.7m Deficit
2. **Trust Financial Recovery Team** pressure £2.8m
3. **Income benefit** £3.6m (mainly ERF, CPD, bowel screening and Carparking)
4. **Non-pay** pressures £1.7m (PFI, Stocks, Utilities)
5. **CNST** one-off benefit £1.2m
6. **Non-Recurrent HCA** benefit £1.1m
7. **MARS** pressure £1m
9. **NR Pay** Pressures £1.7m, backdated pay and pension opt-in
10. **Bank Holiday profiling Benefit** £0.2m
11. **Undelivered WRP** pressure £14.3m

YTD Actual £54.17m Deficit

*Impact of reprofiled WRP £0.8m

Key Risks

East Lancashire Hospitals NHS Trust

Key Risks

The Trust's financial plan for 2025/26 is **break-even,** including £43.3m deficit support funding (DSF); however the Trust has revised the forecast outturn for 2025/26 to a £10m deficit (exc DSF) against the break-even plan, The key risks associated with delivery of the revised forecast are:

- Full delivery of the **Waste Reduction Programme of £60.8m** is required with a minimum **most likely £42.9m** if the Trust's **M10 FOT** is to be met.
- Delivery of the One LSC Estates and Procurement Transformation Programme in March 2026
- Cash flow forecasting is signalling cash will continue to be a significant challenge in the absence of DSF despite the Trust receiving some cash support in January. A further application for cash support in March was not approved by NHSE NW on the basis that the LSC system plan will be delivered, so DSF would be paid. Receipt of the full DSF allocation would require the Trust to repay the cash support received in January. Should DSF be withheld this would lead to significant cash flow challenges in March.
- The impact on income of **withholding of Deficit Support Funding** if the System does not deliver the financial plan.
- **Divisional positions to be within budget**, and all pressures contained within the funding available in the plan.
- The financial impact of any further **industrial action**
- The risk of an **Activity management plan (APM**) impacting ERF assumptions related to overperformance.

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Cash

2025/26 Cashflow Forecast

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Cash Flow Forecast	M11	M12	M1	M2	M3	M4	M05	M06	M07	M08	M09	M10
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Cash Balance	**13,852**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**
Cash Inflows												
Capital PDC funding	10,173	3,115	-	-	-	-	-	-	-	-		
Other capital funding	2,032	2,716	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Deficit Support Funding	-	17,223		-	-	-	-	-	-	-	-	-
Other ICB and NHSE income	63,663	61,910	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500
Other NHS and non-NHS income	3,094	5,310	3,600	3,600	3,600	3,600	3,300	3,300	3,300	3,300	3,300	3,300
VAT	1,500	1,500	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
PDC revenue support	0	(10,831)	-	-	-	-	-	-	-	-		
Interest	167	167	150	150	150	150	150	150	150	150	150	150
Total Inflows	**80,630**	**81,111**	**80,000**	**80,000**	**80,000**	**80,000**	**79,700**	**79,700**	**79,700**	**79,700**	**79,700**	**79,700**
Cash Outflows												
Capital Expenditure	(7,728)	(11,507)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Salaries	(31,994)	(30,405)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)
PAYE/NIC/Pension Benefits	(20,931)	(20,938)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)
NHS Litigation Authority Contributions	(0)	(0)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)
Other NHS Purchase Ledger Payments	(3,296)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)
Non-NHS Purchase Ledger Payments	(27,533)	(15,260)	(20,100)	(20,100)	(20,100)	(20,100)	(19,800)	(19,800)	(19,800)	(19,800)	(19,800)	(19,800)
Total Outflows	**(91,482)**	**(81,111)**	**(80,000)**	**(80,000)**	**(80,000)**	**(80,000)**	**(79,700)**	**(79,700)**	**(79,700)**	**(79,700)**	**(79,700)**	**(79,700)**
Net Cash Flow	**(10,852)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**		
Closing Cash Balance	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**

Key points and cash forecasting assumptions

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- With Deficit Support Funding (DSF) not being awarded since M7, **the Trust applied to receive £18.1m of Provider Revenue Support (PRS) PDC in Q4**, of which £10.8m was received in January. The Trust made a second application for a March draw down of the balance as the pressure continues on the cash position, this application was not approved on the basis that the Trust is expected to **receive withheld DSF by the end of the financial year as the LSC system overall is forecasting to deliver to plan.**
- The PDC Revenue support received in January helped to pay some of the suppliers that have had payments withheld however there are still significant approved payments awaiting processing. This will continue to be the case until the DSF is received to ensure the Trust is able to pay staff and make statutory payments while maintaining its £3.0m minimum cash balance.
- As previously reported, the Trust is having to be very proactive in managing its cash which means prioritising payments to suppliers on a daily basis and ensuring robust debt recovery is in place. This is now a critical part of the finance team's work given the withholding of DSF in months 8 - 10.

Statement of Financial Position

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	As at 31st March 2025 £000	As at 31st January 2026 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	18,304	(864)	17,580	724
Property, plant and equipment	266,094	266,907	813	267,083	(176)
Right of use assets	31,946	32,003	57	32,705	(702)
Inventories	11,310	11,686	376	11,688	(2)
Receivables (NHS)	17,592	29,287	11,695	26,844	2,443
Receivables (non-NHS)	19,605	25,570	5,965	24,248	1,322
Cash and cash equivalents	16,786	13,852	(2,934)	10,030	3,822
Total assets	382,501	397,609	15,108	390,178	7,431
Liabilities:					
Trade and other payables (capital)	(6,418)	(5,534)	884	(4,829)	(705)
Trade and other payables (non-capital)	(71,452)	(98,540)	(27,088)	(98,547)	7
Lease related liabilities	(32,433)	(32,900)	(467)	(33,560)	660
PFI related liabilities	(228,045)	(218,726)	9,319	(219,402)	676
Provisions for liabilities and charges	(3,439)	(3,451)	(12)	(3,451)	0
Other liabilities: deferred income	(13,693)	(6,539)	7,154	(9,275)	2,736
Total liabilities	(355,480)	(365,690)	(10,210)	(369,064)	3,374
Total assets employed	27,021	31,919	4,898	21,114	10,805
Financed by taxpayers equity					
Public dividend capital	332,933	350,339	17,406	337,681	12,658
Revaluation reserve	21,711	21,712	1	21,712	0
Income and expenditure reserve	(327,623)	(340,132)	(12,509)	(338,279)	(1,853)
Total taxpayers equity	27,021	31,919	4,898	21,114	10,805

Receivables have increased in-month linked primarily to income in relation to anticipated industrial action

Deferred income has reduced by £2.7m in-month relating to PFI income and Health Education income, as this is paid quarterly to the Trust.

Cash and cash equivalents has gone up because of the £10.8m of PDC received in January.

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Capital

Capital

East Lancashire Hospitals

Capital Forecast	2025-26			M10			M11	M12	2025-26
	Initial Plan	Adjustments to Initial Plan	Revised Plan	Plan	Actual	Variance	Forecast	Forecast	Total
	£'000			£'000	£'000	£'000	£'000	£'000	£'000
Internally Funded									
Donated Assets	500	1,712	2,212	420	1,381	961	42	789	2,212
PFI lifecycle cost	3,604	2,086	5,690	3,000	4,742	1,742	474	474	5,690
CHO ROU assets	4,656	2,561	7,217	4,656	5,461	805	-	1,756	7,217
Other ROU asset (intra-DHSC group)	12	-	12	12	-	12	-	12	12
Other ROU assets	6,332	-2,561	3,771	-	1,482	1,482	-	2,289	3,771
Other internally funded schemes	6,889	-3,506	3,383	5,720	3,189	-2,531	183	11	3,383
Externally funded									
UEC #2		2,225	2,225	-	949	980	350	926	2,225
Net Zero	1,980	-	1,980	-	1,403	990	473	104	1,980
Diagnostics	1,435	-	1,435	-	45	45	480	910	1,435
Elective Recovery	1,044	-	1,044	-	-	-	348	696	1,044
UEC	5,749	-2,783	2,966	-	-	-	989	1,977	2,966
Estates Safety	757	1,031	1,788	-	371	371	473	944	1,788
RAAC		4,279	4,279	-	378	378	357	3,544	4,279
Digital		710	710	-	223	223	-	487	710
Retinopathy pf Prematurity (ROP)		69	69	-	69	69	-	0	69
EPR (Oracle) to GP Connect integration		1,827	1,827	-	-	-	-	1,827	1,827
Funding to replace use of cash reserves		3,612	3,612	-	205	-	1,601	1,806	3,612
Cyber Security		2,598	2,598	-	-	-	-	2,598	2,598
2526 Connecting Care Records - Interoperability -		287	287					287	287
Sec7A Health Inequalities Equipment		150	150					150	150
Single SD Wan		302	302					302	302
Total	**32,958**	**14,147**	**47,557**	**13,808**	**19,898**	**5,527**	**5,770**	**21,889**	**47,557**

NB: Since reporting at M10 the RAAC programme of works is forecast to incur £159k of expendiutre in year. The total CDEL will be adjusted in future months to reflect this and some other changes as national allcoations have been confirmed

Capital

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- The Trust's Capital Programme for 2025/26 **has increased by £0.5m to £47.6m** related to an additional £0.5m PDC funded scheme and is forecast to be spent in full achieving the revised plan.
- The Trust has responded to all the MOUs that remained outstanding by the deadline of midday 16th of February, with assurances that the money will be spent by 31st March.
- The £11m included for right of use asset (ROU) related spend which matches the allocation from the ICB has now been fully matched to specific schemes. CHP Leases are forecasted at £7.2m, Year-to-date spend has been recognised at £5.4m, with a remaining £1.8m due by year-end. The planned expenditure for 2025/26 has been reprofiled to recognise slippage on the endoscopy scheme which has now been moved to 2026/27. This has been replaced with the third robot in 2025/26.
- Year to date, **the Trust has recognised £19.9m** of capital expenditure, consisting of £6.9m of right of use assets related spend and £4.7m of PFI lifecycle related spend with most of the remaining balance spent on Estates related schemes.
- The expenditure to date represents an **overspend of £5.8m against plan** with the £2.3m of ROU asset and £1.6m of PFI lifecycle spend recognised ahead of plan offsetting slippage elsewhere.

Glossary

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

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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

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TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/038
Report Title:	East Lancashire Hospitals NHS Trust Improvement Plan (RSP Exit Criteria)		
Author:	Kate Atkinson, Director of Service Development & Improvement		
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 key messages at Month 10 are: • Progress has been made in compiling all associated evidence to support the Improvement Plan and this is currently being assessed by NHSE through a joined SharePoint site. • At month 10, the Trust is reporting a deficit of £3.64m, against deficit plan of £2.52m, therefore £1.12m behind the plan. Year to date the Trust is reporting a deficit of £54.17m against; against a deficit plan of £38.73m, therefore £15.44m behind plan (excluding the DSF). • There continues to be a reduction in the run rate with the normalised position improving at M10 by a further £0.3m and therefore this has been rated as green under RSP Criteria 2. • The progress made on the Exit Criteria is reflected in our progress on the Legal Undertakings and reflect the positive participation and benefit of the Recovery Support Programme. In summary of the 16 points in the undertakings, 13 are complete (Blue), 2 on track for completion (Green) and 1 with mitigation work underway (Amber). • Similarly, for the RSP Exit Criteria of the 41 key actions covering the 5 Exit Criteria, 26 are complete (Blue), 10 on track for completion (Green), 2 with mitigation work underway (Amber) with 3 marked as off track, with insufficient mitigation (Red). These relate to delivery of the financial plan and WRP plan as outlined above. • The CQC action plan for intermediate care has been included as part of the IIP. Of the 41 action, 36 are complete (Blue), 4 on track for completion (Green) and 1 with mitigation work underway (Amber). There are no significant issues to escalate.			

	• Work has commenced on the development of a presentation to March IAG against all Exit Criteria, the Trust's forward strategy and next steps upon transition from the Recovery Support Programme. The meeting will be held on 18th March and we look forward to welcoming regional and national colleagues to the Trust.
Key Issues/Areas of Concern:	The key risk is the current performance of the financial plan at Month 10 being £15.44m behind plan. Work is ongoing to improve this through identification of mitigations and to continue to deliver the agreed financial plan.
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:	24th February 2026
Outcome:	Improvement Plan feedback noted and is now included in the report to Trust Board.

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East Lancashire Hospitals NHS Trust Integrated Improvement Plan

Update Report Month 10

Improvement Plan Contents

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Introduction to the Integrated Improvement Plan

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- The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan was developed in early 2025/26 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 plan has now been further developed to become an Integrated Improvement Plan (IPP) from Month 9.
- The IIP will bring together all key improvement requirements, including regulatory undertakings, CQC actions, external review recommendations, governance and leadership improvements, the Financial Improvement Plan, the Medium-Term Improvement Plan, and eventually will link/reflect the priorities in the new Trust Strategy.
- A single integrated approach will provide a clear line of sight across all improvement activity and strengthen assurance for the Executive and Board.
- 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 continues 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. The IIP will focus only on material improvement work, not business as usual (BAU) activity. As actions are completed and assured, they will transfer into standard oversight by the relevant Board subcommittee, preventing unnecessary growth of the plan.
- 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

RECOVERING: Apr 25 to Mar 26 | **STABILISING & PERFORMING: Apr 26 to Mar 28** | **TRANSFORMING: Apr 28+**

Safe, Personal and Effective Care

Direct NOF 5 evidence has a red boarder

Safe

Deliver Safe, High Quality Care

- Quality – Safety & Investigation priorities **Quality**
- Quality – Health, safety and risk priorities **Quality**
- Quality – Audit and effectiveness plan **Quality**
- Trust Strategy refresh /redesign **Board**
- Clinical transformation and reconfiguration **Quality / F&P**
- Green Plan priorities **F&P**
- Community Neighbourhood health model **Quality**
- Our wider role in health prevention / anchor institution **P&C**
- Sustaining workforce transformation **P&C**
- Clinical transformation and reconfiguration **Quality**
- Clinical Strategy delivery plan **Quality**
- UEC pathway /flow improvement / neighbourhood development **Quality / F&P**
- Digital enablement to support transformation **DD&T**
- Addressing local health inequalities **Quality**
- DERI delivery plan – development of education, training and research **P&C**
- Embed risk management and accountability Framework **Audit**
- Elective Improvement plan **Quality / F&P**
- Applying a health equality lens to delivery **F&P**
- Build on culture of compassion and belonging **P&C**
- One LSC Objectives **F&P**
- Embed & develop financial sustainability **F&P**
- Health equity – managing systemic influences **Quality**

Personal

Health Inequalities

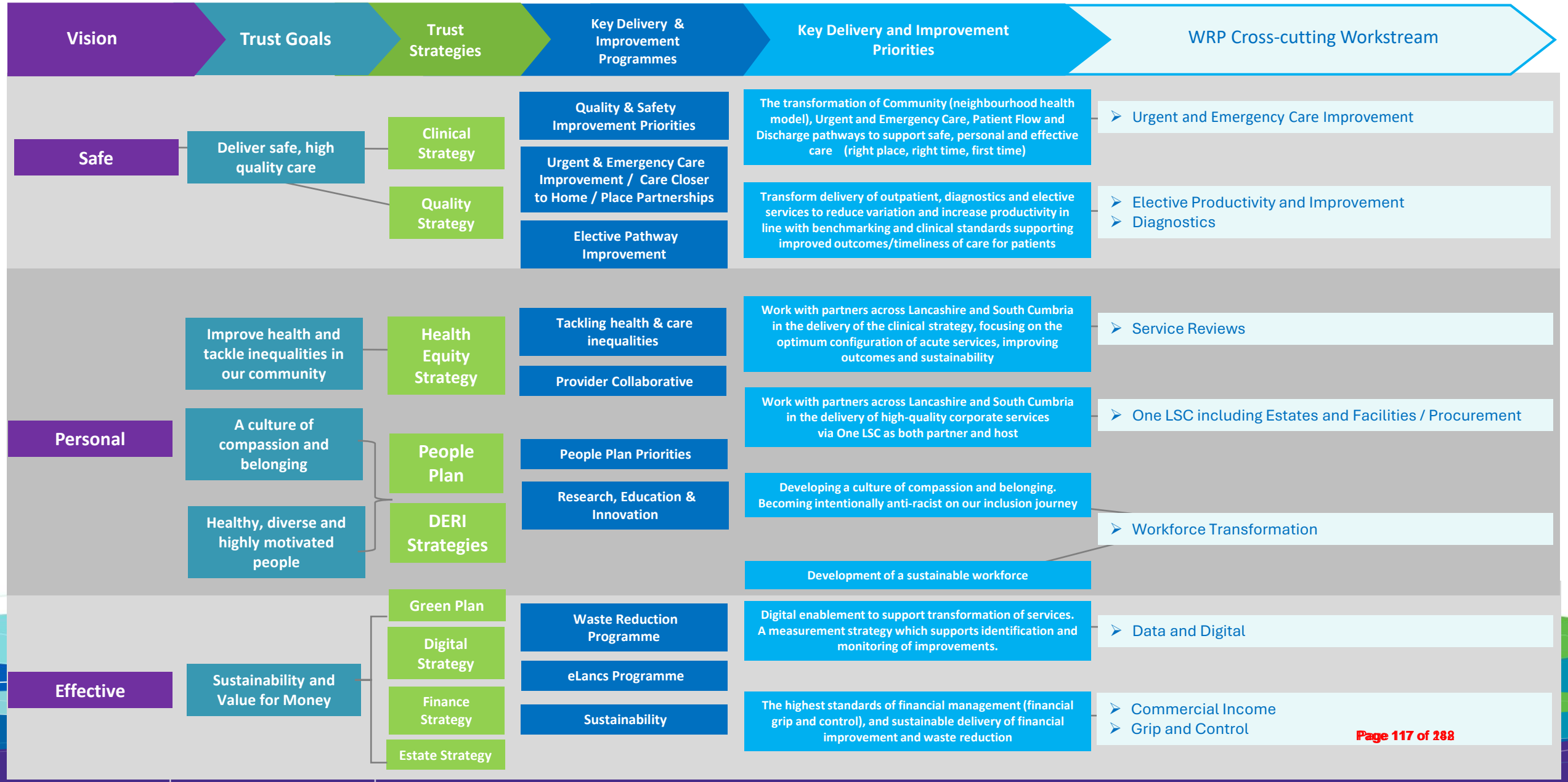
- Key Health Inequalities Delivery plan – understanding communities **Quality**
- Service reviews – developing sustainable workforce **F&P**
- Investment evaluation / Financial service reviews **F&P**
- Medium-term financial plan aligned to CIs **F&P**
- External well led review **Board**
- Full Trust Strategy Re-fresh **Board**
- WTE Reductions in line with WRP Plan **P&C / F&P**
- Strengthening grip and control **Audit**
- PMO established **F&P**
- SLG development **P&C**
- Reduction in variable pay / sickness management reduction plan **P&C / F&P**
- HR framework for organisational change **P&C**
- Delivery of WRP/financial plan **F&P**
- Financial governance – key actions and recommendations **F&P/Audit**
- Divisional IPR and data /coding review **F&P**
- Governance & leadership review **Audit**
- Board development Programme **Board**

Culture and People | **Sustainability & Value for Money** | **Well-Led**

Trust Vision and Goals

Personal | **Effective**

ELHT Strategic Framework - WRP cross-cutting workstreams and alignment



Improvement Plan Governance and Reporting

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Supporting Delivery – Our Programme Management Office, SPE+ Improvement Practice and Communications Approach

The Improvement Hub Team:

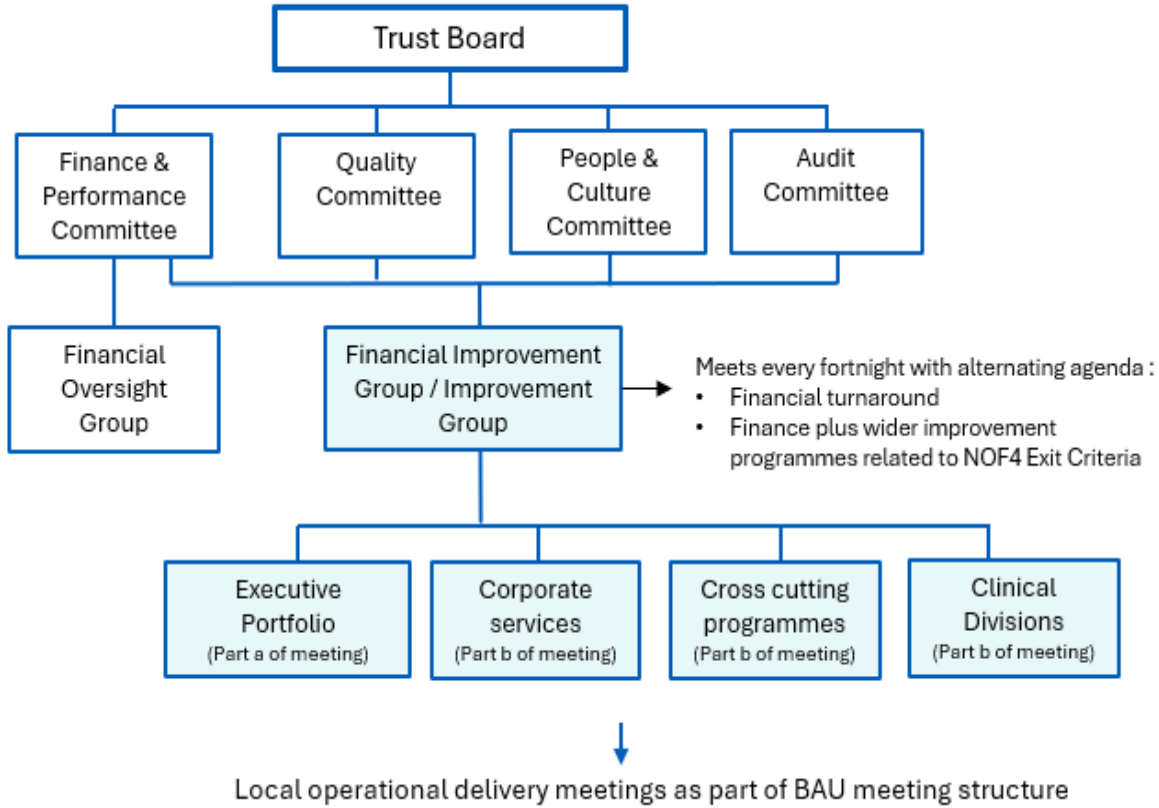
- Develop 'Daily Management' principles based on continuous improvement
- Continue to build Improvement capability and capacity
- Create a wider network of sharing good practice through ELHT and wider system partners
- Support measurement of all work to strengthen a data-based approach
- Support wider 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



The holder of the IIP is currently being agreed with this currently being co-ordinated by the Corporate Governance and Service Development Team.

Leadership and Governance Reviews

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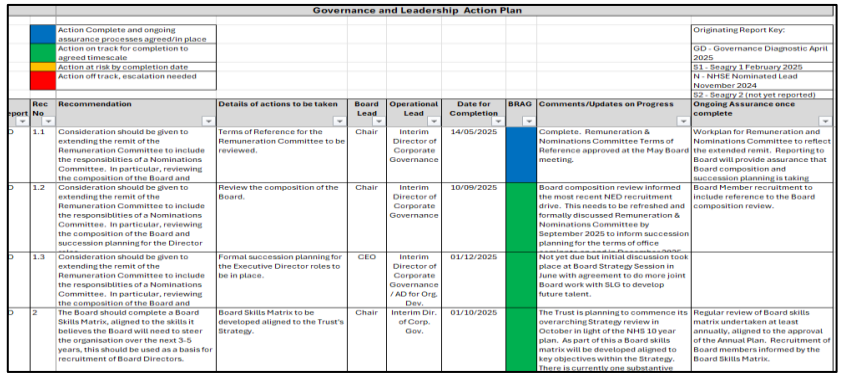
The Leadership & Governance Action plan incorporates the recommendations from 4 reviews. The action plan was approved by Trust Board in July and endorsed through IAG on 29th July 2025. It is monitored via the Audit Committee. There are 88 actions in total, as of February 2026 78 have been completed. Internal audit are currently testing progress against the legal undertakings and completion of actions within the Leadership and Governance Action Plan

L&G Review	Key Actions Required
NHSE Nominated Lead Report (November 2024)	The final report identified 16 recommendations for action. All complete.
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. All complete.
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 with 26 sub-actions. 21 actions are complete, 5 actions on track for completion.
Financial Governance Review (wider review)	Phase 2 Financial Governance Review undertaken by Seagry Consultancy. The report includes 26 recommendations. 21 actions are complete, 5 actions on track .

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 is 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

A summary of progress against the NOF4 Exit Criteria is provided on slide 16 ad is reported to Trust Board

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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

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A summary of progress against the NOF4 Exit Criteria is provided on slide 17 and is reported to Trust Board

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.

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Improvement Plan Delivery Update

Month 10 Report

Key messages this month

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- At Month 10 the year-to-date financial position is a YTD deficit £54.17m against; against a deficit plan of £38.73m, therefore £15.44m behind plan (excluding the DSF).
- YTD delivery of the Waste Reduction Programme continues to improve to £33.9m but this is £13.5m behind our re-profiled plan. Our M10 delivery was the highest delivered all year at £4.8m.
- The FOT likely case is £10m risk to breakeven plan, best case is £4.7m to breakeven plan and downside case is £21.5m risk to breakeven plan.
- On the basis of the Trust Board approval of the likely deficit plan on 11th February 3 key actions within RSP Criteria 1 (Deliver the financial plan and WRP submitted) have been turned to Red to signal these are off track, within insufficient mitigation. The Trust has undertaken non-elective activity in excess of the funded levels, due to the nature of the block contract, which has driven the increase in pay and non-pay costs to ensure the services commissioned are delivered safely and effectively. This has been reflected in the planning for 2026/27 and the expected contract offer.
- There continues to be a reduction in the run rate with the normalised position improving at M10 by a further £0.3m and therefore this has been rated as green under RSP Criteria 2.
- RSP Criteria 3 has been fully updated to reflect the successful submission of the Trust's medium-term plan and work is now focussed on the development of detailed delivery plans and refining of associated workforce plan profiles.
- The progress made on the Exit Criteria is reflected in our progress on the Legal Undertakings and reflect the positive participation and benefit of the Recovery Support Programme. In summary of the 16 points in the undertakings, 13 are complete (Blue), 2 on track for completion (Green) and 1 with mitigation work underway (Amber).
- Similarly, for the RSP Exit Criteria of the 41 key actions covering the 5 Exit Criteria, 26 are complete (Blue), 10 on track for completion (Green), 2 with mitigation work underway (Amber) with 3 marked as off track, with insufficient mitigation (Red). These relate to delivery of the financial plan and WRP plan as outlined above.
- The CQC action plan for intermediate care has been included as part of the IIP. Of the 41 action, 36 are complete (Blue), 4 on track for completion (Green) and 1 with mitigation work underway (Amber). There are no significant issues to escalate.
- Work has commenced on the development of a presentation to March IAG against all Exit Criteria, the Trust's forward strategy and next steps upon transition from the Recovery Support Programme. The meeting will be held on 18th March and we look forward to welcoming regional and national colleagues to the Trust.

Month 10 Key Headlines

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Summary of Financial Position

- In month **deficit of £3.64m**, against **deficit plan of £2.52m,** therefore **£1.12m behind the plan**.
- YTD **deficit of £54.17m** against; against a **deficit plan of £38.73m,** therefore **£15.44m behind plan** (excluding the DSF).
- **The Trust has revised the forecast outturn for 25/26 to a £10m deficit to the break-even plan, agreed at an Extraordinary Trust Board on the 5th of February 2026.**
- In month **WRP delivered £4.8m** against the WRP Delivery plan, therefore **£1.7m adverse to plan** (£1.2m adverse to PFR plan)
- YTD **WRP delivered £33.9m** against the WRP Delivery plan, therefore **£13.5m behind plan**. (£14.3m adverse to PFR YTD plan)
- **Cash balance** at the end of January was **£13.8m**, an increase of £3.8m compared to M9 cash position of £10m.
- **Capital** plan 2025-26 is **£47.6m**. At M10, spend is **£19.9m**, £5.8m ahead of plan.
- Paid/worked WTE have decreased by **78 WTE** from Month 9 to **9,610 WTE**
- One of the biggest drivers of the Trust's financial position is the level of activity undertaken in excess of the funding within the block element of the contract. In part this was offset in the plan by the DSF, although withholding the DSF does impact on cash. This drives pay and non-pay costs, impacting on the ability to deliver the WRP as planned. This is a key factor in the planning for 2026/27.

BRAG
Completed successfully
On track to deliver
Some elements not on track, mitigations to deliver
Off track, with insufficient mitigation

Regulatory Undertakings Summary Assessment

Undertaking Focus	No. of Key Actions	BRAG Status Summary for Key Actions				Overall BRAG	Summary of Progress	Next Steps
Financial Planning	3	2	1	0	0	G	Financial plan for 2025/26 agreed. Quarter on quarter run rate reduction since Q3 2024/25. £10m risk to breakeven plan (the legal undertakings do not specifically cover delivery of the financial plan but it is linked to plan agreement).	Ongoing focus on delivery of WRP and reduction of operational pressures where possible for 2025/26 towards best case. Support OneLSC transformation to secure benefits.
Recovery Support Programme	3	2	0	1	0	A	Detailed Integrated Improvement Plan (IIP) developed, including supporting delivery plan and improved governance and oversight. Formal external reporting to IAG and NHSE is in place. Whilst the Trust is now forecasting a £10m risk to breakeven plan which affects delivery of some of the Exit Criteria all other criteria are on track or completed. The Trust has undertaken non-elective activity in excess of funded levels, which due to the nature of the block contract, has driven the increase in pay and non-pay costs to ensure the services commissioned are delivered safely and effectively. This has been reflected in the planning for 2026/27 and the expected contract offer.	Ongoing completion of all outstanding IIP actions. Deliver revised FOT. Finalise delivery plans for 26/27. Further develop IIP for ongoing use in 26/27. Participate in Barrier and Limitations review.
Leadership and Governance	3	2	1	0	0	G	The governance and leadership action plan combines recommendations from all reviews completed with 78/88 actions completed. No risks to delivery flagged. The Board development plan is in place with initial sessions completed.	Executive and Board Development. Recruitment of Finance Director (interim arrangements agreed).
Funding Conditions and Spending Approvals	3	3	0	0	0	B	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activities.	Continue to comply with statutory requirements.
Meetings and Reports	4	4	0	0	0	B	Detailed IIP in place with formal external reporting to IAG and NHSE Internal oversight and financial reporting significantly improved	Continue to comply with external reporting and oversight arrangements
Total Actions	**16**	**13**	**2**	**1**	**0**			

RSP Exit Criteria Self-Assessment – Month 10

BRAG
Completed successfully
On track to deliver
Some elements not on track, mitigations to deliver
Off track, with insufficient mitigation

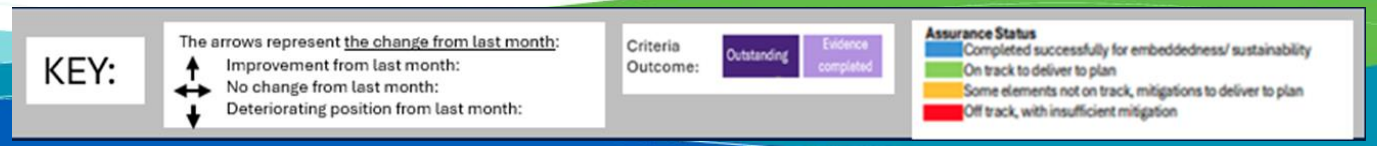
RSP Criteria	No of Sub-Criteria	No. of Key Actions	BRAG Status Summary for Key Actions				Overall BRAG	Summary of Progress	Next Steps
Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025	5	12	6	1	2	3	R	M10 YTD deficit of £54.17m against deficit plan of £38.73m YTD WRP delivered £33.9m. The FOT likely case is £10m risk to breakeven plan. The Trust has undertaken non-elective activity in excess of funded levels, due to the nature of the block contract, which has driven the increase in pay and non-pay costs to ensure the services commissioned are delivered safely and effectively. This has been reflected in the planning for 2026/27.	Ongoing focus on delivery of WRP and reduction of operational pressures where possible for 2025/26 towards best case. Support OneLSC transformation to secure benefits.
Deliver quarter-on-quarter run rate improvement throughout 2025/26	2	5	2	3	0	0	G	There has been a quarter-on-quarter run-rate reduction since Q3 24/25.	Continue to reduce costs recurrently and in turn reduce the underlying deficit into 2026/27.
Develop a medium-term financial recovery plan covering the period post 2025/26	1	4	1	3	0	0	G	The Trust has submitted its 3-year Medium-term plan numerical templates (activity, workforce, finance and triangulation tool), narrative plan and EQIA on 11th February 2026. The Trust has worked proactively with Commissioners on demand management/commissioning intentions.	Respond to feedback as required. Continue to mature delivery plans, particularly in respect of WRP plan maturity and associated WTE plan to ensure delivery from Month 1. Continue to work in partnership to develop other demand mitigation plans and robust implementation plans.
Demonstrate effective financial and organisational governance structures and mechanisms	6	14	11	3	0	0	G	Leadership and governance review completed and Leadership and Governance Action Plan in place. 78 of 88 actions completed. Completion of actions is being tested by Internal Audit. Board development programme initiated, phase 1 complete. The WRP process improved and monitoring process tightened.	Board development phase 2 is ready to commence in April, following the recruitment of three new NEDs in February 2026. Continue to mature WRP development and delivery.
Full participation in the Recovery Support Programme	4	6	6	0	0	0	B	The Trust is fully engaged with the IAG, System Turnaround. Director and national RSP leads. A financial recovery programme is in place.	Barriers and Limitations review from April 2026. 2026/27 WRP development. Align PMO to Strategy and Improvement.
Total Actions	**18**	**41**	**26**	**10**	**2**	**3**			

CQC Action Plan for Intermediate Care - Summary Month 10

CQC domain	Delivery	Risk	Total actions	Key themes	Update / escalations	B	G	A	R
Safe	↑	↔	29	Medicines optimisation (11), Safe staffing (8), Risk involvement (6), Safe environments (4)	FFP3 Mask Fitting for February at 72.2% - awaitng more appointments as previously escalated due to some sessions stood down.	26	2	1	0
Responsive	↑		8	Person-centred care (5), Listening & involving people (2), Care continuity (1)	N/A	8	0	0	0
Caring	↑	↔	1	Kindness, compassion & dignity	N/A	1	0	0	0
Effective	↑	↔	1	Consent to care & treatment	N/A	1	0	0	0
Well Led	↑	↔	2	Governance & sustainability	N/A	0	2	0	0
Total Actions			**41**			**36**	**4**	**1**	**0**

Work has been completed to standardise the format of the action plan in line with the Trust standard and adoption of BRAG ratings.
At Month 10 36/41 actions are complete.

The action plan is monitored via the Trust Wide Quality Group and to the Quality Committee who in turn provide assurance to the Board of progress against plan. Our action plan is shared and monitored externally with the Care Quality Commission (CQC).



EVIDENCE & ASSURANCE

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Detailed updates for all areas of focus for Regulatory Undertakings, RSP Exit Criteria and CQC monitoring are included in assessments to NHSE through a dedicated SharePoint site.

This will transition to a power BI report by Month 12.

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TRUST BOARD MEETING

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/039
Report Title:	Maternity and Neonatal Services Update		
Authors:	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: • Assurance on quality and safety programmes within maternity and neonatal services aligned to the National Perinatal Safety Ambitions and the ten CNST MIS Year 7 safety actions. • An update on ELHT's response to the Maternity and Neonatal Three-Year Delivery Plan (reported bi-monthly via Quality Committee, with escalation to Trust Board by exception). • Escalation of any safety intelligence identified through the NHSE Perinatal Quality Oversight Model that may pose a risk to safe care delivery. • Assurance of progress against continuous service improvement, using a "what good looks like" approach.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board of Directors is asked to: • Receive and note the CNST MIS Year 7 update and compliance position. • Discuss any identified safety concerns or delivery barriers, informed by Floor to Board reporting and Safety Champion oversight. • Provide advice and guidance on maternity and neonatal safety issues, including agreed actions, timescales, and mitigations where required.			

Previously Considered by:	
Date:	
Outcome:	

1. PERINATAL QUALITY SURVIELLANCE DATA – EXCEPTIONS

1.1 Perinatal SPC Report

1. The FCCG 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 FCCG Maternity and Neonatal Data & Digital Group and further the Divisional Management Board.

2. The December 2025 exception report (**Appendix 2**) highlights:
    - The Induction of Labour rate in December 2025 was 42% which is the average of the previous 12 months.
    - The C-section rate in December was 47%, now a 5-month run above the 24-month average of 45% - this is not beyond the accepted variation controls, nor is it yet a recognized trend.
    - A special cause variation was highlighted in the November 2025 exception report, as the %Apgar score <7 had seen a sustained increase. This trend has not continued in December 2025.
    - Term admissions to NICU have now seen a 7-month trend below the average of 5%.

1.2 Maternity Outcomes Safety System (MOSS)

MOSS provides the below CUSUM chart and table of events which demonstrates there have been no safety signals for ELHT with regards to stillbirths and/ or neonatal deaths since the publication of this system in December 2025.

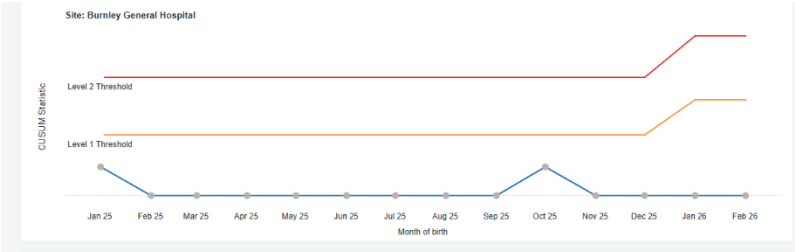


Table of Events - Trust: East Lancashire Hospitals NHS Trust

Date of term birth	Events (term only)	Site name
02 Dec 25	1 Term Stillbirth(s)	Burnley General Hospital
18 Oct 25	1 Term Neonatal Death(s)	Burnley General Hospital
17 Oct 25	1 Term Stillbirth(s)	Burnley General Hospital
26 Sep 25	1 Term Stillbirth(s)	Burnley General Hospital
28 Jul 25	1 Term Neonatal Death(s)	Burnley General Hospital
02 Mar 25	1 Term Stillbirth(s)	Burnley General Hospital
22 Jan 25	1 Term Neonatal Death(s)	Burnley General Hospital
20 Jan 25	1 Term Stillbirth(s)	Burnley General Hospital

1.3 NW ODN Regional Dashboard

The Northwest Operational Delivery Network (NW ODN) has developed the Neonatal Quarterly Dashboard which includes activity and transfer data across the NW ODN such as unit closures and a range of clinical and outcome measures to allow comparison of activity with national benchmarks, this is inclusive of the National Neonatal Audit Programme (NNAP) measures. The dashboard currently shows data up until Financial Year Q3 - December 2025.

This dashboard includes key performance measures against the perinatal optimisation pathway. Perinatal optimisation refers to the process of reliably delivering evidence-based interventions in the antenatal, intrapartum, and neonatal period to improve preterm outcomes. The BAPM Perinatal Optimisation Pathway covers seven key elements;

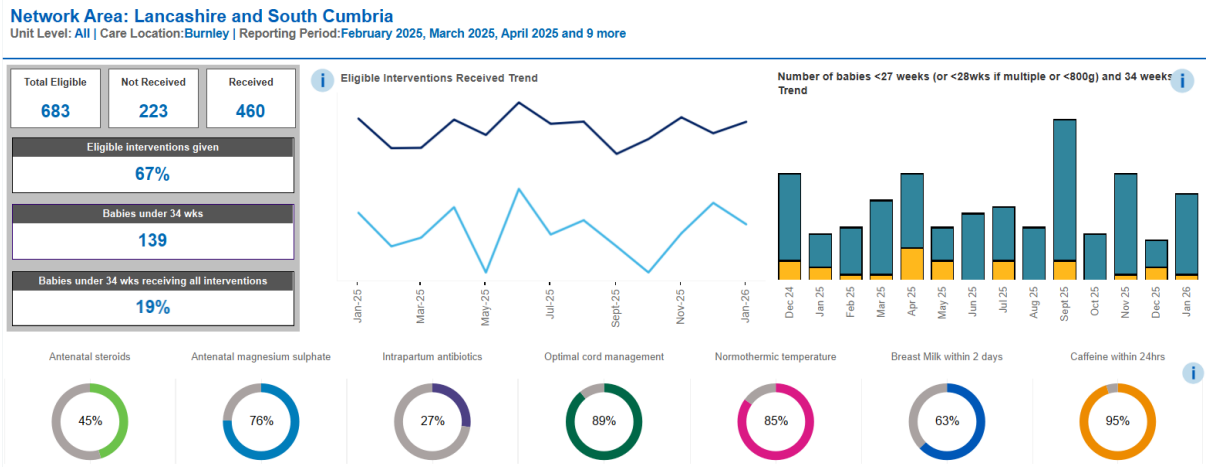
<u>Antenatal Optimisation</u>

1. Optimising place of birth
2. Optimal antenatal steroids
3. Magnesium sulphate
4. Intrapartum antibiotics

<u>Peripartum Optimisation</u>

5. Optimal cord management
6. Normothermia
7. Early maternal breast milk

The extract below demonstrates the average compliance against each measure for the previous 12 months:



1.4 Data Management Processes

Divisional data management processes are in place to ensure data quality issues are highlighted and rectified via discussion at perinatal data & digital group, prior to exceptions and themes being reported through the division 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. FLOOR TO BOARD – QUALITY COMMITTEE OVERVIEW

See full report in **appendix 3**, an overview of content is as below;

- Assurance of ELHT onboarding to the new MOSS presentation developed locally to ensure shared understanding between all colleagues of MOSS processes.
- Introduction to the maternity specific requirements of the Medium-Term Planning Framework
- A full update of progress against the NHS Maternity Equality and Equity Plan
- UNICEF BFI GOLD annual summary
- 'Urgent review of homebirth services following Prevention of Future Deaths report' letter response

3. IMPLEMENTING RCOG-COMPLIANT MATERNITY TRIAGE (Aligned to BSOTS Model)

ELHT Maternity Services launched the new maternity triage model on Monday 2 February 2026, delivering the primary objective of the project: implementation of the RCOG Best Practice Maternity Triage Model (December 2023) using the Birmingham Symptom-specific Obstetric Triage System (BSOTS) to establish a standardised, risk-based approach to urgent maternity care.

A full project overview and progress presentation has been developed and presented to board level safety champions as per **appendix 4,** with executive summary as below:

- **Reason for change:** Non-compliance with RCOG national maternity triage standards; corporate risk score 20.
- **Action taken:** Implemented RCOG-aligned BSOTS model with revised staffing, dedicated triage estate, digital workflow (Badger Net), and enhanced training and communications.
- **Early impact:** 694 attendances in first 2 weeks (avg. 49/day). Initial Assessment performance improved week-on-week (30-min compliance 49% → 59%).

- **Exception:** Performance deteriorates when attendances exceed ~50–55/day, with midweek and 5–6pm surge pressures. Delays are capacity-driven, not process failure.
- **Mitigation:** Twilight staffing adjustment, KPI dashboard monitoring, breach review, capital investment in phoneline and infrastructure, ongoing rapid-cycle improvement.

Position: Model successfully implemented and improving, but surge capacity remains the key operational risk requiring continued oversight. The project group remains in place with weekly meetings to continue to monitor embedding and rapid improvements required.

4. CQC INFORMAL WALKROUND OF MATERNITY SERVICES

An informal visit by CQC is due to take place on the 9th of March 2026, including staff focus groups and walk rounds of the below areas:

- Antenatal Clinic
- Antenatal Ward
- Triage
- Central Birth Suite
- Postnatal Ward
- Community

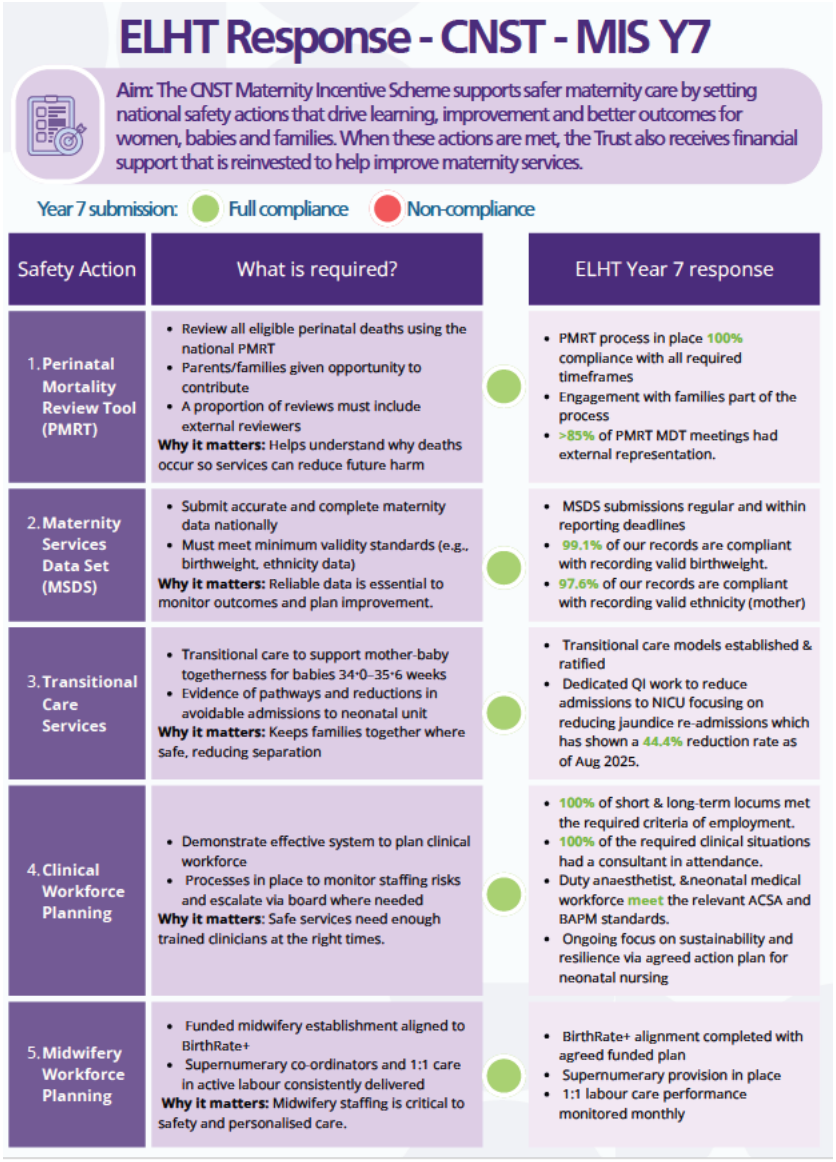
ELHT Maternity services will prepare a presentation to demonstrate current service performance data, progress against key national delivery plans and showcase service successes and quality improvements.

5. NHS ENGLAND NEONATAL SITE VISIT

NHSE IPC regional colleagues visited the neonatal unit at Burnley General Hospital on Wednesday 25th February 2026 to offer support and advice in view of an ESBL colonisation outbreak picked up in routine weekly surveillance swabs of neonatal babies in October 2025. The NHSE were pleased to see that all the babies had remained well and have been discharged home. The team observed ANTT and hand hygiene practices on the NICU and noted both to be of extremely high quality included strict adherence observed aligned with uniform policy. Feedback on the day included the replacing of all wooden furniture, including cots on the neonatal unit and purchasing a new fridge and freezer for the unit. A full report of their visit is to follow and will be aligned to Trust wide quality governance process and oversight.

6. CNST – MATERNITY INCENTIVE SCHEME

6.1 Summary overview



ELHT Response - CNST - MIS Y7

Aim: The CNST Maternity Incentive Scheme supports safer maternity care by setting national safety actions that drive learning, improvement and better outcomes for women, babies and families. When these actions are met, the Trust also receives financial support that is reinvested to help improve maternity services.

Year 7 submission: Full compliance Non-compliance

Safety Action	What is required?	ELHT Year 7 response
1. Perinatal Mortality Review Tool (PMRT)	• Review all eligible perinatal deaths using the national PMRT • Parents/families given opportunity to contribute • A proportion of reviews must include external reviewers **Why it matters:** Helps understand why deaths occur so services can reduce future harm	• PMRT process in place 100% compliance with all required timeframes • Engagement with families part of the process • >85% of PMRT MDT meetings had external representation.
2. Maternity Services Data Set (MSDS)	• Submit accurate and complete maternity data nationally • Must meet minimum validity standards (e.g., birthweight, ethnicity data) **Why it matters:** Reliable data is essential to monitor outcomes and plan improvement.	• MSDS submissions regular and within reporting deadlines • 99.1% of our records are compliant with recording valid birthweight. • 97.6% of our records are compliant with recording valid ethnicity (mother)
3. Transitional Care Services	• Transitional care to support mother-baby togetherness for babies 34+0–35+6 weeks • Evidence of pathways and reductions in avoidable admissions to neonatal unit **Why it matters:** Keeps families together where safe, reducing separation	• Transitional care models established & ratified • Dedicated QI work to reduce admissions to NICU focusing on reducing jaundice re-admissions which has shown a 44.4% reduction rate as of Aug 2025.
4. Clinical Workforce Planning	• Demonstrate effective system to plan clinical workforce • Processes in place to monitor staffing risks and escalate via board where needed **Why it matters:** Safe services need enough trained clinicians at the right times.	• 100% of short & long-term locums met the required criteria of employment. • 100% of the required clinical situations had a consultant in attendance. • Duty anaesthetist, &neonatal medical workforce meet the relevant ACSA and BAPM standards. • Ongoing focus on sustainability and resilience via agreed action plan for neonatal nursing
5. Midwifery Workforce Planning	• Funded midwifery establishment aligned to BirthRate+ • Supernumerary co-ordinators and 1:1 care in active labour consistently delivered **Why it matters:** Midwifery staffing is critical to safety and personalised care.	• BirthRate+ alignment completed with agreed funded plan • Supernumerary provision in place • 1:1 labour care performance monitored monthly

Safety Action	What is required?	ELHT Year 7 response
6.Saving Babies Lives Care Bundle	• Evidence of progress across all six elements of SBLCBv3 • Continuous QI and engagement with ICB/LMNS QI networks **Why it matters**: Targets key preventable causes of stillbirth and neonatal harm.	• SBL implementation progressed to 97% in Y7 (2 / 70 outstanding actions actively being addressed) • Quarterly engagement with LMNS • Continued audit & QI processes in place
7. Listening to Families & MNVP	• Support a functioning Maternity & Neonatal Voices Partnership (MNVP) • Use feedback and co-produce improvements with families **Why it matters**: Service improvement must reflect the views of those who use it	• Escalation via governance where gaps in MNVP infrastructure have been identified • Key themes from the 2024 annual CQC maternity survey have been reviewed and formed a co-produced action plan of improvements including; *digital video library of patient information, improvements to various patient information leaflets and increased time in community appointments.*
8. Training	≥ 90% attendance from all relevant staff groups at: • Fetal monitoring training • Maternity emergencies training • Neonatal resuscitation / newborn life support • Training completeness evidence across all groups **Why it matters:** High-quality training supports safer care in emergencies.	• >90% of each staff group have attended MDT training for fetal monitoring. • >90% of each staff group have attended MDT training for maternity emergencies. • >90% of relevant staff groups have attended MDT training on neonatal life support.
9. Board Oversight	• Regular implementation of Perinatal Quality Surveillance Model (PQSM) - (local data + learning + triangulation) • Board maternity safety champion involvement and escalation **Why it matters:** Rigorous safety oversight early identifies concerns.	• Floor to Board Safety Intelligence Reporting Pathway in place. • Data dashboard progressed now presenting data as SPC charts for key metrics, with monthly exceptions report. • Triangulation of claims, incidents and claims activities taken place to inform key themes and improvements. • Culture coaches trained and conducted 10 sessions across 2025.
10. Maternity & Newborn Safety Investigation (MNSI)	• 100% reporting of qualifying cases (MNSI / Early Notification) • Families given information in accessible formats and duty of candour applied **Why it matters**: Ensures critical safety events are shared and learned from	• All qualifying cases reported within required timeframes • Family communication standards embedded • Governance assurance to Board

6.2 PMRT Q3 Report

A quarterly report should be received by the trust board including details of deaths reviewed, any themes identified and consequent action plans. This quarter was expected to fall outside of the CNST reporting period for Year 7 and has been discussed via perinatal governance board and the floor to board safety champions meeting prior to this submission, see report in **Appendix 5.**

6.3 Midwifery Safe Staffing biannual report/Oversight

A midwifery staffing oversight report that covers staffing/ safety issues should be received by the Trust Board every 6 months in line with maternity incentive scheme(MIS) safety action 5 and (2015) NICE guidance - safe midwifery staffing for maternity settings (Red flag events : signs that there may not be enough midwives available the report covering Q3/4 would fall outside the CNST reporting period for Year 7, the birth rate plus three-year assessment for took

place over a period of months in 2026, the final report published in December 2025. The report to be presented at March Trust Wide Quality Governance A meeting prior to Trust Board.

7. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board informs all progress with the evidence requirements for the ten CNST maternity safety actions throughout the year 7 reporting period.

Any other matters of concern relating to patient experience, safety and service delivery will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas for wider discussions with appropriate escalation. Progress and evidence in relation to the four themes and deliverables identified within the Maternity & Neonatology three-year delivery plan is reported through ELHT Quality committee bimonthly.

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 - Maternity and Neonatology
March 2026

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	2026	**Agenda Item:**	TB/2026/0
Report Title:	Antimicrobial Stewardship Report		
Author:	Dr H Ziglam, Antimicrobial Stewardship Lead		
Lead Director:	Dr J Hobbs, Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	x			
Executive Summary:	ELHT has experienced a substantial increase (54%) in antimicrobial use since 2019, with Access antibiotic use at 62% and increased reliance on Watch/Reserve agents (table 1). Various audits and point prevalence studies (attached to the email) demonstrate variable compliance with Trust guidelines, documentation gaps (indication and stop/review), and unwarranted variation across directorates. This report outlines current ASC activity, governance needs, performance indicators, findings from audits, and a time-bound implementation plan to improve stewardship outcomes. In addition to rising antibiotic consumption, ELHT is now experiencing a measurable and concerning increase in antimicrobial resistance among key pathogens. Local surveillance data demonstrate a year-on-year rise in E. coli resistance to gentamicin between 2022 and 2025, with resistance increasing steadily over this four-year period. Gentamicin remains a critical agent in our empiric treatment pathways for severe sepsis, urinary tract infections, and gram-negative bacteraemia, and increasing resistance significantly undermines our ability to deliver effective early therapy. This trend reflects the consequences of increased broad-spectrum use, inconsistent de-escalation, and gaps in guideline adherence identified across the Trust. It underscores the urgency of strengthening AMS governance, accelerating the implementation of stewardship interventions, and reducing unnecessary antimicrobial exposure to protect the effectiveness of frontline antibiotics			
Key Issues/Areas of Concern:				
Action Required:				

Previously Considered by:	
Date:	
Outcome:	

Antimicrobial Stewardship at ELHT: Current Challenges and System-Wide Improvement Plan

Hisham Ziglam
Consultant in Infection
Antimicrobial Stewardship Lead
East Lancashire Hospitals NHS Trust (ELHT)

Date: 25 January 2026

Antimicrobial stewardship (AMS) is a critical strategic priority for the NHS, underpinning safe, high-quality care and the long-term sustainability of modern healthcare. It has a great impact on harm reduction, LOS reduction, C. difficile rates, cost avoidance, national benchmarking. As antimicrobial resistance (AMR) continues to escalate—now recognised by the World Health Organization as one of the most significant global public-health threats and listed on the UK Government's National Risk Register—effective stewardship is essential to protecting patient outcomes and preserving the efficacy of existing antimicrobial agents. AMS ensures that our organisation deploys antibiotics responsibly and consistently, through robust governance, evidence-based prescribing, and system-wide oversight. It forms a cornerstone of clinical safety, operational resilience, and national compliance, and is central to ELHT's responsibility to safeguard current and future patients.

The risks associated with rising antimicrobial use and inconsistent stewardship across ELHT were formally raised with Clinical Directors during my presentations to the Clinical Leaders Forum in 2021 and again in 2025. These earlier escalations highlighted the need for dedicated stewardship capacity, stronger governance, and improved adherence to national AMS standards. However, due to ongoing resource constraints, many of these issues have remained unresolved, contributing to the current escalation in antimicrobial consumption and resistance. This report therefore represents a renewed call to action to address long-standing systemic gaps and seeks executive endorsement of the proposed AMS governance structure, support for dedicated stewardship capacity, and approval to implement the KPIs and Q1 2026 actions described herein

1. Executive Summary

ELHT has experienced a substantial increase (54%) in antimicrobial use since 2019, with Access antibiotic use at 62% and increased reliance on Watch/Reserve agents (table 1). Various audits and point prevalence studies (attached to the email) demonstrate variable compliance with Trust guidelines, documentation gaps (indication and stop/review), and unwarranted variation across directorates. This report outlines current ASC activity, governance needs, performance indicators, findings from audits, and a time-bound implementation plan to improve stewardship outcomes. In addition to rising antibiotic consumption, ELHT is now experiencing a measurable and concerning increase in antimicrobial resistance among key pathogens. Local surveillance data demonstrate a year-on-year rise in *E. coli* resistance to gentamicin between 2022 and 2025, with resistance increasing steadily over this four-year period. Gentamicin remains a critical agent in our empiric treatment pathways for severe sepsis, urinary tract infections, and gram-negative bacteraemia, and increasing resistance significantly undermines our ability to deliver effective early therapy. This trend reflects the consequences of increased broad-spectrum use, inconsistent de-escalation, and gaps in guideline adherence identified across the Trust. It underscores the urgency of strengthening AMS governance, accelerating the implementation of stewardship interventions, and reducing unnecessary antimicrobial exposure to protect the effectiveness of frontline antibiotics

2. Current Antimicrobial stewardship Committee (ASC) Activities

The Antimicrobial Stewardship Committee (ASC) at East Lancashire Hospitals NHS Trust meets on a monthly basis and functions as the central coordinating body for all antimicrobial stewardship activity across the organisation. Its core responsibilities include the development, review, and ratification of Trust antimicrobial guidelines, ensuring alignment with national standards and evidence-based practice. These guidelines are maintained on MicroGuide/Eolas and are routinely updated to reflect current UK-AWaRe classifications, local microbiology resistance patterns, and national recommendations issued through Public Health England and NHS England.

In addition to guideline development, the ASC oversees a broad portfolio of operational stewardship activity. This includes the provision of specialist microbiology and pharmacy advice to support optimised antimicrobial therapy; and the planning and execution of stewardship audits, including point-prevalence studies and focused prescribing reviews across high-risk areas. These activities help the Trust monitor compliance with prescribing standards, identify inappropriate broad-spectrum use, and promote safer, more consistent antimicrobial decision-making.

A significant component of current stewardship practice is the Trust's reliance on the Start Smart, Then Focus framework — the nationally recognised AMS toolkit originally developed by Public Health England to standardise safe prescribing behaviour across the NHS. While the framework provides clear expectations for timely initiation, reassessment, and optimisation of antimicrobial therapy, its implementation across ELHT remains

inconsistent. Audit findings repeatedly demonstrate variation in the documentation of indication and stop/review dates, inconsistent application of the 48–72-hour clinical review, and gaps in de-escalation or IV-to-oral switching. This inconsistency limits the effectiveness of stewardship interventions and contributes to unwarranted variation in prescribing across directorates

3. Challenges & Quality Standards.

As part of our 'QS121 Quality Standard – Service Improvement' assessment (updated August 2025), the ASC undertook a detailed evaluation of current Trust-wide stewardship capability, identifying several critical gaps that must be addressed to meet national AMR expectations.

- Firstly, ELHT does not currently have a reliable method to monitor antimicrobial prescribing through the electronic prescribing system (EPMA), limiting our ability to assess compliance with guidelines, stop/review documentation, and adherence to Start Smart, Then Focus principles.
- Secondly, the AMS team structure is not clearly defined or sufficiently resourced; stewardship activity is presently delivered by a single antimicrobial pharmacist and one consultant microbiologist—who also serves as the ASC Chair— with limited dedicated time, which is significantly below what is required for a Trust of this size and does not align with national expectations for multidisciplinary AMS capacity as emphasised in the NHS England AMR call-to-action letter, which highlights the need for strengthened leadership, capability, and resource allocation to meet AMR targets.
- Thirdly, the assessment highlighted a need for stronger senior management support to drive stewardship as a corporate priority and ensure sustained progress. In addition, there is insufficient capacity—both workforce and financial—to deliver the objectives outlined in the National AMR Action Plan, and greater collaboration is required between the AMS team and wider clinical divisions. The assessment also emphasised the need to establish AMS champions across all areas of the Trust to embed stewardship within local clinical cultures, and to ensure pharmacists are empowered and supported to challenge suboptimal antimicrobial prescribing practices. Collectively, these gaps represent key organisational barriers that must be addressed to deliver meaningful, system-wide improvements in antimicrobial stewardship at ELHT.

4. Governance: Proposed Structure and Implementation (Graph 6)

The proposed AMS governance model establishes end-to-end accountability framework that connects strategic oversight, operational delivery, and frontline implementation. The model positions stewardship as a core patient safety priority and aligns it with existing Trust governance pathways, including Quality Governance Committee, the Medicine Optimisation & Safety Committee (MSOC), and the Patient Safety Committee, ensuring that stewardship performance receives regular executive attention and organisational scrutiny (Figure 1).

Under this structure, the ASC functions as the operational engine of stewardship, working alongside Infection Prevention and Control (IPC), Microbiology, Pharmacy, and the wider clinical divisions to coordinate guideline development, audit activity, rapid clinical advice, and optimisation of prescribing practice. The inclusion of AMS champions within all directorates—as well as engagement from primary care colleagues—ensures that stewardship is embedded within local teams and addressed consistently across care pathways.

Implementation of this governance model will be delivered in a phased and disciplined approach. In the first instance, formal executive approval will be secured through Quality Governance Committee, supported by the publication of a Trust-wide AMS Governance Charter defining roles, responsibilities, reporting lines, and escalation routes. Dedicated AMS champions will be appointed across all divisions, with stewardship responsibilities incorporated into job plans and directorate governance agendas. The model will be operationalised through monthly stewardship dashboards, underpinned by EPMA-derived prescribing data, enabling real-time oversight of guideline adherence, documentation standards, and AWaRe prescribing patterns. Enhanced collaboration between the ASC, IPC, and digital teams will ensure that electronic prescribing prompts—for example, mandatory indication fields and stop/review alerts—are embedded to reinforce consistent practice.

Through this strengthened governance framework, stewardship becomes an organisation-wide responsibility with clear leadership, measurable objectives, and systematic oversight. This approach will enable ELHT to deliver sustained improvements in antimicrobial use, support compliance with national AMR expectations, and ensure that the safety and quality of patient care remain central to all antimicrobial-related decision-making.

7. Proposed Performance Indicators

To enable consistent oversight and drive measurable improvement in antimicrobial stewardship across ELHT, a defined set of stewardship performance indicators will be implemented Trust-wide. These indicators will form the basis of reporting to divisional governance structures. The proposed indicators focus on the key domains required to achieve national AMR targets and ensure safe, effective prescribing.

- Antibiotic consumption (DDD/1000 patient-days), overall and by division.
- Broad-spectrum usage: piperacillin–tazobactam, carbapenems, (± co-amoxiclav where relevant).
- Resistance rates: E. coli, Klebsiella, MRSA (selected sentinel organisms).
- Guideline adherence: % prescriptions compliant; % with indication and stop/review recorded.
- **Targets:**
    - Access ≥70%
    - Reduce Watch/Reserve by ≥10% per year
    - Improve guideline compliance to ≥90%
    - Documentation ≥95%
    - Reduce total DDDs year-on-year.
    - build AMS dashboards.

8. Response to NHS England Letter (Nov 2025): Act now – Q1 2026 Actions

- Board-level review: joint IPC/AMS presentation to Trust Board covering performance, benchmarking (ESPAUR; Model Health System), and thresholds (by end Q1 2026).
- Risk & capability assessment: complete IPC Board Assurance Framework and ICB AMS Self-Assessment Toolkit; add findings to risk registers and planning (by end Q1 2026).
- Set and publish three AMR priorities with measurable objectives, executive owners, timelines, and quarterly reviews. Suggested ELHT priorities:
    A. Achieve ≥70% Access use
    B. Reduce broad-spectrum (piptaz/meropenem) DDDs by ≥15% within 12 months
    C. Achieve ≥95% documentation of indication and stop/review dates.

Table 1: Possible reasons of rising antimicrobial consumption across ELHT

1. **Post-pandemic changes in clinical practice**
   - Higher empirical antibiotic use for respiratory infections due to uncertainty
   - Clinician risk-avoidance behaviours, with earlier and broader antibiotic coverage.

This shift in behaviour did not fully return to pre-pandemic patterns.

2. **Increased patient acuity and complexity**
   - More frail, comorbid, and immunosuppressed patients
   - Higher rates of nosocomial infections and multi-morbidity
   - More severe presentations, often requiring empirical broad-spectrum therapy

3. Pressures on staffing and clinical decision-making Since 2019, the NHS has faced:

- Staff shortages across medical, nursing, and pharmacy teams
- High turnover of junior doctors, reducing continuity
- Reduced AMS pharmacist capacity, leading to fewer reviews
- Time pressure, encouraging empirical rather than targeted therapy

All of these contribute to "default to treat" rather than "review and stop".

4. Inconsistent compliance with Trust antimicrobial guidelines: the PPS and audit data clearly show:

- Missing indications, stop/review dates, and duration plans
- Poor adherence to first-line Access antibiotics
- Excessive prescribing of Watch/Reserve agents

5. Lack of robust AMS governance: Where governance is weak, antibiotic consumption always rises because there is no enforcement mechanism.

6. Electronic systems not fully optimised (EPR data)

- EPR does not yet have full AMS alerts, duration limits, or compliance prompts.
- Lack of digital oversight leads to longer courses, duplicate therapy, and non-reviewed prescriptions.

7. Recovery phase pressures (2021–2025)- During elective recovery and heightened throughput:

- More perioperative prophylaxis
- More post-operative antibiotics
- More acute medical admissions
  - Higher activity often correlates with higher antibiotic use.

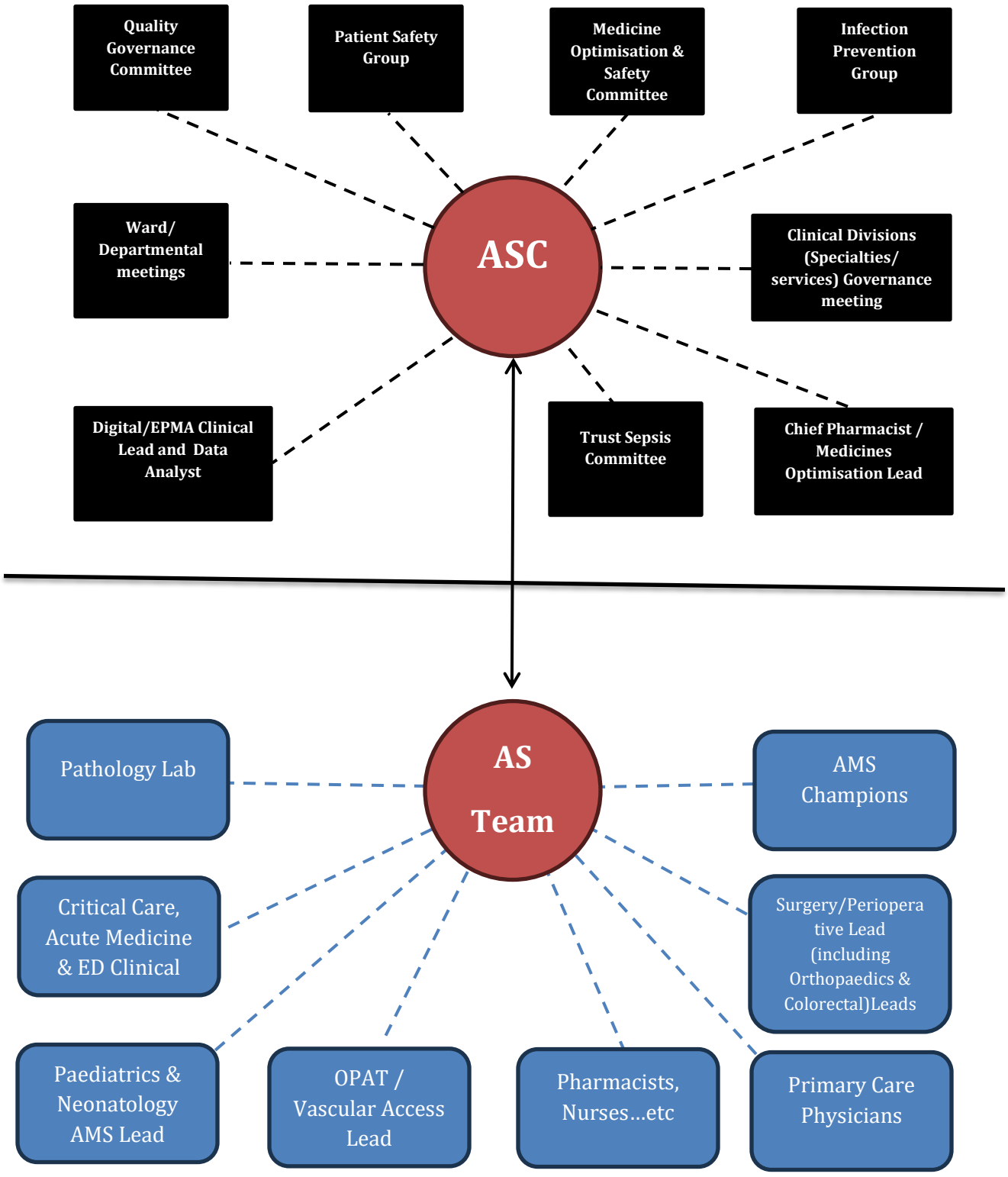


Figure 2: Organisational Governance Model for Strengthening AMS Oversight

TRUST BOARD REPORT

Meeting Date:	11 March 2026	**Agenda Item:**	TB/2026/041
Report Title:	Patient Safety Incident Response Assurance Report		
Author:	Lewis Wilkinson, Incident and Policy Manager Jacquetta Hardacre, Assistant Director of Patient Safety and Effectiveness		
Lead Director:	Mr J Hobbs, Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	None			

Previously Considered by:	Quality Committee
Date:	25 February 2026
Outcome:	Accepted – no actions

Patient Safety Incident Response Framework Report

Reporting period		December 2025 to January 2026
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group and discussed at the Trust Wide Quality Governance Part B meeting in January and February 2026.
1a.	**Alert**	Vacancies and sickness within Quality and Safety Teams (Corporate and Divisional) impacting on work and staff morale. • The team has lost several posts as monies were removed from 2025/26 budget. Several staff have also either left or retired, currently with Quality and Safety Unit have a total of 7 x vacancies. • Within the Patient Safety teams there are 2 vacant posts and a member of staff who has just returned from long term sickness, and 1 member of staff who had to do jury service (total of 8 weeks) at the end of last year which has all impacted on KPI targets within the team. • There have been very long delays to get posts agreed and advertised, some posts being vacant since July 2025. This is impacting on the teams' workloads, staff morale, and staff mental wellbeing. • The Q&S team are prioritising work, but the teams have found thisg this increasingly difficult with all the competing demands. • The vacancies have now been escalated to Deputy Chief Nurse, and all 7 vacancies were approved early Feb. All posts to be advertised for recruitment/redeployment, but this could take at least two months before staff are in post. A new Never Event declared in December – retained foreign object (swab) in SAS Division. • Division have appointed a family liaison officer to speak too and support the patient, round table investigation completed with staff involved to identify what happened and why with any immediate learning. It was agreed at the round table meeting that the incident met the National Patient Safety Never Event Criteria and incident has been reported to ICB and CQC as national required. • Round Table PSR with actions for improvement currently being developed and will be presented at PSIRI for Trust approval and safety improvements. A new Never Event was reported in January 2026 of a retained foreign object (Swab). A patient who underwent joint HPB and vascular surgery on 8th January 2026 had a CT scan in ICU that revealed a swab-like object, and a medium swab was subsequently removed in theatre. • The new Never Event has been reported to ICB/CQC, and a round table has taken place to identify learning and improvements. DOC has been completed with patient. • A full PSII required and lead appointment to complete investigation as well as a FLO to support patient. • It would be advised for a cluster review of all SAS theatre Never Events for last 5 years to take place once current investigations are completed to identify any common themes and identify any further improvement work required and link to risk register.
1b.	**Advise**	Due to pressures within the Trust several PSR and Human Factors training sessions have had to be stood down. • As part of the work to improve PSRs the Trust had indicated any staff member who was required to complete a PSR had to have been trained by the end of March 2026.

		• Agreed to extend the timeline to the end of April 2026 to support divisions. • Currently monitoring the pressures within the system on training and trying to provide further dates when training is stood down due to clinical pressures. • Further dates/times for PSR training have been made available on the Trust Education Hub for staff to book.
1c.	**Assure**	All PSIIs over the last 6 months have been completed within 6-month deadline. • The main challenges continue to stem from system pressures, including delays in appointing FLOs, difficulties releasing staff for interviews and families wishing to have longer to agree TOR or reviewing draft reports, all of which affected the timeliness of investigations. The themes regarding delays with completing serious incidents have remained largely unchanged, reflecting the wider pressures across the trust, and there no immediate solution to those constraints. • The aim is now to complete all PSIIs were possible within four months due to coroners' expectations. The PSII team work closely with the Legal team to identify any PSII required for coroner's court to priories these.

Incident Reporting

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

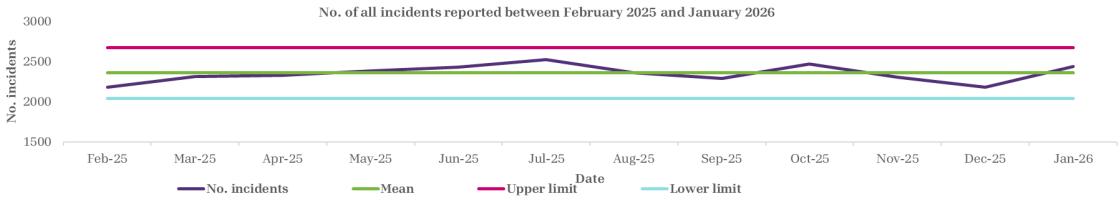


Figure 1: Incidents reported over last 12 months.

1.2 **4615** reported incidents were triaged within 2 working days of being reported in **December 2025 and January 2026**, which equates to 100**%** of all incidents reported within this period.

1.3 At the end of **January 2026** there were **5064** incidents awaiting final approval. Of these **534** cannot be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews. This left **4521** incidents awaiting final approval that could potentially be closed.

1.3.1 The incidents and Policy Team has had a vacancy since late July 2025, the post has now been approved and is in the recruitment process, once in post and trained, this post has the main task of undertaking final approvals.

1.4 The proportion of moderate physical harms remains in line with the average number reported in 2024/25 (1.42%), however is significantly under the proportion of moderate harms that are reported nationally. This may be indicative of a misapplication of the harm guidance and so incidents are graded with the incorrect harm. However, it should also be noted that currently the national data is unvalidated with many trusts reporting data quality issues. (appendix A)

1.5 The proportion of reported severe harms has increased again in January 2026 and is above the average level reported by the Trust in 2024/25. This equates to an increase of 3 from the previous month, however there was no theme or pattern in location of

occurrence. Out of the 8 incidents reported, only 2 have been recorded as "The incident caused the outcome".

1.6 A total of six fatal incidents were reported in December 2025 and January 2026:

1.6.1 2x are related to deaths under review by the Child Death Overview Panel process.

1.6.2 1x is a death following the development of a liver abscess potentially linked to missed follow ups. This is currently under a PSII investigation.

1.6.3 1x is a death potentially linked to delayed recognition of Sepsis. This is currently under a PSII investigation.

1.6.4 1x was related to the death of a patient on the ED corridor, with concerns around whether an ECG should have been undertaken.

1.6.5 1x relates to the death of patient following discharge to a Care Home and concerns related to the patient's insulin dose.

1.7 Two Never Events have been declared to ICB and CQC within December and January both regarding retained foreign objects (swabs). To date the Trust have reported 4 possible Never Events, of which 1 was stood down as after investigation as not meeting the Never Event criteria with the ICB and CQC.

1.7.1 On 28th November 2025 a swab was identified as missing after closure of patient but before patient left theatre and was reported to ICB/CQC on 10th December. A count was completed prior to closure and all correct. A small swab was handed over to surgeon for dabbing, and a medium swab was on the table. The swab was then handed out to another scrub nurse, and a small swab was noticed to be missing when these were being put in the swab safe. Incident was discussed at a Round Table meeting with the staff involved. DoC has been completed and agreed a copy of the final report to be shared with patient.

1.7.2 On 8th January 2026 a patient underwent joint HPB and vascular surgery. On 23rd January 2026 patient had a CT scan in ICU that revealed a swab-like object, and a medium swab was subsequently removed in theatre. Incident was discussed at a Round Table meeting with the staff involved. DoC has been completed and a full Patient Safety Incident Investigation is currently being completed.

1.7.3 Due to two similar incidents occurring within theatres a review/audit of theatre procedures is being completed and on completion of both investigations a cluster review of all similar Never Events will take place

to identify any common themes and identify if any further improvement work is required.

2. Duty of Candour

2.1 There have been 0 breaches of the Trusts Duty of Candour Policy. Duty of Candour monitoring has now been included in the weekly Complex Case meetings for escalation and action.

3. Safety Incident Responses (IR2s)

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

3.2 Overall, the number of IR2s completed within 30 calendar days by handlers within the divisions has generally over the last few months. This is indicative of the increased demand on clinician's time and therefore the ability to complete these within the expected timeframe. The number of IR2s open more the 30 calendar days has also increased. These will continue to be monitored monthly.

4. Patient Safety Responses (PSR)

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

4.2 Overall, there has been an increase in the number of open PSRs completed by the divisions and the number of those that have been open more than 90 calendar days.

4.3 From January 2026 we started to separately measure the Pressure Ulcer PSRs that are undertaken as these form a significant portion of the total PSRs completed. This allows to measure more closely the impact on capacity from PSRs and inform a review of how Pressure Ulcers are investigated.

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

5.1 In **December 2025 and January 2026**, the Complex Case meeting reviewed **21** new incidents and reported **7** incidents that met the PSIRF Priorities and required either a

PSII or MNSI investigation, the PSIIs have been allocated to lead investigators within the Patient Safety Team.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of **January 2026**, the Trust had **24** open PSII incidents of which **8** were being investigated by MNSI.

5.3 At the end of **January 2026** there were **0** PSII which had been open longer than 6 months and **3** MNSI reports.

5.3.1 1x has been received and is expected to be reviewed at PSIRI

5.3.2 1x is awaiting an updated action plan

5.3.3 1x is yet to be received from MNSI

5.4 In **December 2025** and **November 2026**, **8** PSII reports were approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **December 2025** and **January 2026, 12** reports were reviewed, of these there were **8** were new PSII reports. See appendix E for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **January 2026**, the Trust achieved **97%** Level 1a, **92%** Level 1b and **95%** Level 2 for National Patient Safety Training. There is a national recommendation that all NHS staff should complete at least Level 1a Patient Safety Training, the Trust took the decision to include level 1b and level 2 as well for appropriate clinical staff and senior managers and set a KPI target of 95% for all 3 levels.

7.2 Table 1: Patient Safety Syllabus Training (as of end of **January 2026**)

National Patient Safety Training	Target	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Level 1a	95%	95.60%	95.80%	96.20%	Unable to obtain	96.00%	96.00%	98.00%	97.00%	97.00%	97.00%	97.00%	97.00%
Level 1b		87.90%	89.60%	90.00%	Unable to obtain	91.00%	92.00%	94.00%	92.00%	92.00%	92.00%	92.00%	92.00%
Level 2		92.90%	93.30%	93.60%	Unable to obtain	95.00%	94.00%	96.00%	96.00%	96.00%	96.00%	96.00%	95.00%

8 Trust Wide Policies and SOPs

8.1 At the end of **January 2026**, there were **5 (94.74%)** Trust wide SOPs out of **152** overdue their review date, and **21 (91.67%)** out of **310** policies overdue their review date.

8.2 The report provides a breakdown of overdue policies and SOPs as requested by Trust Board and a full list is provided in appendix F.

8.3 HR have the highest number of policies and SOPs overdue.

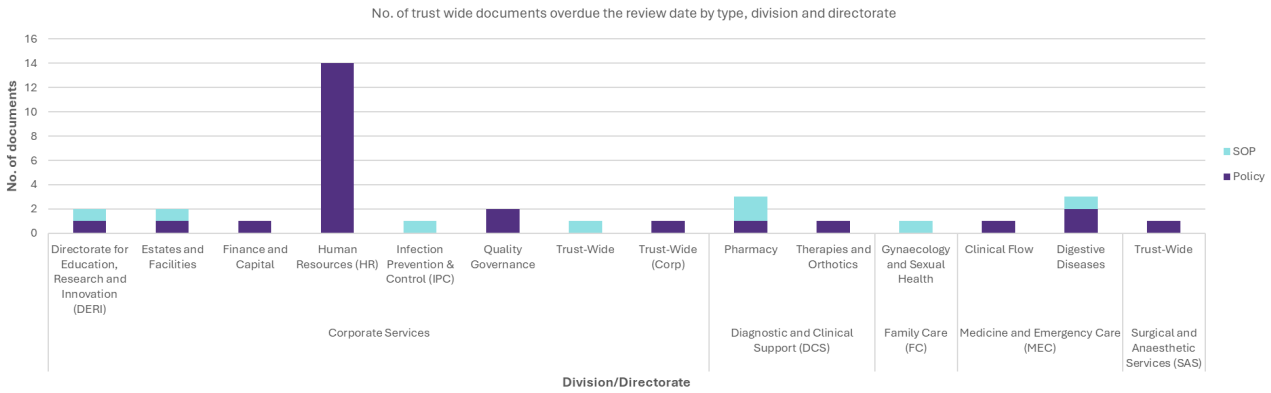


Figure 2: Trust wide policies and SOPs overdue the review date.

Table 2: Trust wide polices and SOPs within review date:

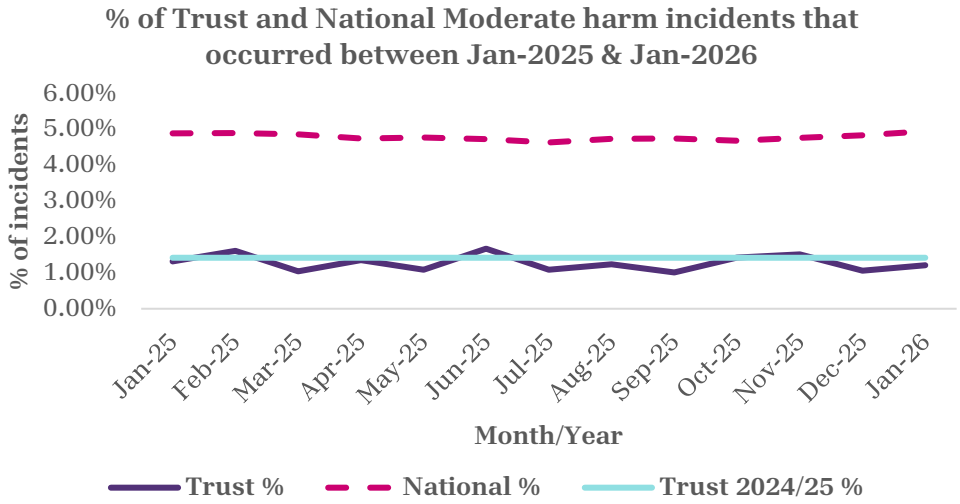
Policies / SOPs	Target	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Trend
Trust wide Policies	90%	94.30%	90.91%	88.14%	86.96%	91.69%	91.03%	90.40%	91.86%	92.00%	91.56%	93.23%	91.67%	↑
Trust wide SOPs		90.21%	88.03%	85.14%	86.18%	92.21%	96.75%	96.13%	88.96%	89.00%	88.54%	96.71%	94.74%	↑

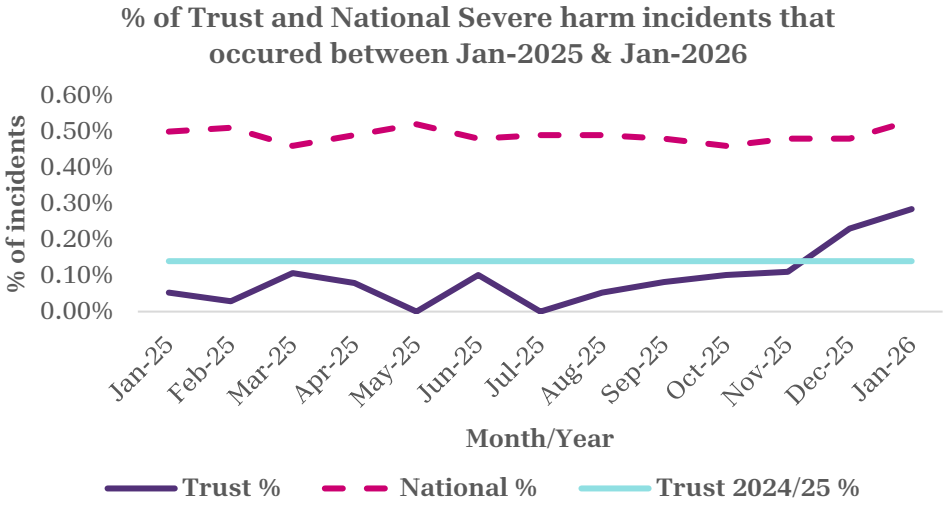
9 Maternity specific serious incident reporting in line with Ockenden recommendations

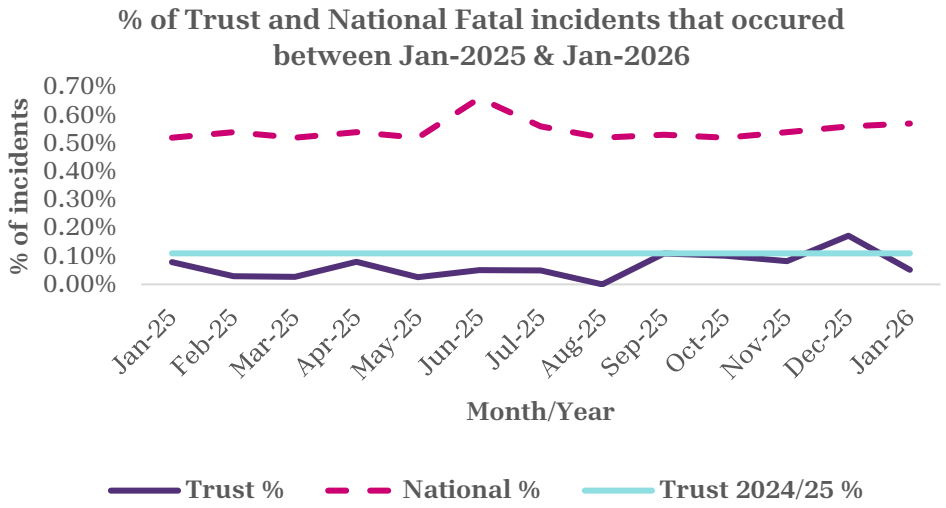
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **86** maternity related incidents have been reported on StEIS of which:

- **56** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **7** have had closure on StEIS requested
- **7** are currently being investigated by MNSI
- **1** is currently under investigation by the Trust.

Appendix A: ELHT Incidents by Moderate harm and above







Appendix B: KPI dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Trend
CIC	Total IR2 reported	524	423	403	484	462	417	494	455	416	434	434	425	
	(total number investigated) % complete within 30 calendar days	(479) 91.41%	(387) 91.49%	(362) 89.83%	(458) 94.63%	(423) 91.56%	(386) 92.57%	(446) 90.28%	(424) 93.19%	(382) 91.83%	(374) 86.18%	(377) 86.87%	(377) 88.71%	↑
DCS	Total IR2 reported	103	97	100	91	110	120	120	153	117	129	118	112	
	(total number investigated) % complete within 30 calendar days	(69) 66.99%	(61) 62.89%	(78) 78.00%	(71) 78.02%	(85) 77.27%	(103) 85.83%	(83) 69.17%	(118) 77.12%	(85) 72.65%	(97) 75.19%	(91) 77.12%	(74) 66.07%	↓
FC	Total IR2 reported	245	259	227	245	254	332	259	290	281	301	240	226	
	(total number investigated) % complete within 30 calendar days	(224) 91.43%	(212) 81.85%	(177) 77.97%	(212) 86.53%	(211) 83.07%	(283) 85.24%	(242) 93.44%	(254) 87.59%	(232) 82.56%	(226) 75.08%	(192) 80.00%	(117) 78.32%	↓
MEC	Total IR2 reported	908	815	962	903	956	930	1012	875	889	970	949	895	
	(total number investigated) % complete within 30 calendar days	(730) 80.40%	(630) 77.30%	(752) 78.17%	(679) 75.19%	(751) 78.56%	(725) 77.96%	(803) 79.35%	(652) 74.51%	(660) 74.24%	(660) 70.72%	(676) 71.23%	(602) 67.26%	↓
SAS	Total IR2 reported	372	314	377	344	335	343	372	357	375	376	355	324	
	(total number investigated) % complete within 30 calendar days	(313) 84.14%	(253) 80.57%	(282) 74.80%	(260) 75.58%	(286) 85.37%	(281) 81.92%	(316) 84.95%	(290) 81.23%	(295) 78.67%	(291) 77.39%	(276) 77.75	(213) 65.74%	↓
Corp	Total IR2 reported	66	43	39	42	52	46	71	45	55	52	40	43	
	(total number investigated) % complete within 30 calendar days	(41) 62.12%	(24) 55.81%	(18) 46.15%	(20) 47.62%	(28) 53.85%	(24) 52.17%	(46) 64.79%	(27) 60.00%	(30) 54.55%	(27) 51.92%	(17) 42.50%	(27) 62.79%	↑
Trust Total	Total IR2 reported	**2218**	**1951**	**2108**	**2109**	**2169**	**2188**	**2328**	2175	2133	2262	2136	2025	
	(total number investigated) % complete within 30 calendar days	**(1856) 83.68%**	**(1567) 80.32%**	**(1669) 79.17%**	**(1700) 80.61%**	**(1784) 82.25%**	**(1802) 82.36%**	**(1936) 83.16%**	**(1765) 81.15%**	**(1684) 78.95%**	**(1701) 75.20%**	**(1629) 76.26%**	**(1470) 72.59%**	↓

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	43	53	32	580	174	124

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Trend >90
CIC	No. open	49	38	38	34	50	70	56	53	52	30	48	19	↑
	No. open more than 90 calendar days	4	2	2	3	1	0	4	2	2	0	0	1	
DCS	No. open	10	6	6	7	9	9	12	7	8	4	16	12	↑
	No. open more than 90 calendar days	0	1	1	1	2	2	2	1	2	1	1	2	
FC	No. open	44	19	53	48	37	54	44	39	19	9	21	24	↑
	No. open more than 90 calendar days	3	2	3	6	6	11	8	6	8	3	3	4	
MEC	No. open	80	66	73	71	88	76	87	92	112	102	153	107	↑
	No. open more than 90 calendar days	19	15	15	12	16	14	18	25	32	19	30	45	
SAS	No. open	34	27	17	14	31	36	79	38	47	26	42	34	↓
	No. open more than 90 calendar days	7	6	6	2	1	2	2	4	6	3	11	6	
Trust	No. open	**217**	**188**	**187**	**174**	**215**	**245**	**278**	**229**	**238**	**174**	**280**	**196**	↑
	No. open more than 90 calendar days	**33**	**26**	**27**	**24**	**26**	**29**	**34**	**38**	**50**	**26**	**45**	**58**	

Pressure Ulcer Patient Safety Incident Response (PU PSRs)- Key Performance Indicators

Division	Number of PSRs open	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Trend >90
CIC	No. open												19	
	No. open more than 90 calendar days												1	
DCS	No. open												0	
	No. open more than 90 calendar days												0	
FC	No. open												1	
	No. open more than 90 calendar days												1	
MEC	No. open												46	
	No. open more than 90 calendar days												2	
SAS	No. open												21	
	No. open more than 90 calendar days												6	
Trust	No. open												**87**	
	No. open more than 90 calendar days												**10**	

Appendix D: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Trend
No. new incidents at Complex case	5	3	0	1	3	4	1	2	3	8	11	10	
No. incidents agreed as PSII including (MNSI)	5	3	0	1	2	4	3	3	6	2	3	4	
Total No. of PSIIs Open including (MNSI)	27(9)	27(12)	22(10)	20(10)	19(9)	17(8)	20(9)	18(7)	21(8)	23(8)	24(8)	24(8)	→
No. over 6 months	10(4)	7(4)	6(4)	6(5)	0(1)	1(0)	0(3)	0(4)	0(1)	3(2)	5(4)	0(3)	↓
No. approved/closed by PSIRI including (MNSI)	2	2	5	2	2	6(1)	0	5(2)	3(2)	1	4	4	

Appendix E: Summary of PSII reports reviewed by PSIRI and the outcome

During **December 2025 and January 2026 8** new PSII reports were presented at the Trusts PSIRI panel**.**

- eIR1314392 – Incident resulting in death – The report was approved without a minor update to one of the safety prompts required.
    - The investigation recommended standardising discharge processes and communication across the Trust. This includes implementing clear procedures for referral requests, defining roles and responsibilities, and ensuring adequate clinical input for triage and booking. Learning should be shared with triaging consultants to reinforce the importance of precise communication, and the Surgical and Anaesthetics Division should consider measures to improve continuity of care for Hepatobiliary patients with prolonged admissions.
- eIR1317426 – Incident resulting in death – The report was approved with some amendments to the action plan dates required.
    - The investigation recommended strengthening processes for inter-hospital transfers by ensuring accurate communication of information to ambulance services and considering alignment with the National Framework for Inter-facility Transfers. Staff in the Surgery and Anaesthetics Division should be reminded of the Interpreting and Translation Policy when caring for patients with language barriers. Additionally, both Medicine and Emergency Care and Surgery and Anaesthetics divisions should share learning from this case to reinforce the importance of collaborative working for timely patient care.
- eIR1307025 – MNSI review – The report was approved. MNSI made no safety recommendations.
- eIR1304688 – MNSI review – The report was approved. MNIS made no safety recommendations, however, did include the following as safety prompts.
    - How can the Trust ensure there is a holistic review of a CTG, in relation to the frequency and timing of contractions in labour, to enable an earlier discussion with the mother around progress with her labour and birth choices?
    - How can the Trust ensure that patients are kept informed when neonatal resuscitation is taking place when staff are focussed on the wellbeing of a baby?
- eIR1317293 – Death of patient in custody – The report was not approved and required multiple amendments and resubmission
    - The investigation identified several safety actions already implemented, including instructing Emergency Department (ED) staff that patients detained under Section 136 of the Mental Health Act (MHA) 1983 who have an acute medical need and present with challenging behaviour must not be removed from the ED by police before a medical review; the development of a new SOP for managing Section.136 patients; and ensuring ED reception staff routinely print Section.136 monitoring forms so they are immediately available when required. Further local safety prompts include finalising and updating ED SOP 40 to clearly define the expected acuity assessment process, minimum nursing experience requirements, and procedures for situations where a patient is not physically present, as well as removing outdated SOP versions from systems such as OLI and SharePoint. A wider safety recommendation is for the Trust to strengthen and expand the Section.136 SOP to cover both paediatric and adult pathways, and to provide a clearer and more consistent Trust wide process for managing individuals detained under Section 136, regardless of whether they present with acute medical needs.

- eIR1309566 – Perinatal Mortality Review – The report was not approved and required resubmission with the PMRT presented.
    - The case will be escalated to the Perinatal Mortality Review Tool (PMRT) process, through which further analysis, actions, and formal feedback will be taken forward. Key safety improvements include establishing clear guidance and a robust protocol to ensure a fetal or neonatal death is confirmed with absolute clinical certainty before this is communicated to families, alongside the involvement of senior staff in delivering such sensitive news. In addition, the service will develop a formal guideline for the management of preterm labour presentations to support consistent clinical decision making, and Room 11 will be designated as the preferred location for managing preterm births wherever possible to optimise preparedness and safety.
- eIR1308452 – MNSI review – The report was not approved and required resubmission to reconsider one of the MNSI recommendations.
    - MNSI recommended that the Trust ensures all Category 1 caesarean births are attended by the full neonatal team regardless of the anaesthetic technique and that the guidance is clarified so it is fully understood by all staff; although a trial requiring full neonatal attendance at every Category 1 caesarean proved unsustainable due to the impact on NICU safety, the SOP for neonatal attendance has since been updated. Several safety prompts were identified, including the need to ensure that mothers are fully informed about the risks and benefits of oxytocin in labour, and to strengthen verbal communication in theatre through consistent use of recognised communication tools so that appropriate support is available during emergencies. The Trust should also ensure staff can engage mothers in face-to-face discussions during labour when decisions are made, and that new staff are reliably trained in the use of the emergency bleep system and know who to call during emergency caesarean births and neonatal resuscitation. Further prompts highlight the need to embed airway management skills within multidisciplinary training and provide regular simulation exercises to strengthen team performance during newborn resuscitation. The investigation also noted that some staff were unaware of where newborn resuscitation documentation was kept, underscoring the need for reliable systems to ensure staff can accurately record events. In addition, the Trust should ensure neurological assessments for suspected encephalopathy are consistently completed and documented in line with national guidance before commencing therapeutic cooling, and finally, that all placentas requiring histological examination are reliably sent for analysis.

Appendix F: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Corporate Services			
Directorate for Education, Research and Innovation (DERI)	C184	Advanced Clinical Practice Role Equivalence & recognition of competence &capability	30/09/2025
	SOP065	Safe collection of Peripheral Vein Blood Culture (Adults & paediatrics, not neonates)	30/09/2025
Estates and Facilities	C158	Electrical Safety Policy	28/11/2025
	SOP113	Procedure for the Management of Oxygen During Periods of High Demand	30/09/2025
Finance and Capital	F20	Welsh, Scottish & Northern Ireland Office Patients Procedure Notes	30/09/2025
Human Resources (HR)	C086	Assistance Dog Policy	31/07/2025
	C099	Clinical Attachment Policy	31/03/2025
	HR11	Supporting Staff with Disabilities Policy	28/02/2025
	HR15	Facilities and Time Off for Recognised Representatives of Trade Unions and Staff Organisations	30/05/2025
	HR31	Alcohol, Drugs and Substance Misuse	30/08/2024
	HR36	Annual, Study and Professional Leave Policy for Consultant Medical Staff	30/01/2026
	HR43	Managing Organisational Change Policy & Procedure	30/05/2025
	HR51	Guidelines for Consultant Job Planning	31/03/2025
	HR52	Acting Down Policy - Guidelines on Senior Staff covering Junior Doctor Rotas	28/11/2025
	HR58	Policy on the Development of Professional Roles	31/12/2024
	HR60	Fair Recruitment and Selection Procedures	31/12/2025
	HR65	Compensatory Rest for Doctors (non resident on call)	30/04/2025
	HR68	Undertaking Private Practice	30/04/2025
	HR80	Agile Working Policy	31/10/2025
Infection Prevention & Control (IPC)	SOP008	Use insertion care maintenance and removal of a Peripheral Intravenous cannula	30/09/2025
Quality Governance	C002	Risk Management Framework 2021-2024	31/12/2025
	C157	Chaperones Accompanying Patients During an Intimate Procedure / Treatment	30/04/2024
Trust Wide (Corporate)	C116	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy (Unified)	31/10/2025
	SOP085	Risk Stratifying Process for Follow Up Patients	30/04/2025

Division/Directorate	Ref	Title	Review Date
Medicine and Emergency Care (MEC)			
Clinical Flow	C150	Patient Flow and Clinical Site Management Service Operational Policy	31/12/2025
Digestive Diseases	CP19	Protocol for the Supply and Administration of Oral Bowel Cleansing Preparation (BCP) prior to Colonoscopy	30/09/2025
	SOP149	Endoscopy to Ward Handovers at ELHT	31/10/2025
Surgical and Anaesthetic Services (SAS)			
Trust-Wide	C014	Consent to Examination or Treatment	30/01/2026

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Quality Committee	**Report to:**	Trust Board
Date of Meeting:	28 January 2026	**Date of next meeting:**	25 February 2026
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This AAA report provides a summary of the Quality Committee meeting held 28 January 2026.

Alert

What	So What	What Next
1. UEC safety	• Referencing the ongoing pressures in the UEC pathway and the prevalence of patients cared for the hospital corridors, the committee were informed that five checklists had been introduced to provide greater oversight and quality assurance of corridor care. • The committee were informed that there was regular Executive-level oversight of UEC care through weekly MDT meetings and regular Executive presence across the UEC pathway. • The committee has asked for data from the audits to be presented at a future meeting.	1 Audit results to come to March Quality Committee.
2. Safer surgical pathway	• The committee were informed that there had been a second Never Event relating to a retained swab in theatres which had required surgical removal post-operatively. • An urgent clinical review had taken place and a conjoined action plan developed based on	2 Report on theatre safety to come to March Quality Committee.

3. Regulation 28 issued following an inquest	learning from this incident as well as wider historical learning from similar events. • The committee also referenced the findings of the MIAA audit of the Safer Surgical Checklist in January 2026. • It was agreed that a 'bundled' approach would be taken relating to safety in theatres and a report provided to March Quality Committee. • The coroner has issued a Regulation 28 notice, requiring assurances to three points: 1. Fluid balance monitoring in ED 2. Recognition of seizure activity in ED 3. EAD triage and communication with threating teams	• Meetings have been arranged and a letter of assurance has been approved with the Legal team prior to submission on 8 December 2025. • A formal report will be brought through Quality Committee in March 2026.
Assurance		
What	**So What**	**What Next**
1. Venous thromboembolism assessment	• The IPR shows that the number of patients risk assessed for venous thromboembolism has shown a month-on-month increase, with further work underway to integrate the Trust's VTE dashboard with the BadgerNet system to capture maternal VTE assessment and further improve compliance data.	• The committee noted the positive progress in this area but suggested that additional detail on prescribing outcomes should be provided in future reports.
Advise		
What	**So What**	**What Next**
1. Nurse Staffing	• The committee noted the downward trend in average fill rates for registrants on the IPR and the increase in nursing red flags.	• The committee will continue to receive monthly updates on safe staffing.

2. HTA Update	• The accompanying safer staffing paper indicated no harm to patients as a result of the staffing challenges, but recognised the impact on staff workload and morale as staff are moved round the organisation. • The committee received the monthly update on the corrective action plan following the HTA inspection. • It was reported that the HTA are to re-inspect the mortuary on 4 February 2026. • It was reported that it would be unlikely that the forensic post-mortem licence will be reinstated following 4 Feb re-inspection. • It was reported that improvements in the mortuary were substantial and likely to be recognised recognised by the HTA. • Regular monthly meetings to review progress are being held with the HTA	• The committee will receive monthly updates on the corrective action plan following the HTA inspection.
3. Mortality Update	• The committee received the regular quarterly paper covering mortality within the organisation. • Crude mortality remains within expected limits. • The Trust SHMI figure has plateaued following the closure of long-standing data gaps giving more accurate picture of mortality figure for the organisation. The SHMI remains above expected due to the issues previously reported around SDEC data. • The Trust's HSMR remains within normal limits • Reported sepsis mortality is below expected.	• The committee will receive a report focusing on respiratory mortality in March 2026. • The committee will continue to receive a quarterly mortality report.

	• Reported pneumonia mortality is above expected. • Further detailed review of pneumonia mortality demonstrated evidence that excess mortality is concentrated within patients with very short length of stay and those with long length of stay. There is evidence that patients are being admitted at an end of life position, creating excess mortality for short length of stay patients and frailty being a potential factor for longer length of stay patients. • A report focusing on respiratory mortality will be presented at March Quality Committee.	
Other agenda items QIRA Summary Report PSIRF Report CQC Update		

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Quality Committee	**Report to:**	Trust Board
Date of Meeting:	25th February 2026	**Date of next meeting:**	25th March 2026
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This report delivers a summary of the items discussed at the Quality Committee meeting held on 25 February 2026.

Alert

What	So What	What Next
1. HTA Inspection	• The committee received a verbal update on the progress of the action plan following the HTA inspection of mortuary services at RBH. • The committee heard that a follow-up visit by HTA had taken place on 4 February 2026, with formal feedback due on 25 February 2026. • Initial feedback from the HTA follow-up visit was mixed, with the HTA inspection team recognising the work that had already been undertaken, whilst acknowledging the size of the work still to be done. The Mortuary Manager believes it will take around 12 months to fully complete all aspects of the improvement plan. • The HTA team expressed significant concerns around the continuing lack of freezer storage capacity and identified a body that should have been in frozen storage, but was still refrigerated. The HTA requested that the Trust immediately provide additional	• The mortuary team will provide a refreshed action plan following the formal feedback from the HTA on 25 February 2026. This will be reviewed on a monthly basis at Quality Committee, with escalation to Trust Board as appropriate. • The mortuary team will provide a paper at March Quality Committee outlining practices at the satellite body stores at Bury, Clitheroe and Pendle.

	freezer storage capacity. In response, the Trust sourced mobile freezer storage capacity to be used whilst the upgrade of the mortuary takes place. • The mortuary team will provide a refreshed action plan following the formal feedback from HTA on 15 February 2026. • The committee requested assurance around the quality and practices in the satellite body stores at Bury, Clitheroe and Pendle • The chair of Quality Committee undertook a quality walkround of the mortuary on 19 February 2026. Feedback was provided to Quality Committee.	
2. Nurse Staffing Exception Report	• The committee received the monthly nurse staffing assurance report. The report indicated that although the numbers of National Nursing and Midwifery Red Flags were low, there were significant numbers of reported staffing incidents that did not meet the threshold for formal Nursing and Midwifery Red Flags (MEC = 88, SAS = 964 in month). • Additionally, several of the indicators relating to nurse/midwifery staffing on the IPR are showing a deteriorating trend (average fill rate registered nurses day; wards <90% registered nurse fill rate; Care Hours Per Patient Day). • The committee recognised the significant amount of work that is undertaken on a daily	• The committee will continue to receive monthly assurance reports relating to nurse staffing and will triangulate this against indicators in the IPR etc.

3. Antimicrobial Stewardship Report	basis to maintain safe staffing levels, however the committee expressed concerns around the impact of mitigations such as asking Ward Managers to drop into the numbers (incident management; sickness/absence management etc.). • The committee expressed concerns around high sickness rates in a number of ward areas. • The Trust's Antimicrobial Stewardship Lead produced a report in response to a series of actions requested by NHSE. The request asked for a joint IPC/AMS presentation to each Trust Board covering performance, benchmarking and thresholds by the end of Q1 2026. The report to Quality Committee provided background to current AMS performance, prior to the formal Board presentation. • The report highlighted a significant increase in antimicrobial use since 2019 (54%); variable compliance with Trust guidelines; documentation gaps and unwarranted variation across directorates. The paper also demonstrated concerning increases in antibiotic resistance within the organisation. • The Trust Antimicrobial Stewardship Committee undertook a detailed evaluation of current Trust-wide stewardship capability and highlighted a number of critical gaps in monitoring, key workforce capacity and	• The chair of the quality committee asked the Trust's Medical Director to work with the Trust's Antimicrobial Stewardship Lead to produce a plan, based on the recommendations outlined in the paper, to improve antimicrobial prescribing practice. • Trust Board will receive a formal presentation, forming the response to NHSE on AMS. • Quality committee will increase the frequency of reporting for IPC and AMS to include quarterly presentations of AMS audit outcomes.

	governance structures that need to be addressed to meet national AMR expectations. • The report proposed a revised governance structure as well as a series of proposed performance indicators to drive improvements in AMS across the organisation. • The report was accompanied by the results of the quarterly antimicrobial prescribing audit (Q1 2025/26). Data was collected from 18 wards across MEC, CIC and FC Divisions. Overall: o Average compliance for patients prescribed anitibiotics appropriately, including an appropriate stop/review date, documented indication and compliance with the formulary was 43% (range 0% to 100%). o On average, 68% of prescriptions had an appropriate stop/review date. o On average, 72% of prescriptions had the indication documented. o On average, 81% were prescribed in line with the Trust formulary. • Quality committee was only able to gain limited assurance from the report in relation to antimicrobial stewardship and expressed its concerns around the audit outcomes. • The chair of quality committee expressed concerns around the current frequency of AMS and IPS reporting through the	

	committee and will review the frequency of reports presented to the committee.	
Assurance		
What	**So What**	**What Next**
1. Mental Health Strategy	• The committee received an update on the Trust's Mental Health Strategy which provided the finalised strategy document alongside the roll-out plan for the organisation. • The committee thanked the team who produced the strategy, noting the significant amount of work which had gone into it and the wide-ranging engagement with patients, families, carers and system partners during its preparation.	• The Mental Health Strategy will be presented to Trust Board for final ratification.
2. LSC Single Pathology Service	• The committee received a report providing an update on the LCS Pathology Single Service programme, focusing on quality management/clinical governance arrangements for the single service. • The report provided significant assurance around these aspects of the proposal and included assurance on various scenarios related to risk, incidents, complaints and how they are handled in the single service. • The report provided assurance that due diligence was completed (with workforce as an exception). • The report provided assurance around the Day 1 operating model and highlighted the risks and regulatory positions for each current service, with assurance that potential	• Work will continue to enable the commencement of a single pathology service for Lancashire and South Cumbria in April 2026.

3. Burnley Elective Surgical Hub Optimisation	mitigations were being worked through ahead of transfer. • Following the Bury Surgical Hub being awarded formal GIRFT accreditation for adults and paediatrics in November 2025, a report was presented to quality committee outlining the recommendations and areas to address to support the Hub to make further improvements to its processes and services. The report included an appended action plan demonstrating thet actions are progressing in a timely manner.	• Work will continue against the action plan, which will be monitored through Divisional governance structures, reported to TWQG B and escalated to quality committee as appropriate.
Advise		
What	**So What**	**What Next**
1. Joint cement availability	• The committee received a verbal report about the national shortage of orthopaedic joint cement and the mitigations that have been put in place to source additional supplies. • The Trust is currently prioritising non-elective joint replacement surgery and clinically urgent elective cases whilst the national shortage continues. Any cancellations of joint replacement surgery has been limited to lower clinical priority cases.	• Additional suppliers of joint cement are being sought and the Chief Operating Officer will oversee the work being undertaken to balance supply and demand.
2. Urgent and Emergency Care Programme Board	• As part of the discussion around IPR indicators the Medical Director highlighted the work being undertaken by the UEC programme board and highlighted concerns around the concerns around the impact of pressures in UEC on morbidity and mortality.	• A report will be presented to Trust Board at a future date. • An update on mortality in respiratory diseases will be presented to the March quality committee.
Other agenda items Integrated Performance Report		

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Maternity and Neonatal Services Report
Holistic End of Live Decision Collaborative Quarterly Report
QIRA Summary Report
Patient Experience Strategy Update
Patient Participation Panel Update
Internal Audit Reports

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	FINANCE & PERFORMANCE	**Report to:**	Trust Board
Date of Meeting:	26/01/2026	**Date of next meeting:**	
Chair:	Liz Sedgley	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. Month 9 Financial Position	• Month 9 position is a deficit of £3.6m an adverse variance to plan of £0.8m. YTD is a deficit of £50.5m compared to a planned deficit of £36.2m (£14.3m behind plan). WRP delivered in month was £3.6m and was £2.8m adverse to plan. YTD the WRP delivered is £29.1m but is now £11.8m behind plan, this is partly been driven by underperformance of the non-pay plan, albeit there is additional non-pay costs directly related to the additional unfunded activity. Analysis of the activity and income for the YTD has show a significant overperformance against the block income contract to the sum of £61.4m. This is partly funded by the DSF of £43.3m but still leaves a shortfall which is expected to be circa £26.7m at FOT.	1 Work is ongoing to review both under and over performing schemes to drive further savings out to the end of 25/26 together with implementing mitigation schemes where possible. Contract negotiations for 2026/27 are addressing both the issues of the activity levels and the new national tariffs identified in year.
2. Cash Position	• Managing the cash position is still challenging and the Trust will have to apply for further funding from NHSE	A cash application will be submitted in February

3. Forecast Outturn & Mitigation planning	• The Trust is investigating all opportunities to push delivery of the WRP to achieve best case position of £53m. The most likely position has been reforecast at £48.5m by the PMO. The committee did not feel this was achievable given the performance to date and current pressures and activity levels in non-electives.	The committee requested that the PMO team present a more detailed plan of the remaining schemes and mitigations / unpalatable options be presented at the next meeting.
Assurance		
What	**So What**	**What Next**
1. Elective & Productivity Cross Cutting Workstream deep dive	• Overall schemes in the programme identified savings of £2.997m and are forecast to deliver £2.4m in 2025/26. With overperforming schemes delivering an additional £820k of savings but underperforming schemes are short by £1,083k The Trust was recognised for the significant progress made as part of the FurtherFaster20 national programme,	1. Further reviews are underway to improve the FOT position linked to both additional elective income and reviews of issues around the under delivering schemes. A new outpatient improvement collaborative is being scoped and launched which will bring significant benefits for 2026/27
2. Review of F&P sub-groups	• A review of the committee's sub-groups was carried out by colleagues from the RSP Team . The findings of the review were accepted and the recommendations approved	2. The findings will now be adopted and the corporate calendar for 26/27 will be adjusted where required
Advise		
What	**So What**	**What Next**
1. National Costing Collection Results	• The 2024/25 submission was made and showed ELHT benchmarked at 100 in line with the national average and better than system peers. The Trust NCC score for 2023/24 was	1. The Team is now part of the OneLSC Analytical Finance team and share learning across the 5 Trusts. The 2024/25 data will be shared with divisions and teams to support service development and identify further savings and opportunities

2. 3rd Surgical Robot business case	110 and confirms the progress made to reduce the run rate. • The 3rd robot has been provided at no cost for a pilot for 6 months to assess the potential benefits. The committee noted the benefits to patient outcomes and experience as well as cost and efficiency benefits and so were happy to support the investment case	2. The business case will be put forward to Trust Board for approval
Other agenda items		

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	11 March 2026	**Agenda Item:**	FP/2026/043b
Report Title:	Triple A Report from Finance and Performance Committee		
Author:	Sallie Bridgen/Liz Sedgley		
Lead Director:			

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	X			
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 23.02.2026 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name:
Finance and Performance
Date of Meeting:
01.06.25
Committee Chair:
Sallie Bridgen
Attendance: Quorate
Key Items Discussed:

ALERT

The Committee received the **Financial Performance report**. At month 10, the Trust is reporting an in-month deficit of £3.64m, against a planned deficit of £2.52m; £1.12m behind the plan.

The year-to-date (YTD) position is a £54.17m deficit against a planned deficit of £38.73m; £15.4m behind plan (excluding the DSF).

In month **WRP** delivered £4.8m against the WRP Delivery plan, therefore £1.7m adverse to plan (£1.2m adverse to PFR plan). The WRP has delivered £33.9m YTD against a plan of £47.4m; £13.5m behind the WRP Delivery plan. (£14.3m adverse to the PFR plan). The Committee requested that the format of WRP reporting be reviewed to improve assurance with input from Simon Gilmore of NHSE

The Trust has revised the **forecast outturn** for 25/26 to a £10m deficit to the break-even plan, agreed at an Extraordinary Trust Board on the 5th of February 2026.

While the under delivery of WRP is disappointing, it is important to note that one of the biggest drivers for the Trusts financial position is a shortfall of £61.4m in the 2025-26 contract offer. If the Trust had received the correct income in line with the activity being delivered it would be in a surplus.

The **cash balance** at the end of December was £13.8m, an increase of £3.8m compared to M9. Cash flow is a significant risk. With Deficit Support Funding (DSF) not being awarded DSF since M7, the Trust has applied to receive £18.1m of Provider Revenue Support (PRS) PDC in Q4 to replace this shortfall, of which £10.8m was received in January. However the March draw down was not approved on the basis that the Trust is expected to receive withheld DSF by the end of the financial year as the system overall is expected to deliver the plan.

In relation to **pay** - Agency spend of £364k, is £144k better than plan and represents a 58% reduction on 2024/25 run rate. Bank spend of £2,995m is £551k better than plan, this represents a 34% reduction on 2024/25 run rate. Paid WTE have decreased by 78 WTE from Month 9 to 9,610.

Sickness remains a key driver of our costs. People and Culture Committee will be addressing this issue in greater detail.

12-hour A&E performance was 17.02% against a trajectory of 17.20%. January activity remained extremely challenging, with 24,861 attendances, an increase of 552 from December, and the Trust declared OPEL 4 from 12th – 15th January and from 30th Jan – 4th February. In addition to increasing safety and quality risks, this also has a significant impact on our efficiency.
See below for assurance through the UEC Transformation Programme Board.

ASSURE

A compliant **Plan for 26/27** was submitted to NHSE on 11th February. There is a savings requirement for the Trust of £31.2m (3.2%) in 2026/27. Work is ongoing to develop robust documentation around these plans to ensure delivery.

The Committee received an update on **Grip and Control**, which is continuing to mature, and all PwC recommendations will be completed by the end of the financial year. The Trust has implemented a range of strengthened controls to support delivery of the 2025/26 financial plan and embed a more robust control environment for the future. These controls are targeted at both pay and non-pay.

The Trust's **Capital Programme for 2025-26** has increased by £0.5m to £47.6m largely for an additional £0.5m PDC funded scheme and is forecast to be spent in full achieving the revised plan.

The Committee received an update on the **Planning Submission** to NHSE, following consideration by Board in December and February, and at a specific Planning session, and at F&P in December and January. The workforce plan has been updated to reflect WRP plans in progress. The finance plan has been updated to reflect updated contracting information and further progression on internal financial plans. Further work with commissioners on commissioning intentions, contract offer is ongoing, with aim to finalise this within the contract window (by 31st March 2025)The new Trust Strategy continues be undertaken in parallel alongside the 5-year delivery plan.

The Committee received a report on the progress made in reducing **length of stay (LoS)** and improving patient flow throughout 2025. Specifically focused on the Medicine and Emergency Care Division, there is a mostly improving length of stay trend, with a high proportion of the Wards seeing a reduction in their length of stay. This workstream will form part of a refreshed **UEC Improvement and Transformation Programme** which has recently been established to strengthen leadership, governance, and accountability across all urgent and emergency care (UEC) improvement activity. The Programme Committee provides senior oversight, decision making and strategic direction to ensure delivery of the Waste Reduction Programme (WRP), within which **length of stay reduction** is a core workstream. This project is **Executive led** and supported by a dedicated senior operational and clinical team to ensure delivery of the project aims and objectives.

The Committee received an update on **One LSC Cross Cutting Workstream Deep Dive – Procurement**, outlining significant additional financial controls. Assurance was given to the Committee that a strengthened suite of procurement controls for FY25/26 is fully in place to enhance governance, value, and compliance. Key additional controls include revised approval hierarchies for both stock and non-stock expenditure, tighter ward-level stock and materials management, and a targeted stock-reduction programme. An expenditure freeze remains active, supported by enhanced scrutiny of single-quote waiver requests and the removal of discretionary spend catalogues. In addition, a new performance-focused KPI framework has been introduced to drive accountability and ensure continuous monitoring. Collectively, these controls provide a more robust, transparent, and disciplined procurement environment.

The Committee received the **MIAA Internal Audit Report – Key Financial Transaction Processing Controls Review**. The report provided assurance that the most significant key controls operated during key processes were appropriately designed and operated effectively in practice. A moderate assurance rating has been awarded due to the high amount debt owed to the Trust and the lack of evidence that debts below £100K are being actively chased. There were good controls noted surrounding the general ledger, cash management and budgetary control elements reviewed. An internal management action plan will be brought to the next Committee meeting to provide assurance that recommendations will be actioned within a timely manner.

The Committee received and noted the **Integrated Performance Report**.

ADVISE

The Committee received an update on the Lancashire and South Cumbria Pathology Single Service programme, which will transfer on 1 April 2026. The programme is now in its final phase of assurance ahead of Board approval. The committee noted the thorough process that legal documentation has been through with company secretary and legal advice, and that due diligence has completed. Areas to be finalised include contract novation, service fragility and estates transformation. The next stage of approval will be at March Board.

The Committee received a report on progress on Clinical Workforce Job Planning. The update highlighted significant progress in establishing team and individual job plans. 85% of directorates have held team Job Planning sessions, and 95% of Individual Job Plans should all be in place by May 2026, to be updated annually. The Committee identified that there is further work to do to ensure team and individual job planning is better aligned to contractual requirements and service needs. A further update will be brought on progress

The Committee reviewed the BAF and Corporate Risk register, and requested that the format of the CRR and the associated Cover Sheet be updated to improve accuracy and assurance. This will be completed in time for March Committee.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	People & Culture	**Report to:**	Trust Board
Date of Meeting:	1 February	**Date of next meeting:**	2 March
Chair:	Liz Sedgley	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. Sickness Absence 2. Appraisal Rates	• The rate increased in mth 9 to 7.32% inc OneLSC from 7.15 in mth 8. The estimated cost of this for the month is £2.3m with long term sickness accounting for 68.5% of total sickness . A recent internal audit review into sickness absence found a number of weaknesses in systems and processes • Appraisal Rates for non medics remains at 79% behind the target rate of 90%. A rapid improvement week will be held mid February to use improvement methodologies to co create a new approach.	1 A detailed response to the MIAA is being developed with a specific sickness improvement programme being launched. The work to increase the number of super nummary days for ward managers is seen as a critical enabler to enable better management of sickness at ward level 3. An update will be given at the March committee with an outline of the timescales etc to implement the improvements identified

Assurance

What	So What	What Next
1. 2025 Staff Survey Results	• The results are still embargoed but the slight increase in response rates indicates that staff are still willing to engage with the Trust . Key themes emerging from the survey are as expected given the challenging operational	1. Further updates will be provided to the committee once bench marking, qualitative data and deeper analysis is available to inform the work programmes to address area of concern

	and financial context in which the Trust and the wider NHS is operating in	
Advise		
What	**So What**	**What Next**
1. Nursing & Midwifery subculture rostering review	• The outcomes from the review were presented however due to the low response rates – only 5% return rate to the questionnaire, further work will be carried out with the BAME network to gather more information by visiting wards and running focus groups to understand what is driving staff choices of specific shift patterns.	1. Once further responses and data is received then work can be undertaken to embed inclusive rostering principles across nursing and midwifery services and the wider workforce.
2. Priority actions from Safe Space Sessions and Arushi Project Update	• Updates were received on both programmes, the committee asked for specific work programmes with accountability, delivery and key dates to be produced . It also noted the risks to delivery being lack of dedicated resource and both overt and passive resistance in some areas as the programmes challenge established systems and behaviours.	2. A detailed work programme will be presented at the April meeting to deliver the 4 key priorities of Fair and Inclusive Recruitment, Positive action for career development Inclusive leadership and management development Building psychological safety and trust in processes
Other agenda items		

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	People & Culture	**Report to:**	Trust Board
Date of Meeting:	2 March 2026	**Date of next meeting:**	13 April 2026
Chair:	Liz Sedgley	**Quorate: (Y/N)**	Y

Introduction

Alert

What	So What	What Next
1. Backlog of Subject Access requests	• There is an emerging risk due to a significant backlog of subject access requests which if not dealt with quickly could result in fines and reputational damage	1 A review is being carried out on the scale of the issue and the resource need to rectify the position to ensure compliance with timescales etc. This will presented to the exec management group and will report back to P&C as part of the Corporate risk register update to the April meeting
2. Appraisals	Appraisal rates for non medics declined again in January to 78% against the target of 90%. An update from the recent Appraisal rapid improvement week was received where by there was excellent engagement from teams across the organisation resulting in new documentation being developed and tested incorporating the feedback given. A 30/60/90 action plan has been created to monitor implantation of the new documentation, processes and procedures.	2 The committee will receive updates as the 30/60/90 day plan is actioned . The committee also asked for the execs and HR Team to investigate and escalate where necessary why and which teams with in the Corporate heading where driving the poor compliance rate of just 48%
3. Sickness Absence	Despite a slight improvement in month on the absence rate to 7.23% compared to 7.37% the trend generally is still declining with some significantly higher rates of 10.49% in E&F .	3. Several work programmes are working to improve this position including the improvements made to processes in response to the MIIAA audit into sickness absence management , the deployment of PNAs to support nursing teams and also the work to

		increase the number of super nummary days for ward managers is seen as a critical enabler to enable better management of sickness at ward level. The committee asked for smarter targets to be set for individual directorates and teams to be set given their current positions to monitor progress against set trajectories to reach the target sickness rates
Assurance		
What	**So What**	**What Next**
1. Safer Working hours report for resident doctors	• The quarterly report and additional report to Dec 25 and a further report to 3 February 2026 (under the revised T&Cs) was received by the committee and assurance could be given that the services provided by the Trust are safe for both patients and the resident doctors.	Quarterly reporting will continue to be submitted to the committee who also asked for the report to include comparative data from neighbouring trusts to enhance the evidence submitted of a good reporting culture within ELHT.
2. Workforce Plan for 2026/27	• The Trust has submitted a compliant workforce plan for the next financial year, The workforce plan has been developed from the divisional plans and includes a WRP reduction of 744 WTE in year one which is a net reduction of 552WTE after the inclusion of OneLSC staff into the ELHT staffing numbers	Work is now being carried out by the divisions and PMO to develop detailed plans to reduce WTE numbers as well as financial savings in order to meet the Financial Plan for 2026/27
3. Annual Temporary Staffing Report	• Although the trust is behind targets for reducing bank and agency against national targets , significant reductions continue to be made despite the context of industrial action and significant increases in demand on NEL	Regular updates will be received on the use of bank & agency via the grip and control report

	pathways. There are only 2 areas being pathology and endoscopy that continue to pay enhanced rates of pay	
Advise		
What	**So What**	**What Next**
1. Feedback from RSP Team 2. The project to transfer E &F functions	• Positive feedback has been received from the RSP team following a deep dive into our work around staff engagement. • NHSE did not give approval for the proposal to transfer E&F functions and several senior employees into Atlas .The nature of this transfer and the timescales required to transact this prior to the financial year end caused some tension with staff side colleagues	Work continues to ensure we are able to see and measure the impact of actions and activities carried out in this area. Work will continue with staff side to improve the relationships with staff side going forward
Other agenda items		

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:	30th Jan 2026	**Date of next meeting:**	TBC
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Internal Audit – implementation & follow up of recommendation	The Trust is significantly behind plan to deliver previous year recommendations. This will impact on the FY25/26 HOIA opinion. Potential for another limited opinion at year end.	The executive should take time to understand why progress has been limited.
IA assurance reports	Theatre Stock IA review - Initial judgement from MIAA is concerning and may impact on finance and patient safety Health & Safety – Limited Assurance Absence Management – Limited Assurance	Management will review and have opportunity to respond to MIAA. Chair of Quality Committee will explore patient safety issues. To be discussed at P&C.
Assurance		
What	**So What**	**What Next**
FY25/26 Internal Audit Plan	There has been a catch up on field work and MIAA are confident that all work will be completed by April 26.	N/A
Advise		
What	**So What**	**What Next**
Financial Implications for the Estates Transformation Programme	Progress 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:	13 February 2026	**Date of next meeting:**	13 April 2026
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This report provides an update on the meeting of the Trust Charitable Funds Committee on 13 February 2026.

Alert

What	So What	What Next
1. No alerts to Trust Board from this meeting.	•	1

Assurance

What	So What	What Next
1. ELHT & Me Financial Performance Report.	• A paper was presented to the committee outlining the details of the financial position of ELHT & Me charitable funds as at quarter three of the financial year 2025-26. • The financial position as at 31 December 2025 shows an accumulated fund balance of £3,223,000 of which £227,000 relates to restricted funds. • The charity currently holds 61 individual funds of which 4 are restricted funds and 57 are unrestricted funds. • The investment of the funds managed by Brewin Dophin demonstrate a net profit of £120,000 as at 31 December 2025.	• The Trust Charitable Funds Committee will continue to receive quarterly financial performance reports.

2. ELHT & Me Fundraising and Performance Report	• The cash balance held as at the 31 December 2025 was £1,686,000. • A three-year draft spending plan was presented to the committee. • A report was presented outlining the fundraising activity and performance between October to December 2025. • The committee heard that this was an extremely successful period for the charity, raising record funds through the charity hub, delivering its Christmas-themed fundraising activities and highly successful prize draw whilst also being supported by numerous members of the community raising funds on behalf of ELHT & Me. • The charity engaged with a large number of businesses, schools and other organisations whilst managing the 'Give a Gift" appeal and delivering a schedule of Christmas themed entertainment creating special moments to enhance patients and their families' experience. • The staff lottery continues to perform well against its target whilst delivering wellbeing enhancements to the ELHT staff environment. • The report additionally outlined combined performance of the charity hub fundraising and retail for the period October to December 2025. • This period saw record sales for the quarter of £46,604 which was split as £39,158 retail and £7,446 charity hub fundraising.	• The committee will continue to receive quarterly reports on fundraising and performance.

	• Total funds available after salary charging for part Fundraising Assistant and Finance was £219,945. • Huge thanks were offered for the dedication shown by the charity hub volunteers who gave their free time at weekends in the lead up t Christmas in addition to their time given during the week.	
Advise		
What	**So What**	**What Next**
1. Funding of Long Service Awards	• Members of staff who have worked for ELHT and its predecessor organisations for a period of 25 years are provided with a gift voucher to the value of £50. • Historically long service awards have been funded by the charity. • When public benefits tests first emerged under the Charities Act 2011, payments that provided a sole benefit to an individual did not meet the criteria as a benefit to the public and as such is not charitable expenditure. • As a result of this, a recommendation was made to the committee that long service awards are no longer paid for by the charity.	• It was agreed that it was no longer appropriate for the charity to fund long service awards and that this should cease. The matter of the funding of long service awards has been referred to the Trust Executive team for consideration.
2. ELHT & Me strategy 2024-27 update	• The report provided a strategy follow up with potential actions for consideration of a new charity hub at Burnley General Hospital. • The current business plan for the charity hub at Royal Blackburn Teaching Hospital runs to 31 March 2026 at which stage a comprehensive report on the journey and performance will be produced and presented	• The committee approved the establishment of the working group to explore the feasibility of establishing a second charity hub at Burnley General Hospital. • The committee will receive reports from the working group.

3. Proposal for the funding of pharmacy prescription collection stations.	at the following Charity Committee meeting. The learning from this report will be used to explore the feasibility of the development of a second charity hub at Burnley General Hospital. • The committee were asked to approve the creation of a working group that includes a committee member with representation from Finance, Charity Staff, Estated & Facilitie, Legal and Volunteer services to investigate the feasibility, staffing and profitability versus investment of a charity hub at Burnley General Hospital. • A previous meeting of the committee approved in principle the case for purchase and installation of prescription collection stations, subject to confirmed costs and a compliant quote from a supplier. • A revised financial summary was presented showing capital costs of £156,179 (inc VAT) and revenue costs of £7,400 annually (exc VAT) • Funding contributions of £10,000 would be provided from pharmacy endowment funds and revenue costs would be secured from the savings provided from the cessation of deliveries and be funded from E5606 (Pharmacy). • The report highlighted the benefits of the proposal in relation to improved patient experience, more convenient collection options, improvements in dispensing times for prescriptions, a reduction in footfall through pharmacy and within the hospital buildings as	• The committee approved the capital financial investment for the purchase and installation of prescription collection stations to support improvement of patient experience at Royal Blackburn and Burney General Hospitals.

	well as improved accessibility for patients when collecting medication. • The proposal would see the purchase and installation of prescription collection stations at both the Royal Blackburn and Burnley General Hospitals.	
Other agenda items Charity Policies for Approval		