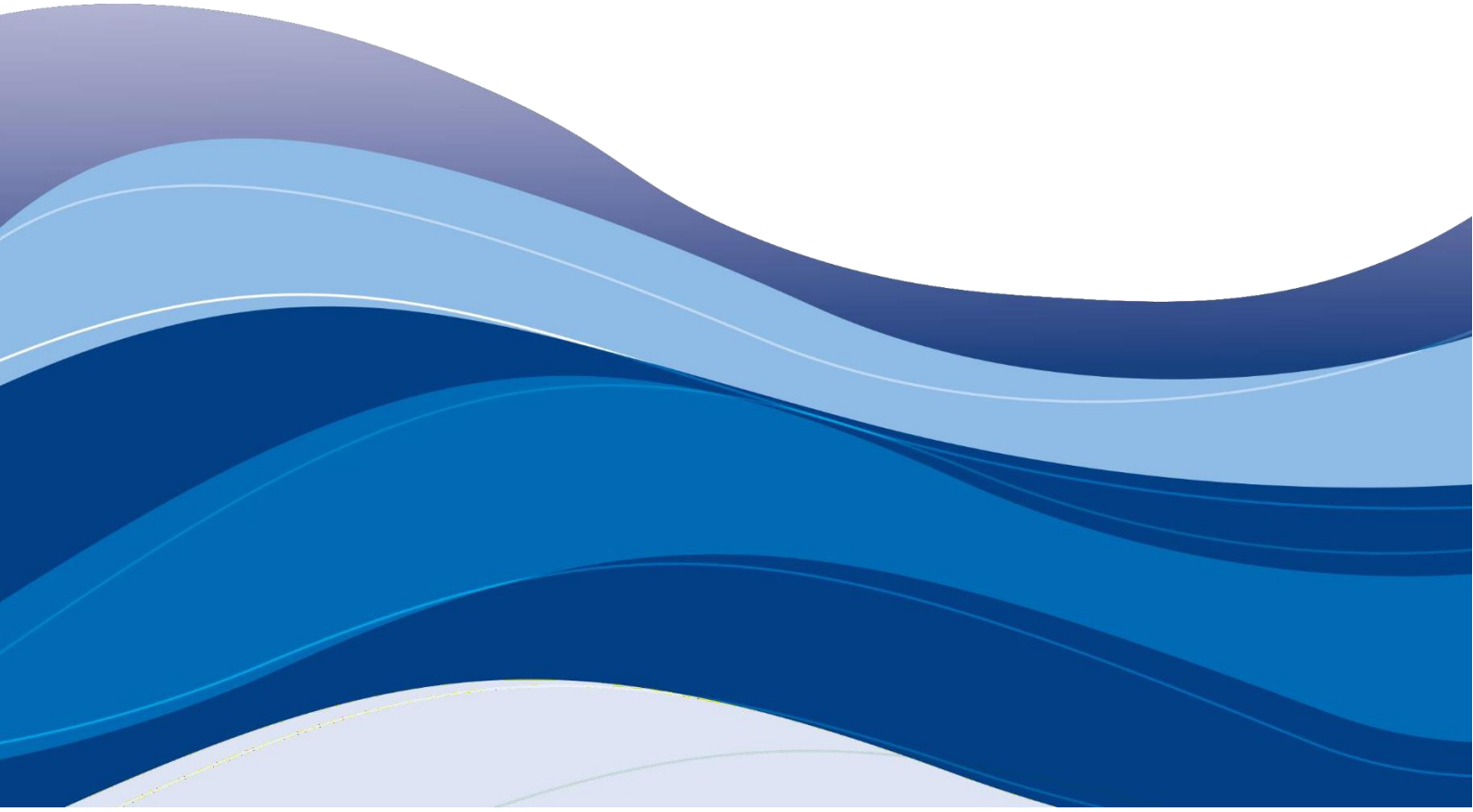
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Annual Report and Accounts

2020/2021



East Lancashire Hospitals NHS Trust Annual Report 2020-21

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Note: The format of the Trust's Annual Report for 2020-21 is in line with the revised Annual reporting guidance in view of the ongoing impact of the COVID-19 pandemic. As such this annual report does not include a Performance Analysis section. This was also the case for the 2019-20 document but has been included in previous years.

Foreword

Welcome to our Annual Report and Accounts for 2020/21. You will see throughout this document and particularly in the 'highlights' section that everyone at East Lancashire Hospitals NHS Trust continues to focus a great deal of time and effort on making improvements to services and ensuring that the quality of everything we do makes a tangible, positive difference to the lives of local people.

We are incredibly proud that this has continued even alongside the huge and undeniable draw on our energy and resources from Coronavirus, which has dominated the lives of everyone over the past 12 months.

The response from the team at the Trust has been astonishing. We can never thank NHS staff enough and there has been the most incredible amount of hard work delivered by all colleagues.

East Lancashire has experienced some of the highest numbers of people infected and needing hospital care in the country, as well as taking patients from other areas where hospitals didn't have enough staff or beds to cope.

At the height of our response to the pandemic we had almost 350 people in our inpatient settings needing care and treatment and we asked ourselves each and every day what more we could do to support our communities.

We added beds wherever we could but particularly in critical and enhanced care wards – moving to 'surge' and 'super surge' plans, often for extended periods of time. For every bed we also

needed to find more trained and qualified staff to look after people admitted with very serious health issues.

There were some very difficult decisions taken, with partners across the wider health and social care system, including to postpone some outpatient appointments and elective surgery. This helped people to stay safe at home if they did not need to come into hospital and helped us redeploy brilliant people to the frontline.

We worked closely with our staff and partners in community health services and settings to ensure we were supporting people to avoid them coming into hospital where possible and, if they were admitted, to get them home as soon as we could.

In addition, we prioritised getting the vaccination programme up and running and this has made the most amazing progress and impact on reducing infections. This is a fantastic achievement – the NHS at its very best - and vaccinations continue every day.

This past year has been one of the most difficult we will ever face in the NHS. But whilst this was going on we continued to move forward. The pandemic allowed us to innovate and learn quickly to keep vital services going through the restrictions in place. This is something we don't want to lose as we move forward and will be building on in the months to come.

In particular, the Trust worked hard to ensure the annual winter pressure found in our hospitals was managed effectively, particularly alongside COVID. We have focused on improving patient flow even when faced with huge demand for inpatient treatment, focusing on waiting times and also working with colleagues at North West Ambulance Service on efficient handovers between paramedics and the A&E team.

Just one of the ways in which we can measure the impact of this is through the results of the annual, national NHS Staff Survey which provides valuable insight into how it really feels to work in healthcare in the UK.

In the questionnaire, there were a range of questions which staff answered anonymously based on 10 themes, such as equality and diversity, health and wellbeing, quality of care for patients and safety culture.

East Lancashire Hospitals NHS Trust (ELHT) scored above average in eight themes and in line with the national average in two. That is some going but no less than expected from the brilliant team here.

Some key feedback included:

- 82% of staff believed the care of patients and our service users is the organisation's top priority (compared to a national average of 79%)
- 75% of staff were happy with the standard of care provided if a friend or relative needed treatment (compared to 74% in 2019)
- 72% recommended ELHT as a place to work (vs a national average of 66%)
- 90% of colleagues believe their role makes a difference to patients

Don't forget, East Lancashire faced some of the highest levels of community infection from COVID in the UK. This was followed by extremely high numbers of people who needed admission and extreme pressure in our hospitals and community settings throughout the pandemic.

We were hit hard by COVID and for a very long period of time indeed. The Trust lost a number of colleagues to the virus too and the emotional burden was incredibly high for everyone. To remain positive about work and be able to make and recognise improvements is incredible.
It cannot be underestimated how difficult the past year has been and how everyone at the Trust and the wider healthcare system has worked unbelievably hard.

We are grateful especially to those who were and continue to be redeployed to areas and specialities outside of their usual place or focus of work. People have worked late, come in early and cancelled leave and other family commitments to care and support each other, as well as our patients and their families.

Colleagues have carried on when they wanted to stop and collapse. They've gone way, way, beyond anything that could be considered an 'extra mile'. They have put their own lives on hold and often on the line without a grumble. It is important also to remember those who have worked from home, schooling and working throughout lockdown which have must have been very

difficult indeed. Each and every person has played their part and we can genuinely never thank colleagues enough.

To summarise, this year has seen unprecedented challenges for NHS organisations. However, the Trust continues to learn, progress and achieve excellence because of our dedicated staff to whom we are indebted.

Professor Eileen Fairhurst MBE **Mr Kevin McGee**

Working with Our Partners - Lancashire and South Cumbria Integrated Care System (ICS)

Responding to the COVID-19 pandemic

Throughout the COVID-19 pandemic, we have worked effectively with our partner organisations across the ICS to manage the local response, enabling joint decision making towards the operational management of services and ensuring consistency in partner, staff, patient and public communications.

Local Resilience Forums (LRFs) were formed with representation from across the ICS including NHS, local authorities, social care, education, police, fire and armed forces as well as the voluntary, faith and community sector. They worked together to manage the response to COVID-19, including personal protective equipment (PPE), rolling out testing and vaccination programmes, supporting vulnerable communities, communicating key messages and continuing priority work programmes.

One of the first responses was the setting up of Hospital and Out of Hospital incident response cells in Lancashire and South Cumbria. The cells' earliest priority was securing the capacity to deal with the first peak through mutual support and agile response to pressures. During the second phase, they restored the delivery of frontline elective clinical services. Working arrangements were designed to avoid silo working and to lock-in positive changes in care models, operational processes and data sharing. Both cells operated under the North West Regional incident command structure.

The Hospital Cell, led by Kevin McGee, Chief Executive of East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospital NHS Trust, two of the four acute hospitals in the ICS, covered elective care, tertiary services, critical care, cancer, mutual aid and clinical prioritisation. The Out of Hospital Cell, led by Dr Amanda Doyle, Chief Officer for Lancashire

and South Cumbria ICS, co-ordinated the work of community services, mental health, learning disabilities and primary care. It also worked with social care, with a Care Sector sub-cell run jointly with the Lancashire LRF and with connections to Cumbria.

A Joint-Cell brought these two groups together supported by system-wide functions such as workforce, digital, communications and engagement and included clinical representation, military support and representatives from North West Ambulance Services. Shared sub-cells covered the key areas of testing, digital strategy, PPE and clinical supply, and planning – the latter involving close liaison with Business Intelligence colleagues. The cells and sub-cells continue to meet regularly and produce regular updates for partner organisations, MPs and councillors.

The Gold Command Winter Pressures Room was established in preparation for the second wave of the pandemic. Its initial purpose was to support local NHS operational activity and Out of Hospital services facing winter pressures. As a tactical support service, it monitors and analyses pressure on individual trusts and organisations – including A&E attendances, COVID cases, people awaiting a COVID test result before admission, staff sickness, bed capacity, discharge delays, and queueing ambulances. Data is looked at from a system perspective, and capacity redistributed to where it is needed most.

Work at the command room, as well as the System Vaccinations Operations Centre (SVOC), is ongoing seven days a week through collaboration between all Trusts and CCGs, NHSEI leads and ICS executives. It has made a phenomenal difference in terms of collaborative working and system thinking for the benefit of patients.

As the availability of PPE was identified as a key issue in April 2020, the Lancashire and South Cumbria PPE and Consumables Policy Group was established to ensure a consistent approach to PPE usage and inform capacity planning for hospitals. This was soon extended to cover PPE policy for primary and community care, ensuring a consistent system-level approach.

The start-up of a local manufacturing route in late June provided a sustainable and reliable supply, as well as creating around 100 new jobs in Preston. A re-usable gown service provided another sustainable source, which was also promoted and used nationally. These initiatives complemented good practices such as the day-to-day careful monitoring of stock and the management of allocation.

The LRF supported in distributing PPE to nursing and care homes, and the advisory group shared links to the ordering portal with all organisations and sub-cells. Public guidance about appropriate PPE use was kept updated on the ICS website and shared through social media.

A successful rollout of COVID-19 antigen testing took place across Lancashire and South Cumbria, covering NHS and social care staff, patients, care home residents and the public – including though workplaces. A Lancashire and South Cumbria NHS Testing Group worked with the LRF and the Hospital and Out of Hospital Cells. Partners collaborated to organise and implement COVID testing across the region, which included PCR, Lateral Flow and Loop-mediated Isothermal Amplification (LAMP) testing, rapid tests for patients in acute hospitals, setting up regional and local testing centres, plus mobile testing units. The armed forces also helped nearly 200 local businesses and organisations establish rapid testing of their employees.

Asymptomatic testing was also rolled out, with the aim of preventing transmission and community spread. Originally introduced in NHS Trusts, Lateral Flow tests are now being used for regularly testing essential workers and members of the public who are most at-risk from the virus. As part of the full re-opening of schools in March 2021, additional opportunities for asymptomatic testing were made available for households and bubbles of school pupils and staff.

In November 2020, a COVID Vaccinations Board was set up to provide oversight to the COVID-19 vaccination programme in Lancashire and South Cumbria, as operating procedures, decisions and guidance emerged nationally. The team supported the coordination and development of various vaccination sites and provided strategic nursing capacity and pharmacy capability.

ELHT, with the support of partners, acted as lead provider to recruit staff to support the large vaccination centres. The centres are additionally resourced with members of acute Trusts, CCGs, NHS Midlands and Lancashire Commissioning Support Unit and wider system colleagues. Between early December 2020 and the end of March 2021, we gave over 850,000 first doses and over 120,000 second doses. And by the time you read this we will have given many more. Vaccines have been delivered at 11 hospital hubs, 36 GP-led PCN vaccination centres, 12 pharmacy-run centres, seven large vaccination sites, and care homes, as well as to housebound residents. A new risk assessment tool (QCOVID®) helped identify an

additional 19,000 adults potentially at a high risk from COVID-19, who were then prioritised to receive the vaccine.

Partners including local councils, the military, police, local businesses, volunteers, returning clinical staff and many more have supported the delivery of the vaccine. More than 1,300 local people offered their support following an appeal for volunteers, and over 20,000 volunteer hours have been undertaken so far (up to end March 2021).

The ICS led the clear communication of public messages, including materials in different languages and formats, about the importance of being vaccinated and how to attend appointments safely. Insight research started in early 2021 to understand views and attitudes towards the vaccine within health inequalities groups and vulnerable communities to inform adjustments in messaging and approaches. In partnership with Muslim faith leaders, a number of videos were produced in several languages to be shared with their communities to increase uptake, and the ICS is also exploring options to deliver temporary clinics in mosques.

COVID-19 virtual wards were launched to monitor vulnerable patients with COVID in their own homes. ELHT, GP practices and local providers worked together to provide the pulse oximetry at home service for eligible patients, identified as being particularly at-risk from the virus due to their age or a pre-existing condition. Patients are given a pulse oximeter so they can measure the oxygen levels in their blood several times a day, which helps spot the early signs of silent hypoxia; when the body is starved of oxygen but without causing noticeable symptoms such as breathlessness.

This effective digital solution enables early treatment to be given, which both improves patients' chances of recovery and ensures that they only go to hospital if necessary. CCGs are considering how the remote monitoring offer could be extended beyond oximetry at home.

CCGs and local authorities across Lancashire and South Cumbria have worked together to establish a network of designated settings for COVID-19 care. They ensure that all people requiring admission to a care setting or back to their own care home can be discharged from hospital safely, which helps to reduce the spread of COVID-19 within other settings. Those discharged to a designated setting will have tested positive for COVID-19 in the 48 hours prior to discharge, where they will be able to undergo the necessary period of isolation. Working with acute Trusts and the communities, CCGs developed these settings across seven of the eight CCG areas, but allowing access to settings from all areas, with the first ones in place

from November 2020. Designated settings are separate settings (even if they are co-located with a care home), with a separate staffing team and health and care support.

Lancashire County Council and Blackpool Council hold the contracts for the services commissioned from the care homes involved, but the costs are being recharged via the CCGs to the National Discharge Fund. CCGs commissioned the associated medical oversight/input into their homes. They were inspected before the service commenced by the Care Quality Commission (CQC) to make sure the policies, procedures, equipment and training were in place to maintain infection control and support the care needs of residents.

Performance Overview

Introduction and Background

East Lancashire Hospitals NHS Trust was established in 2003 and is a large integrated health care organisation providing acute secondary and community healthcare for the people of East Lancashire and Blackburn with Darwen. Our population includes patients who live in several of the most socially deprived areas of England.

We aim to deliver high quality, high value care and contribute to a health gain for our community. Located in Lancashire in the heart of North West England, with Bolton and Manchester to the South, Preston to the West and the Pennines to the East we have a combined population of approximately 530,000. We employ over 8,000 staff, some of whom are internationally renowned and have won awards for their work and achievements.

We offer care across five hospital sites, and various community locations, using state-of-the-art facilities. In addition, our patients are also offered a range of specialist hospital services which are provided either by the Trust, neighbouring Trusts, with some being delivered in Manchester.

The majority of the Trust's services are funded by NHS East Lancashire and Blackburn with Darwen Clinical Commissioning Groups (CCGs) and NHS England. The Trust continues to work alongside our commissioners and local authorities to deliver the best possible care in the most appropriate locations for the people of East Lancashire.
Our absolute focus on patients as part of our vision "to be widely recognised for providing safe, personal and effective care" has been demonstrated in the Trust's continued progress and being rated 'Good with areas of outstanding' by the Care Quality Commission (CQC).

The year has been one of the greatest challenges of a generation: a global pandemic – COVID-19. The spread and effect of the virus has impacted upon all NHS organisations and public services and caused devastation in our local communities. We have lost many of our patients to the virus and tragically our own staff.

This annual report describes a very different organisation than previous years, and perhaps a very different East Lancashire as the world reshapes post-COVID. It has been said that we can't go back to normal as normal wasn't working. It is our task to create a new normal. We will make sure we play our part in the forging and reshaping of public services across the integrated care system.

Performance Report

Chief Executive's Statement

I would like to pay tribute to all our staff and volunteers who continue to work tirelessly to develop services for our patients and to improve the patient experience.

Staff at ELHT achieved some amazing things during a year in which the Trust faced the biggest challenge the NHS has ever seen. The COVID-19 virus dominated both the working lives and personal lives of all ELHT staff during this reporting period.

The Trust reported a one per cent financial performance surplus for the 2020-21 financial year, which is in line with the 2019-20 financial plan.

While the pandemic impacted on the Trust's ability to achieve all constitutional targets, it was able to continue to treat as many urgent patients as possible. This was, in the main, thanks to the commitment of staff and by introducing new ways of working. The introduction of video and telephone consultations enabled as many patients as possible to be seen without the need to visit our hospital sites. This protected both our staff and patients, and dramatically reduced travel to and footfall though our hospitals.

We were incredibly proud to achieve the completion of our £10m Acute Medical Unit on schedule, despite the challenges faced due to COVID-19. Located at the front of the Royal Blackburn Teaching Hospital the state-of-the-art Unit brought together the existing Acute Medical Units into a single facility. It incorporates the enhanced, short stay Ambulatory Emergency Care Unit to form an 'Emergency Care Village'.

The annual NHS Staff Survey is carried out across hundreds of organisations and involves millions of NHS staff members. This year, our results revealed high levels of staff satisfaction at the Trust despite the pressures of the pandemic. The Trust Board welcomed the findings and thanked the record levels of staff for taking part at such a difficult time.

The annual survey is a great way of benchmarking our performance against other NHS organisations across the country, and to highlight any specific areas we as a Trust need to focus on. It really is a testament to our staff that, even during the immense pressures of the

pandemic, record numbers took the time to engage with the survey and let us know their thoughts. Our final response rate for this year's survey was 55% per cent, which means 4,795 colleagues took the opportunity to have a say and influence the way the Trust is run. This is an increase of 8% from the previous year's response and above the national average.

This year's survey provided a unique opportunity to learn how a global event can place additional pressure and requirements on staff, the Trust and the NHS as a whole.

It is truly in times of adversity that you see teamwork, commitment and fortitude shine through. Our staff and volunteers worked tirelessly to deal with the operational pressures that we experienced, and the Trust remains committed to delivering safe, personal and effective care to every patient every time.

Vision and values

Our vision is to be widely recognised for providing safe, personal and effective care.

We will do this by achieving our objectives to:

- put safety and quality at the heart of everything we do
- invest in and develop our workforce
- work with key stakeholders to develop effective partnerships
- encourage innovation and pathway reform and deliver best practice

Our objectives are underpinned by our values. We have committed in all our activities and interactions to:

- put patients first
- respect the individual
- act with integrity
- serve the community, and
- promote positive change.

In achieving the objectives our staff observe our operating principles:

- Quality is our organising principle
- We strive to improve quality and increase value
- Clinical leadership influences all our thinking
- Everything is delivered by and through our clinical divisions
- Support departments support patient care
- We deliver what we say we will deliver
- Compliance with standards and targets is a must; this helps secure our independence and influence
- We understand the world we live in, deal with its difficulties and celebrate our successes.

Our staff are committed to delivering these challenges by continually improving the quality of the services we provide to meet the needs of our local population. Our improvement priorities for the year were to:

- reduce mortality
- avoid unnecessary admissions
- enhance communication and engagement
- deliver reliable care
- ensure timeliness of care.

Our services

The clinical and support services within the Trust during 2020/21 responded exceptionally well to the COVID-19 pandemic resulting in a number of innovative ways of delivering care to our patients and the wider community within East Lancashire. Colleagues continued to ensure our services provided safe, personal and effective care throughout the pandemic. The Trust is extremely proud and grateful of all our colleagues and the services they delivered during this extremely difficult time. Patient safety and care remained our priority throughout the pandemic with a high level of resolve demonstrated by our teams and partner organisations.

Our focus throughout 2020/21, as a minimum, was to ensure timely patient access to emergency care and high clinical urgency interventions including cancer services. Despite the challenges posed by the pandemic, some examples of our service redesign during this time included:

- Fourth room at Burnley General Teaching Hospital (BGTH) for Endoscopy since 1 March 2021 and operational seven days per week. This will help with managing our endoscopy waits due to the pandemic.
- A comprehensive refresh of new equipment for endoscopy has been agreed and will be in place during 2021/22.
- Robotic assisted surgery at BGTH.
- Two MRI scanners at BGTH.
- The Digestive Diseases Team commencing training for Colon Capsule Endoscopy to strengthen the diagnostic service offer for our patients.
- The successful implementation of the COVID Virtual ward in response to the pandemic. This enabled the provision of safe, personal and effective care of patients with COVID-19 at their home/usual place of residence.
- Development of non-face-to-face appointments for a large number of services using video and telephone for our patients at rapid pace in response to the pandemic. This will be incorporated into our outpatient service provision extending the advice and guidance service during 2021/22.
- The successful tender process for a regional Artificial Intelligence (AI) for stroke services. This will improve the accuracy of diagnosis and the quality of patient care. Go-live is planned for summer 2021 for ELHT.

- During October 2020, ELHT started the process to become an early implementation site for the development of an Alcohol Care Team. This will allow ELHT to develop effective alcohol care pathways ensuring we meet the needs of patients in line with new models of care
- Our new Acute Medical Unit (AMU) B was opened and received its first patient on the 27 November 2020. This is now part of our 73-bedded AMU floor providing acute care for our patients close to the Emergency Department and forms a key part of our vision for the emergency care village at ELHT.
- Completion of five additional cubicles in the Emergency Department (ED) opened in December 2020 to support attendances during the pandemic. There will be a further eight cubicles for the ED expected to be operational during April 2021.
- NHS 111 First roll-out from August 2020 to support urgent care access outside of ED. This includes direct access to GP appointments. ELHT was also an early adopter for the NHS 111 First direct booking and went live in November 2020.

We provide a full range of acute hospital and adult community services. We are a specialist centre for Hepatobiliary and Pancreatic Surgery and Interventional Vascular Centre.

Royal Blackburn Teaching Hospital provides a full range of hospital services to adults and children. This includes:

- General and specialist medical services
- Elective and Emergency Surgery
- Full range of diagnostic (e.g. MRI, CT scanning) and support services.
- Eleven operating theatres including robotic assisted surgery
- Urgent Care Centre
- Emergency Department
- Surgical Ambulatory Emergency Care Unit (SAECU)
- Two cardiac catheterisation laboratories
- Three endoscopy rooms
- A range of inpatient facilities
- Centralised outpatients department
- Renal Dialysis services (provided by Lancashire Teaching Hospitals NHS Foundation Trust)

Burnley General Teaching Hospital provides a full range of elective hospital services. This includes:

- General, specialist medical and surgical services
- 13 theatres, two obstetric and one procedures room (including robotic-assisted surgery)
- Full range of diagnostic (e.g. MRI, CT scanning) services. There were two new scanners deployed during September 2020 to support the site
- Urgent Care Centre for minor injuries and illnesses
- The Lancashire Women and Newborn Centre, comprising
  - Centralised consultant-led maternity unit
  - Level 3 Neonatal Intensive Care Unit
  - Midwife-led birth centre
  - Purpose-built Gynaecology unit
- Lancashire Elective Centre
- Four endoscopy rooms
- Fairhurst Building including a new specialist ophthalmology centre, maxillo-facial department and outpatient facilities
- Rakehead Rehabilitation Unit for Specialised Neuro-Rehabilitation pathway
- Renal Dialysis services (provided by Lancashire Teaching Hospitals NHS Foundation Trust)

Accrington Victoria Community Hospital provides a Minor Injuries Unit for the local population. The hospital also has access to dedicated specialist services together with a range of outpatient services. Many consultants and specialties use this busy facility which allows local people to be seen within their community. Services include:

- Audiology clinics
- Minor injuries
- Occupational therapy
- Outpatient services
- Physiotherapy
- Renal services (provided by Lancashire Teaching Hospitals NHS Foundation Trust)
- X-Ray.

Clitheroe Community Hospital provides:

- 32-bed inpatient ward on the first floor
- Outpatient clinics and other services on the ground floor, including a restaurant for visitors
- Inpatient and Rehabilitation services for people 16 years old or over.
- Outpatient facility sees patients of any age as requested by the consultants.

Our outpatient services are also provided at a range of local community settings, enabling patients to access care closer to their homes wherever appropriate.

Pendle Community Hospital in Nelson provides

- Rehabilitation service for people following illness or injury.
- Two 24 bed rehabilitation wards
- A 24 bed stroke rehabilitation unit
- East Lancashire Community Stroke Team
- Outpatient services

Trust Statement on COVID-19 and its impact on the Trust

2020/21 was dominated by the Trust response to COVID-19 along with other organisations ensuring the safe delivery of care for both COVID-19 and Non-COVID patients. The Trust had already activated its Incident Command and Control arrangements for the management of the COVID-19 outbreak in March 2020. These arrangements continued throughout the year providing a clear governance and support structure across the organisation.

The Trust Executive meetings supported the effective oversight of the incident and provided a space for any other relevant Trust business not related to the COVID-19 outbreak to be conducted and managed.

An information cascade system was also established to ensure all key priority services received a verbal communication of COVID-19 Bulletins. This included:

- Assessment Units (including Ambulatory Pathways, SAECU, Paediatrics and Maternity)
- Critical Care
- Emergency Medicine
- Medical Handover

- Patient Services
- Theatres

The Operational Co-ordination Centres for the relevant key priority areas were responsible for implementing this verbal cascade system.

The Trust had implemented clear pathways for emergency care and clinically urgent cases including cancer surgery across its sites. There were controlled entry and exit points to ensure safety through prevention and containment of COVID-19 exposure. All service areas had red (COVID-19) and Green (Non-COVID-19) pathways in place. The Trust had also implemented the national clinical priority coding for waiting lists as part of its response towards managing elective care. Urgent elective care cancellations were largely minimised due to the pandemic and patients were booked based on the national clinical urgency code. However, despite our best efforts in booking urgent patients, there were unfortunately patients delayed due to the rise of the pandemic.

We will continue with our robust plan for additional capacity to book patients based on their clinical priority throughout 2021/22.

Dedicated wards were identified to care for both red and green pathway patients ensuring safe, personal and effective care under unprecedented circumstances. The inpatient areas were all supported by the leadership teams ensuring the right level of resources were in place including access to wellbeing schemes. Services were maintained and delivered safely during this time following both the national and local guidelines. All services initiated a restoration and recovery plan during 2020/21 with executive support in preparation for returning to normal activity levels similar to 2019/20 and as mentioned previously, reducing the backlog caused by the pandemic.

The Trust ensured safe and equitable services for its community throughout the pandemic. This was achieved through ensuring emerging policies and procedures throughout the pandemic had clear clinical, operational and corporate service oversight as well as scrutiny. This included the effective management of pathways for vulnerable patients ensuring a case management approach both in the hospital as well as our community services.

Any learning opportunities were incorporated through clinical teams to improve services such as virtual clinical consultations to protect vulnerable groups and the redesign of services in paediatrics to name but a few. The Trust's priority remains to ensure equity service provision for its richly diverse community across East Lancashire.

Staff

Since ratification of the East Lancashire Hospitals NHS Trust (ELHT) People Strategy, the NHS and ELHT has had to manage the ensuing COVID-19 pandemic, which has seen significant and rapid changes in ways of working, the health, wellbeing and resilience of the workforce stretched to new limits, but possibly most of all, the experience and dedication of our workforce stand out when rising to meet the challenges this has brought.

The Trust is now faced with the challenge of managing the restoration of services alongside allowing opportunities for staff rest and recovery and managing the threat of any subsequent COVID-19 rise in infection rates.

To support this, the Human Resources and Organisational Development (HR and OD) Directorate has reviewed the People Strategy Implementation Plan, to ensure that it takes account of lessons learned from the COVID-19 pandemic, supports restoration of services, and ensures that we continue to prioritise looking after our workforce.

The proposed implementation plan also ensures delivery of the actions expected of employers and systems that are outlined in the NHS People Plan. These include specific commitments around:

- Looking after our people – with evidence based and timely health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face and ensuring equality for all
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

The Trust is a major local employer and sees itself as an anchor organisation within the local area. During the course of the pandemic, recruitment activity increased significantly

across the Trust, with ELHT now employs around 8,600 WTE staff compared to a figure of 7,900 WTE staff this time last year. 269 of these are staff the Trust has recruited on behalf of the ICS to provide the COVID-19 vaccination services at the mass vaccination sites. Recognising that, in order to provide consistent high standards of safe, personal and effective care means high staffing requirements at times of peak demand, the COVID-19 pandemic has resulted in an increased reliance on temporary workforce and the Trust has significantly increased its Staff Bank to support this additional demand.

In addition to the information and data from the national NHS Staff Survey, we conduct more focused surveys to enable staff to feedback confidentially their experience of working for the Trust. We do this regularly and then monitor the actions that have been taken to improve the staff experience at our Employee Engagement Sponsor Group chaired by the Chief Executive.

ELHT has made great progress in addressing the Inclusion agenda in the last year. Our four staff networks, Black, Asian and Minority Ethnic (BAME) Network, Disability, LGBTQ+ and Mental Health, have fully established and have developed plans to improve staff experience through their individual experiences which we know, evidence shows us, will benefit the wider workforce and the population we serve. Significant work by our BAME network through the 'Let's talk about race' research and The Big BAME Conversation feedback has led to key commitments by the Board in the Workforce Race Equality Standard (WRES) action plan, to strive to make ELHT an anti-racist organisation. Similar work will be undertaken by our Disability Network in the coming months to inform the Workforce Diversity Equality Standard (WDES) agenda also.

The establishment of our network Freedom to Speak Up Champions has enabled staff to have additional confidence in being able to raise concerns and we look forward to extending this further. We celebrated our second Festival of Inclusion virtually and look forward to our third this year with a theme of 'Civility and Respect'. Whilst we know we have much more work to do, we are confident that we are now seeing the seeds of real change.

Employee engagement

At ELHT we believe our employees are our greatest asset, and we all have a part to play in setting and achieving our vision, values and key priorities.

Our people are at the heart of everything that we do, striving for excellence and driving up standards of care. We want our staff to enthuse pride in their service and similarly for our patients and carers to be proud of us as their local health provider.

As an organisation we are committed to improving employee engagement and empowerment. Our strategy led by the Chief Executive and championed by the Director of Human Resources and Organisational Development (HR and OD) has enabled ELHT to drive the organisation forward by highlighting the importance of employee engagement as well as implementing evidence based interventions to enhance it.

We have devised, implemented and embedded a systematic approach to engage and empower our employees through our ten Enablers of Employee Engagement which has now created an environment whereby our workforce demonstrates high levels of advocacy is truly involved and motivated, working together towards our shared vision of being widely recognised for providing safe personal and effective care.

Financial duties

The Trust reported a £3.0 million adjusted financial performance deficit for the 2020-21 financial year. This is in line with the 2020-21 financial plan. The deficit included £32.8 million expenditure on the back of the Covid-19 pandemic for which the Trust was reimbursed £32.3 million. Due to the pandemic the normal NHS planning arrangements were suspended and all NHS organisations operated on a revised financial framework.

Despite the pandemic the Trust achieved all of its financial duties as set out later in this report.

Better Payments Practice Code

Although it is not a financial duty, the Trust met the Better Payment Practice Code target by paying more than 95% of undisputed invoices within 30 days of receipt of the goods or invoice, whichever is the later.

Where our money comes from

In 2020-21, the Trust received income of £656.8 million compared with £567.0 million in the previous year, including £567.5 million for healthcare services provided to people living in East Lancashire and Blackburn with Darwen.

Most of the Trust's income comes from Clinical Commissioning Groups (CCGs) who purchase healthcare on behalf of their local populations. The Trust negotiates an annual contract with the local CCGs for the payment of services. Due to the pandemic the normal NHS planning arrangements were suspended and the Trust received a set amount from commissioners to a value of £478.7 million.

Where our money goes

In 2020-21, the Trust's total revenue operating expenditure was £667.2 million compared with £589.4 million in the previous year. £441.1 million (66%) was spent on staff costs. Throughout the year the Trust employed an average of 8,233 substantive staff and contracted a further average of 629 bank staff and an average of 228 staff via agencies.

At £49.0 million, clinical supplies and services were the next highest area of expenditure with the Trust also incurring £43.3 million of drug costs and a £18.1 million on clinical negligence 'insurance' premiums.

During the year the Trust's valuer has carried out a revaluation of the Trust estate, this has resulted in a net impairment charge of £20.8 million.

Capital Expenditure

The Trust has continued to invest in healthcare facilities in East Lancashire, including an additional £5.5 million investment on the new Emergency Care Village at the Royal Blackburn Teaching Hospital site, which opened in December 2020. In addition additional funding was made available nationally which enabled the following:

- The ED at the Royal Blackburn Teaching Hospital site to be extended.
- A fourth Endoscopy room to be opened at Burnley General Teaching Hospital.
- Backlog maintenance to be carried out on the Burnley site replacing the theatre ventilation system,

- The pneumatic tube system
- The heating system on the Victoria Wing
- Modernising the Rakehead Rehabilitation Centre
- Medical equipment purchases included an MRI scanner and CT scanner, as well as Endoscopy equipment.

In total the Trust invested £48.0 million on new building works, improvements and equipment and information technology across all of its sites.

Financial Outlook for 2021-22

The financial outlook for the NHS remains uncertain due to the Covid-19 pandemic. NHS organisations have been asked to submit a draft financial plan for the six-month period from 1 April 2021 to 30 September 2021 which will include the costs for restoration of the elective recovery programme.

Modern Slavery Act 2015 - Annual Statement 2020-21

In accordance with the Modern Slavery Act 2015, East Lancashire Hospitals NHS Trust (ELHT) agreed the final statement regarding the steps it has taken in the financial year 2020-21 to ensure that Modern Slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains. The full statement can be found on the Trust's website (www.elht.nhs.uk).

Principal activities of the Trust

Our principal activities are to provide:

- Elective (planned) operations and care to the local population in our hospitals and community settings
- Non–elective (emergency or urgent care) operations and care to the local population in hospital settings
- Diagnostic, therapy and rehabilitation services on an outpatient and inpatient basis to the local population in both hospital and community settings
- Specialist services within a network of regional and national organisations e.g. Level 3 Neonatal services, Interventional Vascular Centre and specialist Hepatobiliary and Pancreatic Centre.
- ELHT also provides robotic-assisted surgery within Urology, Colorectal and Head and

Neck Services.

- Learning and development opportunities for staff and students.
- Additional services commissioned where agreement has been reached on service delivery models and price.
- Support services to deliver the above activity and support the activity of other local health providers where these have been commissioned and agreement has been reached on service delivery models and price.

Lancashire and Cumbria Integrated Care System.

Initially in 2020-21 the Lancashire and South Cumbria Integrated Care System (ICS) continued to work to improve the delivery of more integrated health and care to the 1.7 million population in the geographical area in order to reduce clinical variability, address health inequalities, improve access standards and quality generally, and be more efficient in the use of resources.

ELHT executives were heavily involved in helping to shape and respond to the needs of the Five Year Forward View and new models of care. The work of the Executive extended to broader leadership roles at the 'system' level, including playing pivotal roles in for example the following workstreams: Cancer services, Hyper Acute Stroke, Vascular Surgery services, pathology reconfiguration and the broader configuration of diagnostics services. However, these programmes were 'paused' to free capacity to more effectively address the significant demands of the COVID-19 pandemic.

During the pandemic the ICS worked closely with the In and Out of Hospital 'Cells' to ensure a rapid and co-ordinated response to the very many challenges that presented, from for example enhancing Critical Care capacity, maintaining elective activity as much was possible, to delivering the vaccination programme.

Governance arrangements in the ICS developed to support the collaborative work of partners which were absolutely reflective of the content of the White Paper 'Integration and Innovation: working together to improve health and social care for all' which was published in February 2021. These include an ICS Board and a Provider Collaboration Board led by an independent Chair. The Provider Collaboration Board comprises the Chairs and Chief Executives of the five NHS Trusts in the ICS and is ensuring a cohesive approach to e.g. the recommencement

of work programmes and the recovery and restoration of services following the reduction in the incidence of COVID 19.

In 2020-21 the ICS produced its Clinical Strategy. ELHT's previous Clinical Strategy covered the five-year period 2016-21 and the vast majority of its objectives and planned service developments had been achieved e.g. the introduction and expansion of robotic surgery on both the Blackburn and Burnley hospital sites, improving the Emergency Department facilities, improvement to Paediatric services. In light of the White Paper and the ICS Clinical Strategy ELHT has refreshed its plans in the context of working in the ICS system with all partners and particularly in the Provider Collaboration Board. This new strategy outlines ELHT's clinical offering over the next five years to both the Pennine Lancashire and wider Lancashire and South Cumbria populations.

Local health and care system vision

The Pennine Lancashire leadership (ELHT, East Lancashire Clinical Commissioning Group, Blackburn with Darwen Clinical Commissioning Group, Lancashire and South Cumbria Care NHS Foundation Trust, Blackburn with Darwen Council and Lancashire County Council) have worked together to further develop the integrated care partnership (ICP). This partnership, or the coming together of organisations and the services they provide, works to ensure people in Pennine Lancashire have long and healthy lives, including closer and more integrated working with primary care. ELHT also has a significant role to play in preventing people from becoming ill.

These partnership arrangements aim to secure improved sustainable outcomes for our population. The partnership approach extends between the NHS, Local Authorities, the third sector and patients groups.

Initially in 2020/21 partners continued to work together to develop and implement integrated neighbourhood teams to ensure that high quality, seamless care was delivered across the various agencies in Pennine Lancashire at a locality level.

However, as the incidence of COVID-19 grew significantly in Pennine Lancashire, such that the area exhibited some of the highest community infection rates nationally, partners worked together to co-ordinate and deliver an extremely effective response both in and out of

hospital. There were numerous examples of excellent joint working across traditional boundaries, for instance District Nurses supporting care home staff who had been hit by significant outbreaks and therefore staff sickness, the Hospital Infection Control Team providing expert advice, training and support on the use of Personal Protective Equipment (PPE) in the community setting, staff and public testing and more latterly delivering the vaccination programme.

A fantastic example of integrated working was the advent of the COVID Virtual Ward where senior clinicians from secondary and primary care worked seamlessly to care for patients with COVID-19 in the community setting thereby preventing admission to the extremely pressured hospital. This clinical model received regional and national plaudits and has provided an exemplar to develop further integrated clinical pathways in 2021/2 and beyond.

The experience of dealing with the pandemic has brought partners more closely together than ever before and relationships have never been stronger. This provides the bedrock to further develop the ICP. An agreed set of priorities have been developed for 2021/22, of particular importance is further enhancing the collaboration of provider agencies to deliver high quality, integrated care across traditional health and care boundaries.

Stakeholder Engagement

The Trust's Patient, Carer and Family Experience Strategy 2018 to 2021 sets out how staff, patients, families, carers and stakeholders can all work together to review, develop and improve services. This ensures patients have the best possible experience whilst using our services.

Any patient or carer of a patient is welcome to attend our Public Participation Panel (PPP) to give us their views about the services we provide and work with us to improve them. Set up in 2018, PPP meetings offer the opportunity for independent observers to make a meaningful contribution to the development of Trust services.

A patient story is presented at each public Board meeting. Patients/carers attend in person to relate their experience and identified opportunities for change/improvement direct to the Board. In addition to routine media activity, we work with patients from across the Trust to share their experience of our services. Stories from a purely patient perspective regularly

appear in national and local publications.

The good relationships with the local, regional and national media provide an opportunity to publicly share our plans and developments and celebrate the skill and professionalism of our staff. Our social media accounts are proving an effective and engaging method of two-way contact. During the pandemic there was a huge appetite for information and local news from the public. Our social media strategy to provide engaging informative content encouraged an increase in followers. The Trust's average reach per week across its social media platform as are:

- Facebook – 101,989
- Twitter impressions – 78,000
- Instagram impressions – 2,646 (reach of 2,036)

Patient representatives are routinely involved in Quality Improvement projects. For example, the Frailty Care Pathway project, Electronic Patient Record Project, development of an information booklet for patients, family and carers and the End of Life Steering Group.

To ensure our local MPs and key stakeholder receive core information, they receive a light version of our monthly Staff Team Brief document. Team Brief was halted during the pandemic and a new Stakeholder Brief was created to provide the latest COVID-19 figures, service changes, performance information, areas of development and key messages from the executive board. In addition, the MPs have regular meetings with our Chief Executive.
The Trust works closely with Healthwatch Lancashire and Healthwatch Blackburn with Darwen and with the Carers Services for East Lancashire and Blackburn with Darwen. During normal times, regular meetings are held between the Trust and these organisations and representatives are invited to take part in quality improvement projects. These meetings have been continuing but in a virtual sense, using Microsoft Teams. The Trust continues to be involved in and contribute to Healthwatch projects.

The Trust has established partnerships with the University of Central Lancashire (UCLan) and Blackburn, Burnley and Nelson and Colne colleges which help us attract local young people to come and work at the Trust. The Trust will benefit from students and graduates from UCLan's Medical School as well as IT, HR and Finance and other administrative

professions.

The Trust works closely with the CCGs to ensure that issues raised by GPs and local healthcare providers via the CCG "Connect" mailbox, are investigated and responded to.

We are continuously working closely with our NHS partners. For example, in the Pennine Lancashire Together a Healthier Future programme, we are part of:

1. Partnership Leadership Forum
2. Transformation Steering Group
3. Care Professionals Board
4. Finance and Investment Group
5. Joint Cost Improvement/Quality, Innovation, Productivity and Prevention (QIPP) Plans
6. Out of hospital working groups around development of the Integrated Neighbourhood Teams
7. On a wider Lancashire and South Cumbria footprint, we are part of the Integrated Care Partnership Board
8. Provider Board
9. Acute and Specialist work stream
10. Working groups on ICS priorities e.g. Stroke, Urology, Vascular, CAMHS, Head and Neck Cancer, Diagnostics etc.

Principal risks

The Trust has identified and assessed its risk areas and put in place mitigation strategies.

The Board Assurance Framework and Corporate Risk Register are regularly presented to the senior leadership at the Operational Delivery Board and to the Directors at the Trust Board. The main risks outlined on the Board Assurance Framework during last year were:

1. Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.
2. Recruitment and workforce planning fail to deliver the Trust objectives
3. Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve

the health and wellbeing of our communities.

4. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework
5. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.
6. COVID-19: this is a new risk that has been added to the Board Assurance Framework in March 2020 as a result of the global pandemic related to the COVID-19.

The Trust's assessment of risks 1, 2, 4 and 5 was that these were the highest risks with the most significant impact and likelihood.

Various actions were undertaken to reduce and mitigate the risks and the detail of those is provided in the Board Assurance Framework which is published as part of the Trust Board Reports. The Annual Governance Statement which follows later in the document describes the risk approach for the Trust and provides details of risk management across the organisation and gives more details about the significant risks that the Trust encountered in the year.

Signed: *K. P. McGee (signed electronically)*
Kevin McGee, Chief Executive
Date: 14 June 2021

Accountability Report

Corporate Governance Report

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed *K. P. McGee (signed electronically)*
Kevin McGee, Chief Executive

Date: 14 June 2021

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.
The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Board

14 June 2021 Date K. P. McGee (signed electronically) Kevin McGee, Chief Executive

14 June 2021 Date M Brown (signed electronically) M Brown, Finance Director

Annual Governance Statement 2020-21

Scope of responsibility

1. As Accountable Officer and Chief Executive of East Lancashire Hospitals NHS Trust, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also have responsibility for safeguarding the Trust's quality standards. In carrying out these obligations I and the Trust Board adhere to the NHS Codes of Conduct and Accountability. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum. These include:

The purpose of the system of internal control

2. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Lancashire Hospitals NHS Trust; to evaluate the likelihood of those risks being realised and the impact should they be realised; and to manage them efficiently, effectively and economically.
3. The system of internal control has been in place in East Lancashire Hospitals NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

4. The way in which the Chief Executive of the Trust maintains a sound system of internal control which supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets include:
   a) Ensuring that the accounts of the Trust that are presented to the Board for approval are prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury.

b) Ensuring that the accounts disclose a true and fair view of the Trust's finances.

c) Ensuring that managers at all levels have a clear view of their objectives and the means to assess achievements in relation to those objectives, have well defined responsibilities for making the best use of resources, have the training, information and access to expert advice they need to exercise their responsibilities effectively and are appraised and held to account for the responsibilities assigned to them.

d) Ensuring the Trust achieves value for money from the resources available to it, avoiding waste and extravagance in the Trust's activities.

e) Ensuring the implementation of any recommendations affecting good practice.

f) Ensuring the National Audit Office is provided with information it requests and that the Trust co-operates with external auditors in their enquiries.

g) Ensuring internal audit arrangements comply with the NHS Internal Audit Manual.

h) Ensuring prompt action is taken in response to concerns raised by internal or external audit.

i) Ensuring the Executive Director of Finance properly discharges her responsibilities for the effective and sound financial management and information and that the Trust meets the financial objectives set by the Secretary of State for Health and the assets of the Trust are properly safeguarded.

j) Ensuring that the Codes of Conduct and Accountability are promoted to and observed by staff.

k) Ensuring appropriate advice is tendered to the Board on all matters of financial probity and regularity and all considerations of prudent and economical administration, efficiency and effectiveness.

l) Ensuring that the appropriate action is taken if the Board or Chairman contemplates a course of action which I consider would infringe the requirements of propriety and regularity or adversely affect my responsibility for obtaining value for money from the Trust's resources.

5. As the Accountable Officer, the Chief Executive has fulfilled these duties by:

a) Continuing to review and realign the responsibilities of the Executive Directors

b) Maintaining the Board focus, through my Chief Executive Report, on actions taken to address any areas of slippage on performance and advise the Board of emergent national and regional priorities.

c) Ensuring there is effective partnership between the Trust and the wider health economy and beyond and establishing processes to ensure that I and the senior

management team have effective working relationships with our partner organisations', the Care Quality Commission, local commissioners and social care providers, local and regional education partners, local councils and MPs, other NHS providers including Trusts and GPs and the public.

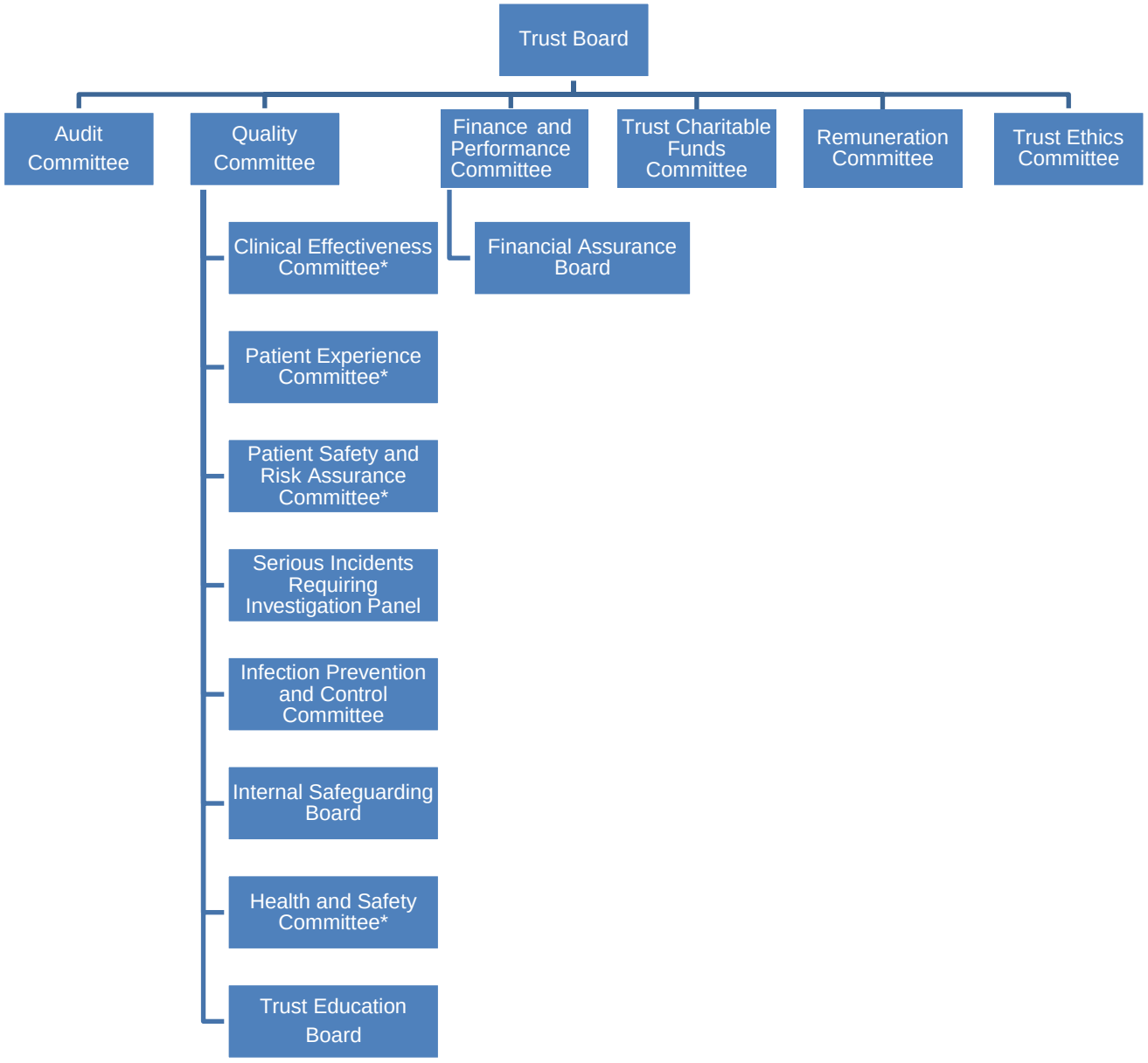
d) Attendance at Chief Executive Forums and other appropriate local, regional and national conferences.

e) Attendance and pro-active participation at the meetings in relation to the Pennine Lancashire Integrated Care Partnership (ICP) and the Lancashire and South Cumbria Integrated care System (ICS).

The Governance Framework of the Trust

Board Committee Structure

6. The Trust Board has overall responsibility for setting the strategic direction of the Trust and managing the risks to delivering that strategy. All committees with risk management responsibilities have reporting lines to the Trust Board.



7. The above Board and Committee structure was temporarily revised during the COVID-19 pandemic. The Trust Board and its immediate sub-committees continued in their original form, albeit with streamlined agendas and shorter meetings in order to release some capacity for senior managers to focus attention on the response to the pandemic. The following committees which feed into the Quality Committee were combined into the new Trust Wide Quality Governance Meeting (TWQGM):

   a) Clinical Effectiveness Committee

b) Patient Experience Committee
c) Patient Safety and Risk Assurance Committee
d) Health and Safety Committee

8. The Serious Incidents Requiring Investigation Panel continued to meet throughout the pandemic. Matters relating to Infection Prevention and Control (IPC) were addressed on a daily basis through the Incident Command and Control meetings and on a monthly basis through the Quality Committee. Healthcare Associated Infections (HCAI) reports were also provided to Divisional Quality and Safety Board meetings.

9. In addition, the Financial Assurance Board, which reports into the Finance and Performance Committee was stood down throughout the pandemic but is being re-established for 2021-22.

10. As a result of the COVID-19 pandemic the Trust established an Ethics Committee as a Sub-Committee of the Trust Board in May 2020; this Committee has been chaired by the Trust's Executive Medical Director and is attended by a number of Non-Executive Directors, Trust Senior Managers, the Director of Public Health from the Local Authority and an independent ethics expert.

Board and Committee Attendance Records and Scope of Work

11. The Trust Board is responsible for monitoring the overall programme for management of risk across the organisation and its activities and decides the risk appetite of the Trust. The Trust Board sets the strategic direction of the Trust and receives regular reports on the performance of the Trust in meeting its objectives.

12. The Board recognises that its long-term sustainability depends upon the delivery of its strategic objectives, within these agreed parameters and also that the relationship with staff, patients, contractors and the public and stakeholders is key to the Trust's success. As such ELHT upholds a duty of care to ensure that Health and Safety is not compromised and therefore as such the Trust will not accept risks that result in a negative impact on Health and Safety. However, within regulatory constraints, the Trust has a greater appetite to take considered risks to pursue innovation and challenge and take opportunities where positive gains can be anticipated regarding organisational issues.

Y Attended D Deputy attended A Apologies received

Name	Role	2020-21						
		May	June	July	Sept	Nov	Jan	Mar
Professor Fairhurst	Chairman	Y	Y	Y	Y	Y	Y	Y
Mr McGee	Chief Executive/Accountable Officer	Y	Y	Y	Y	Y	Y	Y
Mrs Anderson	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y
Professor G Baldwin	Non-Executive Director (from 1 January 2020)	A	A	A	Y	A	Y	Y
Mr Barnes	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y
Mrs Brown	Executive Director of Finance	Y	Y	Y	Y	Y	Y	Y
Mr Catherall	Associate Non-Executive Director	A	Y	Y	Y	Y	Y	Y
Mr Fogg	Non-Executive Director (until end January 2021)	Y	Y	Y	A	Y	A	
Mrs Gilligan	Chief Operating Officer (from October 2020)					A	Y	A
Mr Hodgson	Deputy Chief Executive/Executive Director of Service Development	Y	Y	Y	Y	Y	Y	Y
Mrs Hughes	Executive Director of Communications and Engagement (until November 2020)	Y	Y	Y	Y	Y		
Mr Husain	Executive Medical Director	Y	Y	Y	A	Y	Y	Y
Miss Malik	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y
Mr McDonald	Executive Director of Integrated Care, Partnerships and Resilience (from December 2020)						Y	Y
Mr Moynes	Executive Director of HR and OD	Y	Y	Y	Y	Y	Y	Y
Mrs Patel	Associate Non-Executive Director	Y	Y	Y	Y	Y	Y	A

Name	Role	2020-21						
		May	June	July	Sept	Nov	Jan	Mar
Mrs Pearson	Executive Director of Nursing	Y	Y	Y	A	Y	Y	Y
Mr Rehman	Non-Executive Director (from February 2021, Associate NED until January 2021)	Y	Y	Y	Y	Y	Y	Y
Mr Smyth	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y
Mr Wedgeworth	Associate Non-Executive Director	Y	Y	Y	Y	Y	Y	Y
Miss Wright	Executive Director of Communications and Engagement (from January 2021)						Y	Y

13. 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 risk committees. It is charged with ensuring that the Board and Accountable Officer gain the assurance they need on governance, risk management, the control environment and the integrity of the financial reporting

Name	Role	2020-21					
		Apr	May	June	July	Oct	Jan
Mr Smyth	Non-Executive Director (Committee Chair)	Y	Y	Y	Y	Y	Y
Professor Baldwin	Non-Executive Director (from 1 January 2020)					Y	Y
Mr Barnes	Non-Executive Director	Y	Y	Y	Y	Y	Y
Mr Rehman	Non-Executive Director (from February 2021, Associate NED until January 2021)	Y	Y	Y	Y	Y	Y

14. The Quality Committee provides assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

Name	Role	2020-21								
		Apr	July	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Mrs Anderson	Non-Executive Director (Committee Chair)	Y	Y	Y	Y	Y	Y	Y	A	Y
Mr Fogg	Non-Executive Director (until end January 2021)			A	Y	Y	Y			
Mr Husain	Executive Medical Director	Y	Y	Y	Y	Y	Y	A	Y	Y
Miss Malik	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr McDonald	Executive Director of Integrated Care, Partnerships and Resilience (from December 2020)						Y	Y	Y	Y
Mr Moynes	Executive Director of HR and OD	Y	Y	Y	Y	Y	Y	Y	Y	D
Mrs Patel	Associate Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs Pearson	Executive Director of Nursing	Y	Y	Y	D	Y	D	Y	Y	Y
Mr Wedgeworth	Associate Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y

15. The role of the Finance and Performance Committee is to provide assurance on the delivery of the financial plans approved by the Board for the current year, 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. It maintains an overview of the financial and performance risks recorded on the Board Assurance Framework.

Name	Role	2020-21										
		Apr	June	July	Aug	Sept	Nov 1	Nov 2	Dec	Jan	Feb	Mar
Mr Barnes	Non-Executive Director (Committee Chair)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs Anderson	Non-Executive Director	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y
Mrs Brown	Executive Director of Finance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr Catherall	Associate Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs Gilligan	Chief Operating Officer (from October 2020)						A	D	D	Y	Y	Y
Mr Hodgson	Deputy Chief Executive/Executive Director of Service Development	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr McDonald	Executive Director of Integrated Care, Partnerships and Resilience (from December 2020)								Y	Y	Y	Y
Mr Rehman	Non-Executive Director (from February 2021, Associate NED until January 2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

16. The remit of the Ethics Committee was to provide a mechanism within the Trust for the discussion of ethical issues arising from COVID-19 which may have had an impact on how clinical practice was delivered, ensuring that care continued to be provided in a fair and equitable way.

Name	Role	2020-21					
		May	June	Aug	Oct	Dec	Jan
Mr Husain	Executive Medical Director (Committee Chair)	Y	Y	Y	Y	Y	Y
Mrs Anderson	Non-Executive Director	Y	A	A	Y	Y	Y
Professor Baldwin	Non-Executive Director (from 1 January 2020)	Y	Y	Y	Y	Y	Y
Mrs Pearson	Executive Director of Nursing	Y	Y	Y	Y	Y	Y

Board Performance and Effectiveness

17. The Board is committed to continuous improvement and development. The Trust has worked with the Good Governance Institute since 2015 when it carried out an independent review of the Board's performance. A resultant action plan was developed and completed which paid particular attention to the well-led framework as well as other governance matters to ensure the Trust's ongoing improvements in corporate and clinical governance. Part of the work focused on a measurement of the Board against the Good Governance Institute Matrix of Board Maturity and the action plan was developed to promote and evidence evolution of behaviours and processes. During 2020-21 the Board continued to work with the Good Governance Institute and had several strategy session discussions around the challenges of the evolving health sector landscape and the opportunities for the organisation to continue on its journey of delivering safe, personal and effective care to the population of East Lancashire and indeed the Lancashire and South Cumbria population whilst improving our governance systems and processes and providing increasingly robust assurance.

18. The Trust Board considers the success of each Trust Board meeting in public at the conclusion of the meeting with particular focus on whether Board members have had sufficient focus on aspects such as patient experience, quality, risk and partnership working.

19. The Care Quality Commission (CQC) carried out a Well Led Review of the Trust on the 25 and 26 September 2018. The outcome of the review has resulted in the Trust being awarded an overall rating of "Good" with areas of "Outstanding" by the regulator.

20. The Trust has a clear vision, objectives, values, operating principles and improvement priorities. The hospital services are supported by strong governance processes including well managed risk registers and processes feeding into the Trust Board. This ensures a robust overview of the risks within the organisation. There is on-going work to enhance the Board Assurance Framework and risk management in the Trust and this is included in the action plan from the CQC Well Led Review which is regularly monitored through the Quality Committee. The Trust has a Clinical Strategy in place and has begun the work to refresh it in the last quarter of the 2020-21 year as the existing strategy had fulfilled its aims. The Board held a strategy session, with input from Clinical Divisions on 2 March 2021 to commence the work to refresh the strategy. The Board development programme includes elements of both self and external assessment. The Board is committed in its support of continuous learning and professional development; is clear on roles and accountabilities in relation to Board governance and there are clearly defined and understood processes, for escalating and resolving issues and managing performance. The Trust Board ensures that it actively engages with its patients, staff and its shadow governors and other stakeholders as appropriate on quality, operational and financial performance. Reports are taken to the Trust Board at each meeting on matters of performance and through the assurance committees of the Trust.

Highlights of Board Committee Reports

21. The Audit Committee has been active throughout the year in providing assurance on governance, risk management, the control environment and the integrity of the financial statements. Reports have been considered in detail from management representatives where "limited assurance" opinions have been given by the internal audit service. Audit Committee members assess the strength of assurances received from a number of sources over the course of the year. These sources include but are not limited to:

    a) Internal Audit Reports
    b) External Audit Reports
    c) Anti-Fraud Service Reports

d) The Quality Committee
e) The Finance and Performance Committee
f) External reviews commissioned by the Trust
g) Stakeholder feedback
h) Management responses to internal audit reports, providing updates on actions taken to address any recommendations given as a result of audits.
i) Media reports
j) Learning from other organisations
k) Reports from internal service providers.

22. The Trust Board has additionally considered a number of annual reports, including, but not limited to those in relation to Infection Control, Emergency Planning, Winter Planning, Medicines Management, and the recommendations of national reports. The Trust Board has engaged proactively in the development of a five-year Clinical Strategy for the Trust and the wider health and social care economy that was approved in April 2016.

23. The Clinical Strategy is subject to regular reviews. Whilst it's basic tenets remain as relevant today as when first written it has been revised to be more reflective of the integrated system working prevalent within both the Pennine Lancashire Integrated Care Partnership and also the Lancashire and South Cumbria Integrated Care System.

24. Through this process, we are confident there is a 'golden thread' from the NHS Long Term Plan, Healthier Lancashire and South Cumbria plans, the Pennine Plan, ELHT's Clinical Strategy, the corporate Operational Plan and the individual Clinical Divisional and Directorate plans. In addition, we have ensured that the aforementioned plans are aligned to the six objectives of the NHS England/Improvement (NHSE/I) planning guidance for 2021-22. Such plans have been shared with partners and there are a number of tangible areas of service development that have improved services to patients e.g. Long-COVID Clinics, Primary Care Networks (PCNs) and more integrated working with local and regional partners.

25. The Trust's Chief Executive, who is jointly appointed for the Trust and Blackpool Teaching Hospitals NHS Foundation Trust is also the cell lead for the ICS Hospital Cell.

Quality Governance

26. The Trust is committed to the continuous improvement of the quality of care given to

local people and, in so doing, achieving our organisational aim 'to be widely recognised for providing safe, personal and effective care'. All Executive Directors have responsibility for Quality Governance across their particular spheres of activity and the Executive Medical Director is the delegated lead for Quality on the Board overall.

27. Quality monitoring occurs through our Clinical Governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the TWQGM, Serious Incidents Requiring Investigation Panel (SIRI), Clinical Effectiveness Sub-Committee (CEC), Patient Experience Group Sub-Committee (PEGS), Health and Safety Committee (H and SC), Internal Safeguarding Board and Infection Prevention and Control Sub-Committee. For the past 12 months during the COVID pandemic some of these sub-committees have reported directly through the TWQGM to ensure relevant governance and escalation is still managed in the absence of that particular group. Divisional Directors or their agreed deputies attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

Safe

Incident Management

28. The Trust has robust systems to manage and learn from incidents. The Board receives a regular written report on serious incidents requiring investigation at each meeting held in public where new incidents are reported and an update is given in relation to the progress of the management of incidents, including Duty of Candour and a section on what lessons have been learnt as a consequence of the incident investigation process and how the lessons have been translated to deliver improvements in the quality and safety of services.

29. The Trust also has a Serious Incident Requiring Investigation (SIRI) Panel which is chaired by a Non-Executive Director and also an Extra-ordinary panel for Pressure Ulcers to support the management of these. The Panel reviews the investigations undertaken as a result of never events and serious incidents to ensure that a thorough review is completed, the Duty of Candour is observed and that learning from incidents is circulated appropriately across the organisation. The Panel has senior representatives from local commissioning organisations and provides assurance to the Quality Committee on the matters within the remit of its Terms of Reference.

30. Incidents are reported in accordance with the NHS England Serious Incident Framework (SIF) and no significant control issues have been identified as a result of the incidents investigated during the course of the year.

31. Never Events are also managed in accordance with the SIF, reported via the Strategic Executive Information System (StEIS) and investigated and validated in partnership with our Commissioners, East Lancashire CCG.

Risk Management Strategy, Policy and Plan

32. The Trust's Risk Management Framework has recently been approved (March 2021) but themes and best practice from this framework have been regularly communicated and trained throughout the Trust through 2020 including escalation and governance arrangements from `Ward to Board`. The Risk Management Framework (RMF) has been designed to act as a Policy, Strategy and Procedure to replace the previous Risk Management Policy and is due to be launched Trust Wide in April 2021. The Trust has adopted a Risk Management Appetite with formal arrangements in place for managing strategic and operational risks throughout the Trust.

33. In addition to a system of internal controls, a performance management approach compromising two KPIs (compliance and maturity) is also used in undertaking a health check of the Trust`s risk management culture. There is sufficient energy and momentum across the Trust in effectively minimising and managing risks by strengthening and developing integrated and agile risk management systems and processes which are wrapped around appropriate governance, scrutiny, assurance and oversight. Datix is the principal risk management system while risk registers are used as repositories for risks. As a general principle, the Trust will seek to eliminate or effectively control all risks to patients, staff, and other stakeholders including those which pose a threat to its reputation. Due to COVID-19 and the progression of the Risk Management Framework there has been no Maturity KPI review and this will be picked up within the Trust's restoration work within quarters 1 and 2 of 2021-22.

34. The Trust is committed to implementing a structured, standardised, systematic, integrated, comprehensive, performance-based and whole-system approach to managing both operational and strategic risks. The Trust's risk management process which includes establishing the context, risk identification, assessment, prioritisation, monitoring and review is:

    a) Based on best available information e.g. data.

b) Systematic, consistent, timely and underpinned by a structured enterprise-wide approach that seeks to contribute to efficiency and reliable results.
c) Transparent and inclusive and involves appropriate stakeholders at all levels of the organisation.
d) Enhanced training delivered digitally and face to face throughout the Trust.
e) Dynamic, iterative and responsive to change.
f) Capable of continual improvement and enhancement in patient care and safety.
g) Wrapped around the values of the Trust – Value-Based Risk Management.
h) Focused on encouraging staff to continuously scan the horizon for emerging risks and to ensure appropriate mitigations are in place.
i) Driven by the need to develop and strengthen staff capacity and capability in risk management through education and training.
j) Underpinned by a succinct Risk Management Framework which is available on the Trust's intranet system for staff to access, explore and utilise.

35. The Trust uses Equality Impact Assessments as part of its policy development and ratification process. Policies are assessed against the equality standards and are integrated into the process through the Trust's Policy Council. In the absence of the Policy Council due to COVID-19, the Trust has regularly reviewed its policies in the TWQGM and has sought assurance from Policy Owners that policies are fit for purpose to grant extensions due to the pandemic.

36. Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. In order to complement learning, the Trust also places emphasis on training and developing staff capacity and capability in risk management underpinned by the use of clearly articulated descriptors for likelihood and consequence as well as the use of the 5X5 matrix. These have not only enabled engagement and consistency but have established a common currency, framework and methodology for the assessment of all types of risk. Learning is shared in a wide variety of ways at departmental, divisional and corporate levels through a number of face-to-face meetings and bulletins and the publication of the Trust's Share to Care newsletters. Learning is acquired from a variety of sources including:

a) Analysis of incidents, complaints and claims and identification of trends with appropriate mitigating actions
b) External inspections

c) Internal and external audit reports
d) Clinical audits
e) Outcome of investigations and inspections relating to other organisations
f) Quality Improvement Programmes

Personal

Learning from Complaints and Patient Experience

37. The Trust has made significant organisational, cultural, and behavioural changes and continued to progress on these since it's 'Good' CQC rating in 2019. One aspect to the achievement has been the Trust's improvements in responding to patient and family's concerns and complaints; through strengthening the communication with complainants and providing rigorous investigations that understand the causes of the dissatisfaction. As stated within this document, complaints and the learning from there are closely aligned to incident reporting and Quality Improvement, so not only the individual and area will learn from identified issues, but the organisation as a whole. Key to the Trust's approach is to keep the patient central to the process.

38. Patient Experience is pivotal in all aspects of how the Trust deliver patient care, and to the wider support of their families; with the Patient Experience team supporting staff to enhance all parts of their interactions with patients. The Patient Experience team gather, share and utilise patient experience metrics collated from sources such as Friends and Family Test, national surveys regarding Inpatient, Maternity, Urgent / Emergency Care and Children and Young People. They are also involved in analysing local surveys, where patients and carers have given their views; helping staff to interpret the information into genuine service improvements.

39. Complementing the above work has been the establishment of the Trust's Public Participation Panel, which consists of members of the public providing a critical friend role to the Trust, through examining and being involved in service delivery and improvement work. During 2020/2021 Public Participation Panel members have participated in a vital quality improvement project to develop a high quality care model for the rehabilitation of patients diagnosed with COVID-19 who, as part of their acute hospital admission, required care in the Intensive Care Unit (ICU) at East Lancashire Hospitals NHS Trust. A Children and Young People's Patient Participation Group has also been established at the Trust. The establishment of these panels gives the Trust the foundation and opportunity to consider with our patients where the Trust wants to

go from here in providing experience excellence.

Effective

Clinical Effectiveness

40. The Trust has a Clinical Effectiveness Team which reports regularly to the Clinical Effectiveness Committee, which is a sub-committee of the Quality Committee via assurance reports which measure the quality and safety of care against national best practice indicators. For the past 12 months during the COVID pandemic the sub-committees has reported directly through the TWQGM to ensure relevant governance and escalation is still managed. Having identified areas for improvement, the Quality Improvement team supports clinical teams in the implementation of improvement and action plans and measuring the effectiveness of tests of change on an on-going basis. A summary of the work of the Clinical Audit and Effectiveness Department is reported to the Quality Committee.

Quality Improvement

41. In order to support the delivery of safe, personal and effective care the Trust has a robust process for the identification and agreement of key improvement priorities. The improvement priorities fall into five key areas: Quality, People, Non-Elective Care, Elective Care and Outpatients. Each of the areas has an Executive Lead and members of the Improvement Hub Team assigned to support delivery. The Quality priorities include the Harms Reduction Programme (Falls, Deteriorating Patient, Maternity Neonates, SAFER Surgery, Medication Errors, Hand Hygiene), Nutrition and Hydration, End of Life Care and a range of projects identified by Divisional Teams linking to Clinical Effectiveness (reliability) and Patient Experience. A set of COVID specific improvement priorities were also identified to support delivery of high-quality clinical care for COVID-19 inpatients including the introduction of the COVID admission checklist, Treatment Escalation Plans and Oxygen Management. Progress and assurance on improvement plans has been reported to both the Quality Committee and Finance and Performance Committee.

42. During 2020-21 the improvement teams across the organisation have come together to form the Improvement Hub, led by the Associate Director of Improvement and Deputy Medical Director (Transformation). As part of this our Improvement methodology has been further developed to SPE+ (Improving Safe, Personal and

Effective Care). The six phases are noted to be: Understand; Co-Design, Test and Adapt; Embed; Spread and Sustain. This is based on Lean principles, from our participation in the National Vital Signs Programme, the Model for Improvement and other tools. For large multi-team improvements, we run Value Stream Analysis Events, six-week improvement bursts and Breakthrough Series Collaboratives as appropriate.

43. Whilst our organisational improvement training offer has been paused for the majority of 2020 due to the COVID pandemic we have continued to support Professionals in training to develop and participate in quality improvement projects. A revised and improved training offer has been developed to launch in 2021.

44. The Trust has adopted the Care Quality Commission methodology of assessment to use on a regular basis to understand how quality governance arrangements are working across all spheres of activity by undertaking mini assessments. Regular meetings with the Care Quality Commission enhance a wider understanding of our progress and ensure we are able to access learning from other organisations. The Trust was last inspected by the Care Quality Commission in August/September 2018. The outcome of the inspection was that the Trust was awarded an overall rating of 'Good' with some areas of 'Outstanding'.

45. The Trust produces a regular Share to Care magazine based on sharing the learning and improvement work that has been initiated within the organisation following the identification of challenges, serious incidents and/or common themes.

Data Quality

46. The Trust has a Data Quality Group which reports to the Trust Contracting and Data Quality Group. The group reviews the Secondary Uses Service data quality dashboards and the Dr Foster data quality summary dashboard. We have an online report for key data quality risks which has named leads for each data quality risk and an overall data quality log including risk scoring.

47. We work closely with the local Clinical Commissioning Groups and Commissioning Support Unit including a monthly Contract Performance and Delivery Group where we discuss data quality issues and monitoring of the data quality plan.

48. East Lancashire Hospitals NHS Trust submitted records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

49. The Trust undertakes a weekly review at specialty level of all patients which includes Quality and accuracy of elective waiting time data.

Discharge of Statutory Functions

50. As Accountable Officer my enquiries have confirmed that there are arrangements in place for the discharge of statutory functions and that the arrangements have been checked for irregularities and they are legally compliant. The Trust has taken action to ensure that the estate is statutorily compliant and that compliance processes are audited and monitored through the Estates and Facilities Quality and Safety Board and Trust Quality Committee. The Trust has confirmed compliance with Emergency Planning, Resilience and Response (EPRR) requirements in line with the Civil Contingencies Act 2004 and has substantial compliance with the associated EPRR standards.

51. All members of the Trust Board have signed up to the Trust Risk Management and Governance plans which clearly identify the Board's responsibilities and accountability arrangements. These are reflected in the Trust's Standing Orders and Standing Financial Instructions, the Scheme of Reservation and Delegation and the Trust's Performance Accountability Framework. These are, in turn, repeated in the internal guidance and policies of the organisation.

52. Scrutiny by the Trust's Non-Executive Directors and internal and external auditors provide assurance on the systems and operation of the processes for internal control across the whole of the Trust's activities including probity in the application of public funds and in the conduct of the Trust's responsibilities to internal and external stakeholders.

53. In addition to the Committees outlined in the diagram earlier in this document which have Non-Executive Director membership, the Trust also has the Senior Leadership Group. The function of this committee is: to provide a forum by which the senior staff in the organisation can assist in the development of strategies to present to the Board; monitor operational delivery against the Trust's strategic objectives and policies; advise the Board on the emerging risks to operational and strategic objectives; and the mitigation plans being deployed to ensure the delivery of safe, personal and effective care.

54. The Trust risk management process clearly identifies a score-based system in allocating responsibility for reviewing and scrutinising risks to specific committees and

individuals. Directorate and Divisional risk registers are reviewed and discussed at appropriate directorate and divisional meetings. The Corporate Risk Register, the Trust-wide Risk Register and Board Assurance Framework are also sighted at appropriate meetings which include Risk Assurance Meeting, TWQGM, Quality Committee and the Trust Board. Risk register reports are reviewed and scrutinised at the above meetings to provide assurance as well as consistently confirm the Trust's attachment to the robust scrutiny, governance and oversight of our risk management culture. Whilst risks scoring 1-8 and 9-12 are managed at Directorate and Divisional levels respectively, those scoring 15 and above are escalated by the Divisions for consideration by the Risk Assurance Meeting for inclusion onto the Trust Corporate Risk Register although ownership is still locally owned and led. The Corporate Risk Register and the Board Assurance Framework are linked as they feed-off and inform each other.

55. The Board has in place established risk management groups and supporting governance structures that together are responsible for identifying, assessing, managing and reporting the risks associated with clinical, corporate, financial and information governance. The Medical Director has the lead responsibility for the risk management processes including the development and implementation of the Board Assurance Framework, Risk Management Strategy Policy and Plan and associated learning and development to ensure all staff are appropriately trained and supported thereby ensuring our risk management processes are thoroughly embedded across the organisation.

56. The Executive Medical Director is supported by the members of the Executive Team in providing leadership to the risk management process. Executive Directors are lead directors for the strategic risks on the Board Assurance Framework. In this way the senior leaders in the organisation have an operational and strategic oversight of the key risks to achieving the Trust's strategic objectives. Each area of risk is mapped to the Care Quality Commission's Core Outcomes and risks contained in the Corporate Risk Register. The Trust Board receives a regular update on recommended changes to the Board Assurance Framework taking into account the progress of mitigation plans, positive assurances received since the last report to the Trust Board, and gaps in assurance identified in the period. In addition, two of the Sub-Committees of the Trust Board (Quality Committee and Finance and Performance Committee) continue to undertake deep dives of the risks on the Board Assurance Framework (BAF). Work

to refine both the BAF and the Corporate Risk Register were temporarily halted during the 2020-21 year due to the ongoing pandemic response. During the peak of the pandemic the BAF was revised to allow the Board and its Committees to focus attention on the overarching COVID-19 risk. This was done by linking the five existing risks (transformation, workforce, partnership working, finance and constitutional standards) into a new overarching COVID-19 risk. The work to revise the BAF and CRR was recommenced in quarter four of the 2020-21 year with the revised versions of the BAF and CRR being presented to the Board in March 2021.

57. The Executive Medical Director, as Responsible Officer, reports directly to the Chief Executive Officer. The Executive Medical Director has oversight of the systems and processes to ensure there is strong clinical education across the whole of the organisation, that medical revalidation arrangements are robust and effective and that the professional standards required of our medical staff are met, addressing any shortcomings effectively within the guidance issued by the General Medical Council. The Caldicott Guardian, who reports to the Executive Medical Director, is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

58. The Executive Director of Nursing provides professional leadership to nursing and midwifery staff within the organisation and provides senior leadership along with the Executive Medical Director, to the organisation in relation to patient safety and quality of service delivery. They are supported by the Director of Nursing and Divisional Directors of Nursing within the clinical divisions, who ensure there is a continuing focus on the delivery of safe, personal and effective care. As a senior leadership team, they ensure that there are sufficient appropriately qualified nursing and midwifery staff deployed on a daily basis to meet the levels of capacity and acuity and to meet safe staffing requirements.

59. The CQC action plan is regularly monitored, and the Trust meets with the CQC on a regular basis.

60. The Executive Director of Finance is accountable to the Trust Board and Chief Executive for the Trust's financial risk management activities. They are responsible for ensuring that the Trust carries out its business of providing healthcare within sound Financial Governance arrangements that are controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis. She also has delegated responsibility for 'Registration Authority'. The Executive

Director of Finance is the Board lead for Information Security and the Senior Information Risk Officer (SIRO).

61. The Chief Operating Officer is responsible for the overall management of all patient services, ensuring that all key access targets are met.

62. The Executive Director of Integrated Care, Partnerships and Resilience is the Accountable Emergency Officer under the 2004 Civil Contingencies Act and the Trust Lead for Emergency Preparedness, Resilience and Response. The Trust also has a nominated Non-Executive Director with oversight of EPRR within their specific duties.

63. The Executive Director of HR and OD is responsible for the management of risks within his areas of operational responsibility, especially those risks associated with health and wellbeing, bullying and harassment. They are responsible for ensuring provision of employment services across the Trust and ensuring that there is a systematic approach to managing the risks of employment checks and professional clinical registration.

64. Each clinical division is further supported by Quality and Safety Leads working with the divisions and reporting to the Associate Director of Quality and Safety.

65. The Trust supports the whole workforce to ensure they are appropriately trained and equipped to manage risk relevant to their role and requirements.

66. Under normal circumstances all staff are required to complete Core Skills Training (CST) and any essential to role training identified by their line manager. All managers have access to live CST compliance reports via the Learning Hub. Staff and their managers will receive 90, 60 and 30-day reminders of any CST due, enabling them to schedule this in. However, owing to the need to ensure sufficient operational capacity to manage the COVID-19 pandemic, the decision was made to temporarily step down the requirement for training that was not ‘essential to role’. Similarly, the need to undertake appraisals was halted during the pandemic. Both CST and appraisal compliance have recommenced fully from 1 April 2021.

67. As part of the Appraisal process all staff have the opportunity to contribute to their development via the Learning and Development Journey and are able to further support their personal and professional development using the e-portfolio area of the Learning Hub.

68. The Agency Group meets monthly to review the detail and identify appropriate actions to ensure maximum use and productivity of our workforce. These groups report into the Executive Oversight Committee that meets monthly to review agency spend and

receive assurance that risks and hotspot areas are being addressed in order to reduce agency spend in line with the target set by NHS England and NHS Improvement. There are multiple workstreams which underpin our programme to reduce agency spend and ensure the most effective use of our resources.

The Risk and Control framework

69. The main thrust of the Trust Risk Management Framework is to support the development of an organisation-wide and integrated risk management culture that not only embeds an awareness of safety and risk alertness across all levels of the Trust but empowers staff to frequently scan the horizon for emerging risks. This is also underpinned by an enterprise-wide and consistent approach which includes appropriate ranking, grading, prioritisation, management, escalation and governance of risks in accordance with best practices and the Good Governance Framework. This equally ensures that both operational and strategic risks are consistently managed and mitigated to acceptable or tolerable levels. Significant residual risks are openly accepted, monitored and managed by systematically addressing any gaps in control via action plans while reducing their potential impact to both individuals and the organisation as far as reasonably practicable. Analysis of the severity and likelihood of risks determines their overall ratings, level of management and governance. The overarching performance management framework for risk management within the organisation endeavours to ensure that there are appropriate controls in place to mitigate and manage any risks to the delivery of key performance targets. National priorities highlighted either by NHS Improvement, NHS England or the Care Quality Commission are systematically reported to the Trust Board while risks to the achievement of strategic objectives are monitored through the Board Assurance Framework.

70. The objective of the Risk Management Framework is to support the development of a culture that not only embeds an awareness of safety and risk across all levels of the organisation, but ensures the application of a consistent approach to a risk management process, thus allowing risks to be ranked and graded in order that they may be prioritised. This minimises and mitigates risk to acceptable levels. Where significant risks remain, we can openly accept and monitor those risks, systematically addressing any gaps in control measures and reducing their impact to both individuals

and the organisation so far as reasonably practicable. This is done in line with the Trust's Risk Appetite which has been adopted recently.

71. The identification of risk to the organisation achieving its objectives is undertaken by staff at all levels of the organisation. The Trust focuses on a proactive identification of risks although staff may also identify risks reactively from the following internal and external sources:

a) Non-Clinical Risk Assessments
b) Incident reports, Deep Dives, Internal Reviews, Walkabouts etc.
c) Complaints / Patient Experience or Claims Audits and workplace surveys
d) Clinical risk assessments
e) Patient satisfaction surveys
f) External/Internal Audits, Coroner Reports, External Visits,
g) Regulatory Agency notices (e.g. CQC Reports, Safety Notices e.g. MHRA)
h) National Enquiry Reports, Benchmarking and Key Performance Indicators.
i) Financial
j) Staff COVID Risk Assessments

72. An acceptable risk is one which the Trust Board or the Senior Leadership Group and the Divisions are prepared to accept provided that acceptable mitigation is put in place to address any negative impacts to the achievement of its objectives. Once a risk has been accepted, staff choose from a range of tools often referred as the 4Ts (Treat, Tolerate, Terminate and Transfer) as to how best to effectively control and mitigate the risk. Risk treatment is closely linked to prioritisation which is underpinned by available information and sound judgements. Deciding what is an acceptable risk involves identifying and assessing risks in relation to the impact. A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been mitigated and managed, as far as is considered to be reasonably practicable.

73. As a general principle the Trust will seek to eliminate or control all risk which has a potential to harm its patients, staff, and other stakeholders, which would result in loss of public confidence in the Trust and/or its partner agencies and/or would prevent the Trust from carrying out its functions on behalf of its local residents. However, the following list identifies areas which would never be deemed to be acceptable:

74. Any act, decision or statement which:

a) would result in death
b) would contravene Trust Standing Orders or Standing Financial Instructions

c) would be illegal and/or breach of legislation
d) would result in significant loss of Trust assets or resources
e) would constitute wilful contravention of Trust policies or procedures
f) would fail to observe key targets and objectives

75. The risk grading system in use is adapted from the National Patient Safety Agency "Risk Matrix for Risk Managers" and uses a scoring mechanism of a 5x5 grid approach to grade risks in respect of consequence and likelihood. The Trust uses DATIX to record incidents and risks and access to this system is via the Trust intranet, a web-based package and an application for mobile users.

76. Each entry onto the DATIX system is allocated a manager to review and action the risk and monitor the effectiveness of the risk mitigation plan. Low and moderate risks (those scoring 1-8) are managed at a local level by wards and teams and the department manager using appropriate controls. These are recorded on the local risk register. Significant risks (those scoring 9-12) are managed at a divisional level with assurance being sought through divisional structures and recorded on divisional risk registers. Extreme risks scoring 15 or above escalated by the Divisions, are presented at the Risk Assurance Meeting for approval for inclusion onto the Corporate Risk Register. The Trust has clear risk governance arrangements in place which offer the platform for risks to be discussed, challenged, reviewed, scrutinised, approved and where necessary the score of the risk including title and description may be modified. These mechanisms leverage the opportunity for informed scrutiny, accountability and oversight in line with the Principles of Good Governance. Risks included on the corporate risk register are monitored via the Senior Leadership Group, TWQGM, Quality Committee and the Trust Board.

77. Directorate and Divisional risk registers are reviewed and discussed at Directorate and Divisional Quality and Safety Meetings and the Divisional Management Board respectively in line with the Trust Risk Management Framework. The Trust-wide Risk Register and the Corporate Risk Register are both regularly reviewed, scrutinised and monitored at the Risk Assurance Meeting with the latter also presented to other sub-committees of the Board as articulated above. The meetings where The Trust focuses on ensuring that risks are locally led, owned and managed, thereby prioritising local ownership and engagement as tools for effective risk management and embedding an effective risk awareness culture across the organisation. Whilst this is under normal circumstances, the need to respond to the COVID-19 pandemic meant that the Risk

Assurance Meeting was temporarily stood down between February 2020 and July 2020, oversight and scrutiny of both Risk Registers was therefore maintained via the TWQGM during this time. It is everyone's responsibility from 'ward to board' to actively manage risks However, it is the responsibility of the risk lead/handler to regularly refresh and update them as well as ensuring that appropriate actions are in place to mitigate them. Therefore, effective governance sits with the appropriate committee as stated in the Trust Risk Management Framework.

78. The Trust's key strategic risks in 2020-21 were:

a) BAF Risk 1: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.

b) BAF Risk 2: Recruitment and workforce planning fail to deliver the Trust objectives

c) BAF Risk 3: Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

d) BAF Risk 4: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework

e) BAF Risk 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.

f) BAF Risk 6: Covid-19: this risk was included on the Board Assurance Framework in March 2020 as a result of the global pandemic related to COVID-19 and has remained in place during the course of 2020-21. During the peak of the pandemic this risk has been the main way in which the Trust has reported on BAF risks to the Committees and Trust Board. This has been done by linking the risks set out above (A-E) into the overarching COVID-19 risk. This has enabled the Board and Committee members to maintain levels of assurance whilst focusing on the most pressing matters.

79. The consistently high scoring risks in 2020-21 related to risk 'f' above, as it became the key overarching risk that was reported to the Board and Committee's during the pandemic. As a result of the gaps in assurance for the Finance and Performance Committee and Quality Committees were brought together on a temporary basis in September 2020 as the Joint Quality and Finance and Performance Committee to

specifically focus on these elements. Information reports from the Trust Committees were provided to the Trust Board at each meeting. These covered key elements to ensure that the Trust Board, through the Board Assurance Framework, the Corporate Risk Register and the reports of sub-committees were continually sighted on the risks and the actions being taken to mitigate them and the positive assurances being received in a timely manner.

80. The Trust tests for gaps in assurance via the following actions:

a) Independent assurance provided to or requested by the Audit Committee from internal and external auditors

b) Independent assurance provided to the Quality Committee and supporting subcommittees from external reviews, inspections and assessments and monitoring of subsequent action plans to address any gaps identified

c) Review by internal departments such as the Quality and Safety Unit with Clinical Effectiveness, Clinical Audit and Divisional teams and Directorates reporting to Board sub-committees and the Senior Leadership Group.

d) Rapid responsive reviews of areas of clinical practice in response to incidents, complaints and concerns whether these are raised internally by staff or externally by stakeholders such as Coroners and Commissioners.

81. A range of other actions designed to address identified gaps in controls and assurances have been implemented throughout the year including:

a) Deteriorating Patients: Implementation of a Trust-wide approach to improve the recognition and the response to the deteriorating patients

b) End of life care: Optimise learning from complaints to improve end of life care

c) Hand Hygiene: Increase compliance with hand hygiene and infection prevention guidance through “Prompt to Protect” improvement package

82. Risk management is embedded in the activity of the organisation and the Trust has continued to take significant steps to encourage incident reporting. The Trust has signed up to and promotes the ‘Speak Out Safely’ campaign to encourage an open culture both of raising concerns and learning from them across the organisation. The Trust uses safety huddles across all clinical areas and Share to Care meetings where staff meet on a weekly basis to share good practice and learn from areas of improvement identified in their own practice and from other services across the organisation.

83. The Trust seeks to actively engage with a wide variety of stakeholders to consult and communicate with them on issues of mutual concern. The Trust recognises that there are significant benefits to be gained from this engagement. The Trust also proactively engages with statutory and other stakeholders on a regular basis including staff, Healthwatch, Clinical Commissioning Groups, Local Overview and Scrutiny Committees and local education providers. Under normal circumstances the Trust would hold regular stakeholder events throughout the year and invite stakeholders to meet with the senior leadership teams to ensure transparency of decision-making processes and appropriate consultation takes place. However, during the past year this has not been possible due to the need to minimise footfall on the hospital sites and ensure adequate social distancing measures remain adhered to. Communication from the Trust to the wider public has been focused on the COVID-19 pandemic and has been channelled through the use of social media, local and regional print, radio and television media.

Workforce Strategies

84. The Trust's People Strategy agreed in January 2020 was developed to support the delivery of the Trust's Clinical and Quality Strategies, the priorities of the Lancashire and South Cumbria Integrated Care System (ICS) and the Pennine Lancashire Integrated Care Partnership (ICP). It is also cognisant of the aims and recommendations of key publications:

a. NHS Long Term Plan
b. NHS People Plan
c. NHS Improvement Developing Workforce Safeguards
d. Letter to Chairs and CEOs May 2019 and November 2020 "Improving Our People Practices"

85. The Trust has a divisionally owned, multi-disciplinary annual workforce plan which is developed through the Business Planning process, and triangulates these plans with our Clinical Strategy, Waste Reduction Programme, key service developments, guidance from bodies such as the Royal Colleges and incorporates the outputs of the annual professional judgement reviews in respect of registered and non-registered nurse and midwifery staffing in line with the guidance from the National Quality Board (NQB) to ensure that we deploy the right staff with the right skills at the right place and time. The Trust Board has oversight of the workforce plan which is signed off annually

by the Chief Executive and executive leaders. The Finance and Performance Committee acts as an assurance committee of the Board and receives regular reports detailing workforce related metrics. In addition to the annual workforce planning cycle, the workforce plan is a dynamic plan which is reviewed as and when required as a consequence of changing service need which is identified on an on-going basis through the business case process.

86. To ensure that the Trust effectively deploys its workforce, we have developed detailed action plans in respect of minimising the need for agency usage and increasing our eRostering levels of attainment and oversight of this is held at Executive level through the Agency Group meetings that reports into the Finance and Performance Committee through the quarterly workforce report. The Trust has also embedded an electronic job planning process which provides evidence of available clinical capacity across the seven day working week and assurance is provided through the Integrated Performance Report which is considered by the Finance and Performance Committee on an exception basis and by the Board bi-monthly.

87. During the pandemic, a Resourcing Hub was established to enable swift redeployment of staff from across the organisation, into areas of greatest need ensuring that safe staffing levels were maintained. Daily staffing huddles continue to be operated to enable any gaps to be anticipated and filled without impact to service.

88. The Trust continues to develop new and enhanced roles in its future workforce through the use of evidence-based tools and data, adopting the Health Education England STAR tool to support wider workforce transformation. This is further supported across the Trust and across the Integrated Care System (ICS) using the Workforce Repository and Planning Tool (WRaPT) which is an activity-based workforce capacity and demand modelling tool which allows managers to test scenarios and develop new models of care. This ensures that the Trust has a workforce plan which is safe and sustainable. There are plans to build capacity and capability across the ICP to support workforce transformation and delivery of these methodologies.

89. The Trust also actively benchmarks its performance against key workforce indicators through the data held in the Model Hospital and the Board has oversight of all of all workforce issues and risks through monthly reporting through the Board Sub-Committee's and Senior Leadership Group.

CQC Registration

90. The Trust remains registered unconditionally with the Care Quality Commission to provide the following regulated activities:
    a) Diagnostic and screening procedures
    b) Family planning services
    c) Management of supply of blood and blood derived products
    d) Maternity and midwifery services
    e) Nursing care
    f) Surgical procedures
    g) Termination of pregnancies
    h) Treatment of disease, disorder or injury
91. The Trust is rated as "Good" with some areas of "Outstanding" following the most recent CQC inspection in August and September 2018.
92. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Declarations of Interest

93. The Trust has published on its website a register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance and can be found on the Trust's website under *'Publication Scheme' (Section 6: Lists and Registers).*

NHS Pension Scheme Statement of Compliance

94. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Diversity and Equality

95. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through the Trust Inclusion Group which reports to Board.

96. Metrics to support progress against the Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans are being improved in order to provide assurance.

97. Four staff networks have been established to increase engagement with staff with protected characteristics and these include: Black, Asian and Minority Ethnic (BAME) Network, Disability, LGBTQ+ and Mental Health. There are plans to extend our staff networks.

98. In response to staff feedback, the Trust has established a number of Freedom to Speak up Champions across the organisation, drawn from staff networks, working with the Staff Guardian, to promote confidence in staff speaking out where they experience any form of discriminatory behaviour.

99. Two reports have been produced by the BAME network highlighting staff experience in relation to race and racism and the recommendations from these reports have informed key actions as part of the WRES action plan.

100. During COVID, all staff have been offered COVID risk assessments to support their health and wellbeing with a particular emphasis on BAME heritage staff due to their increased vulnerability of COVID-19 and its effects. All staff have been offered and encouraged to take up the COVID-19 vaccine, again with particular emphasis on BAME heritage staff.

Since 2019, the Trust has an annual Festival of Inclusion which has a focus for a week, on all areas of Equality, Diversity and Inclusion aimed at increasing awareness, understanding, tolerance and respect.

Sustainable Development

101. The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

102. The Trust is improving the performance of its estate by upgrading or replacing aged and dilapidated stock with new or refurbished buildings with inherently better energy performance.

103. The Trust has also adopted the Building Research Establishment Environment Assessment Method (BREEAM) healthcare toolkit for all significant new and refurbishment building projects. The most recent example is the new Emergency

Department and Acute Medical Unit development (phase six) at the Royal Blackburn Teaching Hospital site which opened in late 2020.

Review of economy, efficiency, and effectiveness of the use of resources

104. The Audit Committee is charged with reviewing the economy, efficiency, and effectiveness of the use of resources throughout the course of the year and ensuring that there is a robust system of integrated governance and internal control across all spheres of the Trust's activity. Having reviewed the regular reporting of the Audit Committee on its activities presented to the Trust Board I am satisfied that it has met these requirements during the course of the year and assisted in the further development and improvement in the embedding of internal control systems. Together with the comprehensive programme of quality improvement work for the care of patients reporting to the Quality Committee and the Trust Board I am satisfied that there are clear lines of governance and accountability within the Trust for the overall quality of clinical care and these are reflected in the achievements highlighted in the Trust's annual Quality Account.

Information governance

105. We aim to deliver a high standard of excellence in Information Governance by ensuring that information is collated, stored, used and disposed of securely, efficiently and effectively and that all of our processes adhere to legal requirements. Including completion of Data Protection Impact Assessments, annual Information Governance (IG) training for all staff, contract reviews and a comprehensive information asset management programme. The Trust has a suite of Information Governance policies to ensure patient, staff and organisational information is managed and processed accordingly. Whilst only 'specific to role' training was mandated throughout the COVID-19 pandemic there has been a drive to improve compliance against the IG core skills training modules in the final quarter of 2020-21 which will continue throughout 2021-22.

106. The Data Security and Protection Toolkit sets out standards for maintaining high levels of security and confidentiality of information. Our Information Governance Assessment report for 2020-21 is ongoing with the final submission due at the end of June 2021. The Data Security and Protection framework and workplan is overseen by the Information Governance Steering Group (IGSG) which is chaired by the trusts SIRO.

The IGSG reports into the Trusts Audit Committee, however as a result of the COVID-19 pandemic the IGSG was stepped down throughout the course of the pandemic and will be recommenced in the first quarter of the 2021-22 year. The Trust has reported a total of five information governance incidents to the Information Commissioner's Office (ICO) during the reporting period with no requirement from the ICO for further action by the Trust.

Data Quality and Governance

107. The Trust continued to invest significantly over the past 12 months in cyber defences to ensure personal data is kept as secure as possible, with major investments in software such as Stealthbits (access management, password complexity and folder management), additional Firepower and Checkpoint Firewalls, to enable home working and improve overall resilience and enhanced Active Directory management. In working to obtain Cyber Essentials accreditation, the Trust has been working with Mersey Internal Audit Agency (MIAA) to externally monitor, support and validate the actions taken to ensure compliance. The Trust successfully submitted its DSP toolkit for 2020 which was independently verified and is working on the 2021 submission with MIAA. The procurement of new systems, in particular clinically based systems, is led by a 'Cloud First' approach and supported by detailed DPIA assessments and robust contract monitoring approaches. Although many of the electronic systems in the Trusts are legacy, regular Business Continuity and Data Quality Audits take place and such audits are available for review. All patching and system updates are tested prior to roll out and ELHT responds to Care Cert alerts well within the required timescales. New backup systems are now in place and additional investment in storage provides further resilience. The Trust has replaced all unsupported operating system ELHT managed PC's from its networks and is working with the PFI suppliers to replace any outstanding devices on their systems.

108. Dedicated Information Governance, Subject Access Request, expanded Cyber and FOI teams exist within the Informatics Department and a report is produced to each months IG steering group re progress. A new Head of IG is working alongside system partners to build upon learning from other providers and optimise opportunities for development. Weekly Data Quality reviews take place and data quality issues are addressed by on call and full-time staff during 'down times'. All systems have audit trails and regular reports are produced and access checked to ensure compliance.

109. The Trust has now signed with Cerner for an integrated electronic patient record system (identified as a key risk in last year's report – go live date 26 Sept 2022) and has also procured cloud based electronic observation systems. In addition to this the Trust has invested in enhanced paging and communications systems for clinical and non-clinical staff and a number of state of the art specialist electronic clinical systems (e.g. Endoscopy, Neonatology, Midwifery and Cardiology), which will be implemented during 2021 .

110. The new systems allow for enhanced roles-based access controls and audit. All clinical systems have a full Clinical Safety Case completed by the Chief Nursing Information Officer (CNIO) and these are available for review and audit. Any breaches of data security are initially managed by the IG team and escalated to the Data Protection Officer (DPO), Senior Information Risk Owner (SIRO) and Caldicott Guardian. Advice is sought from the ICO as required. A full training programme re patient confidentiality, Information Governance and Cyber Security is undertaken by staff with compliance numbers produced monthly. The Informatics department issues regular and timely cyber alert emails to staff and undertakes simulated 'phishing' attacked to manage and review compliance. Finally, the Trust commissions external agencies to undertake regular system penetration tests to understand system vulnerabilities and has procured a local pen test toll for regular reviews. The most recent test indicated a high level of protection from outside attack was being maintained. Results are available for audit.

Cyber Security Incidents escalated to the ICO 2021-21.

111. There were no cyber security incidents that occurred in the 2020 - 2021 year which required escalation to the ICO

Annual Quality Account

112. The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

113. The Trust publishes an annual Quality Account which is typically subject to a review by the Trust's External Auditors, who are able to provide independent assurance on the data that is published and the systems that are used to collate the information presented in the Quality Account and in reports to the Board and its Committees on a regular basis. The Quality Account is also reviewed and commented upon by our health and social care partners to ensure that there is a consistent view on the quality

both of the data that is published and the quality of the patient experience of our services. However, due to the changes to the reporting requirements stemming from the COVID-19 pandemic, there was no requirement for the Quality Account to be reviewed by external auditors in the last year. The Quality Account was reviewed by and approved on behalf of the Trust Board (under delegated authority) by the Quality Committee prior to release for publication in December 2020.

114. Among the controls in place to ensure the accuracy of data used in both the Quality Account and on-going internal and external reporting of data are:

a) Specific policies on the recording of data and quality indicators including
   i. Root Cause Analysis Policy
   ii. Risk Management Policy
   iii. Clinical Records Policy
   iv. Production of Patient Information
   v. Information Governance Policy
   vi. Clinical Audit Policy

b) Continued development and expansion of near real time dashboard reporting systems with reporting of quality indicators at every level from ward to Board.

c) Training programmes to ensure staff have the appropriate skills to record and report quality indicators including training on particular software and hardware systems, Information Governance Toolkit training and corporate and departmental induction and mandatory training. Whilst only 'specific to role' training was mandated throughout the COVID-19 pandemic there has been a drive to improve compliance against the IG core skills training modules in the final quarter of 2020-21 which will continue throughout 2021-22.

d) A rolling programme of audits on quality reporting systems and metrics

e) Alignment of the internal audit, clinical audit and counter fraud work plans on a risk-based approach linked to the Board Assurance Framework and the Corporate Risk Register.

115. The Trust utilises its quality and risk associated committee structure to routinely review the data and information that is included within the Quality Report. This provides the Board with assurance that the Quality Report presents a balanced view of the action taken by the Trust in year to ensure the provision of high quality, safe and effective services.

116. Our quality priorities for 2020-21 were:

a) Trust-wide approach to improve the recognition of and response to the deteriorating patient.
b) To reduce the number of inpatient falls
c) To reduce the rate of stillbirths, neonatal death and brain injury occurring during or soon after birth
d) To improve safety culture within theatres through compliance with '5 steps to safety surgery

Review of Effectiveness

117. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report, as well as the content of the quality report attached to the annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, the Finance and Performance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

118. The Head of Internal Audit opinion by Mersey Internal Audit found that: "Substantial Assurance can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently." Due to the impact of the pandemic, there was limited coverage of the quality and workforce areas highlighted in risk assessments. These areas will be considered as part of the 2021-22 risk assessment and planning process.

119. During the year the Trust was scheduled to have 16 internal audits undertaken, however, due to the need to ensure a reduced footfall on Trust sites and the need to manage capacity for clinical care, there was a need to reduce this number and focus on audits in non-clinical areas. 12 reports have been presented to the Trust by Mersey Internal Audit Agency (MIAA) in 2020-21. Of those, three audits received limited assurance ratings, they were noted to be:

a) Translation Services (limited assurance)
b) Catering - Financial Procedures (limited assurance)
c) Records Management (limited assurance)

120. Appropriate actions have been or are being undertaken to address the recommendations set out within the limited assurance reports and management are satisfied that there are no significant control or governance weaknesses identified as a result of the limited assurance reports.

121. The Assurance Framework and the internal auditor's opinion on the effectiveness of the systems and processes supporting the Assurance Framework provide me with evidence that the effectiveness of controls that manage the risks to the organisation in achieving its principal objectives have been reviewed.

122. My review is also informed by internal and external information including:

a) Detailed reports from the Trust's internal auditors (Mersey Internal Audit Agency) and external auditors (Mazars)
b) Performance and financial reports to the Trust Board and its subcommittees
c) NHS Improvement performance management reports
d) NHS England Area Team performance management reports
e) Clinical Commissioning Groups performance management reports
f) Governance reports to the Quality Committee, Audit Committee and Trust Board
g) Compliance with action plans as part of our performance management arrangements
h) Information Governance risk assessment against the Information Governance Toolkit
i) Feedback from local and national staff and patient surveys
j) The work of the Executive team within the organisation who have responsibility for the development and maintenance of the internal control framework within their portfolios.

123. Where reports have identified limitations in assurance these have been acted upon and in relation to auditors' reports have been monitored by the Audit Committee. The Trust Board and its subcommittees have been actively engaged in the on-going development and monitoring of the Assurance Framework and will continue to shape the iterative development of the Assurance Framework and its associated risk management systems and processes throughout 2021-22.

Significant Issues

124. The following issues have prejudiced the achievement of the priorities set during 2020-21 for the Trust:

a) Financial Position: The Trust was able to meet its financial objectives for 2020-21 delivering a £3.0million deficit and living within the Lancashire and South Cumbria Integrated Care System financial envelope. In addition, the Trust lived within its Capital Resource Limit. The planning round was suspended for the 2020-21 financial year and NHS England/Improvement set block contracts for all providers achieving a breakeven position in the first 6 months of the financial year and then was allocated a financial envelope to live within in the later 6 months of the financial year:

b) Workforce: Ensuring the supply of both permanent and contingent workforce continues to be a challenge and in particular during 20/21 in the context of the COVID pandemic. Of highest priority during this time, has been the impact on staff Health and Wellbeing both in terms of COVID related sickness and the impact of working to meet the increased demand and needs of patients and their families during this time.

- Ongoing recruitment of international nurses through the Global Learners Programme and the recruitment of an addition 100 HCAs.
- Use of and provision of mutual aid across partner organisations including bringing back staff programme
- Redeployment of staff from across the organisation from areas that were stepped down during the pandemic
- Continuing to reduce time to hire using a risk-based approach and utilisation of the digital staff passport. The Trust continues to actively monitors time to hire figures in the monthly Agency Group meetings which allows us to manage avoidable delays as well as highlight areas for process improvement. Further improvement work is underway to refine and embed improvements made during COVID.
- Increased advertising through the BMJ for all medical posts.
- Increased internal bank recruitment to reduce reliance on agency supply – significant Healthcare Assistant Bank has continued during 2020 although COVID has meant greater reliance on agency use. The Trust has continued to increase agency to bank conversion for Medical staff.

- Regular reviews of all medical rotas against establishment and budget and review of long term agency workers in line with recruitment activity
- Completing the implementation of the Allocate rota system for Medics in order that the Trust has clearer oversight of its medical workforce for the purposes of planning
- A review of the end to end governance process for Medical bank/agency bookings, rates agreed and off cap/off framework requests
- Ongoing collaboration across Trusts in the North West in relation to options such as a collaborative medical bank and harmonisation of rates.
- Establishment of an ICP People Board with an agreed strategy to recruit 1000 local people into health and social care roles over the next year.

Supporting Attendance

The Trust has a detailed action plan in place to address sickness absence and has identified high impact areas to support improvement, as outlined below:

- The creation of an Attendance Team at the end of 2019 to identify hotspot areas (sickness over 6%) started to see improvements in to 2020 and this work will continue as we emerge from the pandemic to build upon the initial successes.
- Development of supportive approaches to managing COVID related absences.
- Newly developed training for managers, with e-learning to be developed in 2021-22.
- Real time absence reporting rolled out in 2020-21.

Health and Wellbeing

- The Trust launched its new Health and Wellbeing Strategy in January 2019 and the EASE Service is one way in which we are committed to support staff with their health and wellbeing. EASE stands for Early Access to Support for Employees. It is an early intervention service provided by Occupational Health for all staff who are unable to attend work due to musculoskeletal (MSK) or mental health (MH) conditions
- The Staff Health and Wellbeing Strategy Action Plan identifies six key themes to holistically support people at work. These are Leadership and Management, Data and Communication, Healthy Working Environment, Mental health, MSK and Healthy Lifestyles.

- During COVID there has been an increased focus on supporting staff health and wellbeing through individual risk assessments, track and trace support, delivery of the COVID vaccination and flu programmes and increased psychological support to staff. Both internally to the Trust and via the Lancashire and South Cumbria Resilience Hub.
- Appointment of a Non-Executive Director to act as Wellbeing Guardian
- As we emerge from the pandemic the Trust is placing emphasis on building on existing health and wellbeing interventions and building workforce recovery into the elective restoration programme.

c) Patient Flow

Mitigating actions taken include:

- Development of Same Day Emergency Care facilities for:
  - Acute Respiratory conditions
  - Older Persons Rapid Assessment
  - Medical Ambulatory Emergency Care
  - Surgical Ambulatory Emergency Care
  - Children's Observation and Assessment Unit
- The further development of our Emergency Village with the completion of our Phase 6 development to enable us to have an integrated Acute Medical Assessment pathway adjacent to our Emergency Department at the Royal Blackburn Teaching Hospital.
- COVID-19 has accelerated the Trust's need and ability to work differently. It has allowed work plans to be brought forward, and cross-divisional working has been enhanced which will assist the care delivery within the new unit. Examples of this include admission avoidance, speciality in-reach and reduction in length of stay (LOS).
- In line with national guidance relating to Infection Prevention and Control and the segregation of confirmed COVID, suspected COVID and non-COVID pathways we introduced specific Red, Amber and Green clinical pathways for patients.
- We have implemented new processes and arrangements for supporting and monitoring our patient flow discharge and long length of stay.
- Redeployment or necessary modifications to the working environment for

vulnerable staff during the response to COVID-19, e.g. home working or redeployment to lower risk services/areas.

- The Integrated Discharge Service (IDS) has now been commissioned to provide the care home admission and selection service for Pennine Lancashire.
- We have implemented the national hospital discharge policy and operating model published by the Department of Health and Social Care and are actively contributing across the ICS for Lancashire and South Cumbria and the ICP for Pennine Lancashire in relation to hospital discharge.
- Staff were redeployed from other service areas to ensure that our Home First Pathway remained our default discharge pathway.
- During the COVID pandemic the clinical flow team have embraced Lean techniques in the use of visual management to oversee management of COVID bed occupancy and implemented virtual bed meetings to ensure social distancing.

Conclusion

125. In line with the guidance on the definition of the significant control issues I have no significant internal control issues to declare within this year's statement. The system of internal control has been in place in East Lancashire Hospitals NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

126. My review confirms that East Lancashire Hospitals NHS Trust has a generally sound system of governance and stewardship that supports the achievement of its policies, aims and objectives.

Signed: *K. P. McGee (signed electronically)*
Kevin McGee, Chief Executive
Date: 14 June 2021

Directors' Report

As at 31 March 2021 The Trust Board comprises the Chairman, six Non-Executive Directors and five Executive Directors with voting rights as detailed in the Board profile below. In addition, the Trust has three Associate Non-Executive Directors. The Director of Human Resources and Organisational Development, the Chief Operating Officer, Executive Director of Integrated Care, Partnerships and Resilience, Executive Director of Communications and Engagement and the Director of Corporate Governance/Company Secretary also attend the Trust Board to give advice within their professional remits. The Trust Board functions as a corporate decision-making body and Executive and Non-Executive Directors are full and equal members.

The Trust Board provides strategic leadership to the Trust and ensures that the Trust exercises its functions effectively, efficiently and economically. The Board monitors the arrangements to maintain the quality and safety of the Trust's services, including ensuring processes are in place for managing risks.

Non-Executive and Associate Non-Executive Directors have a particular role in scrutinising the performance of the Trust's management in meeting agreed objectives and ensuring that robust systems of financial control and risk management are in place. The Non-Executive Directors of the Trust are appointed by NHS Improvement, acting on behalf of the Secretary of State for Health and Social Care. They are each appointed for a four-year term which may be renewed subject to satisfactory performance. Non-Executive Directors are not employees of the Trust and do not have responsibility for day-to-day management; this is the role of the Chief Executive and Executive Directors but as a 'unitary Board', Executive and Non-Executive Directors share equal responsibility for the Board's decisions, and all share responsibility for the direction and control of the organisation.

The Trust Board meets six times a year and meetings are open to the public except when confidential information is being discussed. Details of public Board meetings are available, including minutes and papers from previous meetings, on the Trust Board section of our website (www.elht.nhs.uk).

The Trust Board delegates its authority to take decisions about the Trust and its services in accordance with a Scheme of Delegation which is available on our website within the

publication section in our Standing Orders and Standing Financial Instructions.

The Executive Directors are appointed by a Committee comprising the Chief Executive and Non-Executive Directors following a competitive interview process.

Information on personal data related incidents that have been formally reported to the Information Commissioner's Office (ICO) can be found in the Annual Governance Statement section of this report.

Voting Board members

Professor Eileen Fairhurst MBE, Chairman, February 2014 to present

Experience

Eileen Fairhurst was appointed to East Lancashire Hospitals Trust in February 2014. She is a highly experienced Chairman and has chaired a number of large, complex public and third sector organisations, including Acute, Specialised Mental Health and Primary Care Trusts.

Within six months of being appointed, she led the Trust out of Special Measures and the Trust now has a CQC rating of 'Good'. She established Salford PCT in 2001 which became one of the highest performing PCTs in the country.

Subsequently, she was Chairman of NHS Greater Manchester, the largest PCT cluster in England.

She has a national profile for partnership working and the governance of organisations. Her partnership working in health has involved regeneration of localities. Her expertise in the practice of regeneration is mirrored in her academic profile with a number of publications and conference presentations.

Eileen has always ensured that perspectives of patients and communities contribute to service developments. She has championed a number of whole systems innovative service re-design programmes, including mental health, children's and women's health, urgent care and the Greater Manchester Healthier Together programme.

Over the years she has been a regular contributor to development programmes for NEDs and Aspirant Executive Directors and Chairs and to national conferences on Governance and leadership.

Eileen has been awarded an MBE in recognition of her contribution to the NHS. A former Professor in Public Health at the University of Salford, she has an international research profile. She is a Founding Fellow of the British Society of Gerontology.

Her contributions to both academic research and the NHS have been acknowledged with a number of academic honours; in July 2007 she received an Honorary DSc from the University of Salford and, in December 2018, an Honorary Doctorate from UCLan. Currently, as a Visiting Professor at the University of Chester, she is developing programmes on governance in the public sector.

Qualifications

BA (Econ), PhD, DSc, Fellow of the Royal Society of Medicine

Mr Kevin McGee, Chief Executive, September 2014 to present

Experience

Chief Executive – Joint appointment with Blackpool Teaching Hospitals NHS Foundation Trust (from 1 May 2019)

Kevin is a qualified accountant with over 35 years' experience working in healthcare, with 23 of those years being at executive level.

Prior to joining East Lancashire Hospitals NHS Trust, Kevin held a range of roles including Chief Executive at both George Eliot Hospital NHS Trust and Heart of Birmingham Primary Care Trust.

He has also held a range of Director positions, including Director of Finance and Chief Operating Officer in large acute hospitals, and Director of Commissioning and Performance Management at a Teaching Primary Care Trust.

Kevin sits on the North West Leadership Academy Board and is a strong advocate of Compassionate Leadership. Kevin also sits on the Senior Leadership Forum for Pennine Lancashire and chairs the Lancashire and South Cumbria Chief Executives' Provider Forum.

Recently Kevin has become a member of the Advisory Committee on Clinical Excellence Awards (ACCEA) and sits on the National Guardian's Office Advisory Working Group.

Kevin received an Honorary Fellowship from UCLan to acknowledge the significant contribution made to the development of the University's School of Medicine through the instrumental strategic support he has provided to UCLan's partnership with ELHT.

In October 2019, East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT) agreed to work in closer collaboration, with Kevin McGee as the Chief Executive and Accountable Officer of both Trusts. Kevin undertook this role on a temporary basis from 1 May 2019, with the role being made permanent from October 2019.
With the onset of the pandemic Kevin has been leading the Hospital Cell for Lancashire and South Cumbria since March 2020.

Mrs Patricia Anderson, Non-Executive Director, June 2018 to May 2019 and October 2019 to Present (Leave of absence taken May 2019 to October 2019)

Experience

Trish has over 30 years of experience working in health and social care services and has enjoyed roles across a wide range of settings, including executive Board appointments. She has proven ability in both the provision and the commissioning of services, strong negotiation and influencing skills, in addition to a strong working knowledge of the key challenges that the NHS is facing. In addition, Trish is skilled in identifying and managing risks within and across organisations. She is clear that the overall goal is to improve health outcomes for the local population and recognises that the Trust will be judged on that delivery.

Trish was the Accountable Officer for Wigan Borough CCG until her early retirement in mid-2018, contributing greatly to the development of a strategic commissioning function across the CCG and the Local Authority. She is keen to maintain her links to the NHS whilst championing

quality patient services and is committed to working in a supportive capacity as a Non-Executive Director at the Trust, providing a constructive perspective as a member of the Board.

Qualifications

BA Joint Honours, CQSW/DipSW, ASW

Professor Graham Baldwin, Non-Executive Director, January 2020 to present

Experience

Graham is the Vice-Chancellor at the University of Central Lancashire (UCLan). As Vice-Chancellor, Graham is responsible for the leadership and management of the University within the principles laid down by the Board of Governors.

Graham is a member of Universities UK, Treasurer of MillionPlus (The Association for Modern Universities) and Deputy Chair of the University and College Employers Association. He also Chairs the Department for Transport's Maritime Skills Commission.

He returned to UCLan in 2019 after spending five years as the Vice-Chancellor of Solent University in Southampton, where he oversaw the development and opening of a number of complex and industry-leading programmes and facilities, including a new indoor sports complex and nursing and maritime simulation centres.

Graham's previous roles have included the Deputy Vice-Chancellor at UCLan and Dean of Academic Development and Director for Cumbria. In addition to academic roles, Graham has been employed as the National Skills Research Director for the Nuclear Decommissioning Authority.

Graham has also worked closely with partner institutions, particularly in Hong Kong, China and the Middle East, and he received an Outstanding Foreign Expert Award from Hebei

Province, China. He has previously been appointed as Honorary Professor at Hebei University in Baoding and was appointed as a Visiting Professor by the National Academy for Education Administration, Beijing. Graham is a member of the Trust's Audit Committee.

Qualifications

BA (Hons)

PGCE

MSc

Ph.D

Mr Stephen Barnes, Non-Executive Director, January 2015 to present

Experience

Stephen Barnes was appointed to the Trust Board on 1 January 2015.

He has been a local government chief executive in Lancashire for the past 22 years and prior to that was a director of finance in local government for six years.

Stephen is an accountant by profession, a past President of the North West and North Wales region of the Chartered Institute of Public Finance and Accountancy and a past Examiner of the final part of the Professional Accountancy Examination.

During his time in Local Government, Stephen has gained broad experience in strategic leadership, partnership working and joint venture initiatives across the private sector, including economic development and regeneration services and community development and engagement.

Stephen is also currently chair of Nelson and Colne college and a board member of the Association of Colleges and chair of the Nelson Town Deal Regeneration Board

Stephen was reappointed for a further two years in January 2021 and has been a member of the Audit Committee in the financial year.

Qualifications

Member of the Chartered Institute of Public Finance and Accountancy

Miss Naseem Malik, Non-Executive Director, September 2016 to present

Experience

Naseem started her public sector career in Local Government. She is a former Commissioner at the IPCC and has held NED roles at Blackburn with Darwen Primary Care Trust and Lancashire Care NHS Foundation Trust.

Naseem is also a qualified (non-practicing) solicitor

Qualifications

BA (Hons), Postgraduate Diploma in Business Administration.

Mr Khalil Rehman, Non-Executive Director, February 2021 to present (Associate Non-Executive Director, non-voting, January 2020 to January 2021)

Experience

With a passion for tackling inequalities and improving the lives and well-being of others, Khalil has spent his career at the intersections of finance, social impact and digital innovation across the private, public and third sectors. He brings over 18 years board and corporate governance experience alongside a sense of curiosity, inclusivity and compassion.

Khalil has a background in delivering humanitarian projects, public health and global healthcare services

across Africa and South Asia and other developing countries. He is currently leading a US and UK philanthropic and social investment foundation delivering Global Health and Social Care in developing countries.

He was previously Chief Executive of an international health charity and Director of Finance and IT of a leading North West based social care charity. Prior to this, he spent 10 years in investment banking in Mergers and Acquisitions and corporate finance advisory roles, followed by a stint in academia at one of the world's top universities as a Research Fellow in social care and post graduate teaching.

Khalil holds a first degree from UCL, an MSc from the Bartlett School, UCL and graduated from executive programs at Harvard Medical School and INSEAD Global Business School. He is currently a non-executive director at Salix Homes and non-executive director and chair of the Audit Committee at Leeds Community Healthcare Trust.
Khalil is a member of the Audit Committee.

Qualifications
MSc,
B.Eng. (Hons)

Mr Richard Smyth, Non-Executive Director, March 2017 to present
Experience

Richard is a recently retired solicitor with 40 years' experience of regulatory issues and criminal litigation. He has had a highly successful career as a criminal lawyer and held senior positions in well-known law firms representing a wide range of clients including global corporations and professional individuals.

His work has included compliance, governance and risk management advice as well as conducting serious and complex cases mainly within the context of business and finance.

Richard is the Chair of the Audit Committee.

Qualifications

BA (Hons), Member of the Law Society

Mrs Michelle Brown, Executive Director of Finance, August 2019 to present

Experience

Michelle joined the Trust in December 2006 from Calderstones NHS Trust, where she was Assistant Director of Finance. She was substantively appointed to the role of Executive Director of Finance for the Trust in September 2019, having ten years' experience in the Deputy Director position. She is a qualified accountant and member of the Chartered Institute of Public Finance and Accountancy (CIPFA).

An alumnus of the National Financial Management Training Scheme, Michelle has trained and worked in a number of NHS organisations across North Wales and Lancashire, including North Wales Health Authority, Glan Clwyd and Wrexham Maelor hospitals and Burnley Healthcare NHS Trust.

Qualifications

BA (Hons), Member of the Chartered Institute of Public Finance and Accountancy

Mr Martin Hodgson, Deputy Chief Executive and Executive Director of Service Development, November 2009 to present

Experience

Martin joined the Trust in November 2009, from Central Manchester University Hospitals NHS Foundation Trust, where he was Executive Director of Children's Services. He has considerable operational management experience and of implementing major strategic change, including the reconfiguration of children's services across Manchester. Martin takes a lead role in the development of strategy, planning and working with partners to improve services both in the Lancashire and South Cumbria Integrated Care System (ICS) and the Pennine Lancashire Integrated Care Partnership (ICS).

Qualifications

BA (Hons), Postgraduate Diploma in Human Resource Management

Dr Jawad Husain, Executive Medical Director, February 2020 to Present

Experience

Jawad joined East Lancashire Hospitals NHS Trust as Executive Medical Director in February 2020.

Jawad is a practicing urological surgeon with extensive general management experience. He also has a strong track record of achievements in change management, service improvement and innovation. He is a team player with a reputation for building successful partnerships, developing strategy and leading delivery within a complex environment. A visible leader, able to engage with colleagues on all levels with integrity and enthusiasm.

He started his career as a consultant urological surgeon at Wrightington, Wigan and Leigh NHS FT in 2002. He has been trained in the North West region and has a sub-speciality interest in management of stone diseases. Jawad established a fully comprehensive stone service at his organization and helped develop the urological department.

He takes a special interest in patient safety and clinical governance. Jawad strongly believes in value-based leadership and helped in embedding a culture which empowered staff and engaged them in improving safety, quality and performance.

He has developed strong relationships with various stakeholders in Lancashire and South Cumbria and has worked to deliver a high-quality service during the COVID pandemic. Jawad chaired the Surgical North West Sector for Healthier Together and has been instrumental in leading the group to design and deliver pathways for management of surgical patients. His collaborative working across organizational boundaries is reflective of his leadership skills in bringing people together to deliver the best in them.

Jawad takes a keen interest in teaching and training and has been the Surgical Tutor for the Royal College of Surgeons. He has been an examiner for the University of Manchester Medical School and mentor for the medical students, educational and clinical supervisor for urology and surgical trainees, and a panel member for National Selector for core surgical trainees.

He is a Clinical Advisor to the Parliamentary and Health Service Ombudsman, NCAS case manager and case investigator and Responsible Officer.

Qualifications

M.B,B.S
FRCS (I)
FRCS (Urol))
Membership of BAUS, MPS, BMA

Mrs Christine Pearson MBE, Chief Nurse/Director of Nursing, January 2014 to present

Experience

Chris is a Registered Nurse with experience in a variety of clinical settings and has worked in acute hospitals, community and primary care services. She has held management and leadership positions as well as roles within education and professional development. She commenced as Chief Nurse at East Lancashire Hospitals NHS Trust in January 2014, where she provides professional leadership to all Trust nurses, midwives and Allied Health Professionals. She takes a shared leadership role for Quality and Patient Safety and is the Executive Lead for Safeguarding.

Qualifications

BA (Hons), MSc, RGN, DNCert

Non-Voting Board Members

Harry Catherall, Associate Non-Executive Director, July 2019 to present

Experience

Harry began his career as an apprentice accountant at Tameside Borough Council aged 16. From there he moved into management at Stockport Metropolitan Borough Council, joining Blackburn with Darwen Council in 1997 as it prepared to be a unitary council. Harry has held a number of different positions at the local authority, starting as Deputy Director of Social Services and various Executive Director roles. In 2012 was appointed Chief Executive, a post which he held until his retirement earlier this year.

He has spent more than half of his working life employed within the area and as such holds East Lancashire close to his heart. He is keen to work with the Trust to develop effective partnership working across the Pennine Lancashire and Lancashire and South Cumbria areas.

Qualifications

FCCA, Qualified Accountant

Sharon Gilligan, Chief Operating Officer, October 2020 to present

Experience

Sharon joined the Trust in December 2017. She has considerable operational management experience and has held Executive Director posts in two Acute Trusts before joining the Trust. Sharon spent much of her career in various roles at Newcastle and Tyne Hospitals NHS Trust before taking up her Executive posts including the Trust Service Improvement Lead and the Directorate manager for the Regional Neurosciences Centre.

She has a track record for delivery and is passionate about excellent patient care and staff development.

Qualifications

BA (Hons)
Post Graduate Certificate in Management Practice
Post Graduate Diploma in Management Practice
MBA

Kevin Moynes, Executive Director of HR and OD, October 2013 to present
(*Joint appointment with Blackpool Teaching Hospitals NHS Foundation Trust)*

Experience

Kevin joined the Trust on 1 October 2013 as the Interim Director of HR and Organisational Development. He joined the NHS in 1978, qualifying as a Registered Nurse (RGN) in 1981 and later as a Registered Sick Children's Nurse (RSCN) in 1986. He obtained his Master's Degree in Nursing from the University of Bradford in 1993.

In addition to his NHS experience, Kevin has worked in the USA and the Middle East and has held a Director of Nursing post within the hospice sector. Kevin leads the Trust's agenda relating to HR and OD with a key focus on Staff Engagement, Staff Health and Well-being, Recruitment and Retention, Learning and Development and Leadership and Talent Management.

In October 2018 Kevin commenced in the role of Joint Strategic Director of HR and OD role for the Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

Qualifications

RGN, RSCN, MSc, MCIPD

Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience, December 2020 to present

Experience

Tony joined East Lancashire Hospitals NHS Trust as a Divisional General Manager in October 2015 and prior to his current role, was Deputy Director then Director of Operations at the Trust.

With 25 years' experience working across public services, Tony has held senior roles in primary and secondary care, physical and mental health services and health and social care in London, Oxfordshire and Lancashire including joint posts spanning the NHS and Local Government.

Tony's current role includes Executive leadership for community and intermediate care services as well as Estates and Facilities, Emergency Preparedness and Technology Enabled Care.

Tony is passionate about integrated care and ensuring services are designed, delivered and developed in partnership with our patients, local communities, staff and partner organisations.

Qualifications

M.A., Postgraduate Diploma in Management

Feroza Patel, Associate Non-Executive Director, April 2019 to present

Experience

Prior to being appointed as an Associate Non-Executive Director Feroza was one of the Trust's Shadow Public Governors for Blackburn with Darwen. During her time as a Shadow Governor Feroza had worked with the Trust to work with staff and other patient representatives to develop services and improve the overall patient experience.

She also has experience as a Governor for her local primary and secondary schools and worked as a volunteer for SureStart Blackburn West where she developed a parent forum and also sat on the Local Management Board.

She has previously worked as a teaching assistant within primary school education where she was the parental involvement leader, managed the parents committee and organised community health events.

Feroza is a member of the Trust's Quality Committee and has also recently accepted the role of Health and Wellbeing Guardian.

Mr Michael Wedgeworth MBE, Associate Non-Executive Director (Non-Voting), April 2017 to present

Experience

Mike Wedgeworth MBE joined the Trust in April 2017.

Mike has been the Chairman of Healthwatch Lancashire, Chief Executive of Hyndburn Borough Council and Chair of Blackburn College, and has held senior executive positions both locally and nationally. He now serves as an assistant priest at Blackburn Cathedral. He is the Non-Executive Director representative for the Lancashire and South Cumbria Integrated Care Systems Board.

Mike was awarded the MBE in 2010 for services to Further Education and the Community of Lancashire and is committed to the values of the NHS, and public services generally, and is very aware of the need to provide safe, personal and effective care to patients.

Mike is a member of the Trust's Quality Committee and the NED champion for Maternity Services. He is also the Chair of the Trust's Serious Incidents Requiring Investigation (SIRI) panel.

Qualifications

BSc, MA

Miss Shelley Wright, Executive Director of Communications and Engagement (Non-Voting), January 2021 to present

(*Joint appointment with Blackpool Teaching Hospitals NHS Foundation Trust)*

Experience

Shelley Wright joined the Trust in January 2021 as Executive Director of Communications which is a joint role also overseeing the communications portfolio at Blackpool Teaching Hospitals NHS Foundation Trust.

Shelley joined from Lancashire and South Cumbria NHS Foundation Trust where she was Executive Director of Communications and prior to this she was Director of Communications for the Mayor of Greater Manchester Andy Burnham and Greater Manchester Fire and Rescue Service.

A former journalist with strong personal connections to both East Lancashire and Blackpool, Shelley uses her significant experience of crisis communications to support both Trusts in their response to COVID as well as leading across all areas of communications activity internally, externally and as part of the wider Lancashire and South Cumbria healthcare system.

Qualifications

National Council for the Training of Journalists (NCTJ) Pre-entry Certificate and Professional Certificate.

Board members who have left the Trust during the 2020-21 financial year

- Mrs Christine Hughes, Executive Director of Communications and Engagement (Non-Voting), June 2016 to November 2020
- Steve Fogg, Non-Executive Director, April 2020 to February 2021

Directors' Statements and Register of Interests

So far as each Director is aware, there is no relevant audit information of which the Trust's auditor is unaware. Each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust auditor is aware of that information, including making enquiries of his/her fellow directors and the auditor for that purpose, and has taken such other steps for that purpose as are required by his/ her duty as a director to exercise reasonable care, skill and diligence. After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration can be found in the remuneration report.

The Directors believe that the annual report and accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Trust's performance, business model and strategy.

It is the Board's belief that each Director is a fit and proper person within the definitions in the Health and Social Care Act 2008 (Regulation of Regulated Activities) (Amendment) Regulations 2014.

Each Director is:

- of good character
- has the qualifications, skills and experience which are necessary for carrying on the regulated activity or (as the case may be) for the relevant office or position
- is capable by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the carrying on of the regulated activity or (as the case may be) the office or position for which they are appointed or, in the case of an executive director, the work for which they are employed
- not responsible for, been privy to, contributed to or facilitated any misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider, and

- not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

There are no company directorships or other significant interests held by directors which may conflict with their management responsibilities other than those disclosed below:

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst MBE Chairman	• Honorary Doctorate UCLan awarded 2018 • Visiting Professor, Chester University	01.03.3021
Kevin McGee Joint Chief Executive Officer and Accountable Officer for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (From 01.10.2019)	• Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust • Honorary Fellow at University of Central Lancashire • Interim Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust (from 01.05.2019), this became a permanent appointment across both Trust's on 01.10.2019. • Lancashire and South Cumbria Hospital Cell Lead from 01.04.2020	26.02.2021
Patricia Anderson Non-Executive Director	• Accountable Officer at Wigan Borough CCG (until 31.05.2018). • Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018) • Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT. • PELC Partnership of East of London Collaborative 1.5 days per month (from 01.12.2020)	01.12.2020

Name and Title	Interest Declared	Date last updated
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Deputy Chair and Director of UCEA • Director of University Alliance • Chair of Maritime Skills Commission • Member of Universities UK • Treasurer of Million Plus	30.03.2020
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College. • Member of the National Board of the Association of Colleges (from 02.03.2017). • Chair of the National Council of Governors at the Association of Colleges • Chair of the Nelson Town Regeneration Board	30.03.2020
Michelle Brown Executive Director of Finance	• Vice Chair of Board of Governors and Chair of the Finance and Resources Committee of St Catherine's Catholic Primary School, Leyland. (No known association with ELHT). • Spouse works for the North West Ambulance Service as a Paramedic.	23.10.2020
Harry Catherall Associate Non-Executive Director	• Member STAR Multi Academy Trust former Tauheedul Academy Trust • Former Chief Executive Blackburn with Darwen Council. • Interim Chief Executive at St Helens Council (from 07.10.2019 to 11.03.2020)	30.03.2020

Name and Title	Interest Declared	Date last updated
Sharon Gilligan Chief Operating Officer (Commenced 01.10.2020)	• Positive nil declaration	30.03.2021
Martin Hodgson Deputy Chief Executive Officer/ Executive Director of Service Development	• Partner is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust.	22.10.2020
Jawad Husain Executive Medical Director	• Clinical Advisor to Health and Social Care Ombudsman • Spouse is a GP in Oldham	02.10.2020
Naseem Malik Non-Executive Director	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment. • Fitness to Practice, Panel Chair: Health and Care Professions Tribunal Service (HCPTS) - Independent Contractor (until 31.07.2020) • Investigations Committee Panel Chair at Nursing and Midwifery Council (NMC) - Independent Contractor. • Relative (first cousin) is a GP in the NHS (GP Practice). • Relative (brother-in-law) is a registered nurse employed by Lancashire and South Cumbria Care NHS Foundation Trust.	04.08.2020

Name and Title	Interest Declared	Date last updated
Tony McDonald Executive Director of Integrated Care and Partnerships (from 03.12.2020)	• Spouse is an employee of Oxford Health NHS Foundation Trust • Member of Board of Trustees for Age Concern Central Lancashire Charity	02.03.2021
Kevin Moynes Executive Director of Human Resources and Organisational Development	• Spouse is a very senior manager at Health Education England (from 02.10.2017) • Governor of Nelson and Colne College (until 01.02.2018). • Joint Appointment as Executive Director of HR and OD at East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust (10.10.2018)	27.10.2020
Feroza Patel Associate Non-Executive Director	• Positive Nil Declaration	01.04.2020
Christine Pearson Executive Director of Nursing	• Seconded to Manchester Health Care Commissioning as Clinical/Nursing Board member for 4 days per month (from 01.12.2019)	26.10.2020
Khalil Rehman Non-Executive Director (from 01.02.2021) Associate Non-Executive Director (01.01.2020 to 31.01.2021)	• Director at Salix Homes Ltd • Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust (from 01.12.2020)	31.03.2021

Name and Title	Interest Declared	Date last updated
Richard Smyth Non-Executive Director	• Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS. (until 01.11.2020) • Spouse is a Lay Member of Calderdale CCG (until 31.01.2019). • Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019.	31.03.2021
Michael Wedgeworth Associate Non-Executive Director	• Positive Nil Declaration.	01.04.2020
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (from 04.01.2021)	• Positive Nil Declaration	01.03.2021

Members of the Trust Board who left the Trust during the 2020/21 year

Name and Title	Interest Declared	Date last updated
Steve Fogg Non-Executive Director (01.04.2020- 31.01.2021)	• Chair of SEED Alliance for Lancashire and South Cumbria.	05.11.2020
Christine Hughes Executive Director of Communications and Engagement (until 04.12.2020)	• Provided temporary strategic communications advice to a Lancashire and South Cumbria Care NHS Foundation Trust (ended 31.12.2019) • Provide advice, guidance, and support to Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) as part of the ongoing collaboration between the two Trusts (from 1.11.2019)	30.03.2020

Remuneration and Staff Report

The Trust's Remuneration Committee has overarching responsibility for the remuneration, arrangements for the appointment and agreement of termination packages for Executive Directors and senior managers. The members of the Committee are the Non-Executive Directors of the Trust. The members are:

- Professor Eileen Fairhurst
- Mrs Patricia Anderson (Non-Executive Director from 1 July 2018 to 10 May 2019 and 3 October 2019 to date)
- Professor Graham Baldwin (Non-Executive Director from 1 January 2020)
- Mr Stephen Barnes
- Mr Harry Catherall (Non-voting Associate Non-Executive Director from 1 July 2019)
- Mr Steve Fogg (from 1 April 2020 to 31 January 2021)
- Miss Naseem Malik
- Mrs Feroza Patel (Non-Voting Associate Non-Executive Director from 1 July 2019)
- Mr Khalil Rehman (Non-voting Associate Non-Executive Director from 1 January 2020 to 31 January 2021, Non-Executive Director from 1 February 2021 to present)
- Mr Richard Smyth
- Mr Michael Wedgeworth (Non-voting Associate Non-Executive Director)

The Remuneration Committee is chaired by the Trust Chairman. Information on the term of office of each Non- Executive Director is provided in the Directors Report section of this Annual Report. The interests and details of the Trust Board are disclosed in the Directors' Register of Interests section earlier this Annual Report.

The Remuneration Policy of the Trust states that it does not make awards on performance criteria. Performance in the role of Directors is assessed separately by the Chief Executive Officer in relation to an Executive Director's role in leading the organisation and achieving performance objectives and by the Chairman of the Trust in relation to performance as a member of the Trust Board. The Trust will review its remuneration policy within the next three months to ensure that the policy covers the approach on the remuneration of directors for future years.

In assessing any pay awards during the course of the year, the members of the Committee have had due regard both for the average salary of the executive director in peer organisations

and the changes in remuneration agreed as part of the Agenda for Change pay scheme. The Executive Directors have received changes in their remuneration only in cases that relate to changes in their executive and operational duties and in line with peer organisations.

The employment contracts of Executive Directors are not limited in term and notice periods are six months. The only provision for early termination is in relation to gross misconduct.

Financial information relating to remuneration can be found later in the tables later in this section.

Remuneration Report

Trust Board members, as the Trust's senior managers, being those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. There are no annual performance-related bonuses or long-term performance-related bonuses payable to Trust Board members and since Non-Executive Board members do not receive pensionable remuneration, there are no entries in respect of their pensions.

Salaries and allowances (subject to audit)

Post Held	From / Started	To / Left	2020/21				2019/20			
			Salary (bands of £5,000)	All taxable benefits (to nearest £100)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) (to the nearest £100)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Executive Directors			**£000**	**£**	**£000**	**£000**	**£000**	**£**	**£000**	**£000**
Chief Executive Officer * Mr K McGee	01/04/2020	31/03/2021	130-135	9,200	297.5-300	435-440	205-210	0	0	205-210
Executive Director of Finance Mrs M Brown	01/04/2020	31/03/2021	150-155	0	140-142.5	295-300	90-95	0	92.5-95	185-190
Executive Director of Communications and Engagement Mrs C Hughes	01/08/2020	13/12/2020	95-100	0	0	95-100	130-135	100	5-7.5	135-140
Executive Director of Communications and Engagement* Ms S Wright	04/01/2021	31/03/2021	15-20	0	2.5-5	15-20	0	0	0	0
Executive Medical Director Mr J Husain**	01/04/2020	31/03/2021	240-245	0	300-302.5	540-545	25-30	0	5-7.5	30-35
Executive Director of Nursing Mrs C Pearson	01/04/2020	31/03/2021	145-150	100	0	145-150	125 - 130	0	0	125-130
Executive Director of Service Development / Deputy Chief Executive Officer Mr M Hodgson	01/04/2020	31/03/2021	220-225	0	357.5-360	580-585	185-190	0	72.5-75	260-265

Post Held	From / Started	To / Left	2020/21				2019/20			
			Salary (bands of £5,000)	All taxable benefits (to nearest £100)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) (to the nearest £100)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Executive Directors			**£000**	**£**	**£000**	**£000**	**£000**	**£**	**£000**	**£000**
Executive Director of Human Resources and Organisational Development* Mr K Moynes	01/05/2020	31/03/2021	70-75	1,500	0	75-80	70-75	1,200	47.5-50	120-125
Executive Director of Integrated Care, Partnerships and Resilience Mr T McDonald	03/12/2020	31/03/2021	40-45	0	32.5-35	75-80	0	0	0	0
Chief Operating Officer Mrs S Gilligan	01/10/2020	31/03/2021	75-80	0	57.5-60	135-140	0	0	0	0

*The remuneration disclosed in the table above represents the Trust's share of the remuneration of the Chief Executive Officer, the Executive Director of Human Resource Director and Organisational Development and the Executive Director of Communications and Engagement, who have been working as joint directors for the Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

For 2020-21, the bandings for the Chief Executive Officer's total salary and pension related benefits were £260,000 - £265,000 and £597,500 - £600,000 respectively. The bandings for the Executive Director of Human Resource Director and Organisational Development total salary £150,000 - £155,000.
The bandings for the Executive Director of Communications and Engagement's total salary and pension related benefits were £30,000 - £35,000 and £35,000 - £37,500 respectively.

** The Executive Medical Director's remuneration includes £131,423 relating to his clinical role during his term of office.

Post Held	From / Started	To / Left	2020/21				2019/20			
			Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) (to the nearest £100) £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Non-Executive Directors										
Chair Prof E Fairhurst	01/04/2020	31/03/2021	40-45	700	0	40-45	35-40	600	0	35-40
Non-Executive Director Ms P Anderson	01/04/2020	31/03/2021	15-20	0	0	15-20	0-5	0	0	0-5
Non-Executive Director Prof G Baldwin	01/04/2020	31/03/2021	5-10	0	0	5-10	0	0	0	0
Non-Executive Director Mr S Barnes	01/04/2020	31/03/2021	10-15	0	0	10-15	5 - 10	200	0	5 – 10
Non-Executive Director Mr S Fogg	01/04/2020	31/01/2021	5-10	0	0	5-10	0	0	0	5-10
Non-Executive Director Mrs N Malik	01/04/2020	31/03/2021	10-15	0	0	10-15	5 - 10	0	0	5 – 10
Non-Executive Director Mr K Rehman	01/04/2020	31/03/2021	10-15	0	0	10-15	0 - 5	0	0	0 – 5
Non-Executive Director Mr R Smyth	01/04/2020	31/03/2021	10-15	0	0	10-15	5 - 10	300	0	5 – 10

Associate Non-Executive Director Mr H Catherall	01/07/2020	31/03/2021	10-15	0	0	10-15	5-10	0	0	5-10
Associate Non-Executive Director Ms F Patel	01/04/2020	31/03/2021	10-15	0	0	10-15	5-10	0	0	5-10
Associate Non-Executive Director Mr M Wedgeworth	01/04/2020	31/03/2021	10-15	0	0	10-15	5-10	200	0	5-10

Since none of the members of the Trust Board included in the table above are members of stakeholder pension schemes, the Trust has not made any related contributions.

Fair Pay Disclosure (subject to audit)

No director received performance related pay or bonuses for their director related services. East Lancashire Hospitals NHS Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2020-21 was £240,000 – £245,000 (2019-20: £150,000 - £155,000) with the Medical Director appointed in February 2020 also performing a clinical role. As a result, this was 9.3 times (2019-20 5.9 times) the median remuneration of the workforce, which was £25,983 (2019-20: £26,018). The median pay calculation does not include external agency staff costs. All agency staff are paid via invoices and may include commission charges to the agencies.

In 2020-21, two employees (2019-20: 71 employees) received remuneration in excess of the highest-paid director, again due to the Medical Director also performing a clinical role. Remuneration ranged from £676 to £267,465 (2019-209: £636 to £264,519).

Total remuneration for the purposes of the highest paid director calculation includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Director's Pensions (subject to audit)

Name and title	Real increase in pension completed at pension age*	Real increase in pension lump sum completed at pension age*	Total accrued pension completed at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Real Increase/(Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Mr K McGee *	12.5-15	40-42.5	100-105	300-305	2481	323	1731
Mr. K Moynes * **	0	0	45-50	145-150	0	0	0
Mr. M Hodgson	15-17.5	40-42.5	65-70	155-160	1321	328	950
Mrs. C Hughes	0	0	40-45	110-115	926	-16	922
Mrs M Brown	7.5-10	12.5-15	40-45	85-90	801	126	642
Mr. J Husain	12.5-15	40-42.5	70-75	215-220	1775	356	1387
Ms S Wright *	0-2.5	0	0	0	27	2	5
Mr T McDonald	0-2.5	2.5-5	40-45	85-90	696	15	584
Mrs. S Gilligan	2.5-5	5-7.5	30-35	60-65	568	37	447

* For the Chief Executive Officer, Kevin McGee, the Executive Director of Human Resources and Organisational Development, Kevin Moynes and the Executive Director of Communications and Engagement, Shelley Wright, the real increases shown in the table above, as well as the pension related benefits in the table of Salaries and Allowances, have been adjusted to take account of the joint sharing arrangement with Blackpool Teaching Hospital NHS Foundation Trust.

** There is no CETV value on reaching Normal Pension Age (NPA).

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

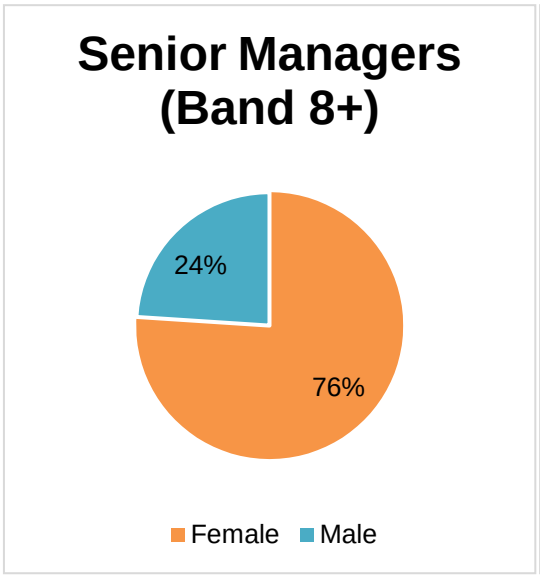
Further information on how pension liabilities are treated can be found in note 8.3 of the Trust annual accounts.

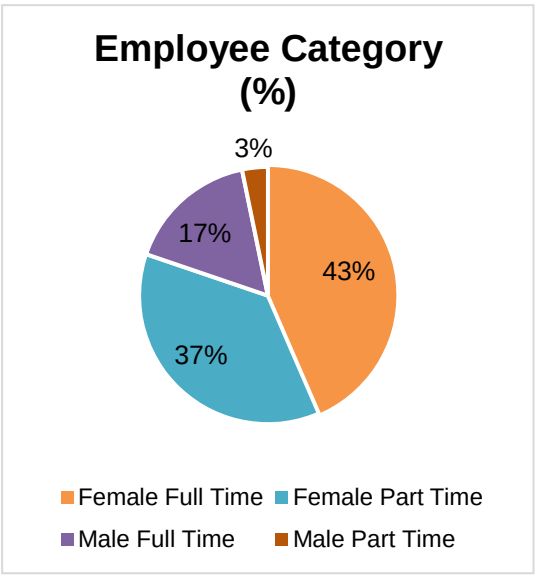
Staff numbers and composition

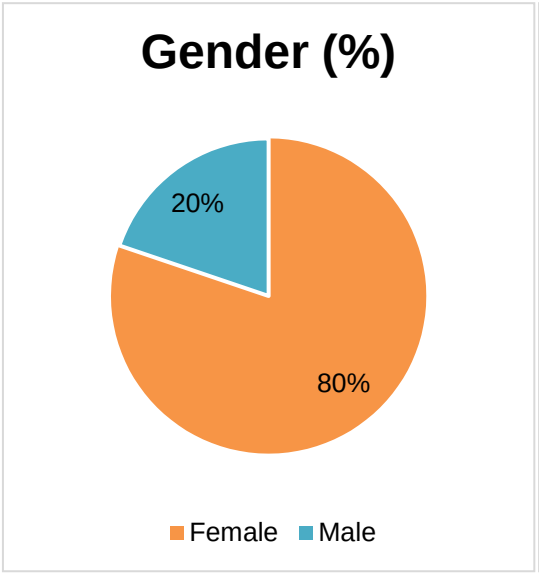
The Trust is a major local employer and we employ over 8,000 people. During the course of the year the Trust has worked hard to recruit and retain staff. The Trust now employs 700 WTE more than at the end of 2019-20 (note 269 WTE are "hosted" staff supporting the COVID-19 Mass Vaccination sites).

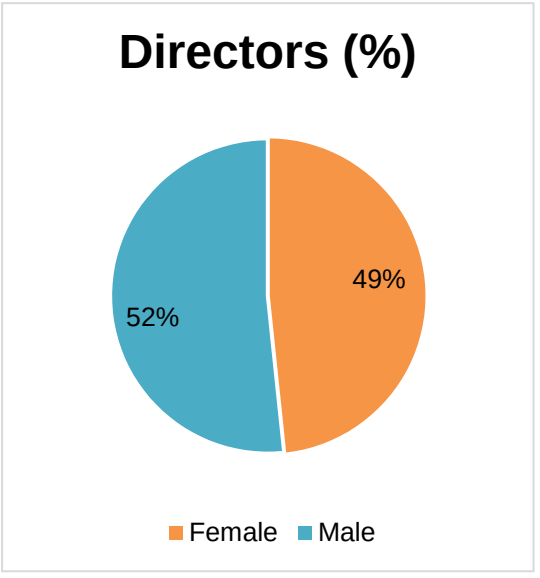
The Trust is fully committed to eliminating gender inequality and continues to monitor the gender profile of the workforce. The current profile is typical of other NHS organisations:

Staff group	Female	Male
Add Prof Scientific and Technic	74%	26%
Additional Clinical Services	87%	13%
Administrative and Clerical	81%	19%
Allied Health Professionals	77%	23%
Estates and Ancillary	56%	44%
Healthcare Scientists	64%	36%
Medical and Dental	39%	61%
Nursing and Midwifery Registered	94%	6%
Students	97%	3%
Grand Total	**80%**	**20%**









Sickness

Sickness absence in 2020/21 stood at 5.53% which is 0.77% higher compared to 2019/20 (4.76%). However, 0.98% of the sickness in 2020/21 was related to COVID-19, therefore without this, it is reasonable to assume that the Trust sickness rate would have stood at 4.54% and therefore lower than 2019/20.

The Trust has implemented a number of initiatives to improve the health and wellbeing of its staff as well as bespoke initiatives and resources to support with the impact of the COVID-19 pandemic. Mental health related absence has seen a rise over the course of the pandemic and the Trust has been instrumental in shaping the creation of the Lancashire and South

Cumbria Resilience Hub, which launched in September 2020 and provides fast track psychological interventions to our workforce and their families.

The Trust monitors sickness absence rates on a monthly basis in the workforce scorecard element of the integrated performance report and through a Quarterly Workforce Report to the Finance and Performance Committee.

Staff policies

The Trust recognises that giving staff access to skills and development supports the delivery of safe, personal and effective care to our patients. The Trust has developed a full range of employment policies to support staff throughout their time working at the Trust. These policies are regularly reviewed in line with employment legislation and best practice. Policies are assessed to ensure that there is equal opportunity for all job applicants and staff, including those who provide services as volunteers. Specific policies have been developed to support people with disabilities during the recruitment process and whilst in their roles.

The Trust has employed a Staff Guardian since 2014 and has successfully introduced the "If you see something say something" campaign which encourages all of our staff to speak out safely if they have any concerns. The guardian works independently alongside Trust leadership teams to support our organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. In the last year, the Trust has trained a number of Freedom to Speak up Champions drawn from our staff networks as a further way of encouraging staff to have the confidence to speak out. The latest National Guardian Freedom to Speak Up Index published in July 2020 shows that ELHT is the best performing Trust within Lancashire and South Cumbria area in respect of our staff being most likely to 'Speak Up' about issues. The Trust's increased score of 81.9% also ranks ELHT as the best performing Acute Trust in the North West.

The Trust has processes and policies in place to ensure that all learners and staff have access to appropriate training, educational qualifications and continuing professional development in order for them to develop their skills and competencies and deliver safe, personal, effective care.

2020-2021 has seen a particular focus on the Trust improving the way we handle disciplinary matters, building further on the work done around informal resolution and ensuring that all colleagues are treated fairly and their health and wellbeing maintained at all stages. A Case

Review Group has been established to ensure that all cases are being handled in an appropriate manner and that we learn from any mistakes made, at all levels. A new Disciplinary Policy has also been launched, incorporating the national work overseen by Baroness Dido Harding and incorporating Just Culture principles.

The Trust recognises a number of trade unions, with whom we consult on workforce training and development issues. In 2020-2021 we continued our commitment to a systematic approach to engage and empower our employees in order to support our vision 'to be widely recognised for providing safe, personal and effective care'. Partnership working has been particularly valuable during the COVID pandemic, with considerable work done to ensure effective employee relations, in line with the national Social Partnership Forum agreements.

All our policies are consistent with our responsibilities under the Equality Act 2010 and are reviewed on a regular basis to ensure compliance and that they adhere to best practice.

The Trust has a strong commitment to the delivery of education and research which now sits under the new Directorate of Education, Research and Innovation (DERI). A combined strategy is in development underpinned by both an education and research plan that align to the local and national agendas. All learners and staff have access to learning and development opportunities to ensure that they have the skills necessary to fulfil their role and contribute to excellent patient care. In addition to our ongoing mandatory training programmes, which are tailored for staff groups, we offer a wide range of clinical and non-clinical training opportunities supported by coaching and mentorship for personal and professional development.

Staff Engagement Indicators

The 2020 National Staff Survey demonstrated that ELHT has achieved its best ever staff response rate of 55% with 4795 respondents. The Trust staff satisfaction responses scored above average for 8 of the 10 themes when compared with all Combined Acute and Community Trusts. The eight themes ELHT scored above average were: equality diversity and inclusion, health and wellbeing, morale, quality of care, safe environment- bulling and harassment, safety culture, staff engagement and team working. The Trust staff satisfaction responses scored average for two of the ten themes when compared with all Combined Acute and Community Trusts. The two themes ELHT scored average were: immediate managers, safe environment- violence. The overall indicator for staff engagement score is 7.2. The

Trust's score of 7.2 is above average when compared with all Combined Acute and Community Trusts (Combined Acute and Community Trust average 7.0)

The results show that as an organisation we continue to maintain the support we provide for our most important asset, our staff. The results are also good news for patients as we know that high levels of employee engagement and satisfaction directly and indirectly influence the quality of patient care and customer satisfaction in our hospitals and clinics.

Staff numbers and costs (subject to audit)

	2020-21			**2019-20**
	Permanently employed	**Other**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Salaries and wages	321,238	16,423	337,661	293,513
Social security costs	33,238	0	33,238	30,157
Apprentice Levy	1,551	73	1,624	1,477
NHS Pensions Scheme	37,158	0	37,158	33,687
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	16,038	0	16,038	14,668
Pension cost - other	103	0	103	83
Termination benefits	0	0	0	0
Temporary staff	0	15,832	15,832	12,886
Total employee benefits	**409,326**	**32,328**	**441,654**	**386,471**
Employee costs capitalised	554	0	554	684
Gross employee benefits excluding capitalised costs	**408,772**	**32,328**	**441,100**	**385,787**
Staff numbers	**2020-21**			**2019-20**
	Permanently employed	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Average staff numbers				

Medical and dental	**667**		**290**		**957**		888
Administration and estates	**1,312**		**154**		**1,466**		1,350
Healthcare assistants and other support staff	**2,711**		**264**		**2,975**		2,763
Nursing, midwifery and health visiting staff	**2,466**		**399**		**2,805**		2,620
Scientific, therapeutic and technical staff	**888**		**18**		**906**		837
Healthcare Science Staff	**137**		**0**		**137**		135
Other	**11**		**0**		**11**		8
Total average staff numbers	8,192		1,065		9,257		8,600
Of the above - staff engaged on capital projects	**14**		**0**		**14**		17

Off-payroll engagements

The Trust employs the services of some staff through invoicing arrangements, rather than through payroll. The numbers of these staff falling under the following criteria are shown below.

All off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months are:

	Number
No. of existing engagements as of 31 March 2021	1
Of which…	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	1

All staff paid through this arrangement are assessed for compliance with IR35.

All off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements.	10

No payments have been made during 2020-21 to former senior managers and no compensation on early retirement or loss of office or other exit packages have been made during this period.

Exit packages (subject to audit)

During 2020-21, there were no exit payments made to any member of staff.

Consultancies

In 2020-21, Trust expenditure on consultancy was £852,000 (2019-20: £444,000).

This matches the year end finance submission to NHSEI.

Trade Union Activities

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
28	26.5

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	22
51%-99%	0
100%	6

Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£192,961
Total pay bill	£441m
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.06%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours

calculated as:

(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 5%

Signed: *K. P. McGee (signed electronically)*

Kevin McGee, Chief Executive

Date: 14 June 2021

Audit Report

Independent auditor's report to the Directors of East Lancashire Hospitals NHS Trust.

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of East Lancashire Hospitals NHS Trust ('the Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, except for the possible effects of the matter described in the 'Basis for qualified opinion' section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

The predecessor auditor was unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust at 31 March 2020 of £8.311 million because the predecessor auditor was unable to attend the year-end physical inventory counts due to COVID-19- related travel restrictions. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary, or whether there was any consequential effect on operating expenses in relation to inventory expenditure for the year ended 31 March 2021.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work

we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities in Respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non- compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing; reviewing management judgements and assumptions in significant accounting estimates, and reviewing any significant one-off or unusual transactions.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of East Lancashire Hospitals NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Karen Murray, Key Audit Partner For and on behalf of Mazars LLP
One St Peter's Square Manchester
M2 3DE
15 June 2021

Audit Completion Certificate issued to the Directors of East Lancashire Hospitals NHS Trust for the year ended 31 March2021

In our auditor's report dated 15 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 15 June 2021 that would have a material impact on the financial statements on which we gave our qualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

Certificate

We certify that we have completed the audit of East Lancashire Hospitals NHS Trust in accordance withthe requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Karen Murray Key Audit Partner For and on behalf of Mazars LLP

One St Peter's SquareManchester
M2 3DE

4 October 2021

Finance Report

Financial review for the year ending 31 March 2021

Financial duties

The Trust reported a £3.0 million adjusted financial performance deficit for the 2020-21 financial year. This is in line with the 2020-21 financial plan. Due to the pandemic the normal NHS planning arrangements were suspended and all NHS organisations operated on a revised financial framework.

Despite the pandemic the Trust achieved all of its financial duties.

	2020-21	2019-20
Break-even duty	✔	✔
In year – the Trust must achieve an in-year revenue break-even position (before technical items)	✔	✔
Cumulative – the Trust must deliver a cumulative break-even position (before technical items)	✔	✔
Capital Resource Limit – the Trust must not exceed its resource limit	✔	✔
External Financing Limit – the Trust must not exceed its financing limit	✔	✔

Where our money comes from

In 2020-21, the Trust received income of £656.8 million compared with £567.0 million in the previous year, including £566.9 million for healthcare services provided to people living in East Lancashire and Blackburn with Darwen.

Most of the Trust's income comes from Clinical Commissioning Groups (CCGs) who purchase healthcare on behalf of their local populations. The Trust negotiates an annual contract with the local CCGs for the payment of services. Due to the pandemic normal NHS planning arrangements were suspended and the Trust received a set amount from commissioners to a value of £478.7 million.

Where our money goes

In 2020-21, the Trusts total revenue operating expenditure was £667.2 million compared with £589.4 million in the previous year. £441.1 million (66%) was spent on staff costs. Throughout the year the Trust employed an average of 8,233 substantive staff and contracted a further average of 629 bank staff and an average of 228 staff via agencies.

At £49.0 million, clinical supplies and services were the next highest area of expenditure with the Trust also incurring £43.3 million of drug costs and a £18.1 million on clinical negligence 'insurance' premiums.

During the year the Trust's valuer has carried out a revaluation of the Trust estate, this has resulted in a net impairment charge of £20.8 million.

Capital Expenditure

The Trust has continued to invest in healthcare facilities in East Lancashire, including an additional £5.5 million investment on the new Emergency Care Village at the Royal Blackburn Teaching Hospital site, which opened in December 2020. Additional funding was also made available nationally which enabled:
the Emergency Department at the Royal Blackburn Teaching Hospital site to be extended;
a fourth Endoscopy room to be opened at Burnley General Teaching Hospital; and
backlog maintenance to be carried out on the Burnley site replacing the theatre ventilation system, the pneumatic tube system, the heating system on the Victoria wing and modernising the Rakehead rehabilitation centre.

Medical equipment purchases included a MRI scanner and CT scanner, as well as Endoscopy equipment.

The Trust was successful in its bid to obtain £11.5 million national funding to implement an Electronic Patient Record which will be implemented over the next two years aiding the Trusts drive for transformation of clinical practice and the seamless integration of patient-care pathways across the health and care economy.

In total the Trust invested £48.0 million on new building works, improvements and equipment and information technology across all of its sites.
A summary is provided below:

Property land and buildings	**15.2**
PFI lifecycle costs	**6.5**
Information technology	**12.5**
Plant and medical equipment	**8.2**
Other capital costs	**5.6**
Total	**48.0**

Revaluation of land and buildings

A revaluation of the Trust estate has been carried out as at 31 March 2021, resulting in a £22.5 million reduction in the value of these assets at the end of the financial year. £20.8 million of this valuation adjustment has been charged to operating expenses as a net impairment, although this is excluded from the adjusted financial performance of the Trust. Further detail is set out in note 12.1 to the annual accounts.

External Financing Limit

The External Financing Limit (EFL) is used by DHSC to measure how well the Trust manages its cash resources and is a threshold the Trust is not permitted to overshoot. In 2020-21, the Trust undershot its EFL by £53.8 million and therefore remained within the overall cash limit set by DHSC.

Capital Resource Limit

The Capital Resource Limit (CRL) is used by DHSC to measure how well the Trust controls its spending on capital schemes with the Trust permitted to spend up to its CRL. In 2020-21, the capital investment made by the Trust represented an underspend by less than £0.1 million against the CRL set by DHSC of £45.5 million.

Better Payment Practice code

Although it is not a financial duty, the Trust met the Better Payment Practice Code target by paying more than 95% of undisputed invoices within 30 days of receipt of the goods or invoice, whichever is the later.

Prompt Payments Code

The Trust continues to support the Department of Health and Social Care's prompt payment code which is an initiative developed by HM Treasury and the Institute of Credit Management (ICM). Details of this code can be found at www.promptpaymentcode.org.uk

Payments made to non-NHS organisations (value)

Total invoices paid (£m)	356.5	299.3
Total invoices paid in target (£m)	350.4	294.0
Percentage achievement	98.3%	98.2%

Charges for information

The Trust does not make charges for information, save for those required in relation to medical records in line with the relevant legislation. The Trust has complied with HM Treasury's guidance on setting charges for information.

Finance income

The Trust receives income from the interest earned on the management of its cash balances. Finance income in 2020-21 amounted to £0.1 million, compared with £0.3 million earned in 2019-20.

Counter Fraud

The Trust is committed to maintaining high standards of honesty, openness and integrity within the organisation. With this it supports the work of the National Fraud Initiative. The Trust has a designated accredited local counter fraud specialist.

External audit

The Trust appointed Mazars to carry out the external audit of the 2020-21 accounts at a cost of £89,400.

Financial Outlook for 2021-22

The financial outlook for the NHS remains uncertain due to the COVID-19 pandemic. NHS organisations have been asked to submit a draft financial plan for the six-month period from 1st April 2021 to 30th September 2021 which will include the costs for restoration of the elective recovery programme.

Annual Accounts

Restrictions on movement in the United Kingdom in March 2020, as a result of the COVID-19 pandemic, meant that Grant Thornton UK LLP, in their capacity as external auditor to the Trust for the 2019-20 financial year, was unable to attend year end inventory counts to complete procedures required by auditing standards for the purposes of their audit.

For this reason only, the auditor issued a qualified opinion. The qualification was a technical 'limitation of scope' and does not imply any criticism of the Trust or any weaknesses in the Trust's internal controls and the Trust was satisfied that its inventory balance is presented fairly in all material respects.

Since this qualification applies to the inventory balance as at 1 April 2020, the external audit opinion on the 2020-21 Trust accounts is qualified in respect of this matter, although the Trust does not consider the value of inventory as at 31 March 2021 to be material and is again satisfied that its inventory balance is presented fairly in all material respects. We are aware that a number of NHS Trusts in the country are affected by the same issue.

Quality report

The Trust has published its Annual Quality Account in line with Department of Health and Social Care requirements and this is available on our website at www.elht.nhs.uk. This Annual Report should be read in conjunction with our Quality Account which provides further key information about the Trust and our performance against quality requirements. It also highlights our major successes in the financial year.

Glossary

Accruals basis

Under the accruals concept, expenses are recognised when incurred, not when the cash is actually paid out, and income is recognised when it is earned, not when the cash is actually received.

AGM

Annual General Meeting

Annual Governance Statement

A statement about the controls the NHS Trust has in place to manage risk.

Amortisation

The term used for depreciation of intangible assets-an example is the annual charge in respect of some computer software.

Annual accounts

Documents prepared by the NHS Trust to show its financial position. Detailed requirements for the annual accounts are set out in the Group Accounting Manual, published by the Department of Health and Social Care.

Annual report

A document produced by the NHS Trust, which summarises the NHS Trust's performance during the year and includes the annual accounts.

Asset

Something the NHS Trust owns-for example a building, some cash, or an amount of money owed to it.

Audit Opinion

The auditor's opinion on whether the NHS Trust's accounts show a materially true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Board Assurance Framework/BAF

The main document that details the strategic risks of the Trust.

Breakeven

An NHS Trust has achieved breakeven if its income is greater than or equal to its expenditure.

Capital Resource Limit

An expenditure limit set by the Department of Health and Social Care for each NHS organisation, limiting the amount that may be spent on capital items.

Cash and cash equivalents

Cash includes cash in hand (petty cash) and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straightaway.

Clinical Commissioning Group

The body responsible for commissioning all types of healthcare services across a specific locality.

Code of Audit Practice

A document issued by the National Audit Office and approved by parliament, which sets out how audits for the NHS Trust must be conducted.

Contingent asset or liability

An asset or liability which is too uncertain to be included in the accounts.

DTOC

Delayed Transfer of Care

EPRR

Emergency Preparedness, Resilience and Response. The Civil Contingencies Act (2004) required NHS organisations to show that they can deal with such incidents whilst maintaining services.

Group Accounting Manual

An annual publication from the Department of Health and Social Care which sets out the detailed requirements for the NHS Trust accounts.

Intangible asset

An asset that is without substance, for example, computer software.

International Financial Reporting Standards

The accounting standards that the NHS has adopted from April 2009.

International Standards on Auditing (United Kingdom and Ireland)

The professional standards external auditors must comply with when carrying out audit.

Inventories

Stock, such as clinical supplies.

IR35

IR35 legislation, also known as 'intermediaries legislation' is a set of rules that aid in the determination of the tax and national insurance that a candidate working through an intermediary should pay, based on the substance of that working arrangement.

Lean principles

Lean was born out of manufacturing practices but in recent time has transformed the world of knowledge work and management. It encourages the practice of continuous improvement and is based on the fundamental idea of respect for people. Womack and Jones defined the five principles of Lean manufacturing in their book "The Machine That Changed the World". The five principles are considered a recipe for improving workplace efficiency and include: defining value, mapping the value stream, creating flow, using a pull system, and pursuing perfection.

Non-current asset or liability

An asset or liability the NHS Trust expects to hold for more than one year.

Non-Executive Director

Non-Executive directors are members of the NHS Trust Board but do not have any involvement in day-to-day management of the NHS Trust. They provide the board with independent challenge and scrutiny.

Operating lease

An arrangement whereby the party releasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

Payables

Amounts the NHS Trust owes.

Primary Statements

The four main statements that make up the accounts: Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement Of Cash Flows.

Private Finance Initiative/PFI

A way of funding a major capital investment, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by the NHS Trust.

Public Dividend Capital

Taxpayers equity or the tax payers stake in the NHS Trust, arising from the Government's original investment in NHS trusts, when they were first created.

Receivables

Amount owed to the NHS Trust.

Remuneration Report

The part of the annual report that discloses senior officers' salary and pensions information.

Reserves

Reserves represent the increase in overall value of the NHS Trust since it was first created.

SAFER

A patient flow bundle from NHS Improvement which is based around five principles, they are: Senior review, All patients, Flow, Early discharge and Review.

Senior Information Risk Owner/SIRO

The establishment of the role of a SIRO within NHS organisations is one of several NHS Information Governance (IG) measures needed to strengthen information assurance controls for NHS information assets.

Sentinel Stroke Audit Programme/SSNAP

The Sentinel Stroke Audit Programme is the single source of stroke data in England, Wales and Northern Ireland.

Statement of Cash Flows

This shows cash flows in and out of the NHS Trust during the period.

Statement of Changes in Taxpayers' Equity

One of the primary statements-it shows the changes in reserves and public dividend capital in the period.

Statement of Comprehensive Income

The income and expenditure account, and the public sector equivalent of the profit and loss account. It shows what income has been earned in the year, what expenditure has been incurred and hence the surplus or deficit for the year.

Statement of Financial Position

Year-end statement prepared by all public and private sector organisations, which shows the net assets controlled by the organisation and how these have been funded. It is also known as the balance sheet.

Those Charged with Governance

Auditors terminology for those people who are responsible for the governance of the NHS Trust, usually the Audit Committee.

True and fair

It is the aim of the accounts to show a true and fair view of the NHS Trust financial position. In other words, they should faithfully represent what has happened in practice.

Vital Signs

An NHSI improvement programme.

This document is available in a variety of formats and languages.

Please contact Trust Headquarters for more details:

East Lancashire Hospitals NHS Trust, Royal Blackburn Teaching Hospital, Haslingden Road, Blackburn, BB2 3HH, Tel 01254 732801, www.elht.nhs.uk

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust
Financial Statements
Year ended 31 March 2021

Safe | Personal | Effective

Version 1.0

Foreword to the accounts

These accounts for the year ended 31 March 2021 have been prepared by the East Lancashire Hospitals NHS Trust in accordance with schedule 15 of the National Health Service Act 2006

Contents

Statement of comprehensive income

	note	**2020-21 £000s**	2019-20 £000s
Operating income from patient care activities	2	**566,973**	517,950
Other operating income	3	**89,699**	49,506
Operating expenses	4	**(667,173)**	(589,389)
Operating (deficit)		**(10,501)**	(21,933)
Finance costs			
Finance income		**75**	277
Finance expenses	9	**(9,249)**	(8,851)
Public dividend capital dividends payable		**(2,222)**	(2,816)
Net finance costs		**(11,396)**	(11,390)
Other gains / (losses)		**(505)**	6
(Deficit) for the financial year		**(22,402)**	(33,317)

Other comprehensive income

Amounts that will not be reclassified subsequently to income and expenditure:			
Impairments		**(1,649)**	(9,891)
Revaluations		**22**	744
Total other comprehensive income / (expenditure) for the year		**(1,627)**	(9,147)
Total comprehensive income / (expenditure) for the year		**(24,029)**	(42,464)

Statement of financial position

	note	31 March 2021 £000s	31 March 2020 £000s
Non-current assets			
Intangible assets	11	**11,304**	6,874
Property, plant and equipment	12	**224,663**	217,255
Receivables		**1,027**	7,092
Total non-current assets		**236,994**	231,221
Current assets			
Inventories	13	**8,032**	8,311
Receivables	14	**23,319**	32,498
Cash and cash equivalents	15	**54,218**	8,490
Total current assets		**85,569**	49,299
Current liabilities			
Trade and other payables	16	**(76,565)**	(43,745)
Borrowings	17	**(3,026)**	(11,751)
Provisions		**(811)**	(558)
Other liabilities		**(7,957)**	(1,505)
Total current liabilities		**(88,359)**	(57,559)
Total assets less current liabilities		**234,204**	222,961
Non-current liabilities			
Borrowings	17	**(95,418)**	(98,443)
Provisions		**(4,317)**	(3,949)
Total non-current liabilities		**(99,735)**	(102,392)
Total assets employed		**134,469**	120,569
Financed by:			
Taxpayers' equity			
Public dividend capital		**243,539**	205,610
Revaluation reserve		**10,634**	12,261
Income and expenditure reserve		**(119,704)**	(97,302)
Total taxpayers' equity		**134,469**	120,569

The notes on pages 5 to 27 form part of these accounts.

The financial statements on pages 1 to 4 and accompanying notes were approved by the Audit Committee on 14 June 2021 and were signed and authorised for issue on its behalf by:

Chief Executive: *K. P. McGee (signed electronically)* 14 June 2021

Statement of changes in taxpayers' equity for the year ended 31 March 2021

	note	Public dividend capital £000s	Revaluation reserve £000s	Income and expenditure reserve £000s	Total reserves £000s
Taxpayers' equity at 1 April 2020		**205,610**	**12,261**	**(97,302)**	**120,569**
(Deficit) for the year		**0**	**0**	**(22,402)**	**(22,402)**
Revaluations		**0**	**22**	**0**	**22**
Impairments	5	**0**	**(1,649)**	**0**	**(1,649)**
Public dividend capital received		**37,929**	**0**	**0**	**37,929**
Taxpayers' equity at 31 March 2021		**243,539**	**10,634**	**(119,704)**	**134,469**

Statement of changes in taxpayers' equity for the year ended 31 March 2020

	note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total reserves
Taxpayers' equity at 1 April 2019		191,988	21,408	(63,985)	149,411
(Deficit) for the year		0	0	(33,317)	(33,317)
Revaluations		0	744	0	744
Impairments	5	0	(9,891)	0	(9,891)
Public dividend capital received		13,622	0	0	13,622
Taxpayers' equity at 31 March 2020		205,610	12,261	(97,302)	120,569

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC, as the annual PDC dividend, in two instalments, the second of which is payable in March based on the estimated dividend payable. Any difference to the actual dividend payable is settled in the following financial year.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating expenses. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve represents the accumulated surpluses and deficits of the Trust.

Statement of cash flows

	Note	2020-21 £000s	2019-20 £000s
Cash flows from operating activities			
Operating surplus / (deficit)		**(10,501)**	(21,933)
Depreciation and amortisation	4	**12,886**	11,125
Impairments and reversals	4	**20,843**	38,866
Income recognised in respect of capital donations		**(1,713)**	(325)
(Increase) / decrease in inventories		**279**	(2,891)
(Increase) / decrease in receivables		**12,102**	(4,892)
Increase in trade and other payables		**19,005**	1,801
Increase / (decrease) in other liabilities		**6,452**	(1,072)
Increase in provisions		**638**	632
Net cash generated from operations		**59,991**	21,311
Cash flow from investing activities			
Interest received		**40**	277
Purchase of intangible assets		**(7,137)**	(3,359)
Purchase of property, plant and equipment		**(21,636)**	(17,496)
Proceeds from sales of property, plant and equipment		**270**	6
Net cash (used in) investing activities		**(28,463)**	(20,572)
Cash flows from financing activities			
Public dividend capital received		**37,929**	13,622
Movement in loans from the DHSC	17.1	**(7,948)**	(1,752)
Capital element of PFI payments	17.1	**(3,786)**	(3,228)
Interest paid		**(9,282)**	(8,844)
PDC dividend paid		**(2,713)**	(4,129)
Net cash generated from / (used in) financing activities		**14,200**	(4,331)
Increase / (decrease) in cash and cash equivalents		**45,728**	(3,592)
Cash and cash equivalents at 1 April		**8,490**	12,082
Cash and cash equivalents at 31 March		**54,218**	8,490

£30.2m of Public dividend capital (PDC) received in 2020-21 has been used to fund specific capital projects with a further £7.7m received to replace interim revenue loans held by the Trust, as part of reforms to the NHS cash regime announced by the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement on 2 April 2020.

Notes to the accounts

1. Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020-21 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. Management has a reasonable expectation that this will continue to be the case.

1.4 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Non-current asset valuations

Valuation services are provided to the Trust by Cushman & Wakefield, a property services firm whose valuers are registered with the Royal Institution of Chartered Surveyors (RICS), the regulatory body for the valuation services industry. Following a full valuation of land and buildings as at 31 March 2020, Cushman & Wakefield has provided a desktop valuation of these assets as at 31 March 2021 to ensure that the carrying amount of these assets does not differ materially from current value. These valuations reflect the current economic conditions and the location factor for the North West of England.

Private Finance Initiative (PFI) - unitary payment

PFI annual contract payments are split between three elements, the payment for services, payment for property (comprising repayment of the liability, finance cost and contingent rental) and lifecycle replacement. The Trust has adopted the national PFI accounting guidance to determine the split between these elements.

Clinical negligence liabilities

The provisions of NHS Resolution in respect of clinical negligence liabilities relating to the Trust, as disclosed in the provisions note, are estimated by NHS Resolution on a case by case basis.

1.5 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see above) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

PFI assets

The valuation for PFI buildings excludes VAT on the basis that the replacement of these assets would be carried out under a special purchase vehicle where VAT would be recoverable.

Segmental reporting

The Trust has one material segment, being the provision of healthcare, primarily to NHS patients. Divisions within the Trust all have similar economic characteristics with healthcare activity being undertaken via ward-based hospital care and through a range of primary care and community services.

Non-current asset valuations

Since 2017-18 the Trust has adopted an alternative site valuation model, whereby the valuation of its estate is based on the value of the modern equivalent asset required to deliver the services the Trust currently provides without taking account of the existing estate and its current utilisation.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the end of the financial year, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services.

While accounting policies for revenue recognition and the application of IFRS 15 are consistently applied, the contracting arrangements in the NHS changed between 2019-20 and 2020-21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

In 2020-21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level.

The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

In the comparative period, 2019-20, the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of IFRS 15 entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

1.7 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. These contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, regardless of whether payment has been made, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software
Software which is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at depreciated historic cost which is considered to be a reasonable approximation to determine fair value due to their relatively short useful asset lives.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset, which range from 5 to 10 years.

1.11 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of the impairment charged to operating expenses and the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of asset components, which are capitalised where they meet the Trust's criteria for capital expenditure. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful economic lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings	60	90
Plant & machinery	3	25
Information technology	5	10
Other property, plant and equipment	3	25

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020-21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under PFI arrangements and loans payable. All of the Trust's financial assets and financial liabilities are classified on this basis.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of DHSC loans held, the effective interest rate is the nominal rate of interest charged on the loan.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. All Trust leases are operating leases.

The Trust as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.16 Provisions

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note but is not recognised in the Trust's accounts.

1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2020-21.

1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022-23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022-23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

2.1 Income from patient care activities (by nature)

	2020-21	2019-20
	£000s	£000s
Acute services		
Block contract / system envelope income	**485,812**	0
Elective income	**0**	63,302
Non-elective income	**0**	142,066
First outpatient income	**0**	40,041
Follow up outpatient income	**0**	29,608
A&E income	**0**	25,139
High cost drugs income from Commissioners	**2,306**	29,538
Other NHS clinical income	**588**	108,003
Community services		
Block contract / system envelope income	**44,390**	43,181
All trusts		
Additional pension contribution central funding *	**16,038**	14,668
Other clinical income	**17,839**	22,404
Total income from patient care activities	**566,973**	517,950

The analysis of income from patient care activites for 2020-21 reflects the current nature of contracting arrangements.

Other clinical income includes £8.2m of funding for the £8.3m annual leave accrual recognised in 2020-21 (2019-20: nil).

* The employer contribution rate for NHS pensions increased from 14.38% to 20.68% (excluding administration charge) from 1 April 2019. As for 2019-20, the Trust continues to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

2.2 Income from patient care activities (by source)

	2020-21	2019-20
	£000s	£000s
NHS England	**85,029**	73,661
Clinical Commissioning Groups	**479,756**	438,568
Other NHS bodies	**861**	1,111
Other	**1,327**	4,610
Total income from patient care activities	**566,973**	517,950

All income from patient care activities relates to contract income.

3. Other operating income

	2020-21	2019-20
	£000s	£000s
Other operating income from contracts with customers:		
Research and development	**1,395**	4,076
Education and training	**15,157**	16,692
Non-patient care services to other bodies	**7,574**	10,095
Provider sustainability fund / Marginal rate emergency tariff income (PSF/MRET)	**0**	12,632
Reimbursement and top up funding *	**51,187**	0
Other contract operating income	**1,736**	4,772
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**10,706**	0
Other non-contract operating income	**1,944**	1,239
Total other operating income	**89,699**	49,506
Total operating income	**656,672**	567,456

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

3. Other operating income (continued)

* As part of reimbursement and top up funding, £12.0m of block projected top up was received to cover the gap between the Trust's underlying cost base and block contract values and income from non-NHS sources in the first six months of 2020-21 and a further £24.7m of retrospective top-up payments was received for this period to restore the Trust to a breakeven financial performance.

This process recognised both gaps in providers' income and additional expenditure caused by the pandemic with both top ups being akin to provider sustainability and financial recovery funding under the previous financial regime.

For the second half of the financial year, funding envelopes were determined at system level with a further £14.4m received.

4. Operating expenses

	2020-21	2019-20
	£000s	£000s
Purchase of healthcare from non-NHS and non-DHSC bodies	**4,320**	4,478
Staff and executive directors costs - *refer to note 8.1 for further detail*	**441,100**	385,787
Supplies and services - clinical	**48,961**	33,717
Supplies and services - general	**8,464**	7,484
Drugs costs	**43,327**	42,093
Establishment	**6,465**	6,899
Business rates paid to local authorities	**2,912**	2,453
Premises - other	**18,138**	12,331
Depreciation on property, plant and equipment	**10,483**	9,476
Amortisation on intangible assets	**2,403**	1,649
Net impairments	**20,843**	38,866
Movement in credit loss allowance: contract receivables / contract assets	**3,453**	288
Clinical negligence premium	**18,058**	16,097
Education and training	**3,695**	2,822
Rentals under operating leases	**9,901**	9,239
PFI charges to operating expenditure	**14,616**	8,918
Other operating expenses	**10,034**	6,792
Total operating expenses	**667,173**	589,389

Expenditure on clinical supplies and services includes £10.7m for the deemed cost of personal protective equipment purchased by the Department of Health and Social Care but passed to the Trust free of charge to use in response to the COVID 19 pandemic (2019-20: nil) with the corresponding benefit recognised in other operating income.

Other operating expenses include £1.8m for car parking and security (2019-20: £1.0m), £1.5m for provision arising in year (2019-20: -£0.1m), £1.2m for transport services (2019-20: £1.0m), £1.0m for outsourced financial services (2019-20: £1.0m) and £0.1m for internal audit services (2019-20: £0.1m).

5. Impairment of assets

	2020-21	2019-20
	£000s	£000s
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	**20,843**	38,866
Total net impairments charged to operating surplus / deficit	**20,843**	38,866
Impairments charged to the revaluation reserve	**1,649**	9,891
Total net impairments	**22,492**	48,757

Net impairments relate to the year end valuation of land and buildings provided by Cushman & Wakefield, the Trust's external valuer.

6. External audit

Audit fees payable to the external auditor for the Trust's statutory audit were £89,400, inclusive of VAT (2019-20: £67,920). Other auditor remuneration in 2020-21 was nil (2019-20: nil).

There is no limitation on the auditor's liability for external audit work (2019-20: £1.0m).

7. Leases

Trust as lessee (operating lease)

	Buildings	Other	2020-21 Total	Restated 2019-20 Total
	£000s	£000s	£000s	£000s
Operating lease expense				
Minimum lease payments	**5,786**	**4,115**	**9,901**	9,239
Total	**5,786**	**4,115**	**9,901**	9,239
Future minimum lease payments due:				
- not later than one year	**4,526**	**2,434**	**6,960**	6,081
- later than one year and not later than five years	**13,110**	**4,105**	**17,215**	20,468
- later than five years	**0**	**0**	**0**	0
Total	**17,636**	**6,539**	**24,175**	26,549

Property related lease arrangements predominantly relate to the occupation of eight Community Health Partnership (CHP) properties by the Trust's community based services. Comparatives for future minimum lease payments due have been restated by £18.0m to reflect the lease arrangements agreed in 2019-20 for six of these properties. A lease arrangements for one further property was agreed in 2020-21. The Trust also expects to spend £1.0m in 2021-22 on a further CHP property in Accrington where the lease arrangement, which is based on the standard five year term, is yet to be agreed. Other future minimum lease payments include £2.6m relating to a managed equipment contract for Pathology services.

Trust as lessor (finance lease)

The Trust does not have any finance lease agreements involving financial considerations where they are the lessor.

In 2019-20, the Trust disclosed £27.4m of future minimum lease receipts relating to the long term arrangement with Lancashire and South Cumbria NHS Foundation Trust for their use of property on the Royal Blackburn Teaching Hospital site. During 2020-21, it was agreed that charges for the use of this property would cease.

8.1 Employee benefits

	2020-21	2019-20
	£000s	£000s
Salaries and wages	**337,661**	293,513
Social security costs	**33,238**	30,157
Employer contributions to NHS Pensions	**37,158**	33,687
Employer contributions to NHS Pensions paid by NHSE on behalf of Trust	**16,038**	14,668
Other costs	**1,727**	1,560
Temporary agency staff	**15,832**	12,886
Total staff costs	**441,654**	386,471
Employee costs capitalised	**554**	684
Total staff costs excluding capitalised costs	**441,100**	385,787

8.2 Retirements due to ill-health

During 2020-21 there were 6 early retirements from the Trust agreed on the grounds of ill-health (2019-20: 2 early retirements). The estimated additional pension liabilities of these ill-health retirements is £0.1m (2019-20: £0.2m). The cost of these ill-health retirements will be borne by NHS Pensions.

8.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

9. Finance expenses

	2020-21	2019-20
	£000s	£000s
Interest expenses		
Main finance costs on PFI obligations	**3,941**	4,057
Contingent finance costs on PFI obligations	**5,308**	4,643
Other interest expenses	**17**	141
Total interest expenses	**9,266**	8,841
Provisions - unwinding of discount	**(17)**	10
Total finance expenses	**9,249**	8,851

10. Better Payment Practice code

	2020-21		2019-20	
	Number	£000s	Number	£000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**93,095**	**356,505**	96,394	299,344
Total non-NHS trade invoices paid within target	**91,393**	**350,428**	94,812	293,960
Percentage of non-NHS invoices paid within target	**98.2%**	**98.3%**	98.4%	98.2%
NHS payables				
Total NHS trade invoices paid in the year	**2,322**	**32,037**	2,693	27,676
Total NHS trade invoices paid within target	**2,241**	**31,520**	2,597	27,412
Percentage of NHS invoices paid within target	**96.5%**	**98.4%**	96.4%	99.0%

The '*Better payment practice code'* requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11. Intangible assets

	2020-21	2019-20
	£000s	£000s
Gross cost at 1 April	**14,481**	13,632
Additions - purchased	**7,137**	3,359
Reclassifications	**(314)**	165
Disposals/derecognition	**(122)**	(2,675)
Gross cost at 31 March	**21,182**	14,481
Amortisation at 1 April	**7,607**	8,633
Charged during the year	**2,403**	1,649
Reclassifications	**(10)**	0
Disposals/derecognition	**(122)**	(2,675)
Amortisation at 31 March	**9,878**	7,607
Net book value as at 31 March	**11,304**	6,874

All intangible assets are purchased software licences.

12.1 Property, plant and equipment valuation information

For 2020-21, Cushman & Wakefield, the Trust's external valuer, has provided a desktop valuation of land and buildings as at 31 March 2021 on an alternative site valuation basis. Allowing for obsolescence and a reduction in the Building Cost Information Service (BCIS) 'All In' Tender Price Index (TPI), as well as £11.0m of transfers from assets under construction, there has been a 5.4% increase in the value of buildings. The value of land remains unchanged.

12.2 Property, plant and equipment (2020-21)

2020-21	Land £000s	Buildings £000s	Assets under construction £000s	Plant & machinery £000s	Information technology £000s	Other property, plant and equipment £000s	Total £000s
Cost or valuation:							
At 1 April 2020	**6,615**	**173,173**	**16,222**	**45,824**	**20,029**	**11,395**	**273,258**
Additions	0	17,287	11,169	9,249	1,820	1,307	**40,832**
Reclassifications	0	19,199	(20,919)	2,100	314	(380)	**314**
Disposals / derecognition	(290)	0	0	(1,646)	0	0	**(1,936)**
Revaluation gains charged to the revaluation reserve	0	22	0	0	0	0	**22**
Revaluation losses charged to the revaluation reserve	0	(1,649)	0	0	0	0	**(1,649)**
Impairments charged to operating expenses	0	(21,905)	0	0	0	0	**(21,905)**
Reversal of impairments credited to operating expenses	290	772	0	0	0	0	**1,062**
Reversal of accumulated depreciation on revaluation	0	(4,312)	0	0	0	0	**(4,312)**
At 31 March 2021	**6,615**	**182,587**	**6,472**	**55,527**	**22,163**	**12,322**	**285,686**
Depreciation							
At 1 April 2020	**0**	**0**	**0**	**34,728**	**12,923**	**8,352**	**56,003**
Disposals / derecognition	0	0	0	(1,161)	0	0	**(1,161)**
Provided during the year	0	4,278	0	3,229	2,259	717	**10,483**
Reclassifications	0	34	0	0	10	(34)	**10**
Reversal of accumulated depreciation on revaluation	0	(4,312)	0	0	0	0	**(4,312)**
At 31 March 2021	**0**	**0**	**0**	**36,796**	**15,192**	**9,035**	**61,023**
Net book value at 31 March 2021	**6,615**	**182,587**	**6,472**	**18,731**	**6,971**	**3,287**	**224,663**
Asset financing:							
Owned	6,615	98,014	6,472	15,822	2,596	3,269	**132,788**
Donated	0	18	0	2,438	2	18	**2,476**
On-SoFP PFI contracts	0	84,555	0	471	4,373	0	**89,399**
Total at 31 March 2021	**6,615**	**182,587**	**6,472**	**18,731**	**6,971**	**3,287**	**224,663**

12.3 Property, plant and equipment (2019-20)

2019-20	Land £000s	Buildings £000s	Assets under construction £000s	Plant & machinery £000s	Information technology £000s	Other property, plant and equipment £000s	Total £000s
Cost or valuation:							
At 1 April 2019	**6,248**	**209,798**	**18,896**	**45,075**	**26,715**	**10,382**	**317,114**
Additions	**0**	**1,709**	**11,812**	**2,063**	**2,546**	**1,437**	**19,567**
Reclassifications	0	14,321	(14,486)	(18)	0	18	**(165)**
Disposals / derecognition	0	0	0	(1,296)	(9,232)	(442)	**(10,970)**
Revaluation gains charged to the revaluation reserve	0	744	0	0	0	0	**744**
Revaluation losses charged to the revaluation reserve	0	(9,891)	0	0	0	0	**(9,891)**
Impairments charged to operating expenses	367	(40,264)	0	0	0	0	**(39,897)**
Reversal of impairments credited to operating expenses	0	1,031	0	0	0	0	**1,031**
Reversal of accumulated depreciation on revaluation	0	(4,275)	0	0	0	0	**(4,275)**
At 31 March 2020	**6,615**	**173,173**	**16,222**	**45,824**	**20,029**	**11,395**	**273,258**
Depreciation							
At 1 April 2019	**0**	**0**	**0**	**33,065**	**20,355**	**8,352**	**61,772**
Disposals / derecognition	0	0	0	(1,296)	(9,232)	(442)	**(10,970)**
Provided during the year	0	4,275	0	2,960	1,800	441	**9,476**
Reversal of accumulated depreciation on revaluation	0	(4,275)	0	0	0	0	**(4,275)**
At 31 March 2020	**0**	**0**	**0**	**34,728**	**12,923**	**8,352**	**56,003**
Net book value at 31 March 2020	**6,615**	**173,173**	**16,222**	**11,096**	**7,106**	**3,043**	**217,255**
Asset financing:							
Owned	6,615	86,858	16,222	9,487	2,713	3,021	**124,916**
Donated	0	19	0	987	3	22	**1,031**
On-SoFP PFI contracts	0	86,296	0	622	4,390	0	**91,308**
Total at 31 March 2020	**6,615**	**173,173**	**16,222**	**11,096**	**7,106**	**3,043**	**217,255**

13. Inventories

	31 March 2021	31 March 2020
	£000s	£000s
Drugs	2,570	2,391
Consumables	5,270	5,728
Energy	192	192
Total	**8,032**	8,311

Inventories recognised in expenses for the year were £89.4m (2019-20: £79.3m).

14. Receivables

	31 March 2021	31 March 2020
	£000s	£000s
Contract receivables	**19,413**	27,706
Allowance for impaired contract receivables	**(2,802)**	(940)
Prepayments	**2,711**	2,391
VAT receivable	**1,343**	1,376
PDC dividend receivable	**1,887**	1,396
Other receivables	**767**	569
Total - current	**23,319**	32,498

In total, £13.1m of current receivables are receivable from NHS and DHSC group bodies (31 March 2020: £21.9m).

15. Cash and cash equivalents

As at 31 March 2021, cash and cash equivalents of £54.2m (31 March 2020: £8.5m) were almost entirely represented by cash deposited with the Governing Banking Service with the balance of less than £0.1m represented by cash in hand (31 March 2020: less than £0.1m).

16. Trade and other payables - current

	31 March 2021	31 March 2020
	£000s	£000s
Trade payables	**748**	3,845
Capital payables	**21,015**	7,200
Accruals	**26,749**	18,679
Annual leave accrual	**8,320**	0
Social security costs	**4,711**	4,232
Other taxes payable	**3,802**	3,166
NHS Pension contributions payable	**5,169**	4,730
Other payables	**6,051**	1,893
Total	**76,565**	43,745

In total, £3.8m of current trade and other payables are payable to NHS and DHSC group bodies (31 March 2020 £5.3m).

17. Borrowings

	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000s	£000s	**£000s**	£000s
DHSC loans	**201**	7,965	**600**	800
Obligations under PFI contracts	**2,825**	3,786	**94,818**	97,643
Total	**3,026**	11,751	**95,418**	98,443

17.1 Reconciliation of liabilities arising from financing activities (2020-21)

	DHSC loans	PFI schemes	Total
	£000s	**£000s**	**£000s**
Carrying value at 1 April 2020	**8,765**	**101,429**	**110,194**
Cash movements:			
Financing cash flows - payments and receipts of principal	**(7,948)**	**(3,786)**	**(11,734)**
Financing cash flows - payments of interest	**(28)**	**(3,941)**	**(3,969)**
Non-cash movements:			
Application of effective interest rate	**12**	**3,941**	**3,953**
Carrying value at 31 March 2021	**801**	**97,643**	**98,444**

17.2 Reconciliation of liabilities arising from financing activities (2019-20)

	DHSC loans	PFI schemes	Total
	£000s	**£000s**	**£000s**
Carrying value at 1 April 2019	**10,520**	**104,657**	**115,177**
Cash movements:			
Financing cash flows - payments and receipts of principal	**(1,752)**	**(3,228)**	**(4,980)**
Financing cash flows - payments of interest	**(144)**	**(4,057)**	**(4,201)**
Non-cash movements:			
Application of effective interest rate	**141**	**4,057**	**4,198**
Carrying value at 31 March 2020	**8,765**	**101,429**	**110,194**

18. Clinical negligence liabilities

At 31 March 2021, £376.7m was included in provisions of NHS Resolution in respect of clinical negligence liabilities relating to the Trust (31 March 2020 £349.3m).

19. Private Finance Initiative (PFI) schemes

The Trust has two separate PFI schemes in operation on each of its main sites as detailed below:

Royal Blackburn Teaching Hospital - Single Site
This scheme has provided a single hospital site within the Blackburn locality and has been operational since July 2006. The contract term is 35 years.

Burnley General Teaching Hospital - Phase 5
The phase 5 unit on the Burnley General site has been in operation since May 2006 and accommodates hospital facilities including elective care, radiology, outpatients and renal services. The contract term is 30 years.

19. Private Finance Initiative (PFI) schemes (continued)

The contracts in place for these schemes are for the construction and provision of healthcare facilities. At the end of the agreement term the sites will revert back to the ownership of the Trust without the need for further payments. Both contracts include options for early termination where there has been a event of default by the Project Company. During the term of the contracts there is provision for planned replacement at regular intervals of components included in these facilities. This ensures that the assets are maintained in the required condition throughout the life of the contract. The Trust is charged for these lifecycle costs through the unitary payments although the charges remain fixed irrespective of the actual pattern of lifecycle costs incurred by the operators. Both contracts include provision for performance and availability deductions against the unitary charge. Unitary charges are subject to an annual inflation uplift which is linked to the published retail price index.

Under IFRIC 12, the assets are treated as assets of the Trust; the substance of the contracts is that the Trust has a finance lease and the payments made comprise two elements – imputed finance lease charges and service charges. As well as provision of the infrastructure assets, the contract for the Blackburn PFI also includes facilities management provision both for the PFI asset and parts of the wider estate, and managed equipment services. The contract for the Burnley PFI scheme also includes facilities management but just for the PFI asset.

19.1 Imputed "finance lease" obligations

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position (SOFP) PFI schemes:

	31 March 2021	31 March 2020
	£000s	£000s
Gross PFI obligations of which are due	**140,227**	149,383
- not later than one year	**6,497**	7,728
- later than one year and not later than five years	**29,934**	30,478
- later than five years	**103,796**	111,177
Finance charges allocated to future periods	**(42,584)**	(47,954)
Net PFI obligations of which are due	**97,643**	101,429
- not later than one year	**2,825**	3,786
- later than one year and not later than five years	**16,565**	16,047
- later than five years	**78,253**	81,596

19.2 Total on-SoFP PFI arrangement commitments

The Trust's total future obligations under these on-SoFP PFI schemes are as follows:

	31 March 2021	31 March 2020
	£000s	£000s
Total future payments committed in respect of PFI arrangements	**589,971**	621,159
- not later than one year	**25,079**	24,740
- later than one year and not later than five years	**106,743**	105,301
- later than five years	**458,149**	491,118

19.3 Analysis of amounts payable to PFI operator

	2020-21	2019-20
	£000s	£000s
Unitary payment payable to PFI operator	**24,739**	24,147
Consisting of:		
- Interest charge	**3,941**	4,057
- Repayment of finance lease liability	**3,786**	3,228
- Service element and other charges to operating expenditure	**7,001**	6,978
- Lifecycle costs	**4,703**	5,241
- Contingent rent	**5,308**	4,643
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**5,699**	943
Total amount paid to service concession operator	**30,438**	25,090

20. External financing

	2020-21	2019-20
	£000s	£000s
Cash flow financing (from SOCF)	**(19,533)**	12,234
External financing requirement	**(19,533)**	12,234
External Financing Limit	**32,091**	18,170
Underspend against the External Financing Limit	**51,624**	5,936

The Trust is given an external financing limit against which it is permitted to underspend.

21. Capital Resource Limit

	2020-21	2019-20
	£000s	£000s
Gross capital expenditure		
Property, plant and equipment	**40,832**	19,567
Intangible assets	**7,137**	3,359
Total gross capital expenditure	**47,969**	22,926
Less: disposals of property, plant and equipment	**(775)**	0
Less: donated capital additions	**(1,713)**	(325)
Charge against the Capital Resource Limit	**45,481**	22,601
Capital Resource Limit	**45,481**	24,605
Underspend against the Capital Resource Limit	**0**	2,004

The Trust is given a Capital Resource Limit which it is not permitted to exceed.

22.1 Breakeven duty - financial performance

	2020-21	2019-20
	£000s	£000s
(Deficit) for the year	**(22,402)**	(33,317)
Add back net impairments	**20,843**	38,866
Remove impact of capital donations	**(1,443)**	(69)
Remove impact of 2018-19 post accounts PSF reallocation (2019-20 only)	**0**	(369)
Adjusted financial performance surplus / (deficit) (control total basis)	**(3,002)**	5,111
Add back income for impact of 2018-19 post-accounts PSF reallocation	**0**	369
Breakeven duty financial performance surplus / (deficit)	**(3,002)**	5,480

22.2 Breakeven duty - rolling assessment

	(2003-04 - 2008-09)	(2009-10 - 2013-14)	(2014-15 - 2018-19)
	£000s	£000s	£000s
Breakeven duty in-year financial performance	380	18,646	11,812
Breakeven duty cumulative position	380	19,026	30,838
Operating income	1,677,587	1,894,341	2,387,303
Cumulative breakeven position as a percentage of operating income		1.0%	1.3%

	2019-20	2020-21
	£000s	£000s
Breakeven duty in-year financial performance	5,480	(3,002)
Breakeven duty cumulative position	36,318	33,316
Operating income	567,456	656,672
Cumulative breakeven position as a percentage of operating income	6.4%	5.1%

The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the subsequent two financial years. NHS England and NHS Improvement (NHSEI) has provided guidance that the first year for consideration for the breakeven duty should be 2009-10.

While the cumulative breakeven position of 5.1% is above the 0.5% threshold, NHSEI uses annual financial targets for NHS Trusts as the primary mechanism for financial control, which the Trust has met for 2020-21.

23.1 Financial instruments - financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments also play a much more limited role in creating or changing risk than would be typical of listed companies. As an NHS Trust, the Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. Treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with no overseas operations. As a consequence, the great majority of transactions, assets and liabilities are UK and sterling based meaning the Trust has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS England and NHS Improvement (NHSEI). Borrowings are typically made for up to 25 years, in line with the life of the associated assets, with interest fixed for the life of the loan at the National Loans Fund rate. The Trust therefore has low exposure to interest rate fluctuations.

23.1 Financial instruments - financial risk management (continued)

Credit risk

Since the majority of income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

Operating costs are incurred under contracts with CCGs financed from resources voted annually by Parliament. The Trust also finances its capital expenditure from funds obtained within its capital resource limit. As a result, the Trust is not exposed to significant liquidity risks.

23.2 Financial instruments - carrying value

	31 March 2021	31 March 2020
	£000s	£000s
Financial assets held at amortised cost		
Trade and other receivables excluding non financial assets	**18,405**	28,200
Cash and cash equivalents	**54,218**	8,490
Total	**72,623**	36,690

	31 March 2021	31 March 2020
	£000s	£000s
Financial liabilities held at amortised cost		
Trade and other payables excluding non financial liabilities	**68,052**	36,347
Obligations under PFI contracts	**97,643**	101,429
Other borrowings	**801**	8,765
Total	**166,496**	146,541

The fair value of financial instruments is not considered to differ from their carrying values.

23.3 Maturity of financial liabilities

	31 March 2021	31 March 2020
	£000s	£000s
In one year or less	**74,760**	48,098
In more than one year but not more than five years	**30,547**	16,847
In more than five years	**103,796**	81,596
Total	**209,103**	146,541

24. Losses and special payments

	2020-21		2019-20	
	Total value of cases	**Total number of cases**	Total value of cases	Total number of cases
	£000s		£000s	
Losses				
Cash losses	**1**	**3**	2	6
Claims waived or abandoned	**27**	**216**	9	237
Stores losses and damage to property	**1**	**2**	6	60
Total losses	**29**	**221**	17	303
Special payments				
Ex gratia payments	**85**	**58**	68	53
Total special payments	**85**	**58**	68	53
Total losses and special payments	**114**	**279**	85	356

25. Related party transactions

During the year none of the Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with East Lancashire Hospitals NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year East Lancashire Hospitals NHS Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent department. Those entities where the value of transactions exceeds £5.0m, ordered alphabetically, are:

Community Health Partnerships
Health Education England
Lancashire Teaching Hospitals NHS Foundation Trust
NHS Blackburn with Darwen Clinical Commissioning Group
NHS Blackpool Clinical Commissioning Group
NHS East Lancashire Clinical Commissioning Group
NHS England
NHS Resolution
St Helens and Knowsley Teaching Hospitals NHS Trust

In addition, the Trust has had a number of notable transactions with other government departments and other central government bodies. Most of these transactions have been with Her Majesty's Revenue & Customs (HMRC) and the National Health Service Pension Scheme.

The Trust has also received revenue and capital payments from ELHT&ME, the charity for which the Trust is the corporate trustee. The financial statements of the Charity have not been consolidated within the financial statements of the Trust on the basis of immateriality, but the latest set of audited accounts of the Charity, relate to the year ended 31 March 2020 and are available on request from Trust Headquarters or via the Charity Comission website (https://www.gov.uk/government/organisations/charity-commission).

The Trust provides financial and administrative support to the Charity for which it is reimbursed. In 2020-21 this reimbursement amounted to £0.1m (2019-20 £0.1m).

26. Contractual capital commitments

As at 31 March 2021, the Trust had £7.5m of contractual capital commitments (31 March 2020: £7.8m), £6.7m of which relates to the Electronic Patient Records initiative.

27. Events after the end of the reporting period

There are no material events after the end of the reporting period to disclose.