

East Lancashire Hospitals NHS Trust Board Meeting



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TRUST BOARD (OPEN SESSION) AGENDA

13 May 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/2026/050	Chairs Welcome and Apologies for Absence	Chair	v	Information
09.32	TB/2026/051	Declaration of Interests	Chair	v	Information
09.35	TB/2026/052	Minutes of the Previous Meeting	Chair	✓	Approval
09.40	TB/2026/053	Action Tracker and Matters Arising	Chair	✓	Discussion
09.45	TB/2026/054	Patient Story	Chief Nurse	v	Information
09.55	TB/2026/055	Board Assurance Framework Risks and Risk Appetite Statement 2026-27	Interim Director of Corporate Governance	✓	Approval
10.05	TB/2026/056	Chair's Report	Chair	✓	Information
10.10	TB/2026/057	Chief Executive's Report	Chief Executive	✓	Information
FORMULATING STRATEGY					
10.25	TB/2026/058	Provider Collaboration Board Strategic Update - PCB Joint Committee Terms of Reference - PCB Decision Making Routes	Chief Executive	✓	Approval
ENSURING ACCOUNTABILITY					
10.30	TB/2026/059	Integrated Performance Report	Executive Directors	✓	Assurance
10.50	TB/2026/060	Financial Performance Report	Director of Finance	✓	Assurance
COMFORT BREAK 11.05 – 11.15					
11.15	TB/2026/061	Integrated Improvement Plan	Exec. Director of Service Improvement	✓	Assurance
11.25	TB/2026/062	Perinatal Quality Oversight Model Report	Chief Nurse / Medical Director	✓	Assurance
11.40	TB/2026/063	Quality Account 2025-26	Chief Nurse / Executive Medical Director	✓	Approval
11.50	TB/2026/064	Delegation to approve Annual Report and Annual Accounts	Int. Director of Corporate Governance	✓	Approval
SHAPING CULTURE					

11.55	TB/2026/065	Freedom to Speak Up	Chief People Officer	✓	Assurance
COMMITTEE REPORTS					
12.10	TB/2026/066	Review of Committee Terms of Reference	Interim Director of Corporate Governance	✓	Approval
12.15	TB/2026/067	Annual Report of Audit Committee	Committee Chair	✓	Assurance
12.20	TB/2026/068	Triple A Report from Audit and Risk Committee a) April 2026	Committee Chair	✓	Assurance
12.25	TB/2026/069	Triple A Reports from Quality Committee a) March 2026 b) April 2026	Committee Chair	✓ ✓	Assurance
12.30	TB/2026/070	Triple A Reports from Finance & Performance Committee a) March 2026 b) April 2026	Committee Chair	✓ ✓	Assurance
12.35	TB/2026/071	Triple A Reports from People & Culture Committee a) April 2026	Committee Chair	✓	Assurance
CLOSING MATTERS					
12.45	TB/2026/072	Message from the Board	Chair	v	Information
12.50	TB/2026/073	Any Other Business	Chair	v	Information
12.55	TB/2026/074	Date and Time of Next Meeting 8 July 2026 at 9.30am, Boardroom, Trust HQ	Chair	v	Information

BOARD MEETING (PUBLIC SESSION)

11 MARCH 2026 9.30AM

BOARDROOM, TRUST HQ

MINUTES

PRESENT

Professor M Thomas	Chairman
Mrs S Bridgen	Non-Executive Director
Mr S Featherstone	Non-Executive Director
Dr J Hobbs	Executive Medical Director
Mr M Hodgson	Chief Executive
Professor A Ireland	Non-Executive Director
Mr A Kamaluddin	Non-Executive Director
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive
Mr P Murphy	Chief Nurse
Ms M Naiga	Non-Executive Director
Mrs C Randall	Non-Executive Director
Mrs L Sedgley	Non-Executive Director
Mrs S Simpson	Executive Director of Finance

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
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	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2026/039
Dr H Ziglam	Consultant Microbiologist	Item: TB/2026/040

APOLOGIES

Professor S Bari	Associate Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mr M Maher	Clinical Director, Obstetrics and Gynaecology

		2025					2026	
		23 Apr	14 May	9 Jul	10 Sept	12 Nov	14 Jan	11 Mar
Prof M Thomas	100%						✓	✓
Mrs K Atkinson	86%	✓	✓	D	✓	✓	✓	✓
Mrs S Bridgen	57%	✓	✓	✓	A	A	A	✓
Prof S Bari	80%			✓	✓	✓	✓	A
Mr S Featherstone	100%			✓	✓	✓	✓	✓
Mrs S Gilligan	100%	✓	✓	✓	✓	✓	✓	✓
Mr M Hodgson	100%	✓	✓	✓	✓	✓	✓	✓
Dr J Hobbs	100%				✓	✓	✓	✓
Prof A Ireland	100%							✓
Mr A Kamaluddin	100%							✓
Mr T McDonald	71%	✓	D	✓	D	✓	✓	✓
Mr P Murphy	86%	✓	✓	✓	✓	D	✓	✓
Mrs M Naiga	100%							✓
Dr N Pease	100%			✓	✓	✓	✓	✓
Mrs C Randall	83%	A	✓	A	✓	✓	✓	✓
Mrs L Sedgley	100%	✓	✓	✓	✓	✓	✓	✓
Mrs S Simpson	71%	✓	✓	✓	D	✓	D	✓
Miss S Wright	100%	✓	✓	✓	✓	✓	✓	✓
Mrs T Anderson	50%	A	✓					
Mrs M Hatch	100%	✓	✓	✓	✓	✓		
Prof G Baldwin	40%	A	✓	A	A	✓		
Mr S Islam	100%	✓	✓	✓				
Mr M Ireland	100%	✓	✓					
Mrs K Quinn	0%	A	A					
Mr K Rehman	100%	✓	✓	✓	✓	✓	✓	
Mr S Sawar	100%	✓	✓	✓	✓	✓		

✓ Attended

A Apologies

D Deputy attended

TB/2026/027

CHAIRMAN'S WELCOME AND APOLOGIES

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

Professor Ireland, Mr Kamaluddin and Ms Naiga were welcomed to the board as newly appointed Non-Executive Directors.

It was clarified that, while the meeting was held in public, it was not a public meeting, and observers were present. Attendees were reminded to avoid the use of acronyms to ensure clarity and accessibility throughout the meeting.

TB/2026/028 REGISTER OF BOARD DIRECTORS' INTERESTS

The Board noted the updated Register of Directors' Interests.

TB/2026/029 DECLARATION OF INTERESTS

There were no additional declarations of interest raised.

TB/2026/030 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 14 January 2026 were approved as a true and accurate record.

TB/2026/031 ACTION TRACKER AND MATTERS ARISING

Financial Performance Report (TB/2026/009) Mrs Giles confirmed that weekly oversight meetings of the Director of Finance with the Chair of Finance & Performance Committee have been arranged for the remaining weeks of the financial year.

Integrated Performance Report (TB/2026/010) Mr Pease confirmed that the Freedom to Speak Up (FTSU) Report due to be presented to the May board meeting, would contain an update on FTSU Mandatory Training.

Mrs Gilligan confirmed that the IPR had been reviewed with support from the Making Data Count team and was one of only 22 Trusts that had scored 5 out of 5. Despite this, the IPR is being reviewed and will be updated to demonstrate which Key Performance Indicators (KPIs) do not have national baselines.

Directors noted that the remaining 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/2026/032 PATIENT STORY

Directors were referred to the patient story, which can be viewed [here](#).

The board formally acknowledged the dedication of staff on Ward B14 delivering care in challenging circumstances.

ACTION: It was agreed that a letter of thanks from the board would be issued to ward colleagues in recognition of the quality of care and feedback highlighted through the patient story.

BY WHO: Company Secretary.

BY WHEN: Immediate.

The board noted the paper setting out the purpose of the patient story and discussed the assurance value of the patient story and reflected on learning arising from the experiences described. It was recognised that corridor care remained a significant driver of poor patient and staff experience, operational pressure, and financial challenge, and would continue to be a major organisational focus into 2026-27.

The board was also advised that work was underway to develop a more sustainable urgent and emergency care (UEC) model, with a commitment that corridor care would be eradicated by mid-December. It was recognised that this was a significant challenge. The Chair requested that progress against the UEC Transformation Programme be a standing item at all assurance committee and board meetings.

ACTION: UEC Programme updates to be a standing item for all Committees and Board until January 2027.

BY WHO: Medical Director

BY WHEN: April 2026

Directors noted that cultural factors and staff support were integral to improving patient experience, particularly in pressured environments. It was agreed that evidence of improvement should include a combination of quantitative and qualitative measures, such as patient feedback, staff surveys, complaint themes, and safe culture tools. The Chair asked that the 2021 Patient Experience NICE Guidance, be shared with board members to support how assurance can be received in relation to patient experience and that a report was provided to the Quality Committee to summarise the work taking place to improve the patient experience.

ACTION: A report will be provided to the Quality Committee regarding complaints and the work taking place to improve patient experience.

BY WHO: Chief Nurse.

WHEN: May 2026.

Directors received and noted the patient story.

TB/2026/03 CHAIR'S REPORT

The chair referred directors to the previously circulated written report.

Directors recorded their thanks to Mr Khalil Rehman, who had left the board in February 2026, for his contribution and service. It was also noted that this meeting represented the final Board meeting for Mrs Simpson.

The board approved Mr Amin Kamaluddin as second Vice-Chair with an external stakeholder and system focus. The Chair confirmed that Mrs Bridgen would remain as first Vice-Chair who would act in the Chair's absence and have a portfolio with an internal focus. The board also agreed the appointment of Mr Featherstone to the role of Senior Independent Director, noting that while this was not a constitutional requirement, it was considered good practice.

Updated arrangements for non-executive director committee chair and membership were confirmed as set out in the appendices to the report. It was confirmed that lead roles for non-executive directors would be limited to those required by statute, wider board champion roles would no longer be maintained.

Directors were also referred to two decisions taken between scheduled board meetings under delegated authority. It was confirmed that these decisions, made on 4 February and 25 February respectively, required formal ratification. The board ratified both decisions.

Directors received and noted the report provided by the chair.

TB/2026/034 CHIEF EXECUTIVE'S REPORT

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

The board was advised that the organisation was entering a period focused on year-end activity and planning for 2026–27, with a medium-term plan covering the next three years. It

was confirmed that a compliant and aligned plan had been submitted to the system on 12 February.

Reference was made to international events in the Middle East and their impact on colleagues. Directors were advised that communications had been issued to staff outlining available wellbeing resources.

An update on the new national cancer plan was provided. The plan, which aimed to achieve national cancer waiting time standards by 2029, had been broadly welcomed. It was reported that the Trust was currently achieving all relevant cancer targets. Growth in planned robotic surgery was highlighted, with the organisation recognised as an exemplar in this area. The board was informed that, nationally, the NHS was projecting to achieve the 18-week Referral to Treatment (RTT) standard by year end and noted that the Trust was performing strongly in relation to long waits, although reducing 52-week waits remained a key priority.

Progress was reported on the establishment of a single pathology service across LSC, planned for April 2026. It was confirmed that work was ongoing, including consultations and due diligence processes and that Lancashire Teaching Hospitals NHS Foundation Trust was due to become the host organisation.

Directors were informed that, as part of One LSC collaboration on corporate services, the Trust had recently welcomed approximately 1,000 estates and facilities colleagues who had transferred in from a neighbouring organisation. It was confirmed that roles would remain unchanged for the vast majority of staff.

The board was referred to actions outlined in the report that had been carried out in response to UEC pressures, including the establishment of same-day frailty emergency care and management of bed capacity during periods of Operational Pressures Escalation Level (OPEL) 4. External support from the national Getting It Right First Time (GIRFT) team was acknowledged, reflecting improvement ownership and progress achieved by the Trust.

In response to concerns raised regarding an increase in violence and aggression towards staff, the Trust's zero-tolerance approach was reiterated, and it was confirmed that action continued to be taken against any patients or visitors involved in such incidents.

The board was advised that the Trust was on track to deliver a record level of efficiency savings. While financial risks remained within the plan, a significant reduction in the financial run rate had been achieved through sustained effort.

Directors were advised that the results of the most recent staff survey were due to be published the following day, and that the executive team had already received a presentation outlining initial learning. It was agreed that People and Culture Committee would review the detail of the staff survey and have oversight of the resulting staff survey action plan, cross referencing where appropriate with the Quality Committee.

ACTION: The outcomes of the most recent staff survey, and the action plans developed to address any areas of concern, will be considered at a future meeting of the People and Culture Committee.

BY WHO: Interim Joint Chief People Officer.

BY WHEN: April 2026.

A range of achievements across the workforce were highlighted, including a series of internal and external awards, excellent rehabilitation work within inpatient services, strong ratings for chaplaincy services, and national recognition received by a clinical nurse specialist in endocrinology.

An update was provided on the AVH site, which was described as being at a pivotal point. It was confirmed that the Trust continued to participate in a multi-agency strategy group, was close to announcing a development partner, and remained fully committed to progressing site development.

Following discussion, it was requested that an update on the national definition of corridor care was requested to be circulated to all Board members to ensure shared understanding.

ACTION: The national definition of corridor care will be circulated to board members.

BY WHO: Interim Director of Corporate Governance.

BY WHEN: Immediate.

Assurance was also sought regarding staff safety in light of increasing aggression, and it was agreed that this would be monitored through the People and Culture Committee (PCC).

ACTION: The People and Culture Committee to monitor staff safety in light of increasing aggression.

BY WHO: Interim Joint Chief People Officer.

BY WHEN: June 2026.

The board welcomed the detailed nature of the report and noted the mechanisms in place to share good practice both internally and with partner organisations. It was confirmed that learning was routinely disseminated through established networks, mutual aid arrangements and national improvement frameworks.

Further discussion took place regarding cervical screening uptake within diverse communities. It was noted that addressing inequality in access and outcomes was a core responsibility of the system, and that services must continue to be designed through a health inequalities lens. Further detailed discussion was agreed to take place outside the meeting if required.

Directors received the report and noted its contents.

**TB/2026/035 PROVIDER COLLABORATION BOARD (PCB) STRATEGIC
UPDATE**

It was noted that the PCB had engaged with internal audit to review its effectiveness, in line with good governance practice. The review was reported as being generally positive and had made recommendations focused on streamlining arrangements. It was confirmed that these recommendations had been incorporated into the PCB's revised structure and work programme for 2026–27.

Ongoing positive engagement with system partners was also noted, including collaboration with colleagues from the Integrated Care Board (ICB). A draft ICB operating model had been shared, and it was acknowledged that service change protocols had not been sufficiently clear in previous years. It was confirmed that further work was underway to improve clarity and alignment in this area.

It was highlighted that the local area included a significant number of churches and mosques that were actively engaged within their communities. Directors noted that opportunities were being explored to better integrate the work of volunteers from faith-based organisations into the work of the PCB in order to strengthen community connection and impact as per the current NHS 10 Year Plan

Directors received the report and noted its contents.

TB/2025/036

INTEGRATED PERFORMANCE REPORT (IPR)

a) Safe

Directors were informed that there had been a deterioration in nurse staffing levels, driven primarily by ongoing urgent and emergency care pressures and high sickness and absence. Vacancies for care support workers were also highlighted, and it was confirmed that recruitment approaches had been adjusted to address these gaps. Members were advised that significant work was underway to address sickness and absence, with new initiatives in development. It was confirmed that reporting against the sickness absence trajectory would take place via the People and Culture Committee (PCC).

The board discussed the impact of UEC pressures on staff experience, patient experience and the Trust's financial position. It was noted that improvements between the position reported and the March forecast had delivered benefits across these areas, with an expectation of further reductions in variable pay if progress was sustained.

b) Caring

Directors noted that overall performance showed normal variation across the majority of services, with UEC areas presenting the most significant pressures, as expected. Members were advised that improvements in patient experience were anticipated, with waiting times identified as the primary contributor to current issues.

An increase in the number of complaints was also reported. The Board noted that learning from complaints was being actively captured and shared with divisions to drive improvement.

c) Effective

It was highlighted that that venous thromboembolism (VTE) screening performance continued to improve. Directors were informed that an audit on the quality of clinical assessments would be presented to the Quality Committee (QUALITY COMMITTEE) at its next meeting.

Mortality indicators were noted to be trending downward overall, with an expected seasonal spike under observation.

d) Responsive

The board noted two performance alerts within the report. The first related to twelve-hour waits in the emergency department, performance had been within trajectory in January but levels remained above the Trust's preferred position. It was reported that patients had recently, for

the first time, been held in ambulances, resulting in a brief escalation to Operational Pressures Escalation (OPEL) 4. Members noted that the Trust had exited escalation quickly and that learning from this episode had informed forward planning. Performance was reported as significantly improved through February and March, with twelve-hour waits reducing to 10.1%, representing the best performance for some time. It was also highlighted that although the Trust continued to operate the busiest blue-light ED in the North West, its average handover time stood at 22 minutes and 4 seconds, outperforming both the regional ambulance service and its agreed trajectory.

The board noted continued strong performance against cancer and referral-to-treatment (RTT) standards, including achievement of the six-week diagnostics target, with 98.25% of patients receiving diagnostic tests within six weeks.

Four-hour emergency care performance month-to-date was reported at 81.83%, exceeding both the Trust's trajectory and national standards. RTT performance was reported as 62.2% by the end of March, stretching to 64.5% following an agreed March improvement sprint. It was confirmed that there were currently no patients were waiting over 65 weeks, and that the number of patients waiting over 52 weeks stood at 585 (1.2% of the waiting list), with a plan in place to reduce this to 465 by the end of March.

e) Well-led

Directors were informed that a substantial amount of work had taken place around mandatory training compliance and discussed the Trust's approach to benchmarking, particularly the impact of including staff on maternity leave or long-term sickness within compliance calculations. It was confirmed that Information Governance training compliance stood at 90%, against a target of 95%.

Vacancy and turnover rates were reported as low. Members noted the completion of a focused rapid improvement week on appraisals, and the introduction of a revised approach intended to make the process more meaningful and valued.

An update was provided on sickness absence, which was being addressed as a comprehensive project reporting to the PCC. Learning from regional networks was being incorporated locally, and a slight improvement in sickness levels was reported. The board expressed interest in the use of listening lab events and improved electronic tracking of sickness data.

It was noted that the Freedom to Speak Up (FTSU) annual report would be presented to the board in May. Directors requested that any future (FTSU) reports incorporated commentary on the recent increase in complaints and the actions being taken in response.

ACTION: The next Freedom to Speak Up Report to incorporate commentary on the increase in complaints and actions being taken in response.

BY WHO: Interim Joint Chief People Officer.

BY WHEN: May 2026.

Support was expressed for a development session for new and existing non-executive directors to strengthen understanding of the IPR. It was agreed to give consideration to a development session in June.

ACTION: Consideration to be given to arranging a development/deep dive day for NED colleagues around the IPR.

BY WHO: Chief Operating Officer.

BY WHEN: June 2026.

Responding to concerns raised regarding the current lack of assurance against the Trust's Summary Hospital-level Mortality Indicator (SHMI), it was explained that data quality and coding issues had contributed to this position, alongside changes to national standards. Directors noted that a report was scheduled for consideration by the Quality Committee and the board in October. The board was also advised that the implementation of the Trust's Electronic Patient Record (EPR) in 2023 had temporarily affected data quality. Subsequent improvements and recent national changes to the inclusion of Same-Day Emergency Care (SDEC) patients in mortality indices were expected to benefit SHMI performance over time. The board acknowledged assurance provided by the Quality Committee, including the fact that this was not drawn solely from data but also from regular qualitative and triangulated reviews.

Directors were reminded of an upcoming development session with the NHSE Director of Safety, Dr Aidan Fowler, focused on board curiosity and the use of data.

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

TB/2026/037 FINANCIAL PERFORMANCE REPORT – MONTH 10

The Board received the Month 10 (M10) Finance Report, which provided an overview of the Trust's financial position and outlook for the remainder of the financial year. The following key highlights were provided:

- The Trust's M10 position was reported as £1.12m behind plan; however, this represented an improvement from earlier forecasts.
- It was confirmed that the Trust remained on a breakeven plan for the year, contingent upon receipt of Delivery Support Funding (DSF).
- The Trust's year-to-date (YTD) position was reported as being £15.5m behind plan, highlighting a significant ongoing financial challenge.
- Further improvements had been delivered across both workforce availability and bank and agency expenditure

Members were advised that decisions had already been taken through the financial oversight process to amend the forecast to a £10m deficit position, aligned to the breakeven plan. It was emphasised that delivery of this position was highly dependent on system-wide working and the receipt of DSF.

The additional following risks were highlighted:

- The continued delivery of the Trust's Workforce Recovery Programme (WRP) and Cost Improvement Programme (CIP)
- Cash was emphasised as a significant ongoing issue for the Trust. Although interim cash support had been provided, this would be repayable should DSF be received. It was acknowledged that this position required close and ongoing daily financial management.
- The Trust's current contract arrangements were not fully aligned to activity levels, particularly within UEC services. This mismatch had significantly informed financial and operational planning assumptions for the next financial year.

The board was reminded of the position in relation to Public Dividend Capital (PDC), noting that this represented additional capital funding not generated through depreciation and that it was required to be spent within the financial year in which it was allocated.

In response to queries raised, clarification was provided that the Trust's deficit at the beginning of the previous financial year had stood at £78m. It was reported that the expected outturn for the current year would be below £60m, dependent on the level of recurrent improvements

delivered during the year. The board formally acknowledged the work undertaken by finance and executive colleagues in stabilising the Trust's financial position and improving grip and control.

Directors went on to discuss the proposed WRP requirement of approximately 3.4% for the next financial year. It was confirmed that work was ongoing to finalise the level of recurrent improvements deliverable in the current year, and the board noted that a reduction from historic levels of over 7% to just over 3% represented a more balanced and sustainable run rate over the medium term. It was acknowledged that the Trust had commenced the 2025-26 year without a fully established programme management infrastructure, which had required rapid development. Directors were advised that this position had significantly improved and that the Trust was entering 2026-27 with a stronger foundation and greater confidence in addressing any financial gaps.

The board recorded its appreciation for the approach taken to financial management during the year, noting that it represented a learning period and that a different approach to income planning was being adopted for the next financial year. It was agreed that the Trust was now better placed for the financial challenges ahead. The importance of greater clarity and transparency regarding commissioned activity and associated funding was emphasised. Members noted that work continued to improve programme and project discipline through the development of fully defined Project Initiation Documents (PIDs), supported by programme management arrangements aligned to transformation and improvement priorities. It was confirmed that the Trust would follow national good practice by applying a contingency buffer of approximately 10–20% to savings targets where appropriate.

Directors noted the financial report.

**TB/2026/038 EAST LANCASHIRE HOSPITALS NHS TRUST IMPROVEMENT
PLAN (RSP EXIT CRITERIA)**

It was noted that the RSP Improvement Plan had been introduced earlier in the year and would now be developed into a more comprehensive, Trust-wide integrated improvement framework, to bring together all key improvement programmes into a single, cohesive plan for 2026/27.

There were five key improvement areas aligned to the RSP exit criteria comprising 41 action points, with 88% assessed as on track for delivery. In relation to leadership and governance actions, 77 of 88 actions had been completed, representing 89%, with no identified risks to delivery. It was further reported that 88% of CQC actions had been completed.

The board received feedback from an external review perspective, which confirmed that strong foundations had been put in place to address all RSP exit criteria and the Trust was now demonstrably progressing against all requirements. Evidence submitted by the Trust had been subject to regular review, with regional colleagues scheduled to complete their review of all submitted evidence in the coming weeks.

Directors acknowledged that, while significant progress had been made, the improvement journey would not conclude at the end of the financial year. It was agreed that continued focus and sustained effort would be required, as areas for further improvement remained.

Directors received the report and noted its contents.

TB/2026/039 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson joined the meeting for this item.

The board received the Maternity and Neonatal Services Update report and noted the progress made across a number of priority areas.

The board was advised that perinatal surveillance data continued to be strengthened through the development of statistical process control (SPC) reporting on a month-by-month basis. An increase in the induction of labour rate was highlighted as an area of concern. It was confirmed that risk assessments had been completed and that this trend was linked to an associated increase in caesarean section rates. A seven-month downward trend in term admissions was highlighted.

Directors were advised that a detailed report on the Maternal Outcomes Signal System (MOSS) had been presented previously to the Quality Committee, with a supporting presentation included as an appendix explaining both the methodology and local significance. It was confirmed that no critical safety alerts had been issued to date.

The board reviewed the Clinical Negligence Scheme for Trusts (CNST) infographic and noted that one descriptor rated “D” in October during the last quarter had been appropriately managed through the relevant governance processes. Assurance was provided through the CNST report, which showed a high number of indicators rated green. A recent infection prevention and control (IPC) visit to neonatal services, undertaken in response to infection concerns, was reported to have been positive.

Strong progress towards achieving UNICEF Baby Friendly Initiative Gold status was noted. Members were also advised that an urgent review of home birth services had commenced, alongside benchmarking work and that this work was being aligned with the medium-term planning framework. Directors were informed that the maternity triage service had gone live on 2 February, following extensive weekly progress meetings. It was also noted that additional theatre capacity for caesarean sections was being considered and would proceed through the appropriate approval and governance processes.

The inclusion of additional equality, diversity and inclusion (EDI) metrics within the report was welcomed but it was noted that data relating to perinatal mortality by maternal ethnicity required further contextualisation, particularly in relation to the total number of births. It was reported that access to a national equalities dashboard would support improved data extraction and reporting. The board was advised that the most recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) case was noted to be under active consideration by the relevant subgroup, and it was confirmed that further detail could be incorporated into future reports to strengthen assurance.

ACTION: More information from the Maternity and Neonatal Equalities dashboard will be provided in future reports.

BY WHO: Chief Nurse / Head of Midwifery.

BY WHEN: May 2026.

The board was advised that the next phase of the maternity and neonatal improvement journey was underway. This had been presented through floor-to-board processes, and the first staff forum had taken place, with feedback captured in real time and early changes already being implemented.

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/2026/040 ANTIMICROBIAL STEWARDSHIP REPORT

Dr Ziglam joined the meeting for this item.

The board received the Antimicrobial Stewardship Report, which had previously been considered by the Quality Committee.

The board was advised that the primary driver for the report was a sustained increase in antimicrobial consumption over recent years. This upward trend was noted to place additional

pressure on antimicrobial resistance profiles and posed a potential risk to patient safety indicators. Concern had been raised that the Trust was at risk of falling out of alignment with national benchmarks if action was not taken. Reference was made to recent correspondence from NHSE, which emphasised the urgent need for decisive action to address antimicrobial resistance, including stronger collaboration with prescribers and more robust oversight arrangements.

It was explained that delivery of the required improvements would necessitate a restructuring of antimicrobial stewardship arrangements across the Trust, including the establishment of clearer leadership and governance arrangements, improved access to reliable and timely data, consideration of dedicated operational support, and the definition of multidisciplinary team roles. It was noted that these changes were intended to strengthen stewardship arrangements over the coming years and support sustained improvement.

The board agreed to accept the proposed approach to antimicrobial stewardship and confirmed that operational control would sit with the executive team. It was agreed that assurance would continue to be provided through the Quality Committee.

Directors received the report and noted its contents.

TB/2026/041 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

The board noted the occurrence of two Never Events. It was confirmed that immediate actions had been taken in response to both incidents and that a more detailed update would be presented to the Quality Committee at either its March or April meeting. Members were also advised that mitigating actions had been implemented and that the incidents were being managed in line with the Patient Safety Incident Response Framework (PSIRF) process.

Directors noted an additional issue raised in relation to sickness absence within a quality governance function. It was noted that further data had been requested, including information from staff surveys and a review of sickness records, in order to better understand the underlying issues.

In response to a request for clarification regarding previously highlighted, red-rated areas within the report, it was confirmed that these issues had been addressed and that no areas remained rated red at the time of reporting.

Directors received and noted the report.

TB/2026/042 TRIPLE A REPORTS FROM QUALITY COMMITTEE

The Board received an update from the Quality Committee, covering matters discussed at its January and February meetings.

It was reported that the meeting in January had received updates on the safe surgical pathway, including ongoing work to strengthen related processes. Issues arising from a Regulation 28 notice following an inquest were discussed, and assurance was sought regarding actions being taken in response.

The board was advised that the February meeting had escalated an alert relating to a HTA inspection. An associated action plan had been reviewed, and updates were provided to assure the board of progress. The Committee had also received the Antimicrobial Stewardship Report. A quarterly audit of antimicrobial prescribing practice had been reviewed, with some results noted as not meeting expected standards. Appropriate actions were being progressed through established governance arrangements.

Directors noted the report.

TB/2026/043 TRIPLE A REPORTS FROM FINANCE AND PERFORMANCE COMMITTEE

The board received an update from the Finance and Performance Committee meetings held in January and February.

It was reported that the Committee had considered two reports, the alerts arising from which had already been discussed in detail earlier in the meeting as part of the M10 Finance Update.

The Board was advised that, at the Committee's January meeting, positive progress had been noted in relation to collaborative working within the One LSC partnership. In particular, the national cost collection report was highlighted as a positive example of effective system working, demonstrating strong collaboration within a small team and reflecting One LSC principles in practice.

It was noted that the Committee had also received an update on progress with clinical workforce job planning. While good progress was acknowledged, the Committee noted that

further work was required to ensure full implementation of individual job planning across services.

Directors noted the report.

TB/2026/044 TRIPLE A REPORTS FROM PEOPLE AND CULTURE COMMITTEE

The reports from February and March meetings were presented to the board for information.

Directors were advised that the Committee had received an update on the recent rapid improvement week event focused on appraisals. It was noted that positive work had been undertaken outside of this event, and that further activity was planned to develop a more fit-for-purpose appraisal system that better supported staff development and organisational objectives.

The board was informed of a priority actions update presented in January relating to safe spaces and the Aarushi Project. It was noted that key risks to delivery included a lack of dedicated resources and both overt and passive resistance to change in some areas of the organisation. Members recognised that sustained board leadership and active engagement would be required to support the successful implementation of these cultural changes. It was confirmed that a further update was due to be provided in April.

Directors noted the report.

TB/2026/045 TRIPLE A REPORT FROM AUDIT AND RISK COMMITTEE

The Board received an update from the Audit and Risk Committee (ARC).

It was reported that an internal audit review relating to theatre stock management had been completed and had a rating of no assurance. Due to the level of assurance, the report had been shared with the ARC for awareness, although it had not completed the full governance process at the time of the meeting. It was confirmed that the internal audit report was scheduled to return to the Committee at its next meeting in April for full consideration.

Directors noted the report.

TB/2026/046 TRIPLE A REPORT FROM TRUST CHARITABLE FUNDS COMMITTEE

Directors noted a number of positive developments relating to the activity of the charitable funds. This included proposals to establish a second commercial hub on the Burnley General Teaching Hospital (BGTH) site. It was confirmed that an agreement had been reached to set

up a working group to take this proposal forward and to assess its feasibility. It was also reported that the Committee had agreed to fund pharmacy prescription collection stations to support improvements in patient experience.

Directors noted the report.

TB/2026/047 MESSAGE FROM THE BOARD

The board noted that International Women's Day was taking place on the Sunday following the meeting and agreed that this provided an important opportunity to recognise the contribution of women across the wider organisation. Members were advised that an event was scheduled for the preceding Friday as part of the Trust's wider celebrations. The valuable work undertaken by the Trust's Women's Network in supporting and promoting equality and inclusion was also highlighted and acknowledged.

TB/2026/048 ANY OTHER BUSINESS

There were no matters of other business.

TB/2026/049 DATE AND TIME OF NEXT MEETING

Wednesday, 13 May 2026 at 09:30, Trust HQ Boardroom.

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	B	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	Update May 2026 – the UEC dashboard has been completed but work on the patient safety dashboard is in progress, with data validation still to be completed.
3.	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.

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
4.	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.
5.	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	B	On the agenda for discussion.
6.	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	B	This work is in progress and is expected to be implemented in IPRs from May onwards.
7.	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	B	Complete. BAF Risks and Risk Appetite Statement for 2026/27 on the agenda for approval.
8.	March 2026	TB/2026/032 Patient Story	A letter will be written to ward B14 colleagues to express the gratitude of the board for the quality of care provided to the patient.	Interim Director of Corporate Governance	Immediate	B	Complete. Letter sent from Chair and CEO.
9.	March 2026		UEC Programme updates to be a standing item for all Committees and Board until January 2027.	Medical Director	April 2026	B	Complete. Scheduled onto the Workplans for Committees and Board. Verbal updates given in April. Written reports to be given going forward.
10.	March 2026		A report will be provided to the Quality Committee regarding complaints and the work taking place to improve patient experience.	Chief Nurse	May 2026	G	Propose this action be transferred to the Quality Committee Action Tracker.
11.	March 2026	TB/2026/034: Chief Executive's Report	The outcomes of the most recent staff survey, and the action plans developed to address any areas of concern, will be considered at a future meeting of the People and Culture Committee.	Interim Joint Chief People Officer.	April 2026	G	Due to the revision to the timings of the Committee, the staff survey and associated action plan will be presented to the People and Culture Committee at its next meeting on 8 June 2026.

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
							Propose this action is transferred to the People and Culture Action tracker.
12.	March 2026		National definition of corridor care to be circulated to Board Members.	Interim Director of Corporate Governance	Immediate	B	Complete. Circulated by email 11/03/26.
13.	March 2026		People & Culture Committee to monitor staff safety in light of increasing aggression.	Interim Joint Chief People Officer.	June 2026	G	Propose this action be transferred to the People & Culture Committee Action Tracker.
14.	March 2026	TB/2026/036: Integrated Performance Report	The next Freedom to Speak Up Report to incorporate commentary on the increase in complaints and actions being taken in response.	Interim Joint Chief People Officer	May 2026	B	On the agenda item number TB/2026.
15.	March 2026	TB/2026/036: Integrated Performance Report	Consideration to be given to arranging a development/deep dive day for NED colleagues around the IPR.	Chief Operating Officer	June 2026	G	Not yet due. Exec workshop being arranged to review the content of the IPR to ensure alignment to the new Trust Strategy. NED session to be arranged following this.
16.	March 2026	TB/2026/039: Maternity and Neonatal Services Update	More information from the Maternity and Neonatal Equalities dashboard will be provided in future reports.	Chief Nurse / Head of Midwifery	May 2026	B	This information is included in the report, however the data available goes up to June 2025 only. Further updates to data are expected imminently.

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/055
Report Title:	Board Assurance Framework Risks and Risk Appetite Statement 2026/27		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Susan Giles Interim Director of Corporate Governance		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
			✓	
Executive Summary:	The Risk Appetite Statement has been drafted using the outputs from the Board Strategy Session on 8 April 2026. The BAF risks for 2026/27 have also been revised following Board review. The detailed controls and assurances have been mapped out and once reviewed by the Board will be presented to the next public meeting of the Board.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board is asked to: • approve the BAF risks for 2026/27; and • approve the Risk Appetite Statement.			

Previously Considered by:	Board Strategy Session
Date:	8 April 2026
Outcome:	Draft Risk Appetite Statement and high-level risks agreed as set out in this paper.

2026/27 Risk Appetite Statement

1 Introduction

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

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

It is recognised that strategic decisions are taken on a case-by-case basis and therefore whilst the Risk Appetite Statement is a guide it does not restrict the Board in its decision-making. The Board may decide to take an informed decision which sits outside its agreed risk appetite.

2 Key context for Risk Appetite Statement 2026-27:

The Trust enters 2026-27 having successfully exited the NHS England Recovery Support Programme (National Operation Framework (NOF) 5) and is now in NOF3, entering a period of stabilisation and building for future success. The Trust is ambitious to move into NOF2 and be amongst the first wave of Advanced Foundation Trusts.

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

2.1 Quality

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

2.2 Our People

- Improving the lived experience of our patients and staff must continue to be one of our key guiding principles
- The pressure on our workforce must be recognised in providing for patient and service needs at a time of increased demand and unrelenting need to reform how we work
- We must transform and reduce our workforce numbers to support financial recovery and recognise and recognise the impact of this on staff morale
- We must continue to support the health and wellbeing of our colleagues
- We need to develop capacity and skills for delivery of reform/change and support our colleagues to work at pace achieve this
- Threat of industrial action remains a live issue within the workforce
- We must continue to address inequities affecting our BAME colleagues, including ongoing action to reduce the ethnicity pay gap and ensure an inclusive culture where all can thrive.

2.3 Finance

- The Trust must stabilise its financial position and still has an ambitious Waste Reduction Programme to deliver based upon transformation.
- The Trust must increase recurrent savings and continue to deliver value for money.
- There must continue to be a strong focus on grip and control.

2.4 System Leadership

- The role of Place and Neighbourhoods is vital to support effective demand management and care closer to home
- System strategy and commissioning is still maturing
- The L&SC Provider Collaborative continues to mature its partnership but needs to increase delivery of key programmes supported by strong governance
- The L&SC System is in deficit with other providers
- There is an ongoing need to balance but recognise the tension of the Trust's duty and desire to collaborate for the benefit of our patients, Trust and system whilst ensuring organisational regulatory requirements are met

2.4 National Context

- The NHS 10 Year plan requires 3 shifts:
 - Moving care from hospitals to communities
 - Making better use of technology

- Focussing on preventing sickness, not just treating it
- The ongoing impact of demand and pressure on services alongside the financial context has the potential to impact on quality at organisational, system and national level
- There continues to be a top-down performance management system approach

3 Use of the Risk Appetite Statement

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

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

4 Risk Appetite Statement

Quality

The Board has an **open** appetite for risks to the quality care. In practice this means that the Board is prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards and is supportive of innovation.

Safety

When it comes to being willing to compromise patient and staff safety, the Board's risk appetite is **none**. There is no appetite to take any risks that will have an adverse impact on safety.

Financial

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

Commercial

The Board has an **open** appetite to seek commercial opportunities that support the organisation's strategic objectives, general income or create value for stakeholders. The

Board encourages entrepreneurial thinking and is prepared to tolerate a degree of uncertainty where commercial initiatives have the potential for significant long-term benefit.

Workforce

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

Innovation

The Board has a **significant** appetite for service transformation and innovation even if this means taking decisions may expose the Trust to significant scrutiny or criticism locally so long as there is a commensurate opportunity for improved outcomes for our stakeholders.

Digital

The Board has an **open** appetite for digital related risks. This means that the Board is willing to pursue ambitious digital transformation, recognising that this may involved short-term disruption, implementation challenges or exposure to scrutiny, in pursuit of improvements to service quality, efficiency, user experience or organisational capability.

Cyber-security

The Board's appetite for cyber security risks is **none**. The Board is not willing to accept any risks that could compromise the confidentiality, integrity or availability of the Trust's information, systems or digital infrastructure.

Regulatory

The Board will have a **cautious** appetite for noncompliance with regulatory requirements. This means that the Board is prepared to accept the possibility of limited regulatory challenge. Although it would seek to understand where similar actions had been successful elsewhere before taking any decision.

Sustainability

The Board has an **open** appetite for taking bold decisions where there is a clear opportunity to enhance long-term resilience, reduce environmental impact and deliver benefits for future generations, even where this may involve short-term operational or financial impact.

5 Risk Appetite Definitions and Target Scores

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

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

Approved by: The Board of Directors

Date Approved:

Date to be Reviewed:

Proposed BAF Risks 2026/27:

Risk No	2025/26 Board Assurance Framework Risk	Risk Score (March 26)	2026/27 Board Assurance Framework Risk from Board workshop April 2026	Proposed risk score (April 26)
1	The strategies and partnership arrangements across the Integrated Care System (ICS) do not deliver the anticipated benefits for our communities and fail to support the financial recovery of the Trust and exit from NHS Oversight Framework Segment 4 (Recovery Support Programme).	C5 x L4 = 20	If the strategies and partnership arrangements across the Integrated Care System (ICS) do not deliver the anticipated benefits for our communities and fail to support the financial sustainability of the Trust, this will impact upon the Trust's ambition to move into NHS Oversight Segment 2.	C5x L3 = 15
2	The Trust may be unable to fully deliver on safe, personal and effective care in line with legislative and regulatory requirements.	C4 x L4 = 16	If the Trust is unable to consistently deliver safe, personal and effective care in line with legislative and regulatory requirements, this will result in avoidable harm, poor outcomes, reputational damage and regulatory challenge.	C5 x L4 = 20
3	A risk we don't achieve national access standards thereby causing harm, impacting on patient experience and increasing health inequalities.	C4 x L4 = 16	If we do not achieve national access standards, we may cause patients harm, adversely impact on patient experience, increase health inequalities and be subject to increased performance regulation.	C4 x L3 = 12
4	The Trust is unable to deliver its strategic objectives because of its inability to sustainably transform the workforce	C4 x L3 = 12	If the Trust is unable sustainably transform the workforce and address issues with culture and staff morale, it will place greater strain on staff, adversely affect wellbeing and engagement, and ultimately increase financial pressure and reduce the Trust's ability to deliver its strategic objectives.	C4 x L3 = 12
5	The Trust is unable to delivery its agreed financial recovery plan.	C5 x L4 = 20	If the Trust is unable to deliver the second year of the agreed financial recovery plan, this will result in regulatory intervention and delay the Trust's ambition to become an advanced Foundation Trust.	C5 x L4 = 20
6	As Host: The Trust is unable to meet its hosting obligations, leading to reputational damage and potential financial implications.	C3 x L5 = 15	As Host: If the Trust fails to implement robust host provider governance, this will lead to reputational damage, financial implications and regulatory criticism.	C4 x L4 = 16
	As Partner: The Trust does not receive the anticipated benefits from OneLSC.	C4 x L4 = 16	As Partner: If the Trust does not receive the anticipated benefits from OneLSC, this may result in workforce, operational, regulatory and reputational issues.	C4 x L4 = 16
7	There is a risk that the Trust may be unable to deliver its Data and Digital Strategy. This could lead to reduced clinical quality, poor user experience, cyber vulnerabilities regulatory non-compliance, financial inefficiencies and compromised patient safety and engagement.	C5 x L4 + 20	If the Trust fails to deliver digital transformation this will limit the Trust's ability to deliver its strategic objectives.	C5 x L3 = 15

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/056
Report Title:	Chair's Report		
Author:	Susan Giles Interim Director of Corporate Governance		
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, including: • Changes to the Board and Chairing of Committees • The establishment of the LSC NED Forum • An update on the Back to the Floor Programme • The outputs of the Board Development session held on 8th April • An overview of the Board Strategy session on 8th April and planned content for 10th June • Commencement of NED appraisals and plans for wider feedback and inclusion of Executive Directors in the Board Director appraisals • Key meetings I have attended since the last board meeting.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to note the contents of the report.			

Previously Considered by:	
Date:	
Outcome:	

Chair's Report

Changes to Board

I would like to welcome Mark Greatrex to the Board as Interim Director of Finance following the retirement of Sam Simpson. Mark is a familiar face to the Board having been with us as Interim Deputy Director of Finance for some months and we can be confident of being in safe hands until Sam's successor joins us.

The recruitment process for the Executive Director of Finance role has concluded and I'm delighted to share that, following a strong interview field, an excellent appointment has been made. The Chief Executive will update Board members once the required Fit and Proper Persons tests have been completed and a formal announcement can be made.

Updates to Committees/Lead NED roles

Following further discussion it has been agreed that Andrew Ireland will become the Non-Executive Chair of Education, Research & Innovation Committee following its inaugural May meeting. Sallie Bridgen will be the new Chair of Charitable Funds Committee, in addition to retaining Chair of People & Culture Committee and Remuneration Committee. I would like to thank Sallie and Andrew for their flexibility on this matter.

In addition, Miriat Naiga will join Shahedal Bari as Board representative on the North West BAME Equity Assembly.

LSC Non-Executive Directors Forum

The inaugural meeting of the LSC NED Forum was held on 22nd April 2026. The intention of the forum is to bring together one NED from each Trust to support collaboration across the Provider Collaboration Board. Terms of reference for the forum are being drafted with the following key responsibilities:

- Facilitate cross-trust NED information sharing and updates
- Provide feedback from NEDs to the PCB Chair via the LSC NED Group Chair
- Support consistent messaging across all five Trust Boards
- Contribute to PCB strategy and planning objectives
- Provide assurance and governance perspectives to the PCB
- Support NED development, including mentoring, coaching, and training
- Strengthen cross-trust communication at NED level
- Develop ideas for NED recruitment and progression
- Support development of Vice-Chairs, Sub-Committee Chairs and future Chairs
- Share updates on regional and national developments
- Liaise, where appropriate, with the North West Regional NED network

I would like to thank Catherine Randall for her support in establishing this forum. Catherine with the NED representative for ELHT.

Back to the Floor

On 22nd April 2026 I had the privilege of complete a back to the floor visit to the Dentistry & Orthodontics, Oral and Maxillofacial Department. I would like to thank Lucy Glynn and team for the warm welcome I received. It was excellent to see the excellent multi-disciplinary and cross department approach and was struck by the high demonstration of compassion and empathy to patients.

Since the Back to the Floor Programme was reintroduced in January 2026 the following visits have been completed:

10 February 2026	Shelley Wright	Radiology
19 February 2026	Simon Featherstone	Mortuary
17 March 2026	Liz Sedgley	Women & Newborn Centre
16 April 2026	Tony McDonald	Domestic Services

I would encourage Board members to complete the Back to the Floor feedback forms and propose that a bi-annual report on the reflections from the Back to the Floor programme is brought to the Board for consideration.

Board Development Programme Update

Phase 2 of the Board Development Programme with The Value Circle commenced on 8th April 2026. I would like to thank Board members for their attendance and contribution at this session, which focussed on building a high performing team with trust and ambition. The following two key actions were agreed at the end of the session:

- what practical steps might be taken to address the issues that were raised in respect of board papers, meeting arrangements, constructive challenge and how to improve Board assurance.
- all members have individual responsibility to consider how they personally contribute to the optimal running of the board – such as reducing unnecessary commentary and ensuring questions and contributions add to genuine insight.

I am taking the first action forward with the Company Secretary. The second action was the focus of the Executive Development session on 22nd April.

The next Board Development session is scheduled for 10th June 2026 and will focus on the Unitary Board – roles and responsibilities and productive behaviours.

April Board Strategy Session

The Board Strategy session on 8th April focussed on risk, in particular reviewing the Board's Risk Appetite Statement and agreeing the Board Assurance Framework risks for 2026/27. The outputs from the session are on the agenda for approval today.

The BAF will be a standing agenda item at the start of every Board meeting and Board members should see the triangulation with the new Trust Strategy and Integrated Improvement Plan 2026/27. I will be looking to Committee Chairs to ensure that there is robust challenge of the BAF in the assurance committees.

The June Board Strategy Session will include an update from the CQC on Well Led, a review of the effectiveness of the assurance committees as well as agreeing the key objectives for each committee for 2026/27.

Non-Executive Director Appraisals

Over the coming weeks I will complete Non-Executive Director Appraisals. We will also be introducing Board Director Appraisals for Executive Directors. This will focus on the Board Director element of their role with the Chief Executive conducting their Executive Director appraisals.

This year will also see the introduction of wider feedback from Board Members in line with the latest NHSE guidance, the Company Secretary will be coordinating this on my behalf.

NW System Leaders 24th April 2026

I would like to thank Simon Featherstone for attending this session on my behalf. The slides have been circulated to Board members. There was significant focus on elective reform, specifically OPD transformation and the development of neighbourhood health. The Chief Executive will provide further detail in his report. The Board will need to ensure grip and control and oversight of variance in delivery.

Meetings attended since the last Board meeting

- Strategic Workforce Assembly March 2026
- Improvement & Assurance Group meetings held in April and May 2026
- Chaired Lancashire & South Cumbria Provider Collaborative Board
- LSC NED Forum April 2026
- Chair and Non-Executive Directors Meeting April and May 2026
- Board Strategy Session April 2026
- Board Development April 2026
- Various 121s with the Chief Executive, Company Secretary, Non-Executive Directors and Executive Directors

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/057
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:	Members are asked to specifically note the Trust's pledge to eradicate corridor care and the range of improvement activity underway to deliver it.			
Action Required by the Board:	None			

Previously Considered by:	None
Date:	
Outcome:	

1. Background

This report is divided into sections covering the following:

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

2. National Updates

NHS waiting list continues to fall despite record winter

Waiting times for A&E departments in England have fallen to a five-year low, despite the NHS seeing record numbers of patients in March as the health service experienced a 'prolonged winter'.

There were 2.43 million total A&E attendances in March – 16,000 more than the previous record high in May 2024. Despite this demand, almost four in five patients arriving in A&E were seen within four hours (77.1%) – the best performance since July 2021.

The record-breaking month was driven in part following reports of a meningitis outbreak mid-March, which saw a marked increase in demand.

NHS experts deployed to tackle corridor care

The Getting it Right First Time (GIRFT) team is supporting leaders in hospitals to learn from NHS trusts which have already made significant inroads into reducing corridor care. The specialist GIRFT teams provide tailored support to each hospital – including identifying how to improve discharge and flow, helping trusts to better understand their own data so they can improve predicting when surges in demand may appear and supporting clinical leaders in improved decision making. Alongside introducing a new, measurable definition of corridor care, the targeted support is the latest in a series of steps the government is taking to drive urgent improvements and show it is serious about delivering for patients.

Taskforce set up to deliver urgent action on maternity

A new National Maternity and Neonatal Taskforce chaired by the Health and Social Care Secretary will ensure women, babies and families receive safer and higher-quality NHS care.

The Government has finalised membership of the taskforce, which will tackle deep-rooted inequalities and deliver urgent action on the recommendations of the independent national investigation into maternity and neonatal services in England, led by Baroness Amos.

The expert panel includes families, senior NHS leaders, royal colleges, campaigners, academics and third sector representatives who collectively have the clinical expertise, lived experience and sector know-how to deliver the changes so desperately needed for families.

Midwives remain the most trusted source of information on pregnancy vaccination

Latest findings from a UK Health Security Agency survey show that Midwives continue to be the most trusted source of information, with over 60% of women reporting that advice from a healthcare professional was an important factor in their decision to be vaccinated.

While around 40% of women were already inclined to accept vaccination, a further 40% reported feeling more confident following a discussion with a healthcare professional. Awareness remains high, with nine in ten women recalling information about pregnancy vaccination and 86% recognising its importance. Access is also strong, with 85% of vaccinated women reporting that receiving vaccines was straightforward.

New national campaign to reduce missed appointments

The NHS has launched a new campaign urging people to turn on 'push alerts' from the NHS App to enable reminders about appointments and rearrange any they can't attend, helping to reduce wasted time and free up appointments for others.

A survey of patients across England found that 12 per cent said they had forgotten about an appointment in the past and 11 per cent had arrived too late. The latest appointment statistics also show that patients did not attend 16 million GP appointments in 2025, with no shows for 1 in 23 appointments (4.3%) – the equivalent of an entire day of missed appointments at every GP practice in England each month. The figures also reveal that the NHS arranged 376 million appointments at GP practices in 2025 – 8.4 million more (2.3%) than in 2024.

The new 'Tap the NHS App' campaign is highlighting the benefits of enabling notifications, with adverts appearing on pharmacy bags, radio channels and social media.

Users are also being encouraged to cancel or rearrange their appointments through the app and to use it to request repeat prescriptions instead of having to visit their GP practice.

National NHS staff survey results released

More than 766,000 NHS workers in England responded to the 2025 National NHS Staff Survey, providing vital data for employers and stakeholders about the staff experience.

Some of the results were positive with an overwhelming 87.78% of respondents to the staff survey feeling their job made a difference to patients. However, the number of staff who would recommend their workplace to others fell slightly to 58.05%, from 60.79% in 2024.

Almost 1 in 7 respondents (14.47%) reported via the survey that they have been physically attacked by a patient or the public in the last year – the highest rate for 3 years.

The survey results also showed a record percentage of staff said they were subjected to unwanted sexual behaviour by the same group – rising steeply to almost 1 in 3 ambulance staff (31%). It also found nearly 1 in 10 staff (9.26%) said they were subjected to discrimination from the patient and the public – the highest on record.

Health and Social Care Secretary welcomes large fall in NHS dissatisfaction

Patients' dissatisfaction in the NHS has reduced by its biggest margin in nearly three decades, according to new survey results.

The King's Fund and Nuffield Trust's British Social Attitudes survey revealed a 5.6 percentage point increase in satisfaction in the NHS, the first increase since the COVID-19 pandemic.

This reflects a significant effort by NHS leaders and staff up and down the country to accelerate improvement over the last year.

£1 billion invested in health protection as new Pandemic Strategy published

The UK's readiness for future pandemics has been set out in the publication of a new Pandemic Preparedness Strategy by the Department for Health and Social Care. The strategy outlines concrete action already taken across government to embed lessons from Covid-19 and included £1 billion of investment in health protection measure. These include enhancing our access to essential vaccines and therapeutics, improving our pandemic surveillance systems and expanding our ability to roll out testing to the whole population.

More dentists as Government boosts number who can practise

The Government has announced significant investment to expand the dental workforce, including increasing professional registration exam capacity, enabling up to 2,400 overseas trained dentists to register annually by 2028-29. This includes a near

tenfold increase in final exam places run by the Royal College of Surgeons of England and expansion of the General Dental Council's Overseas Registration Exam. This will also include an additional 50 UK dental school places annually from 2027.

Two thirds of consultants want to work for new NHS online hospital

Six in ten consultants (60%) have said they would be interested in working for NHS Online alongside their current NHS roles.

NHS Online, which will see its first patients next year, is expected to deliver up to 8.5 million virtual appointments and assessments in its first three years – four times more than an average NHS trust.

The survey of nearly 300 consultants and specialist doctors also found that nearly half (48%) would be willing to offer at least four hours a week of their time, with the opportunity to care for patients innovatively, work flexibly and improve patient experience among their top reasons for wanting to sign up.

3. Regional Updates

One LSC

Recent feedback from the Improvement and Assurance Group (IAG) has been highly positive, providing strong assurance on One LSC's performance and contribution over the past 12 months.

This Group recognised the continued delivery of business-as-usual services during a sustained period of challenge, alongside a significant contribution to system financial recovery. One LSC's contribution for the 2025/26 financial year has been formally ratified and signed off at regional level, totalling approximately £17.5m–£18.5m. A similar level of contribution is also planned for the forthcoming year.

Pathology services come together across Lancashire and South Cumbria

Pathology services across Lancashire and South Cumbria moved to a single organisational model on April 1, with Lancashire Teaching Hospitals NHS Foundation Trust (LTH) acting as the Lead Provider.

Colleagues from ELHT, Blackpool Teaching Hospitals, and University Hospitals of Morecambe Bay have transferred as part of the consolidation to work alongside existing LTH pathology teams. Importantly, this change does not affect job roles, work locations or how services are delivered day to day.

Working as one service provides a great opportunity to improve and grow together. The aim of the programme is to bring services together in a simpler, stronger way and support national plans to make diagnostics more reliable and sustainable for the future.

This includes shared systems and ways of working, investment in digital pathology and better planning for our workforce and equipment.

£1.5m transformation for Barbara Castle Way Health Centre

Barbara Castle Way Health Centre in Blackburn will receive over £1.5m to transform significant areas of its first and ground floors, creating improved spaces for mental health, wellbeing, health promotion and enhanced community services.

Already home to three GP practices and multiple therapy services delivering 48,000 extra appointments a year, the upgraded centre will support even more integrated care closer to home.

This is one of 27 centres announced nationally as part of the national Neighbourhood Health Centre initiative which are all based in areas with higher levels of deprivation. All 27 are set to be fully open by 2027.

NHS North West Race Equity Assembly

From April 2026, the NHS North West Black, Asian and Minority Ethnic (BAME) Assembly will be known as the NHS North West Race Equity Assembly. The Assembly's core purpose remains unchanged - To support a measurable, significant and sustainable step change in tackling racism, discrimination, and health inequalities across the North West NHS.

The change represents an evolution in how the purpose is articulated and follows engagement with Assembly members and Steering Group discussions, reflecting a preference to move away from the term 'BAME'.

While the term has played an important role in highlighting inequalities particularly during the COVID-19 pandemic, it can also obscure the distinct experiences of different communities. The updated name places a stronger emphasis on race equity as an outcome, aligning more closely with the Assembly's strategic focus and the wider direction of travel across the NHS.

The Assembly remains committed to serving communities and colleagues who are racialised as Black, Asian and Minority Ethnic and will continue, where appropriate, to use this terminology and to identify specific groups within the workforce and in communities to ensure a nuanced understanding of need and to support targeted action.

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:

- ULPA for Rossendale Primary Health Care Centre between the Trust and Community Health Partnership Ltd
- ULPA for Bacup Primary Health Care Centre between the Trust and Community Health Partnership Ltd
- ULPA for Yarnspillers Primary Health Care Centre between the Trust and Community Health Partnership Ltd
- ULPA for Darwen Primary Health Care Centre between the Trust and Community Health Partnership Ltd
- ULPA for Barbara Castle Way Primary Health Care Centre between the Trust and Community Health Partnership Ltd
- Settlement and Variation Agreement between the Trust and Consort Healthcare Ltd and Equans Services Ltd

All of the above were signed by Martin Hodgson, Chief Executive and Sam Simpson, Executive Director of Finance on 30 March 2026.

Year End 2025-26

The full details of the Trust's final position for 2025-26 will be covered in more detail within the agenda item on the Integrated Performance Report, but it is important to note the headlines and acknowledge the amount of work from colleagues across the organisation that contributed to its delivery.

The Board can feel justifiably proud of everything the Trust has achieved through immense focus and determination. This has underpinned delivery of the financial position and operational performance achieved.

The year has included rigorous and robust intervention and assurance arrangements underpinned by legal undertakings, but colleagues have also retained an unwavering commitment to high-quality and safe services for patients and their families as a first priority.

This has been one of the most challenging years in the Trust's history, but also resulted in the following:

- £43million of efficiency savings – the most that has ever been delivered at the Trust
- A quarter-on-quarter reduction in our run rate, reducing spending consistently throughout the year
- Reducing the waiting list by nearly 20,000 people, which is an 18.5 per cent reduction and the largest improvement in the region

- Cutting the number of patients waiting over a year for treatment from 4,228 to 340 by the end of March
- Our performance against the 18 weeks Referral to Treatment (RTT) target is currently just below 70%
- Consistently ranking in the top five trusts nationally for theatre productivity, ensuring we make the best use of our capacity in both Blackburn and Burnley
- Moving up to 78th place out of 134 similar trusts in the National Oversight Framework league table, with the highest possible rating for patient safety
- Remaining among the best in the country for seeing patients within four hours in urgent and emergency care, including at Royal Blackburn Teaching Hospital
- Making significant progress in admitting patients within 12 hours of the decision to admit - driven by our commitment to eliminate corridor care and the hard work of teams across the Trust

The response of teams across all services and setting has been incredible. It is valued and appreciated now and will be very much needed as we continue to progress towards our aims for 2026-27 and beyond.

Exit from national intervention arrangements

The Trust presented comprehensive evidence to the part two element of an Improvement and Assurance Group on 18 March, 2026, to a range of regional and national colleagues including NHS England North West's Director of Intensive Support and System Co-ordination Nicola Allen and Improvement Director April Brown of the national Recovery Support Programme (RSP).

The quality of materials, transparency on risks and mitigations and engagement from the senior team were noted in writing afterwards by the group in a written update on the Trust's current position and progress in the RSP process since February 2025.

These included significant progress in:

- Strengthened leadership and governance
- Improved financial grip and control
- Submission of a compliant medium-term plan
- Sustained quality and operational performance
- Receipt of 'substantial assurance' opinion on governance of the RSP process

The recommendation from the meeting was that the Trust should be stepped down from national intervention arrangements.

Provider capability ratings

NHS England has published new provider capability ratings against criteria drawn from the six domains of The Insightful Provider Board. There are four levels of capability – red, amber, amber/green and green. The Trust has been rated as red. It is NHS

England's intention that ratings change over time. It is the Trust's intention to ask for the provider capability rating to be reviewed as soon as appropriate.

Changes to the Executive Team

The Trust's Executive Director of Finance (DoF) Sam Simpson retired on April 17, 2026, and a recruitment process to fill this statutory role enacted.

The position attracted a significant amount of interest and three potential candidates were interviewed on April 29. The results of this will be announced in due course.

In the meantime, as reported to Trust Board in March, Mark Greatrex has taken up the position of Interim Executive Director of Finance and will continue in this role until the substantive post holder can start.

It's important to recognise again the contribution Sam made to the Trust and to the wider NHS and public sector organisations she worked for over a very long career. In addition, the Board's thanks to Mark should be recorded for the support he has and continues to provide in this critical role in the interim.

Industrial action

Resident Doctors took part in the latest wave of industrial action called by the British Medical Association (BMA) in a long-standing dispute with the Government over pay.

The latest dates in a total of 15 periods of industrial action took place during the Easter period from 7 April until 13 April.

As previously, the Trust enacted careful planning across a variety of teams to mitigate the impact and ensure as much planned care was able to go ahead, as well as ensuring urgent and emergency pathways were appropriately covered. The result was that around 300 appointments were cancelled in total.

Update on Urgent and Emergency Care Improvements

The Trust has been caring for patients on the corridor of Royal Blackburn Teaching Hospital (RBTH), as well as on the corridors of the Emergency Department (ED) itself and in escalation spaces on almost all wards, during times of peak demand.

As part of improvement work the Trust has pledged to eradicate the use of corridor care by December 13, 2026. The pledge applies to all forms of corridor care across the Trust, not only main hospital corridors, recognising that care must always be delivered in environments that support safety, privacy and respect.

To deliver this the Trust has enacted a multi-professional Urgent and Emergency Care Improvement Programme, chaired by the Chief Executive and supported by Executive Directors and senior leaders from across all directorates and teams.

The programme has set out the Trust's full ambition on this priority to ensure the commitment is appropriately commuted into practical actions for patients and staff.

A dashboard monitors performance across the national 12 and 4 hour targets, admissions and discharges, length of stay and bed occupancy. There are also a number of workstreams, which include:

- Acute interventions to reset the UEC Pathway
- Length of Stay Reduction
- Care Closer to Home (Step Down and Virtual Wards)
- Weekend Discharges
- Clinical Operating Standards
- 7 Day Working (including Job Planning)

Each work stream is focused on tackling the underlying causes of corridor care and redesigning pathways to improve flow, decision making and patient experience.

The headlines of this focus are that since January the Trust has delivered:

- An increase in the use of virtual wards, with an extra 20 referrals a day
- An eight per cent increase in weekend discharges
- A reduction in length of stay of half a day
- A reduction in the prevalence in corridor care – including a 131-hour period with no patients at all on any corridor

The Trust is working with colleagues across the wider Lancashire and South Cumbria Integrated Care System and health and social care teams in partner organisations locally too.

The Integrated Care Board clearly recognise the demand and acuity of patients using our UEC pathways and are working with partners to commission alternative service models to help alleviate some of this pressure.

An improved contract offer for UEC will also relieve the pressure and support improvement work over the next three years.

Update on Accrington Victoria Hospital site

The Trust is working closely with local patient representatives, the town's MP Sarah Smith and members of Hyndburn Borough Council (HBC), the Lancashire and South Cumbria Integrated Care Board (ICB) and Calico Homes as part of a Strategic Group which aims to regenerate the former Accrington Victoria Hospital site.

Services moved out of Accrington Victoria Community Hospital (AVCH) in September 2024 because it was no longer safe for patients or colleagues. The building closed its doors to the public in December 2024.

The Strategic Group is clear that retail or private housing development has been ruled out and is using the outcomes of a community engagement exercise completed last summer as guiding principles for design and development work. The group's vision includes creating a holistic health and care offering, with a particular focus on those who are elderly or living with chronic or lifelong conditions. Key priorities include:

- Securing approval for a GP practice to return to the site
- Working with partners to secure further health services, including those focused on helping the elderly and those with long term conditions
- Creating flexible spaces for health or community activity such as drop-in clinics or events
- A café
- Homes which support local people, such as frail or elderly residents or those who need extra care to support them to live independently in the community for as long as possible

The following activity is now expected to progress over the next few weeks:

- Hoardings and ground works will begin on-site
- A planning application will be submitted to Hyndburn Borough Council to remove the more recent additions and extensions which surround the original hospital itself
- This application will also detail how Accrington Victoria will be sensitively but safely dismantled, captured architecturally to ensure it can be recaptured in any new designs – and removing anything significant where safe to do so to be reused in future building works

Our colleagues unmuted, now we're making change happen

The NHS Staff Survey results for 2025 were published in March. The results reflect the pressures of sustained operational demand, financial challenges and increased sickness, with overall theme scores declining.

The responses do indicate some early signs of progress in key areas of focus identified in previous years. The headlines included:

- Engagement remains strong with a 43% response rate, increased participation from most divisions and increased responses from colleagues from Black, Asian or Ethnic Minority backgrounds
- The Trust's strongest results were in compassion and inclusion, teamwork and flexible working. These areas continue to be core strengths for ELHT and reflect the values colleagues bring to their work every day
- The results showed early progress in targeted areas with fewer colleagues reporting discrimination or harassment — an encouraging sign in areas where we have already invested focused effort through safe spaces and the anti-racism campaign

- The most notable declines were in questions relating to morale, advocacy and learning and development

Over the coming weeks, the Trust work with divisions and teams to explore the results in more detail and agree actions together. Work is already underway on several priorities, including reviewing the appraisal process, reviewing our wellbeing support, strengthening our anti-racism approach and improving our sexual safety reporting and support.

The intention is for colleagues to be directly involved in shaping the improvements that follow and recent initiatives including Listening Labs have been expanded with excellent engagement so far.

Mutually Agreed Resignation Scheme (MARS)

The Trust launched a updated Mutually Agreed Resignation Scheme (MARS), with colleagues invited to apply between 1 April and 30 April.

MARS is a voluntary scheme that allows colleagues to leave the Trust with a one-off payment, where this helps the organisation make savings and support future changes. It was open to all anyone who has at least one year of continuous NHS service.

A process to consider all applications and update colleagues is now underway. Not all applications will be approved. Decisions are based on a range of criteria including continuing to provide safe and effective services, whether roles vacated would need to be replaced and the amount of financial savings which could be made in 2026–27.

Supporting colleagues to access disabled parking

A review of the number of disabled parking spaces is underway across all sites in response to concerns raised by colleagues with 'Blue Badges' who struggle to park close to their area of work. In the meantime, the Trust has agreed that all Blue Badge holders may use any disabled or visitor spaces as unavailable.

Update to car parking charges

Parking charges at our hospital sites will increase for colleagues, patients and visitors from 1 June 2026.

Under the terms of the Trust's PFI Project Agreements, the Trust is required to apply an annual increase to car parking charges in line with the published Retail Price Index (RPI) inflation rate. This requirement applies to parking for colleagues, patients and visitors and is a contractual obligation rather than a discretionary decision made by the Trust. The Trust is obliged to cover the difference between what parking charges should be under the contract and what is actually being charged which is a significant cost risk.

The new prices will be:

0-3 hours – £2.90

3-8 hours - £4.80

8-24 hours - £7.10

New aseptic unit and clinical trials dispensary officially opened

Two new pharmacy facilities have opened at Royal Blackburn Teaching Hospital (RBTH) marking major milestones in patient care and research.

The refurbished Aseptic Unit and the new Clinical Trials Dispensary have been made possible through investment from the Trust lifecycle programme and National Institute for Health and Care Research (NIHR) funding.

These developments demonstrate the Trust's commitment to high-quality patient care, safety, research and innovation, made possible through the Trust's life-cycle refurbishment programme and a successful NIHR bid.

Collaboration with hospices to support patients at end of life

The Trust has been working with local hospices to improve end of life care.

The work is linked to the Trust's Community Services and aimed at ensuring that people who are end of life can avoid hospital admittance and have an advanced care plan in place.

There is only one chance to get end of life care right and the collaboration work taking place between the Trust, hospices and other partners is helping 94% of patients achieve their preferred place of death.

The work hospices have undertaken includes:

- A member of hospice staff regularly going into our Integrated Care Allocation Team to identify patients suitable for hospice care. In the last six months this has led to 80 referrals
- Expanding the delivery of nurse-led Hospice at Home with 599 referrals in the last six months
- Supporting end of life care for homeless and socially vulnerable people to improve health equity and bereavement support - 136 in-reach sessions delivered with charities such as Church on the Street and Colne Open Door Centre
- Developing hospice in your care home, by providing training and generating champions - with 173 people trained in care homes to support this

This is just one collaborative project supporting the work at the Trust to reduce avoidance hospital admittance and provide best possible patient experience.

CCTV upgrade at Royal Blackburn Teaching Hospital

The Trust has successfully completed a major upgrade of internal CCTV systems across the RBTH site as part of our ongoing commitment to the safety and security of our patients and colleagues.

Delivered by Estates and Facilities in partnership with Consort Healthcare and Equans, the upgrade includes:

- New video management software in the security control room
- Updated control room computers and monitors
- Replacement of older cameras with modern high-definition units
- Instillation of additional high-definition cameras at risk locations

These improvements provide better coverage in key areas and enhance system reliability, helping to support incident response and safeguarding across the Trust and supports the Trust's preparations for the upcoming Terrorism (Protection of Premises) Act (Martyn's Law), due to come into effect in April 2027.

ELHT finalists announced for Mariposa Awards 2026

Colleagues won three awards in the Mariposa International Awards 2026, which recognise excellence in bereavement and compassionate care.

Nominations came from both colleagues and patients and with hundreds submitted, having winners in so many categories is an incredible achievement. They are:

- Dr Helen Collier - Special Recognition award for OBGYN of the year 2026 for her work in Rainbow Clinic
- Nikki Galloway, Bereavement Specialist Midwife who won the Arlo Award - In memory of Arlo Mallen, who sadly passed away in 2021, this award is for a medical practitioner who has gone above and beyond in the level of care they have provided and the Special Recognition Award for Bereavement Midwife of the Year 2026

Also shortlisted were:

- **Bereavement Team of the Year** - CBS Bereavement Team
- **Community Team of the Year** - Kentown Palliative Care Team
- **Compassion Award** - Julie McNevin-Duff

NROL named Regional Champion at NHS Awards

Our Neuro Rehabilitation Online Service (NROL) has been named as Regional Champion in the NHS Awards category for excellence in Patient Involvement and Choice.

NROL, our digitally enabled, multi-trust neuro rehabilitation programme, is one of just 10 services recognised across the North West.

The service supports people recovering from stroke, brain injury and other neurological conditions, delivering online group-based physical, cognitive and communication therapy. The service brings people together from across Lancashire and South Cumbria, combining clinical expertise with peer support to help patients stay motivated and connected.

Patients have been involved at every stage of NROL's development and their feedback has directly shaped the programme, leading to:

Since February 2025, NROL has supported over 240 patients, delivering more than 330 online therapy sessions and around 2,100 hours of additional therapy without the need to travel. Attendance remains strong, and fewer people are leaving the programme early.

As a regional champion, the Team is invited to attend the awards ceremony taking place at NHS ConfedExpo 2026 in Manchester on the evening of Wednesday 10 June. The ceremony will showcase the outstanding work taking place across the NHS and partner organisations and celebrate the national winners.

ENDS

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/058
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 meeting held on 12 March 2026. The terms of reference for the PCB Joint Committee were reviewed and are to be approved by respective Boards. They are appended to this report. At the ExCo meeting held on 24 March 2026, members requested clarification of decision-making routes across the collaborative. This is also appended for information.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to: 1. note the contents of the report; 2. approve the revised PCB Joint Committee Terms of Reference; and 3. note the decision-making routes across the collaborative.			

Previously Considered by:	
Date:	
Outcome:	

Provider Collaboration Board (PCB) Update

Summary of discussion 12 March 2026

1 Active Lancashire – acute to leisure centre pathways

Colleagues from Active Lancashire, Lancashire Teaching Hospitals NHS Foundation Trust and Greenwich Leisure Limited attended the Board to explain how NHS Trusts and leisure centres are already collaborating to use community spaces for services such as MSK, physiotherapy and outpatient care. Leisure centres, often located in areas of high deprivation, offer accessible venues with available daytime space and parking, making them well-suited for patient services.

Several pilots across Lancashire are showing promising outcomes, and Active Lancashire is developing a business case to support relocating services and referring patients into leisure centre settings. It was agreed that Active Lancashire would meet with the PCB Managing Director to explore further opportunities for expanding this approach across the system.

2 Finance and Planning Update

The Directors of Finance were working to mitigate the impact of the non-delivery of the Estates, Facilities and Procurement Optimisation programme within 2025/26. Work would continue on this workstream to deliver the financial benefits in 2026/27. Further clarity would be sought from NHS England (NHSE) in relation to use of subsidiary companies.

3 Pathology Single Service Update

The LSC Pathology Single Service is set to transfer on 1 April 2026, with Lancashire Teaching Hospitals NHS Foundation Trust becoming the Lead Provider and the single accountable organisation for pathology services across Lancashire and South Cumbria. A total of 589 staff (533 WTE) will move under TUPE with full protection of their existing terms, and services will continue in their current form, with the same workforce, functions and locations.

This milestone marks the end of the transition phase mandated by the Provider Collaborative Board and establishes the foundation for a unified transformation programme. From April 2026, the focus will shift to redesigning clinical pathways, consolidating services and improving outcomes for patients under a single leadership structure.

4 Outpatients and follow up reform

Outpatient transformation has been identified as a major strategic priority for the year ahead, with an emphasis on clear programmes, measurable goals and coordinated system-wide delivery. A unified framework is proposed to bring together outpatient and follow-up reform, ensuring efforts

are aligned and supported by digital innovation and clinically led decision-making to prevent fragmented activity.

The Provider Collaborative Elective Reform team will work closely with improvement leads and provider teams to drive delivery, strengthen reporting and reduce unwarranted variation. Early analysis shows significant potential, including up to 88,000 additional new appointment slots if specialties reach Northwest best-in-class performance, as well as notable reductions in DNA rates. A system-wide launch event is planned for 16 April 2026, after which the Elective Reform Team will begin programme initiation and confirm governance arrangements reporting into the PCB.

5 Provider Collaborative Workplan 2026/27

The PCB has developed its 2026/27 annual workplan in collaboration with professional groups and programme leads, with proposed governance changes reflecting recent MIAA recommendations.

Key adjustments include:

- creating a single Clinical Optimisation Portfolio Board to bring together elective, diagnostics and reconfiguration workstreams;
- continuing progress on the One LSC transformation with ELHT as host; and
- establishing a new PCB-led committee to oversee the single EPR business case with delegated authority from partner Trusts.

The Clinical Optimisation Board is expected to deliver around £20m in full-year financial benefits from 2026/27, with detailed delivery plans now being finalised. EPR governance changes will take effect from April 2026, and arrangements for reporting One LSC progress will be agreed with ELHT. Programme leads will support Trusts in completing delivery plans, with progress monitored through the agreed governance structure and quarterly updates to the PCB. Board members also discussed developing a strategic visionary narrative, with Chairs and CEOs planning to explore this further with the PCB Managing Director.

6 Provider Collaborative Budget 2026/27

The 2026–27 Provider Collaborative budget reflects major restructuring due to reduced national income and the loss of £1m in diagnostics funding from NHS England. Member subscriptions will remain unchanged, though provider shares have been revised. The Estates and Facilities programme will require additional non-recurrent funding, which is expected to be offset by future savings. Overall, the establishment will reduce by 25% (from 38 to 28 WTEs), and the operating budget will fall by 27% from £3.7m to £2.657m, with discretionary non-pay budgets removed to limit member contributions. Exceptional costs will continue to require case-by-case approval.

Despite these reductions, the budget is designed to support delivery of the Collaborative's workplan and maintain alignment between resources and expected financial and operational benefits.

Quarterly budget reviews will be undertaken throughout 2026/27 to monitor progress and ensure continued financial oversight.

7 Revised Terms of Reference

The terms of reference for the PCB Joint Committee have been reviewed and updated to consider the recommendations of the MIAA review of the operation and governance of the PCB. The proposed amendments also reflect those agreed by the PCBJC in February 2026.

Changes include:

- removal of the Assurance Committee;
- removal of CSEC;
- combining the Clinical Portfolio Board and Clinical Support Portfolio Board into the Clinical Optimisation Board.

The Chair of PCB is seeking to create a broader Non-Executive Directors Group.

The revised terms of reference are appended to this report for approval by the respective Boards.

8 Updates from the Integrated Care Board

The ICB and NHSE will be meeting on 29 March to agree the final blueprint and operating model, this will in turn be shared with the PCB.

9 Managing Director's Report

Up to January 2026, NHS Trusts in Lancashire and South Cumbria declared an in-month breakeven position, bringing the year-to-date deficit to £150.2m (excluding Deficit Support Funding). Trusts set a cumulative planned deficit of £105.1m and as such there was an adverse reported position of £45.1m. This adverse variance continues to be associated with the Waste Reduction Programme, which was £54m behind plan to the end of January 2026.

National updates have been provided on:

- COPD pathway improvement
- Community services contract
- Model emergency department
- Model acute pathways
- Productivity methodology
- Agenda for change
- Federated data platform
- Revised GP contract.

Clinical change programme:

- Progress continues to be made on reached a consensus for the future model for Urology Cancer
- Changes are being agreed to the interventional radiology services in support of the proposed centralisation of in-patient vascular services on the Royal Preston Hospital site.

Elective care and diagnostics:

The system has been allocated up to £7.4 million in additional funding to help accelerate the elective programme and cover areas of overperformance. As of the end of February 2026, 29 patients were waiting more than 65 weeks, all of whom were scheduled for cardiac surgery or cardiology procedures at Blackpool. This number is expected to fall significantly, with only two patients anticipated to remain on the list by the end of March.

10 Provider Collaborative Benefits report

- One LSC – £9.97m of WRP savings have been delivered year to date with a forecast to deliver £10.74m of savings in months 11 and 12, delivering a total saving of £20.71m for 2025/26.
- Collaborative portfolios – within the reporting period, benefits released have increased to £9.3m. Further actions are underway to deliver the remaining benefits within the financial year.

Terms of Reference

Lancashire and South Cumbria Provider Collaborative Board

Title	Terms of Reference for L&SC Joint Committee Provider Collaborative Board		
Author(s)			
Version	v7.3 DRAFT		
Target Audience	Lancashire and South Cumbria NHS Trust Providers		
Created – date	March 2026		
Date of Issue			
Date ratified			
Review date			
Document Status			
Description	Updated terms of reference for Lancashire and South Cumbria Provider Collaborative Board Joint Committee		
19 Sep 2023	005-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	The purpose of this updating to version 004 is to update the PCB's workplan to include functions relating to new site location for a central facility for pathology services
20 Sep 2023	005-2	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended to take account of comments of Tim Bennett
11 Oct 2023	006-0	Christian Dingwall, Browne Jacobson	
12 Oct 2023	006-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended for review by LSC CoSecs.

02 Nov 2023	006-2	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 13 Oct 2023
09 Nov 2023	006-3	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 03 Nov 20223
23 Nov 2023	006-4	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 23 Nov 20223
18 Dec 2023	v006-5	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following Trust boards approval of v006-4 with authority to Chairs and CEOs to agree further non-material changes, being to: • §5 - JCPCB engagement with ICB and compliance with Trusts’ relevant duties • §6 - JCPCB’s accountability to the Trusts and the Trusts’ accountability for PCB’s exercise of functions • §10 - operational framework for JCPCB engagement with Trust Boards • §12 – reinstated definition of Category 1 decision
May 2025	V007-1		Amended for general drafting, updated references to include PCB Managing Director, Assurance Committee, Executive Committee and general enabling provision (Clause 4.2)
March 2026	V007-3		Amended for general drafting, changes to governance structure.

Lancashire and South Cumbria Provider Collaborative Board Joint Committee

Terms of Reference

Version 007.3 DRAFT

1. Introduction

1.1 Lancashire and South Cumbria Provider Collaborative Board Joint Committee (PCBJC) is a formal joint working and delegation arrangement between:

- Blackpool Teaching Hospitals NHS Foundation Trust (BTHT)
- East Lancashire Hospitals NHS Trust (ELHT)
- Lancashire Teaching Hospitals NHS Foundation Trust (LTHT)
- Lancashire and South Cumbria NHS Foundation Trust (LSCT)
- University Hospitals of Morecambe Bay NHS Trust (UHMBT)

1.2 The member Trusts (***the Trusts***) are NHS provider Trusts within NHS Lancashire and South Cumbria Integrated Care System (ICS). The Trusts have agreed that the PCBJC should continue to be constituted as a joint committee of them to enable increased collaboration and to commit to collective, binding decisions.

2. Name

2.1 Lancashire and South Cumbria Provider Collaborative Board (PCBJC).

3. Establishment

3.1 Each Trust Board has formally approved constituting PCBJC as a ***joint committee*** under s.65Z6 of the National Health Act 2006 with delegated functions in accordance with these terms of reference (ToR).

4. Aims and Objectives

- 4.1 The PCBJC aims to enable greater collaboration between the Trusts to:
- a. Improve the pace of decision making to enable better patient outcomes and quality of patient care
 - b. Provide NHS Lancashire and South Cumbria Integrated Care Board (the ICB), NHS England, local authorities and the wider ICS with a single, collective view of the Trusts on proposals for service change
 - c. Develop, implement, manage and oversee shared clinical, corporate and other services on behalf of the Trusts across Lancashire and South Cumbria as delegated to them including the associated operating delivery and governance models which they may agree to adapt, and
 - d. Support financial stability and sustainability through reduced duplication and a better use of existing resources

4.2 In the delivery of its collaborative objectives it shall have regard to the need to:

- i. ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- ii. ensure that high standards of corporate governance and risk management maintained in the conduct of the business of the PCB ;
- iii. co-ordinate the strategic direction of the PCB and Provider within the overall policies and priorities of the Government and the NHS, define its annual and longer-term objectives and agree and approve strategic collaborative plans to achieve them;
- iv. oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; and
- v. with the ICB, ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs;
- vi. ensure no one provider is exposed to undue risk

5. Delegated Functions and Responsibilities

5.1 Each of the Trusts has agreed to delegate to the PCBJC the exercise of its functions for:

- a. Shared clinical services including but not limited to community services and pharmacy services
- b. Shared corporate services including but not limited to: One LSC, and bank and agency workers
- c. The single Electronic Patient Record (EPR) programme
- d. Single Pathology service

5.3 The PCBJC's exercise of functions shall be limited to matters set out in **the workplan**¹. The PCBJC shall require such committees as it may establish to review its workplan as appropriate and as often as it considers necessary with a view to agreeing updates to in accordance with the **decision making** section below of these terms of reference and always subject to being within its delegated authority.

5.4 The PCBJC shall exercise such further functions as the member Trusts may delegate to it from time to time.

6. Accountabilities and reporting lines/governance structure

6.1 The PCBJC will work within the existing governance structure of partner Trusts together with existing legal frameworks. The principle of subsidiarity will be applied to the work programme of the PCB; issues will be addressed at the most appropriate level of decision making. Partner Trusts confirm that:

- The PCBJC remains accountable to each of the Trusts, and
- Each of the Trusts remains fully accountable for its functions that the PCBJC exercises for it.

¹ 'The Workplan' refers to the aggregation of plans outlined and approved by the change portfolios, the sub committees of the professional working groups.

- The workplans developed by the Portfolios² and the Professional Working Groups³ will be approved by the Executive Committee with regular updates to PCBJC.

7. Decision Making and Voting

- 7.1 Each Board has delegated decision making authority to PCBJC so the PCBJC may make collective decisions that bind the Trusts in relation to its delegated duties and responsibilities.
- 7.2 Whilst it is expected that decisions will be achieved through consensus, it may at times be necessary for proposals to be put to a vote. Prior to any vote the Chair should establish if the vote should be taken on the basis of a) a simple majority b) unanimous consent. In the event of the former a vote, decisions will be approved if a qualified majority of those entitled to vote and present at the meeting approve;
- 7.3 All PCBJC members will have the right to vote regardless of whether the service or issue was 'relevant' to them. An inclusive arrangement will enable a greater sense of collaboration and reciprocity – and where objective views and opinion may assist in decision making.
- 7.4 Each Member or Alternate may exercise one vote.
- 7.5 Any dispute about voting may be escalated in accordance with the Dispute Resolution Process as described below. In instances where agreement cannot be reached then the status quo will be maintained.
- 7.6 The PCBJC reserves the right to enter into a Supply Agreement on behalf of its member organisations (or a variation to an existing Supply Agreement) on behalf of each Trust. Such changes will be documented and approved by PCBJC. As PCBJC will be acting on behalf of its constituent members, any such agreement would be reached in conjunction with its members.

8. Membership

- 8.1 PCBJC will have ten members. Membership of the PCBJC shall comprise the Chief Executive and Chair of each of the Trusts (the Members).

Trust	Member
BTHT	Chair and Chief Executive
ELHT	Chair and Chief Executive
LSCFT	Chair and Chief Executive
LTHT	Chair and Chief Executive
UHMBT	Chair and Chief Executive

² Each portfolio is made up on one or more 'programmes' and each programme is made up on one or more projects.

³ Professional Working Groups are responsible for the development of work plans aligned to their functions (Finance, Digital, Workforce etc), e.g. for One LSC or other portfolios of change.

8.2 Each Trust shall designate an alternate member for each of its Members (Alternate). The Alternate for a Chief Executive must be an Executive Director with voting rights. The Alternate for a Chair must be a Non-Executive Director with voting rights. Attendance of Alternate members must be notified to the Chair and/or Secretary prior to a meeting.

8.3 It is each Trust's responsibility to consider its approach to authorise its Members for the purpose of PCBJC participation.

9. PCBJC Chair

9.1 The Chair of the PCBJC will be a Trust Chair (ex-officio) from a Trust nominated by Members for that appointment by consensus. The Chair shall preside at meetings of the joint committee. In the absence of the Chair at a meeting or part of a meeting, and with the Chair's prior agreement, a Chair from an alternative Trust shall take the chair.

9.2 The term of office shall be two years from the date of appointment and shall relate to the Trust holding the seat for the term, not to any individual in their own right. The Chair of the nominated Trust shall be eligible for reappointment as PCBJC Chair on expiry of their term of office, subject to a maximum tenure of four consecutive years for any one Trust.

9.3 If the Chair steps down during their term of office the role shall be filled by the new Chair of the Trust holding the seat until that term of office is completed.

10. Lead Chief Executive

10.1 The lead Chief Executive of the PCBJC will be one of the Trusts' Chief Executives whom the Members appoint by consensus.

10.2 The lead Chief Executive's term of office shall be two years from the date of appointment. The lead Chief Executive shall be eligible for reappointment to a second term of office on expiry of their initial term of office subject to a maximum tenure of four years.

11. Attendees

11.1 The Chair may permit other persons to attend PCBJC meetings, including individuals or representatives of organisations who request to attend. Any additional attendees shall not count towards the quorum or have the right to vote at meetings.

11.2 In attendance will be:

- Provider Collaborative (PC) Managing Director
- Committee Secretary
- Other colleagues as determined by the agenda or as approved by the Chair

12. Meetings

12.1 The PCBJC shall meet quarterly, and at such times and places as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with Trust Board meetings and are synchronised so that PCBJC members can properly

engage their organisations ahead of PCBJC meetings.

12.2 On occasion it may be necessary to arrange extraordinary meetings at short notice. In these circumstances the Chair will give as much notice as possible to members.

12.3 Meetings of the PCBJC shall not be open to the public.

12.4 Papers shall be shared at a timescale to be agreed by the Chair.

13. Quorum and Binding Decisions

13.1 A binding decision is a decision reached by all members required to be present and achieved either through consensus without dissent or through a unanimous vote. A decision made in this way shall have the effect to be binding on all member trusts without reversion to those trusts for endorsement, approval or ratification.

13.2 The quorum for a meeting of the PCBJC shall be:

- For a meeting or part of a meeting at which a binding decision is required, **all ten** Members/Alternates must be in attendance for that item.
- For a meeting or part of a meeting at which no binding decisions are required, **eight** Members/Alternates must be in attendance.

14. PCB Subcommittees

14.1 The PCBJC may establish one or more subcommittees and delegate to them the exercise of any of the PCB's delegated functions. These include but shall not be limited to, those committees as set out in this Clause 14. Eligibility for membership of a subcommittee shall be restricted to Members or Alternate Members.

Executive Committee

14.2 The Executive Committee is established to oversee the development of workplans arising from the portfolios and professional working groups. It will support the development of initiatives within the remit of the PCBJC. The membership of the Executive Committee shall be limited to CEO/DCEO only.

15. Portfolio Boards

15.1 The PCBJC may agree to create one or more Portfolio Board to assist the PCBJC and its subcommittees with their work. Each PCBJC Portfolio Board shall be chaired by a Member or Alternate Member. Eligibility for membership of a PCBJC Portfolio Board shall be at the discretion of the Members. Portfolio Boards shall be advisory or enabling only and have no independent delegated authority to exercise any of the PCBJC's delegated functions but may make recommendations to the PCBJC for the purpose of its decision-making. Current PCBJC Portfolio Boards are outlined in Appendix A but are not a definitive list.

16. Professional working groups

- 16.1 PC Committees and Portfolios may be assisted by professional working groups. Professional Working Groups (PWGs) are established to create professional advice and support to the ongoing work of the collaborative.

17. Conflict of interest

- 17.1 Joint Committee Members should declare any conflicts of interest for items to be discussed at a meeting at the start of each meeting.
- 17.2 The Joint Committee recognises that each member shall have a direct interest in their own trust. This interest shall not give rise to a conflict of interest for the purposes of the joint committee.

18. Dispute Resolution

- 18.1 The agreed dispute resolution process shall apply and is attached at appendix B.

19. Collective Responsibility and Communication

- 19.1 Once decisions are made, all members will be regarded as having supported the decision, unless at the time of making the decision there is an explicit request to have their name recorded in the minutes as having voted against.
- 19.2 Following each PCBJC meeting, minutes will be prepared and sent to Members. A briefing on key discussions and decisions will be provided for circulation to trust boards.

20. Costs and support functions

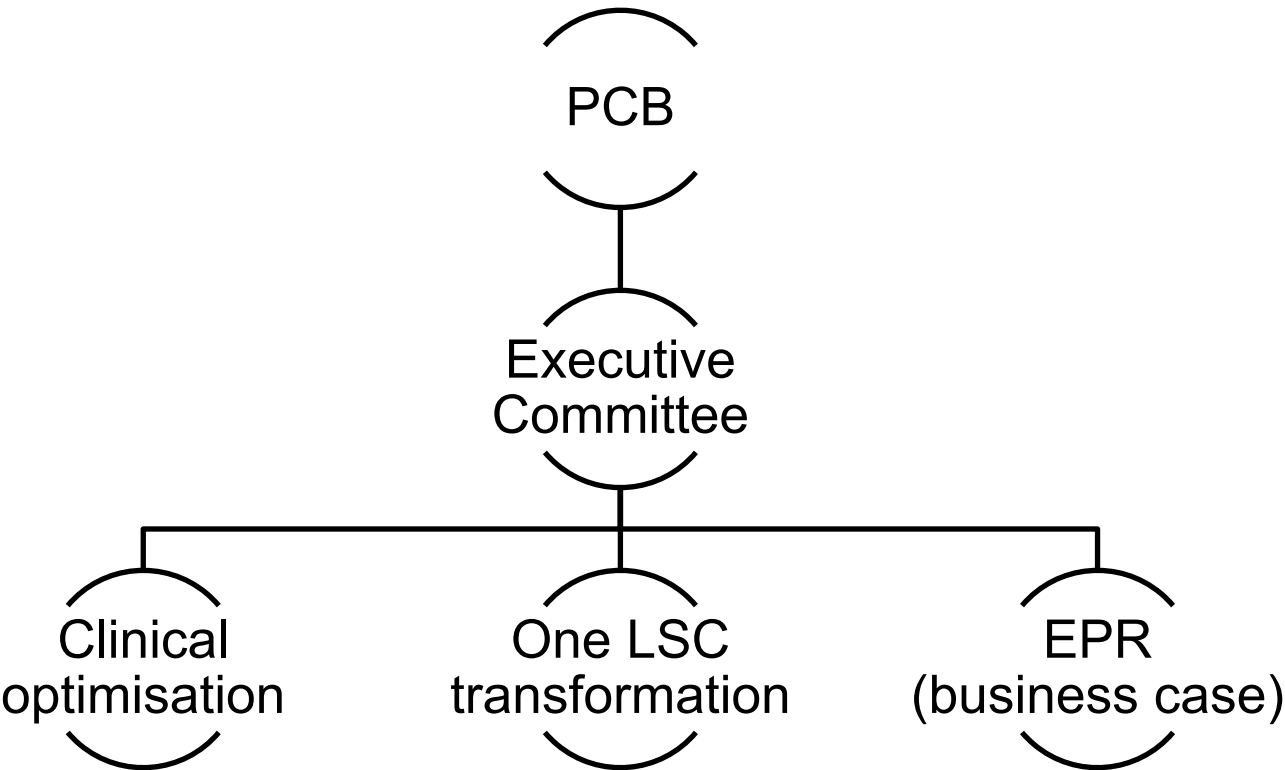
- 20.1 Unless otherwise agreed, costs incurred by and provision of support functions to the PCBJC shall be borne equally by all Trusts. Any request to allocate specific costs on a different basis must be agreed in advance by the PCBJC.
- 20.2 Support functions shall include but not be limited to the office of the MD, PCBJC secretariat.
- 20.3 The PC MD or the Committee Secretary shall be authorised to seek independent legal or financial advice on matters as they relate to the PCBJC. This shall be approved and subject to an agreed sign-off process.

21. Review of the Terms of Reference

- 21.1 The Terms of Reference will be reviewed at least annually.
- 21.2 PCBJC has no other powers than those in the ToR.

Portfolio arrangements

The chart below outlines the portfolio structure of the Provider Collaborative.



Introduction

1. A formal dispute resolution process is a last resort; organisations should do all they can to avoid disputes and, when they do occur, the aim should be to resolve them swiftly. Formal involvement in a dispute is a sign that the parties have failed in their duty to work together effectively for the benefit of the 1.7 million population of the region. This document sets out the dispute process and, to reduce the number and scale of these failures, it also outlines how organisations can be supported in resolving disputes before they require any formal process.

Principles of the dispute resolution process

2. The following principles are to be adhered to for any dispute resolution:
 - The resolution agreement must be in the best interests of the population. It must maintain the quality of health and social care now and in the future, deliver the best possible outcomes for our population, support innovation where appropriate, make care more cost-effective, and allocate risk fairly
 - The resolution agreement must promote transparency and accountability. It should hold the members of the PCBJC accountable to each other and to patients and citizens, and facilitate the sharing of information to achieve the transformation objectives across Lancashire and South Cumbria
 - The parties to the PCBJC must engage constructively with each other within the dispute resolution process when working to reach agreements. This should involve agreeing a framework for negotiations, the sharing of relevant information, engaging appropriate stakeholders where applicable, and agreeing appropriate joint objectives for service improvement and delivery.

Scope and application of the dispute resolution process

3. This dispute resolution process is intended for application to disputes arising beyond the geography of a single organisation or locality.
4. In the absence of any other such arrangements all localities are encouraged to adopt the policy to ensure wherever possible that a swift and satisfactory conclusion for all parties of any dispute is reached in compliance with the disputes resolution process.
5. The dispute resolution process applies to disputes arising from the following:
 - a. Any non-compliance with decisions agreed through the formal PCBJC and ICB governance processes of both Boards and their associated governance, and specific approved minutes detailing specific decisions made at such meetings, and
 - b. Actions that are in breach of the decisions of the PCB.

Outline of the dispute resolution process

6. This dispute resolution process operates in three stages:
 - Stage One - Mediation: The first stage involves advice and/or mediation which must be taken by agreement solely between the disputed parties. **It is expected that this process will be concluded within a two-week period.** If the disputed parties reach an agreement this will be binding upon all parties and the dispute will be considered as settled
 - Stage Two - Negotiation: The second stage involves formal negotiation between the disputed parties with the aim of reaching a negotiated position which is acceptable to all parties. **It is expected that this process will be concluded within a two-week period.** If the disputed parties reach an agreement this will be binding upon all parties and the dispute will be considered as settled
 - Stage Three - Panel Negotiation: The third stage involves a more formal negotiation which will be facilitated by the Accountable Officer of the ICB (or their nominated deputy). **It is expected that this third stage process will be concluded within a four-week period.** This is the end of the dispute resolution process.
7. It is acknowledged that the Parties involved in any formal dispute have recourse to existing legal processes for dispute resolution. It is hoped that the process outlined here will support the local resolution of disputes.

The PCBJC has appointed the following subcommittees

Committee name	Ratified	Reviewed	ToR Version
Executive Committee	TBA	TBA	TBA
Single EPR Programme			

A guide to collaborative processes

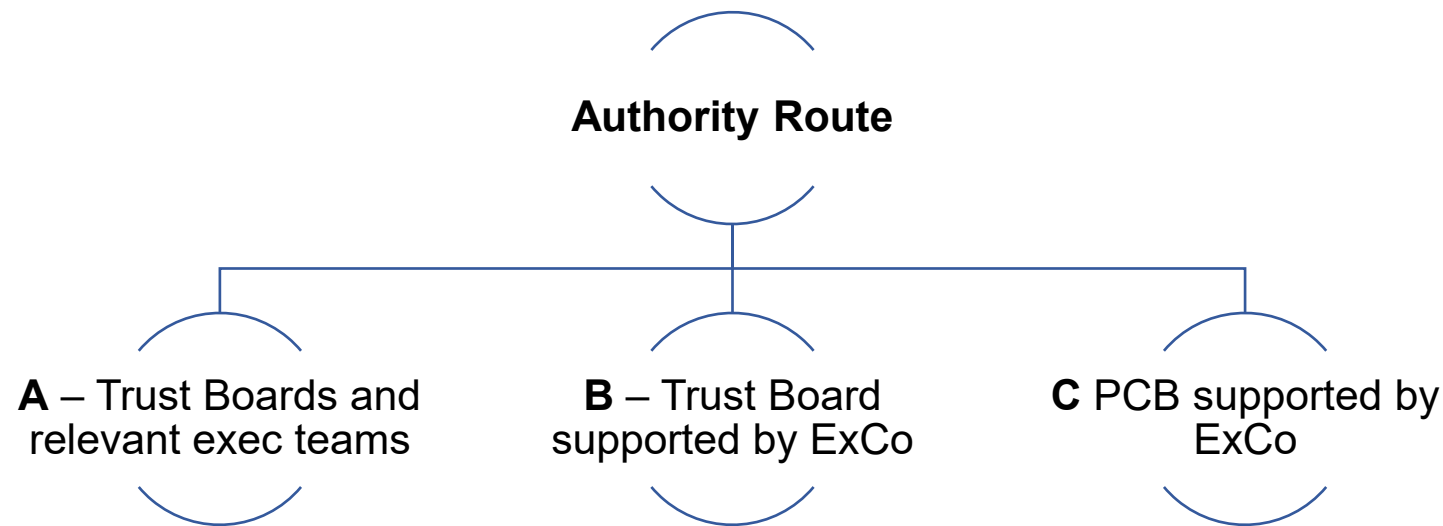
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Background

- This document aims to provide some clarity on decision-making process for leaders when supporting collaborative change or the management of organisational resources. It provides information relating to the delegation of decision making and positions the importance of statutory bodies in that decision making.
- It is important that decisions are made in line respective delegated authority and that programmes are developed to recognise and support the appropriate assent of decision making through the joint combination of collaborative arrangements and the appropriate authority of each Trust Board. PCB has a small number of specific delegations, in scope corporate services (one LSC), pathology and a range of programmes of change.
- It is similarly important to outline the flow of risks and rewards for each statutory body when working on collaborative programmes. Each programme needs to develop suitably granular information in order that the oversight processes can suitably scrutinise proposals and support a robust approval.
- The approval of workplans is core to the orchestration of work which takes place across organisational boundaries. There workplans can relate to the management of process, e.g. mutual aid or supporting change and transformation through formal business cases or improvement practice.

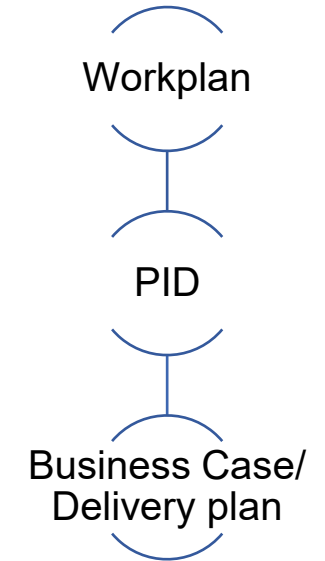
Decision making route

- Where relevant the route to the authority to approve will be as follows:
 - Authority route A Retained by individual statutory bodies with delivery through relevant executive teams (typically **bilateral** agreements)
 - Authority route B Statutory Bodies with delivery through ExCo (typically **multilateral** programmes)
 - Authority route C Delegated to PCB with delivery through ExCo



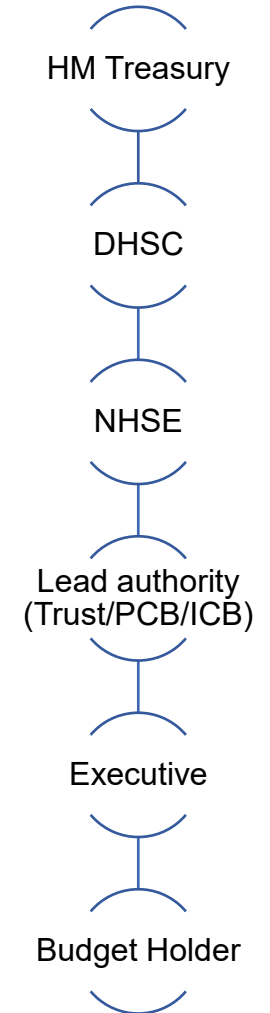
Workplans to delivery

- The development of workplans and their approval is an important element of collaborative working
- Workplans should be developed in two areas:
 - Portfolios
 - Professional Working Groups
- The combination of these workplans form the delivery plan for the collaborative as a whole
- With regard to workplans, it is expected that the following PWGs will develop annualised workplans:
 - DDaT
 - Finance
 - Workforce
 - Operations
 - Clinical
- ExCo will endorse and receive updates on the PWG workplans
- The combined workplan proposals will be shared with PCB for approval on an annualised basis
- Changes to the workplans should be overseen though ExCo



Delegated authority

- A scheme of delegation operates from HM Treasury, through DHSC, NHSE, Statutory Boards, Executives and down to budget holders.
- As a guide, any change process, contract award or novel change with a value of more than £1m requires approval by a statutory Board, unless otherwise delegated.
- For a collaborative programme, if a statutory authority will be required to host a contract on behalf of the wider partnership with a value of greater than £1m then this will still require the approval of the statutory host, irrespective of the partner contributions.
- Statutory Boards also operate under delegation, and these values are tied to the NOF tiering for each Trust. As outlined above, advice should be sought early in a programme or project to ensure that relevant stakeholders can advise on the assent pathway.
- Collaborative programmes and projects need to ensure that approvals are in line with appropriate delegated authority.



Scheme of delegation

- All resources operating within an NHS statutory body operate under a scheme of delegation.
- This scheme of delegation is outlined by each statutory body (Board of Directors/Trust Board).
- As indicated above statutory bodies can delegate authority to the Joint Committee (JC) of the Provider Collaborative Board to develop strategic change processes. The specific services are outlined in schedule 5 of the PCBs ToR.
- For Authority Route B (PCB), the authority rests with the Joint Committee (the Trusts retain the power to decide to rescind the delegated authority but having delegated they cannot then seek to add themselves back in to the authority process.
- Similarly in line with respective schemes of delegation these statutory bodies may agree to collaborate on change processes which aren't delegated to the JC. Whilst this may be coordinated by ExCo, final approval will still reside with these statutory bodies.
- In all cases, statutory bodies should be aware of and engaged in these change processes.
- The final approval for change management is retained by the member statutory bodies.
- There is a risk that these accountabilities become blurred and consequential decision making may be impacted and where there is uncertainty relevant leads should seek clarity.

Statutory body governance

- Each statutory body has a broadly similar scheme of delegation, standing orders and standing financial instructions. There are however some key variables.
- Assent processes* vary by organisation and when collaborative change processes are undertaken it will be important to map though each organisation process.
- Where appropriate Boards will require that officers follow existing guidelines for the approval of cases
- Members of programme boards and project groups therefore must have sight into an executive process linking into Board sub committee processes and ultimately into each relevant Trust Board In line with the scheme of delegation. It is will be important to clarify these relationship on the Terms of Reference for any joint governance process.
- It is suggested that the following two professional groups should support the assent process for each relevant statutory organisation:
- Company Secretaries
- Chief Finance Officers

* The processes by which changes are governed within each Trust, from idea generation through to final approval

Governing a change process

- As outlined above it is anticipated that anticipated changes will be outlined in an annualised workplan and that this workplan will be endorsed at ExCo and approved by PCB.
- A change process needs to be supported by suitable documentation, whether a formal business case, a report or some other schedule (s). Advice should be sought at PID stage as to which route should be followed.
- It should be noted that some NHSE templates which are marked as 'business cases' may not be suitable for decision making within a statutory authority, similarly an approval of funding associated with a successful bid to an external agency e.g. NHSE may not be suitable for Trust approvals.

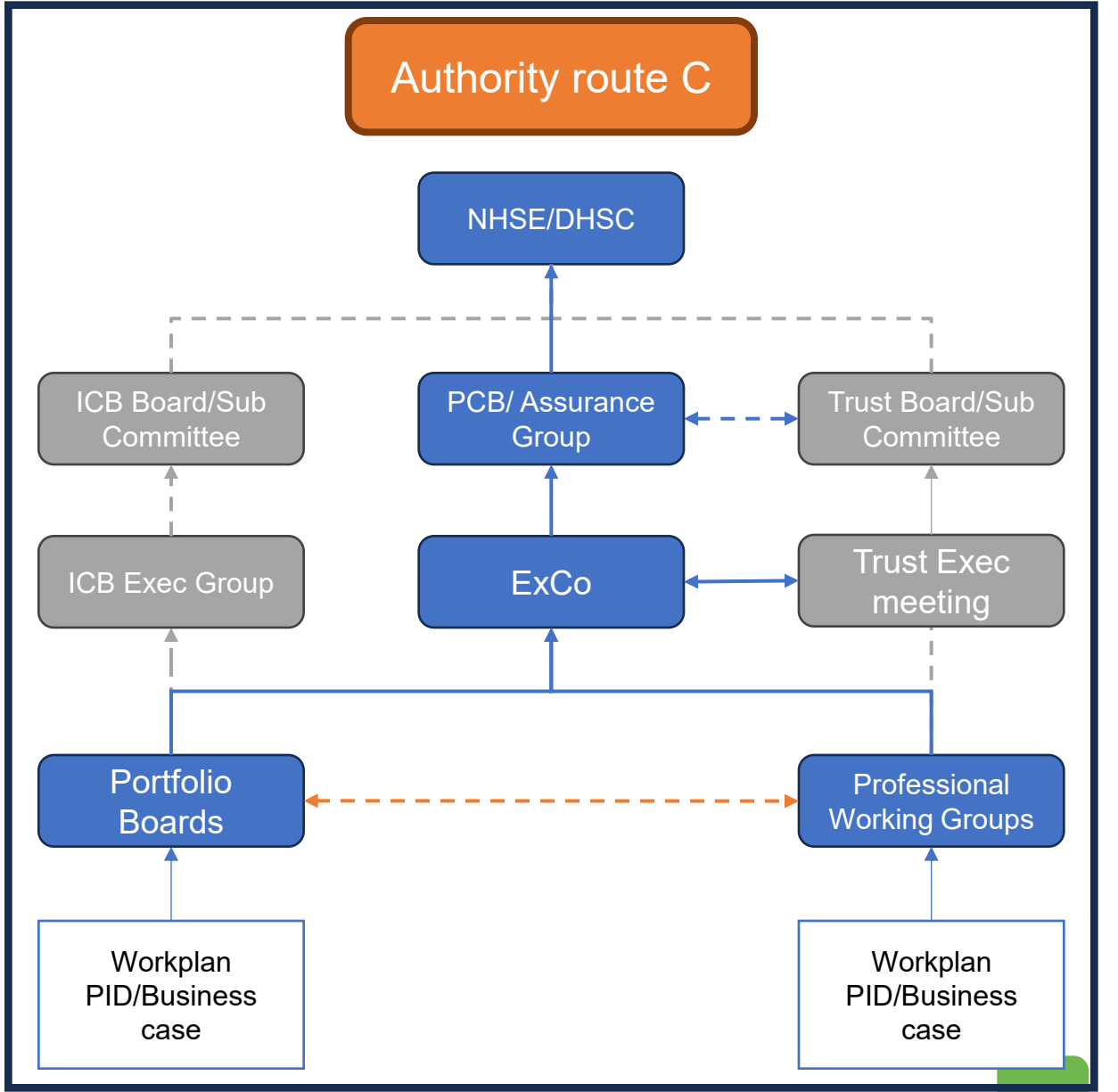
The image displays two organizational charts, labeled 'Authority route B' and 'Authority route C', illustrating the governance structure for a health system. Both charts show a hierarchical flow from 'Workplan PID/Business case' at the bottom to 'NHSE/DHSC' at the top.

Authority route B:

- Workplan PID/Business case** (bottom left) feeds into **Portfolio Boards** (blue box).
- Portfolio Boards** feeds into **ICB Exec Group** (grey box) and **ExCo** (blue box).
- ICB Exec Group** feeds into **ICB Board/Sub Committee** (grey box).
- ExCo** feeds into **Trust Exec meeting** (blue box).
- ICB Board/Sub Committee** feeds into **NHSE/DHSC** (top).
- Trust Exec meeting** feeds into **Trust Board/Sub Committee** (blue box).
- Trust Board/Sub Committee** feeds into **NHSE/DHSC**.
- A dashed orange line connects **Portfolio Boards** and **Professional Working Groups** (blue box).
- Professional Working Groups** feeds into **Trust Exec meeting**.

Authority route C:

- Workplan PID/Business case** (bottom left) feeds into **Portfolio Boards** (blue box).
- Portfolio Boards** feeds into **ICB Exec Group** (grey box) and **ExCo** (blue box).
- ICB Exec Group** feeds into **ICB Board/Sub Committee** (grey box).
- ExCo** feeds into **PCB/ Assurance Group** (blue box) and **Trust Exec meeting** (grey box).
- ICB Board/Sub Committee** feeds into **NHSE/DHSC** (top).
- PCB/ Assurance Group** feeds into **NHSE/DHSC**.
- Trust Exec meeting** feeds into **Trust Board/Sub Committee** (grey box).
- Trust Board/Sub Committee** feeds into **NHSE/DHSC**.
- A dashed orange line connects **Portfolio Boards** and **Professional Working Groups** (blue box).
- Professional Working Groups** feeds into **Trust Exec meeting**.
- Additional connections in Route C:
 - A dashed blue line connects **ICB Board/Sub Committee** and **Trust Board/Sub Committee**.
 - A solid blue line connects **PCB/ Assurance Group** and **Trust Exec meeting**.
 - A solid blue line connects **ExCo** and **Trust Exec meeting**.



BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/059
Report Title:	Integrated Performance Report		
Author:	S Dobson		
Lead Director:	S Gilligan, Chief Operating Officer		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
				✓
Executive Summary:	The Board are directed towards the following sections: Safe • Infection Control: there has been 1 case of Measles so far- this was a baby too young to have MMR vaccination. National guidance for contact tracing was followed. • End of year performance for Healthcare Associated Infections shows overall good performance. Improvement work on earlier antibiotics in pneumonia has commenced and is ongoing. • Klebsiella and Pseudomonas bacteraemia case numbers are just over trajectory. There has been a substantial decrease in E. coli bacteraemia cases compared to last year. there were two MRSA bacteraemia cases on a trajectory of zero, this was the best performance in the ICB. • Nurse and Midwifery Staffing: Overall RN fill rates: Days 89.56%, Nights 97.38%. 23 clinical areas below 90% (5 below 80%) • Harm Free Care: Slips, trips and falls is on a downward trajectory for a 3rd month in a row. But falls with harm 2025-2026 has increased. • Number of patients risk assessed for VTE remains about 90%, but has dropped 4 months consecutively. • Pressure ulcers monthly audit results for Assessment and Documentation of Pressure Ulcers remain below the expected target compliance range of 70–85%. March compliance was 53% indicating continued. Since April 2025, 15.4% of incidents have been confirmed as lapses in care following review. Caring • Feedback: The positive rating for A&E FFT score has improved from 72% to 74%, close to the national average at 79%. UEC Improvement Board in place with 5 workstreams focused on Clinical Operating Standards, Length of Stay, Weekend Discharges, Job Planning, Virtual Ward, the aim is to eradicate corridor care and long waits in ED. Maternity services positive ratings (86%) remain lower than the Trust's internal benchmark (of 90%) and national average of 92%. The Division are			

	reviewing their FFT data to establish the themes and trends, to implement actions to improve the patient experience. • FFT satisfaction rates across Community services remain strong at 96%, exceeding the national average of 94% (February 2026). Satisfaction levels for Inpatient and Outpatient care are also positive, although both sit slightly below the national averages of 95% for Inpatients and 94% for Outpatients. Responsive: • Strong and sustained performance across core access standards, with the Trust consistently meeting or exceeding trajectory across RTT, diagnostics and urgent care. Well-Led Finance • At month 12, the Trust is reporting an in-month surplus of £10.3m, against a planned deficit of £2.52m; £12.4m ahead of plan. • The year-to-date (YTD) position is a £43.2m deficit against a planned deficit of £43.3m; £77k ahead of plan (excluding the DSF). • In month WRP delivered £5.5m against the WRP Delivery plan, therefore £1.1m adverse to plan (£0.7m adverse to PFR plan) • The WRP has delivered £43.2m YTD against a plan of £60.8m; £17.6m behind the plan. Key Metrics • Agency spend in credit of £204k, is £713k better than plan linked to technical release. • Bank spend of £4,276m is £730k adverse to plan, this represents a 5% reduction on 2024/25 run rate. • The cash balance at the end of March was £35.1m, an increase of £16.9m compared to M11. • The annual 2025-26 capital plan is £43.76m, 25/26 spend is £43.75m, £12k below plan. • Paid WTE have increased by 59 WTE from Month 11 to 9,713.
Key Issues/Areas of Concern:	The Trust's financial plan for 2025/26 is break-even, including £43.3m deficit support funding (DSF). The key risks associated with delivery of the plan include: • Full delivery of the Waste Reduction Programme of £60.8m on a recurrent basis. • Divisional pressures to be contained within the agreed budgets/ plan. • The finalised impact of the HCA review of banding inclusive of the associated timescales for both cash and revenue.

	While overall performance remains strong, pressures remain within cancer performance, particularly against the 62-day standard, driven by pathway delays and capacity constraints
Action Required by the Committee:	To note

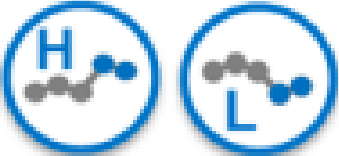
Previously Considered by:	Finance Oversight Group
Date:	20 th April 2026
Outcome:	Noted

Integrated Performance Report

Published: April 2026

Safe | Personal | Effective

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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

The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.

28% of our metrics are consistently achieving target

23% of our metrics are inconsistently achieving target

14% of our metrics are not achieving target, however 2 of these are showing special cause improvement.

35% of our metrics do not have a target currently set.

		Assurance			
		Achieving target	Inconsistently achieving target	Not achieving target	No target set
Variation	Special cause improvement	A&E 4hr, DM01, RTT % >52wks, RTT < 18wks treatment, <18wks for 1st appt	31d cancer, Liquidity Days, Variance to planned performance, WRP	VTE, Complaints	Cancelled on day ops, Income run rate
	Common cause	Avg fill care staff (night), Community F&F, Appraisal (consultant & other medical), 28d cancer, Safeguarding children training	Maternity F&F, Over 12 hr TiD % (type1), Canc on day not rebooked, Vacancy, BPPC NHS No and Value of Invoices, Variance to capital programme	Nursing red flags, Wards<90% RN day fill, A&E F&F, 62d cancer, Appraisal (AFC), Sickness	Crude Mortality rate, In hospital deaths, Stillbirths, % handovers > 30 mins, Handovers > 45 mins, A&E Atts, Bed Occ, Avg and max arrival to handover, Emg avg LOS, C diff, E coli, Pseudomonas, Klebsiella, % occupied 7+, Emg readmissions rate, Other operating expenses run rate
	Special cause concern	Avg fill RN (day), Avg fill care staff (day), Avg fill RN (night), Inpatient F&F, Outpatient F&F, Turnover, Agency spend	CHPPD, MRSA, BPPC Non NHS No and Value of Invoices	IG training	% occupied 14+ & 21+, Employee expenses run rate

SAFE - Summary Scorecard

Metric	Latest Date	Value	Target	Variation	Assurance
Average Fill Rate Registered Care Staff (Day)	MAR 26	92.17%	90.00%		
Average Fill Rate Registered Care Staff (Night)	MAR 26	108.13%	90.00%		
Average Fill Rate Registered Nurses (Day)	MAR 26	89.56%	90.00%		
Average Fill Rate Registered Nurses (Night)	MAR 26	97.38%	90.00%		
Care Hours per Patient Day (CHPPD)	MAR 26	7.58	8.00		
MRSA	MAR 26	2.00	0.00		
National Nursing Red Flags	MAR 26	5.00	0.00		
Patients Risk Assessed for Venous Thromboembolism	MAR 26	91.03%	95.00%		
Wards <90% Registered Nurse (Day) Fill Rate	MAR 26	21.00	0.00		

Metric	Latest Date	Value	Variation
Medication Errors Causing Low Harm and Above	MAR 26	47.00	
Registered Nurse Agency Spend	MAR 26	102531.00	
Registered Nurse Bank Spend	MAR 26	1178915.00	
Slips Trips and Falls Causing Low Harm and Above	MAR 26	58.00	

Alert

Nursing and Midwifery staffing - During March 2026 overall Nurse and Midwifery staffing shows trajectory as achieved. There were increased pressures due to unexpected unavailability for RNs on day shifts, but all areas remained safely staff with staff redeployments. Average fill rate for nurses and for Care staff (Day) is showing a deteriorating performance mainly over the winter period for day shifts.

Action: Short term unexpected unavailability is managed by divisions and monitor, daily, weekly, and monthly, alongside recruitment of vacancies. This is monitored via the Nursing and Midwifery staffing paper via Trust Wide Quality Governance meeting A on a monthly basis.

Infection Control - ELHT has had only had one positive measles case so far this year. This was a baby who was too young to have had any doses of MMR vaccine. This episode resulted in a small number of patient contacts, none of whom were immunosuppressed, and one staff contact (in terms of non-immune staff members).

Action: A 21-day period of exclusion from work was necessary, due to the possibility of developing Measles and transmitting it to patients or colleagues. This is in line with national guidance. The risk assessment process for Measles in children was immediately updated to lower the threshold for isolating febrile children with a rash with recent foreign travel.

Pressure Ulcer - Monthly audit results for Assessment and Documentation of Pressure Ulcers remain below the expected target compliance range of 70–85%. March compliance was 53% indicating continued improvement is required. Since April 2025, 15.4% of incidents have been confirmed as lapses in care following review. themes identified include incomplete risk assessments, delays in repositioning, and documentation gaps.Compliance with mandatory training remains below target. Current completion rates are as follows: Pressure Ulcer e-learning 86.3% and MASD e-learning 86.1%.

Action: 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. Targeted actions and focused support are being implemented in areas of concern.

Training continues to be monitored through the Pressure Ulcer Steering Group. Additional focus is being placed on improving training uptake to support sustained knowledge, practice compliance, and effective prevention of harm.

Advise

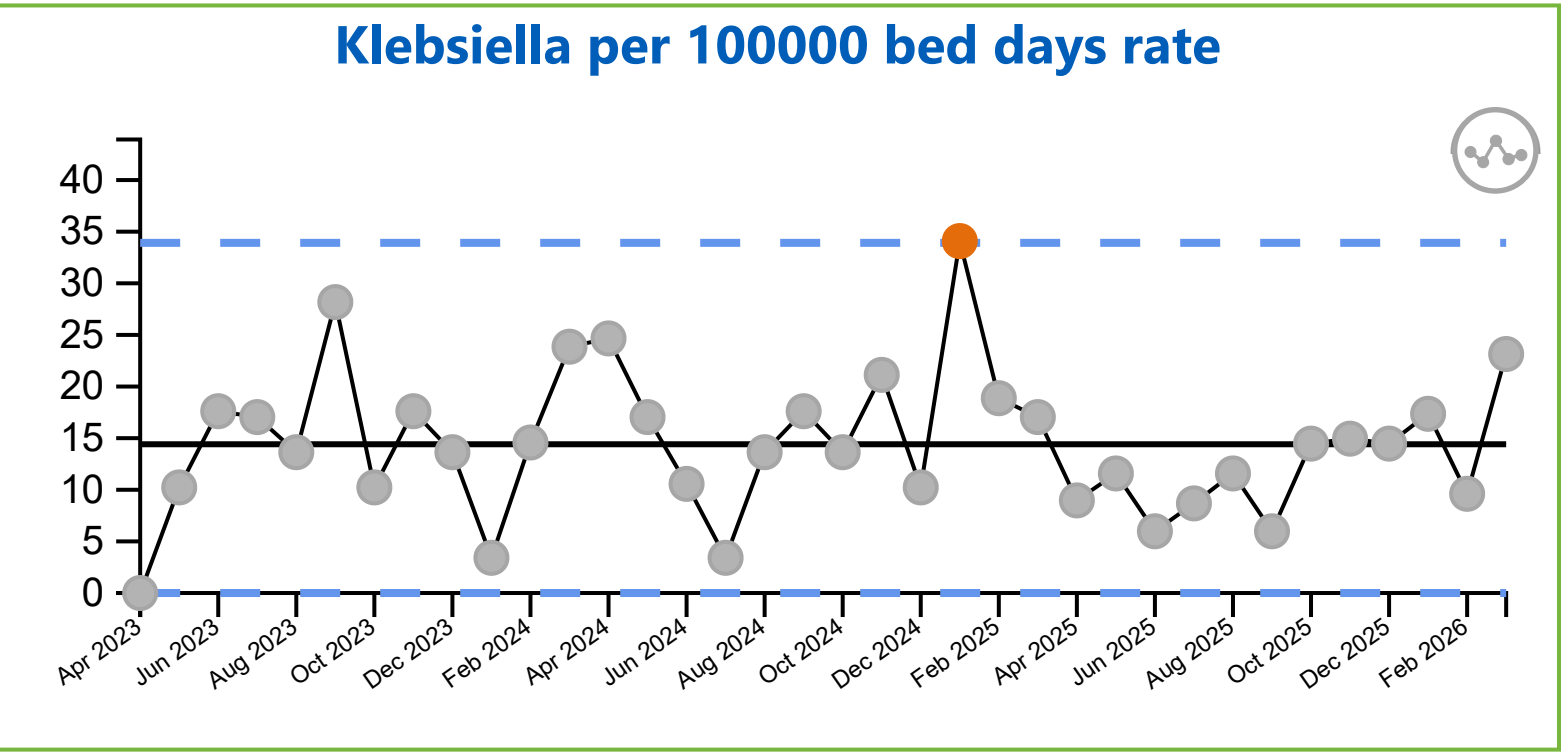
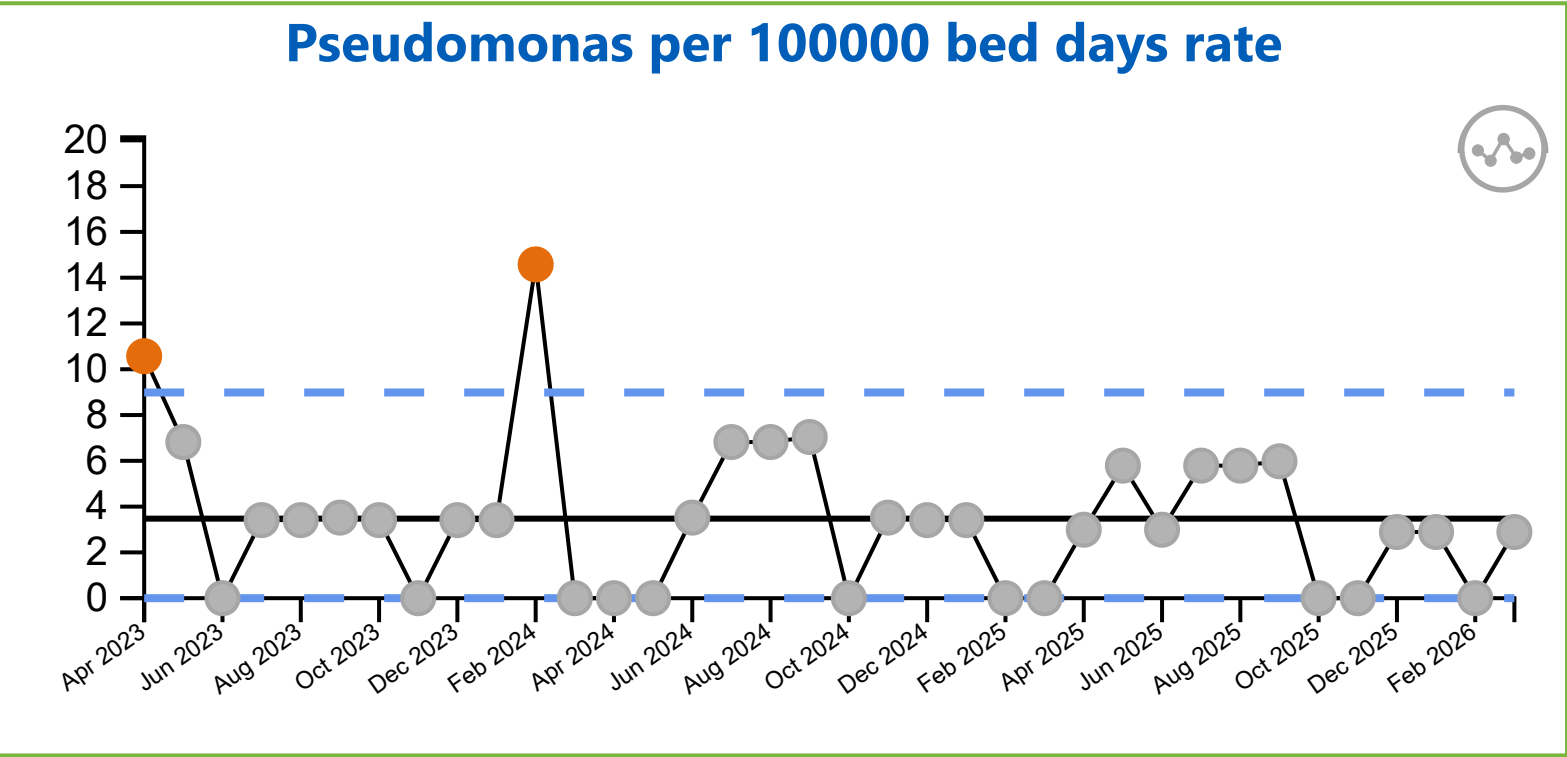
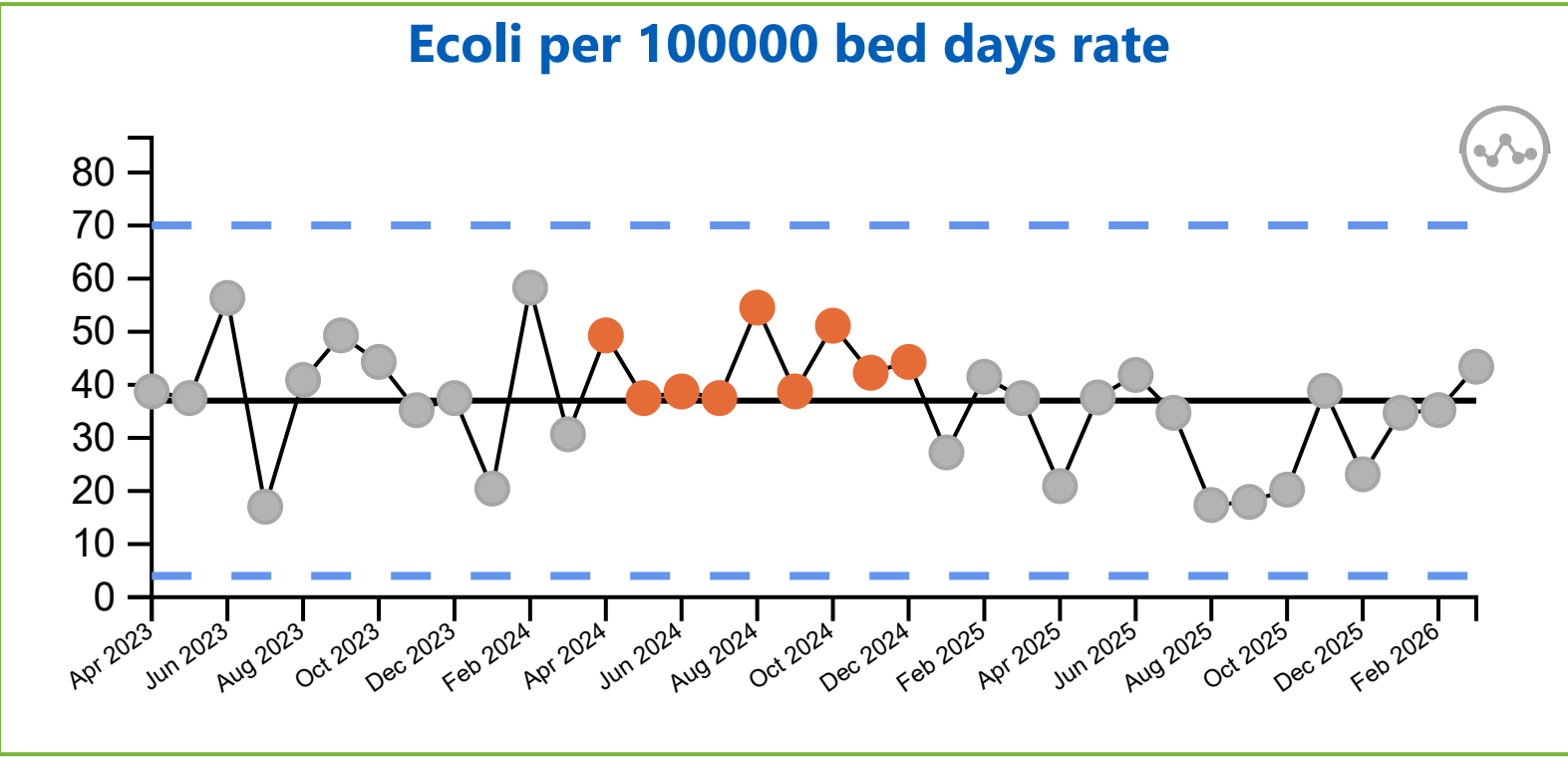
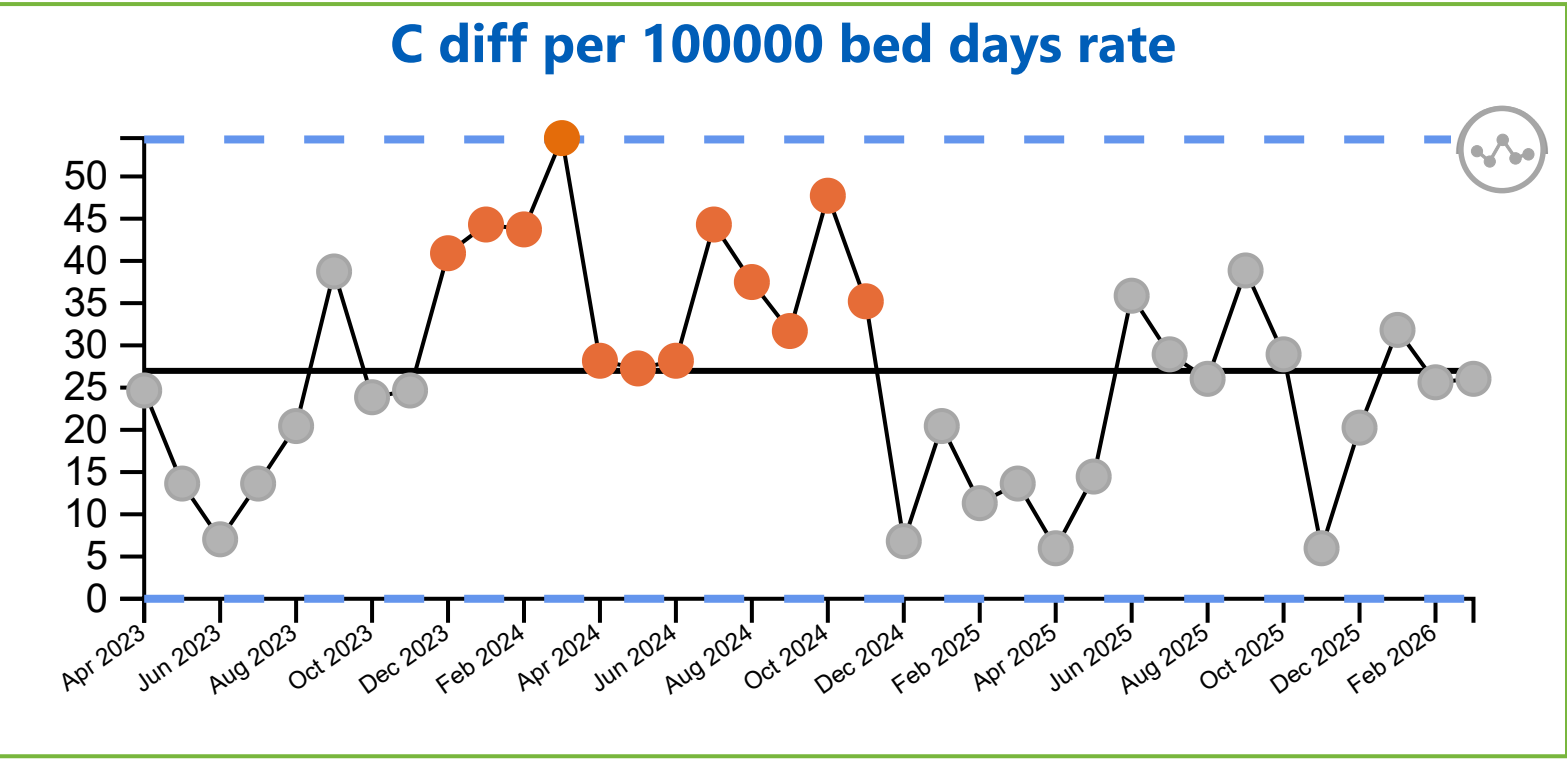
Nursing and Midwifery staffing - Nurse staffing continues to be monitored twice daily in trust wide staffing meetings chaired by Divisional Directors of Nursing. Midwifery staffing continues to be monitored four times a day. Where pressure is increased, each Divisional Director of Nursing and 1 Deputy Chief Nurse then attend the calls.

Pressure Ulcers - April 2026, the Purpose T Skin Assessment replaced the Waterlow assessment within inpatient care – compliance will be monitored via the Pressure Ulcer Steering Group.

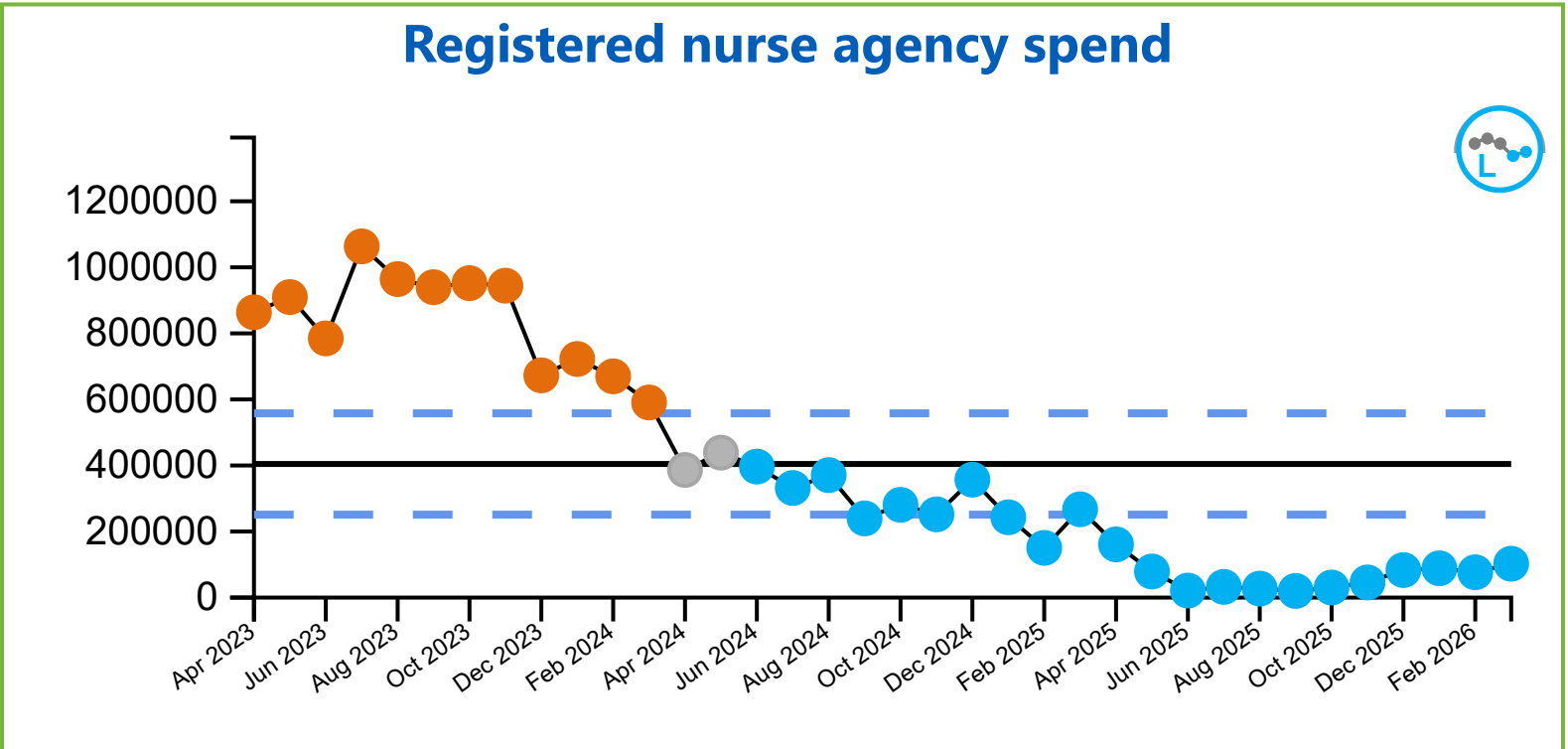
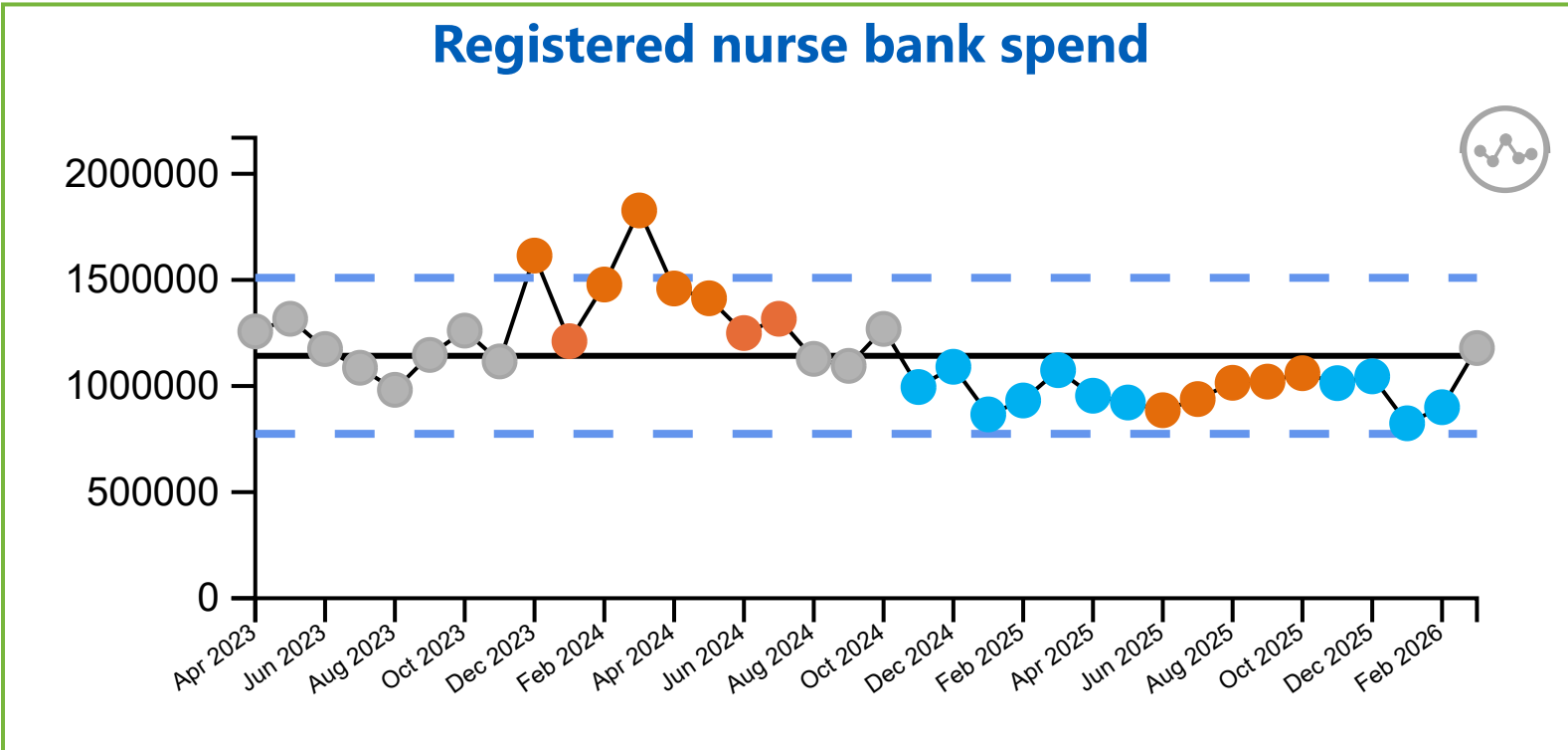
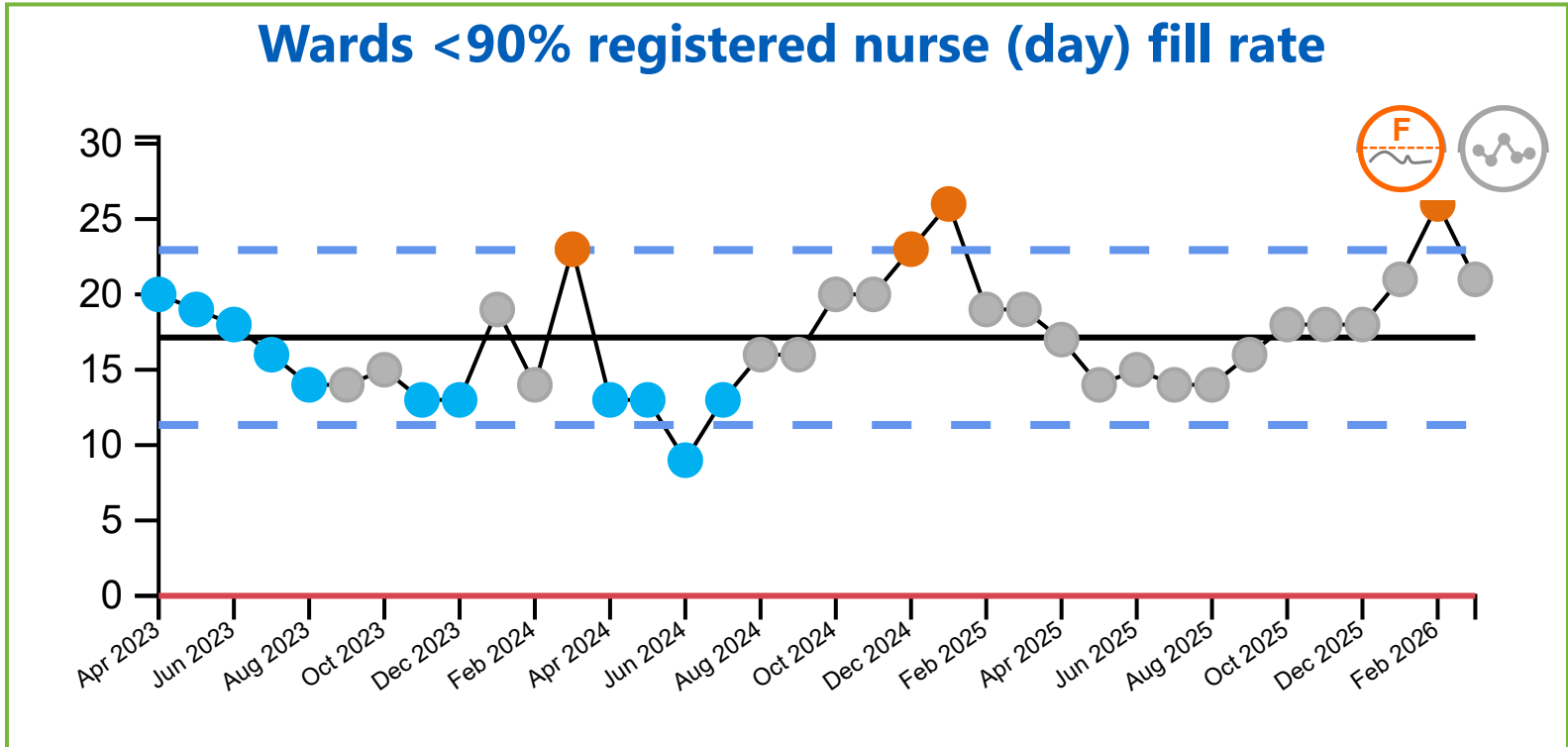
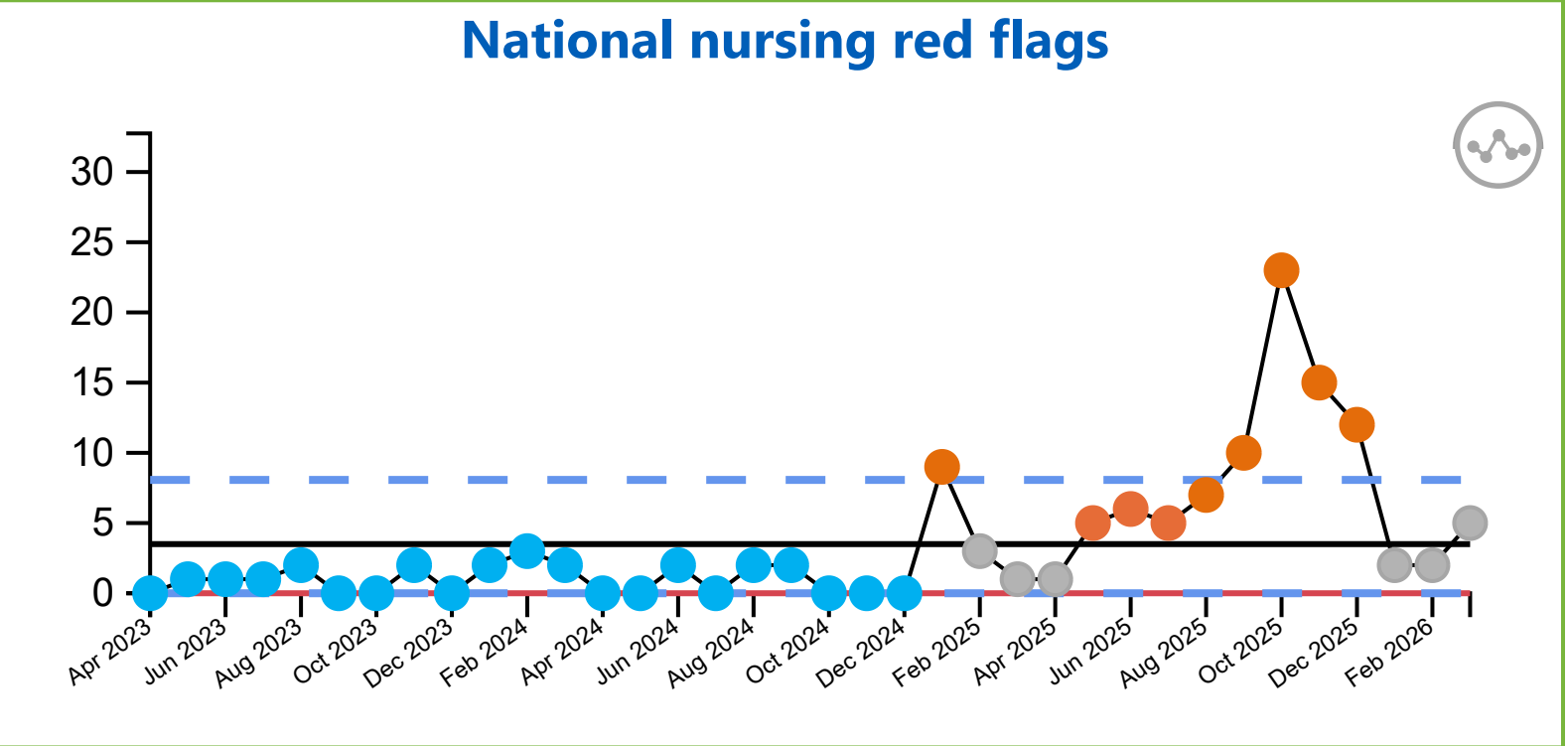
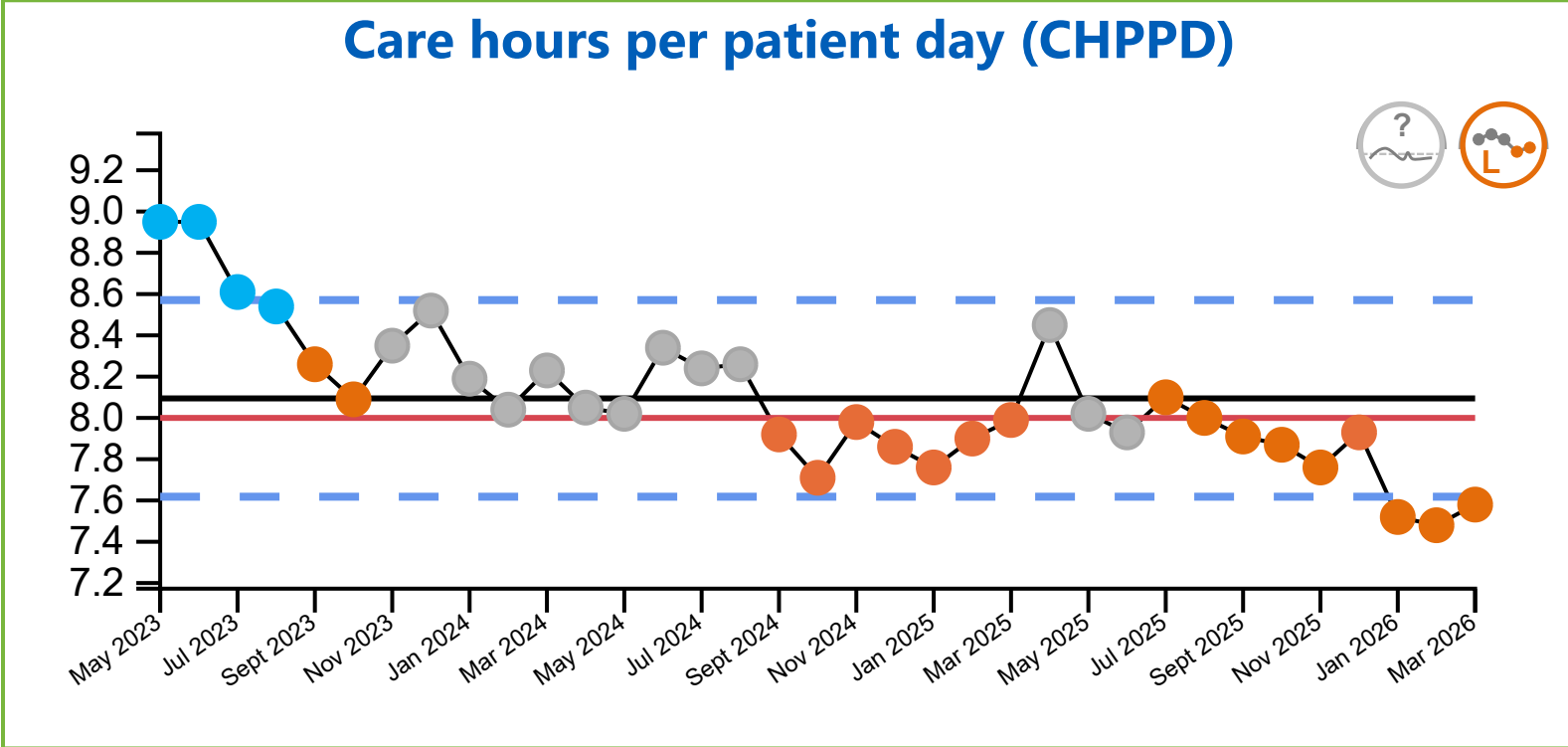
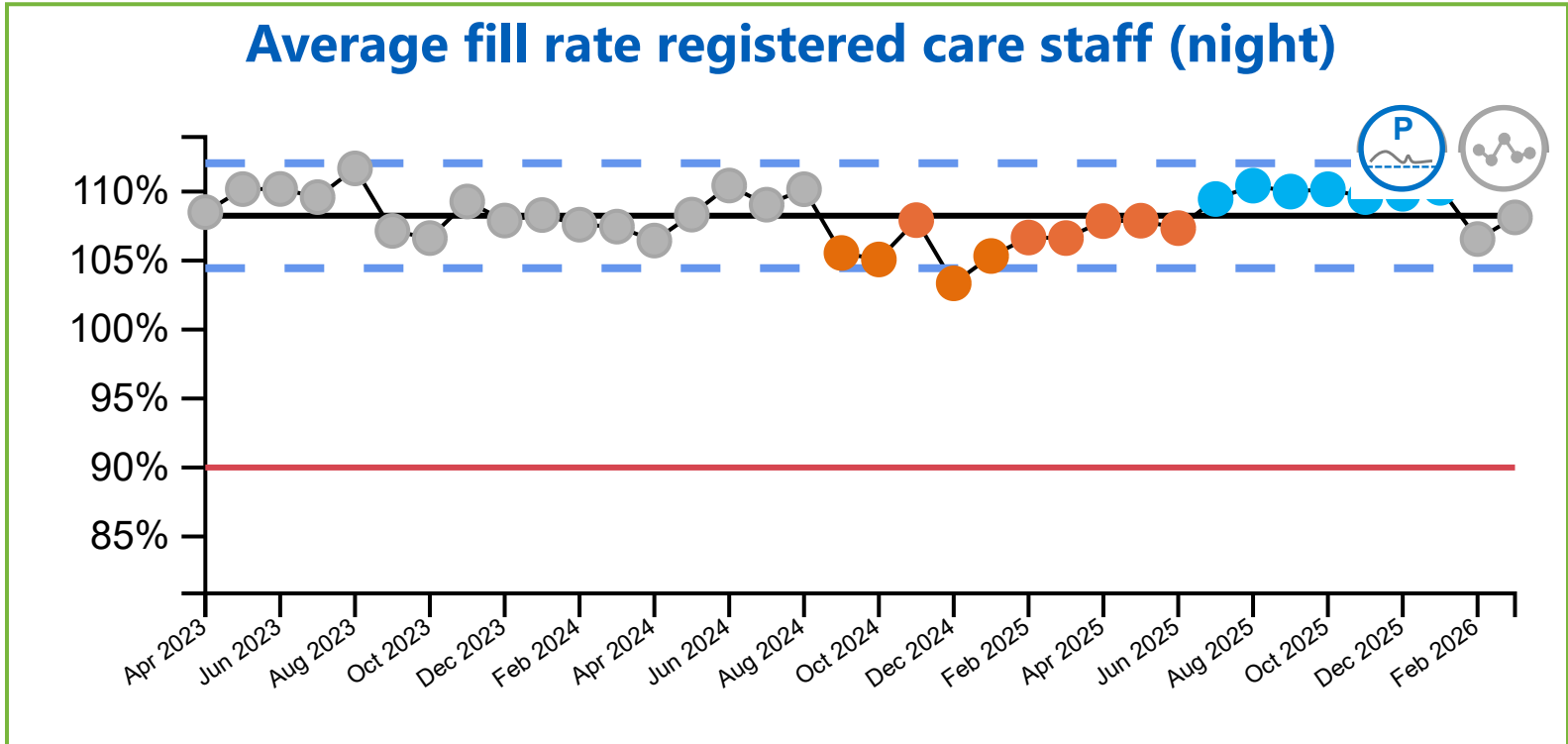
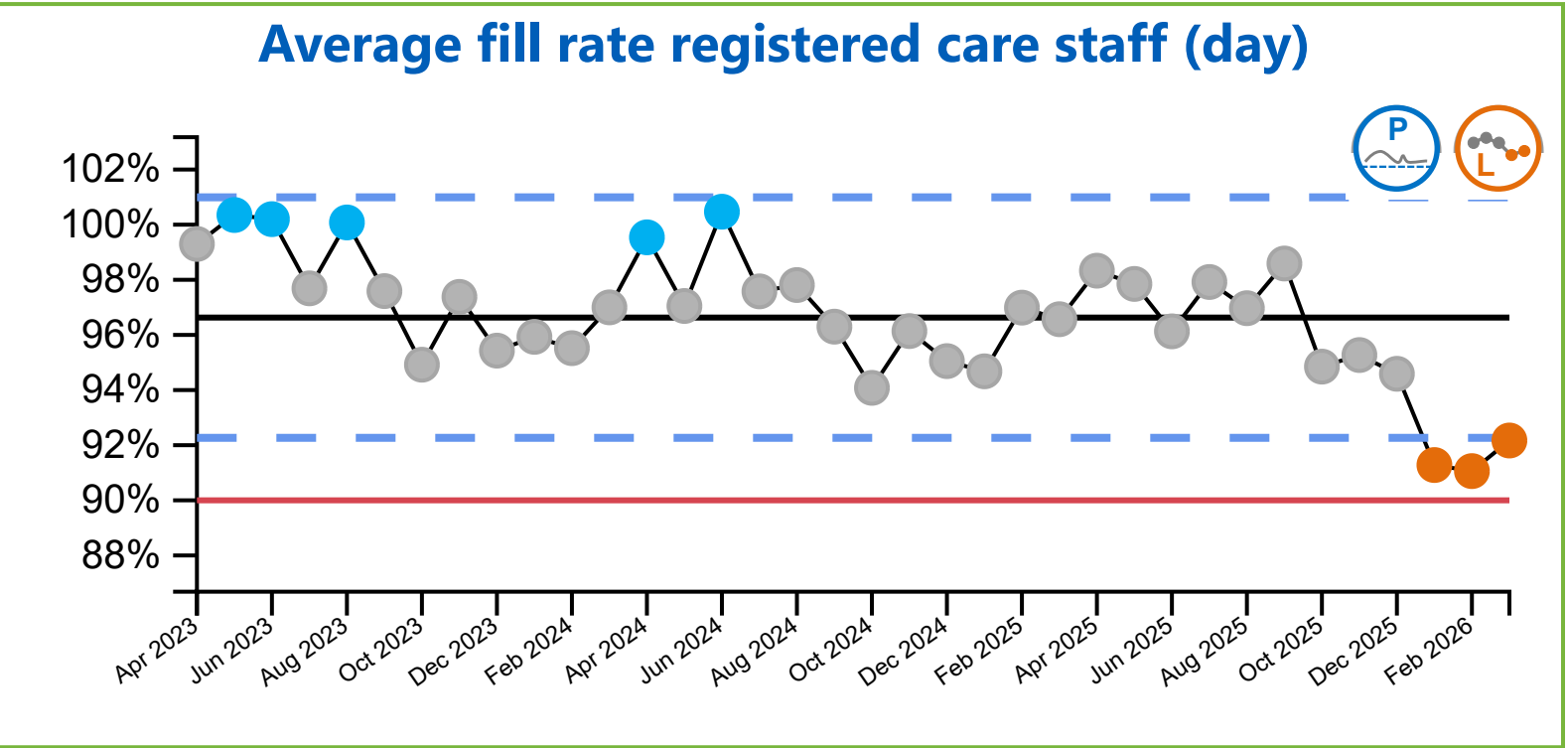
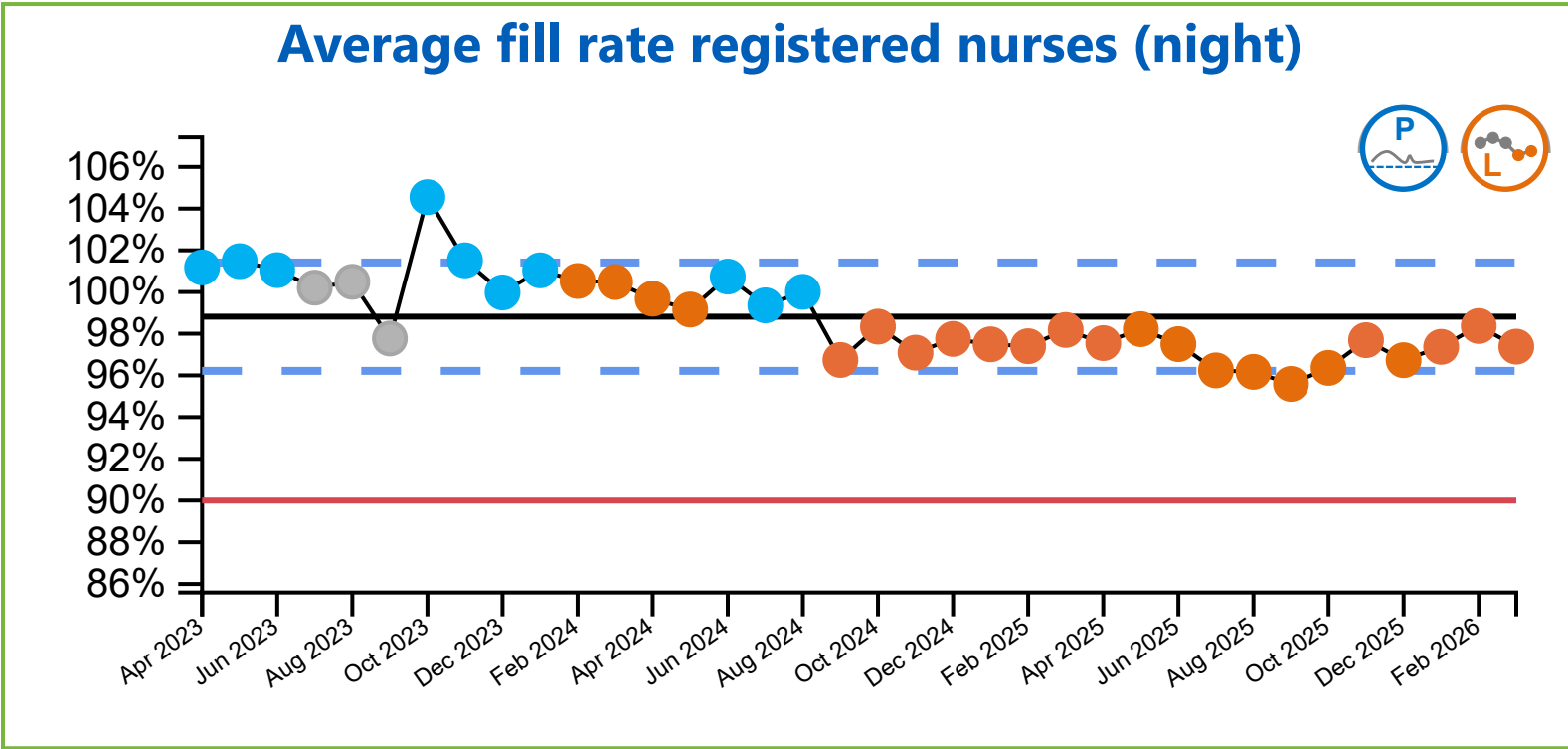
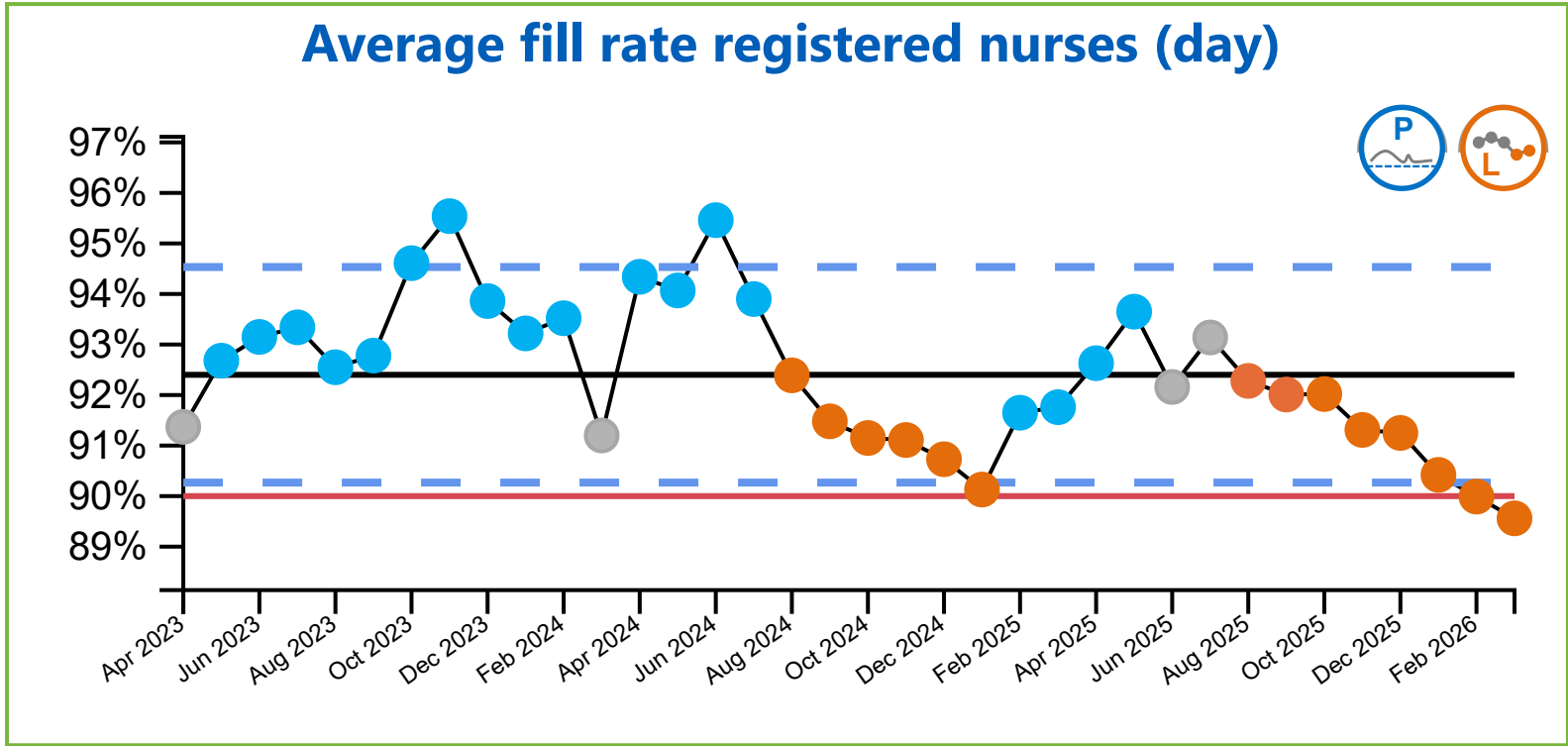
Assurance

Nursing and Midwifery staffing - The overall percentage fill rate for RNs for days was 89.56% and nights was 97.38%. The overall percentage fill rate for CSW for days was 97.38% and nights was 108.1%.

Infection Control - The end of year position has shown a good performance in healthcare associated infection rates (in terms of HCAs acquired in ELHT). The Trust had a similar number of C. difficile infections as last year, 99 against an expected trajectory of 100. Klebsiella and Pseudomonas bacteraemia case numbers are just over trajectory. There has been a substantial decrease in E. coli bacteraemia cases compared to last year.This improvement is impressive, given high activity in the Trust in the last year. Although there were two MRSA bacteraemia cases on a trajectory of zero,



C diff		
In month (Blank)	YTD 98	Same time last year 96
E coli		
In month (Blank)	YTD 124	Same time last year 144
Klebsiella		
In month (Blank)	YTD 42	Same time last year 58
Pseudomonas		
In month (Blank)	YTD 12	Same time last year 10
MRSA		
In month (Blank)	YTD 4	Same time last year 2



In month >

Never events
(Blank)

Serious incidents reported to PSIRF
(Blank)

Medication errors moderate harm and above
(Blank)

Slips trips falls moderate harm or above
(Blank)

YTD >

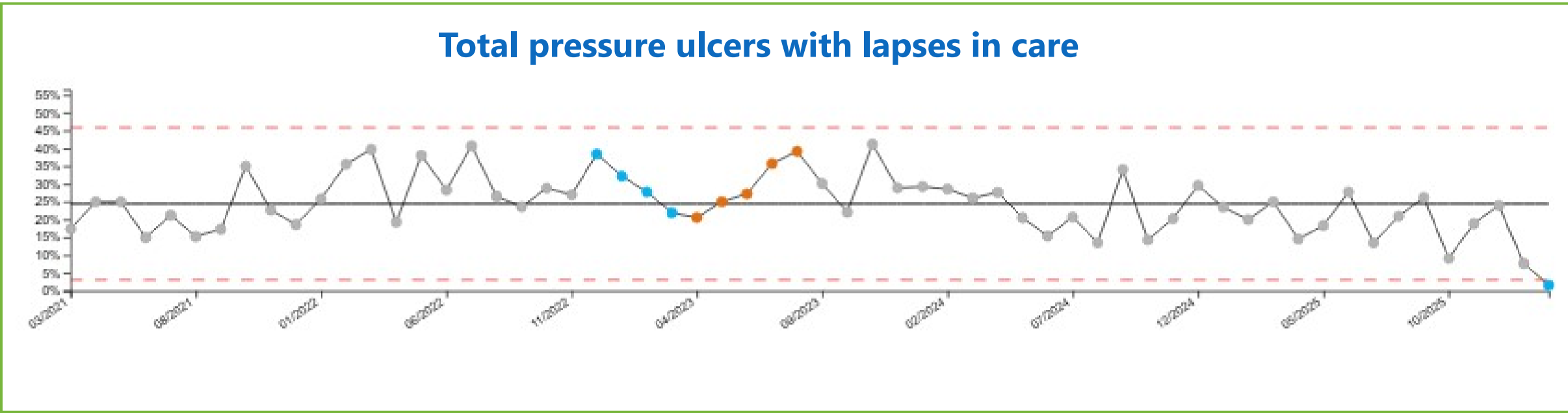
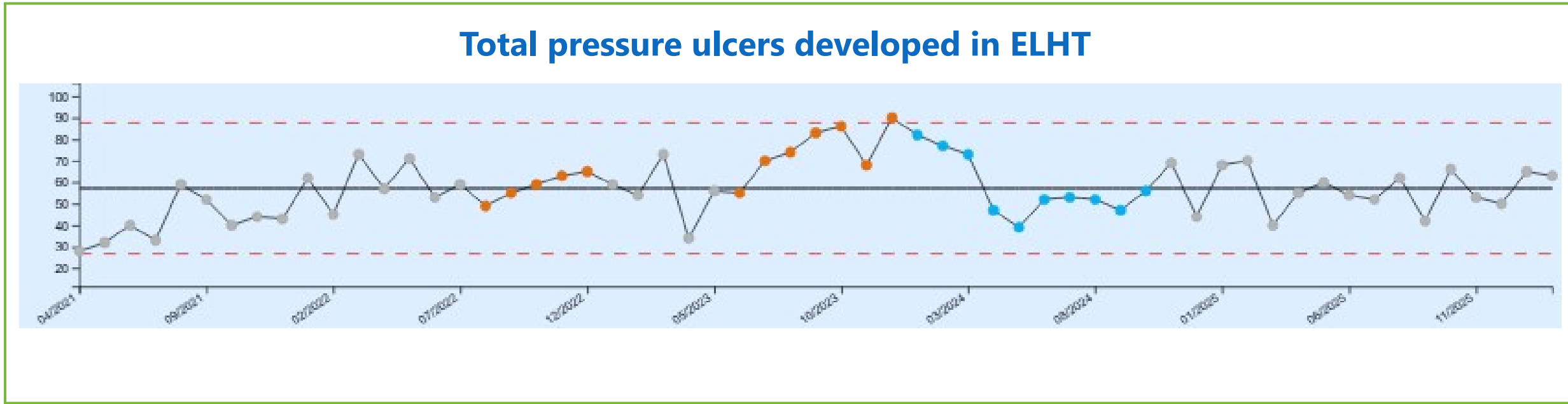
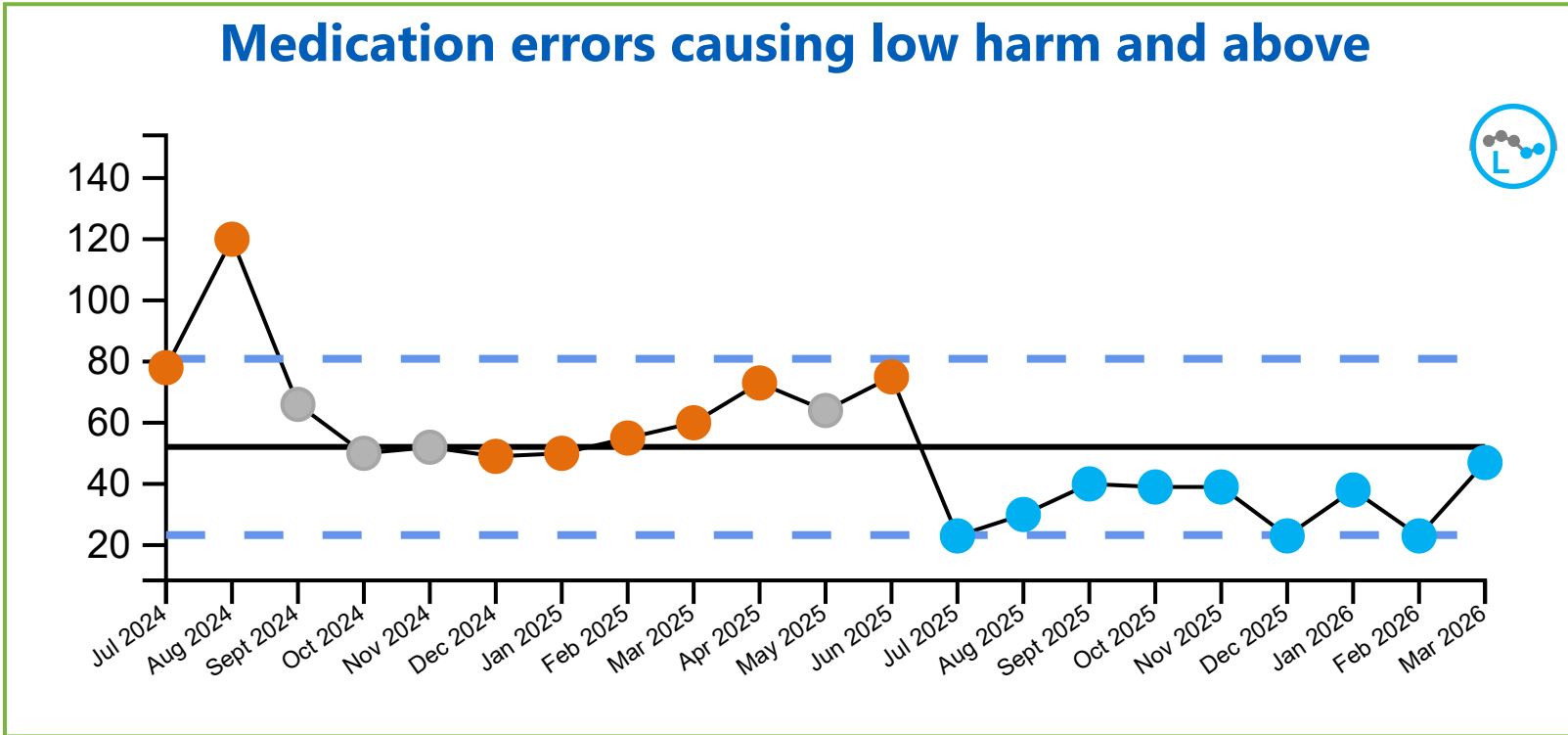
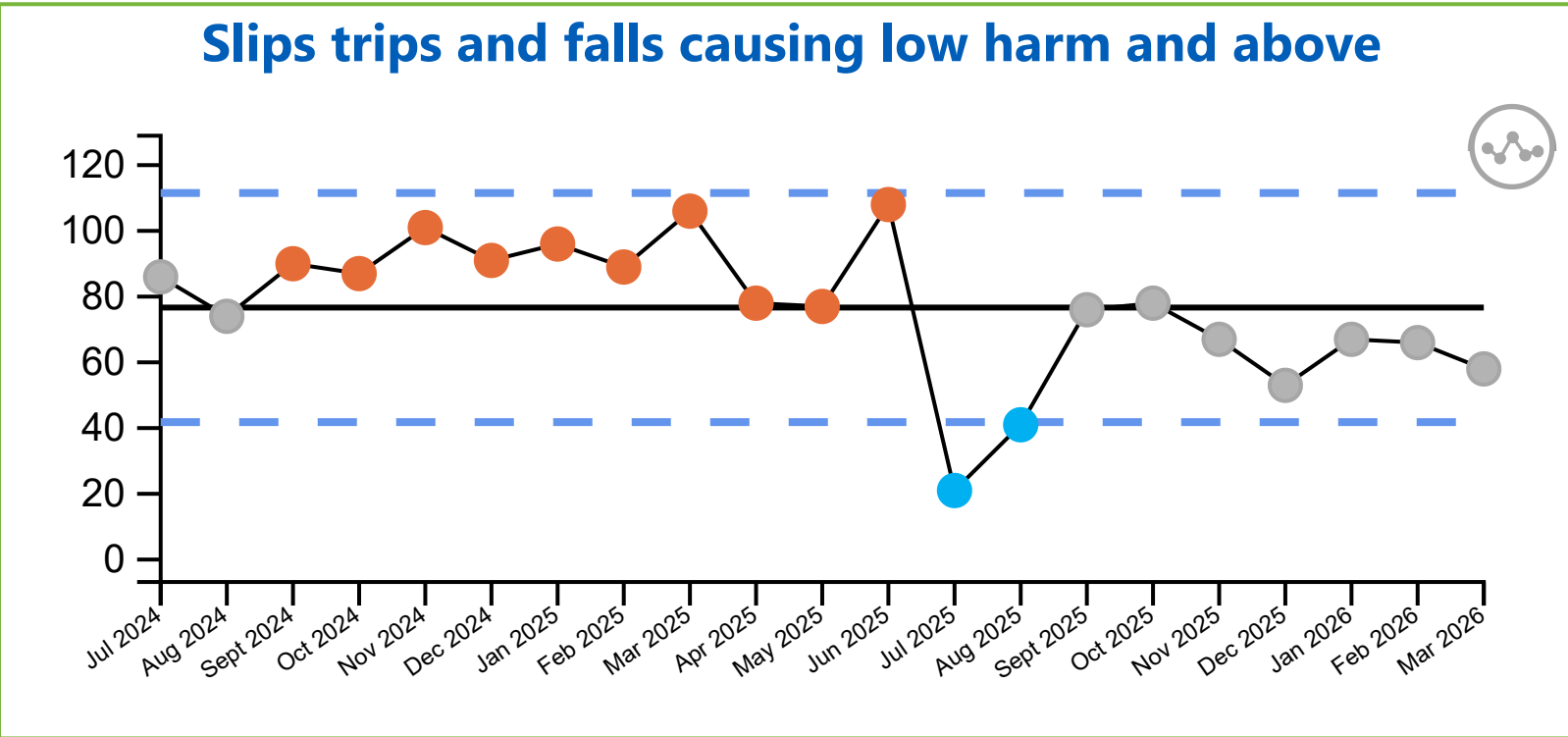
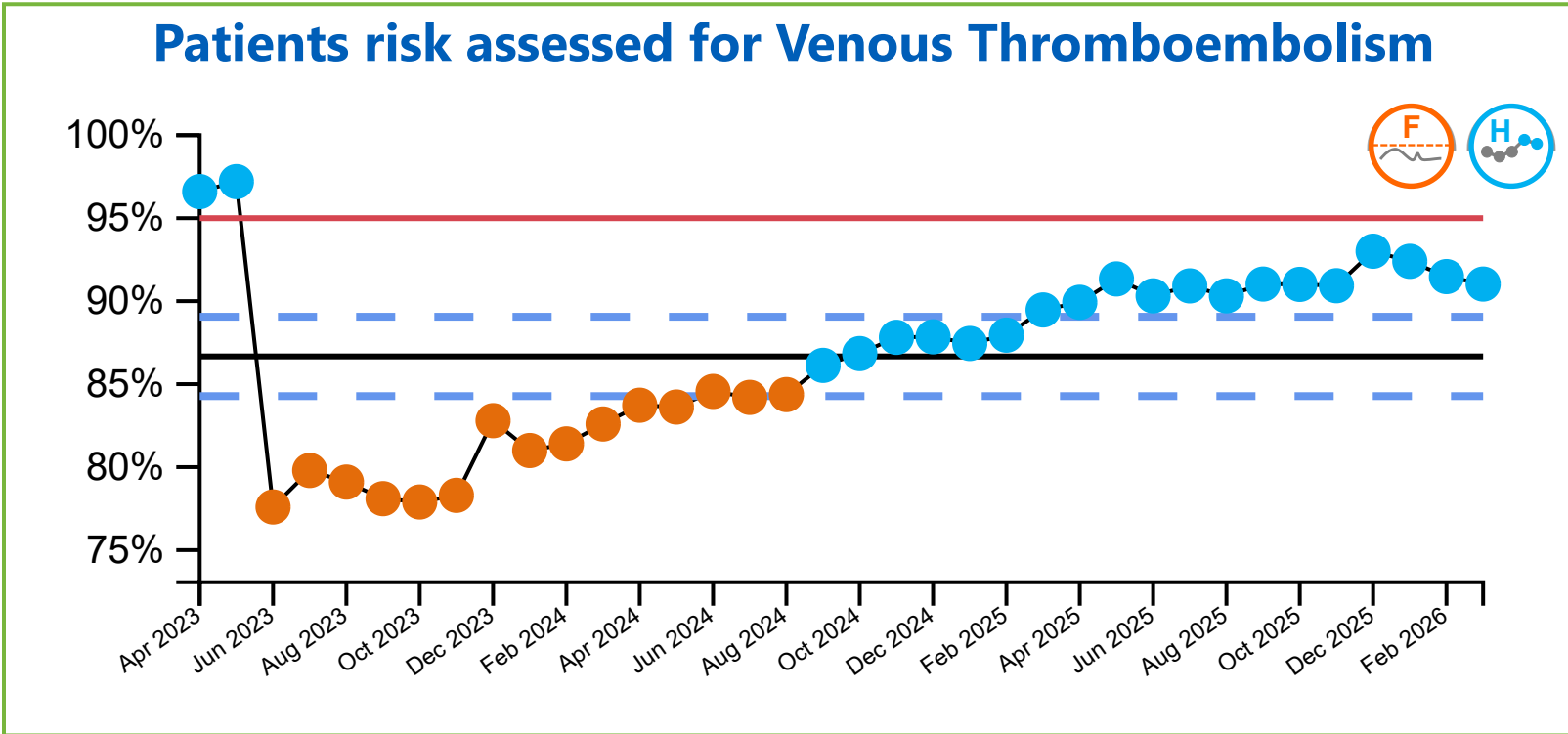
Never events
4

Serious incidents reported to PSIRF
38

Medication errors moderate harm and above
18

Slips trips falls moderate harm or above
34

CAS alerts - Non-compliance
(Blank)



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

METRIC	LATEST DATE	VALUE	TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 26	74.41%	90.00%		
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 26	95.65%	90.00%		
COMPLAINTS RATE PER 1000 CONTACTS	MAR 26	0.32	0.40		
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 26	93.26%	90.00%		
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 26	85.94%	90.00%		
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	MAR 26	93.14%	90.00%		

Alert

The positive rating for A&E FFT score has improved from 72% to 74%, close to the national average at 79% (February 2026). Operational pressures can influence the quality of patient experience and hence the ratings offered. Maintaining alignment with national the trend is a notable achievement given sustained operational pressures. However, closing the 5% gap remains a priority to reach parity with peers. After 8 months of significant deterioration the latest month has now returned to usual variation.

Action: UEC Improvement Board in place with 5 workstreams focused on Clinical Operating Standards, Length of Stay, Weekend Discharges, Job Planning, Virtual Ward, the aim is to eradicate corridor care and long waits in ED.

By When: 13th December 2026. **Owner** - These work streams have Executive Director SROs for each program of works

Maternity services positive ratings (86%) remain lower that the Trust’s internal benchmark (of 90%) and national average of 92% (February 2026). Following a sustained period of improvement, performance has returned to normal variation.

Action: The Division are reviewing their FFT data to establish the themes and trends, to implement actions to improve the patient experience.

By When: June 26 **Owner** - Divisions via patient experience group

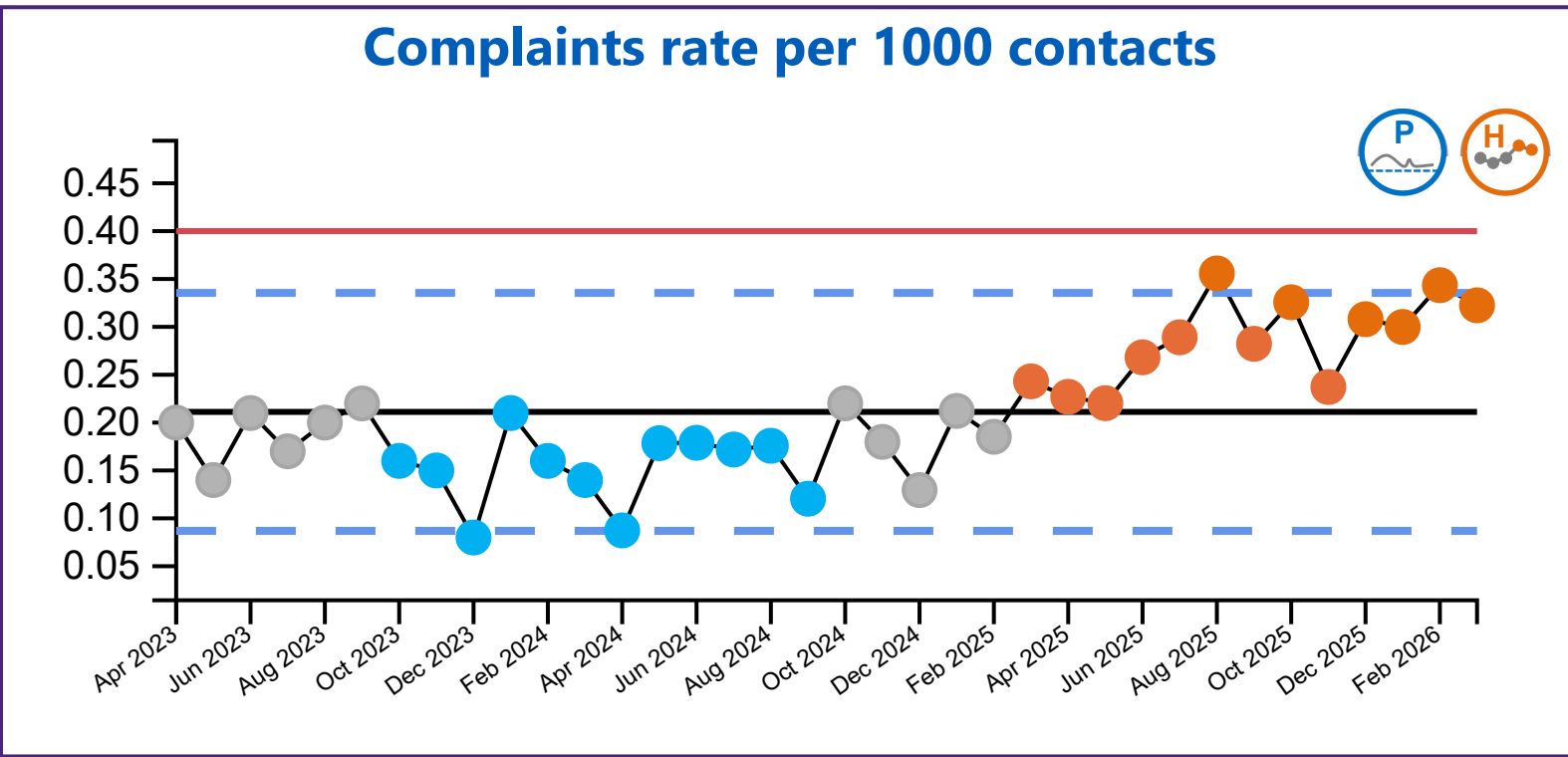
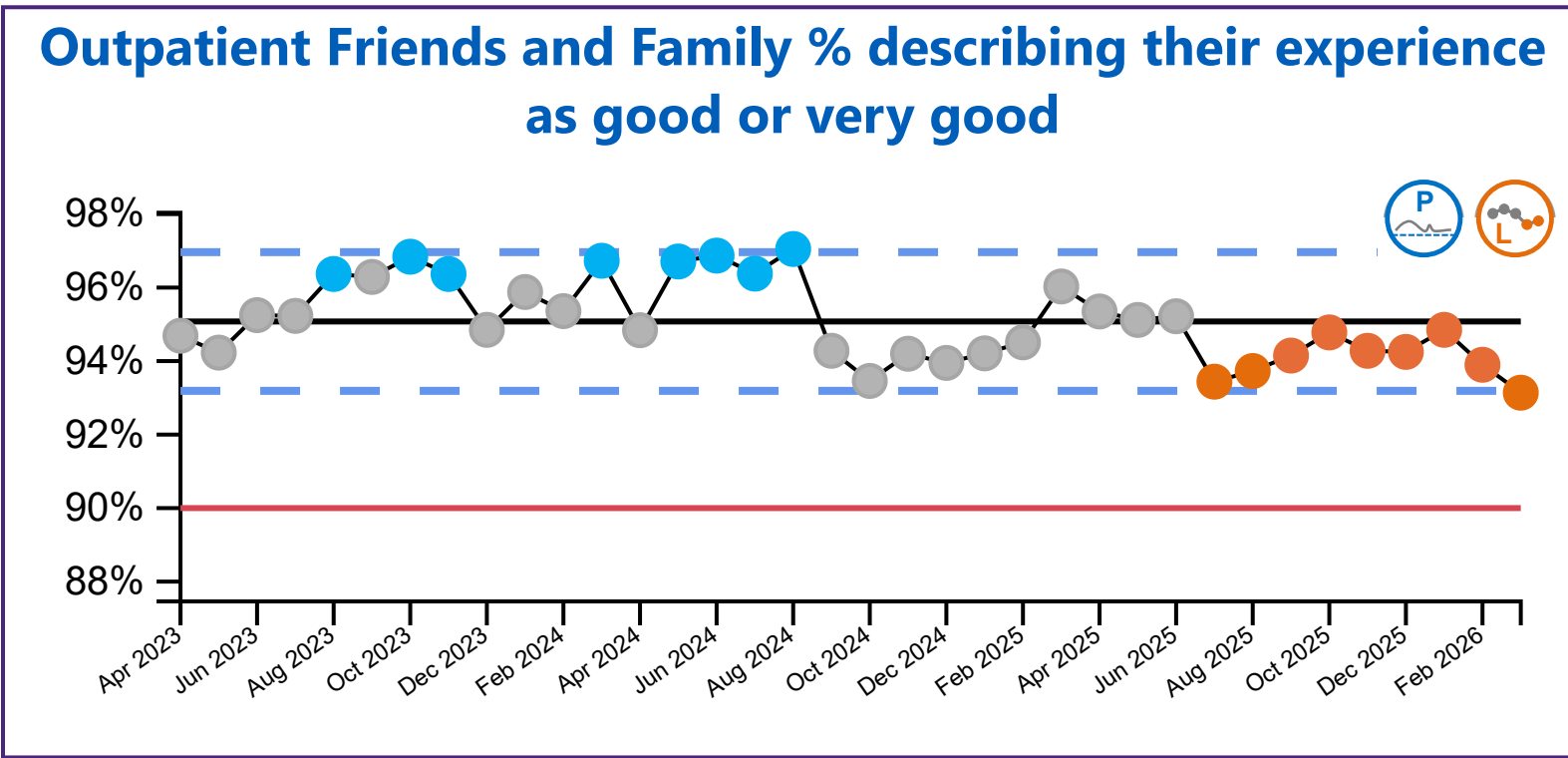
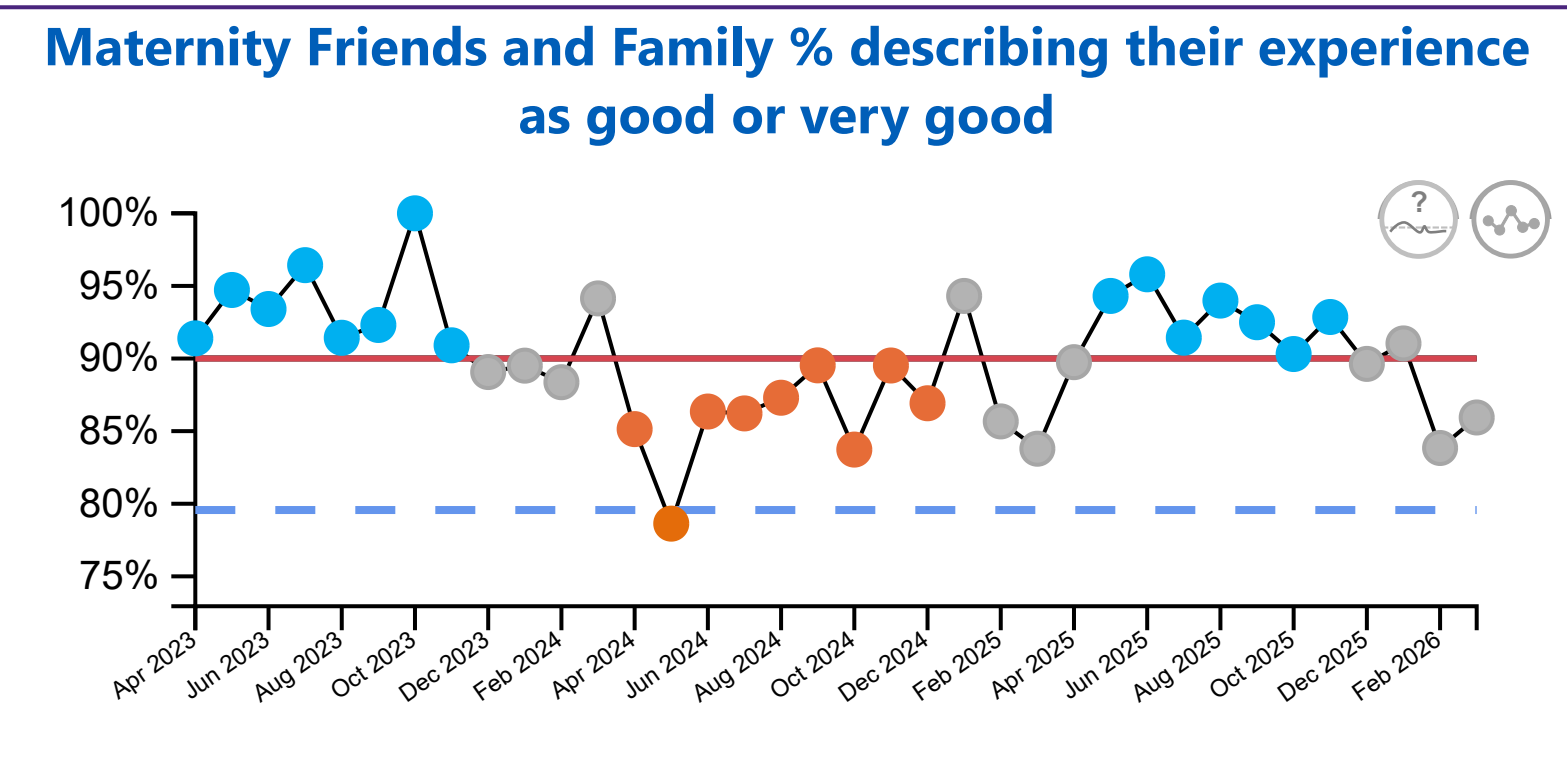
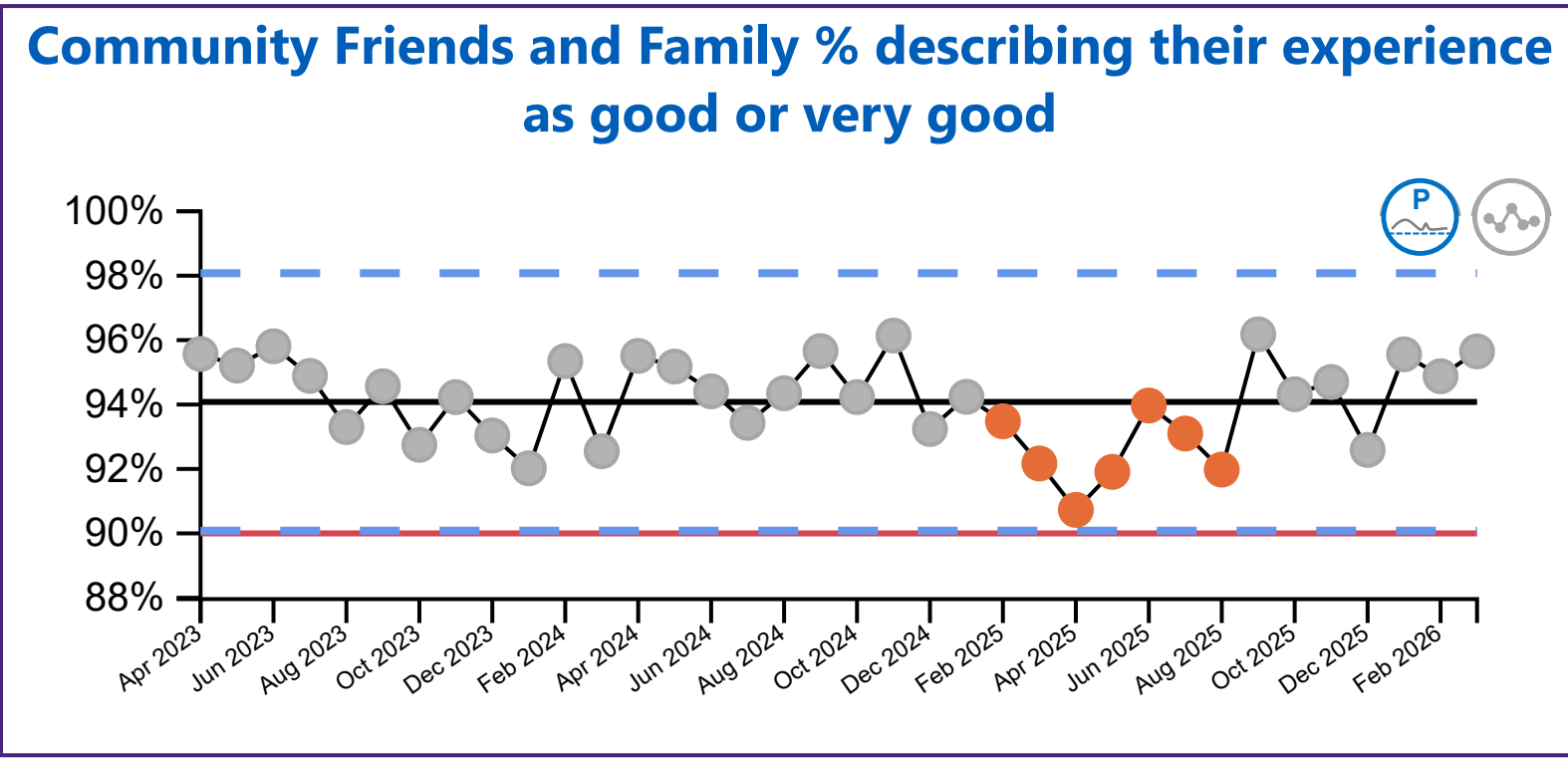
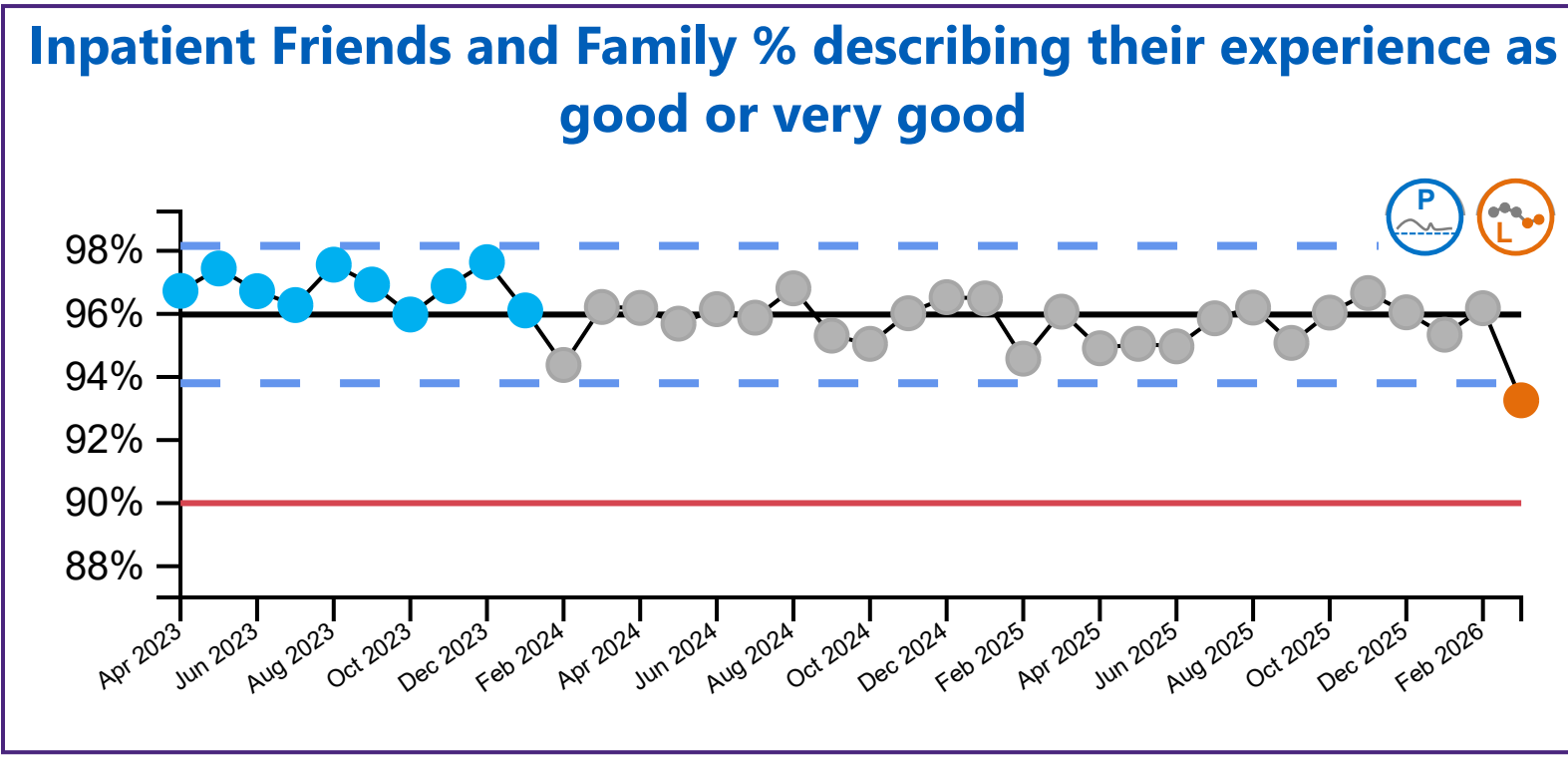
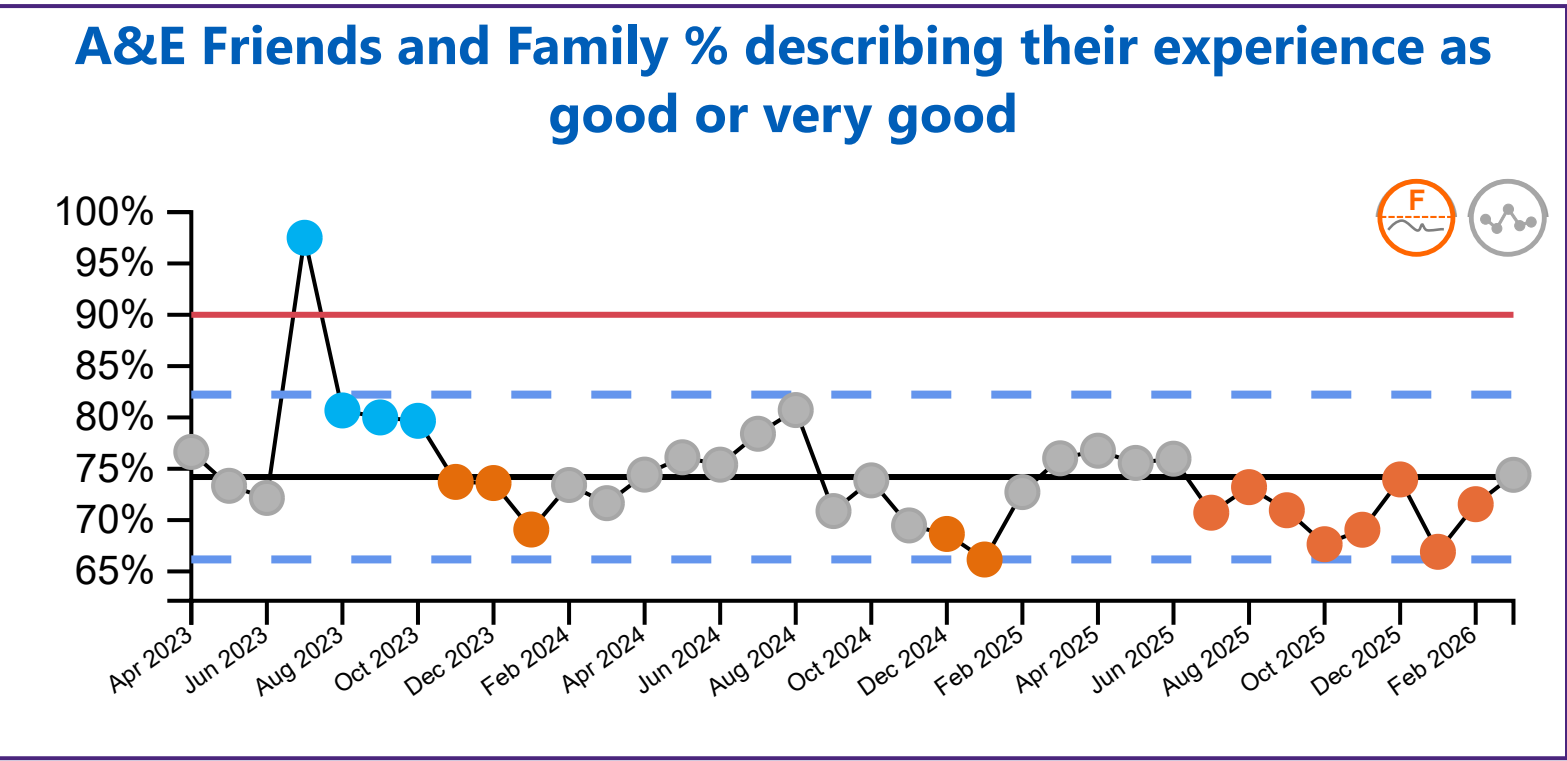
Advise

FFT scores are monitored at Divisional, Directorate, and Ward/Outpatient level, enabling teams to analyse themes and trends alongside their patient-experience and care-improvement initiatives. In addition, FFT feedback is used by specialist services, such as the Palliative Care and the Bereavement team, to benchmark performance and inform service developments in collaboration with wards across the Trust.

The complaint rate remains below the target, however, is showing significant deterioration. The Customer Relations continue to monitor the themes and trends from the areas the complaints are emanating from to support staff to introduce approaches to minimise complaints.

Assurance

FFT satisfaction rates across Community services remain strong at 96%, exceeding the national average of 94% (February 2026). Satisfaction levels for Inpatient and Outpatient care are also positive, although both sit slightly below the national averages of 95% for Inpatients and 94% for Outpatients. Although still above target Inpatient performance has shown a significant decrease in the latest month. This will need close attention to determine if this is just a blip or the start of a more worrying pattern. Outpatient performance although exceeding target has continued to show deterioration from previous levels with a run of 9 months now below the mean.



EFFECTIVE - Summary Scorecard

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	MAR 26	129.00	
CRUDE MORTALITY RATE	MAR 26	2.65%	
STILLBIRTHS	MAR 26	0.00	

METRIC	LATEST DATE	VALUE
HOSPITAL STANDARDISED MORTALITY RATIO	DEC 25	106.50
MATERNAL DEATHS	MAR 26	0.00
SHMI	OCT 25	1.23

Alert

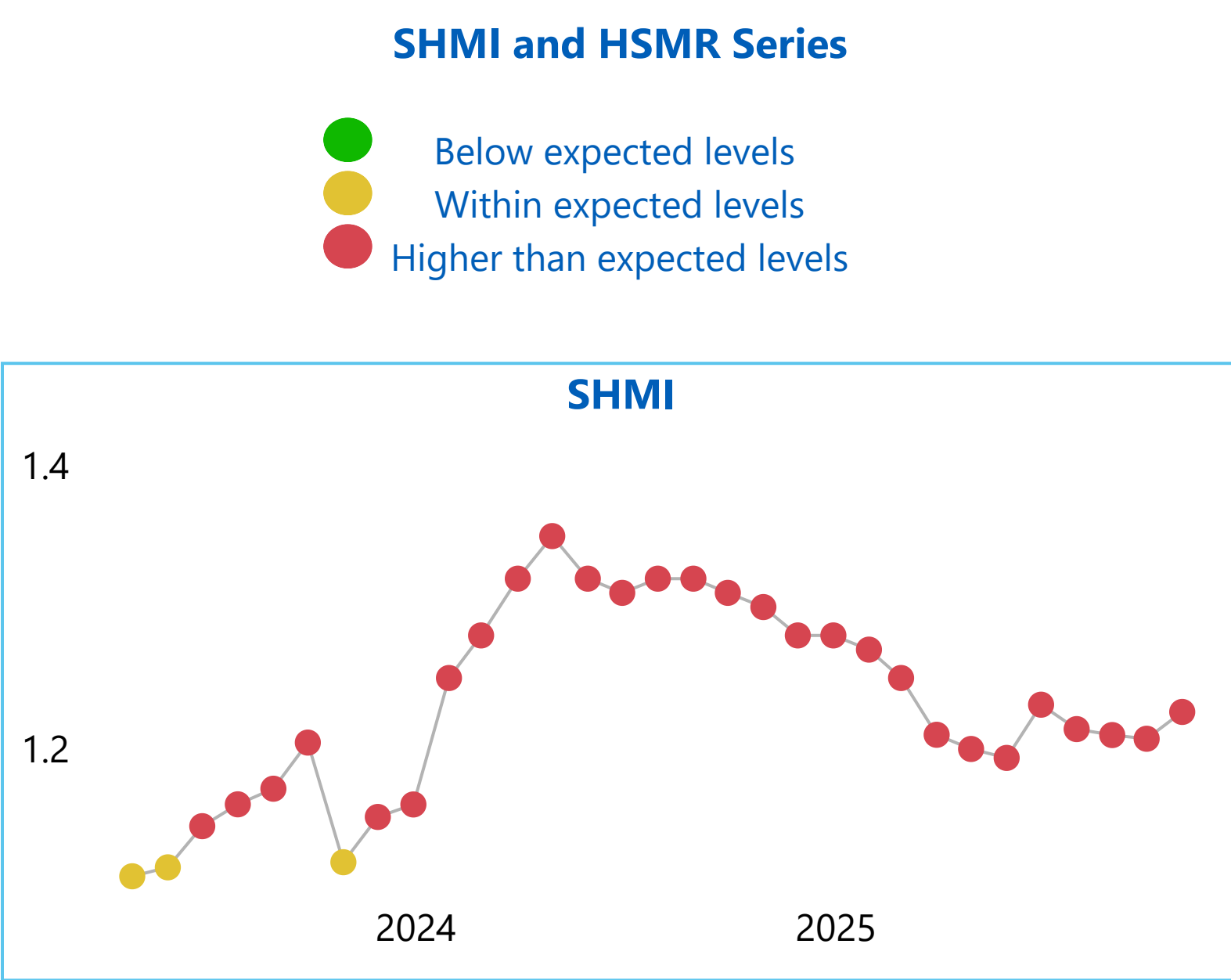
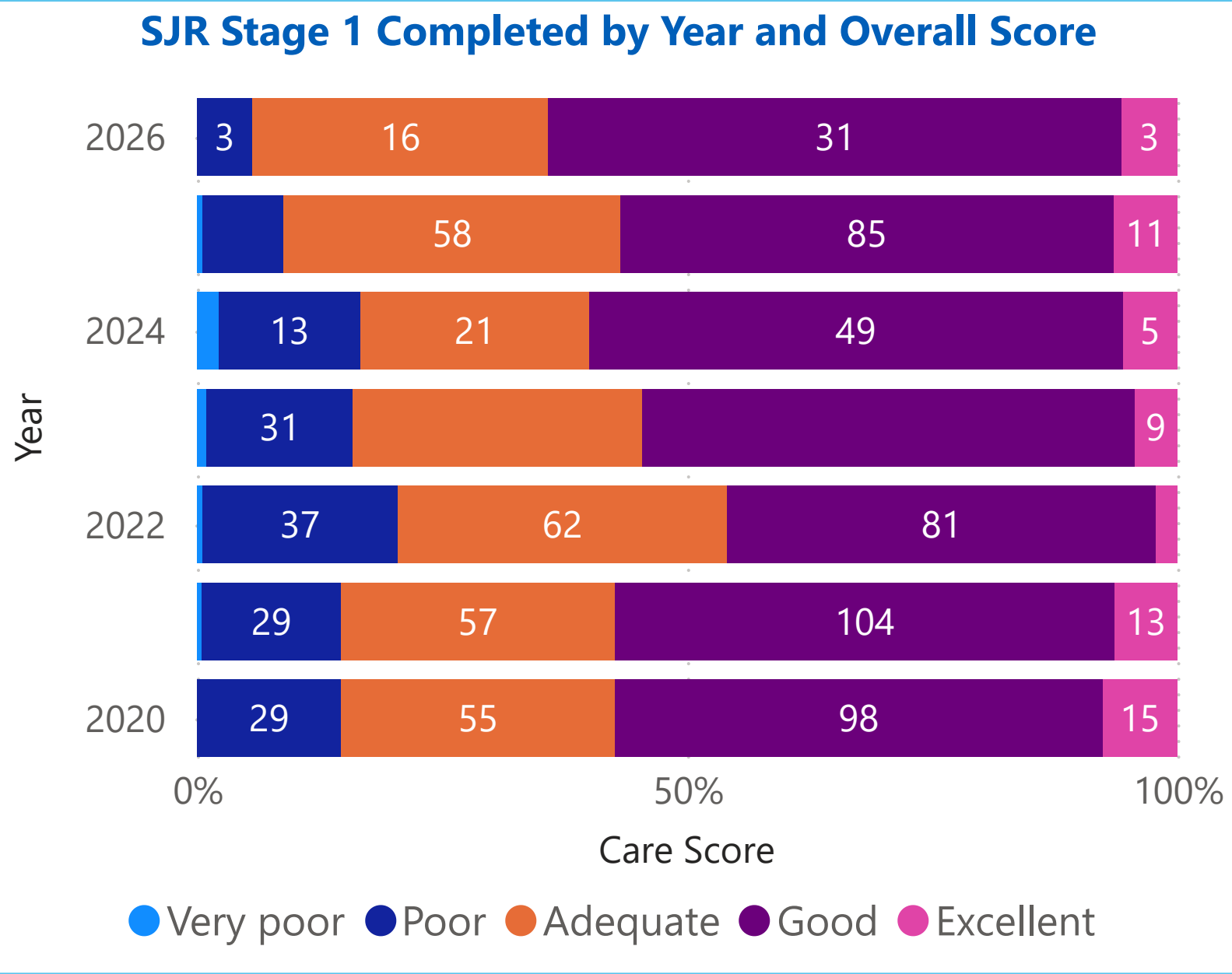
The Trust remains unable to provide full assurance in relation to the HSMR and SHMI mortality indicators due to issues with the impact of inconsistent removal of SDEC activity across NHS Trusts. Current SHMI is 1.23, which is above expected. As expected the decrease seen over the last 12 months related to the elimination of uncoded data has now plateaued.. Current HSMR+ is 106.5, 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 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.

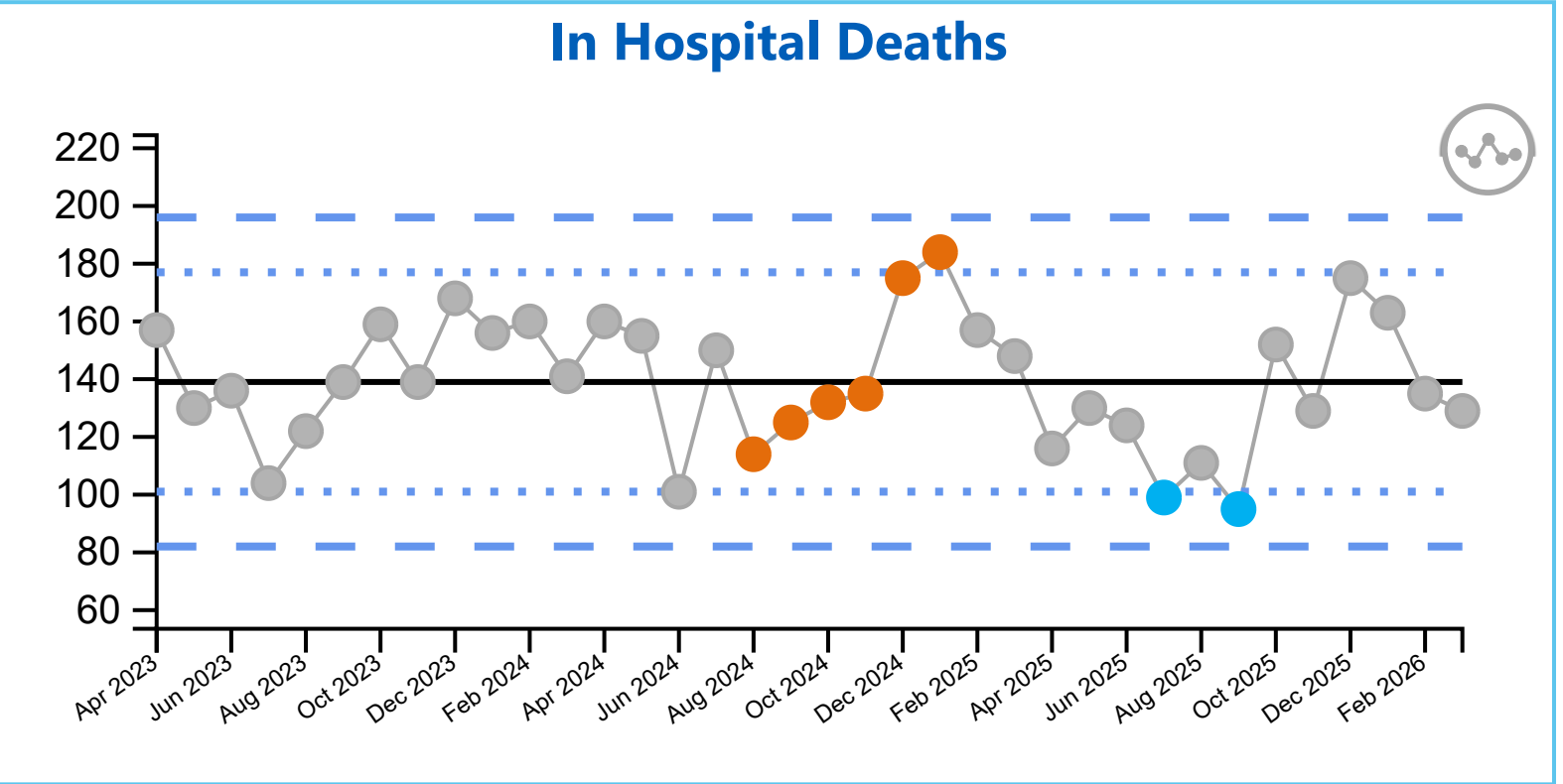
Assurance

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

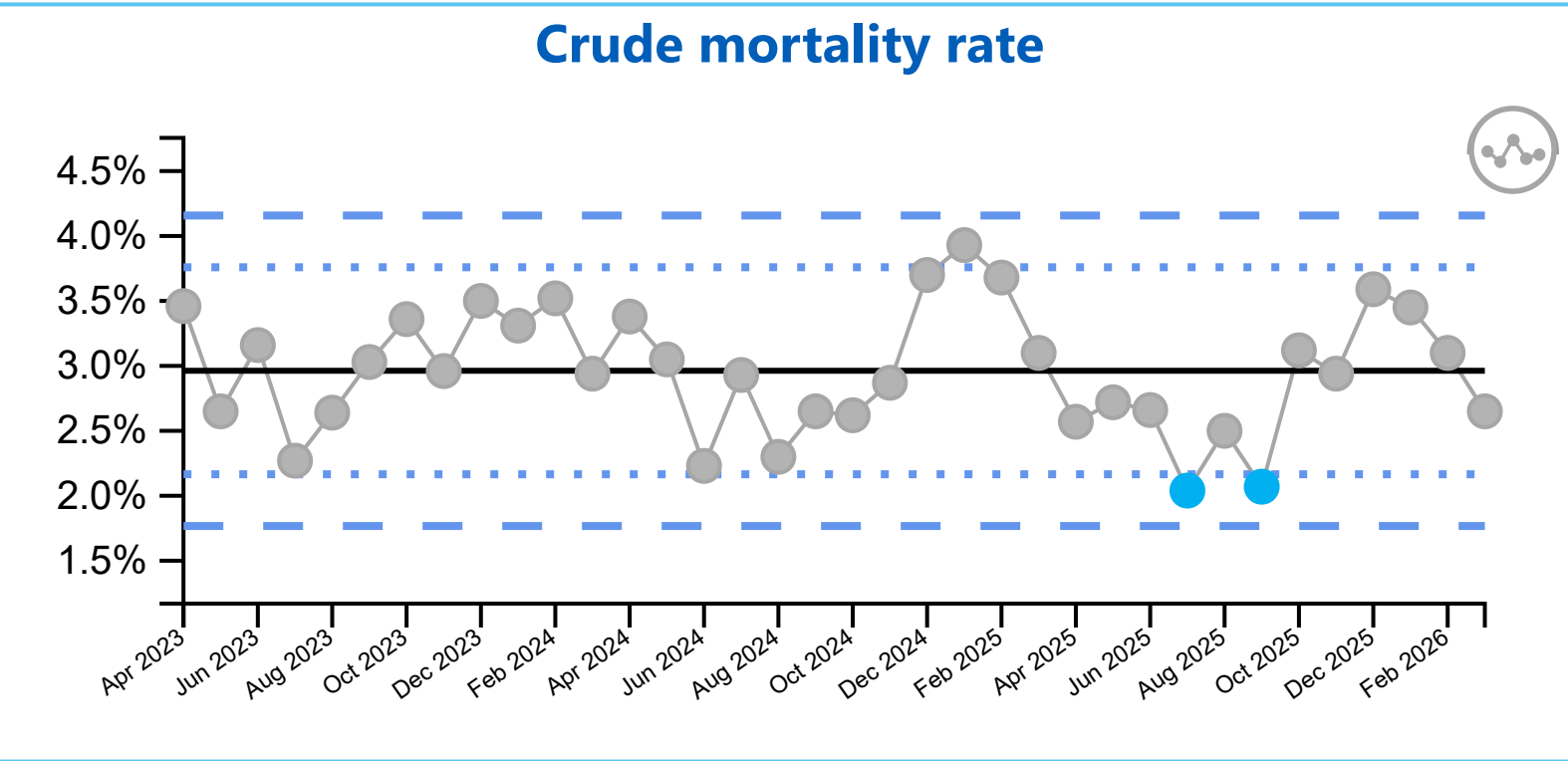
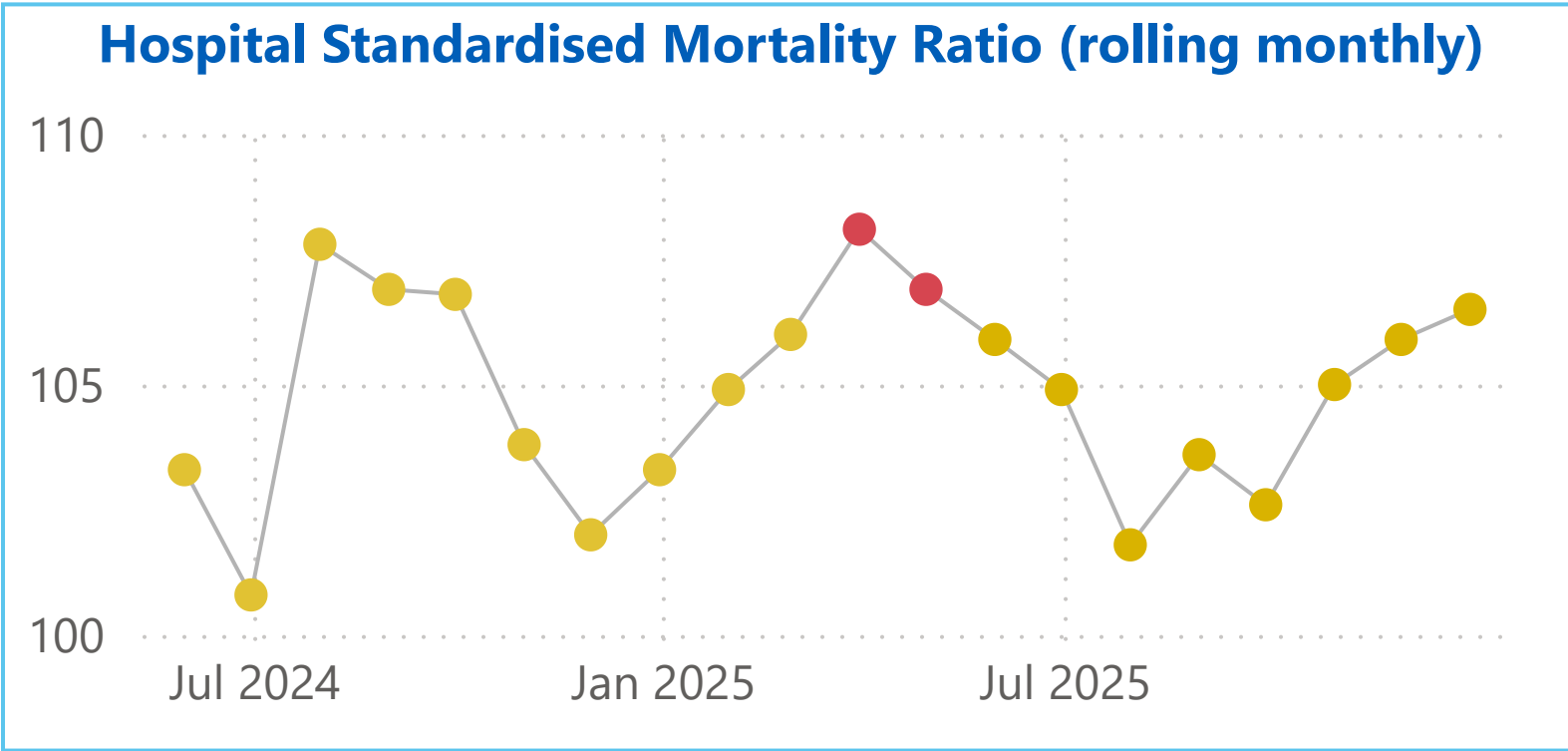


Learning Disability Mortality Reviews

2 deaths in March 2026. 1 adult death reported to LeDeR and ELHT review completed. No actions to note. 1 child death reported. No outstanding deaths for review.



Stillbirths		
In month (Blank)	YTD 24	Same time last year 30
Maternal deaths		
In month (Blank)	YTD 1	Same time last year 1



Metric	Latest Date	Value	Monthly Trajectory	Year End Target	Variation
28D General FDS	FEB 2025	82.90	76.00	80.00	
62D General Standard	FEB 2025	66.60	73.00	75.00	
A&E 4 HR Performance	MAR 2026	81.33	78.00	78.00	
DM01 % Over 6 Weeks	MAR 2026	4.96	5.00	5.00	
Not Treated Within 28 Days of Last Minute Canc	MAR 2026	2.00	0.00	0.00	
RTT Ongoing % Over 52 Weeks	MAR 2026	0.70	1.60	1.00	
RTT Ongoing % Under 18 Weeks	MAR 2026	69.68	61.70	62.20	
Over 12 Hours in Department %	MAR 2026	12.78	15.20	15.20	

Metric	Latest Date	Value	Variation
% Handovers > 30 Minutes	MAR 26	16.47%	
A&E Attendances	MAR 26	25345.00	
Ambulance Handovers >45 Minutes	MAR 26	85.00	
Bed Occupancy G&A	MAR 26	94.79%	
Cancelled on Day Operations	MAR 26	62.00	
Emergency Average Length of Stay (Excl 0 and 1 Days)	MAR 26	10.85	
Patients Over 62 Days (Urgent GP Referral)	MAR 26	261.00	

Metric	Latest Date	Value	Variation
Average Arrival to Handover	MAR 26	22	
Max Arrival to Handover Time	MAR 26	86	

Metric	Latest Date	Value
RTT Ongoing	MAR 26	48267.00
RTT Over 52 Weeks	MAR 26	338.00
RTT Over 65 Weeks	MAR 26	0.00

Alert

12-Hour Time in Department - March performance was improved at 12.8% against the year end trajectory of 15.2%. After sustained improvement earlier in the year, the position has reverted to typical variation around the 16% mean.

Action: UEC Improvement Board in place with 5 workstreams focused on Clinical Operating Standards, Length of Stay, Weekend Discharges, Job Planning, Virtual Ward, the aim is to eradicate corridor care and long waits in ED. **By When:** 13th December 2026. **Owner** - These work streams have Executive Director SROs for each program of works

Bed occupancy for 14+ and 21+ days is showing significant increase in the last two months, this has been noted to be more across community wards.

Action: Review of Community Wards supported by GIRFT team, weekly clinical Multi-Disciplinary Meetings. **By When:** TBC – action plans currently being finalised. **Owner;** Family and Community Care Group Clinical Leaders

Advise

62-Day Cancer Standard - The Trust did not meet the 62-day cancer our trajectory in February, delivering **66.6%** against the national standard of 70%. This was mainly driven by the backlog of pathology and number of treatments, with a particular challenge for capacity within one stop prostate clinics and colo-rectal services.

Action: Tumour-site-specific recovery plans in place. Ensuring weekly oversight of actions and delays. **By When:** April 2026. **Owner:** Cancer Services Manager

Patients not re-booked within 28 days – There were 2 breaches in March, this was due to lifecycle and consultant leave.

Bed occupancy remains high at 94.79,reflecting the demand for acute beds. Performance across this metric shows normal variation, however, the improvement workstreams in relation to length of stay, weekend discharge and virtual ward should support a reduction bed occupancy.

Ambulance Handover Delays - Following the significant increase seen in January, handover times have now returned to normal variation. Maximum arrival-to-handover time has fallen below the mean and remains within statistical limits.

DM01: Showing an increase to 4.96% following implementation of new radiology system. Performance is anticipated to return to normal levels by April 26.

Assurance

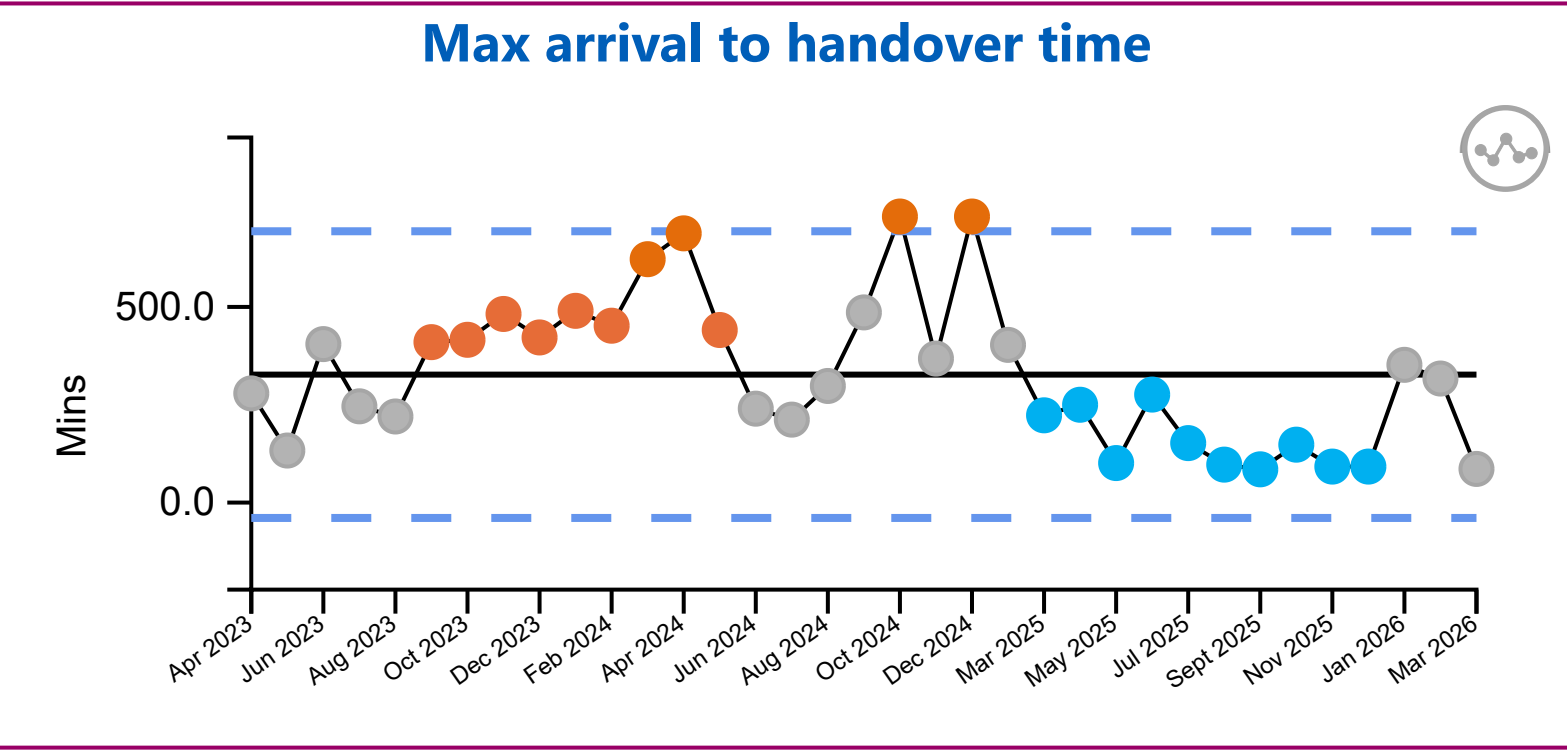
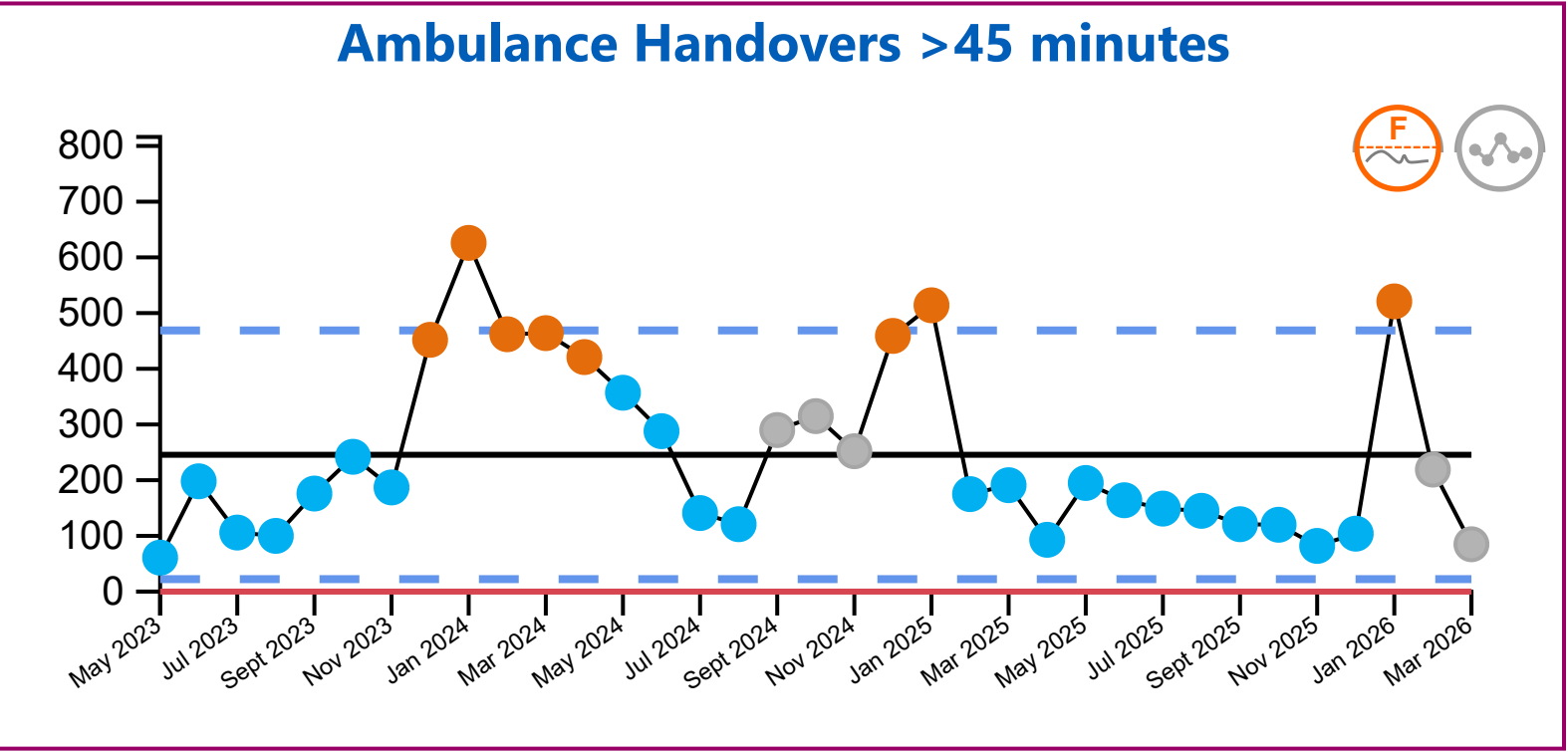
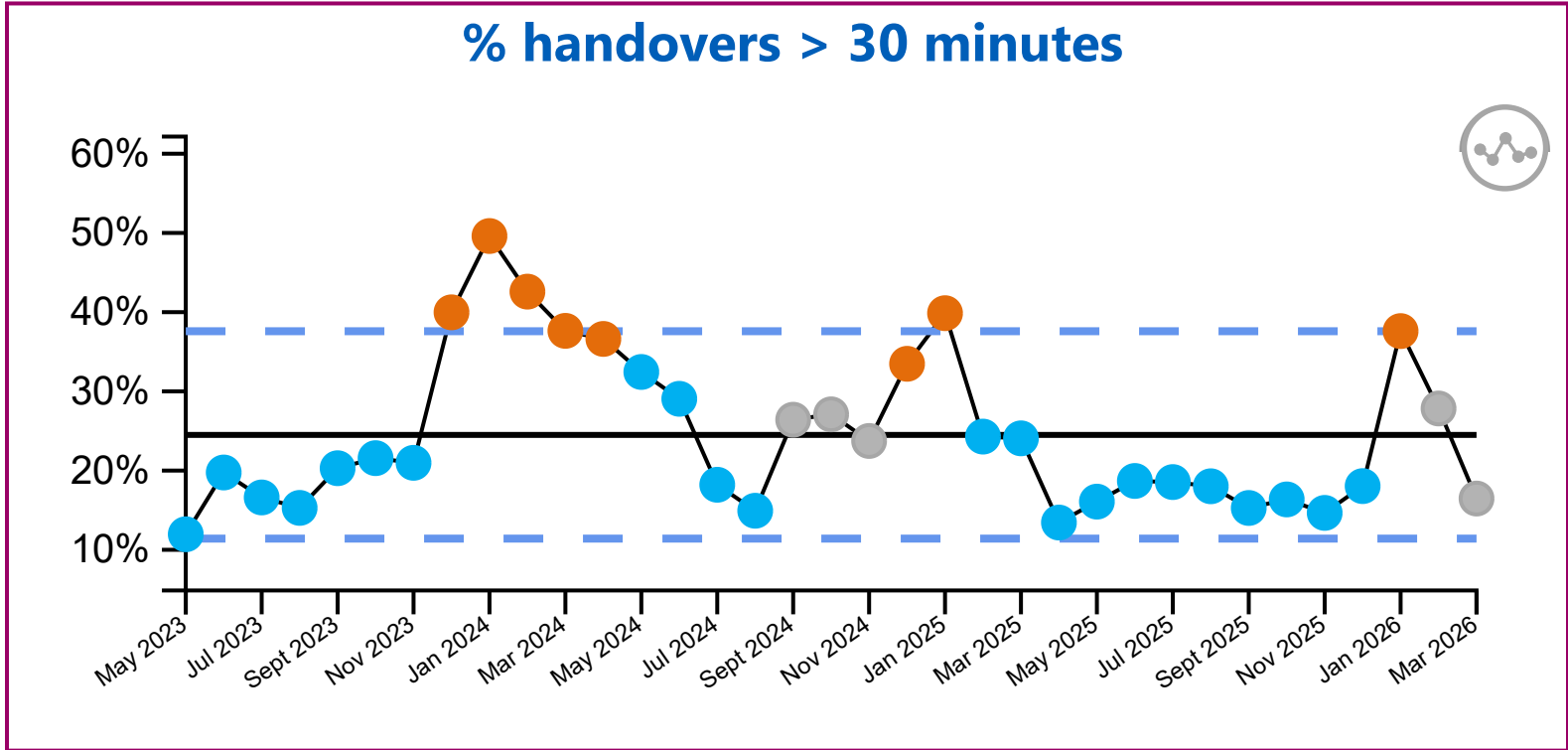
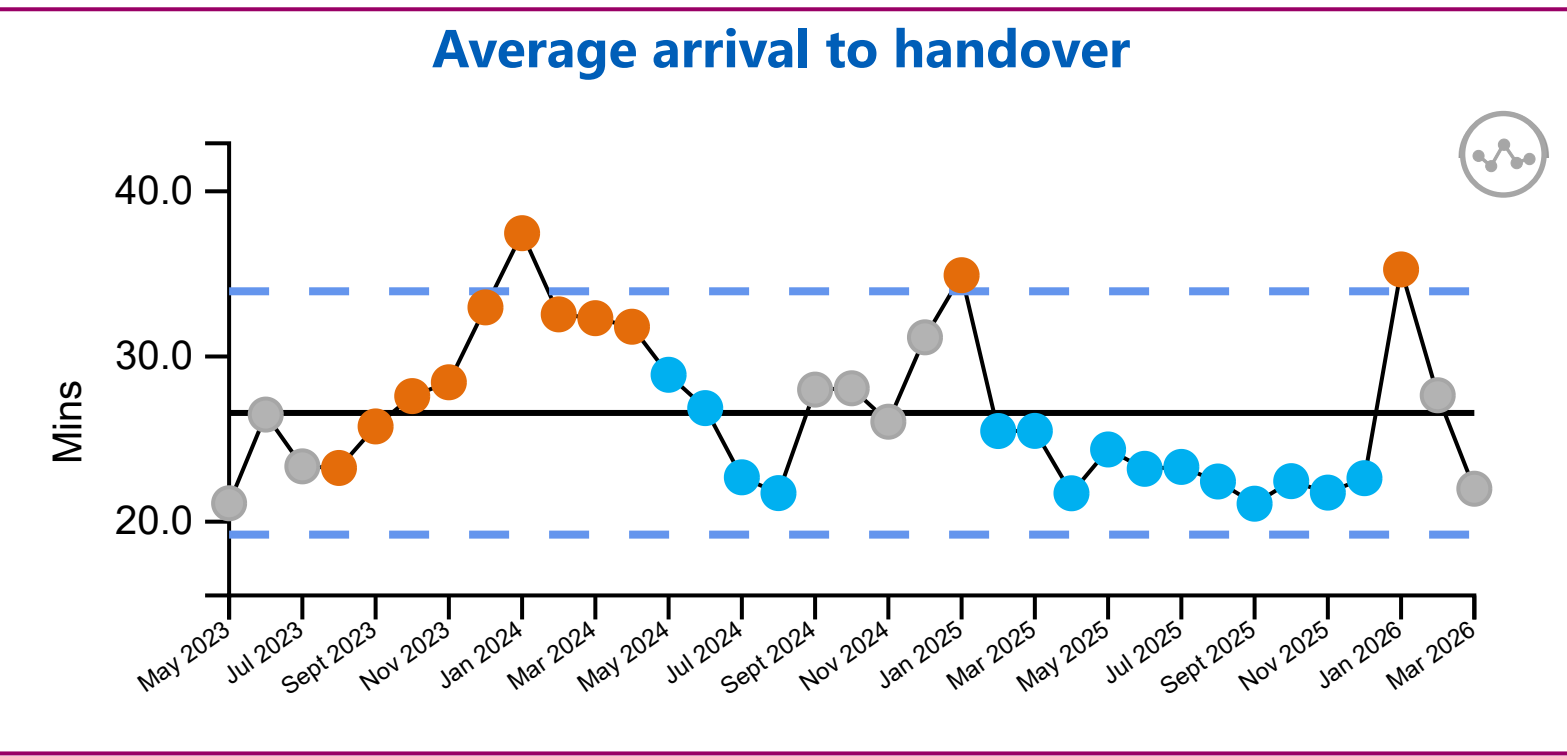
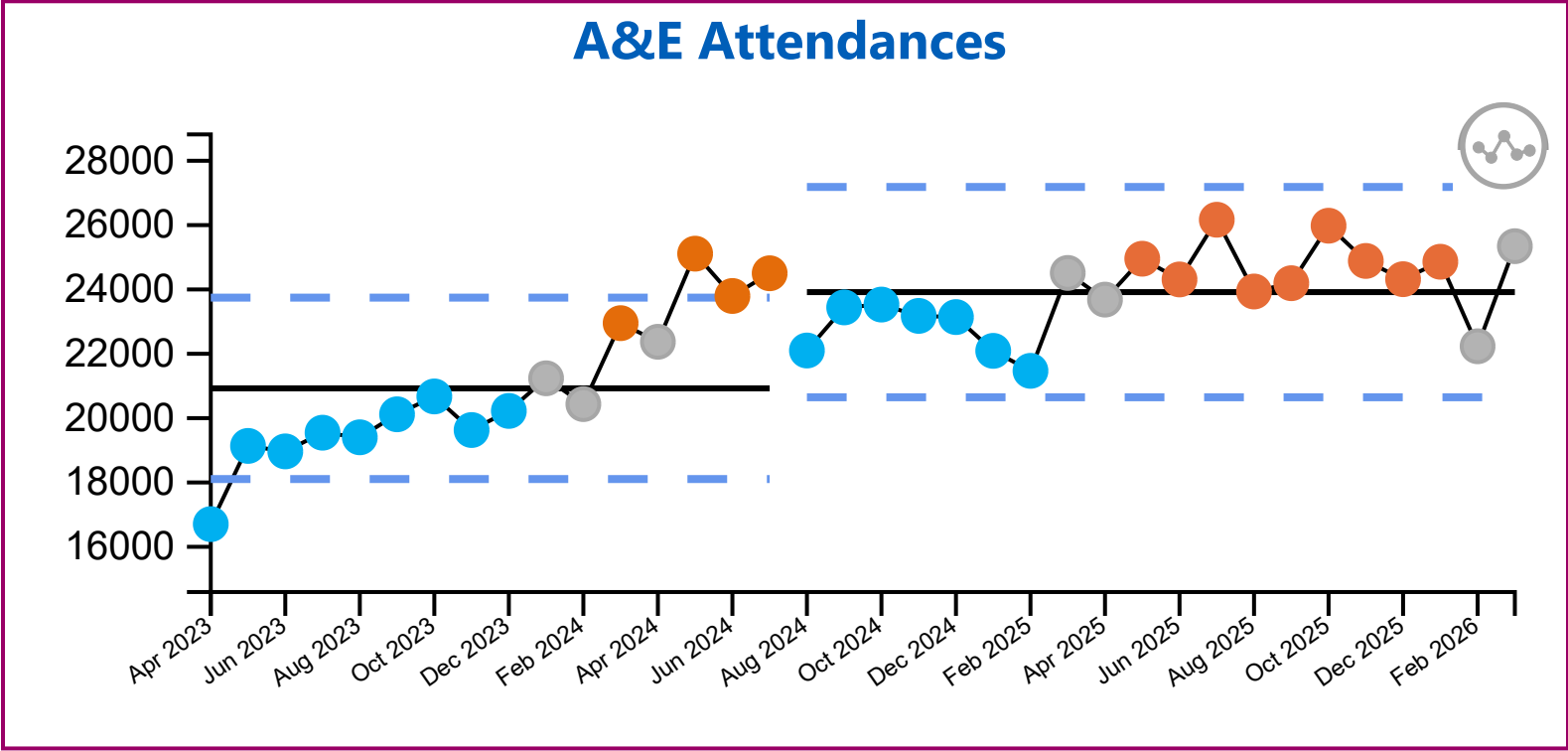
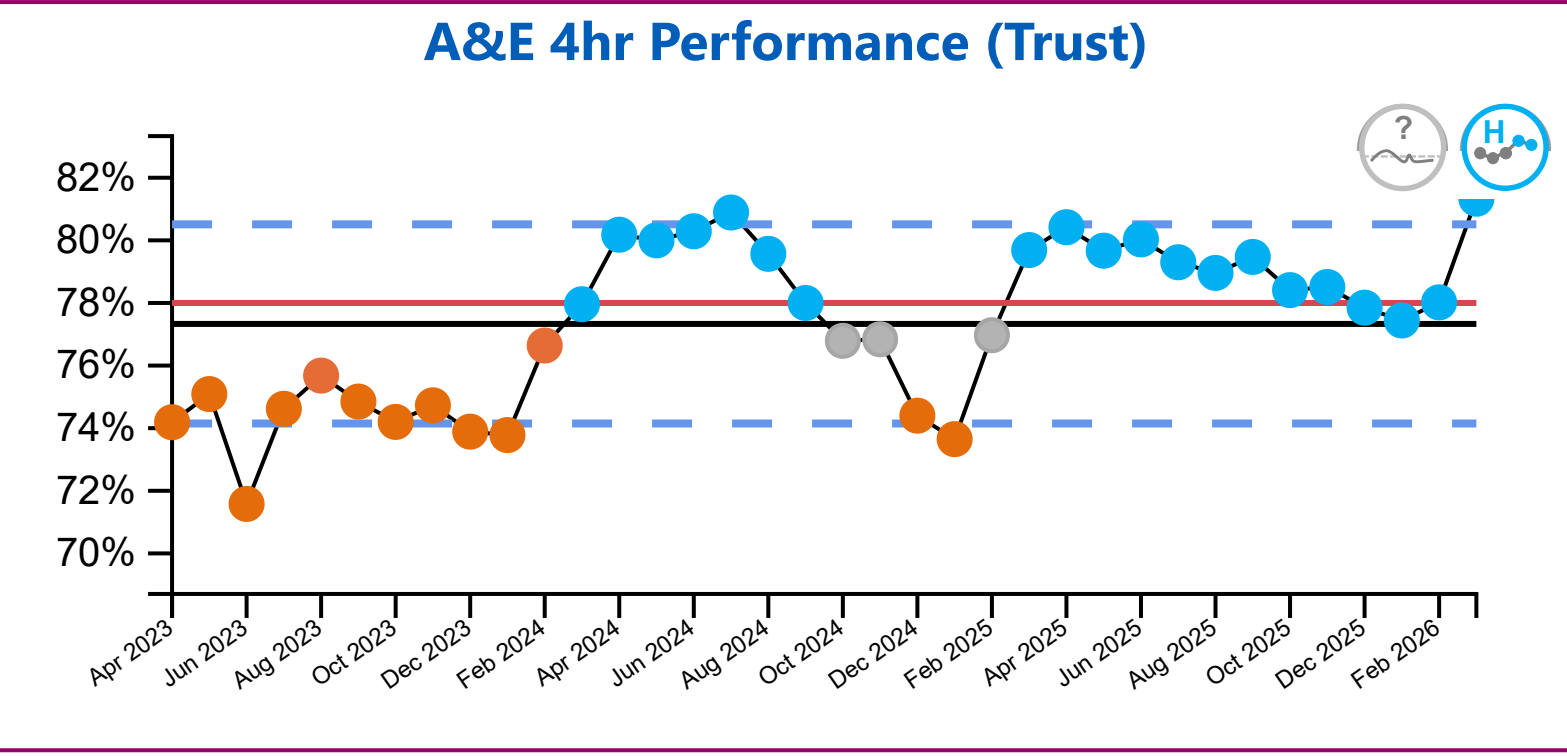
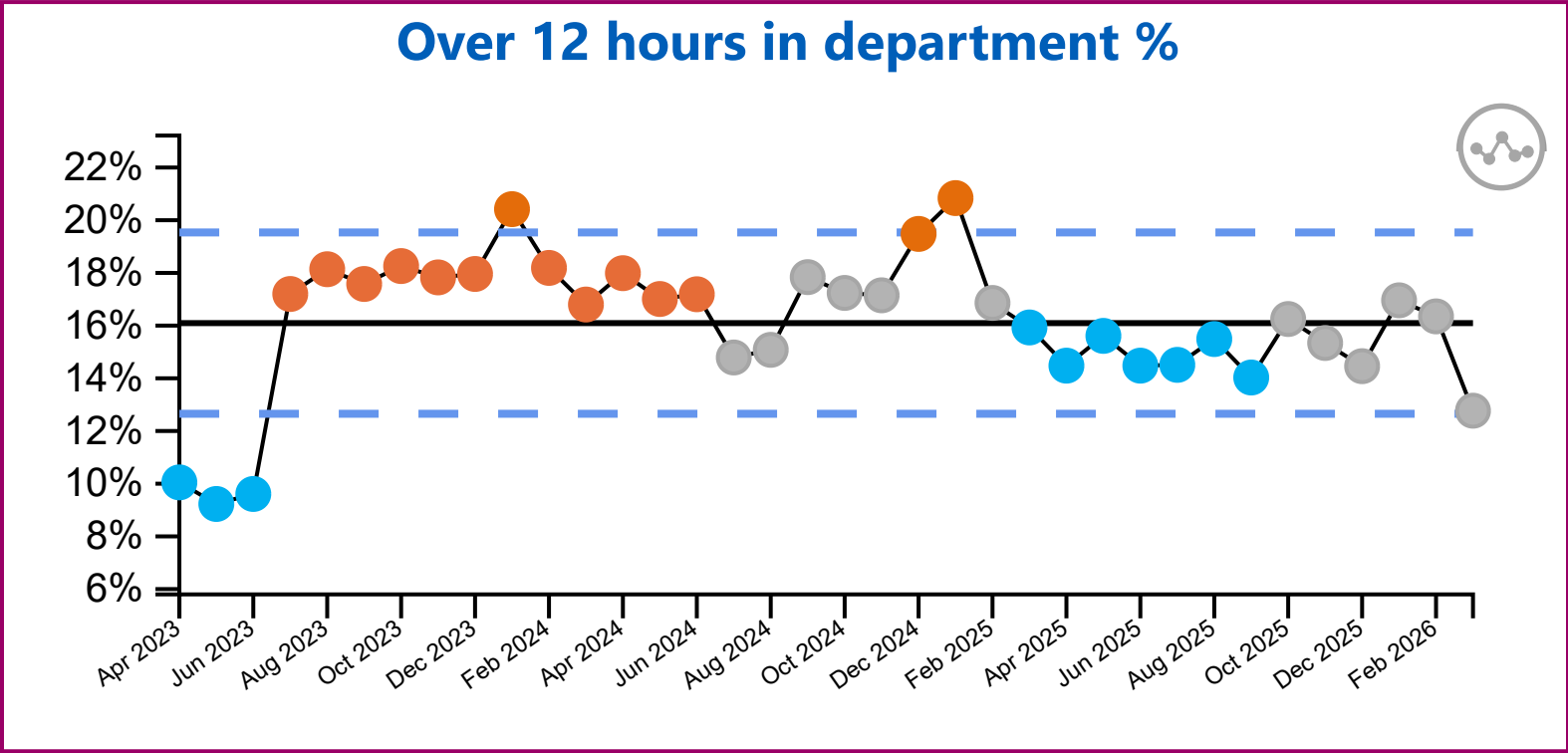
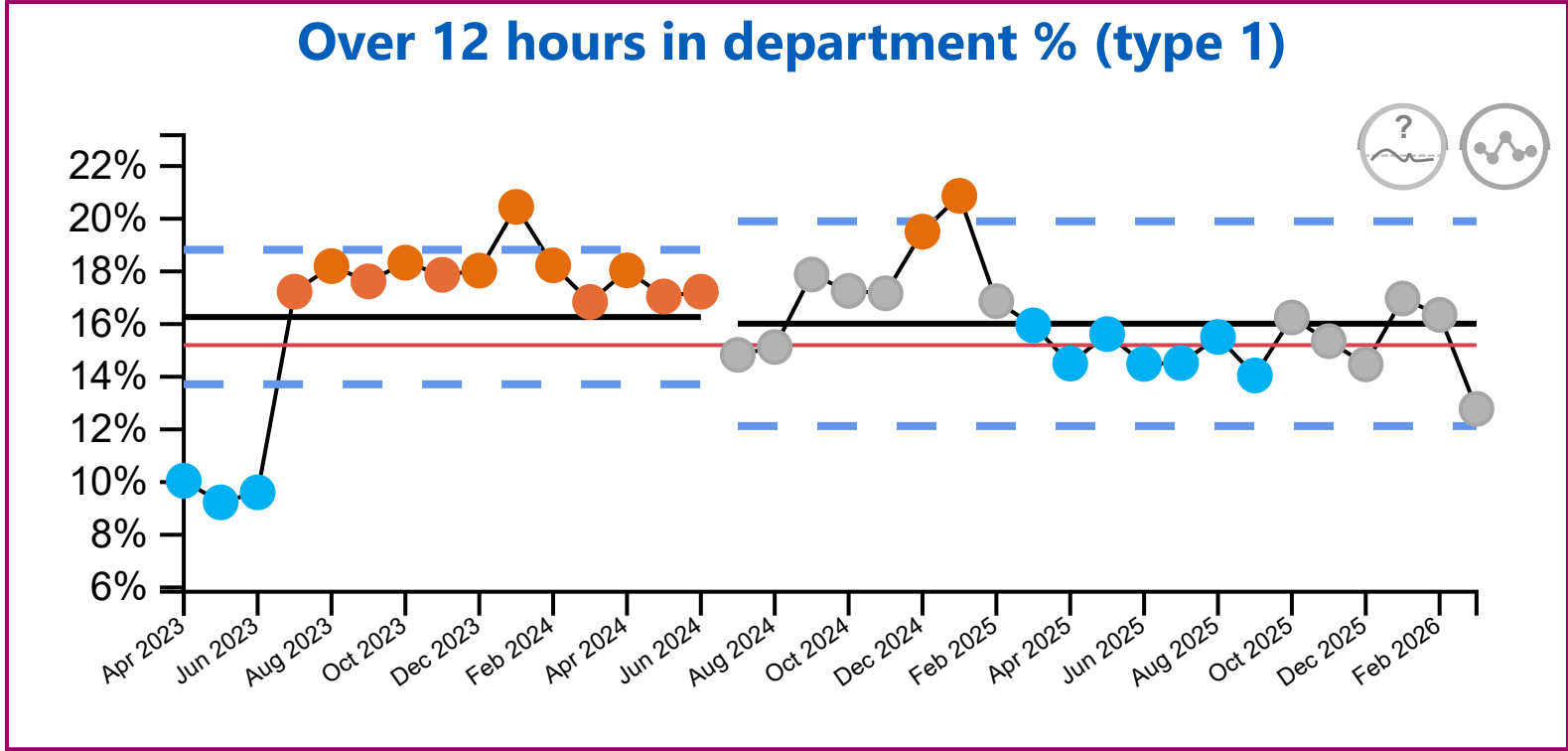
28 day cancer target is showing normal variation, and the Trust regularly achieves monthly trajectory.

RTT performance remains strong with the Trust consistently meeting or outperforming trajectory across all key assurance metrics.

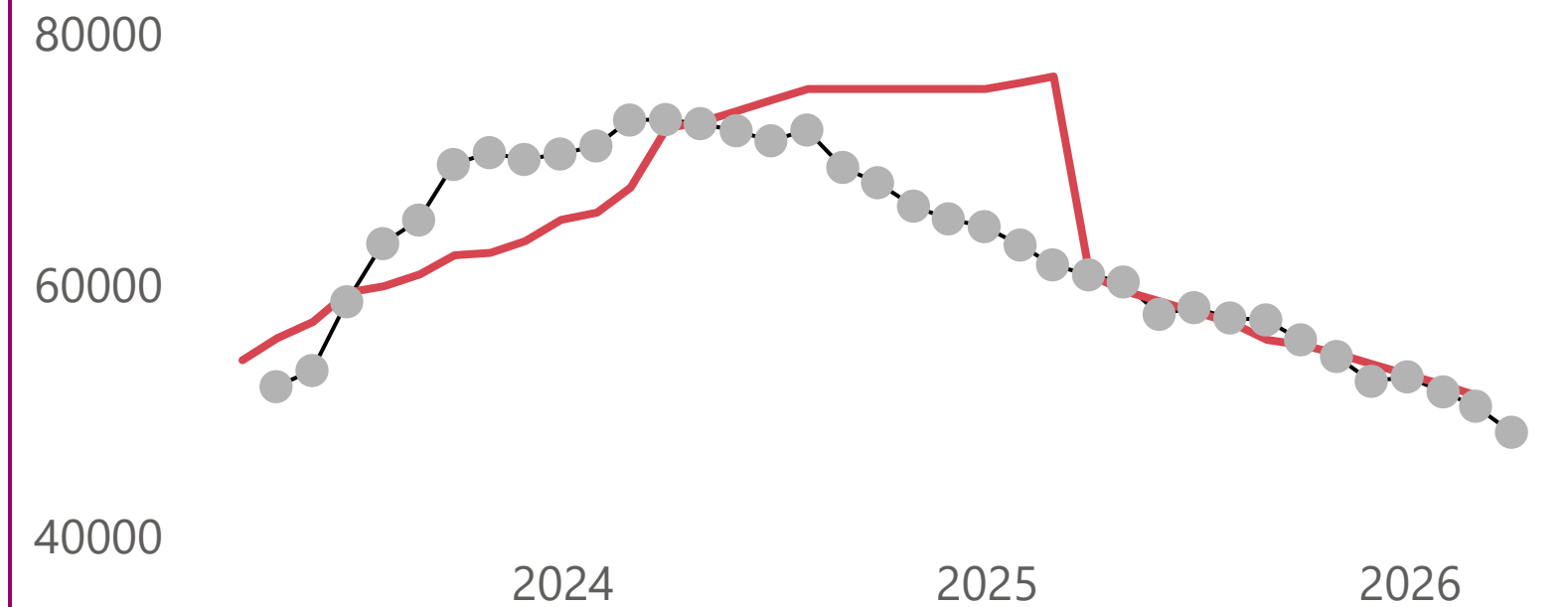
A&E 4-hour target is above trajectory in March with variation highlighting an improving performance.

Emergency readmissions remain within normal statistical variation , with no indication of special cause change.

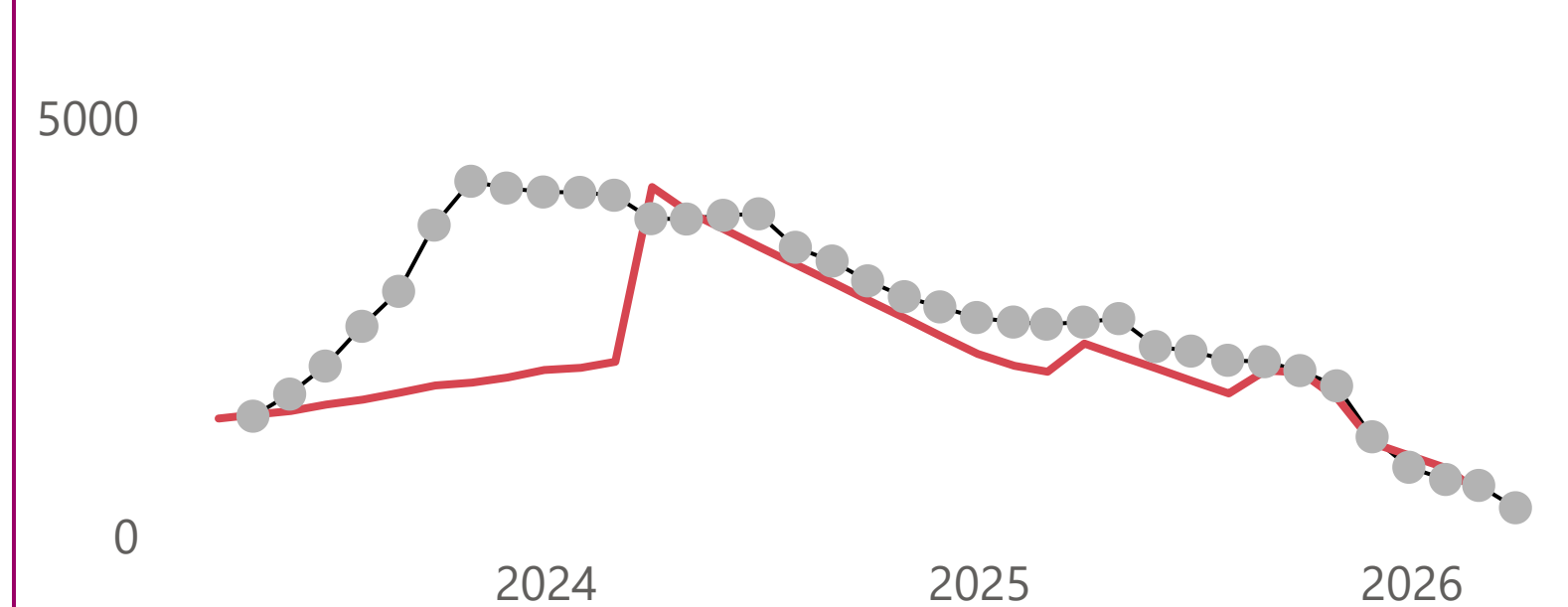
On-the-day cancellations -There were 62 in March, and although this remains a key operational pressure point, the overall trend shows a continued improvement with 9 consecutive data points below the mean.



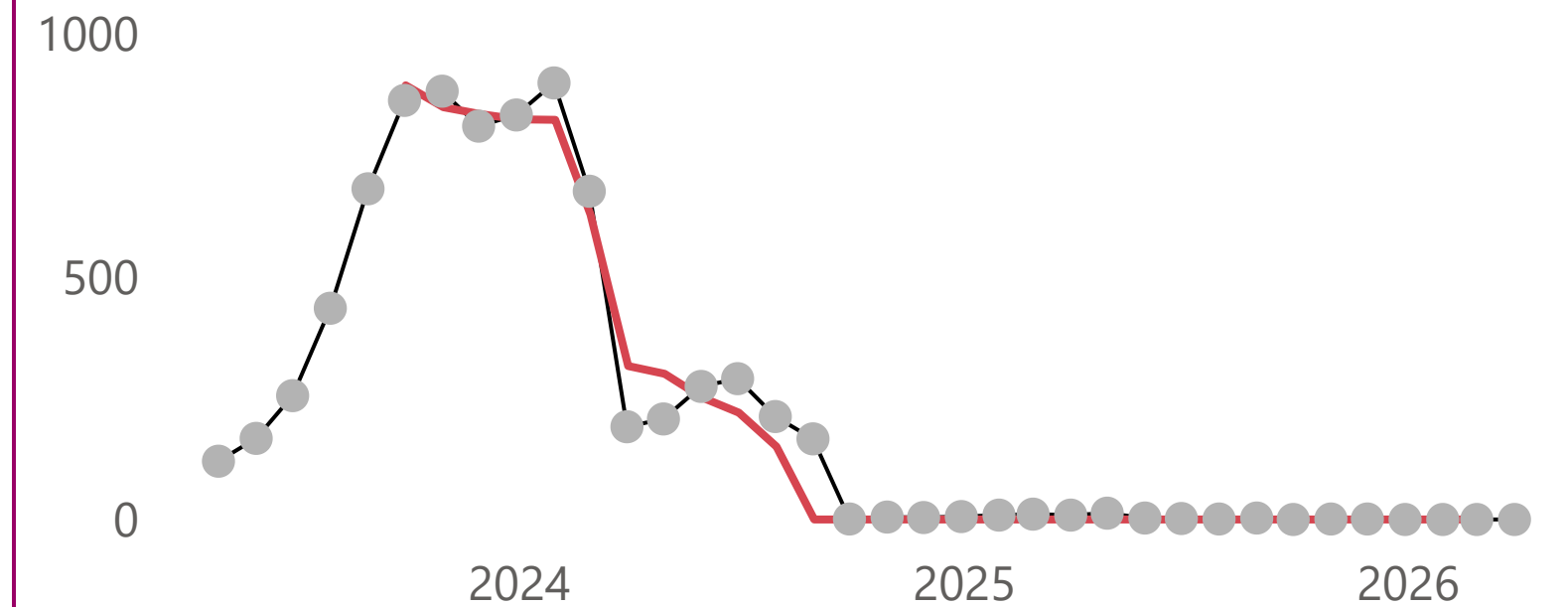
RTT Ongoing



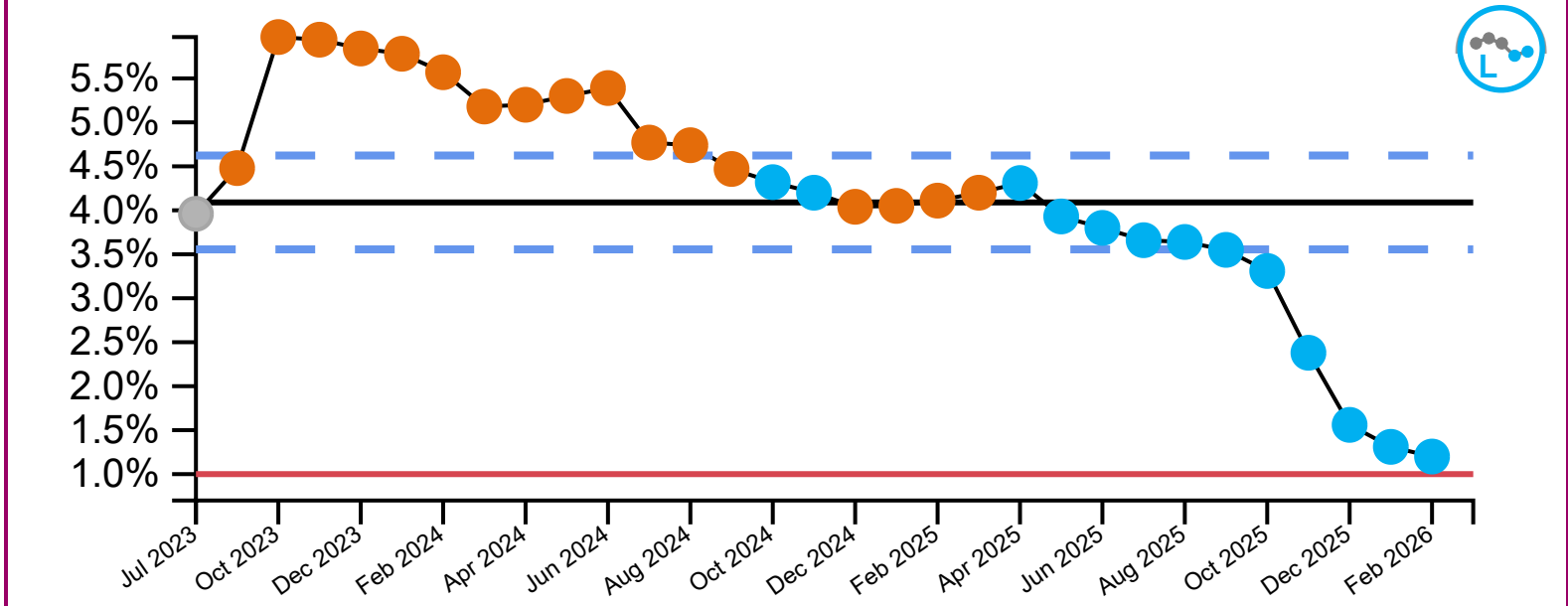
RTT Over 52 Weeks



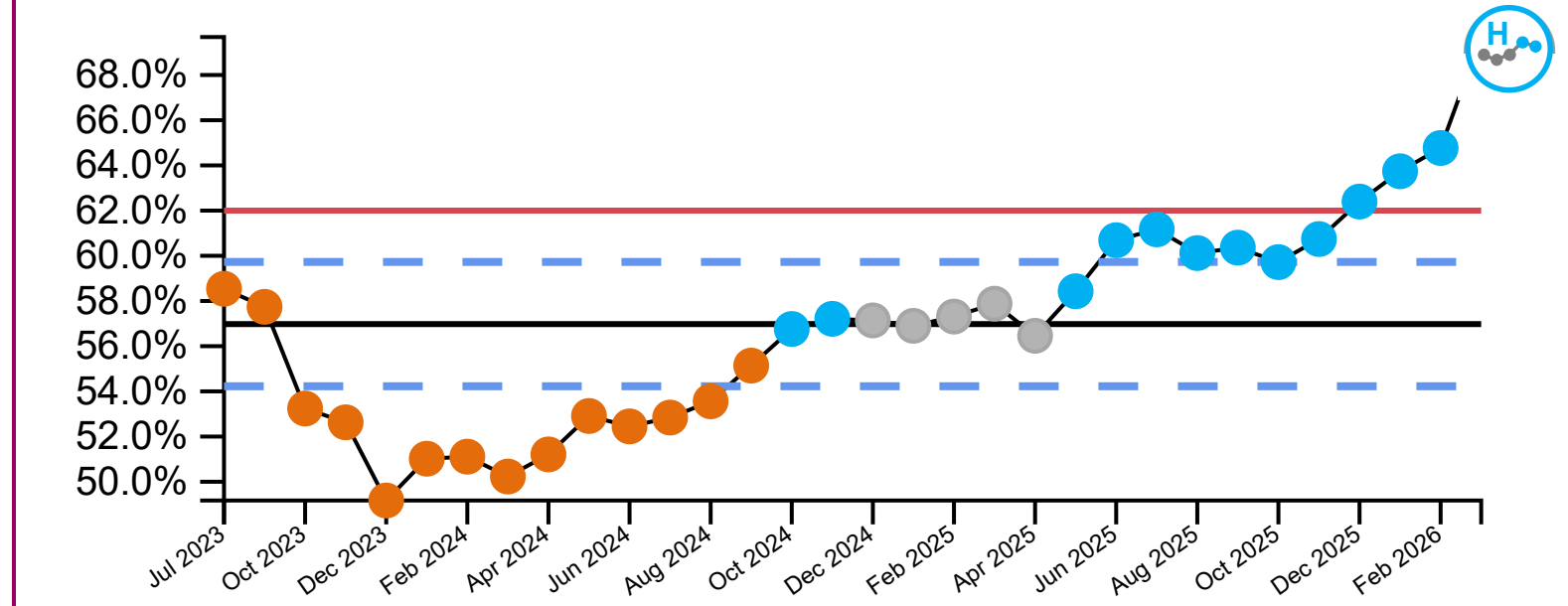
RTT Over 65 Weeks



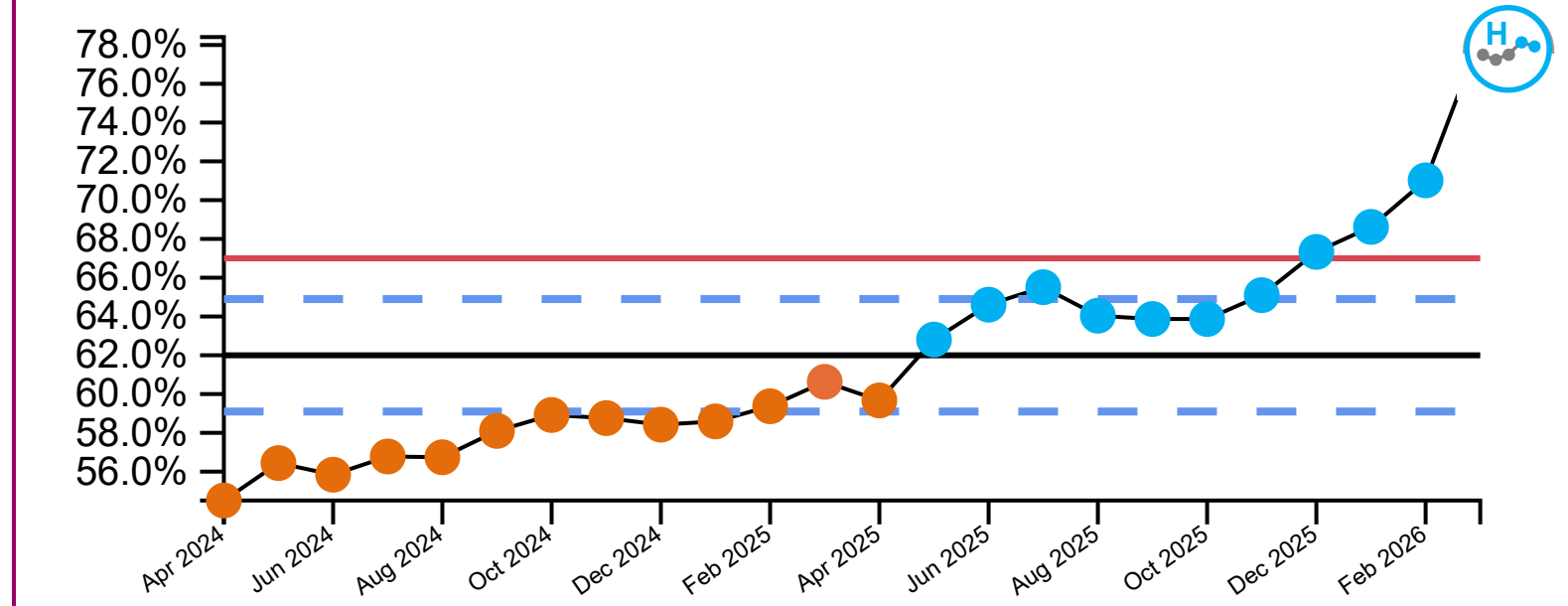
RTT Ongoing % Over 52 weeks



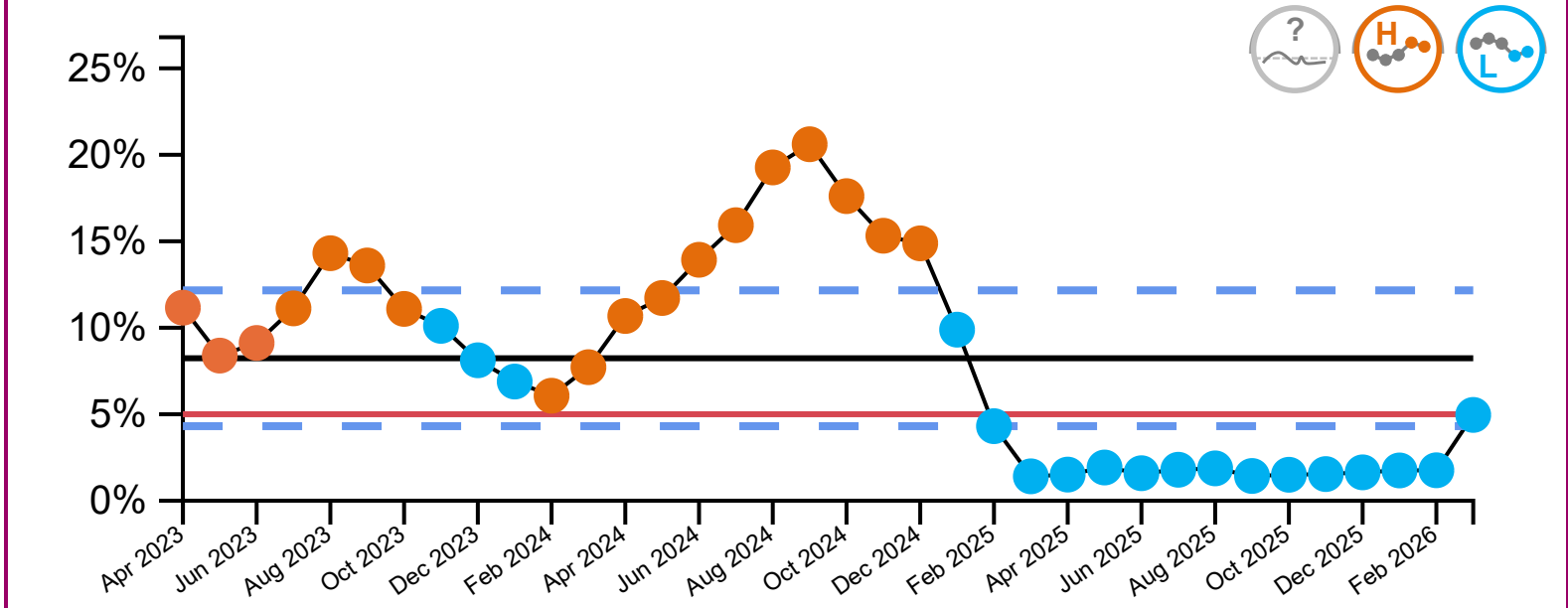
Proportion waiting < 18 weeks for treatment

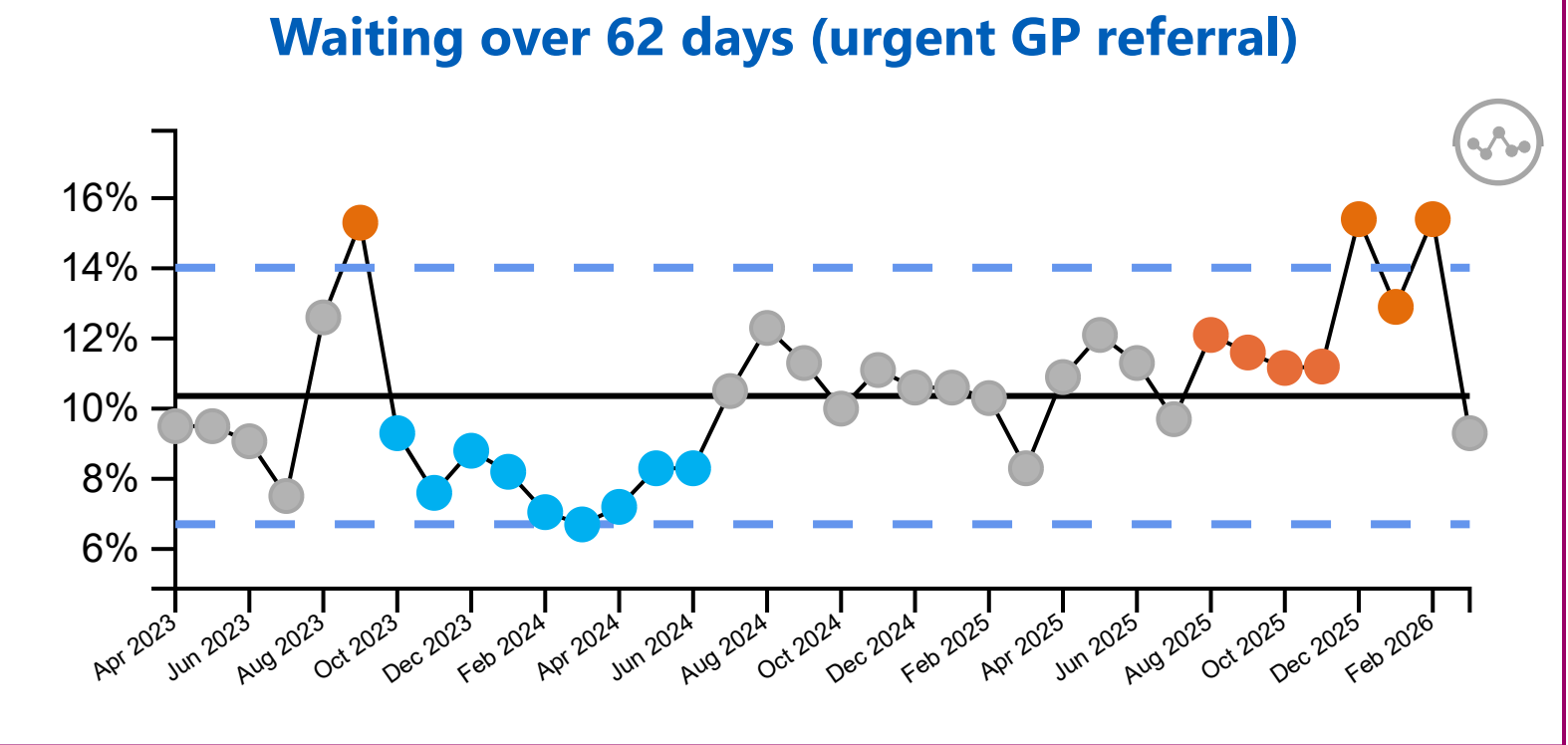
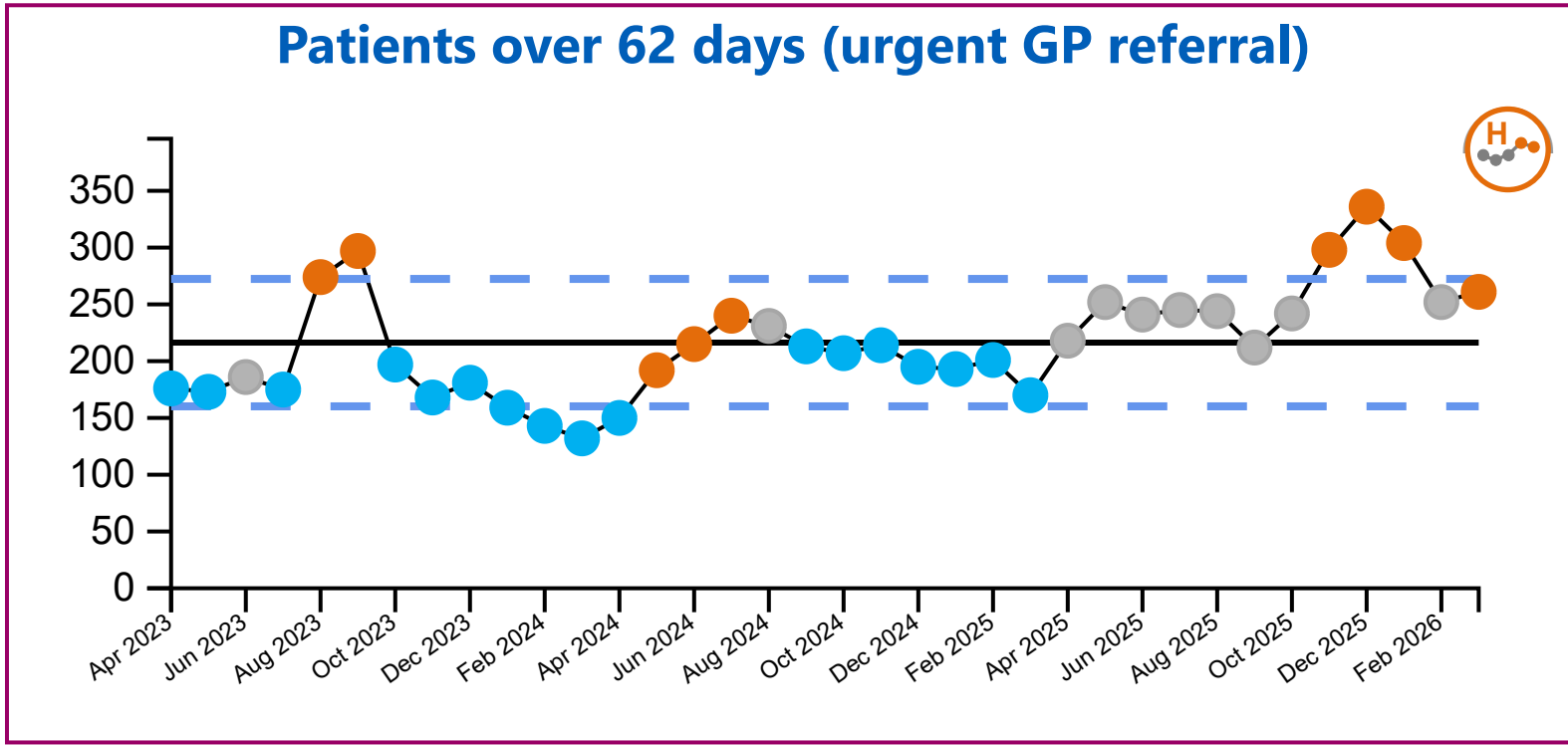
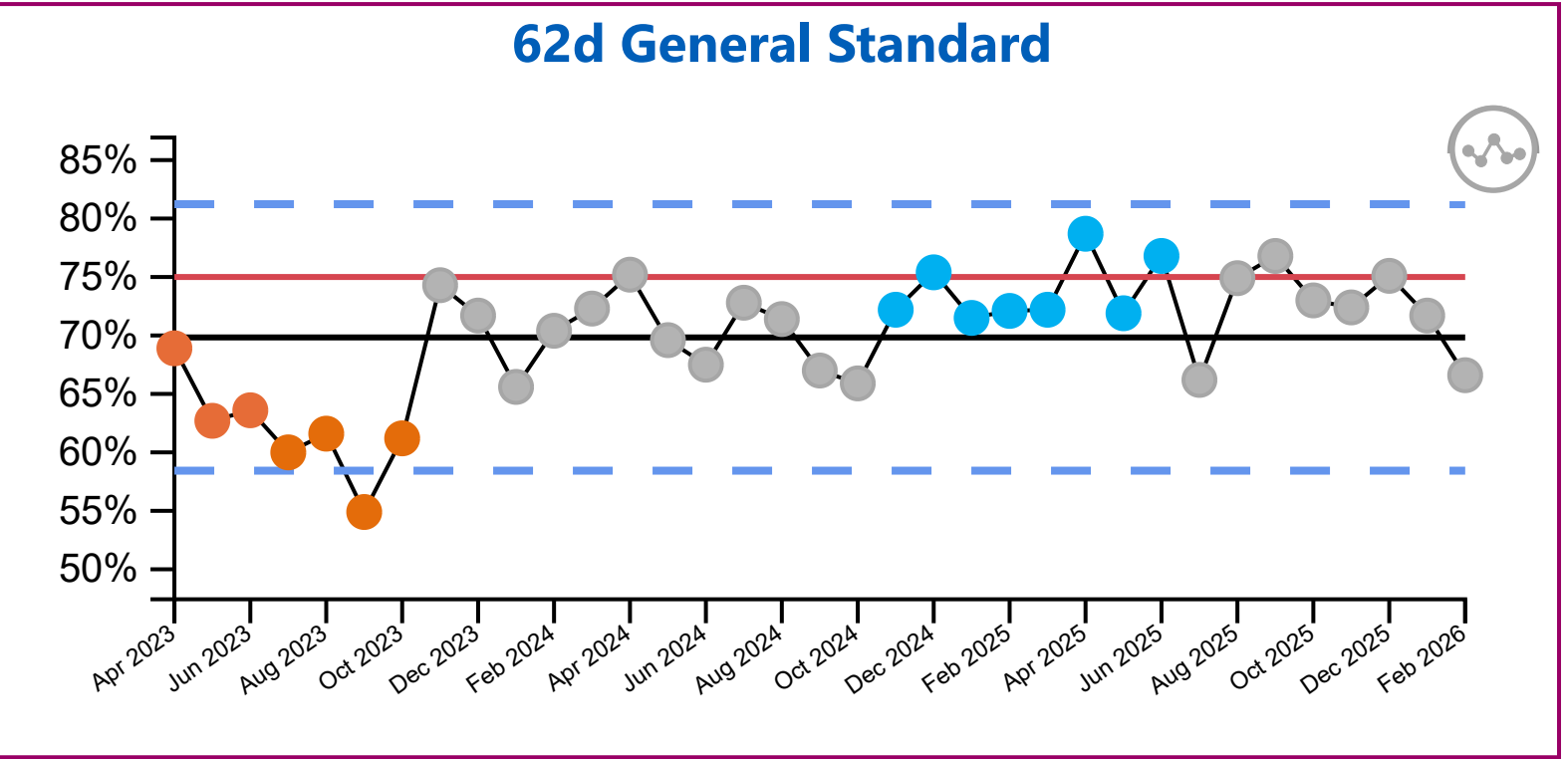
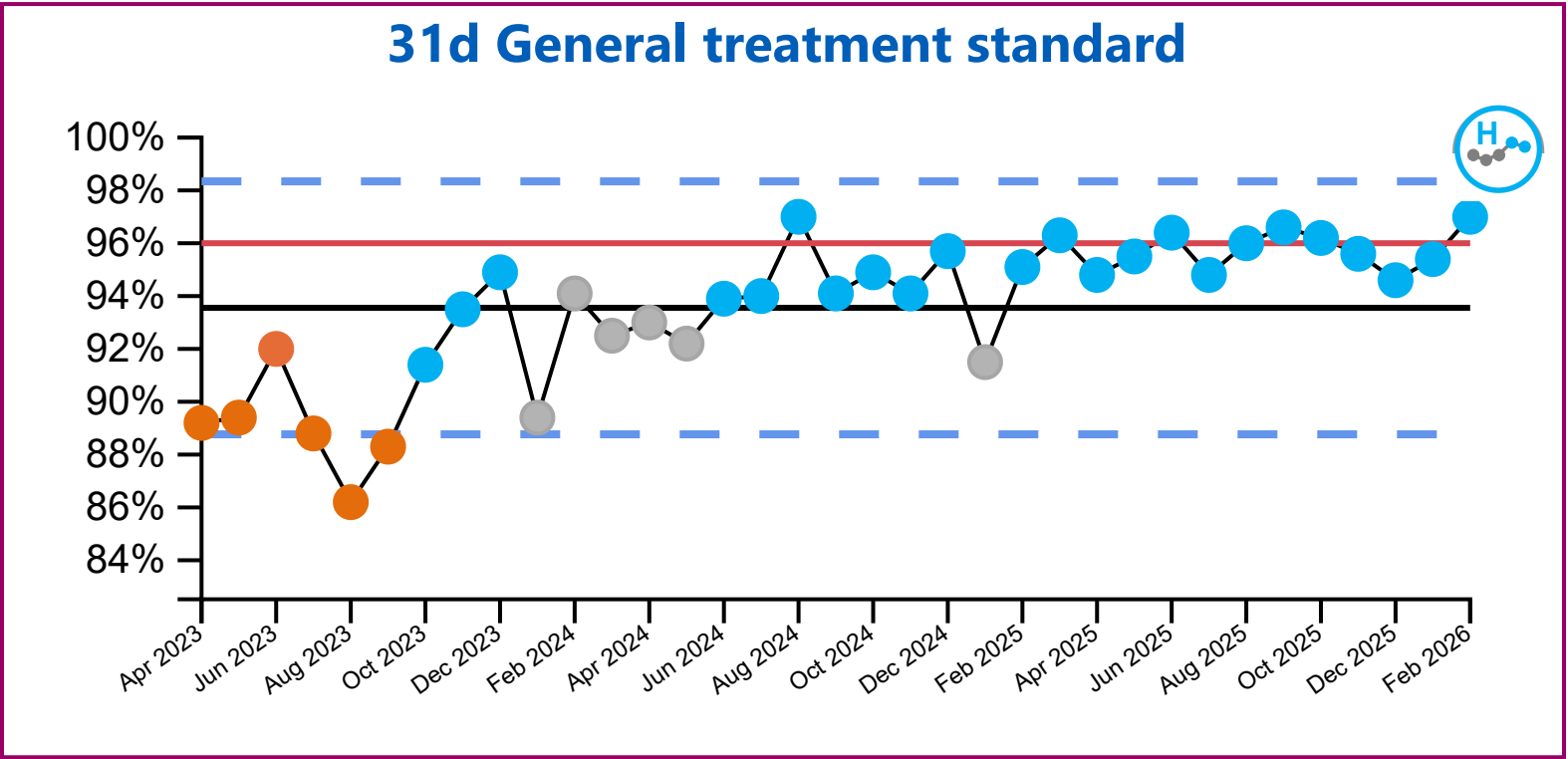
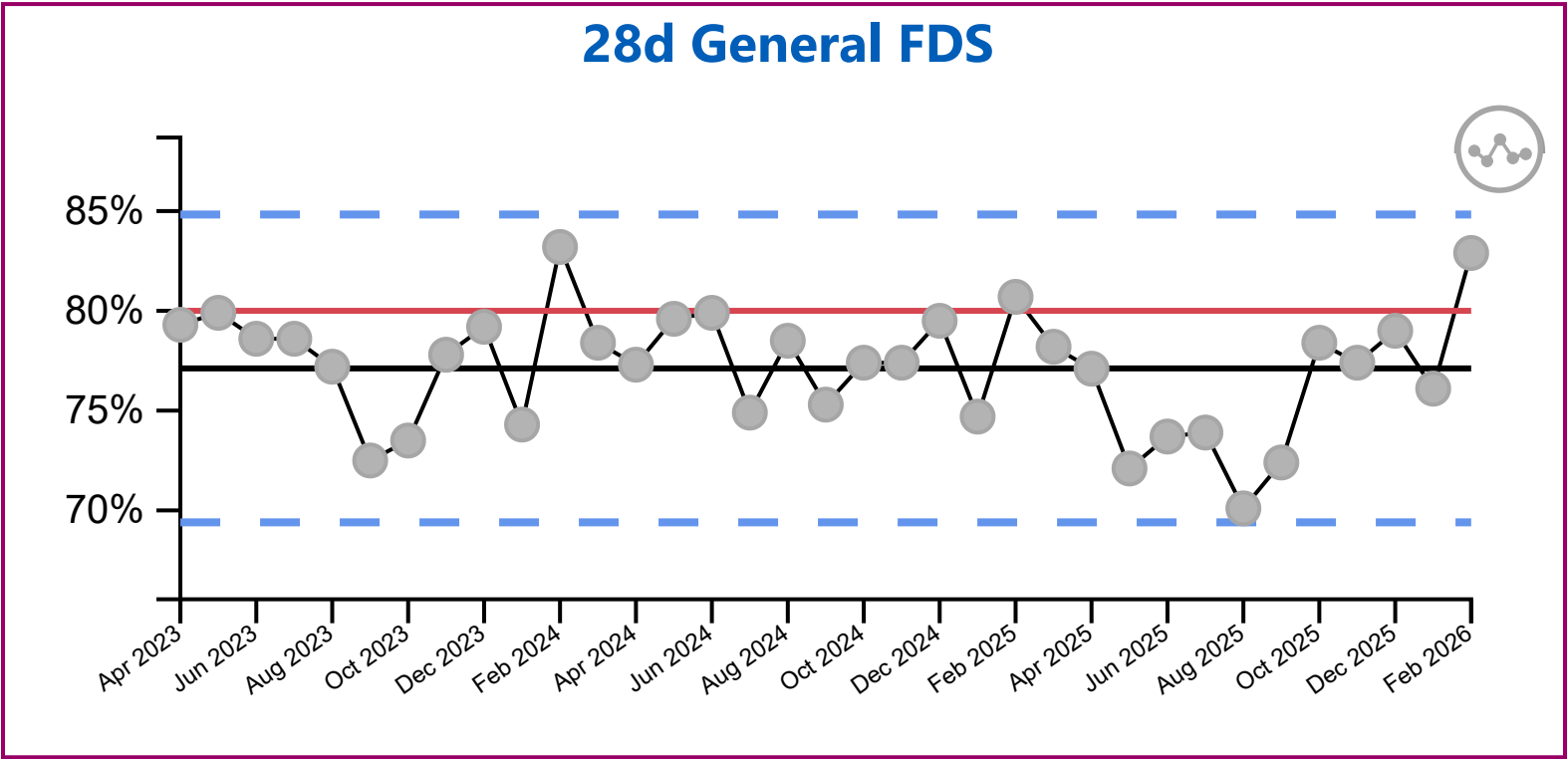


Proportion waiting < 18 weeks for 1st appointment



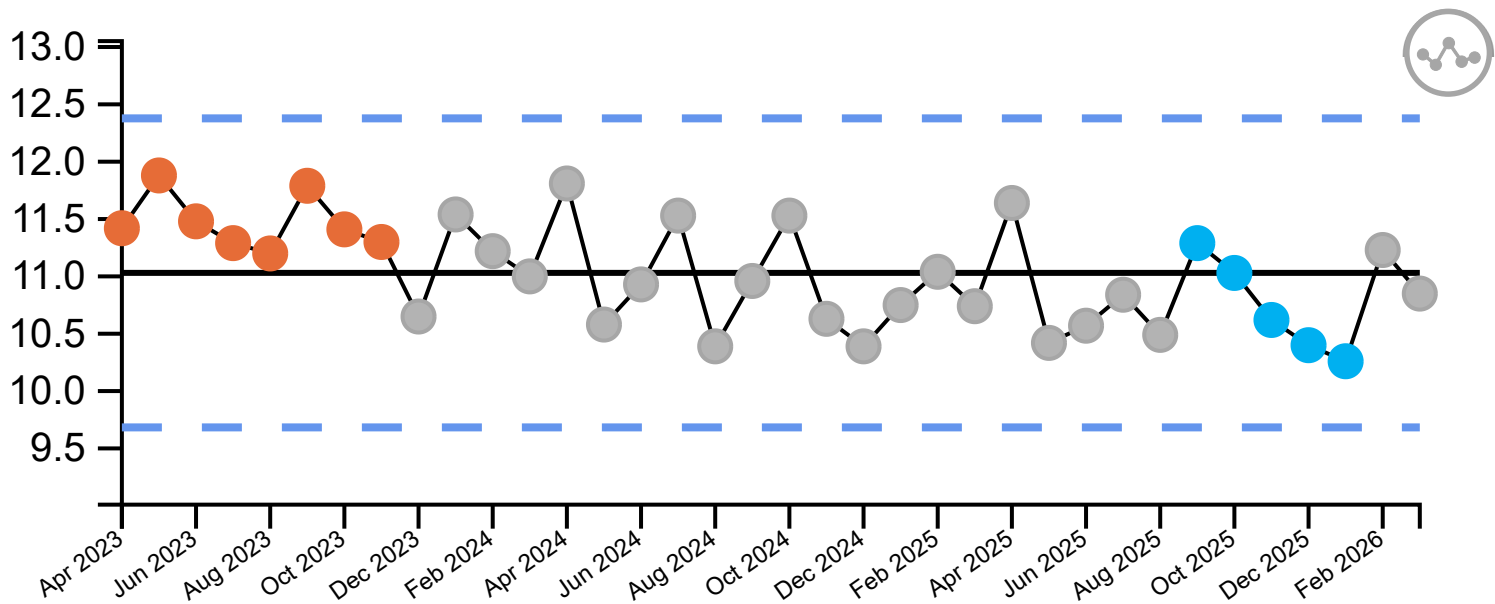
DM01 % over 6 weeks



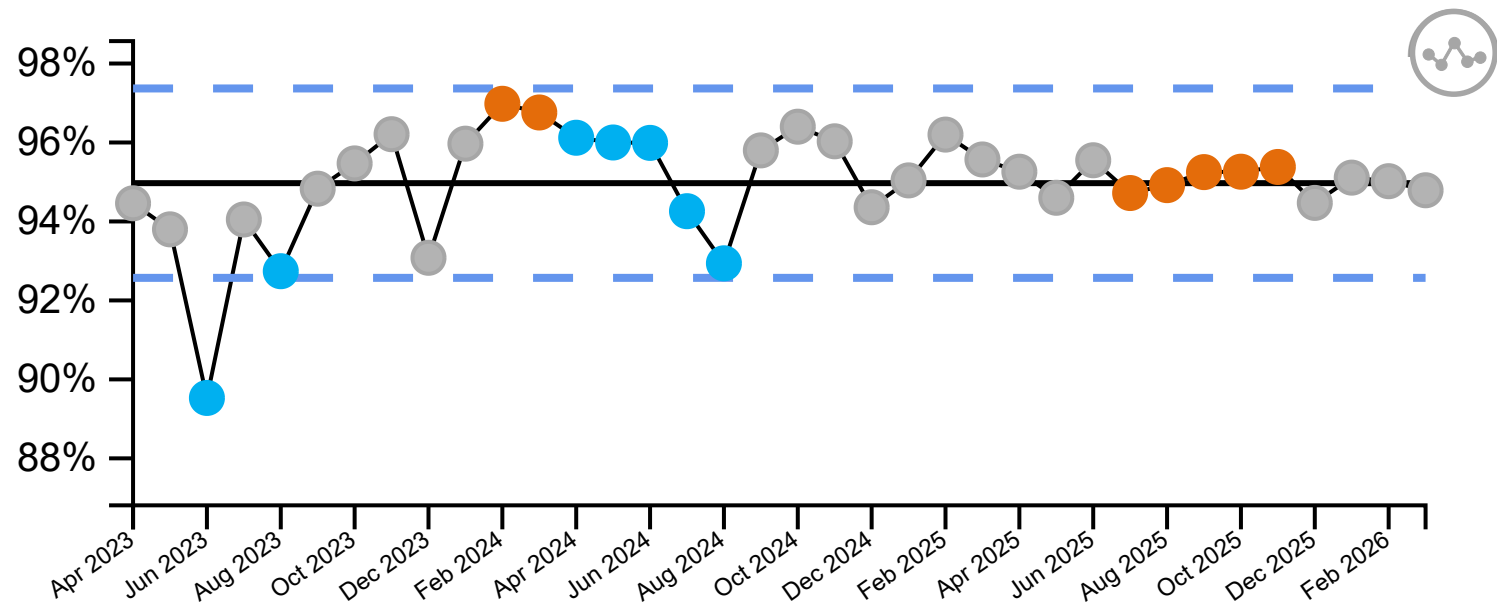


RESPONSIVE - Length of Stay and Bed Occupancy

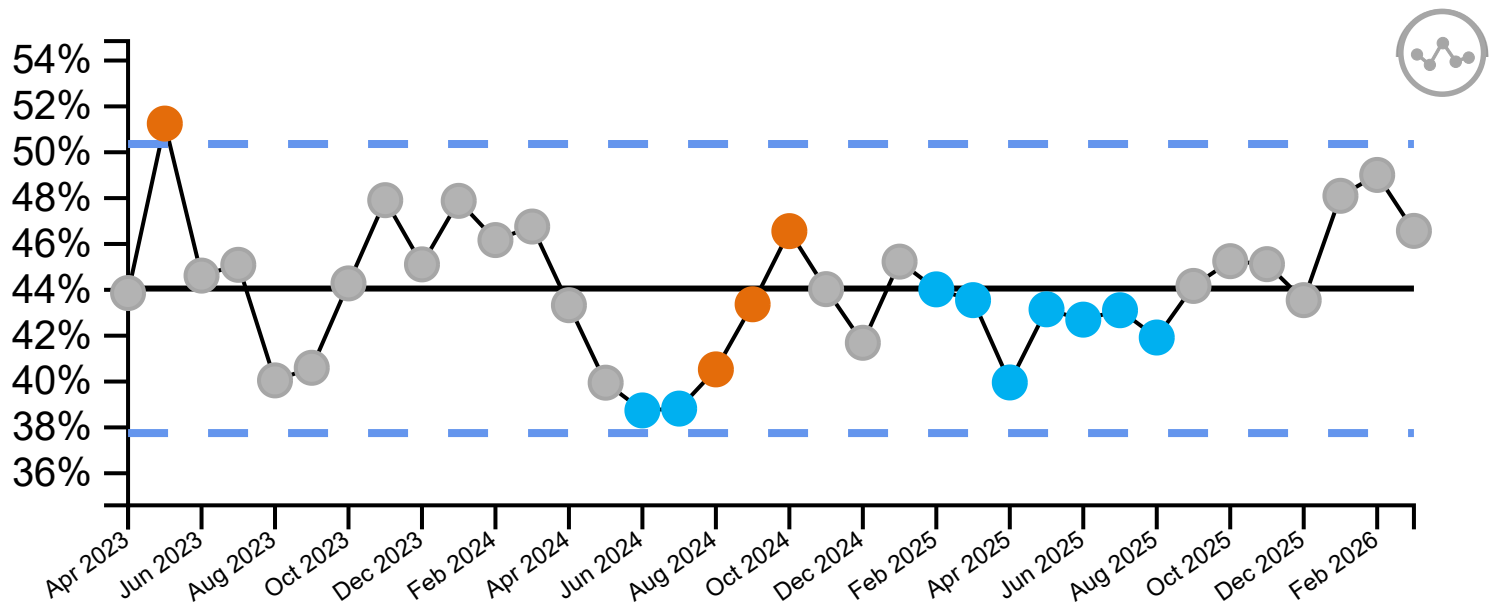
Emergency average length of stay (excl 0 and 1 days)



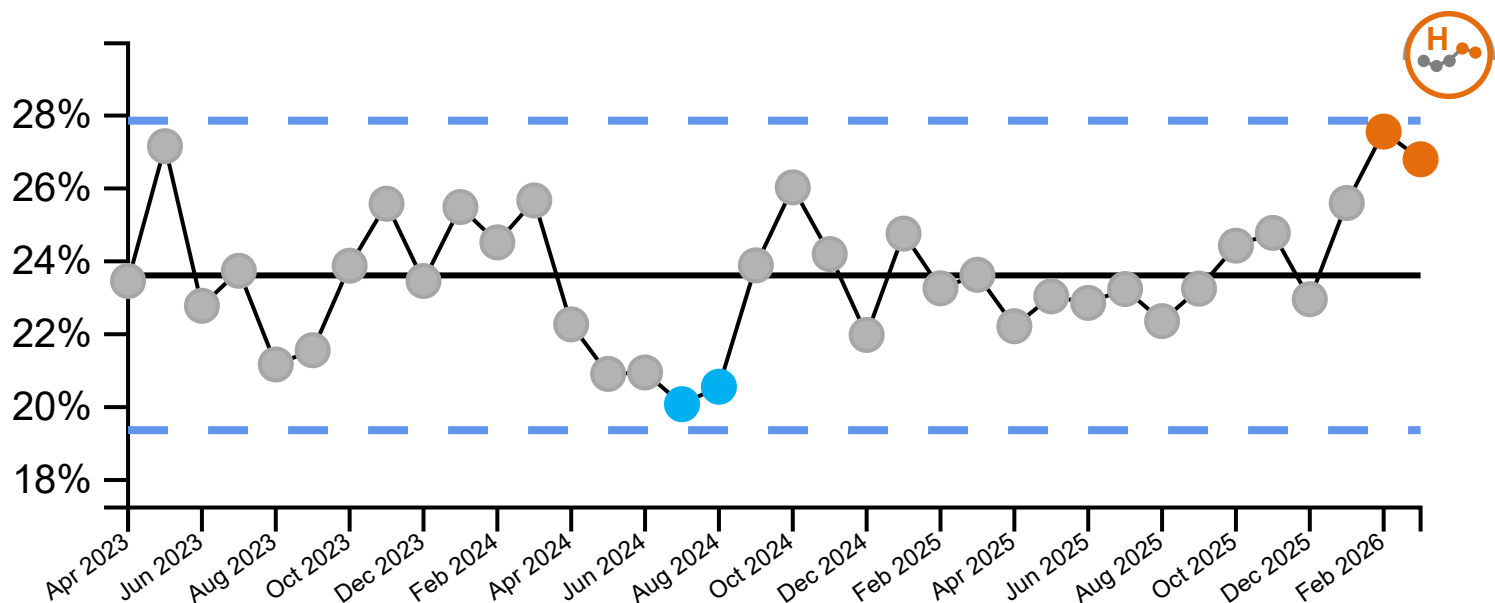
Bed occupancy G&A



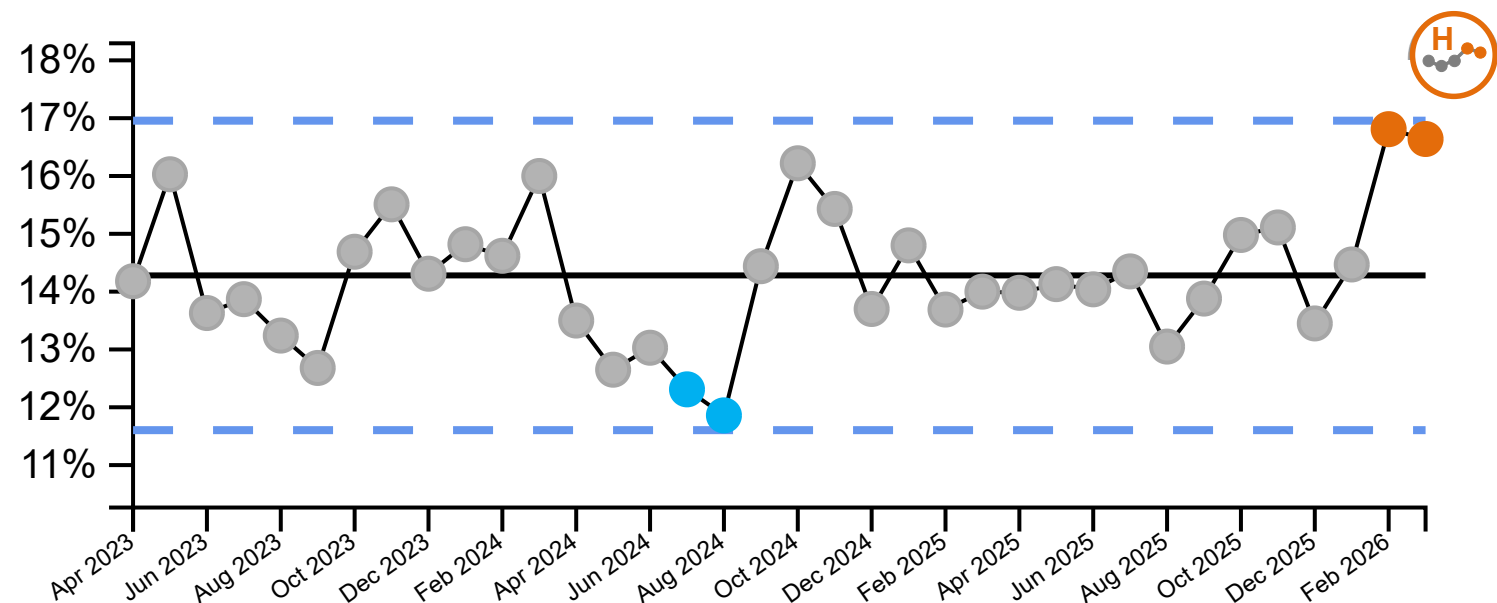
% Beds occupied by Long-Stay Patients 7+ days



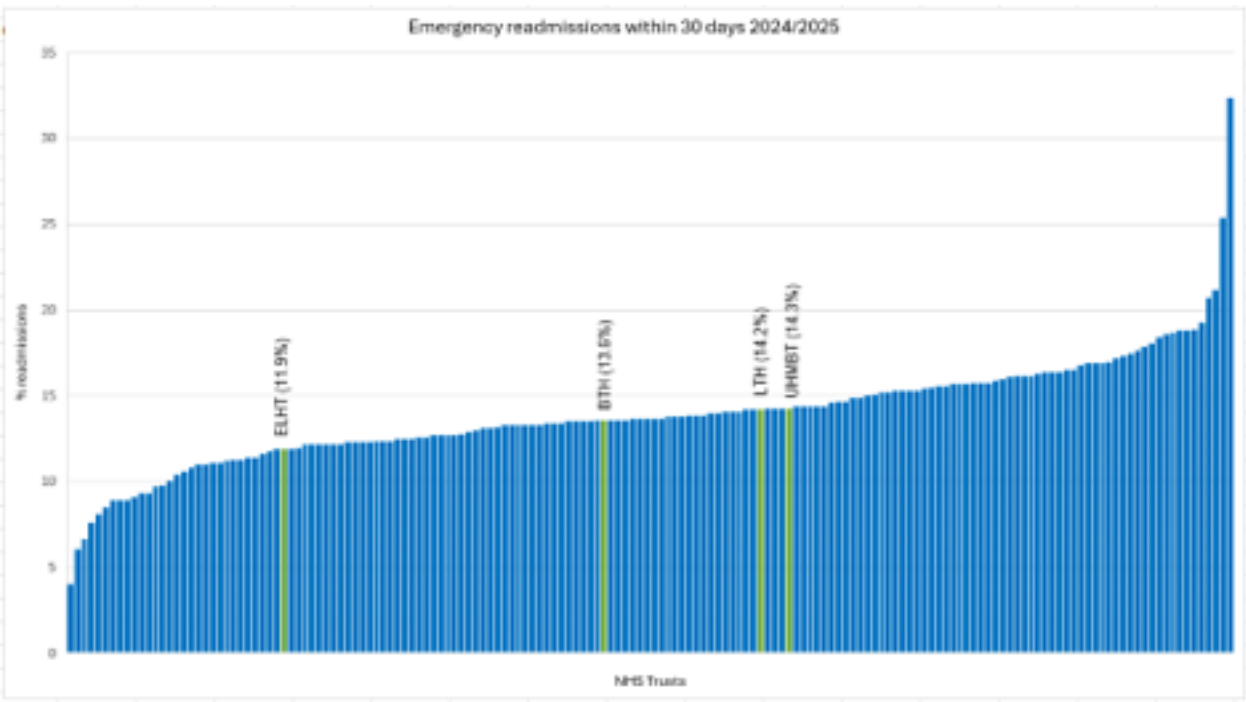
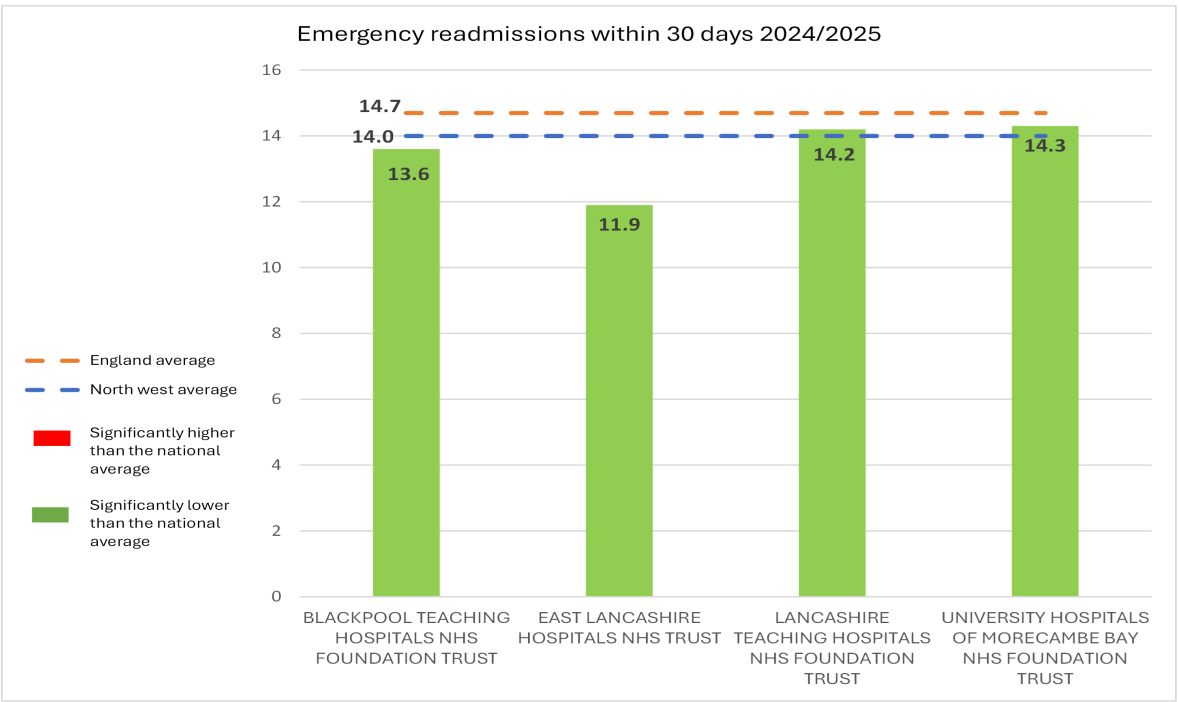
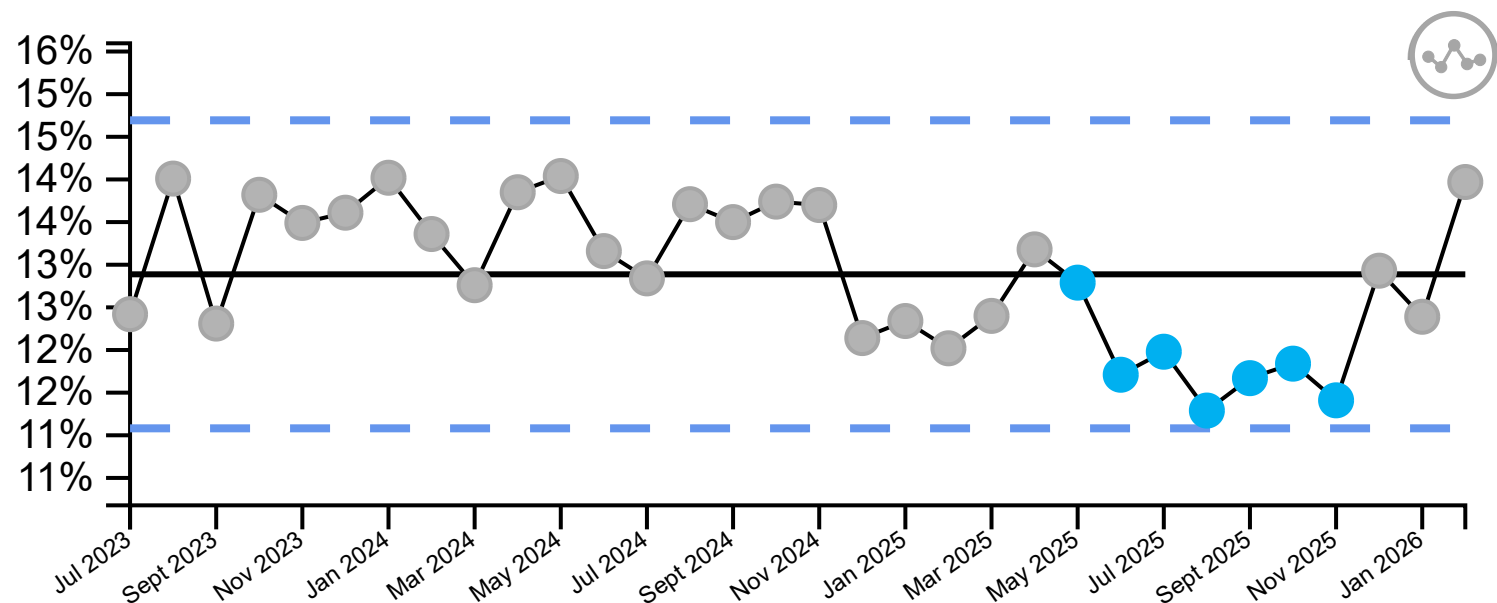
% Beds occupied by Long-stay patients: 14+ days



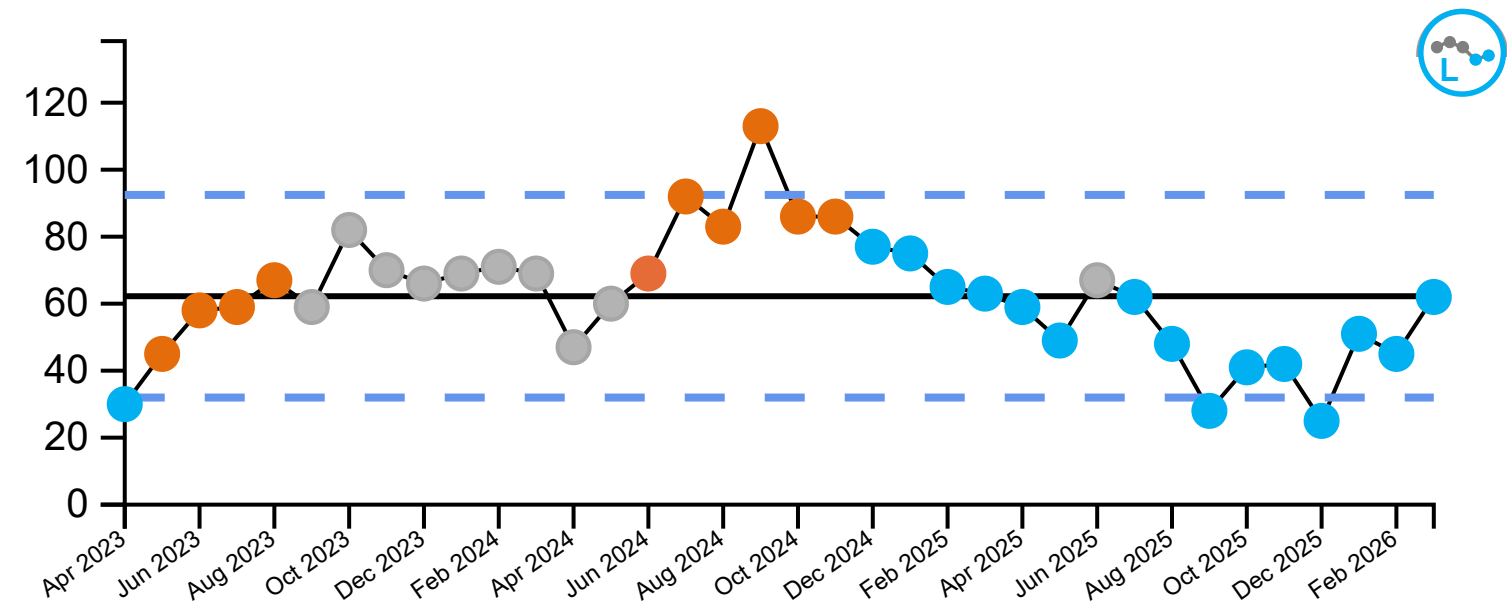
% Beds occupied by Long-stay patients 21+ days



Emergency readmissions rate - prev disch month

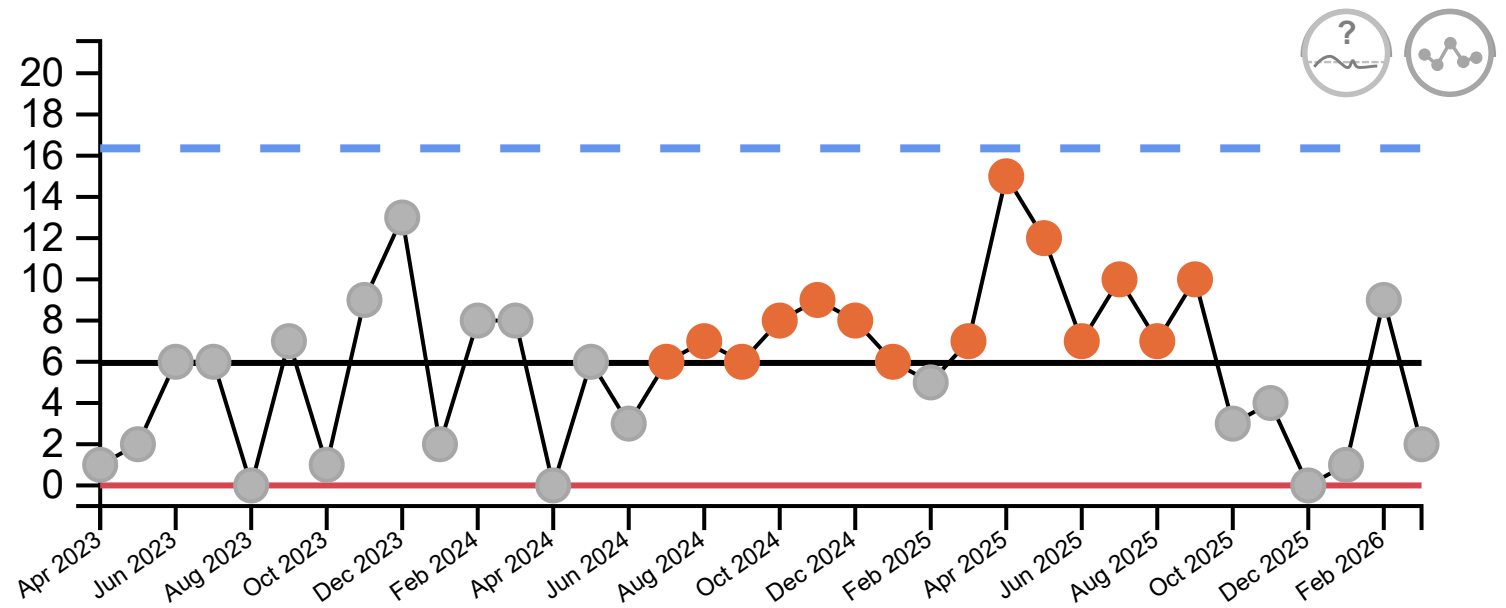


Cancelled on day operations



Urgent operations
cancelled for 2nd time
(Blank)

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



Metric	Latest Date	Value	Target	Variation	Assurance
Appraisal (Agenda for Change)	MAR 26	77.00%	90.00%		
Appraisal (Consultant)	MAR 26	98.00%	90.00%		
Information Governance Training	MAR 26	90.00%	95.00%		
Safeguarding Children L1	MAR 26	95.00%	90.00%		
Sickness	MAR 26	6.21%	4.50%		
Turnover	MAR 26	8.21%	12.00%		
Vacancy	MAR 26	4.60%	5.00%		

Alert

IG training remains 5% below the required target, at 90%. Work is ongoing to improve this, including ensuring the requirement is only assigned to the correct group. The performance in this indicator has now had a trend of 10 consecutive months below the mean. The target for IG training is being aligned across the system, so will be 90% from April 2026

Non-medical appraisal remains a challenge at 77%.

Action: Rapid improvement work underway, new appraisal process and paperwork being trialled, with positive results.

By Who: Transformation, O.D, Inclusion, Staff Experience and Engagement (TODIEE) Team

Advise

Sickness absence current month is 6.21% (6.60% in February), in line with the same month last year. Still some way short of the target and return to normal variation following a run of declining performance in the previous 4 months.

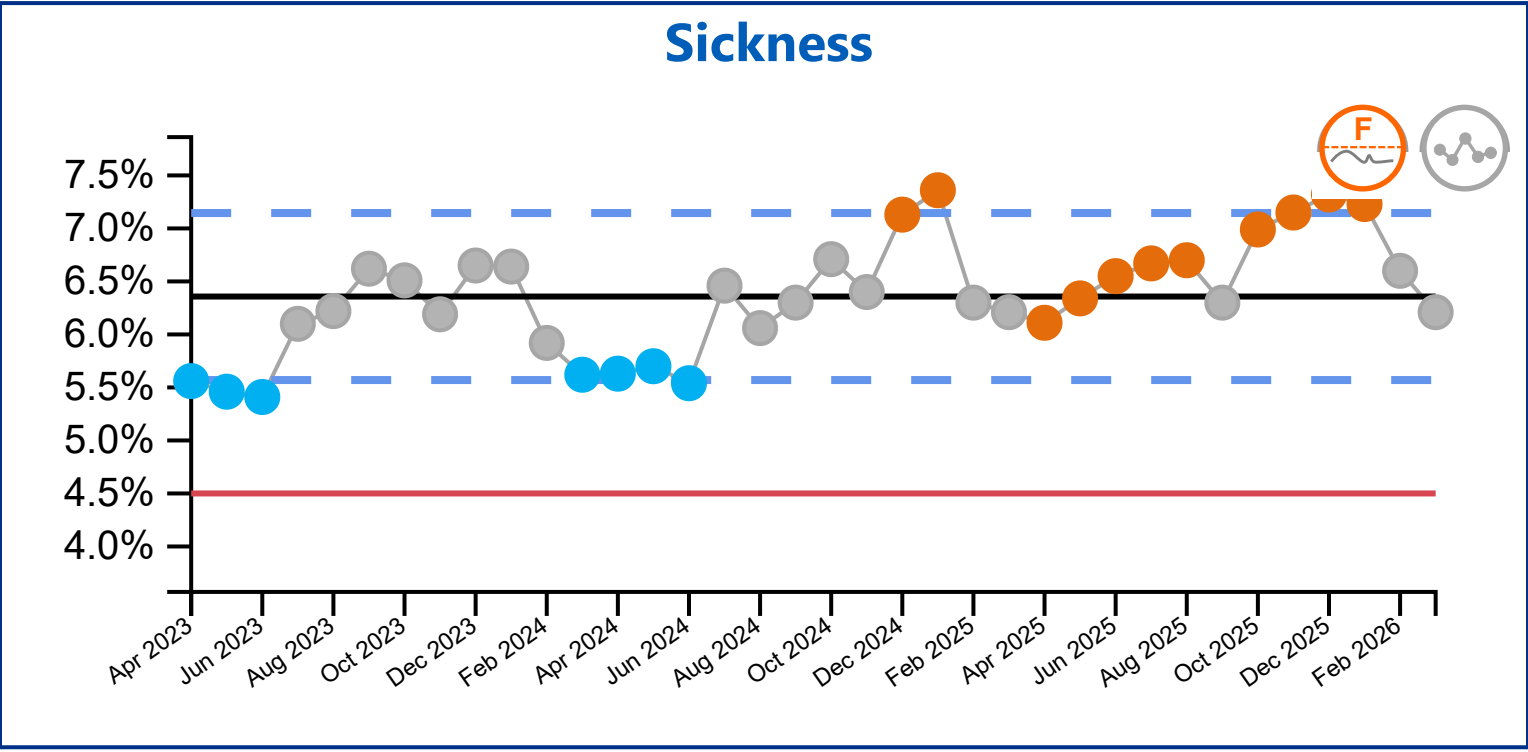
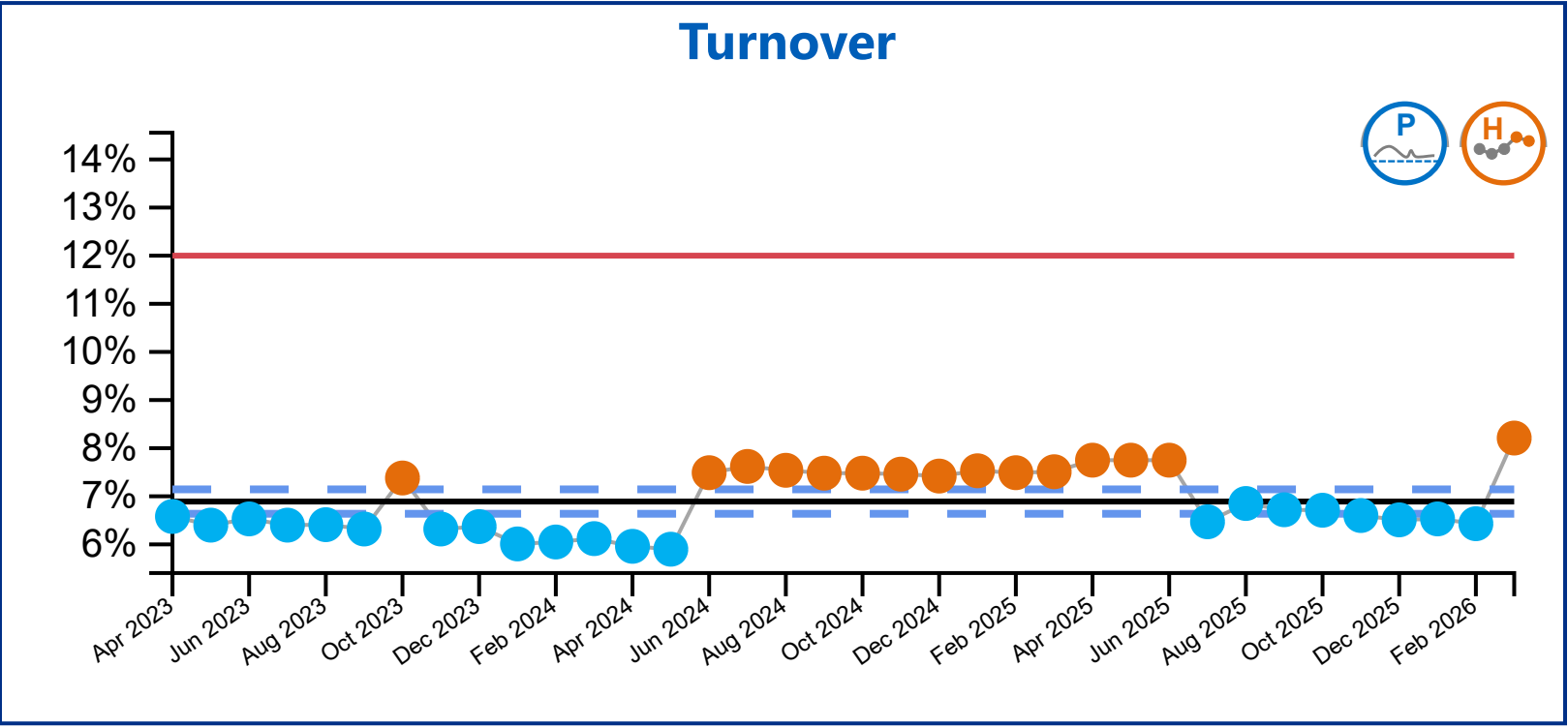
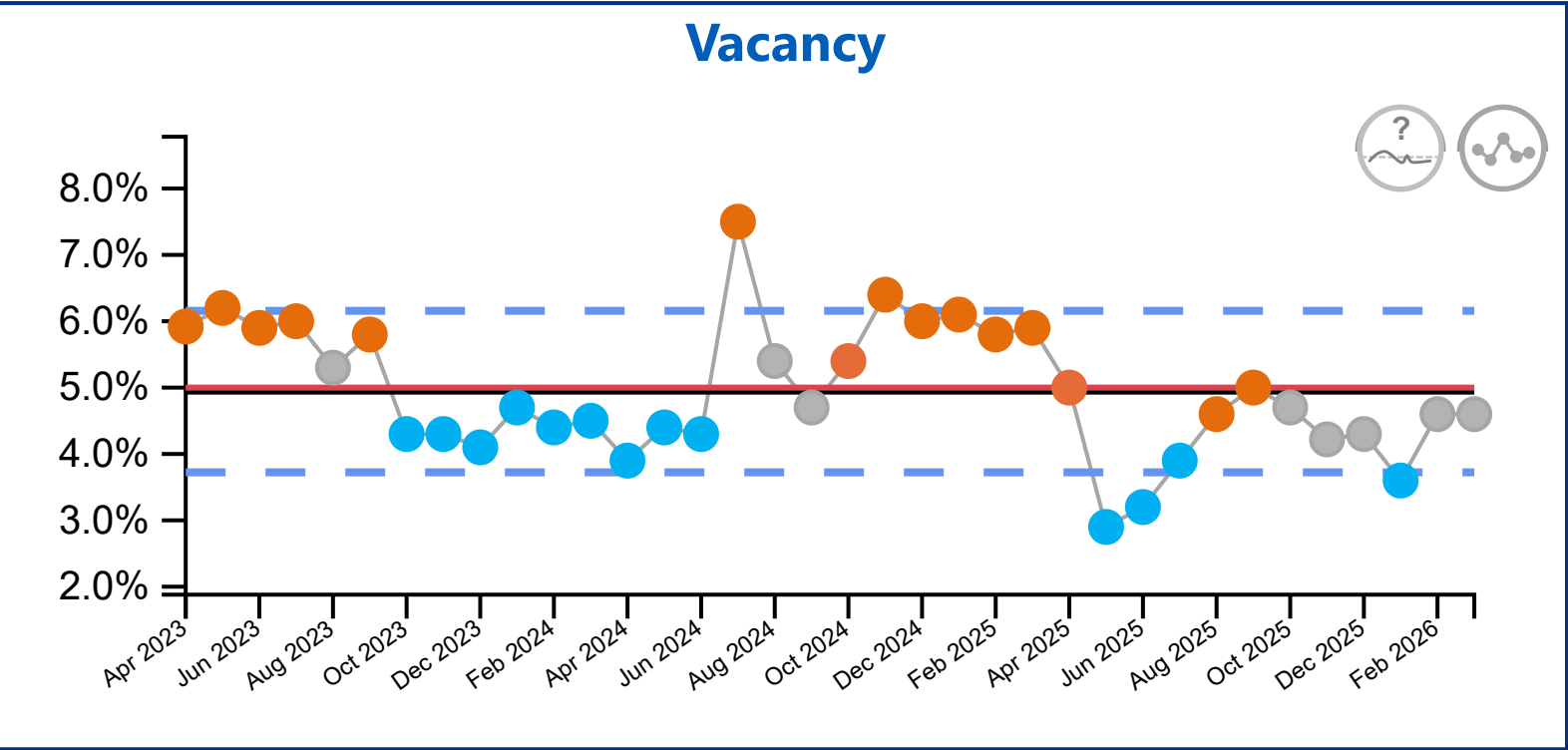
Number of cases in Q4 through Freedom to Speak Up reduced to 35, reductions across categories. 25% reduction in 2025/26 compared to 2024/25. Continue to encourage colleagues to speak up, through FTSU or other methods.

Ongoing work, led my Medical Director, around job planning to improve compliance and quality of job plans.

Turnover is showing a significant increase in the latest month, although remains significantly below the 12% target

Assurance

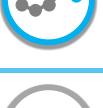
Medical appraisal compliance remains strong – 98% for Consultants and 99% other medics.



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
25/26 Q4	3	7	7	16	35

Job Plans		
Stage	Consultants	Non consultants grades
Awaiting Signatures	216	59
Complete	1	1
Due Soon	21	11
In Progress	2	3
No Current Job Plan	83	19
Not Started	6	13
Referred Back	38	21
Uploaded	2	1
Total	369	128



METRIC	LATEST DATE	VALUE	TARGET	VARIATION	ASSURANCE
AGENCY SPEND AS PROPORTION PAY BILL (£M)	MAR 26	-25.22%	1.20%		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	MAR 26	88.71%	95.00%		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	MAR 26	93.35%	95.00%		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	MAR 26	61.60%	95.00%		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	MAR 26	85.68%	95.00%		
LIQUIDITY DAYS	MAR 26	-16.35	-21.50		
VARIANCE TO CAPITAL PROGRAMME (£M)	MAR 26	-7.36	0.00		
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	MAR 26	25.72	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	MAR 26	-0.69	0.00		

METRIC	LATEST DATE	VALUE	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	MAR 26	80.85	
INCOME RUN RATE (£M)	MAR 26	130.88	
OTHER OPERATING EXPENSES RUN RATE (£M)	MAR 26	18.68	

Alert

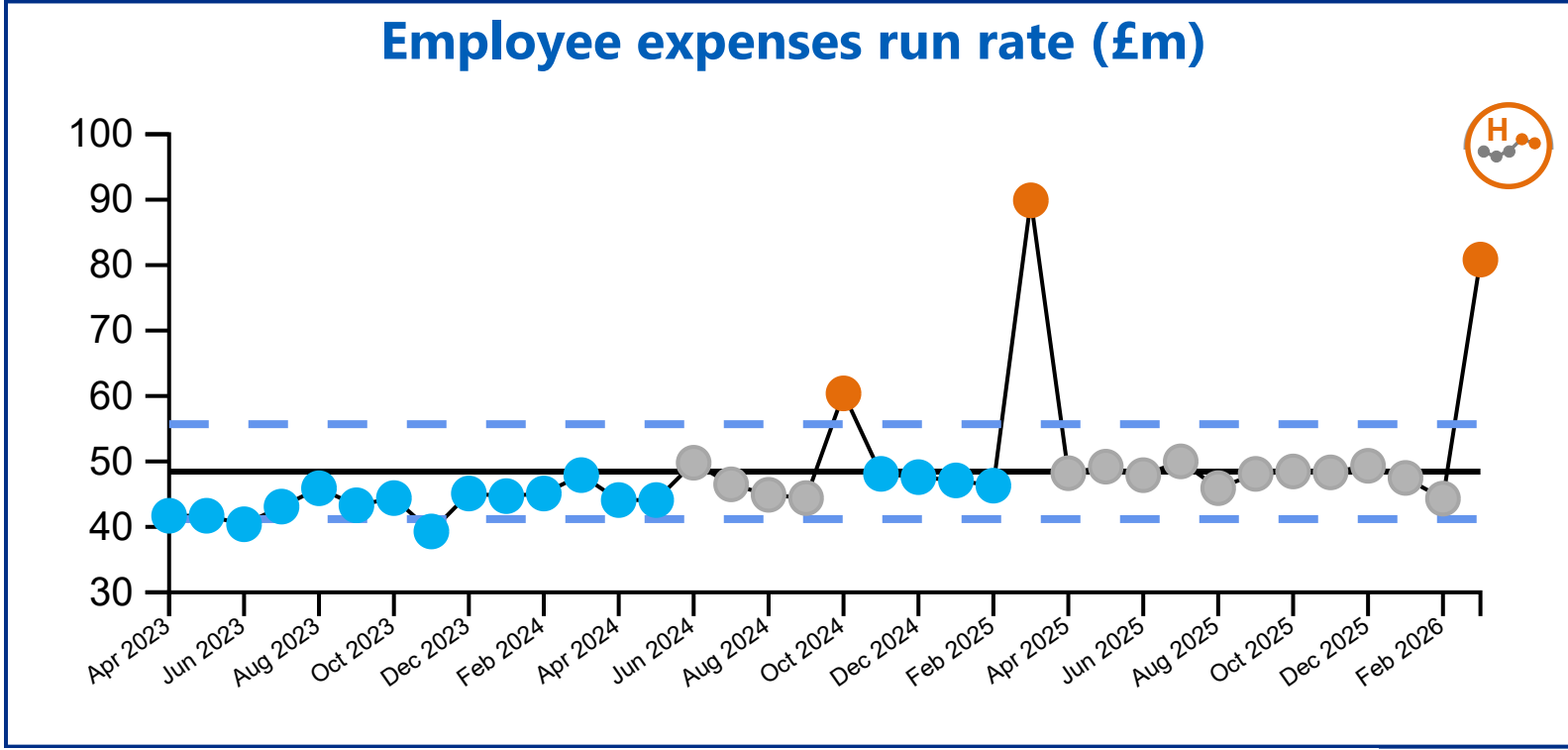
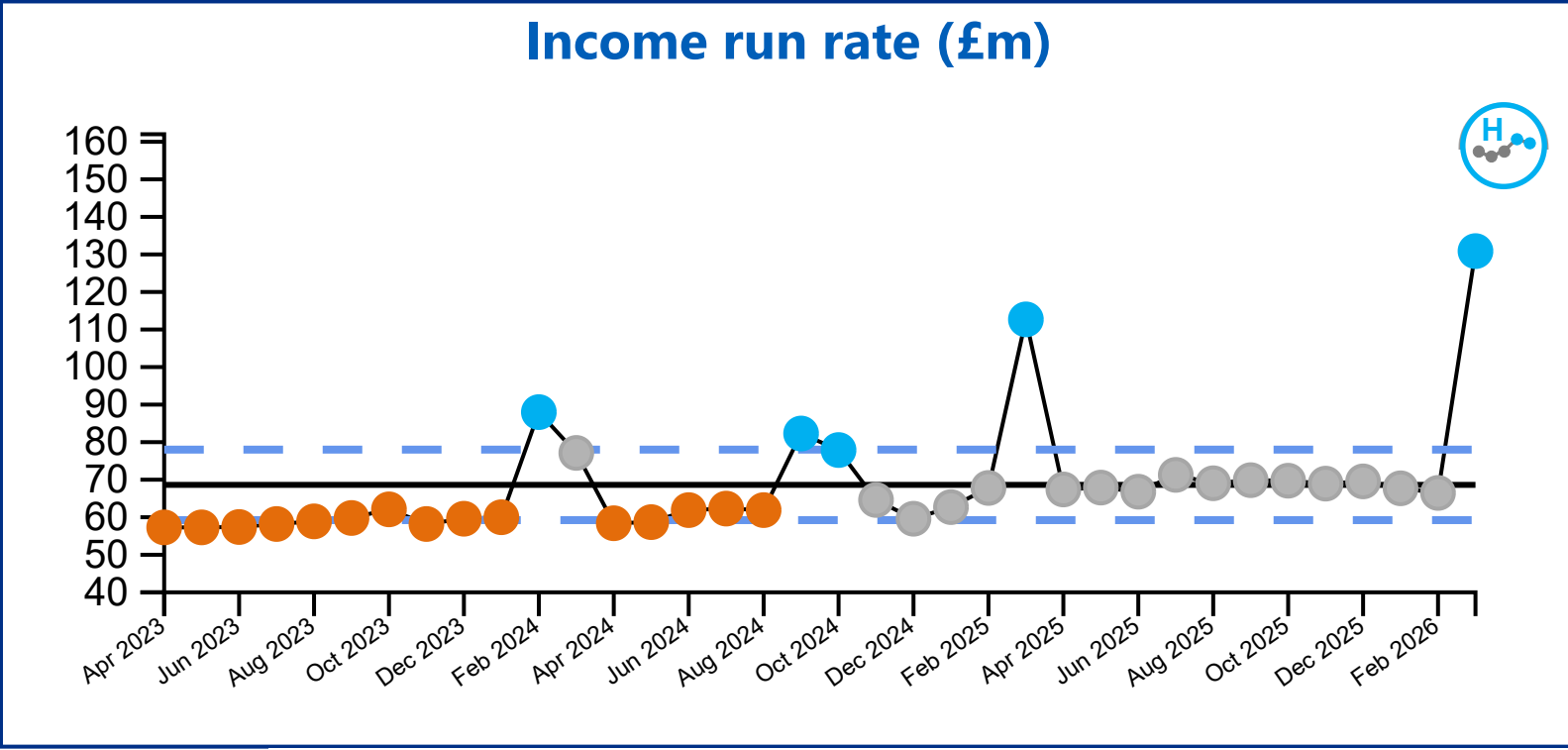
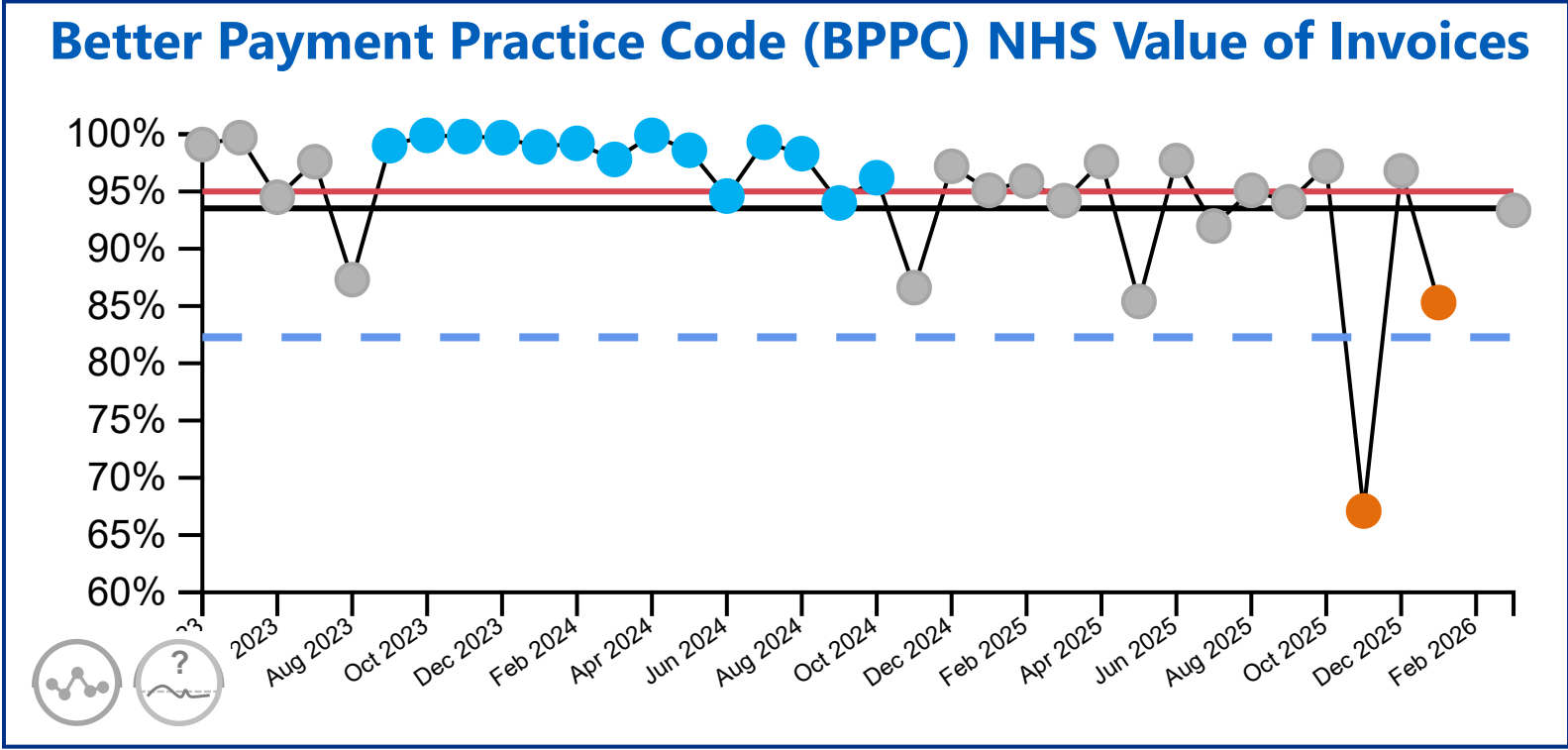
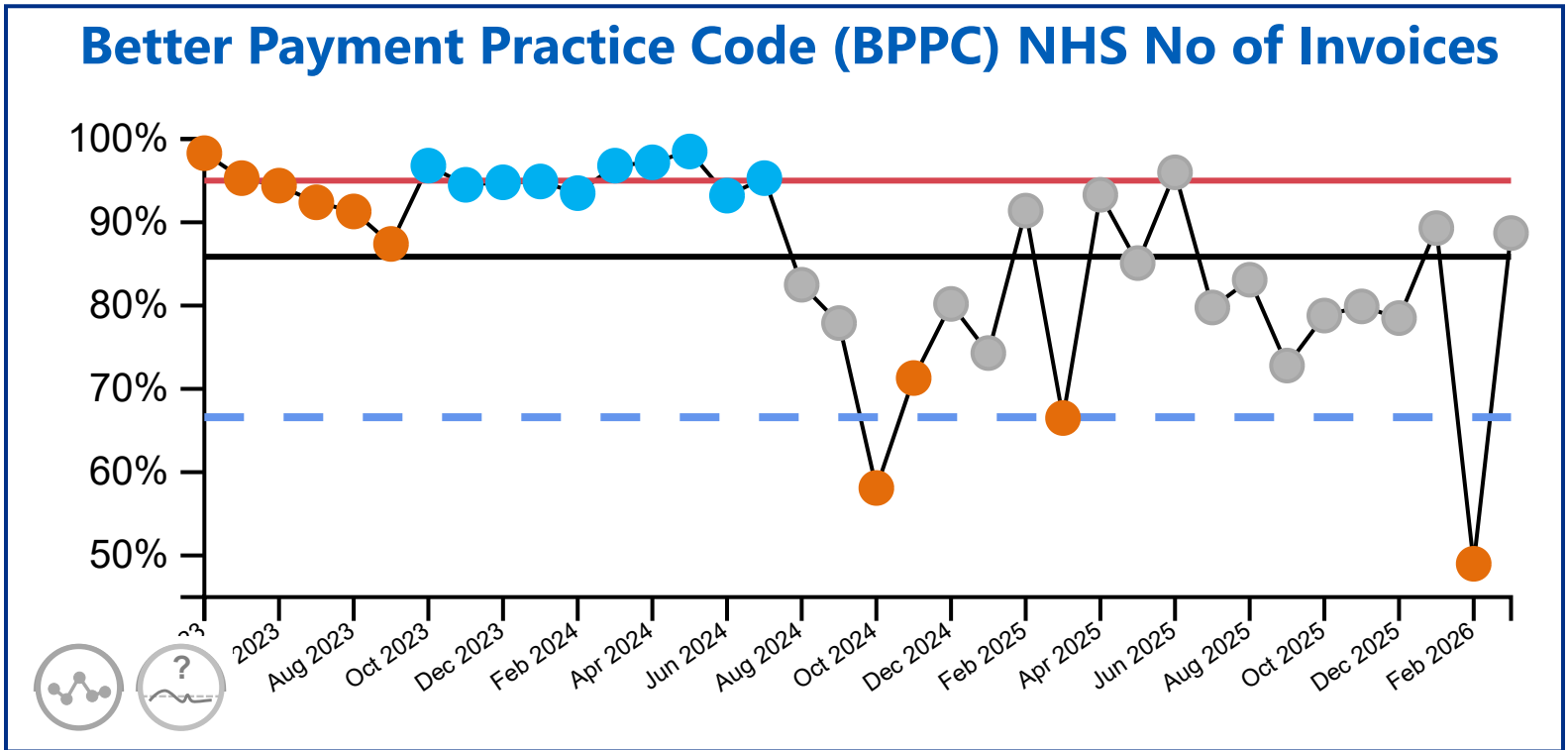
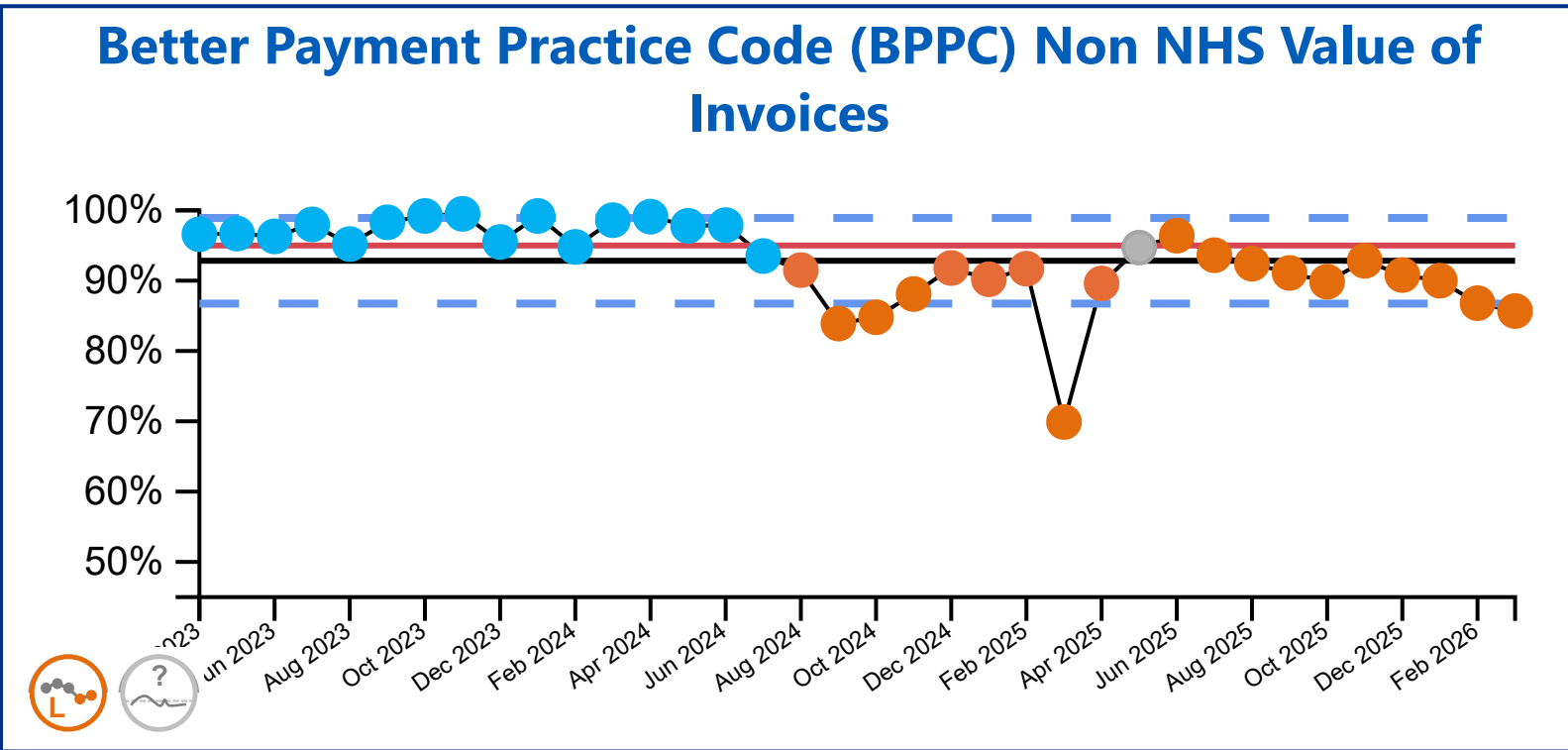
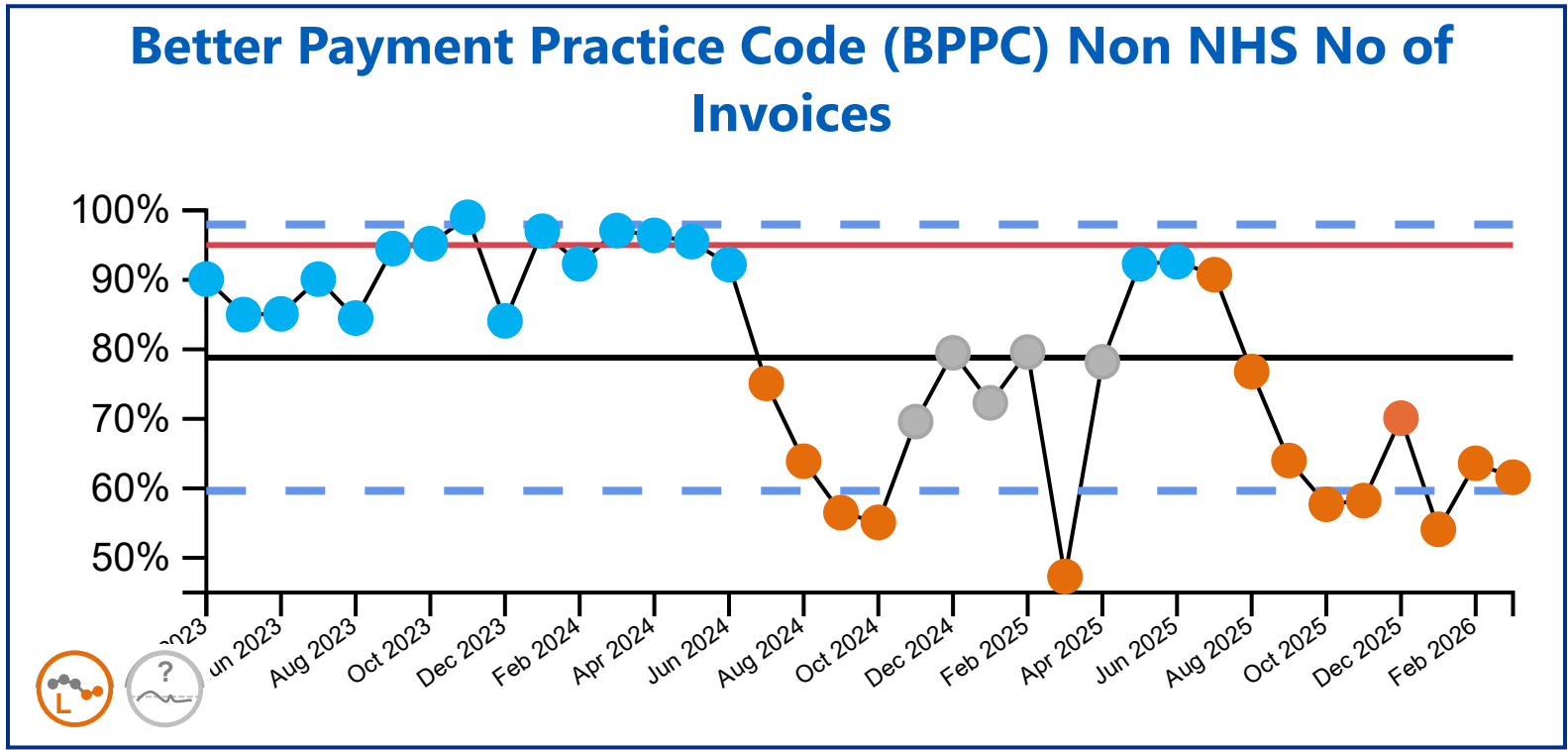
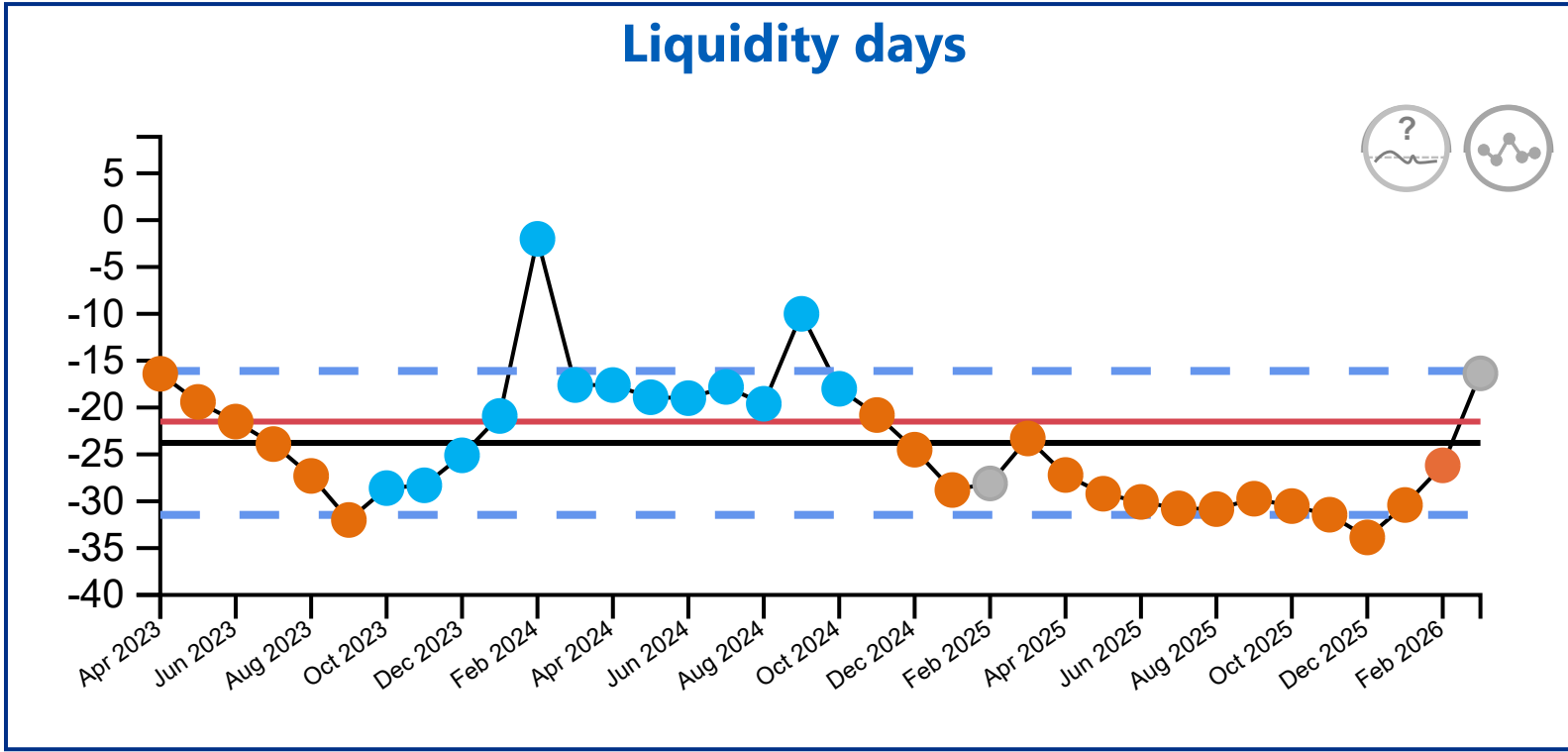
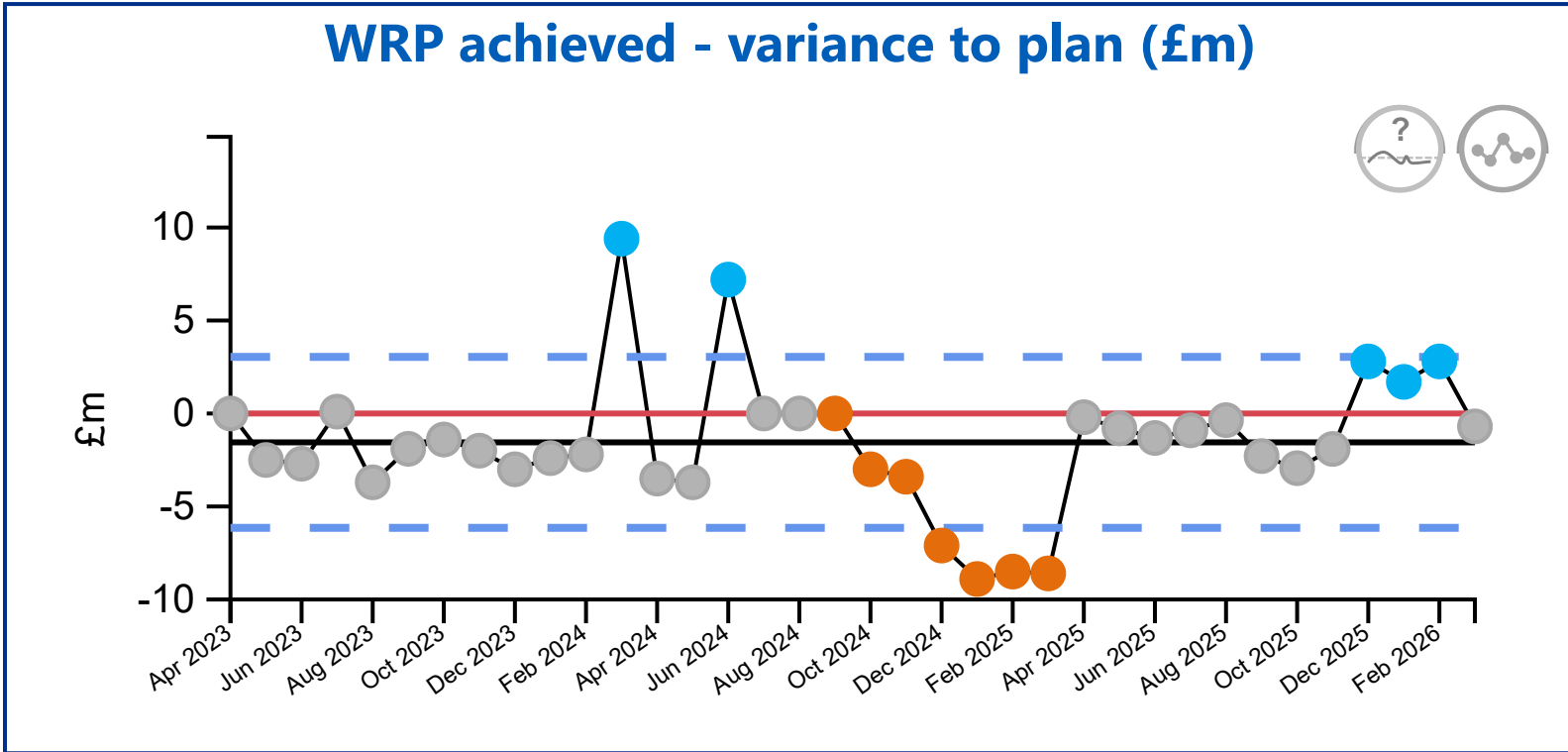
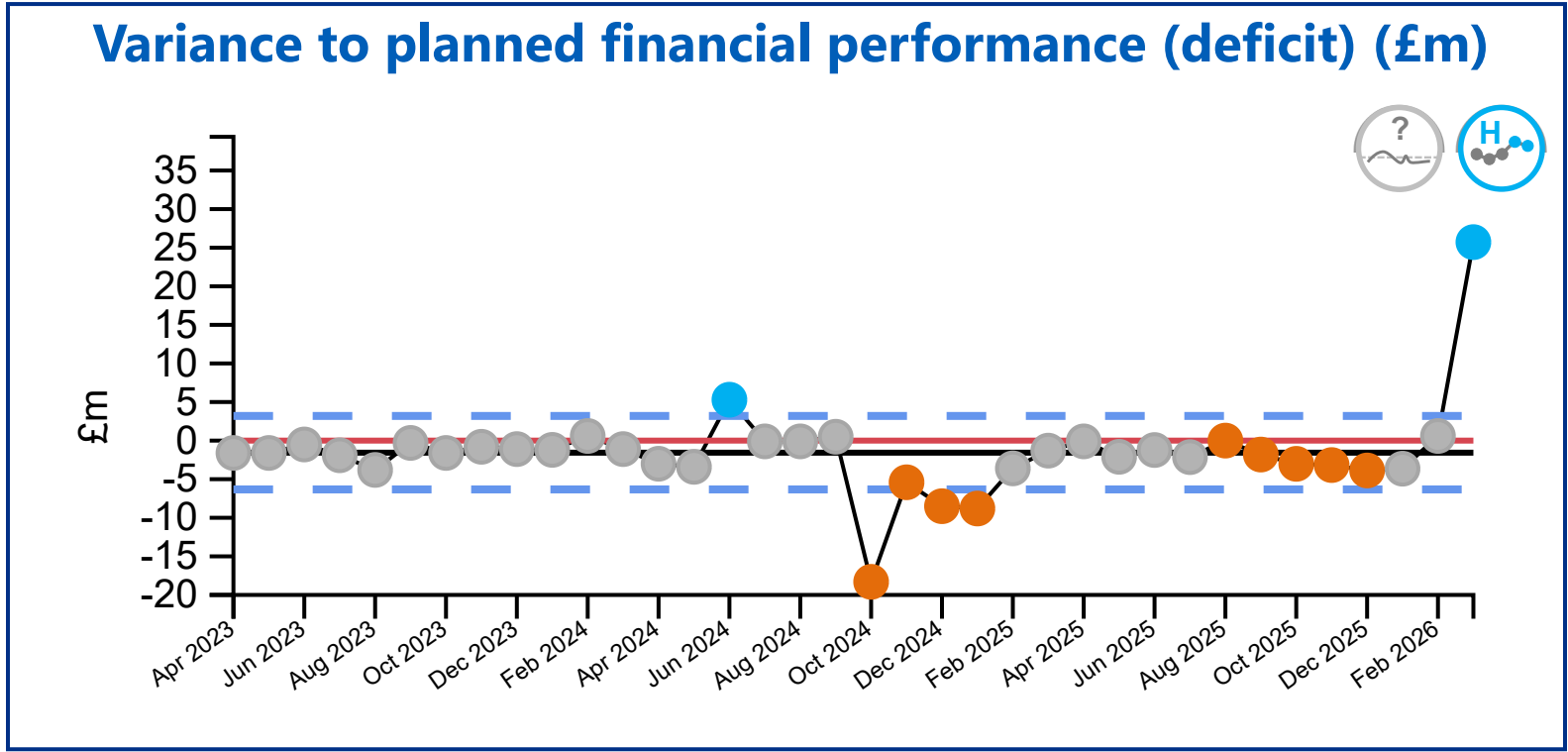
The two BPPC (non NHS Invoices) indicators are causing concern with both below target and showing significant deterioration in performance. Employee expenses run rate has moved from normal variation to a significant increase in March.

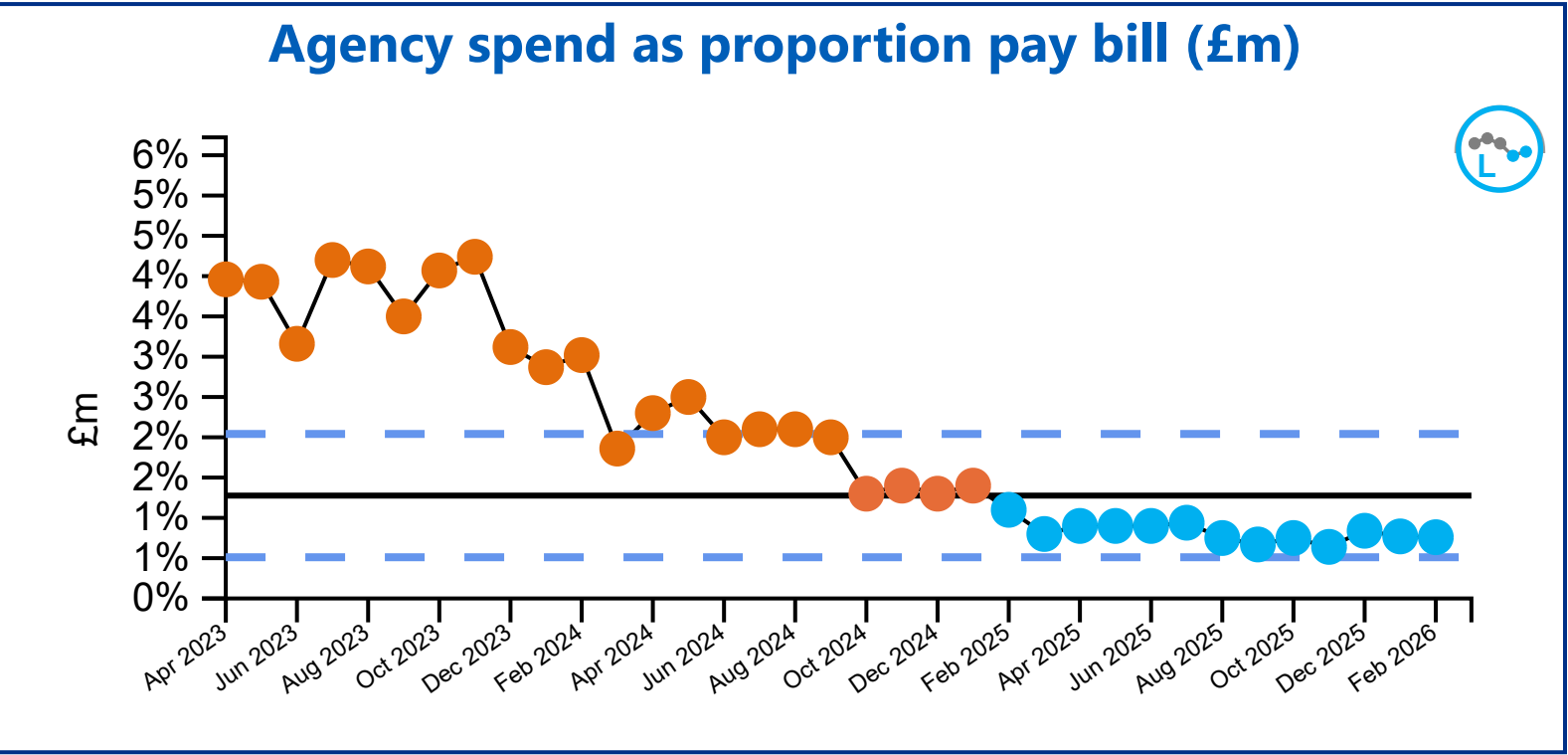
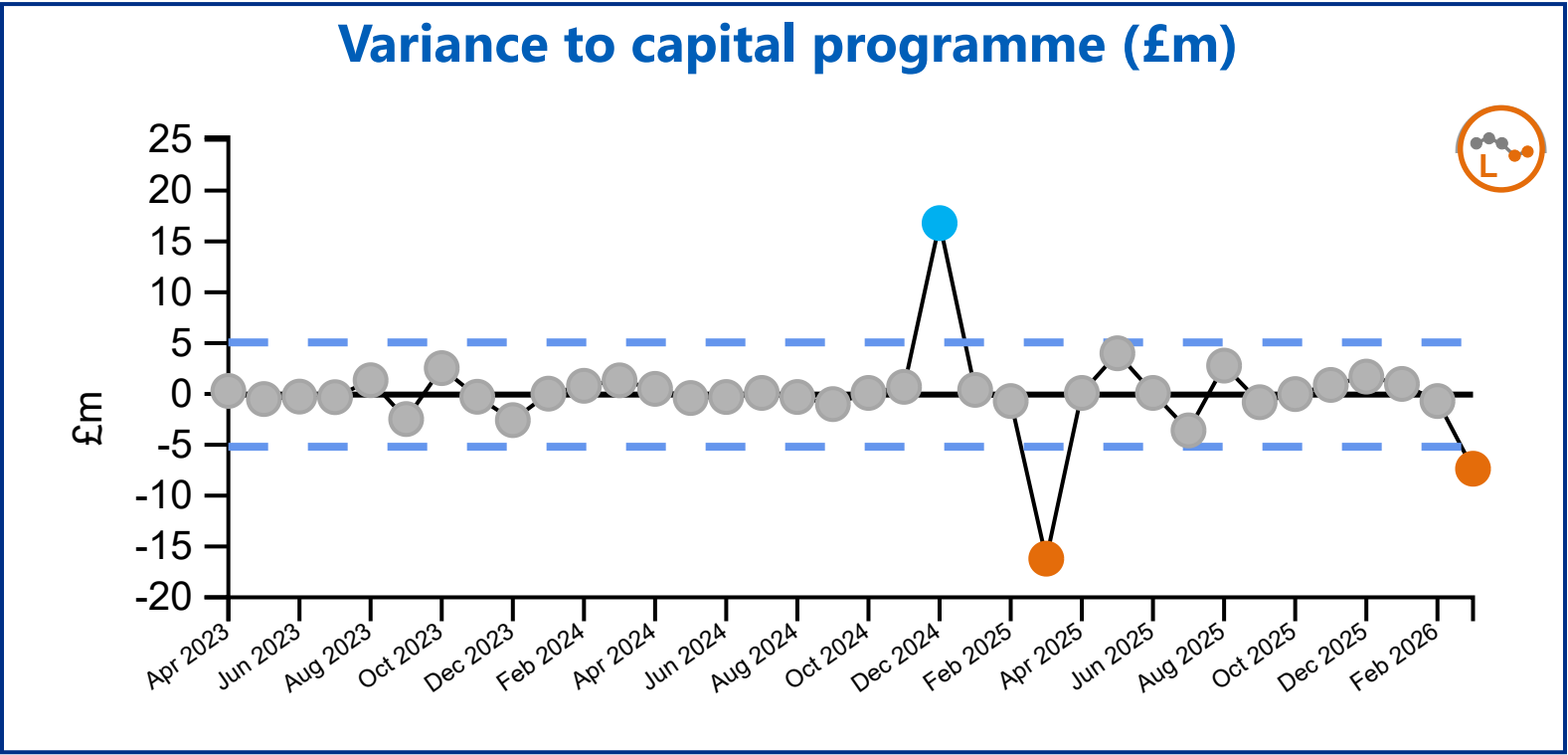
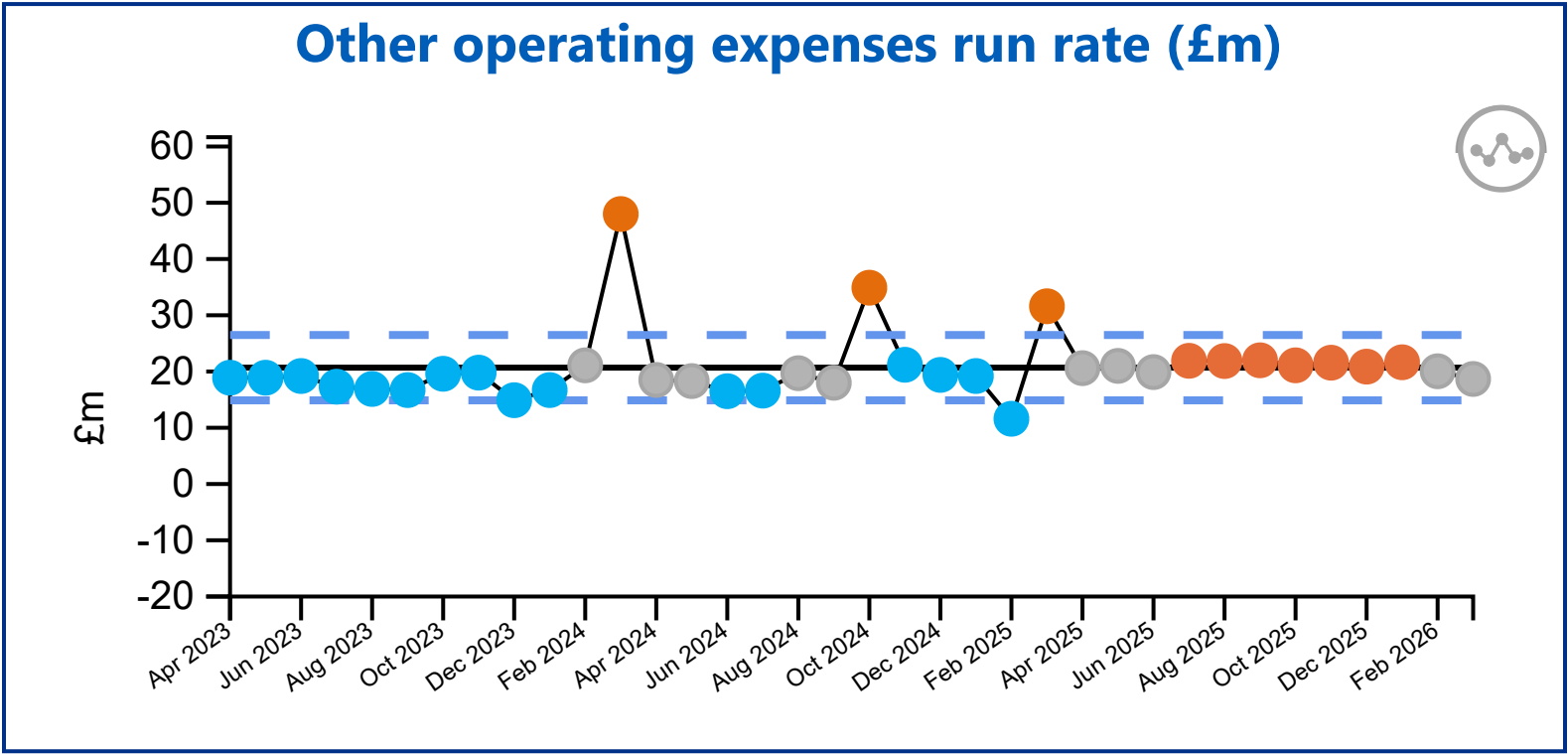
Advise

Better Performance Practice Code: An improved cash position has allowed the Trust to reduce the value of withheld payments of approved invoices to £16.2m, with further reductions expected in April and May by which time the Trust expects to be in a position to pay suppliers on time, although this is contingent on delivery of the 2026-27 financial plan.
Liquidity days has now showing normal variation following a sustained period of deterioration.
Variance to financial performance is showing a significant improvement in the latest month.
Income run rate has also shown significant improvement in the latest month.
Variance to capital programme has been performing consistently although showed significant deterioration in March.

Assurance

Summary Financial Position (Month 12):
The Trust is reporting a surplus of £10.3m for M12, excluding DSF, £12.4m above the plan.
The year-to-date position, excluding DSF, is a £43.0m deficit, £0.1m ahead of plan.
In month WRP delivered £5.5m representing a £1.1m adverse variance to plan (£0.7m adverse to PFR plan), but £0.9m ahead of the position forecast at M11. WRP is now exceeding target and has done for three consecutive months
Cash: The cash balance at the end of March was £35.1m, an increase of £16.9m compared to £18.2m at the end of February.
Capital: The 2025-26 capital plan is £43.761m. At M12, spend is £43.749m, £12k below plan.
Agency spend as proportion of pay bill is performing exceptionally well with a consistent run below target.





BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/060
Report Title:	Financial Performance Report Month 12 2025/6		
Author:	Miss C Henson, Deputy Director of Finance		
Lead Director:	Mr M Greatrex, Interim Executive Director of Finance		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
				✓
Executive Summary:	At month 12, the Trust has reported an in-month surplus of £10.3m, against a planned deficit of £2.52m; £12.4m ahead of plan. The year-to-date (YTD) position is a £43.2m deficit against a planned deficit of £43.3m; £77k ahead of plan (excluding the DSF). In month WRP delivered £5.5m against the WRP Delivery plan, therefore £1.1m adverse to plan (£0.7m adverse to PFR plan) The WRP has delivered £43.2m YTD against a plan of £60.8m; £17.6m behind the plan. Key Metrics - Agency spend in credit of £204k, is £713k better than plan linked to technical release. - Bank spend of £4,276m is £730k adverse to plan, this represents a 5% reduction on 2024/25 run rate. - The cash balance at the end of March was £35.1m, an increase of £16.9m compared to M11. - The annual 2025-26 capital plan is £43.76m, 25/26 spend is £43.75m, £12k below plan. - Paid WTE have increased by 59 WTE from Month 11 to 9,713.			
Key Issues/Areas of Concern:	The Trust's financial plan for 2025/26 is break-even, including £43.3m deficit support funding (DSF). The key risks associated with delivery of the plan included: - Full delivery of the Waste Reduction Programme of £60.8m on a recurrent basis. - Divisional pressures to be contained within the agreed budgets/ plan. - The finalised impact of the HCA review of banding inclusive of the associated timescales for both cash and revenue.			



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Action Required by the Board:	The Board is asked to note the month 12 financial position.
Previously Considered by:	Finance and Performance Committee
Date:	27 th April 2026
Outcome:	The Committee noted the Month 12 position.

M12 Financial Performance Trust Board

13th May 2026

Month 12 Key Headlines

Summary of Financial Position

- In month surplus of **£10.3m**, against **deficit plan of £2.5m** therefore **£12.4m above the plan**.
- YTD **deficit of £43.2m** against; **deficit plan of £43.3m** therefore **£77k ahead of plan** (excluding the DSF).
- The Trust committed to deliver a **£10.2m surplus at month 12** and this has been delivered.
- In month **WRP delivered £5.5m** against the WRP Delivery plan, therefore **£1.1m adverse to plan** (£0.7m adverse to PFR plan)
- YTD **WRP delivered £43.2m** against the WRP Delivery plan, therefore **£17.6m behind plan**.
- **Cash balance** at the end of March was **£35.1m**, an increase of £16.9m compared to M11 cash position of £18.2m.
- **Capital** plan 2025-26 is **£43.761m**. At M12, spend is **£43.749m**, £12k below plan.
- Paid/worked WTE have increased by **59 WTE** from Month 11 to **9,713 WTE**.

M12 FPR Plan vs Actual

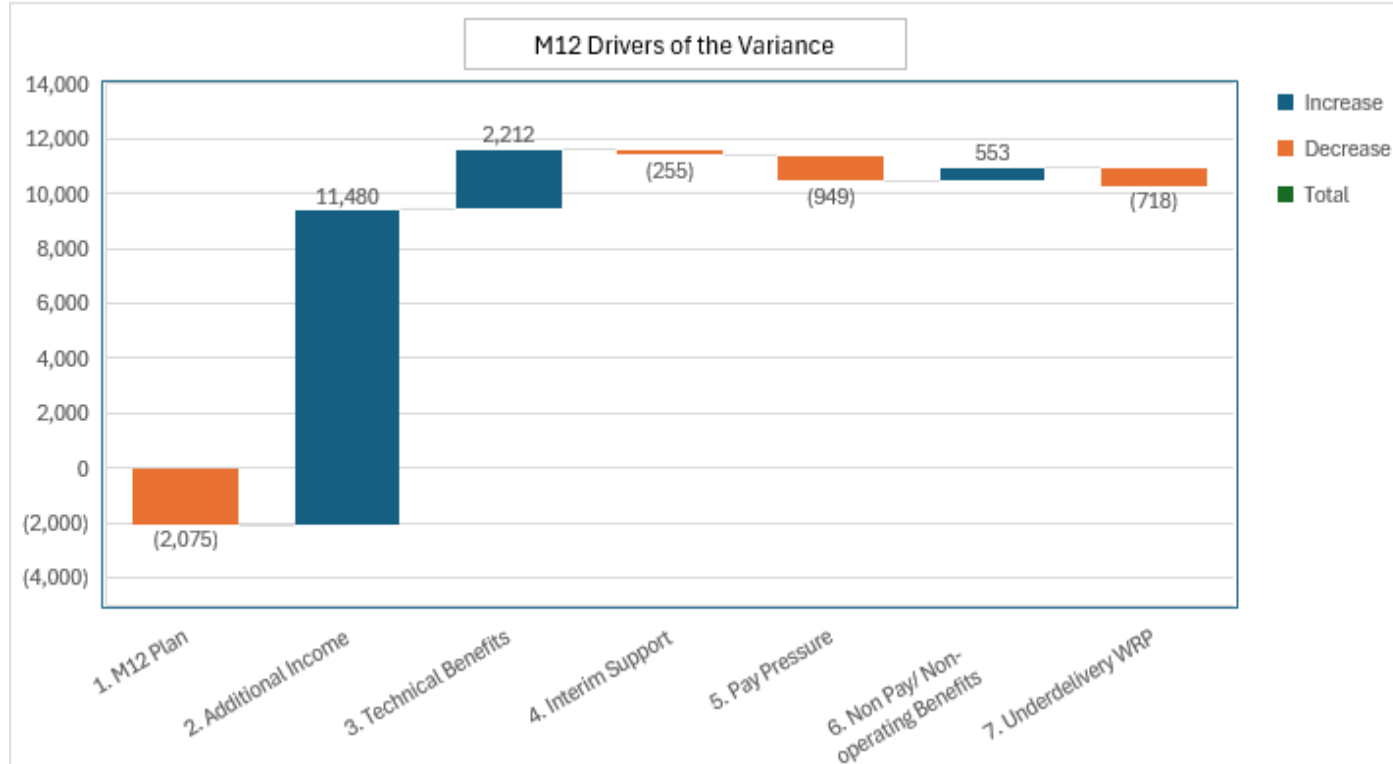
Monthly Actuals	Current Month	Current Month	Variance to Plan
	Plan	Actual	
	£000	£000	£000
Operating Income: Patient Care	64,111	125,052	60,941
Other Operating Income	3,888	5,831	1,943
Total Income	67,999	130,883	62,884
Substantive	(41,091)	(42,355)	(1,264)
Variable Pay: Overtime	(43)	(37)	5
Variable Pay: WLI / Extras	(355)	(519)	(164)
Variable Pay: Bank	(3,546)	(4,276)	(730)
Variable Pay: Agency	(509)	204	713
Other Staff Costs	(192)	(33,861)	(33,669)
Total Pay	(45,736)	(80,846)	(35,110)
Supplies & Services Clinical	(3,694)	(5,224)	(1,530)
Drugs	(4,488)	(3,128)	1,360
Other Non Pay	(10,925)	(12,398)	(1,473)
Total Non Pay	(19,107)	(20,750)	(1,643)
Total Expenditure	(64,843)	(101,596)	(36,753)
Net Expenditure	3,156	29,287	26,131
Non Operating Movements	(436)	(304)	132
Operating Surplus (Deficit)	2,720	28,983	26,263
Other Non Operating Movements	(1,185)	(1,740)	(555)
Adjusted Financial Performance Surplus (Deficit)	1,535	27,243	25,708
Deficit support Funding	(3,610)	(16,944)	(13,333)
Adjusted Financial Performance Surplus (Deficit) Excluding DSF	(2,075)	10,300	12,375

	£m	Recurrent	Non- Recurrent
Patient Care Income Plan	68.00		
Pension Funding	33.69		x
Deficit Support Funding	13.33		x
ICB Variable Income	5.04	x	
Partially Completed Spells	3.54		x
System Funding	2.30		x
Other Income Benefits	1.88		x
Non Operating Income	0.63		x
WRP Delivered	1.70		x
Non-contract variable income various	0.78		x
Patient Care Income Actual	130.88		

	£m	R	NR
Pay Plan	45.7		
Pension pressure	33.69		x
EYU/ Bank Holiday Benefit	-0.29		x
Annual leave Benefit	-0.60		x
Agency benefit	-0.60		x
Bank inc linked to AECU, MDU	0.32	x	
Interim/pmo	0.06	x	
HCA Accrual	0.10	x	
Annual Leave Cover	0.30		x
Capacity Claims	0.35		x
Underdelivery WRP	1.79	x	
Pay Actual	80.85		

	£m	R	NR
Non-Pay Plan	19.1		
Offset with income	1.30	x	
Technical benefit	-0.90		x
PFI Benefit	-0.50		x
Pressure: Insourcing/ Maintenance	0.50		x
Consultancy pressure	0.20	x	x
Stock Pressure	0.40		x
Underdelivery WRP	0.70	x	
Non-Pay Actual	20.8		

Drivers of Variance in M12



1. **M12 Plan:** £2.52m Deficit

2. **Income Benefits:** £11.5m (ERF / Q4 Sprint (£5m) / PCS (£3.5), System funding £2.3m Various other £0.7m)

3. **Technical Benefits:** £2.2m, various across pay and non-pay

4. **Interim Trust Financial Recovery Support:** £0.3m

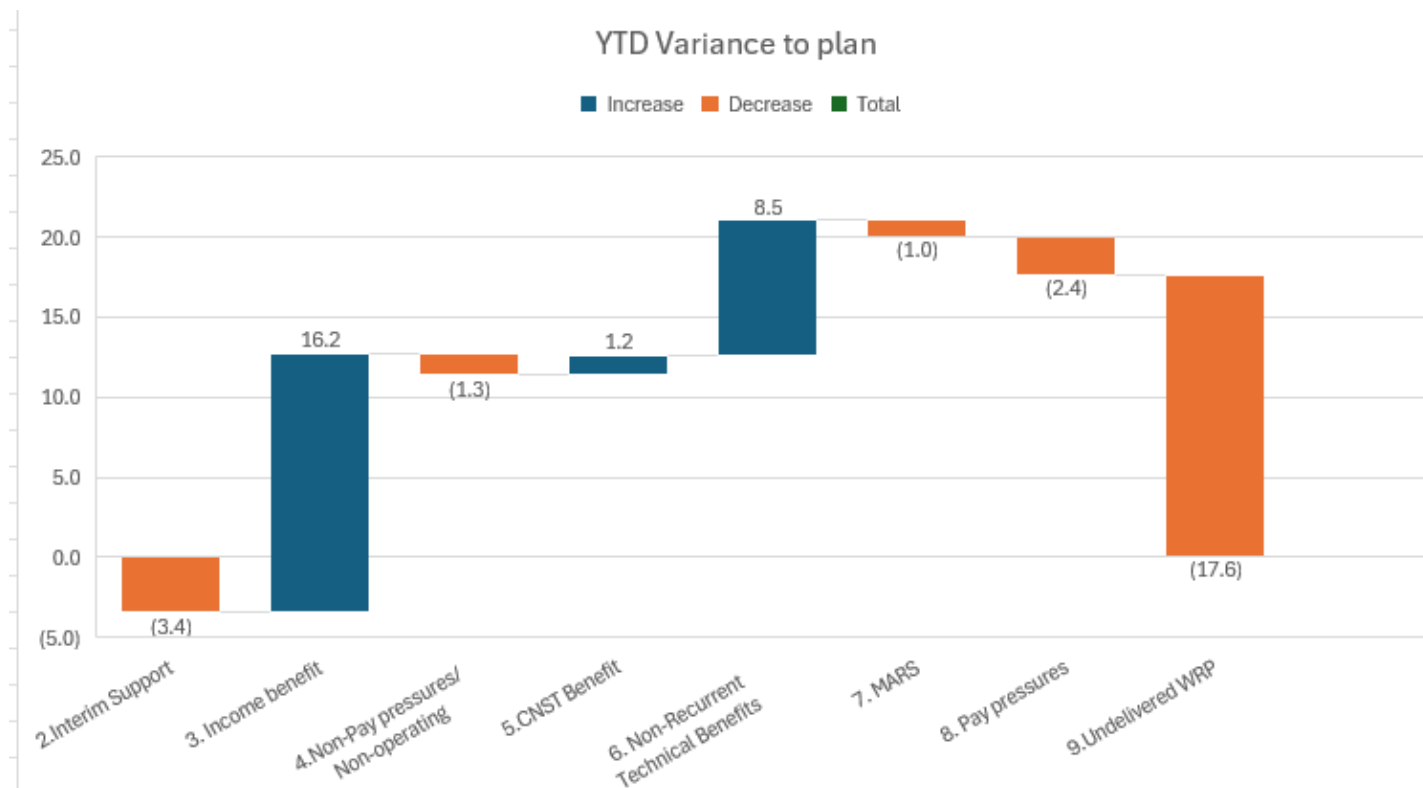
5. **Pay Pressure:** £0.9m adverse, linked to pressures in MDU/ AECU/DL (£0.3m) and capacity claims timing (£0.35m) and an increase in bank to cover annual leave

6. **Non-Pay / Non-operating Benefits:** £0.6m

7. **Undelivered WRP:** £0.7m pay and non-pay

8. **M12 Actual:** £10.3m Surplus

Drivers of Variance YTD



1. **YTD Plan:** £43.32m Deficit
2. **Trust Interim Financial Recovery Support:** pressure £3.4m
3. **Income benefit:** £16.2m (ERF/Sprint, CPD and bowel screening, Car parking, system funding)
4. **Non-pay:** pressures £1.3m (PFI, Stocks, Utilities)
5. **CNST:** one-off benefit £1.2m
6. **Technical:** benefit £8.5m
7. **MARS:** pressure £1m
8. **Pay Pressures:** £2.4m backdated pay, pension opt-in and operational pressures
9. **Undelivered WRP:** pressure £17.6m

YTD Actual: £43.25m Deficit

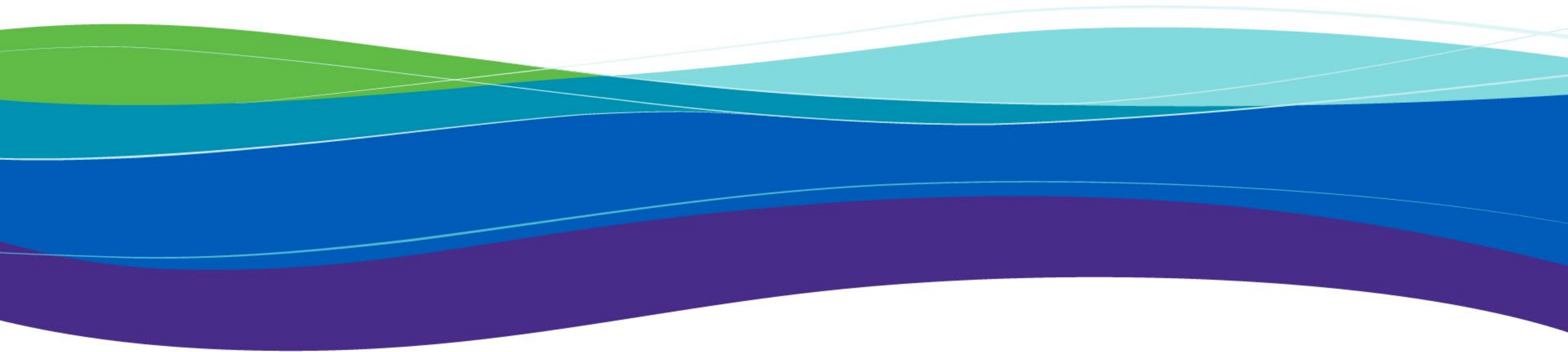
Key Risks

The key risks associated with delivery of the plan will be monitored and reported monthly, they are:

Risk Description	Inherent Risk Score (CxL+R)	Mitigations	Current Risk Score (CxL+R)	Operational Lead	Further Actions	On CRR (Y/N)
Failure to deliver the Trust's Waste Reduction Programme of £60.8m.	C: 5 L: 5 25	WRP FOT adjusted to £42.9m.	C: 5 L: 5 25	Head of PMO	Ongoing management through the PMO	Y
Cash flow management has been challenging since M7 largely linked to the withholding of DSF. DSF has now been received however the Trust is still withholding significant payments.	C: 5 L: 4 20	Focus on cash-releasing efficiencies.	C: 5 L: 3 15	Amina Yaqub	Ongoing management through daily cash management.	Y

The Trust has used numerous mitigations, additional income and technical adjustments offsetting the risk to WRP delivery in 25/26 to deliver the 25/26 plan. The focus for 26/27 needs to be delivery of cash releasing waste reduction schemes to maintain a strong cash balance facilitating payment to suppliers in a timely manner.

Cash



Statement of Cash Flows



East Lancashire Hospitals

NHS Trust

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Cash Flow Statement	As at 31st March 2025 £000	As at 31st March 2026 £000	Prior month £000	Variance £000
Operating Activities				
Operating Surplus/(Deficit)	(37,603)	22,766	(8,595)	31,361
Depreciation and amortisation	24,129	25,304	22,823	2,481
Impairments and reversals	14,568	(2,666)	(761)	(1,905)
Donated assets received credited to revenue but non cash	(434)	(2,053)	(1,381)	(672)
(Increase)/decrease in trade and other receivables	(402)	(14,935)	(16,453)	1,518
(Increase)/decrease in inventories	2,171	(52)	(471)	419
Increase/(decrease) in trade and other payables	10,434	7,321	17,612	(10,291)
Increase/(decrease) in other liabilities: deferred income	12,171	(9,408)	(5,192)	(4,216)
Increase/(decrease) in provisions	(144)	(55)	0	(55)
Net cash inflow from Operating Activities	24,890	26,222	7,582	18,640
Cash Flows from Investing Activities				
Interest received	1,947	2,554	1,757	797
(Payments) for property, plant and equipment and intangible assets	(24,858)	(19,281)	(14,165)	(5,116)
Proceeds from disposal of property, plant and equipment	545	90	103	(13)
Receipt of cash donations to purchase capital assets	52	409	82	327
Net cash outflow from Investing Activities	(22,314)	(16,228)	(12,223)	(4,005)
Net cash inflow before Financing	2,576	9,994	(4,641)	14,635
Cash Flows from Financing Activities				
Public dividend capital received	23,043	31,829	27,579	4,250
Loans from Department of Health - repaid	(200)	0	0	0
Capital element of lease payments	(7,474)	(8,156)	(7,346)	(810)
Capital element of PFI payments	(11,123)	(8,281)	(7,604)	(677)
Interest paid	(698)	(1,211)	(1,098)	(113)
Interest element of PFI obligations	(5,979)	(5,716)	(5,246)	(470)
PDC dividend (paid)/refunded	5,066	(168)	(168)	0
Net cash outflow from Financing Activities	2,635	8,297	6,117	2,180
Decrease in cash	5,211	18,291	1,476	16,815
Cash at the beginning of the year	11,575	16,786	16,786	-
Cash at the end of the financial period	16,786	35,077	18,262	16,815

The cash balance on 31st March was £35.1m, an increase of £16.8m compared to the previous month, mainly because of the additional income received in M12 resulting in a significant surplus at M12.

The £18.7m capital expenditure for month 12 is the main factor offsetting the impact of this surplus on the cash position, although with capital payables increasing by £10.6m in month, the full impact of the 2025-26 capital programme on the cash position is not expected to be felt until the end of the first quarter of 2026-27.

The improved cash position has allowed the Trust to reduce the value of other payables by £10.1m. Consequently, the value of withheld payments of approved invoices has reduced to £16.2m, with further reductions expected in April and May by which time the Trust expects to be in a position to pay suppliers on time, although this is contingent on delivery of the 2026-27 financial plan.

To note the Trust has not yet repaid the £10.8m of PDC Revenue support received within 25/26.

Rolling Cashflow Forecast: M12 25/26- 26/27



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Cash Flow Forecast	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Cash Balance	35,077	18,678	2,285	2,483	3,149	3,592	4,317	6,166	8,014	9,361	11,416	13,716
Capital (net)	(5,040)	(5,041)	(42)	(41)	(41)	(42)	(40)	(41)	(41)	(41)	(40)	(50)
Revenue:												
- Income	79,682	79,683	79,678	79,683	79,683	79,680	79,684	79,686	79,681	79,686	79,690	79,685
- Pay	(59,086)	(59,086)	(58,580)	(58,760)	(59,013)	(58,854)	(58,640)	(58,642)	(59,144)	(58,892)	(58,739)	(58,736)
- Other expenditure	(33,053)	(33,123)	(22,088)	(22,508)	(22,512)	(22,511)	(22,368)	(22,368)	(22,367)	(22,373)	(22,477)	(22,212)
Cash releasing efficiency savings	1,099	1,175	1,231	2,293	2,327	2,453	3,214	3,214	3,219	3,675	3,867	3,783
Net Cash Flow	(16,399)	(16,393)	198	666	443	725	1,849	1,848	1,347	2,055	2,300	2,469
Closing Cash Balance	18,678	2,285	2,483	3,149	3,592	4,317	6,166	8,014	9,361	11,416	13,716	16,185

This forecast is based on the 2026-27 financial plan and assumes that of the £35.1m cash balance brought forward, £32.1m will be used to settle outstanding liabilities relating to 2025-26, including c£10m for the 2025-26 capital programme.

Statement of Financial Position



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	As at 31st March 2025 £000	As at 31st March 2026 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	24,985	5,817	18,042	6,943
Property, plant and equipment	266,094	281,767	15,673	268,730	13,037
Right of use assets	31,946	35,132	3,186	33,278	1,854
Inventories	7,798	7,850	52	11,781	(3,931)
Receivables (NHS)	17,592	27,908	10,316	28,424	(516)
Receivables (non-NHS)	19,605	23,982	4,377	25,498	(1,516)
Cash and cash equivalents	16,786	35,077	18,291	18,262	16,815
Total assets	378,989	436,701	57,712	404,015	32,686
Liabilities:					
Trade and other payables (capital)	(6,418)	(17,420)	(11,002)	(6,842)	(10,578)
Trade and other payables (non-capital)	(71,452)	(78,755)	(7,303)	(88,895)	10,140
Lease related liabilities	(32,433)	(36,095)	(3,662)	(34,219)	(1,876)
PFI related liabilities	(228,045)	(217,372)	10,673	(218,048)	676
Provisions for liabilities and charges	(3,439)	(3,441)	(2)	(3,491)	50
Other liabilities: deferred income	(13,693)	(4,285)	9,408	(8,500)	4,215
Total liabilities	(355,480)	(357,368)	(1,888)	(359,995)	2,627
Total assets employed	23,509	79,333	55,824	44,020	35,313
Financed by taxpayers equity					
Public dividend capital	332,933	364,762	31,829	360,512	4,250
Revaluation reserve	21,711	25,393	3,682	21,711	3,682
Income and expenditure reserve	(331,135)	(310,822)	20,313	(338,203)	27,381
Total taxpayers equity	23,509	79,333	55,824	44,020	35,313

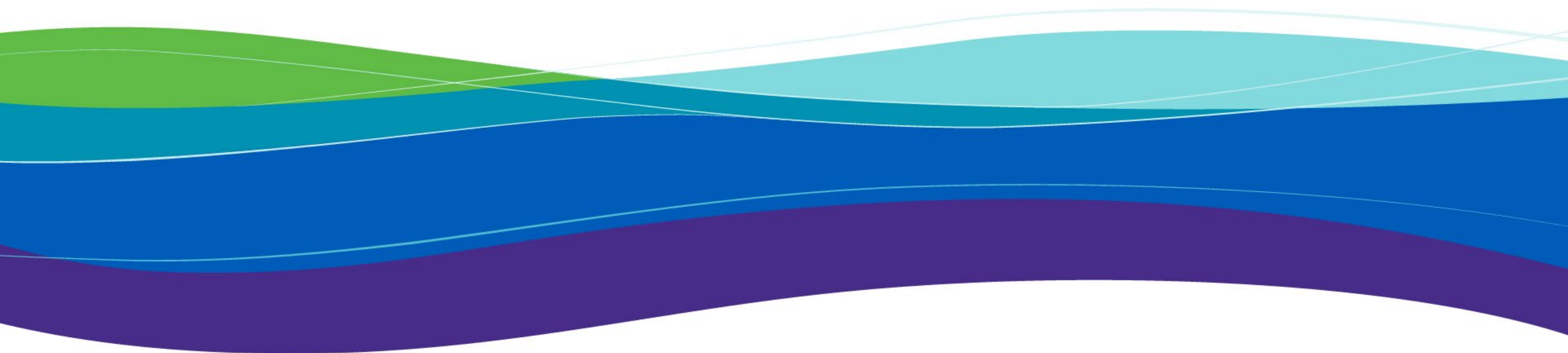
Capital



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Capital



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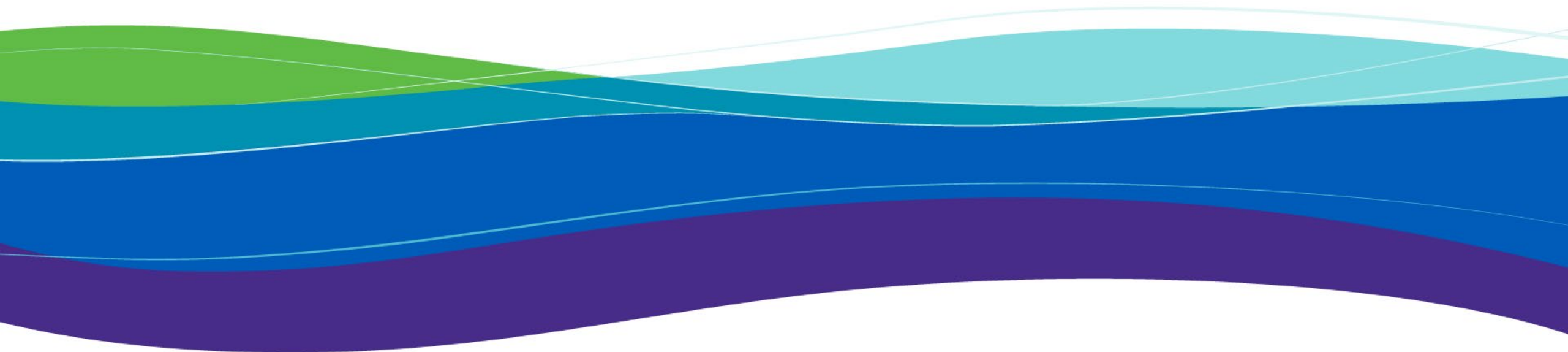
2025-26 capital outturn position	Initial Plan	Adjustments	Revised Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000
Internally Funded					
Donated & Grant Funded Assets	500	1,557	2,057	2,057	0
PFI lifecycle cost	3,604	2,086	5,690	5,690	0
CHO ROU assets	4,656	3,588	8,244	8,244	0
Other ROU asset (intra-DHSC group)	12	-4	8	8	0
Other ROU assets	6,332	-2,814	3,518	3,566	48
Other internally funded schemes	6,889	-3,643	3,246	3,186	-60
Externally funded					
UEC #2	-	2,225	2,225	2,225	0
Net Zero	1,980	0	1,980	1,980	0
Diagnostics	1,435	3	1,438	1,438	0
Elective Recovery	1,044	-245	799	799	0
UEC	5,749	-3,313	2,436	2,436	0
Estates Safety	757	1,031	1,788	1,788	0
RAAC	-	159	159	159	0
Digital	-	410	410	410	0
Retinopathy pf Prematurity (ROP)	-	69	69	69	0
EPR (Oracle) to GP Connect integration	-	1,827	1,827	1,827	0
Funding to replace use of cash reserves	-	3,612	3,612	3,612	0
Cyber Security	-	2,898	2,898	2,898	0
2526 Connecting Care Records - Interoperability -	-	287	287	287	0
Sec7A Health Inequalities Equipment	-	150	150	150	0
Single SD Wan	-	302	302	302	0
Maternity & Neonatal Programme	-	168	168	168	0
CDC Oversight & Assurance Dashboard	-	250	250	250	0
Intra-Oral Scanner - Max Facs	-	200	200	200	0
Total	32,958	10,803	43,761	43,749	-12

- The Trust's Capital Programme for 2025/26 increased to **£43.761m**. At M12, spend is **£43.749m**, £12k below plan.
- The £11.8m included for right of use asset (ROU) relates to spend in line with the allocation from the ICB, £8.2m of which related to properties leased from Community Health Partnerships (CHP).
- Otherwise, £5.7m of capital spend is PFI lifecycle with most of the remaining balance spent on Estates and digital related schemes, £21.0m of which have been externally funded.

Glossary



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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 the Trust to deliver a breakeven position in 2025/26*

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 a Trust's/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 it was recognised through revenue only.*

Glossary

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

PDC Provider Revenue Support - Revenue Support PDC is available to support revenue expenditure for cash-distressed providers for necessary and essential expenditure to protect continuity of patient services **Waste Reduction Programme (WRP)** – this is the terminology for the efficiencies required by the Trust. 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, the Trust uses the NHS financial year

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, the Trust uses the NHS financial year, and the exit run rate is defined by the position on 31 March 2026, 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 Trust's efficiency programme

High-Cost Drugs (HCD) – High-cost drugs that are pass through in nature, so funded at the level of cost incurred

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/061
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 Trust has made good progress throughout 2025/26 evidenced through our improvement plan, the delivery of our financial plan and wider operational performance. The key messages at Month 12 are: • The Trust has achieved its overall financial plan for 2026/27 and is testament to the hard work of colleagues in supporting our financial recovery. • The Waste Reduction Programme (WRP) delivered £5.5m against the WRP Delivery plan in month 12 and year-to-date we have delivered WRP of £43.2m against the WRP Delivery plan, therefore £17.6m behind plan. Whilst there remains under-delivery of WRP the Trust has delivered against its re-forecast WRP from M10 and in total has removed 5.27% of costs, the highest the Trust has ever achieved. • The delivery of the overall financial plan has impacted positively on the Legal Undertakings with 15 out of 16 actions (94%) complete, and 100% complete or on track. • The RSP exit criteria this month have been updated to reflect the year end position – the achievement of the financial plan and completion of all planning for 2026/27 results in a number of improvements to the RSP Exit Criteria with 7 more actions now completed. Of the 41 actions, 80% (33 actions) are complete, with 90% (37 actions) complete or on track for completion. All outstanding actions have been reviewed and will carry forward into 2026/27 and relate largely to ongoing delivery of the Trust's financial recovery plan. • The Care Quality Commission (CQC) action plan has been updated and at month 12, 40 /41 (98%) actions are			

	complete. Since month 11, a further 1 action has turned from green to blue.
Key Issues/Areas of Concern:	- The Trust has made good progress throughout 2025/26 evidenced through the progress on our improvement plan and the delivery of our financial plan and wider operational performance. We have successfully had our medium-term planning submission approved and work is now well underway to ensure ongoing delivery into 2026/27 and sustained improvement. - Work is now underway to undertake a formal end of year review of the Integrated Improvement Plan to close down at Month 12 and then to agree a revised Improvement Plan for 2026/27 and this will be presented to NHS England in June 2026.
Action Required by the Board:	The Board are asked to note the progress and be assured in delivery of the Integrated Improvement Plan at Month 12 2025/26.

Previously Considered by:	Financial Improvement / Improvement Group
Date:	24 th April 2026
Outcome:	Improvement Plan reviewed and noted.

East Lancashire Hospitals NHS Trust Integrated Improvement Plan

Update Report Month 12, 2025/26

Improvement Plan Contents

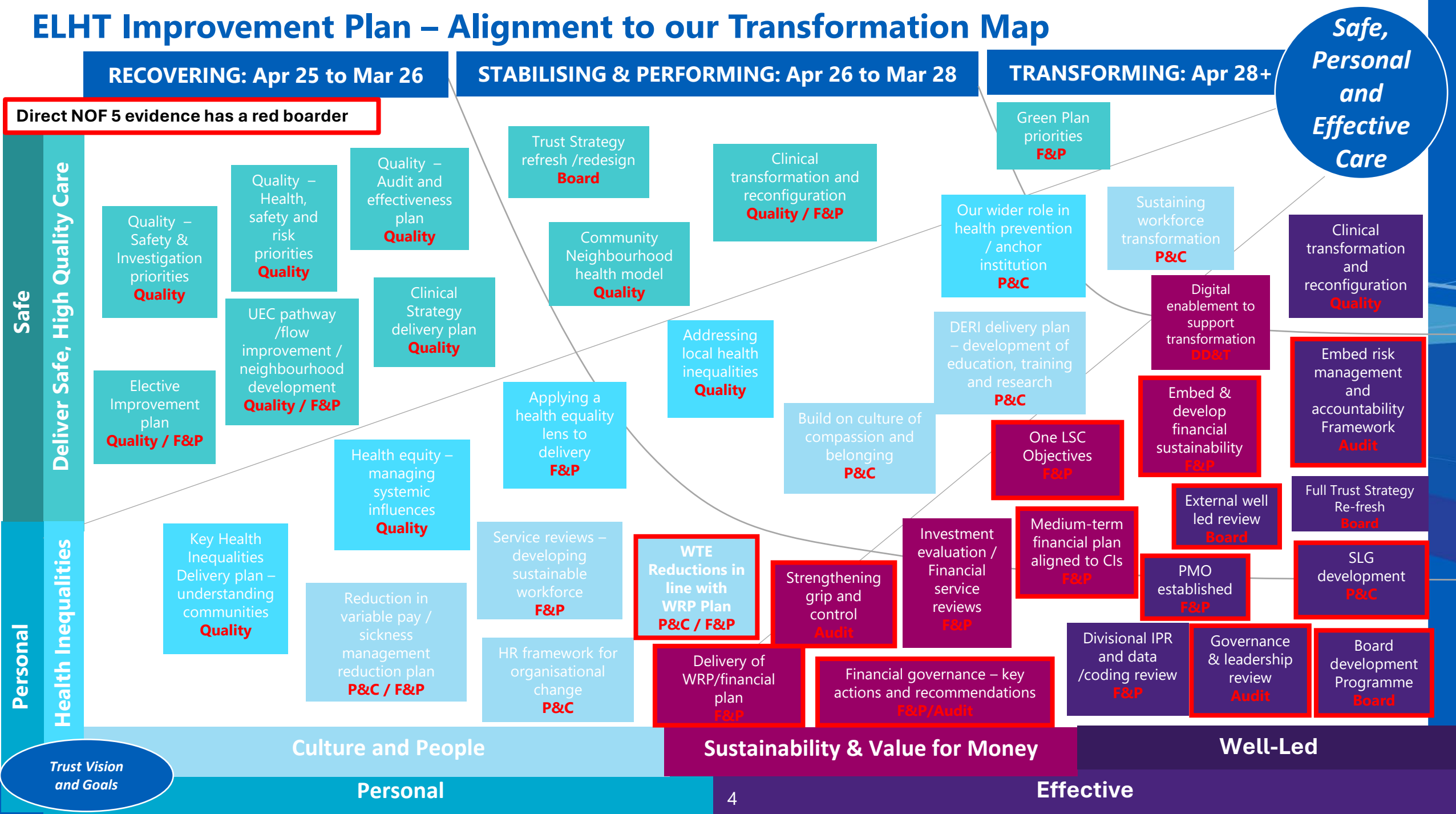
Section	Slide No.
Section 1 – Introduction to the Integrated Improvement Plan	3
• ELHT Transformation Map 2025/26 - how our Integrated Improvement Plan fits into our wider priorities	4
• ELHT Strategic Framework 2025/26 – mapping of our Integrated Improvement Plan to our Trust priorities and plans	5
• Governance of our Integrated Improvement Plan	6
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• RSP Exit Criteria	8
Section 2 – Monthly Update Report	
• Key Messages this month	10
• Executive Summaries of Improvement Plans	11-13
• Evidence and assurance summary	14

Introduction to the Integrated Improvement Plan

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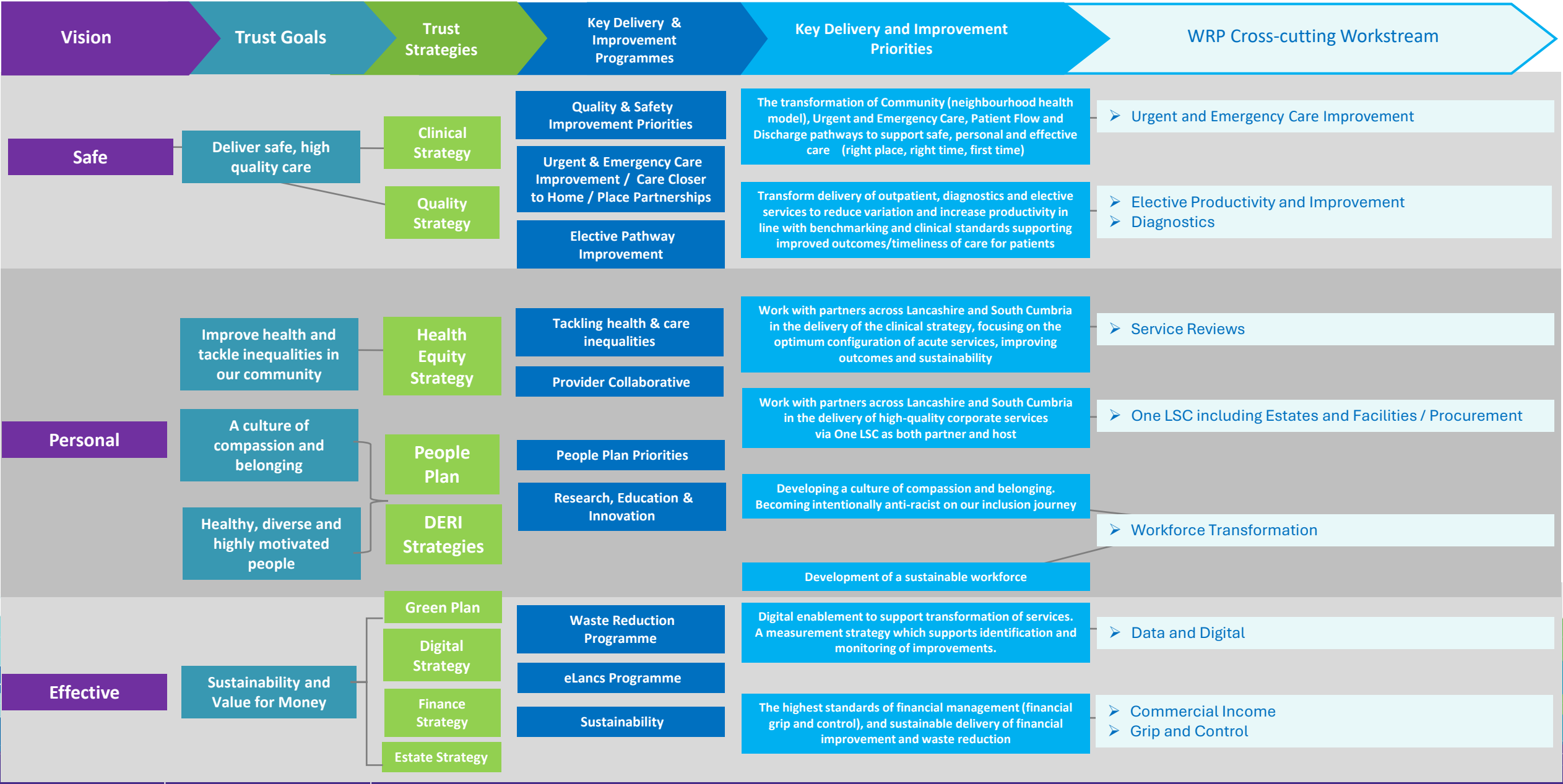
- The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan was developed in early 2025/26 to support the Trust to evidence the improvement actions underway and associated impact in response to meeting the Recovery Support Programme (RSP) Exit Criteria and associated Legal Regulatory Undertakings. The plan has now been further developed to become an Integrated Improvement Plan (IIP) from Month 9 2025/26.
- The IIP brings together all key improvement requirements, including regulatory undertakings, CQC actions, external review recommendations, governance and leadership improvements, the Financial Improvement Plan.
- A single integrated approach provides 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 work required to ensure financial recovery and sustainability and the requirement to strengthen our leadership and governance, which continues be improved. This is what Safe, Personal and Effective care means for ELHT.
- This month represents the last update for the 2025/26 IIP and work is now underway to agree a refreshed IIP for 2026/27 which will link/reflect the priorities in the Trust's Medium-Term Plan submission and the new Trust Strategy.

ELHT Improvement Plan – Alignment to our Transformation Map



ELHT Strategic Framework - WRP cross-cutting workstreams and alignment

2025/26



Improvement Plan Governance and Reporting

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



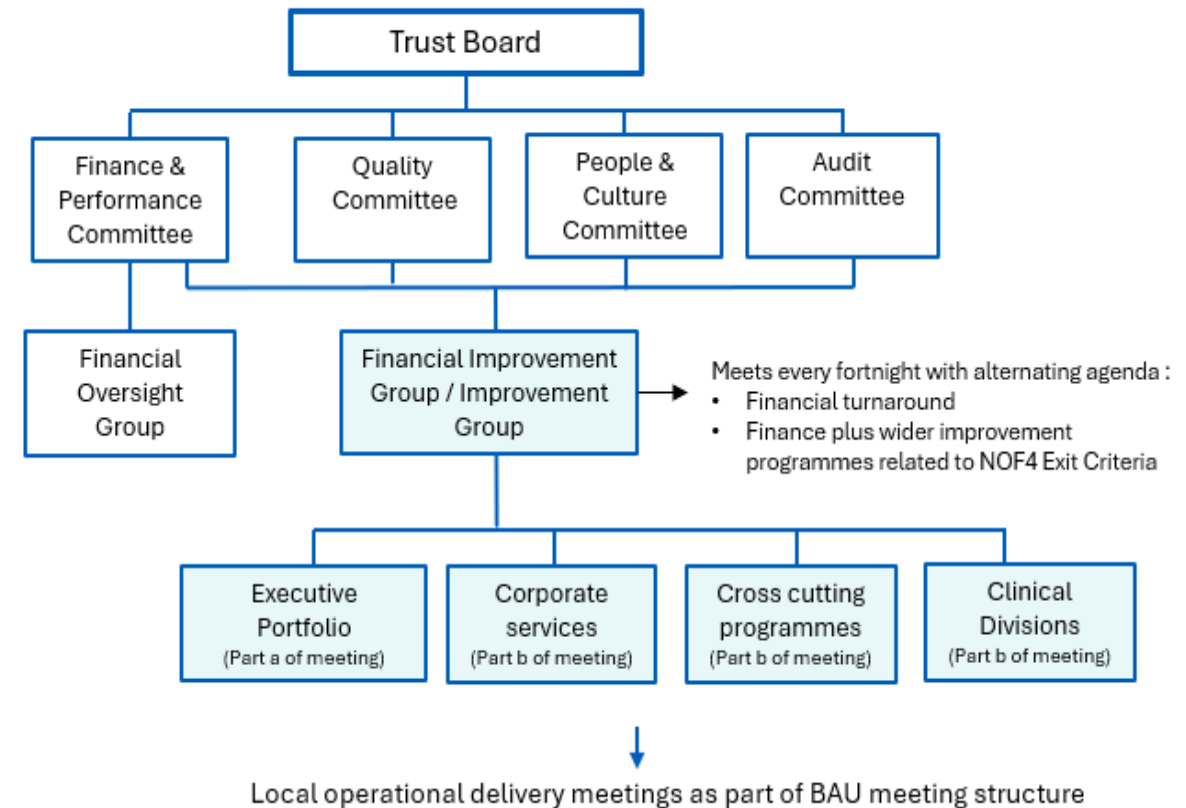
The PMO:

- 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.



Regulatory Undertakings - ELHT

A summary of progress against the NOF4 Exit Criteria is provided on slide 12 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
Meetings and Reports	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.
	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.
Funding Conditions and Spending Approvals	5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.
	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.

RSP NOF 5 Exit Criteria and Evidence Required

A summary of progress against the NOF5 Exit Criteria is provided on slide 13

1

Delivery of financial plan and Waste Reduction Programme

2025/26 break-even position and deficit no more than the £43.3m planned

Achievement of £60.8m WRP and plans in excess of £61m to offset any under delivery

Delivery against key expenditure categories as outlined in the financial plan and WRP

A reduction in who time equivalent (WTE) staffing as agreed in the WRP

Finalisation of Commissioning Intentions with the ICB along with associated costs and in-year and medium-term impact assessment

2

Deliver quarter-on-quarter run rate improvement throughout 2025/26

Quarter-on-quarter improvement in underlying run rate throughout 2025/26

Robust expenditure controls in line with PwC recommendations

3

Develop a medium-term financial recovery plan covering the period post 2025/26

A Board and IAG approved plan for financial recovery and maintenance beyond 2025/6 by the end of Q3

4

Demonstrate effective financial and organisational governance structures and mechanisms

Development of an improvement plan to ensure timely response, evidence and completion of recommendations in the Governance Review of April 2025

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

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

Identification of finance and org risks and effective controls in BAF, Risk Management Processes, AAA reports at Board and subcommittee level

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

5

Full participation in the Recovery Support Programme

Executive Board attendance at monthly IAG meetings

Engagement with Turnaround Director and team and response to requested actions

Timely and accurate reporting of finance data

Establishment of a Programme Management Office (PMO) and appointment of Senior Responsible Officers (SRO) to manage delivery of financial and organisational plans

Improvement Plan Delivery Update

Month 12 Report



Key messages this month

The Trust has made good progress throughout 2025/26 evidenced through our improvement plan, the delivery of our financial plan and wider operational performance.



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- At Month 12 we achieved an in-month surplus of £10.3m, against a deficit plan of £2.5m, which is an overall result of £12.4m above the plan
- This takes our year-to-date and year-end position for 2025/26 to a deficit of £43.2m against a deficit plan of £43.3m, ending the year £77k ahead plan (excluding the DSF)
- The Trust has therefore delivered its overall financial plan for 2026/27 and this is testament to the hard work of colleagues in supporting our financial recovery
- The Waste Reduction Programme (WRP) delivered £5.5m against the WRP Delivery plan in month 12 and year-to-date we have delivered WRP of £43.2m against the WRP Delivery plan, which is £17.6m behind plan.
- Whilst there remains under-delivery of WRP the Trust has delivered against its re-forecast WRP from M10 and in total has removed 5.27% of costs, which is the highest the Trust has ever achieved
- The delivery of the overall financial plan has impacted positively on the Legal Undertakings with 15 out of 16 actions (94%) complete and 100% complete or on track and improvements to the RSP Exit Criteria with 7 more actions now completed. Of the 41 actions, 80% (33 actions) are complete, with 90% (37 actions) complete or on track for completion. All outstanding actions have been reviewed and will carry forward into 2026/27 and relate largely to ongoing delivery of the Trust's financial recovery plan
- The Care Quality Commission (CQC) action plan has been updated and at month 12, 40 /41 (98%) actions are complete. Since month 11, a further 1 action has turned from green to blue
- We have successfully had our medium-term planning submission approved and work is now well underway to ensure ongoing delivery into 2026/27 and sustained improvement
- A formal end of year review of the Integrated Improvement Plan to Month 12 will inform a revised Improvement Plan for 2026/27 and this will be presented to NHS England in June 2026.

Regulatory Undertakings Summary – Month 12

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

Undertaking Focus	No. of Key Actions	BRAG Status Summary for Key Actions				Overall BRAG	Summary of Progress	Next Steps
Financial Planning	3	3	0	0	0	B	Financial plan for 2025/26 agreed. Quarter on quarter run rate reduction since Q3 2024/25. 2026/27 financial plan met with £43.2m deficit against deficit plans of £43.3 therefore £77k ahead of plan (excluding DSF).	Progress delivery plans for 2026/27.
Recovery Support Programme	3	2	1	0	0	G	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. 2026/27 financial plan met with £43.2m deficit against deficit plans of £43.3 therefore £77k ahead of plan (excluding DSF). Whilst WRP delivery remained under plan the Trust met its WRP re-forecast from M10 of £43.2m.	Ongoing completion of all outstanding IIP actions and development of refreshed IIP for 2026/27 by June 2026. Participate in Barrier and Limitations review.
Leadership and Governance	3	3	0	0	0	B	The governance and leadership action plan combines recommendations from all reviews completed with 84/88 actions completed. No risks to delivery flagged. The Board development plan is in place with phase 1 completed and phase 2 commencing 8 April 2026. Executive Development plan commenced February 2026.	Executive and Board Development. Recruitment of Finance Director (interim arrangements agreed, interviews 29 April 26).
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	15	1	0	0		94% complete, 100% complete or on track. M12 FOT has improved to support a mitigation plan in place to deliver financial plan.	

RSP Exit Criteria Self-Assessment – Month 12

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	7	1	4	0	G	2026/27 financial plan met with £43.2m deficit against deficit plans of £43.3 therefore £77k ahead of plan (excluding DSF). Whilst WRP delivery remained under plan the Trust met its WRP re-forecast from M10 of £43.2m. Overall BRAG of green due to delivery of financial plan.	Achieve breakeven plan for 2025/26. Progress delivery plans for 2026/27.
Deliver quarter-on-quarter run rate improvement throughout 2025/26	2	5	5	0	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	4	0	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.	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. 84 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 8 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	33	4	4	0		80% complete, 90% complete or on track for completion. Improvement in month of 7 actions turning from Green to Blue.	

CQC Action Plan for Intermediate Care - Summary Month 12

KEY:	The arrows represent the change from last month:		Criteria Outcome:		Assurance Status
	↑	Improvement from last month:	Outstanding	Evidence completed	
	↔	No change from last month:			Completed successfully for embeddedness/ sustainability
	↓	Deteriorating position from last month:			On track to deliver to plan
					Some elements not on track, mitigations to deliver to plan
					Off track, with insufficient mitigation

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 April 71.74% - due to operational pressures. More appointments are being arranged to increase %.	28	1	0	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	2	0	0	0
Total Actions			41			40	1	0	0

At Month 12, 40 /41 (98%) actions are complete.
Since month 11, a further 1 action has turned from green to blue.

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



East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Detailed updates for all areas of focus for Regulatory Undertakings, RSP Exit Criteria and CQC monitoring are included in the accompanying Excel document (RSP Exit Criteria supporting plan).

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

A dedicated SharePoint Site has been set up to supporting sharing of accompanying evidence:

[East Lancashire Hospitals NHS Trust Improvement Plan - Home](#)

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/062
Report Title:	Perinatal Quality Oversight Model		
Author:	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) collectively informed by Perinatal Transformation Team & Perinatal quadrumvirate team.		
Lead Director:	Peter Murphy – Executive Director of Nursing & Board Level Maternity & Neonatal Safety Champion		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
				✓
Executive Summary:	This report provides assurance and oversight on maternity and neonatal services at East Lancashire Hospitals Trust, in line with the NHSE Perinatal Quality Oversight Model (PQOM).			
Key information /Areas of Concern:	Data & Intelligence: The Perinatal Quality Oversight Dashboard remains in the development phase; data quality is continuously improving with the metrics available aligning with national and local asks. The 'Scorecard' is due to change to a format which will support alignment to the statistical process control (SPC) dashboard and provide further clarity with the outlier status trends and unwarranted variation. The Equality & equity dashboard data is included in this report however this regional dashboard is updated up to June 2025 only. We are expecting an improvement in the data availability with the release of the new Aristotle regional dashboard due for publication imminently. Quality & Safety: Difficulties in analysing themes and trends in the categories of Obstetric and Neonatal incidents due to the current configuration on Datix where 'maternity/obstetrics' and 'neonatal/ NICU' are given as incident category options. This is reflected in the report and has been escalated through board level safety champions to the Trust. Improvement works are underway led by the Trust Datix manager to re-develop the category options to ensure the data is more meaningful to be analysed effectively. Workforce & Training: On the 12th of February, the NHS England Education team visited Neonatology to undertake an Education Quality Review following the results of the 2025 GMC National Training Survey (NTS). The feedback was universally positive and revealed the excellent quality of the educational experience and support provided from			

the senior neonatology clinicians. A full report is expected, with an interim action plan of recommendations received. This does highlight a requirement for consistent Self-Development Time (SDT) for trainees. The team are currently mapping requirements to accommodate this within the neonatal medical rotas. There are current gaps on the rota, which are covered through locum, however recruitment to gaps is in process.

- **Experience & Feedback:**

The CQC Maternity Survey (2025) response rate (25%) was below the national average (39%) and reduced from last year (35%). The key areas for improvement from the survey include opportunity to ask questions about labour and birth, contacts for advice re mental health postnatally, knowledge of medical history and time with midwives postnatally. The free-text analysis further highlights staffing pressures and the impact on delays of care, communication breakdown, and postnatal support. This analysis has informed the CQC Survey action plan as monitored via the Patient Experience and Lessons Learned group.

MNVP Leads were unable to conduct any community sessions since December 2025. MNVP capacity has been escalated as per CNST requirements in Maternity Incentive Scheme Y7, and we are working closely with the LMNS and Healthwatch as they restructure the MNVP infrastructure to support these gaps.

The area with the poorest FFT satisfaction rate in February 2026 is Maternity Triage (80% good | 20% poor) with poor feedback comments including difficulty with the phoneline and wait times both being reviewed and improved via the project group. It is noted that only 10 responses were received (+1200 attendances) and the team are asked to encourage FFT responses to ensure a representative sample set.

- **Operational Performance:**

Maternity triage key metrics are monitored as embedded into the PQOM Dashboard following the launch of the new service model on the 2nd of February 2026. Performance measure in meeting the 30-minute initial assessment period is highlighted within this report as an exception.

Emergency c-section rates continue a 6-month run of increased rates, the 24-month average for ELHT is 45% and the February 2026 rate is 49%.

	The compliance for Grace 1 c/s within 30 minutes was achieved in 77% of cases – this is being reviewed by the Directorate Manager and obstetric leads to further review the data quality and barriers to ensuring Grade 1 c/s meet the expected period of 30 minutes. Initial analyses are indicative of issues with data quality. Improvement & Transformation: As per above, maternity triage implementation project is closed and an optimisation improvement piece continues focussing on initial assessment within 30 minutes compliance. The Birth Reflections pathway was launched in February 2026. This enhanced post birth family engagement process allows for the demand to meet capacity with a triage process in place. This is a quality improvement project, the accurate numbers with the rationale for patients to attend for the consultation debrief and birth reflections is now collated to further inform the required improvements, this information was not available previously.
Action Required by the Board:	The Board is asked to: - Note and take assurance from the PQOM report which highlights the current position in relation to the stability of key safety and improvement metrics. - Support and guide ongoing improvement initiatives.

Previously Considered by:	
Date:	
Outcome:	

Perinatal Quality Oversight Model Report (February 2026 data)

1. Introduction

- 1.1 The purpose of this paper is to provide a 'ward to board' approach supporting sharing of safety intelligence across the multidisciplinary teams within maternity and neonatology aligned with the NHS England Perinatal Quality Oversight Model.
- 1.2 This approach provides assurance that frontline insights are captured and escalated appropriately with timely action and strategic oversight at Board level.
- 1.3 The accompanying perinatal quality oversight model report offers a structured view of key focus areas Safety, Workforce, Improvement, Maternity Incentive Scheme, Experience and Training monitoring performance against national standards and local priorities.

2. Background

- 2.1 The Perinatal Quality Surveillance Model (PQSM) was published in December 2020. The model was refreshed and republished on the 26 August 2025 as the [Perinatal Quality Oversight Model \(PQOM\)](#).
- 2.2 The PQOM provides consistent and methodical oversight of NHS perinatal services and ensures collection of the information and insight needed to drive service improvement.
- 2.3 The model provides a structure with clear lines of responsibility and accountability for addressing and escalating quality and safety risks at trust, ICB, region and national level.

3. Key Highlights – February 2026 Data

- 3.1 All MNSI & PMRT reporting requirements are met.
- 3.2 x2 reported cases to MNSI.
- 3.3 2 MNSI reports received, x1 neonatal death and x1 cooled baby.
- 3.4 3 cases reported via PMRT
- 3.5 3 cases reviewed through PMRT
- 3.6 An external reviewer attended 1 out of 1 PMRT meetings
- 3.7 There was 1 case graded as C, 0 cases graded as D.
- 3.8 MOSS signals flag potential safety issues prompting a locally led critical safety check to determine any real safety issues. There have been 0 signals in February 2026.

Quality & Safety

3.9 153 maternity incidents reported in February 2026. A small decrease from the previous month. The top 3 sub-categories reported as unexpected term admission to NICU, Re-admission of baby and missed or delayed care. (Analysis reviewing re – themes)

18 neonatal incidents reported in February 2026

3.10 Risks – 5 risks currently on the risk register for Neonatology and 14 for obstetrics. 3 within obstetrics scored 15+ (High/ Extreme):

9755 – Insufficient capacity to meet increasing demand for elective sections (score 20)

9640 – Delayed care for women with diabetes in pregnancy (score 16)

10526 – Lack of dedicated second obstetrics emergency theatre (score 15)

Training Compliance

3.11 Compliance above target of 90% for all staff groups for PROMPT, fetal monitoring and newborn life support training.

Maternity (Perinatal) Incentive Scheme Year 7

3.12 ELHT submit compliance to all 10 safety actions within the CNST – Maternity Incentive Scheme Year 7, as signed off by the Local Maternity & Neonatal System following quarterly review meetings.

3.13 NHS resolution have stated that the year 8 guidance for the scheme ‘marks an important transition, the scheme has been refreshed directly in response to the findings of the MIS evaluation, national inquiries, system feedback and feedback from the Trusts, staff, and families. There will now be 6 safety actions labelled A-F. Additional time will be required to understand these changes on the onset of the scheme this year.

Maternity Triage

3.14 The maternity triage unit received 1287 attendees in February 2026, and 41% of women were seen within 30 minutes. Data availability and accuracy have notably improved since the new model aligned to RCOG Best Practice was implemented.

This represents the first month of data since moving to this new model, compliance is closely monitoring by the project group and perinatal leadership team and is informing short- and long-term solutions and improvements.

Recommendations

4. The Trust Board is asked to:
 - Note and take assurance from the PQOM report which highlights the current position in relation to the stability of key safety and improvement metrics.
 - Support and guide ongoing improvement initiatives.

Perinatal Quality Oversight Model

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CNST – Perinatal Incentive Scheme	
Perinatal Transformation	
National Updates	

ELHT Perinatal Summary – February 2026



Total pregnancies booked

512

Total No. of women giving birth

470

Total No. of babies born

476

Neonatal Admissions

56

Transitional Care Admissions

25

Pre-term Births
<37 weeks)

36

Neonatal Death

1

Stillbirth (& Late TOP)

0

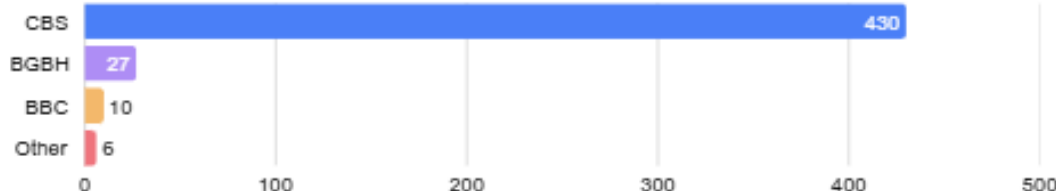
Birth Location - Women giving birth

37

Babies born in a midwifery led unit

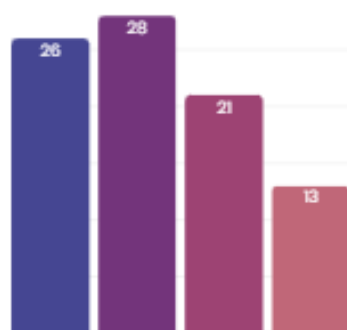
2

Homebirths



Delivery Type - Women giving birth

- Spontaneous vaginal
- Emergency caesarean
- Elective caesarean
- Instrumental delivery



C-Section Rate - 49%
↑ from previous month

Emergency C-Section Rate - 28%
↑ from previous month

Elective C-Section Rate - 21%
↑ from previous month

Maternity Triage Attendances
1287



Number of Women Induced
163 | 35%



Term Admissions to NICU >37wk
31 | 7.19%

Breastfeeding Initiation (babies)
89%

3

New complaints logged

Level 2 x1, Level 3 x2

88%

Maternity FFT Satisfaction Rate

100%

Neonatal FFT Satisfaction Rate

8

New Greatix Reports

116

New Incidents Reported

71% No Physical Harm
25% Low Physical Harm
3% Moderate Physical Harm
1% Fatal

Perinatal Scorecard

Division of Family Care - Section 3 - Maternity Scorecard															* = Data not relevant for month n/a = Data not available at time of report	
Reporting Measure		Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Monthly Trend	
Total Number of Bookings		582	546	528	539	614	622	559	595	616	524	575	603	512		
Number of Bookings by 9 Weeks + 6 Days		357	330	323	303	335	391	337	396	388	360	374	311	325		
Percentage of Bookings by 9 Weeks + 6 Days		63.41	61.68	62.48	58.05	55.83	63.99	61.95	67.58	64.13	70.18	65.85	52.27	64.87		
Number of Woman giving birth		443	514	454	549	519	555	529	547	504	452	503	517	470		
Number of Women Delivered ≥ 37 Weeks		413	476	425	506	477	510	497	492	466	411	469	477	431		
Number of Live Births (Babies)		448	514	455	551	523	561	534	555	511	461	505	521	476		
Number of Spontaneous Onset Vaginal Births		107	149	107	152	134	158	162	123	136	107	124	128	121		
Percentage of Spontaneous Onset Vaginal Births		24.15	28.99	23.57	27.69	25.82	28.47	30.62	22.49	26.98	23.67	24.65	24.76	25.74		
Total Number of Stillbirths (≥ 24 weeks)		1	4	4	2	3	3	2	2	2	1	2	3	0		
Total Stillbirth Rate (≥ 24 Weeks)		2.23	7.72	8.71	3.62	5.70	5.32	3.73	3.59	3.90	2.16	3.94	5.73	0.00		
Number of Homebirths		0	3	5	2	1	3	3	2	6	1	4	1	2		
Number of Babies Born in a Co-located MLU		34	53	29	46	41	49	56	26	32	28	25	40	27		
Number of Babies Born in a Free-standing MLU		12	12	7	18	9	13	18	12	11	9	6	12	10		
Percentage of Babies Born in a MLU	G >30% A >20% R <20%	10.24	12.55	7.84	11.57	9.51	10.99	13.81	6.82	8.38	8.01	6.11	9.92	7.77		
Number of Babies Born in a CLU / Labour Ward		395	446	411	481	470	489	455	507	453	417	458	463	430		
Number of Babies Born – Other Location		7	4	5	4	5	8	4	6	7	5	12	3	6		
Percentage of Instrumental Births	G > 15% A >15-20% R <50%-20%	14.03	12.74	12.85	10.31	14.45	10.99	14.37	12.93	14.81	15.15	13.61	14.31	13.03		

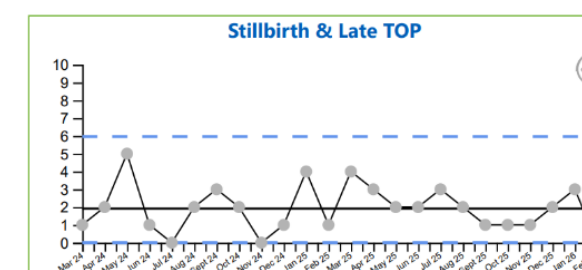
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (Higher or Lower values	Special cause of improving nature or lower pressure due to (Higher or Lower values	Variation indicates inconsistently passing and falling short of the target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

Reporting Measure		Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Monthly Trend
Total Number of Women Induced		193	210	195	235	200	223	208	213	189	176	209	212	163	
Percentage of Women Induced	G <30% A 30-40% R >40%	43.57	40.86	42.95	42.81	38.54	40.18	39.32	38.94	37.50	38.94	41.55	41.01	34.68	
Number of Maternal Deaths	G 0 R >0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Percentage of Babies Born by Caesarean Section	G <30% A 30-35% R >35%	44.54	41.51	45.97	44.30	45.63	43.62	41.60	48.47	46.00	48.92	47.34	47.71	48.95	
Percentage of Babies Born by Emergency Caesarean Section	G <17% A 18-22% R >23%	25.17	22.97	24.40	26.58	25.10	22.34	23.51	27.29	23.39	28.79	28.40	27.48	27.94	
Percentage of Babies Born by Elective (Cat 4) Caesarean Section	G <13% A 14-18% R >19%	19.38	18.53	21.57	17.72	20.53	21.28	18.10	21.18	22.61	20.13	18.93	20.23	21.01	
Percentage of 3rd/4th Degree Tears	G <5% R >5%	5.67	3.31	3.66	3.91	3.53	3.19	4.17	7.09	7.30	3.40	3.02	4.78	3.78	
Percentage of Haemorrhages ≥1500 ml	G <5% A 5-10% R >10%	5.64	3.11	6.39	5.46	6.94	3.96	4.16	4.39	2.98	2.43	3.78	3.48	2.34	
Neonatal death		0	0	1	1	1	1	1	1	2	0	0	1	1	
Percentage of Women Smoking at Delivery		8.58	8.56	8.59	6.74	7.13	5.41	4.91	7.50	5.75	4.65	5.57	3.29	6.17	

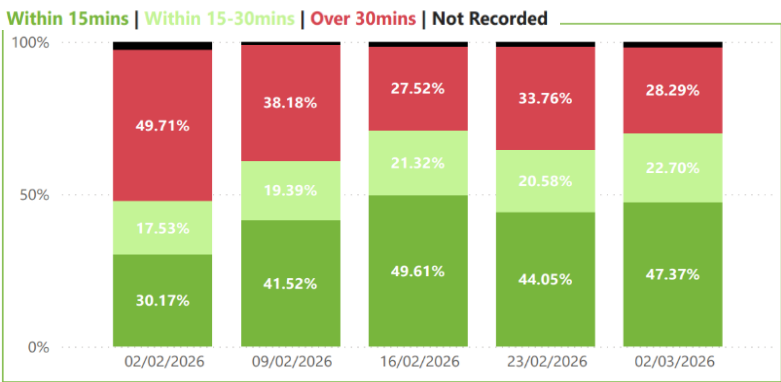
Variation			Assurance		
Common cause – no significant change	Special cause of concern nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistency passing and falling short of the target	Variation indicates consistently passing the target	Variation indicates consistently failing short of the target

Perinatal Quality Dashboard - Summary

- **Women giving birth:** In February, no. of women giving birth decreased by 8.6% in comparison to the previous month. This is like February 2025 and not outside of statistical control measures. In Feb '26, 470 women gave birth to 476 babies.
- **Maternity Triage:** data has been added to the report since go-live of the new model Monday 2nd February 2026.
 - Average 320 attendances per week – 46 per day.
 - IA within 30 minutes compliance – average 41% - increasing each week as the new model embeds but early trends showing higher attendance = lower performance.
 - Reduced fetal movement is consistently the primary reason for attendance to maternity triage.
- **Inductions:** February '26 % of women induced is 35% which is slightly outside of the statistical control measures. This is a sudden decrease from 41% the previous month which is the previous 24-month average.
- **C-Sections:** February '26 c/s rate (%) is at the top of the SPC measures at 50%. This increase has sustained above the 24-month average for the previous 6 months. The increase is reflected in the emergency C/S's where planned C/S has remained largely around the ave. rate.
- **C-Section Grade 1&2 timings:** Feb '26 - Grade 1 C/S were completed within 30 minutes in 77% of cases. Grade 2 C/S were completed within 75 minutes in 86% of cases.
- **ATAINS:** The previous 2 months demonstrate an increase in ATAINS, Feb '26 shows this as approx. 8% which is the top of the statistical control measure. The previous 24-month average is approx. 5%.
- **HIE:** The previous 4 months demonstrate an increase above the 24month average of 0.5% with feb'26 at 1.09%.
- **Stillbirth & Late TOP:** There was 0 stillbirths & late TOPs in February 2026.

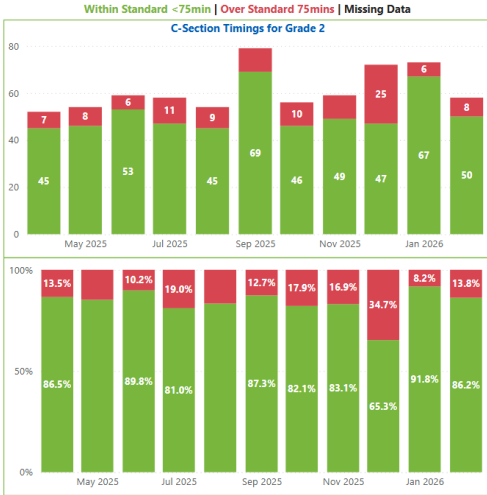
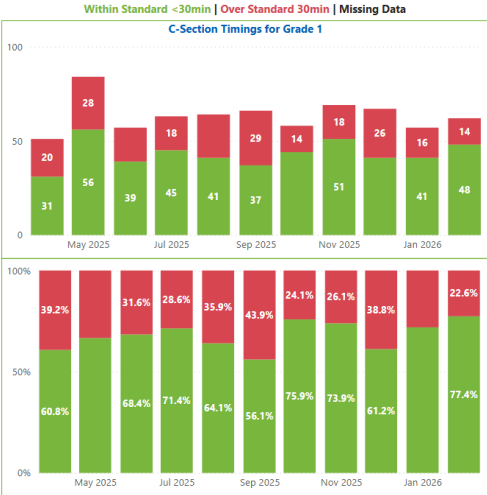
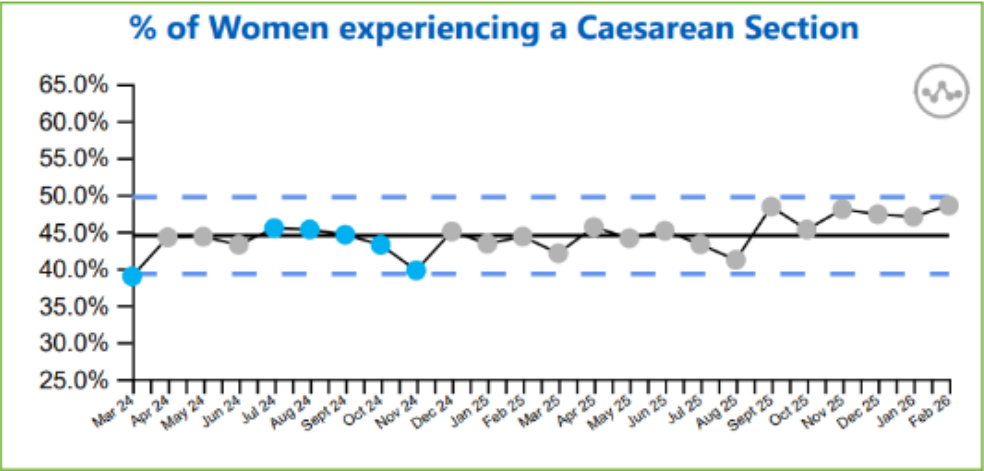


Exceptions – Maternity Triage Initial Assessment



Detail	Action	Risk Register ID & Score
Maternity triage go-live of new model from 2nd February 2026. Initial assessment must be complete within 30 minutes of arrival to the unit. Compliance in February-26, first month of go-live, is 41%.	Project group remains in place post implementation to work on optimisation actions; - Identified peak activity times and impact on IA compliance- Higher demand = lower compliance. - Reviewing unit staffing to consider embedding ward co-Ordinator role and more senior doctor presence. - Quick wins including implementing a dedicated IA room with wipe-down trolleys rather than requiring full linen change after each patient. - Hosted staff reflection forum to learn from the frontline their experiences, concerns, ideas from the first month	New risk written aligned with triage optimisation – to be presented at FCCG Patient safety and risk group in May 2026

Exceptions – C-Section Rate & Timings



Detail	Action	Risk Register ID & Score
February 2026 C-Section rate is 49%. There is a 6-month run of this rate sustained above the 24-month average of 45%. Grade 1 C/S were completed within 30 minutes in 77% of cases.	Concerns escalated through the Family Care Governance processes including continuous discussions with Board Level safety champions and Trust Board. Gynae 4 Theatre is being pro-actively kept free since December 2025 to ensure access to an emergency obstetric theatre. Reviewing the breaches In hours and Out of hours to understand if Out of hour staffing is impacting the ability to open the second theatre	10526 - 15

Equality & Equity Dashboard - Summary

Introduction to the dashboard

- NHS England has launched a new interactive dashboard for Maternity and Neonatal Services. This follows a [Secretary of State announcement](#) in 2025, with the aim of achieving equality in these services for vulnerable groups in the long term.
- The dashboard's purpose is to make health inequalities visible, measurable, and actionable in maternity and neonatal services. This empowers NHS trusts to identify, understand, and eliminate disparities in care, with a particular focus on Black and Asian women and those from deprived backgrounds.
- Currently the dashboard demonstrates:
 - Data quality for recording ethnicity & IMD quintiles
 - Demographics at booking Trust-level data and National comparison
 - Trust-level data re gest. age at booking and modes of birth split by ethnicity and IMD deciles
 - Trust-level pre-term birth (rate per 1000) split by ethnicity and IMD deciles
 - Regional data regarding women’s feedback for feeling that their concerns were taken seriously.
 - National data for stillbirths, neonatal deaths and maternal death split by ethnicity & IMD deciles.
 - Postpartum Haemorrhage data was previously provided but has been temporarily removed as NHS E investigate data quality issues.*

Jan-Jun 2025

Demographics at booking appointment

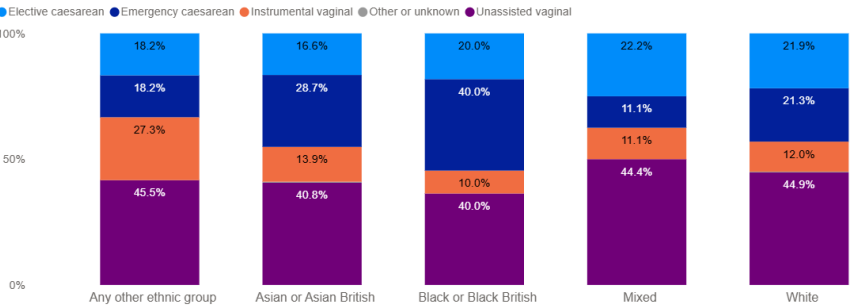
Ethnicity	Trust	Ethnicity	England
Any other ethnic group	2.1%	Any other ethnic group	4.5%
Asian or Asian British	37.3%	Asian or Asian British	18.3%
Black or Black British	2.0%	Black or Black British	7.5%
Mixed	1.4%	Mixed	3.0%
Unknown	3.7%	Unknown	3.5%
White	53.4%	White	63.2%

Deprivation quintile	Trust	Deprivation quintile	England
01 - Most deprived	54.8%	01 - Most deprived	25.1%
02	18.1%	02	22.1%
03	8.1%	03	19.3%
04	11.8%	04	17.1%
05 - Least deprived	6.1%	05 - Least deprived	15.0%
Other or unknown	0.9%	Other or unknown	1.5%

This comparative data shows the ELHT have considerably higher cohort of Asian & Asian British women and considerably higher rate of women in the most deprived IMD quintile.

Metric	Elective caesarean	Emergency caesarean	Instrumental vaginal	Other or unknown	Unassisted vaginal	Total
Any other ethnic group	10	10	15	0	25	60
Asian or Asian British	185	320	155	5	455	1120
Black or Black British	10	20	5	0	20	55
Mixed	10	5	5	0	20	40
Unknown	20	35	20	0	50	125
White	365	355	200	5	750	1675

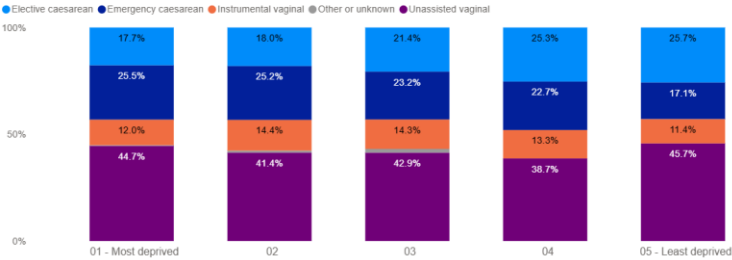
Mode of birth in East Lancashire Hospitals NHS Trust by ethnicity for January 2025 to June 2025



This Trust-level data demonstrates mode of birth split by ethnicity for the period Jan-Jun 25.

- This data shows Black women had a markedly higher C-section rate than White women (40% vs 21.3%), representing an absolute difference of 18.7 percentage points (~88% relative increase). However, the small sample size for Black women (n=55) limits precision, and the observed disparity should be interpreted with caution

Mode of birth in East Lancashire Hospitals NHS Trust by deprivation quintile for January 2025 to June 2025



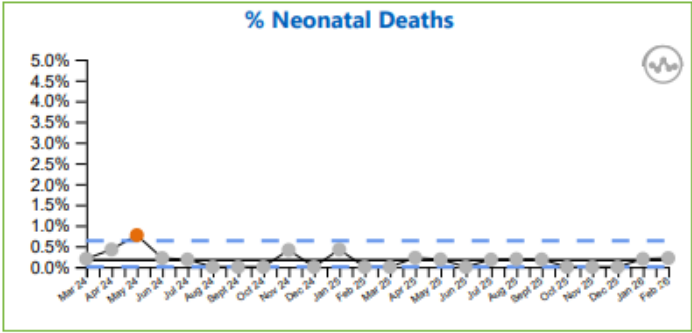
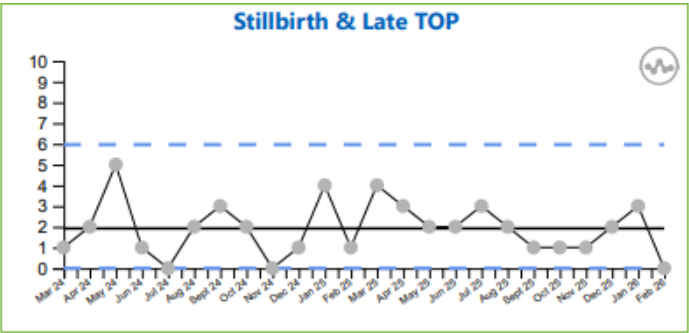
This Trust-level data demonstrates mode of birth split by IMD deciles for the period Jan-Jun 25.

- This data shows that there is a higher emergency c-section rate for women in the most deprived decile (25.5%) compared to least (17.1%). This is an 8.4 percentage point difference which represents a 49% higher rate.

Perinatal Safety

Mortality February 2026 Data

	Maternal Death	Neonatal Death	Stillbirth & Late TOP
	0	4	0
Referred to Coroner	0	2	0



PMRT Reporting

All cases that met the criteria for PMRT in February 2026 were reported to MMBRACE, in line with national requirements.

Reported - 3	MDT Reviews Complete - 3	PMRT Meetings - 1	External Rep at Meetings - 1

PMRT Learning

2 Cases referred to the Coroner in this period; these were medical terminations of pregnancy born with signs of life. Parents were counselled regarding the risks of this; fetocide is not required until 22/40. Discussion required with the Coroner regarding this process going forward to inform parents.

3 cases were reviewed in February. These cases were graded as follows;

Summary of Cases

- Case 1:** Graded C,A; Stillbirth; EPROM, cause of death extreme prematurity at 25+5, lung hypoplasia. Graded C as CTG commenced at 25+4 weeks outside of guidance and not acted upon as was not normal. Missed opportunity to deliver baby earlier, however given the known poor prognosis associated with EPROM this is unlikely to have altered the eventual outcome.
- Case 2:** Graded A, A. 39/40 stillbirth – cord accident – true know in cord. Attended for ELCS no FH
- Case 3:** Graded A,A. 26/40 twin pregnancy, Twin 1 BBA (still alive) Twin 2 born in CBS – poor condition at birth, cause of death HIE. No issues with care.

Key learning and actions:

- CTG monitoring; not routinely performed <26 weeks – should be discussed with Consultant on call.

Assurance/ Alerts to the Board:

- All cases were reviewed and reported appropriately through the Trust's governance process.

MNSI Reporting & Learning

There were 2 cases referred in February 2026;

- 1 cooled baby – HIE on MRI, genetic condition diagnosed postnatally. Investigation in progress.
- 1 cooled baby – normal MRI, investigation in progress.

There were 2 MNSI reports returned in February 2026;

- 1 neonatal death – baby transferred into NICU in poor condition, care reorientated within 8 hours of arrival.
- 1 cooled baby – action plan required, to come through DPSIR/ PSIRI process

Key learning and actions:

- To be added next report

Assurance/ Alerts to the Board:

- 5 cooled babies referred to MNSI in Q4, 3 of these had normal MRIs but have been accepted for investigation due to maternal concerns.

MOSS – Maternity Outcome Signal System February 2026 Data

All Term Stillbirths and Term Neonatal Deaths are monitored via MOSS.
MOSS signals flag potential safety issues prompting a locally led critical safety check to determine any real safety issues.
There have been 0 signals in February 2026.

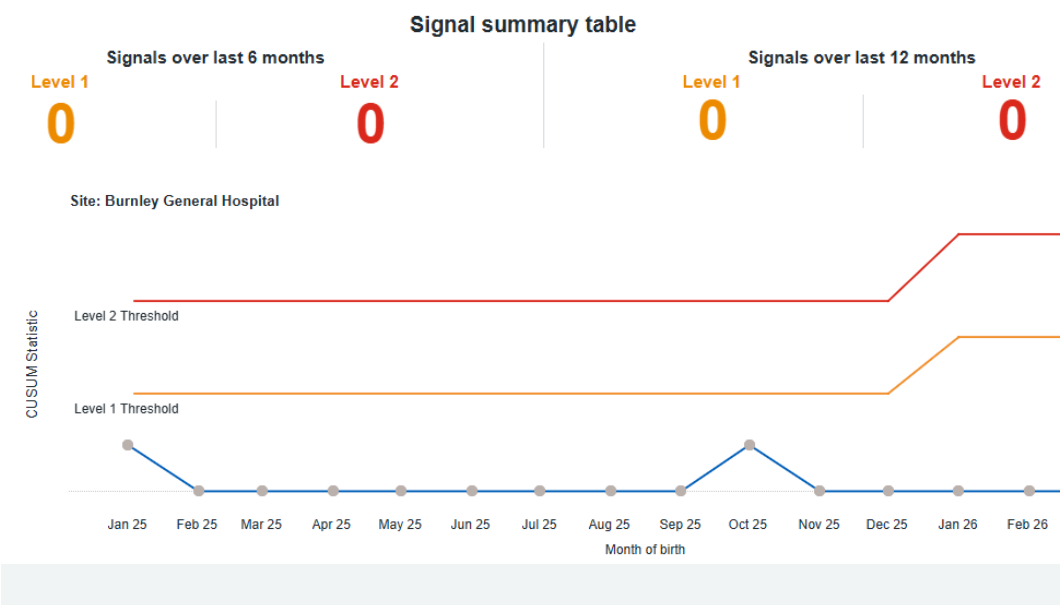
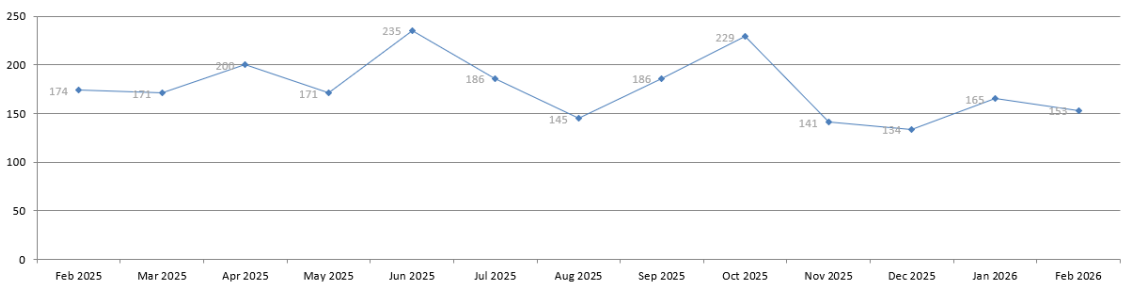


Table of Events - Trust: East Lancashire Hospitals NHS Trust

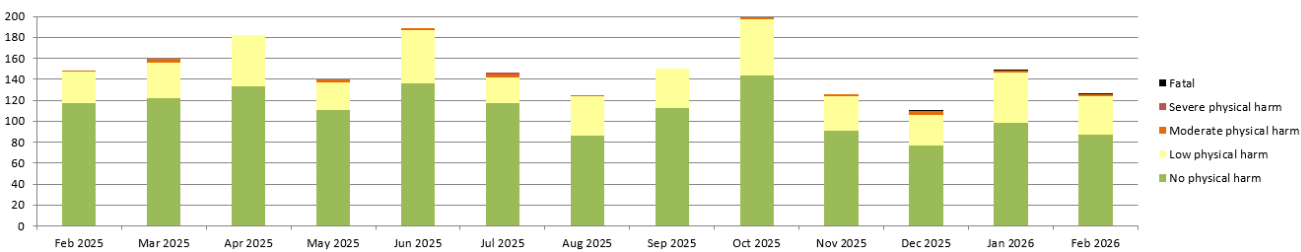
Date of term birth	Events (term only)	Site name
02 Dec 25	1 Term Stillbirth(s)	Burnley General Hospital
18 Oct 25	1 Term Neonatal Death(s)	Burnley General Hospital
17 Oct 25	1 Term Stillbirth(s)	Burnley General Hospital
26 Sep 25	1 Term Stillbirth(s)	Burnley General Hospital
28 Jul 25	1 Term Neonatal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

Maternity Incidents February 2026 Data

Maternity Incidents Reported



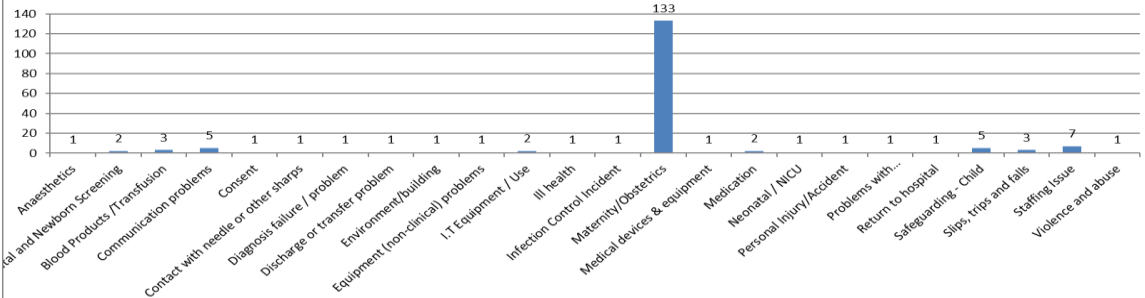
Maternity Incidents - level of physical



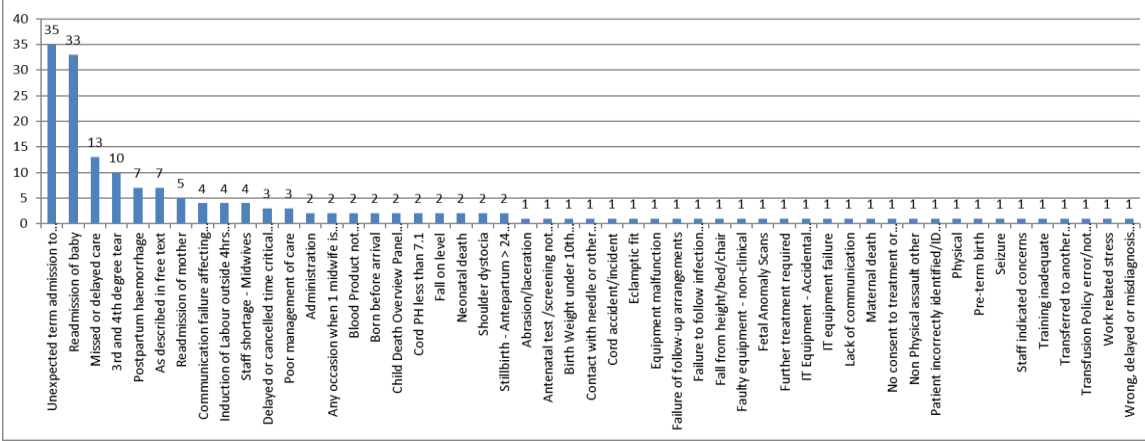
SUMMARY

- In February 2026, a total of **153** maternity incidents were reported.
- Currently, it is more difficult to analyse effectively the themes of obstetric incidents by category, as the Datix system offers 'maternity/ obstetrics' as a category which is too broad.
- The team are working with the Datix manager reviewing all sub categories to re-design the category options to re-format the system to inform themes in a simpler is underway.
- Sub-category analysis shows the top incidents to be Term Admissions to NICU which aligns to the SPC dashboard where Feb data shows 8% ATAIN rate. Readmission of Baby, Missed or delayed care and 3rd/ 4th degree tears are also top categories for this month.

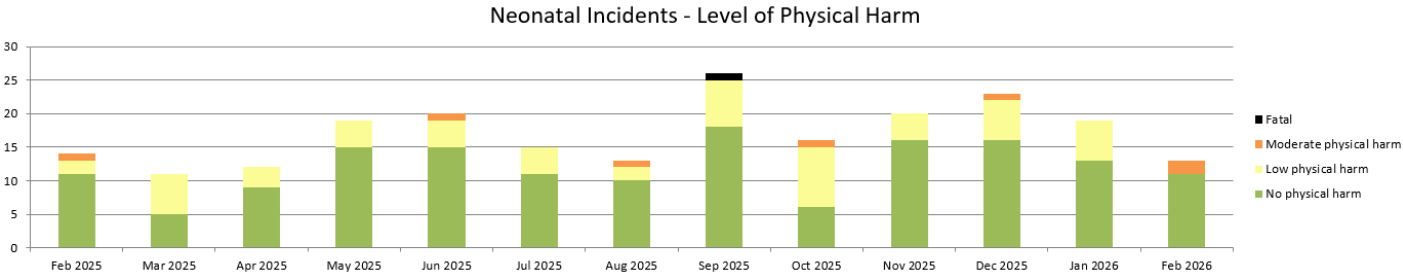
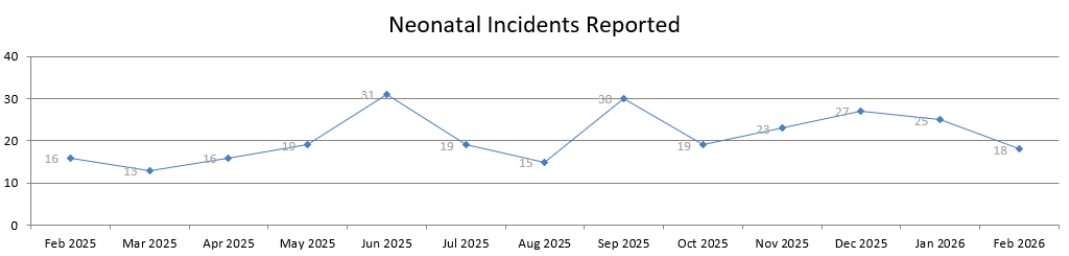
Incidents by Category



Incidents by Sub category

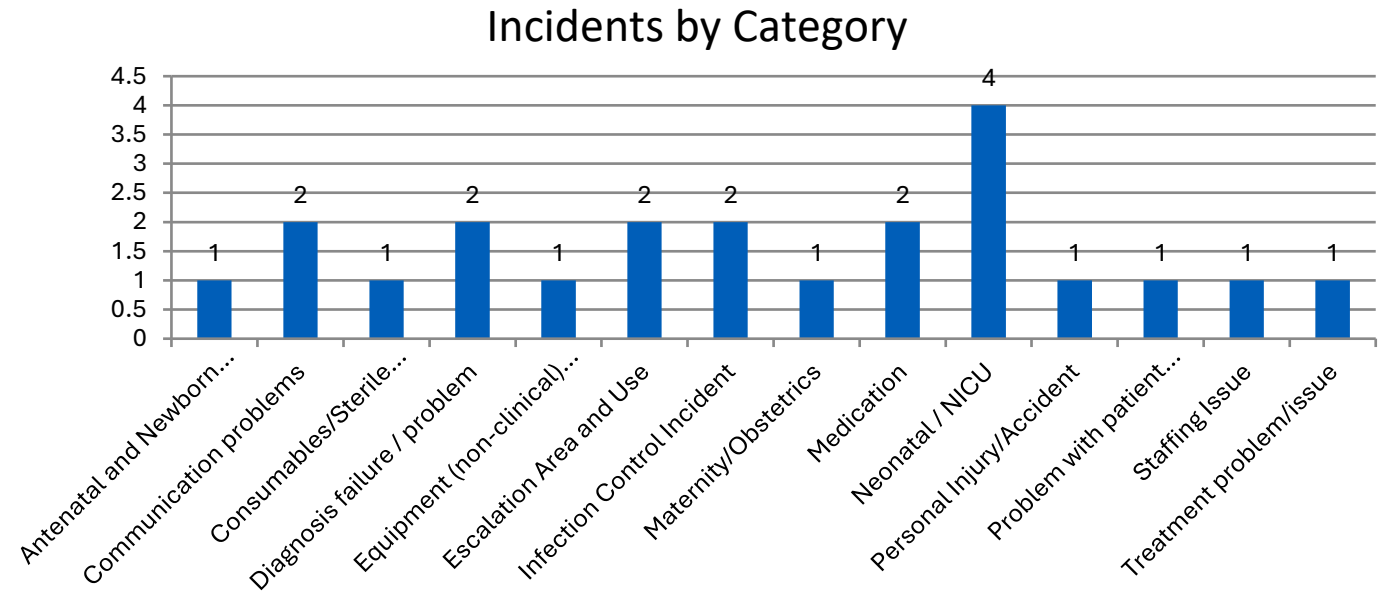


Neonatal Incidents February 2026 Data

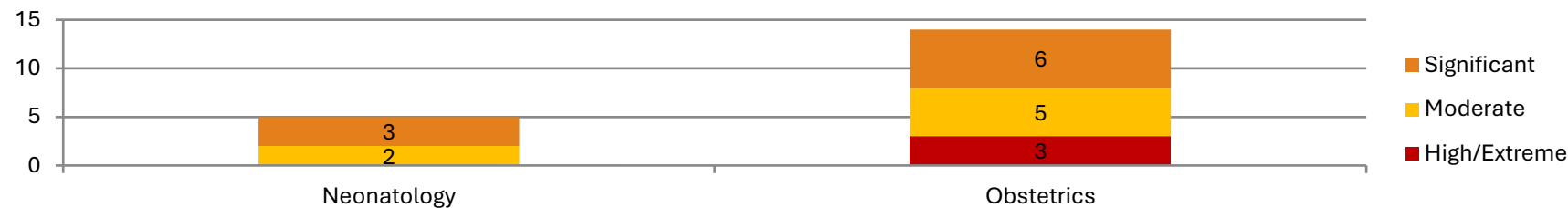


SUMMARY

- In February 2026, a total of 18 neonatal incidents were reported.
- As with Obstetrics, the option for sub-category ‘neonatal/ NICU’ is the data and is under development.



Risks by Directorate and Risk level (current)



High/ Extreme Summary

- 9755 – Obstetrics – Insufficient capacity to meet increasing demand for elective sections – Risk score 20
- 9640 – Obstetrics – Delayed care for women with diabetes in pregnancy – Risk score 16
- 10526 – Obstetrics – Lack of dedicated second obstetric emergency theatre – Risk score 15

Perinatal Training

Fetal Monitoring Study Day	Feb-26 Compliance
MIDWIVES	99%
TOTAL COMPLIANCE OBSTETRIC CONSULTANTS	100%
TOTAL COMPLIANCE ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO OBSTETRIC ROTA	100%

Update Day (inc. SBL, Equality, Equity, & care during labour & postnatal)	Feb-26 Compliance
MIDWIVES	97%
MSWs	99%

PROMPT (Emergencies & MDT Training)	Feb-26 Compliance
MIDWIVES	99%
MSW	97%
OBSTETRICIANS	90%
ANAESTHETISTS	94%

Patient Experience

Maternity Patient Experience – FFT

February 2026 Data



East Lancashire Hospitals

NHS Trust

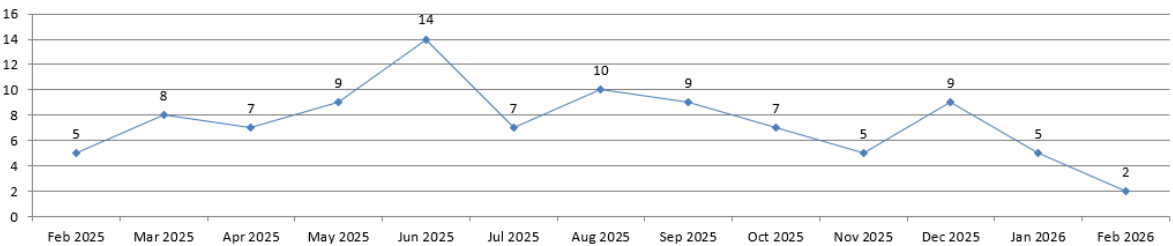
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Type	Ward	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor
Antenatal	Antenatal Clinic Lancs Women Newborn Centre BGTH	83.78%	10.81%	37	19	12	2	3	1
	Antenatal Triage BGTH	80.00%	20.00%	10	6	2	0	0	2
	Antenatal Ward BGTH	100.00%	0.00%	33	25	8	0	0	0
Delivery	Burnley Birth Centre Lancs Women Newborn Ctr BGTH (Delivery)	91.30%	8.70%	23	17	4	0	0	2
	Central Birth Suite Lancs Women Newborn Centre BGTH (delivery)	84.21%	10.53%	19	13	3	1	2	0
Postnatal	Post Natal Ward BGTH (Postnatal)	80.49%	12.20%	41	23	10	2	3	2
Postnatal Community	Blackburn Birth Centre - Park Lee Rd Blackburn (Postnatal Community)	83.33%	16.67%	6	3	2	0	0	1
	Burnley Birth Centre Lancs Women Newborn Ctr BGTH (Postnatal Community)	91.67%	8.33%	12	9	2	0	0	1
	Post Natal Ward BGTH (Postnatal Community)	100.00%	0.00%	11	7	4	0	0	0
	Total	88.02%	8.85%	192	122	47	5	8	9

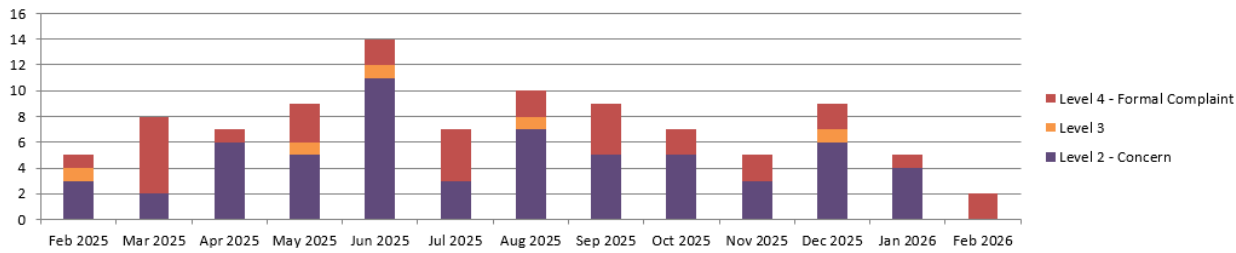
“This service was excellent from pregnancy all the way through to postpartum. I felt supported and heard by caring and friendly professionals. I do believe that without the continued support from this service I would have struggled as a new mother - having non-judgemental professionals who knew what they were doing was very helpful at building my confidence especially as social media is filled with misinformation and fear. Badgernotes also helped me to manage the appointments. I also appreciated the how the service included my husband, this helped not just myself but us as a new family. Starting a new family is an adjustment and this service helped with that. This is a much needed service as I feel now better physically and emotionally prepared to being with my newborn. “

Maternity Patient Experience – Complaints February 2026 Data

Complaints Received - Maternity



Complaints Received - Maternity



SUMMARY

- In February 2026, the FFT satisfaction rate for Maternity is 88%.
- **Spotlight: Antenatal Ward received 33 responses and 100% were good or very good.**
- The lowest response is 80% satisfaction for Maternity Triage. In February a new model was launched which changed the patient journey, a dedicated project group is in place to optimise the new model including patient experience. Staff are encouraged to ask patients to complete FFT as this is a high-volume area (1200+ attendances in Feb 26) and only 10 responses were received.
- Bedside chairs – exploring funding options, a number of chairs on the antenatal and post natal ward requiring replacement, identified as a theme, alerted at trust wide patient experience group (PEG)
- In February 2026, 2 complaints were received in Maternity, both level 4 formal complaints.

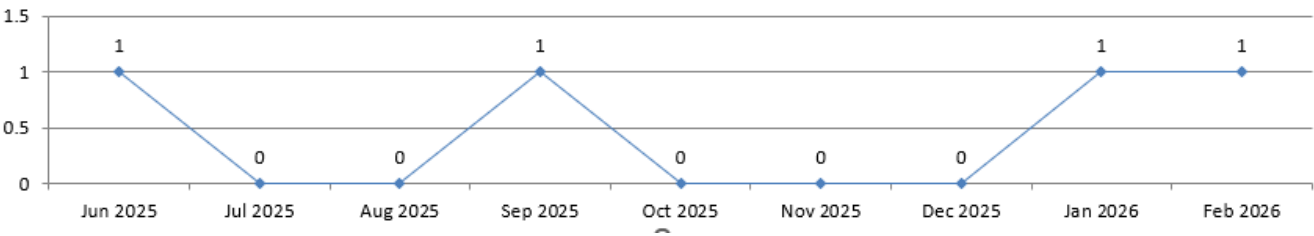
Type	Ward	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor
Inpatients	NICU BGTH (Neonatal Intensive Care Unit)	100.00%	0.00%	15	14	1	0	0	0
	Total	100.00%	0.00%	15	14	1	0	0	0

“My child received the best treatment from birth and after returning from Alder Hey. The staff couldn't do enough for us. As a family we couldn't of asked for better care for our son. Thank you.”

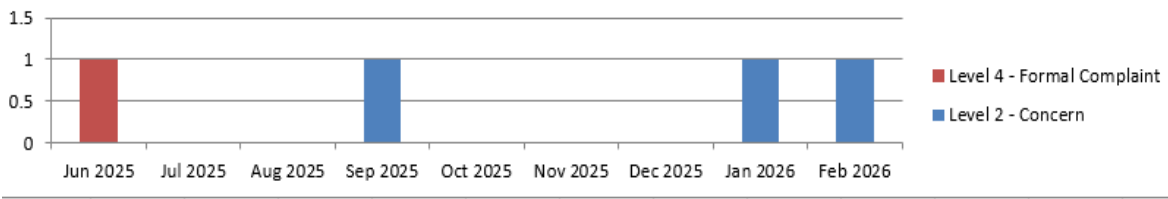
“NICU team all the nurses/doctors health care assistants, ward clerks, cleaners- outstanding care . Phenomenal and professional. “

Neonatal Complaints February 2026 Data

Complaints Received Neonatal



Complaints Received - Neonatal



SUMMARY

- In February 2026, all FFT responses (15) were good and very good.
- In February 2026, 1 complaint was received in Neonatology, level 2 concern. This has been resolved with conversation with staff member involved re-iterating Trust policies regarding use of social media with written apology to patient.

CQC Maternity Survey – 2025 data



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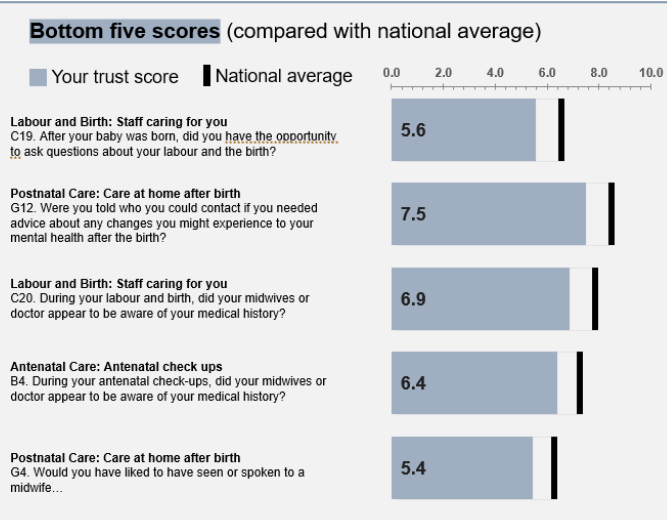
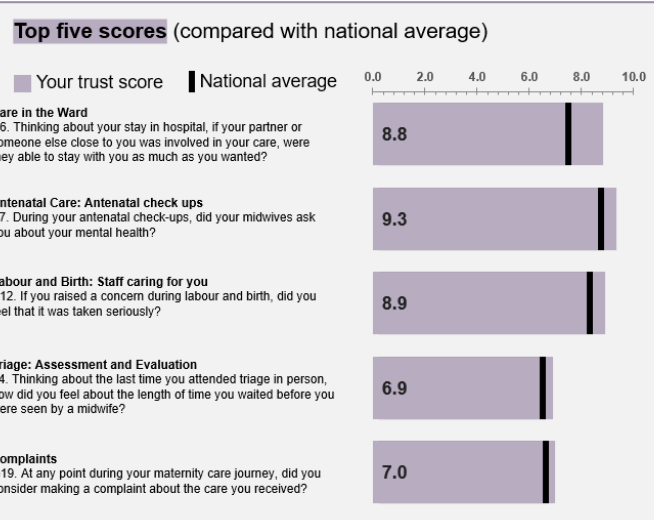
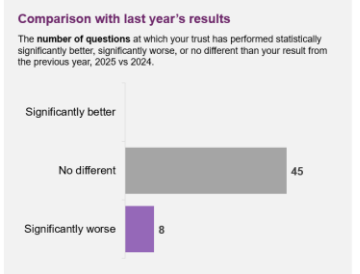
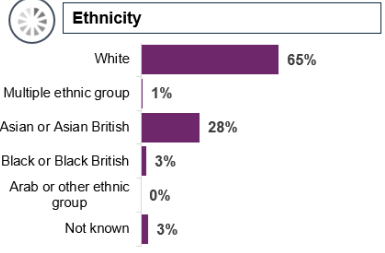
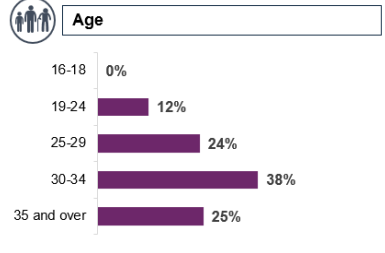
**437** invited to take part

**115** completed

**26%** response rate

39% average response rate for all trusts

35% response rate for your trust in 2024



Free Text Analysis	3 priority areas for improvement
Staffing Pressures	Patient comments often reference staffing & capacity issues ‘midwives were rushed off their feet’, ‘it took hours – I was completely ignored’. Induction and discharge delays due to no rooms or staff to facilitate these are mentioned.
Communication breakdown & not feeling listened to	This is the most prevalent negative theme and it is seen throughout areas of maternity care. Comments reference not being believed when in later stages of labour, symptoms not being taken seriously in triage, poor explanations of care, lack of updates during care delays.
Postnatal support	Postnatal support both inpatient and in community is consistently raised by patients as a negative experience. Comments include poor physical recovery support, unable to access debriefs, and some feeding support gaps.

I can't thank birth centre, post natal and NICU staff at Burnley Hospital enough for looking after myself and my twins after a spontaneous early birth.

"The staff on the postnatal ward were fantastic and also the team who completed my csection."

I had the best care from my antenatal through to postnatal.

Staff Experience & Culture

Staff experience & culture February 2026 Data

Date	Session	Outcomes
19/02/2026	Blackburn Birth Centre Safety Champions Walk round	- Confirmed and supported logistics for launching antenatal education classes in March. Support with communicating to patients. - Update re rolling out 30 min community appts to Blackburn Birth Centre. Planned start Apr-26 - Highlighted issues with women being booked in clinics that have available slots but are not convenient to women resulting in late attendance or DNA. Supporting with conversations with booking team manager to rectify issues. - Staffing issues were raised and understand re. new starter dates and current pressure with new triage go-live given to staff. - Staff fed back that women are now correctly calling triage for clinical needs reducing calls to BBC - Update given to staff re birth centre staffing model consultation
24/02/206	Central Birth Suite/ Triage Safety Champions Meeting	- New triage system is working well overall and is viewed positively by CBS. - Although activity initially felt unmanageable, processes are improving over time (noting sickness pressures contributed). - Concerns regarding the management of high-acuity (“red”) patients requiring immediate transfer to CBS – project team to re-confirm processes - Recognition of pressure during peak times and need for additional staffing support. - Elective section lists scheduled at weekends increase pressure on Birth Suite staffing. Agreed aim to schedule elective lists on Sundays rather than Saturdays with escalation to Triad.

ELHT MATERNITY TRIAGE SYSTEM WEEK 1



You Said

Could estates be looked at further for a set "initial assessment room" (like A&E triage) with couch like community midwives use - reduce cleaning and bed turnover time, and reduce amount of linen being used - this held up patients being seen, especially in an evening

BSOTS handover board did not render well on the original screen assigned to it and the alphabetical order caused initial confusion

Clarification was needed on the pathway for postnatal bereavement ladies. It was highlighted it was not appropriate for these women to attend triage

Those who supported via the go live senior leadership rota highlighted that a senior coordinator role in this unit would be a beneficial substantive post

We did

There is now a set initial assessment room equipped with a wipe-able couch

The Digital Midwife reviewed the issue and identified an alternative screen that improves the board layout, making it clearer and easier to read. She has also contacted BadgerNet to clarify what is included in the March 2026 update and whether it will address the ordering of patients displayed on the board.

Process clarified, postnatal bereavement women will continue to be seen on CBS in an appropriate room

The project group have agreed to review what a triage co-ordinator role would look like, if it is feasible to embed this post and what the process for this would be. As a direct action the senior leadership rota is being extended to support embedding the new processes.

Safe | Personal | Effective

Safe | Personal | Effective

ELHT. *Because that's who we are*

CNST – Incentive Scheme

	Safety Action	Status
1.	PMRT	Signed off
2.	MSDS	Signed off
3.	Transitional Care	Signed off
4.	Clinical Workforce	Signed off
5.	Midwifery Workforce	Signed off
6.	Saving Babies Lives (version 3)	Signed off
7.	MNVP	Signed off
8.	Training Plan	Signed off
9.	Board Assurance	Signed off
10.	HSIB/Early Notification	Signed off

CNST Year 7 was submit on 3rd March 2026.

ELHT met the requirements of all 10 safety actions.

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Saving Babies Lives v3 Care Bundle

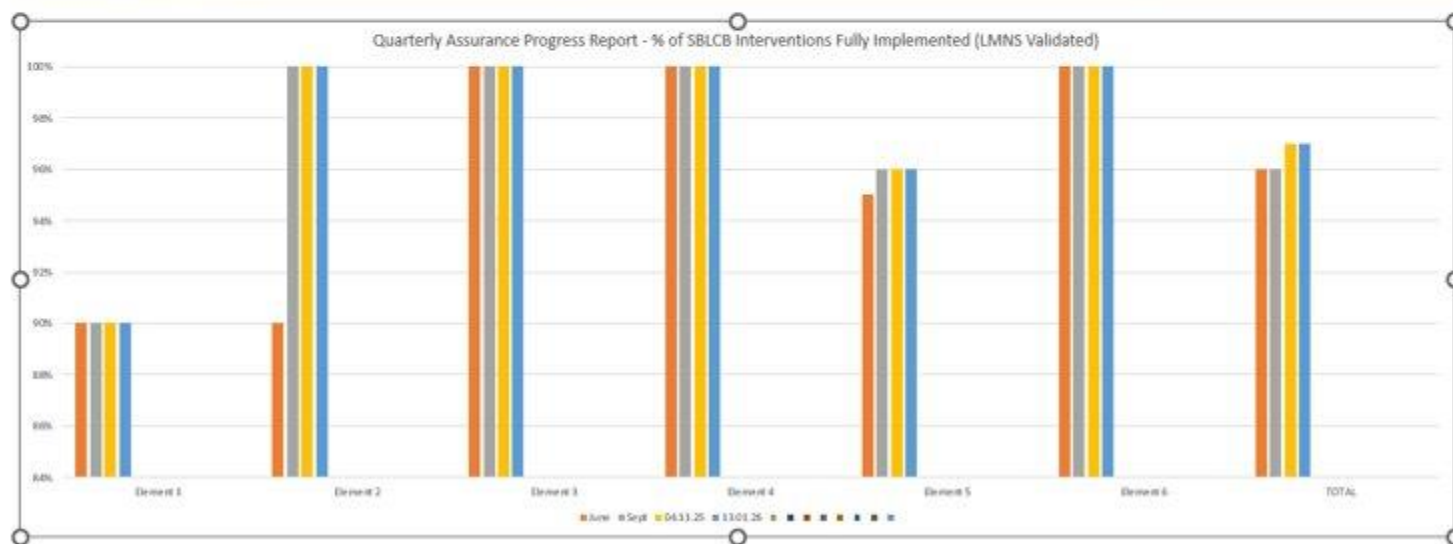


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	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter		Q1	Q2	Q3								
Assurance Review Date	June	Sept	04.11.25	13.01.26								
Element 1	90%	90%	90%	90%								
Element 2	90%	100%	100%	100%								
Element 3	100%	100%	100%	100%								
Element 4	100%	100%	100%	100%								
Element 5	95%	96%	96%	96%								
Element 6	100%	100%	100%	100%								
TOTAL	96%	96%	97%	97%								



Remaining actions to implement

Opt-out referrals recorded for all pregnant smokers (elevated CO levels 4ppm+ or who self-identify or quite in past 2 weeks) **90% compliance**

Each provider trust should have:
- An identified neonatal nursing lead for preterm perinatal optimisation

Current status

Oct-Dec 25 = 87.30%
Consistent improvements across 2025. New process with tobacco teams reviewing all bookings and contacting all smokers from Jan-26

Awaiting confirmation of continued funding for current midwifery optimisation lead role as this funding will be split into x2 roles to cover both midwifery and neonatal

Safe | Personal | Effective

ELHT. *Because that's who we are*

Perinatal Transformation

ALERT	Maternity triage initial assessment within 30 minutes requires rapid improvement project – Feb 26 average compliance at 41%
ASSURE	- Maternity triage new model go-live on 2nd February 2026 as planned. - Birth reflections pathway launched 23rd February 2026 as planned. - Martha’s Rule: pilot on Postnatal Ward of Patient Wellness Questionnaire showed success as February 2026 audit showed PWQ was asked and recorded in 95% of cases. - Digital Videos project: 1 year review of the digital videos project (launched Jan-25, review Jan-26) showed success. 63% of women who gave birth in 2025 accessed the video suite. 990 women accessed the videos in a language other than English. 100% of MNVP survey respondents gave positive feedback about the videos.
ADVISE	- X2 applications made via RCN QI for grants up to £2500 to support midwifery and nurse-led projects Digital Patient Information Videos and Family Integrated Care (FiCare) - Successful NHS E capital bid funds allocated and procurement underway for enhance maternity triage telephone system, door access system and signage.

[Link to Maternity & Perinatal Transformation – Q4 \(Jan-Mar 26\) Overview](#)

[Link to Neonatal Transformation – 2026/27 Overview](#)

National Updates

Summary:

- **National Maternity & Neonatal Investigation (ongoing)** – Interim report + national call for evidence in February 2026. Early findings highlight systemic issues across Trusts and gap between vast amount of recommendations that already exist and implementation of these.
- **MMBRACE 2025 report (2024 data) – National Maternal death rate 12.82 per 100,000 births; increase vs pre-2019 baseline** – Local data shows sustained statistic from 2023 data for stillbirths, neonatal and maternal deaths per 1000 births which are as expected for this Trust. This is an improvement from the local 2019 baseline data.
- **Maternal Care Bundle publication** – Jan 2026 - Reinforces actions in response to latest MBRRACE findings. Focus areas Cardiac disease, VTE, sepsis, mental health, stronger risk identification and escalation expectations.

Emerging national direction of travel:

- Shift from “more recommendations” → implementation & accountability
- Increasing use of real-time / rapid data (data briefs, dashboards)
- Stronger national push on:
 - Safety culture + PSIRF
 - Equity as a core safety issue
 - System-level oversight (ICS / boards)

BOARD OF DIRECTORS

Meeting Date:	13 th May 2026	Agenda Item:	TB/2026/063
Report Title:	Quality Account 2025/26		
Author:	Lizzie Saunders – Quality Governance Lead Jacquetta Hardacre – Assistant Director of Patient Safety & Effectiveness		
Lead Director:	Julian Hobbs – Medical Director Pete Murphy – Chief Nurse		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
				✓
Executive Summary:	The Trust's draft Quality Account for 2025/2026 has been prepared in accordance with national regulatory requirements. The document outlines the Trust's performance against its quality priorities for 2025/2026, reports on nationally mandated quality indicators, and sets out the proposed quality improvement priorities for 2026/2027. The Quality Account also includes the required statements on clinical audit, research, CQC compliance, data quality, complaints, learning from deaths, and other mandated quality processes. Several data items and narrative sections remain outstanding pending the release of national datasets or receipt of information from internal leads; these will be incorporated prior to final publication. The draft Quality Account was reviewed by the Quality Committee in April 2026, with minor amendments requested. These have been addressed where possible, with remaining updates dependent on information awaited from key staff. In line with statutory requirements, the final Quality Account must be published on the Trust's public website within the mandated timeframe. As the Trust Board and Audit Committee will not meet again before the publication deadline, delegated authority for final approval is sought.			
Key Issues/Areas of Concern:	None highlighted within the report			
Action Required by the Committee:	1. Receive and review the draft Quality Account for 2025/2026. 2. Approve the content of the draft Quality Account for circulation to external stakeholders for their formal statements. 3. Agree delegated authority from the Trust Board for the Quality Committee to provide final approval of the Quality Account prior to publication, due to timing constraints within the governance cycle.			

Previously Considered by:	N/A
Date:	
Outcome:	

1. Introduction

- a. Quality Accounts are mandatory annual reports from providers of NHS healthcare. They are designed to inform the public about the quality of the services delivered and to demonstrate accountability for clinical standards, patient safety, and continuous improvement.

2. Background

- a. The structure and content of the Trust's Quality Account are largely prescribed by national regulation. For 2025/2026, the Quality Account must include:
 - i. The Trusts priorities for quality improvement 2026/27
 - ii. Performance against the quality priorities set for 2025/26
 - iii. Performance against nationally mandated quality indicators and processes during 2025/26
 - iv. Performance against locally determined quality initiative during 2025/26
- b. The Trust Chairperson and Chief Executive are responsible for approving and signing the final Quality Account. The final version must also include validation statements from key external stakeholders.
 - i. Historically, the mandated format has required the inclusion of outcome data and information relating to the following quality processes:
 - 1. Clinical audit and confidential enquiries
 - 2. Research and development
 - 3. CQUIN
 - 4. CQC compliance
 - 5. Data quality assurance
 - 6. Information quality and records management
 - 7. Clinical coding audit
 - 8. The CQC statements/compliance
 - 9. Complaints management
 - 10. Learning from deaths
 - ii. In addition, performance data must be reported against the following nationally defined quality indicators:
 - 1. Hospital Mortality (SHMI)
 - 2. Percentage of deaths with palliative care coding
 - 3. Patient Report Outcome Measures (PROMS)
 - 4. Readmissions within 28 days discharge

5. Recommendations from staff as a provider of care
 6. Friends and Family Test in emergency department
 7. Venous Thromboembolism (VTE) risk assessment (*awaiting information from VTE Lead*)
 8. Clostridium difficile infection rates
 9. Patient Safety Incidents
 10. Never Events
- c. The mandated format also requires the Trust to identify several quality improvement priorities for the forthcoming year, each with associated targets.
- d. There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the Quality Account. Approval through the Trusts internal governance processes is sufficient.
- e. All providers must publish their Quality Account on a clearly accessible page of the Trust's public website. The webpage link must then be submitted to NHS England.
- f. Several sections and data items are still awaited or may require updating once national datasets are released. The following sections will be completed prior to final approval and publication.
- i. 2.1 Personal Care – further information is being sought to strengthen patients/ carers contributions to Trust meetings
 - ii. 3.5 Statements from Stakeholders – to be added following circulations of the approved draft to stakeholders
 - iii. 3.6 Statement of Directors' Responsibility – to be signed upon completion of the final version
- g. The draft Quality Account was presented at the Quality Committee in April 2026; A small number of amendments were requested; these have either been incorporated or are pending information from relevant Trust leads. These included:
- i. Information of Health Inequalities work over last 12 months – completed Section 2.9
 - ii. Updated Governance Structure – completed Section 1.4
 - iii. Patient Participation in Quality Improvement work – competed Section 1.4

- iv. Awaiting further information to be included in Section 2.1 under personal care to include patients and carers as active contributors to Trust meetings and how the trust has strengthened the connection between patient feedback and incident reporting. (awaiting information from Lead)

3. Recommendation

- a. Members are asked to receive the draft Quality Account and approve its content prior to circulation to external stakeholders for their formal statements.
- b. As the Trust Board and Audit Committee will not meet again before the statutory deadline for publication, the Trust Board is asked to delegate authority for final approval of the Quality Account to the Quality Committee.

QUALITY ACCOUNT

2025 - 26

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EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2025-26

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

At East Lancashire Hospitals NHS Trust (ELHT), our patients are at the centre of everything we do. We are proud to deliver care that is **Safe**, **Personal** and **Effective** and to play a key role in improving the health and wellbeing of the communities we serve.

As the main provider of high-quality acute, secondary- and integrated healthcare across East Lancashire and Blackburn with Darwen, we offer a comprehensive range of services to a population of around 566,000 people. Many of the communities we support live in some of the most socially deprived areas of England, and our services extend across approximately 1,211 square kilometres.

We employ more than 9,000 colleagues working across four hospital sites and a wide range of community services within six geographical areas: Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale. We also host over 3,500 support service colleagues from ELHT, Blackpool Teaching Hospitals, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay who are part of One LSC.

Alongside our acute, secondary and community services, ELHT is a specialist centre for hepatobiliary, head and neck and urological cancer services, as well as cardiology and vascular care. We are also a network provider of Level 3 neonatal intensive care. The Trust has 830 core beds and supports nearly two million patient contacts each year - from emergency and lifesaving care to planned operations, treatments and procedures - delivered within modern, state-of-the-art facilities.

Our commitment to delivering **Safe**, **Personal** and **Effective** care underpins our vision and continues to drive improvement. This focus has been reflected in our rating of Good and some specific areas rated Outstanding by the Care Quality Commission (CQC).

Our work is supported by more than 150 dedicated volunteers who generously give their time, skills and enthusiasm. They play a vital role in enhancing the experience of patients, families, carers and visitors across our services.

As a teaching organisation, we work closely with the University of Central Lancashire, Lancaster University and Blackburn College to help develop the future workforce of doctors, nurses and allied health professionals.

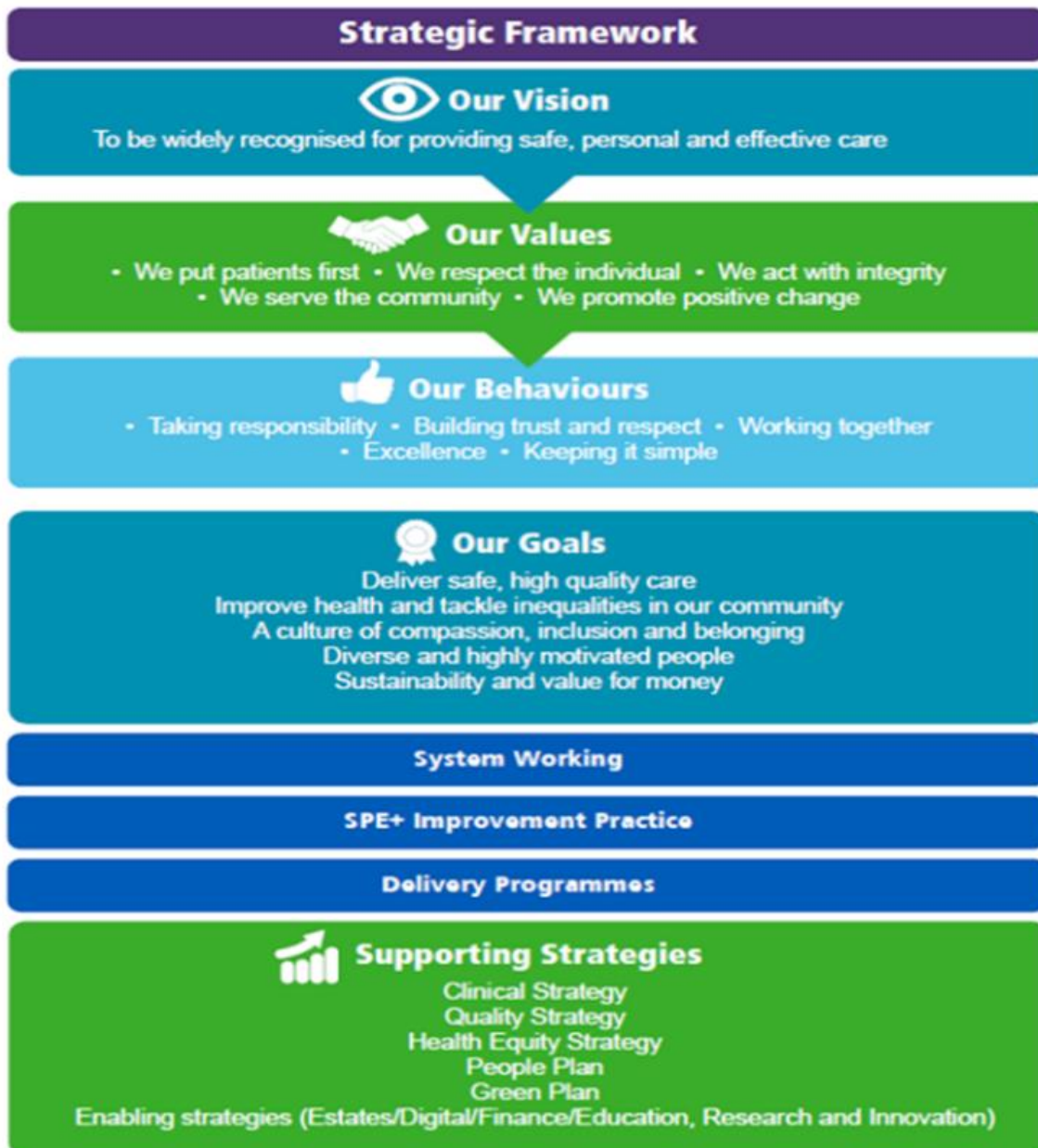
Two private finance initiative (PFI) schemes support elements of the estate at Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital.

1.2 Our Vision and Values

Our vision and objectives are key to our operating principles and improvement priorities which help to guide the way we work and what we strive to achieve.

Our values underpin those, ensuring our services are the very best they can be for our patients and our environments are respectful and supportive for all.

The Trust is currently developing a new Trust Strategy that will come into place in 2026.



1.3 Our Future

Putting Quality at the heart of everything we do – Delivering Safe, Personal and Effective Care.

As health and care organisations in Blackburn with Darwen and Lancashire we have, for many years, shared a common purpose to integrate our service provision and work together effectively to improve health outcomes for our residents.

As part of neighbourhood working with partners across both Blackburn with Darwen and Lancashire, we will continue to work collaboratively to:

- Improve the health and wellbeing of the population and reduce inequalities.
- Provide consistent, high-quality services that remove unwarranted variation in outcome.
- Consistently achieve national standards/targets across the sectors within the partnership.
- Maximise the use of our Pennine Lancashire financial allocation and resource.
- Further develop local neighbourhood models building joined up pathways for both emergency and elective case across the area and supporting more out of hospital care.

We will work collaboratively with partner organisations to develop out of hospital health care and a number of specific health priorities locally including a focus on ageing well, mental health, and improvements in elective and emergency care.

With organisations across the wider Lancashire and South Cumbria (LSC) system, we will be an active partner in developing a joint service vision to improve outcomes in population health and healthcare. We will support wider system priorities including tackling inequalities in outcomes, experience, and access, enhancing productivity and value for money and to help support broader social and economic development.

This is underpinned by the 3 key objectives or 'shifts' of the 10-year NHS plan, including increasing digitisation of healthcare, more preventative care and more out of hospital care.

Our quality commitments focus on initiatives that will:

- **Provide Safe care** - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.
- **Provide care that is Personal** – Deliver patient centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.
- **Provide Effective care** – Deliver consistent effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes.

Strengthening Our Partnerships

Working in partnership across Place Based Partnerships within Blackburn with Darwen and Lancashire (PBPs), the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Lancashire and South Cumbria Integrated Care System/Board (LSC ICS/ICB) has been a fundamental part of our improvement journey so far and will continue to underpin all our work within the coming year.

Our drive to improve the quality of care delivered across our communities will see the Trust work increasingly through partnerships across our localities. We will further develop our role as part of an integrated offer, working more closely with our commissioners and with other local providers, including GPs, Community and Mental Health Trusts, and colleagues in social care.

We will work as part of a joined-up system across Lancashire and South Cumbria ICS contributing to and learning from best practice across the region and working to ensure equity of care for our communities.

As our partners at the ICB and Place develop their new structures, plans and priorities in the coming years, so too will we. By adjusting and developing our plans, we will ensure our priorities and underpinning delivery are aligned. This will ensure maximisation of our combined partnership contribution to improving the health and wellbeing of the population of East Lancashire.

1.4 Our Approach to Quality Improvement

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

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

To ensure that we are delivering **Safe**, **Personal** and **Effective** care we have an embedded process for the identification and agreement of key improvement priorities. The Trust has an agreed set of Key Delivery and Improvement Programmes which are refreshed each year (see Figure 1 for 2025/26 priorities). Our improvement priorities are directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider system, which align with national requirements.

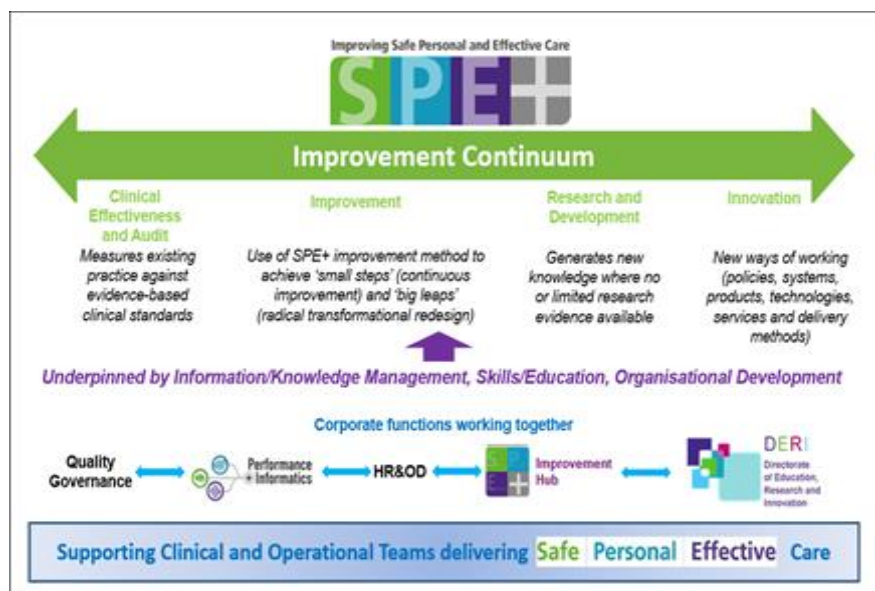
We are committed to involving patients in the improvement of services and work actively with our Patient Participation Panel, who are involved in a range of our improvement programmes. We aim to ensure patient lived-experience and patient stories is included and all improvement projects have clear patient experience measures.

ELHT annually review and refresh its key delivery and improvement priorities, aligned to the Trust Strategic Framework (under section 2.3 – Priorities for Quality Improvement 2025-26). The SPE+ Improvement Practice is underpinning to support the delivery of improved outcomes and ELHT being recognised as a learning and improvement organisation.

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

We continue to develop relationships with colleagues, across the organisation and wider system to bring together colleagues involved in improvement (Clinical Audit and Effectiveness, Improvement, Research and Development, Transformation, and Innovation) to support shared learning and spread and celebration of success (see Figure 1).

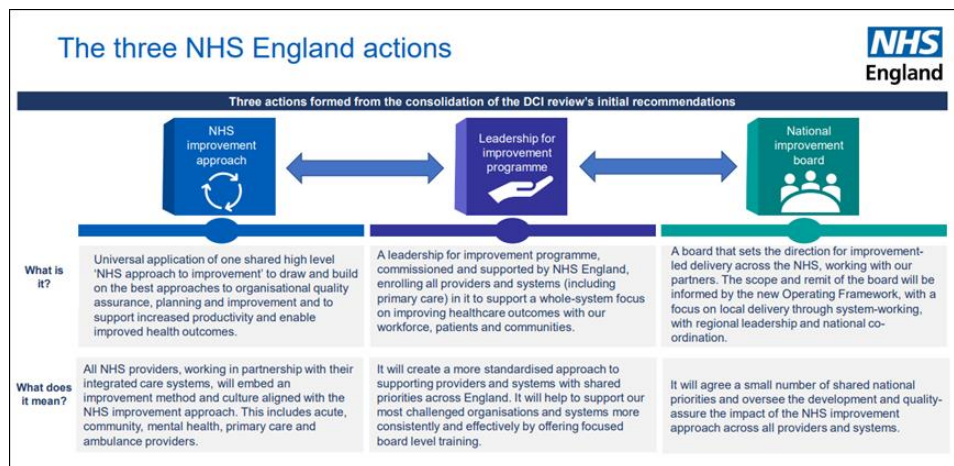
Figure 1



An NHS Approach to improvement

NHS England have set the expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach (Figure 2). This framework supports our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems.

Figure 2



NHS Impact

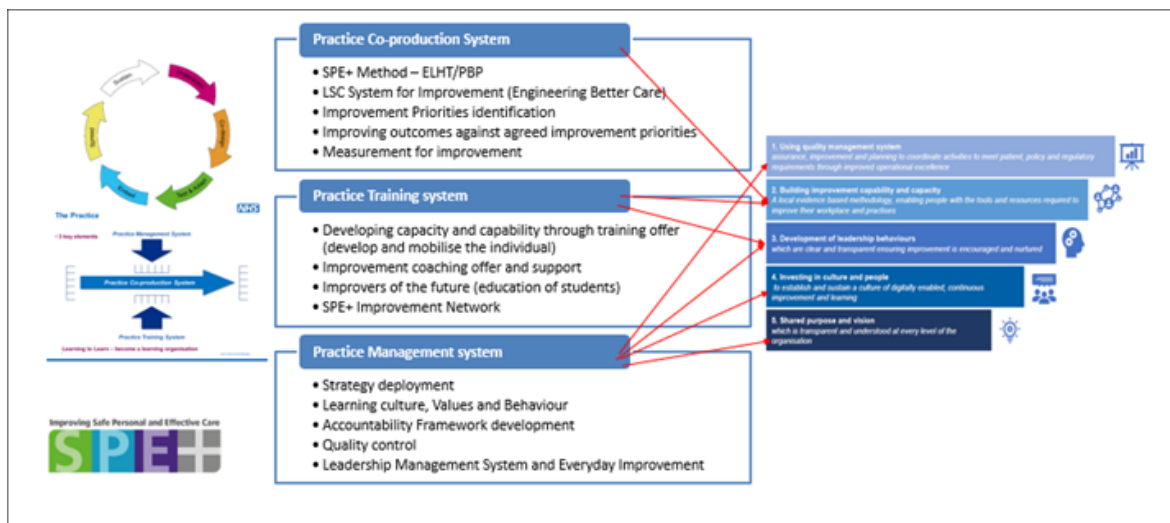
NHS Impact (Improving Patient Care Together) (Figure 3) is the single shared NHS Improvement approach, providing key concepts and principles to create the right conditions for continuous improvement. As an organisation, we are working to embed these principles in all that we do.

Figure 3



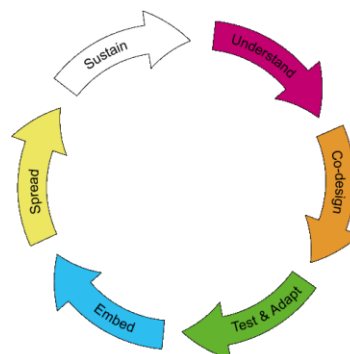
The SPE+ Improvement Practice element of the Improvement Continuum is comprised of three key elements which are encapsulated into an Improvement Practice Development Plan. They map to the five components of the recommended NHS improvement approach, and this is depicted below (Figure 4) and within the Practice Development Plan and Commitments.

Figure 4



Improvement Practice

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



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

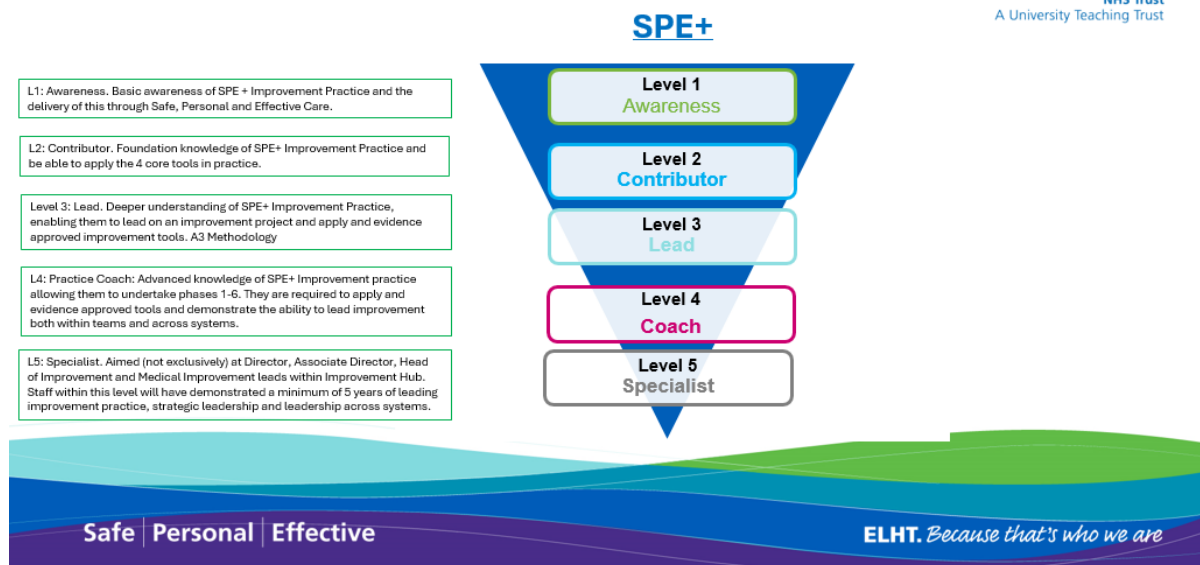
Beyond the Improvement Practice methodology and improvement priority workstreams is the fundamental principle of building improvement into our management system so that it becomes a part of everything we do, bringing together planning, improvement and quality

contract and assurance and creating a culture of improvement and learning across the organisation.

SPE+ Improvement Practice Training Framework

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

ELHT SPE+ Improvement Practice Training



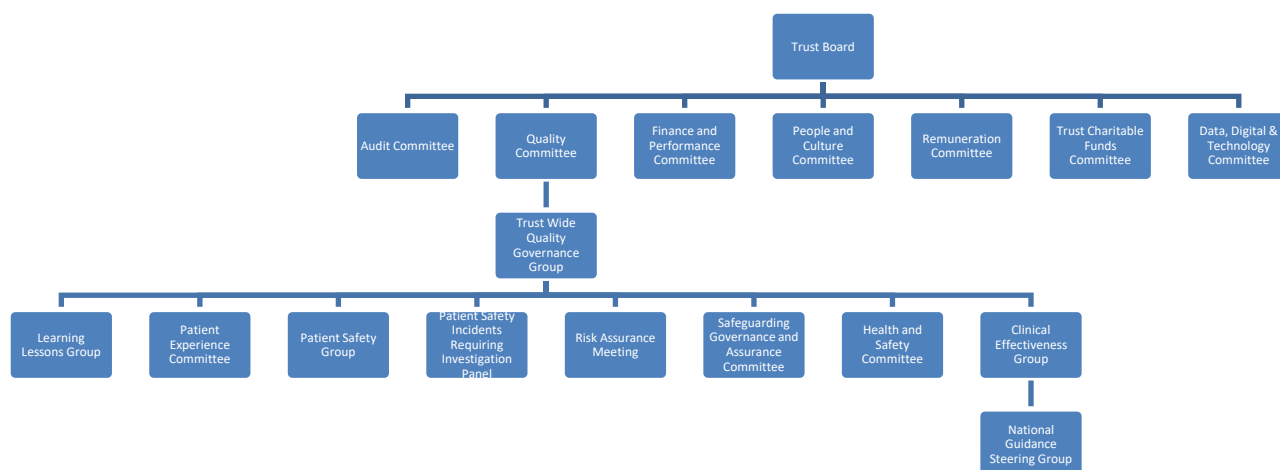
The Improvement Hub Team supports the organisation by coaching and facilitating on defined improvement programmes and projects linked to Trust and Divisional priorities. Colleagues in training, that is 'future improvers,' are supported to develop, contribute and lead quality improvement projects - Multi-professional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

During 2025/2026 the Improvement hub have supported events ranging from observations to week-long Rapid Process Improvement Weeks and also includes training and education across the organisation. As a team we have supported workshops, mapping events, audits, observations, collaborations, NWAS Academy teams and GIRFT visits, demonstrating trust wide impact.

Monitoring and Assurance

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

Dr Julian Hobbs is the Executive Medical Director and the Lead for Clinical Quality.



Board of Directors

The Trust Board has responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of strategy and policy. During 2025/26, the Integrated Performance Report (IPR) has undergone a full review, and a new Trust IPR has been implemented in line with national best practice. Quality dashboard is included as part of the IPR and is reported to the Board at each meeting. Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

Finance and Performance Committee

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

People & Culture Committee

The purpose of the P&C Committee is to provide the Board with assurance in relation to workforce and organisational development matters across the Trust. Including oversight of the delivery of the People strategy.

Data, Digital and Technology Committee

The DD&T Committee provides the Board with assurance in relation to the delivery of the digital strategy of the Trust and oversight of data and digital risks as well as compliance with information governance.

Quality Committee

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

Audit Committee

The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together. The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the

assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

Trust Wide Quality Governance (TWQG)

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

Clinical Divisions Quality meetings

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

Patient Safety Group

Established as a sub-group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient safety across all spheres of Trust activity and that improvement of patient safety is at the heart of the work of the Trust. Chaired by the Assistant Director of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for patient safety for quality governance within corporate and the Divisions.

It brings together the business of the corporate clinical leaders within the Trust, who with senior members of the Divisional teams supported by members of the Quality and Safety Unit, have day-to-day responsibility for patient safety driving improvement initiatives in this area.

Patient Experience Group

Established as a sub-group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient experience across all spheres of Trust activity and that improvement of patient experience is at the heart of the work of the Trust. Chaired by the Deputy Chief Nurse it is the Trust wide operational focus for accountability for patient experience for quality governance within corporate and the Divisions.

This group combines an overview focus on complaints management with feedback from patients and their carers/families. This group monitors the Friends and Family Test results, Annual Patient Survey feedback themes and links with key partners such as Healthwatch to maintain direct links with community groups.

Clinical Effectiveness Group

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

Quality Improvements Triage

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

Partnership Working

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

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

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

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

1.5 Our Quality Account

Quality Accounts are annual reports produced by all providers of NHS services to give patients, the public, and stakeholders clear information about the quality of the services they deliver. Our Quality Account reflects our commitment to continuous, evidence-based improvement and to being transparent about our progress.

The content and structure of Quality Accounts are set out in legislation and must include:

- The Trust's priorities for quality improvement for 2025–26
- Performance during the previous year against the Trust's stated quality priorities
- Performance during the previous year against a range of nationally mandated quality indicators, initiatives, and processes
- Performance during the previous year against additional locally selected quality indicators, initiatives, and processes

Our Quality Account has been developed throughout 2025–26, drawing on ongoing monitoring and reporting of our quality priorities and indicators. This includes internal oversight within the organisation and external reporting to the public, commissioners, regulators, and national bodies.

We welcome feedback on this report or on any aspect of our services.
If you would like to share your views, please contact:

Associate Director of Quality and Safety
 East Lancashire Hospitals NHS Trust
 Fusion House
 Evolution Park
 Haslingden Road
 Blackburn
 BB1 2FD
 Email: qualityandsafetyunit@elht.nhs.uk

1.6 Our Regulator's View of the Quality of our Services

Between the 4th and 6th March 2025, the Care Quality Commission (CQC) carried out an unannounced inspection of Community Hospitals Inpatient Wards. During this visit, the CQC inspected Marsden and Hartley at Pendle Community Hospital, Ribblesdale at Clitheroe, Albion Mill, Ward 19 and Ward 22 and Rakehead at Burnley General Hospital. No patient safety concerns were raised during the inspection. Following the inspection, the report was received and identified key areas for development. A robust action plan was developed and shared with the CQC to address these.

The last comprehensive Care Quality Commission (CQC) inspection took place from 28 August to 27 September 2018. The CQC visited the Trust to conduct a series of inspections concluding with a 'Well-led' review. Following their review, the report was published on 12 February 2019 and the Trust was rated as being Good overall, with areas of Outstanding. The CQC scores for each of the combined Trust, main hospital sites and overall are as follows:

Ratings for a Combined Trust	
Acute	Good
Community End of Life	Outstanding
Community Health Inpatient Services	Requires Improvement
Community Health Services for Adults	Good
Mental Health for children and young people	No longer part of the organisation
Royal Blackburn Teaching Hospital Overall - Good	
Safe	Good

Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-Led	Good

Burnley General Teaching Hospital Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-Led	Good

The CQC also awarded the use of Resources rating based on an assessment carried out by NHS Improvement.

The CQC combined rating for Quality and Use of Resources summarises the performance of our Trust, taking into account the quality of services as well as the Trust's productivity and sustainability. This rating combines the five Trust-level quality ratings of Safe, Effective, Caring, Responsive and Well-led with the Use of Resources rating.

East Lancashire Hospitals NHS Trust Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-Led	Good
Effective use of Resources	Good

All areas for improvement continue to be monitored through the appropriate assurance committee structure and the Trust and CQC have regular engagement meetings.

Our Mortuary Service was inspected by the Human Tissue Authority on Wednesday 4th February 2026. The HTA noted that significant improvements had been made since the previous inspection. There were a number of findings which resulted in a Corrective and Preventative Action Plan being issued by the HTA. A Mortuary Improvement Board has oversight and responsibility for delivery of this action plan under the Executive Leadership of the Chief Nurse.

Our Transfusion and Haematology Services were inspected by the Medicines and Healthcare products Regulatory Agency (MHRA) on 29–30 November 2023. This resulted in an Improvement Action Plan which is on-going under the leadership of the Hospital Transfusion Committee. Compliance has improved significantly and there is now only one action that is not fully completed. The trust is seeking a review with the MHRA regarding this final action to determine if the progress made is sufficient to close this.

1.7 Our Chief Executive's Statement on Quality

Welcome to the 2025-26 Quality Account for East Lancashire Hospitals NHS Trust (ELHT).

On behalf of all colleagues, may I begin by saying how proud I am of our achievements this year, as well as our response to some of the significant challenges we have faced too.

The first thing to say is that the integrated Trust has delivered strong operational performance and made a real difference to patients and their families, including:

- Reducing our waiting list by nearly 20,000 people which is an 18.5 per cent reduction and the largest improvement in the region
- Cutting the number of patients waiting over a year for treatment from 4,228 to 340 by the end of March
- Consistently ranking in the top five nationally for theatre productivity, ensuring we make the best use of our capacity in both Blackburn and Burnley
- Moving up to 78th place out of 134 in the National Oversight Framework league table, with the highest possible rating for patient safety
- Remaining among the best in the country for seeing patients within four hours in urgent and emergency care, including at Royal Blackburn Teaching Hospital
- Making significant progress in admitting patients within 12 hours of the decision to admit - driven by our commitment to eliminate corridor care and the hard work of teams across the integrated Trust

This has been delivered despite ongoing and sustained pressure and demand which often presents itself first through urgent and emergency care pathways but, in reality, requires a co-ordinated response from all hospital and community teams to manage effectively. Data demonstrates that the integrated Trust continues to receive the most emergency ambulance conveyances in the North West and has one of the busiest A&E departments in England, seeing on an average of 60 more patients each day now than last year.

In 2025-26, more than any other year, this has resulted in patients being cared for on corridors and in escalation spaces, which we continue to prioritise in our improvement work to reduce prevalence and ultimately eradicate altogether. As part of this ambition, all teams continue to work together with colleagues across the wider health and social care system in Lancashire and South Cumbria too.

Running alongside all of this activity, the integrated Trust has faced an unprecedented challenge to reduce costs in 2025-26. Beginning the year with a £43 million deficit plan (pre-Deficit Support Funding), a challenging Waste Reduction Programme was initiated and the Trust achieved its plan with savings delivered exceeding £43 million.

In February 2025 the integrated Trust was enrolled into NHS England's National Recovery Support Programme (RSP) to help us recover our financial position and strengthen our Governance processes. I would like to thank colleagues from the RSP who have helped us to improve this year by:

- Reducing day to day spending every quarter consistently
- Delivering the largest cost reduction programme in our history – a total of £43m since April 2025 – and our revised financial plan for 2025-26
- Retaining strong operational performance, as well as high-quality and safe services

The performance outlined in this report will provide further assurance that increased oversight was not a reflection of the quality of care provided by the integrated Trust. In March, the integrated Trust presented comprehensive evidence to a range of regional and national colleagues and regulators who recommended it should be stepped down from national intervention arrangements and exit the Recovery Support Programme.

Throughout the year, teams have continued to work together and have shown a remarkable, unwavering commitment to delivering safe, personal and effective care. Around 80 per cent of colleagues live in East Lancashire and are therefore invested in delivering the very best possible care to their own families and friends. This is at the heart of the integrated Trust's success.

This teamwork is always especially prevalent in times of industrial action, both during the affected days and afterwards as we welcome colleagues back to their duties. This year Resident Doctors have taken part in a number of periods of industrial action called by the British Medical Association (BMA) in a long-standing dispute with the Government over pay.

As previously, the integrated Trust enacted careful planning across a variety of teams to mitigate the impact and ensure as much planned care was able to go ahead, as well as ensuring urgent and emergency pathways were appropriately covered.

This report also sets out progress across our key delivery and improvement programmes (KDIPs), which support our priorities in areas such as quality and safety, operational performance, research and innovation, digital transformation and provider collaboration.

As part of this, the integrated Trust continues to progress and colleagues at every level are focused on learning, innovation and continuous improvement for patients and their families in their own areas of expertise.

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

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

Quality is central to the vision of ELHT, which aims to be “widely recognised for providing **Safe**, **Personal** and **Effective** care.” This commitment is reflected in the Trust's continued progress and its Care Quality Commission (CQC) rating of “Good with areas of outstanding practice.”

The Trust is dedicated to continually improving the quality of care provided to local people, supporting our organisational ambition to be recognised for delivering **Safe**, **Personal** and **Effective** care. While all Executive Directors share responsibility for Quality Governance within their areas, the Executive Medical Director holds overall delegated responsibility for quality at Board level.

Quality monitoring is delivered through the Clinical Governance structure, with assurance provided to the Board via the Quality Committee. This Committee is supported by several key groups, including the Trust Wide Quality Governance Meeting (TWQG), Patient Safety Incidents Requiring Investigation Panel (PSIRI), Clinical Effectiveness Group (CEG), Patient Safety Group (PSG), Patient Experience Group (PEG), Health and Safety Committee (H&SC), Internal Safeguarding Board, and the Infection Prevention and Control Sub-Committee. Divisional Directors or their nominated deputies attend and report into

these groups. Divisional reporting mirrors the corporate structure to ensure consistent, transparent escalation from “floor to Board.”

The ELHT vision aligns closely with the NHS National Patient Safety Strategy (NPSS, 2019), which focuses on three core aims:

- Improving understanding of safety by drawing insight from multiple sources of patient safety information
- Ensuring staff across the system have the skills and opportunities to improve patient safety.
- Delivering improvement programmes that enable effective and sustainable change in key areas.

Our Quality Strategy is built around these same principles, with a clear link to our Quality Improvement programme.

Our commitment to high-quality care is further strengthened by the continued development of our Public Participation Panel (PPP), which meets monthly with direct support from the Chief Nurse. The PPP plays an active role in shaping and reviewing services, ensuring patient and carer perspectives inform our quality improvement plans.

As the Lancashire and South Cumbria system continues to evolve in line with national integration priorities, we remain committed to supporting system-wide quality improvement. As active partners, we contribute to the development and delivery of high-quality healthcare across the region.

Safe Care

Our approach to patient safety continues to be shaped by the National Patient Safety Incident Response Framework (PSIRF).

ELHT implemented PSIRF in December 2021 as an Early Adopter for the NHS North West region. PSIRF, a key component of the National Patient Safety Strategy, has driven significant changes across our Quality Governance processes and strengthened our links to improvement.

In November 2023, the Trust undertook a thematic analysis to identify new local patient safety priorities. Using insights from patient safety data (January 2021–December 2022), stakeholder feedback, and the national PSIRF criteria, three new local priorities were identified. Due to the volume of investigations aligned to national priorities, the Trust has extended its existing local priorities until April 2026.

Local Patient Safety Priorities (to April 2026)

- **Medication Errors** – with a focus on anticoagulant medicines
- **Discharge planning** – particularly transitions from acute hospital beds to IHSS or care homes
- **Safeguarding patients with learning difficulties** – addressing inappropriate use of the mental capacity act.

The Trust will review its Patient Safety Incident Response Plan and local priorities, with an updated version scheduled for publication in June 2026.

All incidents that meet the PSIRF national or local patient safety priorities are routinely subject to a full Patient Safety Incident Investigation (PSII), carried out by a trained

investigator. These PSIs are coordinated at a Trust-wide level and overseen through the Patient Safety Incidents Requiring Investigation (PSIRI) Panel, with Executive leadership providing assurance.

All other incidents that result in harm, and where learning can be identified, are investigated using a range of Patient Safety Response (PSR) tools. These investigations are coordinated within the divisions and monitored through the Trust's Patient Safety Group.

Clinical Effectiveness

There is a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. The Clinical Audit & Effectiveness Team's function is to support clinical teams in providing assurance against standards to ensure the organisation is delivering best practice according to national guidance. To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate has a 'portfolio' of activity against which they monitor their performance.

This portfolio includes:

- a. National audits, registries and confidential enquiries as mandated by the national contract i.e. the National Clinical Audit Patient Outcome Programme (NCAPOP)
- b. Other national audits, registries and confidential enquiries included in the NHS England Quality Accounts list.
- c. Regional and local audits as determined by commissioners or regional bodies required or for accreditation.
- d. Local quality audits/studies and service evaluations (for example compliance with local care bundles and alignment with other quality governance intelligence - incidents, risk, patient safety and experience etc.)
- e. Monitoring and implementation of relevant national clinical guidance (E.g. NICE Guidance and Quality Standards)
- f. Monitoring and implementation of relevant National Confidential Enquiry (NCE) recommendations
- g. Getting It Right First Time (GIRFT) Gateway review and Further Faster participation (including monitoring of associated Model Hospital metrics)

Nationally there is a drive to collect continuous data to support timely reporting on performance to support quality improvement activities delivered by audit providers. This has meant a continued focus on data completeness and data quality delivery within set deadlines to support ongoing learning and assurance from outcomes. Following on from the implementation of the Electronic Patient Record, due to the complexity of sample identification and the data format, extraction remains primarily manual to support appropriate review and rationale for inclusion/exclusion criteria. This added to increasing elective and emergency hospital activity has increased our data submission requirements and overall workload. Whilst some standardised forms have been developed within EPR to enable swift extraction and submission of data, further work is required with the clinical and informatics teams to expand this to cover our data requirements. Activity continues to be led by designated responsible Trust, Divisional and Specialty Clinical Leads, to enable the development of a portfolio of evidence for providing assurance of compliance with appropriate standards, which are through designated quality governance forums, supported by the central Clinical Audit & Effectiveness Team.

Monitoring and Improving the Safety Culture

The safety of both patients and colleagues is shaped by how strongly safety is valued and prioritised across the organisation. ELHT has established a range of structures and processes—both at and below Board level—to ensure the quality of our services and to monitor and strengthen our safety culture.

To support learning and continuous improvement, the Trust has developed several mechanisms for sharing safety insights and promoting a positive safety culture, including:

- Patient Safety Learning Events, which provide a forum for colleagues to explore learning from incidents, understand the underlying issues, review actions taken to improve safety, and identify further opportunities for improvement.
- ELHT Patient Safety Alerts, used to raise awareness of safety concerns and communicate safety-critical actions requiring immediate implementation across the Trust, Divisions, or Directorates. Compliance and assurance against these actions are monitored through the Patient Safety Group or the Lessons Learnt Group.
- Patient Safety Bulletin, produced quarterly by the Patient Safety Incident Investigation Team, highlighting key learning and safety improvements from both national and local priorities under the Patient Safety Incident Response Framework (PSIRF).
- Patient Safety Incident Dashboard, introduced in 2023 and further enhanced in 2024, providing key performance indicators for assurance at the Patient Safety Group, Trust Wide Quality Governance Meeting, and Quality Committee.
- Patient Safety SharePoint Site, offering colleagues easy access to patient safety information, learning resources, and tools to support safe practice.
- Patient Safety Podcasts, showcasing examples of good practice, staff engagement in the investigation process, and key learning from incidents. These are accessible to all staff via the Patient Safety SharePoint site.
- Patient Safety Stories provide an opportunity for patients, families and carers to share their experience of care and treatment through short videos. These stories are shared with staff and presented at the Trusts Quality Community and Trust Board to support learning, reflection and improvement.

Mortality Reduction Programme

The Trust monitors mortality statistics, performance and identifies areas for focus or improvement through a monthly Mortality Steering Group, chaired by the Executive Medical Director or Deputy Medical Director.

The Trust has robust governance arrangements in place to review, report and learn from patient deaths through the analysis of various data sets, including:

- Mortality benchmarking – HSMR+, SHMI, Crude Mortality
- Medical Examiner Service Activity and Learning
- Adult SJR Mortality Reviews and Learning
- PSIRI process, where a death has resulted from an incident.
- Perinatal, Neonatal and Child Deaths
- Reviews and learning from deaths of people with learning disabilities (LeDeR)

The standardised mortality ratios (HSMR and SHMI) have been subject to significant data quality issues. In part this was because of delayed coding arising from vacancies in that team and the introduction of the Electronic Patient Record. This affected data submission

throughout the 2023-24 year, and therefore the standardised ratios for 12 months after that. This issue has now been resolved, and coding is now being submitted within timescales. As a result, the Trust now reports full 12 month rolling figures.

A second data issue relates to the treatment of Same Day Emergency Care, which was removed from our mortality dataset at the time of introduction of EPR in line with the intended national future direction of travel. The effect of this was to remove a substantial very low risk cohort from our data, and hence this caused an apparent increase in mortality. Consistent application of the data change across Trusts was not achieved - the national deadline for Trusts to make the change was extended from mid-2024 until July 2025 and has since been abandoned. This means the SHMI is expected to be inaccurately high for a considerable period.

During the period in which these data issues have continued, the Mortality Steering Group has used crude mortality rates to identify variation – this has remained within control limits during the year.

The Trust continues to use the Structured Judgement Review (SJR) methodology via an electronic review process that is part of our patient safety governance software system. The review process is in line with the most recent NHS England guidance: Learning from Deaths and includes an overall score. The Trust completed 120 SJR reviews last year, which has again fallen since previous years because of vacancy in the administrative post supporting this. Additional reviewers have been identified and training sessions have been carried out.

Additionally, some other areas perform their own mortality reviews, including the Emergency Department, which reviews all deaths. Stroke and intensive care deaths are also being reviewed. Additionally, all deaths of patients with a recognised Learning Disability (LD) or Autism are subject to SJR and by specialist learning disability reviewers. Following this, information is submitted to the regional Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR) team, for an external review of care to be completed. Such deaths are either highlighted by the input of the LD team during their stay or highlighted by the Medical Examiner Service and submitted for review.

Maternal deaths are reviewed using a primary mortality review and then may be referred to the Coroner or Maternity and Neonatal Safety Investigation (MNSI) programme for further investigation.

All stillbirths and late miscarriages after 22 weeks gestation are reviewed through the perinatal mortality review process (PMRT). This involves a preliminary review, a primary review and a secondary review at the neonatal mortality meeting. All deaths are then further reviewed at multi-disciplinary perinatal mortality meetings.

In addition, any stillbirth of a baby over 37 weeks gestation that occurs during the intrapartum period (during labour) is referred to the Maternity and Neonatal Safety Investigations (MNSI) programme for external review.

All Neonatal Deaths are discussed with the Medical Examiner team and if any care or service delivery issues are identified these are referred to the coroner for further investigation.

Child Deaths are all subject to the Sudden Unexpected Death in Childhood process (SUDC) and co-ordinated through the Trust Safeguarding Team, where appropriate. Any unexpected child death would also be discussed with the coroner.

The Trust continues to review all hospital deaths and has recruited additional Medical Examiners and Medical Examiner Officers to support the service to cover community deaths.

Medical Examiners (ME's)

The Medical Examiner Service became a statutory service from the 9th September 2024 following passing of legislation. All deaths which do not meet the criteria for immediate referral to the Coroner must be referred to the local Medical Examiner Service. This includes all deaths in a hospital setting and all deaths in a community setting.

The ME office, although independent of the Trust, is based at the Royal Blackburn Teaching Hospital site and employs Medical Examiner Officers (MEO's) and Medical Examiners (ME's)

The Medical Examiner Office utilise medical systems both in hospital (e.g. Cerner, Ice, Sectra) and community (EMIS, NWAS). The MEO's are able to create a complete case for the Medical Examiner, and by performing appropriately delegated tasks they allow the MEs to focus on case scrutiny. Proportionate scrutiny of a death is undertaken by a ME, who is an experienced doctor with additional training (completed through the RC Pathologists) in death certification and the review of documented circumstances of death.

Once a case has been reviewed, there is a discussion with the attending practitioner regarding the proposed cause of death. The ME office can provide support if required in agreeing an accurate and acceptable cause of death. Either the ME or MEO will then speak with the NOK / informant regarding the cause of death and circumstances around the death. The NOK / informant may provide additional information and comment on the care provided to the deceased. Any concerns can be raised to the MEO/ ME. The ME team can see any complaints, incidents, safeguarding alerts that may already be place. Positive feedback regarding care is also received from the NOK / informants.

Any concerns regarding care identified by the ME service, that do not necessitate a Coroners referral, can raised through the Trusts normal governance processes (e.g. IR, SJR's). The ME work closely with the Coroner / Coroners officers and help facilitate referral in cases where it is felt following ME review a Coroners referral is required.

Data from the Medical Examiner Service has shown that in nearly 20% of cases, recently bereaved families had passed positive comments back to the teams looking after their loved one at the end of their life.

The ME office provides the Trust with a monthly Mortality Report which is presented at the Mortality Steering Group. In this the ME service can report any trends or themes which have been noticed and provide ongoing input into the Trusts Learning from Deaths processes.

In 2024/2025 the ME office reviewed 4892 deaths - 2004 hospital deaths and 2888 community deaths. The Medical Examiner Service became a legal requirement for ALL deaths not immediately referred to the Coroner - both hospital and community - in September 2024. 75 hospital Governance referrals were made (including SJR;s and Incident Reports), 98 hospital concerns resolved, were resolved by the Medical Examiner Service. 348 fast release deaths were supported by the ME Service. Feedback into community governance processes were also made.

The Lead Medical Examiner works closely with all relevant stakeholders including for example the Senior Coroner, Lead Registrar, Faith leaders and the regional and national Lead ME's. East Lancashire ME office is one on a small number nationally to provide an 'out of hours' weekend service to assist with any fast release deaths - reflecting the requirements of the local population.

Where incidents are raised by the ME office, these are investigated under the Trust's usual LFPSE (Learning from Patient Safety Events) processes. Cases in which poor care is felt to have contributed to death are discussed at a weekly complex case meeting to ensure appropriate investigation is undertaken. Points for learning are fed back within clinical divisions.

The ME office additionally provides a report to the Trust Mortality Steering Group describing their activity, which allows themes and trends to be identified.

Personal Care

Now in its second year, our Patient Experience Strategy has moved from a framework for change into a mechanism for tangible cultural shift. Over the past twelve months, we have transitioned from simply "listening" to ensuring that the patient voice is a structural requirement of our governance and safety mechanisms.

A feature of this second year has been the deliberate broadening of public and patient presence within our formal governance structures. We have moved beyond traditional consultation; patients and carers now sit as active contributors within Trust meetings, ensuring that lived experience directly influences executive decision-making and service design.

Our Public Participation Panel (PPP) remains a forefront of this work. Particularly, the PPP has grown its impact by engaging in more governance meetings, service development initiatives and sought to broaden the PPP membership. Supported by the Quality Improvement (QI) team, the panel is working to refine how the panel analyses Trust data, allowing them to identify and scrutinise areas for improvement.

We continue to treat patient experience as a core component of patient safety. By triangulating various "intelligence streams," we create a holistic view of our care environment.

The Friends and Family Test remains our most agile tool for high-volume feedback. We have moved toward more sophisticated thematic analysis of FFT comments, allowing Divisions to implement rapid-cycle improvements based on real-time recommendation trends.

We regard complaints and concerns as critical patient safety indicators. Over the past year, we have strengthened the connection between patient feedback and incident reporting, enabling individual concerns to act as an early 'smoke alarm' for emerging or wider systemic risks. This more integrated approach supports proactive identification and management of latent safety issues, rather than reactive responses once harm has occurred. Alongside this, we have maintained a strong focus on improving the quality and timeliness of our complaint responses, in line with Trust timescales, recognising the importance of thoughtful, timely communication to those who take the time to raise concerns with us.

The use of Patient and Staff Stories remains a cornerstone of our Board and Divisional meetings. By grounding our performance data in the reality of individual experiences, we ensure that the "human cost" of our services stays at the forefront of our safety culture. These narratives have proven invaluable in bridging the gap between clinical outcomes and emotional wellbeing.

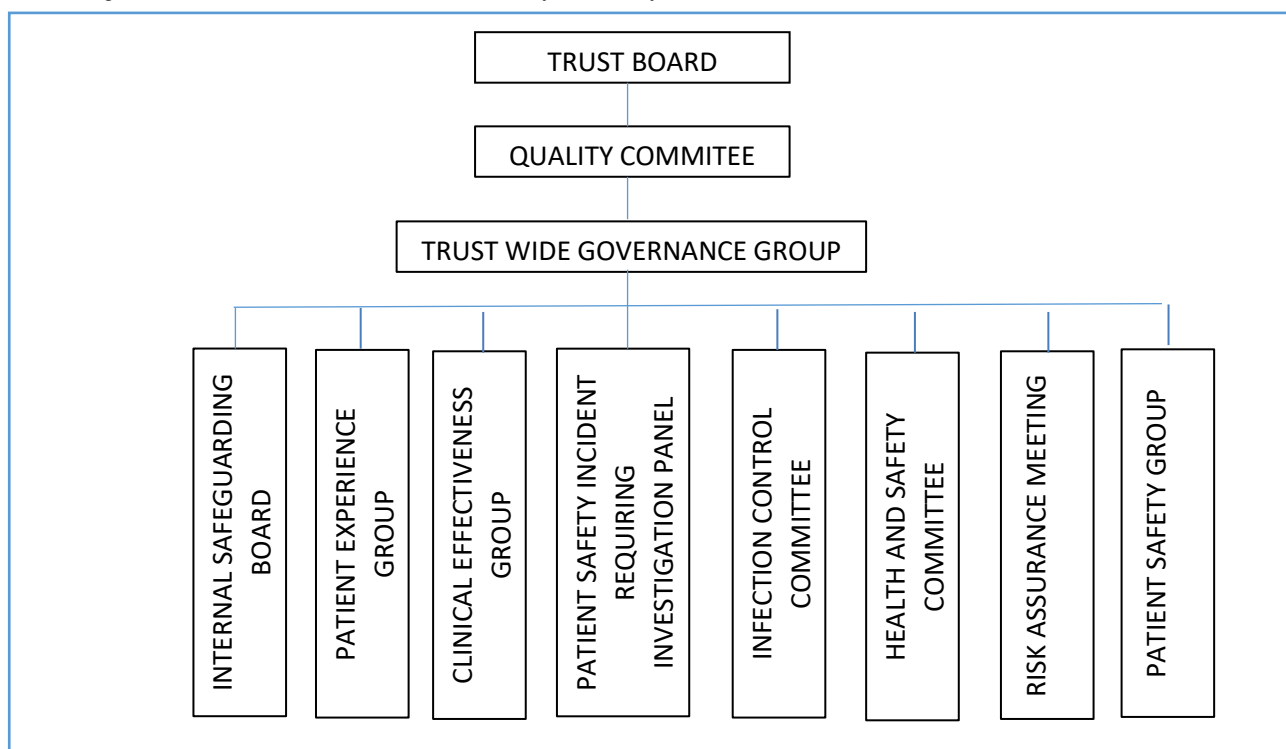
As we move further into Year Two, our focus remains on depth and diversity. We are committed to ensuring that our engagement reaches all corners of our community, ensuring that every patient, regardless of their background, has a clear, influential seat at our table.

Governance Arrangements for Quality

Improving quality remains the Board's highest priority and is central to the Trust's vision of being widely recognised for providing **Safe**, **Personal** and **Effective** care. Quality and safety are embedded at the heart of everything we do, and delivering care that meets the highest standards is increasingly becoming our baseline expectation rather than an aspiration. This continual focus for quality gives patients, families and stakeholders greater confidence in the Trust as progress.

To support this, the Trust has established a robust governance and committee structure, illustrated in figure 1, which ensures the Board receives clear assurance on the delivery of the Trust's objectives and that risk to providing **Safe**, **Personal** and **Effective** care are effectively identified, managed and monitored.

Figure 1: Trust Governance Structures for Quality and Safety



2.2 Quality Monitoring and Assurance

To support delivery of our quality improvement work streams, the Trust has defined a meeting structure that supports the flow of information to and from the Trust Board. The corporate meeting structure is reflected within each of the Trust's clinical divisions thereby ensuring the Board has proper oversight of performance at all levels of the Trust, down to ward level. The meeting structure also provides a clear route of escalation for issues that need executive decision. Meetings take place on a regular basis and utilise standardised information to drive and inform the discussion. The data contained within the various performance dashboards showing monitoring of quality improvement areas is a mixture of outcome targets and process milestones that are presented to demonstrate performance at all levels of the Trust.

The Board Assurance Framework (BAF) and the Corporate Risk Register provide assurance to the Board that risks to patient safety, reputation and quality are appropriately managed in a timely way. The risk management process is designed to ensure current and potential future risks to quality are identified and included on the risk register, for example new technologies and changes in policy and funding. There are clear directorate and divisional reporting structures with specific triggers and processes by which risk and mitigating actions are reported and escalated. There is a clear and dynamic process for the management of risk in the organisation and both the BAF and the Corporate Risk Register are regularly reviewed to ensure appropriate, preventative, and corrective actions have been taken.

The Trust Board is ultimately accountable for the delivery of quality outcomes, and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality Governance Unit, comprising three specific portfolios of patient safety/clinical risk, patient experience, and clinical effectiveness. Similarly, Divisional Medical Directors, Divisional Director of Operations and Divisional Director of Nursing are responsible for the delivery of quality outcomes within their divisions and the Trust Board

holds Divisional Senior Management Teams to account for delivering quality outcomes within their respective divisions. This principle of accountability and responsibility is reflected from Board to Floor and supports the delivery of our quality objectives.

During 2025-26 the East Lancashire Hospitals NHS Trust continued to provide and / or subcontracted 8 NHS Services. These services have been identified using the CQC's definition of regulated activities. The services provided during the year were:

- Treatment of disease, disorder, or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Management of supply of blood and blood-derived products

The Trust has reviewed all the data available on the quality of care in all these NHS services. The Trust continues to use its integrated quality, safety, and performance scorecard to facilitate this and has begun using a Quality Dashboard to support triangulation. Reports to the Trust Board, the Quality Committee, Trust-wide Quality Governance Group and Senior Leaders Group all include data and information relating to quality of services. Progress against last year's priorities for quality improvement, as set out in our Quality Account 2025-26; have been managed by way of these reporting functions.

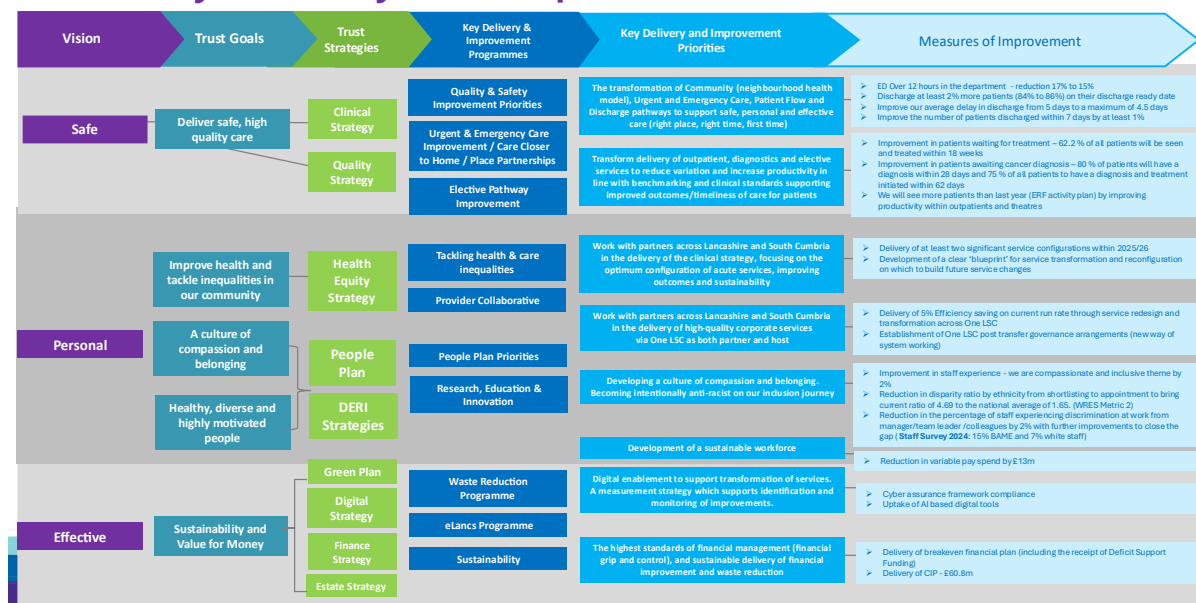
The income generated by the NHS Services reviewed represents 98% of the total income generated by the East Lancashire Hospitals NHS Trust for 2025-26. (2024-25 98%).

2.3 Priorities for Quality Improvement 2025/26

The Trust co-ordinates a comprehensive rolling programme of Quality Improvement and PSIRP initiatives and the publication of the Quality Account give us the opportunity to highlight some of the initiatives which we will specifically focus on during the coming year(s).

The Trust has identified a number of Key Delivery and Improvement Programmes to support the achievement of Trust goals. The Improvement Hub team is deployed each year to directly support delivery of a sub-set of these priorities through application of the SPE+ improvement approach. This is agreed through the annual planning process. The Improvement Hub team also support development of skills for improvement through training for others to apply the SPE+ improvement approach. Over time the improvement practice will be used increasingly to support delivery of Trust Goals.

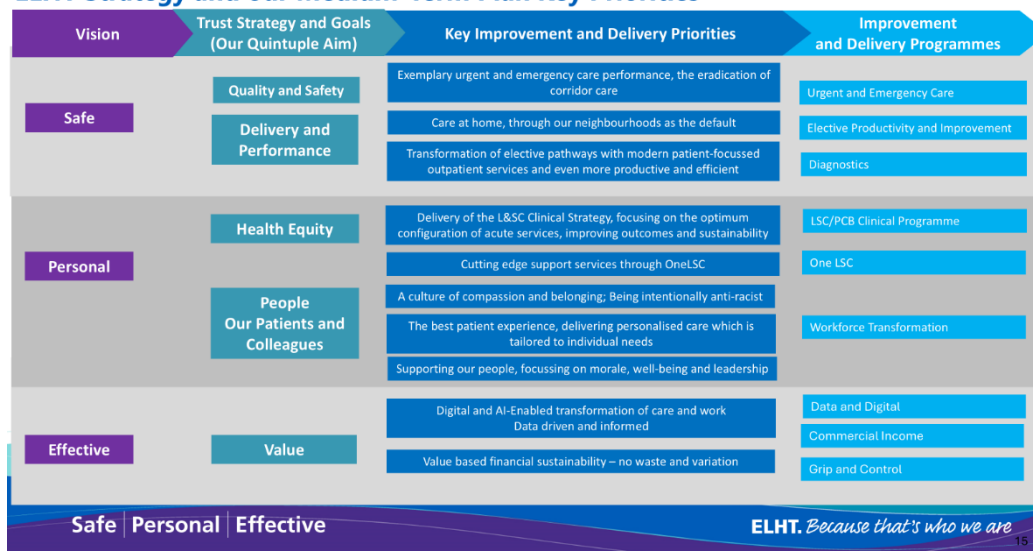
ELHT Key Delivery and Improvement Priorities 2025-26



Priorities for 2026/27

The Trust's strategy is in the process of being refreshed and key delivery and improvement priorities have been aligned to the Trust's revised 5 Goals and the 10 Year Health Plan. These are set out below:

ELHT Strategy and our Medium-Term Plan Key Priorities



Improvement Hub Team Priorities 2026/27

Improvement Projects for 2026/27 within the organisation will continue across a broad spectrum delivered by local teams. For the Improvement Hub Team the priorities will be focussed within Key Programmes supporting improvements in both Quality for patients and staff, supporting operational improvements across the Urgent Emergency Care Pathway as well as contributing to support the organisations Waste Reduction

Programme. Underpinning all programs will be a structured Improvement education and training programme to support developing capability.

Trust Goal(s)	Improvement initiatives/programmes
Quality and Safety	ELHT UEC Transformation and Improvement Programme to eradicate corridor care
Quality and Safety	HELD (Holistic End of Life Decision-making) improvement collaborative designed to strengthen recognition of dying and ensure timely, person-centred Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions.
Delivery and Performance	Develop and deliver an outpatient improvement collaborative to support the redesign and transformation of outpatient pathways
People: our colleagues and patients	• Becoming an intentionally anti-racist organisation • Reduction in trust wide sickness absence • Reduce variable pay • Sexual safety project • Appraisal • Wellbeing and morale
Value	• Waste Reduction Programme (WRP) Training (Level 2 Improvement Practice: Contributor) • Triage and support for all staff ideas supporting the Waste Reduction agenda • Support delivery of specified Waste Reduction Projects requiring an improvement approach

Underpinning the delivery of key improvement projects and projects, the Improvement Hub will focus on supporting ongoing development and embedding of the SPE+ Improvement Practice with a focus on increasing capacity and capability in improvement. In particular there will be focus on:

- Improvement Practice Training Offer – Level 1: Awareness
 - Improvement Practice Training Levels 2: Contributor and 3 Lead
 - Participation in Clinical Quality Academy
 - Quality improvement (QI) training for Colleagues in Training Groups
- Improvement for the workforce of the future
- Creating Improvement Network

2.4 Mandated Statements on the Quality of our Services

2.4.1 Clinical Audit and Confidential Enquiries

Clinical Audit involves improving the quality of patient care by reviewing current practice and modifying it where necessary. The Trust takes part in Regional and National Clinical Audits, and we also carry out local audits. Sometimes there are also National Confidential Enquiries which investigate an area of health care and recommend ways of improving it. The Trust also takes part in these Confidential Enquiries.

During 2025-26, 61 national clinical audits and 12 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 55 (90%) national clinical audits and 12 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that ELHT was eligible for and subsequently participated in are set out in the table below. The National Clinical Audits and National Confidential Enquiries that ELHT participated in, and for which data collection was initiated or completed during 2025-26 also appears in the table below alongside the percentage of cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required / Sample Submission
Adult Asthma Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Benchmarking exercise programme for older people (BEPOP)	NIHR	Intermittent	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	NHS England	Continuous	Yes	100%
British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infection using recent Guidance (BOOMERANG)	BAUS	Intermittent	TBC	TBC
BTS UK Interstitial Lung Disease (ILD) Registry	BTS	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Children and Young Peoples Asthma Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Elective Surgery (National PROMS Programme)	NHS England	Continuous	Yes	100%
Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST	BAUS	Intermittent	TBC	TBC
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Learning Disability and Autism Programme (LeDeR)	NHS England	Continuous	Yes	100%
Learning Disability Benchmarking Audit Year 6	NHS Benchmarking	Intermittent	Yes	100%
Major Haemorrhage Audit 2025	NHSBT	Intermittent	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	TBC
National Acute Kidney Injury Audit	UK Kidney Association (UKKA)	Continuous	Yes	100%
National Adult Diabetes Audit – Core (NDA)	NHS England	Continuous	Yes	100%
National Audit of Cardiac Rehabilitation	University of York	Continuous	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%

National Audit of Care at the End of Life (NACEL)	NHS benchmarking	Intermittent	Yes	100%
National Audit of Inpatient Falls (FFFAP)	RCP	Intermittent	Yes	100%
National Audit of Metastatic Breast Cancer (NAoMe)	NATCAN	Continuous	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	RCP	Continuous	Yes	100%
National Audit of Primary Breast Cancer NAoPri)	NATCAN	Intermittent	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	100%
National Bowel Cancer Audit (NBOCA)	NATCAN	Continuous	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Child Mortality Database	University of Bristol	Continuous	Yes	100%
National Comparative Audit of Blood Transfusion – Audit of NICE Quality Standards QS138	NHSBT	Intermittent	TBC	TBC
National Diabetes Foot Care Audit (NFDA)	NHS Digital	Continuous	Yes	100%
National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	Continuous	TBC	TBC
National Early Inflammatory Arthritis Audit (NEIAA)	BSR	Continuous	Yes	TBC
National Emergency Laparotomy Audit (NELA): Laparotomy (Lap)	RCA	Continuous	Yes	TBC
National Emergency Laparotomy Audit (NELA): No Laparotomy (NoLap)	RCA	Continuous	Yes	TBC
National Gestational Diabetes Audit	NHS Digital	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	Yes	100%
National Joint Registry (NJR)	HQIP	Continuous	Yes	TBC
National Kidney Cancer Audit (NKCA)	RCP	Continuous	Yes	100%
National Lung Cancer Audit (NLCA)	NATCAN	Continuous	Yes	100%
National Major Trauma Registry (NMTR)	NHSE	Continuous	No	NA
National Maternity and Perinatal Audit (NMPA)	RCOG	Continuous	Yes	100%
National Neonatal Audit Programme (NNAP)- Neonatal Intensive and Special Care	RCPCH	Continuous	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	NATCAN	Continuous	Yes	100%
National Ophthalmology Database (NOD) National Cataract Audit	RCOphth	Continuous	No	NA

National Paediatric Diabetes Audit (NPDA)	RCPCH	Continuous	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	NATCAN	Continuous	Yes	100%
National Pregnancy in Diabetes Audit - Adults (NPID)	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit (NPCA)	NATCAN	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Perioperative Quality Improvement Programme	RCA	Continuous	TBC	TBC
Pulmonary Rehabilitation Organisational and Clinical Audit	RCP	Continuous	Yes	100%
RCEM: Adolescent Mental Health	RCEM	Intermittent	No	NA
RCEM: Mental Health Self Harm	RCEM	Intermittent	No	NA
RCEM: Care of Older People (COP)	RCEM	Intermittent	No	NA
RCEM: Time Critical Medications (TCM)	RCEM	Intermittent	No	NA
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOT UK	Continuous	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA	Intermittent	TBC	TBC
Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS Digital	Continuous	Yes	100%
UK Parkinsons Audit	Parkinson's UK	Intermittent	Yes	TBC

Key to Audit Coordinator abbreviations

BAUS	British Association of Urological Surgeons
BCIR	Breast and Cosmetic Implant Registry
BOAMS	British Association of Oral & Maxillofacial Surgeons
BSR	British Society for Rheumatology
BTS	British Thoracic Society
FFFAP	Falls and Fragility Fractures Audit Programme
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care Audit and Research Centre
NATCAN	National Cancer Audit Collaborating Centre
NCAP	National Cardiology Audit Programme
NHSBT	NHS Blood and Transplant
NICOR	National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Care and Research
NRAP	National Respiratory Audit Programme
RCA	Royal College of Anaesthetists
RCEM	Royal College of Emergency Medicine
RCOG	Royal College of Obstetricians and Gynaecologists
RCOphth	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists

RCS	Royal College of Surgeons
PROMs	Patient Recorded Outcome Measures

National Confidential Enquiries (NCE's)

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2025 -26	Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Emergency Surgery in Children & Young people	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Rehabilitation following Critical Illness	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Limb Ischaemia	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Illness in people with a Learning Disability	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Stabilisation of the critically ill child	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Pleural Procedures	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Rib Fractures	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and serious morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	MBRRACE-UK, NPEU, University of Oxford	Intermittent	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

Key to Audit Enquiry Coordinator abbreviations	
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries – United Kingdom
NPEU	National Perinatal Epidemiology Unit

The results of 38 national clinical audit reports and 6 National Confidential Enquiry reports were received and reviewed by the Trust in 2025-26. Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- National Audit reports will continue to be presented at specialty/ multi-specialty effectiveness meetings or other appropriate forums where lessons learnt, subsequent recommendations and action will be agreed so that practice and quality of care can be improved.
- A list of all National Audit Reports received is collated and shared with the Medical Director, Divisional / Directorate Clinical Effectiveness Leads, and is monitored via Divisional and Trust Clinical Effectiveness Groups to provide assurance that these reports are being reviewed and lessons learnt, and any subsequent recommendations and action captured.
- The Medical Director / Designated Deputy may request clinical leads to present finding at Clinical Leaders Forum or Quality Committee for further assurance.
- National audit activity which highlights the need for improvement will have associated improvement plans developed and monitored at an appropriate forum for assurance.
- The Clinical Audit Annual Report will include a summary on the participation in national audit activity along with learning, assurance, or subsequent actions for improvement.
- 249 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2025-26. The results of which were presented / scheduled to be presented at specialty/ multi-specialty audit or other appropriate forums, and the Trust intends to take the following actions to improve the quality of healthcare provided:
- All local audit activity will continue to be presented and discussed at specialty/multi-specialty effectiveness meetings and/or appropriate forums where lessons learnt are captured, assurance identified and or recommendations for actions agreed to

support improvement.

- Monitoring of action matrices will occur at subsequent clinical effectiveness or designated fora to ensure that actions are implemented to agreed timescales led by the Specialty Clinical Effectiveness Lead or forum chair.
- Meeting minutes and associated action matrices will be available for discussion at Divisional Clinical Effectiveness meetings or appropriate management forums. Outcomes will be included in divisional reporting to the Trust Clinical Effectiveness Group.

All local clinical audit activity will also be included in annual reporting as a record of all activity and lessons learned as a result of audit to provide assurance and support improvement in quality and patient care.

2.4.2 Research and Development

The number of patients receiving relevant health services provided or subcontracted by ELHT in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee is 8566 recruited participants across 56 studies.

2.4.3 National Tariff Payment System and CQUIN

For 2025-26, the mandatory CQUIN scheme continues to be paused, see statement from NHS England below:

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.

Please note the mandatory CQUIN scheme has been paused. A set of non-mandatory quality indicators which systems may choose to use can be found on the FutureNHS Collaboration Platform(a FutureNHS account is required to access this content).

Note: There has been no agreement with commissioners to continue this scheme during this reporting period, although ELHT have continued to monitor some of the quality indicators from 2023-24 requiring monitoring as part of our local audit programme.

2.4.4 Care Quality Commission Compliance

East Lancashire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2025-26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 25 to Jan 26 (most recent figures):

· Admitted Patient Care	143,588
· Outpatient Care	855,945
· Accident and Emergency Care	286,746

The percentage of records in the published data - which included the patient's valid NHS number, was:

Performance for Apr 25 to Jan 26 (most recent figures):

· Admitted Patient Care	100%
· Outpatient Care	100%
· Accident and Emergency Care	95.9%

The percentage of records in the published data - which included the patient's General Medical Practice Code was:

Performance for Apr 25 to Jan 26 (most recent figures):

· Admitted Care	98.5%
· Outpatient Care	99.4%
· Accident and Emergency Care	96.0%

East Lancashire Hospitals NHS Trust will be taking the following actions to improve data quality:

- Continue to use the Second User Service (SUS) data quality tools and other benchmarking tools to identify areas of improvement.
- Support data quality improvement within the meeting structures
- Continue to embed data quality ownership across the Trust.

2.4.6 Information Quality and Records Management

The Trust aims to deliver a high standard of excellence in Information Governance by ensuring information is collated, stored, used and disposed of securely, efficiently and effectively and that all our processes adhere to legal requirements. This includes completion of Data Protection Impact Assessments, annual Data Security Awareness Training for all colleagues, contract reviews and continued development of the information asset management programme. The Trust also utilises the national training for Information Asset Owners and supporting the owners through this process. The Trust has a suite of Information Governance policies to ensure patient, colleagues and organisational information is managed and processed accordingly.

As reported in last year's report, in 2024/25 the Data Security Protection Toolkit (DSPT) underwent a significant update to align with the National Cyber Security Centre's Cyber Assessment Framework (CAF). These changes aim to shift the focus from a compliance checklist to a set of broad principles that drive good decision-making and support a culture of continuous improvement. The Trust was unable to achieve all the expected mandated outcomes and therefore has a status of "Approaching Standards"

The Trust is currently working towards an improved position of the 2025/2026 period, and the final submission is 30th June 2026. This programme of work is overseen by the Senior Information Risk Owner through the SIRO Meeting as well as the Data and Digital Committee when required.

2.4.7 Clinical Coding Audit

The Data Security and Protection Toolkit (DSPT) is due to take place in May 2026 (200 FCE's) our new Trainer is also an Auditor so can carry this out for us with a second auditor from the Lancashire Coding Collaborative.

The department now has a Qualified Trainer/Auditor who started with us 30.3.26 and is also part of the LCC.

We carried out some internal audit on the Trainees - Band 2 Performance Audits (50 episodes per coder x 2 audits, but the programme has been limited due to staffing issues and having no Qualified Auditor in place.

The Senior Clinical Coders have been currently covering the role to minimise risk within the team, whilst a review of the structure and requirements of the Clinical Coding Team takes place.

All coders have had random spot checks, checking for co-morbidities and standards.

Now that ELHT are part of the Lancashire County Council and One LSC, the Trust are able to use auditors from other Trusts to carry out this role.

2.5 Complaints Management

Feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, individually and for the wider NHS, as well as contributing to a culture of learning from experience. Patients, relatives, and carers are encouraged to communicate any concerns to colleagues with the aim of addressing those concerns immediately. The Trust has adopted the principles of good complaints handling, as set out by the Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values as follows:

Getting it right - Being customer focused - Being open and accountable – Acting fairly and proportionately - Putting things right - Seeking continuous improvement.

These principles are in line with the Trust Vision and Values.

The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, these are now presented at Trust Board meetings.

The Customer Relations Team deals with concerns raised formally and informally, ensuring that individual concerns are addressed effectively, and lessons are learnt from the issues raised. During 2025 - 26, 2697 enquiries were received from a variety of sources (2555 in 2024 - 25). The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. Within the 2697 enquiries, 565 were logged as formal complaints during this period (254 more than the 311 received in previous year). Some concerns raised are awaiting triage due to the complexity and this figure may increase following the outcome of the triage process. Complainants are contacted as soon as possibly following raising their concerns.

The current policy ensures that complainants are kept informed and updated and that greater compassion is evident within responses. Complaints handling is available to staff to support awareness of complaints requirements and correct procedures to ensure that complaints are dealt with in a timely and appropriately manner, providing assurance that lessons are learned from complaints across the Trust and themes have been identified. This training includes local resolution, complaints policy, colleagues' responsibilities and response writing. Regular reports now include more detail of these.

Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year 2025 - 26, 5 complaints were referred to the Ombudsman, records and information have been provided, and the cases are under consideration for investigation by the Ombudsman.

2.6 Duty of Candour

The Duty of Candour (DoC) requirement, set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20, has been a statutory obligation for provider organisations since 2015 and is a condition of registration with the Care Quality Commission (CQC).

The Trust maintains a Being Open and Honest Policy, which ensures that an apology is provided to all patients, families, and carers when the Trust has caused moderate harm or above. To support consistent delivery, the Trust has implemented a Standard Operating Procedure for tracking and monitoring Duty of Candour activity. Each division has access to a dedicated Duty of Candour dashboard, enabling real-time oversight of compliance and timeliness. This dashboard is reviewed weekly at the Trust's Incident Complex Case Meeting, providing an additional layer of monitoring and assurance.

Oversight of the Duty of Candour process is held by the Medical Director and the Associate Director for Quality and Safety, with regular assurance reports submitted to the Trust's Quality Committee. To support staff understanding and compliance, the Trust provides a Duty of Candour e-learning package, accessible to all colleagues via the Trust's Learning Hub.

For the reporting year 2025/26, the Trust recorded no breaches of Duty of Candour requirements in line with Regulation 20.

2.7 NHS Staff Survey Results

The NHS Staff Survey is conducted by the Picker Institute Europe and National data. The Trust is required to publish the results of two elements of the survey as follows:

Indicator	Question	% Result
KF21 (Q15)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	52.5%
KF26 (Q14c)	Not experienced harassment, bullying or abuse from other colleagues	83.7%

For Q15, ELHT has seen a decline on the previous year's percentage (62.0%). ELHT is lower than the national average of 53.17%.

For Q14c, ELHT has seen a decrease in the previous year's percentage (83.5%). ELHT is better than the national average of 81.42%.

2.8 Medical and Dental Staffing

During the 2025/26 financial year, the Trust has maintained a stable Medical and Dental (M&D) workforce establishment, with a strong focus on optimising Whole Time Equivalent (WTE) utilisation and reducing reliance on Bank and Agency (B&A) staffing. This has been achieved through consistent grip and control measures via the Vacancy Control Panel and a continued emphasis on workforce efficiency rather than establishment growth.

Throughout the year, the Trust's M&D WTE establishment has remained broadly constant, reflecting robust vacancy scrutiny and effective workforce planning. Rather than increasing establishment, the focus has been on maximising the productivity, availability and deployment of our substantive workforce. The attached WTE figures demonstrate this stability across the reporting period.

Month	Establishment
Mar-25	856.5
Apr-25	856.5
May-25	841.3
Jun-25	853.3
Jul-25	856.2
Aug-25	855.9
Sep-25	855.3
Oct-25	855.3
Nov-25	857.6
Dec-25	857.6
Jan-26	856.3
Feb-26	856.3

A key priority for 25/26 has been reducing reliance on contingent labour by optimising existing workforce provisions. A range of targeted schemes have supported this approach, including job plan optimisation, annual leave reconciliation, improved and more effective rostering, strengthened sickness management processes, and enhanced controls around B&A usage. Collectively, these measures have driven a reduction in Bank and Agency reliance while maintaining safe staffing levels.

Medical and Dental workforce oversight continues through established Trust governance arrangements. Workforce gaps, vacancy positions and agency usage are regularly reviewed with Divisions, enabling proactive recruitment activity, rota assurance, and the development of agency exit plans where required. This ongoing scrutiny has ensured alignment between workforce supply, service demand and financial sustainability. The Trust has continued work to improve workforce utilisation, with a particular focus on accurate rostering, leave management and the effective deployment of medical capacity through the Medical rostering project. These improvements have contributed directly to reduced variable pay spend and greater transparency over workforce utilisation.

Please see below combined Bank and Agency spend comparison for Medical & Dental staff for 24/25 and 25/26:

	April	May	June	July	August	September	October	November	December	January	February	March	Total
24/25	£2,008,072	£2,153,241	£2,370,255	£2,461,709	£2,240,388	£2,261,118	£1,801,252	£1,646,119	£1,802,123	£1,454,690	£1,577,363	£1,743,627	£23,519,957
25/26	£1,500,362	£1,496,165	£1,559,685	£2,116,122	£1,294,075	£1,223,028	£1,501,245	£2,166,798	£1,989,508	£1,061,700	£1,304,169	£1,743,627	£18,956,484

Overall, during 25/26 the Trust has demonstrated more effective control of its Medical and Dental workforce. By maintaining a stable WTE establishment and focusing on optimisation rather than expansion, we have reduced reliance on contingent staffing and strengthened our ability to deliver **Safe**, **Personal** and **Effective** care. The Trust's continued focus on job planning, rostering and workforce data will remain central to sustaining these improvements in future years.

2.9 Health Inequalities

Over the last 12 months, East Lancashire Hospitals NHS Trust has strengthened its health equity development to address unfair and avoidable differences in access, experience and outcomes across its population. Clear governance and leadership arrangements have been established through the Health Inequalities Committee, providing executive oversight and direct assurance to Trust Board. Health equity considerations are increasingly embedded within service change, quality improvement and decision-making processes, aligned with national requirements including Core20PLUS5, the NHS Long Term Plan and the Equality Act. This work positions health equity as a foundational lens through which quality and safety are assessed and improved, and it will directly inform the Trust's revised overarching strategy.

Progress has focused on building sustainable capability and impact. Workforce awareness and inclusive leadership capability have been developed, partnerships with voluntary and community sector organisations have been strengthened, and data maturity has improved to better identify and monitor inequalities in care. The introduction of health equity dashboards, targeted focus on priority wards and services, enhanced patient and public engagement, and the Trust's growing role as an anchor institution support a shift towards more preventative, place-based and community-centred care. Together, this health equity development underpins the Trust's commitment to delivering safe, effective and personalised care that is equitable for all, ensuring equity is embedded as core business rather than a standalone programme.

3.0 PART THREE - QUALITY ACHIEVEMENTS, STATUTORY STATEMENTS AND AUDITOR'S REPORT

3.1 Achievements against Trust Quality Priorities

The table below gives an overview of progress against key quality improvement priorities outlined in Section 2.3. Please note that where data and metrics have been provided sample size will vary.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Aim: For >3000 members of staff at ELHT to have been exposed/engaged with the Improvement Practice core material by 31st March 2026. Year 1: 3900 colleagues engaged with improvement through engagement contacts, events and training. Year 2: 1390 colleagues engaged with improvement through engagement contacts, events and training.		
Total number of substantive and staff in training engaged in SPE+ Improvement Practice – contact, events, training = 5290		
SPE+ Improvement Practice	Level 1 Improvement Practice – Awareness (Classroom via Trust	45 x Corporate Induction Sessions completed = 745 new staff in post trained in Level 1: Awareness

Culture & Improvement Capability Building Total numbers trained may also include Bespoke Improvement Practice Training delivered in addition to scheduled training by both the Improvement Hub and Improvement Colleagues within Divisions / Workshops and Colleagues in Training / External Colleagues	Corporate Induction) To provide awareness to new staff commencing employment within ELHT to the SPE+ approach and Improvement practice within the Trust.	
	Level 2 Improvement Practice – Contributor (Classroom) To allow staff to develop a foundation knowledge of SPE+ Improvement Practice within ELHT.	5 x Level 2 Improvement Practice Training Sessions = 17 staff trained
	Level 2 Improvement Practice Bitesize: (In-person / Virtual) - TIMWOODS 5Whys - PDSA To provide bitesize training of the 4 core tools covered within Level 2 Contributor classroom session. This allows staff to develop a foundation knowledge of core improvement tools within a 15-minute session.	Number of staff trained in each tool: - TIMWOODS = 103 5 Why's = 43 6S = 19 - PDSA = 39 This covers multiple sessions completed both face to face and virtually via MS Teams.
	Level 3 Improvement Practice – Lead (Classroom) To allow staff to develop a deeper understanding of SPE+ Improvement Practice within ELHT.	3 x Level 3 Improvement Practice Training Sessions = 6 staff trained

	Level 4 – Daily Management Training	Pilot – Daily Management Workshop delivered for Clinical Governance team. 19 x staff trained	
	Level 4 – Coach Clinical Quality Academy (Hosted by NWS)	1 x Team 6 x Cross-Divisional & MDT Members including Therapies, Corporate Nursing and Nutrition & Dietetics 9 x Virtual & Face to Face CQA Sessions held	
Colleagues in Training The Improvement Hub team, work in conjunction with the Department of Education, Research and Innovation (DERI) and UCLAN to support a range of trainees and newly qualified colleagues to develop their improvement skills and undertake improvement projects – ‘Our Improvers of the Future’	Multi-Professional Preceptorship Level 2 Improvement Practice Training – Contributor sessions		4 x Preceptorship sessions delivered virtually via MS Teams 138 x newly qualified multi-professional colleagues trained.
	SSC4 Medical Students (UCLan) 2024/25 cohort – Level 3 Improvement Practice Training – Lead Workshops		9 x number of QI workshops delivered (2 x within FY 2025/26) 199 x SSC4 Medical students (supported across the Burnley and Westlakes Campuses) 9 / 19 SSC4 QI case studies submitted by the ELHT Central IH Team to UCLan 37% of SSC4 cohort chose ELHT / Secondary Care QI case studies (74/199) 2024/25 SSC4 cohort grades: 45 x Merits, 92 x Good Pass, and 50 x Passes
	SSC4 Medical Students (UCLan) 2025/26 – Level 3 Improvement Practice Training – Lead Workshops		8 x number of QI workshops delivered (2 x within 2026/27) 8 x number of face-to-face QI Drop-in sessions (4 x within 2026/27) 214 x SSC4 Medical students (supported across the Burnley x 182 and Westlakes x 32 Campuses) 7 / 19 SSC4 QI case studies submitted by the ELHT Central IH Team to UCLan 34% of SSC4 cohort chose ELHT / Secondary

		Care QI case studies (74/214)
Improving the SSC4 experience undertaking QI in Secondary Care To improve the overall feedback from the SSC4 Medical Students that undertake their QI Projects within Secondary Care (ELHT)	• Increase in number of SSC4 Medical Students (7%) • ELHT Secondary Care QI case studies continue to link to 'live' programmes of work and identified key improvement priorities • Increased opportunities to apply QI Theory within workshops • Increased opportunities to work with peers undertaking the same case-study • Further specified and condensed improvement tools for students • Introduction of ARIEL the 24/7 Support Assessment AI Chatbot • Continuation of drop-in sessions throughout the year, this has now increased to weekly.	
Year Of Improvement (YOI) For >3000 members of staff to have engaged in improvement practice core activity by 30th April 2025 (as per YOI Proposal Briefing Paper) RBH = Royal Blackburn Hospital BGH = Burnley General Hospital CCH = Clitheroe Community Hospital NHSE = NHS England	• Further specified and condensed improvement tools for students • Currently in year 2 of the YOI programme • 1 x Rapid Process Improvement Week within Radiology with a focus on reducing the time patients wait for their X ray examinations at Royal Blackburn Hospital (RBH). 4 staff within Radiology were taken through the week with an outcome of reducing wait times from a median of 39 minutes per week to 23 minutes in week.7 PDSA's were commenced/ planned during this week and work continues. • 11 x 'pop up' engagement days completed over RBH, Burnley General Hospital (BGH) and Clitheroe Community Hospital (CCH) – discussed education/ training offers, idea generation, staff surveys, coaching conversations etc = 356 staff engaged • Corridor conversations continue on a monthly basis to gather data for YOI reporting. This promotes the Improvement Hub team and the training offer and captures a monthly view of staff perceptions around improvement based on the 4 key improvement questions from the NHS Staff Survey = 184 staff engaged. • Bitesize training has been introduced to the Education Hub with all staff who have received bitesize retrospectively added. • A quiz has been developed for each of the 4 bitesize training and is live on Education Hub. The aim is to ensure staff demonstrate competencies. Pass rate set to 80% for each quiz. • TIMWOODS - 48% of staff trained have completed and passed the quiz • 5 Why's – 100% completed and passed the quiz • 6S - 77% completed and passed the quiz • PDSA – 53% completed and passed the quiz	

	• Communication PDSA's undertaken re: awareness of the Improvement hub and training – poster created for each area to display, Trust News/ Oli posts created. • Level 1 attendees are now contacted at the end of the month to reiterate the training offer. • Level 3 training offer has been redesigned due to lack of attendees to the classroom and feedback regarding capacity in diaries to complete full day training. This now includes an online MS teams Welcome call and 5 x face to face modules with a workbook, in order to facilitate staff to work through an improvement project. This also stipulates that the project is registered with QI triage. PDSA's underway. • Level 4 training proposal was created and awaiting trial in division.
Engagement Events	• The Improvement Hub (IH) team have undertaken 11 days across the organisation to engage with staff. These have taken place over the RBH, BGH and CCH sites • The engagement days have primarily been aimed at raising awareness of the IH team within the Trust, what we do and how we can support teams and individuals. Available improvement practice training and education has also been promoted as part of the engagement sessions. We have also been able to assist in other Trust agendas such as promoting the Annual Staff Survey and encouraging staff to submit their waste reduction and cost efficiencies ideas. • The IH team have engaged with 356 x staff members within these days and recorded 139 x waste reduction and cost efficiencies ideas • There are plans in place to create further engagement days for 2026/27, co-designed by the IH team using feedback collected from staff.
UCLan Pre-Reg Nursing conference Nursing	Presentation delivered to Pre-Registration Student Nurses in October 2025 to demonstrate Quality Improvement in Practice including: ELHT SPE+ Improvement Theory, Improvement Tools, Reporting and QI Case Studies.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Aim: To strengthen engagement in the Trust's Financial Recovery and Waste Reduction Programmes. Total ideas triaged: 1707		
Waste Reduction and Cost Improvement	Waste Reduction & Cost Improvement Ideas Submission Process: To identify waste reduction opportunities that contributes to the Trust WR and CIP target 1707 ideas have been submitted by colleagues about how to reduce spend and work more efficiently between 1 st January 2025 and 31 st March 2026.	

(This also includes ideas from other similar platforms in the Trust which were brought together into one for consistency).

Since July 2025, the Improvement Hub has been responsible for managing staff-initiated ideas. A new process has been introduced during 2025 to improve the flow and closing of the loop of ideas, ensuring ideas are reviewed and triaged weekly, directed to the appropriate place, first time such as subject matter experts (SME's), Trustwide forums or Divisions.

Achievements:

- Staff-initiated ideas have provided valuable frontline insight into waste, variation, and inefficiencies
- Ideas are submitted from a wide range of wards, departments, services and roles showing strong Trustwide engagement
- All ideas are reviewed and triaged weekly for impact, feasibility, and duplication
- Relevant ideas are re-routed to Divisions, SMEs, or Trustwide forums for review and action
- Some ideas have progressed into formal WRP schemes, while others have been delivered as quick wins
- Staff receive a timely acknowledgement and initial feedback, so they understand how their suggestion is progressing
- The process has strengthened engagement, ownership, and the continuous improvement culture.

Staff Generated Ideas Themes

- Reducing waste and costs
- Digital and paperless solutions
- Smarter stock management
- Improving patient communication
- Workplace improvements
- Environmental sustainability
- Streamlining processes
- Better use of time / productivity
- Better equipment utilisation

CPAG (Clinical Procurement Advisory Group):

- The programme has also contributed to the establishment of the Clinical Procurement Advisory Group (CPAG), created to focus on staff generated ideas relating to clinical and non-clinical procurement and changes in clinical practice. To date:
 - 71 x schemes have been identified, triaged and reviewed
 - Currently 45 / 71 are active schemes
 - Identified In Year Savings = £4652.77
 - Identified Full Year Savings = £120,380.42

CPAG Scheme Themes

- Infection prevention and clinical consumables
- Linen, clothing and patient belongings

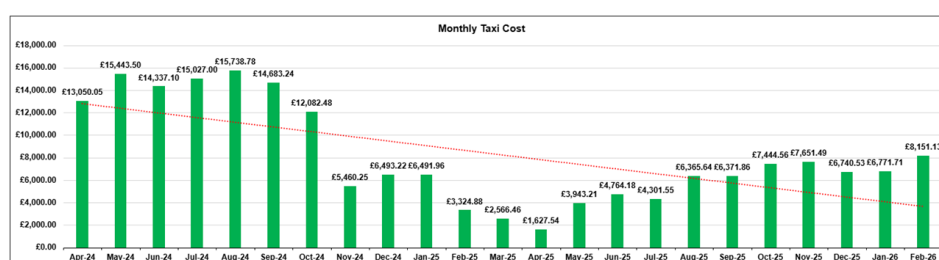
- Waste reduction and sustainability
- Equipment and asset management
- Product switches and standardisation opportunities

Taxi's: To reduce avoidable Taxi usage Trust wide by £30,000, by the 31st of March 2026.

Our objective for 2025/26 is to introduce tighter grip and controls for the booking & authorisation of taxis, as well as a reduction in usage for patients, pathology specimens, bloods, pharmacy medicines, letters and other.

- Successfully reduced avoidable taxi usage through tighter controls, clearer approval pathways, and the introduction of the automated electronic Taxi Request Form, improving oversight and accountability
- Taxi spend has substantially improved: April 2025 - February 2026 spend is £64,133.40, compared to the previous annual baseline of £124,698.92 (April 2024 - March 2025), reflecting strong financial improvement and a projected saving of £60,565.52 for 2025/2026, a reduction of around 48.5%. (see chart below)
- Stopped taxis for 'To Take Out medications' reducing unnecessary journeys and improving governance and reducing risk around medication transport
- Implemented a Trustwide exceptions list for time critical requests (e.g., pathology specimens and urgent medicines), standardising and supporting staff decision making
- Improved operational efficiency by reducing delays for time critical staff transfers through a clearer, streamlined approval process that supports site pressures and ensures consistent decision making across Divisions
- Strengthened auditability and data accuracy with over 1825 electronic requests, enabling better monitoring of usage trends
- Reduced taxi mileage supports the Trust's Green Plan and contributes directly to the Waste Reduction Programme and supporting financial recovery.

Monthly Taxi Spends (April 2024 - February 2026)

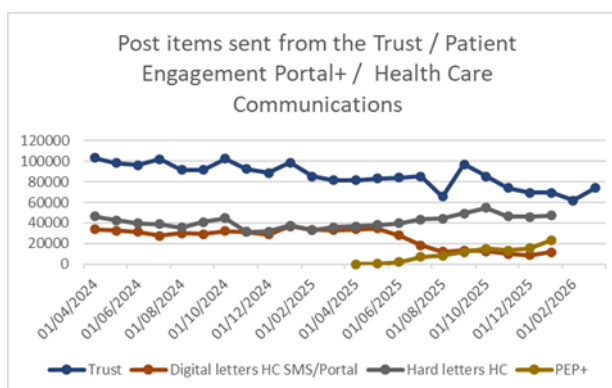


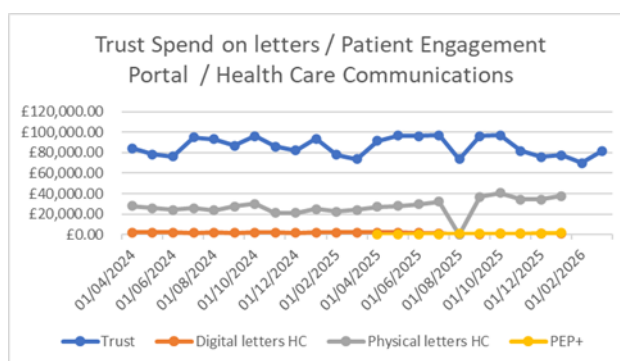
Assign Outpatient Letter to the most appropriate form of postal delivery (Phase II)

Supporting our patients to have the right information at the right time, in the right format for them. To increase the identification of information and communication needs relating to patient letters (written and digital).

To reduce the patient letters and postal spend by £255,741 by 31st March 2026.

- A reduction of 201,579 letters being sent by the Trust on the previous year, leading to 17.8% reduction (April 2025 March 2026)
- There has been a 25.7% reduction in use of Taxi's to deliver patient letters in months 1-12 (April 25- March 26)
- In months 1-12 we had a reduction in the number of bank shifts to deliver patient letters 31.8% (April 25-March 26)
- A 19.4%% reduction in the number of scheduled runs to deliver letters from transport in months 1-12 (April 25 – March 26)
- A £10,318.82 increase in spend on the previous year increase of 1.01% (due to inflation in postal prices)
- Reduction in 1st class items of post by 76,270, approximately 27% (April 25-March-26)
- A reduction in 2nd class items of post by 128,872, approximately 18% (April 25-March-26)
- Better understanding of the current budgets, methods of postal delivery, the digital platforms and available formats when sending patient information and available data around the internal/external postal processes
- Embedded weekly The Patient Communication & Postage Improvement Task & Finish Group meetings
- Increased engagement with Divisions and department with Monthly Postal Report sent out
- Frequent Communications and Updates shared via existing Trust-wide functions
- Developed and maintained relationships with Royal Mail, Pitney Bowes and ELHT Procurement
- In October 2025 the number of special collection point runs were reduced from 3 to 2 on BGH Hospital Site
- 2 x Internal Spot-check Audits have taken place to understand the reason for Returned Mail to ELHT (June & October 2025). The audits demonstrated a 70% reduction in returned mail via the main reception at the RBH
- A campaign was agreed and supported by the Exec Team to remove all / reduce reliance on First Class postage at ELHT in December 2025 – initial data analysis indicates a reduction in January and February 2026
- A review of the usage of pre-paid envelopes commenced in December 2025, but looked at the full year use of pre-paid envelopes
- A review to standardise the number of envelopes used commenced in December 2025. This will support the “clean” mail initiative
- A Full Revision of The Revise Postal Service SOP (156) has been undertaken and published in February 2025 and evidenced-based recommendations and increased grip and control measures have been incorporated.





Reducing Variable Pay Rapid Process Improvement Weeks: To reduce variable pay by £16.1m by the 31st of March 2026

To deliver Rapid Process Improvement Weeks (RPIW's) bi-weekly for the next 12 months (April 2025 – March 2026) / until all cost centres have been through. To solely focus on reducing the variable pay spend, across all teams that are reliant on the use of bank and agency, from across all of the Divisions

- Robust Programme designed and developed to deliver Variable Pay RPIWs using evidenced-based improvement methodology
- Divisional Affordable Variable Pay Reduction Targets set to support aim
- A Reducing Variable Pay Checklist created
- Key Themes identified, in-week Myth busting actioned
- 9 x Reducing Variable Pay RPIWs delivered
- 40 x Cross-Divisional Multi-Disciplinary Teams attended
- Over 97 x Schemes / PDSA's identified to reduce spend across both Pay and Non-pay
- Staff members were trained in 3 x Bitesize Improvement Tools as part of the week – TIMWOODS, 5Whys and PDSA's
- Creation of new supporting tools such as Bank & Agency and Shift Rate calculators and a dedicated SharePoint Staff created as part of the RPIWs
- Promotion, demonstrations and access to existing tools / reports
- Subject Matter Experts / Guest Speakers attended and supported the RPIWs
- Overall the Trust has reduced variable pay in excess of £10m in 25/26

Reducing Non-Pay Rapid Process Improvement Weeks (RPIWs)

Two RPIWs were held in December 2025 at BGH and RBH

The purpose of these weeks was:

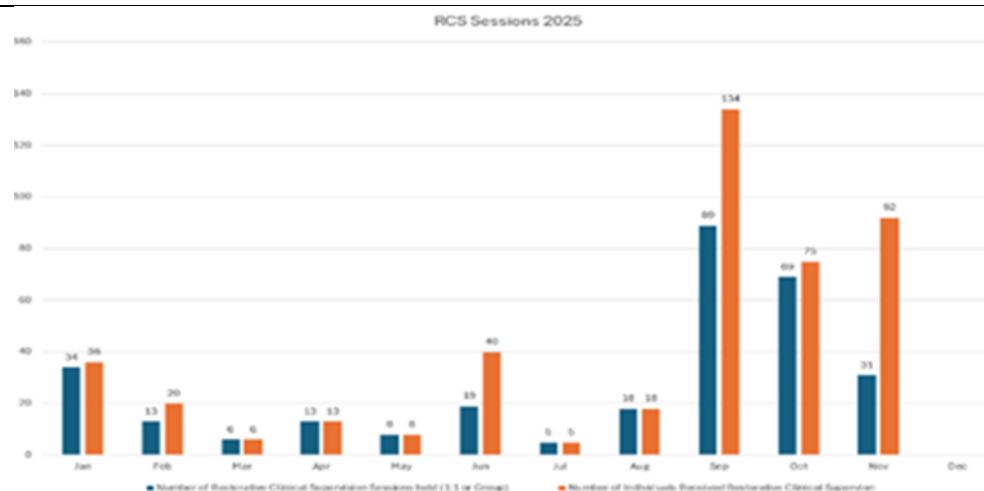
- To ensure every patient and colleague has the right stock, when they need it
- To embed improvement method with stock management – reducing variation in practice.

As part of the weeks, initial discovery work was undertaken and identified that there were areas of variation in practice with regards to stock management across divisional wards/departments/areas and teams.

- Materials managed areas being organised slightly differently
- Non-materials managed areas have their own local practices

	• Evidence of great practice • Evidence of a lot of work already done • Evidence that some simple adjustments to stock levels would reduce the need for top up/ next day delivery order costs etc • Lack of standardised processes in some areas. Outputs • 71 x ideas generated over the 2 x RPIWs cross-referenced and plans for action developed • A standard set of best practice principles developed re: stock management • Flowchart for returns process to give clarity • Understand the governance required for a 'Swap Shop' • Gathering examples of spreadsheets held in non-materials managed areas to create a standardised template.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Improving Trustwide Sickness Absence The primary objectives of the Trustwide Sickness Absence Group are: 1. To reduce sickness absence rates across all departments to align with or improve upon national NHS benchmarks 2. To promote physical & mental wellbeing among staff through targeted interventions and supportive policies 3. To enhance employee experience, engagement and satisfaction. The Improvement Hub Team have supported the following programmes of work.		
Professional Nurse Advocate Programme Staff sickness absence within ELHT has been identified as a key challenge, impacting service delivery, patient outcomes and staff morale. The Professional Nurse Advocacy (PNA) was launched in March 2025. The aims to support nursing retention and improve the health and wellbeing of the nursing workforce. A pilot was undertaken in September 2025 to provide additional supervision, support and opportunities to speak up within the areas with the highest sickness and absence rates. These were initially identified as Medicine and Emergency Care wards and the Emergency Department. • PNA Supervisors attended the Emergency Department at various times throughout the week from September 2025 to March 2026 • Focussed Restorative Clinical Supervision (RCS) in groups offered during November 2025 • Bi-monthly PNA Forum to provide supervision and themes from conversations with staff • This programme of work is currently on pause.		



Baseline: Trust wide Individual & Group RCS average Jan –Aug 25 = Grp: 17.125 Inv: 18.25 per month

Current (Trust): Jan –Aug 25 = Grp: 29.82 Inv: 40.64 per month

Data Source: PNA activity Log 2055-2026 Activity Log V1.xlsx

Estates & Facilities (E&F) Improving Staff Well-being and Reducing Sickness Workshops

In August 2025, the Estates & Facilities Division launched their first Improving Staff Well-being & Sickness Absence Improvement Workshop. The Senior Management Team, Team Leaders and Supervisors recognised that to reduce sickness absence and improve staff well-being that they had to work differently, as one division, one team and with one aim. We used available HR and Healthroster Tools and Dashboards to further understand the problem and identify opportunities for improvement.

- 3 x Improvement Workshops undertaken between August 2025 – February 2026)
- Each Workshop has had a structured Approach, with an Agenda and set Aims and Objectives, underpinned by the SPE+ Improvement Methodology – Asking:
 1. **Why are we here today?** Framing the Problem
 2. **Do we get it right?** Appreciative Enquiry
 3. **What stops us from getting it right?** The Elephant in the Room / Process Mapping and TIMWOODS Waste Tool / Reflections
 4. **What could we do differently?** Wouldn't it be great if ... / Future State Idea Generation / Learning from Others
 5. **Working Together** – Prioritising ideas / Resource Impact Matrix / You Said, We did
- 25 x Ideas to Improve Staff Well-being and Reduce Sickness ideas generated
- SMART AIM developed and agreed for 2026/27
- Been a pilot area to test the HR Sickness Tracker and Special and Emergency Leave Return To Work Form
- Presented progress at the Trust-wide Sickness Absence Project Group

Appraisals Rapid Process Improvement Week

Redesign the appraisals process within ELHT to ensure that all staff receive a valuable and equitable appraisal.

Aim for the week: By 31st March 2026, the appraisal process will be reviewed and revised in line local and national criteria. The new model will have been tested and demonstrate an improving trend in all four identified metrics.

Prior to and over the course of the rapid improvement week: - Engaged with staff to collect quantitative and qualitative data - Over 80 different ideas generated - Review of the appraisal process based on staff feedback - A potential 63% reduction in waste / frustrations were identified within the current process and core functions - A new appraisal process was designed within the week to support achieving its definition and purpose with minimal core content and tested with appraisers and appraisees – this continues to be actively tested with over 80 Appraisers and Appraisees - Feedback for staff engaged with during testing has been positive particularly with regard the definition, content and document reduction. - The new appraisal approach differs significantly from the current system and will require new skills from both appraisers and appraisees.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Aim: For 100% of N&H Project Teams (x 9) to go back to basics for nutrition and hydration, for all inpatients with a decision to admit by 31st May 2026.		
Quality Support vulnerable and frail patients	ELHT Nutrition & Hydration (N&H) Collaborative Delivery: Speed of Meal Service – from the food trolley arriving to last patient receiving their meal Quality: Overall MUST Compliance for all 9 x N&H Collaborative Teams within 24hrs of Admission (Excludes Emergency Department, Maternity & COAU) People: 100% patient satisfaction with lunchtime meal service Cost: 0% food waste left on plates	- The ELHT N&H Collaborative has been running for 715/768 days (the original end date was extended due to financial recovery and site pressures) 9/12 of the original teams are still participating (this is due to ward closures as part of the financial recovery i.e community wards and specialist needs of specific patient groups i.e maternity) - N&H Planning and Guiding Team still established and meeting on an ad hoc basis - Learning Sessions 3 (April 2025) & 4 (August 2025) Workshops (4 days in total) have now taken place, these sessions actively encourage “collaborating” with colleagues. - Electronic audit and PowerBi reporting system embedded - Monthly Collaborative Touchpoint Calls in place - Bespoke Task & Finish Groups for Patient Experience & Food Waste Metrics set-up with collaborative cross-divisional team members – development of agreed elements ongoing. Focus of increasing Patient and Families awareness of what they might need to bring to hospital when attending, improving communication between the Ward Teams and the Kitchen to escalate / shared learning and going back to basics with the inpatient menus and working with the Foodie Group / Menu Development Teams to achieve this. 4 x standardised change package elements have now been agreed to be implemented across the

		9 x participating teams, with a view to scale-up and spread Trustwide (where applicable) - Submitted as a 'live' QI case study as part of the SSC4 Medical Student Programme - The standard work designed and agreed at Learning Session 3 (April 2025) for Meal Service Delivery (Colour Coded Bays) has been scaled up and spread to 14 x wards - Presented Update and Overview at Exec Improvement Wall in September 2025 - Discussions and planning to spread beyond pilot commenced - ELHT N&H Collaborative Celebration Event scheduled to take place in May 2026.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Aim: To ensure end of life care is timely, compassionate, and person-centred through better recognition, decision making, planning and communication by 31st September 2026.		
Quality Support vulnerable and frail patients	HELD Improvement Collaborative (DNACPR) HELD (Holistic End of Life Decision-making) is an ELHT improvement collaborative designed to strengthen recognition of dying and ensure timely, person-centred Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions.	- Established the HELD Project Faculty to provide clear leadership, governance and support across all workstreams. - Delivered a Trust wide improvement approach aligned with national best practice to strengthen DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) and end of life (EOL) decision making. - Completed the Trustwide DNACPR audit (11 November 2025); the full report has been drafted March 2026 for ratification. - Launched a staff survey to understand staff experiences of DNACPR and EOL practice, with findings due May 2026. - Improved the Last Days of Life (LDOL) Nursing and Medical documentation/report to support earlier recognition of dying and more consistent EOL care. - Delivered Learning Sessions 1 and 2, building engagement across teams and incorporating lived experience insight. - Achieved strong nursing engagement and growing clinical involvement across areas taking part. - Progressed an IT change request to improve Trustwide visibility of ReSPECT forms and resuscitation status, supporting safer decision making. - Put in place a new process for the Palliative Care Team to review all EOL related complaints, helping identify and track themes.

		- Continued developing comparable data for the HELD programme, including audit, survey and LDOL (Last Days of Life) report outputs. - Held regular Faculty meetings, collaborative calls and workstream meetings to maintain progress and oversight. - Supported project teams to make full use of the Action Period to run targeted tests of change and build local ownership of improvements.
	Discharged Patients showing last days forms completion Were Both the forms completed Both Forms Created 1165 414 Apr 2025 Jun 2025 Aug 2025 Oct 2025 Dec 2025 Feb 2026 96 106 98 72 81 73 117 95 132 114 94 87 20 27 26 29 38 22 36 35 48 51 40 42 This measure focuses on the creation of the Last Days of Life document, which is an important indicator of recognising when a patient is in the final stages of life and ensuring that key actions and care needs are addressed. A total of 1579 patients who have died were recorded, and 414 had both required forms created (35.5%). Monthly data shows variation in compliance, with the highest compliance in January 2026 (51 forms). The lowest compliance volume appears in April 2025 (20 forms). Overall, form creation improved midyear (July-August) but dropped again in September and October.	

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:
Quality Support vulnerable and frail patients	Quality Assurance Assessment Framework (QAAF) - The QAAF team are currently taking part in the NWAS Improvement Academy, facilitated by the Improvement Hub team which is due to complete on 24th April 2026 in a Celebration event. However, this is a longer-term piece of work that will continue beyond the NWAS academy. - The Quality Assurance Assessment Framework (QAAF) (previously NAPF) has been redesigned and launched on 15th September 2025. The previous NAPF process was not providing adequate levels of assurance and had not been revisited for 10 years, hence the reason for redesign. - The aim of the new QAAF framework is to increase assurance around standards of care by creating an MDT focussed, bespoke framework that is appropriate to all areas within the Trust. The previous NAPF assessment was outdated with generic questions that were not necessarily applicable to all areas – giving a false sense of assurance. Compliance to the assessments is also thought to improve as each	

	clinical area has specific and meaningful questions that are relevant to their area of work. • Through collaboration with subject matter experts, the QAAF framework has been developed and questions / scoring methods re written aiming to increase assurance and compliance to the Trust quality standards. • This project is in Test and Adapt with PDSA's ongoing with regards to the assessment and documentation. Data led improvement work is now a focus as the programme progresses including action planning and data/ reporting. • By utilising the improvement methodology to underpin the various stages of the process, the framework continues to evolve, and the data is being used more strategically in order to identify themes and areas for further improvement, thus improving quality care for all patients. Trustwide Bed Census • Trustwide bed census completed to understand patient flow, delays and pressures across Urgent Emergency Care (UEC). • 470 patients were reviewed in total across all occupied beds (those in-scope). • Included full review of all occupied beds and Emergency Department (ED) activity plus an audit of all ED admission referrals. • Multidisciplinary ward teams assessed every patient, identifying barriers to discharge and improvement opportunities. • Strong Trustwide engagement supported shared understanding of UEC challenges. • Findings now provide a robust evidence base to inform the UEC Improvement Plan and 2026/2027 planning, with a focus on improving flow, reducing delays and enhancing patient experience.
	Radiology Rapid Process Improvement Week Several IR1's and complaints had triggered the improvement work as both patients and other departments were being impacted on the waiting times, in addition to the negative impact to Radiology staff morale. To reduce the median waiting time within Main X-ray dept at RBH to 30 minutes. • The IH team were approached to facilitate an RPIW within RBH Main X-ray department with the focus on reducing the median waiting time that patients experienced from the point of attending the department to having their examination completed. • Pre week staff engagement was completed and utilised a Value Stream Map approach to identify areas of waste and variation • 62 x ideas were created pre week with a further 55 x ideas during the RPIW • 7 x PDSA's were commenced / completed during the week • Pre week data: median waiting time= 39 minutes, median attend to start time = 25 minutes. • Post RPIW data: median waiting time reduced to 25 minutes (41% reduction), median attend to start time reduced to 11 minutes (56% reduction). • Feedback from the RPIW and wider Radiology team was very positive and has inspired further improvement work around CT scans from ED.

Key Delivery Programme:	Improvement Project Title, Goal / Aim:	Achievements:																																																							
Urgent and Emergency Care (UEC) – Preventing Hospital Attendance																																																									
Vision: To eradicate corridor care; to ensure the patient experiences the best care in a safe environment, to support colleagues across the pathway to be able to deliver the care.																																																									
Aim(s): 1. Eradicate corridor care at ELHT (including escalation spaces on Wards) – number of patients and time spent. 2. No ambulance hospital handover over 45 minutes at ELHT. 3. Less than 10% of patients spending over 12 hours in the Emergency Department at ELHT. <i>(Maintaining 78% and above of patients seen and treated within 4-hour performance).</i> 4. Reducing length of stay at ELHT in line with peers to 7.5 days.																																																									
Urgent & Emergency Care Pathways Focused on eradicating all corridor care at ELHT by optimising use of alternative pathways prior to ED; reviewing and improving Emergency Department processes; and streamlining our transitions of care within the hospital; through to discharge effectively using pathways	Background The Urgent and Emergency Care (UEC) Improvement Programme throughout 2025 focused on key stages of the patient journey informed by our Teams delivering the care. Utilising the improvement approach to understand and learn about our challenges with a solution focused mindset has led to a positive impact in several key steps in a patient journey																																																								
	Timely and efficient ambulance hospital handovers	We’ve significantly increased the number of patients handed over from NWAS within 30 minutes. In January 2025, around half of patients met this standard; by December 2025 this had risen to 83%. This improvement has come from close joint working between ED and NWAS teams, and performance is holding steady.																																																							
	Ambulance hospital handover time (source: ELHT UEC improvement data pack) NWAS Average Handover Time <table><thead><tr><th>Date</th><th>This Year</th><th>Prev Year</th><th>Target</th></tr></thead><tbody><tr><td>04-Jan-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>11-Jan-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>18-Jan-26</td><td>43:12</td><td>36:00</td><td>21:36</td></tr><tr><td>25-Jan-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>01-Feb-26</td><td>43:12</td><td>36:00</td><td>21:36</td></tr><tr><td>08-Feb-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>15-Feb-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>22-Feb-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>01-Mar-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>08-Mar-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>15-Mar-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>22-Mar-26</td><td>21:36</td><td>36:00</td><td>21:36</td></tr><tr><td>29-Mar-26</td><td>00:21:53</td><td>00:27:30</td><td>21:36</td></tr></tbody></table>		Date	This Year	Prev Year	Target	04-Jan-26	21:36	36:00	21:36	11-Jan-26	21:36	36:00	21:36	18-Jan-26	43:12	36:00	21:36	25-Jan-26	21:36	36:00	21:36	01-Feb-26	43:12	36:00	21:36	08-Feb-26	21:36	36:00	21:36	15-Feb-26	21:36	36:00	21:36	22-Feb-26	21:36	36:00	21:36	01-Mar-26	21:36	36:00	21:36	08-Mar-26	21:36	36:00	21:36	15-Mar-26	21:36	36:00	21:36	22-Mar-26	21:36	36:00	21:36	29-Mar-26	00:21:53	00:27:30
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Ensuring a quicker time to be seen in	By understanding the challenges faced on one of our integral processes in the department and changing how																																																								

	ED by a clinician	we work, we've reduced the time for a patient to be seen by a clinician by more than 50%. This means patients are reviewed quicker and have a clinical plan much sooner in their journey. This improvement has sustained.
	Introduction of the Medical Decisions Unit (MDU)	Building upon the AECU developments in the autumn, the MDU opened in December 2025 to ensure patients see the Acute Medic earlier in their journey, adding value to their care sooner with the aim of avoiding unnecessary admissions. Over 1800 patients have already been through the Unit since opening.
	Proactive discharge planning	Strengthening the use of the Discharge Dashboard has improved daily decision making, supplemented with a Divisional daily discharge huddle ensuring support is directed where it's needed and helping identify trends that guide operational planning and opportunities for improvement. Ensuring our inpatient beds are not occupied by patients who medically optimised for discharge.
	Urgent Treatment Centre Improvement Plan	A plan on a page has been developed focused on UTC with changes already implemented, and further changes planned as we head into the New Year. Informed by our patient feedback, our colleagues experiences and the drive of Leads in the Department to make improvements all focused on improving the experience of care.

Developing the ELHT UEC Programme in 2026

East Lancashire Hospitals NHS Trust (ELHT) has committed to eliminating all forms of corridor care by 13 December 2026, supported by a comprehensive Urgent and Emergency Care (UEC) Improvement Plan.

Introduction of the UEC Programme Group aligning financial requirement with operational and improvement focused pieces of work, Executive led, Operational, Medics and Nursing driven, underpinned with improvement method and thinking.

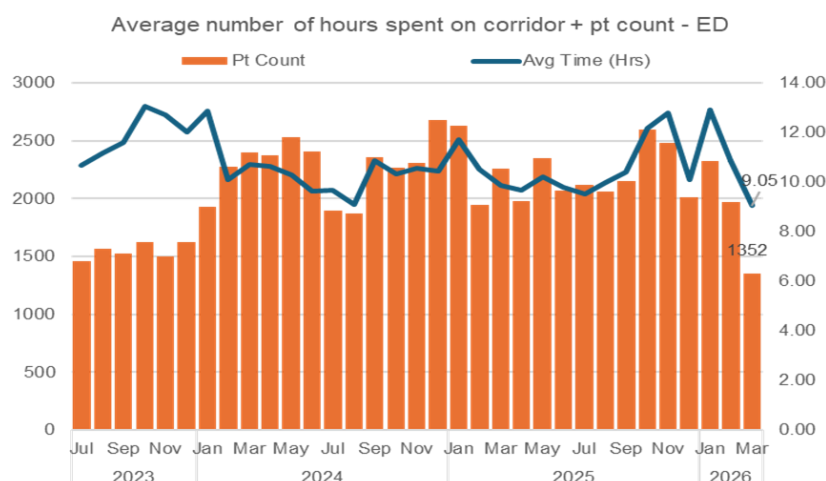
The workstreams include Achieving the Clinical Operational Standards; Right Patient, Right Bed - reducing length of stay; Care Closer to Home - increasing utilisation of the Virtual Ward; Corridor Care quality and safety; 7-day service infrastructure and job planning.

The programme ensures patient and colleague experience and quality of care is driving the Trust towards the key objective of eradicating corridor care at ELHT.

12-hour Time in Department (%) (source: ELHT UEC improvement data pack)



Corridor care hours and patient count (source: ELHT UEC improvement data pack)



3.2 Harm Reduction Programme

The Harm Free Care portfolio continues to provide robust, triangulated oversight of patient safety, quality, and experience across East Lancashire Hospitals. Across the reporting period (April 2025-March 2026), there has been notable progress in safeguarding, nutrition and hydration, medicines management, and consistently high patient experience scores, with FFT ratings generally in the low-mid 90% range. However, several areas require continued focus to ensure sustained improvement and reduction of avoidable harm.

Quality Assurance and Audit Framework (QAAF)

Positive movement is evident across safeguarding, nutrition and hydration and medicines management. Conversely, documentation, environment/IPC standards, and aspects of harm-free care processes remain variable, requiring strengthened oversight and targeted improvement plans.

Patient Safety: Harm Themes

- Falls
- Medication Errors
- Nutrition (Enteral/Parenteral/Oral)

- Ligature Incidents
- Pressure Ulcers

Cost and Workforce (Nursing and Midwifery) Measures

- Safer Staffing

Patient Experience and complaints

- Complaints.
- Mandatory Training and Appraisals across Corporate Nursing
- FFT

Strategic Portfolios Under Development

- Mental Health
- Learning Disability & Autism
- Dementia
- Enhanced Care (ETOC)

Overall Conclusion

The Harm Free Care portfolio demonstrates clear areas of improvement, growing analytical maturity, and increasingly integrated quality intelligence. However, several high-risk domains require continued strategic attention — including documentation standards, IPC resilience, pressure ulcer prevention, falls reduction, and workforce sustainability. Progress in mental health, dementia, learning disability and enhanced care shows strong strategic alignment but will require sustained investment, cross-divisional collaboration, and continued leadership focus to achieve consistent harm-free care for all patients. The Chaplaincy and spiritual care service continues to provide high impact interventions to staff, patients and relatives and there is a strategy for 2026 to make the reporting of this more robust.

3.3 Achievement against National Quality Indicators

3.3.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) was introduced by the Department of Health and Social Care in 2011-12 and reports on risk adjusted ratios of deaths that occur in hospitals and up to thirty days after discharge, divided by the number of deaths that were expected given the size of the Trust and other factors such as the patient's age, method of admission and underlying medical conditions.

The latest published SHMI trend data up to October 2025 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Latest published rolling 12 months to Oct 25
East Lancashire NHS Trust SHMI Value	1.23
East Lancashire NHS Trust % of deaths with palliative care coding	26
East Lancashire NHS Trust SHMI banding	Higher than expected
National SHMI	1.00
Best performing Trust SHMI	0.72
Worst performing Trust SHMI	1.40

East Lancashire Hospitals NHS Trust considers that this data is insufficiently robust to draw conclusions.

Following direction from NHSE, the introduction of the Oracle Millennium EPR was used as an opportunity to move to the intended future process of classifying Same Day Emergency Care (SDEC) as part of the Emergency Care dataset, as opposed to the admitted patient dataset on which mortality is calculated. Trusts which were early adopters of this have noted significant changes in standardised mortality ratios as a result of the substantial reduction of low-risk spells included. Many Trusts did not change their reporting, and the deadline for national implementation was delayed.

NHSE have now advised that further rollouts of SDEC recording changes be stopped and Trusts that have already moved SDEC recording will be asked to revert back to recording these as non-elective admissions. We await further guidance on this from NHSE and are currently still excluding SDEC activity from our admitted activity data.

An alternative mortality ratio used by the Trust is HSMR+ (Dr Foster). However, the removal of SDEC will continue to impact mortality figures on this measure as it uses the same dataset as SHMI. The HSMR indicator that was previously used by Dr Foster historically has been higher than expected at the Trust, which is known to be at least partially reflective of low palliative care coding (see 3.3.2). There has been a substantial revision of the HSMR methodology, leading to the introduction of HSMR+. Overall, the new methodology has improved the apparent mortality ratio, as it omits the palliative care coding and more accurately reflects deprivation and comorbidity which are significant factors in the Trust population.

The Trust Crude Mortality statistics - the number of deaths per admission, and the absolute number of deaths - are being closely monitored. There number of deaths is showing normal variation around the mean of 140 per month and the crude rate is also showing normal variation around the mean of 3%.

East Lancashire Hospitals NHS Trust is taking the following actions to improve

- Continuing to monitor the crude mortality and identify alerting groups from this data.
- Continuing to monitor the timeliness and quality of data submission to ensure that accurate standardised mortality data can be produced.
- Continuing to ensure that clinical coding deadlines are met on a monthly basis, ensuring the completeness of clinically coded data.
- Continuing the 'Learning from Deaths' processes and introducing quality improvement work, where necessary, to address alerting groups.
- Building on the introduction of the bereavement team and the seven-day palliative care team to ensure patients receive the optimal care at the end of life.

3.3.2 Percentage of Patient Deaths with Palliative Care Coding

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator. The SHMI makes no adjustments for palliative care. This is because there is considerable variation between Trusts in the coding of palliative care. Using the same data as the SHMI this indicator presents crude percentage rates of death that are coded with palliative care at either diagnosis or treatment speciality level.

East Lancashire Hospitals NHS Trust percentage of deaths with palliative care coding	26%
National percentage of deaths with palliative care coding	44%
Trust with highest percentage of deaths with palliative care coding	69%
Trust with lowest percentage of deaths with palliative care coding	18%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

The Trust has a lower-than-average score for specialist palliative care coding. This is reflected in part by differences in coding palliative care input in some areas of the Trust such as critical care.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services by:

- The Trust has now introduced a seven-day palliative care service.
- The Trust continues to develop the end of life / bereavement team and in February 2025 opened a new Bereavement Suite. Feedback from the National Audit of Care and the End of Life (NACEL) has shown significant improvement.
- The Trust has launched a quality improvement project relating to end of life and advanced care planning.

3.3.3 Patient Recorded Outcome Measures (PROMs)

Patient Recorded Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering two clinical procedures PROMs calculate health gains after surgical treatment using pre- and post-operative surveys.

The two procedures are:

- Hip Replacement
- Knee Replacement

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected pre-op and 6 months after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients; this data has been collected by all providers of NHS funded care since April 2009.

The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for both of the PROMs procedures using the EQ-5D measure of health gain. The 'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-reported general health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

3.3.3.1 Hip Replacement Surgery

Hip Replacement Surgery	2021-22	2022-23	2023-24	2024-25	2025-26
ELHT	88.4%	91.0%	88.1%	No Data*	No Data
National Average	89.5%	89.4%	88.8%	No Data*	No Data

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2021-22	2022-23	2023-24	2024-25	2025-26
ELHT	78.8%	86.1%	78.7%	No Data*	No Data
National Average	82.1%	82.6%	80.9%	No Data*	No Data

*PROMS data is finalised up to 2023-24. NHS Digital provided an update statement in January 2026:

Over the past year, we have investigated a variety of challenges with the way the data are processed on complex legacy systems. We aim to provide a more detailed data quality note to outline these issues. We propose that given the processing challenges and relatively low response rates, that the next data, relating to final 2024/25 is released as management information, rather than as an official statistic. We plan to release it during the first quarter of 2026.

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

ELHT has a process in place to ensure patients receive a pre-operative questionnaire for completion at their pre-operative assessment.

Patients can decline to complete the questionnaire (optional); in these cases, questionnaires are still collated to monitor ELHT submission rates and inform where education and patient information may be required.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve participation rates.

Random spot checks will be continued to prevent a decline in participation rates; regular feedback will be given on a to the Pre-op assessment coordinator via email.

Patients are encouraged to complete the post-operative questionnaire at 6 months via the hip and knee school.

3.3.4 Readmissions within 30 Days of Discharge

The following table sets out the Trust's performance during the last 5 years for emergency admissions within thirty days of discharge. We have used national figures published by the

Health and Social Care Information Centre (HSCIC) which show the percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission: indirectly standardised by age, sex, method of admission and diagnosis/procedure.

Age Band		2020-21	2021-22	2022-23	2023-24	2024-25
All ages	Rate	14.9%	14.7%	13.8%	12.4%	11.9%
	Banding	Significantly lower than the national average at the 95% level but not at the 99.8% level			Significantly lower than the national average at the 99.8% level	
<16	Rate	13.3%	15.1%	15.4%	11.1%	9.0%
	Banding	Significantly higher than the national average at the 99.8% level			Significantly lower than the national average at the 99.8% level	
16+	Rate	14.4%	13.7%	12.3%	11.5%	11.7%
	Banding	Significantly lower than the national average at the 99.8% level				

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

The overall ELHT 30-day readmission rate produced by the HSCIC is 11.9%, which is significantly lower than the national average.

- For the 0-15 age group, the rate is 9.0%, which is significantly lower than the national average.
- For the 16+ age group the rate is 11.7%, which is significantly lower than the national average.

3.3.5 Responsiveness to Personal Needs of Patients

The Trust values and encourages feedback on how its services perform and uses a variety of methods including patient satisfaction surveys. We also believe that involving and co-producing service developments with patients and the public will help us to continually improve the care, experience, and services we provide and have a well-established Public Participation Panel (PPP) which helps the Trust build on established relationships between health professionals, patients, carers and the public. PPP members ensure we are putting the voice and needs of patients at the forefront of decision making and that the views of patients, carers and families are represented at all levels of the organisation.

The Trust participates in the national programme of patient satisfaction surveys. The Care Quality Commission uses the results from the surveys in the regulation and monitoring and inspection of Trusts in England. Results are shared with key operational groups to develop action plans to address any issues identified.

The Adult Inpatient Survey required a sample of 1250 consecutively discharged inpatients, working back from the last day of November 2024 who had at least one night in

hospital. There were 470 usable responses received giving a final response rate of 40%. This compares with a response rate of 34% in the 2023 survey.

Table 1 below details the top 5 scoring questions for the Trust in 2024 with a comparison to the 2023 score if available.

Top 5 Questions	Score	
	2023	2024
Were you ever prevented from sleeping at night by any of the following? Room temperature	9.19	9.31
During your time in hospital, did you get enough to drink?	9.23	9.19
Were you given enough privacy when being examined or treated?	9.21	9.02
To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	8.95	8.99
Overall, did you feel you were treated with respect and dignity while you were in hospital	8.87	8.92

Table 1 – ELHT top 5 scoring questions

Table 2 below details the bottom 5 scoring questions for the Trust in 2024 and a comparison with the 2023 score if available.

Bottom 5 Questions	Score	
	2023	2024
Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping.	3.91	3.29
Thinking about the location(s) selected at Q6, how long did you wait in total before you were admitted to a ward?	-	3.61
Thinking about any medicine you were to take at home, were you given any information?	3.97	4.04
Were you able to get food outside of set mealtimes?	5.33	5.42
To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.07	5.47

Table 2 –ELHT bottom 5 scoring questions.

In comparison to other Trusts who took part in the survey, ELHT has performed about the same for most questions. There continue to be challenges around the number of patients attending the Emergency Department and requiring admission.

IQVIA, who administer the survey on behalf of the Trust, have recommended areas the Trust may want to consider strengthening. The survey details have been shared with key

operational groups for action planning as appropriate. The Trust has also incorporated 6 key questions into our Patient Experience, Engagement and Involvement Strategy 2024 – 2027 to measure improvement.

3.3.6 Recommendation from Colleagues as a Provider of Care

The data made available to the East Lancashire Hospitals NHS Trust by the National Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This provides an indication of whether our colleagues feel the Trust provides a positive experience of care for our patients.

- 47.1% of colleagues said – if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation. (Down from 55.8% last year)
- 61.6% of colleagues said – care of patients/services users is the organisations top priority. (Down from 73.6% last year)

The Trust scored 6.28 for the overall colleague engagement score on the 2025 national staff survey (down from 6.8 last year) which is lower than the NHS national average of 6.72.

3.3.7 Friends and Family Test Results (Inpatients and Emergency Department)

The Friends and Family Test (FFT) is a well-established means to measure the experience of patients that have recently received care within acute hospital Trusts. Based on approaches like Trustpilot or Tripadvisor

Patients are invited to respond to a question, in the context of each service, ‘Overall, how was your experience of our service?’, by choosing one of six options ranging from very good to very poor. Patients can give their reviews and opinions at any time during their episode of care, which is used by staff to drive improvement.

Patients are able to answer the FFT question via completion of an FFT card or online via the Trust’s website. FFT feedback is also collected from patients via SMS texting across Accident & Emergency, Outpatient attenders, maternity and community services.

The following table sets out the percentage positive rating for the period April 2025 to March 2026 for inpatients and emergency care and how these results compare with other Trusts nationally.

	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
Inpatient positive % rating												
ELHT	95	95	95	96	96	95	96	97	96	95	96	93
Nat Average *excludes independent sector providers	95	94	95	95	95	94	94	95	95	94	95	Not yet available

A&E positive % rating												
ELHT	77	76	76	71	73	71	68	69	74	67	72	74
Nat Average	80	80	80	80	81	79	77	77	78	78	79	Not yet available

The East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

We value the feedback from our patients and ensure it influences how we develop and deliver our services; therefore, staff are supported to collect information from patients.

Over 32,000 inpatients and emergency care attenders have provided feedback during the period April 2025 – March 2026. The Trust has received consistently high scores from inpatients, with an average of 95% of inpatients rating their overall experience as either very good or good.

There are ongoing challenges around the number of patients attending the Emergency Department and Urgent Care Centres which has impacted on the positive response rate across Emergency Care.

Advice and support will continue to be provided to specific areas so that feedback is collected and recorded in a timely manner and used to influence service improvements.

3.3.8 Venous Thromboembolism (VTE) Assessments

		1 st April 2025- 31 st March 2026				
	VTE RISK Assessments 22-23	Q1	Q2	Q3	Q4	Total
ELHT	Number of VTE-risk assessed Admissions	13417 (90.5%)	13982 (90.76%)	13870 (91.64%)	13642 (91.64%)	54911 (91.15%) YTD data
	Total Admissions	14818	15405	15136	14886	60245
National	Number of VTE-risk assessed Admissions	ELHT reporting on VTE is continuing to evolve and improve since the transition to Cerner as it was discontinued since end of June 2023 and resumed after ten months interval from April 2024. Q4 to be validated. National figures revealed National average of 92% overall National average for NHS Acute care providers was 91% overall. Northwest regional average was 90.7 % Lancashire and South Cumbria ICB average to Q3 was 85% Regional average across all seven regions remains less than the expected standard of 95% There are 15 Acute Trusts overall who achieved the National standard of 95% in Q3 https://www.england.nhs.uk/?s=VTE https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2024-25/q1-revised/				
	Total Admissions					
	Percentage of admitted patients risk-assessed for VTE					
	Best Performing Trust	99.2%				

Worst performing Trust	4%

The above data for Quarters 1-3 is validated and Q4 data is awaiting validation. Trust Informatics team have developed a VTE reporting system from Cerner data on completed hospital episodes of inpatient admissions that is not reliant as it had been historically on clinical coding. This is continually being reviewed and updated to enhance the reliability of the reporting through system upgrades within Cerner. This is to ensure that reporting on behalf of organisation is accurate and robust and reflective of all true in-patient admissions that require a VTE risk assessment on admission as per NICE guidelines.

The annual VTE risk assessment figure over the four quarters is 91.15% which is an improvement of 5.7% from last year's Trust figure of 85.46%. This is slightly above by 0.15% from the national average which is presently at 91% for the Acute sector NHS Trusts and above the Northwest regional average which is 90.7% for Q3. The Trust figures are improving but is yet to get back to its pre-Cerner figures which were 98.3%, 97.90% and 98.45% between 2020/21, 2021/22 and 2022/23. There was paucity of reporting and data in 2023/24 with transition to Cerner preceding this which had a significant impact.

VTE committee monitors the Divisional and Directorate VTE risk assessment figures and Trust figures with action plans as part of the VTE Harms reduction program. Live data reporting of VTE figures of real time in-patients in beds was facilitated as part of this updated reporting by Informatics that continues to be tested, evaluated and updated with system upgrades as required by findings of exploration as continuous quality improvement. Examples of recent changes to Cerner implemented through QI project and Task and finish group by Trust VTE committee are as below:

1. Trust Clinical informatics and VTE committee are working together through a dedicated Task and Finish group to implement appropriate Cerner updates and pathway to enable VTE risk assessment for patients waiting longer hours in the Emergency Department before being admitted into wards as well as same day emergency care ward. The process flow has been agreed and approved by the Data and Digital steering group and currently under development prior to testing, training and then formal launch by June 2026.
2. Clinical Digital informatics team is currently working with the Maternity team to align the Badger net data system used in Maternity services with the Cerner Millennium and Bedrock reporting system as clinical audits have identified scope for improvement in data alignment as the full data set from Badger net does not seem to pull through currently into the information reports for submission due to some IT issues. This is currently being reviewed by the two Trust teams as an area of focussed priority. Resolving this IT issue will help the reporting figures to reflect the good standard of practice with VTE risk assessment in maternity which clinical audits revealed was 100%. This would positively drive the Trust figures up reflecting current practice. Please note: This is an issue nationally across numerous Trusts using the Badger net maternity system with some Trusts electing not to report maternity data as a result. An ICB wide solution to this would be helpful.
3. A mandatory data field in CERNER system was implemented from September 2025 to ensure that all admitted patients on admission had VTE risk assessment completed as part of admission assessment. At request from senior ICU consultants, a bypass data field was introduced subsequently to enable them to review patients for suitability/eligibility to ICU and this is currently being closely monitored through spot audits and reaudits in wards. Further updates to Cerner are probably needed to prevent inappropriate use of this data field that bypasses mandatory VTE risk assessment on admission and removing this bypass as an option is also being explored.

4. The Surgical and Anaesthetic services Division (SAS) and Community and Integrated Care Division have consistently achieved the envisioned performance metrics for this year at 98.5% to 99% over the last quarter 4. Maternity challenges with data extraction issues from Badgernet and Variable assessment rates in same day emergency care as well as variable degree of use of the bypass tab of Cerner that overrides the mandatory assessment are posing challenges for Family Care (FC) and Medical and Emergency care (MEC) Divisions which will be resolved in the coming months.

All the above work in progress will positively enhance the Trust capability to enable VTE risk assessment data collection and reporting to be made more robust alongside other QI measures.

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

VTE risk assessment at ELHT has improved by 5.7% compared to last year and 0.15% above National average for Acute NHS Trusts and 0.45% higher than regional average in Northwest in Q3 published figures. The Trust annual figures are 91.5% which is 6.5% higher the Lancashire and South Cumbria ICB average in Q3 published by NHSE which is 85% . Trust VTE performance metrics is therefore showing a trajectory of improvement as above which continues in an upward trend. Systems and processes are in place at ELHT for risk assessing all admitted patients utilizing the national VTE risk assessment tool on admission on Cerner EPR system. This is currently well embedded and continually being monitored and improved as needed.

Trust VTE risk assessment consistently improved from just above 95% in 2012, to 97% since July 2013, above 97.5% since July 2014 and above 98.3% since July 2016 until April 2020. There was a drop in the VTE risk assessment figures noted by 0.40 % overall during the pandemic times in 2020/21 which resumed Trust trajectory at 98.45% in 2021/22 and 2022/23. Trust VTE risk assessment figures continued to be significantly above National average of above 95% at 98.47% for the two consecutive years prior to Cerner implementation. With ongoing Continuous QI approaches through VTE committee work Trust figures are consistently improving and will hopefully be back to previous figures as a high performing Trust in this aspect again by next year.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

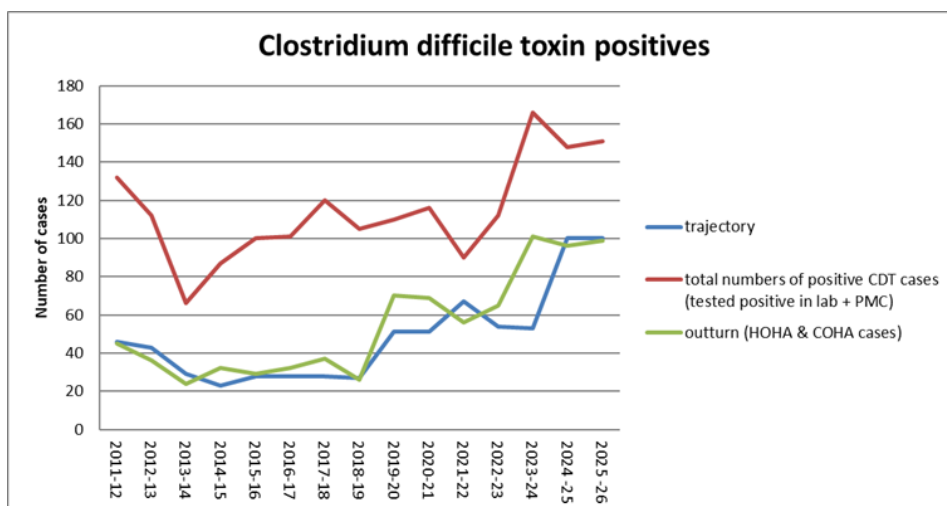
- VTE committee continues bimonthly meetings and receives assurance reports on VTE risk assessment data as well as Hospital acquired VTE from Divisions and related actions for ongoing continuous quality improvement.
- VTE committee terms of reference updated again and now reports regularly to the Trust Clinical Effectiveness committee as it is now a subcommittee of this.
- Monitoring of identification, reporting and management of Hospital acquired VTE through formal reporting by all divisions is robustly enabled through the committee oversight.
- Trust Policy CP17 Part 1: on Venous Thromboembolism (VTE): Reducing the Risk of Hospital-Acquired Deep Vein Thrombosis or Pulmonary Embolism in Patients aged 16 and over was reviewed in April 2025. A NICE guidance update was issued towards end of September 2025 recommending undertaking VTE risk assessment on ED patients waiting longer than 12 hours from decision to admit. Once the ED pathway in line with updates to NICE Guideline that is currently being developed is implemented and in

place, the Trust policy will also be updated to reflect this change effectively implemented at Trust.

- VTE committee working group is working closely with the Trust informatics teams and Robust Informatics reporting that is fit for purpose is in place and continues to be improving with focussed work committed towards aligning Badger net data and updating bypass data fields to mandatory fields.
- Educational event was delivered for Foundation year trainees at change of rotation again this year with live Cerner demonstration of VTE work streams and task lists on Cerner to enable better compliance with risk assessment as well as prophylaxis prescribing. Further ongoing training is planned with every rotation change.
- A ward-based spot audit on VTE risk assessments and prescribing was undertaken in Ward B8 and in Orthopaedic ward as part of QI work.
- Trust wide audit on Hospital acquired VTE reporting and evaluation commissioned by VTE committee through the clinical audit and effectiveness team for 2024/25 year was completed and action plans implemented fully. The reporting tool has since been digitalised and integrated into Datix to enable a Trust wide consistent approach.
- Reaudit of HAVTE, VTE risk assessment and Management of Suspected and confirmed VTE is included in the forward planner for next year as ongoing QI initiatives enhancing the quality and efficacy of this Trust harms Reduction programme.
- VTE committee administrative support that was in place in the past from Trust Governance was withdrawn due to short staffing and recruitment freeze considering the extraordinary financial pressures for the Trust last year and this is currently being reviewed to be reinstated by the Clinical effectiveness group.

3.3.9 Clostridium Difficile Rates

In 2025/26, there has been 99 reportable cases (HOHA- Hospital Onset Hospital Acquired & COHA- Community Onset Hospital Acquired) against a trajectory of 100 cases. This is an increase of three cases compared to last year.



East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Post infection reviews have now been replaced with patient safety reviews (PSR's) aligning Infection Prevention & Control with the Patient Safety Incident Framework. PSR's are not required for all individual HCAI cases, they will only be completed if the case meets the following criteria : a) Confirmed

transmission from genotyping/ribotyping indicating outbreak (two or more patients where cross contamination has occurred) b) Areas part of a Period of Increased Incidence (two or more cases within 28 days) c) Hospital associated infection on death certificate.

East Lancashire NHS Trust has taken actions to improve this rate and so the quality of its services by:

There have been ongoing quality improvement projects around improving the management of Clostridium difficile cases with the introduction of an electronic diarrhoea care plan and a dedicated Clostridium difficile care plan now live on the electronic patient record system (EPR) . IPC and the Consultant Microbiologist, alongside DERI, are progressing a Clostridium difficile learning package for the medical staff on the management of cases.

3.3.10 Patient Safety Incidents

Since July 2024 ELHT report all incidents which involve patients automatically to the Learning from Patient Safety Events system (LFPSE) when reported on the Trusts risk management system (Datix).

East Lancashire Hospitals NHS Teaching Trust can use this information to understand its reporting culture; higher reporting Trusts usually have a strong safety culture and as such the Trust continues to actively encourage the reporting of incidents and near misses.

Figure 1: Patient Safety Incidents

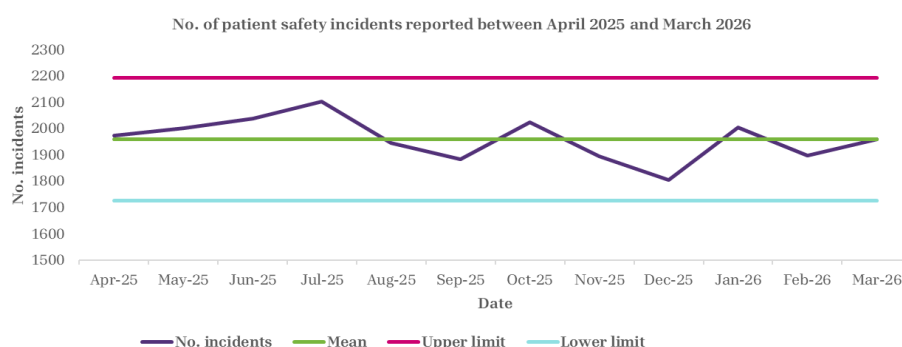


Figure 2: No Harm

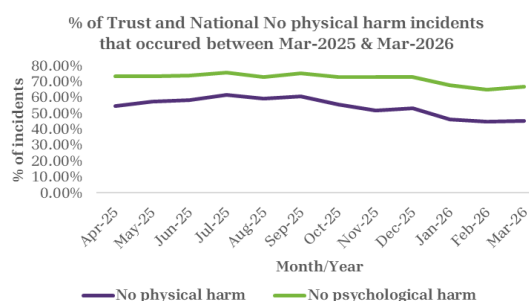


Figure 3: Low Harm

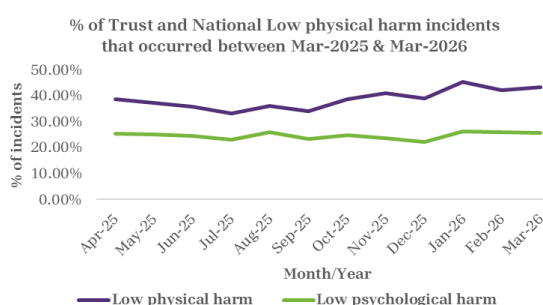


Figure 4: Moderate Harm

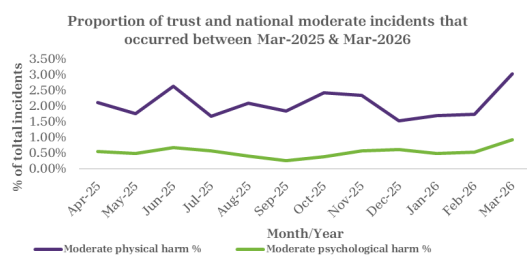


Figure 5: Severe Harm

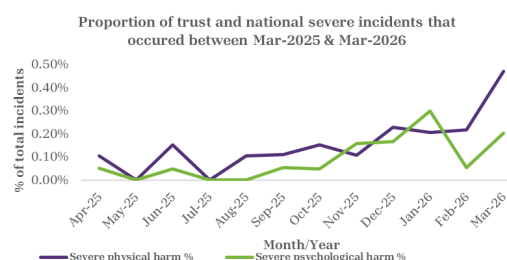
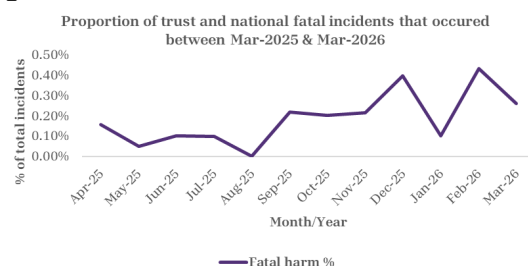


Figure 6: Fatal



East Lancashire Hospitals NHS Trust considers this data is as described for the following reasons:

The average number of incidents per month reported by the Trust in 2025/26 (2362) has remained similar to the previous year (2313). Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared.

No harm and low harm incidents form the greatest proportion of those reported:

- No physical harm average for 2025/26 is **54.35%** (figure 2)
- No psychological harm average for 2025/26 is **72.07%** (figure 2)
- Low physical harm average for 2025/26 is **38.63%** (figure 3)
- Low psychological harm average for 2025/26 is **24.75%** (figure 3)

Towards the end of the year there has been a small increase in the reported number of moderate harm (see figure 4) +1.28% and severe harm (see figure 5) +0.25% physical harms. A number of these incidents relate to delays in the Glaucoma service; a risk was identified and raised on the Trusts Risk Register and appropriate mitigating actions put in place.

The Patient Safety Team are educating staff across the Trust to improve their understanding of the LfPSE guidance harm. For example: actual impact to the patient regardless of care issues, which will likely result in a change in the proportions of harms.

The Trust continues to build on improvements to investigation processes and dissemination of learning:

- The Patient Safety Team has been delivering Introduction to Human Factors training since April 2024, and Patient Safety Response (PSR) Investigation training was developed and launched in mid-2025 along with Family Liaison Officer training.
- It has been agreed that all staff undertaking a PSR investigation must complete both the Human Factors and PSR Investigation training sessions. This requirement ensures investigators are aligned with the Patient Safety Incident Response Framework (PSIRF) standards and methodology, supporting higher-quality PSR investigations and more effective improvement actions.

- A monthly training session is now also provided for staff responsible for the Trust's third level of response (IR2s) to incidents reported. These sessions offer an introduction to SEIPS and focus on conducting high-quality investigations at this level, including the development of robust improvement actions. This is expected to strengthen the overall quality and consistency of IR2 investigation outcomes.
- The Patient Safety Team is currently working to enhance the way thematic factors are identified and recorded within Datix. Once implemented, this will support improved recognition of systemic issues and better inform wider organisational improvement work.
- Over the past year, several of the Trust's PSR investigation templates have been reviewed and updated to provide clearer guidance for investigators and ensure a consistent approach aligned with PSIRF investigation standards.

3.3.11 Never Events

A Never Event is a serious incident that is recognised as being entirely preventable if all the correct guidance is followed and all our systems work to create a safe situation for patients and colleagues. Over 2025/26 the Trust has reported 4 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Retained foreign object	3*
Wrong site surgery	1

**After investigation one of the three reported Never Events retained foreign object post procedure was reviewed and agreed the incident did not meet the National criteria for a Never Event due to a manufacture fault with the piece of equipment and all the national and local safety checks had been completed. It was agreed with ICB that this incident no longer met the Never Event criteria. The incident has been included within the figures for full transparency.*

Two of the reminding three Never Event incidents has been fully investigated and the Trust found important learning that has been shared with colleagues across the organisation, with our commissioners and the patients. Detailed safety improvement plans for this incident have been developed, updated and assurance on the completion and embedding of learning has been overseen by Patient Safety Group and Patient Safety Incident Requiring Investigation panel. The other Never Event at the time of the Quality Account being published was still under investigation.

Learning from Never Event Incidents

On three occasions within 2025-26 the Trust has not met the expectations of **Safe**, **Personal** and **Effective** care regarding Never Events. Currently the Trust identified several key changes in systems and processes from the wrong site surgery and the first retained foreign object post procedure incident and learning was shared within the Trusts. The learning included:

Wrong site surgery - removal of wrong polyp

- To ensure a formal LocSSIP is in place for all outpatient surgical procedures, actively used and monitored using regular audits
- Include clear steps for pre-procedure verification, site confirmation, and post-procedure documentation
- Use consistent and anatomically accurate terms across consent forms, clinical notes, and verbal communication

- Where practical, the clinician obtaining consent should also perform the procedure to maintain continuity and clarity
- Provide visual aids or diagrams where appropriate to ensure site confirmation immediately prior to procedure
- Introduce a mandatory verbal and visual confirmation of the lesion with the patient before excision

Retained Foreign Object - Swab

- Ensure all counts upon commencement of wound closure and prior to skin closure are in line with National and Local policy, including not completing count during layer closure or closure of skin
- Silent focus with minimal activity and disturbance needs to be adhered to when completing counts and safety steps
- Any discrepancy relating to patient safety including counts processes must be communicated to the entire theatre team, including anaesthetists to prevent potential for emergence from anaesthesia and sequent re-induction of a patient.

3.3.12 Learning from Deaths

Learning from Deaths was introduced by the National Quality Board to ensure that Trusts had robust processes in place to identify, report, investigate and learn from deaths, to improve patient care and outcomes. The Mortality Steering Group is responsible for managing the Learning from Deaths process within the Trust.

Notably, the guidance predated the introduction of the Medical Examiner system. All deaths within the Trust are now reviewed by the Medical Examiners' Office, and the Medical Examiner team present regular reports to the Mortality Steering Group, as well as identifying cases where they feel there are significant concerns with care, which are fed back via the Datix system and managed as incidents.

In addition, the Trust had a pre-existing process of reviewing a proportion of deaths via the Structured Judgement Review (SJR) process, with trained reviewers undertaking reviews using the methodology developed by the Royal College of Physicians. This methodology assigns a score to particular elements of care and an overall score for a patient's care. A score of 1 or 2 identifies a concern that care was poor, and a secondary review process is triggered to determine whether or not this poor care contributed to the patient's death. If this is felt to be the case further patient safety investigation is carried out.

The identification of cases to be reviewed follows the processes identified within 'Learning from Deaths' and in line with National Guidance. Not every death is subjected an SJR; the primary reasons for triggering an SJR are listed in the Trusts 'Learning from Deaths' Policy.

Breakdown of deaths in 2025-26 and number of completed SJR's for this time period.

		2025-2026
Total number of inpatient deaths 2025 / 2026	Q1	450
	Q2	413
	Q3	574
	Q4	545
Total		1982

Number of Stage 1 and 2 SJR's completed 2025 / 2026 (May contain deaths from current and prior years)		SJR 1	SJR 2	Deficiencies in care which may have contributed to death
	Q1	38	4	1
	Q2	42	4	2
	Q3	83	8	3
	Q4	81	3	1
Total		244	19	7

The number of SJRs carried out in this financial year has been adversely impacted by a reduction in the number of available reviewers and vacancy in the administrative support to the reviewers. These issues are the subject of an ongoing action plan.

The learning points from SJR reviews are collated into areas of good practice and areas for improvement which are tied into the Trust improvement priorities. Whilst end of life care remains a significant area for improvement, there has been notable evidence of improvement likely to be a result of the introduction of the end-of-life care and bereavement team and their support to ward based teams.

In addition to the general SJR process, mortality reviews also take place within individual specialties, including the Emergency Department, stroke services and intensive care. Paediatric, neonatal and maternal deaths have specific review processes.

Paediatric Mortality

At East Lancashire Hospitals NHS Trust, all Paediatric deaths including out of hospital deaths are reviewed through a mortality process. In 2019 a strengthened review process more akin to the structured judgement review process used in adults was implemented. All paediatric deaths are subject to a multidisciplinary primary review with a paediatric consultant and senior nurse reviewing the case in a structured way. This review is currently being updated in 2026 to ensure more relevant information for Children who are expected to die and change the process for Sudden Unexpected death in Childhood and also for children who die in other hospitals.

Following this all deaths are Secondary reviewed at the paediatric mortality meeting as part of the Paediatric Learning and Development day consisting of consultant's senior nurses and doctors in training. Actions for improvements are noted, and implementation is monitored through this meeting.

Moving forward with the Mortality reviews over the next 12 months and to align with the Child Death Review Process, secondary reviews will take place for unexpected deaths after the final CDRM meeting ensuring results of any postmortem are available and relevant learning can be shared. In addition, we are trying to ensure that ELHT clinicians are invited to mortality reviews at the tertiary children's hospitals so information from this can be fed into the local reviews.

The paediatric lead for mortality also chairs all local Child Death Review Meetings which are usually for expected deaths and any learning from this is fed back to the Mortality

Meeting. In addition the lead also attends the regional Child Death Investigation Group which is a multidisciplinary group of police, SUDC nurses, Coronial staff and paediatricians reviewing Sudden Unexpected Deaths regionally.

The table below demonstrates the number of cases reviewed by the process.

Total number of Paediatric Deaths by Location and quarter the Death occurred 2025 / 2026		In Hospital
	Q1	5
	Q2	6
	Q3	2
	Q4	3
Total		16
Number of Stage 1 and 2 PMR's completed during by quarter 2025 / 2026 (May contain deaths from current and prior years)	Completed	PMR 1
	Q1	6
	Q2	10
	Q3	3
	Q4	3
Total		22

In summary areas of good practice noted through this process are:

- Paediatricians and Children's Community Teams for Children and Young People with life limiting conditions.
- When advance care planning is done well it has an incredibly empowering impact on the family whose voice can be clearly heard in the process.
- Resuscitations started by North-West Ambulance Service and continued in the Emergency Department with general paediatric input are extremely systematic and processes for bereavement support and escalation to the Child Death Overview Panel robustly followed.

Key issues for which actions have been generated relate to the following:

End of Life Care and Advance Care Planning should be started at earliest opportunity. This may prevent escalation of care to tertiary centres when a ceiling of care has been reached, if families and professionals agree that this is in the best interest of the individual child or young person.

- Discussion of what the agreed ceiling of care is, and it being clearly documented to prevent invasive interventions should be completed early in the patient journey when it is clear that further escalation would not have a positive outcome.
- Advance Care Planning should be considered and evidenced even before End-of-Life Care in order to ensure child and families wishes are captured and to support and inform difficult conversations that need to take place when a child or young person's health deteriorates.
- Primary care management of the acutely unwell child needs to be supported to empower GP's and ensure children get the most appropriate and timely review.
- Childhood suicide has been more prevalent nationally and local trends although low are evident in the reviews.

- As part of the review of child mortality it has become evident that there is a gap in service with the need for a Bereavement/Palliative care nurse based locally to empower families and promote Advanced Care Planning. This discussion is currently taking place with commissioners and has been incorporated as part of the community specialist nursing review. There are now two Kentown nurses in place at ELHT who fulfil this role, with one post permanent and the other funded until 2026 with no current agreement for future funding.

Learning Disability Mortality Reviews (LeDeR)

The NHS Long Term Plan made a commitment to continue learning from deaths (LeDeR) and to improve the health and wellbeing of people with a learning disability and autism.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and autism and to reduce health inequalities.

By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

ELHT contribute to this process by notifying NHS England of all the deaths of people with a learning disability or autism. Following the notification of death a structured judgement review is completed and recommendation and actions for learning are shared within the organisation at the regional LeDeR lessons learnt group. Thematic cause of death is also reported annually to NHS England's national standards.

In summary areas of good practice noted through this process are:

- Use of flagging of learning disability and autism in electronic care
- Use of learning disability and autism care plan
- End of life care planning

Key issues noted and reported via learning disability and autism operations group:

- Earlier identification of end-of-life care planning
- Better recording of accessible information alerts on patient record, and identification of patients with autism
- Identification of potential delays in discharge for patients with complex social situations particularly when the patient lacks capacity
- Learning disability noted on DNACPR, as reason for DNACPR, which contravenes NHSE guidance.
- Delays in response to referral to learning disability nursing team.
- Use of electronic record mental capacity act assessments
- Use of learning disability nursing recommendations

Reviews are completed at a monthly learning disability and autism mortality meeting. Where necessary actions are formulated. Outcomes from this meeting is included in a monthly report to mortality steering group. Actions are monitored and reviewed at learning disability and autism operations group and reported to ELHT Patient Experience Group.

Breakdown of Learning Disability deaths in 2025-26 and number of completed LeDeR's for this time period by financial quarter:

Adult inpatient deaths and number of those which had a Learning Disability or Autism Stage 1 and 2 LDA-SJR's completed 2025 / 2026 (Completed LD-SJR's may contain deaths from prior quarters/years)	Quarter	LDA-SJR 1 Completed	LDA-SJR 2 Completed	Deficiencies in care which may have contributed to death
	Q1	9	1	1
	Q2	9	0	0
	Q3	9	0	0
	Q4	6	0	0
Total		33	1	1

3.3.13 Seven Day Service Meeting the Clinical Standards

The Trust continues to benchmark its delivery of 7-day services (7DS) against all ten national clinical standards to ensure that patients receive consistently high-quality care regardless of the day of admission. Current audits show no significant difference in Hospital Standardised Mortality Ratio (HSMR) between weekday and weekend admissions, indicating that in-hospital mortality is not adversely affected by the day patients arrive. However, analysis of outcome measures has identified a one-day increase in average length of stay for patients admitted at weekends. This suggests an opportunity to action clinical decision-making, access to key diagnostic and therapeutic services that are essential for timely care pathways across the full seven-day period.

To support improvement, the Trust has completed comprehensive benchmarking of current service provision across all ten 7DS clinical standards, identifying areas of strong compliance as well as opportunities for further alignment with national expectations.

Oversight of the 7-day services programme is maintained through the Urgent and Emergency Care (UEC) Improvement Group, which operates under a dedicated Project Initiation Document (PID) specifically focused on 7DS delivery. This governance structure provides clear accountability, coordinated action planning, and systematic monitoring of progress, ensuring that service improvements are prioritised and that any gaps highlighted by benchmarking or outcome measures are addressed in a structured and sustainable way.

3.3.14 Colleagues can speak up (Freedom to speak up)

ELHT is committed to ensuring the highest standards of service and the highest ethical standards in delivering this service. The Freedom to Speak up (Whistleblowing) policy (HR20) is in place to support and assist colleagues in raising concerns without fear of discrimination or reprisal. ELHT will deal with all disclosures consistently, fairly and confidentially. Anyone who works (or has worked) in for East Lancashire Hospitals NHS Trust can raise concerns under this policy. This includes agency workers, bank colleagues, temporary workers, students, volunteers and governors.

Anyone raising a concern under this policy is not at risk of losing their job or suffering any form of reprisal as a result. ELHT will not tolerate the harassment or victimisation of anyone raising a concern. Nor will the Trust tolerate any attempt to bully colleagues into not raising any such concern. Any such behaviour is a breach of ELHT values as an organisation and, if upheld following investigation, could result in disciplinary action.

Colleagues can raise concerns in a variety of ways and advice is given that in the first instance to raise the concerns with their line manager (or lead clinician or tutor) if

colleagues member feels able to do so, however if this is not an option or this step does not resolve matters, the other options are:

- Though the Staff Guardian - identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to colleagues at any stage of raising a concern, with direct access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.
- If a concern remains, then they can be brought to the attention of our Executive Director or Non-Executive Director with responsibility for whistleblowing or one of the external bodies as listed in the Trust Policy.

Feedback to the person who raised the concern is critical. The sense that nothing happens is a major deterrent to speaking up. There are situations where this is not straightforward due to the need to respect the privacy of others involved in the case. However, there is almost always some feedback that can be given, and the presumption should be that this is provided unless there are overwhelming reasons for not doing so. Feedback is given to those who speak up in a variety of ways, mainly face to face, letter or via email.

ELHT are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns and will respond in line with the model published in Sir Robert Francis's CQ (2015) Freedom to Speak up: an independent report into creating an open and honest reporting culture in the NHS.

The Trust board is provided with regular information in a full board report about all concerns raised by our colleagues and what actions are being taken to address any problems.

3.3.15 NHS England National Improvement Standards for Learning Disability

The NHS England National Improvement Standards for Learning Disability (Year 8) audit 2024/25 is currently ongoing and will be submitted to NHS England by 31st March 2026. The outcome report, which will outline areas for action this coming year, will follow in the next few months.

The learning disability delivery plan for learning disability 2024-2027 outlines the actions for service improvement based on recommendations from previous NHS standards audit, LeDeR actions from learning and previous benchmarking audits. This delivery plan was formally launched in 2025. The outcomes of the plan's actions are monitored and reviewed at the learning disability and autism operational group with a report to the Patient Experience Group with action progress and completions.

An update of the outcomes from the NHS England National Improvement Standards for Learning Disability (Year 8) audit 2024/25 will be included in the report to Patient Experience Group in April 2026.

3.4 Other Quality Achievements

3.4.1 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 is specifically recognised 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.

3.4.2 Virtual wards milestone sees 45,000 patients cared for at home

Now in its third year, the Trust's virtual wards programme, Hospital at Home, has seen more than 45,000 patients being treated in the comfort of their own home instead of being admitted to hospital.

Through a virtual ward approach, patients are assessed, treated and supported at home, helping to reduce the pressure on the Trust's inpatient wards and services and freeing up space for others to receive care quicker.



3.4.3 All in a day's work for knee surgery at Burnley Hospital

Patients having partial knee replacement surgery can now be home the same day thanks to a new day-case procedure introduced by the Trust.

The procedure, carried out by surgeons at Burnley General Teaching Hospital, is the result of extensive work by orthopaedic, anaesthetic and physiotherapy teams who have created a safe pathway which focuses on patient confidence, safety and independence.



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

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

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

3.4.5 £1.6m secured for theatre improvements

Theatres at Burnley General have received an investment of around £1.6million from the NHS Targeted Investment Funding (TIF).

The money has been used to buy a range of equipment and systems that will support the elective recovery programme by ensuring additional activity at Burnley's surgical hub can be provided.

3.4.6 10 years of robotic surgery marked with patient celebration

The Trust celebrated ten years since the introduction of robotic-assisted surgery at ELHT. A special event was held to mark the anniversary, bringing together patients, clinicians and partners to reflect on the impact of our robotic programme.

Frank Steele, the first patient to undergo robotic colorectal surgery at ELHT shared his personal story with delegates, crediting the procedure with enabling a rapid recovery, avoiding the need for chemotherapy or a stoma and allowing him to return quickly to normal life. He also gave special thanks for the care and follow-up support he received.



3.4.7 National leadership in jaw fracture research

The Trust has taken a leading national role in improving care for patients undergoing surgery for jaw fractures, launching the major MANTRA (Mandibular Trauma and Antibiotic Use) clinical trial in collaboration with the Lancashire Clinical Trials Unit.

The trial is sponsored by ELHT and supported by a £2.5 million NIHR grant. It will recruit nearly 3,000 patients across approximately 30 NHS hospitals



3.4.8 Positive outcomes being achieved in unique medication reduction project

A partnership between the Trust and Constantia Healthcare Group has delivered life-changing results for older care home residents – including 101-year-old Evelyn Ainsworth.

The project, the first of its kind in the UK, focused on reducing the number of medications given to residents in Constantia's nine care homes across Lancashire, Yorkshire and

Teesside. More than 300 residents were reviewed, and many saw improvements in their health and wellbeing after their prescriptions were adjusted.



3.4.9 World first heart trial begins with East Lancashire patient

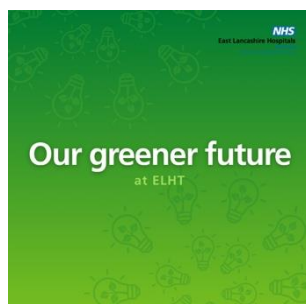
Great-Grandmother Sandra Hargreaves made history as the **first person in the world** to join a pioneering study testing 14 new sizes of an innovative heart stent. After being admitted to Royal Blackburn Hospital with a heart attack, Sandra met the criteria for the ULTRA LONG study designed to improve treatment for complex artery narrowings and chose to take part with support from the Trust's cardiology and research teams.



3.4.10 Leading the charge toward a greener NHS

The Trust is taking major steps to become one of the greenest NHS Trusts in the North West with a series of innovative projects already delivering significant environmental and financial benefits.

The Trust has made substantial progress in reducing emissions from clinical care. It became the first Trust in the region to fully decommission leaking piped nitrous oxide systems, a move expected to prevent more than 51,000 tonnes of carbon emissions over the next decade.



3.4.11 £2m donation transforms opportunities for patient care

The Trust received an exceptional £2m donation from The Kay Family Foundation—the largest single gift ever made to the charity ELHT&Me.

The donation will support key developments including new visual field machines for Ophthalmology, 13 neonatal incubators for NICU, mobile x-ray units for bedside imaging, an additional scalp cooler for chemotherapy patients, and 18 bladder scanners to support community teams and reduce avoidable catheterisation.



3.4.12 From Milan to Marsden: hospital hosts winter Olympic-style rehab games

Patients on Marsden Ward at Pendle Community Hospital competed in their own Olympic-style games to help with rehabilitation.

The week-long event coincided with the opening of the 2026 Winter Olympics and was full of fun and movement designed to support rehabilitation for stroke patients on Marsden Ward.

Activity resulted in 28% of those taking part being able to stand, with support, for the first time since their stroke and 9.5% taking their very first steps, with support, since their stroke.



3.4.13 Honorary Clinical Professorship for ED Clinical Director

Dr Georgina Robertson, Clinical Director for Emergency Medicine and Head of Undergraduate Education, has been awarded an honorary clinical professorship by Lancaster University in recognition of more than 30 years of service, leadership and commitment to developing the next generation of doctors. Dr Robertson has been a key figure in shaping the Emergency Department, mentoring trainees and strengthening medical education across the Trust.



3.4.14 Trailblazing midwife achieves professional doctorate

Consultant Midwife Rebecca Sessions became the first midwife at ELHT to be awarded a Professional Doctorate (PrD) in Health from the University of Central Lancashire.

Rebecca's doctoral research examined informed consent in maternity care, with a particular focus on consent discussions related to induction of labour. Her mixed-methods study produced valuable insight to support safer, more informed decision-making for women and families. The work culminated in a 65,000-word thesis and provides an evidence base that will directly influence practice within our maternity services.



3.4.15 East Lancashire maternity support worker first ever to receive an Honorary Fellowship

Keelie Barrett is the first ever maternity support worker to receive an Honorary Fellowship by the Royal College of Midwives (RCM).

This is a major milestone recognising her national impact on maternity care and staff wellbeing.



3.4.16 East Lancashire community nurses awarded prestigious Queen's Nurse title

Four community nurses at East Lancashire Hospitals NHS Trust have been given the prestigious title of Queen's Nurse. Amanda Prescott, Amy Rogers, Rebecca Smith and Debbie Hood, who all work in the Trust's Family and Community Care Group, were handed the accolade by nursing charity The Queen's Nursing Institute (QNI) for their commitment to high standards of patient care, learning and leadership.

3.4.17 Star Awards winners announced

The Trust announced the winners of the Star Awards 2025 during a virtual event in September. Colleagues were shortlisted from more than 500 nominations by a range of

judges from across the Trust Board and teams in a range of settings and services in 12 categories.

Thousands of colleagues tuned in as part of the live online event and commented on celebration posts on social media. This year's Star Awards were sponsored by Equans, Consort and Burnley General Hospital Phase V SPC Ltd.

3.5 Statements from Stakeholders

3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire

3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)

3.5.3 Lancashire County Council

3.6 Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulations 2011 to prepare Quality Accounts for each financial year. The Department of Health and Social Care has issued guidance on the form and content of annual quality accounts incorporating the above legal requirements.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Signed By Order of the Board:

Chairman:

Chief Executive:

Date:

3.7 GLOSSARY

Term	Explanation
Acute Kidney Injury (AKI)	Acute kidney injury is a sudden episode of kidney failure or kidney damage that happens within a few hours or few days.
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Advancing Quality Alliance	The Advancing Quality Alliance was established to support health and care organisations in the Northwest to deliver the best health, wellbeing and quality of care for all by being a trusted source of quality improvement expertise for the NHS and wider health and social care systems.
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Board Assurance Framework (BAF)	The BAF is a key framework which supports the Chief Executive in completing the Statement on Internal Control, which forms part of the statutory accounts and annual report, by demonstrating that the Board has been properly informed through assurances about the totality of the risks faced by the Trust.
Care Bundle	A group of interventions which are proven to treat a particular condition
Care Quality Commission (CQC)	The independent regulator for health and social care in England
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary
Clinical Commissioning Group (CCG)	Clinical Commissioning Groups are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clostridium Difficile Infection (CDI)	A type of infection
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trust's income to the achievement of quality improvement goals
Commissioning Support Unit (CSUICB)	Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners, for example by providing business intelligence services and clinical procurement services.
COPD	Chronic Obstructive Pulmonary disease – This is the name used to describe a number of conditions including emphysema and chronic bronchitis
Datix	An electronic system that supports the management of risk and safety involving patients and colleagues
DNACPR	Do not attempt cardiopulmonary resuscitation – this is a treatment that can be given when you stop breathing (respiratory arrest) or your heart stops beating (cardia arrest)
Dr Foster Guide	A national report that provides data on patient outcomes in hospitals in the UK
Duty of Candour	The Duty of Candour is a legal duty on hospital Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.
EQ-5D	Instrument for measuring quality of life
Family Liaison Officer (FLO)	Acts as a single point of contact for the relevant person, patient, next of kin in regard to liaise with on the investigation of a serious incident

Get It Right First Time (GIRFT)	A programme to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improvement patient outcomes
GROW	Gestation related Optimal Weight, used to assess fetal size and growth of baby.
Healthwatch	Healthwatch England is the national consumer champion in health and care and has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
Health Education England (HEE)	Supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.
HCV	Hepatitis-C virus
Hospital Episode statistics	A data warehouse containing records of all patients admitted to NHS hospitals in England
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths occurring within hospitals
Indicator	A measure that determines whether a goal or an element of a goal has been achieved
Information Governance Toolkit	An online tool that enables NHS organisations to measure their performance against information governance requirements
ICB/ICS	Integrated Care Board/System are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Lean	Lean is a system of continuous process improvement, which is increasingly being applied to health services in the UK and overseas to: improve the quality of patient care; improve safety; eliminate delays; and reduce length of stay.
LocSSIPs	Local Safety Standards for Invasive Procedures is a document that outlines the specific safety and quality steps required for a particular invasive procedure within a hospital or healthcare facility.
Morbidity	The disease state of an individual, or the incidence of illness in a population
Mortality	The state of being mortal, or the incidence of death (number of deaths) in a population
MBBRACE	Mothers and babies: reducing risk through audits and confidential enquires across the UK
MSOC	Medicines Safety Optimisation Committee
National Confidential Enquiries (NCEs)	A process to detect areas of deficiency in clinical practice and devise recommendations to resolve them
National Early Warning Scores (NEWS)	A tool to standardise the assessment of acute illness severity in the NHS
National Patient Safety Alerts (NPSA)	National patient safety alerts are issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS Trusts in England
Never Event	Never Event are serious medical errors or adverse events that should never happen to a patient
NHS England (NHSE)	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012

NHS Improvement (NHSI)	A body that supports foundation Trusts and NHS Trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHS Number	A twelve-digit number that is unique to an individual and can be used to track NHS patients between NHS organisations
National Institute for Health and social Care Excellence (NICE)	A body to improve outcomes for people using the NHS and other public health and social care services by producing evidence-based guidance and advice for health, public health and social care practitioners. NICE develops quality standards and performance metrics for those providing and commissioning health, public health and social care services and provides a range of information services for commissioners, practitioners and managers across the spectrum of health and social care
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential survey and research.
Nursing Assessment Performance Framework (NAPF)	Measures the quality of nursing care delivered by individuals and teams and is based on the 6Cs Compassion in Practice values.
Palliative Care	When there is no cure for an illness, palliative care tries to make the end of a person's life as comfortable as possible
Parliamentary and Health Service Ombudsman	A body that investigates complaints where individuals perceive they have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England
Patient Administration System (PAS)	An electronic system used by acute Trusts to record patient information such as contact details, appointments and admissions
Patient Advice and Liaison Service (PALS)	A service that offers confidential advice, support and information on health-related matters
Patient Safety Incident Response Framework/Plan	New National incident reporting and investigation requirements.
PFI	Private finance initiative a way for the public sector to finance public works projects through the private sector.
Place based partnerships	Place based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing.
Quality and Safety Framework	The means by which quality and safety is managed within the Trust including reporting and assurance mechanisms
Red Flag Drugs	Within ELHT specific drugs/drug classes are identified as those where timeliness of dosing is crucial, and these are known as RED Flag drugs . Healthcare professionals involved in the medication administration process must make every effort to secure the timely availability of these drugs for dosing
Research Ethics Committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector
Secondary Uses Service	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments
SIRO	Senior Information Risk Owner, this person takes on overall responsibility for the Trusts information risk policy.

Structured Judgement Review (SJR)	A methodology for reviewing case records of adult patients who have died in acute general hospitals. The primary goal is to improve quality through qualitative analysis of mortality data.
Summary Mortality Indicator (SHMI)	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die
Venous Thromboembolism (VTE)	A blood clot forming within a vein
WHO Checklist	A checklist that identified three phases of an operation, before induction of anaesthesia, time out, sign out that helps minimize the most common and avoidable risks endangering the lives and well-being of surgical patients

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/064
Report Title:	Request to delegate approval of the Annual Accounts and Annual Report		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Mark Greatrex Interim Chief Finance Officer Susan Giles Interim Director of Corporate Governance		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
			✓	
Executive Summary:	The Annual Accounts have been submitted to the auditors. The Annual Report and Annual Governance Statement are being drafted for consultation with both internal and external audit. Once we have an agreed version they will be circulated to Board members for comment.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board is asked to delegate authority to the Audit Committee for the final approval of the Annual Accounts and Annual Report (including the Annual Governance Statement).			

Previously Considered by:	
Date:	
Outcome:	

BOARD OF DIRECTORS

Meeting Date:	13 th May 2026	Agenda Item:	TB/2026/065
Report Title:	Freedom to Speak Up Report		
Author:	J Butcher, Head of Freedom to Speak Up		
Lead Director:	N Pease, Interim Chief People Officer		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
				✓
Executive Summary:	This report outlines key developments in the Freedom to Speak Up (FTSU) service at ELHT from 2025/26.			
Key Issues/Areas of Concern:	233 concerns were raised last year, which is reflective of the average amount for previous years. Concerns raised mainly relate to support with HR processes, inappropriate behaviours and lack of support from manager. Nationally, the FTSU function will transfer to NHS England at the end of June 2026, but the Guardian role remains protected in future contracts. EDI data shows growing confidence among BAME and disabled staff to speak up, supported by diverse ambassadors and mandatory training. Training at level 1 and 2 is near compliance however, training at level 3 compliance remains below target and requires attention. We have concentrated a large proportion of this report to the results of the Staff Survey for ELHT and comparison of national data to see how closely linked the speaking up questions are to 4 other relevant questions within the 2025 NHS Staff Survey			
Action Required by the Committee:	Continued Trust support is essential during this transition period and to maintain momentum in creating a safe, inclusive culture. Support to increase the compliance of FTSU training at level 3			

Previously Considered by:	
Date:	
Outcome:	

Background

1. The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged and supported to do so and can do it safely in a protected environment. Following on from the Sir Robert Francis Review, it is a requirement of the NHS Standard Contract that Trusts appoint a Freedom to Speak Up (FTSU) Guardian. ELHT employee 1.7 WTE Staff Guardians.

Introduction

2. This report has been prepared to advise the Committee of progress made since the last bi-annual report in October 2025. It provides data for the full year 2025/26. This report is also being shared with Trust Board.

National Updates

3. It has been widely publicised that following the publication of the *Patient Safety Landscape Review*, the functions of The National Guardian Office will transfer to NHS England and the National Guardian Office will close at the end of June 2026. We have had several meetings with NHSE regarding the transfer and how the services and support will look going forward.
4. NHSE have confirmed that Freedom to Speak Up, and the role of Guardians remains essential and will be included in the NHS Standard Contract for 2026/27.
5. From 6 April 2026, workers who report sexual harassment at work can benefit from protection under whistleblowing law. The law will make clear that workers who 'blow the whistle' on sexual harassment can benefit from whistleblowing protections against detriment and unfair dismissal. Previously, a worker would have to claim that their whistleblowing disclosure about sexual harassment fell under one of the existing categories of wrongdoing, such as a danger to health and safety. ELHT speaking up policy will be updated to reflect this important change.

Number of cases, themes and actions taken

6. In 2025/26, 233 concerns were raised. A decrease of 25% from last year (Appendix 1),
7. We have seen a reduction in cases throughout the year from last year's figure of 313 but, 233 is more in line with the average (228) amount of concerns in one year compared with the last 9 years (Appendix 2)

8. We saw an unprecedented rise in anonymous cases during Q2 being raised, however in Q4 we have only seen 1 case raised anonymously which is more in line with the average of around 1 to 2 per quarter. We saw the spike in Q2 (Appendix 3) due to a concern raised in ED for which anonymity was protected for individuals. Whilst these are difficult to feed back on, we continue to take the concerns seriously and provide assurance at a divisional level.
9. Nursing and Midwifery have raised the most concerns throughout the year totalling 80 and Administrative and clerical remain the staff group have raised the second most highest concerns totalling 62, 34 concerns in 25/26 have been raised from Additional Clinical Staff. We have seen a positive increase in Medics raising concerns in 2025/26. (Appendix 4). For context, over the last 9 years Administration and clerical staff have raised the most concerns at 604, followed by Nursing and Midwifery staff at 580.
10. Appendix 5 shows a summary of themes of concerns raised through FTSU for 2025/26.
11. The 31 concerns raised in Q3 regarding culture are due to a cultural review which took place in Histopathology. A full report and action plan is now sat with the Division for action and is being monitored for completion with the Divisional Director, HR Business Partner and FTSU Guardian. So far, the action plan is meeting the current times for implementation of actions.
12. Support through HR process continues to be the top concern raised throughout 25/26 with a total of 69 cases. This is mainly in relation to service changes, a large number of IG breaches identified, support through disciplinary / investigations, annual leave carry over and concerns over employment rights – reflective of current climate and service changes taking place. We are working extremely closely with our HR teams and Senior Managers in relation to time taken to address HR investigation and matters. We understand that there is an issue with the allocation of investigating managers and understand that this is something that HR are working towards increasing.
13. It remains that through concerns raised, we are hearing that staff of all grades are feeling the recent system and financial pressures evident throughout the Trust. This is manifesting in staff feeling a lack of support, burnout, increased inappropriate behaviours and low morale, hence the third highest concern raised at 29 is a perception of lack of support from Managers. We acknowledge that Managers are struggling to find the time to support staff as they usually would, meaning traditional routes of speaking up are becoming impaired or not addressed. Again, we are feeding this information back to our HR colleagues for additional support were required for

managers and also ensuring that Managers are aware of assistance that is available for our colleagues via Occupational Health department and Wellbeing Teams etc.

EDI data / Perceived detriment

14. Of the 233 concerns that were raised during this period, 13% of colleagues identified as BME. 21 concerns raised by colleagues who declared a disability and 5 colleagues were from our LGBTQ plus community.
15. During this reporting period, 20 concerns were raised relating to perceived racial discrimination. 14 of these concerns were submitted anonymously during Q2, in response to online discussions about the Emergency Department. These individuals felt racially targeted. As a result, an external independent review has been undertaken in the Emergency Department to examine and address the issues raised.
16. We received 3 concerns for alleged sexual misconduct, all from women. One has proceeded to formal investigation, which has resulted in a disciplinary hearing, one has left the Trust, and the other is not willing to come forward at this time but is being supported.
17. There have been 21 concerns raised regarding perceived detriment of disabled colleagues. Mainly around inappropriate behaviours and attitudes, usually from managers dealing with their case, and around difficulties implementing reasonable adjustments.
18. We are encouraged that we are seeing our colleagues speak up about concerns of this nature now and we would expect that the mandatory training that is now in place is being used as a tool to give them the confidence to speak up. The next part of this encouragement would be to share with our colleagues widely some of these concerns raised and the outcomes to show that their concerns are heard and dealt with in line with Trust Policies and Procedures.
19. We are also encouraged that a more reflective number of colleagues who have a protective characteristic feel brave and supported enough to raise concerns that they may have not felt able to do so in the past. We would think that the fact that we now have 22 ambassadors from various backgrounds has assisted in this increase.
20. Several of our ambassadors have taken part in the Sexual Safety Training, allowing them to support colleagues who raise concerns regarding this issue.

Freedom to Speak Up Mandatory training

21. FTSU training Levels 1 and 2 became mandatory for all staff on 18 October 2023. FTSU training Level 3 became mandatory for Band 9 and above on 26 February 2024.
22. We are reporting above compliance rare for level 1 and level 2 training however, we would wish to highlight the risk that compliance for Level 3 training is below the 90% target and ask that all colleagues required to undertake level 3 training do so as soon as possible as this is aimed at senior management, executive level and NED's and an example should be demonstrated that all are in support of speaking up. (Appendix 6)
23. Automatic reminders are sent to all staff who are non-compliant but this hasn't yet helped to increase compliance. We will aim to encourage staff to complete during Freedom to Speak Up week also.

Freedom to Speak Up Week

24. FTSU week is took place between 13-17 October 2025 and the theme is 'Follow Up in Action', focusing on how important action is in speaking up to provide reassurance that colleagues voices translate into meaningful change. The majority of our ambassadors took part in raising awareness of the service.
25. As part of the learning from this week we have started to monitor how many colleagues use the FTSU service a escalated route in that they have previously raised their concerns through other channels but have not had any feedback, seen any change or satisfactory outcomes, we will be able to report on this finding in future reports.

Staff Survey

26. Following the results of the 2025 staff survey which showed a decrease of 0.33% under the "we have a voice that counts" people promise theme, we have concentrated on these results and how they are linked to the people promise theme "we are compassionate and inclusive" questions and how they link closely with each other, (Appendix 7)
27. Overall recommendations are to strengthen psychological safety and speaking up culture and to continue and strengthen with the work streams and actions that have already been taking place within the organisation i.e. listening labs, FTSU training as mandatory, "you said we did" style of approach, the introduction and embedding of the behavioural framework, inclusive recruitment etc. The data also indicated an

improvement in staff engagement and advocacy is required, addressing these issues will be critical to closing the gap between organisational values and staff experience, ultimately improving colleagues' engagement, retention and the quality of care delivered.

28. A further recommendation would be to ensure that concerns lead to visible action and improvement, as the data suggest speaking up does not always result in meaningful change, impacting on confidence in care quality. Therefore, an improvement in all processes for responding to concerns and increasing transparency around actions taken following concerns raised and ensuring there is feedback to colleagues who raise these concerns to close the loop and give assurance that their voice counts.
29. We will be linking in and working with all relevant teams where we can support these recommendations.

Conclusion / Recommendation

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

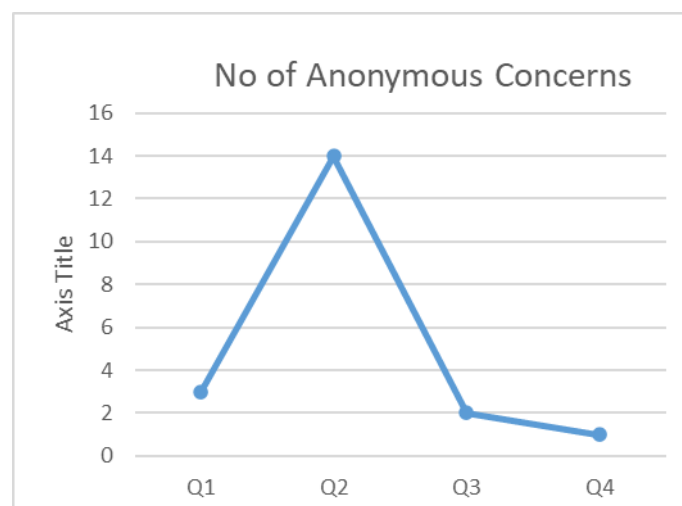
Appendix 1 – Number of cases per year showing percentage increase or decrease

Date Range April to March	No of Cases	% increase or decrease
2016/17	38	n/a
2017/18	140	268.42%
2018/19	175	25.00%
2019/20	231	32.00%
2020/21	254	9.96%
2021/22	261	2.76%
2022/23	205	-21.46%
2023/24	236	15.12%
2024/25	313	32.63%
2025/26	233	-25.56%

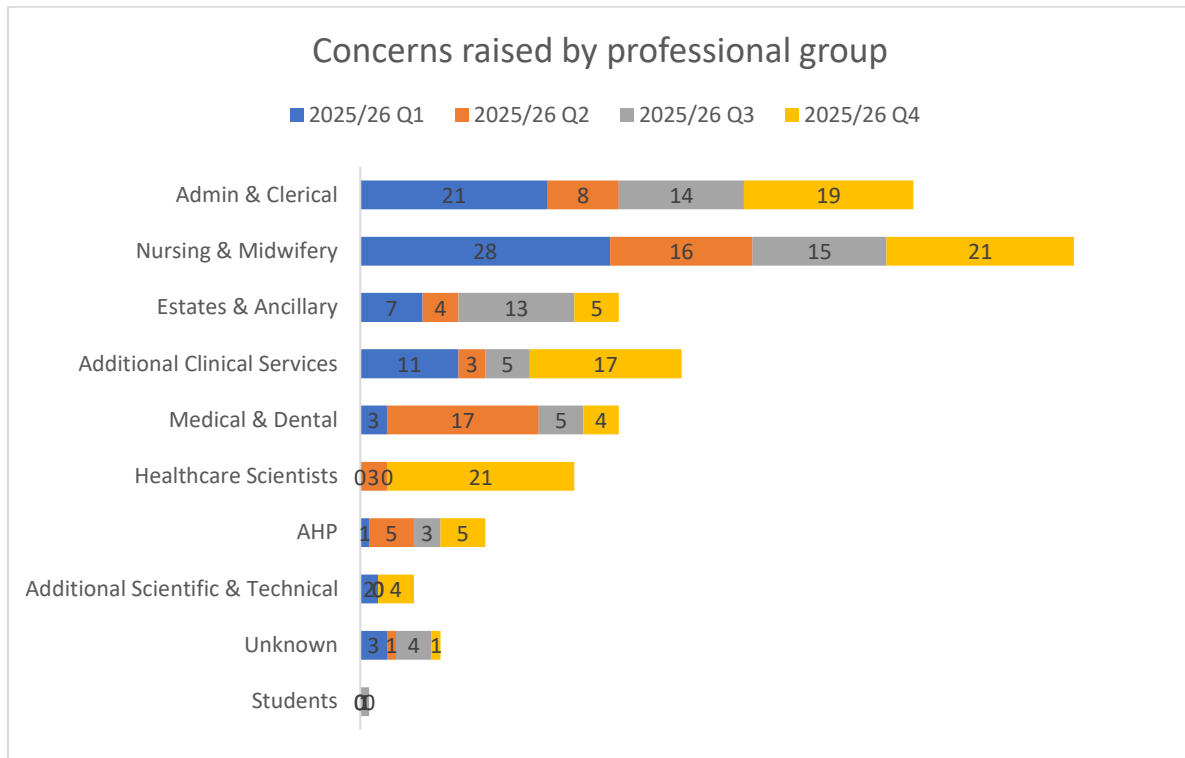
Appendix 2 – Summary of number of concerns by quarter and year.

No of concerns	Q1	Q2	Q3	Q4	Total
2022/23	41	59	49	56	205
2023/24	55	62	70	49	236
2024/25	40	61	115	97	313
2025/26	76	62	60	35	233

Appendix 3 - Number of anonymous concerns from April 25 to March 26



Appendix 4 – Number of concerns raised by professional group from April 25 to March 26



Appendix 5 – Summary of concerns by theme from 25/26

Theme	2025/26			
	Q1	Q2	Q3	Q4
Total Cases	76	62	60	35
Support through HR Process	30	16	14	9
Perceived Inappropriate Attitudes and Behaviours	11	10	2	4
Culture	0	1	1	1
Perceived lack of support from manager	12	5	7	5
Working Environment	2	0	1	0
Perceived Racial Discrimination	1	16	2	1
Perceived bullying by manager	4	3	2	6
Perceived bullying by colleague	2	1	7	2
Wellbeing	3	2	1	4
Patient Care	4	2	4	3
Perceived Disability Discrimination	3	2	1	0
Safety Risk Staff	3	1	6	0
Lack of communication	1	0	2	0

Recruitment Practices	0	0	0	0
Work Related Issues	0	0	4	0
Perceived Sexual Misconduct	0	1	2	0
Perceived Sexual Orientation discrimination	0	0	1	0
Perceived maternity discrimination	0	1	0	0
Perceived detriment	0	1	2	0
Fraud	0	0	1	0

Appendix 6 – Summary of mandatory training compliance by level as of 28/02/2026.

Level	Name	Audience	Compliance rate (as of 28/02/26)	Compliance rate (as of 16/09/25)
Level 1	Speak Up	All staff	94%	89%
Level 2	Listen Up	All staff	92%	87%
Level 3	Follow Up	Band 9 and above	58%	60%

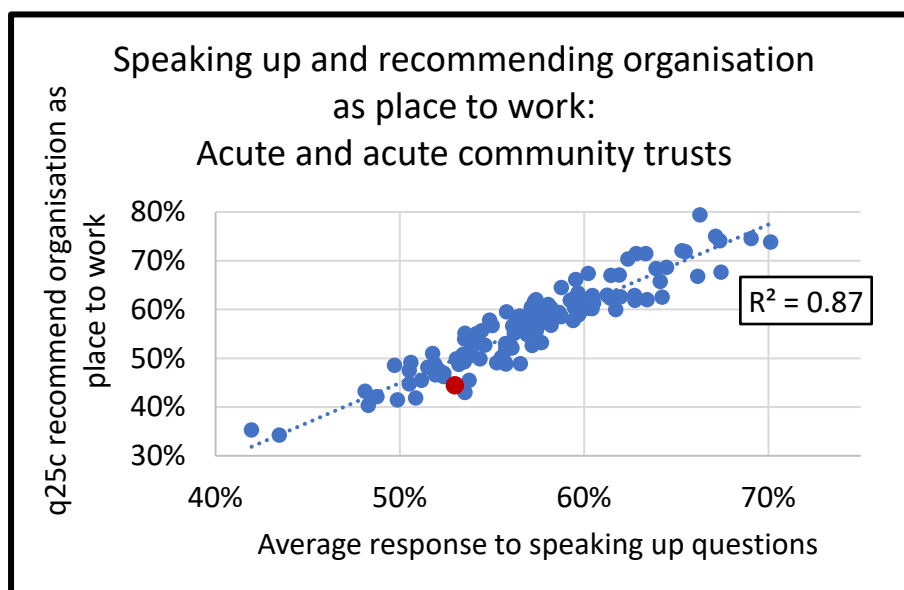
Appendix 7

Staff Survey – People Promise Theme – “we have a voice that counts”

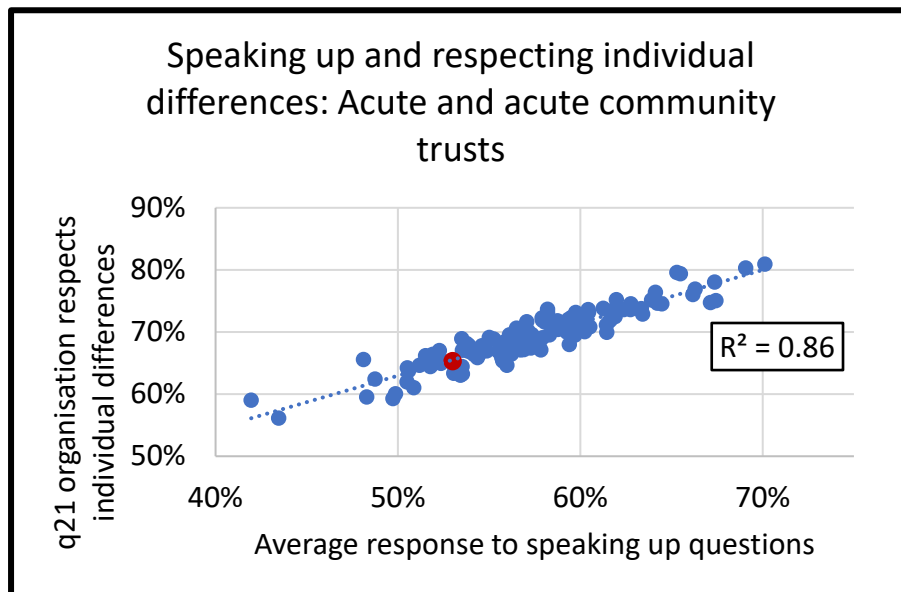
1. National staff survey results have now been published and shared widely across the organisation.
2. “We each have a voice that counts” – ELHT (-0.33 from last year) 6.7 score in 2024 falling to 6.37 score 2025. Below shows the results against the 4 relevant questions by staff group. The average is 53% overall.

Metric	Organisation 2025	Add Prof Scientific and Technical	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	5275	120	725	1,926	394	353	93	244	1,418
Metric	Organisation 2025	Add Prof Scientific and Technical	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	5275	120	725	1,926	394	353	93	244	1,418
Q20a I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	65.0%	79.7%	68.3%	54.5%	79.7%	45.9%	64.5%	71.7%	75.6%
Q20b I am confident that my organisation would address my concern (Agree/Strongly agree).	49.7%	62.7%	52.6%	44.7%	58.8%	36.6%	45.7%	52.7%	54.3%
Q25e I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	52.3%	67.2%	53.8%	48.6%	65.1%	35.4%	52.2%	62.7%	54.3%
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	39.6%	47.9%	42.7%	37.1%	44.9%	27.1%	33.7%	43.6%	42.1%

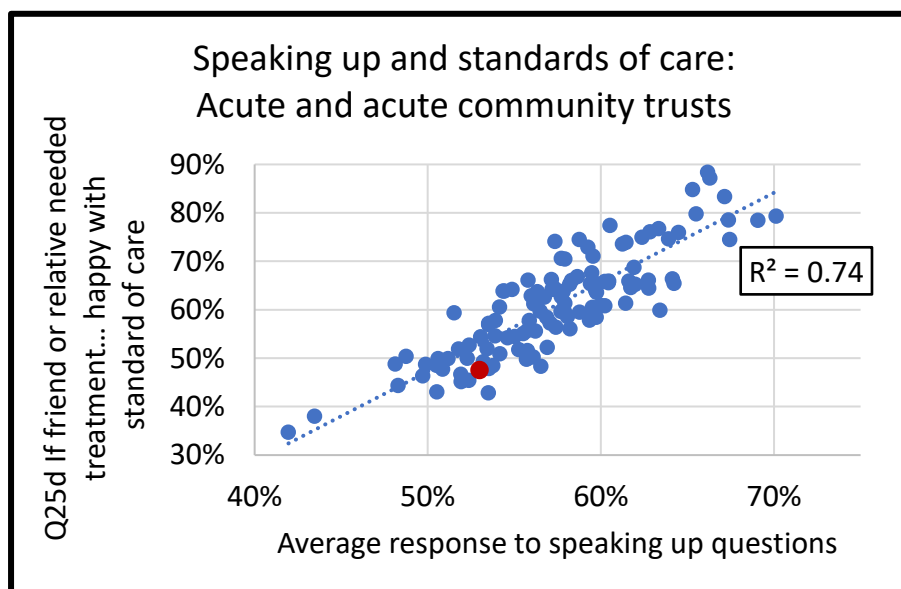
3. For this report, we have concentrated on the people promise theme of “we have a voice that counts” and how these results are linked to the People Promise theme “we are compassionate and inclusive” questions relevant to speaking up and how they link closely with other question under the People Promise theme of “we are compassionate and inclusive” the average score for the four questions in the table above is 53% for ELHT.



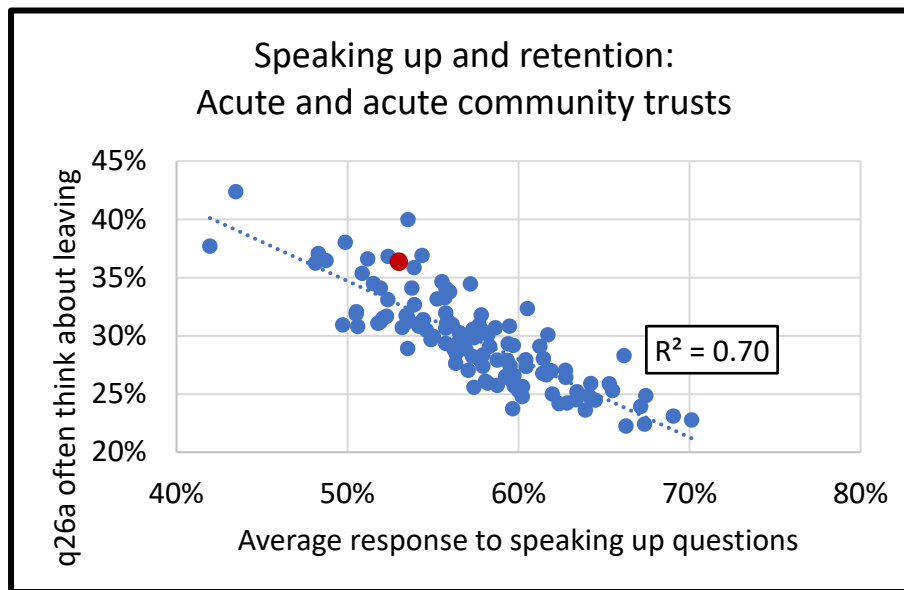
While 53% of staff feel safe to speak up, only 44% would recommend the Trust as a place to work, this suggests that although colleagues may feel comfortable in raising concerns, this does not fully translate into overall satisfaction with the organisation.



While 65% of staff feel that the organisation respects individual differences, only 53% feel safe to raise concerns. This suggests that although the organisation is perceived as inclusive, this does not fully translate into colleagues feeling confident to speak up.



While just over half of staff (53%) feel safe to speak up, fewer (48%) would be happy with the standard of care provided to a family member or friend. This suggests that confidence in care quality is relatively low despite moderate levels of psychological safety.



53% of colleagues feel safe to speak up, 36% report that they often think about leaving. This suggests that although over half colleagues feel able to raise concerns, a significant proportion are still considering leaving the organisation.

4. Overall, the findings indicate a disconnect between positive perception of organisational values and colleagues lived experience. While most colleagues believe that the organisation respects individual difference (65%), this is not consistently reflected in other key measures. Only 53% of colleagues feel safe to raise concerns, suggesting that psychological safety is not yet fully embedded. This gap is further reflected in lower levels of advocacy, with just 44% of colleagues willing to recommend the organisation as a place to work.
5. In addition, 36% of colleagues report frequently thinking about leaving, indicating a significant retention risk. This suggests that even where elements of culture are perceived positively, they are not sufficient to ensure colleagues satisfaction or commitment.
6. Particular concerns are that only 48% of colleagues would be happy with the standard of care given to friend or family member. The fact that this figure is lower than the proportion of colleagues who feel safe to raise concerns does not consistently translate into improvements in practice or potential outcomes.
7. Overall recommendation to strengthen psychological safety and speaking up culture and to continue and strengthen with the work streams and actions that have already been taking place within the organisation i.e. listening labs, FTSU training as mandatory, "you said we did" style of approach, the introduction and embedding of the behavioural framework, inclusive recruitment etc. The data also indicated an improvement in staff engagement and advocacy is required, addressing these issues will be critical to closing the gap between organisational values and staff experience, ultimately improving colleagues' engagement, retention and the quality of care delivered

8. A further recommendation would be to ensure that concerns lead to visible action and improvement, as the data suggest speaking up does not always result in meaningful change, impacting on confidence in care quality. Therefore, an improvement in all processes for responding to concerns and increasing transparency around actions taken following concerns raised and ensuring there is feedback to colleagues who raise these concerns to close the loop and give assurance that their voice counts.

BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/066
Report Title:	Board Committee Terms of Reference		
Author:	Susan Giles Interim Director of Corporate Governance/Company Secretary		
Lead Director:	Susan Giles Interim Director of Corporate Governance/Company Secretary		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
			✓	
Executive Summary:	The Terms of Reference for the Board Committees have all been reviewed. Proposed amendments are made in blue font for ease of reference. As part of the review the Chair has reviewed the Non-Executive Director chairing and membership of the Board Committees, and this was presented to the Board in the March Chair's Report. Each Committee has a workplan for 2026/27 to ensure that it has a schedule of reporting which should enable the Committee to fulfil their responsibilities within their respective Terms of Reference. Key points to note are: 1) The Audit & Risk Committee Terms of Reference are aligned to the NHS Audit Committee Handbook example terms of reference. Minor amendments proposed. 2) Remuneration Committee Terms of Reference now make explicit their duty to review remuneration for all non-agenda for change staff, not just Very Senior Managers. 3) The Charitable Funds Committee Terms of Reference have been fully rewritten to align with the revised template. The main amendments are to clarify the Board's collective role as corporate trustee including responsibility to approve the Annual Report and Accounts, reference to compliance with the UK Charity Governance Code and Fundraising Regulator's Code of Practice, and responsibility for approving an ethical investment policy. 4) The membership of Quality, Finance and Performance, and the People and Culture Committees have all be reviewed and amended to ensure a balance of Executive Director representation across the Committees.			

	5) The Data, Digital & Technology Committee Terms of Reference have been slightly amended to include the Director of Service Improvement & Development. 6) The Education, Research & Innovation Committee Terms of Reference were approved by the Board in January 2026. There are no proposed amendments, they are therefore not being re-presented to the Board.
Key Issues/Areas of Concern:	
Action Required:	The Board is asked to approve amendments to the Terms of Reference for the following Committees: • Audit & Risk Committee • Remuneration & Nominations Committee • Charitable Funds Committee • Quality Committee • Finance & Performance Committee • People & Culture Committee • Data, Digital & Technology Committee

Previously Considered by:	Finance & Performance Committee Quality Committee
Date:	April 2025
Outcome:	Approved for submission to the Board for final approval.

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) has established a Committee to be known as the Audit and Risk Committee (“the Committee”).
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the [Standing Financial Instructures](#) and Scheme of [Reservation and Delegation](#), with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to provide assurance or escalate concerns to the Board and Chief Executive as the Accountable Officer in relation to:
 - Governance;
 - Risk management;
 - The control environment;
 - Integrity of the financial statements; and
 - Other elements of the Annual Report and Accounts.
- 3.2 The Committee will ensure that the Trust has robust audit arrangements.

4 Responsibilities

The Committee’s responsibilities can be categorised as follows:

4.1 Governance, risk management and internal control

- 4.1.1 The Committee shall review the adequacy and effectiveness of the system of governance, risk management (including review of the Board Assurance Framework and Corporate Risk Register [at every Committee meeting](#)) and internal control, across

the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives;

4.1.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- The Trust's risk management and control framework;
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance;
- The policies and procedures for all work related to counter-fraud, bribery and corruption as required by the NHSCFA.

4.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control together with indicators of their effectiveness.

4.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

4.1.5 As part of its integrated approach, the Committee will have effective relationships with other key Board Committees so that it understands processes and linkages. However these other Committees must not usurp the Audit Committee's role.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector internal audit standards, 2017* and provides independent assurance to the Committee, Chief Executive as the Accountable Officer and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved;
- At least once in a five-year period the Committee shall appoint an Auditor Panel to oversee the market-testing of the internal audit provision to ensure value for money and effectiveness;

- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organization; and
- monitoring the effectiveness of internal audit and carrying out an annual review.

4.3 External Audit

4.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
 - discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
 - discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
 - reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
 - ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- 4.3.2 At least once in a five-year period the Committee shall appoint an Auditor Panel to oversee the market-testing of the external audit contract. The Auditor Panel will advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.

4.4 Other Assurance Functions

4.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

- 4.4.2 These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).
- 4.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the Quality Committee, for which assurance from clinical audit can be assessed.
- 4.4.4 The Committee will review the Quality Account prior to its presentation to the Board for approval.

4.5 Anti-Fraud

- 4.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that need NHSCFA's standards and shall review the outcomes of work in these areas.
- 4.5.2 With regards to the local Anti-Fraud Specialist it will review, approve and monitor anti fraud work plans, receiving regular updates on anti-fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

4.6 Management

- 4.6.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 4.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews and or accreditation reports).
- 4.6.3 The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year.

4.7 Financial Reporting

- 4.7.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- 4.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- 4.7.3 The Committee shall review the annual report and financial statements before submission to the Board, or on behalf of the Board where appropriate delegated authority is place, focusing particularly on:
- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee

- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

4.8 System for raising concerns

- 4.8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.
- 4.8.2 Review any reported incident of whistleblowing, fraud, corruption or possible breach of ethical standards or legal or statutory requirements that may have a significant impact on the Trust's published financial accounts or reputation.

4.9 Governance regulatory compliance

- 4.9.1 The Committee shall review the organisation's reporting on compliance with the *NHS Code of Governance* and the fit and proper persons test.
- 4.9.2 The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.
- 4.9.3 The Committee shall review, on behalf of the Board, the operation of and proposed changes to the standing orders, standing financial instructions and scheme of delegation.
- 4.9.4 The Committee shall receive a report on, and review, all instances of waivers to standing orders.
- 4.9.5 The Committee shall receive any reports on any non-compliance with standing orders and standing financial instructions and any justification for non-compliance and the circumstances around the non-compliance.
- 4.9.6 Where the Committee considers there is evidence of ultra vires transactions this will be escalated by the Committee Chair to the Board.
- 4.9.7 The Committee will review the schedule of losses and compensations.
- 4.9.8 The Committee will receive any reports on reviewing banking arrangements.

- 4.9.9 The Committee will review schedules of debtors/creditors balances over 6 months old and £5,000 and management plan for these.
- 4.9.10 The Committee will provide assurance in respect of emergency preparedness.
- 4.9.11 The Committee will review an update on information governance arrangements within the Trust and the work of the SIRO.
- 4.9.12 Receive regular cyber security reports, including updates on cyber-related workstreams, risk, controls and other relevant information governance reports.
- 4.9.13 Review the Data Security and Protection Toolkit prior to submission.
- 4.9.14 The Committee will collaborate with other Audit Committees to ensure effective systems of control across the provider collaborative.

4.10 Host Arrangements

- 4.10.1 Where the Trust hosts services the Committee will ensure that there is an appropriate governance and accountability framework in place to manage any risks to the Trust as host. This will include ensuring that there are appropriate risk management, internal control arrangements and reporting in place to manage any risks to the Trust as host, as well as the internal audit arrangements for the hosted service.
- 4.10.2 The Committee will receive an annual report from the hosted service setting out the total remuneration packages of the Directors of the hosted service together with assurance that the correct governance and decision making processes have been followed by the Provider Collaborative Board as the decision making bodies in this matter, before any implementation instructions are delivered to payroll.

5 Membership

- 5.1 The Committee will comprise a membership of four Non-Executive Directors including:
 - Audit Committee Chair, who shall have recent and relevant financial experience
 - [Chairs of Board Committees](#)
- 5.2 The Committee should corporately possess knowledge / skills / experience / understanding of:
 - Accounting;
 - Risk management;
 - Internal / external audit;
 - Technical or specialist issues pertinent to the organisation's business;
 - Experience of managing similar sized organisations;
 - The wider relevant environments in which the organisation operates; and
 - The accountability structures.
- 5.3 Only voting Board members have the right to vote at meetings.

- 5.4 Members are expected to attend at least 75% of meetings.
- 5.5 The Chair of the Trust shall not be a member of the Committee.

6 In attendance

- 6.1 The following will be in regular attendance at meetings:
- Executive Director of Finance
 - Director of Corporate Governance/Company Secretary
 - External Auditors
 - Internal Auditors
 - Anti-Fraud Specialist
 - Associate Director of Quality Governance
 - ~~Assistant Director of Health, Safety and Risk Management~~
 - ~~Deputy Medical Director for Quality Governance~~
- 6.2 Persons identified above as being in regular attendance must identify a deputy to attend on their behalf if they are unable to attend themselves.
- 6.3 The Chief Executive shall be invited to attend the meeting where the Annual Accounts, Annual Report and Annual Governance Statement will be presented.
- 6.4 Other Executive Directors/Managers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.
- 6.5 Persons in attendance will not have voting rights.
- 6.6 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.
- 6.7 At least once a year the committee will meet privately with internal auditors, external auditors and the Anti-Fraud Specialist, without management present.
- 6.8 The Head of Internal Audit, representative of external audit and Anti-Fraud Specialist have a right of direct access to the Committee Chair.

7 Quorum

- 7.1 A quorum will comprise three members.
- 7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.
- 7.4 Associate Non-Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

8 Frequency

- 8.1 The committee will meet at least 6 times per year to conduct its regular business as well as an additional meeting to review the Annual Accounts and Annual Report. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.
- 10.2 The Committee will provide an annual report to the Board on its work in support of the Annual Governance Statement, specifically commenting on the:
- Fitness for purpose of the Board Assurance Framework;
 - Completeness and 'embeddedness' of risk management in the organisation;
 - Effectiveness of governance arrangements;
 - Appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.
- 10.3 The annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
- 10.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

11 Relationship with other Board Committees

- 11.1 The Chairs of the Board Committees will form the membership of the Committee to ensure a direct link to and from the Audit Committee.
- 11.2 Information will flow between the Board Committees via the common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.
- 11.3 Where an external review has significant financial, quality or workforce implications the Committee will refer that matter to the relevant Committee for consideration.

12 Reports from Sub-Committees

- 12.1 The Trust Executive Risk Assurance Group will report to the Committee via a Triple A (Assure, Advise, Alert) Report.

13 Review

- 13.1 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and the Board.
- 13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Date of Board approval:

Date of review:

REMUNERATION AND NOMINATIONS COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) has established a Committee with delegated authority to act on its behalf in determining the remuneration, terms of service and allowances for the Chief Executive and Executive Directors to be known as the Remuneration and Nominations Committee (“the Committee”).
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the [Standing Financial Instructions and Scheme of Reservation and Delegation](#), with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to determine the appropriate remuneration, allowances and terms and conditions of Executive Directors and to succession plan for the Board of Directors.
- 3.2 [The Committee will also consider the remuneration, allowances and terms and conditions of groups of staff who are not on Agenda for Change.](#)
- 3.3 Specifically the Committee will determine:
 - 3.2.1 all aspects of salary (including performance related elements/bonuses);
 - 3.2.2 provisions for other benefits, including pensions and cars;
 - 3.2.3 arrangements for termination of employment and other contractual terms.

4 Responsibilities

- 4.1 To fulfil its purpose the Committee will:

(Remuneration responsibilities)

- 4.1.1 Determine the policy on the remuneration of Executive Directors and Very Senior Managers (VSMs) [or other staff groups](#) not on Agenda for Change. Taking into account pay and employment conditions across the Trust and wider NHS and benchmarking against other Trusts of similar size and complexity;
- 4.1.2 Appoint and set the terms and conditions for any Associate Non-Executive Directors;
- 4.1.3 Agree and oversee, on behalf of the Board, performance of the Chief Executive and Executive Directors;
- 4.1.4 Ensure publication, within the Annual Report, of the total remuneration from NHS sources of all Board Directors;
- 4.1.5 Recommend and monitor the level and structure of remuneration for Very Senior Managers;
- 4.1.6 Approve any non-contractual termination payments to staff in-line with the Trust's Special Severance Pay Policy;

(Nomination Responsibilities)

- 4.1.7 Annually review the structure, size, composition and diversity of the Board and make recommendations for change, where appropriate;
- 4.1.8 Evaluate the balance of skills, knowledge and experience of the Board, and using this evaluation to inform succession planning for the Board;
- 4.1.9 Provide assurance to the Board that there is appropriate succession planning in place for Board Directors, taking into account future challenges, risks and opportunities facing the Trust;
- 4.1.10 Review the description of role and capabilities for any Executive Director appointment;
- 4.1.11 Ensure that the appointment process is designed to attract the best candidates that fully reflect a wide range of backgrounds and the Trust's commitment to equality, diversity and inclusion, and that recruitment processes will consider candidates on merit and against objective criteria;
- 4.1.12 Approve any matters relating to the continuation in office of any Executive Director including the suspension or termination of service of an Executive Director as an employee of the Trust, subject to the provisions of law and their service contract;
- 4.1.13 Approve any temporary or interim arrangements for appointing Executive

Directors;

- 4.1.14 Ensure that the Trust has an appropriate policy in place to check proposed Board appointees and existing Board Directors comply with the requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

5 Membership

- 5.1 The Committee will comprise the following membership:
- Trust Chair
 - All Non-Executive Directors (one of whom shall be Committee Chair)
 - Associate Non-Executive Directors
- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.

6 In Attendance by invitation:

- 6.1 The following will be in attendance at meetings by invitation from the Committee Chair:
- Chief Executive
 - Chief People Officer
 - Director of Corporate Governance/Company Secretary
- 6.2 Persons in attendance may not be present for discussion relating to their own appointment, remuneration, terms of service or other such matters where they have a conflict of interest.
- 6.3 Persons in attendance will not have voting rights.
- 6.4 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

- 7.1 A quorum will comprise four Non-Executive Directors.
- 7.2 In the event that the Committee Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 Associate Non-Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

8 Frequency

- 8.1 The Committee will meet at least four times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair.
- 10.1 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year, providing an overview of the assurances received and making any recommendations to improve the effectiveness of the Committee.

11 Relationship with other Board Committees

- 11.1 The Chair of the Remuneration & Nominations Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee,.

12 Reports from Sub-Committees

- 12.1 The Committee does not have any sub-groups.

13 Review

- 13.1 The Committee shall review its effectiveness on an annual basis, escalating any recommendations for change to the Board.
- 13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Date approved by the Board:

Date of review:

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) is corporate trustee of the charity ELHT & Me. It collectively assumes the legal responsibilities of a Trustee under the Charities Act.
- 1.2 As corporate trustee, the Board has established a Committee with delegated authority to act on its behalf in matters relating to the management, investment and application of Charitable Funds to be known as the Charitable Funds Committee (“the Committee”).
- 1.3 The Committee is accountable to the Board in its capacity as Corporate Trustee of the Charity, and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to ensure that decisions made in relation to charitable funds are clearly distinguished from NHS operational decisions, maintaining the legal separation required by charity legislation.
- 3.2 Specifically the Committee will:
 - provide the Board with assurance that charitable funds are being used in line with the objects of the charity, Charities Commission guidance and donor intent; and
 - Seek assurance that there are robust systems and processes in place to comply with statutory and regulatory requirements for charities.

4 Responsibilities

- 4.1 To fulfil its purpose the Committee will:
 - 4.1.1 Set a corporate strategy for the management of charitable funds;

- 4.1.2 Assure the Trust Board that the policies and procedures for the management and administration of these funds are adequate, effective and observed;
- 4.1.3 Approve the charity's ethical investment policy and ensure that all investment decisions are aligned with this;
- 4.1.4 Review the investments held by the Trust at regular intervals;
- 4.1.5 Approve and review the appointment of those managing investments on behalf of the corporate Trustee;
- 4.1.6 Review the performance of funds on a regular basis and make recommendations to the Board regarding the management and performance of funds;
- 4.1.7 Approve and review the application of funds
- 4.1.8 Ensure fundraising activities are ethical, transparent and compliant with the Fundraising Regulator's Code of Practice;
- 4.1.9 Review and recommend the charity's Annual Report and Annual Accounts for approval by the Board in its capacity as Corporate Trustee; and
- 4.1.10 Review compliance with the UK Charity Governance Code, ensuring remedial action is taken where practice falls short of compliance.

5 Membership

- 5.1 The Committee will comprise the following membership:
 - Three Non-Executive Directors, one of whom shall be chair
 - Executive Director of Finance
 - Chief Nurse
 - Executive Director of Communications & Engagement
- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.
- 5.4 Other Executive Directors may be invited to attend the Committee for specific items.

6 In attendance

- 6.1 The following will be in regular attendance at meetings:
 - Director of Corporate Governance/Company Secretary
 - Charity Manager
 - Deputy Head of Financial Control
 - Divisional Directors of Operations will be invited to attend for any agenda items r
- 6.2 Persons in attendance will not have voting rights.

- 6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

- 7.1 A quorum will comprise three members including at least one Non-Executive Director and one Executive Director.
- 7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.
- 7.4 Associate Non-Executive Directors and non-voting Executive Directors count towards the quorum of the Committee.
- 7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

- 8.1 The committee will meet at least 4 times per year aligned to the reporting schedule of investment managers. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair to provide a summary of its decisions and actions.
- 10.2 The Board as corporate Trustee will approve the Charity's Annual Report and Annual Accounts prior to submission to the Charity Commission.

11 Review

- 11.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.
- 11.2 The Board will formally review the terms of reference for the Committee at least every two years.

Date approved by the Board:

Date for next review:

QUALITY COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to patient and staff safety and clinical governance to be known as the Quality Committee ("the Committee").
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to have grip and control of quality across the Trust to provide assurance or escalate concerns to the Board.
- 3.2 Specifically the Committee will:
 - 3.2.1 Promote and lead the Quality Strategy that strives to ensure delivery of Safe, Effective and Personal care;
 - 3.2.2 Monitor the delivery of any Trust-wide quality and safety metrics and associated performance measures as defined within the Quality Strategy, identifying and understanding any significant variation and ensuring an appropriate response;
 - 3.2.3 Ensure that there are effective structures, processes and controls in place to promote safety and excellent in the standards of care and treatment;
 - 3.2.4 Monitor compliance with CQC standards and other quality related regulatory frameworks; and
 - 3.2.5 Monitor performance in relation to contractual quality schedules including services contracted out to third parties, ensuring compliance with CQC standards and other quality

related regulatory frameworks.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

- 4.1.1 Oversee the production of the Trust's Quality Account in line with national guidance and endorse them for approval by the Trust Board;
- 4.1.2 Ensure that the Trust considers and implements recommendations and guidance from external bodies and national enquiries insofar as they relate to quality and safety;
- 4.1.3 Ensure that appropriate processes are in place to ensure compliance with all standards and guidance issued by regulators, Royal Colleges and other professional and national bodies;
- 4.1.4 Oversee the development and implementation of the Trust's Quality Strategy;
- 4.1.5 Confirm that appropriate action is taken in response to adverse clinical incidents, complaints and litigation, ensuring that lessons are learned across the Trust;
- 4.1.6 Ensure that examples of good practice are disseminated across the Trust;
- 4.1.7 Ensure that the clinical audit forward plan is relevant and comprehensive, and to monitor compliance with the plan;
- 4.1.8 Monitor the Infection Prevention and Control Board Assurance Framework, ensuring robust timely actions are in place to address any areas of weakness;
- 4.1.9 Oversee any relevant programmes within the Trust's Planning Framework;
- 4.1.10 Confirm that a robust system is in place to ensure effective quality impact assessments are undertaken in relation to all waste reduction and financial improvement plans;
- 4.1.11 Receive Chair reports from sub-groups set out below in respect to areas of concern, seeking assurance that robust timely action plans are in place to resolve concerns;
- 4.1.12 Escalate to the Board any significant concerns about standards of care and treatment within the Trust or where it considers any service to be unsafe;
- 4.1.13 Review and gain assurance with respect to the Trust's health and safety obligations being met, ensuring robust timely action plans are in place to address any weaknesses; and
- 4.1.14 Oversee the strategic and operational quality and safety risks assigned to the Committee on the Board Assurance Framework and Corporate Risk Register by:
 - i) Monitoring **at every meeting** the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;
 - ii) Commissioning deep dive reviews for any risk within the Committee's remit;
 - iii) Referring appropriate risk matters to the Audit Committee for their consideration.

5 Membership

- 5.1 The Committee will comprise the following membership:
- Three Non-Executive Directors, one of whom shall be chair
 - Chief Nurse
 - Executive Medical Director
 - Chief Operating Officer
 - Chief Integration Officer
- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.
- 5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.
- 5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6 In Attendance

- 6.1 The following will be in regular attendance at meetings:
- Director of Corporate Governance/Company Secretary
 - [Deputy Director of Nursing](#)
 - [Deputy Director of Finance](#)
 - Associate Director of Quality and Safety
 - [Assistant Director of Nursing \(Corporate\)](#)
 - [Assistant Director of Service Delivery & Improvement](#)
 - Senior Quality Assurance Manager of Lancashire & South Cumbria Integrated Care Board.
- 6.2 Persons in attendance will not have voting rights.
- 6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

- 7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.
- 7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.
- 7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

- 7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

- 8.1 The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.
- 10.2 The Quality Account will be presented to the Board annually.
- 10.3 Quality and safety performance will also be monitored at every Board meeting as part of the Integrated Performance Report.
- 10.4 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

- 11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.
- 11.2 The Chair of the Quality Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee, particularly in relation to any quality and safety related internal audits.
- 11.3 Where a matter relating to quality or safety has a significant financial implication the Committee will refer that matter to the Finance and Performance Committee for consideration.

- 11.4 Where a matter relating to quality or safety has significant workforce implications, particularly in relation to professional staffing reviews relating to nursing, allied health professionals and midwifery services, the Committee refer that matter to the People and Culture Committee for consideration.

12 Reports from Sub-Committees

- 12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

- Trust wide Quality Governance Group
- Patient Safety Group
- Patient Experience Group
- Clinical Effectiveness Group
- Health and Safety Committee
- ~~Executive Risk Assurance Group~~
- Safeguarding Committee
- Hospital Transfusion Committee
- Mortality Steering Group
- Infection Prevention Committee
- Medicines Safety and Optimisation Group

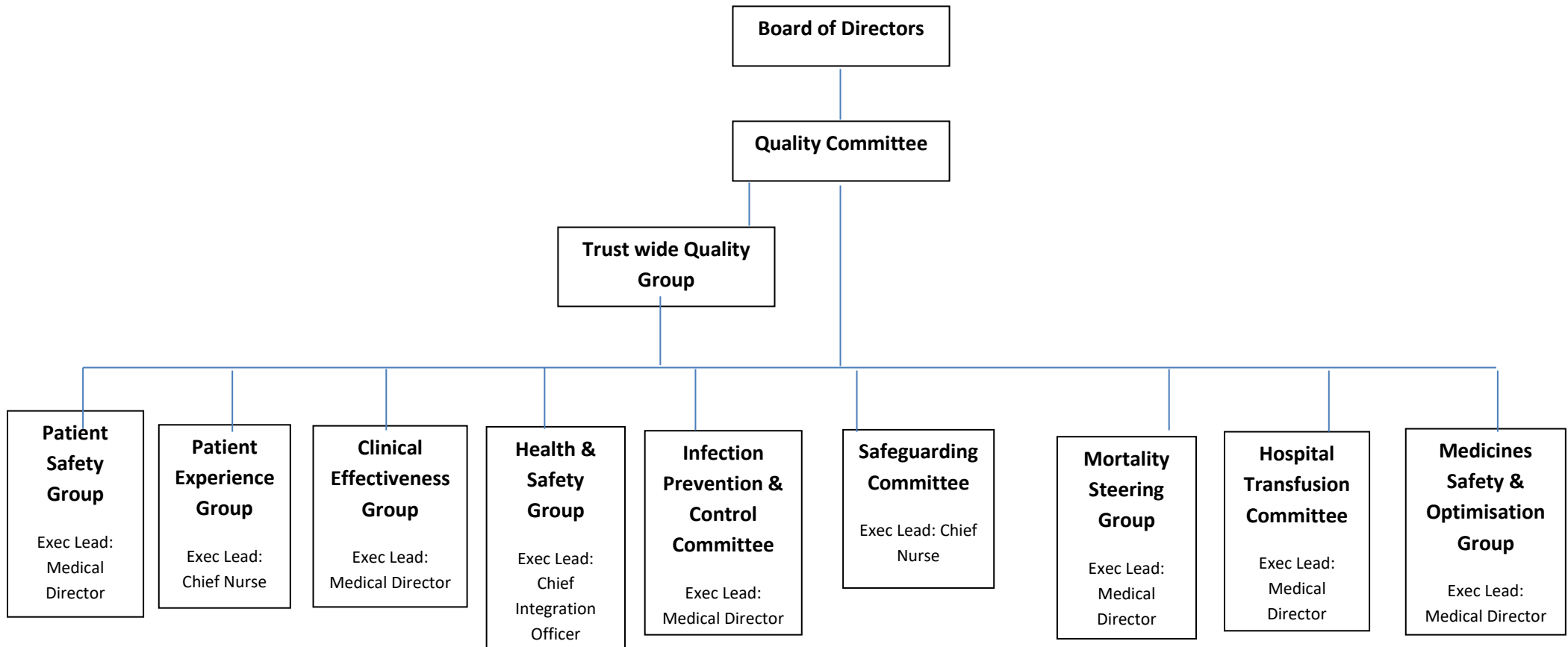
13 Review

- 13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.
- 13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Approved by the Board:

Date of review:

Quality Committee Sub-Committee Structure



Notes:

The Trust Wide Quality Group receives direct reports from the sub-groups for the purpose of improving the assurance and accountability reporting to the Quality Committee.

The Quality Committee may commission reports directly from the sub-groups.

All of the sub-groups may escalate directly to the Quality Committee via Annual Reports and Triple A reporting.

FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) has established a Committee with delegated authority to act on its behalf in matters relating to financial and operational plans to be known as the Finance and Performance Committee (“the Committee”).
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to have grip and control of financial and operational performance to provide assurance or escalate concerns to the Board.
- 3.2 Specifically the Committee will:
 - Provide assurance on the delivery of the financial and operational plans approved by the Board for the current year;
 - Examine exceptions to the achievement of those plans and action taken to correct exceptions;
 - Develop forward plans for subsequent financial years for consideration by the Board; and
 - Examine in detail risks to the achievement of national and local performance and activity standards.

4 Responsibilities

- 4.1 To fulfil its purpose the Committee will:

- 4.1.1 Monitor and oversee the effectiveness of the Trust's planning processes and annual business plan supported by:
- i) reviewing the effectiveness of the Trust's activity planning methodology;
 - ii) overseeing the preparation and negotiation of annual contracts with commissioners;
- 4.1.2 Review the draft annual business plans prior to Board approval and submission to the commissioner/national regulator of the NHS. The Committee has particular responsibility for obtaining assurance on:
- Operational plans
 - Financial plans
 - Cash balances
 - Capital plans
 - Estates and facilities plans
 - Digital plans
- 4.1.3 The Committee will work with People & Culture Committee to consider the workforce plans, particularly from the perspective of the financial impact of these.
- 4.1.4 Review the Trust's annual financial plan and ensure that key assumptions are realistic and explicit;
- 4.1.5 Monitor and review the Trust's performance against national and local standards and activity plans, seeking corrective action and assurance where activity has deviated from plan;
- 4.1.6 Monitor and review procurement effectiveness including the supplier net promote scores;
- 4.1.7 Monitor the Trust's financial performance in relation to use of resources, income and expenditure, and capital expenditure programme seeking corrective action and assurance where performance has deviated from plan;
- 4.1.8 Monitor delivery of waste reduction and improvement programmes (productivity and efficiency savings) seeking assurance on variances from plan and relevant recovery actions;
- 4.1.9 Review the cash flow forecasts, liquidity position and aged debt position of the Trust;
- 4.1.10 Review the PFI contract governance and contract management;
- 4.1.10 Assess the financial implications of performance against the Trust's principal contracts;

- 4.1.11 Assess any proposed borrowing arrangements and make appropriate recommendations to the Board;
- 4.1.12 Provide assurance that operational performance reporting is robust.
- 4.1.13 Oversee and monitor compliance with national oversight framework;
- 4.1.14 Oversee the strategic and operational finance and performance risks assigned to the Committee on the Board Assurance Framework and Corporate Risk Register by:
- i) Monitoring **at every meeting** the effectiveness of the controls and assurances in place, and progress against ~~the agreed risk mitigations~~ **ensuring that they action plans** to address gaps in control and assurance;
 - ii) Commissioning deep drive reviews for any risk within the Committee's remit;
 - iii) Referring appropriate risk matters to the Audit Committee for their consideration; and/or
 - iv) Escalating any concerns regarding financial and operational risks to the Board.
- 4.1.15 Monitor and gain assurance on the Trust's Emergency, Preparedness, Resilience and Response;
- 4.1.16 Oversee the development and deployment of the IM&T Strategy including issues relating to cyber security and digital security risks.
- 4.1.17 Receive and review reports on System, Place and Collaborations as pertaining to the Trust to identify potential impacts and delivery upon wider commitments to system partners.
- 4.1.18 Consider the financial implications of any system wide opportunities and risks and make recommendations to the Board in respect of these.

5 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- ~~Chief Executive~~
- Chief Finance Officer
- Chief Operating Officer
- Executive Director of Service Development and Improvement
- ~~Chief Integration Officer~~
- Chief People Officer

- Chief Nurse

- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.
- 5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.
- 5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6 In attendance

- 6.1 The following will be in regular attendance at meetings:
- Director of Corporate Governance/Company Secretary
 - Deputy Director of Finance
 - Associate Director of Service Development and Improvement
 - Assistant Director of Finance
- 6.2 Persons in attendance will not have voting rights.
- 6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

- 7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.
- 7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.
- 7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.
- 7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

- 8.1 The committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.
- 10.2 Financial performance will also be monitored by every Board meeting as part of the Integrated Performance Report and the Financial Report.
- 10.3 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

- 11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.
- 11.2 The Chair of the Finance and Performance Committee will be a member of the Audit Committee, and the Chair of Audit Committee will be a member of the Finance and Performance Committee, to ensure that there is a direct link between Committees, particularly in relation to any financial and operational performance related internal audits.
- 11.3 Where a financial or operational decision has significant quality or safety implications the Committee will refer that matter to the Quality Committee for consideration.
- 11.4 Where a matter relating to a financial or operational decision has significant workforce implications the Committee will refer that matter to the People and Culture Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

- Finance Oversight Group
- Finance Improvement Group
- Capital Investment Group
- Sustainability Group
- ~~Data and Digital Committee~~
- ~~Information Governance Steering Group~~
- ~~Hosted Services Group~~
- ~~Central Services Executive Committee~~

12.2 In addition to the standing sub-committees the Committee may establish time-limited programme boards for strategic programmes being implemented. Any such programme boards will formally report to the Committee until such time as they are formally stood down.

13 Review

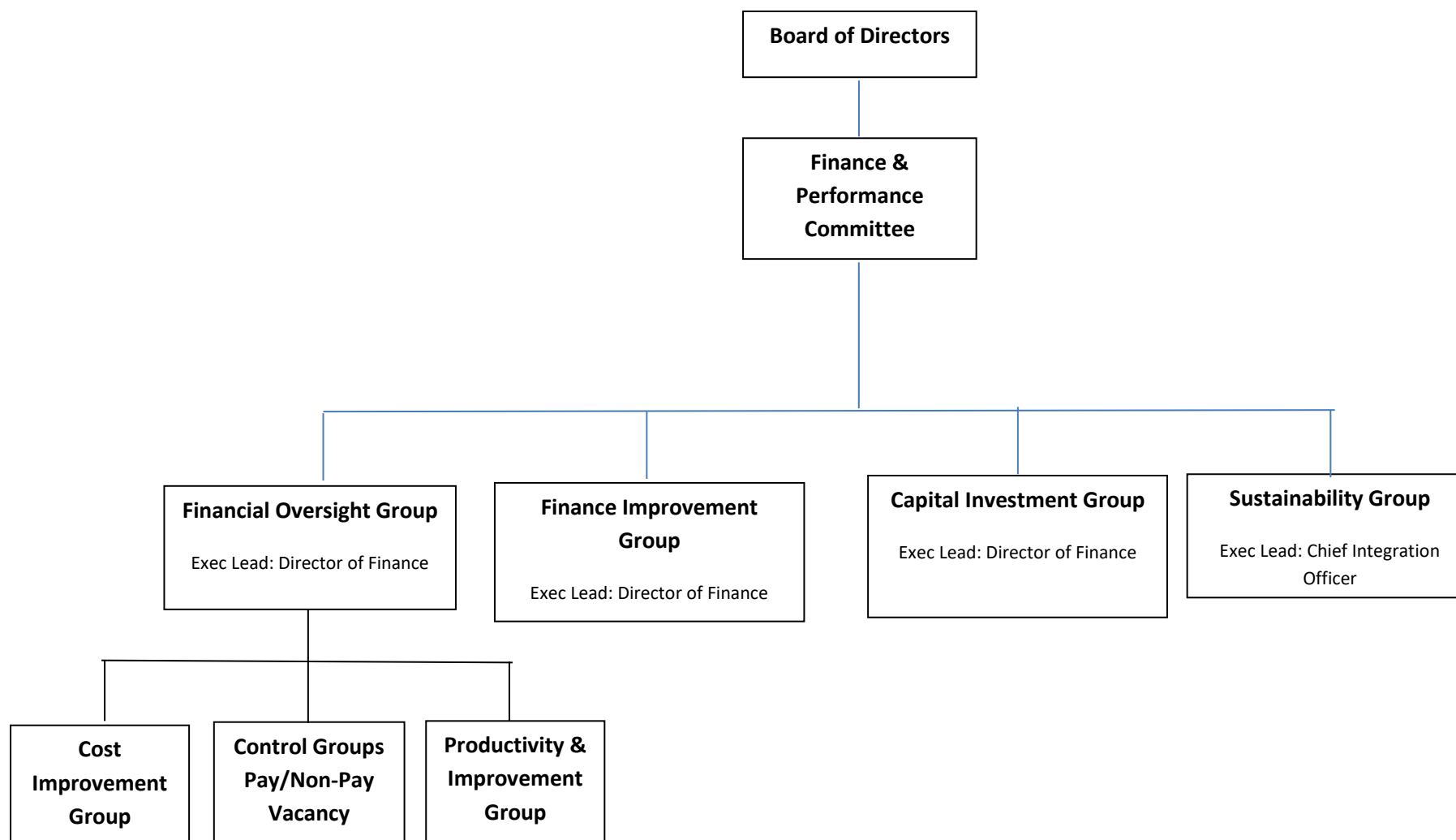
13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Approved by the Board of Directors:

Date of review:

Finance and Performance Committee Sub-Committee Structure



PEOPLE AND CULTURE COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) has established a Committee with delegated authority to act on its behalf in matters relating to workforce, organisational culture, staff safety and governance to be known as the Quality Committee (“the Committee”).
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the [Standing Finance Instructions and Scheme of Reservation and Delegation](#), with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to have grip and control of workforce and organisational development related matters across the Trust to provide assurance or escalate concerns to the Board.
- 3.2 Specifically the Committee will:
 - 3.2.1 Oversee the development and implementation of the Trust’s People Strategy and recommend it to the Board for approval;
 - 3.2.2 Monitor the delivery of any Trust-wide workforce metrics and associated performance measures, identifying and understanding any significant variation and ensuring an appropriate response;
 - 3.2.3 Provide assurance to the Board on the development, implementation and review of the workforce plans in order to support service improvement; and
 - 3.2.4 Monitor workforce aspects of the Annual Plan.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

- 4.1.1 Obtain assurances that the Trust's workforce plan supports the annual objectives of the organisation through the identification of an appropriate workforce model and development plan;
- 4.1.2 Contribute to the development of an effective workforce and organisational development strategy that is aligned to the clinical strategy and financial sustainability of the Trust, and make appropriate recommendations to Board for approval;
- 4.1.3 Receive assurance on behalf of the Board that the Trust's workforce policies satisfy relevant standards and guidance issued by regulators, Royal Colleges and other professional and national bodies;
- 4.1.4 Assuring the Board of compliance with key national and statutory workforce requirements, including the National People Plan, People Promise and NHS HR OD Futures;
- 4.1.5 Monitor performance and data quality of workforce information ensuring action is taken to address underperformance;
- 4.1.6 Receive assurance reports on the results of the NHS Staff Survey and have oversight of the resulting action plan;
- 4.1.7 Receive assurance about staffing safeguards from the Guardian of Safe Working and Freedom to Speak Up Guardian;
- 4.1.8 Promote a culture of open and honest reporting amongst the workforce;
- 4.1.9 Receive assurance regarding the Trust's Equality, Diversity and Inclusion Strategy;
- 4.1.10 Receive Chair reports from sub-groups set out below in respect to areas of concern, seeking assurance that robust timely action plans are in place to resolve concerns;
- 4.1.11 Escalate to the Board any significant concerns about staffing levels or other workforce related aspects within the Trust; and
- 4.1.12 Oversee the strategic and operational workforce risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register [at every meeting](#) by:
 - i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;
 - ii) Commissioning deep drive reviews for any risk within the Committee's remit;
 - iii) Referring appropriate risk matters to the Audit Committee for their consideration.

5 Membership

- 5.1 The Committee will comprise the following membership:
- Three Non-Executive Directors, one of whom shall be chair
 - Chief People Officer
 - Chief Nurse or Executive Medical Director
 - Executive Director of Finance
 - ~~Executive Director of Service Development and Improvement~~
 - Executive Director Communications & Engagement
- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.
- 5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.
- 5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6 In Attendance

- 6.1 The following will be in regular attendance at meetings:
- Director of Corporate Governance
 - Deputy Director of People and Culture
 - Director of Education, Research and Innovation
 - Associate Director of Culture and Belonging
 - Associate Director of Occupational Health, Wellbeing and Engagement
 - Partnership Officer
- 6.2 Persons in attendance will not have voting rights.
- 6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

- 7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.
- 7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.
- 7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.
- 7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

- 7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

- 8.1 The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

- 9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.
- 9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.
- 9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.
- 10.2 Key workforce metrics will also be monitored at every Board meeting as part of the Integrated Performance Report.
- 10.3 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year, providing an overview of the assurances received and making any recommendations to improve the effectiveness of the Committee.

11 Relationship with other Board Committees

- 11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.
- 11.2 The Chair of the People and Culture Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee, particularly in relation to any quality and safety related internal audits.

- 11.3 Where a matter relating to workforce and culture has a significant financial implication, particularly in relation to workforce planning and any headcount reductions, the Committee will refer that matter to the Finance and Performance Committee for consideration.
- 11.4 Where a matter relating to workforce and culture has significant quality implications, particularly in relation to professional staffing reviews relating to nursing, allied health professionals and midwifery services, the Committee refer that matter to the Quality Committee for consideration.

12 Reports from Sub-Committees

- 12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:
- People and Culture Delivery and Governance Group
 - Staff Safety Committee
 - Employee Sponsor Group
 - BAME Oversight Group
 - Joint Negotiating and Consultative Committee
 - Joint Local Negotiating Committee
 - Hosted Services Group

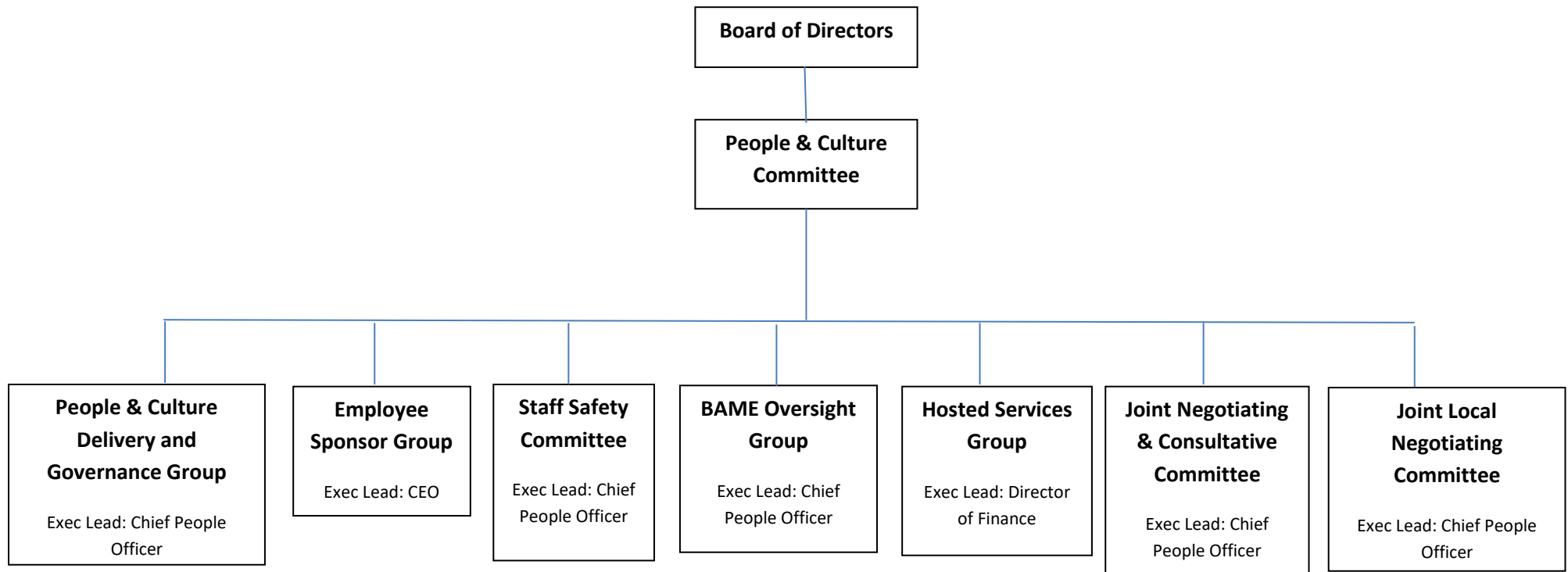
13 Review

- 13.1 The Committee shall review its effectiveness on an annual basis, escalating any recommendations for change to the Board.
- 13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Approved by Trust Board:

Date of review:

People and Culture Sub-Committee Structure



DATA, DIGITAL & TECHNOLOGY COMMITTEE TERMS OF REFERENCE

1 Constitution

- 1.1 The Board of Directors (“the Board”) has established a Committee with delegated authority to act on its behalf in matters relating to the data and digital arrangements of the Trust to be known as the Data, Digital and Technology Committee (“the Committee”).
- 1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - 2.1.1 Investigate any activity within its terms of reference;
 - 2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;
 - 2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and
 - 2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

- 3.1 The primary purpose of this Committee is to provide the Board with assurance as to the digital strategy of the Trust and oversight of data and digital risks.
- 3.2 Specifically the Committee will:
 - Provide strategic oversight and assurance on the development and delivery of the Digital Strategy;
 - Seek assurance that there are robust systems and processes in place to meet statutory and regulatory requirements for data and digital governance, including but not limited to cyber-security and business continuity; and
 - Seek assurance that strategic and operational data and digital risks have been identified and are being proactively mitigated.

4 Responsibilities

- 4.1 To fulfil its purpose the Committee will:
 - 4.1.1 Oversee the Trust’s Digital Strategy and alignment with national, regional and system NHS digital priorities;

- 4.1.2 Approve digital investment proposals and seek assurance of post-implementation benefits realisation;
- 4.1.3 Be assured of the Trust's compliance with data protection, digital clinical safety standards, cybersecurity and interoperability standards and legislation;
- 4.1.4 Review the digital aspects of the draft annual business plans prior to Board approval and submission to the commissioner/national regulator of the NHS.
- 4.1.5 Oversee the strategic and operational data and digital risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:
 - i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;
 - ii) Commissioning deep dive reviews for any risk within the Committee's remit;
 - iii) Referring appropriate risk matters to the Audit Committee for their consideration; and/or
 - iv) Escalating any concerns regarding financial and operational risks to the Board.
- 4.1.6 Monitor and gain assurance on the Trust's Digital Emergency, Preparedness, Resilience and Response;
- 4.1.7 Consider the digital implications of any system wide opportunities and risks and make recommendations to the Board in respect of these.

5 Membership

- 5.1 The Committee will comprise the following membership:
 - Three Non-Executive Directors, one of whom shall be chair
 - Chief Integration Officer (SIRO)
 - Medical Director (Caldicott Guardian)
 - Chief People Officer
 - [Executive Director of Service Improvement and Development](#)
- 5.2 Only voting Board members have the right to vote at meetings.
- 5.3 Members are expected to attend at least 75% of meetings.
- 5.4 Other Executive Directors may be invited to attend the Committee for specific items.

6 In attendance

- 6.1 The following will be in regular attendance at meetings:
 - Director of Corporate Governance/Company Secretary
 - Director of Digital, Data & Technology OneLSC
 - Chief Information Officer

- Chief Clinical Information Officer
- Chief Nursing/AHP Information Officer
- Data Protection Officer

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

8.1 The committee will meet at least 6 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

- 10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.
- 10.2 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

- 11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.
- 11.3 Where a decision of the Committee has significant financial, workforce or quality implication the Committee will refer that matter to the relevant Board Committee for consideration.

12 Reports from Sub-Committees

- 12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:
 - Data and Digital Group
 - Information Governance Steering Group
- 12.2 In addition to the standing sub-committees the Committee may establish time-limited programme boards for strategic programmes being implemented. Any such programme boards will formally report to the Committee until such time as they are formally stood down.

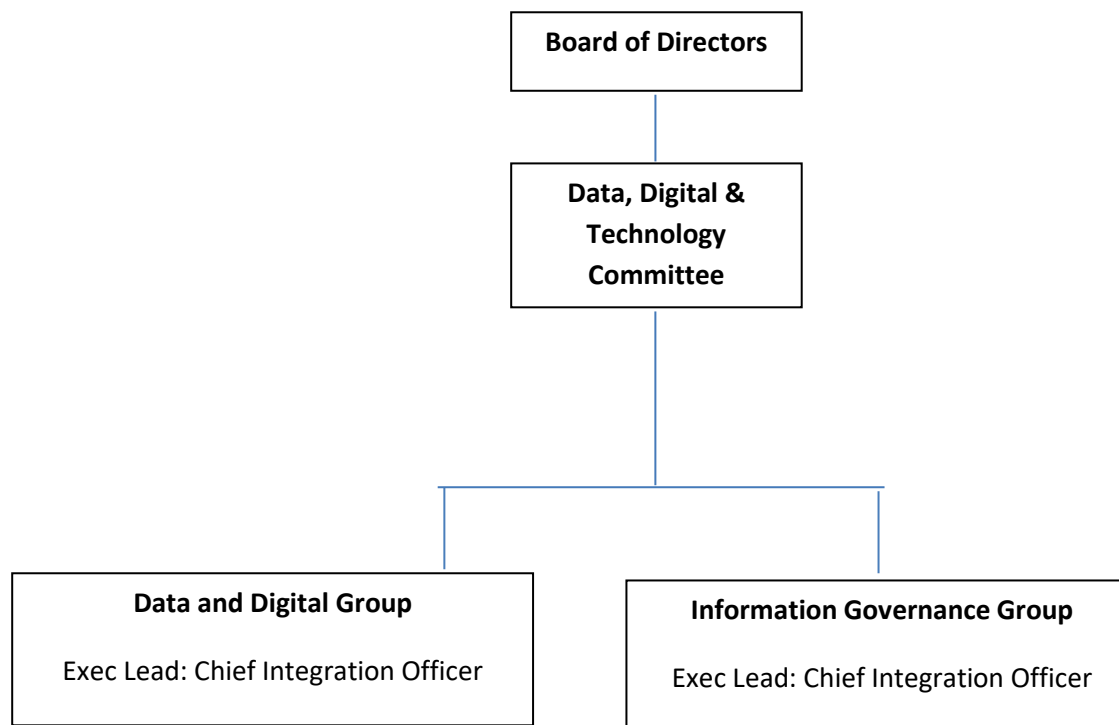
13 Review

- 13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.
- 13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Approved by the Board:

To be reviewed:

Data, Digital and Technology Committee Sub-Committee Structure



BOARD OF DIRECTORS

Meeting Date:	13 May 2026	Agenda Item:	TB/2026/067
Report Title:	Audit Committee Annual Report		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Liz Sedgley Chair of Audit Committee		

Purpose of Report:	To Assure	To Advise/ Alert	For Decision	For Information
	✓			
Executive Summary:	The NHS Audit Committee Handbook recommends that the Audit Committee produces an Annual Report for the Board, in support of the Annual Governance Statement, on how it has met its terms of reference over the previous year, highlighting the significant matters that it has discussed.			
Key Issues/Areas of Concern:	During 2026/27 the Committee will focus upon: - Ensuring timely follow up of MIAA recommendations, particularly those from previous years; - Improving the effectiveness of risk management; and - Use of clinical audit to provide internal assurance.			
Action Required by the Board:	The Board is asked to note the report and be assured that the Audit Committee has operated effectively in 2025/26.			

Previously Considered by:	
Date:	
Outcome:	

Audit Committee Annual Report

1 April 2025 to 31 March 2026

This report covers the work of the Audit Committee for the financial year 1st April 2025 to 31st March 2026.

1 Introduction

The Audit Committee (“the Committee”) provides an independent and objective review of the system of internal control. It seeks high-level assurance on the effective of the Trust’s governance framework (clinical and corporate) and reports to the Board on the level of assurance received.

The Committee receives assurance from management and validates the information it receives through the work of internal and external audit and anti-fraud. The Committee has decided that our external auditors will not be used for non-audit work, thereby ensuring their independence is maintained.

The Audit Committee is made up of five non-executive directors, this includes the Chairs of the other Board Committees. In line with the NHSE Code of Governance for the Providers, the Chair of the Trust is not a substantive member of the Committee but is invited to attend one meeting during the financial year.

The Executive Director of Finance and Director of Corporate Governance attend the Audit Committee to support the work of the Committee.

2 Terms of Reference for the Committee

In April 2025 the Committee reviewed its Terms of Reference and made some minor amendments to ensure alignment with the hfma NHS Audit Committee Handbook (“the hfma Handbook”). Committee membership was also strengthened to include all the Committee Chairs to strengthen oversight. In October 2025, following an external financial governance review, the Terms of Reference were further amended to ensure that that the Assistant Director of Risk and Clinical lead for Risk were in regular attendance and to formalise the reporting from the Executive Risk Assurance Group into the Committee.

3 Effectiveness of the Committee

At the end of 2025/26 the Committee commenced a review of its effectiveness utilising the effectiveness checklists in the hfma Handbook. The results will be collated and presented to the June 2026 Audit Committee meeting. The review of the processes underpinning the work of the Audit Committee has identified the following areas for improvement:

- Executive Directors to attend to speak to limited assurance reports;
- An Annual Audit Committee Report to be provided to the Board;
- Continued focus on the timeliness of papers;
- An increased focus on improving the effectiveness of the risk management framework;

- Ensuring that there is sufficient oversight of compliance with regulatory requirements across the Committees;
- Seeking assurance from management on the timely implementation of recommendations from internal audit reviews;
- Receiving sufficient assurance on data quality;
- Assurance received from the clinical audit function; and
- Ensuring lessons are learned from Anti-Fraud investigations.

Throughout 2025/26 the Audit Committee was observed by an external consultancy specialising in financial governance as well as members of the NHS England Recovery Support Programme. They noted that the Committee Terms of Reference follow best practice and the work of the Committee is distinctly focused on oversight to ensure effective controls, systems and processes. Agendas were noted to be clear, allowing sufficient time for challenge and discussion. Representation of risk management (including clinical) was noted to be an area for improvement, which was addressed in the October review of the Terms of Reference.

4 Attendance at meetings of the Audit Committee

The Committee met six times during the year. For a meeting to be considered quorate three Non-Executive Directors must be in attendance. All meetings held in 2025/26 were quorate.

		Apr 25	Jun 25	Jul 25	Oct 25	Nov 25	Jan 26
Mr K Rehman	100%	✓	✓	✓	✓	✓	✓
Professor G Baldwin	100%	✓	✓	✓	✓	✓	
Mrs L Sedgley	100%	✓	✓	✓	✓	✓	✓
Mr S Featherstone	100%		✓	✓	✓	✓	✓
Mrs S Bridgen	60%		A	✓	✓	✓	A

The Executive Director of Finance and Interim Director of Corporate Governance were in regular attendance, with invitations extended to members of the Executive Team and senior managers to present assurance papers as required. In addition, the Chief Executive attended the June 2025 to present the Annual Governance Statement, Annual Report and Annual Accounts.

In addition, the Chair of the Audit Committee is a member of the Lancashire and South Cumbria Audit Chairs Forum and provided regular feedback from those meetings.

5 Reports to the Board

The Chair of the Committee regularly reported to the Board via an Assure, Advise and Alert report to the next available Board meeting. This report provided assurance to the Board but also escalated areas of concern. During the year the Committee advised the Board on several areas of concern and kept the Board abreast of steps being taken to improve the system of internal control.

6 The work of the Committee during 2025/26

At the start of the year the Committee set its workplan, aligned to the example agenda and timetable set out in the HFMA Handbook. The Committee also approved the work plans for internal audit and the Anti-Fraud service. It received and reviewed regular progress reports and concluding annual reports from internal and external audit and the anti-fraud team. This allowed the Committee to determine its level of assurance in respect of the organisation's internal controls.

A summary of the areas of work on which the Committee received assurance during 2025/26 are set out below:

Risk Management:

At the October 2025 meeting the Committee approved the new Risk Management Strategy and Framework for the Trust and recommended it for approval by the Board.

Board Assurance Framework:

The Committee received the Board Assurance Framework at the April 2025, October 2025 and January 2026 meetings. It was assured on both the content and that it was fit for purpose. At the October 2025 meeting the Committee approved a new BAF format for 2026/27.

The Committee will receive the internal audit review at the Board Assurance Framework at the April 2026 meeting.

Annual Report and Accounts for 2024/25:

The Annual Report and Accounts for 2024/25 were approved, via delegated authority from the Board, at the June 2025 meeting.

The Head of Internal Audit Opinion and Annual Governance Statement were reviewed and found to be consistent. It was agreed that the Annual Governance Statement presented a correct view of the system of internal control and should be incorporated into the Annual Report 2024/25.

Internal Audit:

The Committee received assurance that internal audit complied with the internal audit charter at the April 2025 meeting.

In June 2025 the Committee approved the Internal Audit Annual Plan for 2025/26. Throughout the year the Committee received progress reports at every scheduled meeting.

In cases where limited assurance reports were received, the Executive Director for that area was invited to present a verbal assurance update to the Committee. In addition during 2025/26 all

internal audit reports, and associated action plans, were presented to the lead Assurance Committee.

Whilst the Head of Internal Audit Opinion remained 'limited' for 2025/26 it was noted that significant improvements had been made in strengthening governance and leadership. It was also recognised that towards the latter end of the year the Trust received several 'moderate' and 'significant' assurance reports.

The need for timely implementation of recommendations remains an area of focus for the Committee.

External Audit:

At the July 2025 meeting the Committee reviewed the Auditors Annual Report noting the value for money opinion and significant weaknesses identified.

Regular update reports were received about the work of the auditors, as well as changes within the accounting regime and the health sector which would impact upon the Trust.

Anti-Fraud:

In April 2025 the Committee approved the Anti-Fraud Workplan for 2025/26. At the same meeting the Committee also received and was assured by the contents of the Anti-Fraud Annual Report for 2024/25. It was noted that the Trust had been rated green overall for its Anti-Fraud Functional Standard Return.

The Committee received regular Local Anti-Fraud Progress Reports at each of its scheduled meetings including an overview of progress of individual cases on anti-fraud. Assurances were provided about the processes in place to tackle fraud and bribery.

During the year Committee members, as well as other Board members, attended a webinar on the new failure to prevent fraud legislation and approved a number of policy changes to ensure that the Trust was compliant with the new legislative requirements.

Management Action Plans:

The Committee oversaw the implementation of a new internal process for tracking management action plans in response to internal audit reviews. The Committee formalised the reporting structure for the Executive Risk Assurance Group, which has oversight of internal audit outstanding actions.

Governance:

The Committee had oversight of the Leadership and Governance Action Plan and Grip and Control Action Plan linked to the Trust's compliance with the NHSE Legal Undertakings. In October 2025 the Committee received a report demonstrating compliance with the NHSE Code of Governance for Provider Trusts.

Tender and Quotation Exception Reports:

Assurance was received on the reasons for Tender and Quotation procedures being waived during 2025/26.

7 Conclusion

As the primary governance committee of the Board, the Audit Committee has preserved its independence from operational management by comprising a solely Non-Executive Director membership and meeting privately with internal and external audit and anti-fraud throughout the year.

The Committee fulfilled its work programme for 2025/26. It took key assurances from internal and external audit and in turn provided assurance to the Board.

The Chair of the Committee considers that the Committee has fulfilled its role as the Board's senior governance committee and has advised the Board on the adequacy and effective operation of the organisation's internal control systems.

Members of the Audit Committee would like to thank all those who have supported it in carrying out its duties and responding to requests throughout the year.



Liz Sedgley

Chair of Audit Committee

Committee Escalation Report

Name of Committee:	Audit Committee	Report to:	Trust Board
Date of Meeting:	13 April 2026	Date of next meeting:	June 2026 (TBC following discussion with External Audit)
Chair:	Liz Sedgley	Quorate: (Y/N)	Y

Introduction

Alert

What	So What	What Next
1. Implementation and follow up of Internal Audit Reports	1. The Trust has a significant number of items outstanding going back to 22/23 and 12 critical and high risk items relating to the 24/25 audit plan .This is having a negative impact on the HOIA Opinion and areas of weakness previously identified have not been corrected.	1 A paper will be taken to Execs outlining the issues and the steps needed to address the backlog .
2. No assurance given on the Theatres Stock Accounting treatment	2. The audit highlighted a lack of understanding and awareness by various teams working in theatres on how the automated system operated leading to an overstatement of the theatres stock valuation in previous years	2. Management have responded to the findings and a number of immediate actions have been taken to address the weaknesses highlighted . The exec team has been requested to review other automated stock systems within the Trust to ensure similar issues do not exist in other areas . The medical director is reviewing this and other limited assurance reports - LOCSIPS/NATSIPS and reporting back to the April Quality Committee on the effect of these on safety within Theatres.
3. Limited assurance on Health & Safety Procedures	3. Weaknesses in health and safety controls increase the risk of preventable harm to staff and patients and reduce operational resilience. Compliance failures expose the Trust to significant regulatory breaches.	3. An action plan has been developed to address the weaknesses identified and regular reports on progress will be brought back to Audit committee throughout 26/27.
4. Limited Assurance on Absence Management	4. No management response or action plan was presented on this limited assurance report, which was received at the end of January.	4. The People & Culture Committee will be asked to follow this up at the next meeting

Committee Escalation Report

Advise		
What	So What	What Next
1. The Internal Audit Plan for 26/27 2. Modern Slavery Statement	1. The plan for 26/27 was approved by the committee. 2. The Modern Slavery Statement for 25/26 was presented and approved by the committee	1. The areas selected for testing in Qter1 will start and should allow for more time to implement recommendations and carry out follow ups which should have a positive influence on the HOIA Opinion for 26/27 2. The Statement will be signed and published on the Trust's website
Assurance		
What	So What	What Next
1. Counter Fraud Report for 25/26 2. Review of Debtors and Creditors 3. Waivers Report	1. The assurance rating for GFS 013 was green for 25/26 2. A review of debtors and creditors at Mth11 was presented and demonstrated that the balances are correctly reported and systems and processes to identify and collect balances are working well 3. The report showed good performance across the Trust ensuring that waivers are kept to a minimum	1. The report will be submitted online and there is a plan to address the two amber areas to ensure complete compliance in 26/27 2. Regular reviews of debtors and creditor balances will continue to be presented to the committee in 26/27 3. Ongoing training and refinement of processes will continue to support good practice in this area in 26/27
Outcome of Board Assurance Framework Discussion: The Committee noted the year end position of the BAF. MIAA have recently completed their review of the Assurance Framework and found that the BAF is structured in line with best practice, the organisation regularly reviews risk appetite, which is used to inform the BAF, and the BAF clearly reflects the risks discussed by the Board. However, there could be greater visibility of the use of the BAF by the organisation. 9 recommendations were made by MIAA and the Committee received an action plan to address these. 3 recommendations have already been completed, the remaining 6 are on track for completion. 2 recommendations particularly relevant to Board and committees are to ensure that there is sufficient focus on actions to mitigate the risk and reduce the score over the year, and that Triple A reports to Board clearly articulate the discussion of the BAF.		
Other agenda items		

Committee Escalation Report

Name of Committee:	Quality Committee	Report to:	Trust Board
Date of Meeting:	27 March 2026	Date of next meeting:	29 April 2026
Chair:	Simon Featherstone	Quorate: (Y/N)	Y

Introduction

Alert

What	So What	What Next
1. HTA inspection CAPA action plan update.	- The committee received the monthly update report on the corrective actions in the Mortuary following the HTA inspection in 2025. - The report included additional actions following the HTA re-visit in February 2026 and provided assurance that all actions were being addressed. - The committee were made aware of the importance of the Mortuary refit, due to take place in Summer 2026, which will address a number of key outstanding actions in the CAPA plan. - It was reported that this issue forms the most significant risk relating to the corrective action plan, and that if the refit of the mortuary was not completed to timeline in Summer 2026 it would result in the organisation being unable to achieve HTA compliance within 12 months. This would risk removal of the mortuary licence leaving us unable to store bodies as	- The Chair of Quality Committee will ensure that Finance and Performance Committee are sighted on the risks relating to the Mortuary refit. - Quality committee will continue to receive monthly updates on the progress of the required actions in the Mortuary and provide an update to trust Board as required.

Committee Escalation Report

2. The committee received a report through the Mortality review group AAA that there had been three unexpected deaths in paediatrics which were being reviewed for any possible linkages.	well as the ongoing restriction on the licence to undertake post-mortem activity. - The committee chair will raise these concerns with the chair of Finance and Performance for discussion at Finance and Performance Committee. - The committee heard from the chair of the mortality review group that an investigation had taken place to determine whether there were any linkages between the three deaths. Assurance was provided by chair of mortality steering group that there were no linkages between the deaths – they were all unrelated in different directorates with no common factors. Lessons learned from all three deaths will be pulled out via the mortality SJR process and disseminated	

Assurance

What	So What	What Next
1. Emergency department regulation 28 update	- The committee received a report relating to the required actions following the issuing of a regulation 28 report by HM Coroner. - The committee were assured that all actions were being addressed, with clear timelines and ownership of all actions.	Ongoing monitoring of the required actions will be through TWQG B with flags to Quality Committee as appropriate.

Advise

What	So What	What Next
1. Pneumonia improvement plan – mortality update	Following previous data presentation that indicated the Trust was an outlier in terms of respiratory mortality rates, the committee received a report which outlined our current position and set out a clear plan for improved	Update in 3 months with ongoing reporting through Quality Committee

2. UEC improvement plan workstream	compliance with the community-acquired pneumonia (CAP) care bundle. • The committee heard that the Dr Foster data relating to pneumonia standardised mortality (January 2025 – December 2025) indicated that there were 2167 spells, with 335 deaths against an expected 263, giving a relative risk of 127.5. The paper additionally indicated that the Trust has the highest length of stay for CAP in the region. • It was noted that concerns remain relating to data, however it was felt important to provide assurance that the committee be assured that pneumonia care at the Trust represents best practice. • The paper outlined current Trust performance against the four elements of the CAP bundle and it was demonstrated that performance required improvement. To this end, the paper set out a clear set of actions for improvement, with clear targets, timelines and ownership. • The committee received a paper outlining the work in progress for improving performance across the UEC pathway and for eliminating corridor care by 13 December 2026. • The paper provided a helpful current position of the organisation, identified clear and appropriate metrics and provided a clear plan for improvement, with measurable metrics and clear timelines for improvement.	• The committee will receive quarterly updates on progress against the plan and will provide updates to Board as appropriate. • Given the cross-cutting nature of the work, it was agreed that reports should also be presented at Finance & Performance and People & Culture sub-board committees.

Committee Escalation Report

3. Health & Safety update	• The committee received the regular, quarterly Health & Safety update paper. The paper provided a helpful presentation of the current position with key risks identified, and a series of recommendations. • Following discussion it was agreed that the report needed to be presented to the Executive Team for consideration, with a subsequent feed-through to quality committee for assurance purposes once a clear action plan has been developed.	• The committee will continue to receive quarterly update papers relating to Health & Safety.
Other agenda items: Nursing Professional Judgement Nurse Staffing Exception Report QIRA Summary Report PSIRF Report Deferred items: Theatre Safety Update – no presenter available Quarterly Cancer Report – paper not received		

Committee Escalation Report

Name of Committee:	Quality Committee	Report to:	Trust Board
Date of Meeting:	29 April 2026	Date of next meeting:	27 May 2026
Chair:	Simon Featherstone	Quorate: (Y/N)	Y

Introduction

Alert

What	So What	What Next
1. Concerns around infections prevention and control processes and performance	Whilst the IPR infection prevention control indicators are showing performance in line with expected outcomes for C.difficile and MRSA etc, a number of concerns were raised relating to infection prevention and control processes and performance within the organisation - Poor performance in relation to NHS National Standards of Healthcare Cleanliness 2025. - Significant vacancies in the E&F cleaning team of c. 60 wte, with high sickness levels (c. 30%) amongst the existing workforce. - Increased risk of healthcare associated infection and regulatory non-compliance; reputational risk reinforced by invited NHSE neonatal visit highlighting sink cleanliness concerns. - Significant capacity issues within the Trust's IPC team impacting on their ability to undertake audit and key training roles. - IPC team currently operating on a business continuity plan.	- The committee has requested an increase in the current annual reporting schedule for IPC. - Quarterly IPC reporting to include IPC BAF presentation. - Flag to People and Culture committee relating to vacancies and sickness levels within the E&F cleaning workforce. All vacancies should be processed without delay to enable recruitment to the Patient Services team. - IPC team will work with the Patient Services Team to target specific high-risk areas. - Business case being produced to address potential IPC team capacity. - IPC Annual Report to be presented to May Quality Committee along with the IPC BAF.

Committee Escalation Report

2. Venous Thrombo-Embolicism (VTE) performance within the organisation 3. Backlog of glaucoma cases	• Previous report to Quality Committee indicated poor performance in relation to anti-microbial stewardship. • Annual IPC report and IPC BAF currently delayed and therefore unable to be presented to Quality Committee. • Performance with VTE assessment is good (>93%), however VTE prophylaxis audit demonstrated poor compliance: 56% compliance with prescribing standards within 14 hours of admission and correct dosing per Trust guidance (103 patients audited across medical and surgical wards) • Risk of preventable harm from missed/late prophylaxis; gap between timely risk assessment and corresponding prescribing actions. • The presentation of the Patient Safety Incident Response Framework (PSIRF) report highlighted concerns regarding harm to patients within the glaucoma service. • The glaucoma service has staffing issues specifically consultant cover. A business case has been progressed through Finance & Performance committee for an additional substantial consultant, however there remains a significant backlog of cases, with the service currently closed to new referrals.	• VTE Committee to review findings and agree improvement actions; re-audit planned after actions. • Report to come to Quality Committee via TWQG B. • Quality Committee will receive a full paper outlining harm to patients and all mitigating actions. • Mutual aid has been requested in the NW region, with no offer of assistance. • The service are seeking support form agency locum staff.

4. Mortuary services improvement action plan	• Reported harm to glaucoma patients indicates 18 patients have currently experienced harm at a Moderate or Severe level, due to prolonged wait times for intervention. • The committee received its monthly update on the corrective actions following the recent HTA inspections. • The committee received moderate assurance that the actions are being progressed in a timely manner. • The key risk remains around the date of the refurbishment of the mortuary site at Royal Blackburn hospital. The work will address key issues around the long-term storage capacity for bodies as well as the safe storage of bariatric bodies. • The Estates & Facilities Capital Plan was presented at Finance & Performance committee in April, which indicated that funds had been allocated for the project and the committee heard that the work would be done in line with the requirements of the action plan, however it was reported at Quality committee that there was a potential three months' delay to the work being undertaken. • Any delay in the work being undertaken risks action by the HTA, up to and including the removal of the mortuary licence to store bodies as well as risking reputational damage with HM Coroner with ongoing delays to reinstating post-mortem examination in the facility.	• The committee will receive monthly reports on the mortuary action plan. • The chair of the committee will write to the Chief Executive Officer and the Finance Director to seek clarity on the timings of the mortuary refurbishment work.

Committee Escalation Report

Advise		
What	So What	What Next
1. Trust Mortality 2. The draft Quality Accounts were presented to the committee. 3. Following a series of MIAA reports relating to theatres which provided limited or no assurance and two never events linked to retained swabs, Quality Committee asked for a paper to be presented providing assurance around theatre safety.	- The committee received the latest in a series of papers aimed at providing a clearer position of the Trust's position in relation to mortality. - The papers were triggered due to the inability to gain assurance from the SHMI data for the organisation. - The paper provided an overview of condition specific SHMI and compliance with related care bundles. - The draft Quality Accounts were presented to the committee and discussed. It was agreed that any comments on changes or additions should be communicated to the Chief Nurse by 5 May, to enable presentation to Trust Board in May. - Quality Committee received a comprehensive paper which aimed to provide assurance around safety and the safety culture in theatres. - The paper provided responses to the MIAA audits and provided assurance that the findings were accepted by the service and that actions were underway to address the key findings.	- The Medical Director has agreed to provide a composite paper which brings together the findings of all separate papers and to suggest a number of additional metrics that can be presented at Quality Committee to provide ongoing and improved assurance around mortality within the organisation. - A follow-up paper will be presented to Quality Committee in August 2026, once the actions around the MIAA audits are more progressed and following a further review of the safety culture in theatres.

Committee Escalation Report

4. Revisions to the Board Assurance Framework were discussed as related to Quality Committee business.	- The report also provided significant data relating to compliance with mandatory national audits: - National Emergency Laparotomy Audit - National Joint Register - National Major Trauma Registry - National Hip Fracture Database - The committee recognised the work that had gone into preparing the papers and recognised the moderate assurance the data showed, however felt there was insufficient information on the safety culture operating within theatres and has requested a follow-up paper which addresses the issue of Work as Done versus Work as Reported. - All proposed changes were agreed by the committee following discussion and minor alterations.	
Assurance		
What	So What	What Next
Outcome of Board Assurance Framework Discussion: The Committee reviewed the draft Risk Appetite Statement and requested that the context makes clear that Board considers strategic decisions on a case by case basis with the risk appetite being a guide rather than prescriptive. The Committee endorsed the wording of the BAF risks 2 (quality) and 3 (performance) for 2026/27.		
Other agenda items: UEC Update		

Committee Escalation Report

New Trust Strategy – Quality Domain
Maternity and Neonatal Services Report

Committee Escalation Report

Name of Committee:	Finance and Performance	Report to:	Trust Board
Date of Meeting:	30.03.2026	Date of next meeting:	27 APRIL 2026
Chair:	Liz Sedgley	Quorate: (Y/N)	Y

Introduction

Alert

What	So What	What Next
The Committee received the Finance Report for Month 11. The Trust is reporting an in-month surplus of £0.6m, against a planned deficit of £2.52m; £3.12m ahead of plan. The year-to-date (YTD) position is a £53.6m deficit against a planned deficit of £41.3m; £12.32 behind plan (excluding the DSF). In month WRP delivered £3.8m against the WRP Delivery plan, therefore £2.6m adverse to plan (£2.4m adverse to PFR plan) The WRP has delivered £37.7m YTD against a plan of £54.4m; £16.1m behind the WRP Delivery plan. (£16.7m adverse to the PFR plan) Agency spend of £337k, is £172k better than plan and represents a 61% reduction on 2024/25 run rate. Bank spend of £3,310m is £236k better than plan, this represents a 27% reduction on 2024/25 run rate. The cash balance at the end of February was £18.2m, an increase of £4.4m compared to M10. The annual 2025-26 capital plan is £43.3m, YTD spend is £25m, £10m ahead of plan. Paid WTE have increased by 45 WTE from Month 10 to 9,655. The Committee received an update on the Waste Reduction Programme:	Considerable progress has been made in delivering efficiencies and grip and control. While there is ongoing work to do, the Committee commended the team and thanked them for all their hard work getting us to this point. Risks remain around: • full delivery of the Waste Reduction Programme of £60.8m on a recurrent basis. • The finalised impact of the HCA review of banding inclusive of the associated timescales for both cash and revenue. • The financial impact of any further industrial action. • The finalised impact of the stock usage in theatres and the associated implications to the in-year position. Work is underway to develop clear plans with robust documentation.	Ongoing focus to deliver best possible position for M12. An update will be provided after the Finance Improvement Group on 27th March.

Committee Escalation Report

• M11 delivered £3.8m versus and an internal reforecast plan of £4.2m. • YTD £37.7m delivered compared to a reprofiled target of £53.9m, £16.3m adverse to plan YTD. • The WRP programme is forecast to outturn at £42.3m A final WRP Plan 2026/27 has been submitted with a savings requirement for the Trust of £31.5m (3.3%) in 2026/27. The Committee were updated on progress against our Grip and Control actions. The report from the Corporate Risk Register highlighted a growing number of subject access requests The cash position is still very tight despite the receipt of the PDC funding Planned Industrial Action by resident doctors	There is a risk that not all schemes will be at fully developed by 31st March and so a plan for ongoing development has been set out alongside work to assure delivery of the M1 target. While the Trust is in a stronger position than last year, the Committee recognised the ongoing challenges around developing and delivering the plan. This is taking up considerable resource and carries a potential reputational risk The Trust is currently holding back £26m of payments, priority is given to small independent businesses so as not to cause undue financial distress to them This action will add both financial and performance pressures .	The CPO is carrying out a review and this will be monitored via the People Committee Cash is monitored daily and a rolling cash forecast is regularly updated and reported to the committee Action plans will be in place to ensure patient safety is maintained.
Advise		
What The Committee received a report on the final planning submission to NHSE. The committee were assured that it has been updated to reflect more up to date workforce and financial information from exit run rate and finalised contract offers.	So What The Plan will steer our work in 26/27.	What Next The new strategy development is on track for presentation to Board, and a final workshop with and stakeholders planned for 30th March. A draft strategy will be presented to April's F&P Committee prior to Trust Board

Committee Escalation Report

The Committee received an update on the ROSE WRP system and considered a recommendation regarding the appropriate level of user access and permissions across organisations participating in the platform. The committee In principle agreed with the recommended option. The Committee received a due diligence report on the transfer of pathology services to LHT (as agreed by Trust Board). Within the due diligence process, key segments of the transfer have been reviewed (finance, contracts, quality and safety etc) to ensure that all key tasks and risks had been identified and either finalised or progressed sufficiently ready for a safe and successful transfer. Stage 1 of the financial transfer covers direct costs and staff only. Stage 2 will cover assets, income, contracts and overhead costs and will follow once Stage 1 is embedded.	This system is intended to enhance reporting and facilitate collaboration. The update had not yet been reviewed by executives. • ELHT's role changes from provider to client from 1 April. The Pathology Services Agreement provides the contractual mechanism for ELHT to hold LTH to account on performance, quality and service standards. • Realisation of the financial savings opportunity estimated at between £1 million and £6.5 million per annum is dependent on the transform phase.	The Committee requested that further work is undertaken at executive level to ensure the system is ready for implementation. ELHT has a weekly transfer operational group through which key actions are being tracked and progressed in preparation for transfer to provide additional assurance and this is led by the Director of Service Development and Improvement, ELHT Executive lead for the transfer.

Assurance

What	So What	What Next
The Committee received an updated BAF and CRR. The Committee discussed issues around Access Requests, Trust Cash Position and Planned Industrial Action. The Committee received the IPR. Performance in February shows improving operational flow but persistent pressure in key areas. A&E 4-hour performance remains above trajectory, but 12-hour waits (16.4%) and bed occupancy (95%) continue to be a challenge. RTT diagnostics performance is strong, and cancer performance met the national 62-day standard but fell short of internal trajectory.	The Committee were assured that risks are being effectively managed. The Board also confirmed that matters discussed in the meeting did not materially change this position The Committee commended colleagues for delivering strong performance.	Ongoing oversight. The Board will be reviewing the BAF in May. The CRR will also be updated.

Committee Escalation Report

The Committee were updated on progress against our Grip and Control actions.		Ongoing focus is required in this area.
Other agenda items The committee received a report in Part 2 on OneLSC		

Committee Escalation Report

Name of Committee:	Finance and Performance Committee	Report to:	Trust Board
Date of Meeting:	27 April 2026	Date of next meeting:	1 June 2026
Chair:	Amin Kamaluddin	Quorate: (Y/N)	Y

Introduction

Alert

What	So What	What Next
1. The 'no assurance' report from the MIAA into theatre stock management issues.	1. The review identified the inconsistent application of procedures within theatres, particularly at the point of item use, which indicated that the theatre inventory valuation had been overstated for a number of accounting periods. Regular stock counts had also not been undertaken which would have identified any discrepancies.	1. An internal management action plan is being developed and will be brought to the next Committee meeting to provide assurance that recommendations will be actioned within a timely manner.

Advise

What	So What	What Next
- The ongoing pressures and issues on the Trust's urgent and emergency care pathways. - Work still needed to address 12-hour and cancer performance. - Work still required to strengthen dashboards and associated reporting mechanisms.	12-Hour Time in Department - March performance was improved at 12.8% against the year end trajectory of 15.2%. The typical position has reverted to 16% mean. 62-Day Cancer Standard - The Trust did not meet the 62-day cancer our trajectory in February, delivering 66.6% against the national standard of 70%.	- UEC Improvement Board in place with 5 workstreams. These work streams have an Executive Director SROs for each program of works. The aim is to eradicate corridor care and long waits in ED. By When: 13 December 2026. - Tumour-site-specific recovery plans in place. Ensuring weekly oversight of ac ons and delays. By When: April 2026. Owner: Cancer Services Manager

Committee Escalation Report

Assurance		
What	So What	What Next
1. Finance plan 2. The Trust successfully met its financial obligations for 2025-26. 3. The 2026-27 WRP Plan and restructure of the Trust's PMO. 4. The Trust's strong operational performance in 2025-26	1. YTD deficit of £43.2m against; deficit plan of £43.3m therefore £77k ahead of plan (excluding the DSF). 2. M12 full year delivery is £43.2m. This is £17.6m away from the original WRP plan. 3. £31.5m WRFIP target for 2026-27 / £24.5m of the plan (78%) is fully developed 4. The PMO has now formally transitioned under the Director of Service Development and Improvement	1. The Trust focus is now to achieve a fully developed plan of c£31.5m by the end of May. 2. As at 08/04/26 the Trust has identified £39.9m of schemes for 2026/27 including the pre-pipeline. 3. The Grip and Control update show progress against the Grip and Control actions as at 8th April 2026 and as reported to Audit Committee in April 2026. 4. 84% of PwC recommended actions are now complete with clear plans in place for all remaining actions.
Outcome of Board Assurance Framework Discussion: The Committee reviewed the outputs of the BAF workshop with the Board on 8 th April. The context for the Risk Appetite Statement was updated to reflect the Trust's duty to ensure value for money and threat of industrial action from all staff groups, not just the junior doctor workforce. The Committee endorsed the wording of the BAF risks 3 (performance) and 5 (finance) for 2026/27.		
Other agenda items:		

Committee Escalation Report

Name of Committee:	People & Culture	Report to:	Trust Board
Date of Meeting:	13 April 2026	Date of next meeting:	8 June 2026
Chair:	Liz Sedgley	Quorate: (Y/N)	N

Introduction

Alert

What	So What	What Next
1. Large number of OneLSC cases that ELHT HR team are dealing with 2. Evidence that staff are feeling that they can't speak up about their concerns 3. Level 3 compliance with FTSU Training 4. Limited assurance report on Absence management	1. The ELHT team are currently picking up all OneLSC HR cases without any additional support or resources from the partner trusts. 2. FTSU are now monitoring if it is the first port of call for staff to speak up indicating that there are issues with staff talking to the managers and their teams about issues 3. Level 3 compliance – band 9 and above is currently at 58% well below the target rate 4. The action plan to address the issues raised was not received by the committee	1 This will be followed up at execs and the issue raised with HR directors of the other Trusts. 2 This will be taken to execs to refine a plan to support early resolution of issues in an informal setting and training and support of managers to develop the skills to manage and support staff more effectively 3 This will be followed up by the governance team to identify non compliance 4 The matter will be raised with the CPO and the plan brought to the next committee meeting

Advise

What	So What	What Next
1. Approach to staff stories 2. Changes to mandatory training compliance targets	1. The staff stories for 26/27 will focus on the effect on staff of organisational change, appraisals, speaking up and physiological safety 2. The Trust is not aligned with both the targets set and which staff are included compared to the other trusts in LSC	1. Staff stories will continue throughout 26/27 and will continue to highlight staff concerns, and key risks affecting staff wellbeing and morale 2. The committee approved the motion to reduce mandatory target rates from 95% to 90% and to exclude staff on long

Committee Escalation Report

3. Bi-monthly meetings	3. For 26/27 the committee will move to bi-monthly meetings	term sick and maternity leave which will help align ELHT with other organisations in LSC
Assurance		
What	So What	What Next
1. Strategy Engagement	1. After consultation and workshops the people strategy will focus on 3 key themes: - Put our workforce first, protecting capacity, capability wellbeing and morale. - Be a supportive, inclusive and compassionate organisation - Develop our workforce for the future	1. Comments from the committee will be incorporated and a final draft will be presented to Execs and then Trust Board for approval and then communicated with the organisation
2. Sickness Absence	2. There was an improvement in month 11 to 6.6% compared to 7.23% , whilst still above trajectory the improvement is welcome	2. The work programmes which have helped to reduce the rate will continue.
Outcome of Board Assurance Framework Discussion: The Committee reviewed BAF Risk 4: The Trust is unable to deliver its strategic objectives as a result of its inability to sustainably transform the workforce. The risk score has remained at 16 the reflect the current position with regards to the national staff survey results and reducing WTE as part of waste recovery programme.		
Other agenda items		