East Lancashire Hospitals NHS Trust Board Meeting

Safe | Personal | Effective

TRUST BOARD (OPEN SESSION) AGENDA

10 September 2025 at 09.30

Boardroom, Trust Headquarters, Royal Blackburn Teaching Hospital

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
09.30	TB/2025/109	**Chairs Welcome and Apologies for Absence**	Chair	v	Information
09.32	TB/2025/110	**Declarations of Interests**	Chair	✓	Information
09.35	TB/2025/111	**Minutes of the Previous Meeting held on 9 July 2025**	Chair	✓	Approve
09.40	TB/2025/112	**Action Tracker and Matters Arising**	Chair	✓	Discussion
09.50	TB/2025/113	**Patient Story**	Chief Nurse	v	Information
10.00	TB/2025/114	**Chair's Report**	Chair	✓	Information
10.05	TB/2025/115	**Chief Executive's Report**	Chief Executive	✓	Information
FORMULATING STRATEGY					
10.30	TB/2025/116	**Annual Planning 2026/27**	Exec. Dir. of Service Development & Improvement	✓	Information
ENSURING ACCOUNTABILITY					
10.40	TB/2025/117	**Financial Report**	Executive Director of Finance	✓	Assurance
11.00	TB/2025/118	**Integrated Performance Report**	Executive Directors	✓	Assurance
11.30	TB/2025/119	**Mortality Deep Dive**	Executive Medical Director	✓	Assurance
COMFORT BREAK 11.45 – 11.55					
11.55	TB/2025/120	**Patient Safety Incident Response Assurance Report**	Executive Medical Director	✓	Assurance
12.00	TB/2025/121	**Maternity and Neonatal Services Update**	Chief Nurse/ Executive Medical Director	✓	Assurance
12.15	TB/2025/122	**Accountability & Oversight Framework**	Executive Director of Service Development & Improvement	✓	Approve
12.25	TB/2025/123	**Medical Appraisal and Revalidation**	Executive Medical Director	✓	Assurance
12.30	TB/2025/124	**Emergency Preparedness, Resilience and Response Annual Statement**	Chief Integration Officer	✓	Approve

12.35	TB/2025/125	**Board Assurance Framework**	Executive Directors/Int. Director of Corporate Governance	✓	Assurance
12.40	TB/2025/126	**Corporate Risk Register**	Executive Medical Director	✓	Assurance
SHAPING CULTURE					
12.45	TB/2025/127	**Aarushi Project Update**	Interim Chief People Officer	✓	Assurance
ITEMS FOR NOTING					
---	TB/2025/128	**Nursing Professional Judgement Review**	Chief Nurse	✓	Information
---	TB/2025/129	**Triple A Reports from Quality Committee** a) July 2025 b) August 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2025/130	**Triple A Reports from Finance & Performance Committee** a) July 2025 b) 2 September 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2025/131	**Triple A Reports from People & Culture Committee** a) August 2025 b) September 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2025/132	**Triple A Report from Audit and Risk Committee** a) June 2025 b) July 2025	Committee Chair	 ✓ ✓	Assurance
CLOSING MATTERS					
13.00	TB/2025/133	**Data, Digital & Technology Committee Terms of Reference**	Int. Director of Corporate Governance	✓	Approve
13.05	TB/2025/134	**Audit Committee Terms of Reference**	Int. Director of Corporate Governance	✓	Approve
13.10	TB/2025/135	**Message from the Board**	Chair	v	Information
13.15	TB/2025/136	**Any Other Business**	Chair	v	Information
13.17	TB/2025/137	**Date and Time of Next Meeting** 12 November 2025 at 9.30am, Venue TBC	Chair	v	Information

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/110
Report Title:	Register of Board Directors Interests		
Author:	Kea Ingham Corporate Governance Manager		
Lead Director:	Susan Giles Interim Director of Corporate Governance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**To Note**
				✓
Executive Summary:	It is a statutory requirement for the Trust to maintain and publish a Register of Interests for the Board of Directors. This is in line with the Trust's commitment to ensuring openness and transparency in its decision making. The Register has been updated with the Declarations of Interest for new Board members.			
Key Issues/Areas of Concern:	There is one declaration of interest needs to be updated, which is being followed up. A verbal update will be provided at Board.			
Action Required by the Board:	The Board is asked to note the updated Register of Interests.			

Previously Considered by:	
Date:	
Outcome:	

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust	Potentially a material conflict of interest might arise. If service areas where family members worked were being discussed Mrs Atkinson would make a declaration and the Chair would consider the circumstances and may ask Mrs Atkinson to withdraw from the discussion.	07.08.2025
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Director CY IPS Ltd • Director UCLan Cyprus • University of Lancashire Resources Limited • Chair of Maritime Skills Commission • Board Member of Universities UK • Chair of MillionPlus • Chair of University Vocational Awards Council • Chair of Lancashire Innovation Board • Chair of Preston Regeneration Board • Member Burnley Town Board • Member Burnley Economic Recovery Board • Member Lancashire Business Board	A material conflict of interest does not exist as these roles are not connected to the Trust.	03.09.2025
Professor Shahedal Bari Non-Executive Director	Positive nil declaration	Declaration to be updated to reflect that Prof. Bari is employed at University Hospitals of Morecambe Bay, potentially a material conflict	03.09.2025

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
		could arise in connection with this. If discussions were taking place where this was an issue Prof. Bari would declare an interest and the Chair would consider the circumstances and may ask Prof. Bari to withdraw from the discussion	
Sallie Bridgen Non-Executive Director	• Non-Executive Director of Syncora (part of the Calico Group) • Spouse is a Non-Executive Director at Blackpool Teaching Hospitals (BTH) • Self-employed - Sallie Bridgen Consultancy • Associate - Housing Diversity Network, Ruby Star Associates	A material conflict of interest does not exist as this role is not connected to the Trust.	01.07.2025
Simon Featherstone Non-Executive Director	• Positive nil declaration	N/A	02.09.2025
Susan Giles Interim Director of Corporate Governance / Company Secretary	• Director of Board Matters Ltd. • Chair of Hearings Panels for Social Care Wales • Non-Executive Director Immigration Advice Authority • Joint Audit Committee Member of Cumbria Police, Fire & Crime Commissioner • Trustee of North West Cancer Research • Trustee of Thrive Social Housing • Independent Remuneration Panel Member Wigan Council • Independent Standards Person York and North Yorkshire Combined Authority	A material conflict of interest does not exist as Mrs Giles does not have other consultancy clients within the East Lancashire area; and the other roles are not connected to the Trust.	22.08.2025

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Sharon Gilligan Chief Operating Officer and Deputy Chief Executive	• Positive nil declaration	N/A	07.08.2025
Melissa Hatch Associate Non-Executive Director	• Business Development professional at Citizens Advice. Responsible for charitable income generation.	A material conflict of interest does not exist as this role is not connected to the Trust.	08.08.2025
Julian Hobbs Executive Medical Director	• Positive nil declaration	N/A	12.08.2025
Martin Hodgson Chief Executive	• Spouse is the Group Delivery Officer at Liverpool University Hospital NHS Foundation Trust.	A material conflict of interest does not exist as LUFT is within a different ICB region.	08.08.2025
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust	A material conflict of interest does not exist as Oxford Health NHS Foundation Trust is within a different ICB region.	07.08.2025
Peter Murphy Chief Nurse	• Positive nil declaration	N/A	08.08.2025
Dr Neil Pease Interim Chief People Officer	• Director of Star Bay View Ltd • Chief People Officer at Lancashire Teaching Foundation Trust Hospitals (LTH)	Potentially a material conflict may arise in connection with Dr Pease's role at LTH. If	20.08.2025

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
		discussions were taking place where this was an issue Dr Pease would declare an interest and the Chair would consider the circumstances and may ask Dr Pease to withdraw from the discussion.	
Catherine Randall Non-Executive Director	• Executive Director Derian House Lead for Clinical Services • Independent Chair at Blackburn Church of England • Honorary Professor at the University of Central Lancashire • Spouse is a GP in Blackburn with Darwen	Potentially a material conflict may arise in connection with Mrs Randall's role at Derian House. If discussions were taking place regarding children's hospice services Mrs Randall would declare an interest and the Chair would consider the circumstances and may ask Mrs Randall to withdraw from the discussion.	07.08.2025
Khalil Rehman Non-Executive Director	• Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust • Vice Chair of Seacole Group • TSI Caritas Ltd • NED at UCLan • Appointed as NED and Charity Trustee at NHS Charities Together	A material conflict of interest does not exist as these roles are not connected to the Trust.	13.11.2024

Name and Title	Interest Declared	Is there a conflict of interest with ELHT role?	Date Updated/ Confirmed
Shazad Sarwar Chairman	• Committee member of Together Housing Group (from 01.09.2021) • Managing Director of Msingi Research Ltd. (from 01.07.2015)	A material conflict of interest does not exist as these roles are not connected to the Trust.	13.11.2024
Liz Sedgley Non-Executive Director	• Self Employed Accountant Liz Sedgley FCCA Accountancy and Management Consultancy • Governor at Nelson and Colne Colleges Group	A material conflict of interest does not exist as the roles are not connected to the Trust.	08.08.2025
Sam Simpson Executive Director of Finance	• Positive nil declaration	N/A	05.03.2025
Shelley Wright Executive Director of Communications and Engagement	• Positive nil declaration	N/A	13.11.2024

BOARD MEETING (PUBLIC SESSION)

9 JULY 2025 9.30AM

ACTIVITY ROOM, DOVESTONE GARDENS, BURNLEY

MINUTES

PRESENT

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

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Professor S Bari	Associate Non-Executive Director
Mrs M Hatch	Associate Non-Executive Director
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Mr N Pease	Interim Chief People Officer
Miss S Wright	Executive Director of Communications and Engagement

IN ATTENDANCE

Mr E Aronson	Independent Healthcare Consultant	Observer
Dr A Brown	Intensive Improvement Director, National Recovery Support Team – Chief Operating Officer's Directorate	Observer
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs S Giles	Interim Director of Corporate Governance/ Company Secretary	
Mrs J Hardacre	Assistant Director of Safety and Risk	
Mr R Purewal	Senior Healthcare Director, C2-AI	Observer
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2025/062
Mrs C Vozzolo	Associate Director of Service Development	

APOLOGIES

Mrs K Atkinson	Executive Director of Service Development and Improvement
Professor G Baldwin	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mrs C Randall	Non-Executive Director

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

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

TB/2025/083 CHAIRMAN'S WELCOME AND APOLOGIES

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

TB/2025/084 DECLARATIONS OF INTEREST

There were no declarations of interest raised.

TB/2025/085 MINUTES OF THE PREVIOUS MEETING

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

The minutes of the meeting held on 14 May 2025 were approved as a true and accurate record.

TB/2025/086 MATTERS ARISING

There were no matters arising.

TB/2025/087 ACTION MATRIX

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

Directors noted the position of the action matrix.

TB/2025/088 CHAIR'S REPORT

Directors received an overview of Mr Sarwar's activities since the previous meeting, including his continuing engagement with local members of parliament (MPs) to better understand the concerns of local constituents and to advise them of the significant challenges facing the Trust. It was noted that there had been a recent 'board-to-board' session with colleagues from NHS England as part of the NHS Oversight Framework (NOF) segment 4 which had been largely positive. Directors were advised that a recent maternity and neonatal system call had also recently taken place, at which there had been clear recognition of the diverse communities across Lancashire and South Cumbria (LSC) and of the need to use the lived experience of mothers as a 'golden thread' to drive the development of these services going forward.

Directors received and noted the report provided by the chair.

TB/2025/089 CHIEF EXECUTIVE'S REPORT

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

At a national level, updates were provided on the delivery of 100,000 more treatments for patients in March 2025 then during the same period the previous year, the publication of the NHS Urgent and Emergency Care (UEC) Plan 2025-26, money pledged for the NHS in the Government spending review, a review of maternity and neonatal services, the publication of a new analysis of health inequalities in England by the UK Health Security Agency and a boost for clinical trials. References were also made to the recent publication of the next NHS 10-Year Plan and its focus on three main shifts from hospital to community care, analogue to digital and treatment to prevention. It was noted that there would be a substantial amount of work taking place to bring care closer to people's homes as part of this, as well as a stronger focus on the provision of mental health care and on the increased usage of artificial intelligence and other technologies to benefit both patients and staff.

Directors were informed that a new national Performance Accountability Framework was due for publication in the very near future which was expected to outline a return to transparency of care and 'league tables' for NHS trusts. It was explained that the Trust would transition into segment 5 of this new operating model once it was enacted due to its financial challenges and was expected to transition to segment 3 once it had achieved the relevant exit criteria. The review by the current Chair of NHSE, Dr Penny Dash, into patient safety across health and care were also referenced, as well as its findings that the current system was too complex and confused and had focused too much on patient safety at the expense of other key barometers of quality.

Directors went on to discuss the publication of the NHS UEC Plan for 2025-26 and the approach outlined within for the coming winter and of the need to redouble efforts around corridor care. The establishment of a new independent taskforce and investigation into maternity and neonatal services was also discussed and it was noted that 10 trusts were due to have urgent reviews conducted in the run up to December 2025 as part of this.

At a regional level, updates were provided on a review of the One LSC Shared Collaborative Agreement (SCA) by the Provider Collaborative Board (PCB) at its meeting in May 2025, changes to the LSC Integrated Care Board (ICB), the confirmation of Lancashire Teaching Hospitals (LTH) NHS Foundation Trust as host trust for LSC pathology services, the ongoing development of a single vascular network across LSC and the effects of partnership working on reducing health inequalities.

At a Trust level, updates were provided on recent changes to the Trust Board, including the recent appointment of Dr Julian Hobbs to the post of Executive Medical Director. The formal thanks of the board were extended to Mr Islam for filling the role of Interim Medical Director over recent months. Updates were also provided on the Trust's main financial headlines, the introduction of a new senior clinical fellow role in the emergency department (ED), additional estates funding for Burnley General Teaching Hospital (BGTH), ongoing public engagement on the future of Accrington Victoria Community Hospital (AVH) and improvements to the commercial hospital bus service now in operation.

Directors received a brief overview summary of other recent positive developments at the Trust. It was highlighted that there had been a suite of recognition and awards for Trust colleagues, including the shortlisting of a Cardiac Care Ward Sister, Zoe Shorrock, for the Practice Supervisor of the Year Award and the awarding of an honorary clinical professor title to the Trust's Clinical Director and Consultant in Emergency Medicine, Georgina Robertson.

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

In response to concerns raised by Mrs Sedgley on the potential for patients who were not digitally enabled to be overlooked as the NHS pivoted to a greater use of technology, Mr Hodgson explained that a key part of the new 10-year plan was a move to a community neighbourhood health model to facilitate patients being able to go for appointments at venues closer to where they lived. He acknowledged that the increased emphasis on the use of technology and AI more generally would require additional work with patients around any potential issues with access.

Mrs Hatch observed that Healthwatch organisations were due to be abolished as part of the 10-year plan and emphasised the importance of maintaining the oversight around the lived experience of patients going forward.

Addressing concerns raised by Professor Bari around the vascular service reconfiguration and the importance of ensuring that any critical cases could be escalated quickly and appropriately regardless of proximity to any central site, Mr Hodgson acknowledged that there were a range of legitimate concerns of this nature and indicated that work was ongoing with colleagues from LTH and from the wider vascular network to ensure that these would be addressed prior to any changes being implemented.

Mr Islam added that several areas were currently being served by LTH as part of the wider vascular network and advised that the North West Ambulance Service (NWAS) was closely involved in the discussions currently taking place due to the expected need for increased conveyances going forward. He explained that the minutiae of certain elements still needed to be finalised and that regular communication was taking place with LTH colleagues and relevant vascular leads to facilitate this.

Mr Sarwar referred to the recent challenges relating to patients with mental health needs and informed directors that a cost summary of the associated costs had been requested for further discussion. He emphasised that while the Trust would never turn away patients in need, it was ultimately not a mental health provider and would need to continue to consider the increasing financial burden being placed on it by providing care to them.

Directors received the report and noted its contents.

TB/2025/090 PATIENT STORY

Directors were referred to the patient story circulated prior to the meeting and noted that it was the first story that had been provided a Black, Asian and Minority Ethnic (BAME) patient.

Mr Murphy stated that the story emphasised the importance of clear communication and of a holistic approach to patients and their needs. Mr Sarwar acknowledged that the level of cultural sensitivity referred to in the story was not always present with other patients.

It was noted that the patient story had been presented at the most recent meetings of the Quality Committee and of the Senior Nursing and Midwifery Forum to share the learning, with the full library of patient stories available on the Trust's intranet for anyone to access when they wished.

It was agreed that the patient would be invited to participate in the Trust Patient Participation Panel (PPP) as part of wider efforts to make this group more representative of its local population. Board members agreed that the Trust should give more thought to reviewing how the voices of patients is heard at Board.

Directors received the Patient Story and noted its content.

TB/2025/091 GREEN PLAN

Directors were referred to the previously circulated report and were advised that it provided a local and national overview of its green plan, including an overall 'plan on a page' and the associated potential savings. It was explained that the plan was being presented to the board for noting and approval for presentation at the next meeting of the Finance and Performance Committee for approval to be published on the Trust website by the NHSE deadline of the 31 July 2025.

In response to comments from Mr Featherstone on the wider health benefits of climate change and the risks to the Trust's implementation of its green plan due to its competing financial priorities, Mr McDonald explained that the work being done in financial and clinical areas were directly supporting many of its aspirations as part of its green plan.

Mrs Giles reminded directors that a full 'deep dive' into the Trust's green plan was planned to take place at a future board strategy session.

Directors approved the Green plan on a page and confirmed that they were content to delegate approval of the Trust's Green Plan to the Finance and Performance Committee.

TB/2025/092 HEALTH AND SAFETY STRATEGY AND POLICY

Mrs Hardacre joined the meeting at this time.

Directors were advised that the Trust's Health and Safety Strategy and Policy had been revised following an internal audit review in April 2024, which had delivered a rating of 'moderate assurance' but had made a number of recommendations. It was explained that the board was being asked to formally sign off the policy and associated framework. It was noted that a follow up review has been included within the Trust's internal audit plan for the current year.

Mr Hodgson reminded directors that certain aspects of health and safety had been an area of challenge for the Trust previously, particularly the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (RIDDOR), and explained that the revised strategy and policy being presented was a key part of the wider architecture being developed around this area.

Mr Sarwar stated that health and safety needed greater visibility and oversight at board level and suggested that quarterly updates were provided to the Quality Committee going forward.

ACTION: Quarterly updates on Health & Safety to be provided to the Quality Committee.

WHO: Executive Medical Director BY WHEN: October Quality Committee

Directors confirmed that they were content to approve the Health & Safety Strategy.

Mrs Hardacre left the meeting at this time.

TB/2025/093 FINANCIAL REPORT

Directors received an overview of the Trust's financial performance as of month 12 of 2024-25. It was highlighted that the Trust was reporting a total deficit of £7.6m as of month two (M2) of 2025-26, excluding its Deficit Support Funding (DSF), and was currently £2m behind its overall plan year to date. It was explained that the Trust had agreed to spread the £50m of its unidentified savings schemes in equal twelfths throughout the year when initially submitting its plan for 2025-26, and that this was part of the reason that it was partially off plan. Directors noted that the Trust would have to continue reporting in this manner, despite having fully

identified the full value of its Waste Reduction programme (WRP) schemes in the intervening period. It was also noted that a temporary injection of additional cash may be required later in the year if the Trust was not able to successfully deliver its cost reduction programme.

Mr Hodgson emphasised the importance of the Trust being able to successfully deliver the cost saving schemes that had now been identified. He also stressed the need for the Trust to continue to ensure that none of its cost saving measures affected the quality of its services or their performance and reported that there was tangible evidence, through the Quality Impact Risk Assessment (QIRA) process, that quality had not been negatively impacted.

Mr Sarwar reminded colleagues that the Trust would be in breach of its legal obligations if the savings plan that it had signed up to was not delivered

Directors noted the financial report.

TB/2025/094 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

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

b) Safe

Directors were informed that that a Never Event had recently been declared following an incident in which an oral and maxillofacial surgery patient had had a small part of a metal device left inside their mouth during a procedure. It was explained that although the incident did not fit Never Event criteria, the Trust had been advised to declare it as such by ICB colleagues.

Directors went on to note that the Trust was under trajectory with regard to clostridium difficile (C. diff) and Methicillin-Resistant Staphylococcus Aureus (MRSA) cases. It was also highlighted that the volume of lapses in care in relation to pressure ulcers was decreasing despite a rise in the overall volume of pressure ulcers being reported.

In response to a query from Mr Featherstone around whether the pressure ulcers being seen were community or hospital acquired, Mr Murphy explained that it was a combination of both but indicated that a particularly large cohort of patients were coming into the Trust from residential care homes with existing pressure ulcers.

c) Caring

It was reported that nurse safe staffing fill rates were above 90% and within normal variation. Directors noted that the number of nursing vacancies across the Trust were minimal and that agency and bank spend continued to fall.

d) Effective

Directors were informed that the quality of mortality data coming through had started to improve over recent months. It was reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) currently stood at 1.27, slightly above expected levels, and its Hospital Standardised Mortality Ratio (HSMR) stood at 106, less than expected levels.

It was noted that work was ongoing to correct the mortality data from the previous year, and was being overseen by the Mortality Steering Group (MSG).

Significant progress had been made to reduce the coding backlogs referred to at previous meetings, and it was expected that the situation would be fully addressed in the near future.

e) Responsive

Directors received a summary of the Trust's most recently updated performance figures, including its performance against the four-hour A&E standard, ambulance handover times, 65-week waiters and cancer and faster diagnosis standards. It was highlighted that ambulance handover times remained lower than the NWAS average and that improvements had also been seen the volume of patients waiting for 12 hours or longer in the ED. It was also noted that the Trust was ahead of trajectory for Referral to Treatment (RTT) performance and was on track to achieving the 62.2% target it had agreed to by March 2026.

f) Well-led

It was reported that sickness and absence rates and appraisal rates continued to be areas of challenge for the Trust and that a pre-meet had taken place earlier in the day with relevant colleagues to discuss how the People and Culture Committee would support this agenda going forward.

Mr Pease confirmed that an update on the system sickness reduction plan had been provided to the People and Culture Committee in May 2025. He indicated that work was ongoing to assess and quantify how effective these reduction schemes were proving to be at each Trust in LSC.

It was agreed that additional communication would be put out across the organisation to emphasise the cost implications from high sickness levels and the benefits from reducing this, Mr Sarwar requested greater oversight of sickness absence through the People and Culture Committee and at future meetings of the board.

ACTION: Communications to all staff emphasising the cost of high sickness absence rates.

BY WHO: Executive Director of Communications BY WHEN: September Board

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

TB/2025/095 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Directors were referred to the previously circulated report and agreed to take it as read. It was highlighted that there had been a total of 4,705 incidents reported in April and May, along with a decrease in the numbers of severe harms. Directors were advised that there had been a total of four fatal incidents reported, three of which were currently going through the Patient safety Incident Investigation (PSII) process and one which was following a different process due to involving a child death.

Directors received the report and noted its contents.

TB/2025/096 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson joined the meeting at this time.

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

Safety Action 4 - Clinical Workforce: Directors noted that the Trust was currently non-compliant against this action due to an ongoing risk relating to the Trust's neonatal nursing workforce action plan and its neonatal workforce and their compliance with British Association of Perinatal Medicine (BAPM) standards. It was confirmed that a further update would be provided to the board at its next meeting.

Safety Action 5 - Midwifery Workforce: Directors were advised that the Trust was currently non-compliant against this action due to the ongoing issues with its midwifery staffing establishments not aligning with Birthrate+ findings. It was confirmed that an associated midwifery staffing paper had been presented at the most recent meetings of the Trust Wide Quality Group (TWQG) and Quality Committee and that the matter was due to be discussed in more detail at the closed session of the board later in the day.
Safety Action 8 – Training: It was confirmed that the Trust was currently non-compliant against this action due to a shortfall in Newborn Life Support (NLS) training compliance amongst the neonatal medical team. Directors noted that additional training sessions had been scheduled to address this and that the compliance target was expected to be reached by the end of November 2025.

Directors went on to be referred to the maternity performance report and noted that this was the first time such a report had been presented to the board. It was confirmed that there were no alerts or areas of concern to be raised.

It was noted that the Trust's maternity and neonatal cultural improvement plan referred to in the report was considered as part of safety action 9 of the CNST MIS and that a further update would be provided to the board once the associated programmes of work had come to fruition.

Following comments raised around the formatting of the report and on the potential for more detailed data sets to be provided in future iterations, Mr Murphy reminded directors that the format of the reports presented to the board were done so according to requirements outlined by CNST and to avoid being penalised as it had been in the past. He added that work was ongoing to further improve and refine the formatting of future maternity reports as much as possible within these constraints.

Miss Thompson left the meeting at this time.

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

TB/2025/097 AARUSHI PROJECT UPDATE

Directors were informed that this item had been deferred to a future meeting.

TB/2025/098 TRIPLE A REPORTS FROM QUALITY COMMITTEE

The reports were presented to the board for information.

Directors received the report and noted its contents.

TB/2025/099 TRIPLE A REPORTS FROM FINANCE AND PERFORMANCE COMMITTEE

The reports were presented to the board for information. It was highlighted that there would be an additional focus on delivery against the Trust's WRP at future meetings, as well as the robustness of grip and control mechanisms.

Directors received the report and noted its content.

TB/2025/100 TRIPLE A REPORTS FROM PEOPLE AND CULTURE COMMITTEE

The reports were presented to the board for information. Directors noted that concerns had been raised at the most recent meeting of the Committee around the volume of reviews and consultations that staff side colleagues were being asked to participate in and the substantial impact this was having on their available capacity.

Directors received the report and noted its content.

TB/2025/101 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

Directors received the report and noted its contents.

TB/2025/102 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

Directors received the report and noted its contents.

TB/2025/103 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2025/104 OPEN FORUM

It was noted that no questions had been raised by members of the public prior to the meeting.

TB/2025/105 BOARD PERFORMANCE AND REFLECTION

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

Mr Sarwar stated that the patient story had set the tone of the meeting in several key ways by emphasising the importance of the Trust being able to deliver its services to a very diverse

local population. He added that the ongoing morale challenges amongst Trust staff and of the financial challenges facing the organisation itself had been writ large in the discussions that had taken place during the meeting.

Mr Hodgson commented that there had been clear links between the items discussed by the board and the emerging national landscape and architecture.

Directors noted the feedback provided.

TB/2025/106 MESSAGE FROM THE BOARD

Mr Sarwar stated the message from the board was around the importance of recognising how the Trust could give the power back to patients and the public over the coming years. He emphasised the Trust's commitment to transformation and ensuring that patient voices continued to drive its activity and changes.

Mr Sarwar concluded by extending the formal thanks of the board to colleagues in the Trust for their continuing to manage the significant demands being placed on them and the organisation.

TB/2025/107 DATE AND TIME OF NEXT MEETING

Wednesday, 10 September 2025 at 09:30. Venue to be confirmed.

Board of Directors (Open Session) Action Tracker

Key:

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

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
1.	May 2025	TB/2025/060: Patient Story	Consideration be given to having a patient or relative attend Board in person for the Patient Story.	Chief Nurse	September 2025	A	Work is progressing to identify patients/family members who would be willing to share their experience in person.
2.	July 2025	TB/2025/092: Health and Safety Strategy and Policy	Quarterly updates on health and safety to be provided to the Quality Committee	Assistant Director of Health, Safety and Risk	October 2025	B	Quarterly H&S Updates included on the Quality Committee workplan for the year. Propose this is now removed from the Board's action tracker.
3.	July 2025	TB/2025/094: Integrated Performance Report – Well-led	Additional communications to be put out across the Trust regarding the cost of high sickness and absence levels and the benefits from reducing these.	Executive Director of Communication and Engagement	September 2025	B	Complete

BOARD OF DIRECTORS MEETING

Meeting Date:	10th September 2025	**Agenda Item:**	TB/2025/114
Report Title:	Chair's Report		
Author:	Mr S Sarwar Chair		
Lead Director:	Mr S Sarwar Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
	✓			
Executive Summary:	The Chair's Report provides an update on the activity of the Chair during the months of July and August 2025. The report provides assurance in relation to compliance with Fit and Proper Persons requirements and completion of NED appraisals.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to note: 1. The agreement of the financial waste reduction plan 2. Continuing to meet our obligations under the legal undertakings 3. Collaboration between ELHT and UCLAN on anti-racism 4. Compliance with NED appraisals 5. Compliance with Fit and Proper Persons requirements 6. An update on Board member compliance with Core Skills and Essential to Role Training			

Previously Considered by:	
Date:	
Outcome:	

Chair's Report

Fit and Proper Persons

As Chair I have responsibility for ensuring that the Board complies with the Fit and Proper Persons Regulations. I can confirm that the annual checks have been completed on my behalf and submitted to NHS England at the start of July 2025. Further detail is provided within Appendix 1.

Appraisals

Non-Executive Director appraisals have now been completed and I have completed the Chief Executive's appraisal. My own appraisal was completed and submitted to NHSE by end of July 2025. All NED appraisal paperwork will be signed off during September and submitted to NHSE by their deadline of 30th September 2025.

Seagry Wider Financial Governance Review

The Trust commissioned the second phase of the review of financial governance from Seagry. The fieldwork was carried out during July and August and a draft report has been received to be discussed by the Board. The report reflects the strengthened governance arrangements since the phase 1 report in February 2025 as well as making recommendations for further improvement. These recommendations will be captured and tracked through the Governance and Leadership Action Plan and monitored via the Finance Improvement Group, Audit and Risk Committee and Board.

Board Core Skills and Essential to Role Training Compliance

I have asked the Corporate Governance Manager to provide me with a compliance report for Board in terms of Core Skills and Essential to Role Training. 12 Board members are fully compliant whilst 5 members have some sessions outstanding. Board members have all been reminded of their outstanding sessions and are reminded to complete these during September. I will provide an update of compliance within my next Chair's report.

Meetings attended

- Chaired the Board Strategy and Extraordinary Board meetings in July and August and the Board Development workshop.
- Attended the LSC Provider Collaborative Board, where the focus continues to be on financial challenge, clinical configuration and 1LSC
- Participated in the stakeholder Panel for the recruitment of LSC ICB Chief Executive and congratulation to Aarron Cummins on being appointed to the role.

- Attended monthly Improvement & Assurance Group (IAG) meetings together with Board colleagues.
- Informally met with the CEO and Chair of LCS ICB, Chairs of other Provider Trusts and the System Turnaround Director.
- Continue to meet with RSP Improvement Director regarding progress in response to our legal undertaking.
- Attended the ELHT and UCLAN Joint collaborative on Anti-Racism. At ELHT this has been led by Ms Uma Krishnamoorthy and is an important aspect of developing an inclusive culture at ELHT and I want to offer my personal thanks to Uma for leading this work with UCLAN but also the positive impact it continues to have at ELHT. I also need to recognise Professor Graham Baldwins leadership at UCLAN that has made this collaboration possible.
- I visited Derian House Children's Hospice, and want to extend my thanks to Catherine Randall for the invitation. They provide respite and end of life care to more than 400 children. Am amazing place that provides such high level compassionate care and it would be remiss of me not to mention the quality and values of the staff I met on my visit. This is a service that we must cherish and support. They have developed a feature length film all about Derian House and is out now streaming on Amazon Prime called the "The Little Things". The link to this is Prime Video: The Little Things
- I was invited by the Honourable Sarah Smith MP to "Get Hyndburn Working" event. An opportunity for major organisations to come together to develop a joined approach to supporting people back into work across Hyndburn. I want to extend my thanks to Sarah for bringing a lot of leaders together to play a role in supporting economic prosperity for all.

Appendix 1

Confirmation of Fit and Proper Persons Checks

The FPPT Framework was implemented in response to Tom Kark KC 2019 review in alignment with the Care Quality Commission's requirements regarding directors being required to be fit and proper, strengthening patient safety and good leadership in health care organisations.

To comply with regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all its Board members meet the FPPT requirements.

FPPT requirements play a significant role in strengthening accountability of directors of NHS bodies. Regulation 5 stipulates that Directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying on a regulated activity, however, Chairs retain flexibility to approve individual Directors who may not have met requirements in exceptional circumstances after an assessment and with controls put in place.

This paper confirms that the annual FPPT checks have been completed for each Board member, with the outcome recorded on ESR and submitted to NHS England (NHSE). The scope of checks included all Executive and Non-Executive Directors irrespective of their voting rights (including interim roles).

FPPT Framework

Board members are required to complete an annual self-attestation along with a social media check and a three yearly cycle of DBS checks. All aspects of the checks are also recorded on ESR in line with the criteria set out in the Framework.

Trust compliance has been informed by the application of the Trust's Policy on FPPT including:

- Pre-employment checks for all new appointments undertaken in line with NHS Employment Standards.
- Standard employment checks as per the Trust's recruitment and selection process.
- Disclosure and Barring Service (DBS) checks.
- Search of insolvency and bankruptcy register.

- Search of Companies House register to ensure that no Board member is disqualified as a director.
- Search of the Charity Commission's Register of Removed Trustees.
- Social media checks.
- Satisfactory completion of the self-declaration.
- All new appointments for Non-Executive Director positions are undertaken in conjunction with NHS England.
- Annual and on-going Declarations of Interest for all Board members.
- Annual self-attestation declarations from all Board members.

An internal audit of Fit and Proper Persons procedures and records was undertaken in 2024/25 and received an opinion of Limited Assurance. An action plan and updated FPPT Policy will be presented to the Remuneration & Nominations Committee on 24th September 2025.

All Board members competed the FPPT self-attestation declarations during May and June 2025. A summary of the annual checks' outcome was passed to NHSE Regional Directors at the start of July 2025.

Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and informing the Trust Chair.

There is one outstanding action in relation to FPPT references for Board Directors who left during 2024/25. This is being followed up and an update will be reported to the Remuneration & Nominations Committee on 24th September 2025.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/115
Report Title:	Chief Executive's Report		
Author:	Shelley Wright, Executive Director of Communications		
Lead Director:	Martin Hodgson, Chief Executive		

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

Previously Considered by:	None
Date:	
Outcome:	

1. **Background**

This report is divided into sections covering the following:

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

2. **National Updates**

The 10 year Health Plan announced

The 10 Year Health Plan for the NHS was published in July, which will guide health and care service transformation over the next decade.

It has been shaped by the experiences and expectations of patients, the public and people working in health across the country with over 220,000 contributions made as part of a consultation launched in October last year.

The plan focuses on three ‘shifts' – from hospital to community, from analogue to digital, and from treatment to prevention to personalise care and give more power to patients.

These areas of focus are in line with the work that the Trust is already working towards and making good progress. Specific case studies were provided to colleagues internally and to regional and national teams at NHS England as part of the launch to enable them to be used as examples of good practice.

Draft planning framework

A draft planning framework has been published by NHS England to support the implementation of the 10 Year Health Plan.

For the first time it moves from an annual plan to a ‘medium term’ five-year plan with clear requirements of what is expected from provider organisations, Integrated Care Boards and the regional tier of NHSE.

Annual funding settlements and planning cycles have made it difficult to focus on thoughtful, long-term strategic planning of services. To break this cycle, this framework shifts the focus towards a rolling five-year planning horizon.

Industrial Action by resident doctors

Resident doctors took part in industrial action from 25-30 July as part of a dispute between their union (the British Medical Association) and the Government.

More care was delivered during the July 2025 resident doctors' strike than in the five-day June 2024 walkout, with NHS analysis estimating that an additional 11,071 appointments and procedures went ahead.

Staff absence due to industrial action was lower during this latest round, with around 1,243 fewer staff absent each day on average compared to last June – a 7.5% drop – helping trusts to maintain more services and protect patient care.

NHS delivers record numbers of treatments

The NHS performed a record number of checks for treatments, cancer checks and other tests in June, as 18-week performance hit its best level in three years.

NHS staff pulled out all the stops to treat a record number of patients, with 103,563 – or 2% – more treatments delivered than the same month last year (1.56 million vs 1.45 million).

The proportion of patients waiting less than 18 weeks for treatment in June was 61.5%, the highest since June 2022. The longest waits of over 52 and 65 weeks also fell.

This progress came amid a surge in people coming forward for care, with 141,809 more referrals onto the waits list – or 3.2% – than the year before (1.83 million vs 1.69 million); meaning the waiting list rose slightly by 9,712, to 7.37 million. That equates to an estimated 6.23 million patients waiting for care.

It was also a record June for the number of diagnostic tests and checks delivered (2.5 million).

Review of patient safety

An independent review of patient safety across the health and care landscape has been published.

Led by Dr Penny Dash, the review was commissioned by the Department of Health and Social Care and focuses on the effectiveness of existing structures and identifies areas for improvement.

The Health and Social Care Secretary has now asked Dr Dash to conduct two further reviews moving her focus from operational effectiveness to patient safety and quality.

The first review will examine the roles and remits of six key organisations and make recommendations on whether patient safety could be bolstered through a different approach. These are:

- CQC, including the Maternity and Newborn Safety Investigations programme (MNSI)
- National Guardian's Office (NGO)
- Healthwatch England (HWE) and the Local Healthwatch (LHW) network
- Health Services Safety Investigations Body (HSSIB)
- Patient Safety Commissioner (PSC)

- NHS Resolution (quality and safety functions only)

A further review will focus on quality and its governance. This will guide the government's next steps as it continues its drive for positive cultural change across health and social care.

Job boost for newly qualified nurses and midwives

The government's Graduate Guarantee was launched in August as part of action to make sure there are enough jobs for every newly qualified nurse and midwife in England.

It intends to remove barriers for trusts and create opportunities for graduates, ensuring a seamless transition from training to employment.

Trusts are being encouraged to adopt a time-limited approach to utilise existing vacant healthcare support worker roles to create time limited registered nursing posts

An online student hub supports newly qualified nurses and midwives applying for their first roles by bringing together multiple job sites and offering practical guidance on applications, interviews, and preparing to start work.

NHS publishes waiting list breakdowns to tackle health inequalities

Data published for the first time ever by the NHS show patients in the poorest communities and those from an Asian or Asian British background are more likely to be waiting longer than 18 weeks than any other group.

Tackling health inequalities is at the heart of the 10 Year Health Plan which sets out how people living in working class and deprived communities will benefit from billions of pounds of funding diverted from other areas.

The rollout of neighbourhood health centres will first be targeted at the places where healthy life expectancy is lowest, including deindustrialised cities and coastal towns, reducing the estimated £240-330 billion cost of sickness to the economy.

The NHS is also at the heart of tackling economic inactivity with Further Faster 20 teams tackling waiting lists in the areas most affected, employment advisers in back pain clinics, and health and growth accelerators assessing the economic benefits of various health interventions.

NHS App overhaul will break down barriers to healthcare and reduce inequalities

The NHS App will be transformed so it gives every patient - whatever their postcode or background - information, choice and control of their own healthcare so they have the best information at their fingertips.

The improved NHS App will democratise care, so everyone, including those from working class communities, has the information they need about their conditions or procedures they're due to go through.

Using artificial intelligence (AI), the new My Companion tool will give patients direct access to trusted health information, so there are always two experts in every consulting room - the clinician and the patient.

It will help patients articulate their health needs and preferences confidently - providing information about a health condition if they have one, or a procedure if they need one.

World-first AI system to warn of NHS patient safety concerns

Patients will receive better care thanks to a world-first AI early warning system being developed to automatically identify safety concerns across the NHS, helping stop failures before they escalate.

It follows a pledge by the Health and Social Care Secretary to overhaul health and care regulation, root out poor performance and guarantee patients safe, quality care.

The new safety warning system, being developed as part of the government's 10 Year Health Plan, will rapidly analyse healthcare data and ring the alarm bell on emerging safety issues.

NHS to bring 'sponge-on-a-string' cancer test to the high street

Dozens of high-street pharmacies in England will offer new 'heartburn health checks' to test for Barrett's oesophagus, which can be a precursor to oesophageal cancer.

The test involves patients swallowing a small pill on a thread, which expands into a penny-sized sponge when it reaches the stomach. After a few minutes, it is safely pulled out to collect cells from the lining of the oesophagus, which are tested for pre-cancerous changes in the lab.

Pharmacists will help spot patients who are regularly using over-the-counter medications to ease their heartburn or reflux symptoms but haven't come forward to their GP, aiming to spot early changes in the lining of the oesophagus that otherwise may have been missed.

Home testing kits for lifesaving checks against cervical cancer

Women and people with a cervix across England who haven't come forward for vital health checks will be offered home testing kits.

The ground-breaking initiative aims to revolutionise cervical cancer prevention rates by tackling deeply entrenched barriers that keep some women away from potentially life-saving screenings, including a fear of discomfort, embarrassment, cultural sensitivities and the struggle to find time for medical appointments.

3. **Regional Updates**

New Chief Executive announced for the Lancashire and South Cumbria Integrated Care Board (ICB)

Aaron Cummins has been appointed as the ICB's next Chief Executive, pending formal national approval.

With over two decades of senior leadership experience within the NHS, Aaron will bring strong leadership and skills to the role and financial and quality improvement experience.

Aaron is currently Chief Executive at University Hospitals of Morecambe Bay NHS Foundation Trust and will join the ICB in November.

New ambulance handover standard introduced in the North West

All hospitals in the North West with Emergency Departments have implemented the North West Integrated Escalation Protocol (known locally as Release to Rescue).

The standard was published in NHS England's Urgent and Emergency Care plan for 2025/26 in June 2025 and highlighted as part of the Government's 10 Year Health Plan, which stipulates that no ambulance handover should exceed 45 minutes at any trust.

To ensure that this standard can be achieved safely there has been extensive collaborative work across the region and locally with a wide range of stakeholders, including ELHT colleagues and the North West Ambulance Service (NWAS).

Extensive work has already taken place at the trust and further plans are being implemented within the Emergency Department to avoid patient handover delays but all colleagues have a part to play in ensuring ambulance crews are released as quickly as possible.

This will ensure ambulances are available to respond to patients who need them.

Pathology service update

All provider Trust Boards have approved a plan to form a new single service for pathology, with Lancashire Teaching Hospitals NHS Foundation Trust (LTH) as the lead provider, supported by colleagues across the system.

A consultation phase with impacted pathology colleagues is now underway but for most, there will be no immediate changes and they will continue working in their current role, location and team.

Current plans are working towards establishing the single service from 1 February 2026, with the aim of standardising processes across the network and equity of access to improve patient care.

Boost for GP practices to help people back to work

Lancashire and South Cumbria will receive £100,000 of a £1.5m WorkWell pilot fund which is expected to support up to 56,000 disabled people and people with health conditions into work by spring 2026.

This innovative model brings together integrated care boards, local authorities and Jobcentre Plus to provide a single, co-ordinated gateway to work and health support services.

Lung Cancer Screening Programme improving early diagnosis in Lancashire

More than 100 people were diagnosed with lung cancer in Lancashire over a 12-month period having participated in the Lung Cancer Screening Programme.

Between April 2024 and March 2025, of the 113 lung cancers detected as part of the programme locally, 94 were stages one and two. This equates to 83 per cent – higher than the national average of 75 per cent.

In Lancashire and South Cumbria, just 28 per cent of people who had lung cancer were diagnosed with early-stage lung cancer in 2023 – by 2025 this has increased to 41 per cent.

Lancashire and South Cumbria patient safety initiative in the running for top industry award

Lancashire and South Cumbria Critical Care and Major Trauma Specialised Services Clinical Network has been named as a finalist at the HSJ Patient Safety Awards 2025, in the category Improving Medicines Safety.

Over the past four years, the network, a collaboration between ELHT, Blackpool Teaching Hospitals, Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay has been developing monographs – guides that describe the uses, doses, safety issues, and other considerations involved in the use of a drug – which have been implemented and utilised in adult critical care wards in Lancashire and South Cumbria.

4. Local and Trust specific updates

Use of the Trust Seal

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

On 13 August 2025 the seal was applied to an Agreement for Surrender and Grant of New ULPA for St Peters Health Centre, Burnley between the Trust, and Community Health partnerships Ltd. This was signed by Martin Hodgson, Chief Executive.

On 13 August 2025 the seal was applied to the Underlease for Part of St Peters Centre, Burnley between the Trust and Community Health Partnerships Ltd. This was signed by Martin Hodgson, Chief Executive, and Peter Murphy, Chief Nurse.

On 29 August 2025 the seal was applied to a Deed between the Trust and Siemens Healthcare Ltd for the Provision of a Managed Equipment Service for Radiology Equipment. This was signed by Martin Hodgson, Chief Executive, and Sam Simpson, Executive Director of Finance.

Changes to Trust Board

Julian Hobbs has joined the Trust Board as Executive Medical Director. Prior to this role he was Medical Director at the Dudley Group NHS Foundation Trust for seven years and is a consultant cardiologist by background. He has also worked at Liverpool Royal and Liverpool Heart and Chest Hospital with extensive experience in medical management roles.

The Trust has made some changes to the portfolios for two colleagues on the Executive team and Trust Board. Data and Digital has moved from Sam Simpson to Tony McDonald.

This is in part a reflection of the challenges the Trust is currently facing to reduce our costs and deliver the largest waste reduction programme in its history of £60.8million.

In addition, it has become clear through recent policy development at a national level, most notably referenced in the Government's recently published 10 Year Plan for Health, that the advent of Digital and Data as one of the 'three shifts' described will be critical to the successful delivery of the other two, namely neighbourhood focused services and prevention of illness wherever possible.

The Trust's ambitions will be better served by sitting the portfolio closer to integrated care. Tony will become Chief Integration Officer, working closely with colleagues in the Data and Digital team, which is part of One LSC and includes Stephen Dobson as Chief Information Officer for the Trust.

Finance headlines

Significant work continues to deliver the organisation's significant financial recovery plan, which is being supported by colleagues from the national Recovery Support Programme (RSP) following the recategorisation of the Trust in the NHS Oversight Framework to segment four (NOF 4).

The details of this will be covered in detail within the financially focused paper on the agenda and the figures change day to day, but highlights include:

- Agency spend in July was 45% less than the same month last year
- Around £4.2m of efficiency savings were delivered in July

Over £60.8 million of potential savings have been identified for 2025-26 and a Programme Management Office is now in place to ensure that projects are delivered.

New daily panels are also to be set up to increase monitoring of spending on non-pay goods and services and will closely scrutinise all requisitions put forward by teams across the Trust to ensure value for money and identify spending which can be reduced or stopped.

This is also reported in more detail separately to the Board, but a number of related initiatives of note are included below:

- **Cross-cutting workstreams**: There are now a number of cross-cutting workstreams that are looking at areas of spend that impact multiple directorates, including pay, data & digital, service reviews and commercial income. There are representatives from a range of directorates on these workstreams who are working together to review all related ideas and keep projects moving forward positively.

- **Changes to catering provision:** Following a review of catering at the Trust, the deli at Park View, Blackburn and coffee shop at Pendle closed on 1 August. The difficult decision was made as the facilities were simply not taking enough sales to break even. Closing the two cafes will help save the Trust an estimated £65,000 a year, which will support the current financial turnaround plan. Colleagues working in those areas have been offered alternative roles within the catering division.

- **Walking aid recycling**: A walking aid recycling scheme launched at Royal Blackburn Teaching Hospital earlier this year has proved so successful it has been extended to other sites. Nearly 1,000 walking aids have been returned, refurbished and reused rather than sent to landfill – and saved £8,000 at the same time. This includes 433 crutches (of which 361 have been reused) and 429 frames (of which 392 have been reused). Drop off points have now been set up at Burnley, Pendle and Clitheroe where crutches, sticks or frames can be returned so they can be used by future patients.

New strategy being co-designed

Senior leaders came together in August for an important session to begin planning the Trust's future strategy.

A number of current strategies are due for a refresh but with key changes to the healthcare system in Lancashire and South Cumbria, as well as the changes nationally, it's the right time to review everything and set a new course.

As part of this activity, all the Trust's key strategies are being brought together into one concise, unified document that clearly sets out future priorities.

This will act as a reminder of our purpose and aims, and most importantly inspire people to want to work at the Trust and make a difference.

The new strategy will be co-designed with colleagues, patients, key stakeholders and the public over the coming months.

CQC rating for community inpatient service

The Care Quality Commission (CQC) published a report following an unannounced inspection of the Trust's community inpatient service in March this year.

The Trust has a range of community inpatient services that specialise in providing patients with rehabilitative care before returning home. Community inpatients account for around 2% of total admissions across the Trust.

They are based across four sites:

- Albion Mill (one ward with 13 beds)
- Burnley General Hospital (three wards with a total of 69 beds)
- Clitheroe Community Hospital (one ward with 32 beds) and
- Pendle Community Hospital (two wards with a total of 48 beds).

The service narrowly missed being rated good. Although rated 'requires improvement' overall, there were many areas of positive feedback in the report.

It was rated 'good' for caring, effective and well-led, which is a positive reflection of the dedication of colleagues.

Inspectors commented how patients were treated with kindness, empathy and compassion and patients told inspectors they were happy with their care overall.

They also noted that the service had a proactive and positive culture of safety, it supported people to manage their health and wellbeing to maximise their independence, choice and control, and leaders were visible and approachable for patients and staff.

New support to reduce sickness

Managers now have a checklist to use when an employee phones in sick. They can use this to talk through different health and wellbeing support and resources available and the professional services that the Trust can refer to. This will ensure that colleagues are signposted to support at the earliest opportunity.

Evidence shows that musculoskeletal (MSK) and mental health conditions are responsive to early, effective intervention – and these are the two top reasons for sickness absence at the Trust.

Introducing a new Quality Assurance Assessment Framework (QAAF)

From 15 September, a new Quality Assurance Assessment Framework (QAAF) will replace the Trust's current Nursing and Assessment Performance Framework (NAPF).

The NAPF assessments were introduced in 2015 as part of ongoing quality checks. They include a comprehensive assessment of standards, linked to themes monitored by the Care Quality Commission.

Over the past decade, this has evolved into a well-established nursing accreditation programme but now recognise the need for a broader, interdisciplinary approach.

Led by the Chief Nurse, the new QAAF is grounded in CQC standards and national guidance and has been co-produced with subject matter experts. Themes include safeguarding, patient experience, harm-free care, and leadership.

It is a continuous, interdisciplinary assessment tool applied across inpatient wards, emergency pathways, procedural areas, community health services, and outpatient settings.

£1.6m secured for theatre improvements

Theatres at Burnley General are benefitting from an investment of around £1.6million which has been awarded from the NHS Targeted Investment Funding (TIF).

The funding aims to help improve patient experience by speeding up elective recovery and tackling waiting lists.

The money has been used to buy a range of equipment and systems that will support the elective recovery programme by ensuring additional activity at Burnley's surgical hub can be provided.

Areas that have benefitted from the investment include ENT, urology, gynaecology, ophthalmology and general surgery.

The improvements will support ongoing work in Theatres to enable the Trust to ultimately apply for GIRFT Elective Surgical Hub Accreditation.

Step up pathway from primary care to Albion Mill

A pilot step-up pathway to Albion Mill has been launched with primary care before being rolled out to all other community services.

Albion Mill is a 13-bed intermediate care unit based in Blackburn where Blackburn with Darwen residents and/or GP registered population who are aged 18 and over can receive comprehensive care including daily GP oversight, physiotherapy, occupational therapy, nursing and social care.

The service is open to those being treated for an exacerbation of condition, trauma or illness, which has resulted in a need for therapy, rehabilitation or recovery that cannot be delivered in a person's own home.

Befriending service pilot launched by Community Services

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

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

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

After just one week of operating the initiative was already showing signs of success with patients stating what a difference just one phone call made.

Anti-racism and allyship training re-launched

The Trust has re-launched the introduction to anti-racism and allyship training – a vital step in its ongoing commitment to becoming an anti-racist organisation and fostering an inclusive, respectful, and equitable workplace for all.

It is open to all colleagues, providing an opportunity to reflect, learn, and take meaningful action as individuals and as a collective.

It's also about empowering each of us to be effective allies – to speak up, show up, and stand with colleagues, patients and the public from underrepresented communities.

Apprentices complete training

A total of eight apprentices completed their training at the Trust in June and July.

Apprentices are an integral part of the ELHT team, often learning on the job in both clinical and non-clinical settings.

From those gaining hands-on experience in clinical areas, to colleagues studying professional qualifications and senior leaders pursuing Masters-level qualifications, these colleagues are shaping the future of healthcare at the Trust.

Celebrating 150 young lives transformed through ELHT and The King's Trust partnership

The Trust has supported 150 young people into employment through the 'Get into Hospital' programme in a partnership with The King's Trust.

The King's Trust, a charity dedicated to empowering young people aged 18–30, runs the 'Get Into' courses to help those facing adversity build the skills needed to live, learn and earn.

The programme at ELHT offers a pathway into meaningful careers in health and social care and has helped young people gain vital experience, confidence and skills to secure long-term roles in healthcare. Participants have gone on to secure substantive work in areas such as patient services and laundry.

Wedding on Ward C6

Colleagues on ward C6 at Royal Blackburn pulled out all the stops to arrange the wedding of inpatient Mark Marshall and his bride Terri.

After receiving sad news regarding Mark's health, both he and partner Terri made the decision that they wanted to get married at the earliest opportunity.

This wish was granted by the C6 team who organised a registrar, and one colleague even baked their wedding cake.

Ward 19 team help Burnley fan Carl score the first 2025/26 shirt

A patient at Burnley General Teaching Hospital was the very first person to receive Burnley FC's brand-new 2025/26 season shirt - thanks to the team on Ward 19.

Carl Sudworth, a long-term inpatient and lifelong Burnley FC supporter, was seriously injured after being struck by a car following a match at Turf Moor. Since then, he has been undergoing a lengthy and challenging recovery at the Trust.

Colleagues reached out to the Club and arranged it to ensure that Carl was the first to receive one just 15 minutes before they were available to the public.

NHS Staff Survey 2025

The Trust is making final preparations to launch the national Staff Survey for 2025 with a new provider and an expanded reach to include colleagues from One LSC.

Building on lessons from 2024, we've strengthened our approach to engagement, accessibility and visibility of impact and a multi-channel campaign, supported by Staff Networks and targeted divisional activity will maximise participation to allow as full a picture about staff experience to be understood.

Key mitigations include tailored support for non-office-based and international staff, visible recognition efforts and improved feedback mechanisms. The survey will continue to be fully digital however the new provider supports the use of helpdesk for telephone responses to the survey and for surveys to be sent to home email addresses. It is hoped that this addresses some of the challenges.

The survey for bank workers will also take place and again, the response rate has been low since this survey was introduced and is highlighted for specific action to ensure an improvement.

Millions tune into 999: The Critical List

The theatres team at the Trust starred in the three-part fly on the wall documentary 999: The Critical List, which was aired on Channel 4 in April.

Each episode of the programme was watched by over 1 million people with an additional 300,000 tuning in using the streaming service, C4 On Demand.

The 2025 Star Awards

The shortlist for the annual Star Awards has now been announced, the highlight of the Trust's colleague recognition calendar.

This year there were over 500 nominations across 12 categories, all spotlighting teams and individuals who are making a difference to the Trust and our patients. There was also a People's Health Hero award which was open to nominations from the public.

Thank you to everyone who took part in the judging panels which consisted of representatives from the Trust Board and colleagues from a number of areas across the Trust.

The winners will be announced at a virtual awards ceremony which will take place on Wednesday, 17 September courtesy of sponsorship from Equans, Consort and Burnley General Hospital Phase V SPC Ltd.

Medical Examiner service honoured at retirement celebration for Senior Coroner

Colleagues from the Trust's Medical Examiner Service have been presented with an award for outstanding service and partnership with the Muslim community in Blackburn by the Blackburn Muslim Burial Society.

The award was presented to the Team by Dr Asif Garda, Clinical Chair for East Lancashire Medical Services (ELMS) at a celebration dinner marking the retirement of Senior Coroner Dr James Adeley.

Award-winning praise for ELHT's Veteran Team

The Trust's Armed Forces Veteran Team have won the 'Most Outstanding NHS/Healthcare Award' in the 2025 Covenant and Services Awards.

The annual awards, held by the National Armed Forces and Emergency Services Events (NAFESE) team, celebrate the best in service from armed to emergency to volunteer.

The Team has also been shortlisted for a national 'Soldiering On' Award in the 'Working Together' category - the winners of these awards will be announced in October 2025.

ENDS

BOARD OF DIRECTORS MEETING

Meeting Date:	10 Sept 2025	**Agenda Item:**	TB/2025/116
Report Title:	Planning Update - 2026+		
Author:	Catherine Vozzolo, Associate Director of Service Development		
Lead Director:	Kate Atkinson, Director of Service Development & Improvement		

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

Executive Summary:

NHSE has published a draft planning framework for the NHS for planning from 2026 onwards.

The planning framework is well aligned to ELHT's current planning process and our system planning processes. The key changes are noted:

- Plans will now move to a 5-year medium term planning timeframe.
- Completion of fully triangulated plans are required by the end of Q3 2025/6.

All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. This means developing plans that:

- build and align across time horizons, joining up strategic and operational planning
- are co-ordinated and coherent across organisations and different spatial levels
- demonstrate robust triangulation between finance, quality, activity and workforce.

The ELHT planning process started in June/July with our planning workshop held across system providers and commissioners and a detailed timeline of actions identified. A system planning group has met monthly since the workshop to further refine our planning process.
Internal ELHT planning meetings are stood up weekly from September to progress with planning and to complete all phase one activities and finalise plans for phase two planning.
Immediate next step actions are outlined.

Key Issues/Areas of Concern:

Initial risks are identified as:

- Capacity to develop detailed and triangulated plans given the timescale has been brought forward/condensed and that focus is also on delivery of financial recovery plans (and operational and clinical delivery) in Quarter 3
- Requirement to have detailed working assumptions now at system level to feed into planning work. This requires

	rapid development and agreement of impact of commissioning intentions, growth assumptions etc. • Role of ICB v NHSE Regional Teams in planning still to be clarified • Timely availability of national guidance and supporting material Work is now ongoing to identify mitigation plans for all risks and these will be further developed over the coming weeks.
Action Required by the Committee:	The Trust Board are asked to note the planning guidance issued and update provided.

Previously Considered by:	Finance and Performance Committee
Date:	02/09/2025
Outcome:	National, System and Trust updates noted and discussed.

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Planning Update
Finance and Performance Committee
2nd September 2025

26th August 2025

Safe | Personal | Effective

ELHT. *Because that's who we are*

Contents

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Executive Summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- NHS England has published a draft Planning Framework for the NHS
- The planning framework is well aligned to East Lancashire Hospitals NHS Trust's (ELHT's) current planning process and our Lancashire and South Cumbria (L&SC) system planning processes. The key changes are noted:
  - Our plans will now move to a 5-year medium term planning timeframe.
  - Completion of fully triangulated plans are required by the end of Quarter 3 2025/6.
- It is positive to note that there is a clear emphasis on the role of continuous improvement within the Framework and boards in setting the conditions for improvement and ensuring a clear approach to capability and capacity building at all levels
- Work had already begun at system level to map out key activities required to meet this deadline, and these align well to the new national timeframe and outlined phases
- Work has also already commenced internally to begin preparation, particularly in respect of a full organisational strategy re-fresh and development of future Waste Reduction Programme (WRP) plans linked to financial recovery and the Programme Management Office (PMO) establishment
- The ELHT planning process started in June/July with a planning workshop held across L&SC system providers and commissioners and a detailed timeline of actions identified. A system planning group has met monthly since the workshop to further refine our planning process and begin preparatory activities
- Internal ELHT planning meetings are stood up weekly from September to progress with planning and to complete all phase one activities and finalise plans for phase two planning as outlined in the Planning Framework
- Risks and next steps are outlined and work will be undertaken over the coming weeks to firm up actions and timescales into a detailed delivery plan

National Update

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- NHS England has published a Draft Planning Framework for the NHS in England.

- The Ten Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services. To support this, a new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services. Annual funding settlements and planning cycles have made it difficult to focus on thoughtful, long-term strategic planning of services. To break this cycle, the new framework shifts the focus towards a rolling five-year planning horizon.

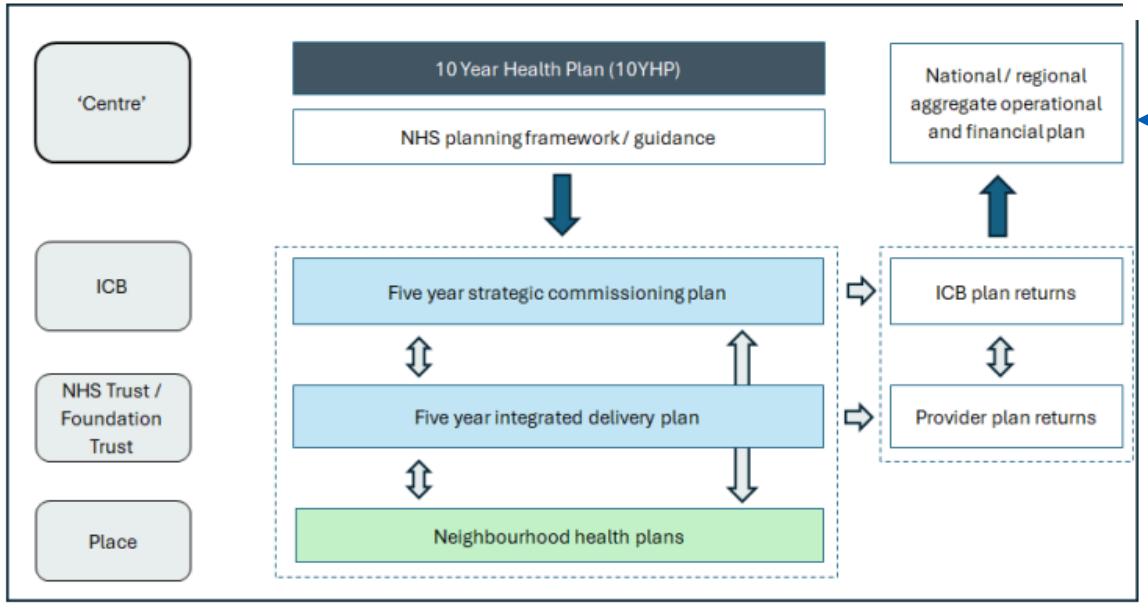
- All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. This means developing plans that:
  - build and align across time horizons, joining up strategic and operational planning
  - are co-ordinated and coherent across organisations and different spatial levels
  - demonstrate robust triangulation between finance, quality, activity and workforce

National Update

The role of the Board:

- Ultimately accountable for development and delivery of plans – expected to play an active role in setting direction, reviewing drafts and constructively challenging assumptions ensuring the plan is evidence-based and realistic in scope
- Set the conditions for continuous improvement, ensuring clear data-driven and clinically led improvement approach in place. Systematic approach to building improvement capacity and capability at all levels
- Duty to collaborate – working across the system to deliver shared objectives

Relationship between key elements of the national planning architecture



Key NHS planning roles and responsibilities

Providers:

- Develop strategic, operational and financial plans to deliver on national and local priorities, including pathway redesign and service development.
- Develop and continuously improve the foundations for integrated planning including robust demand and capacity modelling and triangulation across quality, finance, activity and workforce plans.
- Ensure strong clinical leadership in plan development and linked decision making.
- Collaborate with system, place and provider collaborative partners to ensure plans support the delivery of the best outcomes for local populations and the most effective use of collective resources.
- Work with ICBs to ensure plans reflect agreed commissioned activity levels and align to the overall system strategy.

Regions:

- Support ICBs and providers to 'create the conditions' for effective, integrated planning across the region, including assessment of planning maturity.
- Lead those planning activities where a regional or cross-system response is required e.g. strategic infrastructure planning, long term workforce planning, education and training capacity planning.
- Support and assure ICB and provider responses to nationally mandated elements of NHS planning including risk assessment, coordinating appropriate support, and plan acceptance.
- Work closely with national teams to design national planning products and processes and support capability and capacity building.

ICBs:

- Set overall system strategy to inform allocation of resources to improve population health outcomes and ensure equitable access to healthcare.
- Lead system level strategic planning, ensuring effective demand management and optimal use of collective resources.
- Set commissioning intentions and outcome-based service specifications to enable providers to undertake effective operational planning aligned to national and local priorities.
- Convene and co-ordinate system-wide planning activities e.g. pathway redesign, neighbourhood health, fragile services, capital and estates.
- Work closely with region on planning activities where a cross-system or multi-ICB response is required.
- Co-ordinate system response to nationally determined NHS planning requirements, working with region and providers.

National:

- Set strategic direction and national priorities and standards for the NHS.
- Develop and continuously improve the national planning framework, including specific requirements for the nationally co-ordinated element of NHS planning.
- Support capability and capacity building across the system and promote sharing and adoption of best practice.
- Deliver centrally developed resources, such as analytical tools, data packs, modelling assumptions, and templates to reduce duplication and ensure consistency.
- Provide guidance and technical support to underpin planning and assurance processes
- Work closely with regions, ICBs and providers on the design and refinement of national planning products and processes.

National planning architecture:

- Five-year organisational plans together with neighbourhood health plans will be the core outputs of integrated local planning processes
- NHSE and DHSC will issue specific guidance to support their respective development
- NHSE to work with government to review the requirement for ICBs and their partner trusts to prepare a five-year joint forward plan (JFP) and joint capital resource use plan (JCRUP)

National Update – Indicative timetable

East Lancashire Hospitals NHS Trust
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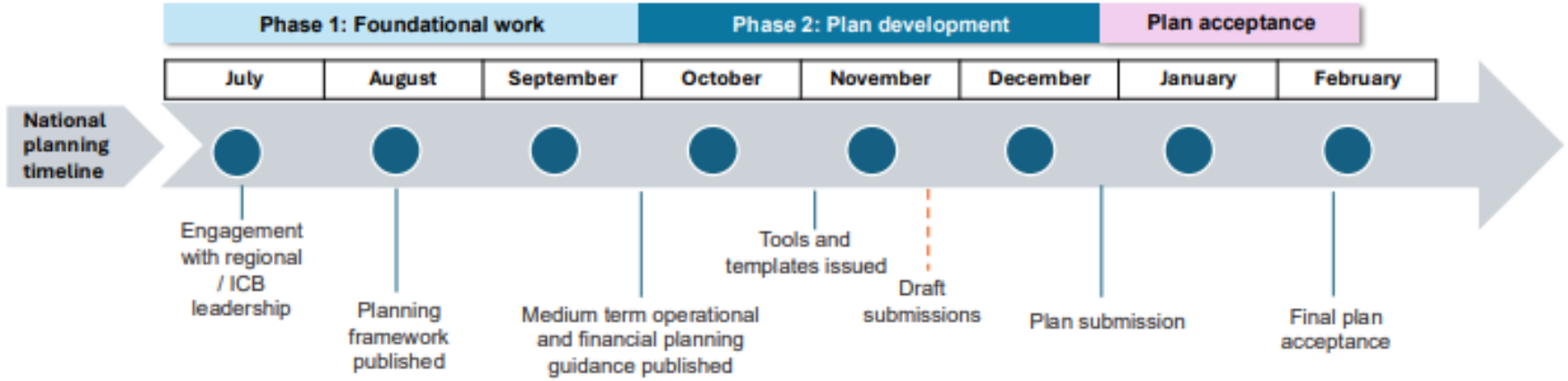
Indicative timetable for 2026/27 – across two phases



Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers		Review of draft plans	Plan assurance and acceptance	
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers	Integrated planning		Finalise plans & board sign-off	Respond to outcome of plan assurance	Prepare to implement plans
Provider activities	Set up process, governance and build a robust evidence	Complete foundational work	Integrated planning		Finalise plans & board sign-off		
Outputs		Underlying financial position Block contract reviews		Draft Planning returns	Five year plans National returns		

Phase 1 – lay the foundations for success

Phase 2 – fully developed, triangulated and assured plans through a multi-disciplinary process, and signed off by boards.

The phases are not rigid and core activities across phases may overlap and interact with each other.

Supporting resources to be published from September.

National Update – Phase one activities

East Lancashire Hospitals NHS Trust
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	ICB	Provider[2]	Place partners
Phase one: Setting the foundations	Perform a refresh of the clinical / organisational strategy as required to ensure they are updated to reflect changes in national policy (e.g. the 10YHP) or local context. Review organisational improvement capability. Establish appropriate governance structures and agree responsibilities and ways of working to support the integrated planning process, including engagement with patients and local communities		Provide place-level input on population needs and local priorities including Joint Strategic Needs Assessment (JSNA)
	Assess population needs, identifying underserved communities and surfacing inequalities, and share with providers Review quality, performance and productivity of existing provision using data and input from stakeholders, people and communities Develop initial forecasts and scenario modelling for demand and service pressures Generate actionable insights to inform service and pathway design with providers Create outline commissioning intentions for discussion with providers	Review quality, performance and productivity at service level as well as the organisation's underlying capabilities (workforce, infrastructure, digital and technology) Establish a robust financial baseline based on underlying position and drivers of costs Identify key sources of unwarranted variation and improvement opportunities through benchmarking and best practice Identify service and pathway redesign opportunities including reviewing fragile services Undertake core demand and capacity analysis and develop initial forecasts and scenario modelling	

National Update – Phase two activities

East Lancashire Hospitals NHS Trust
A University Teaching Trust

	ICB	Provider[3]	Place partners
Phase two: Integrated planning	Develop an evidence-based five-year strategic commissioning plan to improve population health and access to consistently high –quality services	Develop a credible, integrated organisational five-year plan that demonstrates how national and local priorities will be delivered, including securing financial sustainability	Lead the co-design of integrated service models at place level Develop Neighbourhood Health Plan and supporting place-based delivery plans
	Bring together neighbourhood health plans into a population health improvement plan in discussion with people, communities and partners Iterate initial forecasting and scenario modelling for demand and service pressures Finalise commissioning plans to inform provider plan development Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are aligned to the priority areas of the plan	Iterate core demand and capacity analysis and scenario modelling to reflect service redesign opportunities Develop clear service level plans that meet national and local priorities, including implementation plans best practice care pathways Triangulate and finalise finance, workforce, activity and quality plans Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are in place to deliver plans	

Core Planning Outputs

East Lancashire Hospitals NHS Trust
A University Teaching Trust

ICB Strategic Plans: Population health, commissioning strategy

Provider Delivery Plans: Quality, performance, transformation

Neighborhood Health Plans: Integrated local services

National Plan Returns: Aligned financial and workforce templates

System Update

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- Commissioners have completed initial engagement on commissioning intentions for 2026/27, having hosted 4 sessions to gain the views of local authorities, VCFSE and patient representatives as well as NHS partners. A summary of the feedback grouped into key themes is attached at appendix 1.
- The next phase will be an assessment of the long list of commissioning intentions which will be assessed against a set of criteria. These include strategic priorities and the ambitions set out in the 10-year plan as well as applying evidence-base, data intelligence, best practice, national guidance and patient insight. The financial position will also be considered and the need to make difficult decisions is recognised.
- Communication from the ICB on 4th August states that the ambition is to share the outcomes of that assessment in early Autumn. This will include a refined list of commissioning intentions which will be scrutinised in further detail before reaching the final short-list and future recommendations.
- Discussions are ongoing between commissioners and PCB leads to work together to review the emerging list of commissioning intentions in order to support the further development of these, with a focus on being able to help to inform the 'so what' impact, which can then be fed into planning assumptions for activity, performance, workforce and finance and ensure alignment of priorities. This is due to take place on 3rd September 2025.
- System planning leads met in July 2025 and had already drafted a proposed planning timetable. This already aligns well to the national timetable published and so will now be updated fully to reflect the most guidance issued.
- Work has begun to be mobilised via the system planning group to flesh out the approach to planning for 2026/27 so that planning activity can begin in earnest from September.
- Planning leads are working together to ensure updates to Trust Board/sub-committees (as appropriate) in September are aligned.

Trust Update

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- Work had already commenced on a move to a multi-year plan and refresh of Trust strategies.
- The foundations of all Phase one activities are already in place and these will be collated during September.

Phase One Activities	Work already underway
Refresh clinical / organisational strategy	• Strategy re-fresh kick off session held on 13th August with Trust Board and Senior Leadership Group • Working group and refresh of plans in development
Review organisational improvement capability	• Work underway to re-view improvement hub team priorities and capacity aligned to PMO • Paper in development for capability building for review by end of September by Executives
Establish governance structures to support integrated planning	• Internal planning group already stood up • Further work required to review and align to financial recovery programme / Finance Improvement Group etc
Review quality, performance and productivity at services levels as well as organisation's underlying capabilities	• Existing organisational processes to be used
Establish robust financial baseline based on underlying position and drivers of costs	• Work ongoing as part of monthly reporting and forecasting
Identify sources of unwarranted variation and improvement opportunities through benchmarking and best practice	• Work ongoing via cross-cutting workstreams being established as part of financial recovery and other existing work programmes e.g. Getting it Right First Time (GIRFT) • Optimise use of service reviews across all specialties and embed as part of annual planning
Identify service and pathway redesign opportunities including reviewing fragile services	• Optimising use of service reviews and cross-cutting workstreams to identify opportunities, maximising use of Improvement Hub team support on key priorities, links to wider PCB programmes and commissioning intentions
Undertake core demand and capacity analysis and develop initial forecasts and scenario modelling	• Activity and performance forecasting is already an ongoing process • Work will commence to refresh modelling from last year • Work underway to link demand and capacity planning to job planning

Risks

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Initial risks are identified as:

- Capacity to develop detailed and triangulated plans given the timescale has been brought forward/condensed and that focus is also on delivery of financial recovery plans (and operational and clinical delivery) in Quarter 3
- Requirement to have detailed working assumptions now at system level to feed into planning work. This requires rapid development and agreement of impact of commissioning intentions, growth assumptions etc.
- Role of ICB v NHSE Regional Teams in planning still to be clarified
- Timely availability of national guidance and supporting material

Work is now ongoing to identify mitigation plans for all risks and these will be further developed over the coming weeks.

Next Steps

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Initial key next steps are summarised below:

Action	Lead	Date
Collation/completion of all phase one activities	Trust Planning Group	30/09/25
Work with partners to finalise plans for phase two activities and develop detailed planning timelines	Trust Planning Group	30/09/25
Collate all underlying assumptions to create base plan	Trust Planning Group	31/10/25
Work across PCB and ICB to agree requirements for strategy refresh and alignment to ongoing work on acute clinical reconfiguration / PCB priorities and to commissioning intentions to support creation of a detailed set of assumptions	Director of Service Development and Improvement System Planning Group	31/10/25
Finalise plans for Trust strategy refresh including next Board Strategy session in October	Director of Service Development and Improvement	30/09/25
Work with the PMO / Recovery Director and SROs on core assumptions and opportunities from cross-cutting workstreams to feed into future productivity, improvement and waste reduction programmes	Trust Planning Group / Recovery Director	31/11/25

Developing Commissioning Intentions 26/27

Feedback from Engagement sessions

Key Themes

1. Developing principles for Commissioning

Commission intentionally for integration to improve access and reduce complexity. Understand system and organisational impact of the collective CI

Would like to see system wide, few highly impactful things, commissioned and delivered consistently to deliver potential bed closures

Commissioning for outcomes rather than driving process

Understand and spread best practice at pace and scale

Vital importance of prevention and early intervention

Understand opportunities to commission for the populations, communities and the whole person rather than specific conditions, health sectors or organisations

Potential to prioritise and focus on key areas to improve delivery based on local needs; need to be cognisant of workload capacity in commissioners and providers

Be realistic about what can be achieved especially with £35M less staff in ICB by March 26

Commissioners to recognise the need for bed closures to be sustained in order to remove costs from block contract. Therefore need to understand data – and impact of CI on activity

Join up timelines for development of CI with organisational operational plans

Celebrate success

How to ensure delivery of Green agenda and ensure accountability

2. Partnership Working

Enthusiasm from partners to be involved with developing and supporting commissioning intentions/decisions

Improved collaboration with partners to develop shared ownership of outcomes as well as risk and mitigations; want to move into a collective courageous commissioning space

Use Better Care Fund as an enabler to tie community, social and healthcare together

Make engagement an iterative process with multiple touchpoints with commissioners throughout the commissioning cycle/year

Commissioning should not take place in isolation/silos

Support for working collaboratively particularly with VCFSE sector partners and local authority. Acknowledgement that short term contracts lead to instability and impact on expertise and skills being retained as part of the wider workforce supporting health and wellbeing. Aim for 3-5yr contracts as well as increased investment for VCFSE (including Hospices) to strengthen the sector and facilitate improved efficiency and outcomes

Peer led support and community champions with care closer to home

Ensure engagement insight reaches the right people with accountability for how insight is used; support and guidance for commissioners on using insight and co-production methods

3. <u>Place/Neighbourhood Developments</u>

Data sharing seen as an essential element to support partnership working. Maximise Shared Care Record; universal access for digital sharing of information, improved patient experience and outcomes, ensuring efficiency

Clarity of vision for Integrated Neighbourhoods required; what is the core offer and then what can be built on at Place level to respond to specific community requirements

Vital importance of prevention and working with wide range of partners to deliver improved healthy life expectancy

Develop system principles around "Left Shift" – how to ensure investment is put into community?

"Left shift" along the continuum – but also understand potential for right shift with opportunities for primary or community professionals involved from admission to expediate discharge

Community based services focussed on prevention and early intervention

Good examples in LSC of successful neighbourhood working; build on good relationships, ensure appropriate leadership, identify funding, quantify the impact of scheme and ensure delivery

Determine how to optimally train discharge and ward colleagues on value and access to Place/Neighbourhood services

4. <u>Suggestions relating to specific Commissoning Intentions</u>

Children and Young People; prevention, improved waiting times, importance of school readiness

Frailty and EoL should be separate workstreams as have differing cohorts and different professional skills and leadership is required

Support for Women's Health Hubs (within current resources)

Potential to reduce duplication; pathways, sites, standardisation

Engage with Digital and Estates re cash releasing savings.

Appendix 1 Record of Discussions

(amalgamated notes from 4 workshops)

Workshop 1

Local Authority, VCFSE 18th June 2025

Working in partnership

- Consider integrated roles within NHS and local authority. Helps to ensure we are not shunting the cost from NHS to other partners/organisations – especially VCFSE who are often the partners that suffer during commissioning, and are already small, underfunded and under resourced.
- Commission outside of NHS for better outcomes e.g. use hospices – they are the experts in EoL
- Commissioning without losing the voice of 'Place'. Build on LA boundaries and joint footprints
- H&WBs need to be part of all conversations about commissioning intentions
- VCFSE partners need to be connected to workstream leads (Jane Cass is central point of contact for VCFSE to the workstreams.)
- New operating model should support building new commissioning structures
- Commission for outcomes that we all agree on
- Existing VCFSE services need fully integrating into how we commission/deliver
- Clarity of language; NHS talks about people/diseases/services interchangeably which can cause confusion. Consider how commissioning is framed for local authority – workstream names are not in a language used by LAs
- A lot of stuff which needs to be delivered needs to be done at place
- We need to understand our populations and ensure co-production is in place
- The challenge is making sure people can get the right help and support in the right way.

LSC 2030 roadmap:

- Integrated Neighbourhood Teams – where is it up to and what does it look like at the next level?
- Each workstream needs to consider interdependencies
- Is there any duplication between each one – workstreams and partners?
- What are the gaps?
- Ensuring traction of workstreams; alignment and joint working is key to success
- Could proposed staff structures be shared with VCFSE once ICB staff consultation begins?

Specific Commissioning Intentions

- Hospices could be tasked to undertake EoL commissioning – courageous commissioning!
- Needs to be focused on unpaid carers across all priorities
- Children and young people need to be an area of focus particularly in terms of prevention – they are where we can make the longer-term gains
- We need to ensure children are school ready. E.g.; Aware there are long waiting lists for speech and language therapy services

- Falls prevention to be a key workstream within Frailty

Focus on prevention

- Long-term condition management seems to include a lot of elements of prevention, so is this the right term to use? If so, prevention perhaps needs a focus of its own
- The NHS needs to decide what is within its control when it comes to prevention and it needs to be brought out within the transformation portfolio
- Prevention to be delivered in Place with the right nuances
- Prevention is key but needs culture change
- Better Care Fund could be used better
- Reduce economic inactivity die to poor health
- Issue raised of labelling Frailty alongside EoL as a workstream. Frailty or Ageing Well should not be confused with EoL
- Bring all partners back together once the longlist is reduced to short list (NB – planned for 2nd October).

Workshop 2

NHS Partners 9th July 2025

Scaling up best practice / Developing an Improvement approach / Improving commissioning

- Develop/continue a collaborative approach with providers to identify tangible good practice examples and scale.
- If something is being done well in one area and benefits are being realised, it needs to be replicated.
- Interrogate data around unwarranted variations.
- Patient centric rather than acute or community centric
- Using exemplar settings that are well established to harness expansion of this work - health centre and neighbourhoods examples
- To determine; Where are we now? Where do we want to get to and why? How do we get there?
- We don't always connect outcomes to processes.
- We are too siloed in the way we commission – separating mental health, primary care, cancer etc – we are not commissioning for the person.
- Need to pay for results and not the process. If we don't change, we will continue to get the same results just with different processes.
- Importance of educational aspects towards prevention
- How do we drive commissioning for outcomes when we aren't set up to enact. Creating a mindset shift to enable this
- Creating a health and social care model rather than two separate models. Accelerate work in collaboration
- Expedite Digital
- Educating the public / setting expectations - can Universities help?

- Encourage working together from ICB rather than purely commissioning
- Do we need to minimise the number of priorities and focus on some key areas across the ICB to improve delivery based on local needs

Place

- Clinicians are only a part of the picture – social prescribers would sit better with the VCFSE rather than practices – but would need to show the benefits of this for the health care economy for it to make sense to people.
- Recognition that clinicians are expensive and not always the right people needed to support – overused in some areas, underused in others.
- ICB recognising that Place needs to focus on populations
- Whilst ensuring there isn't duplication across place (e.g. end of life care) for a standardised model that is driven by place that is locally tailored
- Plug gaps in Intermediate Care – but always think Home First
- Need more GPs and VCFSE colleagues in the commissioning discussions/decisions
- Can Community/VCFSE be involved from point of admission?
- Expansion of Rapid response
- Expansion of MBRN style approach across ICB; push out to other LTC
- Assess use of Virtual Wards and identify opportunities for expansion
- Need to indicate the need to develop place focussed collabs/ACOs across the ICB
- Move to commissioning around people and populations not conditions or organisations
- Historic differences in commissioning / service availability makes it difficult for services to interact/work with each other; need to standardise where appropriate, how to build on the vital and vulnerable work
- Opportunities within Leisure Centres
- Estate issues with left shift and potential stranded costs
- Risk adversity from hospital staff
- Need to invest in VCFSE with longer term contracts and be clear on the outcomes we expect to see.
- VCFSE as system leaders - Can we entrust more power to VCFSE as 'system leaders' – why don't we allow them to commission – do we have the courage to give them the funding to make commissioning decisions?
- In the eyes of our population, system leaders could be considered the likes of Age UK, Marie Curie etc.
- Personal example shared: man with Parkinson's attended cardiac rehab to support his friend, yet the outcome was that he saw an improvement in his Parkinson's. Highlights that inclusion/exclusion criteria can prevent support, perhaps needs to look at long-term condition support more generally.

Left Shift

- The 'left shift' must go further than just acute to community, needs to be a left shift from primary care to prevention, self care, community assets as well.
- Left shift needs to ensure that resources are 'shifted' also

- If we are going to listen to our communities, we may need to consider a different perspective around where funds are distributed in commissioning – need to look at value for money.
- Enhance the care that existing resources can provide rather than just pushing acute services into a community setting
- Consider 'right shift' – can primary care clinicians move to support hospital discharge for example?
- We need to have shared ownership of outcomes, and also risk, through better collaboration.
- Clinical leadership in strategic commissioning is so important, including being able to tackle clinical resistance.
- Left shift needs to be more focussed on preventative work
- Instilling confidence in wider health system so it enables them to use wider services
- Bravery to recognise the outcomes of patients and align them towards the right care provision
- Neuro rehab – some dressings in hospital could move out
- Too many different models of care e.g. Diabetes
- Integration across ARRS/PCN/Virtual Clinics
- Treating to not need them to go to hospital rather than keeping them from hospital

Neighbourhood approach

- Easy to quantify acute spends – less easy to know the financial implications of early discharge for example
- Involving all stakeholders to establish collaborative inclusive models for the future
- Ability to flag when a patient needs additional support
- Responsibility to allow for neighbourhood thinking
- Bringing health and care together
- Importance of education to influence - obesity example
- Ensure there is clarity in how we are using better care fund. Should be to enabler to tie community, social and healthcare together
- Trust across our system to foster confidence in changes to enable the left shift

LSC2030

- Must align with 10yr plan milestones
- How we can identify the wider enablers to drive delivery
- Are we clear on the vision? We don't have a clear system wide vision for what 2030 looks like and potentially need wider engagement and involvement
- Ensuring it is evidence based - staying true to what the blueprint is stating
- Being bold / brave
- If data and insights are telling we should take a different tack then be brave to deliver things differently

Enablers:

- AI predictability being used in other areas – early prediction of deterioration.
- Duplication – need digital transfer of information – patients are still repeating their story. Professionals need to ring each other. Universal access to SCR

- IT systems and information sharing / Shared Care Record
- Consider how we can utilise acute expertise to second into community to spread and grow resources
- Estate - utilising the facilities in the right way so they are effective for creating the required left shift. Examples where we haven't perhaps maximised this - Finney house, Longridge

Service reconfiguration

- What we define as acute services aren't really, they are much more complex: Specialised acute services, Elective, Unplanned, Community services, Anchor organisations
- Clinical configuration needs to focus on the following: Neighbourhood, DGH, Acute rather than just redesigning the acute configuration
- Some acutes have 2-3 sites carrying out electives. Consolidate onto one site.
- How do we foresee the wider impact of decisions e.g. knock on impact to parts of the system not immediately impacted
- Is it appropriate to have multiple SPOA?

Single Integrated Children's Community Health Service Model

- Commission a single provider. This would involve;
    - Stakeholder engagement/ co-production
    - 3 year programme
    - Business Case development
    - Scope
    - Funding envelope
    - Procurement

To gain the following outcomes;

- Better sharing of information
- IT system
- Joint working
- Address gaps and duplication
- Ability to flex workforce and skill development
- Lead to better outcomes in later life
- Reduce management costs

Workshop 3

Working with people and communities - providing insight to Commissioners 17th July 2025

NHS, Healthwatch and Spring North

Community & Care closer to home

- Commission services closer to home & in the community
- Community champions and earlier community-based support
- Focusing on closer to home
- Trusted organisations to be in the communities…people will come back.
- Access, closer to home, coordination, and education
- See primary care in our community (we thought community centres or family hub type settings).
- Set up and step-down services
- There is a lot of talk around the Core plus 5, but we often overlook other concerns, such as Core 20 plus 5 (which forgets about the people who don't fit that)
- Focus on community-based preventative support
- Avoid the tipping point by starting with prevention
- How will the national neighbourhoods and frailty work support this work

Developing how we commission

- Clear demonstrative line of sight between engagement and commissioner's decisions (having an impact and improving outcomes)
- Intelligence received connects with the right commissioners in the ICB, builds lived experience and engagement into the commissioning template, and gives it sufficient time
- Co-production resource to support commissioners and train on using co-production techniques
- Education during service changes for patients
- Not helping to have top 3 for each area (UEC, etc) as there is overlap and need to be seen not just what we will commission but how we will commission. How do we become a truly intelligent lead organisation? Commissioning internally, ensuring we use insight, how do we?
- Community and peer-led education, wider context, and ambitions.
- Comms requires context for patients to understand, hybrid delivery, in-person, and online. How well do we explain changes in services/provisions?
- Make sure we are listening deeply and not using engagement as a tick box.
- Establish a clear mechanism for joined-up engagement to avoid duplication.
- Central point to gather information from engagement and silo working-joined up thinking
- Keep the commissioner's insight
- Data sharing between organisations could share info and insight, health/VCFSE
- The value of lived experience/connectors, community, navigators, and volunteers
- More signposting, knowing what is available in your area
- Insights are not reaching the commissioners. What is the pathway to feed this information in?
- Getting commissioning flexible to Place, various commissioning services right across, not just a postcode lottery

- Intentionally build a user/lived experience contributions to define commissioning intentions
- Pass intelligence on to providers for them to use
- The new population footprint is an opportunity to align population health data to commissioners
- Feedback loop is crucial
- Clarify and confirm how much Healthwatch and Spring North data is being used in 26/27 CI
- Long-term plan of using lived experience to shape CI
- Commission intentionally for integration to improve access to reduce complexity
- A service change can be better for us. Shout about the good stuff, pre-empt transformation issues
- Appreciate the good stuff and celebrate it with patients while being realistic
- Understanding what is within our gift and what isn't and understanding what services we can demonstrate & put into the community

VCFSE sector

- Length of contract (subject to achieving desired outcomes), e.g., commission VCFSE over 3-5 years
- Not just what, but how? Give VCFSE more trust and funding.
- Far more than currently, commission VCFSE on long-term contracts
- Definition of community between NHS & VCFSE
- Share data with VCFSE to contact individuals
- Dedicate findings for Co-production over core design, VCFSE can do more with a lot less funding
- Loss of talent and impact on services when projects have to close(measurable impact), Real impact of short-form funding on VCFSE orgs.

Barriers, challenges and solutions

- Prioritise digital Wishlist, avoiding exclusion
- Make sure we are using digital appropriately to free up time for people who need F2F
- Allow for innovation to bed in
- For all projects/CIs, make sure everything is right at the start, including the budget
- Be brave enough to challenge providers to be more innovative and work with us
- ICB to protect transformation at all levels where outcomes are important
- We need a one stop shop, not loads of hubs
- Estates – multiple owners of one building
- Issues with funding
- The commissioners have to respond to waiting times as the outcome to fix how to bring in this work more easily (limited resources).
- Find an opportunity for joint LA/NHS commissioning that focuses on Prevention (oral health) integrated care, and better outcomes (frailty)
- Lancashire CC, where is their involvement? need to come together
- NHS and LAS are coming away from each other; they need to work better together
- Use the current opportunities of the new model ICB design to describe integrated commissioning
- Different parts of the commissioning process need to work together

- Upskilling opportunities are important; need to ensure we are not just reliant on goodwill
- Improve childcare!

Workshop 4

Place and Planning 18th July (shorter session than previous, on line and showcased best practice examples for discussion)

Improving Commissioning processes

- Expecting a 3yr Operational Planning process this time, detail TBC
- Planning guidance likely to have a significant focus on mobilising neighbourhood health
- Need to consider opportunities to better align system discussions around operational planning and aim to create plans for agreement earlier in the year
- Engagement with Local Authorities must happen at the start of that planning, not after decisions have already been made internally within the ICB
- Ensure Place is connected to Planning functions
- Need to ensure data is used optimally to support service change. For example, there is no data capability to split PEOLC patients and over 65s although overlap is recognised
- Impact of schemes showcased really impressive e.g.; bed days. Need to understand how best to roll out at scale and pace
- Place have draft place CIs/delivery intentions developed jointly with our LAs and wider partners
- Need to understand the out of hospital left shift strategic commissioning plan as well as the phasing of the neighbourhood model and funding
- Need to consider Alliance commissioning as this will be heart of neighbourhood health collaboratives as no one organisation/sector can delivery neighbourhood health
- All Place footprints have a clinical and care professional forum and most have a primary & secondary care interface meeting. These have themed work programmes but can also support/ tackle local issues as they arise. With changes in ICB Operational Model, need to consider whether the clinical and care professional fora adapt to focus around a hospital footprint.

Neighbourhood / Left Shift

- NHSE Neighbourhood Health guidelines focus predominantly on health. However need joint working with LA, Employment, CVS, Education in particular to improve self help and care
- Would like to see system wide, few highly impactful things, commissioned and delivered consistently to deliver potential bed closures
- Potential for Women's Health Hubs (within current resources) to bring together specialist knowledge, reduce inappropriate referrals, enhance pain management and reduce Gynae waiting lists
- Acknowledgement of critical role for hospices in providing wrap around step-up response for PEOLC patients
- Frailty progress is linked to Engineering Better Care and was jointly delivered with Place. This is the foundation for the LSC frailty model and needs to be a priority schemes for LSC

- Enabling left shift is critical. To remove costs from acute block to transfer to then invest in community teams, need to ensure sustained ward/bed closures. Are there opportunities for dual running costs to support transition?
- Determine how to optimally train discharge and ward colleagues on value and access to Place/Neighbourhood services
- Maximising the Locally Enhanced Services (LES) to sustain and spread the innovative work. LES can also support primary care with their increased pressures as well as historical inequitable funding
- Place have developed a detailed proposal to support operational planning which has clinically led authorship
- Evidence from BwD is that co-location of INTs enables good links with IHSS for further input and subsequent self-referral options. Can also support step-down pathways so that IHSS can hand over to INTs for day to day care
- Understand the requirements for bases for INT although recognise that most work and staff time is in homes and community venues

<u>Shared Care Record</u>

- Need urgent digital investment to create a single, accessible care plan across LSC – professionals having the ability to read/write directly into records etc. This would support Frailty and PEoLC outcomes in particular through improved coordination and help NWAS reduce unplanned conveyances through making preferred place of care/death visible. Recognised this is aligned to 10 year plan: The NHS App will be transformed into a world-leading platform for access, empowerment, and care planning. Need to ensure all are aware of and connected to current plans to bring this to fruition.
- SCR needs to urgently become a single, live care plan that follows the patient. Currently, it can read from PC EMIS but not write back and there are still several barriers to address - including challenges with SCR sustainable funding. All critical for left shift - coordinated care. Need full support from all including Executive to leverage additional funding to achieve this
- In PEoLC, good engagement with SCR but need to ensure LSC aligns our SCR with the 10-year digital and NHS App ambitions.
- SCR needs to overcome NWAS interoperability issues
- Happy to support in discussions with PCB and planning leads

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/117
Report Title:	Financial Performance Report Month 4 2025-26		
Author:	Mrs A Yaqub, Assistant Director of Finance		
Lead Director:	Mrs S Simpson, Executive Director of Finance		

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

Executive Summary:

1. The Trust has agreed a break-even annual financial plan for 2025/26, inclusive of £43.324m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
2. The Trust is reporting a deficit of £5.8m, against a M4 in month plan of £3.7m deficit; £2.1m behind the plan. This is the deficit excluding the £3.6m of deficit support funding.
3. The Year-to-date position reported is a £26.2m deficit against a plan of £20.7m; £5.5m behind plan, excluding the DSF.
4. The Waste Reduction & Financial Improvement plan delivered in-Month is £4.1m against an original plan of £5.0m, an adverse variance of £0.9m (£0.2m adverse to plan on the reprofiled WRP plan).
5. Year to date, the WRP delivered is £10.8m against the original plan of £14.1m, an adverse variance of £3.3m and £1.2m adverse to the reprofiled WRP Plan
6. Agency spend at M4 is £468k, 0.9% of gross pay costs against a 1.2% target.
7. The annual 2025-26 capital plan is £35.3m, For M4, year to date spend is £8.9m, £0.6 m ahead of plan.
8. The cash balance at the end of July was £9.6m, an increase of £2.5m compared to the M3 cash position of £7.1m.

Key Issues/Areas of Concern:	Risks to delivery of the financial plan
Action Required by the Board:	To note the content.

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

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M04 Financial Performance Trust Board

Sam Simpson, Executive Director of Finance

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Month 4 Financial Position

Month 4 Key Headlines

East Lancashire Hospitals NHS Trust

Summary of Financial Position

- The Trust is reporting a deficit **of £5.8m, against a M4 in-month plan of £3.7m** deficit; £2.1m behind the plan.
- The Year-to-date position reported is a £26.2m deficit against a plan of £20.7m; **£5.5m behind plan,** excluding the DSF.
- The WRP delivered £4.1m in month against the original plan of £5.0m, a variance **of £0.9m.** (£200k adverse to plan on the reprofiled WRP plan)
- Year to date, the WRP delivered is £10.8m against the original plan of £14.1m, an adverse variance of **£3.3m** and £1.2m adverse to the reprofiled WRP Plan)

Key Metrics

- **Agency spend in month of £468k**, is £43k better than plan and represents a **45% reduction** on 2024/25 run rate, above NHSE's minimum expectation of a 30% reduction
- **Bank spend in month of £4.2m** is £558k adverse to plan, with £827k pressure relating to industrial action, this and represents a **7% reduction** on 2024/25 run rate, below the NHSE's minimum expectation of a 15% reduction. This would have a been a favourable variance of £269k in month without the industrial action.
- The cash balance at the end of July was **£9.6m,** an increase of £2.5m compared to the M3 cash position of £7.1m.
- The annual 2025-26 capital plan is **£35.9m**, For M4, year to date spend is £8.9m, **£0.6m ahead of plan.**
- Worked (Paid) WTE have reduced 61 WTE from Month 3 to **9753**

Key Risks

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

- Income within the plan is based on the planning version of the agreed ICB contract schedule, which is still subject to change.
- Full delivery of the Waste Reduction Programme of £60.8m
- Current cash flow forecasting is signalling cash will become a significant challenge by October 2025, if delivery of the 2025-26 plan does not improve.
- Divisional positions need to be managed within budget, and all pressures are contained within the funding available in the plan
- The financial impact of the HCA review of banding inclusive of the associated timescales. The prospective position still needs to be confirmed to ascertain the recurrent pressure.
- The financial impact of any potential redundancies or any further industrial action
- The impact of the withholding of Deficit Support Funding if the system/ Trusts are delivering the financial plan

M4 Plan vs Actual

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Monthly Actuals	Current Month	Current Month	Variance to Plan
	Plan	Actual	
	£000	£000	£000
Operating Income: Patient Care	63,519	66,386	2,867
Other Operating Income	3,821	4,895	1,074
Total Income	**67,340**	**71,282**	**3,942**
Substantive	(41,451)	(44,442)	(2,991)
Variable Pay: Overtime	(43)	(40)	2
Variable Pay: WLI / Extras	(480)	(691)	(211)
Variable Pay: Bank	(3,623)	(4,181)	(558)
Variable Pay: Agency	(511)	(468)	43
Other Staff Costs	(195)	(187)	8
Total Pay	**(46,302)**	**(50,009)**	**(3,707)**
Supplies & Services Clinical	(3,698)	(4,735)	(1,037)
Drugs	(4,497)	(5,710)	(1,213)
Other Non Pay	(11,324)	(11,459)	(135)
Total Non Pay	**(19,519)**	**(21,904)**	**(2,385)**
Total Expenditure	**(65,821)**	**(71,913)**	**(6,092)**
Net Expenditure	**1,519**	**(631)**	**(2,150)**
Non Operating Movements	(436)	(446)	10
Operating Surplus (Deficit)	**1,083**	**(1,077)**	**(2,160)**
Other Non Operating Movements	(1,179)	(1,161)	(18)
Adjusted Financial Performance Surplus (Deficit)	**(96)**	**(2,238)**	**(2,142)**
Deficit support Funding	(3,610)	(3,610)	0
Adjusted Financial Performance Surplus (Deficit) Excluding DSF	**(3,706)**	**(5,849)**	**(2,142)**

Income: £3.9m Favourable to plan, £0.9m relates to increased income (HCD and CLEAR) offset in non-pay expenditure, £1.6m of this relates to pay award funding for the backdated pay award, offsetting a pay pressure of £1.8m. The Trust therefore delivered £1.5m of WRP on income, relating to a block HCD agreement of £1.1m and £0.4m relating to carparking income.

Pay: Pay is £3.7m adverse to plan**,** £1.8m of this variance relates to the additional pay award costs, £717k relates to industrial actions costs, £172k relates to MARS payments made in M4 (26/27 benefit of £207k) £162k relates to in-month pressures around agency usage and mandatory shadow days for F1 doctors. The Trust also had an in-month benefit of £150k to plan as bank holiday enhancements are factored in equal 12th into the budget. The remaining variance relates to undelivered WRP to the value of £0.9m

Non-Pay: Adverse to plan by £2.4m, £1.1m is offset by additional income relating to HCD, £0.5m worth of pressures relating to theatres stocks £0.3m and utilities £0.2m.

Month 4 : Plan vs Actual

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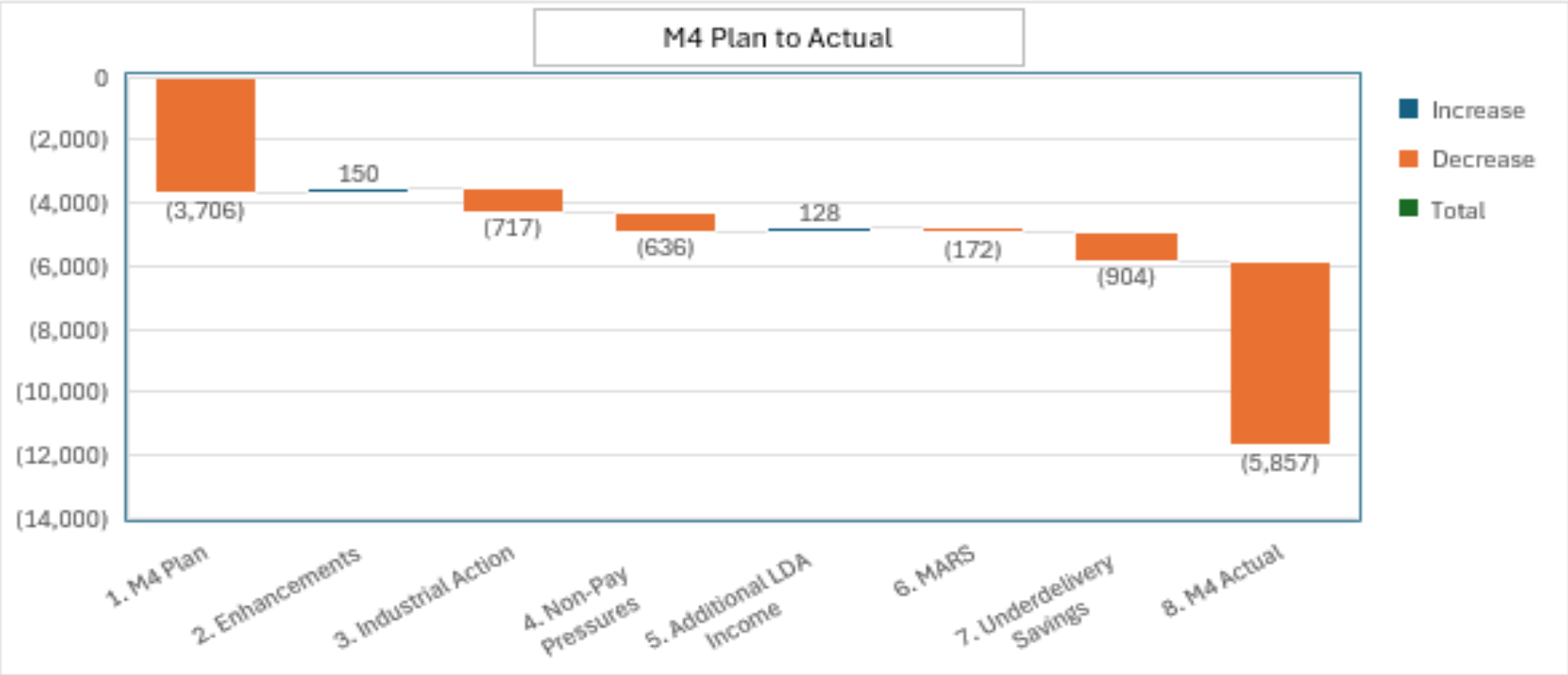

2.Enhancements: £150k benefit in months where there are no bank holidays as BH are profiled in the plan at £150k a month

3.Industrial Action: £717k in-month unfunded pressure

4. Non-Pay Pressures: £0.7m pressures relating to theatres stocks £0.3m and utilities £0.2m , a further £0.2m relating to pay pressures inclusive of backdated medical PAs and F1 mandatory shadow days.

5.Income: Increased LDA income favourable to plan by £128k, based on an updated contract schedule

6.MARS: £172k worth of MARS costs, an in-month pressure

7.Undelivered savings: undelivered WRP across pay and non-pay offset by WRP delivered through income schemes.

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Cash

Cash position

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- The cash balance on 31st July was **£9.6m**, an increase of **£2.5m** compared to the previous month.
- The main reasons for this movement is a £3.2m increase in deferred income with £3.0m of education received in July relating to future periods, as well as the £5.3m increase in non-capital payables, which largely relates to £2.9m increase in the accrual for the pay award which will be paid to staff in August.
- The additional funding for the increased pay award is the main reason for the £1.9m increase NHS receivables with the £2.7m increase in non-NHS receivables largely attributable to a £2.0m increase in the VAT debtor.
- This is due to the June VAT return being the final return in which the Trust can include VAT transactions relating to the previous financial year, as a result of which submission is usually delayed to match the extended deadline of 7th August.
- These increased current asset values partly offset the impact of the increased liabilities detailed above on the Trust's cash position.

Statement of Cash Flows 31st July 2025

Cash Flow Statement	As at 31st March 2025 £000	As at 31st July 2025 £000	Prior month £000
Operating Activities			
Operating Surplus/(Deficit)	(33,629)	(5,287)	(4,656)
Depreciation and amortisation	24,129	8,048	6,021
Impairments and reversals	14,568	0	0
Donated assets received credited to revenue but non cash	(434)	0	0
(Increase)/decrease in trade and other receivables	(402)	(12,571)	(7,909)
(Increase)/decrease in inventories	(1,341)	215	(37)
Increase/(decrease) in trade and other payables	9,972	13,157	7,834
Increase/(decrease) in other liabilities: deferred income	12,171	218	(3,020)
Increase/(decrease) in provisions	(144)	6	(57)
Net cash inflow from Operating Activities	24,890	3,786	(1,824)
Cash Flows from Investing Activities			
Interest received	1,947	636	496
(Payments) for property, plant and equipment and intangible assets	(24,858)	(5,279)	(3,913)
Proceeds from disposal of property, plant and equipment	545	97	94
Receipt of cash donations to purchase capital assets	52	0	0
Net cash outflow from Investing Activities	(22,314)	(4,546)	(3,323)
Net cash inflow before Financing	2,576	(760)	(5,147)
Cash Flows from Financing Activities			
Public dividend capital received	23,043	990	990
Loans from Department of Health - repaid	(200)	0	0
Capital element of lease payments	(7,474)	(2,512)	(1,872)
Capital element of PFI payments	(11,123)	(2,469)	(1,852)
Interest paid	(698)	(511)	(397)
Interest element of PFI obligations	(5,979)	(1,916)	(1,437)
PDC dividend (paid)/refunded	5,066	0	0
Net cash outflow from Financing Activites	2,635	(6,418)	(4,568)
Decrease in cash	5,211	(7,178)	(9,715)
Cash at the beginning of the year	11,575	16,786	16,786
Cash at the end of the financial period	16,786	9,608	7,071

Statement of Financial Position

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	As at 31st March 2025 £000	As at 31st July 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	18,412	(756)	18,234	178
Property, plant and equipment	266,094	264,188	(1,906)	264,679	(491)
Right of use assets	31,946	35,358	3,412	35,124	234
Inventories	11,310	11,095	(215)	11,348	(253)
Receivables (NHS)	17,592	24,469	6,877	22,531	1,938
Receivables (non-NHS)	19,605	25,309	5,704	22,565	2,744
Cash and cash equivalents	16,786	9,608	(7,178)	7,071	2,537
Total assets	382,501	388,439	5,938	381,552	6,887
Liabilities:					
Trade and other payables (capital)	(6,418)	(3,974)	2,444	(4,295)	321
Trade and other payables (non-capital)	(71,452)	(84,610)	(13,158)	(79,285)	(5,325)
Lease related liabilities	(32,433)	(35,997)	(3,564)	(35,724)	(273)
PFI related liabilities	(228,045)	(227,366)	679	(227,984)	618
Provisions for liabilities and charges	(3,439)	(3,462)	(23)	(3,395)	(67)
Other liabilities: deferred income	(13,693)	(13,911)	(218)	(10,673)	(3,238)
Total liabilities	(355,480)	(369,320)	(13,840)	(361,356)	(7,964)
Total assets employed	27,021	19,119	(7,902)	20,196	(1,077)
Financed by taxpayers equity					
Public dividend capital	332,933	333,923	990	333,923	0
Revaluation reserve	21,711	21,712	1	21,712	0
Income and expenditure reserve	(327,623)	(336,516)	(8,893)	(335,439)	(1,077)
Total taxpayers equity	27,021	19,119	(7,902)	20,196	(1,077)

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Capital

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Capital

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- The Trust 2025-26 capital plan is £35.9m, an increase on £0.7m relating to a grant funded capital scheme.
- For the financial year to date at Month 4, the Trust has recognised £8.9m of capital expenditure, consisting of £6.1m of right of use assets related spend, £1.2m of PFI lifecycle related spend with most of the remaining balance spent on Estates related schemes. This represents an overspend of £0.6m against plan although Trust is still forecasting to spend in line with the capital plan.
- This excludes the RAAC work, where the Trust is expecting a further £4.5m to be awarded in year.
- MOUs have been received at this stage for the £2.0m Net Zero solar panel and £0.8m Estates Safety capital schemes.
- Of the £11.0m of right of use asset (ROU) related spend, £3.0m has been added to Trust planned spend in line with the allocation from the ICB.

Capital forecast	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	2025-26
	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Donated assets	-	-	210	42	42	42	42	42	42	701	1,163
PFI lifecycle costs	-	1,200	300	300	300	300	300	300	300	304	3,604
CHP ROU assets	-	4,656	-	-	-	-	-	-	-	-	4,656
Other ROU assets (intra-DHSC group)	-	12	-	-	-	-	-	-	-	-	12
Other ROU assets	-	1,407	-	-	-	-	-	-	-	4,925	6,332
Other internally funded schemes	-	937	572	572	572	572	572	572	572	2,044	6,985
UEC #2	-	-	-	-	-	-	-	700	700	825	2,225
Net Zero	-	689	-	301	330	330	330	-	-	-	1,980
Diagnostics	-	-	-	-	276	276	276	-	-	-	828
Electiive Recovery	-	-	-	-	272	272	272	272	272	274	1,634
UEC	-	-	-	-	900	900	900	900	900	1,266	5,766
Estates Safety	-	-	-	-	-	150	150	150	150	157	757
Total	**-**	**8,901**	**1,082**	**1,215**	**2,692**	**2,842**	**2,842**	**2,936**	**2,936**	**10,496**	**35,942**

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/118
Report Title:	Integrated Performance Report		
Author:	Stephen Dobson One LSC Director of Data, Digital & Technology		
Lead Director:	Sharon Gilligan Chief Operating Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	The Board is directed towards the areas of concern highlighted below.			
Key Issues/Areas of Concern:	The Trust Board is directed towards the following issues of concern: **A&E** • Attendances high in July (26,167), 14.54% patients waited over 12hrs in department (slightly below target but still high). **RTT** • 1 Patient breach >65 weeks for Oral and Maxillo-Facial Surgery. **Cancer** • Faster Diagnosis Standard at 73.7% (below 80% March 2026 target); Colorectal, Digestive Diseases & Dermatology remain challenged. **Cancellations on the day** • 62 on-the-day cancellations, 10 patients not treated within 28 days **Finance** • Reported deficit in month £5.8m vs £3.7m plan (excl. DSF) therefore £2.1m off plan. • YTD deficit £26.2m vs £20.7m plan (excl. DSF) therefore £5.5m off plan. • WRP delivery £10.8m YTD vs £14.1m planned therefore £3.3m off the original plan and £1.2m off reprofiled plan. • Cash risk if DSF (£43.3m) withheld; liquidity remains fragile **Mortality** • SHMI remains elevated (1.25, reducing but still high); HSMR+ at 108.1, above expected range. **Staffing** • 16 wards <90% RN fill rate (day), 2 wards <90% (night); 5 nursing red flags reported.			

	Harm Free Care • Moisture-associated skin damage up to 73 (from 61 in June). • Pressure ulcer risk assessments below target (55% vs 70–85%). • Falls with harm in June 2025 = 6. Awaiting falls checklists from division. This did reduce in July = 0. **Infection Control** • CDT outbreak in Critical Care Side B (RBH) led to 3-month closure for refurbishment. • IGAS outbreak (Ward C3, RBH) with confirmed cross-transmission. Both outbreaks now closed. **Caring / Patient Experience** • FFT scores dipped in Outpatients (93%) and Maternity (91%). • 119 active Level 4 complaints; average closure time 64 days (improved, but still long) **Staffing / Workforce** • Sickness absence increased for third month, now 6.67% (highest in 12 months). • 35% of absence due to mental health; 23% due to MSK. **Job Planning** – • Consultant job plan compliance down to 72%; non-consultant grades at 65%. **Appraisals** • AfC appraisals 80% (below 90% target). **Training & Compliance** • Information Governance training 92% (below 95% target). • Mandatory training mostly good, but BLS at 88% and Safeguarding Adults L3 at 88%
Action Required by the Board:	The Board is asked to note the contents of the report and be assured by the action being taken to address areas of under-performance.

Previously Considered by:	Quality Committee, People & Culture Committee, Finance & Performance Committee
Date:	27th August, 1st September and 2nd September 2025
Outcome:	

Integrated Performance Report

Published: August 2025

Contents

East Lancashire Hospitals NHS Trust
A University Teaching Trust

How to read an SPC Chart

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

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

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

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

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

Summary

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The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
17.5% of our metrics are consistently achieving target
30.2% of our metrics are inconsistently achieving target
19.0% of our metrics are not achieving target, however 7 of these are showing special cause improvement.
33.3% of our metrics do not have a target currently set.

Assurance

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

SAFE - Summary Scorecard

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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	JUL 25	97.92	90.00		
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	JUL 25	109.46	90.00		
AVERAGE FILL RATE REGISTERED NURSES (DAY)	JUL 25	93.14	90.00		
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	JUL 25	96.24	90.00		
MRSA	JUL 25	0.00	0.00		
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	JUL 25	91.80	95.00		
NATIONAL NURSING RED FLAGS	JUL 25	5.00	0.00		
WARDS <90% REGISTERED NURSE (DAY) FILL RATE	JUL 25	14.00	0.00		
CARE HOURS PER PATIENT DAY (CHPPD)	JUL 25	8.10	8.00		

METRIC	LATEST DATE	VALUE	VARIATION
C DIFF PER 100000 RATE	JUL 25	34.09	
ECOLI PER 100000 RATE	JUL 25	40.91	
KLEBSIELLA PER 100000 RATE	JUL 25	10.23	
PSUEDOMONAS PER 100000 RATE	JUL 25	6.82	
REGISTERED NURSE AGENCY SPEND	JUL 25	32346.82	
REGISTERED NURSE BANK SPEND	JUL 25	938483.67	

Safe | Personal | Effective

Alert

During July 2025 overall Nurse staffing was achieved at trajectory for RN and Care Support workers. 16 clinical areas were below the fill rate of 90% for the month of July 2025 during day shifts. Of which 1 ward fell below 80% fill rate, this relates to unexpected unavailability and movement of co-ordinators. 2 clinical areas were below the fill rate of 90% for the month of July 2025 during night shifts in the Family Care Division. These were all due to unexpected unavailability and services are diverted to the Burnley Birth Centre or Birth Suite- which does not reflect in the fill rate %.
Nursing red flags for July 2025 was 6, due to delays in intentional rounding and less than 2 registered nurses on duty (which were recorded incorrectly). There were no patient harm as a result for this but could result in poor patient experience. 1 was reported wrong, meaning final total was 5. Midwifery National NICE red flags for July 2025 was 0.
There had been issues with drain flies within the Elective Centre, BGH. Actions were taken to prevent disruption to patient lists. The issue has been resolved and will be monitored closely. There have been issues with flying ants within the Neonatal Unit, BGH. Actions were taken and patients were unaffected. The issue has been resolved and will be monitored closely.
Moisture associated skin damage incidents increased from 61 in June to 73 in July.

Advise

Nurse staffing continues to be monitored twice daily in a trust wide staffing meetings chaired by Divisional Directors of Nursing. Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse.
The CPO outbreak on Ward C1, RBH is ongoing. No further cases have been identified since the last case on the 8th May 2025. A follow up outbreak meeting was held on 6th August with external partners including UKHSA, ICB and LCC where a decision was made to formally close the outbreak.
Reported pressure ulcer incidents decreased from 59 in June to 57 in July. Compliance with uploading clinical photography to Datix remains below the expected standards, thought there was a slight increase from 74.82% in June to 77.5% in July. Divisional action plans are in place, each containing specific measures to drive further improvement. The Trust's with the Assessment and Documentation of Pressure Ulcers, increased by 50% to 55% in the July audit, remaining below the target range of 70-85%. Staff have been reminded to complete all relevant risk assessment within four hours of patient admission.

Assurance

The overall percentage fill rate for RNs for days was 93.14.1% and nights was 96.24%. The overall percentage fill rate for CSW for days was 97.29% and nights was 109.46%.
There has been a CDT outbreak declared on Critical Care Unit Side B, RBH involving 2 patients. Samples were sent off for ribotyping and were found to be the same indicating possible cross-transmission. The IPC Team carried out commode, hand hygiene and environmental audits and a report outlining required action was shared with the Unit. Side B has since been closed for a period of 3 months for refurbishment. A follow up environmental audit will take place when the Unit reopens. An outbreak meeting was held with external partners including UKHSA, ICB and LCC. As no further cases were identified and appropriate measures were implemented with the support of the IPC Team, the outbreak was closed. An IGAS outbreak was declared on Ward C3, RBH involving 2 patients. The samples were sent to Colindale Reference Lab for typing and were found to be the same strain. The IPC Team conducted commode, hand hygiene and environmental audits and provided targeted education and support to enhance IPC practices. An outbreak meeting was held with external partners including representatives from UKHSA, ICB and LCC who were satisfied with the infection control measures implemented. As no further cases had been identified, the outbreak was closed.
Compliance with Pressure Ulcer (90.3%) and Moisture-Associated Damage (91%) e-learning remains high. This is continually by the Pressure Ulcer Steering Group to support sustained improvement and ongoing staff education.

SAFE - Infection Control

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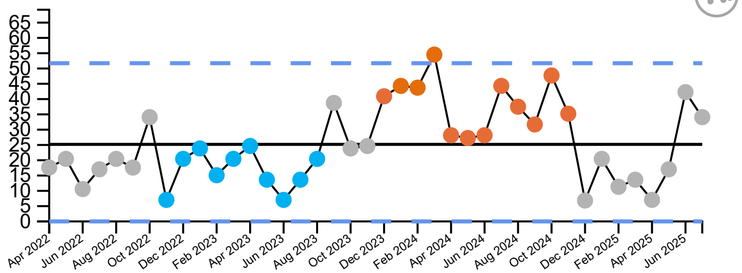
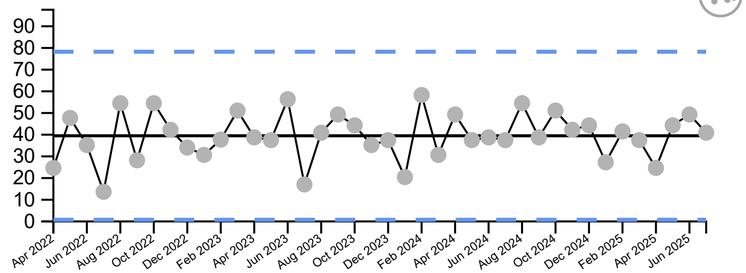
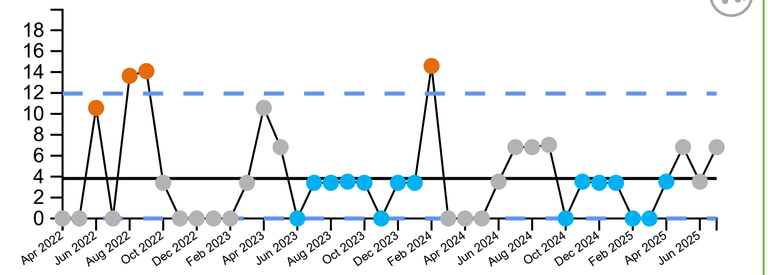
C diff per 100000 rate



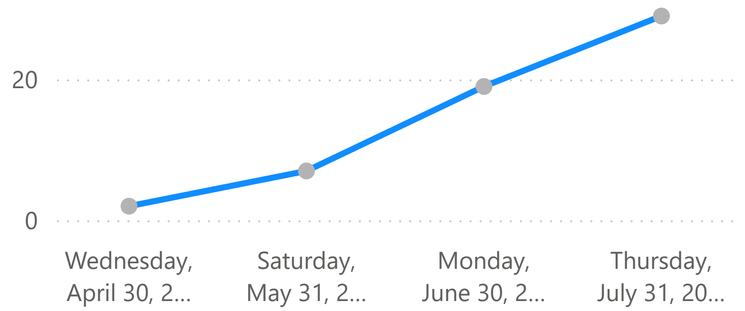
Ecoli per 100000 rate



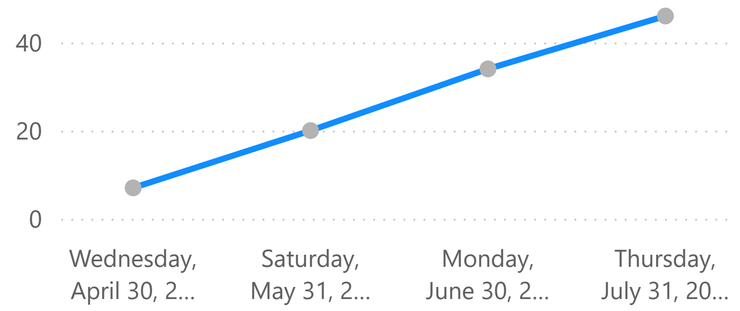
Psuedomonas per 100000 rate



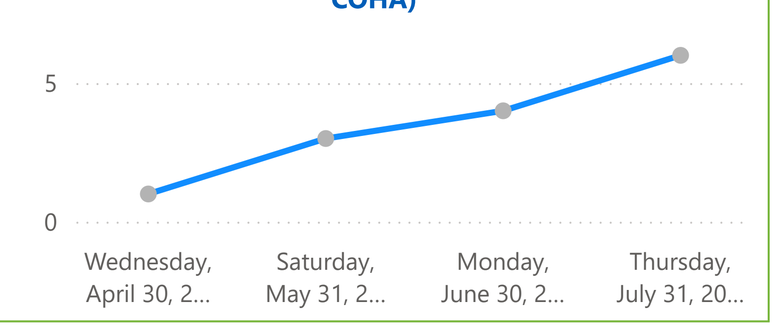
C.diff Cumulative from April (HOHA& COHA)



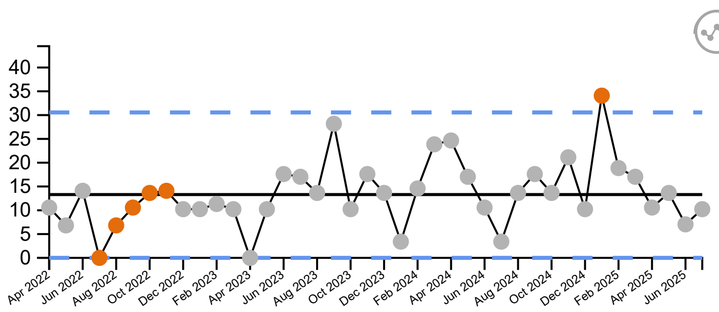
E-Coli cumulative from April (HOHA & COHA)



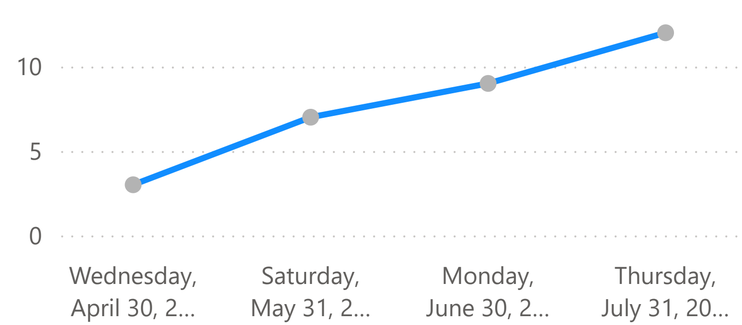
P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)



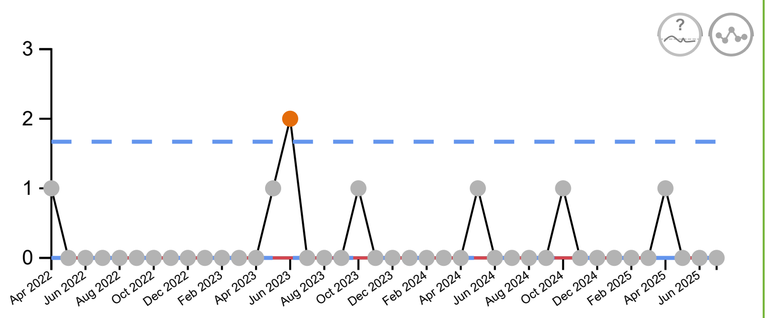
Klebsiella per 100000 rate



Klebsiella cumulative from April (HOHA& COHA)



MRSA



SAFE - Staffing

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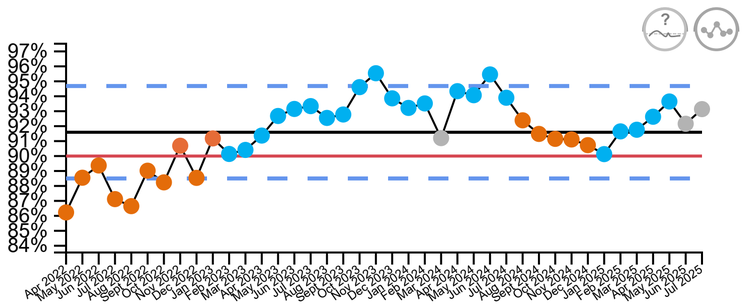
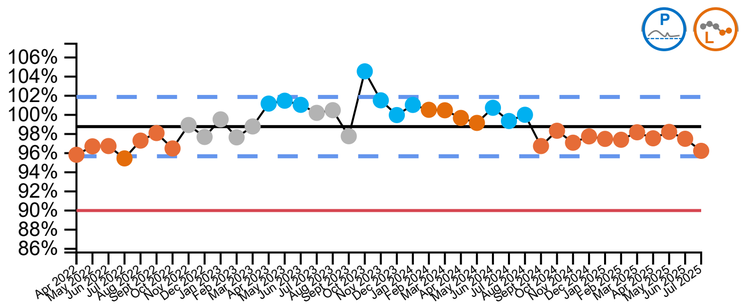
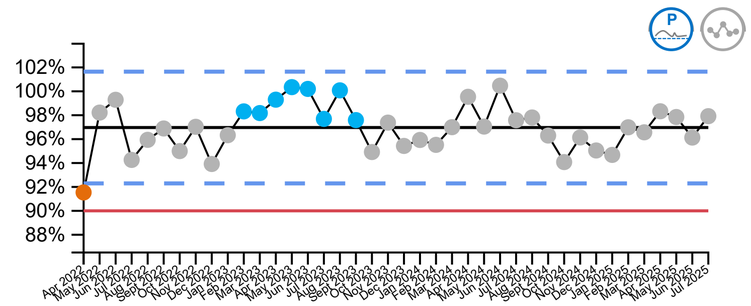
Average fill rate registered nurses (day)



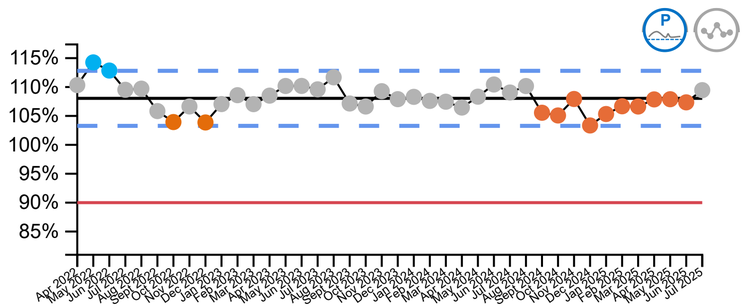
Average fill rate registered nurses (night)



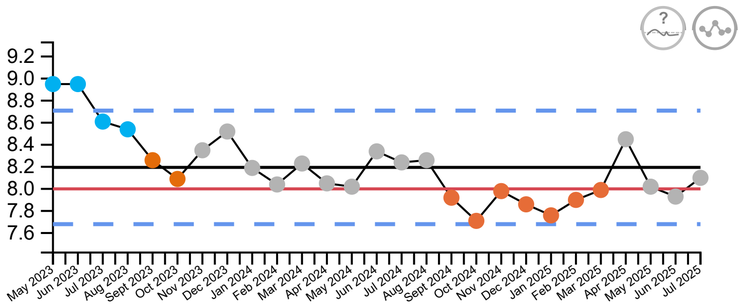
Average fill rate registered care staff (day)



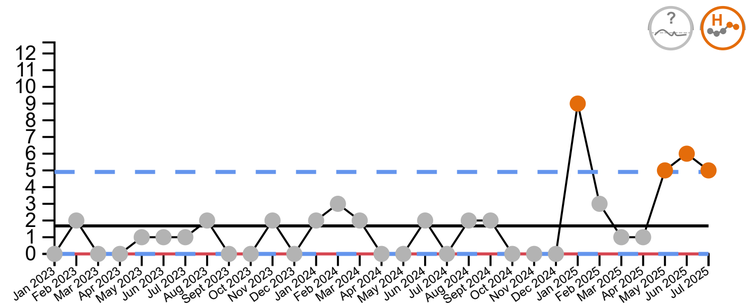
Average fill rate registered care staff (night)



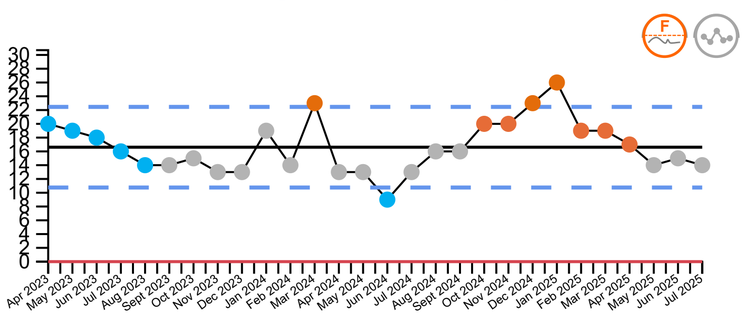
Care hours per patient day (CHPPD)



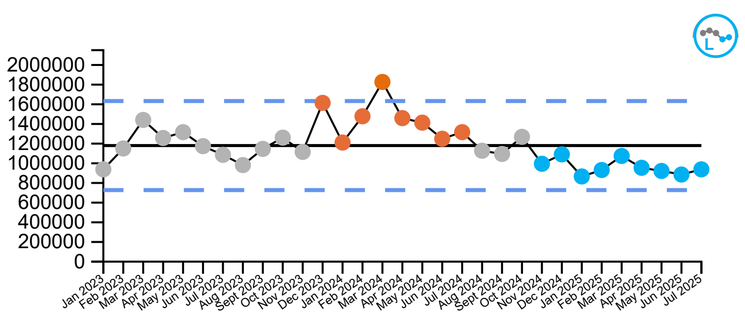
National nursing red flags



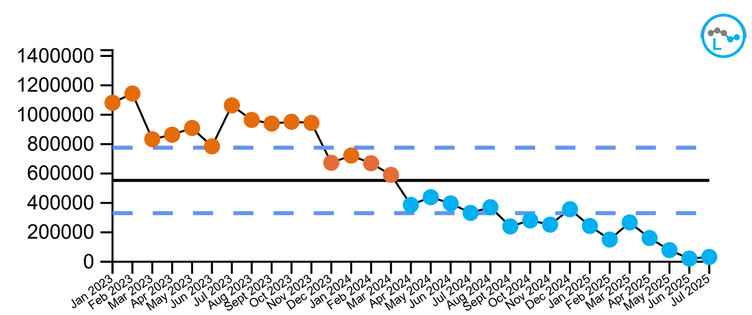
Wards <90% registered nurse (day) fill rate



Registered nurse bank spend



Registered nurse agency spend



SAFE - Incidents and Pressure Ulcers

East Lancashire Hospitals NHS Trust
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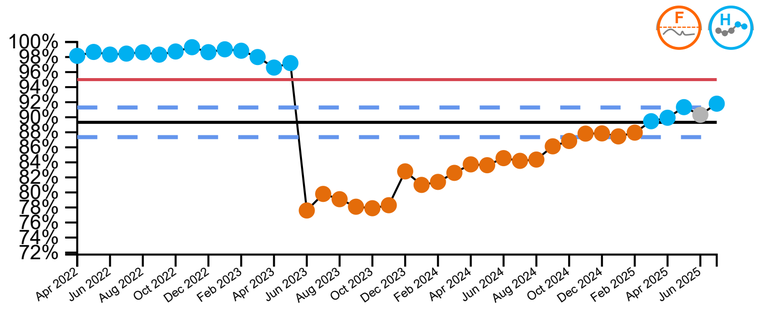
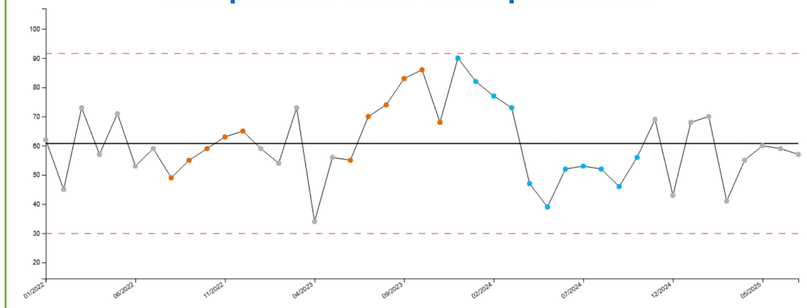
	Never events	Serious incidents reported to PSIRF	Medication errors serious/fatal harm	Slips trips falls causing moderate or above harm	
In month >	1	4	0	1	
YTD >	1	10	0	9	CAS alerts - Non-compliance: 1

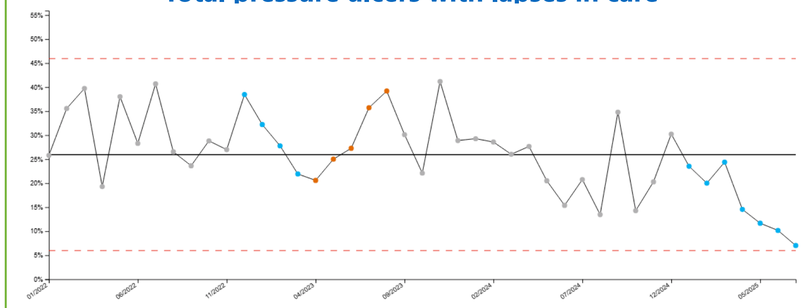
Patients risk assessed for Venous Thromboembolism



Total pressure ulcers developed in ELHT



Total pressure ulcers with lapses in care



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

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JUL 25	70.72	90.00		
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JUL 25	93.10	90.00		
COMPLAINTS RATE PER 1000 CONTACTS	JUL 25	0.28	0.40		
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JUL 25	95.86	90.00		
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JUL 25	91.44	90.00		
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JUL 25	93.44	90.00		

Alert

Outpatient's positive Friends and Family Test (FFT) score has experienced a slight decline from 95% to 93%, which is now one percentage point below the national average of 94%. Given the department's history of consistently high scores, this drop is not considered significant but will be monitored closely to determine if any intervention is required.

Advise

The positive Friends and Family Test (FFT) score for Maternity services has fallen to 91%, down from 95% in the last reporting period. While small fluctuations in these scores are common, the Family Care Division is closely monitoring this decline. The service's performance data is being thoroughly reviewed in various forums, including the Trust's Patient Experience Group, to ensure appropriate actions are taken.

The Trust currently has 119 active Level 4 complaints, an increase from 114 in July 2025. Of these, 21 (18%) are second responses from complainants who have reopened their cases with additional questions. The Customer Relations Team is actively collaborating with the divisions to address and resolve complaints that have exceeded the 40 day threshold. The average time to close a complaint has decreased to 64 days, an improvement from the 67 day average recorded in the previous month.

Assurance

The Trust's inpatient, outpatient, and community services continue to achieve Friends and Family Test (FFT) positive recommendation rates that meet or exceed the national average.

CARING - Feedback

East Lancashire Hospitals NHS Trust
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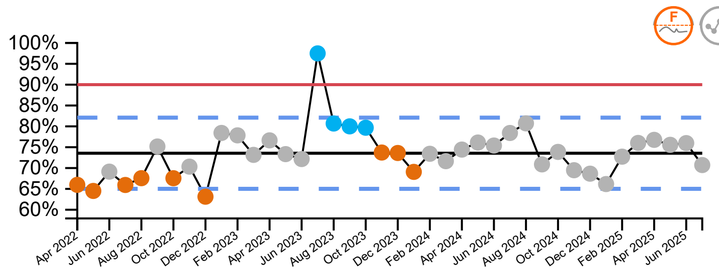
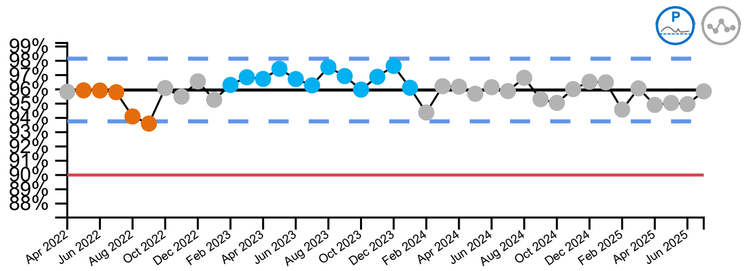
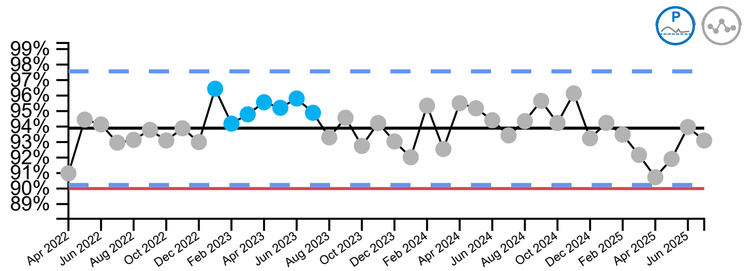
A&E Friends and Family % describing their experience as good or very good



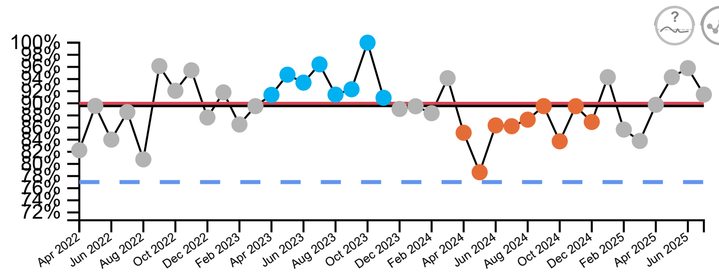
Inpatient Friends and Family % describing their experience as good or very good



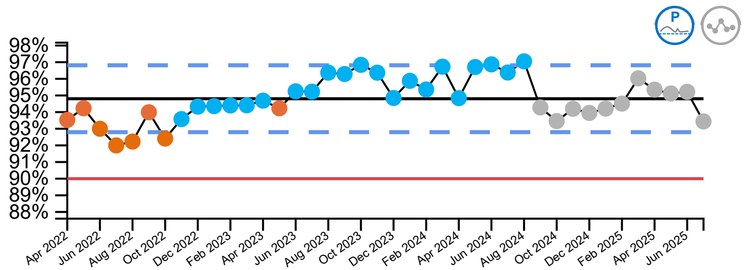
Community Friends and Family % describing their experience as good or very good



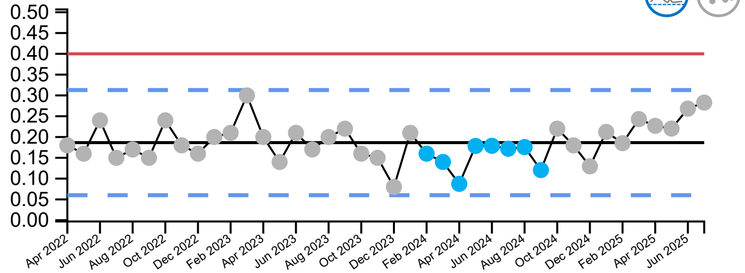
Maternity Friends and Family % describing their experience as good or very good



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



Complaints rate per 1000 contacts



EFFECTIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	JUL 25	99.00	
CRUDE MORTALITY RATE	JUL 25	2.04	
STILLBIRTHS	JUL 25	3.00	

METRIC	LATEST DATE	VALUE
MATERNAL DEATHS	JUL 25	1.00
SHMI	FEB 25	1.25
HOSPITAL STANDARDISED MORTALITY RATIO	MAR 25	108.10

Alert

The Trust remains unable to provide full assurance in relation to the HSMR and SHMI mortality indicators primarily due to issues with data submission. Data submission is now occurring within necessary timescales but given the intrinsic delay in availability of secondary data from NHSE, and the effect of the rolling 12-month period used for mortality indicators, our SHMI data to Feb 2025 still includes uncoded data. SHMI remains very high (1.25 in this data), although has been reducing, but confidence remains low. The data published nationally did contain a caveat until this month that our data contains a high percentage of invalid diagnosis codes and also notes that the trusts that have removed SDEC activity are reporting higher SHMI. The former caveat has been removed, although the issue still influences our data (invalid diagnosis 6% vs national average of 2%). The impact of SDEC removal appears substantial and is being further explored.

The standard HSMR+ calculation (based on a rolling one-year data set) is still unavailable, although the Trust has an 11-month rolling figure, progressively incorporating additional months. Unfortunately, this has now exceeded the expected limit at 108.1. This figure is also affected by the removal of the SDEC data from our submission.

The post responsible for managing Doctors revalidation reports and the SJR process has now been filled, but the capacity for SJR reviews remains low, and the number of completed SJRs remains lower than target.

Advise

A mortality update will be delivered to Quality Committee in August.

Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate, which does not exceed control limits, and indeed has been showing a reduction, which is likely primarily a seasonal effect.

EFFECTIVE - Mortality

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Stage 1 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	14
Backlog	> 100
5 - Excellent Care	1
4 - Good Care	5
3 - Adequate Care	6
2 - Poor Care	2
1 - Very Poor Care	0

Stage 2 SJR Reviews

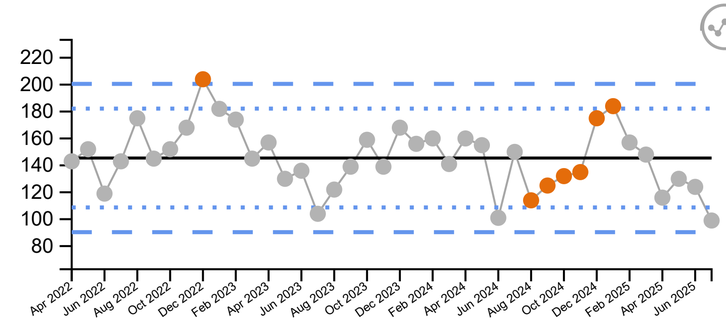
Completed in most recent month

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

Learning Disability Mortality Reviews

5 reviews completed, 0 deaths recorded in July, 5 reviews to be completed at August meeting

In Hospital Deaths



SHMI and HSMR Series

Below expected levels
Within expected levels
Higher than expected levels

Stillbirths

3

Year to date stillbirths

12

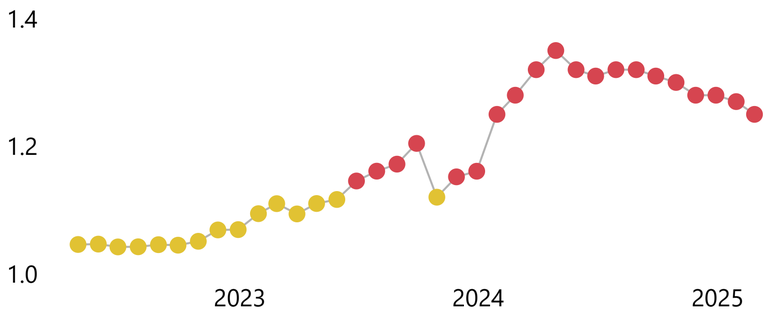
Maternal deaths

1

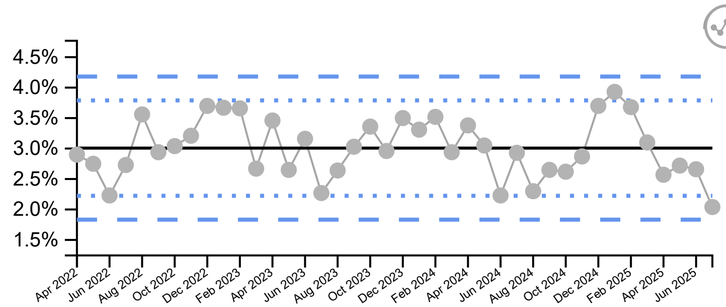
Year to date maternal deaths

1

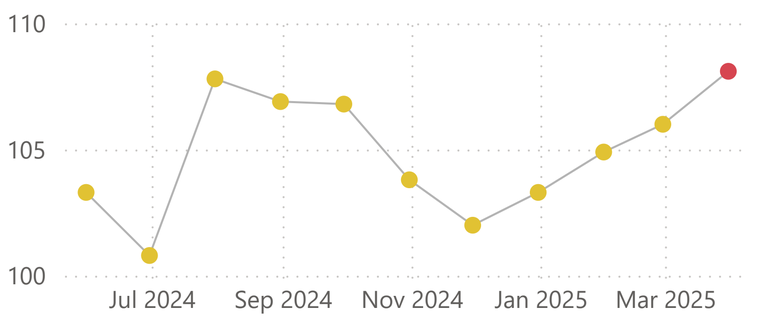
SHMI



Crude mortality rate



Hospital Standardised Mortality Ratio (rolling monthly)



Safe | Personal | Effective

RESPONSIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
28D GENERAL FDS	JUN 2025	73.70	80.00		
62D GENERAL STANDARD	JUN 2025	76.80	75.00	H	
A&E 4HR PERFORMANCE (TRUST)	JUL 2025	79.30	78.00	H	
DM01 % OVER 6 WEEKS	JUL 2025	1.79	5.00	L	F
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	JUL 2025	10.00	0.00		
RTT ONGOING % OVER 52 WEEKS	JUL 2025	3.66	1.00	L	F
RTT ONGOING % UNDER 18 WEEKS	JUL 2025	61.17	62.00	H	F

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
OVER 12 HOURS IN DEPARTMENT %	JUL 25	14.54	15.20	L	

METRIC	LATEST DATE	VALUE	VARIATION
A&E ATTENDANCES	JUL 25	26167.00	H
BED OCCUPANCY G&A	JUL 25	94.72	H
CANCELLED ON DAY OPERATIONS	JUL 25	62.00	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	JUL 25	10.80	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	JUL 25	245.00	
% HANDOVERS > 30 MINUTES	JUL 25	18.55	
AMBULANCE HANDOVERS >45 MINUTES	JUL 25	149.00	

METRIC	LATEST DATE	VALUE	VARIATION
MAX ARRIVAL TO HANDOVER TIME	APR 25	250	
AVERAGE ARRIVAL TO HANDOVER	JUL 25	23	

METRIC	LATEST DATE	VALUE
RTT ONGOING	JUL 25	57371.00
RTT OVER 52 WEEKS	JUL 25	2100.00
RTT OVER 65 WEEKS	JUL 25	1.00

Alert

Faster Diagnosis Standard – Performance was 73.70%, below the target of 80% by March 2026, but showing a slight improvement from 72.10% in May. The most challenged specialties are Colorectal and Dermatology, impacted by clinician sickness and staffing levels. A new clinician will join the Trust in September, and work is ongoing with the Cancer Alliance to identify opportunities to support Dermatology.

RTT Long Waits – One patient breached 65 weeks in OMFS, due to the inability to offer reasonable patient choice as a result of workforce gaps and specialty demand. From September, the Trust will add capacity through insourcing, and is working with UCLAN to better manage demand and capacity.

Cancelled On-the-Day Operations decreased to 62. Work continues to improve theatre productivity, focusing on reasons for cancellations. In July, 10 patients were not treated within 28 days of cancellation: 3 due to patient choice, 2 were not medically fit, 1 required RBH & ICU, 3 due to clinician capacity, 1 required bariatric transport

Ambulance Handovers > 45 minutes – 149 incidents reported. ED teams are working collaboratively with NWAS to improve handover times. July saw the highest number of ED attendances recorded. Ambulance Max Handover Time – Still not available from NWAS.

Advise

% of Ambulance Handovers > 30 minutes – 18.55%, a slight increase of 0.23% from June, despite record ED attendances in July (26,167) – an increase of 1,756 from June. ELHT continues to work with NWAS to improve handover processes.

RTT > 52 weeks – 3.66% of patients are waiting over 52 weeks (target: 1% by March 2026). OMFS and Digestive Diseases remain the most challenged specialties. Additional OMFS capacity will come online from September via insourcing, and further opportunities are being explored with UCLAN.

Patients Waiting > 12 Hours in ED – 14.54%, below the 15.2% target. Improvement work continues to reduce the number of patients waiting over 12 hours in the department.

Assurance

62-Day Combined Standard – 76.8%, exceeding both the internal trajectory and the national ambition of 75% by March 2026.

A&E 4-Hour Performance – 79.30%, above the 78% standard, despite increased attendances.

Diagnostic Performance (DM01) – Remains strong at 1.79%, meaning 98.21% of patients were seen within 6 weeks.

Average Ambulance Handover Time – 23.3 minutes at ELHT; NWAS average handover time was 26 minutes.

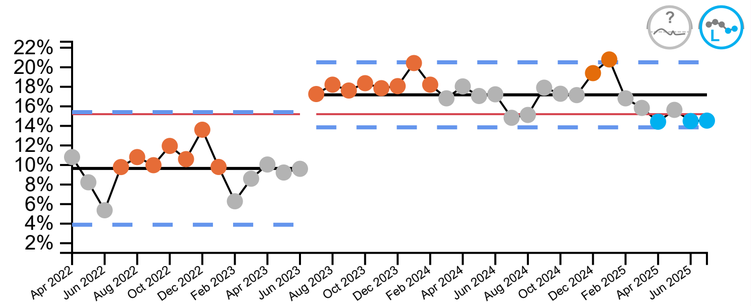
Theatre Utilisation – Remains strong and continues to support elective recovery.

RTT < 18 Weeks – Current performance is 61.17%, with ongoing efforts to meet the target of 62.2% by March 2026.

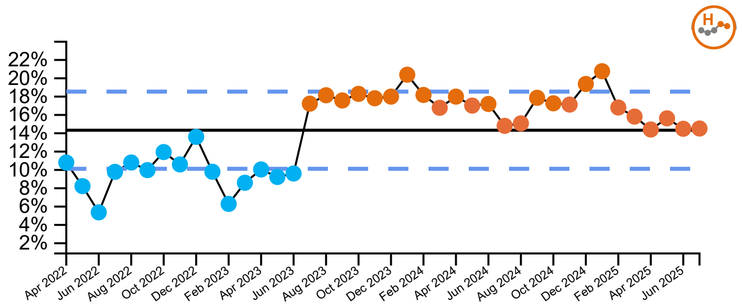
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

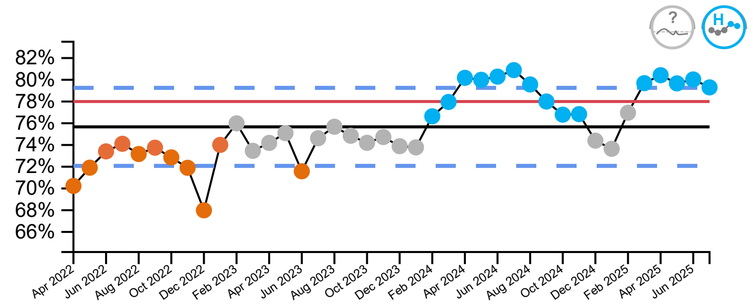
Over 12 hours in department % (type 1)



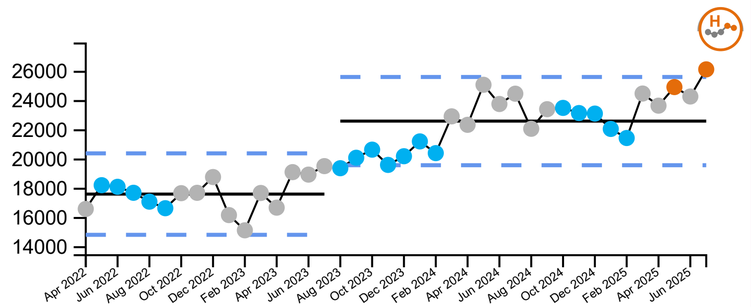
Over 12 hours in department %



A&E 4hr Performance (Trust)



A&E Attendances



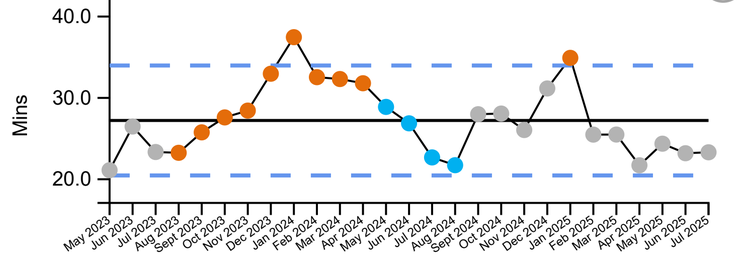
Average arrival to handover time (mins) (latest month)

23

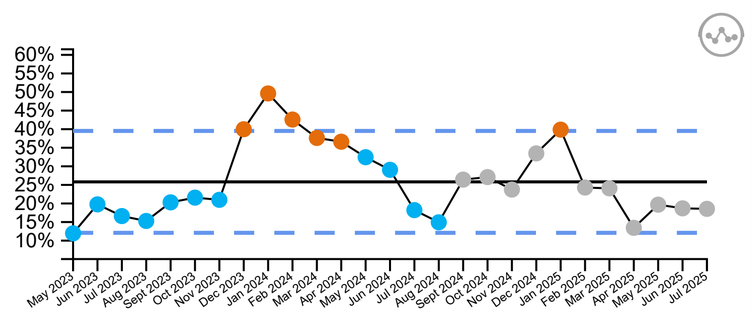
Maximum arrival to handover time (mins) (latest month)

(Blank)

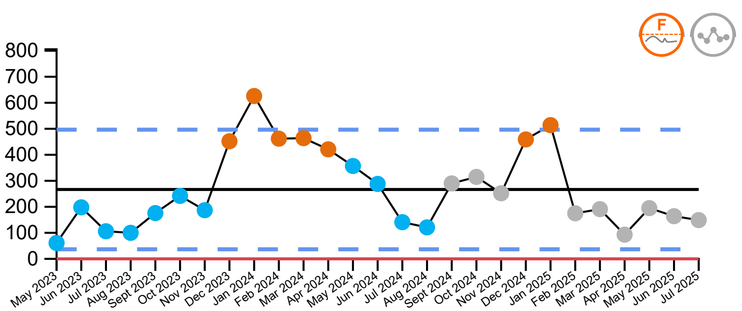
Average arrival to handover



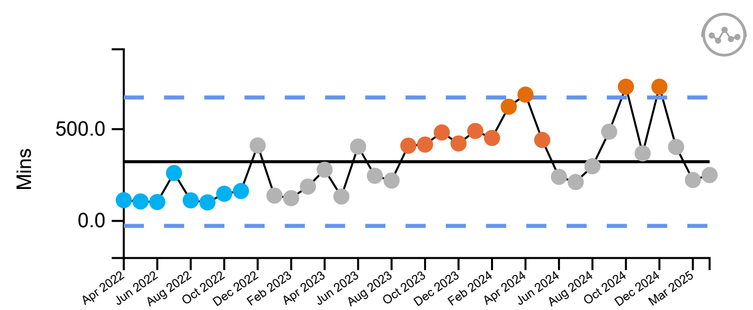
% handovers > 30 minutes



Ambulance Handovers >45 minutes



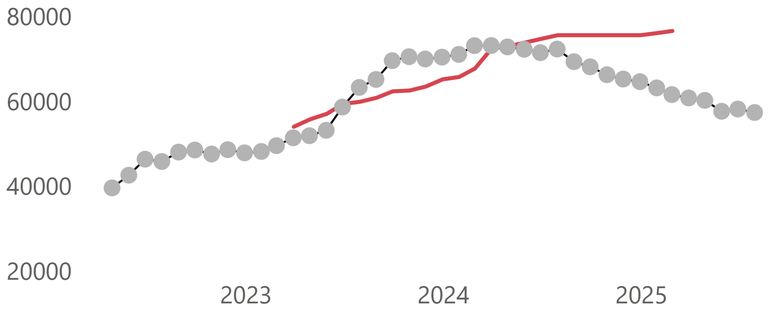
Max arrival to handover time



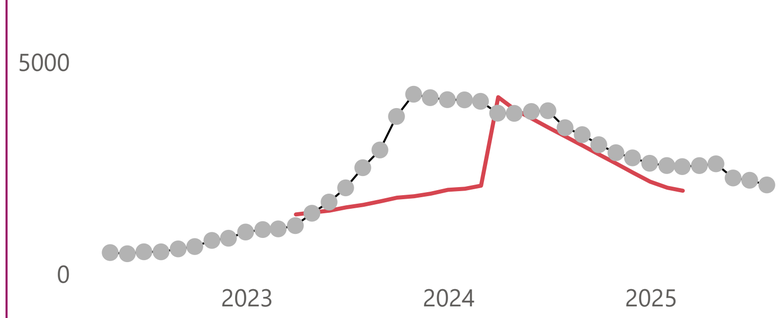
RESPONSIVE - RTT and Diagnostics

East Lancashire Hospitals NHS Trust
A University Teaching Trust

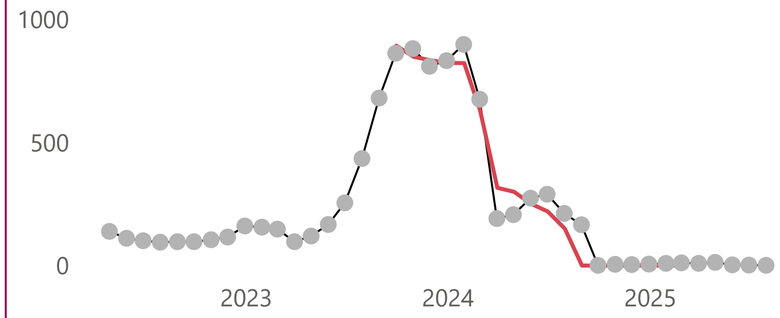
RTT Ongoing



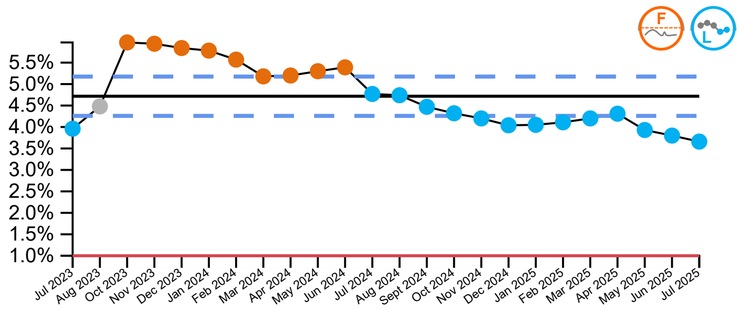
RTT Over 52 Weeks



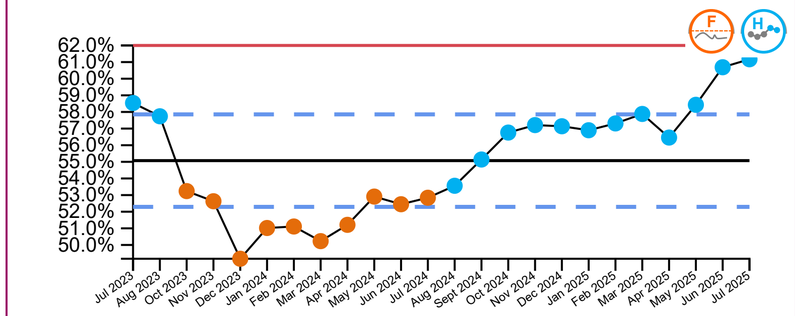
RTT Over 65 Weeks



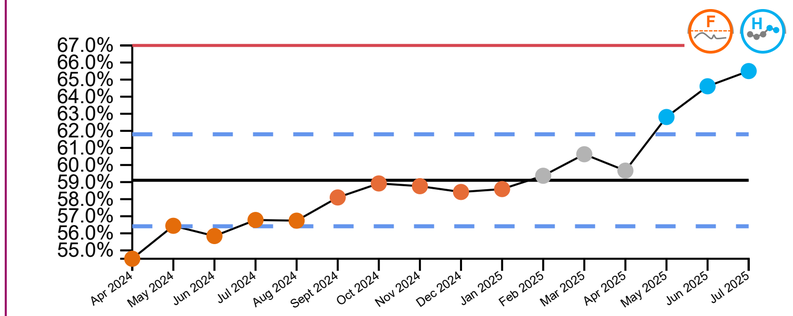
RTT Ongoing % Over 52 weeks



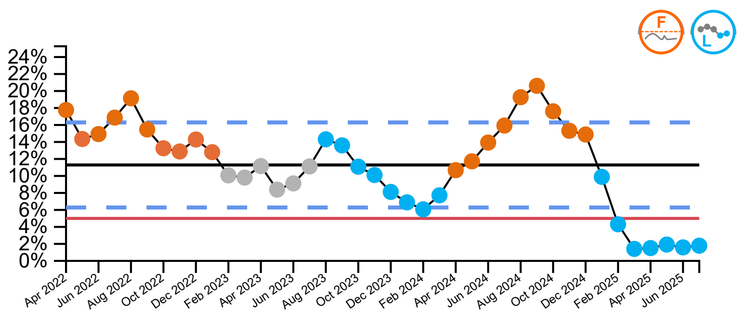
Proportion waiting < 18 weeks for treatment



Proportion waiting < 18 weeks for 1st appointment



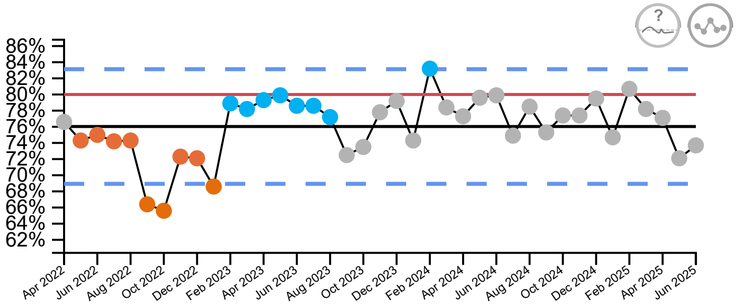
DM01 % over 6 weeks



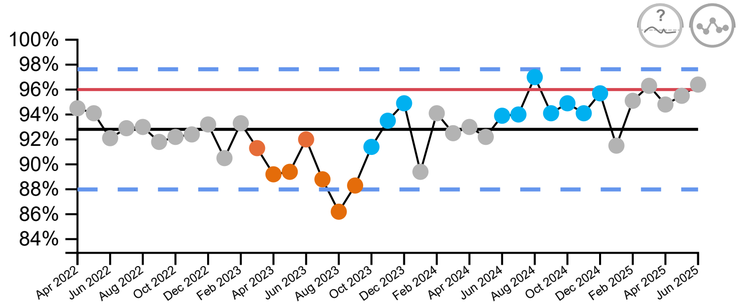
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

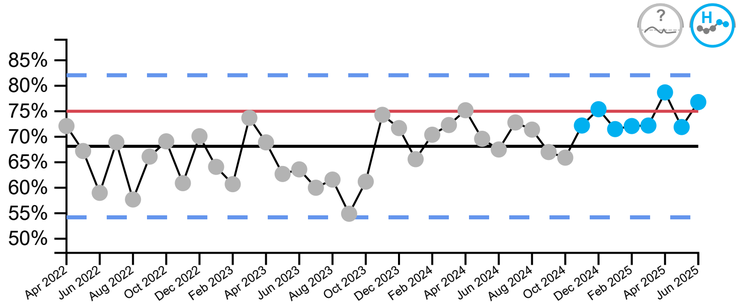
28d General FDS



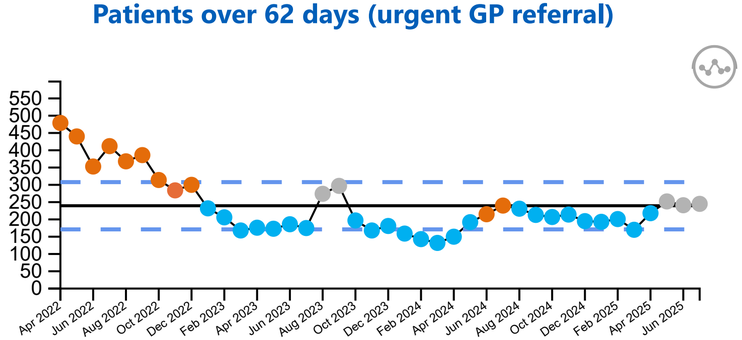
31d General treatment standard



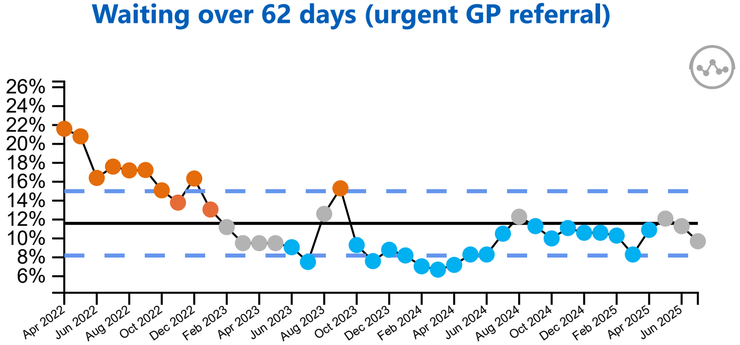
62d General Standard



Patients over 62 days (urgent GP referral)



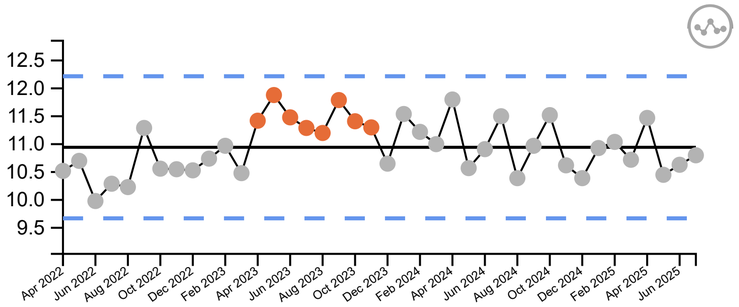
Waiting over 62 days (urgent GP referral)



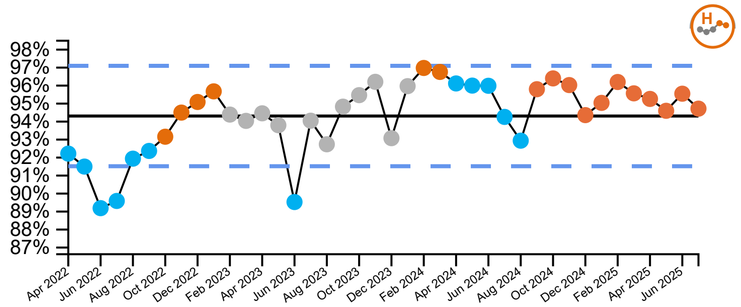
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

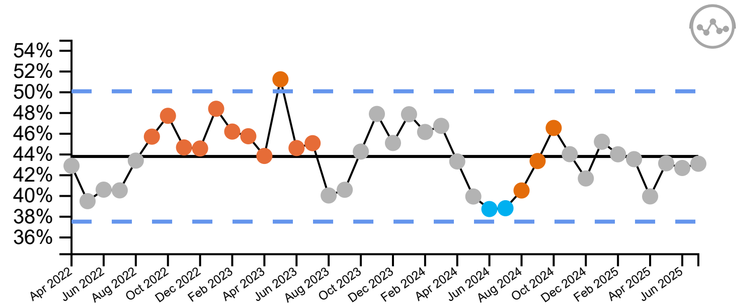
Emergency average length of stay (excl 0 and 1 days)



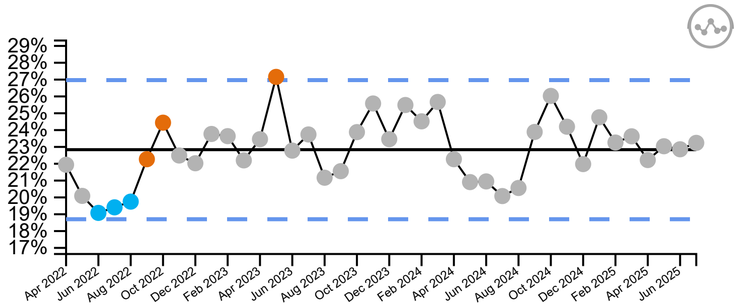
Bed occupancy G&A



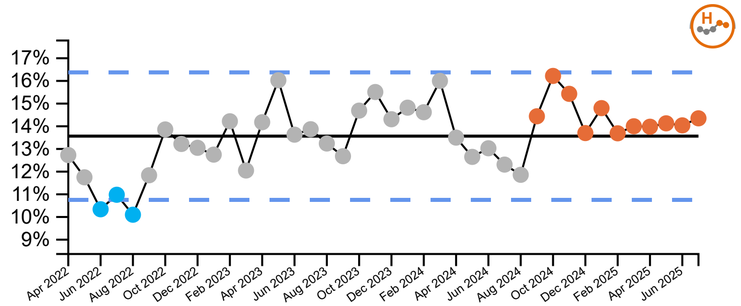
% Beds occupied by Long-Stay Patients 7+ days



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



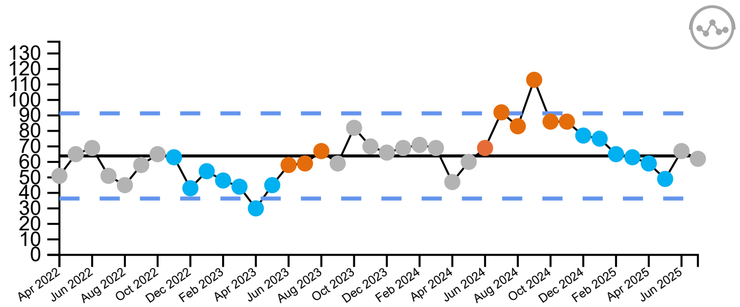
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

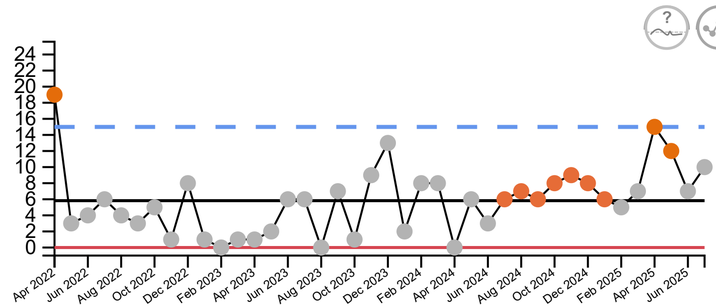
Cancelled on day operations



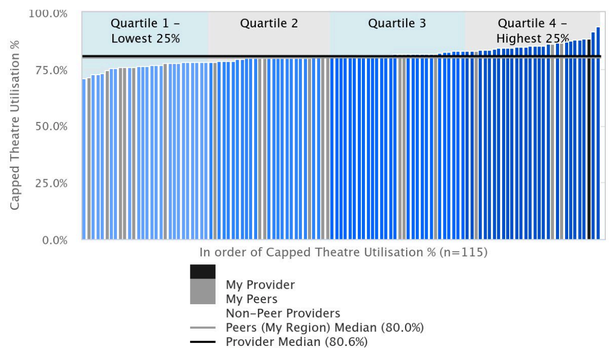
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	JUL 25	80.00	90.00	H	F
APPRAISAL (CONSULTANT)	JUL 25	97.00	90.00		P
APPRIASAL (OTHER MEDICAL)	JUL 25	98.00	90.00		P
INFORMATION GOVERNANCE TRAINING	JUL 25	92.00	95.00		F
SAFEGUARDING CHILDREN L1	JUL 25	96.00	90.00	H	P
SICKNESS	JUL 25	6.67	4.50		F
TURNOVER	JUL 25	6.47	12.00	L	P
VACANCY	JUL 25	3.90	5.00	L	?

Alert

Improvement in Non-Medical appraisal from 79% to 80%, but remains behind target of 90%.
Compliance in Information Governance has improved by 2% to 92% (target of 95%)
Sickness absence has increased for a third successive month by 0.12% in month, to 6.67%.

Advise

35% of all sickness absence is attributable to mental health conditions, with 23% being MSK. A specific programme of work has been established to focus on wellbeing and managing attendance.
72% of Consultants have a job plan either live or at sign-off stage, down slightly from 74% in July. 65% of non-Consultant grades have a live job plan or awaiting signature (69% in May).

Assurance

Medical appraisals remain above target – 97% for Consultants and 98% for other grades
Safeguarding Children L1 training has further improved to 96% (against target of 90%)
Vacancy and turnover levels remain low, 3.9% and 6.47% respectively.

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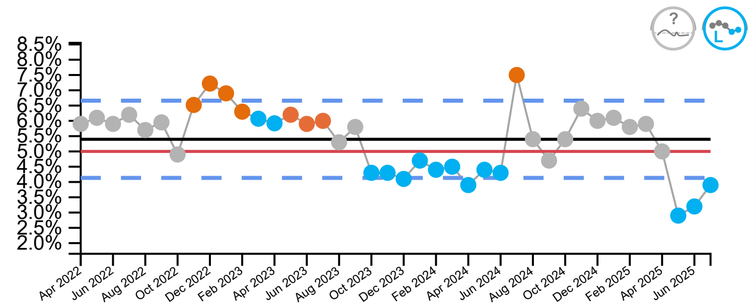
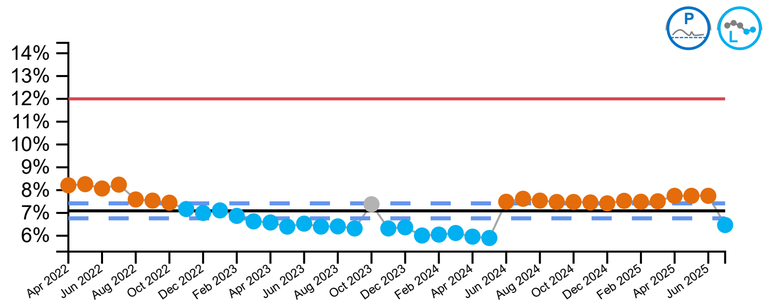
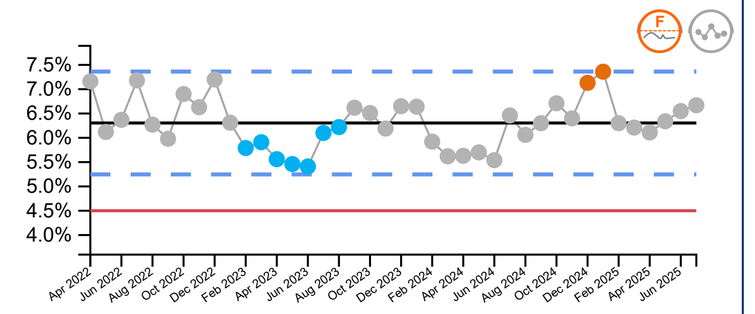
Vacancy



Turnover



Sickness



Freedom to Speak Up Cases by Elements

Concerns with elements of...

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

Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	89	10
Complete	110	56
Due Soon	69	13
In Progress	43	15
No Current Job Plan	13	13
Not Started	52	17
Referred Back	3	2
Uploaded	0	0
Total	**379**	**126**

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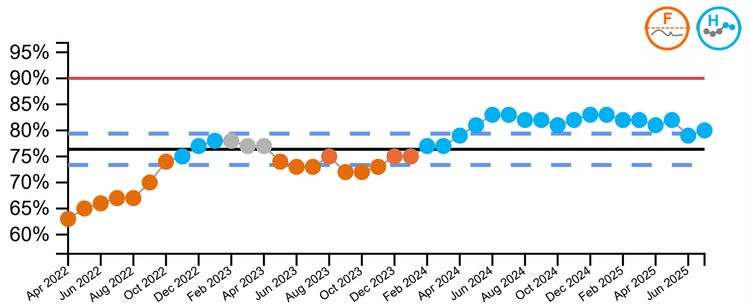
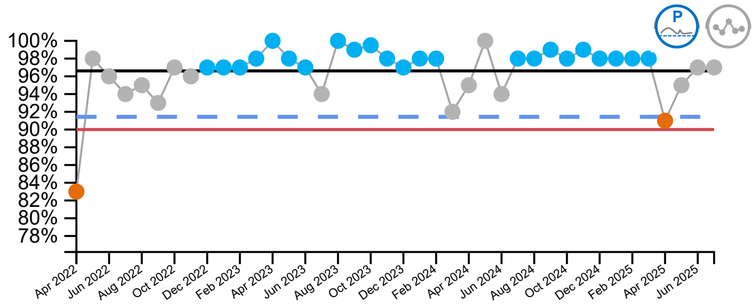
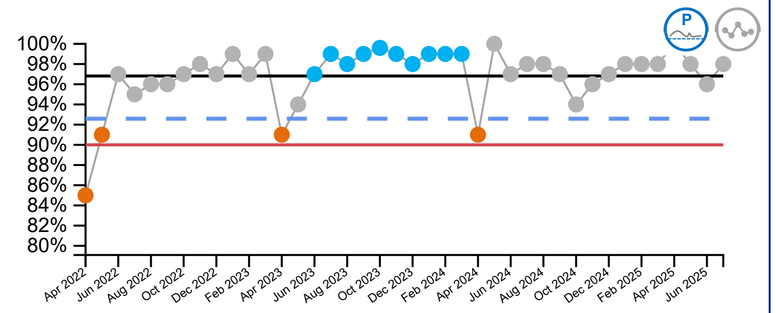
Appraisal (agenda for change)



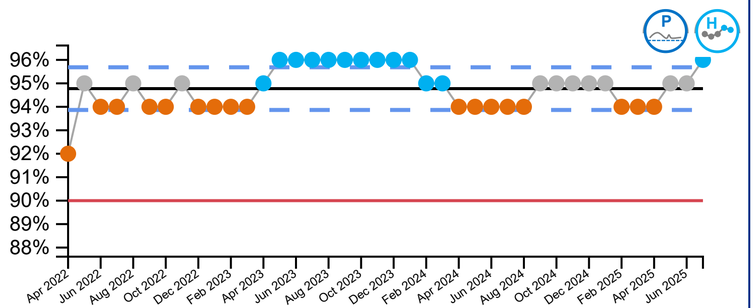
Appraisal (consultant)



Appriasal (other medical)

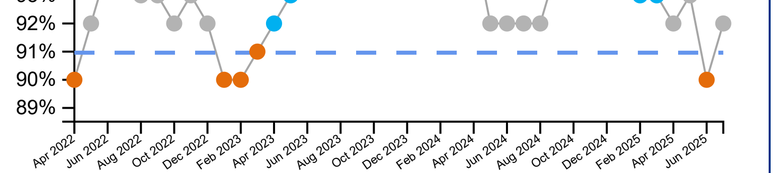


Safeguarding Children L1



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

Information governance training



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WELL LED FINANCE - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	JUL 25	79.77	95.00		?
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	JUL 25	91.98	95.00		?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	JUL 25	90.74	95.00		?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	JUL 25	93.62	95.00		?
LIQUIDITY DAYS	JUL 25	-30.77	-21.50	L	?
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	JUL 25	-2.14	0.00		?
WRP ACHIEVED - VARIANCE TO PLAN (£M)	JUL 25	-0.90	0.00		?
AGENCY SPEND AS PROPORTION PAY BILL (£M)	JUL 25	0.94	1.20	L	F
VARIANCE TO CAPITAL PROGRAMME (£M)	JUL 25	-3.58	0.00		?

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	JUL 25	50.01	0.00	H
INCOME RUN RATE (£M)	JUL 25	71.28	0.00	
OTHER OPERATING EXPENSES RUN RATE (£M)	JUL 25	21.90	0.00	

Alert

Cash Risk and DSF Conditions: The Trust faces a critical cash risk if DSF is withheld due to underperformance. Immediate focus on cost reduction and delivery of WRP will maintain our cash balance without the need to request borrowing from NHSE.
WRP Delivery: The trust achieved £4.1m WRP in Month 4 against a reprofile plan of £4.2m. Cumulatively the trust had delivered £11m of savings which is £1m adverse to the reprofile plan. The risk adjusted forecast is £54.7m.
Workforce Spend: Pay spend increased in M04 v M03 by £1.8m, linked primarily to the impact of the pay award, which is funded by the ICB with no impact on the bottom line.
Contracting and Activity Planning: Activity and finances have been agreed for 2025-26 contract and will be imminently signed.
Contract does not reflect activity being delivered through the NEL pathways or in Maternity. Deconstruction of the block contract guidance has been issued for 2026-27. Formal contract meetings have commenced for 2025-26.

Advise

WRP Reporting Alignment: There is good progress to streamline and align reporting between PMO, finance, and improvement teams at Divisional and Trust level. An in house team had developed a fully automated reporting for WRP using Power Bi which will be implemented in Month 5.
Cash Flow Management: A recent cash flow forecast has been prepared to take into account the latest divisional forecast. The cash balance increases by £2.5m to £9.6m in July, but significant risks remain, and this is being monitored closely.
System Collaboration: Continued engagement with ICB and system partners is essential, particularly around shared savings schemes and commissioning intentions.

Assurance

Financial Position (Month 4): The Trust has agreed a break-even annual financial plan for 2025-26, inclusive of £43.3m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
The Trust is reporting a deficit of £5.8m, against a M4 in month plan of £3.7m deficit; £2.1m behind the plan. This is the deficit excluding the £3.6m of deficit support funding. The net reported deficit is £2.2m.
The Year-to-date position reported is a £26.2m deficit against a plan of £20.7m, £5.5m behind plan, excluding the DSF.
The WRP delivered £4.1m in month against the original plan of £5m, a variance of £0.9m.
Year to date, the WRP delivered is £10.8m against the original plan of £14.1m, a variance of £3.3m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance. Plans have been made to mitigate this underperformance in the latter end of the year.
Cash: The cash balance on 31st July was £9.6m, an increase of £2.5m compared to the M3 cash position of £7.1m.
Capital: The annual 2025-26 capital plan is £35.9m, For M4, year to date spend is £8.9m, £0.6m ahead of plan but still forecasting not to exceed the annual plan.

WELL LED - Finance

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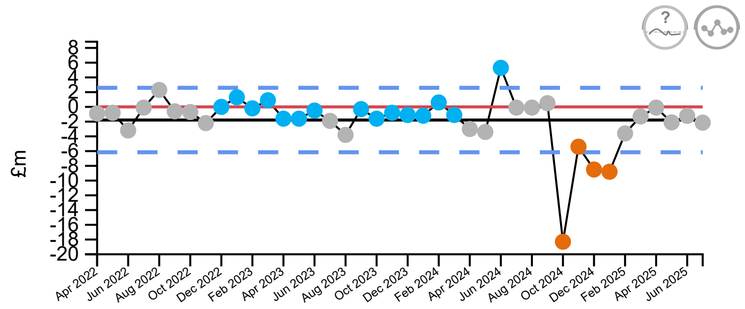
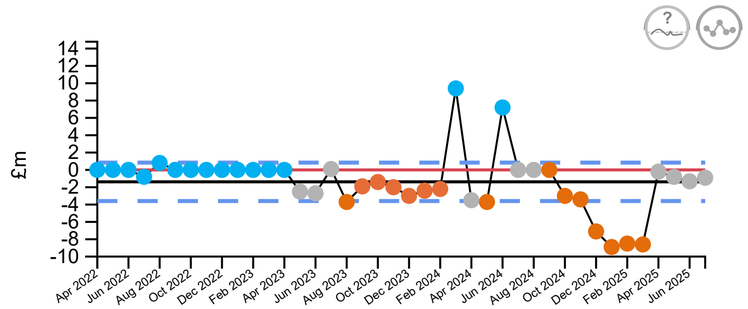
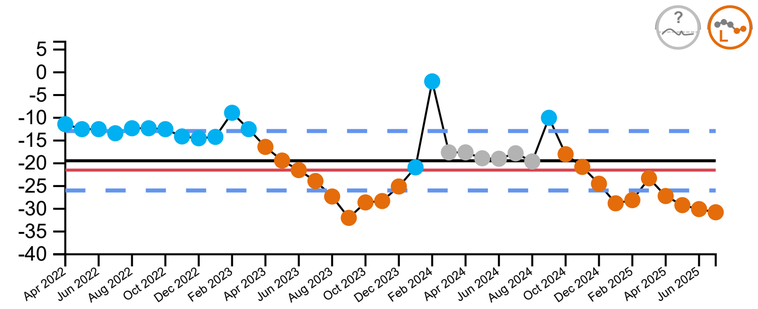
Variance to planned financial performance (deficit) (£m)



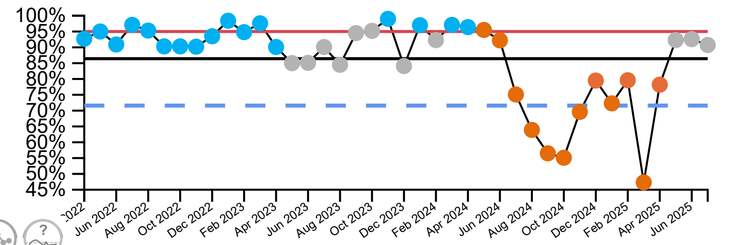
WRP achieved - variance to plan (£m)



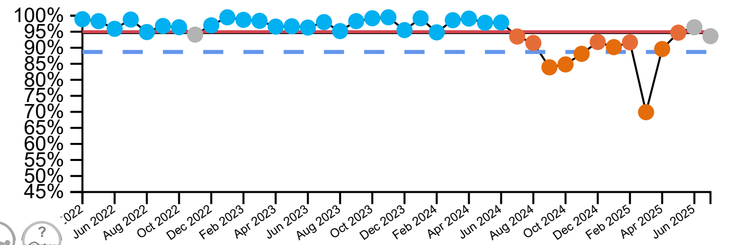
Liquidity days



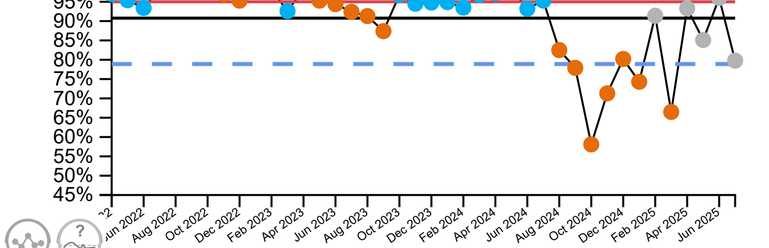
Better Payment Practice Code (BPPC) Non NHS No of Invoices



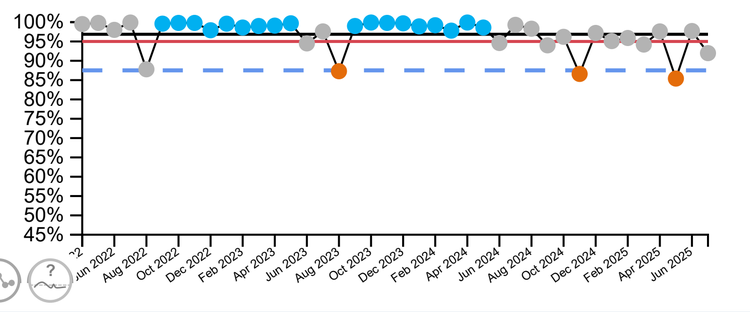
Better Payment Practice Code (BPPC) Non NHS Value of Invoices



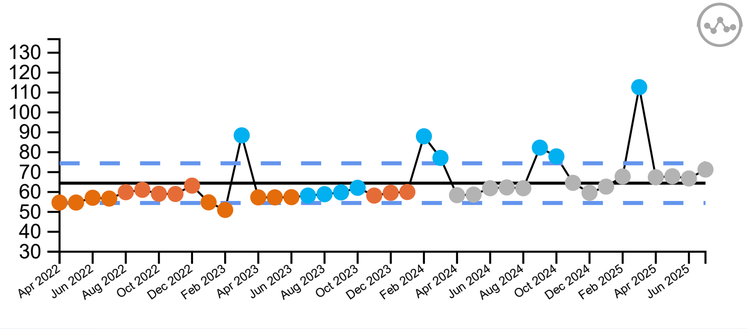
Better Payment Practice Code (BPPC) NHS No of Invoices



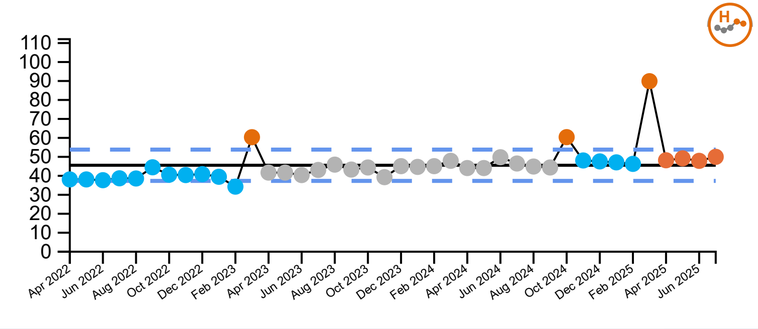
Better Payment Practice Code (BPPC) NHS Value of Invoices



Income run rate (£m)



Employee expenses run rate (£m)



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

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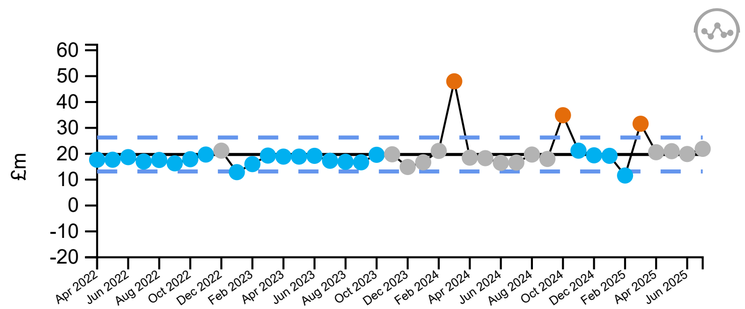
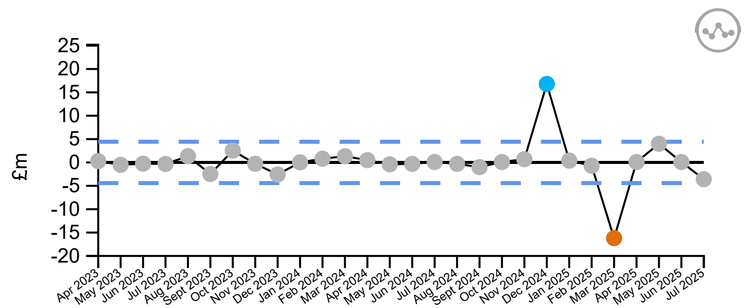
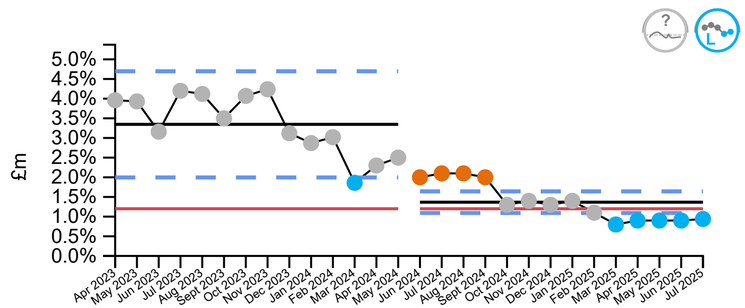
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion pay bill (£m)



BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/119
Report Title:	Mortality Update		
Author:	Charles Thomson, Deputy Medical Director for Quality Governance		
Lead Director:	Julian Hobbs, Executive Medical Director		

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

Executive Summary:	**Alert** The standardised mortality ratios used nationally to monitor mortality at Trusts show that ELHT has a higher mortality than expected. **Assure** This rise is driven by the early adoption of the SDEC coding change in 2023 which was not implemented by the majority of Trusts. It is not driven by quality of care. Specific positive assurance is provided in relation to the quality of care. **Advise** Actions to address coding, normalise mortality and further improve the quality of care are listed. An action plan is in development to be reported to Quality committee.
Key Issues/Areas of Concern:	• Excess mortality suggested by SMRs • Data quality issues • Quality of care and outcomes assurance
Action Required by the Board:	• To review the assurance provided. • Consider options for bringing our data submission. • Note the plan related to quality improvement

Previously Considered by:	
Date:	
Outcome:	

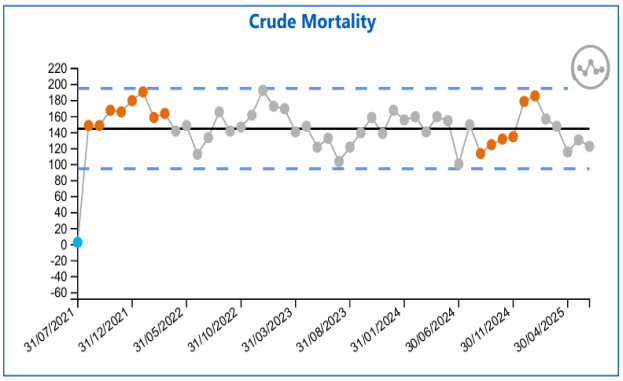
Introduction

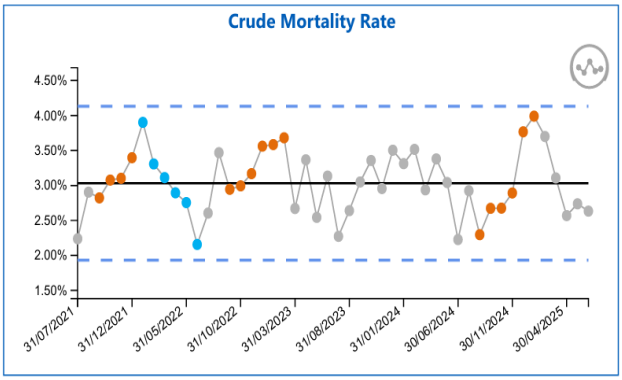
1. Standardised mortality ratios describe whether a specific population are more or less likely to die than a standard reference population – for example patients hospitalised at a given hospital against a standardised population across all UK hospitals. A standardised ratio is calculated as observed deaths/expected deaths – a ratio above 1.0 – or 100 where this is used – indicating more deaths than might be expected.
2. A key calculation is the number of expected deaths. Clearly, hospitals might have a different case-mix profile, and therefore a standardised model can refine its 'expected' estimate based on age, sex, diagnosis and other factors.
3. The Trust reports two mortality ratios. The SHMI (NHS England) uses diagnostic group, age, gender, admission method and Charlson comorbidity score to calculate 'expected' deaths and also includes deaths within 30 days of admission.. The HSMR+ (Dr Foster / Telstra) also includes the index of multiple deprivation, and measures of comorbidity, and frailty.
4. Mortality ratios have limitations – NHSE notes 'the SHMI is not a measure of quality of care' and a high value 'should not immediately be interpreted as indicating poor performance' – they do provide a simplistic method of comparing trusts and creating league tables.
5. The Trust was identified as a mortality outlier in 2013. This, along with continued public and media interest, warrants close board monitoring of our mortality indicators. Not only to assure safety but also to maintain staff and public confidence.
6. The standardised mortality indicators that we monitor are currently high. The most recent figure for the SHMI [representing the period April 2024 to March 2025] is 1.21. This is higher than expected, and amongst the worst nationally.
7. The current figure for the HSMR+, is 108 and is an approximation as this is a rolling 11-month figure from May 2024 – March 2025. This is has now exceeded expected levels.
8. The purpose of this paper is to review possible reasons for elevated mortality ratios at ELHT and provide assurance as to processes for ongoing monitoring of care.

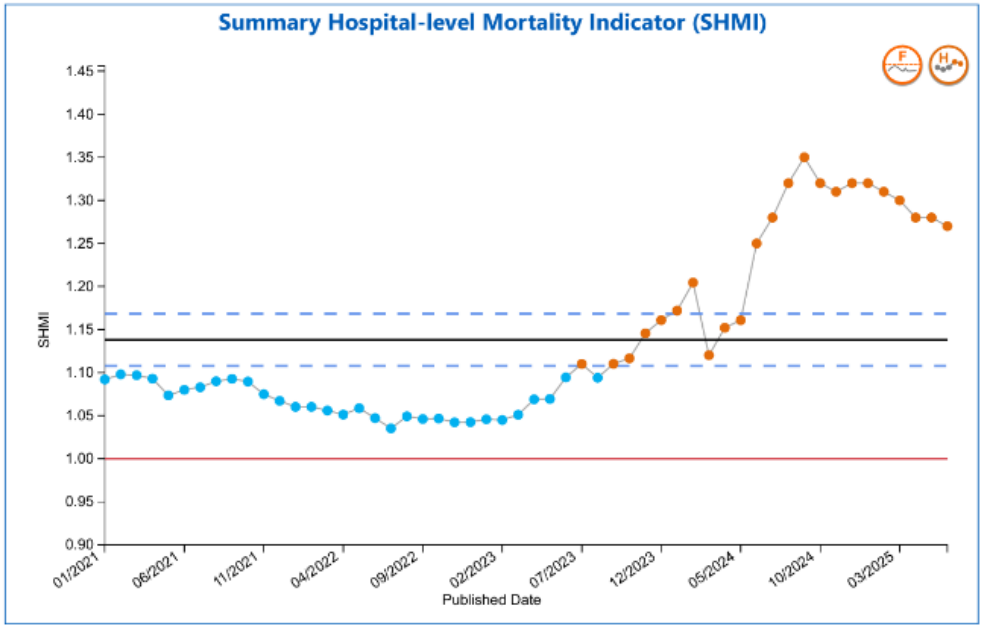
Current concerns

Data Quality

9. The Mortality Steering Group monitors mortality indices. SHMI and HSMR have increased since the introduction of the EPR in 2023 and the effect can be seen in the graphs below.







10. The first two graphs show the monthly absolute mortality and the crude mortality rate since 2021. As can be seen, the figures are essentially static (the rate has been adjusted to remove the effect of same day emergency care activity). The SHMI graph above, however, shows a month-on-month increase starting from mid-2023.
11. It should be noted that the SHMI is based on a 12 month rolling data set, which runs five months behind. Thus, at the time of writing the most recently published data on 14th August 2025, covers the 12 months from April 2024 to March 2025. Notwithstanding this, the increase of SHMI in the face of a static absolute mortality is

surprising. This is futher evidence that the rise in mortality indices is due to a data issue rather than a quality care or outcome issue.

12. Given the data do not show an actual increase in crude mortality, the possible explanations are threefold
    a. There has been a real national decrease in mortality rates at other hospitals which has not been matched at ELHT, meaning the number of deaths expected by the model would fall.
    b. There has been a real change in case mix at ELHT towards lower severity cases where the expected mortality would be lower.
    c. There has been a change in our data submission which has resulted in inappropriate stratification of some patients, again reducing our expected mortality.
13. Whilst these three possibilities are not mutually exclusive, we are aware of factors that would have the effect described in (c). These are a failure to submit coded data to HES/SUS (Hospital Episode Statistics / Secondary Uses Service) and the removal of SDEC activity from the admitted patient dataset.
14. *Failure to submit coded data to HES/SUS* – starting from approximately the beginning of the 23-24 year, we began to fail to submit data. Two different issues were identified:
    a. The data extract from Millennium failed and required adjustment.
    b. Our clinical coding fell too far behind, as a result of reduced staffing and unfamiliarity with the new system reducing coding speed.
15. The net effect of this was that there are substantial data gaps in the SUS data for the entire 23-24 year. Dr Foster / Telstra therefore ceased using this data (explaining our current 11 month rolling data set which starts in May 24), although NHSE continued to produce the SHMI based on what data they had – deteriorating month on month as another historical coded month dropped out.
16. These problems have now been resolved, and coding is achieved by the ‘flex point’ for data submission.
17. *Removal of SDEC activity from admitted patient dataset* – In 2023 NHSE indicated that all Trusts should start to report same day emergency care data within the Emergency Care Data Set (ECDS) rather than as part of admitted patients, with a deadline of July 2024. Given the imminent introduction of Millennium at that time, it was therefore decided to make this change in June 2023 when the EPR went live.
18. The effect of this was the removal of significant numbers of low-risk patients from the submitted data used for the mortality indices. It is noteworthy that ELHT reports about

65% of the number of non-elective spells compared with pre-pandemic activity in Jan 2019-Dec 2019 (this is supplementary data available as part of SHMI dataset). Our analytics team have investigated this and confirmed this is the impact of SDEC, rather than ongoing data gaps, although according to the SHMI supplementary data, elective spells are also decreased, and this warrants further investigation.

19. Crude mortality calculated for ELHT non-elective patients in the SHMI dataset is 5.1% (England average 3.4%), but if the SDEC data is restored crude mortality falls significantly.
20. Although the initial deadline for transferral of data to ECDS was July 2024, as at February 2025 under 40 trusts had made the transition, and some of these are submitting the same day data to both the ECDS and admitted patients dataset.
21. A new date of July 2025 has been set, but the effect will then take 12 months (plus a further five months due to the publication lag) to wash out from the submitted data sets, and a further 24 months to wash out from the model.

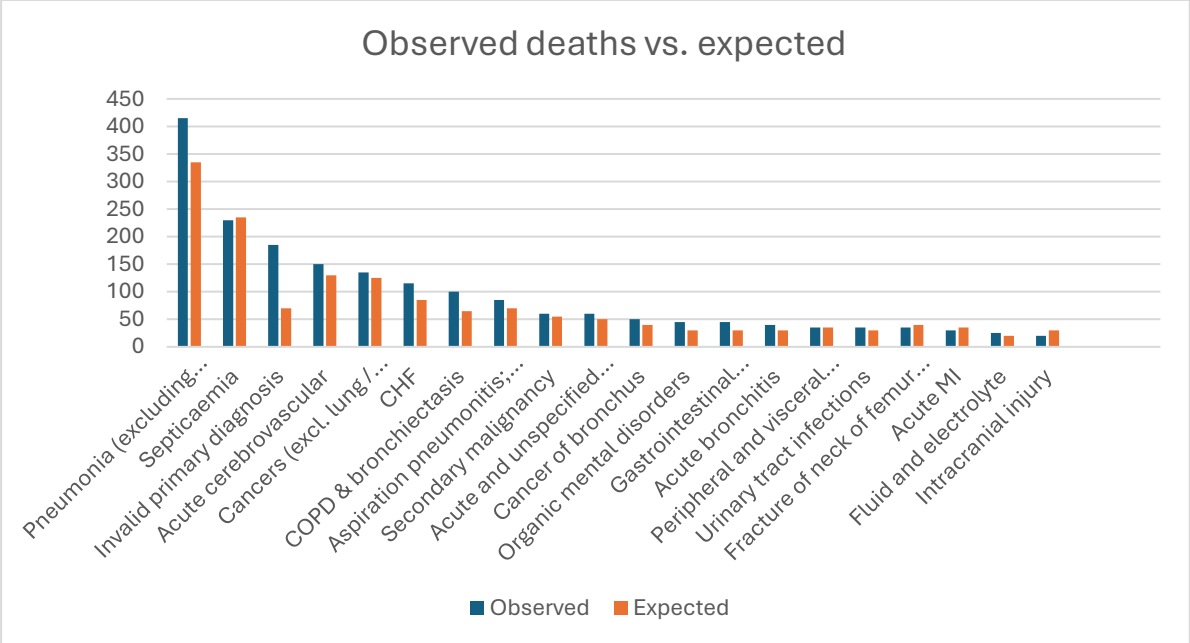
Historical SHMI / HSMR

22. ELHT has had a historically high SHMI, which has always run above 1.00, although within expected (see above graph), and HSMR also – before the 23/24 data issues – was running above expected at around 115.
23. Extensive consideration of the reasons for this has taken place previously, which can be summarised as follows
    a. *Assumptions made within models* – the standardised models aim to correct for various factors within the models. Two fairly well-established issues are palliative care coding and deprivation. The former (historically very low in ELHT) was used for risk stratification in HSMR, which adversely affected our HSMR. This has now been resolved with the HSMR+ model now excluding this widely gamed statistic. The impact of the replacement frailty measure is yet to be explored. Deprivation (which is high in our area, with 48.4% of spells from patients in the most deprived quintile against a national average of 23.1%) is not accounted for in SHMI, but it is unlikely that this has a substantial impact.
    b. *Comorbidity coding* – prior to access of our coders to LPRES and the electronic record comorbidity coding was often quite poor, but this seems to be a much reduced problem – recent SHMI data set reports depth of coding as 6.4 against a national average of 6.1.
    c. *Primary diagnosis coding* – there are three potential issues here that we recognise. Firstly, there is the question of whether coders accurately translate

the record into codes. Our best evidence (recent MIAA report) suggests that coding is of good standard. Secondly, there is a question as to whether diagnoses are accurately reflected in the clinical record. Work has been done previously to try to prompt diagnosis, rather than symptom coding, and our current symptom code (R-code) rate is 11.9% (national average 14.5%), so while there may be work to do, there is little evidence that this is a fundamental problem. Finally, mortality coding is based on the first in-patient finished consultant episode, which may well be a factor as our AMU turnover is very high. It means occult diagnoses may not be made until a later FCE (for example metastatic malignancy).

Quality of care

24. The most fundamental question raised by our elevated mortality ratios is whether they reflect underlying problems in the quality of care.
25. The graphs below summarise an analysis of the SHMI data set for March 2024-February 2025. The first graph shows diagnostic groups in which there are more than 30 expected deaths. Other cancers is a composite, but other groups are diagnostic baskets within SHMI. It shows the groups contributing most towards our observed deaths are pneumonia, septicaemia, 'invalid diagnosis', acute cerebrovascular disease, cancer, heart failure and COPD.



26. The single largest contributor to excess ('observed' less 'expected') deaths in this dataset remains the 'invalid primary diagnosis' which mostly represents the uncoded cases.
27. Pneumonia as a diagnosis shows itself as the single largest real contributor to excess deaths, with COPD, congestive heart failure and stroke behind. These groups also account for a large proportion of the observed deaths, along with septicaemia (where the observed deaths are actually fewer than expected).
28. The Trust conducts an audit of care for pneumonia based on the AQ audits, although we no longer have routine access to comparative data. The results are shown in the table below.

Trend Graph	Month	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	Denominator	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)
		%	%	%	%	%	%	%	%	%	%	%
Oxygen saturations within 1 hour of arrival		100	100	100	100	100	100	100	100	100	100	100
CXR performed within 4 hours of arrival		64	72	60	58	36	40	50	69.39	66	54	72
CURB 65 documented by the post take ward round.		100	100	100	100	92	100	100	100	100	100	100
Antibiotics given within 4 hours of arrival.		92	78	70	60	44	58	62	72	72	60	68
Composite process Score		**89**	**87.5**	**67.5**	**79.5**	**68**	**74.5**	**78**	**85.43**	**84.5**	**78.5**	**85**
Appropriate Care Score		**56**	**50**	**48**	**36**	**22**	**30**	**30**	**46**	**52**	**40**	**48**

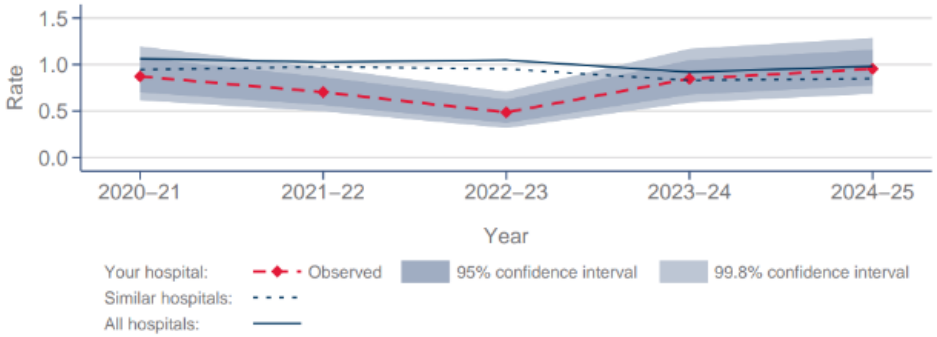
29. Comparative data from AQ trusts for the period to May 2025 shows the following mean scores, suggesting that ELHT is performing at an above average level for these initial care measures, except for CXR performed within 4 hours, where we fall marginally below average.

Oxygen assessment	Chest x-ray	Initial antibiotics	CURB-65	Appropriate Care Score (perfect care)	Composite Process Score
99.4%	**73.2%**	**58.5%**	**64.1%**	**40.9%**	**76.5%**

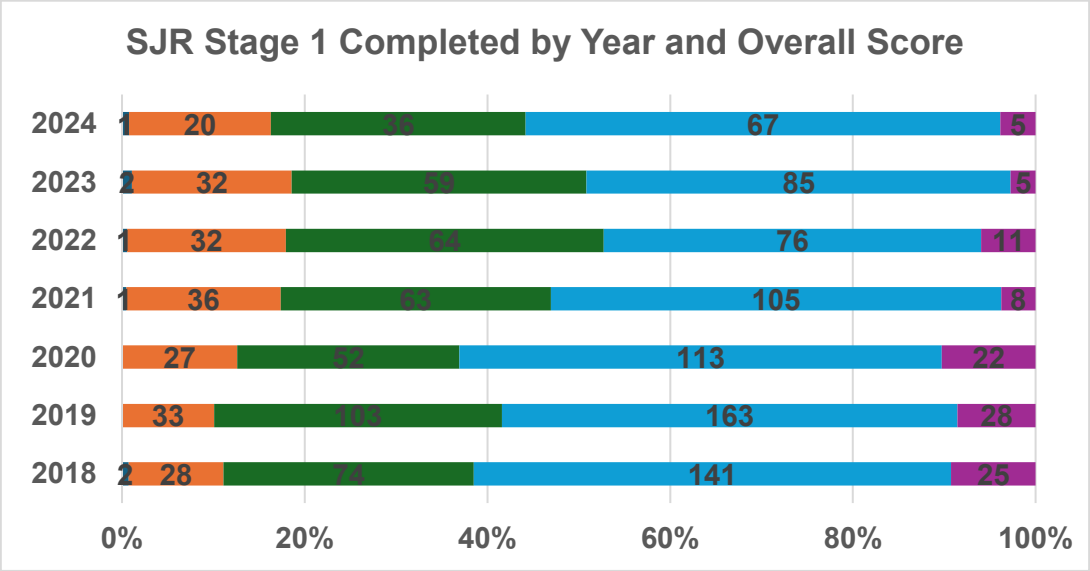
30. Similar AQ like data exists for sepsis, included in the table below, and again providing assurance of the front-door elements of care.

Trend Graph	Month	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	Denominator	(n=38)	(n=27)	(n=22)	(n=17)	(n=23)	(n=21)	(n=21)	(n=20)	(n=21)	(n=15)	(n=16)
		%	%	%	%	%	%	%	%	%	%	%
Early warning Score within 60 mins.		100	100	95.45	100	100	90.48	100	95	100	100	100
Oxygen Commenced within 60 mins.		100	100	100	100	100	100	100	100	100	100	100
Blood Cultures Obtained within 60 mins.		81.58	81.48	100	76.47	78.26	76.19	71.43	80	80.95	60	81.25
Broad spectrum antibiotics given within 60 mins. (High Risk)		86.11	96.15	93.75	94.12	90	94.44	94.74	90	100	92.86	93.33
IV Fluids Commenced within 60 mins. (High Risk)		80.56	92.31	72.22	88.24	80	77.78	84.21	75	64.71	78.57	60
Initial Lactate Obtained within 60 mins.		86.84	55.56	50	88.24	95.65	90.48	85.71	85	90.48	80	75
Fluid balance commenced where Sepsis was diagnosed		97.37	100	95.45	100	95.65	90.48	95.24	100	100	100	100
Composite process Score		89.58	88.3	83.97	91.74	90.71	87.6	89.31	88	90.55	86.60%	86
Appropriate Care Score		57.89	48.15	31.82	58.82	56.52	47.62	61.9	65	57.14	40	43.75

31. The Trust contributes also to the rolling national COPD audit, the National Heart failure audit and the SSNAP audit for stroke, which provide assurance again relating to care of these conditions.
32. Audits will tend to look at particular markers of care relating to the presenting condition, however there may be other factors that become relevant. Without doubt, one of these is that the identified conditions are frequently markers for generalised frailty – i.e. they occur in those with other chronic conditions, illustrated by the fact that whilst 48% of patients coded with pneumonia who die do so within the first week, 32% die after two weeks or more in hospital.
33. Another source of assurance is the National Cardiac Arrest audit, which shows the rate of cardiac arrests per 1000 admissions to fall within an expected range.



34. Additional assurance of our care is provided by analysis of our Learning from Death reviews using the Structured Judgement Review methodology. Most cases are found to have adequate or better care, as illustrated on the graph. In 2024 of the 129 SJRs, only one found the care was very poor, and twenty that the care was poor..
35. The most frequent themes arising from these reviews are known challenges, which are being addressed. They include ED delays, response to deterioration, out of hours medical cover at peripheral sites, end of life care and the use of Millennium.



Summary

36. In summary, ELHT currently has standardised mortality indicators which are above or close to being above the expected levels. This paper has reviewed the reasons for this situation, which can broadly be grouped into three
    a. **Data Quality issues since 2023** – the period around and following the introduction of EPR lead to specific data quality issues
        i. Failure to submit coded data – this issue has now been resolved, although require ongoing monitoring and assurance of timeliness of coding.
        ii. Removal of SDEC data from the relevant data set – this is still a significant issue.
    b. **Other 'data' concerns** – ELHT has historically had slightly higher than expected mortality ratios, some of the explanation for which is likely related to
        i. Assumptions within models – for example the decision to exclude deprivation in SHMI, or the use of palliative care coding, historically low at ELHT, to risk stratify.
        ii. Suboptimal primary diagnosis coding and comorbidity coding – these are closely monitored, and assurance is noted in this paper that these are unlikely to be major contributors.
    c. **Quality of care assurance** - Whilst we have demonstrated that data quality issues have resulted in a greater than expect mortality ratio, the possibility of real care deficiencies should always be considered. This paper has provided assurance from care audits for pneumonia and sepsis and noted the monitoring of other clinical effectiveness data which is able to provide a level of assurance in this regard.
37. The substantial increase in SHMI since 2023, is due to data quality issues since that time are likely to have had the primary impact.
38. The failure to ensure a consistent and timely transition of the same day care submission of all hospitals has created substantial discontinuity and distortion of the model. This means that the Trust cannot rely on standardised mortality ratios to provide assurance of care quality.

Assurance processes

39. Mortality is monitored at the monthly Mortality Steering Group, which takes place on the first Wednesday of the month, except for August and January. A monthly mortality

report is provided by the data team, which is also summarised monthly in the IPR. An annual report is provided to Quality Committee and board.

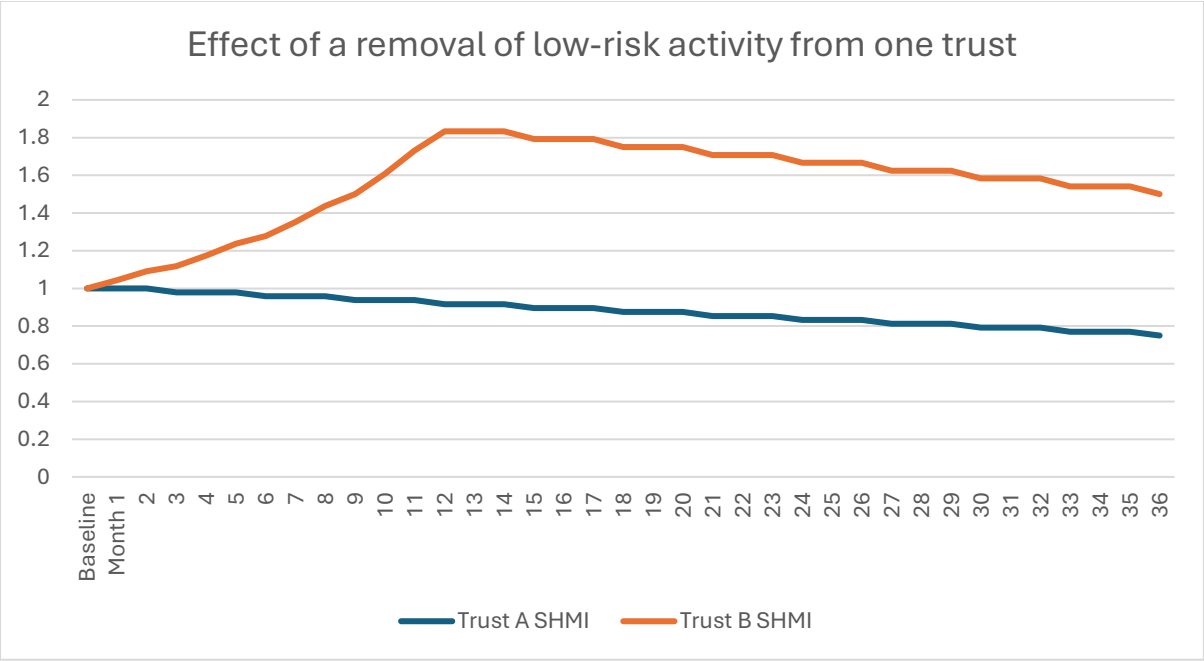
Actions

40. The SHMI has been improving as the uncoded data issue has been resolved. In principle, July 2025 represented a further deadline for all Trusts to start excluding SDEC data from their datasets, and if this is adhered to then Trust SHMI may further improve as the underlying model is updated. This will take 12 months to impact.
41. The Quality Committee therefore considered further actions that will be taken, and these will be monitored by Mortality Steering Group with updates provided to the Quality Committee.
42. The actions relating to data quality: -
    a. Explore the restoration of SDEC data to our submitted data – in the event that the July 2025 deadline is not met, then the Trust will look at restoring its own SDEC data to the submitted dataset in order to achieve a comparable figure.
    b. Review current data submission – the Trust will review its data submission to identify any other explanations for our reduction in recorded spells since 2019.
    c. Continue to optimise other data – the Trust will continue audit and review of comorbidity coding, and specific attention to the new HSMR+ models inclusion of frailty will be undertaken.
43. The actions relating to care quality -
    a. Increase compliance with care bundles– Whilst performance on sepsis and pneumonia care bundles is comparable or better than peers, performance could still be improved. In addition, consideration will be given to other opportunities to optimise care for these conditions.
    b. Review, strengthen and improve audit and outcome for other conditions with apparent excess mortality – other conditions such as cerebrovascular disease, COPD and heart failure are audited, but these areas will be re-examined to optimise care.
    c. HELD collaborative – the Trust has initiated a collaborative on Holistic End of Life Decision-making (HELD). It is vitally important that medical futility is recognised, and where hospital care is likely to be of no value, patients should be supported within the community. If a hospital admission can be avoided as a routine part of death then this is both better for the individual and also improves mortality indices.

d. Improve the care of deteriorating patients – the Deteriorating Patient Steering Group is implementing an action plan to improve inpatient recognition and management of deterioration. This will build on the successful implementation of Call for Concern (Martha's rule) and the role of the Acute Care Team.
e. Optimise the clinical use of Millennium – optimisation of the efficiency and safety aspects of the Millennium EPR is continuing.

Appendix A – Model of SHMI

The graph below is a simplified model of the impact on a standardised mortality ratio of one hospital within the cohort removing a proportion of low-risk activity from its submission whilst the other does not.



In this model two identical trusts have 1000 patients and 100 deaths. At month 1, Trust B removes its low-risk patients (SDEC) and reports 500 patients with 100 deaths. Model rebases quarterly and uses preceding 3 years data as model.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 SEPTEMBER 2025	**Agenda Item:**	TB/2025/120
Report Title:	Patient Safety Incident Response Assurance Report		
Author:	Lewis Wilkinson, Incident and Policy Manager Jacquetta Hardacre, Assistant Director of Patient Safety and Effectiveness		
Lead Director:	Mr J Hobbs, Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	X			X
Executive Summary:	The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.			
Key Issues/Areas of Concern:	New Never Event – retained foreign object declared to ICB and CQC in July, investigation completed presented at PSIRI on 20th August 2025, it was discussed that the incident did not meet the Never event criteria and for ICB to consider standing down, trust awaiting ICB decision.			
Action Required by the Committee:	None			

Previously Considered by:	Quality Committee
Date:	27 August 2025
Outcome:	Excepted – no actions

Patient Safety Incident Response Framework Report

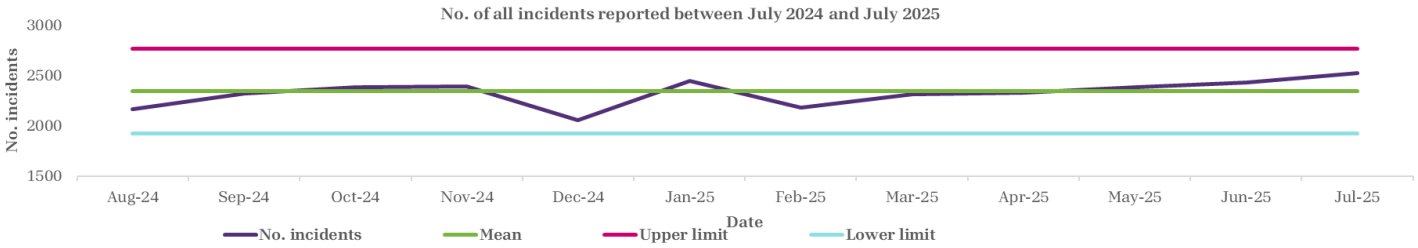
Reporting period		June 2025-July 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group and discussed at the Trust Wide Quality Governance Part B meeting in July 2025.
1a.	**Alert**	There has been one breach of the Trusts Duty of Candour Policy in SAS in July 2025. The breach was due to a delay in delivering verbal duty of candour and has highlighted an issue in Opthamology where Cerner is not used, and any DoC conversations are not documented, so it is not possible to evidence conversation has occurred. • The importance of delivering DoC has been reinforced with Opthamology, a process put in place to ensure any DoC conversations are recorded within. • Issues have been raised by patients/families stating DOC has not been completed even when recorded on DATIX and in Patient Records as completed. This was raised and discussed at TWQG Part B with several concerns being raised regarding process and understanding of DoC. • A review of the current processes/systems being carried out to identify any gaps and to look at developing improvements. Update / feedback of review will be provided to TWQG Part B in September. New Never Event has been declared to ICB and CQC in July which was related to a retained foreign object of a distal segment (end broke off) of a curved osteotome, used within surgery for a mandibular sagittal split identified on post op x-ray. • DOC completed with patient and a copy of the final report will be shared with patient. • A PSII Round Table review has been completed, report and safety improvement plan presented at PSIRI on 20th August 2025 where it was discussed that this incident did not meet the Never Event criteria and for ICB to consider standing down. (awaiting final updated report before discussion is made). • Incident reported to MHRA and manufacturer for investigation, trust awaiting outcome of this investigation.
1b.	**Advise**	The proportion of moderate physical harms remains in line with the average number reported in 2024/25 (1.42%), however is significantly under the proportion of moderate harms that are reported nationally (4.84%). On average reported severe harms remain under the levels reported in 2024/25, and as with moderate remains is significantly different from the national rates. This may be indicative of a misapplication of the harm guidance and so incidents are graded with the incorrect harm. However, it should also be noted that currently the national data is unvalidated with many trusts reporting data quality issues. • The Incident and Policy Team are completing a review of harm levels in September and October against National harm level descriptions. • New Incident Handlers training (1.5hr via Teams) developed and available for staff to book though the Education Hub. • Conversation to take place with DERI regarding Quality and Safety (including Incident reporting) needs to form part of the Trust Staff Induction.

1c.	**Assure**	In May 2025, the Incidents and Policy Manager and the Medicines Safety Officer, started to review all medication incidents together daily. This has allowed an easier identification of themes and trends in relation to medication incidents and an awareness of improvement work to address the issues. It also enables the information to be highlighted within Patient Safety and Governance processes. The daily medication incidents review process is also enabling more accurate recording of patient harms and appropriate learning responses to be identified as being able to review the incidents with the correct expertise makes these decisions easier. We are now looking to expand to this process with other specialities

1. Incident Reporting

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

Figure 1: Incidents reported over last 12 months.



1.2 **4905** reported incidents were triaged within 2 working days of being reported in **June and July 2025**, which equates to **98.89%** of all incidents reported within this period.

1.3 At the end of **July 2025** there were **957** incidents awaiting final approval. Of these **293** cannot be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews. This left **644** incidents awaiting final approval that could potentially be closed.

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

1.5 On average reported severe harms remain under the levels reported in 2024/25, and as with moderate remains is significantly different from the national rates. (appendix A)

1.6 Six fatal incidents were reported in June and July 2025:

1.6.1 One related to the management of a patient by Primary Care whilst the patient was at Albion Mill. Further information is being sought from Primary Care via the ICB. There were no concerns in relation to the care from ELHT.

1.6.2 One related to the management of a patient's diabetes.

1.6.3 One related to a potential delay in the neurological review of a patient.

1.6.4 One related to delays in a patient's treatment due to issues when transferring between specialities.

1.6.5 One involved the death of a patient whilst in police custody.

1.6.6 One was a notification of a child death for the Child Death Overview Panel and has since been changed to no harm. Incident raised as required for reporting purposes.

1.7 The first Never Event for 2025/2026 (April to March) was declared to ICB and CQC in July which was related to a retained foreign object of a distal segment (end broke off) of a curved osteotome, used within surgery for a mandibular sagittal split identified on post op x-ray

1.7.1 DOC completed with patient and a copy of the final report will be shared with patient.

1.7.2 A PSII Round Table review has been completed with all staff involved, report and safety improvement plan presented at PSIRI on 20th August 2025 where it was discussed that this incident did not meet the Never Event criteria and for ICB to consider standing down. (awaiting final updated report before discussion is made and agreed).

1.7.3 Incident reported to MHRA and manufacturer for investigation, trust awaiting outcome of this investigation.

1.8 In May 2025, the Incidents and Policy Manager and the Medicines Safety Officer, started to review all medication incidents together daily, this has allowed an easier identification of themes and trends in relation to medication incidents and an awareness of improvement work to address the issues. It also enables the information to be highlighted within Patient Safety and Governance processes. Below are some of the recent themes that have been identified.

- Errors when clerking in patients resulting in incorrect medications prescriptions, resulting in patients being administered the wrong medications, delayed doses, and missed doses.
    - A focus group is being set up to explore the prescribing issues, to understand why they are occurring and how it can be improved.
- Storage of controlled medications, cupboards not being locked, logs not being completed to state what's in cupboards, missing controlled drugs from patient lockers, and controlled drugs being left by patients' bedsides and not stored correctly.
    - The controlled drug incident report has recently been submitted to Medicines Safety and Optimisation Committee (MSOC) which

highlights the issues and is being shared with the Divisional Nursing Directors, it will be requested that safety improvement plans are produced for each area to address the issue. The safety improvement plans will then be overseen by MSOC.

- There has been a theme of delayed doses of medication due to Medicines Finder application not being utilised by wards to locate medications when they run out of stock out of hours.
    - The cause of this has been explored and it was highlighted that the Medicines Finder was not easy to find in the Trust intranet. The link has now been moved to the front page of the intranet and the issue now appears to have been resolved; the effectiveness of this will continue to be monitored via the indent reports when reviewed in the daily medication's incidents review.

1.9 The daily medication incidents review process is enabling more accurate recording of patient harms and appropriate learning responses to be identified, due to the incidents being reviewed with speciality expertise which makes these decisions easier. Patient Safety are now looking to expand this process with other specialities, starting in September 2025 the Incidents and Policies Manager will start a monthly review with the Medical Devices Safety Officer to look at all Medical Devices Incidents, and is also in the process of arranging a monthly review with the Research Quality and Governance Manager.

2. Duty of Candour

2.1 There has been **1** breach, of the Trusts Duty of Candour Policy in **July 2025** in SAS where verbal duty of candour was not completed until after the 10-working day trust deadline.

3. Safety Incident Responses (IR2s)

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

3.2 Overall, the number of IR2s completed within 30 calendar days by handlers within the divisions has generally improved, with some slight decreases from individual divisions. The number of IR2s open more the 30 calendar days has also decreased.

4. Patient Safety Responses (PSR)

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

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

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

5.1 In **June and July 2025**, the Complex Case meeting reviewed **7** new incidents and reported **6** incidents that meet the PSIRF Priorities and require either a PSII or MNSI investigation, the PSIIs have been allocated to lead investigators within the Patient Safety Team.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of **July 2025**, the Trust had **17** open PSII incidents of which **8** were being investigated by MNSI.

5.3 At the end of **July 2025** there was **1** PSII which had been open longer than 6 months and **0** MNSI reports. The overdue PSII report has been reviewed and approved by PSIRI in August 2025.

5.4 In **June** and **July 2025**, **8** PSII reports were approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **June** and **July 2025, 16** reports were reviewed, of these there were **7** were new PSII reports. See appendix E for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **July 2025**, the Trust achieved **96%** Level 1a, **92%** Level 1b and **94%** Level 2 for National Patient Safety Training There is a National recommendation that all NHS staff should complete at least Level 1a Patient Safety Training, the Trust took the decision to include level 1b and level 2 as well for appropriate clinical staff and senior managers and set a KPI target of 95% for all 3 levels.

7.2 Since the introduction of the new Education Hub, it is possible to breakdown the overall Trust compliance figures by divisions, and these have been included within each division's patient safety KPI dashboard.

7.2.1 Corporate Services (not including DERI, Quality Governance or Estates & Facilities) is showing the lowest compliance of 87% for Level 1b, which is required for all Senior Managers 8a and above to complete.

7.3 Table 1: Patient Safety Syllabus Training (as of end of **July 2025**)

National Patient Safety Training	Target	Aug 24	Sept 24	Oct 24	Nov 24	Dec24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Level 1a	95%	94.10%	94.30%	94.90%	94.80%	95.20%	95.40%	95.60%	95.80%	96.20%	Unable to obtain	96.00%	96.00%
Level 1b		84.70%	85.10%	85.90%	85.60%	86.00%	87.30%	87.90%	89.60%	90.00%	Unable to obtain	91.00%	92.00%
Level 2		90.90%	91.10%	92.10%	92.00%	92.10%	92.70%	92.90%	93.30%	93.60%	Unable to obtain	95.00%	94.00%

8 Trust Wide Policies and SOPs

8.1 At the end of **July 2025**, there were **6 (96.75%)** Trust wide SOPs out of **152** overdue their review date, and **27 (91.03%)** out of **299** policies overdue their review date.

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

8.3 Pharmacy has significantly reduced the number of overdue policies and SOPs that they had overdue.

8.4 HR have the highest number of Polices overdue; however, this has reduced and they continue to work to reduce the number further.

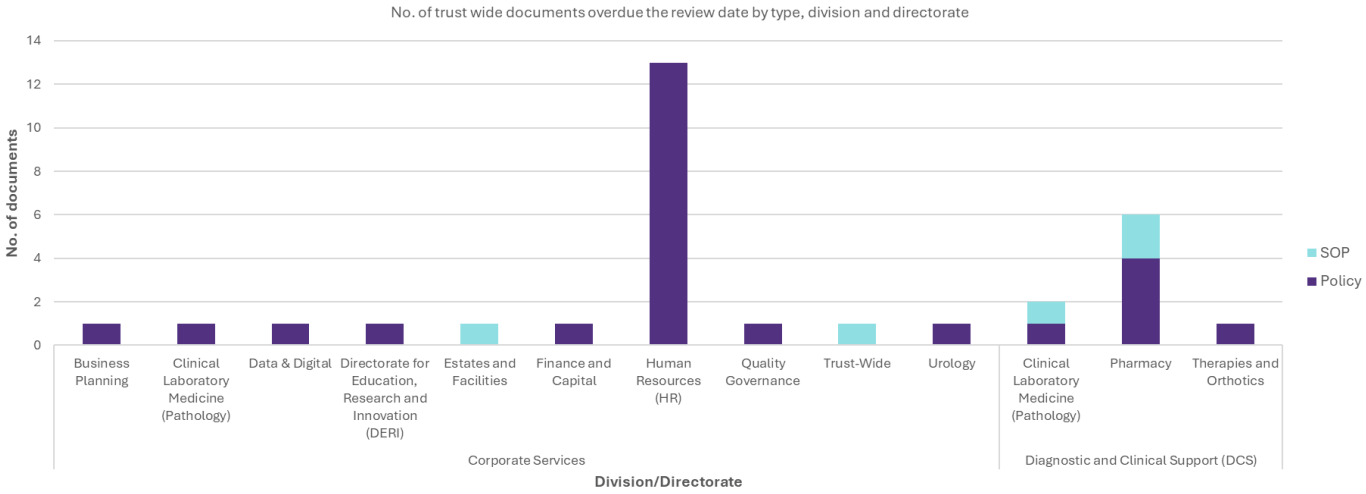


Table 2: Trust wide polices and SOPs within review date:

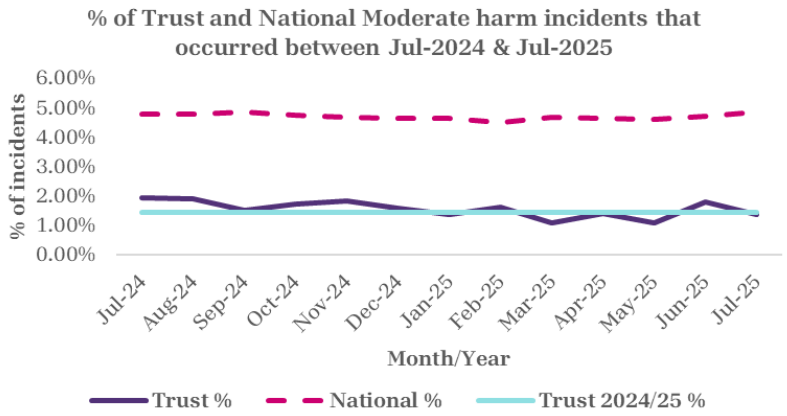
Policies / SOPs	Target	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Trend
Trust wide Policies	90%	88.70%	93.20%	94.56%	95.56%	95.58%	94.28%	94.30%	90.91%	88.14%	86.96%	91.69%	91.03%	
Trust wide SOPs		86.90%	100%	98.63%	100%	97.92%	94.44%	90.21%	88.03%	85.14%	86.18%	92.21%	96.75%	

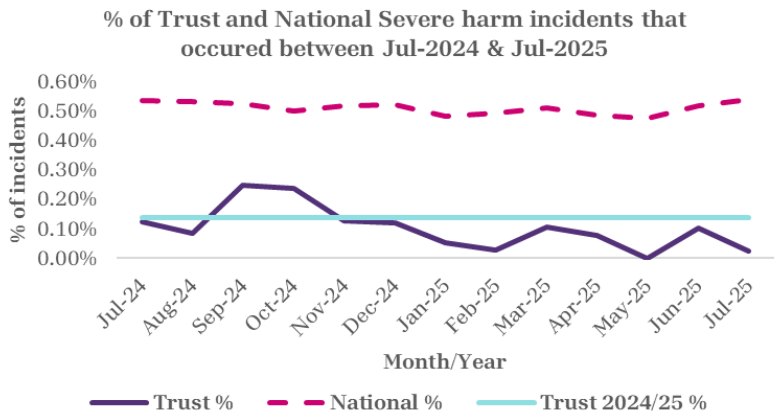
9 Maternity specific serious incident reporting in line with Ockenden recommendations

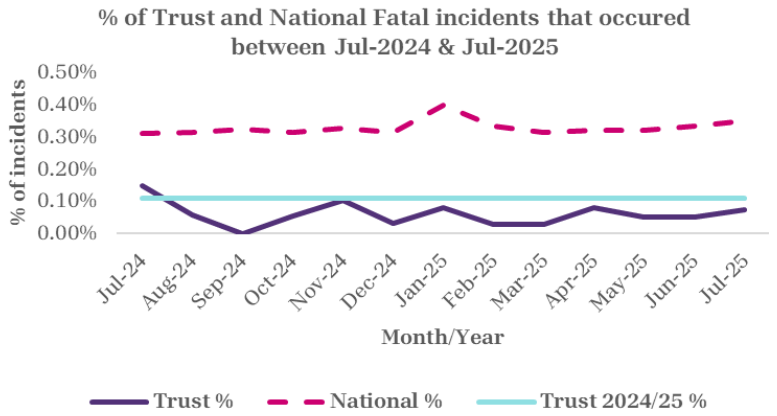
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **81** maternity related incidents have been reported on StEIS of which:

- **51** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **5** have had closure on StEIS requested
- **7** are currently being investigated by MNSI
- **1** has been reviewed at PSIRI and is awaiting amendments prior to approval.
- **2** are currently under investigation by the Trust.

Appendix A: ELHT Incidents by Moderate harm and above







Appendix B: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Trend
CIC	Total IR2 reported	471	375	398	444	405	405	524	423	403	484	462	417	
	(total number investigated) % complete within 30 calendar days	(424) 90.02%	(316) 84.27%	(344) 86.43%	(388) 87.39%	(373) 92.10%	(356) 87.90%	(479) 91.41%	(387) 91.49%	(362) 89.83%	(458) 94.63%	(423) 91.56%	(386) 92.57%	
DCS	Total IR2 reported	149	125	116	164	189	118	103	97	100	91	110	120	
	(total number investigated) % complete within 30 calendar days	(103) 69.13%	(77) 61.60%	(82) 70.69%	(124) 75.61%	(154) 81.48%	(85) 72.03%	(69) 66.99%	(61) 62.89%	(78) 78.00%	(71) 78.02%	(85) 77.27%	(103) 85.83%	
FC	Total IR2 reported	272	232	259	235	268	210	245	259	227	245	254	332	
	(total number investigated) % complete within 30 calendar days	(198) 72.79%	(169) 72.84%	(228) 88.03%	(179) 76.17%	(224) 83.58%	(187) 89.05%	(224) 91.43%	(212) 81.85%	(177) 77.97%	(212) 86.53%	(211) 83.07%	(283) 85.24%	
MEC	Total IR2 reported	936	849	945	936	921	778	908	815	962	903	956	930	
	(total number investigated) % complete within 30 calendar days	(804) 85.90%	(694) 81.74%	(768) 81.27%	(758) 80.98%	(707) 76.76%	(495) 63.62%	(730) 80.40%	(630) 77.30%	(752) 78.17%	(679) 75.19%	(751) 78.56%	(725) 77.96%	
SAS	Total IR2 reported	393	346	347	341	357	326	372	314	377	344	335	343	
	(total number investigated) % complete within 30 calendar days	(315) 80.15%	(304) 87.86%	(312) 89.91%	(298) 87.39%	(310) 86.83%	(248) 76.07%	(313) 84.14%	(253) 80.57%	(282) 74.80%	(260) 75.58%	(286) 85.37%	(281) 81.92%	
Corp	Total IR2 reported	82	52	67	74	76	32	66	43	39	42	52	46	
	(total number investigated) % complete within 30 calendar days	(45) 54.88%	(24) 46.15%	(35) 52.24%	(30) 40.54%	(22) 28.95%	(20) 62.50%	(41) 62.12%	(24) 55.81%	(18) 46.15%	(20) 47.62%	(28) 53.85%	(24) 52.17%	
Trust Total	Total IR2 reported	**2303**	**1979**	**2132**	**2194**	**2216**	**1869**	**2218**	**1951**	**2108**	**2109**	**2169**	**2188**	
	(total number investigated) % complete within 30 calendar days	**(1889) 82.02%**	**(1584) 80.04%**	**(1769) 82.97%**	**(1777) 80.99%**	**(1790) 80.78%**	**(1391) 74.72%**	**(1856) 83.68%**	**(1567) 80.32%**	**(1669) 79.17%**	**(1700) 80.61%**	**(1784) 82.25%**	**(1802) 82.36%**	

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Trend >90
CIC	No. open	56	51	52	72	83	52	49	38	38	34	50	70	
	No. open more than 90 calendar days	2	1	3	5	5	2	4	2	2	3	1	0	
DCS	No. open	14	24	12	13	9	9	10	6	6	7	9	9	
	No. open more than 90 calendar days	1	2	0	0	0	0	0	1	1	1	2	2	
FC	No. open	54	37	39	39	38	45	44	19	53	48	37	54	
	No. open more than 90 calendar days	14	7	6	4	5	5	3	2	3	6	6	11	
MEC	No. open	96	93	60	61	71	82	80	66	73	71	88	76	
	No. open more than 90 calendar days	27	32	13	7	9	15	19	15	15	12	16	14	
SAS	No. open	34	37	35	41	28	48	34	27	17	14	31	36	
	No. open more than 90 calendar days	12	10	5	6	7	7	7	6	6	2	1	2	
Trust	No. open	**254**	**242**	**198**	**226**	**232**	**236**	**217**	**188**	**187**	**174**	**215**	**245**	
	No. open more than 90 calendar days	**56**	**52**	**27**	**22**	**26**	**29**	**33**	**26**	**27**	**24**	**26**	**29**	

Appendix D: KPI Dashboards for PSIIs

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

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

The two Never Events presented at PSIRI these were reported in December 2024 and Jan 2025.

During **June 2025 six** new PSII reports were presented at the Trusts PSIRI panel**.**

- Incident resulting in death (eIR1301876) – The report was approved with some amendments to add a safety recommendation and requires the submission of an action plan. Below is a summary of safety recommendations identified in the report:
    - The Trust to clearly differentiate and provide examples when completing enhanced care assessments, the differences between falls with and without harm, and the differences between at risk and at significant risk of falls, to remove ambiguity and variability in the completion of the assessments.
    - The Radiology department to consider a trust wide system and process, to ensure referrers urgently communicate with Radiology any inpatient CT head scan referrals for suspected brain injury following a head injury.

- Never Event (misplace NG tube) (eIR1304184) – The report was not approved with some amendments to be to the wording and some further clarity added to one of the recommendations. Below is a summary of safety recommendations identified in the report:
    - All staff on the Paediatric Wards to be reminded that nothing is passed via an NG tube until it has been confirmed that it is positioned correctly. It is recommended this done via the Safety Huddles, Induction Training, Study Days and any other appropriate communication routes.
    - Update the induction training sessions to ensure that it is explicit that nothing is to be passed via an NG tube until it has been confirmed that it is positioned correctly.
    - Ensure that staff receive a regular reminder via Study Days that nothing is to be passed via an NG tube until it has been confirmed that it is positioned correctly.
    - Empower staff to undertake respectful challenge when they observe unsafe practice taking place, and to report this timely and appropriately.
    - Include on Induction Training and Study Days, what is a Never Event and what is a Patient Safety Incident, and how these should be reported.

- Incident resulting in death (eIR1302251) – The report was approved with some minor amendments to be made. Below is a summary of safety recommendations identified in the report:
    - The Surgery and Anaesthetics division to consider the development of a formalised process for the on-call teams to define roles and responsibilities, provide clarity about the escalation process and to provide guidance on thresholds for in person senior reviews of patients.
    - The Emergency Department to consider reviewing the resuscitation area step down process to incorporate a holistic review of patients ensuring that any necessary tests are undertaken to inform the decision-making process.
    - The Emergency Department to implement a process to monitor adherence to the resuscitation area step down process. Improvement actions to be developed and implemented as a result of monitoring.

- Never Event (retained foreign object) (eIR1300698) – The report was approved with some minor amendments to be made but requires submission of the action plan. Below is a summary of safety recommendations identified in the report:
    - The Trust to remind Divisions to ensure they communicate in the relevant forums - including the Trust-wide patient safety group with the relevant directorate forums - about any cross-divisional policy changes.
    - The Surgery and Anaesthetic Services Division - following discussion with the Family Care Division - to consider review of the SOP in view of any agreed safety recommendations and/or findings of this report.
    - The Trust – via Clinical Effectiveness group – to review the Trust's post-partum haemorrhage guidance and current purple wristband SOP alongside the new regional maternity guidelines.
    - Family Care Division to ask clinicians to use the surgical intervention function on BadgerNet when documenting about intentionally retained packs/swabs.

- Incident resulting in death (eIR1302220) – The report was approved with some minor amendments to be made but requires submission of the action plan. Below is a summary of safety recommendations identified in the report:
    - The Medicine and Emergency Care Division to review the process for managing a ward without a substantive multidisciplinary team. To ensure improved senior oversight of patient care, continuity of working practices that follow usual ward processes and provides clear routes of escalation and support for staff.

- Each baby counts (eIR1295036) – This investigation was undertaken by MNSI; the report was approved. Below is a summary of safety recommendations identified in the report:
    - It is recommended that the Trust review the processes and training that exist so that clinicians are equipped with the information and skillset to perform intermittent auscultation in line with local and national guidance.
    - It is recommended that the Trust review the processes and training that exist so that clinicians are equipped with the information and skillset to perform maternal observations in line with local and national guidance.

Five reports that were previously reviewed by the panel were returned for approval, all were approved, however two required the resubmission of the action plan.

During **July 2025 one** new PSII reports were presented at the Trusts PSIRI panel, one meeting was stood down in July 2025 due to capacity issues affecting quoracy**.**

- Incident resulting in death (eIR1304220) – The report was approved with no amendments required. Below is a summary of safety recommendations identified in the report:
    - The Trust to clearly differentiate and provide examples when completing enhanced care assessments, the differences between falls with and without harm, and the differences between at risk and at significant risk of falls, to remove ambiguity and variability in the completion of the assessments.
    - The Radiology department to consider a trust wide system and process, to ensure referrers urgently communicate with Radiology any inpatient CT head scan referrals for suspected brain injury following a head injury.

Four reports that were previously reviewed by the panel were returned for approval, one was not approved and required resubmission with an updated action plan, two were approved, and one was approved with amendments.

Appendix F: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Corporate Services			
Business planning	C151	Fuel Disruption Plan	30/06/2025
Clinical Laboratory Medicine (Pathology)	IC15	Admission and Transfer of Suspected and/or Confirmed Infected Patients	31/07/2025
Data & Digital	C155	Policy for prevention of duplicate electronic patient records (including merging and unmerging of records	31/07/2025
DERI	C029	Safer Handling	30/05/2025
Estates and Facilities	SOP147	Requesting Additional Security Staff	30/05/2025
Finance and Capital	F06	Appropriate Use of Charitable Funds Policy	31/07/2025
Human Resources (HR)	C086	Assistance Dog Policy	31/07/2025
	C099	Clinical Attachment Policy	31/03/2025
	HR07	Early Resolution Policy	31/03/2025
	HR11	Supporting Staff with Disabilities Policy	28/02/2025
	HR15	Facilities and Time Off for Recognised Representatives of Trade Unions and Staff Organisations	30/05/2025
	HR31	Alcohol, Drugs and Substance Misuse	30/08/2024
	HR43	Managing Organisational Change Policy & Procedure	30/05/2025
	HR50	Adoption and Adoption Support (Paternity) Pay and Leave Regulations	30/05/2025
	HR51	Guidelines for Consultant Job Planning	31/03/2025
	HR58	Policy on the Development of Professional Roles	31/12/2024
	HR65	Compensatory Rest for Doctors (non resident on call)	30/04/2025
	HR68	Undertaking Private Practice	30/04/2025
	HR77	Uniform / Dress code	30/05/2025
Quality Governance	C157	Chaperones Accompanying Patients During an Intimate Procedure / Treatment	30/04/2024
Trust Wide	SOP085	Risk Stratifying Process for Follow Up Patients	30/04/2025
Urology	CP34	Assessment and management of urinary and faecal incontinence in adults (in-patients)	31/03/2025

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/121
Report Title:	Maternity and Neonatal Services Update		
Author:	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) collectively informed by Perinatal Transformation Team & Perinatal quadrumvirate team.		
Lead Director:	Peter Murphy, Executive Director of Nursing. Board Level Maternity/Neonatal Safety Champion.		

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

Previously Considered by:	
Date:	
Outcome:	

1. CNST – MATERNITY INCENTIVE SCHEME

1.1 Summary overview

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● We are within required periods for all metrics for deaths of babies from December 2024 as per guidance. ● **New Clarification:** MIS have confirmed that the new metric regarding 50% of PMRT meetings should have external representation is inclusive only of babies who died from April 2025.
2. Maternity Services Data Set (MSDS)		● July will be the reporting month for this Safety Action. Compliance will be evidenced at November Trust Board. ● The scorecard currently shows May 2025 data which has passed both data quality checks required.
3. Transitional Care (TC)		● Annual Transitional care (TC) audit will be submitted to January 2026 Trust Board. ● The Jaundice readmissions Quality improvement project now live following test of change currently being monitored as the response for this Safety Action due to be presented to the Safety Champions on the 2nd of October 2025.
4. Clinical Workforce		● **Identified risk** - The Neonatal Nursing Workforce action / improvement plan to be revised in year 7 period to close with evidence of year 5/6 improvements. The annual Neonatal workforce paper will demonstrate workforce analysis v activity including qualified in speciality (QIS) trained nurse and re-evaluate if compliance is at risk <70%. Confirmation of if this remains at risk following the annual review with be brought to November Trust Board, the action plan will be revised if the risk remains. ● **New Clarification**: the Neonatal Medical Workforce is now compliant with BAPM standards for tiers 1, 2 and 3. To be formally noted in Trust Board minutes.
5. Midwifery Workforce		● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. Submission of all required data is underway to be completed by September. ● **Identified risk** - Current funded midwifery establishment does not reflect Birthrate + findings and recommendations. Plan/mitigations reflected in biannual midwifery staffing reports trust board for year 6.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 93% overall implementation following the LMNS assurance visit in June 2025. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7. User Feedback		● **Potential Risk -** New asks within the CNST Y7 guidance for MNVP require enhanced meeting attendance and attendance at engagement sessions in community. MNVP lead has raised capacity issues as a barrier to these asks at August Floor to Board meeting with Safety Champions. Transformation Lead

		has requested clarity on the meeting ask in the guidance from LMNS to confirm if attendance at Perinatal Governance Board meets requirements. Meeting chaired by DDMN took place on the 29th of August with MNVP lead, Healthwatch and LMNS to discuss barriers and direct support as required with a collatable approach to review the evidence to meet the requirements of SA7 and the deliverables of the MNVP work plan
8. Training		● No changes to guidance for Safety Action 8 in CNST Year 7. Compliance will continue to be monitored to ensure 90% targets are met by submission date on 30th of November 2025. ● **Identified risk** – Neonatal medical team NLS compliance is currently 80%. This is being managed by the Neonatal lead consultant who anticipates no barriers to reaching 100% within the period - fail/ safe adopted
9. Board Assurance		● An update on progress with the Culture Improvement Plan will be brought to September Trust Board. Culture coach session feedback has been reviewed for themes as discussed by the quadrumvirate on the 13th of August 2025. ● Triangulation of claims, incidents, and complaints will now be monitored at Floor to Board meetings, with progress updates to be brought to Trust Board.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarterly MNSI report will be submitted to Trust Board in September. ● Year 7 guidance requires that MNSI information be provided to patients in a format that is accessible to them. Any exceptions to this are to be reported to Trust Board.

1.2 Key updates and exceptions per Safety Action

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

1. The Perinatal Mortality Review Tool (PMRT) dashboard below demonstrates that all metrics are currently on track for CNST Year 7. [Correct at the time of authoring this report – 18/08/2025]

   Please note the metric 'Number of PMRT meetings with external member present' is a new ask within the guidance for the Year 7 and as such the 50% compliance will be monitored for deaths of babies from April 2025 onwards only. The PMRT meetings for these deaths are due to take place from September 2025 onwards.

CNST - PMRT

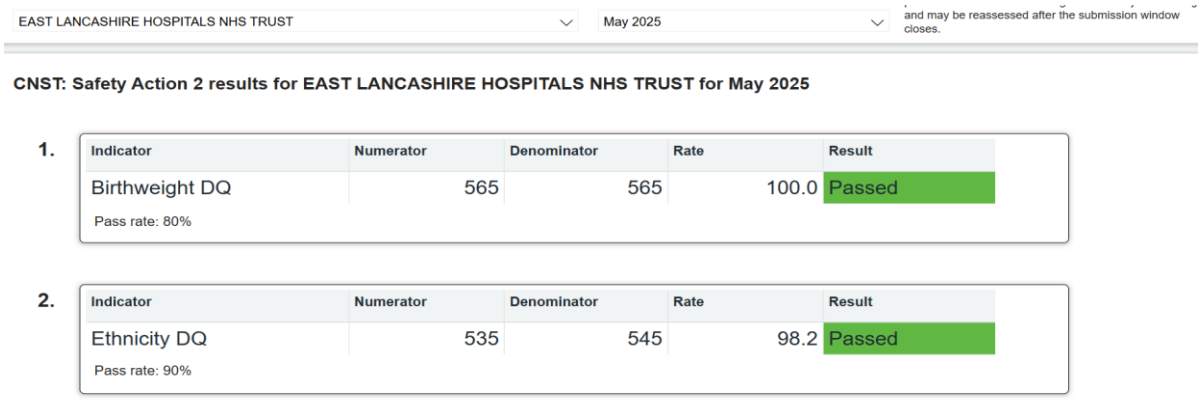
(All measures reported against month of death)

* = Data not relevant for month
n/a = Data not available at time of report

		Reporting Measure	Threshold	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Monthly Trend
SAFETY ACTION 1	PMRT01	Total Number of Stillbirths (= 24 weeks)		2	3	1	4	3	1	1	1	
	PMRT01b	Number of Neonatal Deaths		1	2	0	0	1	0	0	0	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		1	0	0	1	0	0	0	0	
		Total Eligible Cases		4	5	1	5	4	1	1	1	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		4	5	1	5	4	1	1	1	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT06a	c) i Number PMRT tool started 2 months		4	5	1	5	4	1	n/a	n/a	
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*	*	
	PMRT05a	c) ii Number PMRT published reports by 6 months		4	5	1	0	0	0	0	0	
			75%	100.0%	100.0%	100.0%	*	*	*	*	*	
	PMRT05c	Number PMRT published reports not due		0	0	0	5	4	1	1	1	
	PMRT05d	Number PMRT with External Member Present *monitored from Apr-25 deaths onward		n/a	2	0	1	0	0	0	0	
			50%	n/a	40.0%	0.0%	20.0%	*	*	*	*	

2. The PMRT Q1 report is included as per Appendix 1, this has been shared with the Maternity and Neonatal Safety Champions.

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


EAST LANCASHIRE HOSPITALS NHS TRUST

May 2025

and may be reassessed after the submission window closes.

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

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	565	565	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	535	545	98.2	Passed

Pass rate: 90%

3. The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics publication series, as above, publishes each month and is used to evidence compliance with the data quality measures required for this safety action. The Scorecard provides data with a 3-month delay; the current update demonstrates May 2025 compliance.

4. July 2025 is the month submitted into MIS Year 7 evidence to evidence compliance for this reporting year. July results will be brought to Trust Board in November.

1.2.3 Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

5. The service has now moved towards an annual TC audit, meaning that the next audit covering the MIS Year 7 reporting period will be submitted to Trust Board in January 2026.

6. The service is conducting a quality improvement (QI) to reduce jaundice readmissions, indicated through local data as a key theme for postnatal readmission. Progress updates will be provided to the Maternity and Neonatal Safety Champions at Floor to Board on the 2nd of October 2025 and will be included in this Trust Board report and the LMNS Quality Assurance Panel reporting in November 2025.

1.2.4 Safety action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard?

7. The MIS Year 7 guidance sets out criteria for employing long and short-term locums. Audits of compliance will cover February to August 2025 as per technical guidance requirements and will be submitted to the November Trust Board.

8. Updated MIS Year 7 guidance requires that the quarterly consultant attendance audit be replaced by one audit covering any 3-month period in the reporting year. A quarter 1 audit will be completed and submitted to November Trust Board. Any exceptions will be discussed prior at Perinatal Governance Board and Floor to Board.

9. Evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day has been provided in the form of a duty anaesthetist one month rota, as in MIS Year 6. We are compliant with this ask.

10. Neonatal services ask that full compliance with the British Association of Perinatal Medicine (BAPM) national standards of staffing are met as demonstrated in the report provided by the Neonatal Clinical Director, appendix 2.

11. As the service is required to demonstrate compliance with BAPM standards for neonatal nursing staffing, an updated version of the action plan as submitted in previous CNST years 5/6 will be submitted to November Trust Board. A report evidencing compliance with BAPM standards for the neonatal medical workforce will also be submitted to November Trust Board.

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

12. The bi-annual midwifery staffing report [Appendix 3] details the conclusion of the Birthrate + improvement case and reflects amendments to include maternity triage specific staffing requirements, this also includes the WTE junior clinical fellows (JCFs) for ease. Following the revised July 2023 submission of the improvement case presented as a standing item at ELHT July 2025 trust board followed by finance & performance committee.

13. ELHT midwifery staffing funded establishment with the application of professional judgment as reflected in the biannual paper (direct ask of CNST SA5) is compliant with the outcomes of the Clinical posts of – 7.50 deficit with a 6.80 specialists 2022 Birthrate+ calculations.

Midwifery staffing oversight reports to cover the remaining CNST requirements are provided as part of the monthly reports presented at trust wide quality governance A and Quality committee were planned versus actual staffing levels and red flags with rationale and mitigation to cover shortfalls is reviewed. Maternity and Neonatology services manage their safe nurse staffing levels daily via the birth rate plus acuity app, (Maternity) Northwest connect tool based on BAPHAM requirements (Neonatology) to inform the joint safety huddles and be reflected in the daily staffing templates to reflect any redeployment, safe skill mix and risk assessments to mitigate shortfalls. All templates are available on SharePoint

The midwife to birth ratios remains static 1 :26/27, 100% compliance with supernumerary labour ward co-ordinator & the provision of 121 care in labour at 100% compliance.

14. The Birthrate+ exercise was completed in 2022 and must be repeated every 3 years as per MIS requirements, meaning this is due for renewal in 2025. Relevant meetings have taken place with Birthrate+ colleagues to initiate the 2025 reassessment; data analysis is underway with a timeline for the final midwifery workforce report to be completed in October 2025.

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

15. A quarterly review of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 19th of June 2025. Compliance increased to 64/70 interventions implemented overall, which equates to 93%. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	9/10 interventions implemented and evidenced **(90%)**
Element 2 - Fetal Growth Restriction	19/20 interventions implemented and evidenced **(95%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective Fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

16. Review meetings have been scheduled throughout the CNST Y7 reporting period as follows:
    a) 23rd September 2025 (Quarter 1)
    b) 4th November 2025 (Quarter 2)
    c) 13th January 2026 (Quarter 3, sign off)

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

17. *Evidence of an action plan coproduced following joint review of the annual Care Quality Commission (CQC) Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.*

    The CQC action plan is ongoing as monitored via the Perinatal Patient Experience and Lessons Learned Group. Key themes have been identified through joint review; further local feedback requirements have been discussed with the MNVP who is conducting engagement sessions based on these themes. This deep dive into local feedback will further inform meaningful actions.

    Progress with the coproduced action plan has been shared with the Maternity and Neonatal Safety Champions at the August Floor to Board meeting, this is due to be shared to the LMNS in September.

18. Further requirements of this safety action must be evidenced via MNVP Lead attendance at several business and governance meetings, and by MNVP engagement with local community groups prioritising hearing from those experiencing the worst outcomes. ELHT MNVP Lead has raised concerns with capacity to fulfil all required tasks, some of which are additional to those of previous CNST reporting years. This has been acknowledged through the Floor to Board meeting with Safety Champions as a potential risk to compliance for this safety action.

    A meeting is arranged for the 29th of August with the Divisional Director of Midwifery and Nursing, Healthwatch Project Lead, LMNS Programme Manager, Transformation Lead and MNVP Leads to discuss these barriers, support required to achieve compliance and to agree next step in relation to CNST reporting.

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

19. *Fetal monitoring and surveillance (in the antenatal and intrapartum period) training*: *90% attendance required for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota.* All relevant staff groups are currently over 90%.

20. *Maternity emergencies and multi-professional training (PROMPT): 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants*. All relevant staff groups are currently over 90%.

21. *Neonatal basic life support (NLS): 90% attendance required for neonatal consultants, junior doctors (who attend any births unsupervised), neonatal nurses (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives.* All relevant staff groups are currently over 90% aside from the neonatal medical team which has improved to 80% compliance. This is being monitored by the Neonatal Consultant Training Lead who reports no barriers with reaching full compliance by November.

1.2.9 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

22. Safety Champions are continuing to meet with the perinatal leadership team at a minimum of bi-monthly at Floor to Board meetings. The last meeting took place on the 7th of August 2025. Minutes attached as appendix 4.

23. The Safety Champions discussed the letter received from Jim Mackey and Duncan Burton (23 June 2025) relating to the upcoming National Investigation into Maternity and Neonatal Services [appendix 5]. The 5 key recommendations of this letter are as below, it is recognised that these align to the current Maternity and Neonatal 3 Year Delivery Plan themes as demonstrated and updates/ response will be visible through the bi-monthly Floor to Board Quality Committee report which is formatted to reflect progress against the 3-year delivery plan themes.

    - **Be rigorous in tackling poor behaviour where it exists. Where there are examples of poo**r
      team cultures and behaviours these need addressing without delay.

    Aligns to Theme 3: A culture of safety, learning and support.

    - **Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up,**

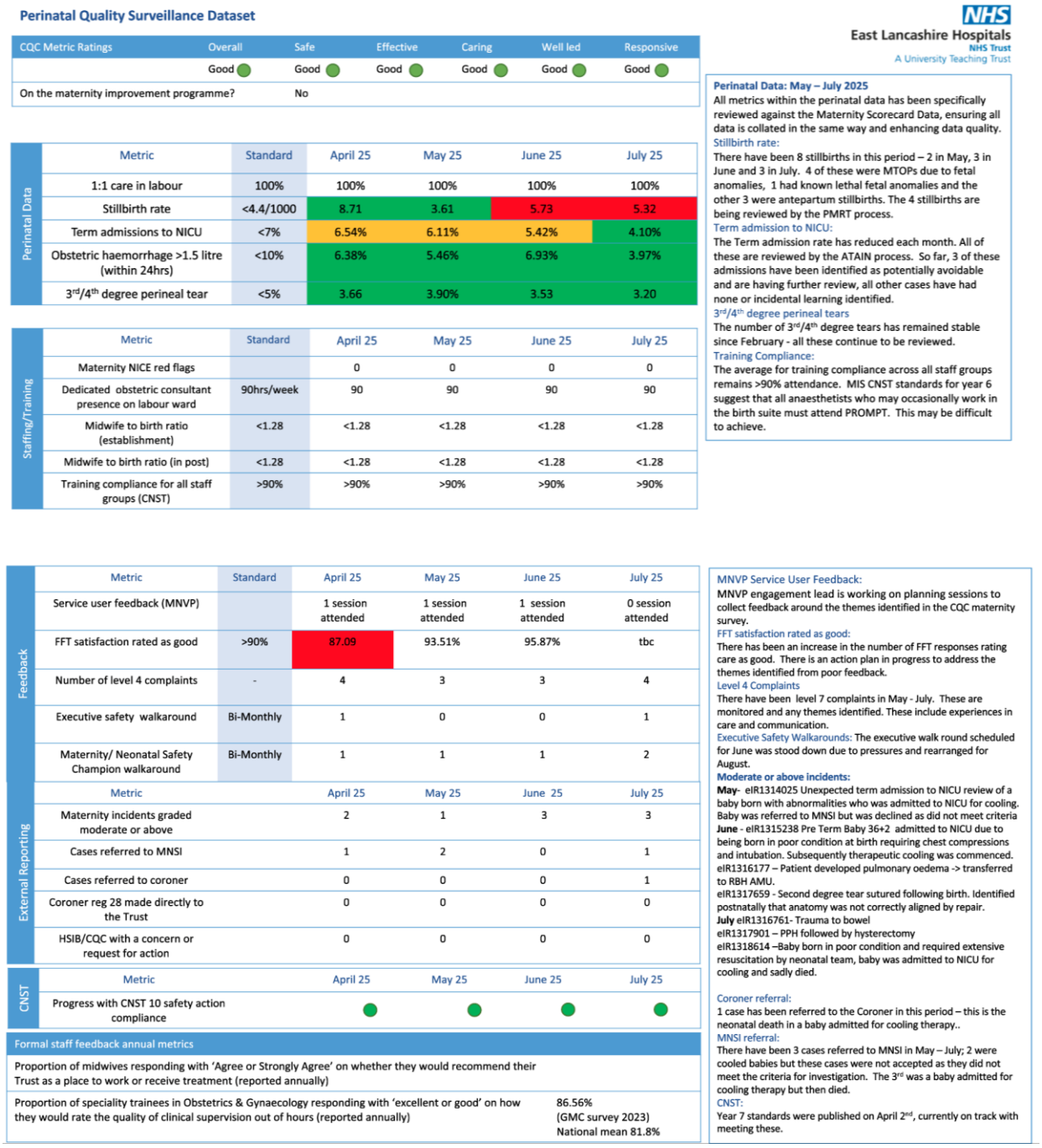
learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
Aligns to Theme 1: Listening to Women and Families & Theme 3: A culture of safety, learning and support.

- **Ensure you are setting the right culture: supporting, listening, and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.**
Aligns to Theme 3: A culture of safety, learning and support.

- **Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience, and delivering improvements to both.**
Align to Theme 4: Standards and structures to underpin safe, personal, effective care.

- **Retain a laser focus on tackling inequalities, discrimination, and racism within your services, including tracking, addressing variation, and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.**
Aligns to Theme 1 Listening to Women and Families (Continuity of Care), Theme 2 Growing, retaining and supporting our workforce (anti-racism) and Theme 3 A culture of safety and learning.

24. Perinatal Quality Surveillance Model (PQSM) Minimum Data Set August 2025 data:



Perinatal Quality Surveillance Dataset

NHS East Lancashire Hospitals NHS Trust — A University Teaching Trust

CQC Metric Ratings	Overall	Safe	Effective	Caring	Well led	Responsive
	Good	Good	Good	Good	Good	Good
On the maternity improvement programme?		No				

Perinatal Data

Metric	Standard	April 25	May 25	June 25	July 25
1:1 care in labour	100%	100%	100%	100%	100%
Stillbirth rate	<4.4/1000	8.71	3.61	5.73	5.32
Term admissions to NICU	<7%	6.54%	6.11%	5.42%	4.10%
Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	6.38%	5.46%	6.93%	3.97%
3rd/4th degree perineal tear	<5%	3.66	3.90%	3.53	3.20

Staffing/Training

Metric	Standard	April 25	May 25	June 25	July 25
Maternity NICE red flags		0	0	0	0
Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
Midwife to birth ratio (establishment)	<1.28	<1.28	<1.28	<1.28	<1.28
Midwife to birth ratio (in post)	<1.28	<1.28	<1.28	<1.28	<1.28
Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

Perinatal Data: May – July 2025

All metrics within the perinatal data has been specifically reviewed against the Maternity Scorecard Data, ensuring all data is collated in the same way and enhancing data quality.

Stillbirth rate:
There have been 8 stillbirths in this period – 2 in May, 3 in June and 3 in July. 4 of these were MTOPs due to fetal anomalies, 1 had known lethal fetal anomalies and the other 3 were antepartum stillbirths. The 4 stillbirths are being reviewed by the PMRT process.

Term admission to NICU:
The Term admission rate has reduced each month. All of these are reviewed by the ATAIN process. So far, 3 of these admissions have been identified as potentially avoidable and are having further review, all other cases have had none or incidental learning identified.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears has remained stable since February - all these continue to be reviewed.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance. MIS CNST standards for year 6 suggest that all anaesthetists who may occasionally work in the birth suite must attend PROMPT. This may be difficult to achieve.

Feedback

Metric	Standard	April 25	May 25	June 25	July 25
Service user feedback (MNVP)		1 session attended	1 session attended	1 session attended	0 session attended
FFT satisfaction rated as good	>90%	87.09	93.51%	95.87%	tbc
Number of level 4 complaints	-	4	3	3	4
Executive safety walkaround	Bi-Monthly	1	0	0	1
Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	1	1	1	2

External Reporting

Metric	April 25	May 25	June 25	July 25
Maternity incidents graded moderate or above	2	1	3	3
Cases referred to MNSI	1	2	0	1
Cases referred to coroner	0	0	0	1
Coroner reg 28 made directly to the Trust	0	0	0	0
HSIB/CQC with a concern or request for action	0	0	0	0

CNST

Metric	April 25	May 25	June 25	July 25
Progress with CNST 10 safety action compliance	●	●	●	●

Formal staff feedback annual metrics	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	86.56% (GMC survey 2023) National mean 81.8%

MNVP Service User Feedback:
MNVP engagement lead is working on planning sessions to collect feedback around the themes identified in the CQC maternity survey.

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

Level 4 Complaints
There have been level 7 complaints in May - July. These are monitored and any themes identified. These include experiences in care and communication.

Executive Safety Walkarounds: The executive walk round scheduled for June was stood down due to pressures and rearranged for August.

Moderate or above incidents:
May- eIR1314025 Unexpected term admission to NICU review of a baby born with abnormalities who was admitted to NICU for cooling. Baby was referred to MNSI but was declined as did not meet criteria
June - eIR1315238 Pre Term Baby 36+2 admitted to NICU due to being born in poor condition at birth requiring chest compressions and intubation. Subsequently therapeutic cooling was commenced.
eIR1316177 – Patient developed pulmonary oedema -> transferred to RBH AMU.
eIR1317659 - Second degree tear sutured following birth. Identified postnatally that anatomy was not correctly aligned by repair.
July eIR1316761- Trauma to bowel
eIR1317901 – PPH followed by hysterectomy
eIR1318614 –Baby born in poor condition and required extensive resuscitation by neonatal team, baby was admitted to NICU for cooling and sadly died.

Coroner referral:
1 case has been referred to the Coroner in this period – this is the neonatal death in a baby admitted for cooling therapy..

MNSI referral:
There have been 3 cases referred to MNSI in May – July; 2 were cooled babies but these cases were not accepted as they did not meet the criteria for investigation. The 3rd was a baby admitted for cooling therapy but then died.

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

25. Progress with the Maternity and Neonatal culture improvement plan continues as monitored by the Perinatal Quadrumvirate. All scheduled culture coach sessions have now taken place across the services, the feedback has been reviewed to identify initial themes, and these have been discussed in the August quadrumvirate meeting. The transformation team are

triangulating these themes with feedback received through other routes such as walk rounds, ongoing improvement work to ascertain if completion of ongoing work would have the intended positive impact required to address the themes. The leadership team are conscious of the higher levels of burnout reported in the SCORE culture survey results and are therefore consolidating time and resource into existing improvement work to ensure this can progress in a timely manner and reach it intended outcome prior to further work being commenced. The thematic analysis with this phase two of culture feedback will be presented at November trust board to include the improvement plan deliverables and completion for phase 1 (2023 /24).

1.2.10 Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

26. The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/MNSI cases reported and accepted or rejected. The rationale and further detail are also included within the data set for assurance and/or discussion where required.

27. A detailed overview of cases within the reporting period to present are provided in the quarterly reports produced by the Quality and Safety Lead. The quarter 1 report is submitted as per appendix 6.

2. MATERNITY AND NEONATAL PERFORMANCE DATA – EXCEPTIONS AND IMPROVEMENT PRACTICE

28. The Family Care Divisional Analyst has developed performance data in the Statistical Process Control (SPC) chart format (**Appendix 7**). These charts will be aligned with the perinatal quality assurance dashboard as part of Safety action 9. Divisional process currently in place to review at the monthly Perinatal Dashboard meetings to identify any exceptions and themes, to then be reported into Bimonthly Perinatal Governance Board for oversight, monitoring, and assurance. The current state is under review to streamline the process further; themes and trends will be identified prior to the meeting with the initial understanding for the clinicians with the specialist knowledge relevant to the identified metric to manage any identified improvements. If the trend is not a result of expected or understood variation bespoke sessions will be scheduled with the relevant directorate team.
29. The Transformation Team will then schedule to undertake any improvement work identified, as necessary. This process ensures QI projects are data informed, and clinician time and resource is directed to priority pieces of work.

3. CONCLUSION

30. On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board serves to inform progress of the ten CNST maternity safety actions throughout the year 7 reporting period.
31. Any other matters of patient safety concerns will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas for wider discussions and escalation as and when required.

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing

Martin Maher, Clinical Director Obstetrics/Gynaecology

Rajasri Seethamraju, Clinical Director Neonatology

Charlotte Aspden, Directorate Manager of Maternity and Neonatology

September 2025

Appendix 1: Q1 PMRT Report

Quarterly PMRT report

Q1|April - June 2025

Title	**Family Care Division Quarterly PMRT Report (Apr-Jun 2025)**
Author	Helen Collier, Consultant Obstetrician & Perinatal Lead
Executive sponsor	Peter Murphy, Executive Director of Nursing & Midwifery
Summary	This report aims to enable the division to demonstrate actions taken in response to mortality within the division and to share learning from mortality reviews. This report is a mechanism for sharing improvements and changes in practice made as a result of investigations into mortality. The report enables the sharing of good practice across directorates and wider within the organisation where appropriate.
Recommendations	

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits, and improvements (safe, efficient, and sustainable care and services) and the organisation's corporate objectives Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe, and effective care through clinical pathways The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact (delete yes or no as appropriate and give reasons if yes)

Legal	Yes/~~No~~	Financial	Yes/~~No~~
Equality	Yes/~~No~~	Confidentiality	~~Yes~~/No

Appendix 2: Neonatal Medical Staffing BAPM Compliance

CNST Safety Action 4 – Neonatal Work Force

Neonatal Intensive Care Unit

All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.

This is well met in ELHT as the general paediatrics and neonatal units are based at separate sites and do not cross cover.

Tier 1

Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support

Tier 1 neonatal rota at LWNC Burnley has a good day time cover with at least 4-5 tier 1 doctors and all out of hour shifts after 5 pm, night shifts and weekends/ bank holidays have an FY2 and either an ANNP/ST1-2 trainee or Junior clinical fellow at ST1-2 level.

The rota template is maintained with 8 slots on the junior Tier 1 with Foundation doctors and 8 slots on the senior tier 1 with ANNP/JCF/ST1-2 trainees. In case of gaps, cover is managed internally with swaps/locums without changing the template.

Rota template attached for 4 months as appendix 1

Tier 2

EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift)

LWNC Burnley has around 2000 ITU days/year and there is an ST4-8 trainee or ANNP or Senior Clinical Fellow ST4-8 level on call all times.

The rota template is maintained such that there are 8 WTE staff covering on-calls at all times.

In case of gaps, cover is managed internally with swaps/locums without changing the template.

Rota template attached as appendix 2

Tier 3

Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist

LWNC NICU has 10 WTE consultant who provide 24/7 availability of a consultant neonatologist

NICUs undertaking more than 2500 IC days per annum should provide two consultant led teams during normal working hours.

Appendix 3: Bi-annual Staffing Report

Appendix 4: Floor to Board – Safety Champions Meeting Minutes - *due to the minutes containing patient identifiable information they have not been included in the Board papers*

Appendix 5: Letter received from Jim Mackey and Duncan Burton (23 June 2025) relating to the upcoming National Investigation into Maternity and Neonatal Services

Appendix 6: MNSI Report

Appendix 7: SPC Performance Report

Appendix 3: Trust Board Report (July 2025): Midwifery safe staffing- Joint ELHT/Local maternity and Neonatal system (LMNS) Round table Report following Birth Rate Plus (BR+) recommendations

Purpose

To describe ELHT current midwifery staffing position with how many midwives are required to provide safe optimal care. Reviewing September 2022 BR+ recommendations, given the changes in models of care over the last three years, the application of professional judgment to inform the recommendations is a key when agreeing on final midwifery staffing numbers. ELHT Trust board members are asked to review this midwifery workforce exercise with findings including the additional posts required to deliver safe clinical and specialist care. The asks of CNST, (Ten safety Actions) Ockenden, twenty-two immediate and essential actions and the deliverables as set out in maternity and Neonatal three-year delivery plan four themes have been considered.

This paper is an abridged version of the biannual midwifery staffing oversight reports submitted to ELHT trust board as part of CNST safety action 5 aligned to the ELHT improvement business case informed by the September 2022 BR+ assessment and recommendations.

-7.50 Wte clinical roles

-13.42 Wte specialist roles

-20.92 Variance

Total for Birth rate plus requirements = 296.34 including annual leave uplift of 24.24% required to cover mandatory training

This exercise is building on the previous improvement cases submitted to the board, including the 2023 and 2024 biannual BR + and professional judgment Midwifery Safe Staffing Reports.

As part of the review, the rationale for all midwifery posts, (both clinical and specialist) was explored in detail together with the national directives and recommendations.

Benchmarking against other services, considered, variations in service configuration and population needs mean that you are unable to make direct comparisons with other units. However, services that are of comparable size and acuity do have similar staffing ratios to total clinical and specialist midwifery workforce requirements this includes community services.

As part of the review, trusts need to ensure that the correct uplift for midwife training is within the establishments. Midwifery training requirements are also an ask of CNST safety action 8, thus Mandatory.

This following three bullet points reflects how the review is worked out with findings, supported with calculations reflected in table format.

- Clinical staffing (midwives who are “part of the numbers,” working within the wards, community, and departments These midwives form majority of the midwifery workforce. If there is a shortfall in this number, then clinical care is adversely affected. **(Table 1)**

- Specialist and manager time, once any clinical component of the job (where they are “part of the numbers”) has been deducted. These make up about on average between 10-12% of the midwifery workforce. **(Table 1)**

- Uplift. Uplift or headroom is used to describe staff absence. Midwives will be away from work for distinct reasons including annual leave, mandatory training, and sickness this needs to be accounted for when planning how many midwives are required to provide care. Any miscalculations would lead to a shortfall in midwifery staffing. We have used an uplift calculator to consider how many additional midwives are required to cover these elements. Training hours are based on Mandatory core competency requirements and essential to role and nonessential to role training**. (Table 2)**

Table 1

Actual midwives in post. PWR April 2025			
Clinical Midwives staff in post (SIP) clinical	240.76	(Includes 12.40 clinical contribution in specialist roles)	
Specialist /manager midwives (SIP)	29.51	This is actual midwives available to work and does not include maternity leave. When a midwife goes on maternity leave their post will be recruited.	
Total Midwives SIP	**282.27**		

Funded: Midwives required			
Funded midwives clinical	248.44	-7.50	
Funded midwives' specialist /managers	31.75	Funding for these posts is a mixture of baseline, 'business as usual' funding as well as NHS England -system development funding (SDF). Please note several SDF specialist posts are non-recurrently funded at present. (Reference *in post -Table 3)	
Total funded Midwives	**280.19**		
Recommended following round table review increasing uplift to 24.42% - 296.40			
Recommended Clinical Midwives	255.94	The clinical midwife number to consider the raised uplift with the configuration of ELHT estate.	
Recommended Midwives specialists /managers BR+	29.51		
Recommended With uplift	**285.45 296.40**	**- 10.95**	

Recommended uplift.

Recommended uplift allowance for ELHT. It is based on the clinical head count of midwives who all require 58 hours of training and therefore will not be available to do clinical work during this time.

Table 2

Midwives	total WTE	total head count	Annual leave (per WTE)	training hours required (per midwife per year)	number of bank holidays	sickness absence rate (%)	mat leave included and (%)	carers/ compassionate	A-EQUIP
WTE @27 days AL 0-5 years service	94.5	121	19136.25			note actual =	add only if part of uplift		
WTE @29 days AL 5-10 years service	110	144	23925						
WTE @33 days AL 10+ years of service	80	110	23388.75						
Total	284.5	375	66450.00	58	8	4.00%	0%	1.0%	0.50%
		Uplift Required	24.42%						

Findings

The recurrent funding required including following the joint round table review. Is reflected within ELHT improvement case. (* in post)

Table 3

Description / Details	Band	WTE
Band 6 Triage posts/ Maternity triage model / PNW coordinator/ CBS induction/C/section cover	Band 6	7.50
Maternity/Neonatal Staffing eroster Coordinator (In Post) SDF funded. (Non-recurrent) *	Band 4	1.00
Birth reflections coordinator (Pending advert- SDF funded. (Nonrecurrent)*	Band 4	1.00
Perinatal optimisation lead midwife – Ockenden requirement in post/ SDF funded/ non recurrent *	Band 7	1.00
Recruitment & Retention lead (In post SDF funding- Nonrecurrent*	Band 7	0.80
Deputy digital lead maternity/ Neonatology (Previous SDF funded) New post.	Band 6	1.00
Deputy Diabetes specialist/ Nurse/ Midwife – New post/Not funded* (pressure)	Band 6	1.00
Professional Midwifery Advocate - New post/ Not funded	Band 7	1.00

Conclusion

ELHT maternity services offer assurances of an additional safe staffing review with the application of external professional judgement opinion informed by the Associate Director – Maternity, Newborn, and Women's Health LSC/ ICB) considering birth rate plus recommendations.

This round table exercise as set out in the recommendations of the paper purposely excludes the revised costings for the ask of recurrent funding for additional clinical and specialist posts, non-recurrent specialist posts, and uplift requirements to full fill all Mandatory training requirements. The ELHT improvement case reflects all costings with details of the actual post which are non-recurrent, together with the two new posts required and uplift requirements of 24.24%.

Appendix 5: Letter from Jim Mackey and Duncan Burton on maternity and neonatal care - 23 June 2025

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

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

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

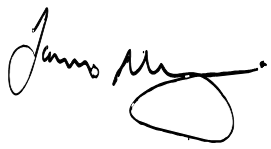
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

Appendix 6: CNST Year 7 SA 10 update /Aug 25

Name	Incident	MNSI consent	MNSI DOC letter sent	Accessible format requested	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard	Date ref. NHSR
MI037412	Intrapartum stillbirth	Yes	Yes		n/a	Yes	Yes	n/a	n/a	n/a
MI037539	Cooled baby	Yes	Yes		Yes	Yes	Yes	Yes	Yes M24CT645036	17.07.25 Delay in MNSI accepting case
MI037544	Cooled baby	Yes	Yes		Yes	Yes	Yes	Yes	Yes M24CT645/034	09.07.25
MI037527	Maternal death	Yes	Yes		N/A	Yes	Yes	n/a	n/a	n/a
MI038572	Cooled baby	Yes	Yes		Yes	Yes	Yes	Yes	temp number - 173236	26.10.24 Declined by NHSR
MI038665	Intrapartum Stillbirth	Yes	Yes		n/a	n/a	n/a	n/a	n/a	n/a
MI038734	Cooled Baby	No	Yes		Yes	No *MNSI informed of cooled baby but no consent from family	n/a	n/a	n/a	No consent
MI 038811	Intrapartum stillbirth	Yes	Yes		n/a	Yes	N/A	n/a	n/a	n/a
MI 039077	Intrapartum stillbirth	Yes	Yes		n/a	Yes	Yes	n/a	n/a	n/a
MI 039154	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039170	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039194	Cooled Baby	Yes	Yes		Yes	Yes	No -Normal MRI results, no family/ trust concerns	n/a	n/a	n/a
MI039263	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M24CT645/093.	17.02.25
MI040230	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/001	01.04.25 (delay as rejected on first referral and re referred)
MI039555	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M24CT645/094	5.3.25

Name	Incident	MNSI consent	MNSI DOC letter sent	Accessible format requested	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard	Date ref. NHSR
MI040242	Intrapartum stillbirth	Yes	Yes		n/a	Yes	Yes	n/a	n/a	n/a
MI 040824	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/005.	22.4.25
MI041660	Cooled Baby	Yes	Yes		Yes	Yes	Yes	Yes	M25CT645/011	19.5.25
MI041980	Cooled Baby	Yes	Yes	No	Yes	Yes	No – did not meet criteria	n/a	n/a	n/a
MI042700	Cooled Baby	Yes	Yes	No	Yes	Yes	No – Known fetal abnormalities	n/a	n/a	n/a
MI 044834	NND	Yes	Yes	No	Yes	Yes	Yes	n/a	n/a	n/a
MI 045009	Mat Death	No								

Appendix 7

Maternity Performance Report

Published: June 2025

How to read an SPC Chart

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

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

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

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

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:
- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Bookings & Antenatal

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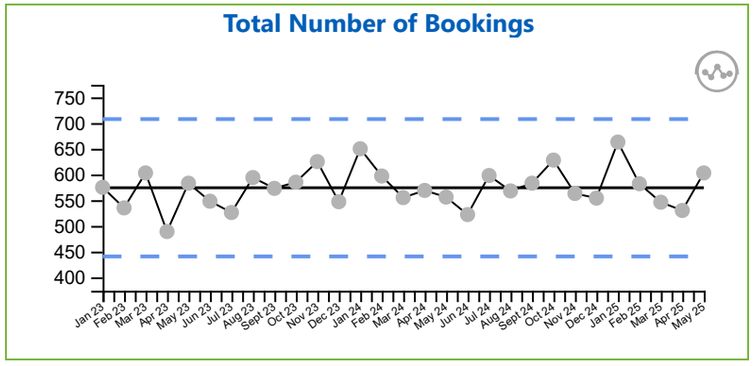

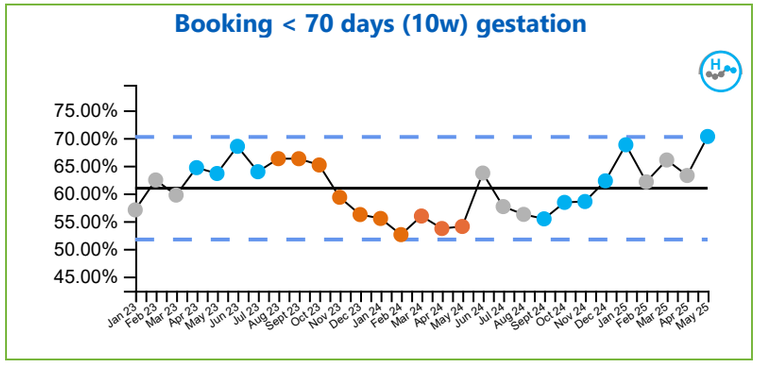

Deliveries

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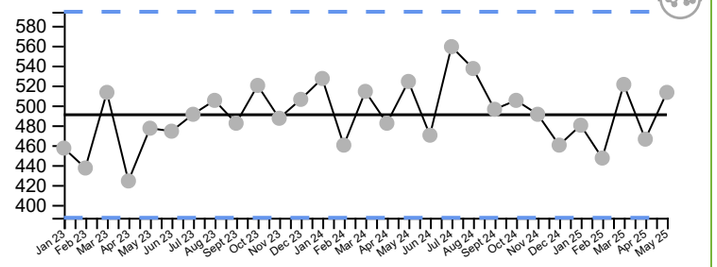
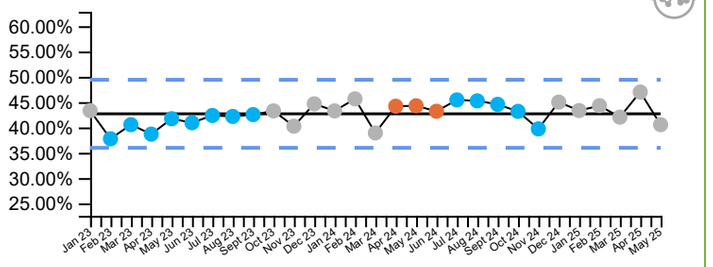
A University Teaching Trust

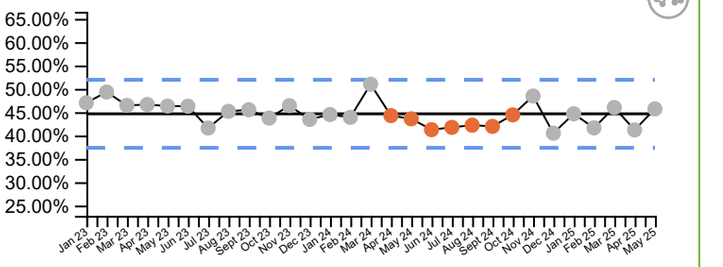
Number of Woman giving birth



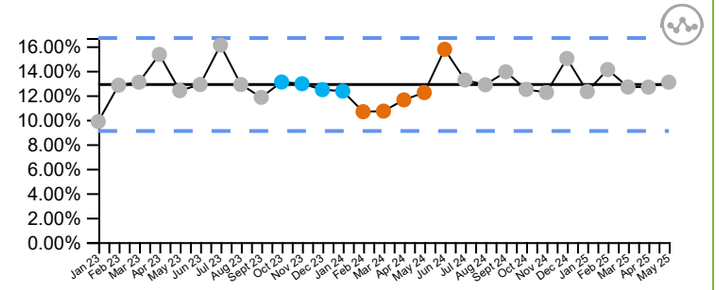
Total Number of Women experiencing a Caesarean Section



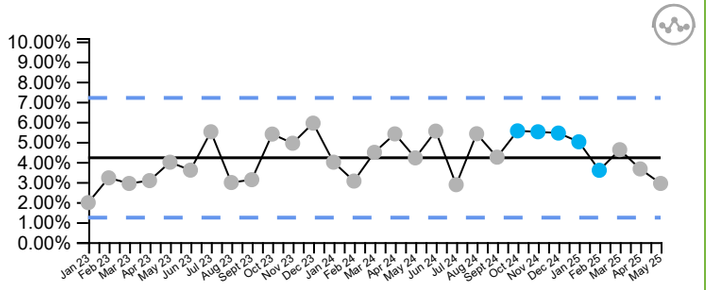
Spontaneous Delivery Rate



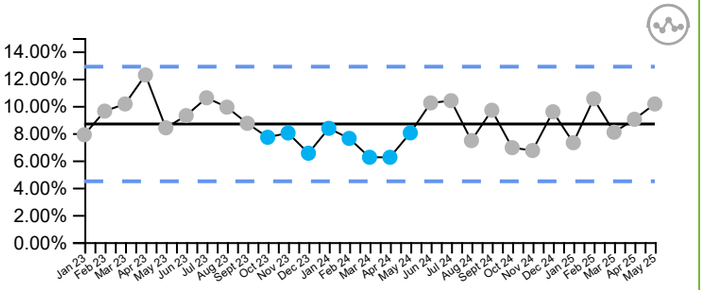
Number of Women Instrumental Births



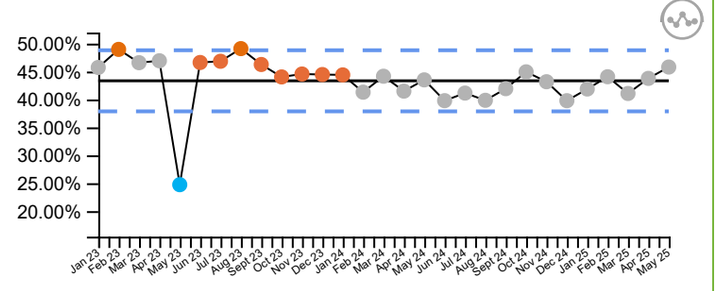
Number of Women Ventouse Births



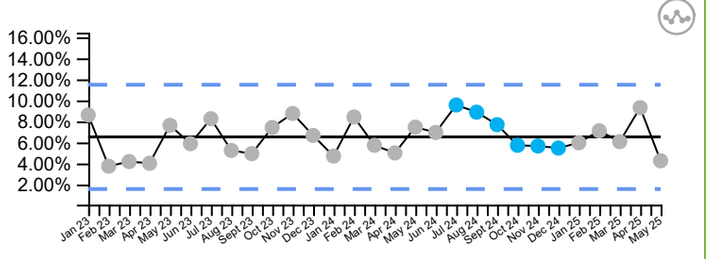
Number of Women Forceps Births



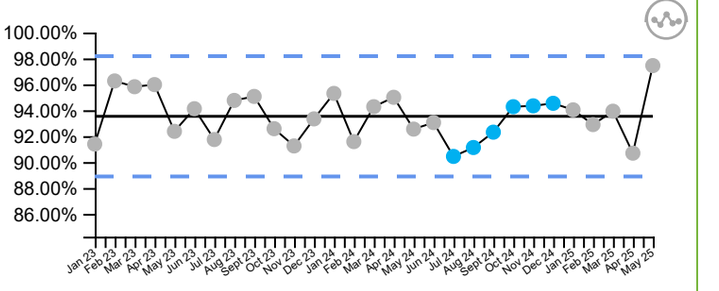
Total Number of Women Induced



Total Number of Women Unsuccessfully Induced requiring Caesarean Section



Total Number of Women Successfully Induced



Deliveries

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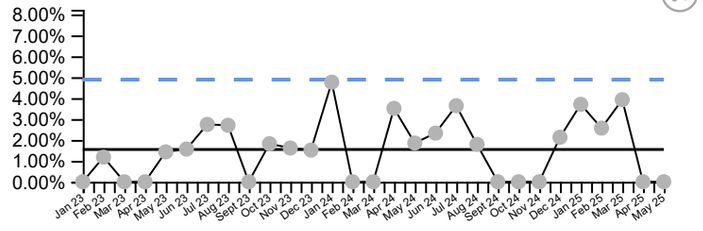
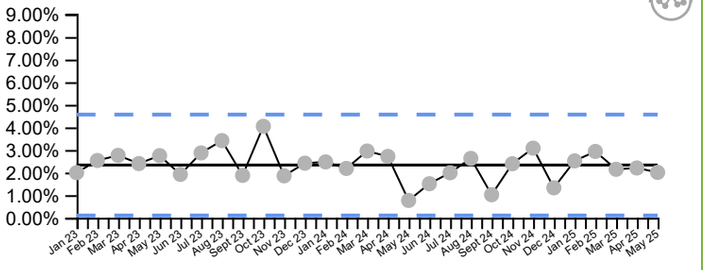
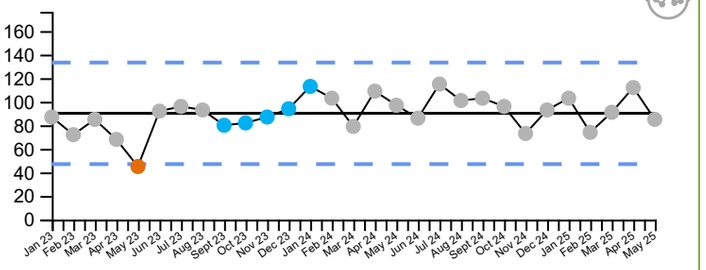
Women induced for reduced fetal movements <39 weeks gestation



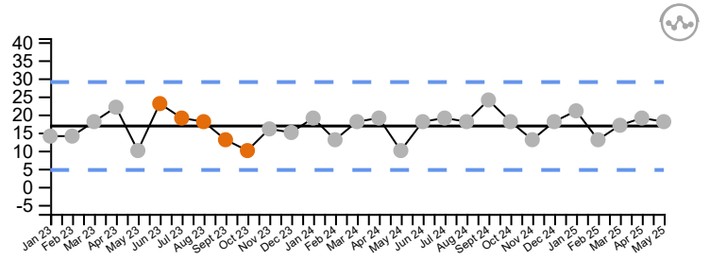
LSCS at full dilatation



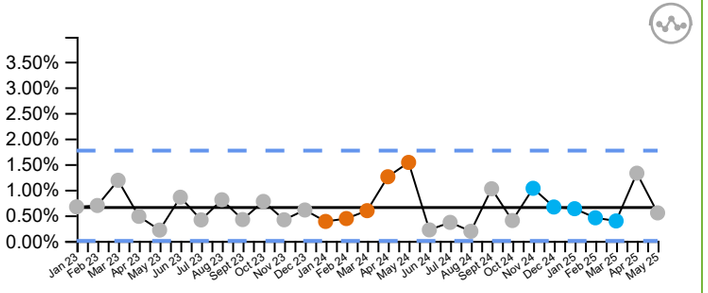
Number of Women with a previous caesarean section



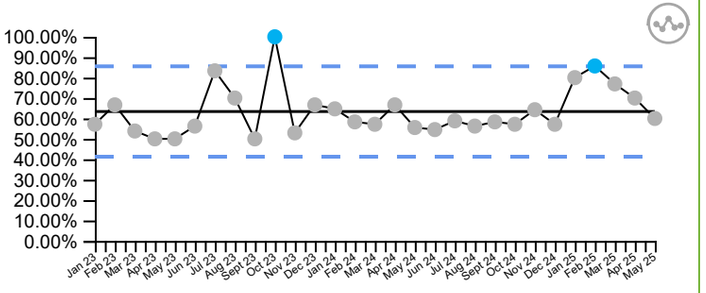
Number of women having a vaginal birth, after a previous caesarean section



Total number of deliveries before 27 weeks gestation



Live births less than 3rd centile delivered > 37+6 weeks



Neonates & Mortality

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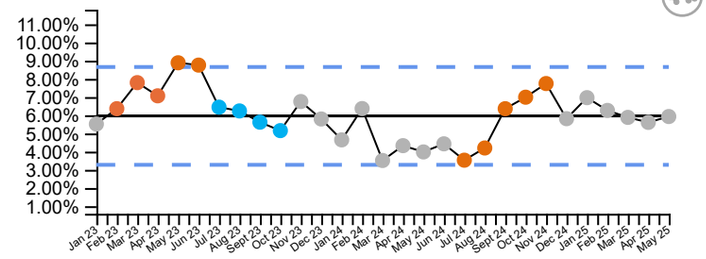
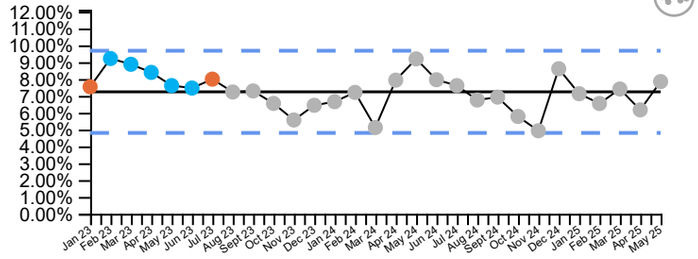
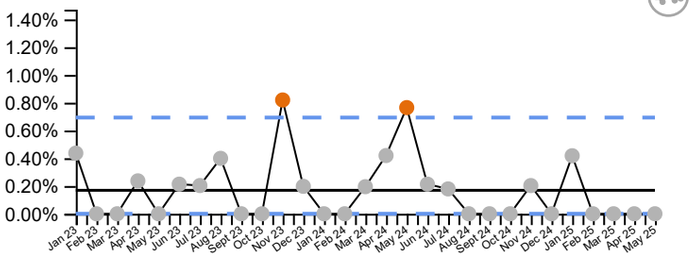
Admissions to Neonatal Unit >37 weeks



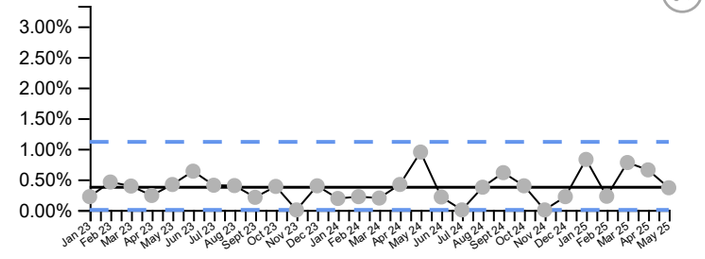
Pre-term births (Under 37 weeks)



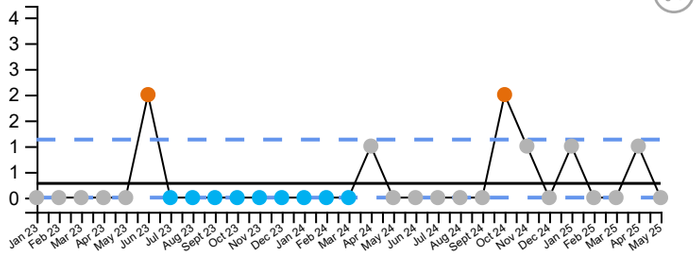
Neonatal Deaths



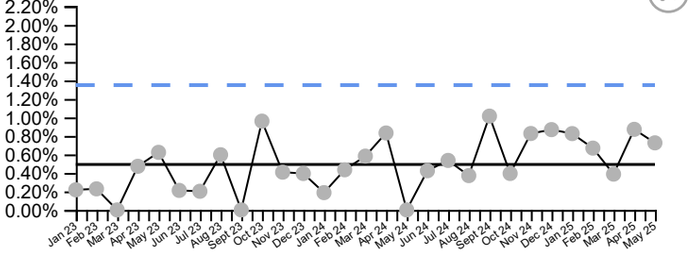
Stillbirth



Rate of intrapartum stillbirth



HIE (Hypoxic-Ischemic Encephalopathy)



Incidents

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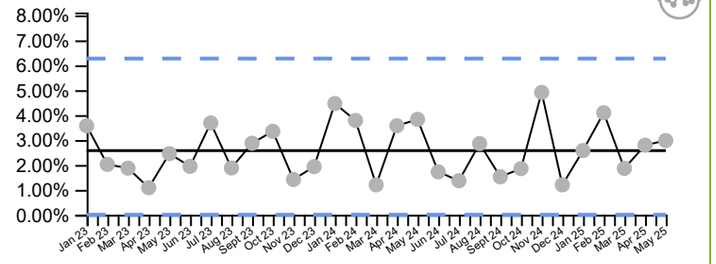
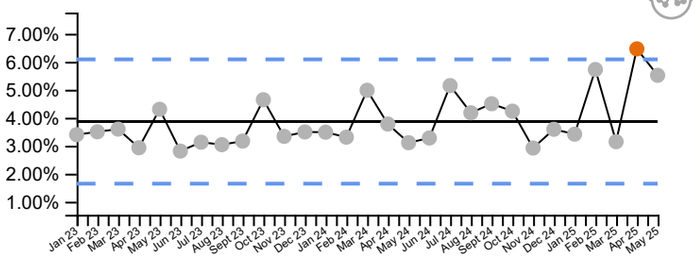
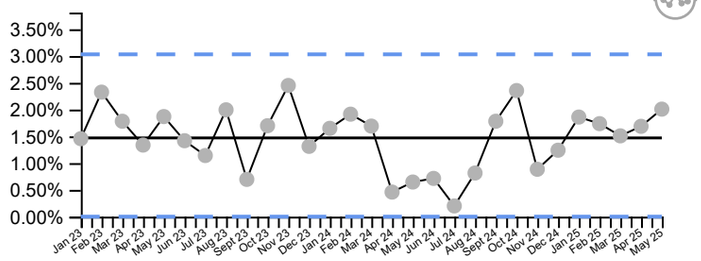
3rd/4th degree tears



PPH >= 1500ml



Apgar score <7



Smoking

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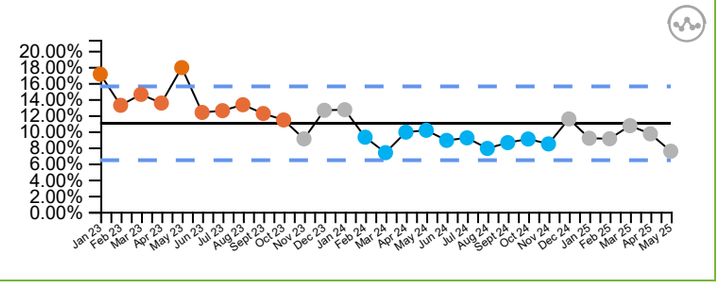
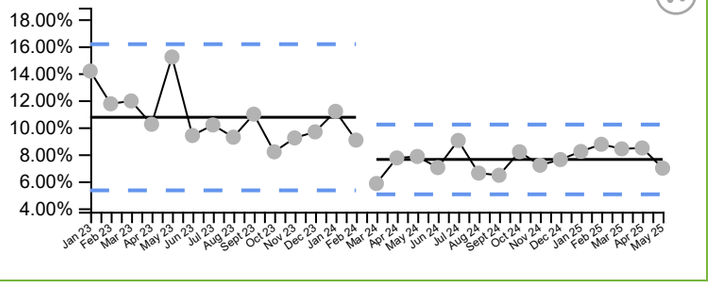
Proportion of women who were current smokers at booking appointment



Smoking at delivery



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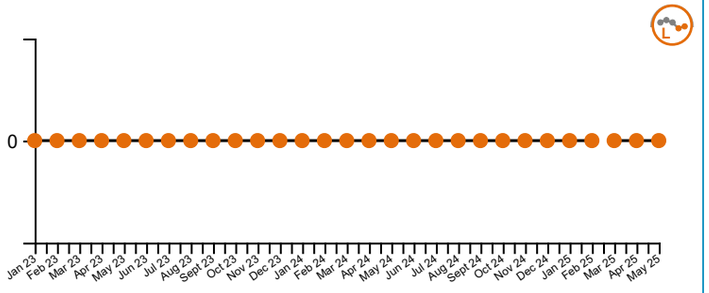
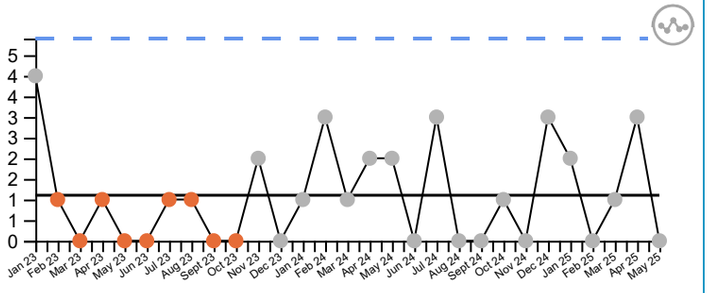
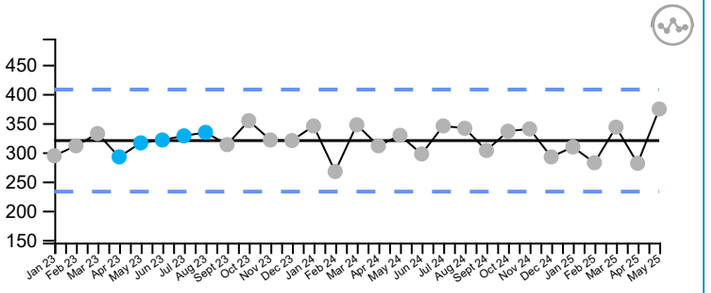
Placement on Continuity – Black/Asian Women



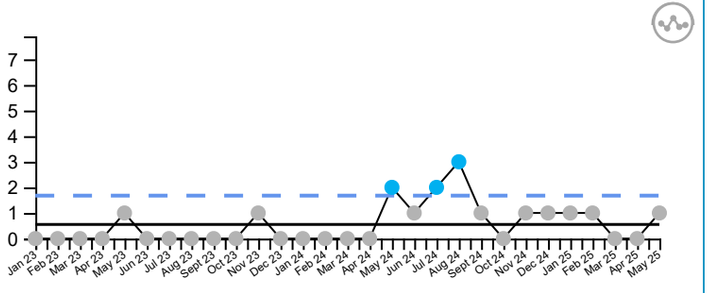
Placement on Continuity – Women in most deprived areas



Women receiving 121 care



Rate total babies born midwife not present



Screening KPIs

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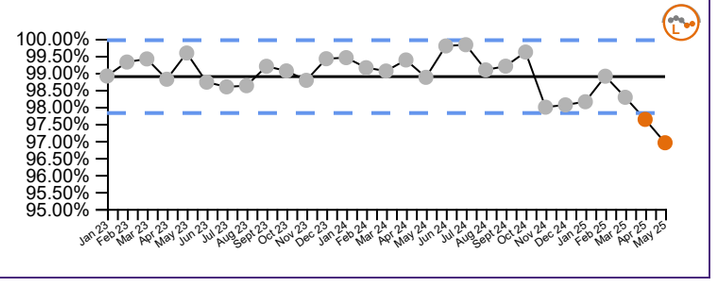
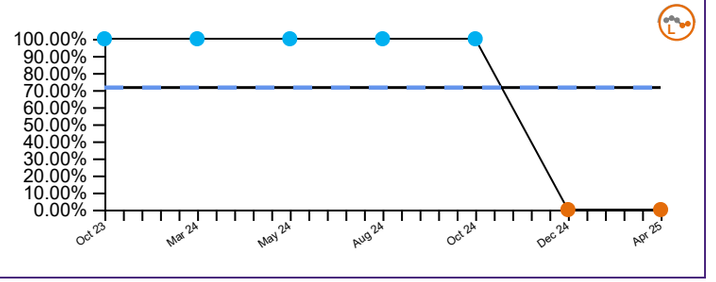
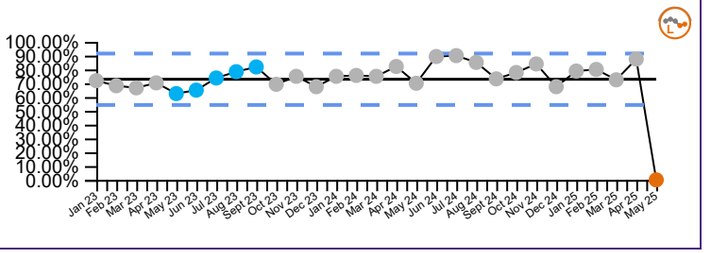
Babies that have achieved NP1 (screening complete within 72 hours of birth)



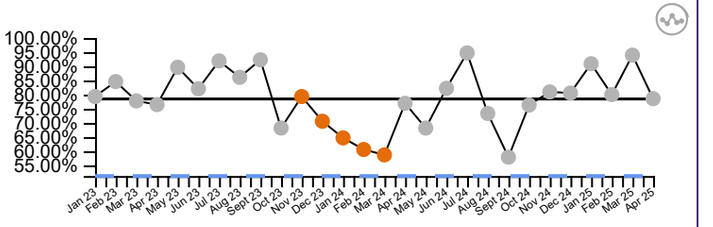
All babies born that have had Ophthalmology appointment less than or equal to 14 days of newborn eyes examination



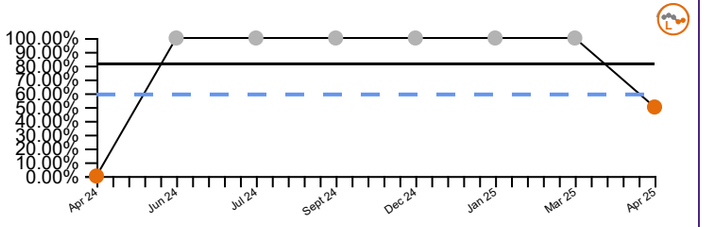
All babies born that have had USS within 4-6 weeks of birth or 38-40 weeks corrected age if born <34 weeks gestational age



All babies born that have attended orthopaedic specialist assessment or discharged following US by 6 weeks of birth or 40 weeks corrected age if born <34 weeks gestational age



All babies with screen positive testes results requiring urgent review and seen by a consultant paediatrician/associate specialist within 24 hours of newborn testes examination



BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/122
Report Title:	Accountability and Performance and Improvement Oversight Framework		
Author:	Kate Atkinson Executive Director of Service Development & Improvement Susan Giles Interim Director of Corporate Governance		
Lead Director:	Kate Atkinson Executive Director of Service Development & Improvement		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**To Note**
			✓	
Executive Summary:	The Accountability and Oversight Framework sets out how the accountability is delegated from the Board throughout the Trust. One of the key changes within the Accountability Framework addresses the recommendation from the NHSE Nominated Lead's review in November 2024 with regards to having a single person accountable for finance within each division. Whilst the divisional triumvirate will share responsibility for finance, the Divisional Director of Operations shall assume single accountability for financial performance. The same principle of shared responsibility but with a single person accountable will apply to mortality, for which the Divisional Medical Director will be accountable; and patient experience, for which the Divisional Director of Nursing will be accountable. A revised Performance and Improvement Oversight Framework is also included which works on the basis of a scoring framework derived from a series of oversight domains. Performance against the domains will determine the level of autonomy and oversight frequency.			
Key Issues/Areas of Concern:				
Action Required by the Board:	Accountability and Performance and Improvement Oversight Framework			

Previously Considered by:	Executive Team & Senior Leadership Group
Date:	2 September 2025 & 19 August 2025
Outcome:	Agreement to remain with a Divisional Triumvirate but with a single line of accountability as follows: Financial performance – Divisional Director of Operations Mortality – Divisional Medical Director Patient Experience – Divisional Director of Nursing

East Lancashire Hospitals
NHS Trust
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East Lancashire Hospitals NHS Trust Accountability and Performance and Improvement Oversight Framework

September 2025

Safe | Personal | Effective

ELHT. *Because that's who we are*

Document Purpose

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Accountability is a fundamental principle of good governance. Decision-makers who act on behalf of an organisation should be accountable for the decisions and actions that they take.

The Accountability and Performance and Improvement Oversight Framework underpins the delivery of safe, personal and effective care.

Its key purpose is to foster a culture of responsibility, accountability, empowerment and continuous improvement whilst enabling early identification of emergent risks, and mitigating actions, to support the delivery of the Trust's vision, goals and operational plans.

We will align information which balances quality, operational delivery, impact on staff and patients with the finances, to give an accurate organisational overview. The delivery of safe, personal and effective care depends upon many different parts of the organisation working together. Therefore, this Framework will not only ensure the Trust has a consistent approach to accountability and performance management but will also encourage collaboration, communication and co-operation between teams to ensure any early warning concerns or failings trigger the appropriate improvement action and response.

This Framework applies in the normal running of the Trust's business. It may, in escalated time, be superseded by the Major incident Plan or Emergency Preparedness, Resilience and Response (EPPR) policy.

Key Supporting Documents:

- Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation, Risk Management Framework
- Accountability for financial management is set out in detail in the Standing Financial Instructions and Scheme of Delegations, and through the Finance One L&SC Way – Divisional Finance Performance Framework (Appendix 1)

Contents

East Lancashire Hospitals NHS Trust
A University Teaching Trust

East Lancashire Hospitals
NHS Trust
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1 Introduction

Safe | Personal | Effective

ELHT. Because that's who we are

ELHT Strategic Framework

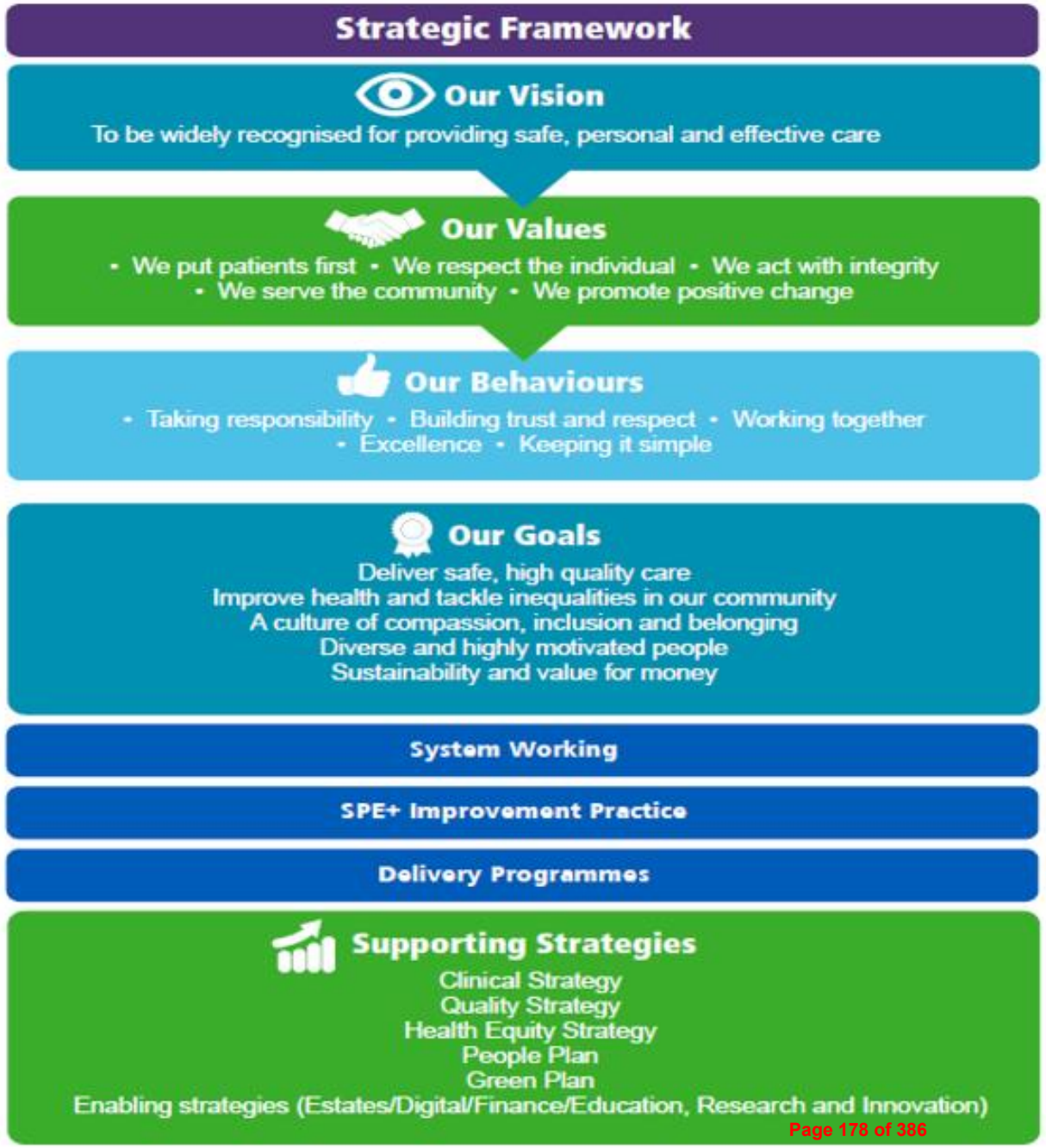
Our collective organisational vision is to be widely recognised for **providing safe, personal and effective care.** Our Trust vision is underpinned by our core values. We have committed in all our activities and interactions to put patients first, respect the individual, act with integrity and to serve the community and promote positive change. Our Strategic Framework (right) summarises how our vision and values are delivered throughout the organisation.

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

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

HOW we deliver strategies, goals and vision is through our system working, our business structure and key delivery programmes. All our work is underpinned by our improvement practice. We have **10 key delivery and improvement programmes**, **SPE+ improvement practice** and **business planning** to support delivery.

Our supporting strategies are the cornerstones of our Trust Strategic Framework, providing the plan and the **WHAT** – these strategies provide the details of how we will collectively support delivery of our vision and goals.



ELHT Behaviour Framework

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Take ownership of your work and use initiative to deliver your objectives and role expectations. Be accountable for your own performance and development by taking responsibility for your own actions and decisions.

Recognise the importance of self awareness and the impact you have on others. Value difference, diversity and inclusion, ensuring fairness and opportunity for all. Be open and listen carefully to the views and opinions of others. Build relationships based on trust, respect, compassion and kindness.

Communicate clearly and concisely, to ensure the message is understood by all. Actively work to prevent over-complication or confusion, demonstrating a clear, simple, non-bureaucratic approach to work.

Form effective partnerships and relationships with people internally and externally from a range of diverse backgrounds. Strive to work with others to reach a common goal; sharing information, supporting colleagues and seeking expertise, ideas and solutions from others where needed. Actively listen and take on board the views and opinions of others.

Seek out opportunities to create effective change and suggest innovative ideas for improvement. Review your ways of working, including seeking and providing feedback to improve services. Demonstrate a **can-do** and professional attitude.

Safe | Personal | Effective

This Framework provides a set of core behaviours and defines how staff can contribute to the success of our organisation. Adopting and embracing these behaviours will help us to achieve our Trust's ambition to deliver Safe, Personal and Effective care.

ELHT Key Delivery and Improvement Priorities 2025-26

Vision	Trust Goals	Trust Strategies	Key Delivery & Improvement Programmes	Key Delivery and Improvement Priorities	Measures of Improvement
Safe	Deliver safe, high quality care	Clinical Strategy	Quality & Safety Improvement Priorities	The transformation of Community (neighbourhood health model), Urgent and Emergency Care, Patient Flow and Discharge pathways to support safe, personal and effective care (right place, right time, first time)	➢ ED Over 12 hours in the department - reduction 17% to 15% ➢ Discharge at least 2% more patients (84% to 86%) on their discharge ready date ➢ Improve our average delay in discharge from 5 days to a maximum of 4.5 days ➢ Improve the number of patients discharged within 7 days by at least 1%
		Quality Strategy	Urgent & Emergency Care Improvement / Care Closer to Home / Place Partnerships	Transform delivery of outpatient, diagnostics and elective services to reduce variation and increase productivity in line with benchmarking and clinical standards supporting improved outcomes/timeliness of care for patients	➢ Improvement in patients waiting for treatment – 62.2 % of all patients will be seen and treated within 18 weeks ➢ Improvement in patients awaiting cancer diagnosis – 80 % of patients will have a diagnosis within 28 days and 75 % of all patients to have a diagnosis and treatment initiated within 62 days ➢ We will see more patients than last year (ERF activity plan) by improving productivity within outpatients and theatres
			Elective Pathway Improvement		
Personal	Improve health and tackle inequalities in our community	Health Equity Strategy	Tackling health & care inequalities	Work with partners across Lancashire and South Cumbria in the delivery of the clinical strategy, focusing on the optimum configuration of acute services, improving outcomes and sustainability	➢ Delivery of at least two significant service configurations within 2025/26 ➢ Development of a clear 'blueprint' for service transformation and reconfiguration on which to build future service changes
			Provider Collaborative		
	A culture of compassion and belonging	People Plan	People Plan Priorities	Work with partners across Lancashire and South Cumbria in the delivery of high-quality corporate services via One LSC as both partner and host	➢ Delivery of 5% Efficiency saving on current run rate through service redesign and transformation across One LSC ➢ Establishment of One LSC post transfer governance arrangements (new way of system working)
	Healthy, diverse and highly motivated people	DERI Strategies	Research, Education & Innovation	Developing a culture of compassion and belonging. Becoming intentionally anti-racist on our inclusion journey	➢ Improvement in staff experience - we are compassionate and inclusive theme by 2% ➢ Reduction in disparity ratio by ethnicity from shortlisting to appointment to bring current ratio of 4.69 to the national average of 1.65. (WRES Metric 2) ➢ Reduction in the percentage of staff experiencing discrimination at work from manager/team leader /colleagues by 2% with further improvements to close the gap (**Staff Survey 2024**: 15% BAME and 7% white staff)
				Development of a sustainable workforce	➢ Reduction in variable pay spend by £13m
Effective	Sustainability and Value for Money	Green Plan	Waste Reduction Programme	Digital enablement to support transformation of services. A measurement strategy which supports identification and monitoring of improvements.	➢ Cyber assurance framework compliance ➢ Uptake of AI based digital tools
		Digital Strategy	eLancs Programme		
		Finance Strategy	Sustainability	The highest standards of financial management (financial grip and control), and sustainable delivery of financial improvement and waste reduction	➢ Delivery of breakeven financial plan (including the receipt of Deficit Support Funding) ➢ Delivery of CIP - £60.8m
		Estate Strategy			

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2 Accountability Framework and Organisational Structures

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ELHT. *Because that's who we are*

Accountability Framework: The most important asset that we have is our people

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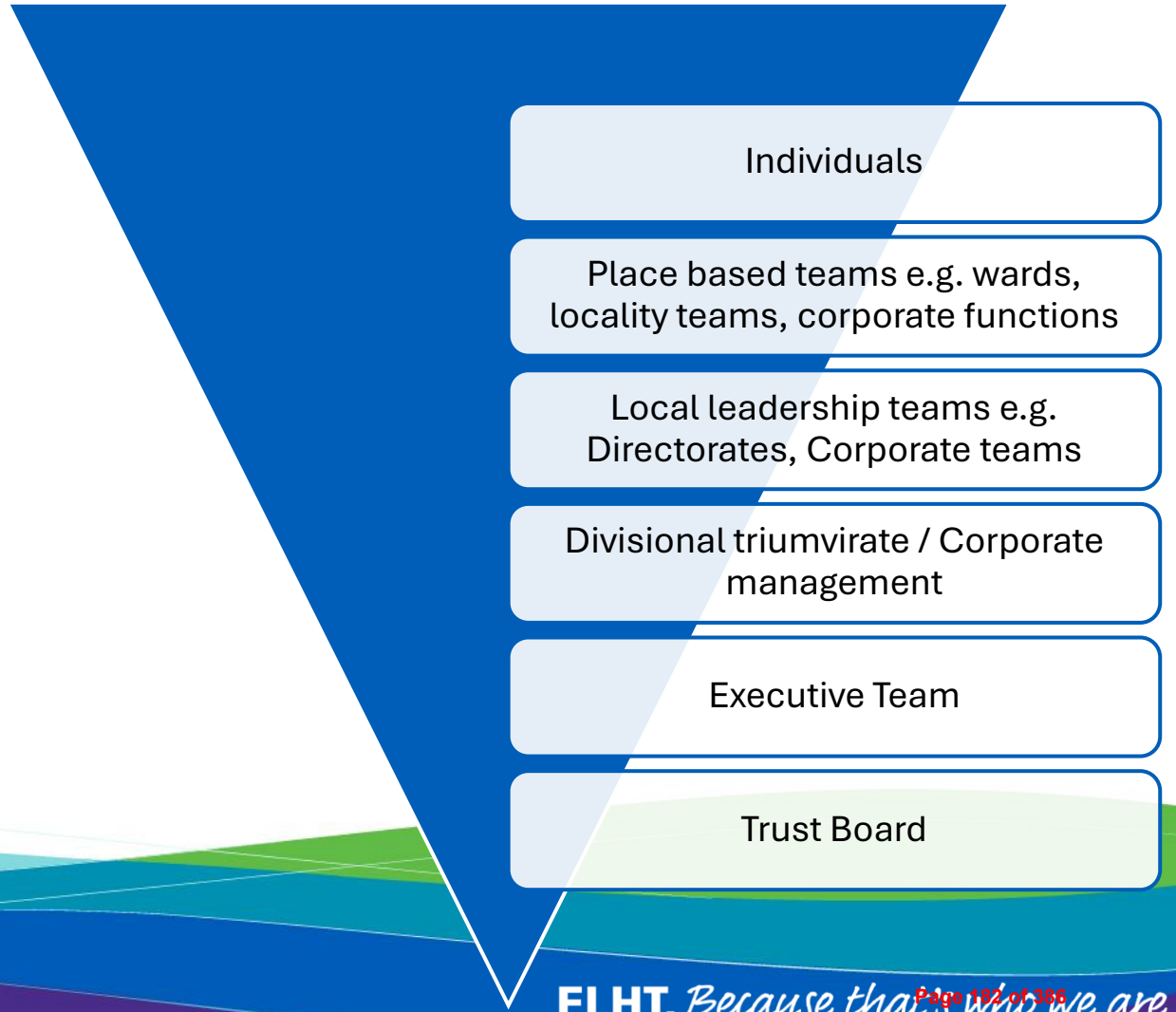
- The Accountability Framework aims to empower our staff to continually improve the services that they provide. It is therefore vitally important that we allow the voices of all our staff to be heard and that we create an environment that allows them to make improvements, as well as making sure they have the tools to make it happen.
- Leadership styles will be developed to foster this environment, creating a positive, outstanding place to work.



The role of individuals

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- Individuals will understand the objectives of their department through their departmental business plans. The annual agreement of team and personal objectives will enable the identification of the contribution that all colleagues will make to delivering safe, personal and effective care.
- We want to empower staff to play a prominent role in taking ownership of success. Business planning and Personal Development Review (PDR) processes will provide the clarity, and our culture will provide the autonomy to deliver the best results. Staff are encouraged to collaborate across all hierarchical levels to get the support they need to be successful.
- All individuals are encouraged to raise any issues of concern through their departmental hierarchy remembering that 'the standard you walk past is the standard you accept.' It is of upmost importance that our staff continue to identify areas of improvement and are able to raise concerns freely.
- Individuals must ensure they are up to date with all mandatory and role specific training and adhere to all policies relating to their role and department.

The role of local and place-based leaders and leadership teams

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- Local and place-based leaders (Directorates, individual teams, ward-based teams etc) are considered accountable for their areas of responsibility. They are therefore fully responsible and accountable for the management of their teams and for services they lead and deliver.
- Accountable managers are key to fostering a positive working environment that allows our staff to flourish, being open to improvement ideas from staff, promoting new learning and promoting a culture that empowers staff to improve their working environment. This is a fundamental part of the role of our local leadership.
- Accountable managers are also responsible for identifying proactively issues of underperformance and for acting upon them promptly and avoiding the necessity for escalation within the organisation. This applies to all areas of quality, delivery, impact on patients and workforce and finances. To do this, accountable managers are expected to use the tools within the SPE+ Improvement Practice to assist with the identification of problems, root causes and potential solutions. This will ensure full engagement of stakeholders and further foster the empowerment of our staff.
- It is important for all teams to identify and mitigate any issues, out with their control that impact on performance. These mitigations may include working with colleagues and other teams across the organisation and escalating where appropriate through line managers/organisational hierarchy.

The role of Divisional Triumvirate / Corporate management

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- The Divisional triumvirate and Corporate management teams will be pivotal in creating an environment that allows the staff in those areas to flourish. Communication channels will work from 'Ward to Board' and vice versa with these teams translating organisational objectives into break-through objectives for their areas and with the achievement of these being done through a culture of continuous improvement.
- The Divisional Triumvirate and Corporate management teams will actively encourage and demonstrate the use of SPE+ Improvement Practice as a key enabler to allowing our staff to improve their areas of work. They will foster an environment of continuous learning and improvement, leading the way in this.
- The Divisional Triumvirate is accountable for the delivery of their division's objectives and is made up of a Divisional Medical Director, a Divisional Director of Nursing, and a Divisional Director of Operations. Within the clinical divisions, the Divisional Medical Director is responsible for medical staffing and likewise the Divisional Nurse Director for nurse staffing and the Divisional Director of Operations for managerial staffing.
- To strengthen leadership, accountability and governance and to ensure delivery across the quadruple aim (quality, delivery, people, money), there will be joint responsibility for these areas across the Divisional Triumvirate but the Divisional Director of Operations will assume lead accountability for the Divisional financial performance, the Divisional Medical Director will assume lead accountability for the divisional mortality performance and the Divisional Director of Nursing will assume lead accountability for patient experience.
- For corporate teams (not part of OneLSC), this accountability will be through the management structures of the individual corporate departments and is likely to be a single manager. Where triumvirate/multi-professional arrangements exist in corporate teams, the budget holder will be the single line of accountability for financial performance.
- OneLSC is subject to its own accountability arrangements through the Central Services Executive Committee and Professional Working Groups.
- Divisional triumvirates and Corporate managers/leadership teams are directly accountable for achievement of their area's objectives and responsible for the effective management, including risk management, of all their teams and services which they deliver.

The role of the Executive Team

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- The Executive team will lead by example in demonstrating a leadership style that gives our staff a voice and empowers them in their roles, recognising that our staff are our greatest asset, highly skilled and dedicated to providing safe, personal and effective care.
- The Executive team will actively encourage improvement through the SPE+ Improvement Practice framework, with PDSA (Plan, Do, Study, Act) and root cause analysis as standard alongside the use of measurement for improvement, being fully versed in its use and demonstrating its use through their roles as a team and individually.
- The Executive team will use visual management and the Gemba (go and see) to support them in gaining assurance. They will demonstrate improvement coaching as another tool to empower our staff and encourage a learning organisation. They will celebrate the success of our teams by supporting Improvement Report Outs as well as other ways of recognising our staff.
- All members of the management structure report either directly or indirectly, to the Executive team, and then to the Chief Executive. The Executive team is collectively accountable to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall goals, key delivery and improvement programmes and improvement priorities for consideration and approval by the Trust Board. The Executive team and ultimately the Chief Executive are jointly responsible for implementing the decisions of the Board of Directors and its Committees and providing information, support, and assurance to the Board of Directors.
- Working with the Divisional Triumvirates and Corporate Management teams, the Executive Team will oversee the operational business of the Trust and will ensure delivery of objectives through the Executive Leadership Wall, Senior Leadership Group meetings and quarterly Performance and Improvement meetings. Executives will have a good overview of operational performance, issues in regard to workforce, fiscal management, patient experience and quality/safety standards being attained.

The role of the Trust Board

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- The Board is responsible for formulating strategy, ensuring accountability and shaping the culture of the organisation.
- The Board delegates its authority through the organisation as set out in the Scheme of Reservation and Delegation.
- The Chair's role is to lead the Board of Directors to ensure that the organisation has the vision, strategy and resource in place to deliver the objectives of the Trust and to create the conditions for good governance.
- The Chief Executive is the 'Accountable Officer' for the Trust and he delegates this responsibility through the Executive Directors to ensure that the Board's vision and strategy is achieved and that all risks are effectively managed
- The purpose of NHS boards is to govern effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:
    - In the quality and safety of health services
    - That resources are invested in a way that delivers optimal health outcomes
    - In the accessibility and responsiveness of health services
    - That the public can appropriately shape health services to meet their needs
    - That public money is spent in a way that is efficient and effective

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3 Performance and Improvement Oversight Framework

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ELHT. Because that's who we are

Annual Planning and Objective Setting

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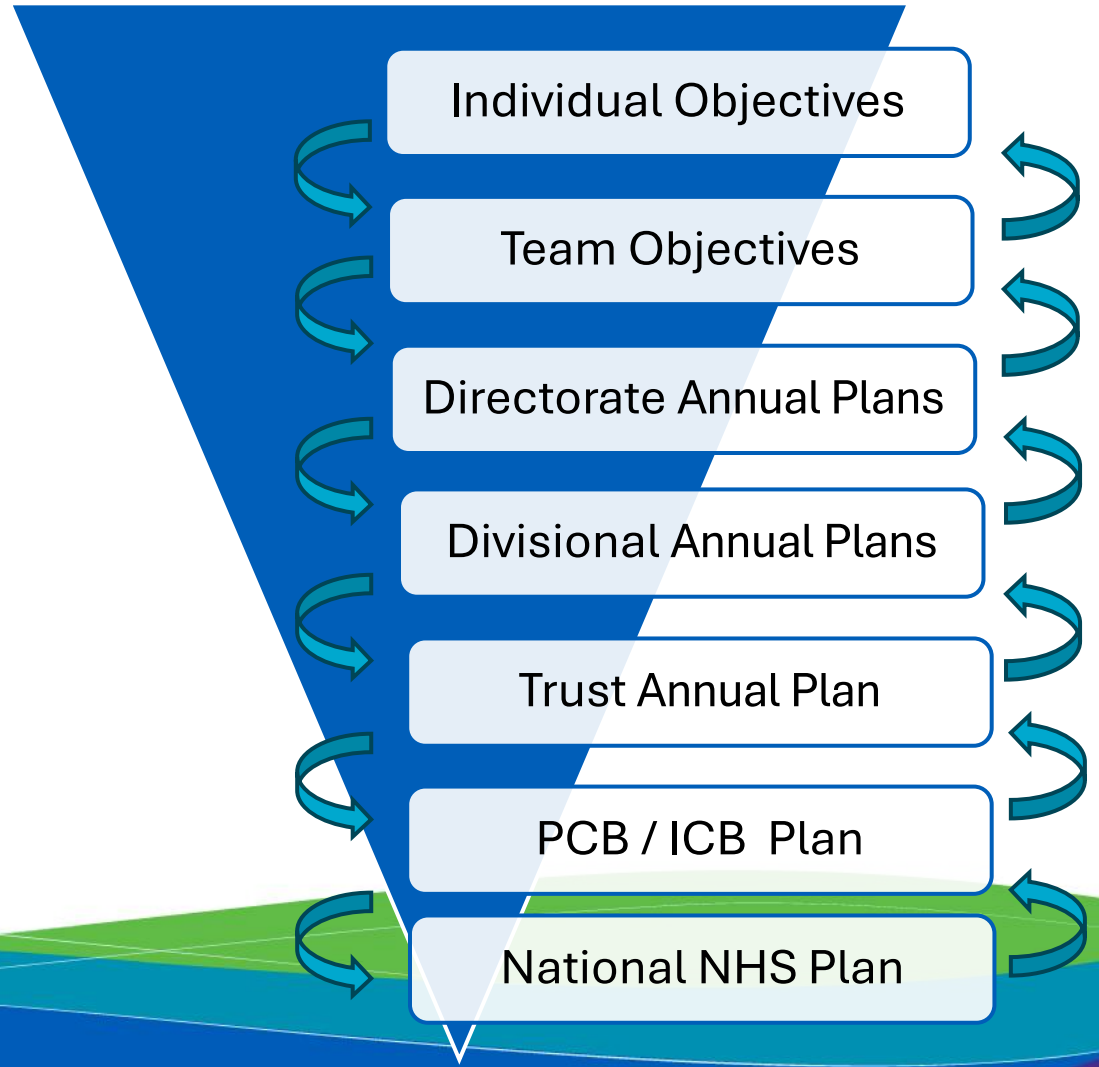
- The planning cycle links Directorate, Divisional and Corporate function plans to Trust wide strategies, programmes and plans, and also PCB/ ICB wide plans and strategies. The annual plans pull everything together in one place for a clinical team.
- Annual priorities are set each year through our planning cycle, which drive the practical actions that deliver our strategic objectives and priorities. This is coupled with the delivery of the Trust strategies and plans, which form our Strategic Framework.
- Our annual plans include workforce, finance, activity, performance, quality and safety. They incorporate any objectives for that Division/Directorate that is part of Trust strategies such as the Clinical or Quality Strategy, as well as key aspects of our Key Delivery and Improvement programmes and Key Delivery and Improvement Priorities.
- The annual plan is therefore the central 'go to' document for a departmental team and pulls their key parts of the relevant Trust strategies, programmes and plans into one place.
- This ensures that departmental plans are aligned fully to Trust strategies and our overarching vision, values and goals. This process, through appraisals, also aligns team and individual objectives to the Trust vision, values and goals.
- Our Trust Annual Report captures all the Trust's activities.



Performance and Improvement Oversight Framework Domains

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- The Performance and Improvement Oversight Framework (PIOF) focusses on the domains outlined opposite.
- All domains are equally weighted, with the exception of Quality and Safety, which is the override for the PIOF scores.
- To achieve its key purpose of early identification of emergent risks and mitigating actions the framework is based on objective and transparent KPIs, assesses performance against relevant National and Local targets and supports the organisation to monitor delivery of performance contained within the Trust's and wider System annual plans.

Performance Monitoring and Reporting Cycle

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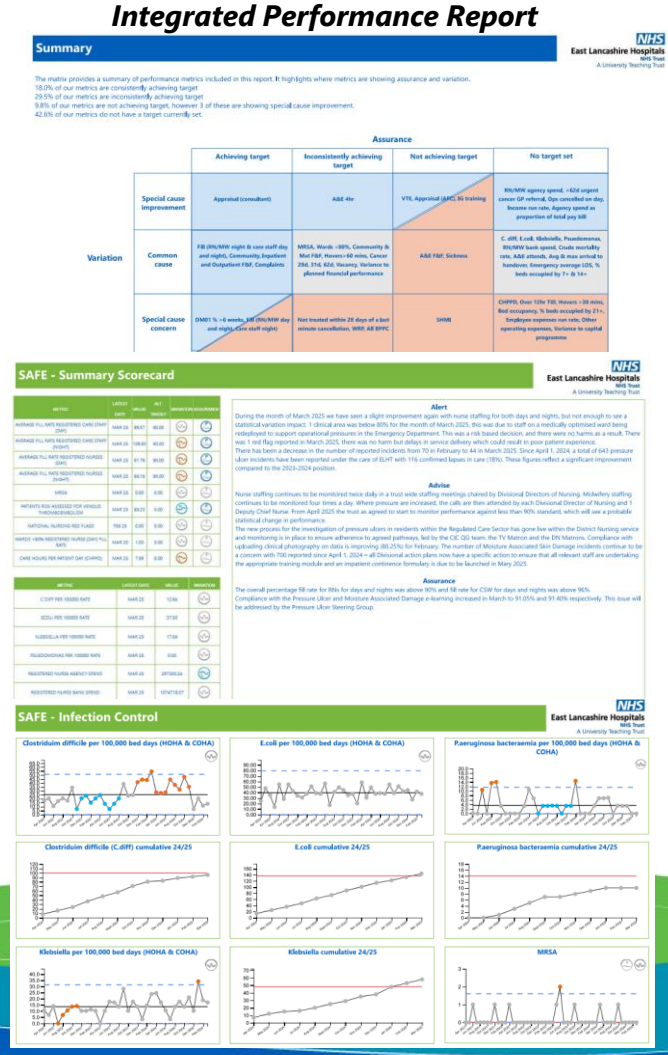
- Strategic priorities – each Trust Strategy has a plan on a page for will be a strategic dashboard monitored through relevant sub-committees of the Trust Board on a bi-annual basis
- The IPR covers all aspects of the annual objectives and will balance the elements of quality, operational delivery, workforce and impact on patients and finance. The Integrated Performance report will continue to be developed with a focus on the use of Statistical Process Control (SPC) charts to support more effective monitoring of performance and identification of trends for special cause concern (requiring corrective action and improvement) and special cause improvement (to support opportunities learning from success).
- Our Trust Key Delivery and Improvement Priorities will be monitored via the Executive Improvement Wall with key improvement measures added to the Trust IPR summary to support monitoring at board level.
- Divisional plans will be monitored through Performance and Improvement Reviews through agreed Key performance Indicators relating to Divisional Business Plans covering quality, operational delivery, workforce and impact on patients and finance.
- A monthly and quarterly reporting cycle will be published to ensure timely availability of reporting to support the Performance and Improvement Reviews..



Performance and Improvement Reviews

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- The objective of the Performance and Improvement Reviews is to review the performance of each Division in relation to the agreed Business Plan and KPIs. Each Division will have a set of indicators derived from the PIOF, related to its core business. Divisions will be held accountable for delivery of these key metrics and identification of improvement plans where required.
- These sessions will be of a 'Board to Board' style between the Divisional Triumvirate/Corporate Management team and the Executive Team.
- The Performance and Improvement reviews for Corporate teams will be attended by representatives of the clinical divisions.
- The reviews will provide a forum for Divisions/Corporate Teams to discuss issues and challenges facing services with Executive Directors and agree solutions in partnership and also to share and celebrate success and good practice.
- Divisional Performance Reviews will be scheduled at the start of each new financial year.
- The meetings will maintain action logs.
- Teams will work together to provide a data pack prior to each meeting which will be used by the Executive Directors. In conjunction with the Divisions a list of key lines of enquiry will be drawn up to focus the discussion on the most important issues and actions.
- In line with plans to continuously improve the IPR, ongoing work will be undertaken to review and improve the data packs to enable consistency of reporting in line with the PIOF.

Scoring Framework

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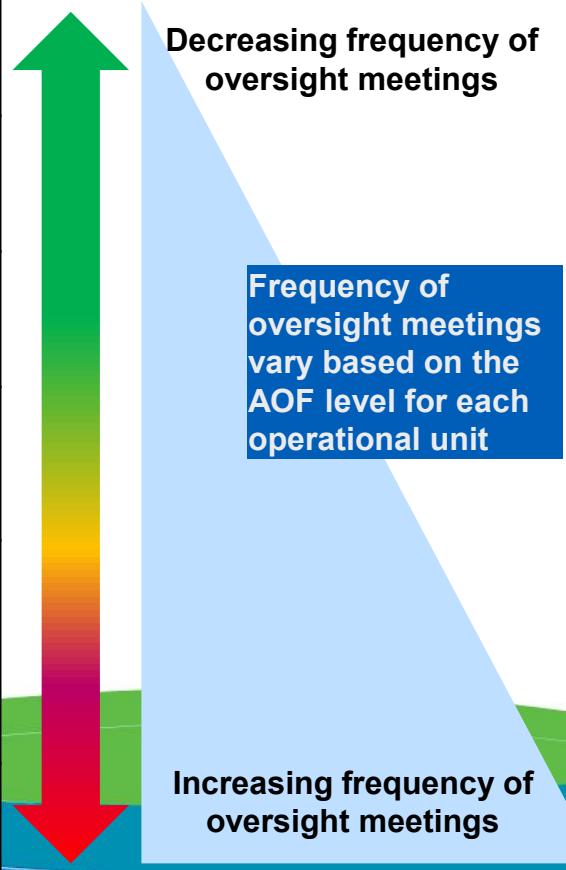
The PIOF domains are combined to create a single score for each Division / Corporate team, determine the level of autonomy and oversight frequency.

Level	Category	Characteristics	Oversight Frequency	Intervention to Support Recovery
1	Outstanding	High performing; sustained evidence of performance, minimal risk	Half yearly Performance Review	• No additional escalation required. • Full autonomy and decision rights
2	Good	Strong achievement of PIOF standards, minimal risk	Every 6 months	• AOF meeting focused on domains scored 3 or higher • Any areas of risk (i.e., scoring 4 or above) requires action plan/trajectory
3	Concerns requiring investigation	Satisfactory achievement, some areas may have opportunities for improvement	Quarterly	• As per risk level 2 • Targeted support as required and agreed with Executive Team
4	Immediate concerns	Not delivering PIOF standards / locally agreed trajectories, some significant risks, recovery trajectories agreed	Bi-Monthly	• As per risk level 2 • Targeted support mandated for areas of delivery risk
5	Material Issue	Not delivering PIOF standards / locally agreed trajectories or recovery trajectories not in place, extensive areas of risk	Monthly	• As per risk level 2 • Intensive Oversight • Decision rights suspended as agreed with Executive Team • Full turnaround covering all domains of delivery risk
6	Special Measures	Failure and special measures required	Oversight frequency and intervention to be agreed by the Executive Team	



PIOF Dashboard

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To support the PIOF review process, a performance dashboard for the organisation will be developed that captures in one place the overall score, individual domain scores and performance.

		Current	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
Division	**Overall Level**	**2**	**2**	**2**	**2**	**3**	**2**
Domains	Quality and Safety	2	2	2	2	2	2
	Patient Experience	1	1	1	1	1	2
	Operational Delivery	1	1	2	2	4	3
	People and Culture	3	4	4	4	4	3
	Finance	1	1	1	1	1	1
	Strategy and Improvement	4	4	4	4	3	3

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Appendix 1: Finance One L&SC Way – Divisional Finance Performance Framework

Finance One L&SC Way – Divisional Performance Framework

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Purpose:
The purpose of this framework is to:

- Enhance assurance on delivery of the Trust's financial plan, securing best value for patients
- To promote Divisional financial accountability and empowerment to deliver their financial plan
- Provide a clear framework of support and escalation if under achievement is forecast

Pre-requisites:
The following needs to be in place for the framework to operate

- There is a clear "Accountable Officer" for Finance in the Division (Usually the Clinical Director or Divisional General Manager)
- The Accountable Officer has the appropriate powers to lead and direct the activities of all staff in the Division
- The Division's financial control target has been calculated using the standard work agreed through the Finance One L&SC Way programme
- The Accountable Officer for the Division has formally signed off the Divisional control target
- Finance systems and processes are operating to at least minimum standards
- The Division's forecasting procedure is operating in line with the standard work agreed through the Finance One L&SC Way programme

If for any reason the Division's control target has not been signed off in line with the relevant deadline then the Division is treated as being on RED for more than six months under this framework until the issue is resolved.

If the Division's forecasting procedure is not operating to required standards, due to issues in the control of the Division, it will be treated as RED for more than six months under this framework until the issue is resolved.

Finance One L&SC Way – Divisional Performance Framework

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Basis of Measurement:
The key metric for the finance performance framework is the validated forecast outturn variance for the division expressed as percentage of the Division's total expenditure budget.

Based on the validated forecast variance a RAG rating will be applied as follows:

- GREEN = Forecast balance or underspent
- AMBER = Forecast variance up to 1%
- RED = Forecast variance > 1%

RAG Rating and Escalation:

Status	Definition	Actions
GREEN	Validated forecast outturn is balance or underspend	• Grip and control measures at default
AMBER	Validated forecast outturn is up to 1% overspent	• Grip and control measures enhanced • Recovery plan required in one month (next forecast) • Monthly escalation meeting with CFO • If AMBER for more than six months default to RED

RED	Validated Forecast Outturn is greater than 1% overspent	• Grip and control measures enhanced
		• Complete pause in recruitment until recovery plan agreed
		• Recovery plan required in two weeks
		• Weekly escalation meetings with CFO
		• If RED for more than 3 months
		  ○ Turnaround Director appointed to the Division
		  ○ Escalation meeting with full Executive Team, chaired by CEO
		• If RED for more than six months:
		  ○ Further escalation meeting with full Executive Team, chaired by CEO
		  ○ Executive commission Governance, Capability and Capacity review of Division
		  ○ Executive consider suspending Accountable Officers delegated authority

BOARD OF DIRECTORS

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/123
Report Title:	Annual Submission to NHS England Northwest: Framework for Quality Assurance and Improvement 2024-25 on Medical Appraisal, Revalidation, and Medical Governance		
Author:	Dr Uma Krishnamoorthy Associate Medical Director, Appraisal and Revalidation Ms Suzanne Gawn Deputy Medical Director, Professional Standards		
Lead Director:	Dr Julian Hobbs Executive Medical Director and Responsible Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**To Note**
			✓	
Executive Summary:	This report provides assurance to Trust Board on compliance against GMC and NHS England standards for medical appraisal and revalidation as well as professional standards and related medical governance. The report provides assurance that Trust is fulfilling all Statutory responsibilities that are expected under Responsible officer regulations 2010 updated 2013.			
Key Issues/Areas of Concern:	The recommended Higher Level Regional Office report template is used to comply with NHS England recommendations, as this report further to Board approval and sign off, needs to be submitted to NHS England by the National deadline of 31/10/2025.The usual Board paper template cannot be used for the main body of report in view of the above National requirement.			
Action Required by the Board:	The Board is asked to approve the report and sign the compliance statement for submission to NHS England.			

Previously Considered by:	NA
Date:	NA
Outcome:	NA

2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	East Lancashire Hospitals NHS Trust
What type of services does your organisation provide?	Secondary care provider organisation

	Name	Contact Information
Responsible Officer	Dr Julian Hobbs	Julian.Hobbs@elht.nhs.uk
Medical Director	Dr Julian Hobbs	Julian.Hobbs@elht.nhs.uk
Medical Appraisal Lead	Dr Uma Krishnamoorthy	Uma.Krishnamoorthy@elht.nhs.uk
Appraisal and Revalidation Manager	Mrs Susan Smith	Su.smith@elht.nhs.uk
Additional Useful Contacts	Ms. Suzanne Gawne-Deputy Medical Director for Professional Standards	Suzanne.Gawne@elht.nhs.uk
	Miss Rachael Spencer-Appraisal and Revalidation Administrator	Rachael.spencer@elht.nhs.uk

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?
NO as ELHT has its own formally appointed Responsible Officer (RO)

If yes, who is this with?

Organisation: • East Lancashire Hospitals Trust (ELHT) has its own formally appointed Responsible officer (RO)
Please describe arrangements for Responsible Officer to report to the Board: • The Responsible officer (RO) for the reporting period covered by this annual report which is 1.4.2024 till 31.3.25 was Mr Jawad Husain who was also Executive Medical Director since 2020, and he reported directly to Trust Board. • The newly appointed Executive Medical Director, Dr Julian Hobbs is the formally appointed new Responsible Officer currently for ELHT at the time of writing this report. He commenced in role from August 2025. • ELHT has a Service level agreement in place with East Lancashire Hospice and Pendleside Hospice and supports RO services for the two hospices. The Associate Medical Director for Appraisal and Revalidation (AMD A&R), Dr Uma Krishnamoorthy, was appointed as the RO for the two hospices since retirement of predecessor Mrs Rineke Schram from October 2020. The annual reports for the two hospices will be submitted to the Boards of the two organisations and submitted as two separate reports to NHS England as per requirements, as they are independent Designated Bodies (DB).
Date of last Responsible Officer Report to the Board: • 11.09.2024 (Appendix1 – Copy of Board report 2023/24)

Actions from last year:

Please see under section 3 the actions for this reporting period 1.4.2024 to 31.3.2025.

Actions committed to in last report to Board in 2024 are as follows:

- Ensure appropriate number of appraisers are continually recruited and trained to keep up with demand for capacity. AMD A&R and team: Complete and ongoing
- Ensure that appraisers continue to be supported with 0.25 SPA in job plans for appraiser role through directorates and divisions. RO, DMDs and CDs: Complete and Ongoing
- Launch the questionnaire survey of appraisers for their views on satisfaction in appraiser role and intention to continue and support resources that they need which Trust can offer for long term. AMD A&R and team: Complete (Appendix 2- Appraiser survey results conducted for year ending 31st March 2025 – this is awaiting presentation at the quarterly appraiser network in Autumn 2025. Interim results were shared and discussed at the Peer review meeting hosted by ELHT in October 2024 as outlined in Appendix 8)
- Continue the Quality assurance review on 100% appraisals using the generic QA review template and complete the additional Quality assurance review using PROGRESS tool on a sample of appraisals. AMD A&R and team: 100% generic QA review complete, QA review on a sample using PROGRESS QA review tool -in progress and carried over
- New service user pilot in palliative care and anaesthetics is completed. Develop a new SOP as appropriate once fully completed. DMD PS and team- Pilot completed, mixed reviews, therefore SOP not progressed and instead agreed on an explicit set of instructions developed to supplement the questionnaire as consensus by A&R team- Complete (Appendix 3 Medical Service User Feedback Questionnaire with instructions that was developed locally at ELHT)
- Repeat the analysis of doctors with performance concerns as reaudit every two years. DMD PS and HR team- Complete
- Ensure that a seamless process is developed locally to provide activity and performance data for reflection at appraisals to all consultants – Head of Performance and Informatics with AMD A&R and team By Sept 2024: Complete (Appendix 5 Joint presentation at Appraiser network on newly developed and implemented Performance reporting for medical appraisals)

Actions for next year:

- See all actions to be progressed in 2025/26 under section 3 of this report

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher-Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: **EAST LANCASHIRE HOSPITALS NHS TRUST**
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	• Yes
Action from last year:	• Mr Jawad Husain was RO for this reporting period ending 30.3.2025
Comments:	• Medical Appraisal and revalidation policy was updated as outlined in last report and ratified on 9.4.2024. (Appendix 6) This has been fully implemented since and disseminated and available in Intranet.
Action for next year:	• Continue as at present. Also see action summary under section 3

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	• Yes
Action from last year:	• Continue as at present and see section 3 and appendix 1 • Continue new appraiser recruitment and training in line with increasing demands and backfill for those retiring or relinquishing appraiser role due to other reasons. New appraiser training was held leading to recruitment of new appraisers during the reporting year. Recruitment drive for appraisers is ongoing in current year as well, at the time of writing this report.
Comments:	• RO role is well supported with sufficient funding, capacity and resources. For the reporting period, there were 754 doctors connected to ELHT as their Designated Body which is an increase by 4% from the previous year's figure of 727 and an increase of 11.5% compared to 2022/23 of 676. • There is a year-on-year increase in number of connected doctors to ELHT evidenced since 2015 and 60% increase compared to the number of connections six years ago (471 connected doctors in 2019) reflecting a positively enhanced work force with added demands on the medical appraisal and revalidation (A&R) team. • There is an increased need for appraisers (at end of period covered by this report on 31.3.2025 n=93) who need to be supported with appropriate PA allocation of 0.25 SPA in their job plan (for 6-8 appraisals per year) , dedicated for the appraiser role through directorates/divisions. • As the RO does not hold separate dedicated budget for A&R, this has always been supported, directly through the Divisions and their Directorates, and this needs to continue to be supported through Divisional and Directorate budgets as part of their Core Governance and Business activity, in the absence of a separate central RO budget.
Action for next year:	• Continue as at present and see under action summary in section 3 • Continue periodically monitoring the appraiser demand versus capacity and continue new appraiser recruitment and training appropriate to demands. • Clinical Directors and Divisional Medical Directors to continue supporting the ongoing appraiser nominations for recruitment in proportion to the increasing workforce within their respective directorates and divisions and proactively support the backfill appraiser appointment for those retiring or relinquishing appraiser role due to other reasons in a timely manner to

	avoid demand capacity gap. DMDs and CDs to continue meeting appraiser capacity as per demands as part of their core governance and core business functions and plans with RO team oversight. (Appendix 7 Report on the review of appraiser capacity versus demand for 2024/25)

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	• Yes
Action from last year:	• Nil action and Nil issues
Comments:	• There are robust and clear Standard Operating Procedures for the management of new starters at the Trust and leavers from the Trust and to enable GMC connections for starters and disable GMC connection for leavers.
Action for next year:	• Continue as at present

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	• Yes
Action from last year:	• Appraisal policy for ELHT hospitals was updated and ratified at time of last report (9.4.2024) and effectively implemented since
Comments:	• See Policy in Appendix 6
Action for next year	• Continue as at present and review policy when due for review in January 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	• Yes
Action from last year:	• The original onsite peer review meeting was undertaken in June 2023 and nil pending actions from then.
Comments:	• A peer review group meeting was hosted by ELHT for the seven peer group organisations as a virtual meeting over Microsoft Teams on 29.10.2024 (Airedale Hospitals, Blackpool Teaching Hospitals, ELHT, Lancashire and South Cumbria Lancashire Teaching Hospitals, University Hospitals of

	Morecambe Bay, Warrington and Halton Teaching Hospitals). (Appendix 8 Minutes of the Peer Group Meeting)
Action for next year:	• Continue as at present and see action summary under section 3

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	• Yes
Action from last year:	• See below as well as under section 1B
Comments:	• All locum and short- term doctors connected to ELHT as their DB are treated equitably in line with Trust processes and policies and have access to all supportive resources so that their outcomes and experiences with A&R are positive. Appraisal rates of 98.5 % are in par with appraisal rates among consultants at 98.2% and overall appraisal rates at 98.2% demonstrating equitable outcomes. This is a significant improvement over the years and appraisal rates are comparable now to consultant and staff grade appraisal rate figures with demonstrable equitable outcomes at ELHT. • The medical appraisal policy under section 18.1 (Appendix 6) clearly states how it supports locum or short-term placement doctors working in the organisation including those with a prescribed connection to another organisation. • There were 223 doctors under the temporary or short -term contract holder doctors for the appraisal year 2024/25 which is a 11% increase from last year (was 201 in 2023/24) and a further 92 under 'other doctors with a prescribed connection' who come under Medical Bank only which is a total of 315 doctors in this cohort. This is a significant increase of 11 % from 2023/24 and 27% compared to figures over 2022/23 at 249. • 71 doctors were International medical graduates in their very first job in the UK NHS and 42 doctors had commenced in role only within 1 to less than 6 months before 31.3.2025. The 42 doctors who joined late were not due an appraisal during this reporting period window. Those appointed on or after October 2024 in their very first NHS jobs were allocated appraisal months 6 months of being in the Trust. Please also see further the narrative under section 2 on Metrics. • Of the 275 doctors who were due an appraisal during this period 271 (98.5%) had an appraisal completed.

	• Only four doctors in this cohort (1.5%) had an approved missed appraisal due to maternity leave in two doctors, one missed appraisal from the last organisation at time of joining who connected with ELHT only in late March 2025, and the fourth doctor was a postponement due to his exams clashing with appraisal month and made a formal request for postponement. • The focused work over the years has resulted in this demonstrable improvement over the years from 80% appraisal completion for this cohort in 2017 to consistently high figures, above 95% over the past five years and above 98% this year. • Very short -term agency locum doctors are supported, with provision of exit reports signed by their line manager and not through the appraisal team as per current ELHT processes as they are connected to the respective agency as their DB. • All doctors employed at ELHT including locum and short term employed doctors have access to all the learning and development resources available through the ELHT education hub, and e-learning for health online and have access to the varied courses through learning and development team as well as Post Graduate Medical Education training resources on offer besides departmental teaching sessions, to keep up their Continuing Professional development (CPD). • All are supported with corporate induction as well as specialty specific induction besides accessible core skills and mandatory training resources. • All consultant job plans are supported with core SPA of 1.5 (equivalent to six hours per week) to support CPD activities including clinical audit, Quality improvement initiatives, research and to attend educational activities internal and external. • Those doctors who are locum/short term and connected to ELHT as their Designated Body are supported with their appraisal and revalidation like substantively employed doctors. • Appraisers receive a collated annual feedback report to enable their own reflections in their role as appraiser to be included within whole scope of work appraisal discussions at their own annual appraisal. • There is a good leadership development training package offer for all new clinical directors supported by DMD for Professional standards besides a Trust wide generic offer for all staff through the ELHT Education hub.
Action for next year	• Also see action under response to Section 1B below

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	• Yes
Action from last year:	• The above process is well embedded in our organization • Medical appraisal policy section 11 covers this comprehensively. Also see details under 1A (vi) & section3
Comments:	• All doctors connected to ELHT are supported with an annual governance report (as an extracted report from Datix) routinely over the last ten years. This support was through a Governance facilitator who extracted the reports for each doctor from Datix the month before their appraisals to include any incidents, complaints, claims or coroners' inquests the doctors was named, in any capacity. This support was interrupted due to the governance administrator responsible for this reporting, leaving the role in July 2024 and the new person to replace her was appointed only after a one-year period in July 2025 further to escalation to executives in November 2024 via the Head of HR. • This resulted in a gap in this governance resource support provision for medical appraisals during this reporting period. As an alternative measure, doctors were all asked to proactively self-declare any incidents, complaints, claims or coroners' inquests they were aware of and involved in and submit reflections at appraisal. Likewise, appraisers were advised to explore this as a priority focus at appraisals in the absence of governance report until the process resumed again from July 2025. • ELHT doctors at consultant level have always been supported with Dr Fosters Clinical Outcome Benchmarking Performance data report as part of supporting information provided by the Trust over the last more than ten years. The Dr Fosters reporting resource pack was decommissioned by Trust in November 2024. A new locally developed Performance and Activity report through Clinical Informatics team is in place to replace the above, since December 2024. • The newly developed Activity and Performance reporting based on Dr Fosters metrics, is summarised into a clinical outcome benchmarking report by Trust informatics team and provided for all connected

	consultants for annual which includes peer benchmarking at local and national level. This helps identify and reflect on any outlying clinical outcomes for actions as appropriate and applaud excellence and good practice when noted. • For non-consultant grade of doctors, this resource in this format is not available currently and this is across the Nation. They can request their activity and performance data through Divisional informatics and Theatre man data for surgical team and maintain their own log of clinical activity for reflections. This is recommended for all non-consultant grade doctors connected to ELHT as their DB. • Those doctors who are short term and locum and connected to another DB are also supported with a Governance report at request through appraisal and revalidation team on request so that it forms part of their whole scope of work inputs into appraisal. • ELHT doctors who work in other organisations including private/independent sector are mandated to submit a Letter of good standing from them to cover the requisite assurances under Whole scope of work. This is checked and monitored closely through QA review processes. • If additional information is requested from a doctor to be discussed at appraisal, this is shared as an RO note in the RO note section within the L2P system which is shared with appraisee and appraiser so that it is included in appraisal discussions.
Action for next year:	• Continue current process and see section 3

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	• Yes
Action from last year:	• Please note the gap in Governance report administrator between July 2024 and June 2025 which is now reinstated from July 2025 and working seamlessly again as per SOP 5 within appraisal policy in Appendix 6. • The newly developed Performance and Activity outcomes report for consultants is also well embedded currently and its administrative processes covered by SOP 6 within appraisal policy in Appendix 6.
Comments:	• As above and SOP 14 in appraisal policy in Appendix 6 covers processes to be followed for anyone exempt from letter of good standing from other places of work which includes a documented template for self-declaration assurance process.
Action for next year:	• Continue as at present

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	• Yes
Action from last year:	• Appraisal policy for ELHT (Appendix 6) has been updated and ratified as per last year's report and is now well embedded after implementation
Comments:	• See appendix 6 for copy of ratified policy in place
Action for next year:	• Continue as at present

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	• Yes
Action from last year:	• ELHT A&R team continually monitors the supply and demand for appraisers in line with number of connected doctors and ensures there are enough trained appraisers to effectively support and deliver the

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	appraiser functions. See Appendix 7 summary report that outlines review undertaken on appraiser demand and capacity for the reporting period.
Comments:	• Currently there are 106 Appraisers at the time of writing this report who have all been trained in line with National guidance. During the reporting period end there were 93 appraisers with further 13 appraisers recruited and training event was held on 3rd September 2024 as well as 22nd July 2025 for additional ongoing demands.
Action for next year:	• Continue to monitor the appraiser demand and capacity as number of connected doctors continue to increase as under Section 1A(ii) and continue ongoing recruitment and training

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	• Quarterly appraiser network events continue for the above. • QA review is undertaken for all appraisals (100%) submitted to RO using a Generic locally developed template. • PROGRESS review of a sample of appraisals as planned could not be completed last year as was interrupted- now in progress.
Comments:	• An e-learning module is in place for ELHT that was developed for appraisers as part of new appraiser training as well as part of appraiser refresher training for all. • New appraiser recruitment and training is held as per capacity and demand monitoring results periodically by A&R team. • Quarterly appraiser network and training sessions enable CPD for appraisers with both internal and external speakers (example: GMC), network opportunities with peers and calibration and peer review opportunities. • Appraisers are provided with anonymised collated feedback report from appraisees on an annual basis that helps them to reflect on their appraiser performance and discuss same at appraisals under whole scope of work.
Action for next year:	• Ensure that the PROGRESS QA review audit in progress is completed and presented at appraiser network in 2025- see section 3

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	• Yes
Action from last year:	• To continue as before
Comments:	• L2P appraisal and revalidation management system is in use since April 2015 and is well embedded. Robust QA processes are in place by the firm which passes on assurance annually. Due diligence is undertaken before each contract renewal. • Trust was informed by L2P on 6.11.2024 that the firm was acquired by Patchwork Health and continue to operate as before as L2P with Nil changes to operational aspects that impact users.
Action for next year:	• Continue as at present

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	• Yes- the above is followed robustly in line with GMC requirements and RO regulations
Action from last year:	• Continue as before
Comments:	• Please see section 4 in medical appraisal policy-appendix 6. • There are SOPs in place for all relevant aspects linked to this: SOP 9 for management of non-engagement concerns and relevant escalation routes. • A teams-based approach is now in place to support the revalidation readiness assurance preparedness with a share point live link to report that is continually updated by A&R team which is accessible for A&R team members. SOP 12 within appendix 6 outlines the process for medical revalidation readiness assurance checklist completion to enhance the robustness of this process within medical appraisal policy. Please also see section 1C(ii)
Action for next year:	• Continue as at present

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	• Yes- the above process is robustly embedded

Action from last year:	• Continue as before
Comments:	• As above. Please also see response under section 1C(i) as well. • For those doctors who require a deferral recommendation for valid reasons, these reasons are discussed as a team within A&R team fortnightly catch ups with AMD A&R and Deputy MD for Professional Standards who makes recommendations on behalf of RO, to have a good understanding of reasons for deferral. • A deferral action plan is documented and shared and agreed with the doctor by AMD A&R ahead of deferral recommendation and this is also shared as an RO note in the L2P system with the appraiser as well as the doctor. This acts as a prompt for timely completion of agreed actions with clarity on expectations from doctor and appraiser thus enabling timely recommendation post deferral within timescales and avoidance of a second deferral. Please also see under section 1C(i)
Action for next year:	• Continue as at present

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	• Yes
Action from last year:	• To continue as before
Comments:	• Yes. Effective clinical governance is well embedded in our policies and processes, and this continues to grow and evolve. The appraisal policy in appendix 6 and the range of SOPs within the policy cover this comprehensively. Our responses to all the above questions 1A-1D as well as the following questions under remaining subsections of 1D up to 1G covers this with added assurance in addition to details below. • Patient centred care and clinical effectiveness that promotes and enhances patient safety and quality of care is always promoted and actively nurtured at ELHT through its Governance structures, policies and systems. Doctors are contractually obliged to follow Trust policies that adhere to the above commitment by Trust. • All doctors are supported with appropriate resources to keep self-UpToDate with CPD in addition to core CPD allocation of 1.5 SPA time for consultants and similar for non-consultant grade.

	• All support is provided for doctors with A&R across the range of Supporting information needed that reduces bureaucracy and pressure on them to seek data. example: governance report and performance data provision besides appraiser feedback individually and collectively as annual report and support in a streamlined manner with collation of patient and colleague feedback in every revalidation cycle. • Clinical audit and effectiveness department has a robust process of annual forward planning trust wide and within every specialty which enables doctors to actively participate in clinical audits, QI projects and other clinical effectiveness initiatives. Research and innovation are actively encouraged for all medical professionals. • The A&R team is accessible to all, friendly and approachable and fully trained and responsive to all queries to support doctors. • The Trust Quality strategy and its closely linked Behavioural framework have a key focus on Compassion and Compassionate and Inclusive values and leadership. Compassionate and Inclusive approaches are therefore inbuilt into the related policies and processes Trust wide. These are embedded into medical A&R policy as well as those linked to managing concerns regarding doctors and Freedom to speak up, disciplinary, grievance and resolution and other HR policies. • The Trust in its pursuit to progress across the compassion/Inclusion continuum, is committed to becoming a more visible and intentionally Anti-Racist organisation through Project Aarushi which is an innovative QI initiative in collaboration with Care Quality Academy to reduce inequities in staff and patient experience, recruitment and progression besides enhanced leadership commitment to this aspect of Compassion in action. Trust is also progressing to next stages further to receipt of BRONZE award from BAME assembly last year and will apply for silver by end of the year. • ELHT has a newly established Health Inequality Committee in place with multi-disciplinary membership that strives to address systemic inequalities through data driven approaches. • ELHT is a formal early signatory organisation of the Sexual safety charter by NHSE and has an Operational Task and Finish group set up through the Women staff network that has compiled the Trust Policy on Sexual Safety in the Workplace for staff and all service users as well as a range of workstreams to enhance this.

	• ELHT has been an active participant as a pilot site in first wave of the NHS resolution offer of Compassionate conversations training in 2023/24 as highlighted in last report.
Action for next year:	• Trust had committed to expressions of interest to NHSE to become a pilot site among one of the six organizations in the Northwest to implement and embed the LOTUS Compassionate leadership framework and toolkit by NHS England through a collaborative initiative with NHSE at the time of writing the last report. However, this was not possible due to the extraordinary financial and operational pressures Trust faced during this reporting period. Trust may consider this as part of second wave pilots in future.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	• Yes
Action from last year	• Continue as before
Comments:	• Effective systems are in place for monitoring the conduct and performance of all doctors working in our organization. This is covered within relevant policies as referred to within the medical appraisal policy itself. (appendix 6) • Professional standards group as a multi-disciplinary advisory group led by the Deputy Medical Director for Professional Standards and chaired by Head of HR, supports the RO functions related to this aspect. Terms of reference are in place for this group approved by the JLNC- Joint Local negotiating Committee which also act as a consultation body for all related policies. • There are appropriate support systems for reflections on related events from doctors as advised by RO, feeding into appraisals. Formal investigations and/or other similar additional evidence advised by RO - appears as RO note for appraiser, doctor and appraisal lead to ensure is part of appraisal and QA reviews.
Action for next year:	• Continue as present

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	• Yes

Action from last year:	• To continue as before
Comments:	• Activity and performance report for Clinical Outcome Benchmarking against local and National peers. (see transition from Dr Fosters to a Locally developed report by Trust Informatics team) • Governance data annually – incidents, claims, complaints, coroners' inquests, significant events (See gap with this between July 2024 and June 2025) • Annual appraiser feedback collated as report, based on appraisee feedback for the year annually. • RO note shared with appraiser and doctor if any additional information is requested by RO to share at appraisal. • Deferral action plans if any are shared as RO note so that actions are clear with timelines for completion. • All guidelines and resources are accessible for all connected doctors in the L2P resource section as well as in the Intranet. • See also section 1B(i)
Action for next year:	Continue as at present

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• HR 39: Responding to concerns about clinical performance. • HR09: Trust Disciplinary Policy • HR06: Trust Sickness Absence Policy • HR20: Freedom to Speak up Policy. • HR 07: Early Resolution Policy • HR36: Study and professional Leave Policy • HR51: Guidelines for Consultants and SAS e-job planning • HR46: Medical Appraisal Policy
Action for next year:	• Ensure ratification and implementation of the newly developed Trust policy for Sexual Safety in the Workplace that has recently been completed and awaiting final consultation and ratification.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• All policies are in place and UpToDate subject to appropriate policy council ratification and Equality impact assessments. • Appropriate robust processes to operationalize policies as Standard operating procedures are in place subject to similar governance approval processes. • A multi-disciplinary Professional standards group continues in place as an advisory body for the RO on matters related to concerns regarding doctors. This is led by the Deputy Medical Director for Professional standards and chaired by Head of HR and has in its core membership the DMD Professional standards, AMD A&R, Director of Medical Education, Head of HR, Associate Director for patient experience, and Head of Occupational health/wellbeing team beside co-opted members as needed. • Good relationships are in place with GMC ELA with whom periodic meetings are held with regards to cases needing escalations and reporting to GMC. • Discussions are also held by DMD Professional standards with the NHS Resolution Practitioner Performance Advisory Service (PPAS) advisor of a legal background as well as periodic updates with the Designated Non-executive director. • Support is also available from the Trust Freedom to speak up Guardian and champions who are independent. • Bi-Annual analysis and review audit is undertaken by DMD professional standards on the type and outcome of concerns as well as demographics of the doctors involved (including age, gender, specialty, ethnicity, country of primary medical qualification, length of time working in the UK). This report has been shared with Board and at local forums such as PSG and JLNC covering (Appendix 4) • Please also see responses related to this under section 1D (i-iv)
Action for next year:	• Continue as at present and Biannual report once every two years

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• MPIT is used effectively as per policy besides any other RO to RO means of communication as appropriate. • Any concerns identified about locum doctors on their exit report are sent by medical staffing to the DMD for Professional Standards who liaises directly with the doctor's RO to ensure support for the doctor and that any learning is identified and actioned. SOPs 3,4 in medical appraisal policy relate to incoming and outgoing MPIT forms (appendix 6)
Action for next year:	• Continue as at present

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• Safeguards for all above are in place and well embedded at ELHT • EDI annual mandatory training is part of induction and annual update training. • Equality Impact assessment is undertaken for all policies. • PSG is a multi-disciplinary body bringing diverse voices together. • ELHT has a thriving staff inclusion network with at least nine different staff networks feeding into this. • ELHT has a newly established Health Inequality Committee in place with multi-disciplinary membership that strives to address systemic inequalities through data driven approaches • Please also see response under 1D(iv)
Action for next year:	• Continue as present

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• GMC expert speaker was invited to deliver a session at the appraiser network on updated Good Medical Practice guidance updates, Focus

	on Discriminatory behavior and Bystander duties (June 2024), National Consultant Information Program (NCIP) presented by NCIP lead Miss Maire Morton (September 2024) and more recently a focus talk by GMC on Fairer Conversations and feedback – Reducing Discrimination (July 2025) • Regional and National inquiries and reports are part of the RO updates by RO, as well as DMD Professional Standards and AMD A&R updates at appraiser networks periodically. Example: NHS Ten-year plan summary in July 2025 appraiser network • All relevant national and NICE guidance are part of the key reference documents for all policies that are implemented to guide the local clinical practice. • Effective processes are in place through Trust clinical effectiveness and audit team to drive gap analysis against National/NICE guidelines and ensure their implementation. • NHS people plan and promise besides principles of NHS constitution and National documents are part of Trust clinical strategy and all related Trust work. • ELHT has a dedicated Quality Improvement Faculty as well as Clinical effectiveness and audit team besides the Health Inequalities Committee and People and Culture committee that continually work towards driving evidence-based improvements as well as development opportunities in relation to governance from the wider system that ELHT is well integrated with. • Please also see responses under other 1D (i-vii)
Action for next year:	• Continue as before

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Y/N	• Yes
Action from last year:	• Continue as before as robust systems are in place
Comments:	• All relevant policies are current and in line with Regulatory and national requirements. They are, subject to Equality Impact Assessment for fairness and equity. • All professional standard concerns about doctors escalated to the DMD for professional standards are discussed at Professional Standards Group (PSG). The Employee Case Review meeting takes place monthly and discusses professional standards concerns for all

	other staff and is also chaired by the Head of HR and attended by core members of the PSG for consistency • The RO has oversight of all formal cases as does the Designated Non-executive director, GMC ELA and PPAS advisor. • Any decisions to exclude a doctor would be discussed with the CEO also as per Trust policy and this has not been required in the last four years • Reporting of concerns to Trust Board takes place once every six months as per updated arrangements and includes any restrictions on practice. • On reviewing the Messenger review report again this year at the time of writing this report, the DB is assured of all key recommendations being fulfilled at the organization and continuing in an ongoing manner. • Please also see responses under 1D (i-Viii)
Action for next year:	• Continue as at present

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	• Yes
Action from last year:	• To continue as before
Comments:	• Robust pre-employment checks are in place through medical staffing team and HR, that ensures, that all doctors employed by Trust, including locum and short-term doctors have appropriate qualifications and are suitably skilled and knowledgeable to undertake professional duties. • Processes are in place to ensure that professional references are checked by medical staffing team as well as by Specialty Clinical Director and/or their delegated deputy for all appointments. • Any queries or concerns arising from references or special support and/or supervision needs are discussed with DMD for professional standards or the MD/RO with any related A&R queries through AMD A&R.
Action for next year:	• Continue as at present

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• Professional standards are linked directly to Trust values as highlighted within the Trust Quality strategy and its closely linked Behavioral framework. Both have a key focus on Compassion and Compassionate and Inclusive values and leadership. • Compassionate and Inclusive approaches are inbuilt into the related policies for managing concerns to compassionately support doctors who are subject to performance concerns investigations whether internal or through external GMC/others. • Professional standards group models the multi-disciplinary framework that nurtures diversity and inclusion to be fostered through its diverse membership and expert inputs and insights for advisory consensus. • ELHT was one of the five pilot sites who successfully implemented the NHS Resolution “Compassionate Conversations Training” through a cascaded training via the Train the trainer approach which was in progress at the time of the last report and has been completed since. • ELHT had signed up expressions of interest to take part in a pilot/ regional early adopter site for the NHS England initiative on the LOTUS compassionate leadership framework and toolkit implementation at the time of the last report. Unfortunately, due to the extraordinary pressures faced by Trust this was not possible to be launched as anticipated. • All doctors on whom performance concerns investigations are initiated are provided with supportive Trust resources through OH and wellbeing team as well as external resources such as ➢ Employee Assistance Program. 24/7 telephone support ➢ Occupational Health and Wellbeing Department. ➢ Wellbeing website ➢ Practitioner Health Service ➢ Access to Work Mental Health Support by Able Futures ➢ Practitioner Performance Advisory Service

	➢ Freedom to Speak Up Guardians • Please also see responses under 1D(i-ix)
Action for next year:	• Continue as at present

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation **at all levels.**

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• Trust has committed to becoming an intentional, visible and proactive Anti-Racist organization with commitment to compassion and inclusion in action through an initiative called Project Aarushi that commenced at time of the last report as a collaborative venture with CQA. The tenure of this project has been extended to 3-years with acknowledgement that culture work takes more time. Trust developed its "Antiracism Charter and Position statement " as well as "Anti Racism and Allyship framework- Behavioral expectations" as part of this initiative for the first time. A comprehensive training program has been developed and in place now that is accessible for staff. This initiative aims to reduce inequities in patient experience, staff experience, staff recruitment and progression and influence leadership and culture promoting growth across the Inclusion continuum. Trust is developing collaborative approaches towards addressing Anti-racism and commenced the planning phase of joint working with University of Central Lancashire commencing with a Memorandum of understanding being drafted. • Trust is an early signatory of the NHSE Organisational Charter on Sexual Safety in the workplace. As part if this commitment. Trust has recently developed a new policy for Sexual Safety in the Workplace (awaiting ratification) in line with NHSE National policy as well as "Sexual Safety and Allyship – Behavioral Expectations". A new anonymous online reporting system for this is currently under consultation for development soon to be incorporated within Datix. • The process developed at the time of last year's report to support medical staffing team management of long-term leave request for staff in bank system (maternity leave, paternity leave, planned sickness absence and career breaks included) continues. This ensures that bank staff working exclusively in bank requiring long term leave as above are supported fairly, compassionately and inclusively.

	• Please also see under 1F(i) and Please see section 2 Metrics response to first question on International Medical Graduate/Overseas doctors in their very first job in the UK on support provided for them in Appraisal
Action for next year:	• Ensure ratification of the Trust policy for Sexual Safety in the Workplace through Policy council after approval through appropriate forums. • All the training programs related to above inclusion initiatives on anti-racism and sexual safety need ongoing support from Trust Board to continue to embed at all levels.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• Dedicated Freedom to speak up Guardian and Champions across the Trust are in place that staff can approach. This is supported by a 'HR20: Freedom to Speak up - Staff Raising Concerns policy' • Staff are supported by policy 'C075: Openness and Honesty when things go Wrong- incorporating requirements of Duty of Candor' • Trust has a Quality Improvement Faculty in place that supports a range of Quality improvement initiatives focused on Continual and ongoing learning that is integral to a learning culture. • Lessons learnt from incident reviews are shared through Divisional Lessons Learnt Forums within Serious Incident Review Group for team-based reflections and learning and report to Trust patient safety group. • Trust has an effective TODI- Transformation and Organisational Development and Inclusion Team that supports a range of Learning/training resources Trust wide. • Learning culture is nurtured across the organization at all levels and across all multi-disciplinary specialty areas through the varied platforms, educational and training activities. • Please see responses under earlier 1D and 1F (i-ii)
Action for next year:	• All the training programs related to Anti-racism, sexual safety and inclusion initiatives need ongoing support from Trust Board to continue to embed at all levels as outlined under section 1F(ii) .

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• Formal complaints procedure is in place and covered by related policies all of which are referred to under supporting documents within the medical appraisal policy. Also see responses under Section 1D
Action for next year:	• Continue as at present

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act

Y/N	• Yes
Action from last year:	• To continue as before
Comments:	• Please see under responses in 1D(v) and 1F (i, ii, iii)
Action for next year:	• All the training programs related to inclusion initiatives need ongoing support from Trust Board to continue to embed at all levels as outlined under section 1F(ii).

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	• Yes
Action from last year:	• Continue as before
Comments:	• RO, DMD Professional Standards and AMD A&R with Appraisal team, regularly attend Regional RO network meetings organized by Higher Level RO. • RO, DMD PS and AMD A&R attend GMC RO Reference Events. • AMD A&R is also a Regional RO appraiser as well as RO to the two hospices that have an SLA with ELHT over several years • AMD A&R chairs the Quarterly appraiser networks at ELHT. GMC speakers are periodically invited to speak at these. • Peer review meeting hosted by ELHT took place in October 2024. Seven organisations participated namely East Lancashire, Lancashire

	and South Cumbria, Lancashire teaching, Morecambe Bay, Blackpool, Airedale and Warrington and Halton hospitals. This is further to the formal peer to peer review process undertaken for ELHT in summer 2023 and to monitor ongoing progress and actions across all Trusts that participated. Please see Appendix 8. • A&R coordinator and A&R administrator attend the quarterly Northwest A&R admin/manager's network. • All the above enables us to ensure that our processes are consistent with national/GMC policies and with other organisations.
Action for next year:	• Continue as at present

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. **PLEASE SEE NARRATIVE BELOW:** • There were 754 doctors connected to ELHT as their DB, at end of year 31.3.2025. • Of these, 42 were IMG doctors. These 42 doctors were in their very first job in the UK, and NHS who joined Trust within less than 1-6 months of 31.3.2025. • These IMG doctors' appraisal month was allocated further to extended induction only from 1.4.2025 onwards so that they have sufficient time to settle into the new system, new country and new role in their first job in the UK NHS. • This is a compassionate offer and change within ELHT, compared to previous years when a priming appraisal used to be allocated within 1-3 months of joining. This change considers the fact, that appraisal preparations add to pressures as we know from appraisee feedback over the years and participation in appraisal is a totally new concept for them with added pressures for this group of doctors going through major transformational changes already. • Please note that IMG doctors joining ELHT between 1st April to 1st October are all allocated appraisal months within the current appraisal window and the above exemption only applies to IMGs joining in the latter part of the year on or after 1st October 2025. • The welcome and introduction email to all new doctors joining the Trust and connected as their DB sent by the A&R team includes information on all resources as well as a link to the e-learning for appraisees to understand the process and principles before they have an appraisal at ELHT.	754 total **712 connected doctors were eligible for appraisals during this period (denominator)** **See narrative on left for exemption details**
Total number of appraisals completed	**699 out of 712 (98.17%)**
Total number of appraisals approved missed All 13 had reasons that were known and understood	**13**
Total number of unapproved missed	**0**
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	**120**
Total number of late recommendations 100% of recommendations were made in a timely manner	**0**
Total number of positive recommendations	**114 (95%)**
Total number of deferrals made	**6 (5%)**

Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**0**
Total number of trained case investigators	43 MHPS trained
Total number of trained case managers	9
Total number of concerns received by the Responsible Officer[2]	12
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March (working days)	572 days
Median duration of concerns processes closed (working days)[3]	114
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0 by ELHT
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	NA
Total number of new doctors joining the organisation Total number of doctors employed between 01/04/2024 to 31/03/2025 Substantive - 202 Bank Only - 149 Overall total - 351	351 See Narrative
Total number of new employment checks completed before commencement of employment Pre-employment checks are made for ALL colleagues who are employed by ELHT prior to commencing employment - except for deanery trainees hosted by the Trust during their rotation Checks are already made by the Deanery (HEE) would be used for those colleagues who are completing additional paid shifts via ELHT Medical Bank while on a formally recognised Training Program	351 See Narrative
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	NA

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

- Good assurance on all aspects of NHS England and GMC requirements as per responses detailed above in the report content.
- All actions from last year have been completed apart from one action in progress as it was interrupted last year. The action in progress is:
    - Quality Assurance review of a sample of appraisals using the PROGRESS QA review National tool. (Note: Assurance is in place for the organisation due to 100% of appraisals undergoing Quality assurance review using a locally developed Generic QA review tool. The action in progress is over and above the generic QA review.)

Actions still outstanding

- As above

Appendices:

1.Annual Report to Board Submitted to NHSE 2023/24

Appendix 1 - ELHT ANNUAL REPORT TC

2. Evaluation of Questionnaire survey of ELHT Appraisers

APPENDIX 2 ELHT APPRAISER SURVEY 2

3. Medical Service User Feedback Questionnaire with Instructions

Appendix 3 - Medical Service User

4. Bi-annual audit of Doctors with Performance concerns

PSG data Aug 2022 - July 2024.pptx

PPAS OAR EAST LANCASHIRE HOSPI1

5.Updated Activity and performance Data for Medical Appraisal at ELHT

Appendix 5 - Updated Activity Per

6. HR46: V3.7. Appraisal Policy for Consultants, Associate Specialists, Specialty Doctors Non-Deanery.

Appendix 6 - HR46 v3.7 Appraisal Policy

7. Review of Medical Appraiser Demand versus Capacity at ELHT

Appendix 7 - Appraiser Appraisee

8. Agenda and Notes from the Peer Review Meeting Hosted by ELHT October 2024

Appendix 8 - Peer Review Meeting Age

Current issues

The below are an ongoing challenge for the Trust Medical A&R team. Support is needed for the below:

1. Ensure that ongoing medical appraiser recruitment in line with demands due to work force expansion is supported continually by appropriate nominations by Clinical Directors and Divisional Medical Directors as part of Directorate and Divisional core Governance and Business activity as there is no centralized RO budget allocated for this.

2. Ensure there is consistency in job plan allocation of 0.25 SPA for all Trust appraisers and that they continue to be supported with 0.25 SPA in job plans for appraiser role (for 6-8 appraisals per year) through Directorate CDs and Divisional DMD's as above as part of core governance and business activity in directorates and divisions with RO team oversight, as there is no centralized RO budget allocated for this.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

1.Trust wide dedicated appraisal workshops for all doctors to be reinstated – AMD A&R with support from A&R team

2. Enhanced appraisal support resources for the increasing number of IMG doctors new to the UK in their first job in ELHT - AMD A&R with support from DMD PS and A&R team

3. Complete the PROGRESS QA review of sample appraisals-AMD A&R with support from A&R team

4. Continue as before with the Bi-annual audit of doctors with performance concerns once every two years when due -DMD PS

5. Continue monitoring appraiser appraisee ratio and demand versus capacity evaluation periodically and a detailed end of year review annually – A&R team with lead support from AMD A&R

5. Implement the policy on Sexual Safety in the workplace further to ratification- Sexual Safety Task and Finish Group with support from the Women Staff network that commissioned the Task and Finish Group

6. Continue to progress the Inclusion initiatives and related training with appropriate support- Trust Board to support TODI team (Transformation, Organisational Development and Inclusion) on the sustainable implementation of the already launched Anti-Racism and Allyship training as well as Sexual Safety e-learning and onsite training, support Aarushi team on Anti-Racism initiatives, and Women's Staff network on Sexual Safety Initiatives besides all other Staff Inclusion networks' agendas to progress the organisation in its journey across the Inclusion continuum.

7. Ensure that ongoing medical appraiser recruitment in line with demands due to work force expansion is supported continually by appropriate nominations by Clinical Directors (CD's) and Divisional Deputy Medical Directors (DMD's) as part of Directorate and Divisional Core Governance and Business activity as it has always been the case since Medical A&R was implemented, and as there is no centralized RO budget allocated for this in the Trust – CD's and Divisional DMD's with RO team oversight

8. Ensure there is consistency in job plan allocation of 0.25 SPA for all Trust appraisers and that they continue to be supported with 0.25 SPA in job plans for appraiser role (for 6-8 appraisals per year) through directorates and divisions by CD's and Divisional DMD's as above as part of Core Governance and Business activity in Directorates and Divisions with RO team oversight, as it has always been the case since Medical A&R was implemented, and as as there is no centralized RO budget allocated for this in the Trust- CD's and Divisional DMD's with RO team oversight

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

- Good assurance is in place at ELHT on effective processes to support medical appraisal and revalidation and related governance processes. Has been a good year overall with 98.2% appraisal rates and Nil unapproved missed appraisals. Trust has always consistently achieved high medical appraisal rates above 95% since 2015 and above 98% over the last three years and this continues.

- 100% of those requiring revalidation (N=120) had a timely recommendation made to the GMC with 114 positive recommendations (95%) and only 6 approved deferrals (5%) and Nil non engagement.

- All relevant policies and SOP's for enhancing robustness of governance at ELHT linked to statutory RO responsibilities are current and UpToDate and formally ratified further to equality impact assessment.

- ELHT plays an integral part as an active system partner for all the peer organisations in the context of medical appraisals. The peer review report in 2023 and taking the initiative to organise and host the 7 Trusts at the peer review meeting in October 2024 demonstrate our proactive and collaborative approaches.

- 100% of appraisals are subject to Quality assurance review using a generic QA review template with feedback enabled to appraisers besides the provision of annual collated feedback report to all appraisers as part of supporting information in their role as appraiser for their own appraisals.

- This report provides assurance to Trust Board and NHS England on compliance against GMC and NHS England standards for medical appraisal and revalidation as well as professional standards and related organisational governance.

- The report provides assurance that Trust is fulfilling all Statutory responsibilities that are expected under Responsible officer regulations 2010 updated 2013.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman)

Official name of the designated body:	East Lancashire Hospitals NHS Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/124
Report Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2025		
Author:	Heather Taylor,		
Lead Director:	Tony McDonald, Chief Integration Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	This paper describes the current position of the Trust in relation to the NHS Core Standards Assurance for emergency preparedness, resilience and response (EPRR) and provides the Trust Board with assurance that ELHT meets its statutory duties under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 and its other non-statutory obligations.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Trust Board is requested to receive the statement of compliance contained within this report that the trust is declaring itself as substantially compliant to NHS England Core Standards. They are also asked to receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.			

Previously Considered by:	
Date:	
Outcome:	

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2025

Executive Summary

1. This report provides an overview of the Trusts emergency preparedness, resilience and response during the past 12 months and provides assurance that East Lancashire Hospitals Trust meets its statutory duties under the Civil Contingencies Act 2004, NHS Act 2006 and the Health and Social Care Act 2012 and its other non-statutory obligations.

2. This report also summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements based on the completion of the annual EPRR Core Standards Framework and Statement of Assurance submission.

Background/Introduction

3. The Trust under the Civil Contingency Act 2004 as a Category 1 Responder has the following responsibilities:

    - Carry out a risk assessment.
    - Have in place plans to respond to emergencies.
    - Have in place business continuity plans.
    - Collaboration and co-operation with other agencies
    - Warn and inform the public and other agencies.
    - Training and exercising.

4. The Trust has a statutory obligation to train and exercise with a live exercise every three years, and annual tabletop exercise and a six-monthly test of the communication cascade. An exercise programme for 2025 was developed and the following exercises are in place for 2025
    - Exercise Creta (External)
    - Exercise Formo (External)
    - Exercise Kaus Australis (External)
    - Evacuation and Shelter Exercise (Internal)
    - Lockdown Exercise (Internal)
    - National Power Outage Exercise (Internal)

5. The NHS England Core Standards for EPRR 2025 sets out how NHS organisations are to meet their responsibilities and the NHS England EPRR Framework (2022) states that NHS provider organisations are required to have appropriate systems in place.

6. The Trust's EPRR responsibilities are managed and overseen by:

    - Accountable Emergency Officer – Chief Integration Officer
    - Head of Emergency Planning Resilience and Response (EPRR)
    - Deputy Chief Integration Officer – overseeing the work of the Head of EPRR.

Trust wide EPRR Plans

7. The following plans were reviewed as part of the annual review cycle:

    - Adverse Weather Plan
    - Evacuation and Shelter Plan
    - EPRR Policy
    - Pandemic Flu Plan
    - Major Incident Plan

Business Continuity

8. All divisions have been asked to review their business continuity plans for 2025.

9. A sample of the trusts business continuity plans were peer reviewed earlier this year and following the feedback we will be updating our processes for 2026.

10. A full training programme for staff who complete BCPs for their division will be rolled out to update on the changes.

EPRR Assurance Process

11. The Trust is participating in the Assurance exercise. This annual assurance process marks compliance against the NHS England Core Standards for EPRR and ensures that NHS organisations are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

12. All organisations are required to complete the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process self-assessment template.

13. The deadline for completing this year's assurance programme is Friday 3rd October 2025.

14. The comprehensive EPRR core standards assurance process is in the final stages of completion and ELHT are on target to submit an initial level of Substantial Compliance, which this Trust Board is asked to ratify (Appendix A). The completed self-assessment and action plan will be circulated following the submission in October 2025.

15. As previously reported, this is a process of continuous improvement cycle where the trust aims to be fully compliant across all standards by our submission next year. The Trust will continue to progress towards fully achieving these core standards with a robust action plan.

16. There will be no Deep Dive area (non-mandatory standards) for 2025/26.

Training

17. An audit of current trained loggists has been carried out and those requiring refresher training have been requested to book onto the online course provided by

UKHSA. The trust currently has twelve (12) members of staff who form the loggist cadre. The trust will look to increase this number going forward into next year.

18. Throughout 2025 directors and senior managers on-call have been attending NHS England's Strategic and Tactical Health Commander training courses, receiving excellent feedback from the participants.

19. Further eLearning packages have been rolled out to all directors and senior managers on call to ensure that we comply with EPRR minimal occupational standards.

20. Training has been provided to our Emergency Department colleagues for Initial Operational Response (IOR) HAZMAT response, as required by NHS England.

21. Evacuation and Shelter training was provided to several staff from Medicine, Surgery and Paediatrics. This was identified as good practice following a fire on D3 and will now be rolled out to all wards.

Testing and Exercising

22. The trust has taken part in three exercises that have been developed by the ICB. These were:
    a. Exercise Creta – January 2025
    b. Exercise Forma – June 2025
    c. Exercise Kaus Australis – July 2025

23. The exercises allowed several participants across the Trust to come together to test how effectively the Trust responds to incidents. Participants included representation from the Strategic (Gold) and Tactical (Silver) on call rotas, Staff from our Clinical Site team, Emergency Department and the Estates and facilities.

24. The aim of the Exercise Creta was to test the Trusts internal ability to clear capacity to receive casualties from a mass casualty incident. Specifically:
    - Create 10% bed base in 6 hours.
    - Create 20% bed base in 12 hours.
    - Double level 3 capacity in Critical Care for 96 hours from incident declaration

25. The exercise was received well and found to be extremely useful to all those who took part when questioned at the conclusion of the hot debrief.

26. Exercise Formo was an ICS system exercise to test the ability to support rapid discharge from the Acute Trust in the event of a mass casualty exercise

27. The exercise was well attended by all trusts across Lancashire and South Cumbria and the aim of the tabletop exercise was to follow on from exercise Creta and to feedback on the worksheets completed. All trusts and Northwest Ambulance Service discussed the logistics and challenges of managing mass casualty incidents, focusing on casualty reception, bed capacity, critical care, and recovery

phases. The discussion highlighted the need for coordination, staffing flexibility, and resource management to effectively respond to such incidents.

28. Exercise Kaus Australis was a business continuity exercise using a national power outage scenario. The exercise was a tabletop exercise delivered virtually across the NHS North West region utilising MS Teams. 33 NHS organisations participated.

29. Following the trusts continuous improvement cycle, a hot debrief took place following the exercise and several lessons and actions were identified and will be incorporated into the annual work plan. These included:

    - To roll out the exercise to all divisions. This will be our Major incident exercise for this year and will take place 23 September 2025.
    - To identify a location for a dedicated Incident Coordination Centre that is resilient to loss of power.
    - To procure radios for the Incident Coordination Centre to ensure resilience telecommunication.

Incidents

30. Business Continuity incidents this year include:

    - Burst Water Pipe – Burnley
    - Fire on D3 – Blackburn
    - Flies at Elective Centre – Burnley
    - Industrial Action
    - IT Outage – Blackburn
    - Loss of Water – Blackburn
    - MRI Helium Release – Blackburn
    - Sewage leak with ED – Blackburn
    - Numerous fire incidents with controls panels on Level 0

31. Responses to each incident were managed through the timely establishment of effective incident response teams. After each incident, facilitated debriefs are undertaken to identify any lessons to be learned and good practice that can further improve our responses to such incidents in the future and these are shared formally through the EPRR Committee where actions are tracked.

Multi-agency Working

32. The Head of EPRR is a member of the following meetings and attends regularly, contributing accordingly.

    - Lancashire Resilience Forum – Mass Fatalities Subgroup
    - NHS England triannual review of NHS Core Standards for EPRR task group

33. The AEO attends the Local Health Resilience partnership meetings on a quarterly basis.

EPRR Update

34. Over the next year the focus will be to address EPRR training and exercising for the trust. The team are currently asking all on call staff to complete a competency self-assessment to help the Head of Emergency Preparedness identify gaps and develop training to support staff in their roles.

Recommendations

35. The Trust Board is requested:

    a) To receive the statement of compliance contained within this report that the trust is declaring itself as substantially compliant to NHS England Core Standards.

    b) To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Tony McDonald
Chief Integration Officer
Accountable Emergency Officer
29th August 2025

Appendix A

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

East Lancashire Hospitals Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, East Lancashire Hospitals Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

29/08/2025

Date signed

10/09/2025	10/09/2025	_____
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix B – EPRR Core Standards Assessment 2024/25

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	AEO Chief Executive, delegated to Exec. Dir of Integrated Care, Partnerships and Resilience	Fully compliant	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy in place C159	Fully compliant	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	EPRR reports submitted throughout the year to Board outlieing training and our compliance in relation to the core standards assurance process	Fully compliant	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Reporting process within the EPRR Policy statement which also covers the workplan	Fully compliant	Add to quarterly EPRR committee meeting agenda
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy requires that sufficient and appropriate resources are allocated to the EPRR functions. Currently we are receiving support from Bank 1 day per week to support service	Partially compliant	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The EPRR Policy statement and Corporate Business continuity Plan outlie how the trust will learn from incidents and exercises.	Fully compliant	Need to add board reports

Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are discussed at EPRR Committee. EPRR risk reviewed every 3 months	Fully compliant	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management Policy in place where all risk are considered including EPRR	Fully compliant	
Domain 3 - Duty to maintain Plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Where appropriate partner organisations are consulted with. Currently done through EPRRC	Partially compliant	Develop system for requesting consultation and recording outocmes
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Corporate Business Continuity Plan and Major Incident Plan reviewed 2024. Elements of the plan have been tested recently with our Site Pressures - IMT have been stood up twice daily with representation from all divisons	Fully compliant	Major incident exercise to be planned for 2025
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Plan in place Weather warning shared with divisions	Fully compliant	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The infection Control team has a Hospital Outbreak Policy Policy IC14 v5.1 that's was ratified in December 2023 The trust also has a RPE Policy IC30 v1.0 MERs/SARS/Avian flu Policy - IC08 Management and control of Viral haemorrhagic fever - IC21 IC23 Influenza Policy including pandemic influenza guidance Recent measles outbreak tested these procedures	Fully compliant	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The infection control team have developed an influenza policy that includes the new pandemic guidelines ELHT/IC23	Fully compliant	
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Information included within the CBRN Plan	Fully compliant	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The trust has a MIP which can be used to respond to a mass casualty incident. LRF mass casualty plan in place and accessible via the EPRR and On call Sharepoint sites. These are supplemented by the NHS England Concept of Operations for managing Mass Casualties and the Guidance for managing mass casualty events in the lancashire and South Cumbria Major trauma network. Trust has a Full Capacity Protocol and Extreme Escalation Policy to create capacity when needed in ED	Fully compliant	ICB led exercise in next 6 months

16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation and Shelter Plan in Place. Partial Invacuation was required in September due to sewage leak on C9	Fully compliant	check with duncan re monitoring of local plans
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy in place. Walkthrough of actions within policy was conducted during Southport Riots in August. Lessons identified.	Fully compliant	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Reviewed by Director of Comms Sept 2024 current version remains fit for purpose. Plan used in 2023 for a number of visitors to the blackburn site	Fully compliant	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	LRF Mass Fatalities Plan in place. Head of EPRR involved in review and attends LRF meetings along with Mortuary manager. Previous Plan tested as part of Exercise Goshawk 2022. ELHT mortuary Plan outlines process if we were activated as part of the Resilience Mortuary activation.	Fully compliant	Desktop exercise with Lanc Police has been postponed - awaiting new date
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	On Call Policy sets out standards and expectations. Switchboard 24 hour access to alert SMOC/DOC/SCOC and to receive incident notifications.	Fully compliant	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	All strategic, tactical and operational staff have received training either via department of attending Health Commander training	Partially compliant	UKHSA Kallidus elarning packages to be shared with SMOC/DOCs
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	TNA included within EPRR Strategy and any other training is included in incident response plans as required	Partially compliant	Portfolios to be completed going forward. Elearning packages to be shared and completed by SMOC/DOCs inline with MOS for EPRR
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Corporate Business Continuity Plan and Major Incident Plan reviewed 2024. Elements of the plan have been tested recently with our Site Pressures - IMT have been stood up twice daily with representation from all divisons	Partially compliant	Develop exercise programme for 2025

24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training records kept by Head of EPRR and senior sister in ED for training in department	Partially compliant	Portfolios to be completed going forward. Elearning packages to be shared and completed by SMOC/DOCs inline with MOS for EPRR
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Training of SMOC/DOCs included in Board Reports. Training attendance recorded via Head of EPRR.Awareness of EPRR and Business Continuity included with Corportate Induction. Staff awareness also via departments for BCPs to guide staff on their roles/actions during an incident	Fully compliant	Add training and exercising attendance to future board reports
Domain 6 - Response								
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The trust uses the Board Room within Trust HQ - Birch House as its location for an Incident Coordination space. Further facilities are also available from Consort in their meeting room in XXX Can use virtually ICC via teams as well. All documented within Oncall pack	Fully compliant	further resources required to make fully functioning i.e radios Add ICC training to training programme for 2025
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Planning arrangement are available on Sharepoint and on the network drive for all staff and Senior managers and Directors on call. Hard copies are also stored in the major incident store room	Fully compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The trust has a corporate Business Continuity Plan and each department also has a local BCP which includes an escalation process	Fully compliant	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	The trust has a substantial cohort of trained loggists available to support the decision makers. The on call pack contains details on how to contact in and out of hours via switchboard who also keep a list. On call pack details how to keep personal records and decision logs	Fully compliant	Send out elearning package from UKHSA Kallidus packages
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Process is documented with the On Call Pack	Fully compliant	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	ED have guidelines available in the department	Fully compliant	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	ED have guidelines available in the department	Fully compliant	
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The Comms Team are aware of the Trusts EPRR arrangements and attend EPRRC. There is an on call rota in place for the comms team (24/7). This enables the Trust to provide support during an incident. All comms are logged centrally for future reference.	Fully compliant	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Major incident Comms Plan in place which includes action cards	Fully compliant	

35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The trust communicates with staff during incidents by sending out trust wide emails, notices placed on OLI (Internal website) and via emails to the Divisional OCC email inbox for verbal cascade. The Comms Team hold a list of stakeholders to enable the trust to warn and inform during an incident. We also use facebook and twitter to push messages out to the community.	Fully compliant	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Social Media Policy in place along with Major Incident Comms plan	Fully compliant	
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	AEO attends. Marrix shared by ICB. Current compliance 100% (Standard 75%)	Fully compliant	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	ELHT Head of EPRR and Mortuary Manager attend Mass fatalities meeting. ICB attends other LRF meetings on behald of LSC Trusts	Fully compliant	
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	ELHT developed Mutual Aid agreement across LSC. AEO signed just waiting final signoff across Trusts and ICB	Partially compliant	Chase signoff from other AEOs - clarity needed around staffing to be discussed at LHRP
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all			
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency			
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas			
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	No standard protocol. Each agreement is unique based on the data being shared/processed	Fully compliant	
Domain 9 - Business Continuity								
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Outlined in the ELHT EPRR Policy and Corporate BC Plan	Fully compliant	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Included within Corporate Business Continuity Plan	Fully compliant	Bite size briefing presentation to be added to EPRR Sharepoint to raise awareness

46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	BIA are included within the departmental BCPs and reviewed annually by each division	Fully compliant	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCP review compliance continues within divisions and monitored both within divisions and via the EPRRC	Fully compliant	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Simulation exercise conducted to look at loss of IT systems Lessons identified around actions re IT downtime in BCPs needs more focus	Fully compliant	cloudstrike
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Non Compliance this year - plan in place to meet or approach meeting standards	Partially compliant	copy of action plan
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The BCMS is monitored by the Head of EPRR and fed through the EPRR Committee. Currently isnt reported through boaard and no KPIs in place	Partially compliant	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Internal audit of crtital services by Head of EPRR following NHS BC checklist. These BCPs are monitored through EPRRC. Need to plan for external review in 2025	Fully compliant	Needs to document at EPRRC How to close loop following audit report /continuous improvement
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Process outlines with EPRR Strategy and Corportae Business Continuity Plan action plans from incidents are discussed through EPRR Committee Exercise report s produced to outline lessons identified. Interna; audit in place	Fully compliant	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	NHS supply chain manages own resilience. Email attached from Procurement on how they assess BCPs for providers	Partially compliant	Requires more evidence from ICB/.NHSE/LSC Procurement

Domain 10 - CBRN							
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	EPRR Policy Detailed within the CBRN/hazmat policy	Fully compliant
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Partially detailed within the Corporate BCP and included on the EPRR Risk Register	Fully compliant
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Information is available to all staff and is kept within the areas of Resus, Majors and UTC and also written on the whiteboard within Nurse in charge office of ED	Fully compliant
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Detailed within the Corporate BCP that will be activated along with the CBRN plan.	Fully compliant
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	ELHT trains all staff with ED including band 2s, The lead nurse in ED for Major incidents develops and delivers monthly training. Rota identifies CBRN trained staff. Dry/wet decon for both self-decontamination and non-ambulatory can be facilated at ELHT.	Fully compliant
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Equipment checklist is used by our ED department SOPs are available for all specialist equipment. PRPS suits are regularly maintained	Fully compliant

61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	PRPS - maintained by Respirex Ramgene - maintained by IRS Any other equipment is monitored, maintained and replaced internally and carried out by the lead nurse within ED.	Fully compliant	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	NWAS Acute and Non Acute Trust MOU in place with Veolia	Fully compliant	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	The trust has 9 members of staff within ED who have completed train the trainers but in the main sits with two senior sisters who deliver training on a monthly basis and content reviewed annually.	Fully compliant	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Training on IOR principles delivered by lead nurse in ED via face 2 face training on a monthly basis	Fully compliant	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	ELHT holds the minimum PRPS suits. All other PPE is stored within the ED department. Fit testing records are held by Fit testing team and are accessible via OLI	Fully compliant	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	At the training sessions include a practical - going through the decon unit but no formal exercise has taken place	Partially compliant	Add to training and exercising programme for next year

BOARD OF DIRECTORS REPORT

Meeting Date:	2 September 2025	**Agenda Item:**	TB/2025/124
Report Title:	Board Assurance Framework		
Author:	Executive Team		
Lead Director:	Susan Giles Interim Director of Corporate Governance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	The BAF has been reviewed by the Executives and Board Committees. The risk scores have been reviewed and remain unaltered. The descriptions of the controls and assurances have been simplified and actions have been updated.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to consider whether they are assured that: • Controls are effectively managing the level of risk? • Actions are on track for delivery and will effectively mitigate the risk to an acceptable level?			

Previously Considered by:	Quality Committee (Risks 2&3), Finance & Performance Committee (Risks 1&5), People & Culture Committee (Risk 4)
Date:	27th August, 2nd September and 1st September
Outcome:	The Finance & Performance Committee requested that BAF 5 be updated to reflect the Trust's cash position.

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) do not deliver the anticipated benefits for our communities and fail to support the financial recovery of the Trust, including exit from NHS Oversight Framework Segment 4 (Recovery Support Programme)

Executive Director Lead: Chief Executive / Executive Director of Service Development and Improvement

Strategy: ELHT Strategic framework (Partnership Working)

Links to Key Delivery Programmes: Care Closer to Home/Place-based Partnerships, Provider Collaborative, Tackling health and care inequalities

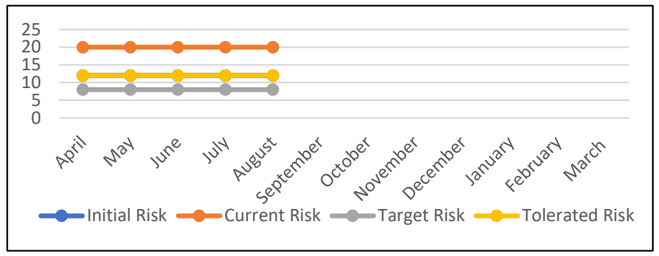
Date of last review: August 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR): Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C5 x L4 = 20**
Initial Risk Rating: C4 x L3 = 12
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Pursue/High/15-20

Controls in place to mitigate the risk:

Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB):

- The ICB has worked with partners to develop a Joint Forward Plan and to create a clinical strategy blueprint. System clinical reconfiguration leadership support has been commissioned to drive forward the system transformation programme.
- The ICB has formalised commissioning intentions for 2025/26 alongside a commissioning delivery plan.
- The system PMO continues to develop to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels of system working and oversight groups to ensure alignment of plans.
- The ICB are developing an improvement plan as part of the Recovery Support Programme to support exit from NHS Oversight Framework Segment 4 (NOF4)

Provider Collaborative Board (PCB):

- The PCB drives key programmes of Clinical Services and Central Service redesign
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles, representation at all other professional working groups.
- The Clinical Services Programme Board, oversees a programme of work focussed on clinical services configuration including fragile services.
- The Central Services Executive Committee oversees the delivery of One LSC including the transformation of the services and associated potential savings and other benefits of Central Services programmes with ELHT acting as the host of One LSC (refer to separate BAF risk 6).
- 3 of 5 Providers in the PCB are part of the Recovery Support Programme and as such, PCB plans will need to support the requirements of the Recovery Support Programme to support collective exit from NOF4.

Place-Based Partnership (PBP):

- Blackburn with Darwen Place and Lancashire Place are now agreed with place based delivery structures continuing to develop and be reflected in system commissioning intentions.
- Place + key forums in place to support delivery where needed across East Lancashire and Blackburn with Darwen e.g. Urgent and Emergency Care Delivery Board and delivery programmes being developed to align to NOF4.

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- 10 Key Delivery and Improvement Programmes and associated improvement priorities have been agreed for 2025/26, alongside 8 key improvement priorities with key measures of success outlined. These will support the delivery of the Trust's Improvement Plan
- Dedicated Recovery Director and PMO in place to support financial recovery. ELHT Improvement Practice has been developed to support delivery and build capacity for Improvement. Improvement Hub Team Properties will be aligned to the PMO supporting delivery of requirements of the Recovery Support Programme.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board for updates on system working/PCB.
- System delivery plans are reflected in updates on Trust Key Delivery and Improvement Programmes.

Independent challenge on levels of assurance, risk and control:

- PCB Business Plan signed off by all partners. Ongoing assurance on delivery provided via PCB Board and oversight groups.
- Trust, PBP, PCB plans feed into ICS-level plans as part of the national operational planning processes and are scrutinised by NHS England.
- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice complete with action plan agreed and sign off at Audit Committee with substantial assurance
- MIAA audit of ELHT Business Planning processes complete with action plan agreed and sign off at Audit Committee with substantial assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Commissioning intentions need to support delivery of tangible improvements and system transformation and financial recovery.	Work with system partners to agree commissioning intentions for 2025/26 and ensure clear plans in place to achieve system transformation and financial recovery	Director of Service Development and Improvement with SRO leads	September 2025	Work completed with commissioners to undertake a complete review of outstanding commission intentions in relation to 2025/26. A programme of reviews has been agreed for completion by the end of Quarter 2 to determine future commissioning requirements to support planning for 2025/26. Outstanding discussion required as to treatment of the fixed contract in relation to the national tariff for non-elective and maternity services. Work ongoing to jointly assess linked to commissioning intentions for 2026/27. Workshops planned with commissioners from July on commissioning intentions for 2026/27 and this is being built into future planning processes in a more robust way to support planning for next year and beyond including the requirements of the 1-Year Health Plan (published in July 2025).	A
2.	System transformation programmes need to deliver significant system transformation to deliver quality and financial benefits and algin to the Recovery Support Programme (RSP)	Work with partners to develop and implement system transformation programmes via the Clinical Transformation Board.	Executive leads	December 2025	System clinical reconfiguration leadership support commissioned and agreed as part of the Recovery Support programme. Work underway to: • undertake a rapid diagnostic of current clinical transformation and reconfiguration plans. • Identification of programmes where transformation can be accelerated • Develop a clinical reconfiguration proposal Initial review of current programmes underway and additional information requests submitted to support system review. Next steps to be determined by the PCB/ICB. Meanwhile progress on reconfiguration of Pathology and Vascular services is underway. Work is required to improve visibility of the PCB collaborative clinical and clinical support programmes to the Trust Board and relevant sub-committees.	A
3.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible and reduce demand in the acute setting.	Executive Director of Integrated Care, Partnerships and Resilience	April 2026	Co-production and co-delivery with place partners of service development and transformation including end to end pathway improvement across primary, community and acute settings. Agreement of clear targets and plans to reduce demand in secondary care, support increase care at home and support delivery of agreed Waste reduction Plan across the UEC pathway. Work underway to map the impact of changes to Primary Care Local Enhanced Services for impact on demand management to the hospital and to clarify opportunities from the system-wide review of Community Services as part of the Kingsgate Review. Blackburn with Darwen identified as Neighbourhood Health model/INT Pathfinder. L&SC successful in being identified as part of the National Frailty Programme.	A
4.	Implement Trust Programme Management Office (PMO) with clear links between Trust key Delivery and Improvement Programmes/Priorities to support financial recovery	Establish PMO and strengthen key delivery and improvement programmes to support realisation of benefits (Delivery, Quality, Cost, People) and delivery of requirements to support exit from NOF 4.	Recovery Director, Director of Service Development and Improvement, Director of Finance	End September 2025	Recovery Director in place and PMO established and developing. Cross cutting programmes agreed and being established. Financial Improvement Group established.	G
5	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment (2026/27)	Refine and develop planning processes for 2026/27 linked to new NHS Plan, national planning guidance, NOF4 exit criteria and aligned to PCB/ICB processes supporting the creation of a new Trust Strategy and supporting plans from 2026/27	Director of Service Development and Improvement	April 2026	NHSE has published draft Planning Framework for 2026 onwards. Work now underway to commence planning activities to create a 5 year medium term plan including working with system partners on priorities and commissioning intentions. Planning update paper present6ed to Finance and Performance Committee and trust Board in September.	G
6.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	End September 2025	Improvement hub team capacity identified to support key improvement priorities for 2025/26, increased monitoring in place to support realisation of benefits aligned to Trust Waste Reduction Programme. Continue to review the offer from NHS Impact to align organisational and national improvement priorities. Work underway to ensure alignment of Improvement Hub Team to PMO with actions on track to support alignment and sharing of skills and alignment of working and reporting. Update report to be presented for approval to Executive Team by 30trh September.	A
7.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	September 2025	Accountability Framework reviewed and refreshed and presented to Trust Board for approval in September.	B

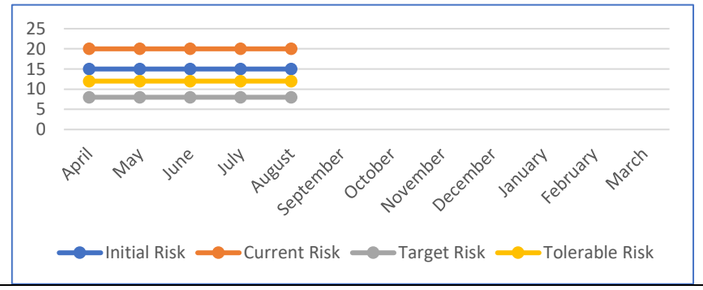
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with legislative and regulatory requirements.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Review: August 2025	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating	Direction of Travel
10086	Lack of adequate online storage for images	**20**	⟺
10065	Pharmacy Technical Service refurbishment programme	**20**	⟺
9755	Delays undertaking elective caesarean sections	**20**	⟺
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**20**	⟺
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**	⟺
10062	Risk of harm and poor experience for patients with mental health concerns	**16**	⟺
9777	Loss of education, research and innovation accommodation and facilities	**16**	⟺
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**	⟺
8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays	**16**	⟺
9900	Poor identification, management and prevention of delirium	**15**	⟺
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**	⟺
4932	Patients lacking capacity to consent to hospital placements may be being unlawfully detained	**15**	⟺

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L4 = 20
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/2-6

Controls in place to mitigate the risk:

Strategy and Planning:

- Quality Strategy in place and delivery monitored by Quality Committee.
- Patient Experience Strategy in place.
- Progress against the 2025/26 priorities is reviewed by the Executive team via the Executive Improvement Wall.
- The current local priorities of the Patient Safety Incident Response Framework extended until September 2025. New local priorities to be agreed from October 2025.

Floor to Board Reporting and escalation (Risk and Quality):

- The established quality assurance process provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- Board and Board Committees receive reports on risk/quality as part of their annual workplan.
- All Divisions have Quality and Safety meetings which coordinate Directorate assurance reports and escalation to the Quality Committee via the Trust Wide Quality Governance Group.
- Statutory requirements are monitored through the Quality Committee sub-groups structure.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register.
- Extreme Escalation Policy in place. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives.
- Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process has been reviewed and updated with ongoing reports to Quality Committee..
- Safe, Personal, Effective Care (SPEC) process in place with Board approved ratings of green/silver/gold wards/areas.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Acute medical physician in-reach into A&E from 8.00am – 12.00 noon and 4.00pm – 8.00pm
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- Monthly complaints and inquest drop-in sessions with each division to monitor performance and highlight risk
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.
- Triple S visits which are informal and report to People and Culture committee quarterly
- Nursing professional judgment review presented to the Quality Committee in January 2025 and to the Board in May 2025
- The number of DOLs applications has been sustained at expected levels.

• The Trust continues to manage current pressures through an IMT approach. • A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT. • A&E and Acute Medical Unit improvement board, developed with alternative weekly executive review • Quarterly Divisional performance meetings where all elements of quality and performance are discussed. • Data and Digital Senate and Data and Digital Board are the forums for implementing and monitoring data and digital strategy.	**Specialist support, policy and procedure setting, oversight responsibility:** • Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting monitored via monthly Quality Review Meetings. • Review and sign off of QIRA by medical director and chief nurse prior to implementation of any initiative • ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings • Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents. • Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. • Regular Updates on ICB EPRR. • Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates) • ICB representatives attend Quality Committee, Mortality steering group, PSIRI **Independent challenge on levels of assurance, risk and control:** • CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework. • The Internal Audit Plan for 2025-26 agreed and underway with relevant quality and safety reviews being monitored through Quality Committee. • Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes. • Public Participation Panel (PPP) involvement in improvement activities and walk rounds. • Patient Safety Partners now participating in a quality governance meetings such as Venous Thromboembolism (VTE) Committee and Accessible Information Standards Task & Finish group. • Customer Relations Team undertaking recommendations from the Mersey Internal Audit Agency (MIAA) report into complaints management at ELHT. • PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny. • Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the People and Culture Committee • JAG accreditation in Endoscopy • Regular GIRFT assessment and bench marking • Participating in GIRFT Further Faster 20 project. • Annual organ transplant report to NHSE • Review of MHUAC with Stakeholders • ICB Quality reviews of services

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of Waste Reduction Programme (WRP) work has commenced to identify opportunities to reduce agency and bank spend on medics. Focus on completed job plans. Service line reviews underway to identify gaps in demand and capacity To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ Executive Nurse Director /Executive Director of People and Culture	Quarterly reviews with projected completion in March 2026.	Long term this has been partially achieved, and the Governance Assurance structure review completed and is being consulted on. Job Planning Scrutiny Committee focusing on productivity and VFM, recognising the need to increase effectiveness of medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes has been embedded as part of leadership training. Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning. Trust's Q&S Team are providing support to the Staff Safety Group in relation to violence against staff.	A

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
2.	Provision of pathology services, with specific issues with histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid, facilitated via the ICB and external outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities. Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department.	Executive Medical Director	Review September 2025	Good progress made in blood sciences to address staffing gaps and to support implementation of improvement work. Ongoing reduction of backlogs in histopathology and clear action plan in place to support ongoing improvement woprk via Trust Improvement Team and external support to review processes and team working to further identify improvement opportunities. Working with the pathology collaborative on benchmarking job plans and reporting activity across L&SC.	A
3.	Functionality of ePR causing issues with data quality, performance and affecting users capability to maximise the potential of the electronic system.	There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract Upgrade of Cerner required to latest version to allow for access to new features and functionality. Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Coding and quality and affect mortality indicators too.	Executive Medical Director	September 2025	Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board. Ongoing training is taking place with clinical/admin colleagues on the ePR. The Cerner upgrade has been approved in May 2025 and will be implemented in September 2025. Ongoing workstreams in place to address coding issues and refreshed mortality data now being received. HSMR data now received and part year data shows mortality score at 100 which is within expected levels. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers).	A
4.	The Quality Impact and Risk Assessment Process (QIRA) has been strengthened in light of the Trust financial recovery process but now requires independent review.	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety. The QIRA process has been strengthened but work is ongoing to fully align to the new Programme Management Office and will be independently audited via internal audit.	Executive Director of Finance / all Executive Directors	September 2025	Recovery director appointed to work with execs and teams in improving financial deficit. PMO office being established with help from PWC to manage delivery of schemes The Trust has re-reviewed and agreed a standardised QIRA process which is fully aligned to the processes of the PMO and the Waste Reduction Programme. The outputs are reported to Quality Committee to ensure sub-committee oversight. As part of the annual internal audit plan this process will be reviewed.	A
5.	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Review of services to assess demand and capacity Work with Place based partners in improving patient pathways Implement GIRFT and Model Hospital best practice approaches to care	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	September 2025	Established relationships through interface meetings with Place based leadership. ELHT is participating in the GIRFT faster forward programme Working with divisions on ensuring that that we capture activity levels. Working with national teams. Service line reviews taking place to determine demand & capacity, non commissioned services and productivity UEC improvement plan re-reviewed and updated for 2025/26	G

Risk Descriptor: A risk we don't achieve national access standards thereby causing harm, impacting on patient experience and increasing health inequalities.

Executive Director Lead: Chief Operating Officer / Chief Integration Officer

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Executive Director Review: August 2025

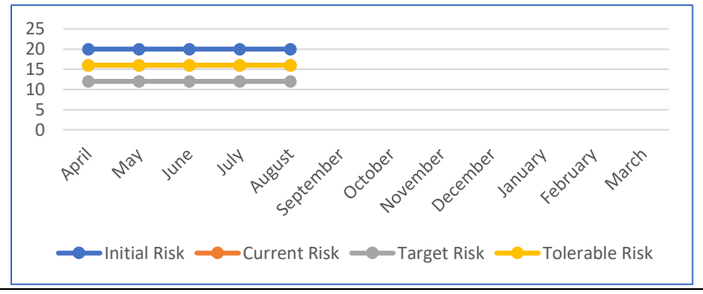
Lead Committee: Quality Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating	Direction of Travel
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**	⟺
8061	Patients experiencing delays past their clinical review date may experience deterioration	**16**	⟺
10139	Lack of available theatres to manage emergency and elective patients (replaces DATIX ID 9895)	**15**	⟺
10095	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	**15**	⟺

Risk Rating (Consequence (C) x Likelihood (L)

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L4 = 16
Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/8-12

Controls in place to mitigate the risk:

Overall planning and delivery processes:

- Systems and processes in place to reduce health inequalities.
- Processes in place to risk assess and prioritise patients on the elective waiting lists and emergency care pathways for clinical harm.
- Annual business planning processes include forecasting of performance for all emergency and elective targets.
- Urgent and Emergency Care Delivery Board oversee the joint PLACE delivery and improvement plan with a focus on priority wards and integrated neighbourhood care.

Operational Management processes:

- Elective improvement plans for 2025-26 include diagnostic clearance plans and outpatient booking to ensure effective support for delivering the overall plan. Overseen by Elective Productivity Improvement Group.
- Emergency Care Improvement Group (ECIG) oversees UEC improvements in the Trust.
- System and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting with ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges
- Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).
- Activation processes in place for enhanced escalation during surge
- A clinically led safe discharge MDT steering group in place.
- Clinical engagement ensuring ownership for discharge planning on admission.
- Step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds.
- Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base.

Oversight arrangements:

- Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO.
- Monthly outpatient improvement group chaired by the Executive Director of Service Development and Improvement.
- Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation.
- The Chief Operating Officer and Deputy Medical Director for Performance hold support and challenge sessions with any specialties that do not achieve theatre utilisation trajectory.
- Elective Productivity and Improvement (EPIG) jointly chaired by Chief Operating Officer and Director of Service Development and Improvement to oversee the delivery of all elective care standards.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Clear trajectories for all key targets in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service
- Health and Equalities Committee chaired by the Chief Nurse
- Clinical champions across all wards to promote best practice with discharge bundles. An electronic daily discharge dashboard has been embedded across all inpatient areas.
- Capped theatre utilisation has been sustained at a minimum of 85% since September 2024.

Specialist support, policy and procedure setting, oversight responsibility:

- Executives meet all with all divisions every morning (Monday – Friday) at 8.00am to address any issues for UEC and operational flow.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums.

Independent challenge on levels of assurance, risk and control:

- Delivery of trajectories are monitored at ICB level through the monthly improvement and assurance meeting with the ICB

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td>1.</td><td>Activity levels for 25/26 may not be achieved consistently.</td><td>The controls and weekly monitoring taking place to work towards the achievement of the 2025/26 activity plan (112.63% of 19/20 plan levels).</td><td>Chief Operating Officer</td><td>March 2026</td><td>A clear activity plan is in place for 2025-26 with productivity assumptions in place to support increased activity at reduced cost whilst maintaining income levels. This will be monitored through usual performance mechanisms but with an enhanced level of monitoring of associated income to ensure all activity is coded appropriately.</td><td>A</td></tr>
<tr><td>2.</td><td>The national ambition for NHS diagnostics in 2025/26, centres on improving patient access to diagnostic tests, reducing waiting times, and ensuring timely reporting of results.

Delays in diagnostic performance could impact on the delivery of RTT and Cancer standards</td><td>Implementation of Modality level delivery plans.

Monitor performance through weekly operational meetings

Monitoring of performance and waiting lists through divisional performance meetings</td><td>Chief Operating Officer</td><td>March 2026</td><td>ICS wide modelling completed, and discussions are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access.

The Trust continues to perform better than the national average and a trajectory is in place to meet 2025/26 planning guidance requirements.

Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating Officer.

Performance for April was 1.93% - 98.07% received a diagnostic appointment within 6 weeks</td><td>G</td></tr>
<tr><td>3.</td><td>Meeting Cancer Standards

National Ambition for the standards

62 day – 75% by March 2026

28 day – 80% by March 2026</td><td>Joint work with the Cancer Alliance on improvement

Continued Tumour site level detail to prevent backlog

Continued transparency of backlog delays at tumour site level for targeted preventative interventions

Weekly patient tracking with divisions for all tumour sites.

Agree trajectories to achieve new targets.</td><td>Chief Operating Officer</td><td>March 2026</td><td>Cancer action plan refreshed for 25/26 and will be monitored through the Cancer Steering Board Current submitted performance, against the National Ambition

<table><tr><th>July 25 Performance (Trust)</th><th>National Ambition by March 2026</th></tr><tr><td>62-day standard 76.80%</td><td>75%</td></tr><tr><td>FDS standard 73.7%</td><td>80%</td></tr></table></td><td>A</td></tr>
<tr><td>4.</td><td>Continued risk of >65 week RTT breaches and risk of not delivering a maximum of 1% < 52 week maximum wait by March 2026.</td><td>Demand and capacity at specialty review completed with improvement actions

With daily micromanagement.

Each directorate is setting an improvement trajectory which will be monitored through weekly operational meetings.</td><td>Chief Operating Officer</td><td>March 2026</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.

Daily monitoring continues to maintain this position for 65 weeks performance

There is now focus on achieving a maximum of 1% of total patients on an RTT pathway waiting no more than 52 weeks.</td><td>A</td></tr>
<tr><td>5.</td><td>UEC

Reducing the number of patients waiting over 12 hours time in the ED Department</td><td>Improvement plan in place to support reducing the amount of time patients spend in the ED corridor this includes:

Streaming to alternative pathways

Admission avoidance via SDEC and IHSS

Use of escalation SOP when required in extreme pressures

Monitor the impact of any reduction in bed capacity</td><td>Executive Director of Integrated Care Partnerships and Resilience/ Chief Nurse</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to reducing the percentage of patients waiting over 12 hours in the ED depart from 17.8% to 15.2%

July performance was at 14.54%

The UEC improvement plan has been reviewed and updated for 2025/26 and work is ongoing with place partners.</td><td>G</td></tr>
<tr><td>6.</td><td>Ambulance handover times</td><td>As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, to an average of 24 mins and to be better than the NWAS average handover time</td><td>Executive Director of Integrated Care Partnerships and Resilience /Chief Operating Officer</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to improving average ambulance handover time to 24 mins</td><td>A</td></tr>
</table>

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Working collaboratively with NWAS colleagues on handover times. There are dedicated meetings with NWAS & ELHT staff on a collaborative approach to improvement. July 2025 average handover time was 23 mins - Percentage of patients with a handover of >30 mins 18.55%	
7.	Discharge 2% more patients on discharge ready date (84% > 86%) Improve average delay in discharge to 4.5 days from 5 days	Embedding of the discharge dashboard to support reduction in longer length of stay and not meeting criteria to reside	Executive Director of Integrated Care Partnerships and Resilience /Chief Nurse	March 2026	Discharge optimisation group established March 2025 under the leadership of the Divisional Medical Director for CIC and Divisional Director of Nursing for MEC	A

Risk Description: The Trust is unable to deliver its strategic objectives as a result of its inability to sustainably transform the workforce.

Executive Director Lead: Interim Chief People Officer

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities, Financial Recovery Priorities, Improvement Priorities.

Date of last review: August 2025

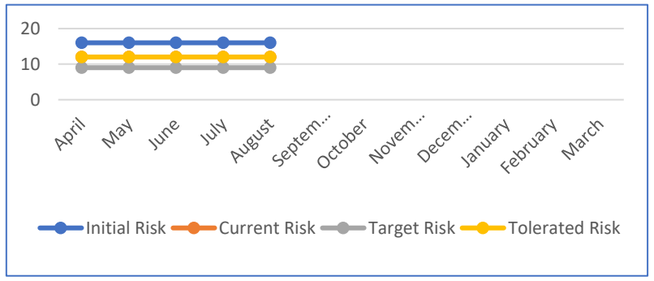
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
9746	Inadequate funding model for research, development and innovation	**16**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L3 = 12**
Initial Risk Rating: C4 x L4 = 16
Tolerated Risk Rating: C4 x L3 = 12
Target Risk Rating: C3 x L3 = 9



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Pursue/High

Controls in place to mitigate the risk:

- Freedom to Speak Up (FTSU) Guardian and Ambassadors in situ reporting to the Staff Safety Group, People & Culture Committee and Trust Board.
- ICB People Committee has developed a revised workforce strategy. Professional Working Groups (PWG) report through PCB ExCo. Operational issues from these forums are picked up through the Executive team.
- The Trust People Plan is operationally delivered through the Senior Leadership Group (SLG), Divisional Management Boards (DMBs) and Divisional Performance meetings and delivery is accountable through People and Culture Committee (PCC) . This also forms part of the well led section of the Integrated Performance Report (IPR) and work is ongoing with RSP Support to provide suitable assurance metrics through DMBs and PCC.
- Grip and Control action plan in place and reviewed through relevant Committees – PCC for all workforce metrics.
- Workforce WRP meetings are held with each clinical division and corporate division weekly and each corporate team fortnightly to review the delivery of WRPs and agree improvement trajectories where required.
- Vacancy control processes reviewed and strengthened with final sign off of any vacancies to be advertised being completed via the Executive Team.
- HR framework has been developed for use to support workforce transformation across the LSC system and has been in place from 1 March 2025. System workforce leads meet fortnightly for consistency and system working.
- A workforce redesign support offer to identify productivity and transformation opportunities is being offer to all services. Best practice guidance in place to reducing variable pay, implementing a series of rapid improvement weeks and developing a toolkit for managers to reduce variable pay.
- Partnership working with Unions has been strengthened across the governance framework. JNCC and JLNC mechanisms in place to oversee organisational and workforce transformation and policy ratification.
- Health and Wellbeing Strategy in place and leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the One LSC governance structures. Managing attendance and wellbeing cross cutting scheme in place to support focused action on sickness absence.

Assurance that the controls are effective:

<u>Service delivery and day to day management of risk and control:</u>

- Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Divisional pay Control meetings monitor control measures implemented around variable pay, vacancy control, grip and control, job planning, annual leave, overpayments.
- Eight Staff Networks covering protected characteristics, each supported by an Executive Lead and Non-Executive Champion, report through the Inclusion Group.
- Freedom to Speak-Up (FTSU) Ambassadors embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. Freedom to Speak up month – October 2025. FTSU included within the Trust's mandatory training programme.
- Workforce dashboards enable divisions to manage workforce availability, sickness, variable pay and headcount and targets for reduction will be set. Additional resource provided through Recovery Support Programme (RSP) to further develop workforce metrics across Divisional and Trust meetings and committees.
- Annual reporting to Board on full EDI metrics with tracking in the quarterly workforce report to People and Culture Committee. Divisional EDI data packs shared with divisions.
- Continued roll out of the Team Engagement and Development (TED) Tool across the organisation enabling teams to manage team culture, using data such as sickness absence, staff survey, culture data to identify areas for targeted support.
- The Trust's Behaviour Framework integrated into the recruitment and appraisal processes. Anti-racism and Sexual Safety behaviour frameworks developed.
- Appraisal and core skills training compliance reporting is monitored through performance meetings and NAPF assessments. Wellbeing conversations as part of annual appraisal. Managers encouraged to have regular check ins and 121s with staff members to dynamically assess wellbeing and morale. Project M is a programme of support for the

• Directorate of Education, Research, and Innovation (DERI) Strategy clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC. • Staff Sponsor Group chaired by the Chief Executive working with divisions to address improvements to culture and staff experience as measured by staff survey. Staff stories come to the Committee to enable triangulation of data with staff experience. • Inclusion Group chaired by the Chair leads oversees inclusion and belonging priorities. • Anti-Racism project established with support from the improvement team. • Reasonable adjustment improvement project – key metrics agreed and are tracked and reported to People and Culture Committee. • Exec led divisional performance meetings oversee delivery of objectives and strategies including workforce metrics at divisional level.	wellbeing of managers and continues to be delivered virtually for people with line management responsibility. Attendance is monitored. Facilitators provide advice and guidance and pick up themes for ongoing focused intervention. • Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice has been built into the Improvement Practice Development Plan. • Recruitment, retention, and staff in post data is monitored through IPR and Workforce Report to People and Culture Committee. • Job planning continues, linked to improved use of eRostering for medical staff to improve transparency. Monitored via weekly Divisional Waste Reduction Programme meetings and reported in IPR. • Variable pay spend reviewed via the Divisional WRP meetings, with robust control measures now in place for booking bank/agency shifts. • Exit interviews – system recording exit interviews is established and reports can be generated by the HR Team. <u>Specialist support, policy and procedure setting, responsibility:</u> • Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda, and Trust activity where collaboration has been agreed. • ICS EDI collaborative is in place to support the development and sharing of best practice. • Trust Wellbeing Lead chairs system group to establish standardisation. • ICS Culture and Belonging Strategic Group established. • Trust Chair and NED EDI lead are members of the regional BAME Assembly. • Trust was part of People Promise Cohort 2 and attended the regional SRO and national meetings. • PMO support for Trust wide workforce schemes to support cost reduction and avoidance. <u>Independent challenge on levels of assurance, risk, and control:</u> • Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) results are nationally benchmarked and action plans with timelines in place. Regular reporting to the People and Culture Committee. • EDS 2022 – system level assessment with ICB, patient and community groups, staff side and voluntary sector. • National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level. • Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB). • Monitored by NHS England and the ICB on our bank and agency spend, with a requirement to report any breaches of NHSE cap – ELHT has remained within the NHSE cap since October 2023 and zero off-framework since August 2023. • Workforce elements included within the Annual Internal Audit Plan agreed for 2025-26. Action plans in place for audits carried out that are tracked though Audit Committee and People and Culture Committee. • Bank and Agency Oversight in place across the system via a workstream of the CPO Professional Working Group. • Internal and ICB vacancy control panels provide oversight on recruitment. • Monthly IAG meetings with the ICB which scrutinise the workforce KLOE.

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Financial recovery – development and full delivery of workforce schemes needed to close the gap given NOF 4 status.	Ensure timely development and delivery of workforce schemes to close the gap in meeting financial recovery targets recurrently. Support for those impacted by change and change readiness programme. Review of organisational change policy and support.	Executive Director of People and Culture	May 2025 and monthly review.	• Workforce schemes fully developed and account for 42% of all WRP schemes – reviewed through PMO and reported monthly to Improvement and Assurance Group (IAG). • Weekly Waste Reduction Programme (WRP) meetings established. Daily management dashboards produced. • Variable pay – rapid improvement weeks held, weekly initially, now fortnightly – targeting highest users of temp staffing. • HR Framework team stood up - MARS scheme implemented. • Review of organisational change policy in partnership with staff side to tighten up controls around redeployment. • Service reviews continuing with selected areas of Trust.	A

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					• Fortnightly oversight group chaired by CPO to oversee all workforce schemes • Increasing vacancy control panels to weekly. • Implementing daily variable pay group.	
2.	Risk of increased staff absence and burnout leading to use of bank and agency workers and higher turnover which impacts on morale and quality of patient care.	On-going delivery of the ELHT People Plan underpinned by a compassionate and inclusive culture. Continued roll out of Health and Wellbeing Strategy with focus on women's health, developing the mental pathway and on reasonable adjustments. Targeted work through Staff Sponsor Group and People Experience MDT to work with teams and divisions. Attendance Management and Wellbeing Management Scheme. Continue to roll out restorative clinical supervision and train up more professional nurse advocates to meet the target ratio of PNAs to staff members.	Executive Director of People and Culture	A milestone report will be provided to the People and Culture Committee in July 2025	• PID and QIRA produced for management of sickness absence scheme under review by Interim joint CPO. • Continued development of mental health pathways and interventions as recommended by the external review. • PCB OH and Wellbeing services have carried out a procurement exercise for a common IT platform in readiness for the future model, contract to be signed and plans need to be developed to migrate all Trusts on to the new system. • Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO and now well embedded. • Recruitment to central resource to support reasonable adjustments completed. • Training for managers in attendance management and reasonable adjustments, review of how this is monitored and whether this is made mandatory for all managers. • MDT on track with divisional feedback of staff survey results and to identify the 3 cultural themes and teams for in-reach support. • Recruiting to further cohorts of PNA training. • Mental Health Network and Well Team response to recommendations of review into psychological wellbeing service and support including for line managers. • Shared learning from LTH being embedded. • Scheme will report to the fortnightly workforce oversight group	A
3.	Risk of loss of service due to national industrial action.	Ongoing monitoring and management of actions through Industrial Action Cell as required.	Executive Director of Integrated Care, Partnerships and Resilience	N/A	• Impact of resident doctor's 5-day strike in July 2025 to be reviewed to assess impact on activity, income and costs. Review to inform future levels of staffing and activity as resident doctors not ruled out further strikes, and are open to talks with the government. • Further risks of action from other staff groups as Nurses rejected the 3.6% pay award in an indicative vote. Official results expected soon, with potential for a formal strike ballot – action would likely be Autumn 2025 • The BMA Consultants Committee is running an indicative ballot on industrial action after rejecting a 4% pay offer, which closes 1 September. • If talks fail to reach agreement, the NHS could face a wave of coordinated strikes across multiple staff groups and the situation is being closely monitored • Received notification that F1 Drs are being balloted seperately	n/a
4.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients	Development of compassionate and inclusive culture. Trust becoming anti-racist. Greater cultural competence of line managers who line manage internationally educated colleagues. Sexual safety project to be fully implemented. Closing the gap of experiences between colleagues who have a protected characteristic and those without. Process for reasonable adjustments to be centralised, greater visibility of those requesting reasonable adjustments and outcomes. Implementation of EDI Improvement Plan, with shared accountability for implementation. Performance Appraisals –inclusion objectives	Chief People Officer	An update report on Aarushi Project to come to Board in September 2025	• ED&I performance report shared with inclusion group. Further analysis needed in some metrics. Focused actions for areas of deterioration. • Achievement of Bronze Award. Silver action plan developed for anti-racism. • Joint statement and commitment with University of Lancashire. • Training brochure for EDI being finalised with prioritised training offer linked to aspects of improvement. • Allyship and Anti racism training was paused due to the financial challenge to release time and capacity, and there is reduced capacity for delivery. Relaunched with dates from August, • Inclusive recruitment toolkit pilot complete and bite-sized training developed, working with OneLSC to understand sustainable delivery plan.	A

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					• TAFG set up for sexual safety, eLearning is available. Policy to be reviewed at Policy Group in August and then JNCC and JLNC • EDS 2022 completed, and results reported. Finalise the plans and bring through committees to monitor progress. • Posts recruited to for support for disability and reasonable adjustments. • Staff experience MDT – linking with divisions to identify the cultural themes for improvement including focus on sexual safety within Theatres and ED • Plans to review staff networks for better alignment • Roundtable being planned with key stakeholders to discuss next strategic steps	

Risk Descriptor: The Trust is unable to deliver its agreed financial recovery plan.

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: August 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
10082	Failure to meet internal and external financial targets	20

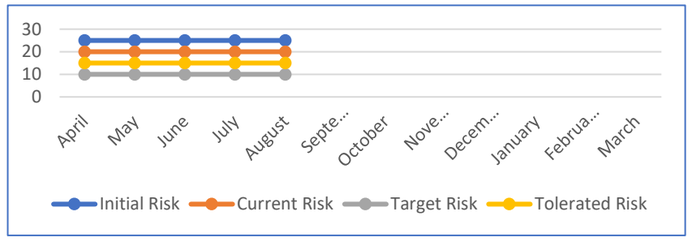
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L4 = 20

Initial Risk Rating: C5 x L5 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/4-6

Controls in place to mitigate the risk:

Organisation

- A full review of the financial accountability meeting structure has taken place to make the best of use of time
- A Programme Management Office (PMO) has been established. The PMO focuses on monitoring progress of plans and implementation to support financial recovery including grip and control, workforce plan and waste reduction programme across the range of cross-cutting groups and divisions including corporate and OneLSC forces groups.
- There is a revised Grip and Control process both implemented and being further strengthened, including a review of the external audit across a wider range of measures, separate investigations to curtail discretionary spend and a new panel process in conjunction with OneLSC to control spend
- The trust has established a Financial Improvement group which meets fortnightly chaired by the CEO to assess progress and challenge delivery. This includes oversight of the Trust's NOF4 exit criteria, WRP and Grip and Control
- A Vacancy Control Panel is in place at divisional and Trust level and this is being further strengthened with additional review fields and a shift to a weekly process
- A variable pay panel is being established to replicate LTH process chaired by the CPO meeting daily to assess spend decisions around key bank and agency areas
- Non-Pay will be assessed by a daily central panel and daily divisional panels using revised cost control criteria in conjunction with the trusts requisition process
- A weekly Pay Control Group, chaired by the Deputy DoF, is in place that reviews the oversight and process behind all payments to staff and contractors.
- The Financial plan for 2025-26 has been developed via the annual planning process and was approved by Trust Board prior to National Submission. This takes account of the Trust's required Control Total and financial improvement.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction and Financial Improvement Programme (WRP & FIP) are reported and scrutinised through Financial Improvement Group (FIG), the PMO Head of Finance, PMO/Finance validation processes, CFO, Deputy Director of Finance, and the Finance and Performance Committee.
- Service Reviews are taking place to support services to identify cost reduction opportunities
- Communication about the financial challenge and actions being taken is being led from the Executives, including PMO messaging, Roadshows, the Recovery Director, use of Intranet, wider media, the regular Team Brief, and through the senior leadership of the Trust.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Delivery of financial plan scrutinised via the revised PMO governance in place, FIG and Finance and Performance Committee with key risks identified as a live RAID document aligned to the WRP delivery tracker and wider finance reporting/oversight
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate
- Divisional, Trust wide and system Waste Reduction Programmes continue to be developed, where there is a fully developed plan in delivery; Quality Impact Risk Assessments (QIRAs) are completed for all schemes and signed off by the Chief Nurse and Medical Director without which schemes cannot appear on the tracker unless a QIRA is not required; and PMO is strengthening assurance on delivery through robust processes via completion and assessment of Project Initiation Documents
- Grip and Control Assessment undertaken by PWC, a Grip and Control action plan has been signed off by Audit Committee, Finance and Performance Committee and Trust Board and reviewed at FIG. Further significant 'strengthening' around process, budgetary removals, requisition processing and panels in commencing; separate investigations are underway to identify high areas of discretionary spends and resulting actions to halt this
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.

Specialist support, policy and procedure setting, oversight responsibility:

- Recovery Director contracted to support the Trust in the implementation of its Financial Recovery Plan
- PwC as undertaken three significant phases of work to support the initial process set up and identifications of opportunity to convert into WRPs.
- A Programme Management Office (PMO) is now in place with internal appointments but also supported by both an external PMO head of finance and a Head of PMO in place with processes, architecture, reporting and controls now in place across delivery of the Waste Reduction and Grip ad Control programme
- Corporate collaboration – full participation in all areas and opportunities identified.
- The Trust and LSC system has a NHSE nominated lead who is working with the LSC System up to summer 2025.
- PwC is working with the Trust and the LSC System as the system entered formal regulatory intervention.
- A financial governance review took place in January 2025 with an action plan agreed, which is monitored via Audit Committee.

<u>System</u> • System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position. • One LSC Central services collaborative programme underway with ELHT as the host. • System financial controls implemented. • Assurance and oversight in place with the System Turnaround Director and the supporting team and NHSE.	<u>Independent challenge on levels of assurance, risk and control:</u> • The Trust is part of the NHS Oversight Framework Segment 4 Recovery Support Programme • Internal audit plan was agreed at Audit Committee May 2025 and underway. External audit of accounts to be presented to Audit Committee in June 2025. • Counter fraud workplan for 2025-26 agreed at Audit Committee April 2025, regular progress reported to Audit Committee • One NHS Finance Towards Excellence Accreditation 3-year reaccreditation was awarded in October 2024

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Inadequate funding for the services commissioned	Work with the ICB on the funding for the services commissioned, in line with the NHS Payment Services guidance.	Executive Director of Finance	Q4 2025/26	A position for 2025/26 has been concluded with deficit support funding agreed for various services whilst further reviews take place. Work is now ongoing with commissioners to review as part of planning and contracting for 2026/27.	A
2.	No signed Contract for 2025-26	To work with the ICB to agree the contract disputes	Executive Director of Finance	End of July 2025	Contract values agreed and all elements of accompanying schedules. Awaiting final issue of contract by the ICB to enable signature.	R
3.	The financial plan will not be met in 2025-26 with a further risk that Deficit Support Funding is withdrawn and overall impact on cash position	To work collectively across with the Trust and with external support to help to turnaround the financial position and financial recovery.	Executive Director of Finance	Monthly updates. End March 2026	Additional measures are in place with additional control groups in place increasing grip and control across pay and non-pay. A Recovery Director has been appointed who is leading a PMO team to support financial recovery. PMO established, monthly reporting and check and challenge in place. FIG established and cross cutting workstreams. Work ongoing to further populate the WRP pipeline to support mitigations. Divisions reviewing and updating forecasts and establishing recovery plans where needed. Ongoing monitoring of cash position and forecasting including application for cash where required.	A

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/126
Report Title:	Corporate Risk Register (CRR)		
Author:	Mr J Houlihan Assistant Director of Health, Safety and Risk		
Lead Director:	Mr J Hobbs Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**To Note**
	✓			
Executive Summary:	The Corporate Risk Register now lists eighteen risks, reflecting a reduction since the previous report following the removal of seven risks, addition of four new risks, one increased risk score and reduction in one existing risk. All other scores remain unchanged. The highest-rated risks concern capacity and demand, assessment and diagnosis pathways, financial sustainability, diagnostic testing and maternity services. A significant proportion (67%) relate to clinical management, suggesting deeper systemic challenges. Continued monitoring and targeted mitigation are vital to ensure safe, effective, and sustainable service delivery. A more detailed summary of the CRR and mitigations is provided within the dashboard.			
Key Issues/Areas of Concern:	• Persistent high scoring risks. Several risks continue to score highly indicating insufficient control measures, risk treatment or strategic exposure beyond the Trust's risk appetite. • Untimely or overdue risk review. A number of risks are not being reviewed within expected timeframes raising concerns about governance discipline and timely identification of emerging threats. • Updating controls and assurances. Controls and assurance entries are not being regularly refreshed which undermines confidence in the accuracy and effectiveness of the risk register. • Ineffective use of the Datix 'actions' section. The 'actions' section field remains underutilised resulting in limited transparency around risk mitigation efforts, impeding the Board's ability to assess risk response effectiveness.			
Action Required by the Board:	Members are requested to be assured that risks on the corporate risk register are actively being managed and mitigated.			

Previously Considered by:	The Trust Board
Date:	14 May 2025
Outcome:	Embedding risk ownership, strengthening governance and performance monitoring, enhancing education and training and addressing historical cultural norms in relation to the use of the risk register will help achieve risk management goals and further solidify the benefits outlined within the report, ensuring a more robust and mature risk management framework and enterprise model.

Risk management and the impact of taking / not taking action

1. Risk management is a statutory and structured process integral to the Trust's safety management system. It enables the identification, assessment, and mitigation of threats that could compromise safety, performance, and compliance. Regulatory bodies such as the Health and Safety Executive and the Care Quality Commission scrutinise risk practices during inspections, making robust governance essential. When effectively implemented, risk management protects patients, staff, and the organisation, ensuring legal compliance, operational continuity, and strategic resilience. Conversely, failure to act on risks can result in harm, regulatory breaches, and reputational damage.

Corporate Risk Register Performance Activity

2. The Corporate Risk Register (CRR) currently holds eighteen risks, reduced from the previous report following the removal of seven risks, the addition of four, one increased risk score and reduction in one existing risk. The highest rated risks relate to capacity and demand pressures, assessment pathways, financial sustainability, diagnostics and maternity services. 67% of risks are linked to clinical management, pointing to deeper underlying systemic challenges that warrant closer scrutiny. The persistence of high scoring risks indicates either insufficient control measures or ongoing exposure that exceeds the Trust's defined risk appetite, requiring a more comprehensive review and more robust mitigation. Additionally, the Datix 'actions' section remains underutilised and poorly defined, resulting in limited transparency around risk mitigation efforts, impeding the Board's ability to assess response effectiveness.

Risk Management Performance Activity

3. The risk register shows ongoing improvement, with fewer open, long-term and tolerated risks, however, concerns persist around overdue reviews, increasing numbers of moderate scoring risks and high scoring risks outside the CRR. Delays in reviewing risks compromise governance discipline and hinder timely identification of emerging threats. Clinical risks continue to dominate, particularly around capacity, demand, assessment and diagnosis pathways, with most risks concentrated in diagnostic and clinical services followed by surgical anaesthetic services. Trust-wide risks remain prominent across directorates with radiology, pathology and theatres also contributing significantly. Inconsistent updates to controls and assurances weaken confidence in the register's accuracy.

Mitigations for risks and timelines

4. A comprehensive profiling and mapping exercise has aligned risks with legislation and strategic priorities. Governance has been strengthened through clearer committee roles, standardised review protocols, and reaffirmed escalation pathways. The Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (ERAG) have increased scrutiny of live and tolerated risks, supported by divisional reporting and KPIs. Staff competencies have improved through coaching, mentoring, and targeted training. Datix module updates have enhanced profiling, approval tracking, and integration with the Board Assurance Framework (BAF). However, the decision by RAM and ERAG not to escalate risks is highlighting a disconnect between service level perception and corporate escalation thresholds. It also raises concerns about the consistency and rigour of risk governance, risk scoring and verifiable data across services to support risk scores. Inconsistent use of Datix system features, particularly the 'actions' section and outdated controls remain barriers to full transparency and accountability.

Challenges

5. Progress has been slowed by external pressures such as industrial action and financial constraints, and internal factors including restructuring, staffing limitations, and competing priorities like e-PR implementation. Cultural resistance and legacy practices continue to hinder adoption of modern risk approaches. Delays in system upgrades and inconsistent documentation further complicate oversight. Despite these challenges, improvements in process standardisation, register quality, and KPI performance demonstrate positive momentum.

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

6. Leadership engagement in risk management is essential to delivering strategic aims. A robust governance framework ensures the integrity of internal systems and supports safe, high-quality care. Linking risks to the BAF strengthens oversight and prevents misuse of the register, aligning operational risk management with strategic objectives.

Resource implications and how they will be met

7. The Health, Safety, and Risk Management team faces capacity constraints amid rising service demands and cross-departmental reliance. These pressures are being addressed through strategic prioritisation, process optimisation, and targeted support to ensure resource limitations do not compromise oversight or performance.

Benchmarking Intelligence

8. Risk identification and measurement are informed by legislation, regulatory standards, case law, and professional guidance. External regulator feedback, strategic changes, workforce evaluations, incident investigations, KPI analysis, and benchmarking exercises contribute to a proactive and informed risk culture.

Conclusion of Report

9. The Trust has made meaningful progress in embedding risk management across its operations. Leadership visibility has improved and the Risk Management Framework (RMF) continues to evolve. However, persistent high scoring risks, overdue reviews, misuse of the risk register characterised by vague and poorly articulated risk entries, inaccurate scoring, insufficient evidence-based data and lack of meaningful review has eroded assurance and weakened mitigation. The failure of services to follow escalation protocols and to revisit or revise risks constructively further compromise oversight. Addressing these issues will be critical to achieving a mature and resilient risk management system.

Recommendations

10. Prioritise enhancements to risk profiling and mapping, ensure regular updates to controls and assurances, and improve the clarity and completeness of Datix entries. Strengthen governance through consistent review cycles, subject matter expertise, and increased awareness of escalation protocols.

Next Actions

11. Focus areas include standardising processes, reaffirming the risk framework, and reviewing live risks. Implementation of the new strategy and BAF integration is underway, alongside development of clearer risk appetite statements and improved governance reporting. Software enhancements, targeted training, and stakeholder

engagement will support these efforts. A long-term plan aims to unify health and safety and risk management frameworks for greater cohesion.

How the decision will be communicated internally and externally

12. Decisions regarding the review and approval of risks and the validity of risk scores are made via Divisional Quality and Safety Board meetings, at Committees / Groups and escalated through approved governance frameworks.

How progress will be monitored

13. Oversight of the CRR is maintained through RAM, Trust-wide Quality Governance (TwQG), and ERAG meetings. A senior executive lead ensures risks are actively managed and mitigated in line with the RMF. Progress is tracked through KPIs and dashboard reporting, enabling continuous monitoring and accountability.

Mr J Houlihan - Assistant Director of Health, Safety and Risk

01 September 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Corporate Risk Register Dashboard Reporting Period September 2025

Key risks arising from the Risk Management Framework supplemented by a set of appendices

Author Mr J Houlihan, Assistant Director of Health, Safety and Risk

Executive Sponsor Mr J Hobbs, Executive Medical Director

Date 01 September 2025

This corporate risk register dashboard is based on industry good practice from across the Healthcare sector

Corporate Risk Register Dashboard

KEY	
▼	Improving Trend
◆	Unchanged Trend
▲	Deteriorating Trend
IRS	Inherent Risk Score (Initial)
RRS	Residual Risk Score (Current)
TRS	Target Risk Score

RISK APPETITE	
None (Zero)	Avoidance of risk and uncertainty is a key objective
Minimal (Low)	Preference for safe options that have a low degree of inherent risk
Cautious (Moderate)	Preference for safe options that have a low degree of residual risk
Open (High)	Willing to consider all options and choose one that is most likely to result in successful delivery
Pursue (Significant)	Eagerness to be innovative and to choose options that suspend previous held assumptions and accept greater uncertainty

RISK TREATMENT OPTIONS	
Accept	Decision not to take further action by accepting the actual or potential consequence until mitigations dependent on external stakeholders are implemented
Avoid	The risk is too severe, and the Executive have decided to terminate the activity that is causing it (most of the time this is not an option)
Reduce	The risk is being managed, and an action plan is being implemented to mitigate it
Transfer	The risk can be transferred to another party
Diversify	The risk can be spread across different areas

Corporate Risk Register Key Performance Metrics - A summary of key performance metrics to note since the last meeting

Current Status - The corporate risk register now lists eighteen risks
Key Changes – Since the previous report, seven risks have been removed, four new risks have been added, one risk has seen an increased risk score, one risk has seen a reduced risk score. There has been no changes or movement in any of the other risk scores.
Risk Composition - Clinical management risks account for 67% of the total number of risks, followed by data and digital (11%), financial (11%) and health and safety (11%) risks
Highest Scoring Risks – Capacity and demand, followed by assessment and diagnosis, diagnostic screening and testing, financial sustainability and maternity
Governance and Process Improvements - Automated reminders prompt risk owners to update entries regularly; TWQG B Chairs Action mandates monthly reviews (around the 7th) with emphasis on risk owners updating controls and assurances, using the actions section in Datix to assign tasks with clear ownership and timelines, rescoring the risk in line with the risk management framework. Aim is to improve report quality and reduce unnecessary follow ups

Strategic Oversight and Maturity
Leadership Engagement - Assistant Director of Health, Safety and Risk continues to work with risk handlers to refine risk definitions, improve data quality and streamline reporting processes leading to improved governance and growing risk maturity
Cultural Shift - Automation and collaboration are driving timeliness, accountability, and more actionable reporting
Persistent Challenges - Clinical management risks remain dominant, indicating more deeper systemic issues
Cross Cutting Risks - Financial, data and digital and operational risks may require more integrated, strategic intervention

Recommendations and Next Steps
Targeted Action Planning - Especially for high-risk areas like finance, digital infrastructure and clinical management
Training and Mentoring - There is scope to build risk owner confidence and consistency through training and mentoring support especially around scoring and data sets to provide better quality assurance evidence
Ongoing Monitoring - To assess the impact of improvements and sustain data quality
Strategic Alignment - Aligning actions outputs more closely with risk appetite, the board assurance framework and Trust strategy and performance priorities could further enhance their value in decision making

Summary of the Corporate Risk Register

	ID	Risk Type	BAF	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Accountable Group	Sub Committee (for Assurance)
1	10376	Clinical	2	Family Care	Non-compliance with national maternity triage standards	5	4	20	J Hobbs	Inadequate	New	TWQG A	Quality Committee
2	10086	Clinical	2	Trust wide	Lack of adequate online storage for images	5	4	20	J Hobbs	Inadequate	◆	TWQG B	Quality Committee
3	10082	Financial	5	Trust wide	Failure to meet internal and external financial targets	4	5	20	S Simpson	Limited	▼	Finance Assurance Board	Finance & Performance Committee
4	10065	Clinical	2	DCS	Pharmacy technical service refurbishment programme	4	5	20	T McDonald	Inadequate	◆	Estates Strategy & Delivery Group	People & Culture Committee
5	10062	Clinical	2	Trust wide	Risk of harm and poor experience for patients with mental health concerns	5	4	20	P Murphy	Inadequate	▲	TWQG A	Quality Committee
6	9755	Clinical	2	Family Care	Delays undertaking elective caesarean sections	4	5	20	P Murphy	Adequate	◆	TWQG A	Quality Committee
7	9336	Clinical	2/3	MEC	Increased demand and lack of capacity within ED leading to extreme pressure and delays in patient care	5	4	20	J Hobbs	Limited	◆	TWQG B	Quality Committee
8	8941	Clinical	2	DCS	Increased reporting times in histology due to increased activity outstripping resource	5	4	20	J Hobbs	Limited	◆	TWQG B	Quality Committee
9	10386	Clinical	2	Corporate	Provision or quality of information in discharge summaries	4	4	16	J Hobbs	Inadequate	New	TWQG A	Quality Committee
10	10371	D&D	2	Trust wide	Failure to correctly update IT systems when consultants leave	4	4	16	J Hobbs	Limited	New	TWQG A	Quality Committee
11	9777	Corporate	2	Corporate	Loss of education, research and innovation accommodation and facilities	4	4	16	T McDonald	Limited	◆	DERI Estates & Facilities Group	People & Culture Committee
12	9746	Financial	5	Corporate	Inadequate funding model for research, development and innovation	4	4	16	N Pease	Limited	◆	DERI SLG	People & Culture Committee
13	8061	Clinical	2/3	Trust wide	Patients experiencing delays past their clinical review date may experience deterioration	4	4	16	S Gilligan	Limited	◆	EPIG	Finance & Performance Committee
14	8033	Clinical	2	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	16	P Murphy	Limited	◆	TWQG A	Quality Committee
15	10139	Clinical	3	Trust wide	Lack of available theatres to manage emergency and elective patients (replaces DATIX ID 9895)	5	3	15	J Hobbs	Limited	New	TWQG B	Quality Committee
16	10095	Clinical	3	Trust wide	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	5	3	15	J Hobbs	Inadequate	◆	TWQG B	Quality Committee
17	9900	Clinical	2	Trust wide	Poor identification, management and prevention of delirium	5	3	15	J Hobbs	Limited	◆	TWQG B	Quality Committee
18	8808	H&S	2	Corporate	Breaches to fire stopping and compartmentalisation	3	5	15	T McDonald	Adequate	◆	Estates Strategy & Delivery Group	People & Culture Committee

Risks removed from the Corporate Risk Register since the last meeting

ID	Risk Type	Sub Type	Division	Opened Date	Last Review	Next Review	Title	Likelihood Score	Consequence Score	Risk Score	Lead	Effectiveness of Controls	Outcome
9545	Medical Devices	Asset Management	SAS	24-Aug-22	19 Aug-25	19 Oct-25	Potential interruption to surgical procedures due to equipment failure	3	4	12	A Marsh	Limited	Equipment upgraded. Reduced risk of device failure. Risk score reduced. Removed from CRR. Managed by Safeguarding Committee / TWQG A
7165	Health & Safety	RIDDOR	Trust wide	25 Jan-17	16 Jul-25	15 Sep-25	Failure to comply with RIDDOR	3	4	12	R Derbyshire	Adequate	90% target achieved and maintained. Risk score reduced. Removed from CRR. Managed by H&s Committee / Quality Committee
9895	Clinical	Standards of Care	SAS	13 Sep-13	16 Apr-25	Risk Closed	Patients not receiving timely emergency procedures in theatres	-	-	-	-	-	Risk Closed. Similar issues regarding theatre capacity and access now included within DATIX ID 10139 on CRR
9851	Data & Digital	Records Management	Trust wide	02 Aug-23	09 May-25	Risk Closed	Lack of standardisation of clinical documentation processes and recording in Cerner	-	-	-	-	-	Risk Closed. Similar issues regarding clinical documentation now included within Datix ID 10247 on CRR.
9653	Clinical	Capacity	Trust wide	19 Dec-22	31 Jul-25	31 Oct-25	Increased demand and lack of capacity can lead to extreme pressures and delays to patient care	3	2	6	P Murphy	Adequate	Increased staffing levels and improved processes delivering efficiencies. Risk score reduced. Removed from CRR. Managed by Elective Productivity and Improvement Group
9301	Patient Safety	Falls Prevention	Trust wide	20 Dec-21	26 Aug-25	24 Oct-25	Risk of avoidable patient falls with harm	2	5	10	J Walton Pollard	Limited	Reduction in numbers of moderate to severe / fatal patient harm over last 12 months. Risk score reduced. Removed from CRR. Managed by Falls Strategy Group / TWQG A
6190	Clinical	Capacity	Trust wide	30 Oct-15	13 Aug-25	30 Oct-25	Insufficient capacity to deliver national targets for RTT and cancer	3	4	12	S Gilligan	Limited	Increased staffing levels and improved processes delivering efficiencies. Risk score reduced. Removed from CRR. Managed by Elective Productivity and Improvement Group

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10376	29 Mar-25	Clinical / Maternity	2	TWQG	Quality Committee	There is a risk of non-compliance with national maternity triage standards that could lead to delayed or unsafe care for pregnant and postnatal women resulting in adverse maternal and neonatal outcomes, regulatory breaches and reputational damage if we do not implement and monitor standardised triage systems, staff training and governance frameworks	J Hobbs		20 ▲			20	20	8	Minimal	Reduce	26 Aug-25	22 Sep-25

Effectiveness of Controls Inadequate
Progress Update – New Risk
New Exec Risk Lead. Triage model flagged as an area of concern following regional assurance visit made by NHSE North-West Maternity Triage Team. Next steps are to review urgent workforce planning to support BSOTS implementation, including junior doctor and midwifery resource, immediate review of telephone triage model to align with RCOG standards, enhanced data capture for near misses and flow related delays, to strengthen assurance mechanisms with real time monitoring and escalation protocols and ensure visibility and accountability. Monthly updates provided to TWQG in relation to progress of risk mitigation along with thematic review of incident data that has arisen

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10086	01 May-24	Clinical / Diagnostic Testing & Screening	2	TWQG	Quality Committee	There is a risk of inadequate or absent secure online storage for diagnostic images that could lead to missed or delayed diagnosis, compromised patient safety and regulatory non-compliance if we do not implement a compliant, integrated and resilient image storage and retrieval solution	J Hobbs	20	20			20	20	4	Minimal	Reduce	26 Aug-25	26 Sep-25

Effectiveness of Controls Inadequate
Progress Update – No change in risk score
New Exec Risk Lead. The risk relates to inadequate or absent secure online storage for diagnostic images and is multifaceted, intersecting clinical management, data and digital infrastructure and medical devices governance. Existing controls e.g. contract extensions, ad hoc image transfers and local storage are insufficient to mitigate the risk. Interim solutions are not sustainable or clinically safe, and the core risk remains unresolved. The primary classification is clinical management as the core impact is on clinical decision making, diagnostic accuracy and patient outcomes. Data and digital is a secondary domain involving digital infrastructure, data storage, interoperability, and compliance with digital standards. Medical devices is a tertiary domain as the issue is not with the device malfunction but with post capture management of diagnostic images. The risk remains high due to persistent systemic and operational gaps. Whilst technical options are being explored, none have been fully implemented or validated. An ICB led digital solution remains pending. Ownership and transfer of this risk is currently under discussion as part of a wider review of data and digital risks. EBME are currently responsible for the management of ultrasound machines.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10082	26 Apr-24	Financial / Financial Sustainability	5	Finance Assurance Board	Finance and Performance Committee	There is a risk of the Trust failing to meet internal and external financial targets that could lead to regulatory intervention, loss of public confidence and compromised patient care if we do not implement robust financial governance, planning and monitoring controls	S Simpson	25	20			25	20	10	Cautious	Reduce	26 Aug-25	23 Sep-25

Effectiveness of Controls Limited
Progress Update – Reduced Risk Score
As of July 2025 (Month 4), the Trust is reporting a year-to-date deficit of £5.8m, which is £2.1m worse than the planned £3.7m deficit, excluding £3.6m of deficit support funding. The Trust remains committed to its agreed break-even financial plan for 2025–26, which includes a non-recurrent £43.324m in deficit support funding and a £60.8m Waste Reduction Programme (WRP). In-month WRP delivery was £4.1m, falling £0.9m short of the original target and £200k behind the reprofiled plan.
Agency spend was £468k, £43k better than plan and reflecting a 45% reduction on the 2024/25 run rate—exceeding NHSE's 30% reduction target. Bank spend totalled £4.2m, £558k adverse to plan, largely due to £827k of industrial action-related costs. Excluding this pressure, bank spend would have shown a favourable variance of £269k. The Trust's cash position improved to £7.1m at the end of June, up £2.2m from Month 2. Capital expenditure year-to-date stands at £6.9m, £4.2m ahead of plan against the annual capital allocation of £35.3m. Workforce numbers (WTE) have reduced by 56.99 from Month 2, now standing at 9,813.31.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10065	26 Mar-24	Clinical / Infrastructure	2	Estates Strategy & Delivery Group	People & Culture Committee	There is a risk that aseptic units may not be maintained to the required regulatory and operational standards, which could lead to contamination of sterile products and patient harm, including death, if we do not implement robust governance, environmental monitoring, and compliance with national aseptic service standards.	T McDonald	20 ◀▶	20 ◀▶			20	20	10	Minimal	Reduce	18 Aug-25	17 Sep-25

Effectiveness of Controls Inadequate
Progress Update – No change in risk score
The aseptic unit remains at high risk due to ongoing infrastructure and equipment failures, including aging cleanroom facilities, air handling unit fragility and isolator breakdowns. Despite some progress, such as the closure of the aseptic unit for upgrade works and the recommissioning of failed isolators, critical remedial works on the chemotherapy POD are still outstanding, and delays in procurement and maintenance continue to hinder risk mitigation. While a range of controls and assurance mechanisms are in place e.g. GMP compliance, internal audits, environmental monitoring, and external audits, they are currently deemed inadequate. Key gaps include expired maintenance contracts, limited contingency capacity, and increasing service demand without corresponding infrastructure investment. Workforce pressures and delays in environmental breach detection further compound the risk. Strategic transformation plans and capital bids are underway, but the unit remains vulnerable until these are fully implemented and operationalised.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10062	22 Mar-24	Clinical / Assessment – Diagnosis	2	TWQG A	Quality Committee	There is a risk of significant harm and poor patient experience for individuals presenting with mental health concerns in acute hospital settings that could lead to adverse clinical outcomes, increased length of stay, avoidable incidents (e.g., self-harm, absconding), and breaches of legal and regulatory standards if we don't implement integrated, person-centred mental health care pathways, staff training, and robust governance structures	P Murphy	16 ▲	20 ▲			12	20	8	Minimal	Reduce	23 Jul-25	22 Aug-25

Effectiveness of Controls Inadequate

Progress Update – Increased risk score. Risk review overdue

Risk score has been increased to 20 following a meeting held with senior clinical and safeguarding leaders to reflect escalating concerns. Key issues include a rise in physical assaults on staff leading to long term sickness absence and increased financial pressures from the need for 1:1 staffing as well as prolonged delays in mental health assessments, with some patients waiting over 136 hours in ED and across the Trust. There has been a notable increase in paediatric patients awaiting placements. Although executive support has been sought to improve data collection through the data and digital team, current systems are unable to fully evidence the extent of harm or poor patient experience. This is compounded by acknowledged underreporting from both staff and patients, particularly those with deteriorating mental health. The situation highlights significant operational, safety and reputational risks requiring urgent system wide intervention

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
9755	13 Ap-23	Clinical / Capacity	2	TWQG A	Quality Committee	There is a risk of insufficient obstetric theatre and staffing capacity to meet the rising demand for elective caesarean sections, which could lead to delays in planned procedures, increased maternal and neonatal morbidity, and breaches of national standards if we do not implement robust capacity planning, workforce optimisation, and service redesign.	P Murphy	20	20			20	20	5	Minimal	Reduce	04 Aug-25	03 Sep-25

Effectiveness of Controls Adequate

Progress Update – No change in risk score

The risk score remains high due to persistent and escalating pressures on elective caesarean section (ELCS) capacity at Burnley General Teaching Hospital. Despite the approval of a revised business case to increase funded capacity from 15 to 20 slots per week, a significant gap remains between demand and available theatre time. The current mitigation strategy i.e. reliance on reutilised theatre lists and emergency capacity is unsustainable, costly, and operationally fragile. This approach continues to impact emergency theatre availability, midwifery staffing, and patient experience, with multiple incidents of delayed or cancelled procedures, prolonged fasting, and increased NICU admissions. Weekly MDT reviews, RAG-rated scheduling, and daily monitoring are in place, but these controls are limited by staffing constraints, lack of guaranteed theatre access, and the ongoing impact of theatre lifecycle works. The risk is compounded by the inability to consistently meet NICE NG192 standards for decision-to-delivery times, posing clinical, legal, and reputational risks. While the revised business case has provided partial relief, the service still lacks the full capacity required to meet demand safely and sustainably. The risk remains under corporate oversight and is linked to broader theatre availability risks (e.g. Risk ID 10139).

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
9366	19 Jan-22	Clinical / Capacity	3	TWQG B	Quality Committee	There is a risk of insufficient capacity to meet increasing demand within the Accident and Emergency (A&E) Department that could lead to extreme pressure on services and delays in patient care if we do not implement robust demand and capacity planning, workforce optimisation, and patient flow improvements.	J Hobbs	20	20			20	20	12	Minimal	Reduce	21 Aug-25	22 Sep-25

Effectiveness of Controls Limited
Progress Update – No change in risk score
New Exec Risk Lead
The risk associated with overcrowding and capacity issues in the Emergency Department remains high, with a current risk score of 20. Despite the implementation of several control measures including SOPs for corridor care, improved triage processes, and increased RN recruitment significant challenges persist. These include frequent 12-hour DTA breaches, limited side room availability, and ongoing reliance on corridor spaces, all of which continue to impact patient safety, staff wellbeing, and service delivery. While some improvements have been noted, such as reduced complaints and better nursing recruitment, the department remains under sustained pressure. Progress is being closely monitored through regular reviews, with executive oversight and data-led improvement plans in place. The department has maintained a RED rating on the NAPF for extended periods, although recent assessments show some areas improving to AMBER. Actions such as the introduction of a dedicated UTC footprint, enhanced streaming pathways, and increased staffing have contributed to better oversight and patient flow. However, the risk remains high due to ongoing high demand, limited bed capacity, and the potential for harm, with further reviews scheduled to assess sustained improvement. Opening of AECU in Sep-25 and 24/7 discharge lounge from end Aug-25 will help divert capacity to more appropriate areas.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
8941	11 Feb-21	Clinical / Capacity	2	TWQG B	Quality Committee	There is a risk of increased histology reporting turnaround times that could lead to delayed diagnoses, compromised patient outcomes, and regulatory non-compliance if we don't increase staffing capacity, optimise workflow, and implement digital pathology solutions.	J Hobbs	20	20			20	20	8	Minimal	Reduce	17 Jul-25	18 Aug-25

Effectiveness of Controls Limited
Progress Update – No change in risk score. Risk review overdue
New Exec Risk Lead
The risk of increased histology reporting times due to rising activity levels outstripping available resources remains high, with a current score of 20. Despite a five-year workforce plan, recruitment of locums, outsourcing, and prioritisation of cancer cases, the backlog of routine cases continues to impact patient care particularly for breast cancer patients, where delays in pathology reporting risk compromising timely adjuvant treatment. While mutual aid and additional bank work have helped reduce the backlog from over 9,000 to around 3,500 cases, turnaround times remain below target, and complaints and incidents persist. The department has experienced further strain following the loss of three pathologists in early 2025, and financial constraints limit the ability to fund locum or outsourced support. Although controls such as triaging, escalation processes, and weekly cancer performance meetings are in place, gaps remain in dissection capacity, equipment reliability, and junior doctor recruitment.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10386	15 Apr-25	Clinical / Discharge	2	TWQG	Quality Committee	There is a risk of incomplete or poor-quality information in hospital discharge summaries that could lead to patient harm, medication errors, readmissions or delayed follow up care if we do not implement and monitor robust discharge communication standards aligned with national policy and regulatory requirements	J Hobbs		16 ▲			16	16	6	Minimal	Reduce	27 May-25	27 Jun-25

Effectiveness of Controls Inadequate
Progress Update – New Risk. Risk Review Overdue
New Exec Risk Lead
Key concerns include missing or incorrect diagnoses, medication errors, poor communication with primary care, and inconsistent discharge processes across departments. Two linked incidents have already highlighted the real-world impact of these issues, including medication discrepancies and lack of discharge documentation leading to delayed treatment and readmission. While several controls are in place such as standardised templates, electronic discharge systems, and mandatory training, gaps remain in assurance and implementation. These include inconsistent multidisciplinary oversight, unclear monitoring of compliance data, and reliance on junior staff under time pressure. A discharge queries mailbox has been introduced, but data monitoring is still in early stages. A discharge summary compliance audit is underway to support risk reduction.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10371	25 Mar - 25	Data and Digital / Records Management	2	TWQG	Quality Committee	There is a risk that the failure to correctly update IT systems when consultants leave the Trust may lead to patient harm	J Hobbs		16 ▲			16	16	8	Cautious	Reduce	08 May-25	06 Jun-26

Effectiveness of Controls Limited
Progress Update - New Risk. Risk Review Overdue
New Exec Risk Lead
The issue arises when investigations or follow-up care remain linked to consultants who are no longer employed, resulting in missed results, delayed diagnoses, and patients becoming "invisible" on holding lists. Two incidents have already highlighted serious consequences, including a delayed cancer diagnosis and continued ICE access for a departed consultant. Controls are currently limited. While IT deactivates accounts based on ESR reports, there is no Trust-wide SOP or consistent process across directorates to manage the clinical handover or removal of requestor names from systems like ICE. The scale of the issue is significant, with hundreds of patients and dozens of inactive consultant accounts identified. Actions are underway to confirm current processes, develop SOPs, and validate affected patient lists.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
9777	09 May-25	Health and Safety / Building Infrastructure	4	DERI Estates & Facilities Group	People & Culture Committee	There is a risk of the loss of critical education, research and innovation (DERI) accommodation and facilities that could lead to significant disruption to academic partnerships, clinical research, staff development, and innovation capacity if we don't invest in maintaining, refurbishing or replacing buildings that are no longer fit for purpose due to disrepair and non-compliance with NHS estates standards.	T McDonald	16 ▲	16 ◆			16	16	4	Averse	Reduce	30 Jul-25	29 Aug-25

Effectiveness of Controls Limited

Progress Update – No change in risk score

The risk of losing Education, Research and Innovation (DERI) accommodation and facilities remains high. The Park View Offices and Burnley Training Centre are in a deteriorating state, with issues such as water ingress, black mould, and structural disrepair. While some services have been relocated, DERI remains in Park View without a viable alternative to meet current and future training and research needs. This poses a threat to the Trust's ability to deliver statutory training, host medical students, and conduct clinical research potentially resulting in loss of income, reputational damage, and compromised patient and staff safety. Although some controls are in place, such as portable teaching equipment, a completed simulation suite, and ongoing scoping of alternative sites gaps remain in funding, assurance, and timely remedial work. The risk is monitored through DERI leadership meetings and safety audits, but unresolved maintenance issues continue to threaten service continuity.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
9746	05 Apr-23	Finance / Financial Planning	5	DERI SLG	People & Culture Committee	There is a risk of reduced participation in research, development and innovation (RD&I) activities that could lead to reputational damage, missed opportunities for clinical advancement, and non-compliance with national research priorities if we don't establish a sustainable funding model to support research delivery in the absence of centralised Trust funding.	M Ireland N Pease	16	16			20	16	8	Cautious	Reduce	08 Aug-25	09 Sep-25

Effectiveness of Controls Limited
Progress Update – No change in risk score
The risk of an inadequate funding model for Research, Development and Innovation (RD&I) at ELHT remains high. The RD&I service is not centrally funded and relies on a complex mix of non-recurrent income from commercial and non-commercial research activity, as well as limited NIHR CRN funding. This model is unsustainable and poses a significant threat to the Trust's ability to meet its statutory obligations, maintain its research portfolio, and achieve University Hospital status. A projected funding gap of over £1.25 million for 2024/25 could lead to redundancies, reduced research opportunities for patients, and reputational damage. While controls such as improved financial oversight, service reviews, and income recovery projects are in place, they are limited in effectiveness due to staffing constraints, non-recurrent income, and the long lead time for return on investment. Assurance mechanisms include regular finance meetings and engagement with senior leadership, but gaps remain in forecasting, infrastructure, and recruitment. Ongoing work includes rebalancing the research portfolio, refining income processes, and developing a sustainable business plan.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
8061	05 Feb-19	Clinical / Appointment	3	Elective Productivity & Improvement Group	Finance and Performance Committee	There is a risk of patients experiencing harm due to delays in clinical review that could lead to deterioration in health outcomes, increased emergency admissions, and breaches of statutory care standards if we don't implement robust waiting list validation, prioritisation, and review mechanisms aligned with national policy and clinical governance frameworks.	S Gilligan	16	16			16	16	8	Minimal	Reduce	07 Aug-25	05 Sep-25

Effectiveness of Controls Limited

Progress Update – No change in risk score

The risk of patients experiencing delays beyond their intended clinical review date remains high. As of August 2025, over 100,000 patients are on the holding list, reflecting a persistent backlog exacerbated by COVID-19, industrial action, and EPR implementation. The risk is that delayed reviews may lead to deterioration in patient conditions or missed clinical interventions. Although RAG (Red-Amber-Green) ratings are used to prioritise patients, inconsistent application and lack of capacity across specialties mean many patients remain uncoded or unreviewed. Controls include daily monitoring, SOPs for RAG rating, and efforts to restore pre-COVID activity levels. However, gaps persist in staff compliance with SOPs, automated reporting, and capacity to manage the backlog. A full review of the holding list SOP is underway, and a new overarching Trust-wide waiting list risk is being developed to replace this entry. Despite some improvements, the volume of patients and the risk of harm remain significant, necessitating continued executive oversight and strategic action.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
8033	08 Jan-19	Clinical / Nutrition and Hydration	2	TWQG A	Quality Committee	There is a risk of patient nutrition and hydration needs not being adequately assessed, met, or monitored that could lead to malnutrition, dehydration, delayed recovery, increased morbidity/mortality, and regulatory non-compliance if we don't implement robust clinical governance, staff training, and monitoring systems aligned with national standards.	P Murphy	16	16			16	16	4	Minimal	Reduce	22 Jul-25	22 Aug-25

Effectiveness of Controls Limited

Progress Update – No change in risk score. Risk review overdue

The risk of delays in meeting patients' nutrition and hydration needs remains high, with a current score of 16. Despite the implementation of controls such as updated policies, training, and the establishment of a Complex Nutrition Team, recurring issues persist. These include inconsistent and inaccurate malnutrition assessments, reliance on estimated rather than actual weights, and poor monitoring and escalation of food and fluid intake. Nutrition and hydration are not consistently reviewed during ward rounds and there are delays in best interest decisions for patients with minimal intake. Access to the Nutrition Support Team is limited and often dependent on referrals from dieticians or nutrition nurses, with ward-initiated referrals constrained by capacity and limited NST ward rounds. Although system and staffing improvements are underway, including Cerner integration, recruitment into key roles, and the development of dashboards and audits, these changes are not yet fully embedded. The risk score has been retained due to the persistence of similar and recurring themes, as well as ongoing incidents and complaints. A full review of the score will be undertaken once improvements are operational and demonstrably effective

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10139	04 Jul-25	Clinical / Capacity	3	TWQG B	Quality Committee	There is a risk of insufficient theatre capacity to meet both emergency and elective surgical demand, which could lead to delays in time-critical interventions, increased patient harm, and failure to meet NHS constitutional standards if we do not implement robust capacity planning, ring-fencing of elective hubs, and operational efficiency improvements.	J Hobbs		15 ▲			15	15	9	Minimal	Reduce	19 Aug-25	19 Sep-25

Effectiveness of Controls Limited
Progress Update – New Risk
New Exec Risk Lead
The risk of insufficient theatre capacity to manage both emergency and elective patients remains high. Despite the introduction of additional emergency lists (e.g. Sunday sessions at RBH) and extended elective sessions, theatres across both Blackburn and Burnley sites are operating at near full capacity (96–100%). Obstetric and gynaecology emergencies are increasingly impacting elective lists. Lifecycle works at RBH are expected to further reduce availability, exacerbating delays and increasing the risk of harm, particularly for time-critical procedures such as caesarean sections and cancer surgeries. Progress has been made in consolidating related risks (e.g. 9755, 9895, 10332) into a single corporate risk (ID 10139). Business cases have been submitted to support additional staffing and capacity, and weekly planning meetings are in place to manage theatre allocation during lifecycle works. However, many controls remain reliant on staff goodwill and non-contractual arrangements, limiting sustainability. The risk score has been retained pending further review of incident data and assurance of long-term solutions.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
10095	14 May-25	Data and Digital / Systems	2	TWQG B	Quality Committee	There is a risk of systemic inefficiencies and workflow obstruction in the Cardiology Pre-Assessment Clinic (PAC) that could lead to failure to meet elective and urgent care targets, delayed patient treatment, and compromised clinical outcomes if we don't implement robust digital integration, workforce optimisation, and pathway redesign aligned with national standards.	J Hobbs	15 ▲	15 ◆			15	15	6	Cautious	Reduce	01 Sep-25	03 Oct-25

Effectiveness of Controls Inadequate
Progress Update – No change in risk score
New Exec Risk Lead
A purchase order has been raised for the system upgrade, with confirmation delivery is expected in Jan-26, with payment still outstanding. In parallel, the possibility of an early contract exit is being assessed by the ICB legal team. ELHT has expressed a clear preference to terminate the current agreement if legally permissible, but this is contingent on securing a safe and compliant alternative to avoid any disruption or exposure to risk. The situation remains under review, and further updates are awaiting from the legal team. ELHT is committee to ensuring continuity of service and will not proceed with any changes unless a robust replacement is in place.

Corporate Risk Register Dashboard

ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
9900	19 Sep-23	Clinical / Assessment and Diagnosis	2	TWQG B	Quality Committee	There is a risk of poor identification, management, and prevention of delirium in patients, that could lead to increased morbidity, mortality, prolonged hospital stays, and long-term cognitive decline, if we don't implement and maintain robust clinical assessment, staff training, and evidence-based care pathways in line with national guidelines.	J Hobbs	15 ◀▶	15 ◀▶			15	15	9	Minimal	Reduce	08 Aug-25	08 Sep-25

Effectiveness of Controls Limited
Progress Update – No change in risk score
New Exec Risk Lead
The risk of poor delirium identification and management remains high, with no change to the current risk score. Despite the implementation of the Single Question to Identify Delirium (SQID) in Cerner and the development of a digital care plan, compliance with screening and diagnostic assessments continues to be inconsistent. While 150 staff have received training and further sessions are planned for resident doctors as part of the induction programme, assurance is hindered by the absence of mandatory training, incomplete documentation, and limited audit data. The National Audit of Dementia (Round 6) shows an upward trend in delirium investigation nationally, but local audits reveal poor compliance, prompting escalation to the medical directorate. Progress includes the integration of delirium prompts into IR1s, the creation of a SharePoint resource hub, and agreement of a Quality Improvement Plan (QIP) for targeted work on wards B2/C4. A change request is required to support improvements in investigation prompts. Actions are underway to escalate training to DERI for consideration as mandatory and to strengthen audit reporting via the Data and Digital team. While controls are in place, their effectiveness remains limited, and assurance mechanisms are still maturing.

Corporate Risk Register Dashboard

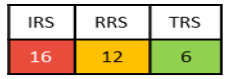
ID	Date Added	Risk Type / Sub Type Category	BAF Risk	Accountable Group	Sub Committee (For Assurance)	Risk Description	Exec Lead	Risk Score Trend				Inherent – Residual – Target Risk Score			Risk Appetite	Risk Treatment	Last Reviewed	Next Review
								Q1	Q2	Q3	Q4	IRS	RRS	TRS				
8808	06 Nov-20	Health and Safety / Fire Safety	2	Estates Strategy & Delivery Group	People & Culture Committee	There is a risk that breaches in fire stopping and compartmentalisation works within Phase 5 at BGH, a PFI building not owned by the Trust, may lead to rapid fire and smoke spread, endangering lives and critical healthcare service provision if rigorous fire safety inspection, maintenance and staff training protocols are not followed	T McDonald	15	15			15	15	5	Averse	Reduce	08 Aug-25	05 Sep-25

Effectiveness of Controls Adequate

Progress Update – No change in risk score

Despite the implementation of multiple controls including fire safety risk assessments, remedial works programmes, and fire safety training significant gaps persist. These include delays in completing fire protection works, limited traceability of historical materials, and concerns raised by Lancashire Fire and Rescue Service (LFRS) regarding the pace of progress. The presence of combustible materials in concealed areas and the lack of test evidence for certain insulation products further compound the risk. The current works in Ward 16 are now forecast to continue until February 2026, effectively creating a live construction site within an operational hospital. Progress has been made through the establishment of a dedicated fire remediation project team, regular Fire Safety Committee oversight, and quarterly engagement with LFRS. A 17% reduction in fire safety incidents has been achieved year-to-date, against a 25% target. However, the risk score remains unchanged due to ongoing concerns about the effectiveness of fire stopping, the potential for enforcement action, and the need for further assurance from the project team. The risk is to remain on the corporate risk register until significant and sustained improvements are evidenced, particularly in high-risk areas such as ICU, theatres, and maternity.

Corporate Risk Register Dashboard Guidance

Colum Heading	Guidance	Example
Risk ID	A unique identifier for each risk is assigned	e.g. Datix ID 00001
Date Added	The date which the risk was created	e.g. 01 Jan-25
Risk Type	The type of identified organisational risk	e.g. infection prevention and control
BAF Risk	A link of the risk to the Board Assurance Framework	e.g. BAF 2
Assurance Group	The Committee or Group with responsibility for overseeing the management of the risk type	e.g. Infection Prevention Control Committee
Risk Title / Risk Type / Risk Sub Type	The risk title should be clearly recorded and provide a basic summary of the risk event, the cause/s and impact that may result from a reasonable worst-case scenario of the risk. A more detailed risk description would be outlined within the concerns section of the risk. The risk type and sub type categories should also be referenced	e.g. there is a risk of 'x' could lead to 'y' if we do not do 'z' risk type - data and digital, risk sub type - cyber security
Executive Lead	A senior executive appointed by the Executive Risk Assurance Group who is accountable for the management, review and response to the risk	e.g. Executive Medical Director
Risk Score Trend	The direction the risk score has moved since it was last reviewed. The trend should be shown as improving, deteriorating or remaining unchanged. Ideally the trend should show over the previous 12 months	e.g. 
Inherent – Residual – Target Risk Scores	A score and RAG based assessment of each risk. IRS: Inherent Risk Score (Initial) RRS: Residual Risk Score (Current) TRS Target Risk Score. Risk scores should be reviewed every time the risk is assessed in accordance with risk review cycles contained within the Risk Management Framework i.e. risks scoring 15+ need to be reviewed every 31 calendar days	e.g. 
Consequence Impact	The impact or consequence that may be felt should exposure to a risk occur. These are set out using the Consequence Scoring Criteria within the Risk Management Framework	e.g. safety of patients, reputational
Risk Appetite	The risk appetite for each applicable risk category should be set out and aligned to the Trust's risk appetite statements i.e. averse, minimal, cautious, open or eager	e.g. the Trust has an averse (zero) appetite towards health and safety risks and seeks to avoid any risk compromising staff or patient safety
Risk Response	How the risk needs to be treated	e.g. risk avoidance, risk acceptance, risk reduction, risk transfer or risk diversification
Last Review	The date when the risk was last assessed	e.g. 01 Jan-25
Next Review	The date when the risk is due to be reviewed i.e. risks scoring 15 or above are reviewed every 31 calendar days	e.g. 01 Feb-25

Risk Types, Descriptors and Risk Governance
Risk governance has been refined by mapping risk types and sub types to specific committees and or groups, assigning chairs and executive leads for oversight and utilising subject matter experts to manage risks within their domains. Regular review of risks is conducted through standardised terms of reference and annual performance reporting. Additionally, the effectiveness of Committees and or Groups in scrutinising risks before escalation to risk assurance meetings (RAM) has been reviewed

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by	Board Assurance Group
	Clinical	Potential for harm to patients due to inadequate clinical management systems and errors in diagnosis, treatment or care	Executive Medical Director / Chief Nurse	Deputy Chief Nurses / Deputy Medica Director	Identified Clinical Leads	Clinical Effectiveness Group	Quality Committee
	Data and Digital	Risks associated with the use, storage and transmission of data and reliability of digital systems	Executive Director of Finance	Chief Information Officr	Identified Data and Digital Leads	Data and Digital Committee	Finance and Performance Committee
	Emergency Planning	Threats in the ability to maintain service provision during, as well as after, significant failures of systems and of responding effectively to emergencies and natural disasters	Executive Director of Integrated Care, Partnerships and Resilience	Deputy Director of Integrated Care, Partnerships and Resilience	Emergency Preparedness, Planning and Resilience Manager	Emergency Preparedness, Planning and Resilience Committee	Finance and Performance Committee
	Financial	Risks of direct or indirect loss in relation to the Trust's financial stability such as budget deficits, financial reporting, fraud and inadequate revenue	Executive Director of Finance	Chief Management Accountant	Identified Finance Leads and Specialisms	Finance	Finance and Performance Committee
	Clinical Governance	Risks relating to the effectiveness of its registration, leadership, decision making, compliance with regulations and operation of its governance framework	Executive Medical Director	Associate Director of Quality and Safety	Identified Governance Leads and Specialisms	Trust Wide Quality Governance	Quality Committee
	Health and Safety	Risks relating to the health and safety of its staff, patients, visitors, contractors, buildings, assets and the environment	Executive Director of Integrated Care, Partnerships and Resilience	Assistant Director of Health, Safety and Risk	Identified Safety Leads and Specialisms	Health and Safety Committee	Quality Committee

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by	Board Assurance Group
	Human Resources	Risks relating to workforce supply, recruitment and retention, skills and competency, behaviours and performance, wellbeing and culture	Executive Director of People and Culture	Deputy Director of People and Culture	Identified HR Leads and Specialisms	Performance and Goverance Meeting	People and Culture Committee
	Infection Prevention	Risks relating to the management and spread of hospital acquired infection and transmission	Executive Medical Director / Chief Nurse	Director of Infection, Prevention and Control	Identified IPC Leads and Specialisms	Infection, Prevention and Control Committee	Quality Committee
	Medical Devices	Risks relating to the safe and effective use of medical devices and whole lifecycle management	Executive Director of Integrated Care, Partnerships and Resilience	Deputy Director of Integrated Care, Partnerships and Resilience	Medical Devices Safety Officer	Medical Devices Steering Committee	Quality Committee
	Medicines Management	Risks relating to the safe and effective prescribing, dispensing and administration of medications	Executive Medical Director / Chief Nurse	Chief Pharmacist	Medicines Safety Officer	Medicines Safety and Optimisation Group	Quality Committee
	Patient Safety	Risks of harm to patients from any source within the healthcare system	Executive Medical Director	Assistant Director of Patient Safety and Clinical Effectiveness	Identified Patient Safety Leads and Specialisms	Trust Wide Quality Governance Meeting	Quality Committee
	Operational Performance	Risk that the Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legilsation and Patient Charter	Chief Operating Officer	Deputy Chief Operating Officer/s	Identified Leads and Specialisms	Elective Productivity and Improvement Group	Finance and Performance Commmittee
	External	Risks originating outside the control of the Trust that have the potential to impact on its operations	Executive Directors	Deputy Directors	Assistant Directors	Sub Committees and Groups	Board

Risk Treatment Options

Treatment	Definition	Response	Example/s
Acceptance	Acknowledging risks and deciding not to take any action by accepting the actual or potential consequence	Used for risks deemed insignificant or low or where cost of treatment outweighs benefits	Minor medical device malfunction knowing a backup is available and impact on patient safety is minimal Short delay with an outpatient appointment knowing this will not significantly impact on patient care
Avoidance	Avoiding the risk altogether or eliminating the risk entirely by discontinuing the activity or process	Used for risks with high potential impact or where consequences are unacceptable	Avoiding a high-risk surgical procedure unless absolutely necessary, opting for less invasive alternative or delaying the procedure until a patient's condition stabilises
Reduction	Reducing the likelihood and impact of the risk	Taking specific action to manage the risk	Implementing strict infection control policy and hand hygiene protocols, wearing appropriate RPE and PPE, isolating patients with infectious disease to mitigate the risk of hospital acquired infection Use of electronic medication administrative systems, implementing double checking procedures and providing training on safe medication practice to minimise medication errors Implementing falls prevention measures and educating staff on falls risk factors to reduce numbers of falls and levels of harm
Transfer	Moving risks to external parties	Transfer of risk through contracts, outsourcing or insurance	Use of liability schemes to transfer risks of legal claims arising from medical negligence Outsourcing of non-core functions to a third-party provider and transferring the risk associated with those services Entering infrastructure projects such as new hospital buildings and transferring the risk of construction and maintenance to a private provider
Diversification	Spreading risks across different areas	Dividing the risk with other parties through collaboration ventures	Sharing a risk of a new treatment with other healthcare organisations or research institutions through collaborative clinical trials, pooling of resources and expertise, reducing the individual risk

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/127
Report Title:	Update on Project Aarushi: Becoming an Intentional, Visible and Proactive Anti-racist organisation		
Author:	Emma Dawkins Associate Director of Organisational Development Dr Uma Krishnamoorthy Associate Medical Director and Consultant Gynaecologist		
Lead Director:	Neil Pease Interim Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	The Aarushi Project aims to transform ELHT into an intentional, visible, and proactive anti-racist organisation using quality improvement methodologies with data insights, in collaboration with Care Quality Academy. This update outlines progress made, including the successful maternity pilot, bronze accreditation under the NW BAME Anti-Racist Framework, and improvements in WRES metrics. Key initiatives include inclusive recruitment, anti-racism and allyship training, and ethnicity pay gap analysis. This is strategically interlinked to Trust priorities and commitment made by the Board, on addressing health inequalities, our EDI strategy, delivering on the requirements of the NHS England EDI improvement plan, Northwest BAME Assembly's Anti-Racism framework and progressing further in enhancing a Compassionate and Inclusive organisational culture to deliver Safe, Personal, Effective care.			
Key Issues/Areas of Concern:	Challenges remain in sustaining engagement, cultural change, and underreporting. The Trust is now working towards Silver accreditation, expanding initiatives Trust-wide, and embedding anti-racism into leadership, recruitment, and patient care. Continued Board commitment is essential to sustain momentum and address systemic inequalities in staff and patient experience.			
Action Required by the Board:	The Board is asked to: • Be assured by the progress outlined within the report and ongoing action plans in progress; and • Reaffirm the commitment of the Board to the programme.			

Previously Considered by:	
Date:	
Outcome:	

Introduction

1. The Aarushi Project was formally approved by the People and Culture Committee on 4th March 2024. The project application on behalf of the Trust was made in September 2023 as part of the Care Quality Academy (CQA) Programme focused on becoming an intentionally anti-racist organisation. ELHT was one of the five regional projects accepted by the CQA through competitive entry process.
2. The focus of the programme was to embed quality improvement methodology, through working with a clinical lead nominated for the organisation and wider team, with support from experts in quality improvement (QI), executive sponsor, and a QI mentor.
3. This aligned with the commitment that had been provided by the Board to the Northwest Black, Asian and Minority Ethnic (BAME) Assembly and NHS England, in response to their letter asking all Trusts to confirm their commitment to the Equality, Diversity and Inclusion Improvement Plan and to sign up to the North West Anti-Racist Framework.
4. This paper provides an update on the progress so far, the impact, the risks and issues as well as next steps. It includes performance data linked to anti racism including staff survey, workforce race equality standards and the ethnicity pay gap.

Executive summary

5. Over the past year, the Trust has continued to advance its anti-racism and Allyship agenda with purpose and accountability. These efforts form a critical pillar of our wider Equality, Diversity and Inclusion (EDI) strategy, aiming to ensure that all staff, patients, and communities are treated with fairness, dignity, and respect. Below is a summary of some of the key achievements which are detailed in Section 19 of the report.
    a. ***Maternity Pilot Project***: Maternity was selected as a pilot area for anti-racism work, including empathy interviews with staff, co-produced learning, and collaboration with the recruitment lead to pilot the new Recruitment Toolkit. As a direct **improvement,** two Band 7 midwives from Black, Asian and Minority Ethnic (BAME) backgrounds have been appointed, where previously there were none highlighting measurable progress in diversifying leadership.
    b. ***Training and Awareness*:** Commenced roll out the anti-racism awareness sessions with divisional management boards and anti-racism and allyship training.
    c. ***Allyship Programme:*** A Trust-wide Allyship framework has been launched.

d. ***Inclusive Recruitment toolkit and Training***: Diverse panels and inclusive job design practices are being embedded across the trust following the successful pilot of the recruitment toolkit.

e. ***Recognition****:* ELHT proudly achieved the Bronze Award Accreditation for the Northwest BAME Anti-Racist Framework, as one of the only four organisations in the region to achieve this in the first round in June 2024, marking a significant external validation of our foundational work and systems improvement.

f. ***WRES Improvements***: Positive movement was noted in metric 1 increase in percentage of BAME staff, metric 2 disparity from shortlisting to appointment and metric 4 access to development.

g. **Ethnicity pay gap reporting:** In line with national requirements the Trust has reported the ethnicity pay gap, which demonstrates the need for further analysis and listening to develop key actions to develop a pipeline of leaders and address systemic bias in systems and processes. This will provide a foundation for actions required for silver accreditation. The Trust is looking to engage national ethnicity pay gap expert Dianne Grayson in a roundtable discussion with senior leaders, members of the BAME staff network and members of the project team. Appendix 12.

6. Some of the challenges in bringing about a wholesale change include;

a. ***Sustaining Engagement***: Ensuring consistent engagement, especially in high-pressure clinical areas, remains a challenge. Difficult decisions to pause training in order to release capacity and to contribute to the financial turnaround have impacted progress.

b. ***Cultural Change at Scale***: Embedding inclusive and anti-racist behaviours Trust-wide requires sustained leadership focus and operational alignment.

c. ***Under-reporting:*** Concerns about underreporting of racism persist. Work is ongoing to strengthen confidence in reporting systems and ensure appropriate triage and visible action.

7. The next steps are to actively work towards achieving BAME assembly's silver anti-racism accreditation by embedding practices and sustaining positive outcomes. Alongside this, we are strengthening our talent management and progression pathways to ensure under-represented groups have equitable access to career and leadership development.

8. The project team is expanding the learning from our maternity pilot to other services, refining the inclusive recruitment practice across the entire Trust, and enhancing data reporting and accountability to demonstrate impact and foster trust.

Background

9. Racism is a complex and deep-rooted issue in society, hence why it is often referred to as a wicked problem which needs significant focus, a transformation in thinking and evidence-based actions, systemic solutions that override human factors to tackle institutional and systemic racism, sustained over a period, to bring about culture change.
10. The Trust commitment to anti racism has been long standing and pre-dates the pandemic with the development of a BAME staff network with executive sponsorship, a deep dive into the lived experience of colleagues during the pandemic. (Appendix 1). The report included clear recommendations which were supported by the Board, however what was needed was a group to strategically conceptualise solutions through data insights, execute and operationalise the work in a sustainable manner to embed the change , in the absence of a singular race equality lead.
11. Whilst Covid shone a light on the health inequalities that already existed, there continues to be external events in wider society that bring issues of racism, islamophobia, and community division in to sharp focus and impact the lives of our workforce and patients. This continues to be an increasing risk and therefore the team continuously need to listen to the voices of staff and patients (including those traditionally thought to be hard to reach) and adapt our approach as our understanding of anti-racism matures, and in line with wider developments.

Purpose, aims and progress to date

12. The purpose of the programme is for the Trust to become an intentional, visible and proactive anti-racist organisation. The Aarushi team aligned the organisation in what it means to be Antiracist through commitment to three key behaviours in actions:
    a. Compassionate and inclusive behaviours in action
    b. Commitment to zero-tolerance to racism in everything we do.
    c. Positively influencing local communities besides, patients and staff
13. Whilst the CQA programme completed in 2024 with all core members of ELHT Aarushi team completing the CQA training certification on QI methodologies, the Aarushi Team remained committed to overseeing actions as part of the Trust's strategic priorities

commitment. The group had support from the Trust to continue the work with acknowledgement that culture transformation work needs more time and at least a change cycle with ongoing efforts and sustained momentum. The group has continued to meet to oversee the actions, and wider attendees have joined the group linking in divisional and wider subject matter experts. The project team also works across the system and wider NHS to share the learning, including conferences like the recent North West Public Health Conference , GMC leadership development day, co-hosting a session with the GMC chair at the NHS Providers conference, NHSE-East of England Responsible Officer's and Medical Director's network at Cambridge and NW Leadership Academy events.

14. The programme identified four key aims which are set out in Appendix 2 based on a review of Trust performance data, evidence-based practice, and the requirements of the anti-racism framework.

15. A poster was completed for the programme and is shared in Appendix 3 which summarises the achievements and approach.

16. Within each of these, high impact actions were planned and implemented, as detailed in the driver diagram (Appendix 4), and a summary of progress, issues and impact is detailed in Appendix 5, highlighting next steps and where support is required.

17. The data used for the project included staff survey data at national and local levels, workforce race equality data, patient friends and family data and health inequalities data at national and local levels. Data is included in the appendix which has been reported into the People and Culture Committee.

18. In addition, as part of the programme, a submission was made for Bronze status against the NW Anti Racist Framework, which was graded by an independent panel and ELHT was one of four Trusts to receive the award in the Northwest. A high-level action plan was developed to embed the learning and to continue to progress to silver.

19. Given the current financial and operational challenges, the timescales for this ambition were reviewed and it is incumbent that options for future delivery are reviewed, where this supports delivery of the aims within the 10-year plan as well as the Trust's strategic aims. The detailed summary of progress found in appendix 5 also includes future actions which will be worked into a full action plans with leads and deadlines.

Risks, issues and mitigations

20. There have been a number of risks and issues with the project that the group have sought to overcome.

a. Time and resource constraints- this is an impact for members of the Aarushi Team including the clinical lead, and the wider Trust. Members have worked since September 2023 above their routine job planned responsibilities on the programme. Not having dedicated time for this can sometimes cause diary clashes impacting presence and contribution despite best intentions. Incorporating the culture lead work within job plans could help long term in Trust aspirations. Resource constraints have led to a reliance on internal delivery, which has meant the building of capacity and expertise, which although sustainable in the longer term, has added time delays.
b. Financial challenge - the extraordinary pressures faced by Trust in the last year meant that the cascade training roll out was paused for several months and has only recently been resumed. There is appreciation that these are factors outside of our control. Wider training and roll out of the best practice of the inclusive recruitment toolkit and cultural competency training need appropriate support resources for sustained implementation.
c. Political pressure - the current political climate locally, nationally and globally that sparked media headlines and certain events, e.g. the aftermath of the Southport and Liverpool incidents. This impacted the morale and confidence of the Aarushi team and wider members and led to a fear of reprisals. The team worked mindfully and intentionally discussing these aspects to dispel fear and realign their best efforts, providing safe spaces and listening.
d. Personal vulnerabilities – undertaking anti-racism work can be personally challenging, especially when team members have personal lived experience of the issues. The work is disruptive meaning individuals can feel personally vulnerable if needing to challenge upwards or within own areas of work. Supervision and peer support, including working in pairs with an ally was used to mitigate this.
e. Lack of understanding in some departments and roles - This was to some degree to be completely expected, but the pause on training led to delays with improvement activity, and the need for additional coaching conversations and expertise. Some services voiced concern around capacity, capability and confidence. Personal development is needed to support people to grow their own understanding to address the systemic issues.
f. Systemic racism – Systemic racism that encourages and perpetuates the status quo to benefit privileged groups is a fact that is well evidenced globally.

Systemic solutions to override human factors are recognised as sustainable solutions for embedding the change journey which include interventions such as Anti-Racism and other specialist forms of inclusive development, inclusive recruitment tool kit implementation, training for recruitment panel members, and cultural competency training for managers, professional nurse advocates and staff. Furthermore, transparent reporting and assurance systems such as embedding EDI and cultural data within the accountability framework (e.g. staff survey data, WRES metrics and FFT evaluation by ethnicity are some examples). Without the appropriate resources to support their scale and spread, they run the risk of failing like numerous change initiatives of this nature. ELHT can rise above this risk with its intentional and proactive commitment to action.

g. Lack of data - This is an ongoing challenge and takes up lot of time and energy for teams to explore and identify data sources and then extract and evaluate. Different systems in use at Trust centrally and in Divisions also cause a degree of confusion for project team. Example: Trust team provided FFT data extracted from Pansenic system which analysis patient feedback comments while Divisions use Incivica system which also provides absolute numbers of FFT besides Pansenic data. Ongoing work to be aligned further to consensus from patient experience team.

h. Raising expectations and not having sufficient support mechanisms in place – the team are conscious of raising awareness without proper processes for raising concerns to ensure that they will be met with sensitive and trauma informed approaches. The Trust will benefit from further review of the Too Hot to Handle recommendations for what development is needed with the people and culture functions.

The journey to silver and gold

21. Becoming a visible and intentionally anti-racist organisation remains a strategic commitment for the Trust and as such the team developed an action plan to achieve silver accreditation, built on the learning from the bronze award. (See Appendix 5 and 6.) Following the guidance from the BAME Assembly the team envisage applying for this in Summer 2026. This will include a focus on:

a. BAME leadership pipelines, including holding the roundtable on the ethnicity pay gap, in readiness to develop a BAME leadership council within the organisation or wider system.
b. Leaders having personal development goal on Anti-Racism agreed in appraisal. Ensure that the appraisal and talent development workstreams embed this in the template and guidance.
c. Extend roll out of anti-racism and allyship framework including evidencing inclusive leadership development for senior leaders, executive directors and other key services.
d. Disaggregation of ethnicity data to be presented at Board meetings so that disparities are understood.
e. Commence the development of an action plan for gold accreditation (recommended 36 months post adoption.)

Conclusion

22. The Trust has a diverse workforce, serves a diverse population and recent international recruitment has taken place at a time of political unrest and resource constraints, which has led to increasing risks around racism and incivility, so doing nothing is not an option.

23. This programme of work supports the development of a compassionate and inclusive culture, where there are agreed standards of behaviour which enables all staff to focus on the delivery of safe, personal and effective care.

24. Staff experience links to patient experience and patient safety (Dawson and West) and there has been an overall deterioration of staff experience and engagement. Whilst there are some improvements in WRES results, transformational action needs to continue, leading to sustained improvements in staff and patient experience and address health inequalities including the impact of racism of health and wellbeing.

25. This programme supports the aims of the health inequality committee in its efforts and supports the three shifts within the Ten-Year Plan. It is necessary therefore that the commitment to anti-racism remains explicit, rather than becomes more generalised given the current disparities that prevail.

Recommendation

26. The Board is asked to receive the report on progress update and ongoing action plans in progress. Board members are asked to reaffirm their commitment.

Emma Dawkins, Associate Director of OD and Dr Uma Krishnamoorthy, Associate Medical Director and Consultant Gynaecologist, 02 September 2025.

THE APPENDIX

Appendix 1: Review on Race Equality, November 2000.

Let's Talk About Race, To what extent has race inequality affected BAME staff of ELHT?

Let's talk about race (final)_compres

Recommendations of review:

1: Executive, Senior Management and Board Buy in

2: Embedding within vision and values

3: Proactive communication

4: A committee with a voice

5: Integrated support infrastructure

6: Recruitment review

7: Training and development

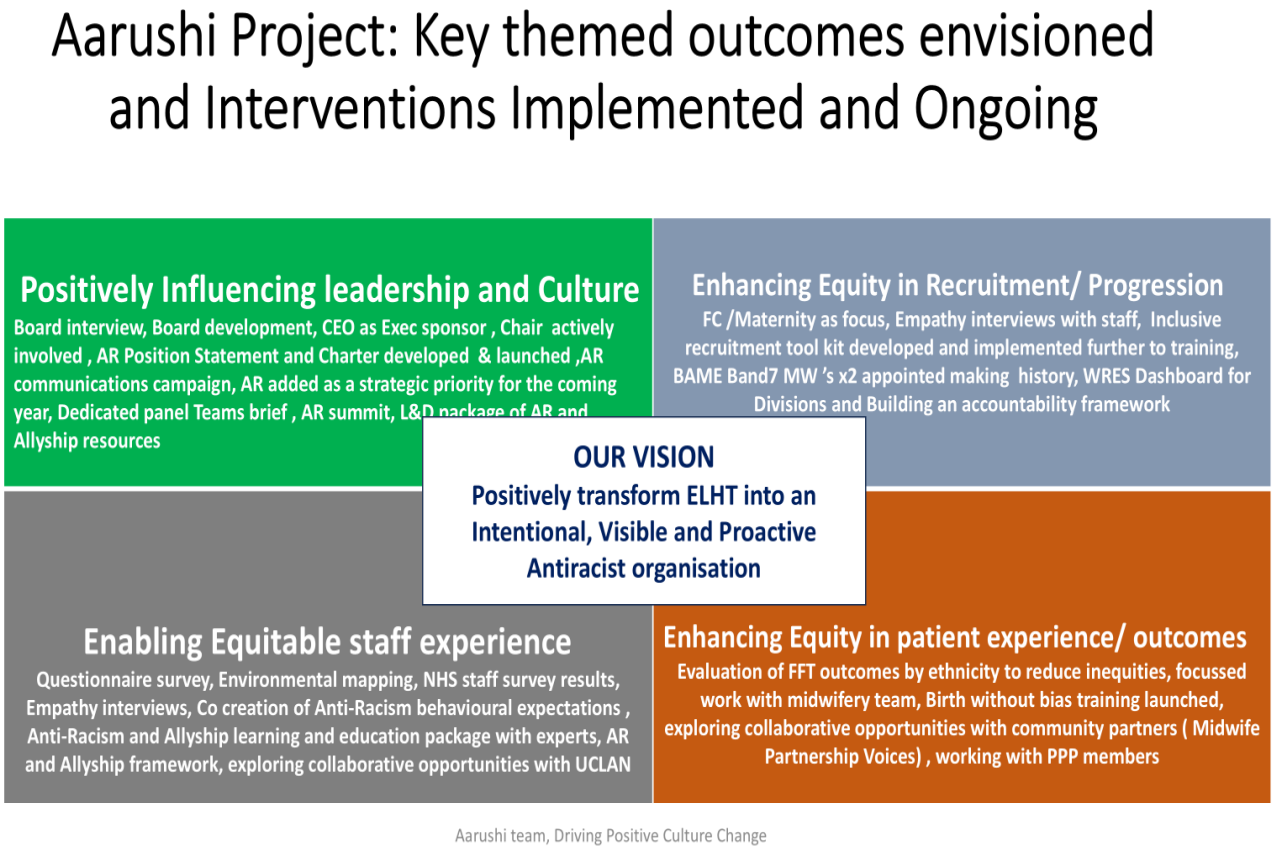
8: Workshops and discussions

9: Developing future leaders

10: Areas for further research

These recommendations were accepted and supported by the Board at ELHT.

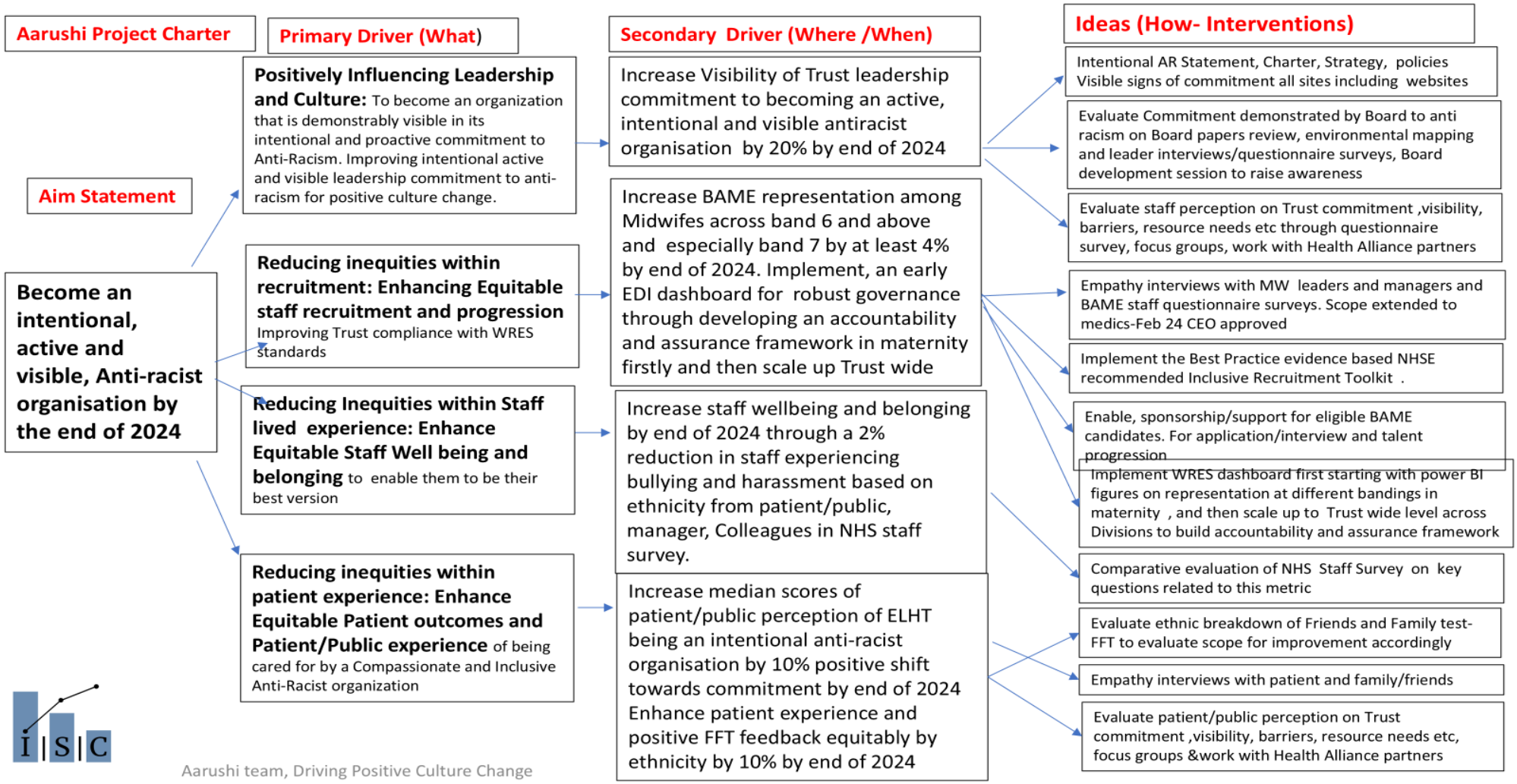
Appendix 2: Vision and themes of Aarushi Project



Appendix 3: CQA Poster

CQA Poster - Aarushi Team.pdf

Appendix 4: Driver diagram



Appendix 5: Summary of actions, impact and next steps

<table>
<tr><td colspan="2">Theme 1 - High Impact Action: Visible commitment to anti-racism</td></tr>
<tr><td>Actions completed</td><td>Actions to do</td></tr>
<tr><td>• Organisational mapping demonstrated improvements with visibility of intentional commitment at Royal Blackburn site.
• Anti-Racist charter developed and launched with cascade of commitment from Board to senior leaders and direct reports.
• External visible commitment on Trust website.
• Anti-racism and allyship framework and training developed with train the trainer programme in readiness for launch. Training was paused as part of wider decision, and we have lost training capacity Risk -.
• Anti Racism and Allyship Behavioural expectations embedded into the Trust behaviour framework and referenced in all relevant Trust HR and Governance related policies.
• Anti-racism expressed as a Trust strategic priority.
• Presentation to divisional board meetings and key Trust partnership meetings.
• Confirmation to NHS England of commitment to achieve silver and gold.
• Birth without Bias training by midwives for midwives.
• Board development with Yvonne Coghill, national WRSE expert.
• Staff stories – internationally educated colleague.
• Agreement to develop an MoU with University of Lancashire for shared commitment to anti-racism and to share resources and expertise and develop wider reach.</td><td>• Visible commitment across all sites – working with Trust communications and wider teams to identify resource to extend campaign.
• Continue to have anti-racism as express strategic priority with senior leaders including all Board members having anti-racism objective set and reviewed in performance appraisals in line with EDI Improvement plan and bronze / silver status.
• Ensure there are supportive mechanisms in place within HR to identify concerns or incidents of alleged racism to a review panel for triage with processes that are demonstrably fair and transparent and instil confidence among all staff, that such reporting will be taken and acted upon seriously by the organisation. Enable accessible reporting and monitoring mechanisms.
• Expertise to be developed within people and culture teams to manage with confidence informal and formal cases of allegations of Racism when reported, and for case managers and investigators.
• Support HR to Implement relevant aspects of the NHSE LOTUS compassionate leadership framework and toolkit resources, towards investigating and managing allegations and concerns related to racism and discrimination.
• Protection of training based on the increasing risks and need to develop greater awareness of anti-racism in action in allies and senior leaders.
• Bespoke training for key teams and areas of higher risk.
• Insight and impact training to embed learning and ensure this moves to action in allyship space and through to local action plans.
• Host the planned visit to ELHT by the NHS England regional team.
• Divisional support to be enabled for sustainable resourcing of Birth without Bias training.
• Campaign focused on experience of internationally educated colleagues
• Complete and formally embed the MOU with University of Lancashire. Extend to other local HEIs and organisations in our footprint subsequently.</td></tr>
<tr><td colspan="2">Impact so far:
• Strategic priority - cascade of anti-racism as continued priority which supports health equity and the experience of the workforce, including internationally educated colleagues.
• Increased visibility of commitment from leaders through Teams brief, Blogs, Communications, Newsletters and at sites – messaging to our patients and community as well as colleagues.
• Achievement of bronze award in June 2024 – positive recognition and roadmap for further progress to silver and gold.</td></tr>
</table>

Theme 2: High Impact Action: Reducing inequalities within recruitment. Enhancing equality of opportunity of recruitment and progression.	
Actions completed	*Actions to do*
• Empathy interviews of nurses, midwives and nursing recruiting managers completed which acted as an intervention to involve people in project and align with ELHT commitment to Antiracism. • Reverse mentoring of leaders in target areas. • Inclusive recruitment toolkit developed adopting the NHSE best practice model and launched. Pilot of toolkit within maternity, Pathology and other areas. Development of case studies. • Development of face-to-face inclusive recruitment training, bitesize eLearning and supportive guides. • Task and finish group to ensure that this is fully mainstreamed. • Divisional EDI data packs produced in 2024. • Appraisal improvement project relaunched. • Ethnicity pay gap reported in 2025. • Stay and thrive programme – Mary Seacole Local leadership programme targeted to internationally educated colleagues in role (Nursing and AHP.) • Career coaching offer developed. • Staff story focused on international recruitment, induction and mentoring support.	• Full adoption by HR of national standard framework policy on recruitment with audit of compliance. • Enable HR and TODI teams to work with OneLSC to embed this as a best practice in new operating model. • Support medical recruitment by medical staffing teams to adopt inclusive recruitment toolkit and adapt training/ toolkit if needed. • Enhance appraisal guidance and training to include anti-racism and allyship principles including awareness of assumptions and bias. • Review the quality of feedback provided to candidates who are not successful at interview with offer of appropriate mentoring/coaching for ELHT candidates including those from BAME background. • Continue to develop the EDI Dashboards and enable Divisional accountability and reporting from Divisions into inclusion network. • Roundtable on ethnicity pay gap planned for October 2025. • Positive action development programmes to be scoped. • Enable cultural competency training
Impact so far: • Impact on BAME Midwifery recruitment evidenced overall from 9.4% to 11.7% • Two BAME band 7 midwives were appointed for the first time in midwifery in ELHT history. • Career progression into Band 6 is improving for BAME midwives. • WRES Metric 2 improved from 2.26 to 1.91 and 1.63 (2025) meaning that white staff are 1.63 times more likely to be appointed from shortlisting which is still a disparity but is improving.	

Theme 3 High Impact Action: Enabling equitable staff experience	
Actions completed	*Actions to do*

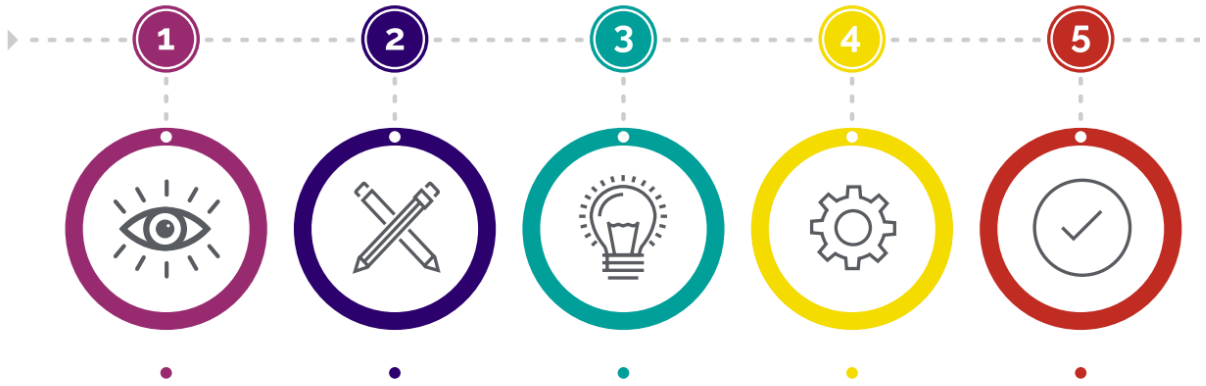
• Questionnaire and environmental mapping.
• NHS Staff survey results reporting included focus on WRES, WDES and other inequalities in Board Report and to the Employee Sponsor Group.
• Cultural data reviewed to identify cultural themes for improvements and teams for in reach in response to staff survey.
• Co-creation of Antiracism and Allyship behaviour framework and expectations.
• Anti-Racism and allyship training and framework developed by expert and trainers internally developed to deliver.
• Additional developed includes inclusive leadership elements:
  ○ Line manager induction
  ○ SPE leadership programme
  ○ Allyship framework
• Listening labs for specific staff networks and staff groups and professions.
• Bid received for Cultural competence training for PNAs to enable sensitive support for global majority colleagues.
• Employee Experience Sponsor Group leads received extended invite to Inclusion Group.
• BAME Network and International Colleague Networks in place to ensure listening, with executive sponsorship.
	• Reciprocal mentoring scheme to be developed.
	• Development of trust in HR processes including how concerns are raised and dealt with.
	• Adoption of the Too Hot to Handle recommendations for people and culture teams and the Trust including greater representation in people teams.
	• Continue to roll out anti-racist and allyship training – consider how this is made mandatory for senior managers and line managers.
	• Continue to develop the EDI Dashboards.
	• Share EDI performance more broadly to raise awareness and build understanding of inclusive approaches and how these builds belonging and engagement for everyone.
	• Consolidation of networks and review of sponsorship and chairs to maintain momentum.
	• Enable cultural competency training to reduce inequalities in patient experience and enhance delivery of Safe, **Personal** and effective care at ELHT besides inequalities in staff experience (WRES metric 8 shows significant discrepancy in staff experiencing discrimination at work from manager/team leader/other colleagues in the last 12 months –15% BAME staff and 7% White staff.

Impact so far: • Cultural improvements identified in divisions based on the staff survey feedback linked to anti-racism or other strands presented to Inclusion Group in June 2025. • PNA role intentionally focused on supporting those staff groups less inclined to raise concerns with increased training on cultural competence. • Increased attendance from divisions at Inclusion Group.	

Theme 4 High Impact Action: Enhancing equity in patient experience and outcomes	
Actions completed	Actions to do
• Evaluation of FFT outcomes by ethnicity to reduce inequalities in patient experience in maternity as pilot. • Focused work with midwifery team • Birth without bias training. • Health equalities committee focused on health inequalities chaired by Chief Nurse. • Collaboration with University of Lancashire and community partners. • Closer working with patient participation groups and staff experience team. • Senior leaders attended the ICB health equity development programme from different divisions. • Training needs analysis completed for health equity training. • Maternity completed the EDS 2022 as the service for review in 2025 and have a developed action plan and will be subject to review in 2026 including with external scrutiny. • Development of EQIRA	• Enable maternity to routinely report the FFT comparative evaluation by ethnicity using the Aarushi project model and subsequently spread and scale to other Divisions. This reporting to be incorporated into Divisional reports to patient experience group thereby creating a reporting and assurance accountability framework. • Enable teams to ensure that the lens of ethnicity is routinely reported for patient experience across all divisions and services. • Aarushi team to work in collaboration with Director of Midwifery and Nursing for FC through Maternity voices partnership and Case Load midwives serving the most deprived local communities (IMD 1 and IMD2) for maternity care under the Enhanced care midwifery team called Willow Team to evaluate their unmet needs if any and focus support accordingly in next phase. • Resume health equity training and development for leaders. • Need to take learning from EDS and apply to wider services around need for data to be disaggregated. • EQIRA to be embedded into ways of working in PMO to address concerns about service reviews and changes to commissioning intentions to identify any potential impacts linked to health equity and workforce.
Impact so far: • Improvement with maternity friends and family test uptake - a five-fold increase in one year (Significant Improvement). Increase from 3.9% of total births to 22.7% of total births in one year – increase of 18.8%. Reducing equity gaps in positive experience in maternity (ongoing). • Health equity committee. • Ongoing transition from being a non-racist organisation to being an anti-racist organisation and this being intentional in the current context.	

Appendix 6: NW BAME Assembly Anti Racism Framework and Checklist

The 5 anti-racist principles - Reflection questions



Anti-racist framework checklist

Summary of direct deliverables

Bronze

The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.

Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.

An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.

The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.

The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

Set up a local BAME leadership council within your organisation.

Evidence of inclusive leadership education for all executive directors.

All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.

An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.

WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).

An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.

The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.

The organisation can evidence diverse representation within their disciplinary and grievance processes.

The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Appendix 7: Anti-Racism Framework Accreditation and Action Plans

Thank you for your submission for Bronze recognition of the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework. The content and evidence of your application was reviewed by Thomasina Afful, Antemeka Cobham-Wilson, and Sharon Chakandinakira. We are delighted to inform you that your organisation has been successful in achieving the key deliverables for Bronze status. Your application included good evidence of very strong pieces of work around antiracism and demonstrated a commitment to change.

The panel found the following pieces of work to be outstanding:

- Strong senior leadership sponsorship for the anti-racism and inclusion work
- The Arushi project
- The Anti-racism statement and charter
- The Anti-racism summit
- The Early Resolution policy

The panel suggests that your actions could be strengthened by:

- Measurement of impact of initiatives
- Baseline data for deliverables 3 – stretch goals and 4 – health inequalities to better evidence impact
- Consider race based inequities that data may identify as having a significant impact on its staff or patient populations but has not previously been a focus of attention

The Silver status action plan is robust.

- We suggest that the while all staff will be set an EDI objective at ELHT, staff at band 8a+ should have an objective around anti-racism in particular.
- Education offers outside of those offered by the Leadership Academy and NHS providers may be explored to ensure that topics areas such as anti-racism and intersectionality are covered in-depth in your inclusive leadership education.
-

Anticipated timelines for the achievement of each level after adoption:

Silver: 18 months

Gold: 36 months

Appendix 8: Action Plan

Draft Silver Status Action Plan

Action	Person/ Team	Timescale	Progress	Comments
Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	**Head of EDI / BAME Network Chairs**	**Q3 2024**		BAME Assurance Group in place. Plans to review and refresh Group to oversee the progress.
All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	**Associate Director of OD**	**Q2 2024**		All staff have been advised to have EDI objective. This is stated in the appraisal checklist on the Learning Hub. Process to report on the % of goals met needs to be established.
Evidence of inclusive leadership education for all executive directors.	**Associate Director of OD**	**Q2 2024**		All executives and board members will participate in Board development on Inclusive Leadership. NHS Providers offer and NHS NW Leadership Academy offer to be circulated. Reciprocal mentoring to be established across the system from September 2024.
An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	**Chief Executive**			This is already in place. Martin Hodgson, CEO attends the BAME staff network. Whilst there are several cochairs with lived experience he was asked to chair the meeting by the members.
WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	**Executive Director of People and Culture**	**Q2 2024**		Development of culture and belonging dashboard to be finalised in Q2 2024 providing quarterly data. Schedule of reporting to People and Culture Committee and Board to be reviewed in line with new governance reporting.

Appendix 9: WRES Results

Workforce Race Equality Standard (WRES) results 2024/2025

The WRES is in place to ensure that employees from Black and Minority Ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It should highlight any differences between the experience and treatment of White staff and Black and Minority Ethnic staff in the NHS, with a view to closing any identified gaps through the development and implementation of action plans focused upon continuous improvement over time.

In 2024/25, the Workforce Race Equality Standard (WRES) Performance presents a mixed picture. Out of the 9 metrics:

- 4 metrics (1, 2, 4, 9) have improved
- 5 metrics (3, 5, 6, 7, 8) have either worsened or deteriorated

WRES Summary for the 2024/25 reporting year- Year on Year Comparison

Metric number and description			Year			RAG Difference between 2023/2024 to 2024/2025
			2022/23	2023/24	2024/25	
1	Percentage of BME staff	Overall	22%	26%	27.5%	**+1.5%**
		Clinical	20.9%	24.5%	26%	**+1.5%**
		Non-Clinical	16.9%	17.8%	18.9	**+1.1%**
2	Relative likelihood of White applicants being appointed from shortlisting compared to BME applicants		2.26	1.91	1.63	**-0.28**
3	Relative likelihood of BME staff entering a formal disciplinary process compared to White staff		1.15	1.14	1.64	**+0.5**
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff		1.84	1.00	0.95	**-0.05**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months	BME	23.88%	22.05%	24.31%	**+2.26**
		White	23.13%	22.73%	24.24%	**+1.51%**

6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	23.23%	22.42%	22.26%	**+0.16%**
		White	18.61%	18.86%	19.67%	**+0.81%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	50.29%	52.28%	51.45%	**-0.83%**
		White	65.76%	64.98%	64.90%	**-0.08%**
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.	BME	14.20%	14.82%	15.77%	**+1.80%**
		White	5.46%	6.68%	6.08%	**-0.60%**
9	BME Board membership	BME	33%	24%	25%	**+1%**

Appendix 10: WRES Benchmarking data against ICS System partners

WRES COMPARISON	Best Performer	ELHT	BTH	LSCFT	LTH	UHMBT
WRES Indicator 2: Likelihood of appointment from shortlisting	0.27	1.63	0.24 Best	1.69	1.50	2.70 Worst
WRES Indicator 3: Relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff	1.00	1.60	0.01 Best	0.88	1.15	2.00 Worst
WRES Indicator 4: Relative likelihood of accessing non-mandatory training	1.00	0.89	0.57 Best	0.90	1.09	1.8 Worst
WRES Indicator 5: Bullying harassment, or abuse from patients/relatives/public	8.8%	24.31%	30.28 %	33.49 % Worst	20.71 % Best	27.93%
WRES Indicator 6: Bullying harassment, or abuse from staff	14.8%	22.26% Best	27.19 % Worst	22.59 %	22.55 %	24.35%
WRES Indicator 7: Belief that the Trust provides equal opportunities for progression	64.2%	51.45%	49.30 % Worst	54.69 % Best	50.80 %	53.92%
WRES Indicator 8: Staff experiencing discrimination at work	3.7%	15.77%	20.11 % Worst	17.41 %	14.30 % Best	16.82%
WRES Indicator 9: % difference between Board membership and workforce	50%	25% Best	20.40 %	12.5 %	7.69% worst	23.10%

Appendix 11: Staff Survey 2024 - People Promise Themes

PP Theme	Organisation 2024	Disabled/ LTC	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups	Gay / lesbian, Bisexual, Other
Description	n = 4224	n = 1065	n = 878	n = 114
We are compassionate and inclusive	7.2	6.8	7.1	7.1
We are recognised and rewarded	5.9	5.3	5.8	5.9
We each have a voice that counts	6.7	6.2	6.7	6.5
We are safe and healthy	6.1	5.4	6.1	5.8
We are always learning	5.6	5.1	6.1	5.6
We work flexibly	6.2	5.6	6.0	6.2
We are a team	6.7	6.3	6.7	6.7
Motivation sub-score	6.9	6.4	7.3	6.5
Involvement sub-score	6.8	6.3	6.9	6.6
Advocacy sub-score	6.5	6.1	6.9	6.4
Staff Engagement Score	6.8	6.3	7.0	6.5
Morale score	5.9	5.4	5.9	5.8

Overall trends for BAME Staff:

Staff from Mixed/Multiple ethnic groups generally report more positive experiences and higher engagement, particularly around learning, motivation, involvement, and advocacy, while in others, they were slightly lower (e.g., feeling recognised and rewarded). Further investigation is required to understand the specific factors contributing to the slightly higher and lower scores in certain areas.

BAME Lowest Scoring Questions

Q	Question	Comparator (Organisation Overall)	White	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/	Experience Gap
q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	67.7%	71.8%	52.1%	-19.7%
q15	Organisation acts fairly: career progression	61.9%	64.9%	51.4%	-13.5%
q24a	Organisation offers me challenging work	70.0%	72.8%	59.4%	-13.4%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	92.3%	94.9%	82.6%	-12.3%
q5b	Have a choice in deciding how to do my work	52.5%	55.0%	43.4%	-11.6%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70.3%	72.5%	62.5%	-10.0%
q16b	Not experienced discrimination from manager/team leader or other colleagues	91.9%	93.9%	84.2%	-9.7%
q4c	Satisfied with level of pay	31.5%	33.4%	24.6%	-8.8%
q7i	Feel a strong personal attachment to my team	62.5%	64.2%	56.2%	-8.0%
q26c	I am not planning on leaving this organisation	57.9%	59.3%	53.0%	-6.3%
q31b	Disability: organisation made reasonable adjustment(s) to enable me to carry out work	71.3%	72.2%	66.0%	-6.2%

Overall trend: White staff consistently report more positive experiences across most survey questions.

Largest experience gap:

- **Q10b** – *Additional paid hours*: 19.1% gap, indicating ethnic minority staff are more likely to work extra paid hours.

Other notable gaps:

- **Q15** – *Fairness in career progression*
- **Q24a** – *Access to challenging work*
- **Q16a** – *Discrimination from patient's/service users*

Smallest Gaps

- **Q31b** – *Reasonable adjustments for disability*: 6.2% gap.

BAME Best Scoring Questions

Q	Question	Comparator (Organisation Overall)	White	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/	Experience Gap
q23b	Appraisal helped me improve how I do my job	23.9%	19.6%	41.0%	21.3%
q23c	Appraisal helped me agree clear objectives for my work	32.6%	29.4%	45.6%	16.2%
q12c	Never/rarely frustrated by work	21.3%	18.7%	31.7%	13.0%
q2a	Often/always look forward to going to work	51.3%	48.8%	60.8%	12.0%
q23d	Appraisal left me feeling organisation values my work	32.2%	29.9%	41.7%	11.8%
q19d	Feedback given on changes made following errors/near misses/incidents	63.3%	61.2%	71.2%	9.9%
q3g	Able to meet conflicting demands on my time at work	47.1%	45.4%	54.0%	8.5%
q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	55.7%	54.0%	62.5%	8.5%
q8a	Teams within the organisation work well together to achieve objectives	55.4%	53.8%	61.9%	8.1%
q25c	Would recommend organisation as place to work	57.7%	56.2%	63.8%	7.6%

Overall trend: In contrast to the previous table, ethnic minority staff report more positive experiences than White staff across all listed questions.

Largest experience gap:

- **Q23b** – *Appraisal helped improve job performance*: 21.3% gap in favour of ethnic minority staff.

Other notable gaps:

- **Q23c** – *Appraisal helped set clear objectives*: 16.2% gap.
- **Q12c** – *Rarely frustrated by work*: 13% gap.

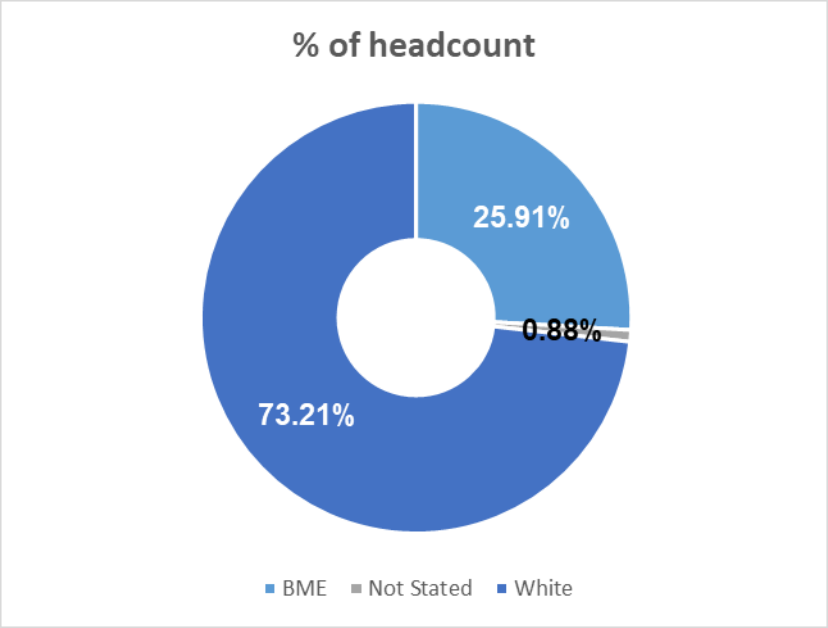
General insight: These results suggest that ethnic minority staff may be having more constructive appraisal experiences and slightly better emotional engagement at work in these areas.

Appendix 12: Ethnicity Pay Gap

Introduction

Unlike gender pay gap reporting, ethnicity pay gap reporting is not mandatory in the UK, but employers are encouraged to publish this data voluntarily to promote transparency and accountability. In line with the NHS EDI Improvement Plan, which aims to eliminate the ethnicity pay gap, this report analyses pay differences between ethnic groups. The data is produced using the same methodology as gender pay gap reporting, through the ESR system, and follows the formula: (White - BAME) / White × 100.

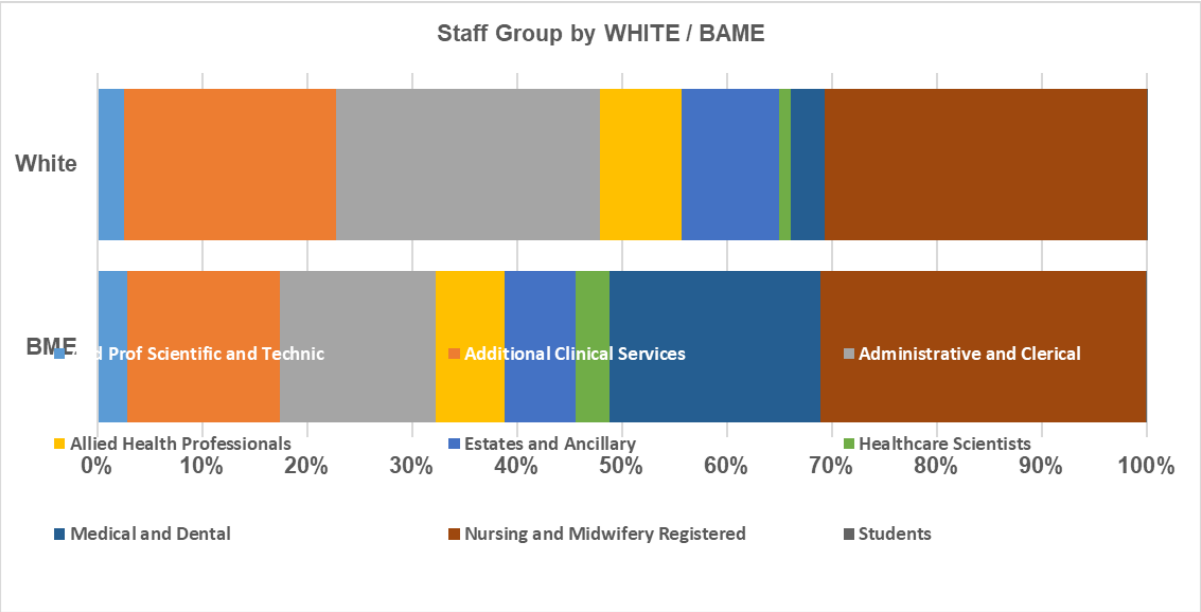
Staff in Post by Ethnicity

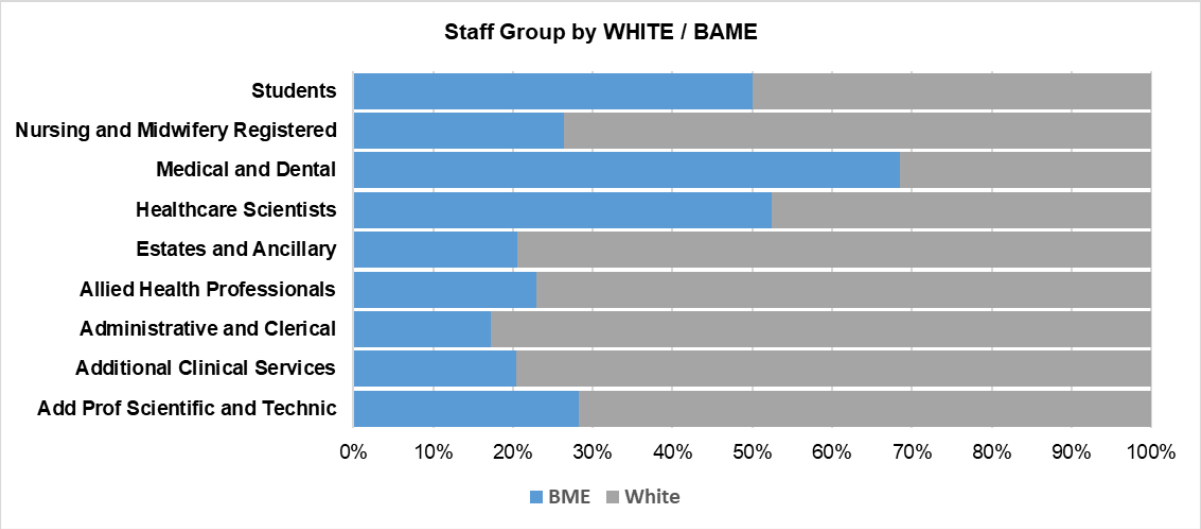


73 % of staff are White, 26 % have BAME ethnic groups and 1% of staff did not state their ethnicity or it is unknown

Ethnic Group	Headcount	Headcount %
BAME	2697	25.91%
Not Stated	92	0.88%
White	7621	73.21%
Grand Total	**10410**	**100.00%**

BAME Representation by Staff Group





High Representation:

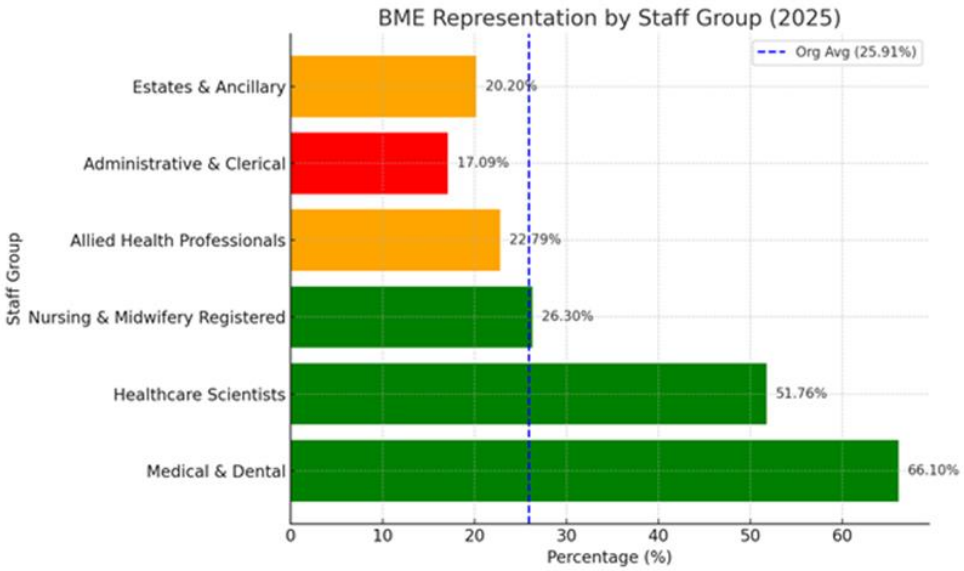
The highest BAME representation is seen in **Medical and Dental (66.10%)** and **Healthcare Scientists (51.76%),** both significantly above the organisational average of **25.91%.**

Moderate Representation:

Nursing & Midwifery Registered (26.30%) and **Allied Health Professionals (22.79%)** show representation close to or slightly below the Trust average.

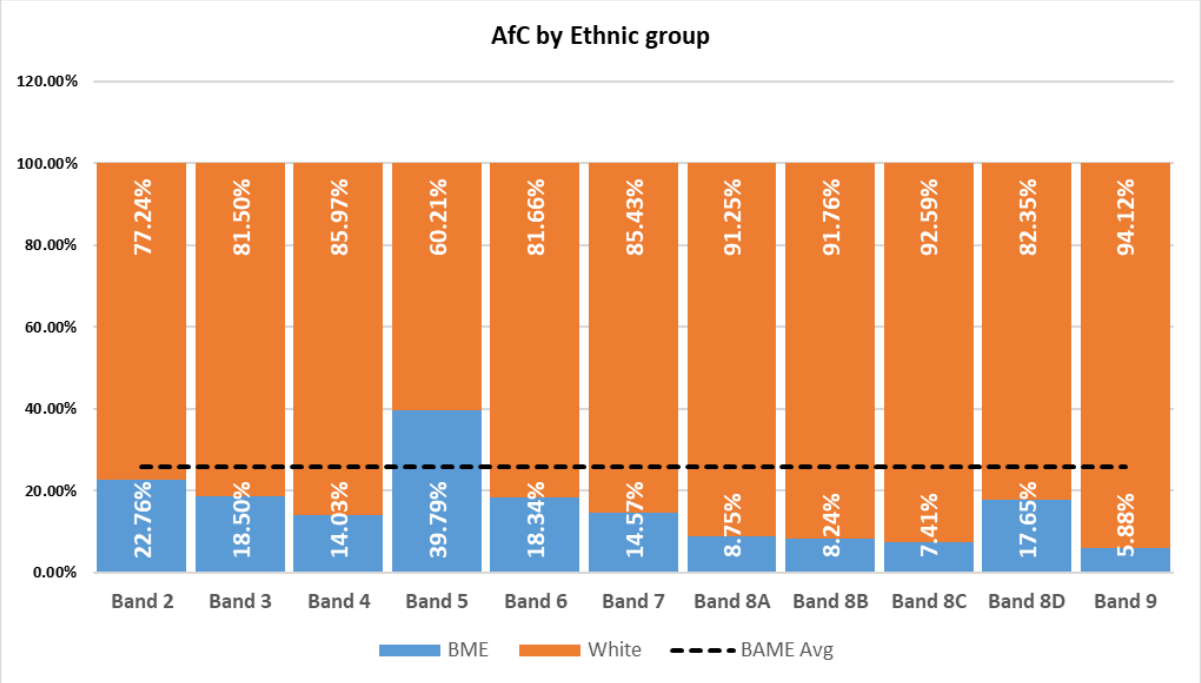
Underrepresented Areas:

Administrative and Clerical (17.09%) and **Estates and Ancillary (20.20%)** remain notably below the overall average, indicating underrepresentation in these staff groups.



Green bars indicate above-average representation,
Orange is moderate,
Red highlights underrepresentation.

Ethnic group by pay grade



BAME Representation by Pay Band

Band 5: A Key Entry Point - Band 5 is the only pay band where BAME representation (39.74%) exceeds the Trust average of 25.91%. This is largely driven by roles in Healthcare Scientists, Nursing & Midwifery, and Allied Health Professionals.

Foundation Roles (Bands 2–4) - BAME representation across Bands 2–4 ranges from 14.03% to 22.76%, consistently below the Trust average. Band 5 marks a clear peak,

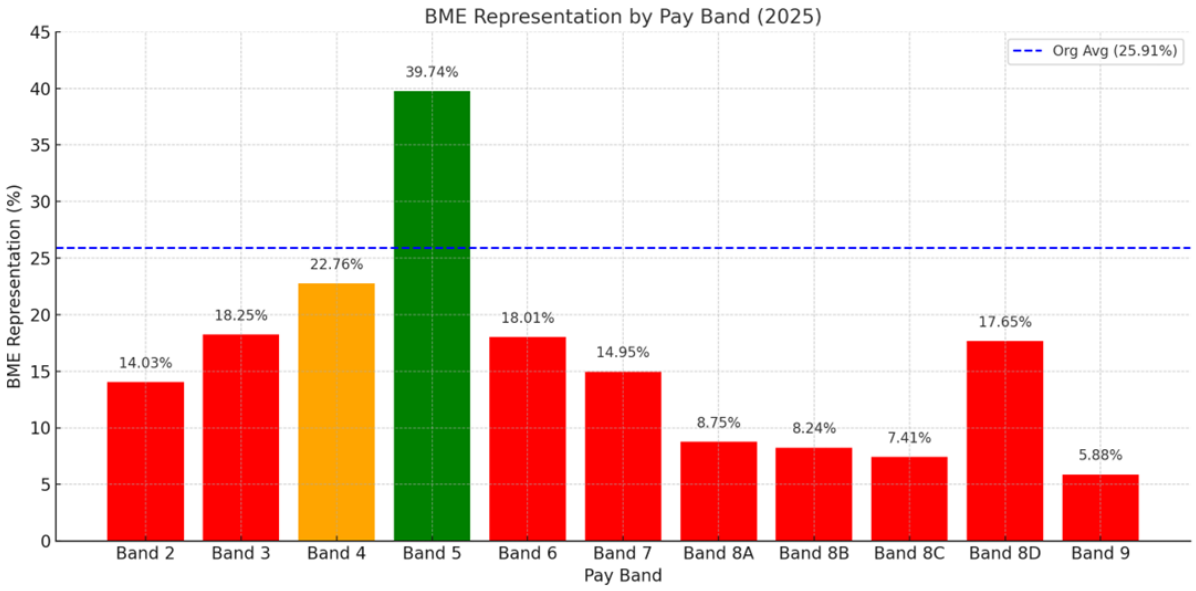
highlighting it as a key access point into the workforce for BAME staff. However, representation declines again in Bands 6 and 7, falling to around 14–18%.

Leadership and Senior Roles (Bands 8A–9) - There is a steady decline in BAME representation across senior pay bands:

- Band 8A: 8.75%
- Band 8B: 8.24%
- Band 8C: 7.41%
- Band 8D: 17.65% *(an anomaly due to small headcount)*
- Band 9**:** 5.88% *(only 1 BAME employee out of 17)*

While Band 8D shows a relatively higher BAME percentage, this equates to only **3** BAME employees, and the small overall headcount at this level means even minor changes can lead to exaggerated percentage shifts.

Here is the chart showing **BAME representation by pay band**. You can clearly see Band 5 as the peak entry point, with declining representation in Bands 6 through 9, and only Band 8D showing a higher percentage due to small numbers.



Average Hourly Pay by Ethnicity

	Average of Average Hourly Rate			
Ethnic Group	ELHT	Agenda for Change (AfC) Band 1-9	Very Senior Managers (VSM)	Medical & Dental
BAME	£21.41	£16.73	£49.35	£39.17
White	£18.55	£17.47	£66.25	£47.88
Variance	-£2.86	£0.73	£16.90	£8.71
Pay Gap	-15.44%	4.19%	25.50%	18.19%

Among Agenda for Change (AfC) staff, the White ethnic group earns an average of £0.73 more per hour than BAME staff, resulting in an ethnicity pay gap of 4.19%.

For Very Senior Managers (VSM), the gap is significantly wider at 25.50%, with White staff earning an average of £16.90 more per hour than their BAME counterparts.

In the Medical and Dental staff group, the ethnicity pay gap stands at 18.19%, with White staff earning £8.71 more per hour on average than BAME staff.

Average Hourly Pay by Ethnicity & Staff Group

AfC including all staff Bands 1 -9

Staff Group	BAME	White	Variance	Pay Gap%
Add Prof Scientific and Technic	20.93	21.50	0.58	3%
Additional Clinical Services	13.38	13.35	-0.03	0%
Administrative and Clerical	14.74	15.49	0.75	5%
Allied Health Professionals	18.56	21.79	3.23	15%
Estates and Ancillary	13.81	13.00	-0.81	-6%
Healthcare Scientists	21.67	23.43	1.76	8%
Nursing and Midwifery Registered	18.59	21.42	2.83	13%
Students	14.53	17.02	2.48	15%
Grand Total	16.73	17.47	0.73	4%
Total	**21.41**	**18.55**	**-2.86**	**-15%**

AHP's display the largest pay gap 15% with white staff averaging £3.23 additional hourly pay.

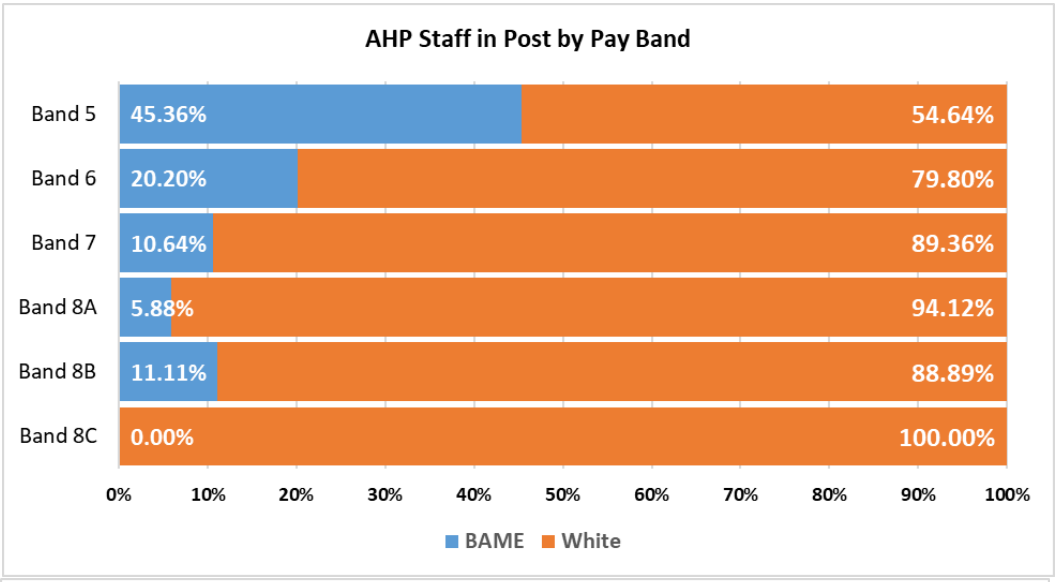
AHP Staff Group Detail

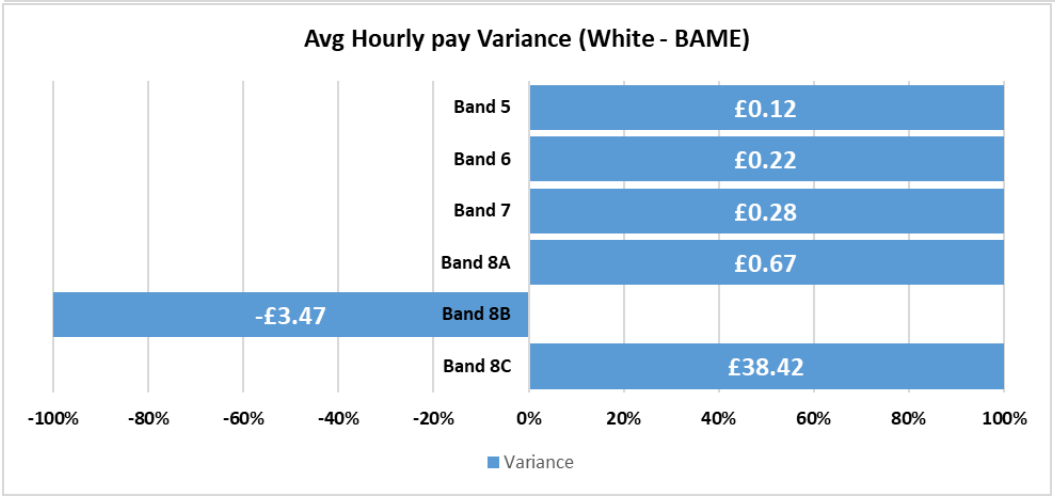
Within the Allied Health Professionals (AHP) staff group, BAME staff are underrepresented in senior pay bands (8A to 8C). Notably, there are no BAME employees in Band 8C roles out of a total of 7 employees.

Representation is stronger in the lower bands, with 45.36% of Band 5 staff identifying as BAME.

Interestingly, Band 8B is the only pay band where BAME staff earn more than their White counterparts. This is due to one BAME employee being on a higher pay point compared to the average for White staff in the same band.

Across Bands 5 to 7, ethnicity pay gaps are minimal, all falling below 2.5%.





AfC Pay Quartiles by Ethnicity

The pay quartiles show the proportion of male and female staff across each of the quartiles. They are calculated through ranking all salaries from the highest to the lowest paid, in terms of hourly pay and dividing the list into quarters.

AFC including all staff Bands 1 -9

Quartile	BAME	White	BAME %	White %
1 – Lower Quartile (Lowest paid up to Band 3 £26,600)	436	1887	19%	81%
2- Lower Middle Quartile (Band 4 – Band 5 £27,500 - £37,796)	684	1858	27%	73%
3 – Upper Middle Quartile (Band 6 – Mid Band 7 (£38,682 - £50,273)	613	1710	26%	74%
4 – Upper Quartile (Highest Paid Mid Band 7+ £50,273 +)	266	1530	15%	85%
Grand Total	**1999**	**6985**	**22%**	**78%**

BAME staff are most highly represented in the Lower Middle and Upper Middle quartiles (27% and 26%).

This suggests relatively strong participation in mid-level roles. In the Upper Quartile—representing the highest-paid roles—BAME representation falls to just 15%, indicating a steep decline in representation at senior levels. BAME staff make up 22% of the workforce, their presence in the top quartile is significantly under-represented compared to the overall proportion.

Recommendations to address ethnicity pay gap:

1) Develop a BAME Leadership Pipeline
Introduce targeted development programmes, mentoring, and sponsorship for BAME staff to support progression into Bands 6–9 and senior leadership roles.

2. Conduct Role-Specific Pay Equity Audits
Focus on staff groups with the largest pay gaps (e.g. AHPs, Medical & Dental) to identify structural or systemic causes and implement corrective actions.

3. Enhance Recruitment & Retention in Underrepresented Areas
Use inclusive recruitment practices and outreach to increase BAME representation in Admin & Clerical and Estates & Ancillary roles, where representation is notably low.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/128
Report Title:	Nursing Professional Judgement Review – August 2025		
Author:	Jed Walton-Pollard (Deputy Chief Nurse) Jane Pemberton (Deputy Chief Nurse) Maureen Dixon (Corporate Finance)		
Lead Director:	Peter Murphy (Chief Nurse)		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	This paper will provide the bi-annual Professional Judgement Review which incorporates a formal evaluation of the Trust's ward/unit/department(s) staffing templates using a triangulated approach. This includes an analysis of 30 days census data utilising the Safer Nursing Care Tool (SNCT) (Shelford Model) during Feb 25, a review of the nurse sensitive indicators (Jan 25 – March 25) and the professional judgement of the senior nursing team.			
Key Issues/Areas of Concern:				
Action Required:	The Board is asked to: • consider the professional judgement and agree the recommendations and further actions. • note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.			

Previously Considered by:	-
Date:	-
Outcome:	-

Introduction

In line with national guidance which recommends a professional judgement is carried out bi-annually. An evaluation exercise was carried out in June 25 against the recommendations of the Feb 25 (winter census) Safer Nursing Care Too (SNCT. This paper will provide the bi-annual update as per national guidance.

The professional judgement was carried out in the month of Feb 25 using the nationally recognised acuity tool (Safer Nursing Care Tool (SNCT) Shelford model) as the Trust has a licence to use this tool. A correlation was also made with the relevant nurse sensitive indicators using data from January to March 25 (see appendix one) along with the professional judgement of the Deputy Directors of Nursing, Divisional Directors of Nursing, Assistant Directors of Nursing, Matrons, and Ward Managers. In line with national guidance, meetings with the above were held between June 25 to July 25, to review every inpatient template so that a correlation can be made with the SNCT data and nurse sensitive indicators.

It is worth noting that the SNCT has changed recently to consider patients receiving 1-1 and 1-2 level of care. This has produced a significant change in the outcome of the SNCT data, compared to the recent census data showing an increase in the recommendation of the budgeted templates. However, the staffing required for patients needing a 1-1 is sought from the internal bank and the enhanced care support worker team which needs to be considered when applying the triangulated approach. Assurance can be given that the divisional and corporate finance teams have been heavily involved, providing accurate and up to date information on establishments. It is worth noting that due to unprecedented demand on patient flow and challenges with Emergency Department capacity, there are extra escalation beds open (34) across the in-patient wards which were taken into consideration with the February 25 census exercise.

Professional Judgement winter Census 25

General Points

- As a result of this review, with a particular emphasis on the triangulated approach the current in-patient templates were professionally judged as safe. However, senior nurses agreed this is only if the bank shifts for the 1-1's were filled. Bank fill rate for this group of staff is >80%.

- The compliance against the templates (Actual v Planned) is monitored monthly in the newly formed Trust Wide Governance Committee and the established Quality Committee. Assurance can be provided the Trust does have a Standard Operational Policy (SOP) for the day-to-day management of nurse staffing which will be described in detail in the newly designed monthly safe staffing report. The Trust continues to maintain fill rates for Registered Nurses and Support workers of greater than 90% for both days and nights. The national quality board recommends that fill rates should be between 90% and 105%.

- There is a minimal nurse patient ratio of 1-8 with an additional shift co-ordinator during the early shift on all acute in-patient wards.

- It has been confirmed by the Safe Staffing Fellows at NHS England (NHSE) that the SNCT census will potentially show some establishments as 'overstaffed' when comparing the census outcome to the establishment on smaller wards. This is exacerbated if acuity/activity is low. The Royal Blackburn site has several smaller (14 & 17-18 bedded) wards which need a minimum of 3 RNs per shift for clinical safety reasons. Three exceptions to this are Ward C5, B22 and B24 which have 2 RNs at night.

- The finance team have confirmed there is an uplift of 22% across all in-patient establishments. This is in line with national recommendations and consistent with the integrated care system. Ward budgets include a 22% uplift to both the budget and the establishment. This reflects the amount of time staff may be unavailable. The 22% is made up of 14% annual leave, 5% sickness and 3% study leave.

- All Ward Managers and community team leaders have supernumerary status one day per week which is not in line with the recommendations of the Francis (2013) report which states ward managers should have supernumerary status five days per week. Work is currently ongoing to secure funding to increase this by 2 days (3 days in total). In comparison with the three other acute providers within the integrated care system, two have their ward managers supernumerary five days and one has them supernumerary three days per week.

- A separate piece of work is currently underway to re-align the Agenda for Change (AfC) pay scale for the Health Care Support Worker workforce. This has involved working with staff side to re-write Job Descriptions along with a set of tasks the band 3 workforce undertake. Since the last professional judgement an options appraisal has been presented at Executive Directors who agreed in principle to a 70% - 30% splint on the in-patient wards.

Professional Nurse Advocate Protected Time.

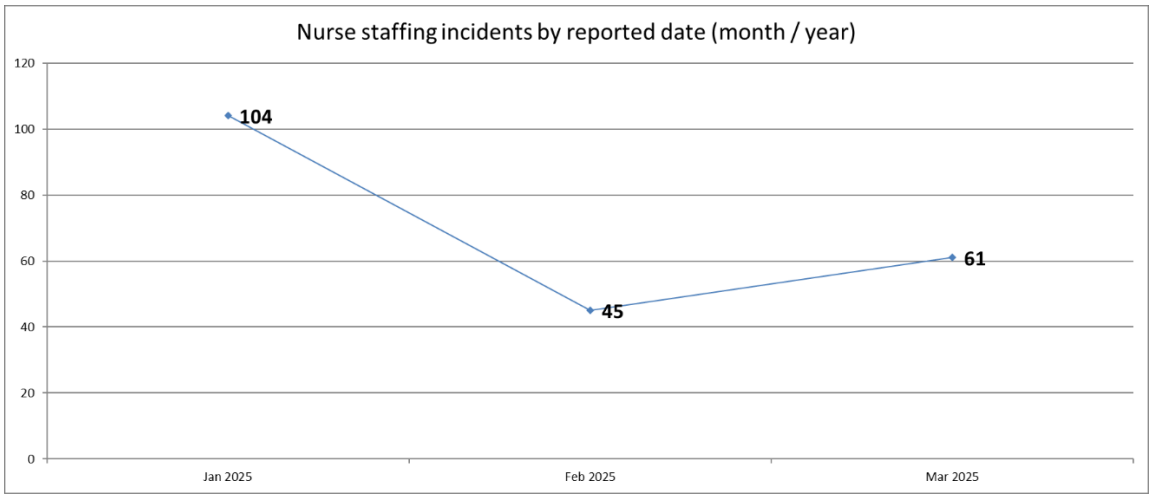
- The impact of the Covid-19 pandemic, the multifaceted and complex issues the aftermath has brought; with nurses feeling burnt out leading to concerns with nurses' mental health. An urgent call to introduce the availability of supportive measures towards the restoration and recovery for all nurses was required.
- In response The Professional Nurse Advocate (PNA) Training Programme was launched in March 21 to support the NHS recovery plan following the Covid-19 pandemic.
- It is a virtual Level 7 accredited programme which is held virtually over 10 days, and the academic assessment may include essays, poster presentations and competency portfolios, depending on which Higher Education Institute is used.
- Monthly data recording is required from the PNA's to enable local, regional and national oversight. Protected time has not been agreed making it difficult for the PNA's

to deliver their objectives and therefore, PNA activity monthly reporting to NHSE from the Trust is extremely poor.

- It is worth noting that NHS England guidance suggests that the Trust will need to work 140 PNA's in the future. This is currently being absorbed within established ward budgets. The Trust currently has approx. 70 RNs trained up to and including May 27. This is monitored at the People and Culture committee.

Nurse Staffing Related Incidents.

Along with fill rates, incidents related to nurse staffing are monitored by the Deputy Director of Nursing. The tables below show the number of staffing related incidents per month and their subcategories for the period of Jan 25 to March 25. There have been no known staffing related incidents which have caused harm.



Subcategory	Total
Delay of more than 30 minutes in providing pain relief - (Due to Staffing)	1
Less than 2 registered Nurses / Midwives present on a ward during any shift	5
Staff indicated concerns	33
Staff shortage - Midwives	13
Staff shortage - nursing	156
Unable to reliably carry out intentional rounding	2
Total	**210**

Registered Nurse and Clinical Support Worker Sickness (Jan 25 to March 25)

The Sickness/Absence rates from Jan 25 to March 25 are displayed in the table below. Although there has been an improvement in RN sickness since the last review, sickness is still over the Trust trajectory of 4%. Whilst the Trust has an absence management policy, it is

acknowledged that this could be more robustly applied if ward managers had supernumerary time to support staff who are absent from work.

Average	Count of staff	Number of staff HC	Staff in post FTE	Occurrences	Covid Sickness %	Non Covid Sickness %	Total %
Support	782	1379	1188	1158	0.01%	10.35%	10.36%
N&M	1537	3380	3017	2066	0.01%	6.55%	6.56%

Nursing Vacancies, Recruitment and Attrition

The Trust currently has approx. 11 WTE RN and 40 Support Worker vacancies across the medical division and a further 15 RNs within the ED due to an increase in the budgeted establishment. There are approx. 101 newly qualified RN's and Nursing Associates being interviewed in August 25 that qualify in Sept 25. In addition, the Trust is currently closing an in-patient rehab ward, and staff are being redeployed into existing vacancies. It is expected that with all the above, there will be zero vacancies across the wards, units and departments at band five level. Work is ongoing to significantly to reduce HCA vacancies and improve retention.

Divisional Points to note.

Medicine and Emergency Care

- It is worth noting that the medical division have completed a large ward reconfiguration across the division which involved several wards moves. Some wards have moved into bigger footprints and some into small ones. Unfortunately, this co-in sided with the timing of the census period and the PJ meetings therefore, it was impossible to compare data. The division is currently working with finance to move funding around (cost neutrally) to re-align the budgets. Therefore, the committee is invited to note in appendix one, some data is not applicable/comparable at this review. However, the professional judgment of the senior team concluded that all the in-patient templates are safe.

- In April 24, the Executive Team agreed recurrent funding to uplift the RN's per shift from 22 to 28 and Health Care Support Workers from 12 to 18. This has now been put into the budget and recruitment is ongoing. Substantive recruitment has been ongoing since the last professional judgement and is expected to be completed in October 25.

- In addition, the Trust has purchased the Safer Nursing Care Tool licence specifically for Emergency Care and staff have been fully trained to use this. However, on further discussion with the NHSE safer staffing fellows, it has become apparent that the tool does not consider patients who have been in the department greater than 12 hours. At present, most patients who require admission spend greater than 12 hours within the department due to pressures around flow. Therefore, it is not recommended any decision is made using the ED Safer Nursing Care Tool. The previous Head of Nursing for Emergency Care has written guidance for the number of staff required in relation to the number of patients at any one time. It is the professional judgment of the senior nursing team that this guidance meets the needs of the department which is broadly in line with RCN workforce standards (see table below).

- It has been confirmed by the NHS England safer staffing team that the SNCT will be amended to capture length of stay in the ED and when rolled out the Trust will utilise again**.**

Reference guide for ED nurse staffing for escalated numbers in the department (this is a guide, and professional judgement must be used from the ED matron- all essential areas of ED must be staffed as per professional judgment)

Number of patients in dept	Total RNs needed	Total HCSW's needed
55	22	12
60	23	13
65	24	14
70	25	15
75	26	16
80	27	17
85	28	18
90	29	19
95	30	20
100	31	21
Plus 1 RN and 1 HCSW for every increment of 5 patients in department.		

Plus 6 extra band 2 HCSW to support with 1:1 care.

Surgical and Anaesthetic Division.

- Wards B22 and B24 are both 23 bedded acute orthopaedic wards which take direct admissions from the emergency department. Using the triangulated approach, the professional judgement of the senior nursing team is asking to increase the RNs on a night shift by 1 however, the SNCT does not support this. The wards are an outlier when comparing them to similar acute wards in the Trust, therefore, it is recommended a further run of the SNCT is completed before any recommendation is made. The

wards may wish to trial bringing in the 4 RN on the day shift a little later in the day to increase staffing at the beginning of the night shift.

- Both theatre complexes on the RBH and BGH site have compared their budgeted establishment using the Association for Perioperative Practice (AfPP) guidance calculator which shows the establishments to be broadly in line with this guidance. However, both Matrons highlighted an issue with theatre 'overruns' which cause further pressure on staffing therefore, a separate business case has been development to address this, and staffing levels have been increased. Since the last professional judgment further funding has been secured for five three session days per week. A further business case has been developed to run a further five three session days. There is, however, an unfunded session in the CT/Angio rooms which sits outside of the traditional theatre schedule however, these are staffed therefore as far as the professional judgment is concerned this is not a safety issue.

- Ward C18a showed a significant difference between the SNST data and the current establishment (see appendix one). This showed the dependency has increased due to the number of patients with intestinal failure post-surgery requiring level 1 care. In order to maintain safety, the ward has used bank on occasions and staff have been moved on a shift basis from critical care. The tool does not recommend a change in establishment unless 2 sets of data support this. The division is currently looking into the tariff for these patients to fund any future increase in establishment.

- The Critical Care Unit is staffed to Guidelines for the Provision of Intensive Care Standards (GPEC) standards. This is monitored through the ICS 'Peer Review' process bi-annually. Due to a recent Cost Improvement Program a decision was made to staff the unit to acuity rather than bed base. This has been agreed with the local Critical Care Network and will be reviewed at regular intervals

Paediatrics

The Paediatric unit has used the SNCT tool for the first time to determine staffing levels required. This data showed side A to overstaffed and side B to be understaffed. However, when added together the establishment is within the SNCT threshold. The tool does not recommend any amendment using one set of data therefore, this will be repeated in six months' time. In addition, the staffing levels on the unit have been benchmarked using Royal College of Nursing Guidance, which stipulates a 1:4 Ratio for children over 2 years and a 1:3 for children under 2 years. The standard ratio reduces further if a side room is used 1:2. The senior nursing team have reviewed their staffing levels using this guidance and agreed when taking seasonal variance into consideration this is broadly met. The internal bank is used when demand increases, and the ward managers are in a supernumerary capacity and can therefore, flex into the rostered numbers when necessary. The unit does at times provide High Dependency Unit care when a child deteriorates although, the Trust is not commissioned to

provide this. When there is a demand for HDU care this is provided on a 1:2 for level two and a 1:1 for level three care. The unit does not keep level three patients' long term, as they are transferred to a tertiary paediatric unit. It is also worth noting a review of the paediatric bed base is under way therefore, there is no ask for resource currently. The senior nursing staff on the review believed the unit was safely staffed and have not reported any harm because of staffing.

Community and Intermediate Care Division

Integrated Care Wards

Wards identified pressure relating to enhanced care requirements (1-1), particularly relating to falls prevention.

Utilising the triangulated approach, it has been identified that wards 22, Ribblesdale, Hartley and require additional HCA hours for twilight and daybreak early shifts to support safe care. Use of these shifts has been proven to reduce the use of additional overnight HCA staff at Pendle and Clitheroe hospitals. This will be managed through bank shifts via the enhanced care criteria (1-1 SOP). In is also worth noting ward 22 has had a significant number of falls than ward 19 which is a similar bed base. This will be monitored through the 'harm free care' governance process.

The Pendle ward (Hartley) have also requested an additional HCA on long days at weekends because they have significant work to do to support meal service including the dishwashing of crockery after every meal. This is captured on an estates held risk register relating to support staff provision to both Pendle wards. Further work needs to be done with the estates division to develop a solution for the weekends. However, near plans are in place to close Hartley ward and move Marsden to the RBH side.

Adult Community Nursing

The CIC division have used the revised CNSST community safer staffing tool. Training was originally completed as a one off for all staff, but to help ensure that all staff have a full understanding of the acuity scoring, we have made this a yearly training for all clinical staff. This will help support a more accurate outcome when completing audits for safer staffing. This work will ensure the recording of acuity and dependency of patients is recorded fully, initially there looks to be a significate case of under scoring the complexity of visits.

The teams are currently going through a consultation to restructure team boundaries and working hours across the DN service. This includes reducing from 14 teams to 13, making each DN more equitable with the number of staff and a more even sized caseload across the service. Whilst the tool showed the WTE head count to be under established in some areas, the professional judgment of the senior leadership had identified that this

consultation with provide a cost neutral re alignment of services and skill mix (see appendix three).

Maternity Staffing

In July 2025, ELHT Board of Directors approved an improvement case to increase the WTE workforce requirements reflected within ELHT birth rate plus recommendations, this has followed a phased approach since the report findings in November 2022. Partial implementation with the recommendations for enhanced midwifery Continuity of Carer (MCOC) as guided by Ockenden (2022) have begun. Maternity services have conducted several successful recruitment events including the appointments of all newly qualified midwives who have trained at ELHT. This has reflected a significant decrease to no vacancies.

At present Month 3 2025 provider worker return (PWR) data reflects Funded and contracted midwives are 279.50wte.

Birth rate plus requirements with a 24.2 % uplift for training requirements is 296.34 WTE, this is excluding maternity leave backfill. Following the recent funding approval this has seen an increase of 11.50 WTE clinical and specialist clinical posts thus in post leaving a deficit only to cover the total 24.2 annual leave requirements. This will reflect in September & October PWR returns.

The independent Birth-rate Plus assessment is mandated and to be completed every three years, ELHT second assessment is underway, final report is due to September 2025.

Birth Rate plus (BR+) is a framework for workforce planning, the principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG). Informs meeting one of the requirements for CNST safety action 5.

Neonatal Nurse Staffing

ELHT neonatal unit nurse workforce requirements are funded and aligned with the Healthcare Resource Group activity calculations for April 2024 to April 2025. British association of perinatal medicine (BAPM) nurse staffing compliance meets the service specification for that period. This is calculated using the relevant national workforce tool and recommendations by (BAPM) standards for nurse staffing. The National Nurse Workforce Tool (NNWT) for direct Patient/Cot side Care and the Northwest Neonatal

Operational Delivery Network (NWODN) Quality Nursing Roles Calculator (QNRC) - For Quality Roles has been completed and submitted to the NWNODN in 2024. This aligns with the asks for CNST safety action 4.

The 2025/26 professional judgement review is underway to include the transitional care clinical model for 24/7 cover, once completed this will be reported for oversight as part of the ELHT professional judgment 6 month reviews.

Finance

The Professional Judgement Review has identified there will be no increase in cost for this professional judgement as budgets were set in April 25 against the last agreed Professional Judgement.

Conclusion

The Quality Committee are asked to consider the professional judgement and agree the recommendations.

The Quality Committee are asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.

Appendix one

Latest Month

Average Fill Rate					CHPPD		Number of wards < 80 %				Number of wards < 90 %			
	Day		Night				Day		Night		Day		Night	
month	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jul-25	93.14%	97.92%	96.24%	109.46%	32048	8.10	1	2	1	3	14	5	2	3

Monthly TREND

	Day		Night				Number of wards below 80 %				Number of wards below 90 %			
							Day		Night		Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)
Jun-24	95.5%	100.5%	100.7%	110.4%	30887	8.34	0	1	0	0				
Jul-24	93.9%	97.6%	99.4%	109.1%	31622	8.24	2	1	0	0				
Aug-24	92.4%	97.8%	100.0%	110.2%	31181	8.30	4	0	0	0				
Sep-24	91.5%	96.3%	96.7%	105.6%	31713	7.92	1	2	1	1				
Oct-24	91.1%	94.1%	98.3%	105.1%	33266	7.71	1	3	0	0				
Nov-24	91.1%	96.1%	97.1%	107.9%	32370	7.98	0	2	0	0				
Dec-24	90.7%	95.0%	97.8%	103.3%	33394	7.86	1	3	0	1				
Jan-25	90.1%	94.7%	97.5%	105.3%	33954	7.76	4	2	0	1				
Feb-25	91.6%	97.0%	97.4%	106.7%	30089	7.90	1	1	0	1				
Mar-25	91.8%	96.6%	98.2%	106.6%	32817	7.98	1	1	0	0				
Apr-25	92.6%	98.3%	97.6%	107.9%	30215	8.45	1	3	0	0	17	4	2	1
May-25	93.7%	97.9%	98.2%	107.9%	32374	8.02	1	4	0	1	14	7	2	2
Jun-25	92.2%	96.1%	97.5%	107.4%	31513	7.93	3	2	1	1	15	8	3	3
Jul-25	93.14%	97.92%	96.24%	109.46%	32048	8.10	1	2	1	3	14	5	2	3

Appendix Two ****** if new ward data is from old footprint**

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Feb 25 With uplift & split from 1-1 Requirement	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status
						In the last 3 Months Jan 25 to March 25 **Assume falls no/low harm & pressure ulcer cat 2 unless stated**				
Ward 19 BGH	23	Early: 4 + 4 Late: 3 + 4 Night: 2 + 4	34.70	38.1	No Change	1	2	4	2	Green
Ward 22 (16) BGH	27	Early: 4 + 4 Late: 3 + 4 Night: 3 + 4	41.54	41.0	No Change	0	4	3	3	Green
CLI RB	32	Early: 5 + 4 Late: 5 + 4 Night: 3+ 4	43.92	40.8	No Change	0	6	1	1	Green
RH	17	Early: 3 + 5 Late: 2 + 5 Night: 2 + 3	34.21	16.4	No Change	1	0	0	3	Amber

Hartley	24	Early: 4 + 3 Late: 3 + 3 Night: 2 + 3	31.48	34.1	No Change	1	0	0	3	Amber
Marsden	24	Early: 4 + 6 Late: 4 + 5 Night: 2+Twi + 3 (change twi to late)	42.09	43.2	No Change	0	0	0	0	Gold
AMU	73	Early: 19 + 13 Late: 19 + 13 Night: 18 + 9	164.42	128.7	No Change	25	5	0	2	Red
B14	24	Early: 5 + 4 Late: 5 + 4 Night: 3 + 3	41.19	44.2	No Change	8	1	0	3	Gold
B2	23 (3)	Early: 5+4 Late: 5 + 4 Night: 3+ 4	44.92	44.1	No Change	New ward	New ward	New ward	New ward	New ward
B22	23	Early: 4 + 6 Late: 4 + 6 Night: 2 + 3	48.02	38.5	No Change	7	3	1	8	SPEC
B24	23	Early: 4 + 4 Late: 4 + 4	37.09	32.6	No Change	5	5	1	8	SPEC

		Night: 2 + 3								
C1	19	Early 4 + 4 Late: 3 + 4 Night: 2 (twi) + 4	44.95	New ward	No Change	11	6	1	3	Amber
B6	22	Early: 4+ 3 Late: 3 + 3 Night: 3 + 3	32.41	36.2	No Change	4	0	0	0	Green
B8	22	Early: 4+ 3 Late: 4 + 3 Night: 3 + 2	33.12	33.9	No Change	3	2	0	2	Green
C10	22	Early: 5+ 4 Late: 5 + 4 Night: 3 + 4	43.97	38.6	No Change	4	0	0	0	Gold
C11	22	Early: 4+ 4 Late: 3 + 4 Night: 2 (TWI) + 3	35.74	34.9	No Change	6	3	1	1	Amber
C14a	17	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	28.9	No Change	6	2	0	4	SPEC
C14b	17	Early: 4+ 2 Late: 3 + 2	26.5	28.7	No Change	2	1	0	4	SPEC

		Night: 2 + 2								
C18a	18	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	33.4	No Change	5	0	1	5	GOLD
C18b	18	Early: 4 + 3 Late: 3 + 3 Night: 2 + 2	29.24	26.0	No Change	7	1	0	3	GOLD
ESU	35	Early: 8 + 6 Late: 8 + 6 Night: 7 + 4	68.52	57.9	No Change	8	0	1	8	SPEC
C5	14	Early: 3+ 4 Late: 3 + 4 Night: 2 + 3	33.0	13.7	No Change	3	2	0	2	Gold
C2	24	Early: 4 + 3 Late: 4 + 3 Night: 3 + 3	30.18 Needs new budget	New ward	No Change	9	4	0	0	Silver
C3	27	Early: 5 + 4 Late: 5 + 4 Night: 3 + 4	44.95	New ward	No change	5	2	1	0	Amber
C9	22	Early: 4 + 4 Late: 4+ 4 Night: 2 + 3	35.73	30.1	No Change	6 (EIR1308 376-fall	0	0	0	Silver

						with harm)				
D1	20	Early: 4 + 3 Late: 4 + 3 Night: 2 + 3	34.30	24.5	NA	7	2	0	0	Green
D3	20	Early: 4 + 3 Late: 4 + 3 Night: 2 + 3	33.30	29.6	NA	3	3	0	0	Green
OPU	46	Early: 10 + 7 Late: 10 + 7 Night: 5 + 7	79.65	73.4	No Change	13	15	1	6	Green
WD 15	24	Early: 5 (4) + 4 Late: 3 + 3 Night: 2 + 3	34.9	31.8	No Change	5	0	2	2	Gold
C6	25	Early: 4 + 4 Late: 4 + 4 Night: 3 + 3	38.51	New Ward	No Change	4	6	0	0	Gold
C8	20	Early: 4 + 4 Late: 4 + 4 Night: 2 + 3	36.85	New Ward	No Change	7	0	0	3	Silver
CCU	10	Early: 4 + 2 Late: 4 + 2	27.54		No Change	4	0	0	1	Gold

		Night: 3 + 1		Does not collect						
Card Ward	26	Early: 5 + 3 Late: 5 + 3 Night: 3 + 2	35.73	44.2	No Change	3	1	1	4	Silver
B18	26	Early: 4 + 3 Late: 4 + 3 Night: 3 + 4	38.72	New Ward	No Change	6	2	1	1	Green
C7	22	Early: 4 + 3 Late: 4 + 3 Night: 3 + 4	38.46	New Ward	No Change	6	0	1	1	Amber
Gynea	16	Early: 3 + 1 Late: 3 + 1 Night: 2 + TWI + 1	27.66 (including hot Clinic)	10.9	No Change	1	0	1	1	Amber
Albian Mill	13	Early: 3 + 3 Late: 2 + 3 Night: 2 + 3	Shared with Council	16.1	No Change	1	1	0	5	NA
Paed A	13 + 4 HDU	Early: 5 + 3 Late: 5 + 3 Night: 5 + 3	42.11	21.4	No Change	0	0	0	1	Green
Paed B & C	37	Early: 8 + 0 Late: 8 + 0	42.3	51.2	No Change	0	0	0	14	Green

		Night: 7 + 0								

Appendix Three

Community SNCT Paper 2025

DMB Paper - CNSST Audit Report (1).doc

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BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/129a
Report Title:	Triple A Report from Quality Committee (July 2025)		
Author:	Simon Featherstone, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		
Executive Summary:	This report delivers a summary of the items discussed at the Quality Committee meeting held on 30 July 2025. The triple A format of this report sets out items for Alert, Action or Assurance from the Committee to the board.			
Key Issues/Areas of Concern:	Trust Board should be aware of the limited assurance around mortality within the organisation, as set out in the Alert section of the report.			
Action Required:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	Quality Committee
Date of Meeting:	30 July 2025
Committee Chair:	Simon Featherstone
Attendance:	Quorate
Key Items Discussed:	End of Life/Bereavement Service Update Human Tissue Authority Finalised Inspection Report & Action Plan Edenfield Action Plan Update Waiting Lists and Resultant Harms Call for Concern – Martha's Rule Organ Donation Bi-Annual Report Mortality Concerns Care of Mental Health Patients in UEC

ALERT

There is a limited assurance around the Trust's position relating to patient mortality.

The quality committee heard the following:

- HSMR and SHMI are both elevated, however there is a lack of clarity as to the validity of the data which contributes to both scores, specifically around the inclusion of SDEC data, general data availability due to the change in the Trust EPR system and the depth of clinical coding.
- Concerns were raised by the Chair of the Mortality Steering Group around deaths relating to Pneumonia where the Trust is an outlier, however it is unclear whether incorrect clinical coding of respiratory deaths has artificially elevated the mortality data relating to this.
- Crude mortality data shows normal variation, however crude mortality is an unreliable measure on its own to determine whether the Trust has a problem with excess patient deaths.
- There is a gap in the Trust's ability to undertake Structured Judgement Reviews (SJRs) of deaths due to insufficient trained individuals to undertake SJRs. This means that valuable learning from deaths is potentially being missed.

Actions:

- The Committee requested the Mortality Steering Group to undertake a review of the Trust's position regarding mortality and to present an action plan to August Quality Committee which enables the organisation to have a clearer view of its position in relation to mortality.

ASSURE

- The Quality Committee received ongoing significant assurance around acute inpatient nurse staffing levels.

- The Quality Committee received significant assurance around the care of patients at end of life and noted the sustained improvements against national benchmarking in the quality of care provided to dying patients and their families since 2018.

- The Committee was assured that ELHT follows best practice with issues relating to organ donation and recognises the work done by the team in attempting to maximise the numbers of patients who go forward for organ donation. The committee noted the potential risks around the lack of a Chair for the Organ Donation Committee but was reassured that the action was being addressed.

- The Committee received assurance around waiting list safety and recognised the work done to ensure that patients who are on the waiting list for services are not experiencing harm.

ADVISE

- The committee asked for greater visibility of Community KPIs as part of the Integrated Performance Report. The Deputy Chief Nurse will present an overview of Community services at the August committee and agree a set of key performance indicators to be included in the IPR on an ongoing basis.

- The committee received a report on the actions taken following the HTA inspection of Mortuary Services at the Trust. The Committee asked for a revised action plan to be presented at August Quality Committee with clear progress and timescales for completion.

- Plans are being developed to establish a Mental Health ED adjacent to main ED at RBH to provide a more appropriate setting for patients attending with Mental Health needs. Discussions are ongoing with LSCFT and a plan will be presented to Quality Committee in September 2025.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/129b
Report Title:	Triple A Report from Quality Committee (August 2025)		
Author:	Simon Featherstone, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓		
Executive Summary:	This report delivers a summary of the items discussed at the Quality Committee meeting held on 27 August 2025. The triple A format of this report sets out items for Alert, Action or Assurance from the Committee to the board.			
Key Issues/Areas of Concern:	This report includes an update on the concerns raised around mortality assurance at the July 2025 Quality Committee			
Action Required:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	Quality Committee
Date of Meeting:	
Committee Chair:	Simon Featherstone
Attendance:	Quorate
Key Items Discussed:	Mortality Update
	Maternity and Neonatology Mortality Deep Dive
	Huan Tissue Authority Inspection Report Action Plan Update
	Safeguarding Annual Report
	Nurse Staffing Professional Judgement Review
	CQC Community Inspection Update

ALERT

Following discussions at the July meeting of the Quality Committee around limited assurance relating to the Trust's Mortality position, the Committee received a paper, delivered by the Chair of the Mortality Steering Group which attempted to provide clarity and greater assurance around inpatient mortality at the Trust.

The paper addressed the two key areas of whether data quality has driven an increase in SHMI and HSMR and whether the elevated mortality ratios reflect any underlying problems in the quality of care.

The discussion around data quality focused on the organisation's relatively static crude mortality data at the same time as an increase in mortality ratios and examined the effects of depth of coding; removal of SDEC data from data submissions; and the impact of the new EPR system on data availability/upload.

The paper used triangulated data sources to review quality of care delivery, including Learning from Deaths reviews using the Structured Judgement Review methodology; audit submission for pneumonia, sepsis, heart failure, COPD and stroke; End of Life Care data; and the recent MIAA report on the Response to Deteriorating Patients.

The paper provided helpful context as to why mortality ratios have risen and suggested a number of actions to ensure delivery of assurance around mortality to the Quality Committee on an ongoing basis.

ASSURE

The Committee received the annual Safeguarding Report which provided significant assurance around safeguarding activity within the organisation. The report demonstrated:

• Demand and activity across the safeguarding agendas continue to increase, particularly in relation to the number
of complex cases.
• Continuous improvement approach to the delivery of the safeguarding agenda and how lessons are learnt and
improvements embedded in practice.
• Compliance with legislation, including The Children Act (1989, 2004), The Care Act (2014), Mental Capacity Act
(MCA) (2005) and Deprivation of Liberty Safeguards(DoLS).

Overall, the report demonstrates a sustained improved safeguarding adult and child position. The Trust is complaint with all adult and child safeguarding training, except for Adult Level 3 where there is a recovery plans and trajectories in place to ensure compliance is reached by end September 2025.

The Committee received an update on the progress being made against the Human Tissues Authority action plan following the visit by the HTA in April 2025. The paper demonstrated good progress against the required actions and provided assurance to the Committee that all required remedial actions are being addressed in a timely manner.

The Committee received the six-monthly Nurse Staffing Professional Judgement Review which incorporates a formal evaluation of the Trust's ward/unit/department(s) staffing templates using a triangulated approach. The report included an analysis of 30 days census data utilising the Safer Nursing Care Tool (SNCT) (Shelford Model) during Feb 2025, a review of the nurse sensitive indicators (Jan 25 – March 25) and the professional judgement of the senior nursing team. This, alongside the monthly nurse staffing exception report provided significant assurance around the process and outcomes of inpatient nurse staffing.

ADVISE

The Committee discussed the recent CQC inspection of Community Inpatient Wards and has recommended that a full discussion of the inspection should be held in Part 2 of Trust Board this month.

The Committee received a presentation from Maternity and Neonatology Services around a deep dive into Mortality within the service. The Committee thanked the presenters for their presentation and requested that a formal paper be developed, based on the presentation, as an agenda item for September Quality Committee before being presented to Trust Board.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/130a
Report Title:	Triple A Report from Finance and Performance Committee (July 2025)		
Author:	Sallie Bridgen Non-Executive Director (Committee Chair)		
Lead Director:	Sam Simpson Executive Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 28.07.2025 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	**Finance and Performance**
Date of Meeting:	**28.07.25**
Committee Chair:	**Sallie Bridgen**
Attendance:	Quorate
Key Items Discussed:	

ALERT

The Committee received the **Finance Report Month 3**.

At Q1 we were 1.2m adverse to plan, but would be £2.4 without CNST rebate of £1.2m. This is explained by: £1.3m unidentified WRP, £0.7m of non pay pressures, and £0.4m pay related costs linked to MARS and enhancements.
There were also significant non pay pressures which impacted the position in month that had not been provided for of £0.7m (Medical supplies £0.3m ,PFI service costs £0.2m, and other costs £0.2m).
We discussed which divisions are driving that – with MEC, DCS and FC the main areas.

In terms of grip and control, looking at pay - we are spending less on agency (48% reduction) and bank (22%) and have reduced our headcount by just under 57 WTE. However we know there is more to do on G&C from PWC Assurance update.

Cash remains a significant risk, and emphasises the urgency of our getting back on track. Also risks around HCA rebanding, redundancy costs and CDC contract Funding

There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 *normalised* position has reduced from £23.2m in Q4, down to £20.9m in Q1, a £2.3m improvement in the bottom line

The Committee requested a report on Pressures, and updates on Cash Flow Risk and Grip and Control be brought to the September Committee.

The Committee received an **Update from the Recovery Director**.

The WRP delivered £2.4m in M03 against the revised plan of £3.4m, a negative variance of £1.0m

WRP YTD is £6.7m against a plan of £9.1m, an adverse variance of c.£2.4m.

£6.7m WRP was delivered in Q1 and the implemented PYE for the year is at £23.95m (39%) of the total plan and increased from £10.89m in M2

- Pay related WRP is on broadly plan to Q1 re-profiled plan
- Non-pay related WRP plan is behind and accounts for the under-delivery of the revised WRP plan YTD however, these are clearly understood and mitigations are in place

- Headcount has reduced by 308 = 47% of the total workforce plan reduction with bank and agency ahead of plan by £0.5m

- Agency spend of £429k, is £82k better than plan and represents a 48% reduction on 2024/25 run rate, above NHSE's minimum expectation of a 30% reduction
- Bank spend of £3,340k is £287k better than plan and represents a 22% reduction on 2024/25 run rate, above NHSE's minimum expectation of a 15% reduction

- PMO development progress is good, SME support now onboarded, PMO finance lead onboarded, Head of PMO start date 1st August. Exit planning underway with PWC

- Cross cutting wokrstreams in establishment and SME contribution and RSP analytics data supporting and helping to buildi a buffer (Restocking the pipeline) and this is already identifying further opportunity for conversion e.g. variable pay unit cost, job planning, sickness absence overpayments, as examples

The Committee recognised the disappointing under-performance, and the risks this poses to delivering the Plan. It also recognised the positive progress in developing the PMO and the positive signs around Implemented values of 39%

For September, the Committee requested a more detailed report of the WRP *at Trust, Divisional and crosscutting level,* of which schemes haven't delivered and why – for learning, accountability and mitigation. This needs to include clear mitigation plans with timelines and stronger forcasting for m 4 and Q2

The Committee recommended Board approves the **Maternity Workforce Planning Improvement Case (Birth Rate +)** *at a cost of £606k in 2025/26 and potentially recurrently of £1,099k.*
The Committee recognised that this is essential for patient safety and compliance, was based on professional judgement and supported by Chief Nurse and CEO. It also noted that we are not fully funded for this, and therefore it adds pressure to our financial position. The Committee requested that we continue to highlight the under-funding, and that further work is undertaken to reduce costs.

The Committee received an update on the **financial impact of challenges around mental health**. A full report will be brought to the September meeting.

The Committee recommended Board approves **ELHT Radiology Services Equipment and LSC System PACS / RIS.**

The Committee Approved the **Green Plan**.

ASSURE

The Committee received an **Improvement Update** on elective care improvement.

Work is now underway with the PMO to establish these programmes as formal cross-cutting programmes and which are fully aligned to the Waste Reduction Programme.

- Initial work has been completed to categorise the WRP plan for elective and has identified £7.5m PYE (£9.5m FYE) of WRP schemes. Further work is also required in order to quantify cost avoidance and income generating opportunities.

The Committee received reports on the **BAF and Corporate Risk register**.
Work is underway to review BAF in August so the committee can focus on the actions needed and sources of assurance.

BAF 1 – Work underway to strengthen how work going on via PCB is reported into the Board
BAF 5 – committee had in depth discussion around financial and WRP reports
BAF 6 – Hosted Service Committee established but still working through identifying and addressing risks to us as Hosts of OneLSC
BAF 7 – Committee support for establishment of a Digital Committee of the Board who will oversee this risk.

CRR good progress with work to simplify report but agreed that paper will in future focus on specific risks assigned to the Committee. Also discussion on ensuring that key risks being discussed by Board/Committees are reflected on CRR/BAF – for example, HTA, compromised system of internal control. This was picked up as an action point.

ADVISE

The Committee received a report on **MIAA Internal Audit Reports/Actions for Committee.** The format of the report will be updated to include timesales and RAG rating.
The Committee received a **Strategic PFI Update and National Cost Collection Update**.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/130b
Report Title:	Triple A Report from Finance and Performance Committee (September 2025)		
Author:	Liz Sedgley Non-Executive Director (Committee Chair)		
Lead Director:	Sam Simpson Executive Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 02.09.2025 The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name: **Finance and Performance**

Date of Meeting: **02.09.2025**

Committee Chair: **Liz Sedgley**

Attendance: Quorate

Key Items Discussed:

ALERT

1. The month 4 deficit was £5.8m, £2.1m away from plan with the YTD deficit being £26.2m against a plan of £20.7m. This is principally due to WRP delivered being £0.9m off target, and the effect of industrial action in month resulting in increased usage of bank costing £827k.There was an additional charge for theatres stock of £0.7m which has been challenged with the supplier. The committee was also updated on the risks identified to the FOT for 25/26 due to WRP slippage and possible withdrawal of DSF.
2. The Trust is facing considerable challenges managing its cash reserves as WRP projects are not driving cash savings at the required rate. The committee received a revised cashflow forecast indicating that additional support will be required in month 7 and were briefed upon the process that will be undertaken to apply for support.
3. The committee heard that a team is being brought together tasked with improving the cash impact of WRP schemes and the approval process around discretionary spend is strengthened further.

ASSURE

1. The PMO is now mobilised and trained and cross cutting workstreams have been mobilised and together with the SMEs who are identifying clearer routes to cash for PIDs requiring this as well as significant further opportunities to be developed to help reduce the financial gap.
2. An update on performance was received detailing the exceptionally high attendances at A&E in August with 3185 ambulance arrivals in the month. Despite this the Trust delivered the A&E 4hour target at 78.96% of patients being seen with 4 hours although 15.5% of Type1 patients waited more than 12 hours and improvement work is continuing to reduce the numbers of patients waiting longer than 12 hours. The committee was pleased to note that there has been a significant reduction in the number of patients waiting for procedures is done to 19619 by the end of August, there were 50,000 of this cohort of patients waiting at the end of March.
3. The improvement update this month highlighted the project in UEC focusing on high intensity users of the service and with targeted support and MDT working has shown significant reductions in the number of attendances for many of these patients .

ADVISE

1. The Finance Assurance Group (FIG) chaired by the CEO is now meeting fortnightly for a check and challenge session with all divisions.
2. A deep dive review is being undertaken into all PIDs following the under delivery of WRP schemes. The initial reviews have found a lack of clarity on the routes to cash savings and financial gains which has been driving the underperformance. These are being reviewed and reprofiled with the scheme holders. Workshops will be held to identify further schemes to mitigate the shortfalls.
3. The existing contract with PWC has been further extended. 19 September at no further cost to the Trust.
4. The first draft of the planning guidance for 26/27 has been received and a number of workshops with system colleagues and key stakeholders have been held over the summer and a detailed plan with timescales has been developed.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/131a
Report Title:	Triple A Report from People and Culture Committee		
Author:	Liz Sedgley, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 4 August 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	People and Culture Committee
Date of Meeting:	4 August 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Sickness and Absence Action Plan and Update Chief People Officer Update Workforce Inclusion Performance Report Safe Working Hours (Doctors and Dentists in Training) Quarterly Report Senior Support and Share Update Staff Side Update Integrated Performance Report

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Sickness absence rose to 6.55% , an update report from the reducing sickness / improved wellbeing programme was received and approved the additional workstreams identified from the work already carried out at LTH which has been proven to reduce sickness absence .The committee requested that sickness absence rates are presented for both long and short term and by divisions together with trajectories being set to monitor performance.
- Appraisal for agenda for change staff compliance has dropped to 79% (target is 90%), The CPO is carrying out a diagnostic review into the issues and will come back to the committee with an action plan to address the issues and improve rates with the commitment to achieve the target within agreed timescales.
- Compliance in Information Governance mandatory training has dropped from 93% to 90% (target is 95%), the committee discussed the measures that could be taken to improve rates linked to pay progression etc.
- The committee discussed the rates of violence experienced by staff at work as noted in the staff survey but also being raised by staff on the Senior Support and Sharing visits. This is in part being dealt with by the increasing number of Red Cards being issued by the Chief Nurse to patients who have repeatedly been

violent or aggressive to staff. This means that the individual will only be treated by ELHT in the case of emergency lifesaving treatment. It was agreed that better communication of this issue should be raised with the public, patients and relatives and that violence towards our staff will not be tolerated.

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ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee heard a staff story about the effects of carrying out and supporting staff during a sexual violence investigation. Such cases can be very complex and lengthy whilst also being emotionally difficult for all those involved and the committee discussed the support that needs to be in place . The committee also discussed how ELHT can support staff in coming forward to report instances of sexual violence in the workplace , knowing that they will be believed , supported and action will be taken against the perpetrators.
- The committee received the quarterly report on Safe Working Hours for Doctors and Dentists in training. No major issues were reported
- The Workforce Inclusion Performance report was presented and the committee approved the report for publication. The committee noted the work being carried out and the first ethnicity pay gap report for several years. A request was made for the data to be reported across staff groups and by divisions and teams so that there is better visibility about outliers which can help target actions.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- A review of the current staff networks is being undertaken with a view to combining some networks in order to reduce the administrative burden on staff and improve outputs .

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/131b
Report Title:	Triple A Report from People and Culture Committee		
Author:	Liz Sedgley, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 1 September 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Committee Name:	People and Culture Committee
Date of Meeting:	1 September 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Chief People Officer Report Board Assurance Framework Corporate Risk Register Staff Mental Health and Wellbeing Report Workforce Update Staff Side Update Integrated Performance Report

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Sickness absence rose again by 0.12% to 6.67% , without One LSC it is 6.41% and the main drivers are Mental health which accounts for 35% of absences and 23% MSK . Actions taken to address this include a renewed focus on the basics of the sickness policy , implementing the shared learning from LTH and case management of long term sickness .
- The month 4 plan of 454 WTE reduction was missed with the actual reduction in WTE being 312. The committee requested an update on the steps being taken to catch up the shortfall together with analysis showing which staff bands, groups and divisions the reductions have come from .
- The e rostering project for medical roles was due for completion by the end of August , to date 72% of medical colleagues are on e rosters with Family Care division going live in early September . Slippage is partly due to the scope of the project being extended to include a review of annual leave calculation across the organisation. The committee requested an update together with clear trajectories to complete the rollout be presented at the October meeting
- The committee heard of the concerns of staff within OneLSC about changes in roles , redeployment etc and due to the volume of work to be dealt with by the job matching panels are now facing long delays in the process. Currently there are 71

jobs having been identified from March with only 19 having gone to through the panel process.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- There is a full plan for the communications to staff on the staff survey which is now being run by IQVIA which is being launched mid-September and for the first time is fully digital. There will be targeted IT helpdesk support available together with local champions in traditionally hard to reach areas. The priority is to grow response rates so that we clearly know what issues are concerning and impacting staff and we can act on them.
- There has been a reduction of 59% in salary overpayments from last July to this July, and a robust process is in place to ensure those overpayments which have been made are recovered.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The committee received an update on the review of the staff mental health pathway review and noted the ongoing consultation taking place to ensure that the ELHT offer to staff is the best it can be. A business case is being built to provide in house psychologists to provide better support staff with complex mental health needs.
- Work is ongoing to collate the various sources that staff voices are heard and reported up to Trust Board. A paper will come back in November outlining the structure for this.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/132a
Report Title:	Triple A Report from Audit and Risk Committee		
Author:	Khalil Rehman, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Audit and Risk Committee meeting held on 27 June 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Name of Group:	Audit Committee	**Report to:**	Board of Directors
Date of Meeting:	27 June 2025	**Date of next meeting:**	14th July 2025
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Limited Assurance Head of Internal Audit Opinion	Committee expressed concern and disappointment at final opinion being limited. Advised executive present that this needed urgent turnaround plan to achieve substantial opinion in 25/26.	Committee follow up and track as part of core monitoring.
Assurance		
What	**So What**	**What Next**
Advise		
What	**So What**	**What Next**
25/26 IA Annual audit plan	Revised plan ratified	Monitor for need to make any in year changes.
Items pertaining to external audit, approval of audited accounts & financial statements for 24/25, Audit completion report	Approved	
Review & approval of annual report & annual governance statement	Approved in principle with some final changes to be agreed outside the meeting regarding wording	
Modern slavery statement	Approved.	

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/132b
Report Title:	Triple A Report from Audit and Risk Committee		
Author:	Khalil Rehman, Non-Executive Director/Committee Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			✓
Executive Summary:	This report sets out the summary of the items discussed at the Audit and Risk Committee meeting held on 14 July 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the board.			
Key Issues/Areas of Concern:				
Action Required:	The board is asked to note the report.			

Previously Considered by:	
Date:	
Outcome:	

Name of Group:	Audit Committee	**Report to:**	Board of Directors
Date of Meeting:	14th July 2025	**Date of next meeting:**	13th October 2025
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Internal Audit	Further IA reports were received – Fit & Proper, Risk Management Core Controls & Enhanced Care Patients were all limited. PSIRF, Health Inequalities and Key financial controls received moderate assurance.	Tracking implementation of recommendations and discussions with other committee chairs where these reports should have further discussion.
Internal Audit – key financial controls	Board are advised that moderate rating in itself does not provide assurance that financial and other data provided at F&P and elsewhere is accurate. MIAA advised it was a limited scope review. There was robust discussion with the DoF to consider wider assurance through the 25/26 IA plan and bringing forward the audit work.	Further discussion with IA and Dof to provide assurance across financial controls not covered in the scope.
Management Responses to IA reports & progress on recommendations Backlog and Tracking of IA recommendations	Unfortunately no clinical representatives were available to attend to discuss limited IA reports relating to patient safety. IA recommendations regarding CIP and management response – critical to learn and embed in PMO and 25/26 approach Impacts on our HOIA opinion (already limited) and plan to achieve substantial in 25/26.	Medical Director & CN discussion to be had to ensure no repeat of this. To be incorporated into PMO Exec/PMO to revise approach and priorities – to be reviewed at Oct AC.
Assurance		
What	**So What**	**What Next**
Financial Governance Action Plan (seagry)	Actions on track.	To be monitored by exception at F&P.
BAF Risk 7 Cyber Security	Further details regarding significant risks and DSPT compliance discussed at 9 July board rather than AC.	Now to be covered at new Data &. Digital Committee.

Waivers & Tenders	New format and better information provided	Next meeting – further actions that could be undertaken to align with PMO and procurement savings.
Advise		
What	**So What**	**What Next**
Auditors Report inc VFM Annual Report	Committee requested amendments	To be finalised outside of the committee – completed and agreed with Auditors.
Anti-Fraud FY25/26 Plan	approved	Follow up reports at future committees.

BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/133
Report Title:	Data, Digital & Technology Committee Terms of Reference		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Tony McDonald Chief Integration Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**For Information**
			✓	
Executive Summary:	Responsibility for data and digital has previously sat within the remit of the Finance & Performance Committee. Following a review of the Committee's workload it was agreed with the Chair, Committee Chair and relevant Executive Leads that a Data, Digital & Technology Committee of the Board should be established. The primary purpose of the Committee will be to provide the Board with assurance in relation to the development and delivery of the Trust's Data and Digital Strategy.			
Key Issues/Areas of Concern:	Having a dedicated Board committee for data and digital will ensure a greater level of scrutiny and oversight of all risks in relation to data and digital, with a specific focus on cyber security.			
Action Required by the Board:	The Board is asked to approve: • the establishment of the Data, Digital & Technology Committee; and • the proposed terms of reference for the Committee.			

Previously Considered by:	Finance & Performance Committee
Date:	2 September 2025
Outcome:	The Committee recommend the Terms of Reference be put forward for approval by the Board.

DATA, DIGITAL & TECHNOLOGY COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to the data and digital arrangements of the Trust to be known as the Data, Digital and Technology Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors with relevant experience and expertise with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to provide the Board with assurance as to the digital strategy of the Trust and oversight of data and digital risks.

3.2 Specifically the Committee will:

- Provide strategic oversight and assurance on the development and delivery of the Digital Strategy;
- Seek assurance that there are robust systems and processes in place to meet statutory and regulatory requirements for data and digital governance, including but not limited to cyber-security and business continuity; and
- Seek assurance that strategic and operational data and digital risks have been identified and are being proactively mitigated.

4 Responsibilities

4.1 To fulfil its purpose the Committee will:

4.1.1 Oversee the Trust's Digital Strategy and alignment with national, regional and system NHS digital priorities;

4.1.2 Approve digital investment proposals and seek assurance of post-implementation benefits realisation;

4.1.3 Be assured of the Trust's compliance with data protection, cybersecurity and interoperability standards and legislation;

4.1.4 Review the digital aspects of the draft annual business plans prior to Board approval and submission to the commissioner/national regulator of the NHS.

4.1.5 Oversee the strategic and operational data and digital risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:

i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;

ii) Commissioning deep drive reviews for any risk within the Committee's remit;

iii) Referring appropriate risk matters to the Audit Committee for their consideration; and/or

iv) Escalating any concerns regarding financial and operational risks to the Board.

4.1.6 Monitor and gain assurance on the Trust's Digital Emergency, Preparedness, Resilience and Response;

4.1.7 Consider the digital implications of any system wide opportunities and risks and make recommendations to the Board in respect of these.

5 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- Chief Integration Officer (SIRO)
- Medical Director (Caldicott Guardian)
- Executive Director of People and Culture

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

5.4 Other Executive Directors may be invited to attend the Committee for specific items.

6 In attendance

6.1 The following will be in regular attendance at meetings:

- Director of Digital, Data & Technology OneLSC
- Director of Corporate Governance/Company Secretary
- Chief Information Officer
- Chief Clinical Information Officer
- Chief Nursing Information Officer
- Data Protection Officer

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

7 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8 Frequency

8.1 The committee will meet at least 6 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year and providing an overview of the assurances received.

11 Relationship with other Board Committees

11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.3 Where a decision of the Committee has significant financial, workforce or quality implication the Committee will refer that matter to the relevant Board Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

- Data and Digital Group
- Information Governance Steering Group

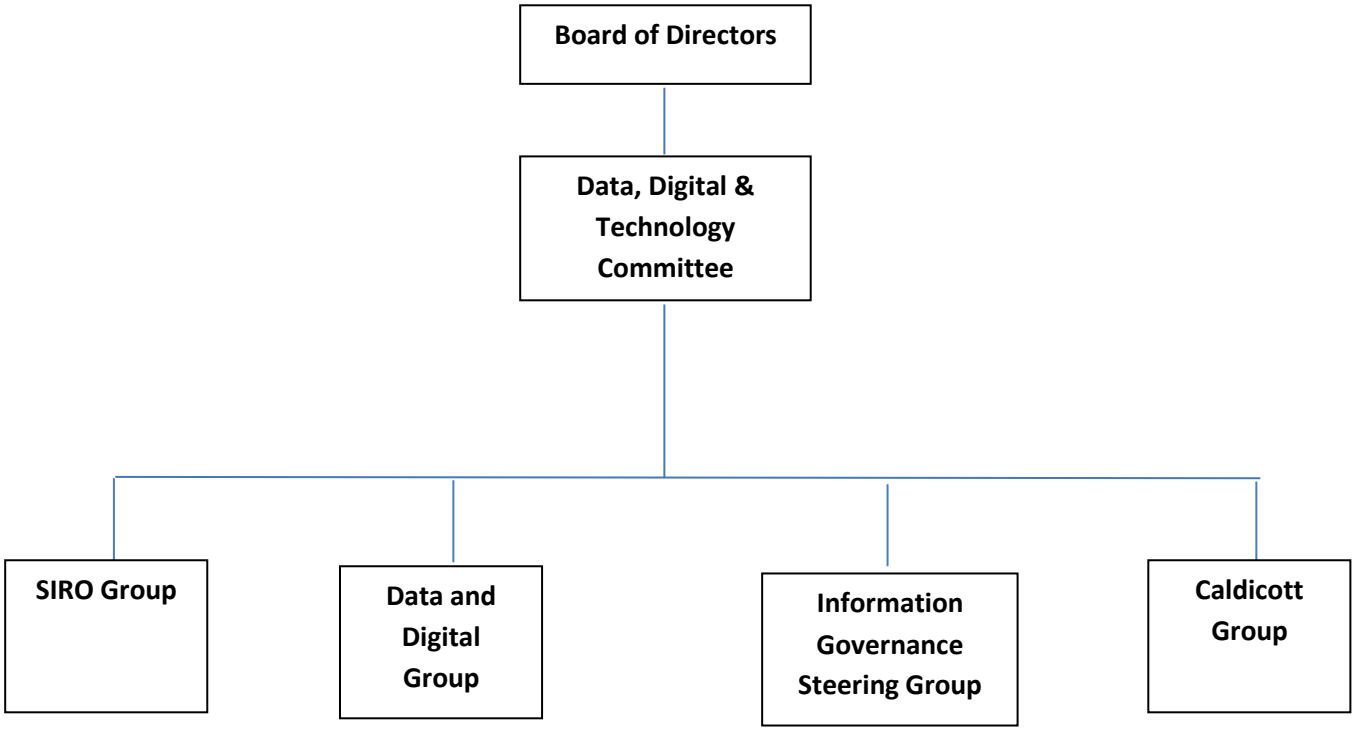
12.2 In addition to the standing sub-committees the Committee may establish time-limited programme boards for strategic programmes being implemented. Any such programme boards will formally report to the Committee until such time as they are formally stood down.

13 Review

13.1 The Committee shall review its membership and effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Data and Digital Committee Sub-Committee Structure



BOARD OF DIRECTORS MEETING

Meeting Date:	10 September 2025	**Agenda Item:**	TB/2025/134
Report Title:	Audit & Risk Committee Terms of Reference		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Khalil Rehman Chair of Audit & Risk Committee		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**For Information**
			✓	
Executive Summary:	The terms of reference for the Committee have been reviewed with several amendments proposed: • Deletion of a duplicated responsibility • Including the Asst. Director of Health & Safety and Risk Management and Deputy Medical Director for Quality Governance as those regularly in attendance • Requirement for officers in regular attendance to nominate a deputy to attend on their behalf when unable to attend themselves • Executive Risk Assurance Group (ERAG) to formally report into the Committee The first two bullet points address recommendations within the Seagry 2 draft report.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board is asked to approve: • the revisions to the terms of reference for the Committee.			

Previously Considered by:	Chair of Audit & Risk Committee
Date:	4 September 2025
Outcome:	Approved revisions to the Terms of Reference for formal approval by the Board and ratification by the Audit & Risk Committee on 14th October 2025.

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors ("the Board") has established a Committee to be known as the Audit and Risk Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference;

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee;

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the Scheme of Delegation, with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3 Purpose

3.1 The primary purpose of this Committee is to provide assurance or escalate concerns to the Board and Chief Executive as the Accountable Officer in relation to:

- Governance;
- Risk management;
- The control environment;
- Integrity of the financial statements; and
- Other elements of the Annual Report and Accounts.

3.2 The Committee will ensure that the Trust has robust audit arrangements.

4 Responsibilities

The Committee's responsibilities can be categorised as follows:

4.1 Governance, risk management and internal control

4.1.1 The Committee shall review the adequacy and effectiveness of the system of governance, risk management(including review of the Board Assurance Framework and Corporate Risk Register) and internal control, across the whole of the

organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives;

4.1.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- The Trust's risk management and control frameworks;
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance;
- The policies and procedures for all work related to counter-fraud, bribery and corruption as required by the NHSCFA.

4.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control together with indicators of their effectiveness.

4.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

4.1.5 As part of its integrated approach, the Committee will have effective relationships with other key Board Committees so that it understands processes and linkages. However these other Committees must not usurp the Audit Committee's role.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector internal audit standards, 2017* and provides independent assurance to the Committee, Chief Executive as the Accountable Officer and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved;
- At least once in a five year period the Committee shall point an Auditor Panel to oversee the market-testing of the internal audit provision to ensure value for money and effectiveness;

- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organization; and
- monitoring the effectiveness of internal audit and carrying out an annual review.

4.3 External Audit

4.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

- 4.3.2 At least once in a five year period the Committee shall appointed an Auditor Panel to oversee the market-testing of the external audit contract. The Auditor Panel will advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.

4.4 Other Assurance Functions

4.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

4.4.2 These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

4.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the Quality Committee, for which assurance from clinical audit can be assessed.

4.4.4 The Committee will review the Quality Account prior to its presentation to the Board for approval.

4.5 Anti-Fraud

4.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that need NHSCFA's standards and shall review the outcomes of work in these areas.

4.5.2 With regards to the local Anti-Fraud Specialist it will review, approve and monitor anti fraud work plans, receiving regular updates on anti-fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

4.6 Management

4.6.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews and or accreditation reports).

4.6.3 The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year.

4.7 Financial Reporting

4.7.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

4.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.7.3 The Committee shall review the annual report and financial statements before submission to the Board, or on behalf of the Board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee

- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

4.8 System for raising concerns

4.8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

4.8.2 Review any reported incident of whistleblowing, fraud, corruption or possible breach of ethical standards or legal or statutory requirements that may have a significant impact on the Trust's published financial accounts or reputation.

4.9 Governance regulatory compliance

4.9.1 The Committee shall review the organisation's reporting on compliance with the *NHS Code of Governance* and the fit and proper persons test.

4.9.2 The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4.9.3 The Committee shall review, on behalf of the Board, the operation of and proposed changes to the standing orders, standing financial instructions and scheme of delegation.

4.9.4 The Committee shall receive a report on, and review, all instances of waivers to standing orders.

4.9.5 The Committee shall receive any reports on any non-compliance with standing orders and standing financial instructions and any justification for non-compliance and the circumstances around the non-compliance.

4.9.6 Where the Committee considers there is evidence of ultra vires transactions this will be escalated by the Committee Chair to the Board.

4.9.7 The Committee will review the schedule of losses and compensations.

4.9.8 The Committee will receive any reports on reviewing banking arrangements.

4.9.9 The Committee will review schedules of debtors/creditors balances over 6 months old and £5,000 and management plan for these.

4.9.10 The Committee will provide assurance in respect of emergency preparedness.

4.9.11 The Committee will review an update on information governance arrangements within the Trust and the work of the SIRO.

4.9.12 Receive regular cyber security reports, including updates on cyber-related workstreams, risk, controls and other relevant information governance reports.

4.9.13 Review the Data Security and Protection Toolkit prior to submission.

4.9.14 The Committee will collaborate with other Audit Committees to ensure effective systems of control across the provider collaborative.

~~**4.10 Management**~~

~~4.10.1 The Committee may request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.~~

4.11 Host Arrangements

4.11.1 Where the Trust hosts services the Committee will ensure that there is an appropriate governance and accountability framework in place to manage any risks to the Trust as host. This will include ensuring that there are appropriate risk management, internal control arrangements and reporting in place to manage any risks to the Trust as host, as well as the internal audit arrangements for the hosted service.

4.11.2 The Committee will receive an annual report from the hosted service setting out the total remuneration packages of the Directors of the hosted service together with assurance that the correct governance and decision making processes have been followed by the Provider Collaborative Board as the decision making bodies in this matter, before any implementation instructions are delivered to payroll.

5 Membership

5.1 The Committee will comprise a membership of four Non-Executive Directors including:

- Audit Committee Chair, who shall have recent and relevant financial experience
- Chair of Remuneration & Nominations Committee
- Chair of Finance & Performance Committee
- Chair of Quality Committee
- Chair of People & Culture Committee

5.2 The Committee should corporately possess knowledge / skills / experience / understanding of:

- Accounting;

- Risk management;
- Internal / external audit;
- Technical or specialist issues pertinent to the organisation's business;
- Experience of managing similar sized organisations;
- The wider relevant environments in which the organisation operates; and
- The accountability structures.

5.3 Only voting Board members have the right to vote at meetings.

5.4 Members are expected to attend at least 75% of meetings.

5.5 The Chair of the Trust shall not be a member of the Committee.

6 In attendance

6.1 The following will be in regular attendance at meetings:

- Executive Director of Finance
- Director of Corporate Governance/Company Secretary
- External Auditors
- Internal Auditors
- Anti-Fraud Specialist
- Assistant Director of Health, Safety and Risk Management
- Deputy Medical Director for Quality Governance

6.2 Persons identified above as being in regular attendance must identify a deputy to attend on their behalf if they are unable to attend themselves.

6.3 The Chief Executive shall be invited to attend the meeting where the Annual Accounts, Annual Report and Annual Governance Statement will be presented.

6.4 Other Executive Directors/Managers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

6.5 Persons in attendance will not have voting rights.

6.6 The Committee Chair may also extend invitations to other individuals with relevant skills, experience or expertise as necessary. Any such individuals will be in attendance only.

6.7 At least once a year the committee will meet privately with internal auditors, external auditors and the Anti-Fraud Specialist, without management present.

6.8 The Head of Internal Audit, representative of external audit and Anti-Fraud Specialist have a right of direct access to the Committee Chair.

7 Quorum

7.1 A quorum will comprise three members.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

8 Frequency

8.1 The committee will meet at least 6 times per year to conduct its regular business as well as an additional meeting to review the Annual Accounts and Annual Report. Additional meetings may be called at the discretion of the Chair of the Committee.

9 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 The Committee will provide an annual report to the Board on its work in support of the Annual Governance Statement, specifically commenting on the:

- Fitness for purpose of the Board Assurance Framework;
- Completeness and 'embeddedness' of risk management in the organisation;
- Effectiveness of governance arrangements;
- Appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

10.3 The annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

10.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

11 Relationship with other Board Committees

11.1 The Chairs of the Board Committees will form the membership of the Committee to ensure a direct link to and from the Audit Committee.

11.2 Information will flow between the Board Committees via the common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.3 Where an external review has significant financial, quality or workforce implications the Committee will refer that matter to the relevant Committee for consideration.

12 Reports from Sub-Committees

12.1 The Trust Executive Risk Assurance Group will report to the Committee via a Triple A (Assure, Advise, Alert) Report.

13 Review

13.1 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.