Blackpool Teaching Hospitals NHS
NHS Foundation Trust

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23rd July 2013

Dear Colleague

Blackpool Teaching Hospitals NHS Foundation Trust – Board of Directors Meeting

A meeting of the Board of Directors of the Blackpool Teaching Hospitals NHS Foundation Trust will be held in public on Wednesday 31st July 2013 at 9.00 am in Room 4, Education Centre, Blackpool Victoria Hospital.

Members of the public and media are welcome to attend the meeting but they are advised that this is a meeting held in public, not a public meeting.

Any questions relating to the agenda or reports should be submitted in writing to the Chairman at the above address at least 24 hours in advance of the meeting being held. The Board may limit the public input on any item based on the number of people requesting to speak and the business of the Board. Enquiries should be made to the Foundation Trust Secretary on 01253 306856 or judith.oates@bfwhospitals.nhs.uk.

Yours sincerely

J A Oates (Miss)
Foundation Trust Secretary

A G E N D A

Agenda Item Number	Agenda Item	Duration
1	Chairman's Welcome and Introductions – Mr Johnson to report. (Verbal Report).	1 minute
2	Declaration of Board Members' Interests Concerning Agenda Items – Mr Johnson to report. (Verbal Report).	1 minute
3	Patient Story DVD – Dr O'Donnell to report.	15 minutes
4	Apologies for Absence – Mr Johnson to report. (Verbal Report).	1 minute

5	Minutes of the Extraordinary Board of Directors' Meeting held on 23rd May 2013 – Mr Johnson to report. (Enclosed).	5 minutes
6	Matters Arising:- a) Action List from the Extraordinary Board of Directors' Meeting held on 23rd May 2013 – Mr Johnson to report. (Enclosed).	5 minutes
7	Minutes of the Previous Board of Directors' Meeting held on 29th May 2013 – Mr Johnson to report. (Enclosed).	5 minutes
8	Matters Arising:- a) Action List from the Previous Board of Directors' Meeting held on 29th May 2013 – Mr Johnson to report. (Enclosed). b) Board of Directors' Meetings: Action Tracking Document – Mr Johnson to report. (Enclosed).	5 minutes
9	Overview of Challenges and Debates Outside Formal Board Meetings from Non-Executive Directors and Executive Directors - Board Members to report. (Verbal Report).	5 minutes
10	Presentation on Key Strategic Issue: Review into the Quality of Care and Treatment – Risk Summit. (Enclosed).	30 minutes
11	a) Quarterly Assurance Report from the Chief Executive and Board Statutory Committees/Board Sub-Committees/Reporting Committees. (Enclosed):- • **Quality** • **Risk** • **Finance** • **Audit** • **Workforce** • **Transformation** • **Strategy and Assurance** • **Trust Annual Reports 2012/13** • **Strategies/Policies/Plans/Guidelines** • **Board Assurance Framework Summary** • **Corporate Risk Register Summary** b) Compliance Monitoring Assurance Report. (Enclosed):- • Corporate Objectives (Strategic Framework) • Compliance Framework Measures including Quarterly Monitoring Return to Monitor (Quarter 1). • Business Critical Measures c) Chief Executive's Report. (Enclosed).	60 minutes
12	Chairman's Report:- a) Chairman's Report. (Enclosed). b) Confirmation of Chairman's Action. (Enclosed). c) Affixing of the Common Seal. (Enclosed).	10 minutes
13	Attendance Monitoring – Mr Johnson to report. (Enclosed).	1 minute
14	Any other Business – Mr Johnson to report. (Verbal Report).	0 minutes

15	Declaration of Confidentiality – Mr Johnson to report. (Verbal Report).	1 minute
16	Date of Next Meeting – Mr Johnson to report. (Verbal Report).	1 minute
	BREAK	
17	Resolution to Exclude Members of the Media and Public The Board of Directors to resolve "That representatives of the media and other members of the public be excluded from Part Two of the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest." in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960) and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997.	1 minute

Total Duration – 2 hours, 27 minutes

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Minutes of an Extraordinary Board of Directors Meeting
held on Thursday 23rd May 2013 at 11.00 am
in the Board Room, Trust Headquarters, Victoria Hospital

Present: Mr Ian Johnson – Chairman

Non-Executive Directors

Mrs Karen Crowshaw
Mr Doug Garrett
Mr Paul Olive
Mr Alan Roff
Mr Tony Shaw

Executive Directors

Mr Gary Doherty – Chief Executive
Mrs Pat Oliver – Director of Operations
Mrs Marie Thompson – Director of Nursing and Quality
Mrs Wendy Swift – Managing Director of Community Development and Transformation *
Mr Feroz Patel – Acting Director of Finance
Mrs Janet Benson – Acting Director of HR & OD *

In Attendance: Mrs Mary Aubrey – Deputy Director of Corporate Affairs and Governance
Miss Judith Oates – Foundation Trust Secretary
Mrs Rachel McIlwraith – Director, PWC

1. Apologies for Absence

Apologies for absence were received from Dr Mark O'Donnell and Mr Robert Bell.

2. Feedback from the Audit Committee Chairman regarding the Annual Report & Accounts and Quality Report Process for 2012/13:-

a) Annual Report and Accounts 2012/13 (Draft ISA 260 Report)

Mr Olive reported that the Audit Committee had considered the ISA 260 Report and the issues contained therein.

The following issues were highlighted to the Board:-

- There was a query in relation to the schedule of unadjusted errors and the mis-match of income monies received from the commissioners.

- There was an unadjustment of £2.7 million, which was similar to last year's figure, and this was shown in the materiality clause of the ISA 260 Report. Mrs McIlwraith reported that this equated to 2% of turnover and was well within the realms of materiality. It was noted that the Audit Committee had considered this aspect and had agreed not to alter the accounts on the grounds of materiality. Mrs McIlwraith confirmed that the finance team had drawn this issue to PWC's attention.

Mr Roff stated that he would welcome information from Mr Patel about how this issue was being dealt with in respect of the PCTs due to their disbandment from 31st March 2013. Mr Patel confirmed that the £2.7 million had defined service developments attached to it.

RESOLVED: That Mr Patel would provide information relating to the service developments to Board members following the meeting.

Post Meeting Note: A breakdown of the £2.7 million provision for income received in 2012/13, which had been provided for in the Annual Accounts, was circulated to Board members on the 24th May 2013.

b) Quality Report 2012/13 (Draft External Assurance Report)

Mr Olive reported that Mrs McIlwraith had reviewed the Quality Report and had highlighted some very minor amendments in relation to the 28 day re-admission rates in terms of definition and arithmetic, none of which were of any material nature.

The only matter of slight concern expressed by PWC was in relation to the impact that the mortality investigation might have on their audit certificate, however, PWC confirmed that the Trust had been transparent in terms of the disclosure regarding mortality within the Annual Report and the Quality Report and also within last year's documentation and therefore they were satisfied that an amendment to the audit certificate was not required but that advice on this issue was still awaited from Monitor.

With regard to the advice awaited from Monitor, Mr Patel informed the Board that the timescale from the Trust's point of view was close of business on the 28th May and that if advice had not been received by the deadline, the recommendation from PWC would be not to include reference to the mortality review in the audit certificate.

Post Meeting Note: Monitor has confirmed that no additional wording is required within the audit certificate in relation to the mortality review.

Mr Olive also reported on minor adjustments to the accounts and an amendment to the management letter which had already been actioned.

Mr Olive advised the Board that the Audit Committee had recommended that the accounts be approved by the Board and be signed off by the deadline of the 30th May 2013.

At this juncture, Mrs Thompson made reference to the wording "investment to improve performance" and pointed out that the decision to invest had been made in July 2012. Mrs Thompson also pointed out that the issues relating to mortality rates were already being addressed. Mrs McIlwraith confirmed that PWC was aware of the proactive work being undertaken by the Trust.

RESOLVED: That Mrs Thompson and Mrs McIlwraith would agree the wording outside the meeting.

Mr Roff pointed out that he had previously suggested an amendment relating to mortality to read "we believe that the high mortality rates have been pervasive across non-elective activity".

c) Annual Report and Accounts 2012/13 and Quality Report 2012/13 and Code of Governance 2012/13

It was noted that this item had already been discussed and that a few minor amendments had been made to the Annual Report and Accounts and the Quality Report.

RESOLVED: That the Annual Report and Accounts and the Quality Report be approved.

It was noted that arrangements would now be made for the document to be printed.

3. Statement Of Directors' Responsibilities In Respect Of The Quality Report

The Statement of Directors' Responsibilities in respect of the Quality Report was presented to the Board for approval.

The Chief Executive advised that the Board was required to confirm that it was satisfied that it had complied with Monitor's requirements in preparing the Quality Report and that it was a fair representation.

RESOLVED; That the Statement of Directors' responsibilities in respect of the Quality Report be approved and signed by the Chairman and Chief Executive.

4. Any other Business

i) Thank You

Mr Olive reported that the Audit Committee had expressed thanks to Mr Patel and his team for the work undertaken in preparing the accounts and to Mrs Aubrey and her team for the work undertaken in preparing the Annual Report and Quality Accounts.

It was noted that the key lesson learned was to start the process early and Mrs Aubrey advised the Board that she would be meeting with PWC to streamline the process for next year.

The Chairman thanked Mrs McIlwraith and her team for the work undertaken in relation to the Annual Report and Accounts and the Quality Accounts; it being noted that the Auditor's had worked well with the finance team but had retained their objectivity.

At this juncture, the Chairman expressed thanks to Mr Olive for the excellent contribution he had made in his role as Non-Executive Director and, in particular, in his role as Audit Committee Chairman and stated that he would be a difficult act to follow. Mr Olive thanked the Chairman for his comments and advised that he had thoroughly enjoyed his Non-Executive Director role, working with a good team of staff, and that he had witnessed many changes. He commented that his successor would experience his own challenges in terms of the organisation and the way forward. Mr Olive confirmed that he would be available for advice in the future and that he would be disappointed if there was not an occasion when the new post-holder needed to contact him.

ii) Appointment of External Auditors

Mr Olive reminded Board members that the Audit Committee and the Council of Governors had approved the appointment of PWC as External Auditors in August 2011 for a two year period and therefore consideration would need to be given to their re-appointment in August 2013 or, alternatively, to tendering for external audit services.

iii) Non-Executive Director Recruitment

The Chairman reported that two Non-Executive Director appointments had been made and that an announcement would be made within the next week.

It was noted that the recruitment of one further NED would take place in July/August 2013.

iv) Revised Structure

The Chairman referred to the new format of Board meetings from the 29th May 2013 and the revised committee structure and pointed out the need to ensure there was a balance of Executive Directors and Non-Executive Directors on the Board statutory committees and Board sub-committees.

It was suggested that the two newly appointed Non-Executive Directors should be given the opportunity to attend different committees as part of their induction.

Mr Patel confirmed that he had agreed the format of the finance report with Mrs Crowshaw and Mr Roff.

5. Declaration of Confidentiality

RESOLVED: That no items be declared confidential under the Freedom of Information Act 2000.

6. Date of Next Meeting

Board of Directors Meeting – Wednesday 29th May 2013.

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Action To Be Taken Following the Extraordinary Board of Directors Meeting

23rd May 2013

Agenda Item to be Actioned	Responsible Lead Person	Date To Be Completed	Progress	Status	RAG Rating
Annual Report and Accounts 2012/13 – Draft ISA 260 Report Provide information relating to the service developments to Board members following the meeting.	Feroz Patel	24.5.13	A breakdown of the £2.7 million provision of income received in 2012/13, which has been provided for in the Annual Accounts, was circulated to Board members on 24.5.13.	Closed	Green
Quality Report 2012/13 Liaise with PWC outside the meeting to agree the wording in relation to "investment to improve performance".	Marie Thompson	24.5.13	This item has been actioned.	Closed	Green

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Minutes of the Blackpool Teaching Hospitals
NHS Foundation Trust Board of Directors Meeting
held on Wednesday 29th May 2013 at 9.00 am
in the Board Room, Trust Headquarters, Blackpool Victoria Hospital

Present: Mr Ian Johnson – Chairman

Non-Executive Directors

Mr Paul Olive
Mrs Karen Crowshaw
Mr Doug Garrett
Mr Alan Roff
Mr Tony Shaw

Executive Directors

Mr Gary Doherty – Chief Executive
Dr Mark O'Donnell – Medical Director
Mrs Pat Oliver – Director of Operations
Mrs Marie Thompson – Director of Nursing and Quality
Mrs Wendy Swift – Managing Director of Community Development and Transformation *
Mr Feroz Patel – Acting Director of Finance
Mrs Janet Benson – Acting Director of HR & OD *

In Attendance: Ms Jacqui Bate – Interim Director of HR
Mrs Mary Aubrey – Deputy Director of Corporate Affairs and Governance
Miss Judith Oates – Foundation Trust Secretary

81/13 Chairman's Welcome and Introductions

The Chairman welcomed attendees to the Board meeting and to the new agenda format.

The Chairman welcomed Anne Smith, Lead Governor, who was in attendance on behalf of the Governors.

The Chairman also welcomed Jacqui Bate, Interim Director of HR, who would be replacing Janet Benson following her departure from the Trust on the 31st May 2013.

It was noted that Paul Olive would also be leaving the Trust on the 31st May 2013 and that a presentation would be made later in the meeting.

82/13 Declarations of Interest

The Chairman reminded Board members of the requirement to declare any interests in relation to the items on the agenda.

There were no declarations of interest in relation to the items on the agenda.

83//13 Apologies for Absence

An apology for absence was received from Mr Robert Bell, Director of Clinical Support and Facilities Management.

* Non-Voting Executive Directors

84/13 Minutes of the Previous Board of Directors Meeting held on 24th April 2013

RESOLVED: That the minutes of the previous Board of Directors Meeting held on 24th April 2013 be agreed as a correct record and signed by the Chairman.

85/13 Matters Arising:-

a) Action List from the Board of Directors Meeting held on 24th April 2013

The Chairman referred to the action list and stated that the majority of the actions were either closed or were the subject of an agenda item for the May Board Meeting or for future Board Meetings.

KPMG Internal Audit Report – Availability of Tools to Assist in Managing Recommendations

Mr Shaw queried whether the PMO should be considering the IT issue in relation to information tools and was advised that this issue should be progressed by the ICT Department.

RESOLVED: That Mrs Swift would ensure that this issue was progressed via the ICT Department.

Action Taken Following The Meeting
This item is on-going.

CVS Representation on the Council of Governors

The Chairman referred to previous discussions about CVS representation on the Council of Governors and asked Mrs Swift to provide an update.

Mrs Swift explained that there was one CVS covering Blackpool, Fylde and Wyre which was a Third Sector Strategic Partner for Fylde and Wyre, however, they did not undertake the role for Blackpool.

It was noted that Blackpool Council was reviewing this issue prior to a decision being made in respect of the Third Sector Strategic Partner for Blackpool.

Future Action Lists

With regard to future action lists, Mr Doherty suggested that those items due to be included on the following month's Board agenda should be marked "closed" provided they had been included as agreed.

RESOLVED: That Miss Oates would produce the action list in accordance with Mr Doherty's suggestion.

Action Taken Following The Meeting
This item has been actioned and will be actioned for future meetings.

b) Action List from Previous Board of Directors' Meetings – Action Tracking Document

Feedback from Non-Executive Directors' Visits

The Chairman stated that feedback from the Non-Executive Directors did not appear on this month's agenda and stated that it would be useful to continue to receive this feedback.

Post Meeting Note: It was noted that this item was included on page 3 of the Chief Executive's Assurance Report.

Feedback was provided as follows:-

Feedback from Non-Executive Directors' Visit to the Haematology/Oncology Unit – 24th May 2013

Mr Garrett provided feedback as follows:-

- There had been a significant improvement to the facilities compared with their previous visit.
- The staff were pleased with the additional space provided.
- The patients' area was busy.
- The only issue he noted was in relation to the production of drugs which could slow down the turnover of patients through the unit.

It was noted that the drugs were produced at Blackpool therefore problems were experienced at Fleetwood. Mrs Crowshaw stated that she had encouraged the staff to apply to the Staff Benefits Committee to obtain funding for improvements to the unit.

- There was some support from volunteers but not on a daily basis.

Mrs Crowshaw pointed out that the patients' relatives were often on site for a full day and asked about the facilities available to them. Mrs Crowshaw suggested arranging lunch at Oliver's Restaurant for patient's relatives.

Mrs Crowshaw provided an update as follows:-

- The team was fabulous and enthusiastic about the way in which they could make a difference and about providing the best for patients by trying to make it a positive experience despite the seriousness of their illness.
- The staff felt very well supported.

With regard to the drugs issue, Mrs Thompson stated that there was a safety issue in terms of the type of drugs being prepared and there was a need to consider whether a different model could be used, perhaps linking with the Director of Pharmacy.

Mrs Oliver confirmed that no drugs were prepared on the unit and that the team was considering expanding the model and also considering whether haematology patients could be treated on the planned investigation unit at Fleetwood, thereby reducing congestion at Blackpool

Mr Garrett pointed out that the staff had raised the drugs issue only when he had asked whether there were any restrictions in the unit becoming more efficient.

RESOLVED: That Mrs Thompson would liaise with the Voluntary Services and Community Engagement Officer about increasing the number of volunteers on the unit.

That Mrs Swift would raise the issue of volunteers at the Voluntary Service Group meeting the following week.

Mrs Crowshaw requested that a letter be forwarded to the staff from the Board advising that feedback from the visit had been reported to the Board, in particular that they had been impressed with their drive and enthusiasm and their interaction with the patients.

RESOLVED: **That Miss Oates would email Andrew Heath (Matron), Sue Jones (Ward Sister) and Sue Faul (Ward Manager) to advise them about the positive feedback that had been provided to the Board.**

Action Taken Following The Meeting
The number of volunteers in the unit has increased slightly with existing volunteers who have taken on a new challenge in addition to their existing role. The next stage is to recruit externally and a volunteer recruitment day is taking place in June, following which it is anticipated that new volunteers can be introduced to the department.

This issue of increased volunteers was raised at the Voluntary Services Group meeting on the 7th June 2013. There is a current shortage of volunteers available and action is on-going to address this.

An email conveying the Non-Executive Directors' positive comments was forwarded to Andrew Heath (Matron), Sue Jones (Ward Sister) and Sue Faul (Ward Manager) on the 4th June 2013.

Progress Report on the Non-Executive Directors' Visit to the Radiology and Pathology Departments – 25th March 2013

Mrs Oliver provided a progress report in respect of Radiology as follows:-

- Neil Upson had been in post for just over five weeks working on MES which would be discussed later in the meeting.
- The staff were fully engaged with the MES model.
- Approval had been given to proceed with the procurement of a CT Scanner.
- A request to support the recruitment of five Radiologists would be discussed at the EDs/DDs meeting the following day.
- Dr Bury had been invited to attend the EDs/DDs meeting to ensure clinical input.
- Weekly meetings were taking place with the staff and Mrs Oliver was involved in the monthly meetings.

Mrs Oliver provided a progress report in respect of Pathology as follows:-

- Some of the work had been reviewed.
- Two business cases were being prepared for the recruitment of a Histopathologist and Microbiologist.
- Weekly meetings were taking place.
- A half day session was being arranged to review the strategy and to ensure that the views of the staff had been captured.

It was noted that the Non-Executive Directors would be re-visiting the Radiology and Pathology Departments on the 29th July 2013.

Mrs Crowshaw commented that it was good to give feedback from the visits and expressed thanks to Mrs Oliver for her efforts in addressing the issues of concern that had been raised by the Non-Executive Directors.

Succession Planning and Talent Management Strategy

The Chairman asked about progress with regard to the Succession Planning and Talent Management Strategy and Mrs Benson advised that this issue was linked to the HR work being undertaken by Emma Dawkins and was due to be submitted to the Board in June.

Main Entrance and Multi-Storey Car Park

RESOLVED: **That Mrs Swift would provide an update in respect of the Main Entrance and Multi-Storey Car Park at the next meeting.**

Action Taken Following The Meeting
A verbal update will be provided at the Strategy and Assurance Committee meeting in June 2013.

Overview of Challenges and Debates – Interaction between Governors and Committees

Mr Garrett reminded Board members of the background to this issue; it being noted that one Governor had by-passed the executive team regarding fund-raising issues. Mr Garrett confirmed that the matter had been addressed via the Chairman.

86/13 Overview of Challenges and Debates Outside Formal Board Meetings from Non-Executive Directors and Executive Directors

It was noted that there had been challenges or debates outside formal Board Meetings from Non-Executive Directors or Executive Directors as follows:-

- Mr Shaw referred to Harry Clarke's presentation at the Finance & Business Monitoring Committee meeting on the 24th April and expressed concern about the negative phrase about "keeping people out hospital". It was suggested that an alternative phrase could be "to make sure patients receive the best care in the right place".

87/13 **a) Monthly Assurance Report from the Chief Executive and Board Sub-Committees/Reporting Committees:-**

The Chief Executive referred to the first assurance report to the Board and advised Board members that he had attempted to produce the report based on previous conversations and had highlighted the positive assurance areas and the areas the Board needed to be aware of as key issues.

Mr Doherty asked Board members for their views on the format of the document before he reported on the content.

The Chairman thanked Mr Doherty for producing his first assurance report and asked Board members for their views on the format and content.

Mr Roff provided comments as follows:-

- It was a good report and the balance was right between providing sufficient detail to ensure that Board members were aware of the issues and the methods of assurance without providing too much detail.
- It would be useful to have more explicit references regarding the back-up documentation and perhaps signposting within the report to the reference documents or to the person to contact for a discussion about a particular subject.
- It would be helpful to include wording around whether full assurance or part assurance was being given in order that Board members were aware of where to direct their attention.
- He had some questions about the sections in which some of the items should be included.
- The report highlighted the fact that the area where most work was required was quality and safety.

Mrs Crowshaw stated that it was a good report and she suggested producing a template indicating the areas to be included under quality (for example ten issues) and highlighting within each report the areas that needed to be drawn to the attention of Board members (for example four issues).

Mr Olive stated that the report was a good start to achieving the aim of an overall assurance report.

Mr Shaw suggested quantifying those areas where the Trust was not performing well.

RESOLVED: That Mr Doherty would address the issues raised by Board members in his next assurance report to the Board.

Action Taken Following The Meeting
This item has been actioned.

At this juncture, Mr Doherty reported in detail on the various sections within the report as follows:-

2. **Quality**

2.1 Cancer Peer Review

- The Trust had responded to the review team pointing out strongly the quality of the Head and Neck service currently provided by the Trust.

- The Cancer Peer Review Team was convinced that the number of cases undertaken by the Trust was too low to ensure the continued competence of the surgical and nursing staff and therefore the Trust should no longer be regarded as an accredited centre.

- The commissioning perspective was that the Trust was not in a sustainable position to continue to undertake this work.

- There were now a number of actions to be considered as follows:-

    - to work with Trust staff to provide more opportunity for their views to be heard.
    - to obtain confirmation that there was capacity elsewhere for the 60 cases to be undertaken.
    - to discuss some of the implications.

- It would be difficult to attract consultants to work at the Trust and consideration would need to be given to manpower planning.

- Consideration needed to be given to the clinical strategy going forward and the areas to expand to mitigate some of the losses.

- There were other issues to be addressed around dermatology due to a recruitment issue at consultant level.

The Chairman stated that a decision would need to be taken now rather than awaiting the clinical strategy review and Mr Doherty agreed with this course of action.

Mrs Crowshaw asked whether there was any opportunity to attract further work and Mr Doherty referred to the possible opportunity to make this part of a wider discussion about hospitals working together.

Mrs Oliver highlighted the good evidence about outcomes at the Trust and pointed out that the Commissioners would be expected to provide the same level of service.

Mrs Thompson pointed out the possibility of the Trust losing staff expertise and Mrs Oliver suggested joint working with Lancashire Teaching Hospitals in order that staff would not lose their skills.

Reference was made to the need to deal carefully with communications and Mr Roff stated that it would be helpful to have a joint statement from Blackpool and Preston as an agreed way forward.

The Chairman commented on the need to be mindful that the decision taken in respect of Head and Neck Services did not set a precedent for other services and he asked the Chief Executive to focus on the way forward locally.

The Chairman asked the Chief Executive to address the above mentioned issues in his assurance report to the Board in two months' time.

RESOLVED: That the Chief Executive would address the above mentioned issues in his assurance report to the Board in two months' time.

Action Taken Following The Meeting
An update will be provided to the Board in July 2013.

2.2 Mortality

It was noted that the issue of mortality would be discussed in more detail later in the meeting.

In brief, Mr Doherty reported that the weekly mortality information indicated that there had been a step change in terms of improvements.

It was noted that significantly more patients had been admitted during Quarter 4 which could have an impact on mortality rates.

2.3 Patient Experience

- The response rate for the Friends and Family Test was low; it being noted that all NHS Providers were expected to achieve 15%.

- Work needed to be undertaken to ensure an increase in the response rate and to ensure responses to the issues being raised.

Mr Garrett asked about the process for non-achievement of the 15% response rate and was advised that either the figures would not be published or the figures would be published with footnotes.

Mr Garrett asked whether the Executive Team was confident that the required returns would be achieved and Mr Doherty emphasised the need to work with the staff to generate enthusiasm to encourage patients to complete the questionnaire.

Mrs Thompson stated that A & E was a challenging area in terms of response rates and that the utilisation of volunteers in this area was being considered, together with other initiatives. The Chairman suggested recognition awards for staff who encouraged patients to complete the survey.

2.4 Informal Monitoring/Soft Intelligence

- The update was noted by the Board.

2.5 Compliance Targets

- It was anticipated that the Trust would deliver on the Quarter 1 targets for cancer waiting times and the waiting times in A & E.

3. **Finance**

- Finance and QuIPP had been discussed in detail at the Finance and Business Monitoring Committee meeting on the 24th May 2013.

- In future, the finance information would be slightly more refined in terms of providing assurance.

4. **Audit**

Mr Olive reported that:-

- The Audit Committee Annual Report, which had been submitted to the Audit Committee in April, summarised the work undertaken during the year and was a good platform for his successor to the role of Audit Committee Chairman.

- The Board was aware of the issues of concern because of previous reporting to the Board and three specific issues were highlighted as follows:-

  - HR & Payroll – Board members were already aware of the issues.

  - Community Clinical Audit – this was work in progress in order to align processes.

  - Procurement Department Annual Report – this was an excellent report and was recommended for submission to the Board on an annual basis.

5. **Risk**

- A report from the Risk Committee would be provided following the first meeting on the 12th July 2013.

6. **Workforce**

- The issue of medical staffing was discussed at the Finance and Business Monitoring Committee meeting on the 24th May 2013.

6.1 Compliance Mandatory Training

- Some progress had been made and the challenge would be to achieve above 90% compliance.

- The mandatory training sessions had been reviewed, resulting in the frequency of attendance being reduced.

Mrs Crowshaw challenged whether there were any areas of non-compliance which could have an impact on patient safety. Mrs Benson advised that reports were being produced which highlighted any gaps in compliance in order that specific staff could be targeted.

RESOLVED: That Mrs Benson would circulate this information to Board members.

Action Taken Following The Meeting
This item is outstanding.

6.2 Nurse Recruitment – Unscheduled Care

- Progress was being made, however, the Board was aware of the significant challenge in this area.

6.3 Over-Payments

- The two key risks for over-payments related to completion of termination forms and completion of assignment change forms.

Mr Olive explained that this was an on-going problem and needed to be resolved. Mrs Benson confirmed that the issue was being addressed and that the Trust had recently recovered £94,000 of over-payments in conjunction with the Local Counter-Fraud Department.

Mr Patel stated that there were a number of issues that needed to be addressed and he was keen to produce a corporate communications pack outlining the processes that needed to be followed.

Mr Doherty stated that he was now aware of the issues and that the system for recovery of over-payments appeared to be working and, hopefully, there would be sufficient improvements and therefore this would no longer need to be addressed in the assurance report.

7. **Transformation**

Mr Doherty stated that some of the items in this section could perhaps have been included in other sections of the report.

Discussion took place about whether this section should be entitled "Strategy".

7.1 Corporate Objectives

- A summary of the submission to the Board in April was provided which included those targets which had not been achieved.

Mr Roff requested that the longer term issues be included in addition to the five strategic themes.

- Mrs Swift was producing the corporate objectives for 2013/14 which may need to be further reviewed.

RESOLVED: That data relating to longer term issues would be included in the draft corporate objectives to be submitted to the Board in June 2013.

That some of the measures would be better placed in the Chief Executive's Assurance Report.

Mrs Crowshaw commented that it was good to highlight the progress being made, particularly as it would be reported to the Council of Governors.

Action Taken Following The Meeting
Updated Corporate Objectives will be submitted to the July Board meeting.

7.3 Integration of Community Health Services – Benefits Realisation Plan

- The issues relating to the integration of community services had been addressed.

Mr Roff suggested that, for future transactions, it would be worthwhile checking whether there had been any effect from the actions from twelve months' ago in order to ensure that lessons were learnt.

RESOLVED: That the completed Benefits Realisation Plan be approved and subsequently closed.

7.4 Fylde Coast Public Consultation

- The Fylde Coast public consultation on the future of older people's rehabilitation services had now been completed and the recommendations had been approved by both Blackpool CCG and Fylde & Wyre CCG.

Mr Shaw expressed concern about the transport issue which had been raised at the consultation meetings and which appeared to have been ignored. Mrs Oliver stated that a meeting was being arranged to discuss the implications of the transport issues; it being noted that this was an issue for the commissioners.

Mrs Swift reminded Board members that they needed to be mindful of the fact that, at present, patients were not necessarily admitted to the unit nearest to their home but to the unit where a bed was available.

7.5 Spiral CIC Update

At this juncture, Mrs Swift declared an interest as a member of the Spiral CIC Board.

- Mr Doherty had visited the Nurse Led Unit and it was interesting to note the work being undertaken regarding terms and conditions.

- Mr Doherty had met with representatives from Spiral from which it was apparent that Spiral wished to be independent and did not think it was appropriate for Trust Directors to be members of their Board.

Mrs Crowshaw asked how the finances had been set up originally.

It was noted that Mrs Swift had received a legal briefing from Hempsons which CIC would need to understand prior to making a decision.

Mr Doherty stated that, provided both organisations understood the implications, and both organisations wished to proceed on that basis, the Trust should accept Spiral's request to be independent.

It was noted that a communications exercise would be needed at Spiral prior to any agreement being implemented.

Mr Shaw suggested that the Trust should offer the opportunity for Spiral to link with the Trust again if it became necessary.

RESOLVED: That Mr Doherty would convey the Board's views to Spiral.

That the Trust would continue to have director representation on Spiral's Board until the contract had been amended and approved.

Action Taken Following The Meeting
The Chief Executive met with Tracy Bush on 14.5.13. and a further meeting is being arranged for the end June.

7.6 ALERT

- Board members were aware of the issues relating to ALERT.

7.7 Developing a Clinical Strategy for Lancashire

- Mr Doherty and Mrs Thompson had attended a Better Value Healthcare event on the 9th May to review the integrated clinical strategy.

- An Away Day was planned on the 21st June for the five NHS Trusts working together.

RESOLVED: That feedback from the Away Day would be reported to the Board.

At this juncture, the Chairman referred to the Morecambe Bay Clinical Strategy Steering Group which Mrs Swift was involved in and Mrs Swift reported on the options from the group.

Mr Doherty stated that the Board needed to have a better understanding of the potential changes which would link in to the work with the five NHS Trusts.

Action Taken Following The Meeting
A verbal update in respect of the Away Day will be reported to the Strategy and Assurance Committee in June 2013.

8. Annual Reports 2012/13

8.1 Audit Committee Annual Report

- This item had been discussed under agenda item 4.

8.2 Clinical Audit Annual Report

8.3 Membership Annual Report

8.4 Patient Relations Annual Report

RESOLVED That the Annual Reports referred to above be approved.

9. Compliance Monitoring Assurance Report

The items included in the Compliance Monitoring Assurance report were noted by the Board.

b) Chief Executive's Monthly Update

Mr Doherty referred to his monthly report which highlighted the following issues:-

- Monitor Quarter 4 Conference Call.
- Induction/Familiarisation.
- Monitor Consultations.
- Working with Key Partners.
- Nurses Day.
- End of Life Posters Launch.
- Facing the Future Together: 1 Trust, 1 Vision, 100 Voices.
- Magic of Volunteering.

With regard to the telephone conversation with Monitor, it was noted that it was becoming increasingly comprehensive. Mr Patel stated that, in future, participants needed to have a view on the issues being triangulated by Monitor.

c) Items for Discussion/Approval

i) Francis Public Inquiry Recommendations – Board Update

The Chairman reported that the afternoon Board Seminar would include detailed discussion about the Keogh Review.

Mrs Thompson reminded Board members that information in terms of an overview had been submitted to the Board at the time of the publication of the Francis Report.

Mrs Thompson outlined the actions taken by the Executive Directors in conjunction with the clinical divisions whereby all the recommendations had been discussed and the key themes had been highlighted and subsequently collated into a matrix with an individual Executive Director/Senior Lead being assigned to each recommendation; it being noted that the recommendations had been divided into those which could be acted upon and those which were not within the Trust's remit.

The Chairman emphasised the importance of all Board members being satisfied with the approach being taken in advance of the detailed discussion at the afternoon Board Seminar.

Mrs Crowshaw commented that this work linked in with the work on the strategy and that some of these initiatives had already been recognised within the Trust and the improvements had been on-going prior to the Francis Inquiry Report.

With regard to the 290 recommendations, it was obvious that Francis' intention was to achieve continuity of care and the Trust was working hard to achieve this.

Discussion took place about the Trust's response to the recommendation on page 2 of the action plan relating to "a system which recognises and applies the values of transparency, honesty and candour".

RESOLVED: That the response in terms of whether the Trust was meeting the recommendation should be amended from "no" to "partial".

Mrs Thompson stated that consideration needed to be given to an arrangement whereby staff could raise concerns without colleagues being blamed and it was suggested that this issue could be addressed at the Corporate Induction under "whistle-blowing".

Mrs Crowshaw challenged how the Board would become aware of any issues of concern in respect of community health services. Mr Doherty stated that the Francis Report related to all NHS organisations but pointed out that the review would focus on the acute side although not exclusively. Mrs Crowshaw confirmed that she was aware of the indicators used to measure services in the community, however, assurance needed to be provided to the Board.

RESOLVED: That the Chief Executive would circulate to Board members information about assurance in relation to community health services.

Mrs Thompson reminded Board members about the introduction of the safety thermometer and the work around pressure ulcers to ensure greater improvement which could be demonstrated.

Action Taken Following The Meeting
The recommendation on page 2 has been amended.

A verbal update will be provided at the Strategy and Assurance Committee meeting in June 2013.

i) Annual Plan 2013/14

Mrs Oliver reported that the Annual Plan, which had been reviewed on several occasions, was due to be submitted to Monitor by the 3rd June.

Mrs Oliver asked for Board members' comments on the narrative by midday on Thursday 30th May, following which the document would be finalised by close of business on the 30th May and submitted on the 31st May.

The Chairman asked about the process and whether improvements could be made to avoid having to review the document a couple of days before the submission date.

Mr Patel pointed out that he had been unable to include the finance narrative within the document in advance of the Board meeting due to the fact that the wording could not be finalised until the Annual Report and Accounts had been approved. It was noted, however, that the narrative had been duplicated in other documents, i.e. Annual Report and Accounts, Going Concern Report, FRR, etc.

Mr Olive asked whether the MES costs had been incorporated into the document. Mr Patel confirmed that the financial model indicated that £0.5 million revenue costs were in reserve for equipment replacement and that the outcome of the MES would not affect this figure.

Mr Patel confirmed that the lack of finance information did not change the materiality.

Mr Doherty provided comments as follows:-

- Page 11 to include wording about the size of the population.
- More reference to be made to transformation.
- Some reference to be made to the fact that life expectancy had increased.
- Appendix 2 to be amended to be slightly more generic.

With regard to the timeline for the document, the Chief Executive proposed that, where possible, more work should be undertaken sooner although he acknowledged that this would be a challenging objective.

Mrs Oliver pointed out that work on the Annual Plan process had started in December 2012 and had been available on Sharepoint since February 2013 and there had been numerous discussions about the content.

It was suggested that the full draft document be discussed at a Board Seminar early in 2014.

RESOLVED: That Board members would forward final comments on the Annual Plan to Mrs Oliver by midday on the 30th May 2013.

That the Annual Plan would be scheduled for discussion at a Board Seminar early in 2014.

Action Taken Following The Meeting
This item has been included on the Board Development Programme for discussion at the Board Seminar in January 2014.

iii) Draft Board Committee Structure Manual

The Chairman referred to the work that had been undertaken in a short timescale in respect of the committee structure.

RESOLVED: That the Quality Committee membership would be amended to include the Chief Executive.

That the Terms of Reference would be amended to include job titles, rather than names, for all committees.

That the membership of the Strategy and Assurance Committee would be reviewed from a legal point of view in terms of all Board members being included within the membership.

That Board members would forward any further comments on the Terms of Reference to Mrs Aubrey by the end of the week.

At this juncture, Mr Garrett referred to updated documents being added to Board-Pad and the fact that any annotations made previously could not be retrieved. Miss Oates explained that there was a method whereby updated documents could be added to Board-Pad without annotations being lost, however, she pointed out that this document had not in fact been updated.

RESOLVED: That Miss Oates would investigate this issue and perhaps ask for advice from ICSA.

Action Taken Following The Meeting
The agreed actions have been addressed.

The Terms of Reference clearly identify the delegated responsibilities of the Strategy & Assurance Committee.

ICSA has confirmed that amended documents should not lose annotations provided the "check-out and edit" method is applied. This then allows users to select the version button on the document and switch between each version allowing annotations to be displayed. This information has been communicated to Board members.

d) <u>Remaining Items Recommended for Decision or Discussion by Board Sub-Committees</u>

i) <u>Finance and Business Monitoring Committee – 22nd April 2013</u>

The minutes of the Finance and Business Monitoring Committee meeting held on the 22nd April 2013 were provided for information.

ii) <u>Audit Committee – 30th April 2013</u>

The minutes of the Audit Committee meeting held on the 30th April 2013 were provided for information.

88/13 <u>Chairman's Monthly Report:-</u>

- The Chairman drew attention to the revised NHS Constitution and, in particular, the revised principles.

- The Chairman reported that he had met with the CCG Chairmen the previous day to discuss the agenda for the Board to Board to Board meeting on the 11th June and that Mr Fisher would be circulating a draft agenda for comments. The Chairman outlined the proposed items for discussion as follows:-

  - Strategic Framework
  - Finance and QuIPP
  - Commissioning Landscape
  - Patient Journey
  - Francis Inquiry
  - Communications

  Mr Patel commented that the finance section should be a whole health economy approach.

RESOLVED: **That Mr Patel would liaise with finance CCG colleagues with regard to the finance item.**

That the draft agenda would be circulated to Board members in due course.

The Chairman emphasised that the meeting would be an excellent opportunity for joint working.

Action Taken Following The Meeting
Discussion took place with CCG colleagues and a joint presentation was formulated.

The draft agenda was circulated to Board members on 5.6.13.

89/13 Attendance Monitoring

The attendance monitoring form was duly noted by the Board.

90/13 Any other Business

a) Contract with Blackpool CCG

It was noted that the contract with Blackpool CCG had been discussed at the Finance and Business Monitoring Committee meeting on the 24th May 2013.

Mr Patel confirmed that the contract was reasonable and was recognised as "good to go" but that the timescale was awaited regarding sign-off of the £3 million.

b) Format of the Meeting

The Chairman asked Mrs Smith for her views about whether improvements could be made with regard to the format of the meeting.

Mrs Smith provided comments as follows:-

- The meeting had been extremely efficient.
- The number of documents had reduced.
- The reports were easy to understand.
- The only issue of concern was around the Chief Executive's assurance report which she did not think highlighted the risk issues and she emphasised the need to be totally open and transparent. Mr Doherty commented that he thought the problem areas had been highlighted, however, he agreed to ensure that future reports emphasised the impact of not achieving some of the targets, etc.

RESOLVED: **That Mr Doherty would review the balance of language used in the assurance report.**

Mr Roff suggested that future reports should include some wording around the level of assurance and the timescale for any further updates.

RESOLVED: **That Mr Doherty would take account of Mr Roff's suggestion in future reports.**

Mrs Smith referred to Mr Shaw's suggestion earlier in the meeting under item 86/13 and suggested the wording "best care in the best place".

Mrs Smith further suggested introducing a monthly draw for those patients who completed the patient survey.

Action Taken Following The Meeting
The agreed actions have been addressed.

c) SUIs

The Chairman referred to the reference reports and challenged whether SUIs would be addressed at the meetings. Dr O'Donnell stated that there was nothing further to add to the report.

Dr O'Donnell advised the Board that he was working with the team to produce a summary of the clinical incidents across the Trust in order to provide a high level view.

With regard to meetings in public, it was acknowledged that a broader view of SUIs would be more appropriate than specifics; it being noted that the specifics would be discussed at the Quality Committee.

d) Quality Improvement Faculty

The Chairman asked Dr O'Donnell to provide an update in respect of the Quality Improvement Faculty.

Dr O'Donnell reported that he had spoken to the national lead at the DoH and also to contacts at Salford and the Health Foundation, all of whom had agreed with the principle of the Trust's plans for a Quality Improvement Faculty but none of whom were able to provide examples of existing models.

It was noted that internal discussions had taken place and it was apparent that, during the course of the next year, significant savings needed to be made and that the primary driver would be finance, however, Dr O'Donnell emphasised the importance of ensuring that quality improvement was the primary driver; it being noted that the PMO would become the back office function to drive the quality improvement resulting in better clinical engagement.

In summary, Dr O'Donnell confirmed that there were no specific plans regarding the Quality Improvement Faculty; it being noted that it was a simple concept but with complicated implications.

e) Presentation to Paul Olive

The Chairman presented Mr Olive with a card and gift and expressed thanks to him for his significant contribution to the Trust during the past 11 years, which was very much appreciated.

Mr Olive accepted the card and gift and stated that he had enjoyed his time at the Trust, some of which had been particularly challenging. Mr Olive outlined the significant amount of change and improvements that had taken place and he commented that he hoped he had made a difference.

f) Presentation to Janet Benson

Mr Doherty presented Mrs Benson with a card and flowers and expressed thanks for her achievements during her short time at the Trust.

Mrs Benson thanked the Board for making her welcome at the Trust and expressed her best wishes to Board members for the future.

91/13 Declaration of Confidentiality

RESOLVED: That items 87/13 (2.1), 87/13 (6.3), 87/13 (7.5), 87/13 (7.7) and 90/13 (c) be declared confidential under the Freedom of Information Act 2000.

That the document status included on the Board reports would indicate the level of sensitivity.

92/13 Date of Next Meeting:-

Strategy and Assurance Committee – Wednesday 26th June 2013 at 8.30 am
Formal Board Meeting – Wednesday 31st July 2013 at 9.00 am

Board of Directors Meeting

Action List - 29th May 2013

Minute Ref	Date of Board Meeting	Issue	Item to be Actioned	Person Responsible	Date to be Completed	Progress	Current Status	RAG Status	Date Closed by Board
85/13 (a)	29.5.13	**Availability of Tools to Assist in Managing Recommendations**	Ensure that this issue is progressed via the ICT Department.	Wendy Swift	31.7.13	The ICT Department has been asked to review the recommendation and this is being addressed.	Complete	Green	
85/13 (a)	29.5.13	**Future Action Lists**	Ensure that the items to be included on the following month's Board agenda are marked "closed" once they have been included.	Judith Oates	on-going	This item has been actioned and will be actioned for future meetings.	Complete	Green	
85/13 (b)	29.5.13	**Feedback from NEDs Visit to Haematology/ Oncology**	Liaise with the Voluntary Services and Community Engagement Officer about increasing the number of volunteers on the unit.	Marie Thompson	5.6.13	The number of volunteers in the unit has increased slightly with existing volunteers who have taken on a new challenge in addition to their existing role. The next stage is to recruit externally and a volunteer recruitment day is taking place in June, following which it is anticipated that new volunteers can be introduced to the department.	Complete	Green	
85/13 (b)	29.5.13	**Feedback from NEDs Visit to Haematology/ Oncology**	Raise the issue of volunteers on the unit at the Voluntary Service Group meeting on 7.6.13.	Wendy Swift	~~7.6.13~~ 31.07.13	This issue was raised at the Voluntary Services Group meeting on 7.6.13. There is a current shortage of volunteers available and action is on-going to address this.	Complete	Green	
85/13 (b)	29.5.13	**Feedback from NEDs Visit to Haematology/ Oncology**	Email the staff on the unit to advise about the positive feedback that has been provided to the Board.	Judith Oates	5.6.13	An email was forwarded to Andrew Heath (Matron), Sue Jones (Ward Sister) and Sue Faul (Ward Manager) on 4.6.13.	Complete	Green	
85/13 (b)	29.5.13	**Main Entrance Multi-Story Car Park**	Provide an update at the Board meeting in June 2013.	Wendy Swift	26.6.13	A verbal update will be provided at the Strategy and Assurance Committee meeting in June 2013.	Complete	Green	
87/13 (a)	29.5.13	**Monthly Assurance Report from the Chief Executive**	Address the issues raised by Board members in relation to the format of the assurance report in the next assurance report to the Board.	Gary Doherty	26.6.13	This item has been actioned.	Complete	Green	
	29.5.13	**Cancer Peer Review**	Address the issues raised by Board members in relation to the Cancer Peer Review at the Board meeting in July 2013.	Gary Doherty	31.7.13	An update will be provided within the CEO Assurance Report to the July Board meeting.	Complete	Green	

87/13 (a)	29.5.13	**Compliance Mandatory Training**	Circulate the report relating to non-compliance to Board members.	Janet Benson/ Jacqui Bate	~~31.5.13~~ 2.8.13	A report reflecting the figures up to the end of July will be circulated to Board members on 2.8.13.	Not Complete Within Date For Delivery	Red	
87/13 (a)	29.5.13	**Corporate Objectives**	Include data relating to longer term issues in the draft corporate objectives to be submitted to the Board in June 2013.	Wendy Swift	~~26.6.13~~ 31.07.13	This action is being implemented and updated Corporate Objectives will be submitted to the July Board meeting.	Complete	Green	
87/13 (a)	29.5.13	**Corporate Objectives**	Include some of the measures in the Chief Executive's Assurance Report.	Wendy Swift	~~26.6.13~~ 31.07.13	This action is being implemented and updated Corporate Objectives will be submitted to the July Board meeting.	Complete	Green	
87/13 (a)	29.5.13	**Spiral CIC Update**	Convey the Board's views to Spiral.	Gary Doherty	5.6.13	The Chief Executive met with Tracey Bush on 14.5.13. and had a further telephone discussion on 12/07/13.	Complete	Green	
87/13 (a)	29.5.13	**Developing a Clinical Strategy for Lancashire**	Provide feedback from the Clinical Strategy Away Day to the Board.	Gary Doherty	26.6.13	The Chief Executive provided an update at the Strategy and Assurance Committee in June 2013.	Complete	Green	
87/13 (c)	29.5.13	**Francis Public Inquiry Recommendations**	Amend page 2 of the action plan from "no" to "partial".	Marie Thompson	5.6.13	This item has been actioned.	Complete	Green	
87/13 (c)	29.5.13	**Francis Public Inquiry Recommendations**	Circulate to Board members information about assurance in relation to community health services.	Gary Doherty	5.6.13	An update will be provided within the CEO Assurance Report to the July Board meeting.	Complete	Green	
87/13 (c)	29.5.13	**Annual Plan**	Forward final comments on the document to Pat Oliver by midday on 30.5.13.	Board Members	30.5.13	This item has been actioned.	Complete	Green	
87/13 (c)	29.5.13	**Annual Plan**	Include the Annual Plan on the Board Development Programme for discussion at a Board Seminar early in 2014.	Pat Oliver/ Judith Oates	5.6.13	This item has been included on the Board Development Programme for discussion at the Board Seminar in January 2014.	Complete	Green	
87/13 (c)	29.5.13	**Draft Board Committee Structure Manual**	Include the Chief Executive in the Quality Committee membership.	Mary Aubrey	7.6.13	This item has been actioned.	Complete	Green	
87/13 (c)	29.5.13	**Draft Board Committee Structure Manual**	Amend the Terms of Reference to include job titles, rather than names, for all committees.	Mary Aubrey	7.6.13	This item has been actioned.	Complete	Green	
87/13 (c)	29.5.13	**Draft Board Committee Structure Manual**	Review the membership of the Strategy and Assurance Committee from a legal point of view in terms of all Board members being included within the membership.	Mary Aubrey	14.6.13	The Terms of Reference clearly identify the delegated responsibilities of the Strategy & Assurance Committee.	Complete	Green	

87/13 (c)	29.5.13	**Draft Board Committee Structure Manual**	Forward comments on the Terms of Reference to Mary Aubrey by close of business on 31.5.13.	Board Members	31.5.13	This item has been actioned.	Complete	Green	
87/13 (c)	29.5.13	**Draft Board Committee Structure Manual**	Investigate the Board-Pad issues raised by Doug Garrett and ask for advice from ICSA if necessary.	Judith Oates	18.6.13	ICSA has confirmed that amended documents should not lose annotations provided the "check-out and edit" method is applied. This then allows users to select the version button on the document and switch between each version allowing annotations to be displayed. This information has been communicated to Board members.	Complete	Green	
88/13	29.5.13	**Chairman's Monthly Report - Board to Board to Board Meeting**	Liaise with finance CCG colleagues with regard to the finance item of the agenda	Feroz Patel	31.5.13	Discussion took place with CCG colleagues and a joint presentation was formulated.	Complete	Green	
88/13	29.5.13	**Chairman's Monthly Report - Board to Board to Board Meeting**	Circulate the draft agenda to Board members in due course.	Judith Oates	5.6.13	The draft agenda was circulated to Board members on 5.6.13.	Complete	Green	
90/13	29.5.13	**Format of the Meeting**	Review the balance of language used in the assurance report.	Gary Doherty	18.6.13	This item has been actioned.	Complete	Green	
90/13	29.5.13	**Format of the Meeting**	Include some wording in the assurance report around the level of assurance and the timescale for any further updates.	Gary Doherty	18.6.13	This item has been actioned.	Complete	Green	

RAG Rating	
Green	Complete within date for delivery
Amber	Incomplete but within date for delivery
Red	Not complete within date for delivery
White	Not yet due

Board of Directors Meeting
Action Tracking Document

Minute Ref	Date of Board Meeting	Issue	Item to be Actioned	Person Responsible	Date to be Completed	Progress	Current Status	RAG Status
225/12(d)	19.12.12	**Succession Planning and Talent Management Strategy**	Discuss the strategy further in three months' time.	Board Members	~~26.6.13~~ 30.11.13	This item will be included on a future Board agenda. This item is scheduled to be submitted to the Board in **June 2013.** This item has been deferred pending the appointment of a HR Director. A HR Director was appointed on 9.7.13 and this item will be actioned once in post.	Not Complete Within Date For Delivery	Red
20/13	27.2.13	**KPMG Independent Review of Quality Governance – Draft Report and Draft Action Plan**	Liaise with KPMG about which Trusts have been successful in terms of publicising useful and real-time data in order that the Trust can learn from best practice.	Dr Mark O'Donnell	~~6.3.13~~ 30.9.13	Dr O'Donnell contacted Dr David Rosser, Medical Director at University Hospital Birmingham, on 12.4.13 regarding real-time data. A visit to Birmingham is in the process of being arranged and is likely to take place in September 2013.	Not Complete Within Date For Delivery	Red
28/13 (b)	27.2.13	**Patient Story Feedback**	Consider the issue of inviting representatives from local patient groups to report to the Board on patient care, and submit ideas to the Board in March 2013.	Marie Thompson	~~27.3.13~~ 31.7.13	This issue will be revisited following the introduction of the new Board format.	Not Complete Within Date For Delivery	Red
33/13 (h)	27.2.13	**Chairman's Communications**	Liaise with Neil Jack regarding the CVS representation on the Council of Governors.	Wendy Swift	~~6.3.13~~ ~~29.5.13~~ ~~26.6.13~~ 31.7.13	Initial discussion has taken place with Neil Jack regarding representation from the third sector and arrangements are being made for further discussions to take place. An update was provided to the Board in March 2013 and Wendy Swift will initiate further discussion. A verbal update was given to the Board in May. No further update is available at this time.	Not Complete Within Date For Delivery	Red
42/13	27.3.13	**Voluntary Services Presentation**	Report progress from the Voluntary Services Committee to the Board in six to nine months' time including the suggestion of a Volunteers' Conference and also a Volunteer's Story to the Board.	Wendy Swift	25.9.13	This item has been included on the draft agenda for the Board meeting in **September 2013**.	Not Yet Due	White

49/13(b)	27.3.13	**Feedback from NEDs Visit - 25.3.13**	Arrange for the NEDs to visit the Radiology and Pathology Departments, possibly in July 2013.	Judith Oates	~~29.7.13~~ 31.8.13	Arrangements will be made for the NEDs to visit the Radiology and Pathology Departments following liaison with Pat Oliver. Arrangements have been made for the visit to take place on 29.7.13. The visit is being re-arranged to take place on the same day as the next NEDs meeting.	Not Complete Within Date For Delivery	Red
49/13(e)	27.3.13	**National Review into the Quality of Care and Treatment**	Ensure that the requirements within the DoH letter are implemented by the end of December 2013.	Marie Thompson	31.12.13	This item is on-going.	Not Yet Due	White
70/13(a)	24.4.13	**Strategic Direction Update**	Arrange a Board to Board meeting with Lancashire North.	Judith Oates	~~30.6.13~~ 31.7.13	Contact has been made with the Secretary to the Governing Body at North Lancashire CCG and a response from their Chief Officer is awaited. Further contact has been made and a decision is awaited about whether to arrange a Board to Board meeting or an Executive Team to Executive Team meeting.	Not Complete Within Date For Delivery	Red

RAG Rating	
Green	Complete within date for delivery
Amber	Incomplete but within date for delivery
Red	Not complete within date for delivery
White	Not yet due

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust

Urgent/High Priority Actions following the Review into the Quality of Care & Treatment

Gary Doherty, Chief Executive

11th July 2013

The Board and I are grateful to the Review Team

both for the way the review was conducted but also for the outcome, which has either confirmed our thinking or raised new areas that will be addressed to make sure we meet the highest standards, both as a provider of care for patients and their families and as an employer

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Committee
Chair: CEO

Fylde Coast Commissioning Advisory Board

Better Care Now Project Board
Chair : Director of Operations

Pathways
Chair : Divisional Director, Unscheduled Care

Delays
Chair : Deputy Medical Director

Workforce
Chair : Medical Director & Director of Nursing

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Problem Identified	Action to Be Taken	When	Lead
Disconnect between those that deliver services and those that set strategic direction	• Review of current engagement processes to immediately increase visibility/engagement e.g. Exec /Leadership patient safety walkabouts, CEO (Chief Executive Officer) question time, refresh of vision and values.	July	CEO
	• Agreement /implementation of new approaches e.g. Listening into Action	Sept	CEO
	• CEO , Executive Team Road shows with staff - Trust wide	July/Aug	CEO
	• CEO , Executive Team Road shows - Unscheduled Care	July/Aug	CEO

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Problem Identified	Action to Be Taken	When	Lead
The pace of change at the Trust in the past couple of years has been slow	• New Programme structure with dedicated Project Management Support	Aug	Director of Operations
	• Daily monitoring of compliance with mission critical points on pathways - with appropriate action/escalation: ➢ Pneumonia ➢ Stroke ➢ Sepsis ➢ MI	August September October November	Director of Operations
	• Establishment of Quality Improvement Faculty	August	Medical Director
	• Review/changes to current engagement processes and initiatives	Sept	CEO

Problem Identified	Action to Be Taken	When	Lead
The incident review system is inconsistent with respects to reporting, classification, multi-disciplinary investigation and dissemination of findings	• Roll out the Families Division system including re-launching the incident reporting policy	Aug onwards	Director of Nursing
	• Do/act on gap analysis so sufficient IT equipment is available	Aug	Director of Transformation
	• Introduce random audits of incidents where the score is reduced, with results being reported to the Quality Committee	July	Director of Nursing
	• Review TalkSafe roll out and target on those areas of greatest risk	Aug	Director of Nursing/Medical Director
	• Review processes for learning from SUI's & link to educational opportunities in the simulation suite / clinical skills centre.	Aug	Director of Nursing/Medical Director

Problem Identified	Action to Be Taken	When	Lead
Medical and nursing staffing levels and skill mix were not appropriate or well managed. The Trust has recruitment challenges particularly with regards to consultants and nurses.	• Strengthen existing approaches to reviewing staffing and skill mix	July	Director of Nursing/ Medical Director
	• Staffing level review by MD & DoN.	July	Director of Nursing/Medical Director
	• Increased out of hours agency nursing support	July & Ongoing	Director of Nursing
	• Benchmark nurse staffing & consider need for external review	Aug	Director of Nursing
	• Review of current escalation options/decision making, including discussion with partners	Aug	Director of Operations
	• Produce Workforce Strategy, working with CCG's, Primary Care , Deaneries, Universities & other Trusts	Oct	Interim Director of HR

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Problem Identified	Action to Be Taken	When	Lead
Medical and nursing staffing levels and skill mix were not appropriate or well managed. The Trust has recruitment challenges particularly with regards to consultants and nurses.	• Enhance the Weekly Performance reports to the Exec team (vacancy levels and staff shortages/transfers between wards) with monthly profile set to improve in all areas	July & Ongoing	Interim Director of HR
	• Develop report to triangulate key data (e.g. vacancies, SUIs, falls, infections, complaints, staff satisfaction etc) to report to the Quality Committee	Sept	Director of Operations
	• Review all consultant job plans in medicine & surgery to reduce pressure on external recruitment – and then agree those areas for immediate recruitment outside of traditional business case process	Aug	Director of Operations /Medical Director

Problem Identified	Action to Be Taken	When	Lead
The panel heard mixed reports from nursing and medical staff regarding the visibility of the leadership team, particularly out of hours	• Increase senior visibility out of hours.	July	CEO
	• CEO , Executive Team Road shows with staff - Trust wide	July	CEO
	• CEO , Executive Team Road shows - Unscheduled Care	July	CEO
	• Review existing processes for Board visits to patient care areas and agree how to strengthen	Aug	CEO/Chairman

Problem Identified	Action to Be Taken	When	Lead
The panel evidenced a number of patient safety concerns during the announced and unannounced visits	• Action plan to be developed to address all issues highlighted within the review (page 46-52) • Areas actioned to date – Ward 12 toilets – work starts Aug Pressure Relieving Mattresses Drug Storage HDU Phase V storage areas Ward 35 retrospective SUI review Safety Crosses – updated	Aug	Director of Operations

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Problem Identified	Action to Be Taken	When	Lead
The panel evidenced the infection control policy not being implemented	• Updated Integrated Staph Aureus Care Pathway launched 13th June 2013	Complete	Director of Nursing
	• Immediate visit to ward 23 & 24 by Divisional Lead Nurse & DoN	Complete	Director of Nursing
	• Read and sign process – all wards	By15/07/13	Director of Nursing
	• Audit of compliance	Aug	Director of Nursing

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Problem Identified	Action to Be Taken	When	Lead
To ensure improvements are sustainable, a programme of transformation and engagement is needed	• Agreement /implementation of new approaches to Trust wide staff engagement in service improvement & cultural transformation	Sept	CEO
	• Review existing arrangements for patient and public involvement and agree how improvements can be made	Sept	Director of Nursing
	• Ensure that whole health system clinical pathways are reviewed and transformed, with a particular focus on frail elderly patients	October	Director of Transformation Director of Operations

Problem Identified	Action to Be Taken	When	Lead
Give full support to, and receive support from, all key NHS stakeholders	• Participate fully in existing clinical networks and work with the Lancashire Area Team in the development and implementation of a Lancashire Clinical Strategy, to ensure that future service models/configurations offer high quality, sustainable care	March	CEO/Medical Director
	• Health Education North West to work in partnership with the Trust to minimise gaps in trainee rotas	October	Medical Director/ Interim Director of HR

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Conclusion

- Much to be done – we are sorry that some of the care we provide is not that of a high performing Trust
- Many strengths to build on to help us meet the highest standards, both as a provider of care and as an employer
- Emphasis will be on focussed actions to deliver specific milestones

Report for Blackpool Teaching Hospitals NHS Foundation Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

RAPID RESPONSIVE REVIEW REPORT FOR RISK SUMMIT

July 2013

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1. Introduction

Overview of review process

On 6 February 2013 the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Definitions of SHMI and HSMR are included at Appendix I.

These two measures are intended to be used in the context of this review as a 'smoke alarm' for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) **Patient and public participation** – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals and also considered independent feedback from stakeholders, related to the Trust, which had been received through the Keogh review website. These themes have been reflected in the reports.

2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be publicly available.

4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these trusts.
- Identify:
    i. Whether existing action by these trusts to improve quality is adequate and whether any additional steps should be taken.
    ii. Any additional external support that should be made available to these trusts to help them improve.

iii. Any areas that may require regulatory action in order to protect patients.

The review follows a three stage process:

- **Stage 1 – Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLOEs). The data pack for each trust reviewed is published at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/blackpool-data-packs.pdf.

Stage 2 – Rapid Responsive Review (RRR)

A team of experienced clinicians, patients, managers and regulators (see Appendix II for panel composition), following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and departments, interviewing patients, trainees, staff and members of the Board. The report from this stage will be considered at the risk summit.

- **Stage 3 – Risk summit**

This brought together a separate group of experts from across health organisations, including the regulatory bodies. They considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned. A report following each risk summit is made publically available.

Methods of Investigation

The two day announced RRR visit took place at the Trust's main site, Victoria Hospital on Monday 17 June and Tuesday 18 June 2013. A variety of review methods were used to investigate the KLOEs and enable the panel to consider evidence from multiple sources in making their judgements.

The visit included the following methods of investigation:

- **Interviews**

Twelve interviews took place with key members of the Board and selective members of staff. The interviews were based on the key lines of enquiry during the visits. See Appendix III for details of the interviews undertaken.

- **Observations**

Ward observations enabled the panel to see the Trust undergo its day to day operations. They allowed the panel to talk to current patients and their families, where observations took placed during visiting hours. They allowed the panel to speak with a range of staff and observe the quality of care and treatment being provided to patients. The panel was able to observe the action taken by the Trust to improve quality in practice and consider whether any additional steps should be taken.

Observations took place in nineteen areas of the Trust, split across two of the hospital sites; Victoria Hospital and Clifton Hospital. See Appendix IV for details of the observations undertaken.

- **Focus Groups**

Focus groups provided an opportunity to talk to staff groups individually and to ask each area of staff what they feel is good about patient care in the Trust and what needs improving. This enabled staff to speak up if they feel there is a barrier that is preventing them from providing good quality care to patients and what actions might the Trust need to consider improving, including addressing areas with higher than expected mortality indicators.

Focus groups were held with six staff groups during the announced site visit. See Appendix V for details of the focus groups held.

The panel would like to thank all those who attended the focus groups who were open with sharing their experiences and were balanced in their perceptions of the quality of care and treatment at the Trust.

- **Listening events**

Public listening events give the public an opportunity to share their personal experiences with the Trust, and to voice their opinion on what they feel works well or needs improving at the Trust in relation to the quality of patient care and treatment. A listening event for the public and patients was held on the evening of 17 June 2013 at De Vere Village Hotel and Leisure near the main Blackpool Victoria Hospital site. This was an open event, publicised locally, and attended by c.120 members of the public and patients.

The panel would like to thank all those attending the listening event who were open in sharing of their experiences and balanced in their perceptions of the quality of care and treatment at the Trust.

- **Review of documentation**

A number of documents were provided to the panellists through a copy being available in the panel's 'base location' at the Trust during the site visit. Whilst the documents were not reviewed in detail, they were available to the panellists to validate findings as considered appropriate. See Appendix VI for details of the documents available to the panel.

- **Unannounced visit**

The unannounced site visit took place at Blackpool Victoria Hospital on the evening of Sunday 23 June 2013. This focused observations in identified areas from the announced site visit, see Appendix VII.

Next steps

This report has been produced by Mike Bewick, Panel Chair, with the full support and input of panel members. This report was issued to attendees at the risk summit, which will focus on supporting Blackpool Teaching Hospitals NHS Foundation Trust ("the Trust") in addressing the actions identified to improve the quality of care and treatment.

Following the risk summit a final version of the report and agreed action plan is published alongside this report on the Keogh review website.

A report summarising the findings and actions arising from the 14 investigations will also be published.

2. Background to the Trust

This section of the report provides background information on the Trust and highlights the areas identified from the data pack for further investigation.

Introduction

Blackpool Teaching Hospitals NHS Foundation Trust in the North West services a population of 440,000. The Trust has one acute hospital site, Blackpool Victoria Hospital. In addition, the trust has two community hospitals, three elderly rehabilitation hospitals, and two other specialist units. Blackpool became a Foundation Trust in 2007 and has a total of 811 beds.

3.4% of the Trust's population belong to non-White ethnic minorities, particularly White and Black Caribbean, and Asian. Smoking during pregnancy and violent crime are particular health concerns for this area.

Finally, the Trust's HSMR and SHMI levels have been above the expected level for the last 2 years and the Trust was therefore selected for this review.

Key messages from the data analysis

The Trust data pack identified a number of key concerns that were used to inform the KLOEs, which are outlined below[1].

Mortality

The Trust has an overall HSMR of 111 for the period January 2012 to December 2012, meaning that the number of actual deaths is statistically above the expected range. Further analysis of this figure demonstrates that non-elective admissions are the primary contributing factor to this figure with an HSMR of 112, also above the expected range.

Currently Blackpool has a SHMI of 114, which is statistically above the expected range. Similar to HSMR, non-elective admissions are seen to be contributing primarily to the overall Trust SHMI with a similar higher than expected figure of 118. Treatment specialities that had higher than expected mortality levels and warranted further investigation were: thoracic medicine, critical care medicine and general medicine.

Blackpool has a large number of alerts and outliers for mortality and is the only trust to meet the selection criteria for both SHMI and HSMR. Patient groups alerted more than once since 2007 are: ischaemic heart disease, acute myocardial infarction, pneumonia and unspecified acute lower respiratory infection.

The Trust identified issues around delays in a senior medical review, timeliness of antibiotic provision, clarity of coding and documentation and fluid balance monitoring. An AQuA (Advancing Quality Alliance) review of Blackpool's mortality rates in early 2012 resulted in a number of recommendations for the trust.

[1] For further information and explanations on the data analysis used please see the published data packs please at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/blackpool-data-packs.pdf

The KLOEs for the RRR informed the panel's observations and interviews to include a review of the specialities in the Trust with higher than expected mortality indicators.

Governance and leadership

There has been significant turnover at Board level in the past 12 months. The Chairman and Medical Director took post in April 2012, the Chief Executive Officer (CEO) left in November 2012 and his successor took post in April 2013. The acting CEO, who was Director of Finance, left in March 2013 as did the Director of Human Resources & Organisation Development; there are acting Directors currently in those two posts. Also the non-executive Chair of Audit Committee retired in May 2013.

A new Board Committee Structure was agreed by the Board in January 2013 and the Sub-Board Committees have been streamlined. Quality Governance arrangements are scrutinized through a number of standing sub-board Committees, in particular a Healthcare Governance Committee which is chaired by the Chief Executive.

A recent CQC inspection at Blackpool Victoria Hospital has found the Trust to be compliant with all outcomes reviewed.

The Trust has identified its highest risks to quality as being mortality, demography and primary care services, medical and nursing workforce, infrastructure and capacity, admission pressures and the Lancashire & Cumbria System Impact reviews.

A high level review of the effectiveness of the Trust's quality governance arrangements was a standard key line of enquiry for the review.

Clinical and operational effectiveness

With 94% of A&E patients seen within 4 hours, which is below the 95% national standard, the Trust has one of the lower percentages from the selected Trusts in this review. However, local data including the co-located Urgent Care Centre indicates the Trust achieved the 95% standard for 2012/13. 94.1% of patients are seen within the 18 week RTT (referral to treatment) target time which is above the national standard and places the Trust in the top half of the trusts being reviewed.

The Trust's crude readmission rate is among the higher readmission rates nationally, at 13.4%. The standardised readmission rate shows Blackpool is within the expected range with an average length of stay of 5.37 days, which is slightly higher than the national mean of 5.2 days.

The Patient Reported Outcome Measures (PROMs) dashboard shows that the Trust was a relatively poor performer in general. The Trust had three instances when it was classified as a negative outlier below the 99.8% control limit. It had a further four occasions where one of the measures returned a score between two standard deviations (95%) and three standard deviations (99.8%) below the average score for England.

In the National Clinical Audits, Royal Lancaster Infirmary; used by the Trust, and Blackpool Victoria Hospital; belonging to the Trust, are outliers.

High level reviews of clinical and operational effectiveness measures were standard KLOEs.

Patient experience

In the Cancer survey, 19 of the 58 questions placed the Trust in the bottom 20%, with no questions in the top 20%. The main concerns were around diagnostics, finding out what was wrong, and deciding on the best treatment.

The Ombudsman's report rated the Trust as B-rated for complaints handling and satisfactory remedies and also low risk of non-compliance, but observed that it was likely to be downgraded at the next review. The Ombudsman investigates complaints escalated to it by complainants who are not satisfied with the Trust's response. It rates Trusts on whether they have implemented the recommendations made at the end of an investigation in a satisfactorily and timely manner, helping to ensure that Trusts learn from mistakes. The Ombudsman rates each Trust's compliance with recommendations and focuses on monitoring organisations whose compliance history indicates that they present a risk of non-compliance. The Trust was above average for complaints escalating to the ombudsman and in the top 50 for complaints overall. There had been two cases of service failure, possibly indicating wider organisational failure.

Regarding the comments recorded on CQC's patient voice system, 85% were negative, with comments focussing on understaffing, bullying, neglect, lack of dignity, poor attitudes and inconsistent advice. Whilst the Trust had an average score on the inpatient survey overall, there were negative indications around information given to patients, doctors responses to questions and delays in the discharge processes.

Keogh review patient voice comments

The patient voice comments received directly to the Keogh review website (at the time of writing this report) identified the following themes from 19 emails and letters:

Positive	Negative
Excellent care and treatment received	Long waiting times for treatment
The relationship between clinicians and coders is improving. The Trust is pursuing a range of initiatives to improve quality and safety of patient care.	Lack of staff on the wards
	Staff not listening to patient concerns
	Patients felt there was a lack of care
	Some members of staff did not feel able to express views in front of management
	Concerns over treatment of elderly patients
	Patients being discharged when they do not feel in a safe condition to leave

A KLOE was included in the review focusing on what patients say about the quality of care and treatment and what the Trust was doing in response to this feedback.

Workforce and safety

In recent months, the Trust's new pressure ulcer prevalence rate has fallen, and has been below the national rate for all but four of the last 12 months. It is apparent that the prevalence rate of total pressure ulcers for the Trust has been largely above the national average over the last 12 months. However, the data also shows that the Trust has been below the average of the selected 14 trusts in this review, for the majority of this time period.

The Trust's medical staff and nursing staff sickness absence rate is above the national average, and the agency staff costs, as a percentage of total staff costs, are slightly higher than the regional median. The Trust has a patient per whole time equivalent staff rate of 21, which is lower than the average capacity of the other trusts nationally.

Also, the consultant appraisal rate of Blackpool is just below 59%, which is among the lowest of the trusts included in this review. The Trust informed the panel that the consultant appraisal rate at the time of the announced visit has increased to 68%.

KLOEs were included in the review focusing on workforce strategy, staffing matters and patient safety.

3. Key Lines of Enquiry

The Key Lines of Enquiry (KLOEs) were drafted using the following key inputs:

- The Trust data pack produced at Stage 1 and made publicly available.
- Insights from the Trust's Clinical Commissioning Groups (CCG), Blackpool CCG, and Fylde and Wyre CCG
- Review of the patient voice feedback received specific to the Trust and prior to the site visit.

These were agreed by the panellists at the panel briefing session prior to the RRR visit. The KLOEs identified for the Trust were as follows:

Theme	Key Line of Enquiry
Governance and leadership	1. Can the Trust clearly articulate its governance process for assuring the quality of treatment and care?
	2. How does the Trust use information locally?
Clinical and operational effectiveness	3. What governance arrangements does the Trust have to monitor and address clinical and operational performance data at a senior level?
Patient experience	4. How does the Trust engage with patients, their families and carers?
Workforce and safety	5. In the context of this review, can the Trust describe its workforce strategy?
	6. How is the Board assured that it has the necessary workforce deployed to deliver its quality objectives?
	7. What assurance does the Board have that the organisation is safe?

4. Review findings

Introduction

The following section provides a detailed analysis of the panel's findings, including good practice noted, outstanding concerns and prioritisation of actions required.

Summary of findings

A number of areas of good practice were identified as part of our review, notably:

- The Trust has an effective Board structure which fully supports the new Executive team in place;
- Mortality and morbidity meetings are held to understand the causes of mortality;
- The Board is pro-active in identifying ways of improving patient experience and patients reported positive experiences on many of the wards;
- There was a high level of commitment and compassion displayed by frontline staff during the visit, and amongst the Consultant group, some who are keen to implement change.

The main priority areas identified for action in each of the key lines of enquiry themes are below.

Governance and Leadership:

The pace of change at the Trust has been slow. The leadership team at the Trust has been trying to do too much and needs to focus on the key areas of concern – The Board should concentrate on the mission critical actions that need to take place to address the mortality concerns in the areas where it is an outlier. The Board should consider forming a project team of senior clinicians to develop and implement action plans to address the mortality concerns at the Trust. In addition, the Board should assure themselves that governance processes identify areas for improvement as they emerge rather than responding once the issue is out of control. The Board should also ensure all of the major programmes that it manages have a strong project management framework, with clear milestones to aid with prioritisation and the tracking of progress. There needs to be a coordinated approach to the implementation of change within the Trust and the focus should be on a bottom-up approach to change, rather than top-down. A number of good initiatives have been put in place at the Trust, but with apparently little success in terms of front-line ownership.

Patients and staff felt that the Trust Board needed to improve communication with them. There appears to be a considerable disconnect between those that deliver services, especially acute care and those that set strategic direction – The Trust should review how it communicates with its staff to ensure that there are systems in place to effectively share learning from incidents and complaints reporting with its staff and to ensure that good practice is shared between wards. The Trust should also expedite the implementation of the Patient Experience Revolution training programme to help staff communicate more effectively with patients.

Governance of serious incidents - The process around the classification of serious incidents is not sufficiently robust to provide consistency. This has resulted in incidents being graded as less serious incidents that should have been classified as SUIs (Serious Untoward Incidents). Additionally, the investigation of SUIs did not display a

consistent MDT (multi-disciplinary team) approach and did not have a designated Executive lead. Finally, the dissemination of findings from SUIs was not reliable and did not achieve the required penetration within the Trust.

Clinical and operational effectiveness:

Although regular mortality and morbidity meetings are held in some departments, the pace of change being implemented from these forums is slow, lessons are not always learned and some important staff groups do not feel involved in the process – The process for reviewing mortality and morbidity across the Trust should be standardised, and must allow for multi-disciplinary attendance. Where issues are identified, the Trust should seek external and specialist support to review cases and identify actions.

Staff described a number of pathways and innovative approaches that had improved patient care, however the panel did not observe the pneumonia pathway in use - The Board should ensure that all pathways have a clear and monitored implementation plan, not just with respect to the roll out process, but also outcomes in terms of use of the pathway and improving mortality. Key pathway compliance should be audited regularly and fed back to the appropriate clinical areas (e.g. pneumonia & COPD, chronic obstructive pulmonary disease) in respiratory ward, fractured neck of femur on Trauma & Orthopaedics (T&O ward) and shared with the CCG routinely.

Patient experience:

Patients felt that staff did not always communicate effectively with them – The Trust should ensure that front-line staff are communicating with patients in an effective and compassionate manner. The Trust should also expedite the implementation of the Patient Experience Revolution training programme to help staff communicate more effectively with patients.

Patients were also concerned about staffing levels at the Trust – The Trust should implement the actions identified in the workforce and safety section below to address patients concerns about staffing levels.

Workforce and safety:

As acknowledged by the Board, the Trust has recruitment challenges, particularly with regards to consultants and nurses - The Trust needs to identify innovative ways to recruit and retain nurses and medical staff and should work with partners in the local health economy (e.g. CCGs and other trusts). The Trust should reconsider its approach to requiring new Consultant appointments to be approved through a business case. A potential approach may be to set aside pre-agreed funds so that consultants can be hired when they are needed.

Review of staffing rotas and discussions at focus groups found that medical and nurse staffing levels and skill mixes were not appropriate or well managed - The Trust needs to urgently assure itself that whilst recruitment of more staff is underway, the current staffing levels at the Trust are safe, particularly on late shifts and out of hours, until further nurses and medical staff are recruited. The Trust should adopt a policy of minimum safe staffing levels on all wards, monitor compliance with the policy and run twice yearly formal establishment reviews using a validated acuity and dependency tool.

Patient safety issues - A number of patient safety issues were evidenced by the panel which are listed in the ‘patient safety’ section. The Trust should ensure it urgently develops an action plan to implement improvements in the specific wards and departments listed.

The following definitions are used for the rating of recommendations in this review:

Rating	Definition
Urgent	The Trust should take immediate action to respond to these recommendations and ensure improvement in the quality of care.
High	The Trust should develop a response and action plan for these recommendations to ensure improvement in the quality of care.
Medium	The Trust should implement these recommendations to ensure ongoing improvement in the quality of care.

Governance and leadership

Overview

The panel's focus for governance and leadership was the Trust's governance processes for assuring the quality of treatment and patient care and how well this was embedded throughout the organisation.

Through staff interviews, focus groups and review of governance documentation, the panel tested whether staff at all levels could describe the key elements of the quality governance processes, i.e. policies and procedures, escalation, incident reporting and risk management.

The panel also investigated how information was used locally within the Trust.

Summary of findings

The following good practice was identified:

- The Trust has an effective Board structure which fully backs the new Executive team in place. The Trust staff displayed an open culture and the leadership team is proactive in looking for solutions to the problems they encounter.
- The Trust recognises the fact that the mortality indicators in certain treatment areas are higher than what they should be and has established a mortality board to oversee activities in this area. The Trust has also appointed a Lead for Informatics who ensures mortality information is available both at the Board level as well as to all directorates.
- The Trust has an engaged and enthusiastic staff group which provided positive feedback about the leadership team, recognising the work that was taking place to improve the Trust.

The following areas of concern were identified:

- The pace of change at the Trust has been slow. The leadership team at the Trust has been trying to do too much and needs to focus on the key areas of concern.
- The Trust has significant staffing and recruitment challenges. There are also gaps in the leadership team that need to be filled with permanent appointments.
- Communication was raised as a major concern, both from patients and staff groups. The governance structure is unwieldy and, to a degree, disconnected from the operational structure. There appears to be a considerable disconnect between those that deliver services, especially acute care and those that set strategic direction.
- The incident review system is unreliable in terms of consistent classification of serious incidents, multi-disciplinary investigation and dissemination of findings.

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Good practice identified
The Trust has an effective Board structure which fully backs the new Executive team in place. Recent appointments to the Board, including the Chairman and Chief Executive (CE) were strong features of this leadership team. The Non Executive Directors (NEDs) also showed high levels of engagement and good knowledge of the activities taking place at the Trust.
The Trust displayed an open culture and the leadership team is proactive in looking for solutions to the problems they encounter. The Trust has invited external reviews from various organisations such as AQuA (Advancing Quality Alliance), KPMG and the Royal Colleges to support its development and improve performance. The Trust recognises that it has challenges related to mortality and staffing that it needs to address, and it has begun to formulate plans to address these issues.
Following the Mortality review by AQuA a mortality board has been established which monitors mortality across the Trust. It is chaired by the CE and reports outcomes from all parts of the organisation. The Trust has also appointed a Lead for Informatics who ensures information is available both at the Board level as well as to all directorates. Close working at senior management level is established. This lead is dedicated to the mortality agenda.
The Trust has an engaged and enthusiastic staff group which provided positive feedback about the leadership team, recognising the work that was taking place to improve the Trust. For example, staff commented positively about the existence of mortality review groups and on the improvements being made to the facilities at the hospital, including wards and car parking.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i)Pace of change Although not helped by a number of changes in the senior leadership team, the pace of change at the Trust in the past couple of years has been slow. Although the Trust has been proactive in terms of conducting external reviews, e.g. AQuA, they have been slow to implement the actions following on from these reviews. When reviewing documentation provided by the Trust, including notes from Board meetings, the panel noted a number of actions that have been due to take place for a number of months	When interviewed the CE and Chairman acknowledged that they do need to focus on the “mission critical” actions at the Trust in the future.	The Trust’s Board should concentrate on the mission critical actions that need to take place to address the mortality concerns in the areas where it is an outlier. The Trust should consider forming a project team of senior clinicians, led by an Operational Manager, to develop and implement action plans to address the mortality concerns at the Trust. This team should be backed by the Board, with external support provided where required. In the longer	Urgent High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
that have not been implemented yet. The number of actions that the leadership team is looking to implement is also too high. This may be hampering the speed of change of the critical actions that the Trust needs to complete. For example, the Trust is looking to implement in excess of 50 new pathways in response to the mortality concerns at the Trust. The Trust may be more effective if it concentrated on the most important areas where it has mortality concerns. The panel observed that milestones for implementing actions were not clearly defined or in some cases were non-existent. This may also be contributing to the delay in implementation. When interviewed, the NEDs agreed that the pace of change has been a point of frustration for them.		term, these change management skills should be developed within the Trust. The lines of accountability should be made clear so as not to undermine the Trust's divisional structure. The Trust's Board should also ensure all of the major programmes that it manages have a strong project management framework, with clear milestones to aid with prioritisation and the tracking of progress. This should be made transparent to staff who are implementing change so that they are clear on the objectives and milestones.	High
Communication A number of communication challenges were found at the Trust: • Information was not being systematically shared across the Trust. This inhibits the pace of change and means that the Trust is not using its resources in the most effective manner. For example, the stroke ward has a long waiting time for pressure relieving mattresses whereas ward 34 (trauma and orthopaedics) has a stock of spare mattresses. Sharing best practice on management of this issue has not been shared	The Trust is currently delivering the Patient Experience Revolution, which is a patient experience training programme aimed at helping staff be at their best for more of the day and become more resilient. It is intended to give staff a voice to raise concerns and to teach them to listen more effectively to patients.	There needs to be a coordinated approach to the implementation of change within the Trust and the focus should be on a bottom-up approach to change, rather than top-down. A number of good initiatives have been put in place at the Trust, but with apparently little success in terms of front-line ownership. This should include: • Creating a Trust-wide system that ensures all	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
between the wards. • Good practice areas found in a number of wards in the hospital (as outlined in this report) were not being shared with other wards. • There is disconnect between what the Board assumes is being implemented and what is actually being done. The Board considers the clinical policy forum as an important quality governance tool, however the clinical policy forum meetings are not well attended. The mortality and morbidity meetings at department level are of mixed rigor. • Some senior clinicians expressed a lack of engagement on some key decisions made at the hospital. For example, the workforce change across therapy services to deliver seven day working was not discussed with key stakeholders who felt very strongly that they would have been able to engage and support the Trust in delivering a high quality therapy service. • There is a lack of connectivity between the Board and clinical leads. This was confirmed to the panel in an interview held with Executive Nurse. • There is a considerable disconnect between those that deliver the services especially in acute care and those that set the strategic direction. • Patients raised mechanisms for and speed of communication as one of their main concerns with the Trust, particularly response times, transparency and face-to-face communication. . *Details of the communication issues raised by patients are shown in the **Patient Experience** section.*		wards have the same access to important equipment, such as pressure relieving mattresses. *Recommendations made in the **'Patient Safety'** section.* • The Board should ensure there are systems in place to disseminate good practice between wards. For example through regular meetings to share best practice between different departments and wards. • The Board should ensure all senior clinicians are capable and confident in managing difficult conversations. They should consider whether this should be part of the Consultant mandatory training programme. • There should be more senior presence in clinical areas which would demonstrate support, increase scrutiny, improve the flow of information and potential for cross fertilization of improvements. This would also improve board intelligence of implementation of decisions and plans. • The Board should ensure that senior clinicians are engaged in decision making to aid timely implementation of changes made. • The Obstetrics team has a rigorous system of reviewing clinical incidents and passing the information / learning points to staff not at the meetings via a newsletter. The Trust should consider spreading this practice across the hospital.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(iii)Governance of Serious Incidents The process around the classification of serious incidents is not sufficiently robust to provide consistency. This has resulted in incidents being graded as less serious incidents, where they should have been classifies as SUIs. Additionally, the investigation of SUIs did not display a consistent MDT approach and did not have a designated Executive lead. The Trust Executive team informed that panel that all SUIs have a designated Executive lead or Deputy Director as outlined in the Trust policy. Finally, the dissemination of findings from SUIs was not reliable and did not achieve the required penetration within the Trust. An example of this is recorded in the section on aspiration pneumonia. *Please also see **'Patient Safety'** section for Reporting of serious incidents.*	None noted	The Board should assure themselves that serious incidents have been graded correctly especially those where the incident has been downgraded. The Trust should ensure that learning from serious incidents are disseminated throughout the Trust in a consistent manner. *Please also see **'Patient Safety'** section for Reporting of serious incidents.*	High
(iv)Staffing levels and recruitment There are also some gaps at the Board level that require permanent appointments, e.g. HR Director and Finance Director. These appointments are key to embedding the culture change required at the Trust and in ensuring that staff are engaged with the change agenda. Making these appointments permanent is key in empowering these important leadership positions. The Trust's Board has some significant challenges in	None noted (there is a workforce strategy in place but not a strategy to appoint directors).	The Trust should look to make permanent appointments to the vacancies it has at Board level as soon as possible. *Please see the **Workforce and Safety** section for the recommendations related to the wider workforce issues.*	Medium Urgent (raised in Workforce and Safety section)

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
ensuring staffing levels are adequate and in meeting the recruitment targets it has set in its workforce strategy. *These are discussed further in the **Workforce and Safety** section, but are noted here as a significant leadership challenge.*			
(v) Governance structure The governance structure is unwieldy and, to a degree, disconnected from the operational structure. There are too many sub board groups. The current arrangements for quality lack focus and require a single line of reporting to the Executive team. Various executives may be involved in a number of committees, but the opportunity for the Executive team to see the whole quality agenda does not seem to exist.	The Trust informed the panel that at the time of the review the Board was in the process of introducing a new Board Governance Structure.	The Trust should consider integrating the Quality, Strategy and Assurance and Risk Committees into an Integrated Governance Committee with key documents having been reviewed by the Executive team prior to going to the committee. The Trust should concentrate on major areas of concern with respect to mortality, lead jointly by the senior team and clinical leads, to effect change more quickly. The Board should ensure that acquired community services are fully integrated into the Trust's governance structures.	Medium

Clinical and operational effectiveness

Overview

The panel explored a key line of enquiry for clinical and operational effectiveness covering the governance arrangements the Trust uses to monitor and address clinical and operational performance data. In particular, the panel sought to ascertain the steps the Trust is taking to improve mortality performance, with a focus on general medicine, critical care medicine, stroke, respiratory diseases and cardiology. As for the review of other aspects of governance and leadership, the panel used a combination of documentation and data review, interviews and observations.

Summary of findings

The following good practice was identified:

- Seven day working has been successfully introduced in some areas of the Trust, with plans to expand this.
- Mortality and morbidity meetings are held in some departments to understand the causes of mortality.
- The Trust uses the Healthcare Evaluation Data (HED) tool to regularly analyse mortality data.
- External audit data (ICNARC case-mix programme) indicates that the Trust's mortality rates in intensive care are within expected ranges.
- The Trust has taken steps to reduce unnecessary admissions.

The following areas of concern were identified:

- Concerns relating to capacity and flow of patients in Accident and Emergency (A&E) and the Acute Medical Unit (AMU), and the impact on patient safety.
- Pace of change in relation to the mortality agenda, and in particular actions taken as a result of the AQuA review of mortality, is slow.
- In some departments, there are limited actions arising from mortality and morbidity reviews.
- Staff described a number of pathways and innovative approaches that had improved patient care, however the panel did not observe the pneumonia pathway in use.
- Limited out of hours service in some areas, in particular stroke care, and issues with staff engagement in the move to seven day working.
- Concerns were raised about integration between the acute and community hospitals, and with community care.
- Concerns were raised that there is a perception amongst some frontline staff that coding procedures were at fault for high mortality.

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Good practice identified
The Trust has successfully implemented seven day working in some areas, including gastroenterology where a seven day endoscopy service is seen as being in line with best practice.
Many staff described regular mortality and morbidity meetings within some departments to review deaths and identify areas of learning. These meetings were described by staff in A&E, cardiology, paediatrics and general surgery.
The Trust uses the HED tool to analyse mortality data at a granular level. The Medical Director works with the Associate Director of Clinical Information to review this information on a weekly basis.
Data from ICNARC (Intensive Care National Audit & Research Centre) indicates that the Trust's performance for all measures is within statistically expected ranges, including for mortality.
The Trust has taken steps to reduce unnecessary admissions: • The end of life care team is making good links with community team to prevent unnecessary admissions. • A new ascites (excess fluid in abdomen due to liver disease that needs to be drained regularly) clinic has been introduced to reduce admissions for drainage.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Introduction of pathways During the panel's announced visit, Board members spoke about the introduction of a number of pathways to improve care within the Trust. Staff described a number of pathways, including the chronic obstructive pulmonary disease (COPD) and pneumonia pathways, and innovative approaches to care, including the speech and language therapy "tele-heath" project. Staff stated the Trust had achieved 90% compliance on the pneumonia pathway. However, during the	None noted.	The Board should ensure that all pathways have a clear and monitored implementation plan which should reflect clinical priorities, not just with respect to the roll out process, but also outcomes in terms of use of the pathway and improving mortality. Key pathway compliance should be audited regularly and fed back to the appropriate clinical areas (e.g. pneumonia & COPD in respiratory ward, fractured neck of femur on T&O ward) and shared with the	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
unannounced visit, the panel reviewed four sets of notes for patients with a diagnosis of pneumonia (two on ward 23, two on ward 24). There was no evidence that a pneumonia pathway was in use for any of these patients. Staff on these wards were aware of the existence of the pathway but were not clear that it was in use for any of their patients. The introduction of a number of pathways forms a significant part of the Trust's plans to reduce mortality. However, these pathways have taken a significant length of time to introduce; for example, the pathway for fractured neck of femur has been under development for around 18 months, and has only recently been signed off by clinicians.		CCG routinely.	
(ii) Mortality governance In interviews, the Board and Senior Managers described a number of pathways that were being introduced as a result of the AQuA mortality review and subsequent work conducted by the Trust. The panel noted that the speed at which these pathways have been introduced has been slower than expected, for example, the pathway for fractured neck of femur has only recently been signed off by clinicians and has not yet been implemented. The panel reviewed the action plan in response to the AQuA report and noted a number of actions due to be completed in 2012 that remained in progress. Staff described regular mortality and morbidity meetings	The Trust continues to implement actions from the AQuA mortality review, and monitors progress regularly through the action plan.	The Trust should seek to increase the pace of change in relation to the mortality agenda by obtaining support from external sources or through the introduction of a turnaround team led by senior clinicians and backed by the Board. In the longer term, these change management skills should be developed within the Trust. The Board should reconsider the structure and need for the Clinical Policy Forum given this recommendation. The process for reviewing mortality and morbidity across the Trust should be standardised, and should allow for multi-disciplinary attendance. Department leads must be held to account to deliver change where issues are identified. Where themes are	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
at which case notes were reviewed. However, there were variations in how these meetings were conducted across the Trust, both in terms of frequency, how cases were selected for review, and staff that attend the meetings. In particular, there was often no involvement of nurses in these meetings, limiting the effectiveness of these meetings as a multi-disciplinary forum. For example, in the Stroke team, nurses have been invited to attend these meetings, but are often unable to due to staffing levels. The panel noted that many of the meetings were not documented, and therefore there is no clear audit trail to demonstrate lessons learnt and improvements to practice as a result. Staff commented that outcomes from these meetings were limited. It is also not clear in the governance structure where the output of these meetings would feed in. The panel reviewed the outputs from mortality reviews within the Scheduled Care division and noted that for the majority of cases there were no lessons identified. Without lessons being learnt and changes to practice being made as a result, there is limited purpose in conducting mortality and morbidity reviews. The panel also spoke to nurses on the HDU (high dependency unit) and in the Cardiology ITU (intensive treatment unit) about the learning gained from mortality meetings. The nurses said they were not involved in those discussions, highlighting lack of nurse involvement in review of deaths in the hospital.		identified, the Trust should consider seeking external, specialist support to review cases and identify actions. The Trust should consider using the NCEPOD (National Confidential Enquiry into Patient Outcome and Death) grading for standard of care. If the rating is less than good, actions need to be identified. The Board should insist on an improved pace of implementation. The Board should ensure there are clear lines of accountability for mortality and should seek assurance that action plans are being implemented and are impacting positively on performance metrics.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The Clinical Policy Forum, which the Board believes is an important quality governance tool, is not effective. The attendee list is too large and unwieldy, the meetings have a low attendance rate, the terms of reference are unclear and consultants did not appear to be engaged with it.			
(iii) Out of hours service provision As noted above, the Trust has taken some steps to move towards seven day working, and the introduction of a seven day endoscopy service is in line with best practice. However, seven day working is not yet fully implemented throughout the Trust (though it is noted that this is a problem shared by many trusts in the country). For example, there is no dedicated stroke consultant cover over the weekend, and during the observation on the stroke unit, staff commented that access to the CT scanner out of hours can be challenging. Also waits for ward referrals for CT scans can take over three days to access, as reported by staff on the ward 19 (general medicine ward). Staff raised concerns more generally that not all patients receive senior medical review over weekends, and that this may negatively impact severely ill patients. There was concern that nurse and junior doctors relied on the acute response team in place of senior doctor review out of hours. Whilst the Trust is taking actions to move towards	All new staff recruited are required to sign contracts that allow seven day working. Existing staff will be required to move to similar contracts. There has been agreement from the Board that a number of new consultants are required to implement the move to seven day working. However, departments must submit a new business case for each consultant recruited. Intensive care consultants are acknowledging the need to be present in the ICU more often out-of-hours, but this has not been formally included in their job plans. Senior nurses are reviewing Advanced Life Support (ALS) training of staff in the ICU and HDU.	Provide more senior medical cover out of hours and ensure that staff are consulted and engaged in the move to seven day working. Fast track discussions with commissioners and the wider health economy regarding plans to move to seven day services. Ensure that all wards have the appropriate skills and staffing ratios to delivery high quality care during out of hours periods. As the Trust recognises the need to recruit more consultants, an overall business case should be approved rather than requiring one for each consultant, to reduce workload and increase the speed of the recruitment process. The Trust must ensure intensive care staffing is of a safe and adequate level out of hours. The Trust should ensure that they standardise clinical observation processes throughout the hospital.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
seven day working, the panel were told that there are major staffing and retention issues, in particular in relation to allied health professionals. A number of staff are leaving as a result of this move, and clinicians commented that they had not been engaged as a key stakeholder. Although EWS (early warning score) scores are used to identify patients who are deteriorating, changing scores are not always escalated to more senior staff / doctors out of hours. In addition there seems to be inconsistencies in the way in which clinical observations were undertaken. Some staff reported they use sphygmomanmeters whilst others reported they used electronic devices. There was one incident in HDU in which a cardiac arrest occurred out of hours. The locum doctor in the unit was unable to manage the cardiac arrest and has since been removed from on-call duties due to concerns about having insufficient skills. The nurse in charge of ICU (who also covered HDU) refused to attend the cardiac arrest and sent another staff nurse. It was also found that some nurse shift leaders in ICU were not trained in Advanced Life Support and had shown resistance to receiving training in this.			
(iv) Integration of community care Patients at the listening event raised a number of comments about the integration of care between the acute hospital and community care:	The Trust outlined plans to build a rehabilitation centre at the Clifton community hospital.	The Trust should look at providing emergency follow-up clinics or direct booking of GP appointments as a strategy to reduce re-attendance and readmission rates.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• Patient interviews indicated that it was common practice to ask patients to make their own urgent GP appointments following discharge which often proved difficult and resulted in re-attendance at A&E. • Patients described untimely discharge to community rehabilitation when they had complex conditions. There was a feeling from patients of being pushed by the hospital rather than pull from the community.		The Trust should consider forming a multi-disciplinary patient focus group to share real experiences of service change and take appropriate action as a result of patient and carer views.	
(v) Coding The Trust informed the panel that there were robust procedures in place for coding patient records. Coding staff attempted to review all medical records of inpatient deaths with relevant consultants, and these were further reviewed by an experienced clinical engagement analyst. Coding staff are also now starting to attend mortality meetings to strengthen their understanding. Despite the Trust's historical belief that coding procedures were at fault for higher than expected mortality rates, there was no evidence that coding staff were under pressure to change coding inappropriately. Whilst interviews with Board members also indicated that the belief that clinical coding procedures were at fault for higher than expected mortality rates was no longer an accepted view point with them, this view does persist with some staff that the panel spoke to on the wards at the hospital. This indicates a lack of engagement with front-line staff in the mortality debate.	None noted.	The Trust should ensure that the ongoing focus for mortality reduction is on programmes to improve quality of care. The Trust should consider designing a suite of regular reports that demonstrate mortality and coding reviews have taken place and the actions that have been implemented as a result of findings. This should be shared with staff to improve understanding of mortality matters at the Trust. The Trust should encourage coding staff to review all cases of inpatient deaths with the relevant clinical consultants in charge (at present only about 80% are) and continue to encourage attendance at mortality meetings.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(vi) Capacity and patient flow During the panel's announced visit, an escalation ward had been opened to increase capacity. The panel was told that this is the second time this ward had been opened since April 2013. The panel visited the ward during the announced visit and observed that it was well staffed; staff are deployed from Unscheduled Care Divisions. However, the need to open an escalation ward outside of the period when winter pressures are highest may be indicative with systemic issues with capacity and patient flow. A further review during the unannounced visit indicated potential issues with staffing; this is considered further below under *"Workforce and Safety*"**.** The panel observed limited evidence of discharge planning and indications of poor patient flow throughout the hospital. For example, observations in the AMU (acute medical unit) identified a patient who had been in the unit for four days, and a further two who had been in the unit for three days. Best practice is for patients to remain on the AMU for 24 hours or less before being admitted to a ward. The AMU, whilst well staffed during the panel's visit, was at full capacity and extremely busy. Also, during the announced visit it was noted that the stroke ward had 29 patients and none had an EDD (expected date of discharge) marked on the whiteboard.	The Trust has reconfigured its emergency pathway, introducing a walk in centre on site to reduce pressures on A&E. Additional bays have been added to the A&E unit, increasing the capacity of "majors" from 11 to 16. Finances have been agreed to increase staffing levels within A&E; recruitment is underway but there are challenges in attracting staff (considered further below in the Workforce and Safety section).	In order to improve bed planning and patient flow, discharge planning should commence upon patient admission and be regularly reviewed. Discharge planning should include community hospitals, social services, pharmacy and transport ensuring that there are improvements made in the patient journey. Patients should be given an expected date of discharge on admission.	Medium

Patient experience

Overview

The panel focused on how the Trust understands and responds to patient feedback on their experience through discussing this with patients, their carers and staff on wards and at the focus groups and listening events, as well as reviewing board and ward level information on patient experience.

Summary of findings

The following good practice was identified:

- The Board are pro-active in identifying ways of improving the patient experience.
- Some wards displayed very good practice in improving the patient experience, particularly the maternity ward. This practice should be shared with other areas of the Trust.
- Across a variety of wards and at the patient and public listening event, patients provided positive feedback and were pleased with the quality of care.
- The panel saw evidence of incidents being used to improve services.
- The Trust's complaints handling policy and overall outcomes are good.

The following areas of concern were identified:

- Patients raised concerns related to communication issues with staff, a lack of staff, variations in the standards of quality of care provided and equipment and facilities.
- Poor promotion of the complaints process.
- The Trust outlined a robust approach to end of life care. However, there was mixed feedback from patients and their families about these services. It is difficult to provide end of life care systematically where there are insufficient staffing levels.

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Good practice identified

The Board is pro-active in identifying ways of improving patient experience. For example:

- Members of the Board conducted a visit in the winter of 2012 to Northumberland Trust to look at ways of capturing patient feedback more effectively. Action is expected to take place in 2013.
- The panel also heard of the Patient Experience Revolution, which is a patient experience training programme aimed at helping staff be at their best for more of the day and become more resilient. It is intended to give staff a voice to raise concerns and to teach them to listen more effectively to patients. It is still early days, but the Non Executive Directors mentioned that they are starting to see a change.
- Since the Chief Executive joined in April 2013 he has already met with three patients' families. He also reads the complaints letters from patients.
- Videos of patient stories are available on the intranet for staff to view and learn from.

Some wards displayed very good practice in improving the patient experience:

- In the Maternity ward all incidents are reviewed and action plans are prepared and shared. Complaints are never handled in a written manner. All are dealt with face-to-face in a meeting where minutes are taken. The lessons learned from this process are shared via the ward newsletter.
- In the Cardiac CCU (Coronary Care Unit) there is a good booking process and information provided to patients on discharges is very good. The documentation was found to be written in plain English, which displays good communication with patients.
- Some wards also had appropriate health education/information leaflets displayed.
- Some wards had notices displaying the ranks of different nurses and the uniforms they each wear.

The panel recommends that these good practices are shared with other areas of the Trust.

Patients currently on the wards and those that attended the patient and public listening event fed back many positive experiences with the Trust. There were some examples of excellent care across many wards, with patients complimenting the quality of care, the attentiveness of staff, the helpful and caring nature of staff, and that staff are doing all they can given their availability.

The wards specifically mentioned by patients were the cardiac ward, orthopaedics, lung cancer, AMU (Acute Medical Unit), Cardiac ITU (Intensive Treatment Unit), Stroke ward, Endocrinology and Gastroenterology.

The panel saw evidence of incidents being used to improve services:

- The Diabetes team outlined an incident reporting process where escalations are made to the relevant person, action plans are put in place and root cause analysis (RCA) is performed if needed. The outcomes of this process are reported back to patients.

Good practice identified
• The patient experience team at the Trust explained how the learning from incidents feeds into the training delivered to staff. • As discussed above, on the Maternity ward the ward newsletter is used to share the lessons learned from incidents and complaints. • Junior doctors and nurses received acknowledgment and feedback upon reporting incidents and had confidence in the system. Junior doctors also had the opportunity to discuss concerns with the medical director at monthly meetings, and these were usually followed up at the subsequent meeting.
The Trust's complaints handling policy and overall outcomes are good. The trust meets its deadlines for responding to complaints. All directors are assigned complaints from an area that isn't under their leadership to promote a challenging atmosphere. Complaints are signed off by these directors, not the Chief Executive. The Interim Director of HR noted that around 90% of complainants are satisfied with the Trust's response. Complaints about staff attitude have decreased in 2012, though it should be noted that some patients are still reporting concerns about communication from staff in the section below.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Patient experience themes The following themes were gathered through speaking to patients at the Patient and Public listening event and on the ward observations:			
a) Communication: There was a lot of feedback relating to communication issues between patients and staff. For example, patients reported: • Lack of pro-activeness from staff to resolve patients' concerns around treatment and prognosis. Communication was thought to be patient-led and not staff-led. • Difficulty getting through to staff members when calling the Trust on the telephone and staff not responding to	The Trust is currently delivering the Patient Experience Revolution, which is a patient experience training programme aimed at helping staff be at their best for more of the day and become more resilient. It is intended to give staff a voice to raise concerns and to teach	The Trust has been slow to implement the Patient Experience Revolution due to changes at Board level. This training is important to improving the patient experience and the Trust should ensure it is expedited and delivered to all staff that deal with patients. The Trust should also ensure it better uses notice boards to communicate with patients in an effective way, e.g. more health education/health information displays which are properly maintained, and displaying the outcomes of patient surveys and complaints.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
voicemails left by patients. • Staff being very busy and hence appearing to be in a rush to deal with people. Some patients didn't feel staff spent enough time discussing their circumstances with them. Some also reported being spoken to in an abrupt manner. • Patients feeling that they were not sufficiently informed of waiting times when at the hospital waiting for an operation. • Patients and their families/carers did not always feel involved in decision making. • Patients reported a lack of communication regarding ward moves, handovers and discharges. • The families/carers of some patients also mentioned that they weren't consulted before the person they cared for was put on the LCP (Liverpool Care Pathway), even though this is not in line with the Trust's policy.	them to listen more effectively to patients.	The Trust should consider putting in place mechanisms at ward level for patient voices to be heard quickly. The Trust should also consider allocating a named contact (doctor/nurse) for patients and their families to contact to improve the continuity of care and to address residual issues on discharge. The Trust should appoint a champion for patient communication at Non-Executive Director level, wider than just patient complaints. This champion should engage with staff and patients at all levels. The Board should seek assurance on the effectiveness of the activities undertaken by the Non-Executive Directors for example, activities such as walking the wards.	

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
b) Staffing levels: Patients fed back concerns over staffing levels and the impact this was having on the quality of care. Examples that patients provided of poor quality care which were thought to be due to low staffing levels, were: • Patients' families having to help feed other patients as nurses are too busy. • Patients left in soiled conditions as there are not enough staff to deal with it. • Patient with serious mobility problems were not assisted with washing and getting to the toilet. • Relatives being unable to see deceased patients over the weekend. There was also a concern that nursing staff spent too much time on administration and paper-work, rather than providing care.	The Trust acknowledges that it has challenges with regards to staffing level and recruitment. *These are discussed further in the **Workforce and Safety** section.*	*Please see the **Workforce and Safety** section for the recommendations related to the wider workforce issues.* The Trust should understand why relatives were unable to see deceased patients over the weekend when the Trust policy states that outside of normal viewing hours, either the portering, nursing staff or on call mortuary staff are available so families can see deceased patients.	Urgent (raised in Workforce and Safety section)
c) Variations in the standards of quality of care: Patients that had visited the hospital on multiple occasions noted variability in the quality of care. On some occasions care was reported as being good, as outlined in the section on good practice above, but on other occasions it was not so good. This included multiple visits to the same ward as well as visits to different wards in the hospital. Patients thought that the quality of service provided at the Trust depended on the members of staff that provided treatment. The panel observed a lack of staff engagement regarding	None noted.	The Trust should use its performance and appraisal system to identify poor performing staff and take action to address this to ensure that the quality of care provided to patients is high. Good practice from some wards is not shared with others. The Trust's Board should ensure that there are systems in place to share good practices between wards. Active involvement of all ward staff to ensure they understand what 'good' care is and how to measure it.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
metrics to support ward improvement. Matrons collated and published the data with little involvement or understanding of ward staff.		The Trust should ensure there is a culture of continuous improvement and shared learning and consider how the information gathered should be used to measure performance.	
d) Equipment and facilities: Patients reported concerns over some of the facilities and equipment provided at the Trust. Common examples related to there not being enough toilet facilities at the hospital (which was also expressed as a concern by some staff members), car parking, wheelchair access for disabled patients/visitors and slow provision of equipment to patients, e.g. specialist shoes and walking frames. The panel evidenced issues with facilities and ordering pressure relief mattresses. See *'patient safety'* section.	The Trust's Board outlined significant investment being undertaken at the Trust to improve facilities, e.g. new 5-storey car park at Victoria hospital and investment to transform Clifton hospital into a rehabilitation centre.	The Trust should continue to invest in the development of its facilities and look to address common concerns raised by patients related to this. They should also ensure equipment is provided to patients in a timely manner.	Medium
(ii) Promotion of complaints process Although the complaints handling policy and outcomes are good, the Trust does not do enough to promote the complaints process. • A number of patients reported that they were unsure of how to take complaints forward. • Patients were concerned that if they raise a complaint their quality of care will be impacted. • Patients also commented that Trust doesn't feed back to them what they do in response to complaints. They	None noted.	Good practice from some wards is not shared with others. The Trust's Board should ensure that there are systems in place to share good practices between wards. The Trust should consider methods of feeding back improvements made following on from complaints/incidents to patient groups, so that patients can see the value gained from raising complaints. One way of doing this could be through the appointment of a Governor from a patient representation group. The Trust should utilise the hospital governors and Trust membership to collect feedback from patients, disseminate information on lessons learned and to increase awareness	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
therefore do not know if it makes a difference. • Some staff members also mentioned that they aren't given feedback and that learning is not shared from complaints, e.g. DSU ward. Some examples of good practice were identified during the review where services have been improved following on from patient complaints through the dissemination of learning from complaints/incidents. However, it appears that there is still more work to do to ensure all areas of the Trust benefit from this learning and that the improvements made are shared with patients to demonstrate the progress that is taking place.		of the Trust complaints process. The Trust should consider establishing a Complaints Review Panel chaired by a Non-Executive Director.	
(iii) End of life care The Trust outlined a robust approach to end of life care: • The patient experience team outlined an ongoing training program for the Liverpool Care Pathway (LCP). Pan-Lancashire funding has been given to deliver an 18 month education plan. • There is a co-coordinator on the ward to support ward staff who participated in ward rounds. • An audit is performed to monitor the use of the LCP. • The lead for LCP was reported as being proactive and works closely with Consultants. • The Victoria Hospital night team includes trained nurses for support out of hours. • Poster and leaflets about end of life care were available for distribution on ward observations, e.g. AMU.	None noted.	The Trust should ensure that staff follow its end of life care policies. The Trust should ensure staffing levels and mix are sufficient to provide staff with the time to follow the policy properly.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• The Trust's policy is that the involvement of family should be at the beginning of the process. However, a number of families reported that they had not been informed about their relative being put on the LCP at the beginning of the process. It is the Trust's policy that family should be involved at the beginning of the process, so the Trust should ensure this is implemented in practice. It is difficult to provide end of life care systematically where there are insufficient staffing levels. See '*Workforce and Safety'* for further details on staffing levels.			

Workforce and safety

Overview

The three KLOEs in the workforce and safety area focused on:

- The Trust's ability to describe its workforce strategy and explain how it is used to deliver high quality care to patients,
- How the Board assures itself that it has the necessary workforce deployed to deliver its quality objectives; and
- How the Trust reviews and monitors its patient safety indicators and what actions are taken to improve patient safety.

Summary of findings

The following good practice was identified:

- The Board has recognised that there are issues relating to staffing levels and are working to recruit additional nursing and medical staff.
- There is a culture of openness amongst staff at the Trust.
- The Executive team outlined a number of areas of investment into staff training and development that was corroborated when the panel spoke to staff groups.
- There was a high level of commitment and compassion displayed by frontline staff during the visit, and amongst the Consultant group, some who are keen to implement change.

The following areas of concern were identified:

- During interviews with the Chief Executive, Chair and Director of Nursing it was confirmed to the panel that the Board recognises that they still need to do more work on the workforce strategy. Staffing levels were reviewed a year ago and the findings were that there are not enough unscheduled Care nursing staff and that the doctor to bed ratio was not sufficient. During focus groups and ward observations the panel learned of insufficient staffing levels and staffing mix on a number of wards. The Trust should improve capacity through the implementation of a robust retention and recruitment policy and also by using internal job planning in a systematic way to review how consultants can be used more efficiently.

- The following patient safety concerns were evidenced by the panel during the announced and unannounced visits:

    - The acute response team aspires to good practice but are unable to accelerate early intervention due to staffing levels on wards.
    - The SALT (speech and language team) spoke of a review of patients with aspiration pneumonia, the results of which showed that 41% had not received a SALT assessment.
    - Incident reporting is inconsistent between wards and some staff members expressed difficulties in reporting incidents.

- There are often delays in obtaining pressure relieving mattresses on wards.
- Documentation was incomplete in a number of areas.
- Cultural issues noted in cardiac surgery department to be discussed with the CE
- Safety crosses not completed
- Issues of compliance with the WHO checklist
- Awareness and implementation of the infection control policy
- Unlocked drug storage cupboard on HDU
- Inadequate toilet facilities

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Workforce strategy

Good practice identified
The Board has recognised that there are issues relating to staffing levels and are working to recruit additional nursing and medical staff: • There is an accident and emergency consultant cover workforce plan in place. The Trust is working with the Deanery to increase consultant numbers and is currently advertising for an additional consultant. Consultant hours have been increased until 10pm in addition to being on call overnight. • The Trust has a recruitment strategy in place to increase the number of nurses by recruiting at local universities and from other countries (Portugal, Ireland). • There are plans in place to recruit 35 new consultants, with 10 already having been appointed and with a further 3-4 having business cases approved.
There is a culture of openness amongst staff at the Trust: • At the junior doctor focus group all who attended spoke positively that they were able to raise concerns and there was a general culture of openness. They commented that the Medical Director met them once a month to ask if they had issues and are reporting the action taken the following month. • At the senior nurse focus group, the nurses spoke positively of working at the Trust and felt they had a voice. • Where 7 day working had been implemented staff spoke positively of improved interdepartmental working.
Staff Development: • The Chair and Chief Executive expressed a commitment to training and development, including training to help address workload issues. • At the junior doctor's focus group, staff reported to the panel that training was good. FY1 doctors reported having been enrolled on a leadership course. • At the junior nurse's focus group, students on the whole reported having a good training experience. • During the observation on the maternity ward, staff spoke positively of a 'Mandatory training date's newsletter' which was published and shared within the ward. • Staff in the cardiology ITU reported good engagement with training and development.
• At a drop in session, staff spoke positively of the occupational health department.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i)Staff Recruitment During interviews with the Chief Executive, Chair and Director of Nursing it was confirmed to the panel that the Board recognises that they still need to do more work on the workforce strategy, for example, rotations for nurses and new models for staffing. Staffing levels were reviewed a year ago and the findings were that there are not enough unscheduled Care nursing staff and that the doctor to bed ratio was not sufficient. Front line staff are aware of plans in place to recruit further nursing and medical staff. Staff reported concerns that the Trust will be able to recruit the additional staff needed. Staff could not articulate any mitigation for the risk of not recruiting the required numbers of staff in a timely manner. Both the Executive team and Clinical Directors interviewed recognised that recruitment was difficult for the Trust. The Interim Director of Human Resources reported to the panel that it is a significant challenge to recruit a further 35 new consultants. The non-executive directors confirmed that they have urged the Board to look at the recruitment model to develop innovative ways of recruiting the number of staff required. The non-executive directors also thought the Board needs to develop its succession planning. There was also a concern raised by Consultants over job planning. Similar to appraisals, it is not done very often. There are concerns that teaching, CPD (continuous professional development) and other roles required within specialities e.g. governance lead, are not covered properly. There is some resentment amongst Consultants that locums	The Chair and Chief Executive confirmed that several million pounds have been invested and have reduced bank staff. Additional staff has been recruited from Portugal and Ireland. There are plans in place to recruit 35 new consultants. Ten have been appointed with a further 3-4 having business cases approved.	The Trust needs to further develop its workforce strategy. The Trust should seek to understand what the true barriers are for recruiting appropriately qualified staff at the right level of experience. Once this is understood, a plan to address any issues can be put in place. The Trust may need to identify innovative ways to recruit nurses and medical staff and work with partners in the local health economy (e.g. CCGs and other trusts) to share thoughts as they are also facing similar recruitment challenges. The Trust should reconsider its approach to requiring new Consultant appointments to be approved through a business case. A potential approach may be to set aside pre-agreed funds so that consultants can be hired when they are needed. This will reduce delays in the recruitment process and avoid potential hires from getting frustrated with long recruitment processes. The Trust should undertake staffing reviews every six months and any investment in additional resource should be monitored to seek assurance that care is safe.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
are brought in and paid higher rates than them. This presents a risk to long-term recruitment/retention of consultants. The Associate Medical Director and interim HR Director both admitted there had not been a meaningful job planning policy until recently. The Trust does not appear to use internal job planning in a systematic way to review how consultants can be used more efficiently. Concerns relating to staffing levels on specific wards are included in the ***Staff Matters*** section below.		The Board should triangulate information on staffing levels at individual ward level with quality information including serious incidents, falls, infection control rates, pressure ulcers, mortality rates, complaints and staff feedback to assure itself that investment in additional staff is impacting patient safety and to identify where further investment is needed. Staffing decisions should also be linked to patient acuity. The Trust should review all consultant job plans across acute medicine and surgery to reduce pressure on external recruitment plans. The Trust should also develop a retention policy to retain staff long term. The Board needs to work with non-executive directors and clinical leaders to develop succession planning for the Trust.	
(ii)Cardiology There is some evidence from interviews with nursing and medical staff that there are significant cultural issues within the cardiac surgery department. The panel will discuss this with the Trust outside of the review as the panel did not evidence that there is currently an impact on patient care.	None noted	To be discussed with the Chief Executive of the Trust.	High
(iii)Clinical Leadership The panel heard mixed reports from nursing and medical staff regarding the visibility of the leadership team, particularly out of hours.	None noted	The Trust should review how it communicates with its staff and to	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The following comments were reported from nursing staff on medical wards: • 'I would love to see senior people come and spend a day on the wards and see what it is really like' • 'I wouldn't know a member of the Executive team if I walked past them in the corridor' Nursing staff on the stroke ward reported to the panel that the Director of Nursing undertakes monthly walkabouts and the Nurse Lead for Urgent Care is often visible on the ward. Staff interviewed were not consistently aware of this or received feedback from these visits and staff did not report ward visits from other members of the leadership team.		actively respond to staff views in their preferences for communications. This may include staff focus groups, using information from exit interviews and ward visits. The Trust should undertake a regular programme for all clinical leaders and Board members to visit patient care areas, including out of hours, and to feedback to frontline staff their observations and actions taken as a result of the visit. Clinical leaders and Board members should be provided with leadership development training where appropriate and should be supported in protecting time to engage with frontline staff.	
(iv)Mandatory Training and Induction During ward observations and focus groups the panel heard a number of concerns relating to training. These are listed as follows: • Nursing staff on a ward described having to complete training in their own time. • Staff on a ward spoke of low completion rates for doctors compared to nurses. • Healthcare Assistants (HCA) on a ward spoke of poor training for HCAs. It was reported to the panel that training has to be done in their own time and Personnel Development Reviews are considered 'just a piece of paper'. • HCAs on this ward were unable to recall the date and	None noted	The Trust must assure itself that there are adequate staffing levels to allow protected time for completion of mandatory training. The Trust may need to use innovative solutions to address this issue for example by offering staff payment to attend outside of normal working hours and planning cover for mandatory training attendance with bank in advance. The Trust should understand why staff are unaware of the ability to or do not feel able to claim time back by the e-rostering	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
contents of their last safeguarding training, • A locum SHO reported having no induction over the three weeks they had been at the Trust. • Ward managers reported the lack of a coordinated approach to mandatory training on induction. It was reported to the panel that staff are arriving at the wards without Basic Life Support training, and without inductions for between 6 to 8 months. • Speech and language therapists reported not being given the time to complete mandatory training.		system whenever they undertake training in their own time. The Trust needs to review the appraisal process for staff to ensure that appropriate development needs are identified and ensure that progress against development plans is monitored.	
(v) Medical appraisal rates. The Director of Human Resources and Associate Medical Director confirmed that appraisal rates for doctors are approximately 68%. Unless rapidly improved this will significantly impair the ability of the Trust to provide a fully revalidated Consultant workforce. (To achieve revalidation Consultants must have had annual appraisal for the preceding 5 years in a well governed appraisal process.)	None noted	The Trust needs to ensure that all doctors (including non Consultant, non training grades) complete the appraisal process in a timely manner. Trainees are appraised via their ARCP process.	High

Staff matters

Good practice identified
There was a high level of commitment and compassion displayed by frontline staff during the visit. The panel learned from a number of patients and relatives at the listening event about the commitment and compassion of nursing staff. Amongst the Consultant group some of the individuals that were interviewed were keen to implement change.
Nursing staff in Accident and Emergency reported good engagement with staff. The panel saw evidence of a waiting list of staff who wanted to join the ward.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i)Staffing levels and staffing mix During focus groups and ward observations the panel learned of insufficient staffing levels and staffing mix on a number of wards. These areas are outlined below: **<u>Stroke Ward</u>** • The Stroke ward manager had a dual role which often results in her being off the ward for significant periods of time. • The junior doctors spoke of low staffing levels on the Stroke Ward. The panel did not think that two registered nurses and two HCA at night was sufficient for a 31 bed ward. • Staff on the Stroke Ward spoke of over dependence of junior nurses but no longer using bank staff. • Staff on the Stroke Ward spoke of the need for more OT (occupational therapy), speech and language therapy and physiotherapy support. • Staff on the Stroke Ward spoke of low registered nurse to patient ratio at nights. • The layout on the Stroke Ward makes it difficult to observe patients with the current level of staff. • There is no dedicated stroke consultant over the weekend. The Royal College recommends 7-day stroke consultant cover. **<u>Orthopaedics</u>** • Junior doctors reported a lack of senior review in post operative period in orthopaedics. • One junior doctor reported seeing patients themselves for four days in a week without senior advice. There should be an SHO doing ward rounds everyday but the SHOs don't comply. Some consultants were noted to perform ward rounds once a week only. **<u>Ward 26 (Geriatric medicine)</u>** • Junior staff reported a lack of support and not being listened to. • Staffing levels are not appropriate for patient needs. • High levels of long term sick leave were reported to the panel. In May	Staffing has been an issue, particularly the amount of trained/specialist nurses available overnight and consultant cover. The Trust has a business plan to get extra staff (see Workforce Strategy section above) and are using the acute response team to backfill. The Trust has employed a medical staff grade doctor for the orthopaedic wards to help manage unwell patients. The Trust informed the panel that the Stroke Ward moves to a new purpose-built Ward in two weeks. As part of the move to the new Stroke Unit there will be a full time supernumerary Unit Manager and nurse staffing on the Stroke Unit has been enhanced. The Trust informed the panel that ward 11 establishment was increased in April 2013 and four new staff nurses have been recruited and are waiting to commence in post. The Trust has reviewed staffing levels on ward 19 and has increased night nursing levels to four nurses. Recruitment is in progress.	The panel understands that the Trust has completed a full staffing level and skill mix review 18 months ago and a recruitment strategy is in place. The Trust needs to urgently assure itself that whilst recruitment of more staff is underway the current staffing levels at the Trust are safe, particularly out of hours, until further nurses and medical staff are recruited.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
2013, on 11 out of 17 days at least one member of staff was on sick leave/absence. • The use of on call doctors over the weekend is a risk as the ward place reliance on the acute response team. • On the unannounced visit this ward had 2 registered nurses plus 1 student nurse for 25 patients; this should be 2 registered plus 2 non-registered. The panel observed debris on the floor. A member of staff was upset and reported that this happens. The Trust informed the panel that staff had bleeped three times for additional staff and help was provided at 22.30. Two falls were reported to have occurred on the day prior to the unannounced visit. The panel chair escalated this concern to the Trust. • Staff on this ward are leaving for less onerous jobs outside the Trust as (despite huge dedication) they suffer the increased workload and fall in standards that come from poor staffing and high sickness levels. **Escalation ward (ward 2)** • The panel observed 14 patients with more arriving on the 18 bed ward. There were two registered nurses and two HCAs for what appeared to be acutely unwell patients. Whilst the panel was there, a senior nurse came to arrange for more staff. The staffing levels observed were less than the associate chief nurse reported and is inadequate for the ward. • Staff are pulled from other wards within their divisions to work on the escalation ward when it is commissioned and also on other wards across the Trust. One nurse the panel spoke to described being moved 3 times in the course of 1 night shift to different areas and that movement of nursing staff from area to area is an everyday occurrence. This leads to staff being spread too thinly resulting in not enough time for discharge planning and escalation of internal waits (a consultant described a patient on his ward waiting for an OT assessment for 10 days). It has become a cycle, where there is pressure in A&E and not enough beds due to little discharge planning and no push to create capacity in specialities, which means that the escalation ward needs to be opened to meet the 4 hour target at the expense of safe staffing levels across the Trust. This leaves less time for the nursing team on			

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
wards to manage patient flow out of their beds. **Ward 11 (Endocrinology)** • Nursing staff reported needing four more nurses. **Ward 19 (General Medicine)** • The panel observed a 21 bed ward with two registered nurses and two HCAs on the night shift. For the night shift, only 2 registered nurses and one HCA were recorded as working which the panel did not think was sufficient. **Critical care ward** • Staff nurse from critical care described being moved to three different wards in one night to supplement ward establishment gaps. **Cardiac Surgery ITU** • Out of hours consultant anaesthetist cover is a potential risk according to nursing staff as they rely on ITU/maternity to cover. **Cardiology CCU** • There should be 4 registered nurses plus 1 trainee on duty at night. The panel reviewed rotas for the last 2 weeks and these showed the ward had 3 registered plus 1 trainee on at night due to sickness. • If a nurse needs to go to A&E they can be gone for 2-3 hours leaving the ward at 2 registered plus 1 trainee which is potentially unsafe depending on the number of high dependency patients on the ward (which can have 3-4 patients on balloon pumps). **HDU/ITU** • There should be 12 registered nurses shared between these two wards. On the night of the unannounced visit the panel observed only 10 nurses on duty. The staff nurse described regularly being short staffed due to sickness.			

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
<u>Urology</u>: • Senior support for junior doctors in Urology was reported as being poor. Other issues noted by the panel: • The consultant focus group spoke of HCAs picking up EWI (EWS – early warning score), but was not sure if they are suitably qualified to do this work. • The consultant's focus groups reported a heavy reliance on junior doctors and locum staff. • The student nurses spoke of a lack of review of non emergency patients at the weekend and out of hours. Not having the right level and mix of staff in some areas presents a significant risk to the Trust.			
(ii)Use of the acute response team The acute response team is stretched and capacity issues on wards means that the acute response team can't fulfil its function as it is used as a staff bank to cover for staff sickness. The acute response team aspires to good practice but are unable to accelerate early intervention due to staff capacity levels on the wards. This also raises concerns regarding the skills, knowledge and expertise to be found in the ward based teams and to be able to recognise and manage deteriorating patients if the Acute Response Team are not available to attend.	None noted.	The Trust needs to ensure that the remit of the team is clearly defined and that ward teams understand what they are expected to deal with. The team should not be used to backfill for staff shortages.	High

Patient Safety

Good practice identified
Participants at the junior doctor focus group who had filled out serious incident forms said they had received feedback in the form of an email or meeting. They spoke of

Good practice identified
being given training on serious incidents at induction. Junior doctors also spoke of receiving feedback from incident reporting every month at teaching sessions with good engagement from the Medical Director.
Student nurses and HCAs stated feedback and lessons learned from complaints is shared at team meetings and safety huddles on the stroke ward.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i)Aspiration Pneumonia The panel learnt of a high rate of deaths at the Trust due to aspiration pneumonia. This was identified through a clinical audit performed by the Trust in January 2013. The summary of the main concerns raised by the audit are: • 41% of patients died due to aspiration pneumonia in January 2013 (26 out of 64 patients). • 76% of these patients (20) had no documentation of presence of aspiration on admission or on post-take. • For 65% of these patients (17) there was some sort of risk identified by some staff (doctor/nurse). • Only 19% of these patients (5) had a basic water swallowing test done. • 46% (12) of these patients were referred to the SALT team. Pneumonia is one of the main areas of concern identified in the SHMI and HSMR mortality indicators. The panel is concerned about the development of pathways to address the mortality concerns at the Trust, as discussed elsewhere in the report. The results of this recent audit add further evidence that pathways need developing and implementing urgently at the Trust. The panel also spoke to nursing staff about a case of	The clinical audit performed by the trust had the following recommendations: • Need for a simple risk assessment score for identifying patients at high risk for aspiration. • Update & review the DTN (Dysphagia Trained Nurse) certification - nurses qualified to perform basic water swallowing test. • Need to follow SLT recommendation and check if it is being done.	Pneumonia is one of the main areas of concern identified in the SHMI and HSMR mortality indicators. The recommendations suggested in the audit report are essential steps that the Trust needs to implement quickly to reduce the number of avoidable deaths related to this issue.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
aspiration pneumonia that had been initially reported as a level 3 serious incident but following review reduced to a level 1 incident from which lessons learned had not disseminated. The Trust Executive Team reported to the panel that the incident following investigation was closed as a level 3 serious incident with completed root cause analysis and lessons learned disseminated to ward staff and speech and language therapists during a ward meeting but that could not be certain that all members of staff had attended the ward meeting.			
(ii)Awareness and implementation of infection control policy During ward observations, the panel saw notices on the wall and on the nurses table drawing attention to a new Staphylococcus Aureus Integrated Care Pathway however three out of four student nurses interviewed were not aware of the new policy. Similarly when asked a physiotherapist on the stroke ward had not heard of the new Staphylococcus Aureus Integrated Care Pathway either. On the unannounced visit the door for a patient in a side room on a ward was open despite a sign on the door labelled as 'reverse barrier nursing'. The door was open because the patient was leaving the room to use a communal toilet, which is a further concern as reverse barrier nursing is used to isolate patients to avoid the spread of infections. On two wards, items were stored in bathrooms and toilets, posing an infection control risk. In particular, there were linen items stored in a patient bathroom.	The Trust informed the panel that a new Staphylococcus Aureus Integrated Care Pathway was being promoted on the wards following its launch on the 13 June 2013. A read and sign for every ward team member is in progress which is due to complete on the 15 July 2013.	The Board should seek assurance that the infection control policy is being implemented on ward 23 and 24 as a matter of urgency. The Trust should ensure that all staff are made aware of changes to Trust policies and staff should confirm that they have read and understood any new or updated policies. The Trust should also ensure all staff are aware of the importance of infection control policy and conduct regular audits to check compliance.	Urgent High High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(iii)Serious Incident Reporting Incident reporting is inconsistent between wards and some staff members expressed difficulties in reporting incidents. Whilst staff on some wards could describe how learning is shared through the incident reporting process, others could not. Nursing staff reported to the panel that incident reporting is 'time consuming' and that there are not enough computers available for reporting because they are being used or are out of use. Nursing staff reported that feedback from incident reporting, complaints and mortality meetings could be done more consistently. Whilst on the unannounced visit the panel observed a set of patient notes on ward 35 where a patient had fallen on the ward, leading to a fractured neck of femur. This was not reported as an incident until two days later, although it was recorded in the patients notes. This is an SUI (Serious Untoward Incident) and should have been reported immediately. Staff were unsure what to report as an incident outside the core infection/pressure ulcer/fall leading to fracture group. Many staff thought that a patient had to be harmed before a report was to be completed (nursing staff & junior doctors on stroke ward, respiratory ward and orthopaedic ward).	None noted	The Trust should review its process for reporting serious incidents to ensure there is sufficient time and equipment available for reporting. The Trust should ensure that the results of all serious incident reporting are made available to Trust staff so that the learning is disseminated and staff are encouraged to maintain a reporting culture. The Trust should ensure that where members of staff are unable to attend a ward meeting where lessons learned are shared the information is communicated to them in another way. The Trust should consider re-launching the incident reporting policy with a trigger list and guidance on what to report in order that near misses are captured as well as events that result in harm for patients.	High
(iv)Facilities Nursing staff reported to the panel that the toilets on the gastroenterology ward (ward 12) are too small and patients	The Trust informed the panel that a plan has been drawn-up commencing August 2013 to upgrade the toilets,	The Trust should urgently review the toilet facilities on ward 12 and ensure that they are fit for purpose.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
are getting stuck in the cubicles. Nursing staff reported having to climb over the top of the cubicles to help patients. Equipment such as hoists and shower chairs were stored in toilets on the respiratory wards as there was no other storage space. The panel chair escalated this concern to the Trust.	make a designated disabled toilet and to improve storage solutions on all the wards.	The Trust should urgently review behaviours with regards to storing equipment in toilets and carry out a review of the use of day rooms and bathrooms in order to ensure that available space is best used for patient care.	
(v)Delays in ordering pressure relieving mattresses Nursing staff on the stroke ward and in the student nursing focus group reported waiting up to ten days for pressure relieving mattresses. Other trusts have systems in place to ensure pressure relieving mattresses are delivered within 4 hours of them being requested. It was reported to the panel that nursing staff on the ward are no longer able to complete purchase orders as part of the cost improvement programme therefore there is a delay in placing the order whilst awaiting approval. The Chief Executive confirmed this is not currently on the risk register.	There were wards in the Trust that when asked did not report any issues in ordering pressure relieving mattresses. Nursing staff on the cardiology ward reported being able to escalate a need for mattresses to the tissue viability nurse who ensured that mattresses were received in a timely manner.	The Trust should urgently seek assurance that nursing staff are able to order and receive pressure relief mattresses in a timely manner. The Trust should ensure that on wards where there are no delays in ordering pressure relieving mattresses, good practice is disseminated throughout the Trust. The Trust should assure itself that a quality impact assessment is completed for all cost improvement programmes and the impact of cost improvement programmes on quality and safety is monitored during and after the implementation of the scheme. The Board should assure itself that risks are escalated appropriately.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(vi)Completeness of Documentation The panel observed several examples of incomplete documentation on wards as follows: • No use of butterfly schemes beyond bedside stickers. • Poor completion of SAS (skin and safety) particularly in the afternoon. • DNAR (do not attempt resuscitation) forms were not correctly documented by doctors. The involvement of relatives was also not documented. • Poor documentation of nursing notes, DNAR forms and nutritional/hydration notes. • Nursing staff on a number of wards reported to the panel that they find the level of documentation challenging given the time available to complete. On the unannounced visit (23 June 2013) the panel reviewed the documented checks performed on wards over the prior week: • The resuscitation trolley on a ward had missing checks on 20/06 (late shift), 21/06 (late shift), 22/06 (early and late shirt), 23/06 (late shift - although note there was still half an hour of that shift left when reviewed). On one ward a check was missing. On another ward it was filled incorrectly. • Four sets of notes for fluid balance charts on a ward were checked. In all cases, food intake was recorded, but fluid input/output was not. This included two patients on an IV drip, for which the panel would expect detailed records to be maintained (the chart did not set out the volume of IV fluids either). The acute response team confirmed that fluid balance sheets were an issue at the trust. • Pressure care: the panel found an example of a patient	During an interview, the Chief Executive recognised that documentation was an area for development at the Trust.	The Trust should seek assurance that documentation is completed to the required standard. The Trust should provide support to staff where documentation issues have been highlighted in RCA. The Trust should provide support to staff who have highlighted challenges in completing documentation in focus groups or where identified as a development need through the appraisal process. The Trust should seek assurance that any investment in training is improving the quality of documentation. Regular audits need to take place to measure against the accepted standards for pressure care, management of fluid balance, routine observations, etc. Actions need urgent implementation to ensure correct care is delivered and is documented.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(on palliative care) who should have had four hourly pressure care treatments. Over the past three days this had only been performed 12-hourly. Documentation issues are regularly highlighted in RCAs HCAs from the stroke ward stated that they find SAS documentation challenging and had not had training on how to complete.			
(vii)Drug storage During a ward observation on HDU (high dependency unit) the panel observed that the DDA (Dangerous Drugs of Addiction) drug fridge was unlocked. It was locked by a nurse when they were made aware the panel member had noticed. During the unannounced visit the panel observed that the DDA drug cupboard was locked, however the drugs cupboard was unlocked and unattended. This was reported to the staff nurse on the HDU and this was escalated to the Trust in a letter from the panel Chair to the Chief Executive.	None noted	The Trust should seek assurance that that the DDA drug fridge on HDU is locked when not in use. Lessons learned should be disseminated throughout the Trust.	High
(viii)WHO checklist Issues were found with the use and monitoring of the WHO (World Health Organisation) checklist. The WHO checklist is a mandatory check at 3 stages on a patient in the operating department for surgery – on arrival, immediately before skin incision and when leaving. On an observation of the theatres the panel learnt that the first part of a checklist had been completed despite the absence of a surgeon and anaesthetist in the anaesthetic room. The audit of practice was once a month and consisted	None noted	The Trust should ensure that the audit of WHO checklist compliance should include observed practice as well as document completion. The Trust should embed the five steps for safer surgery into daily practice.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
of a review of the completion of the paperwork rather than an observation of practice. The WHO checklist has been further developed and is now called 'the 5 steps to safer surgery'. During discussions with senior clinical staff it became apparent that this development had not been communicated effectively.			
(ix)Safety Crosses At the unannounced visit the panel observed that the safety crosses on the cardiology ward, cardiology ITU, respiratory wards and Trauma & Orthopaedic ward have not been completed since the 19 June.	None noted	The Trust should ensure that the ward level information published on notice boards should be updated in a timely manner, displayed in a consistent and standardised way and include steps taken to improve where performance is below expectation. This needs to be recognised and owned by ward staff.	Medium

5. Conclusions and support required

Conclusions

The review identified a number of good areas of practice across the Trust. Some staff groups and particular individuals at the Trust also received praise, particularly the acute response team. The review also identified a number of areas of outstanding concern across all seven key lines of enquiry which will require urgent or high priority action to address as identified in the detailed findings section. The Trust recognises that there are steps it needs to take to address the concerns raised by the review. Some improvement plans are already in motion, and the review team recommends that these are expedited. Other actions are areas the Trust has not yet considered and the panel recommends that the Trust quickly develops action plans to address these concerns. A number of these areas are recommended for discussion at the risk summit to consider what support may be required from the Trust to address these concerns.

Urgent priority actions for consideration at the risk summit

Problem identified	Recommended action for discussion	Support required by the Trust
There appears to be a considerable disconnect between those that deliver services, especially acute care and those that set strategic direction which is preventing implementation of the Trust's quality plan at ward and divisional level (page 16-17).	There needs to be a coordinated approach to the implementation of change within the Trust and the focus should be on a bottom-up approach to change, rather than top-down. A number of good initiatives have been put in place at the Trust, but with apparently little success in terms of front-line ownership.	**To be discussed at the risk summit**
The pace of change at the Trust in the past couple of years has been slow. The high number of actions that the leadership team is looking to implement may be hampering the speed of change of the critical actions that the Trust needs to complete (page 16).	The Trust's Board should concentrate on the mission critical actions that need to take place to address the mortality concerns in the areas where it is an outlier. The Board must prioritise actions that are critical to pathways particularly for stroke, myocardial infarction, pneumonia and sepsis The Trust's Board should also ensure all of the major programmes that it manages have a strong project management framework, with clear milestones to aid with prioritisation and the tracking of progress. This should be	**To be discussed at the risk summit**

Problem identified	Recommended action for discussion	Support required by the Trust
	made transparent to staff who are implementing change so that they are clear on the objectives and milestones.	
The incident review system is unreliable in terms of consistent reporting and classification of serious incidents, multi-disciplinary investigation and dissemination of findings (page 19 and 49).	The Trust should review its process for reporting serious incidents to ensure there is sufficient time and equipment available for reporting. The Trust should ensure that the results of all serious incident reporting are made available to Trust staff so that the learning is disseminated and staff are encouraged to maintain a reporting culture. The Board should assure themselves that serious incidents have been graded correctly especially those where the incident has been downgraded. The Trust should consider re-launching the incident reporting policy with a trigger list and guidance on what to report in order that near misses are captured as well as events that harm patients.	**To be discussed at the risk summit**
The panel evidenced that medical and nursing staffing levels and skill mix were not appropriate or well managed (page 43). The Trust has recruitment challenged particularly with regards to consultants and nurses (page 39).	The Trust needs to urgently assure itself that whilst recruitment of more staff is underway the current staffing levels on the wards and departments listed are safe, particularly out of hours, until further nurses and medical staff are recruited. The Trust needs to further develop its workforce strategy. The Trust should review all consultant job plans across acute medicine and surgery to reduce pressure on external recruitment plans. The Trust should also develop a retention policy to retain staff long term.	**To be discussed at the risk summit**

Problem identified	Recommended action for discussion	Support required by the Trust
	The Board should triangulate information on staffing levels at individual ward level with quality information including serious incidents, falls, infection control rates, pressure ulcers, mortality rates, complaints and staff feedback to assure itself that investment in additional staff is impacting on patient safety and to identify where further investment is needed. Staffing decisions should also be linked to patient acuity.	
The panel heard mixed reports from nursing and medical staff regarding the visibility of the leadership team, particularly out of hours (page 40-41).	The Trust should undertake a regular programme for all clinical leaders and Board members to visit patient care areas, including out of hours, and to feedback to frontline staff their observations and actions taken as a result of the visit.	**To be discussed at the risk summit**
The panel evidenced a numbers of patient safety concerns were during the announced and unannounced visits (page 47-53).	The Trust should develop an action plan to implement the required improvements to patient safety in the specific wards and departments listed.	**To be discussed at the risk summit**
The panel evidenced the infection control policy not being implemented (page 48).	The Board should seek assurance as a matter of urgency that the infection control policy is being implemented on the wards identified by the panel as a concern. The Trust should also ensure all staff are aware of the importance of infection control policy and conduct regular audits to check compliance.	**To be discussed at the risk summit**

Appendices

Appendix I: SHMI and HSMR definitions

HSMR definition

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

How does HSMR work?

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific groups (CCS groups); in a specified patient group. The expected deaths are calculated from logistic regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

How should HSMR be interpreted?

Care is needed in interpreting these results. Although a score of 100 indicates that the observed number of deaths matched the expected number; in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

SHMI definition

What is the Summary Hospital-level Mortality Indicator?

The Summary level Hospital Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio; a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

How does SHMI work?

1) Deaths up to 30 days post acute trust discharge are considered in the mortality indicator, utilising ONS data
2) The SHMI is the ratio of the observed number of deaths in a Trust vs. expected number of deaths over a period of time
3) The Indicator will utilise 5 factors to adjust mortality rates by
    a. The primary admitting diagnosis
    b. The type of admission
    c. A calculation of co-morbid complexity (Charlson Index of co-morbidities)
    d. Age
    e. Sex

4) All inpatient mortalities that occur within a Hospital are considered in the indicator

How should SHMI be interpreted?

Due to the complexities of hospital care and the high variation in the statistical models all deviations from the expected are highlighted using a Random Effects funnel plot

Some key differences between SHMI and HSMR

Indicator	HSMR	SHMI
Are all hospital deaths included?	No, around 80% of in hospital deaths are included, which varies significantly dependent upon the services provided by each hospital	Yes all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days the death is counted multiple times	1 death is counted once, and if the patient is transferred the death is attached to the last acute/secondary care provider
Does the use of the palliative care code reduce the relative impact of a death on the indicator?	Yes	No
Does the indicator consider where deaths occur?	Only considers in hospital deaths	Considers in hospital deaths but also those up to 30 days post discharge anywhere too.
Is this applied to all health care providers?	Yes	No, does not apply to specialist hospitals

Appendix II: Panel composition

Panel role	Name
Panel Chair	Mike Bewick
Lay Representative	Sue Crutchley
Lay Representative	Gillian Stone
Lay Representative	David Tredrea
Lay Representative	Amit Bhagwat
Junior Doctor	Krishna Chinthapalli
Doctor	Steve Graystone
Doctor	Leslie Hamilton
Doctor	Mark Withers
Student Nurse	Sarah Weight
Board Level Nurse	Gill Heaton
Senior Nurse	Simon Featherstone
Senior Nurse	Peter Murphy
CQC Inspector	Julia Harratt/Natalie Young
Senior Trust Manager	Nikki Pownall
Senior Regional support	Preeti Sud
Senior Regional Support	Kim Hoyland
Senior Regional Support	Julie Higgins

Observer – Area Team	Jim Gardiner
Observer – CCG Nominee	Helen Skerritt
Observer – CCG Nominee	Jennifer Aldridge

Appendix III: Interviews held

Interviewee	Date held
Ian Johnson, Chairman and Gary Doherty, Chief Executive	17 June
Andy Knowles, Associate Medical Director	17 June
Marie Thompson, Director of Nursing	17 and 18 June
Tony Shaw, Karen Crowshaw and Alan Roth, Non-Executive Directors	17 June
Governors group	17 June
Adam Bateman, Deputy Director of Unscheduled Care and Andrew Kent, Deputy Director of Scheduled Care	17 June
Feroz Patel, Acting Director of Finance and Jacqui Bate, Interim Director of HR and OD	18 June
Wendy Swift, Managing Director for Community Development and Transformation	18 June
Nigel Randall, Clinical Lead for Medicine	18 June
Russell Millner, Clinical Lead for the Cardiac Centre and Cardiology	18 June
Chris Clarke, Clinical Lead for Critical Care	18 June
Clinical coding team	18 June

Appendix IV: Observations undertaken

Observation area	Date of observation
A&E	17 June
Ward C (Stroke)	17 June
Acute Medical Unit	17 June
Ward 25 (Elderly Medicine)	17 June
Ward 26 (Elderly Medicine)	17 June
Cardiac Centre including Coronary Care Unit, Cardiology Wards and Cardiac ITC	17 June
Theatres	18 June
ITU	18 June
Ward 1 (HDU)	18 June
Ward 11 (Medical)	18 June
Ward 12 (Medical)	18 June
Ward 34 (Trauma & Orthopaedics)	18 June
Ward 35 (Trauma & Orthopaedics)	18 June
Ward 33 (General Medicine)	18 June
Maternity	18 June
Clifton Hospital	18 June
A&E	23 June
Acute Medical Unit	23 June
Wards 23 and 24 (Respiratory Wards)	23 June
Surgical Assessment Unit	23 June

Cardiac Centre including Coronary Care Unit and Cardiac ITC	23 June
Escalation Ward (ward 2)	23 June
Ward 35 (Female Orthopaedic Ward)	23 June
Ward 1 (HDU)	23 June
Ward 25 and 26 (Elderly Medicine)	23 June

Appendix V: Focus groups held

Focus group invitees	Date held
Nurse and HCAs (Band 5 and below)	17 June
Junior Doctors (F1 and F2)	17 June
Senior Nurses	17 June
Team responsible for patient experience	18 June
Doctors (StR 1 upwards)	18 June
Staff drop-in session	17 and 18 June

Appendix VI: Information available to the RRR panel

01 CIP Presentation to FCCAB.pdf	01 CIP Transformation Presentation.pdf	01 The Cost Improvement Plan.pdf
010 Blackpool Quality Rpt2012 - 2013.pdf	01a - Consultation document - Improving Patient Care - the next steps.pdf	01a - PRESS Release - Launch of public consultation.pdf
01a - PRESS Release - Outcome of public consultation.pdf	01b - Annual Members Meeting 2011.pdf	01b - Annual Members Meeting 2012.pdf
02 Monitor Ratings.pdf	03 Bank & Agency Usage.pdf	04 05 08 09 Governor Numbers.pdf
04 Clinical Leadership Development.pdf	04 code of conduct govs 2013.docx	05 - Clarification of Excess Male Mortality.pdf
05 - Male_Mortality.xlsx	05 - Process used to appoint Governors.docx	07 - Extracts from Council of Governors Minutes Feb 12-Feb 13.docx
08 Uncoded Activity.pdf	1 l Extract HR&OD June 12.docx	1 o Extract HR&OD December 12.docx
14 Ward Handover Times.pdf	15 Mortality Review Mtg.htm	16 CITU Minutes 13 March 2013.pdf
16 CITU Minutes 16 May 2013.pdf	16 CITU Minutes 17 April 2013.pdf	17a 86899 INC.PDF
17b 86899 RCA.PDF	17c FCVMSRV208_FC54519 - 5030_2200_001.pdf	17d FCVMSRV208_FC54519 - 5030_2201_001.pdf
17e FCVMSRV208_FC54519 - 5030_2202_001.pdf	19 Mortality CQUIN.xlsx	1a Workforce Strategy Info Organisational Effectiveness Str...y -Action Plan.docx
1b Organisational Effectiveness Strategy.docx	1c Transformation Programme Board Minutes - 17 10 12.docx	1d Transformation Programme Board Minutes - 14112012.docx
1e Medical Workforce Review December 2012.docx	1f Medical Workforce Recruitment Planning May 2013.doc	1g January 2013.docx
1h Board of directors minutesMarch 2013.docx	1i finance comm Medical WF review.pdf	1j Medical%20Workforce%20Review Nov 2012.pdf
1k Extract HR&OD April 12.docx	1m EXtract HR&OD August 12.docx	1n Extract HR&OD October 12.docx
1p Extract HR&OD March 13.docx	1q July 2012.doc	2 MM 020513 mins from 4th April 13.pdf
2 MM 100613 mins from 2nd May 13.pdf	2 MM 211212 Mortality Board Minutes 261112.pdf	2 MM 250113 Mins of 211212.pdf
2 MM 260213 mins from 250113.pdf	2 MM 261112 Mortality Board Minutes 261012.pdf	2 MM 280613 mins from 10th June 13.pdf
2 Number of Staff Groups per ward_Divs 03 06 2013.xls	20 Divisional Mortality Reduction Plan 18 6 13.docx	22 Full Proforma.pdf
22 M and M Meeting 12_3_2013.docx	22 Mortality Meeting June Presentation.pptx	22 Screening Proforma.pdf

24 CPF April 2013.pdf	24 CPF August 2012.pdf	24 CPF February 2013.pdf
24 CPF January 2013.pdf	24 CPF March 2013.pdf	24 CPF May 2013.pdf
24 CPF Membership.pdf	24 CPF November 2012.pdf	24 CPF October 2012.pdf
25 Compliance with CG50 presentation.pdf	25 Compliance with CG50 report.pdf	25 Medical Escalation Level 3 and above.pdf
25 Patients Causing Concern Algorithm.pdf	3 Qualified & Unqualified Nurses Breakdown By Ward.xls	4 MM 040413 mins from 260213.pdf
5 Whistleblowing policy.docx	ACSLTC division final structure 24 04 13.pdf	Action Sheet from 13Jul12.pdf
Agenda.pdf	Agenda.pdf	Audit Committee Annual Report.pdf
Audit Committee AR Appendix A_Terms of Reference.pdf	Audit Committee AR Appendix B_Business Schedule 2012-13.pdf	Benefits Realisation Plan - May 2013 - PDF.pdf
Blackpool CHS Dashboard Q1 12.PDF	Blackpool CHS Dir Risk Register Q1 12.PDF	Board Assurance Framework (Jul to Sept) 24Oct12.pdf
Board Assurance Framework Oct to Dec 2012 RED FINAL.pdf	BVH_Wards.xlsx	Cardiac Dashboard Jan to Mar 2013.pdf
Cardiac Dashboard July to Sept 12.pdf	Cardiac Dashboard Oct to Dec 2012.pdf	Cardiac Risk Register Jan to Mar 2013.pdf
Cardiac Risk Register July to Sept 2012.pdf	Cardiac Risk Register Oct to Dec 2012.pdf	CEO and C and F Dashboard Jan to Mar 2013.pdf
CEO and C and F Risk Register Jan to Mar 2013.pdf	CEO Comms Dir Risk Register Q1 12.PDF	CEO&C Risk Register July to Sept 2012.pdf
CEO&C Risk Register Oct to Dec 2012.pdf	CEOCF Dashboard July to Sept 12.pdf	CEOFundComms Directorate Dashboard Q1 12.PDF
CHS Dashboard Jan to Mar 2013.pdf	CHS Dashboard Q3 2012.pdf	CHS Risk Register Jan to Mar 2013.pdf
CHS Risk Register Q3 2012.pdf	Clin Gov Dashboard Q3 2012.pdf	Clin Gov Risk Register Q3 2012.pdf
Clinical Audit Annual Report 2012-13.pdf	Clinical Gov Dir Dashboard Q1 12.PDF	Clinical Gov Dir Risk Register Q1 12.PDF
Clinical Governance Risk Regis July to Sept 12.pdf	Community HS Dashboard Jul to Sept 12.pdf	Corporate Risk Register (Jul to Sept) 24Oct12.pdf
Corporate Risk Register Q3 Oct to Dec 2012.pdf	CQC Compliance Report May 2013.pdf	CSFM Dashboard July to Sept 12.pdf
CSFM Dashboard Oct to Dec 2012.pdf	CSFM Risk Register July to Sept 2012.pdf	CSFM Risk Register Oct to Dec 2012.pdf
Deaths by Year BTH.docx	Divisional Mortality Reduction Plan 18 6 13.docx	Families Division Structure.doc
February_2013_Consultant Sign Off_Deceased REPORT.XLSX	Fin and Proc Dashboard Jan to Mar 2013.pdf	Fin and Proc Dashboard July to Sept 12.pdf
Fin and Proc Dashboard Q3 2012.pdf	Finance and Proc Dir Dashboard Q1 12.PDF	Finance Dir Risk Register Q1 12.PDF

Finance Report Appendices.pdf	Finance Report.pdf	Finance Risk Register Jan to Mar 2013.pdf
Finance Risk Register July to Sept 2012.pdf	Finance Risk Register Oct to Dec 2012.pdf	Fund Risk Register Jan to Mar 2013.pdf
Fundraising Dir Risk Register Q1 12.PDF	Fundraising Risk Register July to Sept 2012.pdf	Fundraising Risk Register Oct to Dec 2012.pdf
FW Un-coded report April and May.htm	Fylde Wyre CHS Dashboard Q1 12.PDF	Fylde Wyre CHS Risk Register Q1 12.PDF
HR and OD Dashboard Jan to Mar 2013_25th Mar_V2.pdf	HRandOD Dir Dashboard Q1 12.PDF	HRandOD Dir Risk Register Q1 12.PDF
Human Resources Risk Register Jan to Mar 2013_25th Mar_V2.pdf	Human Resources Risk Register Oct to Dec 2012.pdf	Human ResourcesRisk Register July to Sept 12.pdf
ICT Dashboard July to Sept 12.pdf	ICT Dashboard Oct to Dec 2012.pdf	ICT Dir Dashboard Q1 12.PDF
ICT Dir Risk Register Q1 12.PDF	ICT Risk Register Jul to Sep 12.pdf	ICT Risk Register Oct to Dec 2012.pdf
Item 0 Agenda 05 April 2013.pdf	Item 0 Agenda 11 January 2012.pdf	Item 0 Agenda 12 October 2012.pdf
Item 0 Agenda 13 July 2012.doc	Item 10 Items to be recommended for decision or discussion at the Board .pdf	Item 10 Recommended for Decision - Board.pdf
Item 10 Referral for Audit Committee.pdf	Item 10. Items to be recommended for decision or discuss...n by the Board .pdf	Item 11 (a) Q4 Monitoring Return Declaration_April 2013.pdf
Item 11 (a) Q4 Monitoring Return_April 2013 inc cover sheet.pdf	Item 11 (b) Finance Report Appendices.pdf	Item 11 (b) Finance Report.pdf
Item 11 (c) Working Capital Facility Appendix A_April 2013.pdf	Item 11 (c) Working Capital Facility_April 2013.pdf	Item 11 (d) Annual Report and Accounts Cover Sheet.pdf
Item 11 (d) Draft Annual Report.pdf	Item 11 (g) BoD update ALERT 24 04 13.pdf	Item 11 Items for referral to the Audit Committee.pdf
Item 11 Referral for Audit Committee.pdf	Item 11. Items for referral to the Audit Committee.pdf	Item 12 (a) Workforce Report 04-13 v3.pdf
Item 12 Procedural Documents for Approval.pdf	Item 12.1 Unscheduled Care - Risk Management Strategy FV4.pdf	Item 12.2 Surgical Division - Risk Management Strategy.pdf
Item 12.3 Cardiac Services - Risk Management Strategy FV5.pdf	Item 12.4 W and C Division - Risk Management Strategy.pdf	Item 13 (a) Board Report - Board Meetings in Public - Apri...2013 Revision 3.pdf
Item 13 (b) Health & Social Care Act 2012 Action Plan.pdf	Item 13 (d) Affixing of the Common Seal.pdf	Item 13 (e) Chairman's Communications.pdf
Item 13 (f) Declarations of Interests.pdf	Item 14 (a) Finance and Business Monitoring Committee F...Meeting 24.4.13.pdf	Item 14 (b) Healthcare Governance Committee Minutes - 05Apr13.pdf

Item 14 Feedback from Board Sub-Committees.pdf	Item 15 Board Legal Report - April 2013.pdf	Item 2 HCG Minutes 03May12.docx
Item 2 Healthcare Governance Committee Minutes 11 Jan 13.pdf	Item 2 HGC Minutes 12 Oct 12.pdf	Item 2 Previous Minutes 13 July 12.pdf
Item 3.1 Action List from the 13th May Meeting.docx	Item 3.1 Action Sheet - Healthcare Gov Comm - 12Oct12.pdf	Item 3.1 Action Sheet from 11 Jan 13.pdf
Item 3.1 Action Sheet from 13 Jul 12.pdf	Item 4 - Draft KPMG Report - Risk Management Assurance... Arrangements.pdf	Item 4 - Minutes of the Previous Meeting.pdf
Item 4.1 HS Meeting minutes 07.02.13.pdf	Item 4.1 Quality Governance Committee Minutes - 12 July 12.pdf	Item 4.2 Audit Committee 13.11.12.pdf
Item 4.2 Audit Committee 24.5.12 (1).pdf	Item 4.2 Health Informatics Committee 04.3.13.pdf	Item 4.2a Audit Committee Minutes 3.7.12.pdf
Item 4.2b Audit Committee Minutes 11 09 12.pdf	Item 4.3 Health and Safety and Environmental Governance...ittee 25.06.2012.pdf	Item 4.3 HS Environ Gov Committee Meeting 20.12.12.pdf
Item 4.3a Health and Safety Committee Minutes 31 August 12.pdf	Item 4.3b HS Meeting minutes 041012.pdf	Item 4.4 Health Informatics Committee - 29.05.2012.pdf
Item 4.4 Health Informatics Committee Minutes - 16 July 12.pdf	Item 4.4b Health Informatics Committee Minutes - 17 Sept 12 Draft.pdf	Item 4.5 Mortality Board 28 May 2012.pdf
Item 4.5a Mortality Board Minutes 26 Oct 12.pdf	Item 4.5a Mortalty Board Minutes 26 July 12.pdf	Item 4.5b Mortality Board Minutes 21 Sept 12 Draft.pdf
Item 4.5b Mortality Board Minutes 26 Nov 12.pdf	Item 5 (a) - Action List.pdf	Item 5 (b) - Action Tracking Document.pdf
Item 5 Minutes of Previous Meeting.pdf	Item 5.1 Integration of Community Services 28.03.13.pdf	Item 5.2 Lack of Ward Based Pharmacists Surgery.pdf
Item 5.3 Contract for outsourcing Medical Equipment Services.pdf	Item 5.4 IG 23 Failure to Maintain Health Record.pdf	Item 5.5 Temporary Theatre Room 7.pdf
Item 6 (a) Action List.pdf	Item 6 (b) Action Tracking Document.pdf	Item 6.1 E Discharge Cardiac.pdf
Item 6.1 Maternity Theatre Nov 2012.pdf	Item 6.1 Missing Case Notes referral letters and clinical correspondence.pdf	Item 6.1 Unscheduled Care Dashboard Jan to Mar 2013.pdf
Item 6.1 Unscheduled Care Register Jan to Mar 2013.pdf	Item 6.2 CSFM Dashboard Jan to Mar 2013.pdf	Item 6.2 CSFM Risk Register Jan to Mar 2013.pdf
Item 6.2 ICT Dashboard Jan to Mar 2013.pdf	Item 6.2 ICT Risk Register Jan to Mar 2013.pdf	Item 6.2 Lack of Doctors - Surgery.pdf
Item 6.2 Maintenance of Medical Devices.pdf	Item 6.2 Transfer of Acute Coronary Syndrome Patients - Nov 12.pdf	Item 6.3 Clinical Gov Risk Register Jan to Mar 2013.pdf

Item 6.3 Clinical Governance Dashboard Jan to Mar 2013.pdf	Item 6.3 Inability to recruit Junior Medical Staff - Nov 12.pdf	Item 6.3 Missing Case Notes, Referral Letters & Clinic Correspondenc.PDF
Item 6.4 Board Assurance Framework Overview Q4 Jan to Mar 2013.pdf	Item 6.4 Board Assurance Framework Q4 Jan to Mar 2013.pdf	Item 6.4 Lack of admin staff leading to delays in patients ...g listed for ops.pdf
Item 6.4 Lack of PC Replacement Scheme.pdf	Item 6.5 Corporate Risk Register Overview Q4 Jan to Mar 2013.pdf	Item 6.5 Corporate Risk Register Q4 Jan to Mar 2013.pdf
Item 6.5 NHSLA Risk Management Standards Risk Assessment.pdf	Item 7 (a) CEO Assurance Report.pdf	Item 7 (a) Compliance Monitoring Assurance Report.pdf
Item 7 (b) CEO Monthly Update.pdf	Item 7 (c) (i) Appendix 1 - Francis Recommendation Action Plan Apr13.pdf	Item 7 (c) (i) Appendix 2 - Board Report - Francis Board Response.pdf
Item 7 (c) (i) Board Report - Francis Response (updated 24 May am).pdf	Item 7 (c) (ii) Annual Strategic Plan 1314draft 6.pdf	Item 7 (c) (iii) Board Committee Structure.pdf
Item 7 (d) (i) Finance and Business Monitoring Committee...inutes - 22.4.13.pdf	Item 7 (d) (ii) Audit Committee Feedback and Minutes - 30.4.13.pdf	Item 7.1 Cardiac Risk Register Dashboard.pdf
Item 7.1 Cardiac Risk Register.pdf	Item 7.1 CAS Report 1st Jan to 31st Mar 13.pdf	Item 7.1 Finance and Procurement Directorate Dashboard.Risk Register.pdf
Item 7.1 Human Resources and Organisational Developme...ister Summary.pdf	Item 7.2 CNST Maternity Level 2 Assurance Report 020413.pdf	Item 7.2 CommunicationsFundraising Risk Register Summary.pdf
Item 7.2 CSFM Risk Register Dashboard.pdf	Item 7.2 Performance Improvement Directorate Dashboard.Risk Register.pdf	Item 7.3 CSFM Risk Register.pdf
Item 7.3 NHSLA Assurance Report.pdf	Item 7.3 Scheduled Care – Surgery Risk Register Summary.pdf	Item 7.3 Unscheduled Care Risk Register Dashboard.pdf
Item 7.3 Unscheduled Care Risk Register.pdf	Item 7.3 Women's and Children's Directorate Dashboard.Risk Register.pdf	Item 7.4 Annual Workplan 2012.pdf
Item 7.4 Board Assurance Framework Summary Oct – Dec 2012.pdf	Item 7.4 CHS North North Lancashire Risk Register Dashboard.pdf	Item 7.4 CHS North North Lancashire Risk Register.pdf
Item 7.4 Community Risk Register Blackpool Sept 11 (5).pdf	Item 7.4 NHS North Lanc North Risk Register Sept 11.pdf	Item 7.4 North Lanc South Risk Register Sept 11.pdf
Item 7.5 Attendance Monitoring 2012-13.pdf	Item 7.5 Board Assurance Framework Dashboard.pdf	Item 7.5 Board Assurance Framework Risk Register.pdf
Item 7.5 Board Assurance Framework Summary	Item 7.5 Corporate Risk Register Summary Oct - Dec	Item 7.6 Corporate Risk Register Dashboard Q2.pdf

Dashboard.pdf	2012.pdf	
Item 7.6 Corporate Risk Register Dashboard.pdf	Item 7.6 Corporate Risk Register.pdf	Item 7.6 Draft Annual Governance Statement 2013 PSMV2 (04.04.13) (1).pdf
Item 8 (a) - Chairman's Report.pdf	Item 8 (a) Chief Executive Report April 2013.pdf	Item 8 (a) NHS Constitution.pdf
Item 8 (a) Principles of the NHS Constitution.pdf	Item 8 (b) Corporate Objectives 2013-14 - Quarterly Update.pdf	Item 8 (c) KPMG Quality Governance Review Action Plan - High Med Low.pdf
Item 8 (d) Board Assurance Framework Overview Q4 Jan to Mar 2013.pdf	Item 8 (d) Board Assurance Framework Q4 Jan to Mar 2013.pdf	Item 8 (e) Corporate Risk Register Overview Q4 Jan to Mar 2013.pdf
Item 8 (e) Corporate Risk Register Q4 Jan to Mar 2013.pdf	Item 8 Procedural Documents for Approval.pdf	Item 8.1 NPSA Report.pdf
Item 8.1 Risk Assessment and Risk Register Training Report Q4 and Q1.pdf	Item 8.1a Lessons Learned Newsletter Oct 2012.pdf	Item 8.1b Lessons Learned Newsletter Nov 2012.pdf
Item 8.1c Lessons Learned Newsletter Dec 2012.pdf	Item 8.2 StEIS - SUI Report January 2013.pdf	Item 8.2a Lessons Learned Newsletter March 2012.pdf
Item 8.2a Safety Lessons Learned Newsletter - July 2012.pdf	Item 8.2b Lessons Learned Newsletter April 2012.pdf	Item 8.2b Safety Lessons Learned Newsletter - August 2012.pdf
Item 8.2c Lessons Learned Newsletter May 2012.pdf	Item 8.2c Safety Lessons Learned Newsletter - Sept 2012.pdf	Item 8.2d Lessons Learned Newsletter June 2012.pdf
Item 8.3 StEIS Incidents, SCR, Never Event.pdf	Item 8.3 Steis SUI report July-Sept 2012.pdf	Item 8.3a CAS Report 1st Oct - 31st Dec 12.pdf
Item 8.3b CAS Training Report - 02 Jan 13.pdf	Item 8.4 Central Alert System Assurance Report (July – Sept 2012).pdf	Item 8.4 Central Alert System Assurance Report inc CHS (July – Sept 2012).xlsx
Item 8.4 Central Alert System Assurance Report inc CHS April-June 2012.pdf	Item 8.4 CNST Maternity Level 2 Assurance Report.pdf	Item 8.5 CNST Maternity Level 2 Action Plan and Progress Report.pdf
Item 8.5 CNST Maternity Level 2 Action Plan and Progress Report.pdf	Item 8.5 NHSLA Level 3 Report.pdf	Item 8.6 CQC and QRP Profile Report Oct - Dec 2012.pdf
Item 8.6 NHSLA General Level 3 Progress Report.pdf	Item 8.6 NHSLA General Level 3 Progress Report.pdf	Item 8.7 LSMS 6 month Report Apr-Sep 2012 Final.pdf
Item 8.7 Risk Management Annual Report.pdf	Item 8.8 Annual Work Plan.pdf	Item 8.8 Annual Work Plan.pdf
Item 8.8 Annual Workplan Items - RAG Rated.pdf	Item 8.9 Attendance Monitoring 2012-13.pdf	Item 8.9 Attendance Monitoring.pdf
Item 8.9 Attendance Monitoring.pdf	Item 9 - Attendance Monitoring.pdf	Item 9 (b) Patient Safety Report April 2013.pdf
Item 9 (c) Q4 Patient Experience Report Jan to March	Item 9 (d) Q4 Clinical Audit Report 2012-13 FINAL FOR	Item 9 (e) Mortality Reduction Action Plan Update (April

13.pdf	BOARD.pdf	2013).pdf
Item 9 (e) Mortality Reduction Journey Map (April 2013).pdf	Item 9 (f) April 2013 StEIS - Board Report Uploaded.pdf	Item 9 (g) Research & Development Quarterly Update (April 2013).pdf
Item 9 (h) Governance Report April 2013 - Final Q4.pdf	Item 9 (i) Business Monitoring Report - March 13v2.pdf	Item 9 (i) PES Board Report March 13.pdf
Item 9 List of Procedural Documents.pdf	Item 9 Policies - Procedures - Strategies for Approval.pdf	Item 9 Recommended for Decision Board.pdf
Membership Report May 2013.pdf	Mort_Dash_CoE_20130521.xlsx	Mort_Dash_GEN_MED_20130521.xlsx
Mort_Dash_Trust_20130521.xlsx	Mort_Dash_USC_20130521.xlsx	Mortality Report Coding Review.xlsx
Mortality_Report_Apr13.docx	Patient Relations Annual Report.pdf	Per Improvement Dashboard Q3 2012.pdf
Per Improvement Risk Register Q32012.pdf	Perf Imp Dashboard Jul to Sep 12.pdf	Perform Plan Dir Dashboard Q1 12.PDF
Perform Plan Dir Risk Register Q1 12.PDF	Performance Im Risk Register July to Sept 2012.pdf	Performance Improvement Dashboard Jan to Mar 2013.pdf
Performance Improvement Risk Register Jan to Mar 2013 _25th Mar_.pdf	Procurement Dir Risk Register Q1 12.PDF	Procurement Risk Register Jan to Mar 2013.pdf
Procurement Risk Register July to Sept 2012.pdf	Procurement Risk Register Q3 2012.pdf	Quality Improvement Faculty (May 2013).pdf
Readmission_ speciality.xlsx	Scheduled Care structure November 2012.ppt	Stroke_Analysis_Apr13.xlsx
Structure CSFM November 2012.ppt	SUIs - May Board Report.pdf	Surgery Dashboard Jan to Mar 2013.pdf
Surgery Dir Dashboard Q1 12.PDF	Surgery Dir Risk Register Q1 12.PDF	Surgery Risk Register Jul to Sep 12.pdf
Surgical Risk Register Jan to Mar 2013.pdf	Surgical Risk Register Oct to Dec 2012.pdf	Unscheduled Care Risk Register July to Sept 12.pdf
Unscheduled Care structure November 2012.ppt	USCare Dashboard Oct to Dec 2012.pdf	USCare DashboardJul to Sep 12.pdf
USCare Risk Register Oct to Dec 2012.pdf	W and Child Dir Dashboard Q1 12.PDF	W and Child Dir Risk Register Q1 12 .PDF
WandChil Dashboard Jul to Sep 12.pdf	WC Dashboard Jan to Mar 2013.pdf	WC Dashboard Oct to Dec 2012.pdf
WC Risk Register Jan to Mar 2013.pdf	WC Risk Register Oct to Dec 2012.pdf	Women & ChildrenRisk Register Jul to Sept 12.pdf
Workforce Report.pdf		

Appendix VII: Unannounced site visit

Agenda item
Panel pre-meet
Entry into Blackpool Victoria Hospital and announced arrival to site manager
Interview with bed manager to understand current patient levels
Observations undertaken of the following: • Accident and Emergency • Medical Assessment Unit • Wards 23 and 24 (Respiratory Wards) • Surgical Assessment Unit • Coronary Care Unit • Escalation Ward • Acute Medical Unit • Female Orthopaedic Ward (ward 35) • HDU (high dependency unit) • Ward 25 and 26 (elderly care wards)
Meeting held with site manager to understand current staffing and patient levels
Panel left Trust and announced exit

Blackpool Teaching Hospitals NHS Foundation Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

Key Findings and Action Plan following Risk Summit

July 2013

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1. Overview 3

2. Summary of Review Findings including Trust response 7

3. Risk Summit Action Plan 15

Appendices 19

Appendix I: Risk Summit Attendees 20

1. Overview

A risk summit was held on 11 July 2013 to discuss the findings and actions of the Rapid Responsive Review (RRR) of Blackpool Teaching Hospitals NHS Foundation Trust ("the Trust"). This report provides a summary of the risk summit including the Trust response to the findings and an outline action plan for the urgent priority actions. The outline action plan includes any agreed support required from health organisations, including the regulatory bodies.

Overview of review process

On 6 February 2013 the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR)[1].

These two measures are intended to be used in the context of this review as a 'smoke alarm' for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) **Patient and public participation** – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals, and this is reflected in the reports. The Panel also considered independent feedback from stakeholders related to the Trust, received through the Keogh review website. These themes have been reflected in the reports.

2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be publicly available.

4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

[1] Definitions of SHMI and HSMR are included at Appendix I of the full Rapid Responsive Review report published here http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:

  i. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
  ii. Any additional external support that should be made available to these Trusts to help them improve.
  iii. Any areas that may require regulatory action in order to protect patients.

The review followed a three stage process:

- **Stage 1** – **Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLoEs). The data pack for the Trust is published at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

- **Stage 2 – Rapid Responsive Review (RRR)**

A team of experienced clinicians, patients, managers and regulators, following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and interviewing patients, trainees, staff and the senior executive team. This report contains a summary of the findings from this stage of the review in section 2.

The two day announced RRR visit took place at the Trust's main site, Blackpool Victoria Hospital and Clifton Hospital on Monday 17 June and Tuesday 18 June 2013 and the unannounced visit took place at Blackpool Victoria Hospital on the evening of Sunday 23 June 2013. A variety of methods were used to investigate the Key Lines of Enquiry (KLoEs) and enable the panel to analyse evidence from multiple sources and follow up any trends identified in the Trust's data pack. The KLoE and methods of investigation are documented in the RRR report for Blackpool Teaching Hospitals NHS Foundation Trust. A full copy of the report was published on July 16th 2013 and is available online: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

- **Stage 3** – **Risk summit**.

This stage brought together a separate group of experts from across health organisations, including the regulatory bodies (Please see Appendix I for a list of attendees). The risk summit considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned.

The Risk Summit was held on 11 July 2013. The meeting was Chaired by Richard Barker, NHS England Regional Director (North), and focussed on supporting the Trust in addressing the urgent actions identified to improve the quality of care and treatment. The opening remarks of the Risk Summit Chair and presentation of the RRR key findings were recorded and are available online: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Conclusions and priority actions

The RRR identified a number of areas of concern across all seven KLoEs. For the majority of areas the RRR panel identified a number of improvements either already underway at the Trust or planned actions. Seven urgent priority areas were identified for discussion at the risk summit. These are summarised in the following sections and are detailed within the RRR report.

The RRR panel told the risk summit that the Executive team had been open, allowed access to all areas of the Trust and were transparent during the review. The RRR panel considered that the Board displayed a positive attitude and were supportive of the new Executive team in making the required changes. The Trust staff were enthusiastic and committed to change. They were candid about the issues they faced and also the positive aspects of working at the Trust.

The Trust has been proactive in seeking external reviews to find solutions, however the pace of change is not at the level required to deliver the needed improvements in patient care. There has been lots of planning over the last two years, for example on stroke, pneumonia, cardiac and respiratory disease pathways but the Board must prioritise the changes that impact most on mortality and morbidity, in particular for elderly care and focus on the delivery and implementation of changes at ward level. Some of the changes are in the gift of the Trust but it must also work with Blackpool CCG, Fylde and Wyre CCG and the Lancashire Area Team to deliver improvements.

The RRR panel told the risk summit that there was a disconnect between Trust leadership and ward staff which lead to plans not being implemented at ground level, for example the RRR panel were given assurance by the Board that the pneumonia pathway was in place however the RRR panel did not evidence it in use on the respiratory wards. There was evidence of some pathways being developed, but this needs to be more systematic throughout the Trust. The Trust needs a standardised approach across the organisation to engage staff in the implementation of pathways.

The RRR panel found that nursing staff were possibly over reliant on the acute response team, which received lots of positive feedback from doctors and nurses. The panel reported that there is a risk that this will lead to a de-skilling in management of the deteriorating patients by ward staff. The RRR panel evidenced examples of poor documentation to support the care provided on wards. The panel saw lots of data on the wards using safety crosses, however, when probed nursing staff were not engaged with and therefore did not take ownership of the data.

There were a number of examples of issues with staff engagement. Nurses spoke of feeling like they did not having support to challenge poor medical care. In addition, there was a lack of engagement with the consultants about decisions made at a strategic level, for example 7 day working. The Trust leadership must engage with staff in order to deliver the required level of change and the Board must get assurance that what is think is happening on the wards is actually happening. The Trust leadership, including Non Executive Directors must support staff by being more visible on the wards, particularly out of hours.

There was some evidence of public and patient engagement and involvement but the Trust should do more. At the listening event attended by about 120 people the panel heard both positive and negative stories, some but not all of which were historical. The panel heard a number of people speak of good care received from nurses but

that this was inconsistent between wards and patients considered nurses to be over stretched. Communication was reported to the panel as a particular issue with patients not getting information on their treatment and discharge and reported having to chase Trust staff to get responses.

The RRR panel observed that nursing staff levels are inconsistent across the Trust, particularly on elderly care wards. **The RRR panel recognised that recruitment is an issue at the Trust which will need innovative solutions and support from the wider health economy to solve.** The Trust needs to think of alternative systems to ensure they have the right medical and nursing staff in the right place at the right time.

The risk summit panel accepted the outline action plan presented by the Trust but challenged on what the vision for success looks like and asked Trust representatives to develop it at a more granular level. The plan must focus on immediate actions to address the urgent recommendations but then must focus on transformational change and address the issue of mortality directly. The action plan must be much more patient focussed and the feedback from patients and the public must be used as a lever to develop the transformation plan. The risk summit panel told the Trust that this transformational change required a cohesive wider system response and the local health economy and other key stakeholders must have clear responsibilities for delivering the action plan. The delivery of a long term, transformation plan requires the Trust to work with the wider system to develop a workforce strategy for the region (including other Trusts), strengthen clinical networks to support the implementation of pathways, change the culture in the organisation to build on best practice and create a fresh approach to listening to patients and use their experience to drive change through the transformation agenda. The Trust's response is set out in the detailed findings below.

Next steps

As the risk summit had focused on urgent priority actions, the Trust also agreed at the risk summit to provide a detailed action plan to all outstanding concerns and recommended actions included in the RRR report by 8 August 2013.

Follow up of the RRR and risk summit action plan will be undertaken by other organisations within the system, including Blackpool CCG, Fylde and Wyre CCG, the Lancashire Area Team and the Care Quality Commission through the Quality Surveillance Group. A formal follow up will consist of a desktop review and a targeted one day site visit to the Trust in January 2013 reviewing key areas to understand the improvements that have taken place. A report of the follow up findings will be issued to the risk summit attendees and will consider, if there are significant remaining concerns, if there is a need to convene a further risk summit.

2. Summary of Review Findings and Trust response

Introduction

The following section provides a summary of the RRR panel's findings and the Trust's response presented at the risk summit. The detailed findings are contained in the Trust's RRR Report. The Trust response was presented by Gary Doherty, Chief Executive, supported by Mark O'Donnell, Medical Director, and Marie Thompson, Director of Nursing. The agreed outline action plan in response to the urgent priorities is included in the following section.

Overview of Trust response

The Trust thanked the RRR panel for the way the review had been conducted. The Trust welcomed the review and its findings and recognised the issues identified. The Trust want to do everything they can to improve patient experience and be a good employer.

The Trust accepted the report as a fair account and found the review helpful in emphasising what the Trust needed to focus on going forward. The Trust recognised the need to increase the pace of change that the RRR report was a call to action to progress change more quickly. An outline action plan was agreed at the risk summit addressing all the urgent priority actions discussed. The Trust agreed to complete a full action plan that was more outcome focussed and patient centred and forward this to all stakeholders, including Monitor and CQC by mid August. The Trust is keen to work with partners in the local health economy to take forward the action plan and implement change quickly.

The Trust reported to the panel that they have put in place a committee for pathways and workforce alongside the pre-existing delays committee which will report in to the Better Care Now Project Board. The Better Care Now Project Board will give assurance to the Quality Committee and the Fylde Coast Commissioning Advisory Board that a single action plan with milestones is being implemented.

1. Communication

There appears to be a considerable disconnect between those that deliver services, especially acute care and those that set strategic direction which is preventing implementation of the Trust's quality plan at ward and divisional level.

A number of communication challenges were found at the Trust:

- Information was not being systematically shared across the Trust. This inhibits the pace of change and means that the Trust is not using its resources in the most effective manner.
- Good practice areas found in a number of wards were not being shared with other wards.
- There is disconnect between what the Board assumes is being implemented and what is actually being done.
- There is a lack of connectivity between the Board and clinical leads.
- There is a considerable disconnect between those that deliver the services especially in acute care and those that set the strategic direction.

Recommendation

There needs to be a coordinated approach to the implementation of change within the Trust and the focus should be on a bottom-up approach to change, rather than top-down. A number of good initiatives have been put in place at the Trust, but with apparently limited success in terms of front-line ownership.

Trust response

The Trust described the outline action plan to address the issue which included a review of the effectiveness of current arrangements and the development of an action plan to get staff engaged with the strategic direction of the Trust. The Chief Executive has been in post for three months and plans to undertake 'road shows' to engage with staff, with a particular focus on unscheduled care.

The Trust requested external expertise to support the road-shows. The Trust will discuss what support will be provided with the CCGs and Lancashire Area Team before mid August. The CCG offered to provide support to the Trust on developing communication with staff below Matron level.

The risk summit panel accepted the action plan.

2. The pace of change at the Trust has been too slow

Although not helped by a number of changes in the senior leadership team, the pace of change at the Trust in the past couple of years has been slow.

Although the Trust has been pro-active in terms of conducting external reviews, e.g. Advancing Quality Alliance (AQuA), they have been slow to implement the actions following on from these reviews. When reviewing documentation provided by the Trust, including notes from Board meetings, the panel noted a number of actions that have been due to take place for a number of months that have not been implemented yet.

The number of actions that the leadership team is looking to implement are too great which may be hampering the speed of change of the critical actions that the Trust needs to complete. For example, the Trust is looking to implement in excess of 50 new pathways in response to the mortality concerns at the Trust. The Trust may be more effective if it concentrated on the most important areas where it has mortality concerns.

Recommendation

The Trust's Board should concentrate on the mission critical actions that need to take place to address the mortality concerns in the areas where it is an outlier.

The Board must prioritise actions that are critical to pathways particularly for stroke, myocardial infarction, pneumonia and sepsis.

The Trust's Board should also ensure all of the major programmes that it manages have a strong project management framework, with clear milestones to aid with prioritisation and the tracking of progress. This should be made transparent to staff who are implementing change so that they are clear on the objectives and milestones.

Trust response

The Trust described the outline action plan to address the issue. This included the establishment of a Quality Improvement Faculty to triangulate performance information. The Trust will complete daily monitoring of compliance with pathways focusing on the first 24-36 hours of patient care. Where there is variation in compliance identified steps will be put in place to address the issue. The Trust will consider how feedback from staff and results of daily monitoring are used to change the current staff engagement initiatives in place.

The Trust requested examples of good practice from other Trusts.

The risk summit panel told the Trust that the Board must prioritise urgently actions to address areas of high mortality particularly for stroke, myocardial infarction, pneumonia and sepsis.

The risk summit panel told the Trust that they need to engage staff in the delivery of planned changes if they are to be implemented with pace. The risk summit panel urged the Trust to use information to focus this engagement, for example, areas where appraisal rates are poor or there are inconsistencies in application of pathways. The risk summit panel told the Trust that there was not enough emphasis on ownership by clinical staff. The 68% appraisal rate could be symptomatic of engagement

2. The pace of change at the Trust has been too slow

issues. The Trust staff need re-energising and need to be able to hold their peers to account for pathway implementation in order to make the changes required.

The General Medical Council (GMC) told the Trust that all doctors should have an appraisal supported by performance data. The GMC offered support to the Trust to aid revalidation activity.

The risk summit panel told the Trust that they had not done enough to understand what the public and patients thought about their action plans and planned changes. The Trust responded that the action plan would be discussed at the public Board meeting and it would consider if information about serious incident reporting could be shown on the Trust website and other public areas. The risk summit panel recommended that the Trust has lay representation in the governance structure, for example on the Better Care Now Board.

The risk summit accepted the action plan.

3. Serious incidents

The incident review system is unreliable in terms of consistent reporting and classification of serious incidents, multi-disciplinary investigation and dissemination of findings. Incident reporting is inconsistent between wards and some staff members expressed difficulties in reporting incidents. Whilst staff on some wards could describe how learning is shared through the incident reporting process, others could not.

Nursing staff reported to the panel that incident reporting is 'time consuming' and that there are not enough computers available for reporting because they are being used or are out of use. Nursing staff reported that feedback and learning from incident reporting, complaints and mortality meetings could be done more consistently.

Recommendation

The Trust should review its process for reporting serious incidents to ensure there is sufficient time and equipment available for reporting.

The Trust should ensure that the results of all serious incident reporting are made available to Trust staff so that the learning is disseminated and staff are encouraged to maintain a reporting culture.

The Board should assure themselves that serious incidents have been graded correctly especially those where the incident has been downgraded.

The Trust should consider re-launching the incident reporting policy with a trigger list and guidance on what to report in order that near misses are captured as well as harm events.

Trust response

The Trust described the outline action plan to address the issue which includes rolling out the TalkSafe training targeting areas of greatest risk first, a gap analysis on IT to ensure staff are able to report serious incidents and an audit of serious incidents where grading is reduced to ensure the change is appropriate.

3. Serious incidents

The risk summit panel told the Trust they need to be transparent and share with the public information on serious incident reporting. The CCGs offered to provide support on serious incident reporting. The risk summit panel accepted the action plan.

4. Staffing levels and skill mix

The panel evidenced that medical and nursing staffing levels and skill mix were not appropriate or well managed. Not having the right level and mix of staff in some areas presents a significant risk to the Trust.

The Board recognises that they still need to do more work on the workforce strategy, for example, rotations for nurses and new models for staffing. Staffing levels were reviewed a year ago and the findings were that there is not enough unscheduled care nursing staff and that the doctor to bed ratio was not sufficient. Both the Executive team and Clinical Directors interviewed recognised that recruitment was difficult for the Trust

There was also a concern raised by Consultants over job planning as, like appraisals, it is not undertaken often enough. There were concerns from staff that teaching, CPD (continuous professional development) and other roles required within specialities e.g. governance lead, are not covered properly. There is some concern amongst Consultants that locums are brought in and paid higher rates than them which presents a risk to long-term recruitment/retention of consultants. The Associate Medical Director and interim Human Resources (HR) Director both admitted there had not been a meaningful job planning policy until recently. The Trust does not appear to use internal job planning in a systematic way to review how consultants can be used more efficiently.

Recommendation

The Trust needs to urgently assure itself that whilst recruitment of more staff is underway the current staffing levels on the wards and departments listed are safe, particularly out of hours, until further nurses and medical staff are recruited.

The Trust needs to further develop its workforce strategy.

The Trust should review all consultant job plans across acute medicine and surgery to reduce pressure on external recruitment plans. The Trust should also develop a retention policy to retain staff long term.

The Board should triangulate information on staffing levels at individual ward level with quality information including serious incidents, falls, infection control rates, pressure ulcers, mortality rates, complaints and staff feedback. This should be used to assure that investment in additional staff is improving patient safety and to identify where further investment is needed. Staffing decisions should also be linked to prioritise patients with the most acute care needs.

4. Staffing levels and skill mix

Trust response

The Trust described the outline action plan to address the issue including a review of staffing levels and skill mix to ensure that the workforce strategy is robust enough. This will include benchmarking staffing levels with other Trusts. The Trust has already increased out of hours agency support for unscheduled care and will increase staff levels elsewhere in the Trust by October. The Trust will review current escalation options e.g. for unplanned sickness.

The risk summit told the Trust that it was a reoccurring theme that nursing care was good but there was a shortage of nurses. The risk summit panel told the Trust they needed to take immediate action to address nurse shortages where indentified by the RRR.

The Trust requested support from CCG's, primary care partners, the Deanery and universities to find innovative ways of recruiting and retaining medical and nursing staff. The CCGs and Lancashire Area Team offered to support the Trust on workforce issue and obtain assurance on the process. The Trust was advised to work with Health Education England on short and long term strategy.

The Trust also requested best practice examples of where reports have been developed to triangulate performance information with staffing levels/skill mix from other Trusts.

The risk summit panel urged the Trust to use the junior doctors as the 'eyes and ears' of the organisation and to understand why recruitment is an issue at Blackpool. They should also talk to consultants to understand if their training needs to be refreshed so that they can enthuse and engage with junior doctor training. The risk summit recognised that the Trust has a challenge with recruitment but told the Trust that they had not done enough to find a solution with good public relations (PR) from external support.

The risk summit panel accepted the action plan.

5. Clinical leadership

The panel heard mixed reports from nursing and medical staff regarding the visibility of the leadership team, particularly out of hours.

Recommendation

The Trust should undertake a regular programme for all clinical leaders and Board members to visit patient care areas, including out of hours, and to feedback to frontline staff their observations and actions taken as a result of the visit.

Trust response

The Trust described the outline action plan to address the issue. This included increasing senior visibility out of hours for example, attending the hospital when on call out of hours. The Trust will review the existing processes for Board visits to patient care areas and agree how to strengthen, for example each Board member wouldbe

5. Clinical leadership

aligned to wards and be a link for staff on the ward to the Board. Road shows will be used to increase the visibility of the Chief Executive and senior clinical leaders.

The risk summit panel accepted the action plan.

6. Patient safety

The panel evidenced a number of patient safety concerns during the announced and unannounced visits as listed below:

- The acute response team aspires to good practice but is unable to accelerate early intervention due to staffing levels on wards.
- The SALT (speech and language team) spoke of a review of patients with aspiration pneumonia, the results of which showed that 41% had not received a SALT assessment.
- There are often delays in obtaining pressure relieving mattresses on wards.
- Documentation was incomplete in a number of areas.
- Cultural issues noted in cardiac surgery department. There was some evidence of poor working relationships and a lack of clear plan to improve working conditions. This issue will be discussed with CE who will be expected to develop a strategy for improvement.
- At the unannounced visit on 23 June safety crosses showing performance information such as falls, infection control and complaints had not been completed on a number of wards since the 19 June (after the announced visit).
- Issues of compliance with the World Health Organisation (WHO) checklist
- Awareness and implementation of the infection control policy (discussed further below) and the serious incident policy (noted above)
- Unlocked drug storage cupboard on the High Dependency Unit (HDU)
- Inadequate toilet facilities in some areas.

Recommendation

The Trust should develop an action plan to implement the required improvements to patient safety in the specific wards and departments listed.

Trust response

The Trust listed areas of work prioritised:

- Ward 12 toilets – a plan has been drawn-up commencing August 2013 to upgrade the toilets, make a designated disabled toilet and to improve storage solutions on all the wards.
- Pressure Relieving Mattresses, the Trust has procured additional mattresses.
- Drug Storage HDU – the Trust has visited the ward to ensure that the Dangerous Drugs of Addiction (DDA) cupboard is locked
- Phase V storage areas – work has been undertaken to improve storage in the wards identified in the RRR. The ward has also had a ‘clean and tidy’ and will be

6. Patient safety

monitored going forward.

- Ward 35 retrospective serious untoward incident (SUI) review to understand why a fall had not been reported as an SUI in a timely manner.
- Safety Crosses – the incomplete safety crosses have been updated to include missing performance information.

Action plan to be developed to address all issues highlighted within the review. Assurance will be sought by the Quality Surveillance Group.

7. Awareness and implementation of infection control policy

The panel evidenced the infection control policy not being implemented.

On the unannounced visit the door for a patient in a side room on a ward was open despite a sign on the door labelled as 'reverse barrier nursing'. The door was open because the patient was leaving the room to use a communal toilet, which is a further concern as reverse barrier nursing is used to isolate patients to avoid the spread of infections. On some wards, items were stored in bathrooms and toilets, posing an infection control risk. In particular, there were linen items stored in a patient bathroom on a ward.

Recommendation

The Board should seek assurance that the infection control policy is being implemented in all areas of the Trust as a matter of urgency.

The Trust should also ensure all staff are aware of the importance of infection control policy and conduct regular audits to check compliance.

Trust response

The Trust described the outline action plan in place to address the issue. This included an immediate visit to the identified wards by the Director of Nursing which has been completed prior to the risk summit. An audit of compliance will be completed in August 2013.

The risk summit panel accepted the action plan.

3. Risk Summit Action Plan

Introduction

The risk summit developed an outline plan focused on the urgent priority actions from the RRR report. The following section provides an overview of the issues discussed at the risk summit with the developed outline action plan containing the agreed actions, owners, timescales and external support. The risk summit panel recommended that the Trust works with the CCG and the Lancashire Area Team to develop a more detailed action plan and program of support by mid August 2013.

Action plan

Key issue	Agreed action and support required	Owner	Timescale
1. There appears to be a considerable disconnect between those that deliver services, especially acute care and those that set strategic direction which is preventing implementation of the Trust's quality plan at ward and divisional level.	• Review of current engagement processes to immediately increase visibility/engagement e.g. Executive team and Leadership team patient safety walkabouts, Chief Executive (CEO) question time, refresh of vision and values • Agreement /implementation of new approaches e.g. Listening into Action • CEO, Executive Team Road shows with staff - Trust wide • CEO, Executive Team Road shows - Unscheduled Care	CEO CEO CEO CEO	July 2013 September 2013 July/August 2013 July/August 2013
2. The pace of change at the Trust in the past couple of years has been slow. The high number of actions that the leadership team is looking to implement may be hampering the speed of change of the critical actions that the Trust needs to complete.	• New Programme structure with dedicated Project Management Support • Daily monitoring of compliance with mission critical points on pathways - with appropriate action/escalation: o Pneumonia o Stroke o Sepsis o MI • Establishment of Quality Improvement Faculty • Review/changes to current engagement processes and initiatives	Director of Operations Director of Operations Medical Director CEO	August 2013 August 2013 September 2013 October 2013 November 2013 August 2013 September 2013

Key issue	Agreed action and support required	Owner	Timescale
3. The incident review system is unreliable in terms of consistent reporting and classification of serious incidents, multi-disciplinary investigation and dissemination of findings.	• Roll out the Families Division system including re-launching the incident reporting policy • Do/act on gap analysis so sufficient information technology (IT)equipment is available • Introduce random audits of incidents where the score is reduced, with results being reported to the Quality Committee • Review TalkSafe roll out and target on those areas of greatest risk • Review processes for learning from serious untoward incidents (SUI's) and link to educational opportunities in the simulation suite / clinical skills centre	Director of Nursing Director of Transformation Director of Nursing Director of Nursing/Medical Director	August 2013 onwards August 2013 July 2013 August 2013 August 2013
4. The panel evidenced that medical and nursing staffing levels and skill mix were not appropriate or well managed. The Trust has recruitment challenges particularly with regards to consultants and nurses.	• Immediate review of staffing levels and skill mix in areas identified by the RRR report • Checkpoint to review progress made and consideration of implications over winter • Strengthen existing approaches to reviewing staffing and skill mix • Staffing level review by Medical Director & Director of Nursing • Increased out of hours agency nursing support • Benchmark nurse staffing and consider need for external review • Review of current escalation options/decision making, including discussion with partners • Produce Workforce Strategy, working with CCG's, Primary Care , Deaneries, Universities and other Trusts • Enhance the Weekly Performance reports to the Executive team (vacancy levels and staff shortages/transfers between wards) with monthly profile set to improve in all areas • Develop report to triangulate key data (e.g. vacancies, SUIs, falls, infections, complaints, staff satisfaction etc) to report to the Quality Committee • Review all consultant job plans in medicine and surgery to reduce pressure on external recruitment and then agree those areas for immediate recruitment outside of traditional business case process	Trust Trust Nursing / Medical Director Nursing / Medical Director Director of Nursing Director of Nursing Director of Operations Director of HR Director of HR Director of Operations	July/August 2013 Checkpoint to be included in monthly commissioner meetings as part of whole system stock take. July 2013 July 2013 July 2013 and ongoing August 2013 August 2013 October 2013 July 2013 and ongoing August 2013 August 2013

Key issue	Agreed action and support required	Owner	Timescale
	• Work with the wider health economy to develop an effective recruitment strategy which will address staff gaps across the Trust	Director of Operations/Medical Director	August 2013
5. The panel heard mixed reports from nursing and medical staff regarding the visibility of the leadership team, particularly out of hours.	• Increase the senior visibility out of hours • CEO, Executive Team Road shows with staff - Trust wide • CEO, Executive Team Road shows - Unscheduled Care • Review existing processes for Board visits to patient care areas and agree how to strengthen	CEO CEO CEO CEO/Chairman	July 2013 July 2013 July 2013 August 2013
6. The panel evidenced a number of patient safety concerns during the announced and unannounced visits.	• Action plan to be developed to address all issues highlighted within the review (page 46-52 of RRR) • Areas actioned to date: o Ward 12 toilets – work starts August o Pressure Relieving Mattresses o Drug Storage HDU o Phase V storage areas o Ward 35 retrospective SUI review o Safety Crosses – updated Trust to provide assurance to the Quality Surveillance Group (QSG) on the actions completed to date	Director of Operations/Director of Nursing	August 2013 As part of development of detailed action plan.
7. The panel evidenced the infection control policy not being implemented.	• Updated Integrated Staph Aureus Care Pathway launched 13 June 2013 • Immediate visit to ward 23 and 24 by Divisional Lead Nurse and Director of Nursing • Read and sign process – all wards • Audit of compliance	Director of Nursing Director of Nursing Director of Nursing	Completed Completed By 15 July 2013 August 2013

Key issue	Agreed action and support required	Owner	Timescale
Risk summit output - To ensure improvements are sustainable, a programme of transformation and engagement is needed	• Agreement /implementation of new approaches to Trust wide staff engagement in service improvement and cultural transformation • Review existing arrangements for patient and public involvement and agree how improvements can be made • Ensure that whole health system clinical pathways are reviewed and transformed, with a particular focus on frail elderly patients	Trust Trust working with senior regional clinical leadership Trust working with senior regional clinical leadership	September 2013 September 2013 October 2013
Risk summit output - Give full support to, and receive support from, all key NHS stakeholders	• Participate fully in existing clinical networks and work with the Lancashire Area Team in the development and implementation of a Lancashire Clinical Strategy, to ensure that future service models/configurations offer high quality, sustainable care • Health Education North West to work in partnership with the Trust to minimise gaps in trainee rotas	Trust/LAT Health Education North West	March 2013 October 2013

Appendices

Appendix I: Risk Summit Attendees

Risk summit role	Name
Risk Summit Chair NHS England, Regional Director (North)	Richard Barker
RRR Panel Chair NHS England, Deputy Medical Director and Regional Medical Director (North)	Mike Bewick
NHS England, Regional Chief Nurse (North)	Gill Harris
RRR Panel Representative	Julie Higgins
RRR Panel Representative (patient / public (lay) representative)	Sue Crutchley
RRR Panel Representative	Gill Heaton
RRR Panel Representative	Preeti Sud
RRR Panel Representative, CQC	Julie Harratt
Trust Chief Executive	Gary Doherty
Trust Director of Operations	Pat Oliver
Trust Director of Nursing	Marie Thompson
Trust Medical Representative	Mark O'Donnell
NHS England, Communications (North)	Cathy Stuart
Area Team (Lancashire) Director	Richard Jones
Area Team (Lancashire) Medical Director	Jim Gardner
Area Team (Lancashire) Director of Nursing and Quality	Carole Panteli
Chief Operating Officer, Fylde and Wyre CCG	Peter Tinson
Chief Nursing Officer, Fylde and Wyre CCG	Jennifer Aldridge
Chief Finance Officer, Fylde and Wyre CCG	Iain Stoddart

Risk summit role	Name
Chief Operating Officer, Blackpool CCG	David Bonson
Chief Clinical Officer, Blackpool CCG	Amanda Doyle
Chief Nurse, Blackpool CCG	Helen Skerritt
Chairman, Blackpool CCG	Roy Fisher
CQC Regional Director (North)	Malcolm Bower-Brown
CQC	Ann Ford
CQC	Dorothy Smith
Monitor	Tania Openshaw
Dean of Post Graduate Medical Studies, Deanery	Jacky Hayden
General Medical Council, Employer Liaison Advisor	Blake Dobson
Independent Moderator	Sarah Preston
Recorder	Jignesh Mistry

Review of the Quality of Care Provided by 14 Hospital Trusts in England

Blackpool Teaching Hospitals NHS Foundation Trust

Rapid Responsive Review
17 – 18 and 23 June 2013

Overall impressions

- Positive and helpful welcome to the panel, and an openness to the review process.
- Staff are committed and were open with the panel.
- There was some evidence of improvements being implemented.
- Clear issues were identified around clinical leadership and progress with implementation, as well as with staffing levels and skill mix particularly around unscheduled care.
- The Trust can deliver some changes internally, but will require support from wider partners for others, including local commissioners and regulators.

Key findings

1. The pace of change at the Trust has been slow. The leadership team at the Trust has been trying to do too much and needs to focus on the key areas of concern
2. Patients and staff felt that the Trust Board needed to improve communication with them.
3. The approach to mortality and morbidity should be standardised across the Trust
4. As acknowledged by the Board, the Trust has recruitment challenges, particularly with regards to consultants and nurses.
5. A number of patient safety issues were evidenced by the panel including incident reporting and application of infection control procedures.

High priority actions

1. There needs to be a coordinated approach to the implementation of change within the Trust and the focus should be on a bottom-up approach to change, rather than top-down.
2. Focus on the mission critical actions that need to take place to address the mortality concerns in the areas where it is an outlier.
3. Review compliance with the process for reporting serious incidents
4. Undertake a regular programme for all clinical leaders and Board members to visit patient care areas, including out of hours, and to feedback to frontline staff their observations and actions taken as a result of the visit.
5. Board leadership needs to supervise a rapid improvement in medical and nurse staffing levels
   - Review medical cover out of hours and ensure consultant job planning is prioritised to improve availability out of hours
   - Ensure nurse staffing levels and skill mix are safe and continue to review them
   - The Board should triangulate information on staffing levels at individual ward level with quality information including serious incidents, falls, infection control rates, pressure ulcers, mortality rates, complaints and staff feedback to assure itself that investment in additional staff is impacting on patient safety and to identify where further investment is needed. Staffing decisions should also be linked to patient acuity.
6. Develop an action plan to implement the required improvements to patient safety in the specific wards and departments listed in the RRR
7. Review implementation of infection control policy.

Board Assurance Framework (BAF) Changes and Progress April to June 2013

Classification	Total Number of Risks on the BAF 56 / Risk Assessment Number	Description of Top Risks	Action Plan on Track Yes / No	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR	CURRENT YEAR			
								Prev Q4	Q1	Q2	Q3	Q4
	75 BAF/CRR	Failure to Implement ALERT as the Trusts' full electronic patient record	Yes	IT/CO	16	0	8					
	01 BAF/CRR	Failure To achieve Health and Social Care Hygiene Code Standards	Yes	BO / CO / REP/ INC	12	12	8					
	13, 16, 18, 19, 20, 21 BAF	Non-Achievement Of Monitor Compliance Framework performance measures (18 weeks RTT, Cancer & A&E)	Yes	NTAR	16	16	8					
	110 BAF	Implementation – Compliance with Clinical Governance Standards	Yes	IT/CO/RISK	12	12	8					
	141/22 BAF	Non- achievement of CQUIN, Local/National and Contractual Measures (VTE, patient experience, AQ, TARN, End of life, COPD, Enhanced recovery)	Yes	BO, CO, FIN, GOV, REP, NTAR, DOH	12	12	6					
	174 BAF	Cardiothoracic Surgical Services	Yes	REP/RA/DIV	12	12	8					
	178 BAF	Provision of a breast care service	Yes	REP/RA/DIV	12	12	8					
	11 BAF	Effective Attendance to Meet National Sickness targets	NTAR/LTAR	Yes	12	12	6					
	70 BAF/CRR	Failure to reduce Hospital Mortality Rates highlighted during the Keogh Review and Dr Foster and CHKS data shows that risk adjusted mortality rates are high compared to Peer group. Monitor highlighted mortality rates as high risk.	Yes	RA/ REP/ FIN	15	15	10					
	45 BAF/CRR	Failure to reduce Slips, trips and falls	Yes	RISK/DIV/INC//FIN/RA	12	12	8					
	48 BAF/CRR	Failure to comply with Current Health and Safety regulations	Yes	RISK	12	12	8					
	59 BAF/CRR	Failure to reduce the risk of patients acquiring MRSA bacteraemia	Yes	NTAR/ REP	12	12	8					
	60 BAF/CRR	Failure to reduce the risk of patients acquiring Clostridium Difficile	Yes	LTAR/ REP	12	12	8					
	128 BAF	Failure to Prevent the Deterioration of Quality and Safety Standards of Patient Care	Yes	CO/GOV/RISK	12	12	8					
	43 BAF	Breach of Duty Leading to Harm That Results in a Claim	YES	Risk/REP/GOV	12	12	6					
	61BAF	Loss of Data Person Identifiable or Trust Sensitive	Yes	FIN/GOV/REP/ RA/INC/ICO	12	12	6					
	180 BAF/CRR	National Health Service Litigation Authority (NHSLA) Risk Management Standards General Assessment – Maintaining Level 3	Yes	RISK,GN,DIV,INC,FIN	12	12	6					
	150 BAF	Charitable Funds – Non-Compliance with legislation, regulations and donor imposed restrictions	Yes	BO, CO, FIN, GOV, REP, COM	12	9	10					
	105 BAF	Failure to maintain CNST Level 1 and 2	Yes	LTAR/GOV/CQC	12	12	6					
	108 BAF	Clinical Audit Activity process not embedded within divisions and does not support clinical improvement.	Yes	CQC/NTAR/GOV	12	12	8					
	113 BAF	Under Achievement QuIPP	Yes	FIN/BO/CO	16	16	8					
	50/54 BAF	Loss of Income due to Actual Activity Levels below Plan as a Result of Demand Management Schemes	Yes	FIN	12	12	8					
	77/116 BAF	Failure to Achieve Cash Balances / The Organisation Requires Sufficient Liquidity to meet Monitor's Compliance Framework. - Top Risk	Yes	BO/CO/FIN	12	12	8					
	177 BAF	Roll out and effective use of E-Rostering system	Yes	GOV, StOo, FIN	12	12	6					

Board Assurance Framework (BAF) Changes and Progress April to June 2013

	170 BAF	Fraud Within the Trust	Yes	FIN	12	12	6					
	107 BAF	Failure to Attract and recruit Junior/Middle Grade Medical Staff	Yes	RISK/REP/GOV	12	16	6					
	142BAF	Mandatory Training Compliance	YES	RA/RR	12	16	6					
	12 BAF	Attract, Develop & Recruit a highly skilled workforce	YES	GOV	12	16	6					
	127 BAF	Failure to Retain a Safe and Sufficient Workforce	Yes	CO/GOV/ RISK	12	16	6					

Proposed New Risks To Be Added Pending Approval			Action Plan in Place Yes / No	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR	CURRENT YEAR			
								Prev Q4	Q1	Q2	Q3	Q4

Proposed Risks To Be Removed Pending Approval			Risk Moved To	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR	CURRENT YEAR			
								Prev Q4	Q1	Q2	Q3	Q4
	75 BAF/CRR	Failure to Implement ALERT as the Trusts' full electronic patient record	Archive	IT/CO	16	0	8					

Risk Score Changes			Action Plan in Place Yes / No	Changes	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR	CURRENT YEAR			
								Prev Q4	Q1	Q2	Q3	Q4
	150 BAF	Charitable Funds – Non-Compliance with legislation, regulations and donor imposed restrictions	Yes	Consequence reduced to 3	12	9	10					
	107 BAF	Failure to Attract and recruit Junior/Middle Grade Medical Staff	Yes	RISK/REP/GOV	12	16	6					
	142BAF	Mandatory Training Compliance	YES	RA/RR	12	16	6					
	12 BAF	Attract, Develop & Recruit a highly skilled workforce	YES	GOV	12	16	6					

Top Risks	Update on Progress

Board Assurance Framework (BAF) Changes and Progress April to June 2013

75 BAF/CRR	The Trust has completed a review of its approach to the implementation of electronic patient records, and following approval from the Trust Board of Directors, the Trust has engaged with ALERT Life Sciences Computing to mutually agree a change in scope of the ALERT® deployment. It has been agreed that the Trust will continue to use the ALERT® solution in the A&E Department at the Trust and in a selected number of outpatient services including Senior Review Clinic, the Colposcopy Outpatients Service and the Paediatric Diabetes Outpatients Service. Given this, the Trust's forward strategy will be based on the integration of existing systems, along with the use of multiple specialist systems, with all systems being used across the Trust's range of geographic settings and linked via interoperability. Given this change in strategy, "Failure to Implement ALERT as the Trust's full electronic patient record" is no longer a valid risk. This can be removed from the risk register. Individual risk assessments will be completed for each electronic clinical system that is implemented in the future.
01 BAF/CRR	Hand hygiene audits continue to be conducted covertly; the number of participants is increasing within community settings. MRSA Bacteraemia results and Clostridium difficile results are presented to each Division on a monthly basis, these results, are closely monitored by each Division and the Board. With regards to MRSA Bacteraemia, we remain within target for the year. The trajectory for 2013/14 is Zero avoidable. With regards to Clostridium difficile, the Trust continues to perform below the trajectory, the planned trajectory for 2013/14 is 29.
13, 16, 18, 19, 20, 21 BAF	The Trust continues to perform strongly against the majority of the Compliance Framework Measures. Quarter one 18 week access standards were met and overall performance remains strong. There are four clinical areas, namely, oral surgery, Urology, Cardiac surgery and Orthopaedics where we are seeing a downward trend in the admitted and non admitted standard, in order to maintain compliance going forward a capacity and demand review is being undertaken in these specialties to ensure actions are taken to mitigate any risks. A & E performance improved significantly throughout quarter one and we achieved the performance standard both as A & E standalone and combined with Urgent Care Centre. There has been a significant increase in attendances in June and July predominantly minor injuries/weather related conditions which is putting pressure on the department, Primary care are not seeing the same level of pressure, a review of attendees post codes are being reviewed to confirm if the increase is due to visitors to the area. Cancer performance was achieved for quarter one. The 62 day standard is back on track however pressures remains with the 62 day screening standard mainly due to the small number of treatments and patients being treated at neighbouring trusts.
110 BAF	The single admission document is ready for implementation across medical and surgical wards during June 2013. All clinical pathways continue to be approved by Heads of Department, diagnostics, pharmacy and the Clinical Improvement Committee. The majority of local pathways that cut across primary and secondary care are approved by local CCGs. All new starters continue to receive training on ALERT® where required. Training in the use of CyberLab/Rad and the Vision Portal has now been included within the new doctors induction programme. The Vision Programme Team has established links with the Medical Staffing department to ensure that any new starters outside of the standard rotational timetable receive their training prior to commencing clinical activities – this includes the development of a plan for managing short term locum medical staff. The implementation of the Medical Interoperability Gateway (MIG) which allows access to key clinical information from local GP systems (EMIS) is underway, with data sharing agreements being signed by all GP practices that choose to participate. Patients will also be asked for their consent each time a clinician wishes to access this information. Full audit trail capabilities are available within the EMIS system and the MIG.
141/22 BAF	The Trust failed to achieve the CQUIN target for patient experience and dementia in Q4 2012/13. For 2013/14 measures have been agreed which reflect the Trusts strategic direction. At this point in Q1 the main risk to compliance remains dementia.
174 BAF	The action plan is progressing and key issues are being addressed by the Medical Director. Key issues are in relation to the following • Edgecumbe Consulting to commence facilitated meetings through June/July 2013. • Dedicated time will be made available for team members to be involved in this process. • Progress regarding the formalising of sub-specialisations and the development of teams delivering sub-speciality elements. • Development of protocols to manage common post-operative events is ongoing. • Chief Executive and Interim Director of HR&OD meeting to discuss expectations regarding behaviours and performance in leadership positions. The majority of the actions have now been implemented and assurances provided that improvements are being made, as detailed above.
178 BAF	HR investigation completed. External review undertaken action plan to be produced from findings. Pathway in line with national standards agreed by MDT.
11 BAF	Unscheduled Care conducted the planned sickness audit in April 2013 and have planned a further audit in September 2013. The new 'Attendance Management Policy' is currently being piloted by the Unscheduled Care Division for 6 months and this commenced on 1st June 2013.
70 BAF/CRR	• Level one mortality screening process established and automated. • Level 2 screening process in development. • Mortality dashboards available at trust/divisional /directorate level on a monthly basis. • All directorates holding mortality review meetings

Board Assurance Framework (BAF) Changes and Progress April to June 2013

	• Pathway specific audits commenced with action plans due in Stroke and Sepsis • Unscheduled care mortality reduction plan created • New BTH 2013/14 mortality reduction plan created following on from AQuA mortality reduction action plan • The draft report regarding the review into the quality of care & treatment provided by fourteen hospital trusts in England has been received. Comments of accuracy have been submitted to NHS England. The final report has been received on the 17th July. An action plan is in the process of being developed. An overview of the report findings and the action plan will be presented to the Board on 31st July 2013
45 BAF/CRR	2012/13 target exceeded. Training work books now rolled out. Falls sensors now in place across acute wards. Slipper exchange scheme in place in Unscheduled Care. Patient information leaflets being reviewed. Health Economy group looking at pathway development with Blackpool CCG. Annual targets reviewed and set
48 BAF/CRR	Contractors are still monitored and have been the subject of regular visual checks . The yellow non slip paint has been applied in the car park around OPD along with rigid fencing and the area is currently being monitored for falls before additional areas are addressed. Stores trolleys are being stored inside on most occasions, however contractor parking still needs to be addressed as contractors are still parking on site in areas not capable of accepting their vehicles, therefore diverting pedestrians out into the traffic flow. A control of contractors handbook is in the process of being issued which will provide safety guidance to all contractors
59 BAF/CRR	MRSA Bacteraemia trajectory for the year 2013/14 is Zero avoidable. Currently we are within trajectory.
60 BAF/CRR	Monthly Clostridium difficile data continues to be inputted onto the Health Care Associated Infection Data Capture System as and when they occur. The year end 2013/14 trajectory is 29, the Trust is currently under trajectory with 4 incidences so far.
128 BAF	Implementation of strategic framework embedded into clinical quality measures. Including safety thermometer, performance dashboards, monthly reports, quality accounts. Action plan developed and monitored by Exec lead at 1:1 meetings
43 BAF	Quarterly reports in respect of claims are discussed at the Learning From Incidents and Risks Committee and quarterly reports relating to risks identified during a claim are sent to the Divisions
61BAF	The process used by the Data Access Team to manage Subject Access Requests has been reviewed and updated. The Data Access Procedure, Data Access - Subject Access Requests - SAR IG/PROC/001 has been updated and published on the document library Following the trend analysis on information security incidents a generic risk assessment for use by departments to assess local risk has been produced and published - Management of Information Security Risks G12.
180 BAF/CRR	The audit programme has continued to be maintained. The Trust will undertake an internal assessment of the NHSLA standards in September 2013 in order to ensure compliance with the current standards and implementation of actions identified following audit.
150 BAF	The Head of Fundraising and Charitable Funds Accountant met to discuss the rationalisation of charitable funds and finalise an approach to implement the proposed list of Fund Advisors. All of the existing charitable funds and their respective balances were reviewed and the Charitable Funds Accountant is now undertaking a task to merge balances and rename historical funds as appropriate, and in line with the approved rationalisation. The Charitable Funds Accountant will then be able to provide balance statements for each charitable fund. The Head of Fundraising has prepared a letter and form of acceptance which will then be sent to the proposed Fund Advisors with the charitable funds policy and the balance statement(s) for the respective charitable fund(s), to enable them to make an informed decision as to whether to accept the responsibility on behalf of the Corporate Trustee. The aim is for the Fund Advisors to be implemented before August 2013.
105 BAF	All the guidelines have been reviewed and audit proformas completed. Senior staff have been allocated to a standard and an audit timetable is being developed. The informal visit took place on the 28th March and the outcome was positive. There is uncertainty regarding the future assessment process. The monthly meetings continue
108 BAF	Clinical audit process reviewed and reflected in policy. Escalation procedure implemented within policy. Monthly meetings taking place with Divisional Leads. National Audits incorporated into CAAWP. Annual Audit report submitted to Trust Board May. CAAWP 13/14 approved by Trust Board and linked to strategic framework, NHSLA and risk.
113 BAF	The Trust has finalised the 2013-14 QuIPP target at £16.0m following an adjustment for non-recurrent provision reversals. The recurrent QuIPP requirement for 2013-14 however remains £18.5m. Against the 2013-14 QuIPP target of £16.0m, £14.8m of QuIPP has now been identified. Progress has also been made in moving the initiatives through the approval process and £7.1m is now fully approved. As a result of the risk score and remaining QuIPP "gap" the assurance level has been maintained at amber – limited assurance.
50/54 BAF	The Trust has signed assured contracts with Blackpool CCG and Fylde and Wyre CCG. Under these assured contracts the Trust has a guaranteed minimum income level irrespective of activity levels but will not receive any additional income where the agreed activity plans are exceeded. The Specialist Services contract continues to be a PbR based contract. Activity information is circulated on a weekly basis and Divisional teams are monitoring performance in month.
77/116 BAF	At the end of May the Trust had a cash balance of £27.3m which is £0.4m ahead of plan for the period. The Trust is planning to have a cash balance of £18.0m and Liquidity rating of 2 (less than 15 liquidity

Board Assurance Framework (BAF) Changes and Progress April to June 2013

	days) at the end of the 2013-14 Financial Year. The Main Entrance and Car Park capital scheme significantly impacts on cash balances and liquidity across 2013-14 and as a result the planned Liquidity rating is a 2 from September 2013 to March 2014. The Trust continues to actively manage cash balances and liquidity. As a result of the risk score and liquidity rating of 2 the assurance level has been maintained at amber – limited assurance.
177 BAF	Preferences for Unscheduled Care completed, awaiting completion from Scheduled Care. Policy and SOP going to JNCC 21/06/13. External review undertaken re application of system based on training provided and community implementation requirements, report awaited. Web data entry savings identified to workforce QUIP Group
170 BAF	The Finance Department and Local Anti-Fraud Specialist continue to work closely. The Audit Committee also continues to receive quarterly fraud updates. The work to raise awareness and strengthen policies, procedures, processes and systems is ongoing. It is recommended that the level of risk score is maintained at 12.
107 BAF	Closer monitoring of gaps on the junior doctor rotas as changeover approaches in August 2013. Significant improvements between BFW Hospitals and Lead Employer enables a weekly report to be produced and reviewed regularly for action (by Head of Medical Workforce and fortnightly at the MWPPG), to reduce the chances of gaps on rotas at changeover. Already proactive recruitment campaigns have commenced within certain sub specialities as a result of this information. Close working with the Medical Workforce and Recruitment teams is in place to develop recruitment campaigns and activities to reflect a strong Employer Brand, in order to attract junior doctors to take up placements at Blackpool (thus reducing the likelihood of requiring agency doctors which do not attract Deanery funding and becomes a pressure for the organisation). An in depth analysis of junior doctor sickness is being undertaken and a report is due to EDs at the end of July 2013, which will identify underlying reasons for current absence rates. Interventions will be introduced to improve attendance but also increase engagement and morale amongst this group. If this is identified as an underlying cause, and is dealt with appropriately, it could potentially improve reputation of the organisation and increase attraction to placements and return rate of trainees to future Consultant posts
142BAF	Compliance mainly achieved by workbook methods, all tracked in line with MRMT Policy. E-Assessment being developed as an alternative with local content linking to national competence. Training Needs Analysis reviewed as a risk based approach and some subject frequencies have been reduced. CHS teams on board with MRMT workbooks after months of marketing and education.
12 BAF	Workforce processes will be one of the keys to the ongoing success of the Trust. A high level analysis of the end to end process from recruitment and ongoing staff management has begun this month. The ESR team has already started a detailed process mapping exercise which will lead to a clearer understanding of roles and responsibilities for all stakeholders. The Department of Health has stated that ESR will remain centrally funded for the next few years and the Trust should urgently review the work structures, roles and jobs within ESR This will give the Trust a clear view of the workforce situation by Division, Department/ Ward and align the reporting with clinical indicators. The Unscheduled Care Division has recruited 11 nurses from Spain and their induction has begun. Corporate recruitment is on-going and front line nurse staffing levels are continuing to improve. We will be maintaining a focus on pro-active recruitment activity through both national and international campaigns. HR&OD is leading the division's work to attract newly qualified nurses, making Blackpool Teaching Hospitals the employer of choice. There is a plan to go to Ireland for the next stage of recruitment in July however this may be delayed as we are still in negotiation in securing accommodation for overseas recruits.
127 BAF	A Retention Project is underway in Unscheduled Care which will include holding focus groups. The results from these groups will form part of the divisional strategy. The first focus group has already met and discussed actions that would positively impact the division's retention of nursing staff and improvements required to make the exit interview process more effective. The closure of Rossall Hospital, planned for 1st August 2013 will increase staffing levels at BVH and Clifton due to redeployment. In conjunction with staff side an initial mapping exercise for all colleagues within the Unscheduled Care Division who are affected by the closure of Rossall Hospital has been undertaken. Colleagues have been advised in writing of their first option for redeployment. We are continuing to work with those colleagues who did not feel the first option offered was suitable. Not all staff have opted for a work trial, but for those who have weekly meetings will take place for the duration of the work trial to address any questions or concerns. In addition, we have given the commitment to meet with all redeployed colleagues from Rossall three months after their redeployment to ensure staff are progressing and have no concerns.

Proposed New Risks To Be Added Pending Approval	**Update on Progress**

Proposed Risks To Be Removed Pending Approval

Colour	Classification	Code
	Cost	C
	People	P
	Quality	Q
	Delivery	Del
	Environment	Env

Board Assurance Framework (BAF) Changes and Progress April to June 2013

	Safety	S

Abbreviations	Abbreviations of Terms
BAF	Board Assurance Framework
CRR	Corporate Risk Register
FN/PR	Financial/Procurement
IM&T	Information Management and Technology

Adequate Assurance	
Limited Assurance	
Inadequate Assurance	

New risks for Consideration

None

Board of Directors Meeting

31st July 2013

Chief Executive's Assurance Report

1. Introduction

The Chief Executive's Assurance Report aims to highlight key issues for Board attention/discussion. The aim of the report is to inform the Board of the issues that are progressing well, the issues which are not progressing as planned, and therefore the level of assurance that can be provided to the Board in terms of achieving a range of targets/objectives. Where Board members would like further assurance, hyperlinks are included so that the detailed reports can be accessed. Wherever I am in a position to do so I will either give a rating of:

- No assurance - little or no prospect of recovering the position/delivering going forward.
- Limited assurance - improvements are expected but full delivery is considered high risk.
- High assurance - significant improvements are expected and full delivery is considered likely.
- Full assurance - full delivery is expected.

The report is broken into five key sections as shown below, though clearly each area is interlinked to each other/the whole:

- Quality
- Risk
- Workforce
- Audit
- Finance
- Strategy/Assurance

2. Quality

The following items are raised as areas where the Board can take positive assurance:

- All waiting times and infection control "compliance targets" met for Quarter 1 and, despite the challenges of the heat wave leading to very high levels of demand, full assurance is given for all areas going forward with the exception of cancer standards for those patients who begin their care with us but receive their first definitive treatment at Preston or another specialist provider.
- We continue to deliver reductions in our mortality rates, though as we continue to be outside the expected range only partial assurance can be given in this areas with more detail given below
- Overall performance against the 13 Medical Indicators improved, though only partial assurance is given as within four areas (Medical Records, Review of Investigations, Antibiotics Reviewed and VTE Reassessed) performance deteriorated.
- Since the Nursing Indicators were changed in April we continue to see progress being made, with the Families Division at 97% and Scheduled and Unscheduled at 94% against the 95% standard. We have developed and are testing out a suite of nursing care indicators for the community setting which will be added to the community view on the Board Dashboard in Quarter 2.
- The Friends and Family Score for the Trust for June increased, both in terms of the number of responses and the rating given – this has been the case for each month since the Friends and Family Test was introduced.
- We continue to be below the national median for pressure ulcer prevalence in Quarter 1. Partial assurance is given in this area as although the number for Quarter 1 shows a 36% reduction on last year, we had aimed to see a bigger reduction at this point. Community pressure ulcer prevention has also improved.

- On Friday 19th July we received an inspection from the Joint Advisory Group on Gastrointestinal Endoscopy (JAG), who quality assure endoscopy units. Based on the verbal feedback, I expect to receive a fully compliant assessment.

The following are raised as areas where either current performance or potential/perceived performance issues are such that I cannot give complete assurance to the Board.

External Assurance

2.1 Review into the Quality of Care & Treatment provided by 14 Hospital Trusts (Keogh Review)

This is a separate agenda item.

2.2 Francis Inquiry

A gap analysis has been undertaken for the Francis Inquiry and it has been agreed that, once the action plan in relation to the Quality of Care and Treatment (Keogh Review) has been finalised, further work will be undertaken to cross-reference the trends and themes identified in the Francis Inquiry gap analysis which will link into the Quality of Care and Treatment action plan.

2.3 Care Quality Commission Unannounced Inspection

As previously highlighted to the Board, the CQC made an unannounced inspection of the Trust on Tuesday 11th June 2013 to review the Trust's compliance with essential standards of quality and safety. They also reviewed our Trust-wide system for responding to complaints. The specific outcomes that were inspected were:

- Outcome 1: Respecting and Involving People Who Use Services
- Outcome 2: Consent to Care and Treatment
- Outcome 4: Care and Welfare of People Who Use Services
- Outcome 16: Assessing and Monitoring the Quality of Service Provision
- Outcome 17: Complaints

For each standard, the CQC assesses Trusts as either fully met, action needed or enforcement action taken. On 16th July we received the draft report of the visit which classifies us as fully compliant with all standards with the exception of Outcome 17: Complaints, where we were rated as "action needed" because complaints and concerns were not always dealt with in our timescales and people did not always feel their concerns or complaints were managed satisfactorily. The CQC has judged that this has a moderate impact on people who use the service. We are still working to check the report for factual accuracy and a further update will be given at the Board meeting.

2.4 Cancer Peer Review

As previously highlighted to the Board we received a Cancer Peer Review on 9th May. The report flagged head and neck cancer as an area of immediate risk, stating that the number of major surgical procedures undertaken in Blackpool is too low to assure maintenance of competence for surgical and nursing staff. Both Blackpool and Wyre & Fylde CCGs have confirmed that they support the findings of the Peer Review. We are currently working with colleagues in Lancashire Teaching Hospitals NHS Foundation Trust to make arrangements for complex head and neck cancer surgery for our residents to be undertaken there in future.

2.4 Integrated Care Awards – Women's Health Category

The Families Division Substance Misuse Team has recently won the Integrated Care Awards Women's Health Category with their initiative to provide an integrated care pathway for pregnant women who misuse substances.

Their initiative involved developing a multi-disciplinary pathway to care for pregnant women who misuse substances. The key aims were to reduce harm by carrying out a risk assessment and stabilising drug use via substitute prescribing or in-patient detoxification. Women have reported increased satisfaction in the support they have received throughout their maternity care and staff report improved confidence in supporting women. There has been a reduction in the number of babies who require admission to specialised neonatal care for management of withdrawal from drugs (neonatal abstinence syndrome).

The award was presented by Tony Falconer President of the Royal College of Obstetricians and Gynaecologists and it was stated that the judges were really impressed by the apparent mutual respect between the professionals and the women they care for.

Internal Assurance

2.5 Mortality

The preview of the latest national SHMI, relating to deaths up to last December, is 119 which is a further continued improvement in our performance. However, given our comparative position, this must still be viewed as low assurance. Our internal model has predicted each national figure very accurately, and we are forecasting a SHMI of 116 for the next iteration, which would start to improve our relative as well as our absolute position. Our current internally measured SHMI for a rolling 12 month period is 116 and the monthly figure (non-rolling) is 111.

2.6 Falls

The Trust Strategic Framework has identified a target of 30% reduction in falls at low, minor, moderate and serious impact level based on the 12/13 baseline. At the end of Quarter 1 the Trust is currently 8.5 % above trajectory (pre validation). This adverse performance is been driven by the numbers of low – minor harm falls. The downward trend on serious harm falls continues to reduce with 7 serious harm falls reported in Quarter 1 compared with 10 in the same period Quarter 1 last year.. To support learning and continuous improvement a number of actions are in place; a health economy falls strategy is in development, the Trust Falls Steering Group has been refreshed and work continues to improve nurse staffing ratios particularly on the unscheduled care wards.

2.7 Clinical Audit

There are 237 audits on the annual audit work plan. 174 are currently active and the remainder are not due to commence yet. 70% of audits are on timescale for completion and meetings have taken place with Divisional Directors and Quality Managers to follow up the slippage on the 30%.

2.8 Complaints

The number of complaints received/the type of issues raised has stayed largely static comparing Quarter 1 this year to Quarter 4 last year. The Patient Relations Team has handled 1087 informal concerns and enquiries which is a decrease of 200 compared to the previous quarter. The Trust received 100 complaints in Quarter 1, an increase of 2 over Quarter 4. Of the 100, there were 88 (0.34 % of hospital admissions) relating to our hospital services and 12 for our community services. The timeliness of our responses has deteriorated, largely due to performance during May in Unscheduled Care due to a vacancy in the complaints team. Limited assurance can be given as additional staffing has been seconded in and performance improved sharply in June.

3. Risk

The first meeting of the newly established Risk Committee took place on the 12th July 2013. Detailed discussions took place regarding a range of key risks including:

- Cardiac Services - waiting times, the use of Cardiac Day Case Unit to nurse medical escalation patients and Anaesthetic cover.
- Podiatric Surgical Services
- Clinical Support Services Risk Register
- Families Division Risk Register
- Colposcopy IT system

In terms of our overall position in relation to risk the top risks are listed below:

- Failure to reduce Hospital Mortality Rates as identified by the Keogh Review and data shows that risk adjusted mortality rates are high compared to peer group. Monitor highlighted mortality rates as high risk
- Provision of a Breast Care Service
- Failure to Attract and Recruit and Retain a Safe and Sufficient highly skilled Workforce
- Non-Achievement of Monitor Compliance Framework performance measures'(18 weeks RTT, Cancer & A&E)
- Underachievement of QuIPP

The above are all covered in this Assurance Report with the exception of Breast Care Services, where a HR investigation and an external investigation have been completed and an action plan is in the process of being produced. A new Breast Care Pathway has been agreed by a Multi-disciplinary Team in line with national standards.

4. Workforce

The following items are raised as areas where the Board can take positive assurance:

a. Workforce Intelligence

The Trust has been able to develop better analytical capability through the use of IT. This now allows us to review on a weekly basis all ward staffing levels, planned and actual, against head count, and skill mix. This has proven very beneficial in our monitoring arrangements and helps to identify hotspots. Significant progress has been made in the data cleanse of the ESR system as we move towards a unified approach to monitoring establishments. A WI dashboard is now in draft form and will be available at the August Finance Committee meeting.

b. Organisational Development

A review of all OD related activities is underway. This will be complete by the end of August 2013 and will assist in better targeting of resources. All workforce action plans to support the Keogh review have been developed.

The following are raised as areas where either current performance or potential/perceived performance issues are such that I cannot give complete assurance to the Board.

c. Recruitment and Retention

Recruitment and retention remains a major challenge. In order to strengthen our approach to recruitment and all associated pre employment checks, the existing recruitment team has been re-organised to report direct to the Head of Workforce Planning & Resourcing. This will also ensure a more proactive approach to the whole area of recruitment and retention. Links have been made with the GMC and agencies specialising in UK and overseas recruitment to quickly progress the significant increases in clinical staff required. A Retention Project has now begun in the Unscheduled Care Division which will include holding focus groups. The results from these groups will form part of the divisional strategy. The first focus group has already met and discussed actions that would positively impact the division's retention of nursing staff and improvements required to make the exit interview process more effective.

d. Consultant Appraisal

Consultant appraisal was highlighted during the Keogh Review and although we have improved we need to quicken our pace going forward. The Medical Director is meeting with Professor Gulati to see if there is any correlation between appraisal rates at specialty level and other key quality indicators.

5. Audit

A meeting of the Audit Committee took place on 25th June 2013. The key issues discussed include:

- Standing Orders and Delegated Powers of Authority
- External Audit Service
- Register of Waivers
- Terms of Reference
- Internal Audit Progress Report
- External Audit Progress Report
- Governance Briefing Report

6. Finance

Meetings of the Finance Committee took place on the 24th May 2013 and 24th June 2013.

There are a range of key issues to bring to the Board's attention, whereby for each area there is currently limited assurance.

a. Financial Plan as at June

The Trust achieved a surplus of £0.1m for June, which is £0.5m behind plan for the period. The year to date performance at the end of June is a surplus of £0.3m, which is £1.0m behind plan for the period.

b. Operational Budgets

The main concerns in the year to date performance are:

- Cost pressures / unplanned expenditure in the Clinical Support Division relating to an increase in diagnostic work in pathology and radiology. The Acting Director of Finance and the Director of Operations are meeting with the divisional team on a weekly basis to ensure that the divisional turnaround plan delivers an improvement in the division's forecast financial performance.
- Lower than planned gross contribution in the Unscheduled Care Division predominantly relating to the premium cost of higher than planned agency nursing and locum medical and agency medical usage. The Acting Director of Finance and the Director of Operations are engaging with a number of external partner organisations to secure additional resource.

c. Quality, Innovation, Productivity and Prevention (QIPP)

Against the 2013-14 QuIPP target of £16.0m a total of £14.0m has been identified in plans, with identified ideas likely to generate a further £0.5m. This shows a worsening position from Month 2, primarily due to a shortfall in the Emergency and Out of Hospital QuIPP theme. The Director of Service Transformation is arranging a meeting between the Unscheduled Care Division and the Adults and Long Term Conditions Division to urgently identify potential QuIPP opportunities.

d. Cash Balances

The end of June cash balance is £26.5m which is £0.6m below plan for the period. The Trust continues to actively manage cash balances and liquidity, the key focus being on working capital movements. Active management of cash balances is essential in 2013-14 as the impact of significant capital payments relating to the MECP scheme scheduled for completion in December 2013 impacts on the underlying cash position.

e. Year End Forecast

The Trust is currently forecasting a year-end surplus of £4.9m which is £1.5m lower than plan. Further action is required to ensure we deliver an EBITDA margin of 5% and an overall FRR of 3 at the end of the year, including: -

- Utilise unplanned forecast VAT reclaims of £0.9m which are currently not included in the year end position.
- Continue to improve the position in relation to operational budgets and QIPP – an update will be given at the Board meeting.
- A review of pre-agreed service developments and utilise any slippage in the timeframe of implementing these developments.

Given my discussions with key senior leaders I would give high assurance that a financial risk rating of a 3 will be delivered throughout the year.

6. Strategy/Assurance

A meeting of the Strategy & Assurance Committee took place on the 26th June 2013.

The latest draft of the Board Committee Structure Manual, which is a "work in progress document", was discussed.

7. Annual Reports 2012/13 (for approval)

a. Risk Management Annual Report

This document provides an update of progress of the Risk Management Strategy and of the Trust's risk management functions during the financial year 2012/2013, together with proposals for the way forward. The report demonstrates the significant achievements of the Divisions and the Risk Management Team including implementation of systems, processes, procedures and increased risk management training. All of this has contributed to the Trust successfully achieving externally set standards and targets and enabled the Trust to participate in national project work on risk management issues. The report sets out the structure of risk management including the arrangements and responsibilities for risk management in the Trust as portrayed in the Risk Management Strategy. Staff are encouraged to recognise potential risks and feel free to report a clinical or non-clinical incident or near miss knowing that they do so in a fair blame culture.

8. Strategies/Policies/Plans/Guidelines

9.1 Health and Safety Policy

This document sets out the basic policy and aims, together with the organisation and arrangements for its implementation. Supporting measures will be set out where necessary in subsidiary policies and procedures at Trust, Directorate and Department levels.

All members of Trust staff, including those on honorary contracts, working in the community, contractors working on any of the Trust's sites and those working primarily for other organisations, have a duty in the enactment of the policy. The policy applies to all employees and activities of the Trust.

9.2 Patient Safety Including Being Open Strategy (Corp/Strat/020)

This document describes the Trust's commitment to patient safety, and being open and honest following a patient safety incident, complaint or claim. This document describes the steps that the Trust will take to improve patient safety.

9.3 Risk Management Strategy (Corp/Strat/006)

This document describes the Trust's commitment to risk management, which is central to the effective running of the organisation, and describes the steps that the Trust will take for the effective management of risks.

9.4 Standing Orders and Standing Financial Instructions (SO/SFIs)

This document acknowledges that the Trust has powers to delegate and make arrangements for delegation. The Constitution and the Standing Orders set out the detail of these arrangements. Delegated Powers are covered in a separate document entitled "Schedule of Matters reserved to the Board and Scheme of Reservation and Delegation" and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

10. Board Assurance Framework/Corporate Risk Register

The Board Assurance Framework and the Corporate Risk Register summary documents are referred to in the Risk section of this report.

11. Compliance Monitoring Assurance Report

The items included in the Compliance Monitoring Assurance Report are the subject of a separate report.

- Corporate Objectives (Strategic Framework)
- Compliance Framework Measures including Quarterly Monitoring Return to Monitor – Quarter 1
- Business Critical Measures

A further report in respect of the Quarterly Monitoring Return to Monitor (Quarter 1) is attached.

The Board is requested to:-

- Approve the submission of finance returns as per the finance report.
- Approve the completion of 'Confirmed' for Finance by the Chief Executive on behalf of the Board.
- Approve the completion of 'Confirmed' for Governance by the Chief Executive on behalf of the Board.

Gary Doherty
Chief Executive

Corporate Risk Register (CRR) Changes and Progress April to June 2013

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Classification	Total Number of Risks on the BAF 43 Risk Assessment Number	Description of Top Risks	Action Plan on Track Yes / No	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR		CURRENT YEAR		
								Prev Q4	Q1	Q2	Q3	Q4
	01 CRR/BAF	Failure to achieve Health and Social Care Hygiene Code Standards	Yes	BO/ CO/ REP/ INC	12	12	8					
	75 CRR/BAF	Failure to Implement ALERT as the Trusts' full electronic patient record	Yes	IT/CO	16	0	8					
	146 CRR	Failure to maintain Fundraising Procedural and systems documentation	Yes	CO, BO, FIN, GOV, REP	9	6	6					
	176 CRR	The Cancer Data Manager is a stand-alone post within the Trust and does not have any cross-cover.	Yes	RA/ LTAR	15	15	6					
	65 CRR	Failure to Reduce Smoking in Pregnancy	Yes	NTAR	12	12	8					
	66 CRR	Failure to Increase Breast Feeding Rates in Relation to National Standards and National Target	Yes	NTAR	12	12	9					
	183 CRR	Maternity Theatre	Yes	BO/CO/REP/RA/ DIV	12	12	4					
	184 CRR	Temporary Theatre Room 7 Room 7 will be used as the backup theatre for the next 8 weeks	Yes	CQC / NSF	15	0	5					
	185 CRR	Loss of Income to the R&D Department	Yes	HR/FIN	12	12	4					
	186 CRR	Implementation of a Healthcare Facility Service within the Acute Trust	Yes	RISK	12	12	8					
	187 CRR	Failure of intra-operative fluid management (IOFM) therapy	Yes	DOH	15	0	2					
	181 CRR	Failure to Maintain Health Record Availability	Yes	GOV,REP,RA,INC,CNST,NHSLA,ICO,FIN	12	12	6					
	182 CRR	Lack of a Ward Based Pharmacist on Wards 10, 16, SAU, DSU & Pre-op	Yes	BO/INC	16	16	5					
	34 CRR	Failure to Obtain Patient Consent	Yes	INC/RA/FIN/REP/ DIV/NHSLA	12	12	8					
	45 CRR/BAF	Failure to reduce slips, trips and falls	Yes	RISK/DIV/INC//FIN/ RA	12	12	8					
	43 CRR/BAF	Breach of Duty Leading to Harm That Results in a Claim	YES	Risk/REP/GOV	12	12	6					
	48 CRR/BAF	Failure to comply with Current Health and Safety regulations	Yes	RISK	12	12	8					
	49 CRR	Patient Not Identified Correctly - Medication and Intravenous Therapy – Clinical Governance	Yes	INC/RA	12	12	6					
	59 CRR/BAF	Failure to reduce the risk of patients acquiring MRSA bacteraemia	Yes	NTAR/ REP	12	12	8					
	60 CRR/BAF	Failure to reduce the risk of patients acquiring Clostridium Difficile	Yes	LTAR/ REP	12	12	8					
	70 CRR/BAF	Failure to reduce Hospital Mortality Rates as identified by during the Keogh Review and Dr Foster and CHKS data show that risk adjusted mortality rates are high compared to Peer group. Monitor highlighted mortality rates as high risk.	Yes	RA/ REP/ FIN	15	15	10					
	131 CRR	Failure to provide Timely Root Cause Analysis Reports and Lessons Learned	Yes	RISK/GOV/DIV	12	12	8					
	132 CRR	Taking Blood for Cross Matching and Blood Administration Errors	Yes	RISK/GOV/DIV/INC	12	12	8					
	143 CRR	Blenheim House Health Visitors – Loss of Hours	Yes	StOp/ GOV /REP	12	12	6					
	175 CRR	Maintenance of Medical Devices within the Trust	Yes	RISK/External Audit Review	12	12	4					
	180 BAF/CRR	National Health Service Litigation Authority (NHSLA) Risk Management Standards	Yes	RISK,GN,DIV,INC,FIN	12	12	6					

		General Assessment – Maintaining Level 3											
	120 CRR	Failure to Manage of Web Page Incident Reporting System	Yes	RA/INC/DIV	12	9	4						
	133 CRR	Mislabelling of Pathology Samples	Yes	RISK/GOV/DIV/INC	12	12	8						
	139 CRR	Failure to Improve Patient Feedback in some Areas of National Cancer Patient Survey	Yes	DIV/RA/GOV/CO	12	12	6						
	151 CRR	The NWAS (North West Ambulance Service) patient transport contract is not fit for purpose leading to poor patient experiences	Yes	INC	12	12	9						
	145 CRR	Fundraising – Failure to Utilise Tax Exemptions Efficiently	Yes	FIN, REP, GOV	16	12	9						
	156 CRR	Care of the Elderly – Inappropriate Model of Care	Yes	DIV	12	12	12						
	172 CRR	Failure of the E-Discharge System - Cardiac	Yes	RA/INC	16	9	4						
	107 CRR	Failure to reduce the Shortage of Junior and Middle Grade Doctors	Yes	RISK/REP/GOV	12	12	6						

Proposed New Risks To Be Added Pending Approval		Action Plan in Place Yes / No	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
							PREV YEAR	CURRENT YEAR			
							Prev Q4	Q1	Q2	Q3	Q4
	C50 189 CRR	Increased EP Cardiac Waiting times	DIV/RA	YES	19	15	3	N/A				
	C48 190 CRR	Use of Cardiac Day Case Unit (CDCU) to nurse medical escalation patients	Yes	GOV/FIN/REP/DIV/INC	N/A	16	12	N/A				
	C49 191 CRR	Reduced support of onsite surgical vascular services at BTH	Yes	GIV/FIN	N/A	15	15	N/A				
	S63 192 CRR	Use of old Anaesthetic Machines	Yes – business case	COSHH	N/A	15	5	N/A				
	53 193 CRR	Management of Consultation and Subsequent Closure of Rossall Hospital	Yes	SUI, RISK, REP, GOV	N/A	16	12	N/A				
	CHS 012 FA 194 CRR	Inability to meet contractual waiting times for Adult and Long Term Conditions, Community Health Services, Foot and Ankle Surgery due to lack of appropriate theatre sessions.	Yes	RISK	9	16	6	N/A				
	Families Division 195 CRR	Colposcopy IT system	Yes	RA	N/A	16	5	N/A				
	CG 80 196 CRR	Delays in ordering pressure relieving Mattresses	Yes	RISK, FIN, DIV, INC, REP, RA	N/A	16	9	N/A				

Proposed Risks To Be Removed Pending Approval		Risk Removed To	Source	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
							PREV YEAR	CURRENT YEAR			
							Prev Q4	Q1	Q2	Q3	Q4
	146 CRR	Failure to maintain Fundraising Procedural and systems documentation	Charitable Funds Committee And Corporate Trustee	CO, BO, FIN, GOV, REP	9	6	6					
	184 CRR	Temporary Theatre Room 7	No longer a risk	CQC / NSF	15	0	5					

		Room 7 will be used as the backup theatre for the next 8 weeks										
	187 CRR	Failure of intra-operative fluid management (IOFM) therapy	Yes	DOH	15	0	2					
	120 CRR	Failure to Manage of Web Page Incident Reporting System	Yes	RA/INC/DIV	12	9	4					
	75 CRR/BAF	Failure to Implement ALERT as the Trusts' full electronic patient record	Yes	IT/CO	16	0	8					

Risk Score Changes			Action Plan in Place Yes / No	Changes	Previous Risk Score	Current Risk Score	Residual Risk Score	Assurance Level				
								PREV YEAR		CURRENT YEAR		
								Prev Q4	Q1	Q2	Q3	Q4
	120 CRR	Management of Incident Reporting System	RISK/CQC /NPSA/NHSLA	Consequnce decreased to 3	12	9	4					
	134 CRR	Clinical Improvement - Participation in and Recommendations arising from National Confidential Enquiries into Patient Outcome and Death (NCEPOD)	NHSLA/CQC	Likelihood decreased to 2, Consequnce increased to 4	9	8	6					
	F02 CRR 145	Taxation	FIN, REP, GOV	Likelihood reduced to 3	16	12	9					
	146 CRR	Failure to maintain Fundraising Procedural and systems documentation	Yes	Consequence decreased to 2	9	6	6					
	CHS 012 FA	Inability to meet contractual waiting times for Adult and Long Term Conditions, Community Health Services, Foot and Ankle Surgery due to lack of appropriate theatre sessions.	RISK	Consequence & Likelihood increased to 4	9	16	6					
	75 CRR/BAF	Failure to Implement ALERT as the Trusts' full electronic patient record	Yes	IT/CO	16	0	8					

Top Risks	Update on Progress
01 CRR/BAF	Hand hygiene audits continue to be conducted covertly; the number of participants is increasing within community settings. MRSA Bacteraemia results and Clostridium difficile results are presented to each Division on a monthly basis, these results, are closely monitored by each Division and the Board. With regards to MRSA Bacteraemia, we remain within target for the year. The trajectory for 2013/14 is Zero avoidable. With regards to Clostridium difficile, the Trust continues to perform below the trajectory, the planned trajectory for 2013/14 is 29.
75 CRR/BAF	The Trust has completed a review of its approach to the implementation of electronic patient records, and following approval from the Trust Board of Directors, the Trust has engaged with ALERT Life Sciences Computing to mutually agree a change in scope of the ALERT® deployment. It has been agreed that the Trust will continue to use the ALERT® solution in the A&E Department at the Trust and in a selected number of outpatient services including Senior Review Clinic, the Colposcopy Outpatients Service and the Paediatric Diabetes Outpatients Service. Given this, the Trust's forward strategy will be based on the integration of existing systems, along with the use of multiple specialist systems, with all systems being used across the Trust's range of geographic settings and linked via interoperability. Given this change in strategy, "Failure to Implement ALERT as the Trust's full electronic patient record" is no longer a valid risk. This can be removed from the risk register. Individual risk assessments will be completed for each electronic clinical system that is implemented in the future.
146 CRR	The Head of Fundraising has prepared a letter and form of acceptance which will then be sent to the proposed Fund Advisors with the charitable funds policy and the balance statement(s) for the respective charitable fund(s), to enable them to make an informed decision as to whether to accept the responsibility on behalf of the Corporate Trustee. The aim is for the Fund Advisors to be implemented before August 2013. The SharePoint site has been updated and all staff can access further information about the charity and fundraising. The new policies will be uploaded when the Fund Advisors are in place and all staff will be made aware of this. Members of the Fundraising Team liaise regularly with members of staff about sources of funding and participating in fundraising events. Messages and updates are disseminated to staff regularly via email, newsletters, and the intranet as well as through occasional ward walk-rounds and promotional stands. It is proposed that this risk be removed and monitored by the charitable funds committee and corporate trustee.

176 CRR	The Senior MDT Coordinator has been in post for 3 months and has commenced training on the processes to enable her to cover the Performance and Data Manager role. The reporting cycle continues to be met.
65 CRR	The maternity service continues to monitor SATOB and SATOD rates. Co2 monitoring is taking place and is monitored. Liaison continues with the Public Health team The smoking stats are detailed in the attached document  Smoking stats summary for April 201
66 CRR	Breast feeding rates continue to be monitored on a monthly basis.
183 CRR	The first theatre has been completed and funding to complete the second is required. Work has commenced on the Maternity Led Unit
184 CRR	The theatre has been completed, this risk no longer remains
185 CRR	Discussions have taken place with the CLRN and TSNs with a budget agreed for 13/14. This is less than what was anticipated and additional bids will be made to the CLRN to cover shortfalls. A presentation was made to the R&D Committee on 31/05/13 and it has been agreed that R&D will move to attract more commercial research and in turn income to mitigate this risk.
186 CRR	 RADIOLOGY.docx A detailed implementation plan has been produced in the form of a GANTT chart and the project team are meeting weekly.
187 CRR	Equipment sourced and now in place. Risk no longer exists. Request risk to be removed from Corporate Risk Register and Divisional Risk Register and archived.
181 CRR	In the region of 100,000 health record folders have now been transferred from the basement storage area to the new Th7-10 storage area. A storage area for deceased records has been identified within the basement and records transferred and traced to it. Still awaiting outcome of EDMS business case (long term solution). Continue with Records Management and Keeping audits reporting findings to the Health Records Committee and ensuring any agreed actions are implemented. Continue to monitor incident reports and KPIs regarding Records Management and Keeping reporting findings to the Health Records Committee. IG Newsletter and Team Brief used to support awareness raising and disseminate audit findings. Incidents of health records not being available when required continue to occur on an almost daily basis.
182 CRR	Business case to be re-submitted to the Execs this quarter following a request for further data to be provided. No change to risk score
34 CRR	There have been 11 reported incidences in the last quarter involving consent issues, 50% of these incidents detailed where there was an incomplete form, all were low impact. An audit was undertaken in February 2013, specifically reviewing the information provided to the patient at the time of the consent and if this was documented in the patient records. The findings indicated that patients were given information both verbally and in the form of a patient information leaflet. There is a further audit planned for July 2013 on consent training for junior doctors.
45 CRR/BAF	2012/13 target exceeded. Training work books now rolled out. Falls sensors now in place across acute wards. Slipper exchange scheme in place in Unscheduled Care. Patient information leaflets being reviewed. Health Economy group looking at pathway development with Blackpool CCG. Annual targets reviewed and set
43 CRR/BAF	Quarterly reports in respect of claims are discussed at the Learning From Incidents and Risks Committee and quarterly reports relating to risks identified during a claim are sent to the Divisions
48 CRR/BAF	Contractors are still monitored and have been the subject of regular visual checks . The yellow non slip paint has been applied in the car park around OPD along with rigid fencing and the area is currently being monitored for falls before additional areas are addressed. Stores trolleys are being stored inside on most occasions, however contractor parking still needs to be addressed as contractors are still parking on site in areas not capable of accepting their vehicles, therefore diverting pedestrians out into the traffic flow. A control of contractors handbook is in the process of being issued which will provide safety guidance to all contractors
49 CRR	The number of reported incidences that involve medication errors continues to rise, however the actual harm to patients is reducing. The top cause group remains administration errors. The highest reporting areas are Acute Medical Unit, Children's Ward and Pharmacy. There has been an increase in the number of areas that have dedicated pharmacy cover. This has resulted in reduced waiting times for discharge, improved drug reconciliation and improved usage of patient's own medication whilst in hospital.
59 CRR/BAF	MRSA Bacteraemia trajectory for the year 2013/14 is Zero avoidable. Currently we are within trajectory.

60 CRR/BAF	Monthly Clostridium difficile data continues to be inputted onto the Health Care Associated Infection Data Capture System as and when they occur. The year end 2013/14 trajectory is 29, the Trust is currently under trajectory with 4 incidences so far.
70 CRR/BAF	• Level one mortality screening process established and automated. • Level 2 screening process in development. • Mortality dashboards available at trust/divisional /directorate level on a monthly basis. • All directorates holding mortality review meetings • Pathway specific audits commenced with action plans due in Stroke and Sepsis • Unscheduled care mortality reduction plan created • New BTH 2013/14 mortality reduction plan created following on from AQuA mortality reduction action plan • The draft report regarding the review into the quality of care & treatment provided by fourteen hospital trusts in England has been received. Comments of accuracy have been submitted to NHS England. An overview of the report findings will be presented to the Board on 31st July 2013
131 CRR	Training continues around RCA's and report writing with one to one support and training given as required. Lessons learnt are monitored through the LIRC meeting and Governance meetings within the Divisions. Information from the Safeguard system around themes and trends is provided to the Quality managers, who will feed back actions that are being taken to address these concerns. Completion of recommendations from RCA's are monitored by the risk team and any breaches are addressed through an escalation process.
119 CRR	The recent Safe Site Surgery Audit undertaken has highlighted some areas of concern. Audit discussed at Divisional Board 14th June 2013 and action plan agreed. There have been a number of low level incidents reported relating to theatre listings; therefore the risk score is to remain the same.
132 CRR	Gathering supporting evidence for business case presentation to executive directors. Information has been gathered from Trusts that have implemented electronic systems to bolster the business case. There is going to be a meeting arranged between the VISION lead and the Transfusion Practitioner to progress this once all information has been received.
143 CRR	The service provision and locality for Blenheim House are being reviewed. The service remains at high risk of not providing the level of care required. 1 year non recurrent funding agreed by Commissioners – from 3/6/13 1.0 WTE staff nurse working with SHV service. CDC Service review currently being carried out to look at streamlining and efficiencies.
175 CRR	The last MDSC was poorly attended across the clinical divisions. Equipment checks against compliance and validation and the actual undertaking of PPM is continuing and the information is being inputted into the EBME database for both Acute and Community propertied. An advert for a new head of service is now on NHS jobs; assurance level has been updated to green.
180 BAF/CRR	The audit programme has continued to be maintained. The Trust will undertake an internal assessment of the NHSLA standards in September 2013 in order to ensure compliance with the current standards and implementation of actions identified following audit.
120 CRR	The Data Coordinator continues to, upload to the NPSA on a weekly basis. The extractions continue to take place and cross over working for annual leave continues to function including community health services. Completion of incidents for community health services continues to improve. Additional resources have been introduced to help manage the incident process. It is proposed to remove this risk from the Corporate Risk Register.
133 CRR	Gathering supporting evidence for business case presentation to executive directors
139 CRR	2013 survey underway across Cancer patients, outpatient and chemotherapy survey. The Trust is awaiting the results of the survey.
145 CRR	The data import was completed in conjunction with Donorflex and provisional Gift Aid reports have been produced. The Fundraising Department completed this process in time to submit a backdated Gift Aid claim, but the application for a charity reference number from HMRC was not submitted on time. A new Fundraising Administrator has been recruited and Gift Aid is promoted and encouraged in correspondence to donors that make eligible donations. Tax effective giving is also actively promoted in fundraising appeal literature, on the charity's website and in the charitable funds policy which is available to all staff. Gift Aid declarations are now processed as soon as they are received. A Gift Aid claim will be submitted when the charity reference number has been received. The controls now in place are adequate so the assurance level has been changed to green, as Gift Aid data has been input onto a database, matched to corresponding Gift Aid declarations and analysed to ensure all the gifts are in fact eligible for Gift Aid. However the Trust is awaiting a charity reference number from HMRC therefore Gift Aid has not yet been claimed.
151 CRR	The risk assessment has been updated to reflect the commencement of the new NWAS contract on 01/04/2013. The new contract has improved quality measures and time targets for NWAS to achieve, at this early stage some issues of concern remain and therefore the risk score has been maintained at 12 and will be reviewed next quarter after the contract has had time to embed. All issues are raised with NWAS at the time they arise and the Trust works with NWAS to find and implement solutions. Issues and concerns are also raised at the Tripartite meetings between commissioners NWAS and the Trust.

156 CRR	Risk score to remain the same until discussions between the Directorate Manager for Care of the Elderly and the Project Manager for Team Job Planning to progress the report following the Kendal Bluck Review.
172 CRR	Staff trained in the use of the system. Ward managers encourage medical staff to complete. 100% compliance on 8 out of 10 wards (Mar 13 data) Discussed at Directorate meetings. Actions re IT issues outside the control of the Division. Overall risk score reduced
107 CRR	Closer monitoring of gaps on the junior doctor rotas as changeover approaches in August 2013. Significant improvements between BFW Hospitals and Lead Employer enables a weekly report to be produced and reviewed regularly for action (by Head of Medical Workforce and fortnightly at the MWPPG), to reduce the chances of gaps on rotas at changeover. Already proactive recruitment campaigns have commenced within certain sub specialities as a result of this information. Close working with the Medical Workforce and Recruitment teams is in place to develop recruitment campaigns and activities to reflect a strong Employer Brand, in order to attract junior doctors to take up placements at Blackpool (thus reducing the likelihood of requiring agency doctors which do not attract Deanery funding and becomes a pressure for the organisation). An in depth analysis of junior doctor sickness is being undertaken and a report is due to EDs at the end of July 2013, which will identify underlying reasons for current absence rates. Interventions will be introduced to improve attendance but also increase engagement and morale amongst this group. If this is identified as an underlying cause, and is dealt with appropriately, it could potentially improve reputation of the organisation and increase attraction to placements and return rate of trainees to future Consultant posts

Proposed New Risks To Be Added Pending Approval	**Update on Progress**
C29	Failure to facilitate appropriate level of anaesthetic cover when patient's condition deteriorates out of hours Business case still being debated. Difficulty recruiting to locum posts. Remains a problem. Risk level remains the same It is proposed that this risk be placed on the Corporate Risk Register
C50	Increased Cardiac Waiting times It is proposed that this risk be placed on the Corporate Risk Register
C48	Use of Cardiac Day Case Unit (CDCU) to nurse medical escalation patients New Risk Assessment discussed at Divisional Board on 14th June 2013 It is proposed that this risk be placed on the Corporate Risk Register
C49	Reduced support of onsite surgical vascular services at BTH New Risk Assessment discussed at Divisional Board on 14th June 2013 It is proposed that this risk be placed on the Corporate Risk Register
S63	Use of old Anaesthetic Machines New Risk – Presented to Divisional Board on 14 June 2013 It is proposed that this risk be placed on the Corporate Risk Register
53	Management of Consultation and Subsequent Closure of Rossall Hospital
CHS 012 FA	Inability to meet contractual waiting times for Adult and Long Term Conditions, Community Health Services, Foot and Ankle Surgery due to lack of appropriate theatre sessions. Transferred from Community Health Services Division - It is proposed that this risk be placed on the Corporate Risk Register June 2013 - Risk increased from 9 to 16 as this continues to be problematic, complaints continue to increase which could result in a decline in organisational reputation to provide this service. This is also impacting on patient care and patient experience of the service. Only adhoc theatre sessions are supplied resulting in waiting lists continuing to increase. Permanent theatre sessions have been requested and at present there are no permanent vacant sessions available within BVH theatres. Currently the service is running a theatre session every Saturday within the Surgical Day Case Unit. There is currently no timeframe available to resolve this issue. Ongoing discussion between Head of Service and Theatre Manager in order to negotiate theatre slots to accommodate Foot and Ankle theatre requirements. Also looking to utilise Spire Hospital for ad hoc theatre sessions to help reduce waiting lists as a temporary measure.
Families Division	Colposcopy IT system It is proposed that this risk be placed on the Corporate Risk Register
CG 80	Delays in ordering pressure relieving Mattresses

Proposed Risks To Be Removed Pending Approval	Update on Progress

Colour	Classification	Code
	Cost	C
	People	P
	Quality	Q
	Delivery	Del
	Environment	Env
	Safety	S

Abbreviations	Abbreviations of Terms
BAF	Board Assurance Framework
CRR	Corporate Risk Register
FN/PR	Financial/Procurement
IM&T	Information Management and Technology

Adequate Assurance	
Limited Assurance	
Inadequate Assurance	

New risks for Consideration

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Cardiac Division C50	**Reduced EP Cardiac Waiting times**	3	4	12	Increased theatre session Fridays (2 patients) Full validation of all thoracic waiting lists in progress and to be ongoing Extra OPD cardiology clinics where availability of staff and rooms	Considering outsourcing patients dependent on waiting list validation Ensuring full theatre capacity usage Business case ongoing for further consultant EP	Risk Committee		NTAR	12/07/13
CQC Outcome Outcome 13, 15, 17 Regulation 22, 10, 19	Demand for service outweighs current capacity resulting in 18 wk wait targets being breached Use of beds for medical escalation patients has results in cancellation of cardiac patients being admitted for surgery Increase in emergency patients being admitted – unsure if this is a result of increased demand and capacity issues Increased in complaints Increased patient dissatisfaction / organisation reputation issues	Residual Risk and Impact of Controls Implemented					Director of Operations			Next Review Date
Date Added to CORP		C	L	S						11/10/2013
		3	3	9						
Source of the risk										Annual Review Date
FIN / BO / REP										31/03/14

Update on Progress	It is proposed that this risk be placed on the Corporate Risk Register Waiting list assessed. Full validation undertaken. Level of risk of breaching 18 weeks for cardiothoracic surgery has increased for the admitted pathway (Part 1A) for July and August. This is mainly due to the need to bring in patients with previous stop clocks alongside those on an open pathway. All measures to offset the risk have been undertaken.

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Cardiac Division C48	**Reduction in Use of Cardiac Day Case Unit (CDCU) to nurse medical escalation patients**	**4**	**4**	**16**	Cardiology patients are MRSA/MSSA screened prior to admission and appropriate treatment given if required. There is no time available to do this for medical patients admitted from A/E. PCR swabs are obtained on admission. Barrier nursing in the bays. Cath lab scheduling is managed by the Cardiac co-ordinator who ensures patients are listed appropriately to provide efficient utilisation of all catheter labs, taking into account that it is a tertiary centre and need to provide an equitable service for all patients across the region. When cancellations occur, Blackpool in-patients will be added to that days schedule to ensure the labs are fully utilised Maintain good working relationships with DGH colleagues and transfer patients in clinical priority order Aim to have all cardiology procedures carried out within 9 weeks allowing 9 weeks for cardiac surgeons to treat patients if required. Patients are cancelled according to clinical priority and then breach date Elective day case patients are seated in the reception area. Patients are contacted the day before to forewarn them that they may get cancelled Two toilet/shower rooms and 1 toilet for 20 patients Locum consultant cover is provided for the medical patients and a dedicated medical Matron Full support provided by the management team and senior nursing staff	Review of the medical escalation policy and appropriate clinical environment for patients to be nursed	Risk Committee Director of Operations	Medical patients not suitably screened for MRSA/MSSA. Infected patients transferred Inability to mitigate against this risk apart from keeping good relationships with DGH colleagues Capacity used to the maximum with existing inpatients Extra lists to compensate	LTAR/PALS	12/07/13
CQC Outcome	Increased infection risk due to failure to appropriately screen medical patients that are nursed alongside cardiology patients who have undergone invasive procedures. Known infected patients being transferred to CDCU- no side rooms for isolation. Wastage of catheter lab resources due to cancellation of elective day case patients who have been unable to be admitted due to lack of CDCU beds Potential loss of reputation for the Lancashire Cardiac Centre due to the inability to transfer patients from outlying hospitals due to lack of cardiology beds. Loss of reputation as a									
Outcome ,4,6,10,17 Regulation 17,9,24,15,19										
		Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Date Added to CORP		**4**	**3**	**12**						11/10/2013
Source of the risk										Annual Review Date
DIV/RA										31/03/14

	tertiary centre. In order to maintain throughput through the cardiology labs whilst day case patients are unable to be admitted, medical/cardiology patients listed for procedures in this Trust are inequitably undergoing their procedures. This results in inequitable catheter lab scheduling for patients in all outlying hospitals. Financial loss to the trust due to the cancellation of day case patients Increased risk of patients breeching the 18 week target for patients requiring cardiac surgery Increased risk of complaints as elective cardiology patients are being admitted to CDCU but a bed is not available for a number of hours while waiting for medical patients to be discharged. There are no waiting room facilities for CDCU. Poor patient experience due to lack of facilities in CDCU for medical in-patients and lack of immediate access to a bed for cardiology patients. There is a lack of toilet and showering facilities for medical patients				Cancellations undertaken by clinical priority and then breach date. Ward beds used if available for clinically urgent cases					

	which has resulted in patients wandering into the catheter labs looking for a toilet to use. Failure to provide efficient, timely medical management and treatment of medical patients due to the location of the unit from the existing medical unit and the difficulties in getting medical staff to come and review their patients.									
Update on Progress	New Risk Assessment discussed at Divisional Board on 14th June 2013 It is proposed that this risk be placed on the Corporate Risk Register Cardiology strategy discussions have commenced further to this risk assessment being undertaken. There is a definite desire from both clinical divisions to develop a robust patient centric strategy with clear pathway management. This will reduce the need for escalation into CDCU of patients with a cardiology condition.									

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Surgery C49	**Reduced support of onsite surgical vascular services at BTH**	5	3	15	Consultant cover available from alternative sites for emergency care Some on site provision of routine care. Change elective activity for non elective when pressure on service Ensure patients are repatriated in a timely manner Patients seen daily by a consultant and registrar. Team contact vascular services in a timely manner. Theatre capacity arranged as soon as patient is clinically ready for the procedure. Finance team notified of delays in patient throughput. Theatre capacity maximised with alternative cases. Wards escalate beds in line with the needs of the service Maintain good relationships with DGH colleagues Ensure DGHs are aware of our concerns re change in services	Plan for additional activity to offset shortfall where possible Daily monitoring of waiting times	Risk Committee Director of Operations	Plan for additional activity to offset shortfall where possible Daily monitoring of waiting times	CQC/ CNST	12/07/13
CQC Outcome	Patient harms or potential mortality. Consultants not available for urgent support to cardiac services. High risk of bleeding for patients having multiple antiplatelet drugs Inability to gain vascular access in certain procedures. Intra –aortic balloon pump recipients, TAVI, minimally invasive surgical cases with femoral access Uncontrolled femoral haemorrhage in anticoagulated patients Vascular complications following procedures eg ischaemic limbs Increased length of stay due to waits for vascular intervention for	Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Outcome 1,4,10,6,17 Regulation 17,9,15,24,19										11/10/2013
Date Added to CORP										Annual Review Date
Source of the risk										31/03/14
COSHH										

	carotid endartarectomy prior to cardiac surgery Financial implications associated with increased length of stay and impact on patient throughput. Cardiac centres loss of reputation- potential for patients to be referred to Manchester from DGHs									
Update on Progress	New Risk Assessment discussed at Divisional Board on 14th June 2013 It was agreed that the action plan needed to make reference to waiting times for carotid and also the expectation of vascular support on site. It was agreed that minimum standards set needed to be included in to the risk report. It is proposed that this risk be placed on the Corporate Risk Register									

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Surgery S63	End Use of Old Anaesthetic Machines	3	5	15	Machines serviced and supported. Staff testing and manual inspection of machines in place. stop	Establish business case to support the purchase of new equipment Secure appropriate training in the use of new equipment for staff	Risk Committee Director of Operations	New machines required to replace existing ones	AAGBI recommendations	12/07/13
CQC Outcome Outcome 11 Regulation 16	Increased risk of failure leading to potential patient safety incident, reduction in service provision and loss of revenue Environmental leak of anaesthetic gas. Inability to administer optimal anaesthetic Increased risk of litigation using machines in excess of their recommended life. No quality assurance of tampering	Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Date Added to CORP		3	1	3						11/10/2013
Source of the risk										Annual Review Date
COSHH										31/03/14
Update on Progress	New Risk – Presented to Divisional Board on 14 June 2013. The Action plan for the Division was to establish a business case to support the purchase of new equipment but would also look at the option of leasing. It is proposed that this risk be placed on the Corporate Risk Register									

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
USC USC 53	Effective Management of Consultation and Subsequent Closure of Rossall Hospital	4	4	16	Use of agency staff and Rossall reduced to 30 patients Senior nurse present regularly to communicate with staff and engage with staff of changes. Engagement team to visit regularly Reduced to 30 patients, two teams now formed with aim of having 2 registered nurses on the early for each team, 1 registered nurse on the late and one registered nurse on the night. Agency nurses only to be used for the early shift with support from the permanent staff Registered nurse on the early once completed tasks for the morning to concentrate on the discharge planning. HDT offering support where able	Meeting arranged with agency manager re use of agency nurses – to use agency for Early shifts only If sickness continues to reduce bed capacity further	Risk Committee	None documented	CQC, HR	12/07/13
CQC Outcome	Insufficient registered nursing staffing levels to deliver optimum care Reduced morale from staff due to closure of unit Increased sickness due to closure of unit Length of stay increase due to limited registered nurses able to complete discharge planning Delayed discharges due to limited registered nurses able to complete discharge planning						Director of Operations			
		Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Date Added to CORP		3	4	12						11/10/2013
Source of the risk										Annual Review Date
DIV/RA										31/03/14
Update on Progress	This links to the consultation and closure of Rossall on 1st August. Whilst waiting for this to happen there are a number of issues including recruitment, sickness absence, reduced bed numbers and skill mix. The action plan was to transfer staff from Clifton to ensure greater senior representation. It is proposed that this risk be placed on the Corporate Risk Register									

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Community Foot & Ankle Surgery CHS 012 FA	Meet contractual waiting times for Adult and Long Term Conditions, Community Health Services, Foot and Ankle Surgery due to lack of appropriate theatre sessions.	4	4	16	Service transferred to Whitegate PCC Use theatres at VHB for complex procedures Staff working flexibly around ad hoc theatre availability	Transfer Service to Whitegate PCC As sessions are now taking place at Blackpool Victoria, risk mitigated from 3 x 5 to 3 x 2. Request theatre sessions at VHB Request staff to work flexibly	Risk Committee	Whitegate theatre not suitable for complex procedures Permanent theatre sessions not available at VHB Regular theatre sessions not available at VHB	Fylde Coast contract monitoring meeting	12/07/13
CQC Outcome	Fleetwood Hospital Theatre unfit for use Whitegate Theatre does not have laminar airflow Only ad hoc theatre sessions available at VHB						Managing Director Community Development & Transformation			Next Review Date
Outcome 4, Regulation 9 Outcome 10, Regulation 15 Outcome 16, Regulation 10		Residual Risk and Impact of Controls Implemented								
		C	L	S						
Date Added to CORP		3	2	**6**						11/10/2013
Source of the risk										Annual Review Date
										31/03/14

Update on Progress	Transferred from Community Health Services Division - It is proposed that this risk be placed on the Corporate Risk Register June 2013 - Risk increased from 9 to 16 as this continues to be problematic, complaints continue to increase which could result in a decline in organisational reputation to provide this service. This is also impacting on patient care and patient experience of the service. Only adhoc theatre sessions are supplied resulting in waiting lists continuing to increase. Permanent theatre sessions have been requested and at present there are no permanent vacant sessions available within BVH theatres. Currently the service is running a theatre session every Saturday within the Surgical Day Case Unit. There is currently no timeframe available to resolve this issue. On going discussion between Head of Service and Theatre Manager in order to negotiate theatre slots to accommodate Foot and Ankle theatre requirements. Also looking to utilise Spire Hospital for ad hoc theatre sessions to help reduce waiting lists as a temporary measure. 12th July 2013 – Due to continual lack of permanent theatre sessions being available within the trust for the service to use, there continues to be a risk that patient experience is being affected due to increased waiting times for surgery and the service being unable to meet this contractual targets. Theatre sessions are currently running every Saturday within the Surgical Day Case Unit depending on the availability of the Locum Podiatric Surgeon being used within the service. Six theatre sessions have been agreed to be utilised at Spire Hospital during August as a temporary measure to reduce the waiting lists. Currently 88 patients on the waiting list requiring a date for surgery. Longest wait following agreement that surgery is needed is from 23/01/13. Estates have stated to review the Minor Procedure Room at Whitegate Health Centre to identify what work would need to be undertaken to bring this room up to specification for Foot & Ankle surgery to be undertaken within it.

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Families Division FA 25	To Maintain Colposcopy IT Systems	3	4	12	Alert is up and running and all users are trained up to use the system Any data that is not captured is highlighted to the IT team Staff allocated to collect the KC65 data manually QA made aware of the issues Concerns escalated to the Vision team in December 2012. Further concerns raised to informatics	Administrative staff diverted from their own duties to complete year end data manually. Colposcopy IT templates being reviewed with the Vision team, and other options being pursued including development of a MAXIMS based IT system	Risk Committee	Option appraisal needed to look at other options for providing IT support Review of past year's data with manual figures Continue to complete forms manually	CQC NSF	12/07/13
CQC Outcome	Current IT system – ALERT was developed to deal with the issue of providing accurate information 12 months ago and templates developed alongside support form the company. This has been live since July 2012. However the Trust has now decided						Director of Nursing and Quality			
		Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Date Added to CORP		3	1	3						11/10/2013
Source of the risk										Annual Review Date

DIV/RA	not to implement the system Trustwide and it is not a bespoke system used in other Trusts, and there are problems with data input and retrieval Data quality – KC65 data required for national data collection on Colposcopy, and ALERT is unable to provide accurate data therefore this is being manually collected for 2012-13 QA recommendations – inability to comply with urgent QA recommendations from visit 3 years ago. Concerns raised part way through the year – concerns regarding availability of data for inputting onto the KC65									31/03/14

Update on Progress	ALERT was developed to deal with the issue of providing accurate information however as the Trust has decided not to implement the system Trustwide it is not a bespoke system used in other Trusts and there are problems with data input and retrieval. Informatics has proposed a different type of IT system and was working with the Vision team around templates. Additional assurances were required to reduce the evaluated risk which included an option appraisal to look at other options for providing IT support and a review of the past year's data with manual figures. It is proposed that this risk be placed on the Corporate Risk Register

CORP Number	Objective Description Stakeholders	Inherent Risk Score CxL=S Without Control Measures			Key Controls	Resources to bring Action To An Acceptable Standard	Assessor Responsibility of	Gaps in Controls and Assurances	Internal/ External Assurances on Controls	Progress Review Date
		C	L	S						
Clinical Governance CG 80	Delays in ordering pressure relieving Mattresses	4	4	16	Quarterly contract review meeting chaired by procurement with clinical representation Expertise on the contract and service from our provider Medstrom, establishment and monitoring of KPI's under domain of Procurement Department. Clinical governance processes for nursing staff re selection, ordering, transferring and cancellation of the products in place Medstrom IT system with limited controls in place Information report re usage and response provided for quarterly review meeting Mattress supply held in AMU and ward 10 to facilitate high risk patients and	Develop escalation process for notification of loss, damage or repair requirements to products to prevent delays in invoice payment and robust management of product usage Develop escalation process for additional usage of products so divisions are aware of when contract usage bandings are being approached to prevent delays in invoice payment and robust management of product usage Develop escalation process for non payment of contract invoices to prevent delays in product distribution Develop KPI monitoring process that will allow escalation to clinical divisions when breeched and calling of extraordinary monitoring meeting	Risk Committee Director of Nursing & Quality	Escalation process for loss, damage, repair to products. Escalation process for additional usage Number of mattresses in system to support effective turn around times (A, Process for ensuring timely		12/07/13
CQC Outcome	Patient safety compromised due to delays in delivery of pressure redistribution products Dynamic mattress usage has risen significantly and is impacting on availability and impacting on overall hazard Nursing governance processes in place but not always adhered to thus causing additional	Residual Risk and Impact of Controls Implemented								Next Review Date
		C	L	S						
Date Added to CORP		3	3	9						11/10/2013
Source of the risk										Annual Review Date

RISK, FIN, DIV, INC, REP, RA	usage of pressure redistribution products outside of guidelines Medstrom IT system is not robust enough to prevent non compliance of the system and does not support effective product management as only ordering and transfer can be undertaken via the system. Medstrom cancellation processes of pressure redistribution products not robust or user friendly and as a result not always adhered to by nursing staff Contract management and KPI reviews could be more robust Turn around time delivery of pressure redistribution products not specified in contract Outstanding payment of invoices prevents collaborative				implement pressure relieving support as soon as possible following admission Escalation process to identify priority patients in place	Develop and agree SLA clearly identifying the need for 4 hourly turnaround time of products, taking into account the need for robust governance procedures to be adhered to to facilitate success. Identify additional mattress numbers required to support 4 hourly turnaround of delivery and secure central funding for same Carry out audit to identify areas requiring focus for improvement in implementing nursing governance processes with regards selecting, ordering, transferring and returning products Deliver targeted training to areas where there is non compliance with governance processes Formalise governance process for selection, ordering etc into a formal standard operating procedure, publicise and implement via divisional ADN's Review IT (therapy on line) system and modify to make more robust – to incorporate patient hosp. Number as mandatory field, allow cancellation of products on line instead of separate verbal process and develop a report generator to allow staff and management to identify real time data and identify issues/concerns to address in real time. Monitor usage of products on a weekly basis via outstanding request report and products in use for greater than 10 days report and address areas of concern		payment of invoices to prevent adverse effect on contract Robust process for contract management and KPI review Improved Medstrom IT system Targeted training to address wards of non compliance with nursing governance processes No turnaround times specified in contract		31/03/14

	working with company to meet patient demand No escalation process in place to manage additional use of pressure redistribution products Movement of mattresses from AMU not robustly traced due to poor adherence to nursing governance process					with individual areas. Report to be sent via ADN Quality & Safety				
Update on Progress	There are a number of existing control measures in place which included a quarterly contract review meeting chaired by procurement with clinical representation. There are also clinical governance processes for nursing staff regarding selection, ordering, transferring and cancellation of the products. A mattress supply is held within AMU and Ward 10 to facilitate high risk patients and implement pressure relieving support as soon as possible following admission and an escalation process was in place to identify priority patients. It is proposed that this risk be placed on the Corporate Risk Register									

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Compliance Monitoring Assurance Report

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Business Critical Measures

Corporate Objectives Report
Strategic Framework
Quarter 1 2013/14

Tolerances		
On Target	Of Concern	Action Required

Strategic Aim: 100% of Patients & Carers involved in decisions about their care

		Apr	May	Jun	Quarter Actual	VARIANCE Actual - Target		2013/14 Q1	Q2	Q3	Q4	2013/14 Target	YTD
2016 Milestone	100% of patients would recommentd our services to their family and friends												
Key Drivers	Integrated patient experience monitoring and improvement programme	Data not available											
	Shared decision making model	Data not available											
	Expert patient programme	Data not available											

Strategic Aim: Zero inappropriate admissions

		TARGET Apr	May	Jun	Quarter	VARIANCE Actual - Target		2013/14 Q1	Q2	Q3	Q4		
2016	Care in the Community (TBC)												
Key Drivers	Development of capacity in the community	Data not available											
	Patient education programme	Data not available											
	Better care now	Data not available											

Strategic Aim: Zero Harms

		TARGET Apr	May	Jun	Quarter	VARIANCE Target	variance	2013/14 Q1	Q2	Q3	Q4		
2016	95% harm free care												
Key Drivers	Pressure ulcer reduction programme Hospital Seeting	5	2	7	14	12.75	1.25						
	Pressure ulcer reduction programme Community Seeting	6	4	6	16	28.5	-12.5						
	Falls reduction programme	177	162	110	449	414	35						
	VTE reduction programme	Data not available											

Strategic Aim: Zero Delays

		TARGET Apr	May	Jun	Quarter	VARIANCE Actual - Target		2013/14 Q1	Q2	Q3	Q4		
2016 Milestone	All inpatient diagnostic tests to be undertaken within 24 hours of referral												
Key Drivers	Better Care now	Data not available											
	Outpatient Improvement Programme	Data not available											

Strategic Aim: 100% compliance with standard pathways

		TARGET Apr	May	Jun	Quarter	VARIANCE Actual - Target		2013/14 Q1	Q2	Q3	Q4		
2016 Milestone	80% compliance with agreed pathways												
Key Drivers	AQ pathways programme	Data not available until Sept											
	Development of agreed pathways in high mortality conditions/HRG's												
	Clinical Audit Programme					3	3						

Exception Report:

Targets and measures for each programme still in development.

Compliance Framework Measures
Quarter 1 2013/14

Performance				Compliance Framework	Apr	May	Jun	Quarter Target	Quarter to date	VARIANCE Actual - Target		QUARTERLY PERFORMANCE Q1	Q2	Q3	Q4	2013/14 Target	YTD
2010/11	2011/12	2012/13	Rolling 12 months														
4	2	3	3	MRSA	0	0	0	0	0	0		0				0	0
101	53	28	20	Clostridium Difficile	1	3	0	7	4	-3		4				<=29	4
97.69%	95.93%	96.61%	96.35%	A&E % of patients who have waited less than 4 hours	93.20%	98.73%	97.58%	95%	96.50%	1.50%		96.50%				>=95%	96.50%
94.08%	91.89%	94.64%	93.67%	18 weeks admitted pathways	91.82%	93.60%	90.15%	90%	91.86%	1.86%		91.86%				>=90%	91.86%
96.46%	95.76%	97.51%	97.35%	18 weeks non-admitted pathway	96.94%	96.98%	96.80%	95%	96.91%	1.91%		96.91%				>=95%	96.91%
N/A	92.79%	95.34%	95.51%	18 weeks open pathways less than 18 weeks	95.33%	95.47%	95.53%	92%	95.44%	3.44%		95.44%				>=92%	95.44%
95.3%	94.5%	95.03%	95.28%	2wk waiting time urgent GP Referral	93.10%	94.30%	94.10%	93.00%	93.80%	0.80%						>=93%	
95.2%	94.6%	95.26%	95.21%	2wk waiting time breast referral	94.90%	91.30%	95.00%	93.00%	93.90%	0.90%						>=93%	
94.5%	91.3%	94.48%	92.67%	62 day cancer screening waiting time standard	76.90%	84.60%	100.00%	90.00%	87.20%	-2.80%						>=90%	
88.8%	89.2%	86.21%	87.72%	62 day Cancer waiting time standard	84.40%	85.60%	90.70%	85.00%	86.70%	1.70%						>=85%	
99.8%	99.5%	99.04%	98.95%	31 day general	98.60%	99.40%	98.40%	96.00%	98.80%	2.80%						>=96%	
100%	99.5%	97.68%	99.61%	31 day subsequent drugs	100.00%	98.10%	100.00%	98.00%	99.20%	1.20%						>=98%	
100%	99.4%	99.31%	98.56%	31 day subsequent surgery	100.00%	100.00%	100.00%	94.00%	100.00%	6.00%						>=94%	
Not measured		100.00%	100.00%	CHS Data Completeness Referral to Treatment Info	100.00%	100.00%	100.00%	50.00%	100.00%	50.00%		100.00%				>=50%	100.00%
		58.70%	72.30%	CHS Data Completeness Referral Info	72.30%	72.10%	72.50%	50.00%	72.20%	22.20%		72.20%				>=50%	72.20%
		96.60%	95.67%	CHS Data Completeness Treatment Activity Information	95.50%	95.80%	95.70%	50.00%	95.60%	45.60%		95.60%				>=50%	95.60%

Performance				Financial Measures	April YTD	May YTD	June YTD	YTD Target	YTD Actual	YTD Variance		QUARTERLY PERFORMANCE Q1	Q2	Q3	Q4	Full Year Plan	Full Year Forecast
2010/11	2011/12	2012/13	Rolling 12 months														
5.40%	6.00%	4.30%	4.50%	EBITDA % achievement - YTD	3.50%	3.63%	3.67%	4.94%	3.67%	-1.27%		3.67%				5.30%	4.76%
81.10%	117.60%	92.50%	88.10%	EBITDA margin (%) - YTD	72.05%	80.33%	74.65%	100.00%	74.65%	-25.35%		74.65%				100.00%	91.33%
4.70%	2.30%	1.90%	2.20%	Return on Assets (%) - YTD	0.59%	0.44%	0.43%	2.74%	0.43%	-2.31%		0.43%				3.30%	2.45%
0.50%	2.40%	0.90%	1.10%	I&E surplus margin (%) - YTD	0.31%	0.24%	0.32%	1.49%	0.32%	-1.17%		0.32%				1.80%	1.35%
2.6	9.3	17.6	15.9	Liquidity ratio (days)	18.9	17.7	15.9	17.2	15.9	-1.3		15.9				14.5	12.9
				QUIPP Delivery - YTD	0.8	1.5	2.1	2.5	2.1	-0.4		2.1				16.005	13.996

Performance				Risk Ratings	Quarter Target	YTD Actual	YTD Variance		Quarterly Performance Q1	Q2	Q3	Q4	Full Year Plan	Full Year Forecast
2010/11	2011/12	2012/13	Rolling 12 months											
2	2	3	3	Financial Risk Rating	3	3	0		3				3	2
				Governance Risk Rating	0	0	0		0					
				Risk of, or actual, failure to deliver mandatory services	0	0	0		0					

EXCEPTION REPORT:

Cancer: The Trust is predicted to achieve all cancer waiting time targets for the month of June. In terms of achievement for the quarter, the 62 day screening target was failed in April and May, the patients were transferred early in their pathways by the Bowel Cancer Screening Programme which the Trust hosts, however treating Trusts were unable to schedule treatments within the 62 days. The Trust has discussed and agreed reallocation of these breaches and will therefore be able to confirm achievement of all cancer pathways for the quarter. Improvement work is being undertaken across all tumour sites with particular emphasis on working with GPs and patients to reduce the impact of patient choice and non-compliance, shortening of the diagnostic waiting times and timely referral to tertiary centres. Specific work has been undertaken in Lung and Urology to address delays in the pathway. The importance of prior knowledge of screening campaigns to enable the planning of additional capacity has been raised with CCG and Public Health colleagues.

Compliance Monitoring

Compliance Framework	Target	Q4 2012/13	Q1 2013/14
MRSA		1	0
Clostridium Difficile		7	4
A&E % of patients who have waited less than 4 hours	95%	95.02%	96.50%
18 weeks admitted pathways	90%	93.62%	91.86%
18 weeks non-admitted pathway	95%	97.27%	96.91%
18 weeks open pathways less than 18 weeks	92%	95.60%	95.44%
2wk waiting time urgent GP Referral	93%	96.90%	93.80%
2wk waiting time breast referral	93%	93.40%	93.90%
62 day cancer screening waiting time standard	90%	96.50%	92.80%
62 day Cancer waiting time standard	85%	82.90%	86.10%
31 day general	96%	98.90%	98.80%
31 day subsequent drugs	98%	98.50%	99.20%
31 day subsequent surgery	94%	100.00%	100.00%
CHS Data Completeness Referral to Treatment Info	50%	100.0%	100.00%
CHS Data Completeness Referral Info	50%	58.70%	72.20%
CHS Data Completeness Treatment Activity Information	50%	96.60%	95.60%

Cancer performance for Q1 is indicative.

Risk ratings	Target	Q4 2012/13	Q1 2013/14
Financial Risk Rating	3	3	3
Governance Risk Rating	0	0	0
Risk of, or actual, failure to deliver mandatory services	0	0	0
CQC Quality & Safety Standards			

In Year Governance Statement from the Board of Blackpool Teaching Hospitals

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

	For finance, that:	**Board Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Confirmed

	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in **Appendix B** of the Compliance Framework; and a commitment to comply with all known targets going forwards.	Confirmed

Otherwise

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 17 Diagram 8 and page 63) which have not already been reported.

Signed on behalf of the board of directors

Signature	Signature
Name	**Name**
Capacity	**Capacity**
Date	**Date**

Notes: *The contents of this statement are specified in Monitor's Compliance Framework for 2013-14* 1

Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

31st July 2013

Subject:	Q1 Monitoring Return
Report Prepared By:	Feroz Patel, Acting Finance Director
Date of Report:	22nd July 2013
Service Implications:	None
Data Quality Implications:	None
Financial Implications:	None
Legal Implications:	None
Links to the Principles of The NHS Constitution:	None
Links to the Blackpool Way:	Continuous Improvement – it is a requirement of the Trust's License to submit Quarterly Monitoring Returns to Monitor.
Links to Key Organisational Objectives:	Top 10% and delivering value for money – it is a requirement of the Trust's Terms of Authorisation to submit Quarterly Monitoring Returns to Monitor.
Links to Care Quality Commission Quality and Safety Standards	This is linked to all the CQC Standards.
In case of query, please contact:	Feroz Patel, 01253 306782, feroz.patel@bfwh.nhs.uk

Purpose of Report/Summary:

At the end of July 2013 the Trust is required to submit monitoring returns to Monitor, as the regulator, for performance for the year to the end of quarter 1 (30th June 2013). The report has the following key purposes:

- To set out the Trust's Monitor Governance Declaration, Governance Risk Rating and supporting documentation as at quarter 1, in accordance with its License and the Monitor Compliance Framework requirements 2013/14 and,

- To provide information and assurance to the Board, and to Monitor, that the necessary actions are being implemented to address any issues or concerns raised

Key Issues:

The Trust has achieved a surplus of £0.3m which is £1.0m behind the planned surplus of £1.3m with a financial risk rating of 3 at the end of quarter 1 (before exceptional items). The Trust is currently forecasting a year-end surplus of £4.9m which is £1.5m lower than plan before mitigation. The Trust has included certain elements of the Keogh Action Plan in the forecast. The Trust has a number of potential mitigations which are available to deliver an overall FRR of 3 at the end of the year including reviewing pre-agreed service developments and the utilisation of any slippage in the timeframe of implementing these developments. The Trust anticipates that the quarterly financial risk rating will be at least a 3 over the next 12 months. There remain significant risks to the ongoing attainment of planned performance. In particular

these are the resource implications of the Keogh Action Plan, cost pressures / unplanned expenditure in the CS&FM Division, lower than planned gross contribution in the Unscheduled Care Division, the non-delivery of QuIPP schemes and the Trust's cash and liquidity position.

The Board is asked to:

- Approve the submission of finance returns as per the finance report.
- Approve the completion of Confirmed for Finance by the Chief Executive on behalf of the Board.
- Approve the completion of Confirmed for Governance by the Chief Executive on behalf of the Board.
- Following Board approval, Q1 return to be submitted to Monitor.

Risk Rating (Low/Medium/High): Medium **BAF/CRR Number:** BAF 117	**Board Review Date:** 31st October 2013

Report Status: the Author must indicate whether the document is "for information", "for discussion" or "for approval" (please indicate).

1	2	3
☐	☐	√
For Information	**For Discussion**	**For Approval**

Document Status: the Author must indicate the level of sensitivity of the document (please indicate). This relates to the general release of information into the public arena.

1	2	3
☐	√	☐
Not sensitive: **For immediate publication**	**Sensitive in part:** **Consider redaction prior to release.**	**Wholly sensitive:** **Consider applicable exemption**

Reason for level of sensitivity selected:	FOI Exemption 22 - Information Intended for Future Publication

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

31st July 2013

Q1 Monitoring Return

At the end of July 2013 the Trust is required to submit monitoring returns to Monitor, as the regulator, for performance for the year to the end of Quarter 1 (30th June 2013).

There are three elements to this submission, financial performance and performance against the governance standards set out in the Compliance Framework.

Financial Performance

The financial submission (and supporting commentary) consists of the three main financial statements for the period:-

- Income statement (formerly the income & expenditure statement)
- Cash flow statement
- Statement of position (formerly the balance sheet)

These are included within the finance report that will be discussed at the Finance meeting.

The Trust has achieved a surplus of £0.3m which is £1.0m behind the planned surplus of £1.3m with a financial risk rating of 3 at the end of quarter 1 (before exceptional items). The Trust is currently forecasting a year-end surplus of £4.9m which is £1.5m lower than plan before mitigation. The Trust has included certain elements of the Keogh Action Plan in the forecast. The Trust has a number of potential mitigations which are available to deliver an overall FRR of 3 at the end of the year including reviewing pre-agreed service developments and the utilisation of any slippage in the timeframe of implementing these developments. The Trust anticipates that the quarterly financial risk rating will be at least a 3 over the next 12 months. There remain significant risks to the ongoing attainment of planned performance. In particular these are the resource implications of the Keogh Action Plan, cost pressures / unplanned expenditure in the CS&FM Division, lower than planned gross contribution in the Unscheduled Care Division, the non-delivery of QuIPP schemes and the Trust's cash and liquidity position.

Based on the above it is recommended to approve the completion of 'Confirmed' for Finance by the Chief Executive on behalf of the Board.

Governance Standards

Performance against all targets is reviewed in the Business Monitoring report. The targets reviewed by Monitor are a subset of these, as set out in the Compliance Framework.

The Board is required to make a self-declaration, stating whether targets have been achieved as per the attached. The Trust is predicting a fail against the Cancer 62 day general waiting time standard in quarter 4; all other performance targets for quarter 4 will be met. Final validation of all cancer data and confirmation of pathology is still on-going at time of this report.

The main cause for the predicted failure to achieve the 62 day general waiting time standard is an unexpected increase in fast track referrals, particularly in Urology where referrals increased by 42% in the quarter. This has been raised with commissioners and across the wider health economy and the Trust has requested prior notice of health screening campaigns to enable additional capacity to be planned. The Trust has agreed a CQUIN with commissioners aimed at improving the sustainability of the cancer pathway, each tumour site has been tasked with developing and implementing actions to ensure the CQUIN measures are delivered.

An unannounced visit was undertaken by the Care Quality Commission on 11 June 2013. The Trust received a draft report from the Care Quality Commission on 17th Aprill 2013. The CQC has judged that we are compliant with the following standards –

- Respecting and involving people who use services
- Consent to Care and Treatment
- Care and Welfare of People who use services
- Assessing and monitoring the quality of service provision.

The CQC has reported that we have not met the standard regarding 'Complaint's' reporting that systems in place to manage and respond to complaints and concerns were not always dealt with in the trusts own timescales. People did not always feel their concerns or complaints were managed satisfactorily. The CQC has judged that this has a ***moderate*** impact on people who use the service. The Trust have until the 2nd August 2013 to submit any comments relating to any factual inaccuracies in the report.

Based on our current prediction of achievement of all targets the compliance framework score will be one, which results in a risk rating of AMBER/GREEN.

Quality

The Board is required to confirm that it is satisfied that it has systems and processes in place to monitor and continually improve the quality of healthcare provided to its patients, having regard to Monitor's Quality Governance Framework.

Four Committees provide assurance to the Board of Directors via a CEO assurance report regarding internal controls:

1) Finance Committee
2) Quality Committee
3) Risk Committee
4) HR&OD Teaching Governance Committee
5) Transformation and QuIPP Programme Board
6) Startegy and Assurance Committee

The assurance process is supported by:

- Proactive and Reactive Risk Management via Adverse Events Management
- Risk Register Framework – Quarterly Monitoring of Board Assurance Framework / Corporate Risk Registers
- Compliance with Health and Safety National and Local Standards
- Compliance with Risk Management National and Local Standards – NHS Litigation Authority (General) / Clinical Negligence Scheme for Trusts (Maternity),

A critical review has been undertaken of the work of the Risk Committee to provide assurance to the Board with regard to internal controls.

The Board is assured of compliance through a number of reports submitted for information and discussion at times throughout the year for example:

Monthly Reports and Reviews:

- Care Quality Commission Compliance Indicators Report
- Progress on the Trust's Quality and Risk Profile results from the Care Quality Commission
- StEIS/Serious Incidents/Never Events/External Reviews Report
- Business Monitoring Report.
- Local In-Patient Survey.
- Nursing Care Indicators
- Patient Safety and Quality Report

Quarterly / Six Monthly Reports & Reviews:

- Patient Experience Report
- Patient Story DVD
- National Staff Survey Results and Action Plan.
- Patient Safety Walkabout Reports.
- Review of internet homepage which publishes up-to-date performance data and public feedback is taken into account.
- Staff involved in roll out of the Productive Ward and ward managers given ownership to ensure necessary changes are made within the ward environment.
- 'Knowing how we are doing' boards.
- External intranet – publication of key quality, safety and patient experience measures.
- QuIPP programme, quality and safety reviews.
- Review of Board Assurance Framework and Corporate Risk Register
- Clinical Audit Activity Report
- Governance Report

These reports listed above and others assure the Board of compliance and that the Trust is continually working to improve the quality of healthcare to its patients.

Therefore, based on the above it is recommended to approve the completion of 'Confirmed' for Governance by the Chief Executive on behalf of the Board.

The Board is asked to:

- Approve the submission of finance returns as per the finance report.
- Approve the completion of 'Confirmed' for Finance by the Chief Executive on behalf of the Board.
- Approve the completion of 'Confirmed' for Governance by the Chief Executive on behalf of the Board.

Feroz Patel	Pat Oliver	Marie Thompson
Acting Finance Director	Director of Operations	Director of Nursing & Quality

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting
31st July 2013

Subject:	Chief Executive Report
Report Prepared By:	Gary Doherty
Date of Report:	16th July 2013
Service Implications:	For the Board to be updated on matters the Chief Executive has been involved in.
Data Quality Implications:	None.
Financial Implications:	QuIPP essential to sustainability.
Legal Implications:	None.
Links to the Principles of The NHS Constitution:	Links to the Principles of the NHS Constitution throughout.
Links to the Blackpool Way:	The Blackpool Way is in place to promote employee engagement as a means of transforming the culture and performance of the enlarged organisation. The report covers a number of items pertinent to the Blackpool Way.
Links to Key Organisational Objectives:	Providing 'Best in NHS" Care for our patients.
Links to Care Quality Commission Quality and Safety Standards	Links to all CQC outcomes
In case of query, please contact:	Gary Doherty, Chief Executive (ext 6853)

Purpose of Report/Summary:

To provide the Board of Directors with an overview of activities during the past month.

Key Issues:

None to highlight specifically.

The Board is asked to:

Review and note the contents of the report.

Risk Rating (Low/Medium/High): Low **BAF/CRR Number:** N/A	**Board Review Date:** October 2013

Report Status: the Author must indicate whether the document is "for information", "for discussion" or "for approval" (please indicate).

1	2	3
	X	
For Information	**For Discussion**	**For Approval**

Document Status: the Author must indicate the level of sensitivity of the document (please indicate). This relates to the general release of information into the public arena.		
1 X **Not sensitive:** **For immediate publication**	**2** **Sensitive in part:** **Consider redaction prior to release.**	**3** **Wholly sensitive:** **Consider applicable exemption**
Reason for level of sensitivity selected:		

Board of Directors Meeting

31st July 2013

Chief Executive's Report

New Appointments

Following interviews earlier this month we have now made appointments to the positions of Director of HR & OD and Director of Finance.

Nicky Ingham has been appointed to the post of Director of HR & OD. Nicky is currently Director of HR Workforce & OD at Bolton NHS Foundation Trust. She has worked in the NHS in the area of HR for more than 20 years and has held various positions in North West Trusts, including HR Director of Royal Liverpool Children's NHS Foundation Trust (Alder Hey).

Tim Bennett has been appointed to the Director of Finance post. Tim is currently Deputy Chief Executive and Director of Finance, Information and Supplies with University Hospitals of Morecambe Bay NHS Foundation Trust. Tim has also previously worked as Director of Finance and Information at The Cardiothoracic Centre in Liverpool (now Liverpool Heart and Chest Hospital NHS Foundation Trust).

We have also made a number of consultant appointments over the last few weeks including Medicine for the Elderly, Paediatrics, Breast Surgery, Orthopaedics and Acute Medicine. We also interviewed for a consultant in Ophthalmology but were unable to appoint.

Official Opening of the Simulation and Human Factors Facility

I attended the official opening of the simulation and human factors facility on the 4th July as part of patient safety week. The morning consisted of a mixture of keynote lectures and live simulation demonstrations and was officially opened by the Dinwoodie Charity who funded 50% of the project. The centre is an outstanding facility and it was fascinating to watch clinical teams responding to two very challenging simulated situations. One was a surgical post-op patient who deteriorated rapidly due to sepsis, the other was a mum who suffered a major post-partum haemorrhage. The sophisticated life sized manikins are able to replicate a number of conditions in unwell adults and children – more importantly they are able to accurately respond to clinical interventions whether they be CPR, drug infusions, intubation etc. The facility to test and refine "technical" skills and knowledge is important but just as is important is the ability to allow clinical teams to observe themselves communicating and working together in tense situations – research shows that very often these human factors are the key determinant of how a clinical situation turns out. Going forward this facility will be a key part of our plan to improve services for patients by strengthening the skills and team dynamics of staff in key clinical areas.

Visit by CEO of NHS Blood Transfusion Service

The Chief Executive of the NHS Blood and Transplant Service, Lynda Hamlyn, visited the Trust on 4th July. Our Trust is one of only four in the country taking part in a blood stock management pilot. The scheme enables NHS Blood and Transplant to monitor hospital stock levels on a 'live' basis and replenish stock. The benefit of doing this is that there is less wastage, lower costs involved, and makes the best use of the valuable gift of blood given to us by donors. Lynda visited the unit to congratulate and thank our staff for all of their hard work in getting the pilot off the ground and working so well.

Launch of Healthwatch

On the 8th July I attended the launch of the Lancashire branch of Healthwatch. Healthwatch England is the independent consumer champion for health and social care in England, with 152 branches across the country. By law, those who plan and run health and social care services have to listen and respond to what Healthwatch have to say so it is important that we build our relationship with what is effectively a new and very important organisation.

The NHS belongs to the people: a call to action

NHS England has produced a document entitled "The NHS belongs to the people: a call to action". The document calls on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. This is set against a backdrop of "flat funding" which, if services continue to be delivered in the same way as now, will result in a funding gap (on top of the existing £20bn efficiency assumption) which could grow to £30bn between 2013/14 to 2020/21.

The document sets out a number of latest facts on the NHS, including demand, the changing demographics of the patients being treated and the growth in long term conditions. These include:

- The NHS treats around one million people every 36 hours.
- Between 1990 and 2010, life expectancy in England increased by 4.2 years, but the difference in life expectancy between the richest and poorest parts of the country is now 17 years.
- Around 80 per cent of deaths from major diseases, such as cancer, are attributable to lifestyle risk factors such as smoking, excess alcohol and poor diet.
- 25% of the population (just over 15 million people) has a long term condition such as diabetes, dementia and high blood pressure – and they account for 70% of days in a hospital bed.
- The number of older people likely to require care is predicted to rise by over 60% by 2030.

NHS England, along with other national partner organisations, will be providing support to local GPs, charities and patient groups to hold meetings to discuss these issues. These meetings will provide the mechanism for patients and the public to have a genuine say in how the NHS of the future will look. All feedback from these meetings, as well as national events and online contributions via NHS Choices, will be published and used to help shape a longer term strategy for the NHS. This will need to be in place by early 2014 to feed into commissioning plans for GP-led Clinical Commissioning Groups in 2014/15 and 2015/16.

Liverpool Care Pathway (LCP) Review Report

An independent review of the LCP headed by Baroness Julia Neuberger was published in July. The Review panel recognises that, in the right hands, the Liverpool Care Pathway can provide a model of good practice for the last days or hours of life for many patients. Based on the evidence examined by the Review, much of which came from clinicians, the Review panel concluded that the LCP is not being applied properly in all cases and that it should be replaced within the next 6 to 12 months by an end of life care plan for each patient, backed up by condition-specific good practice guidance.

NHS England has welcomed the report and will be carefully considering the findings to respond fully in the autumn.

Gary Doherty
Chief Executive

Board of Directors Meeting

31st July 2013

Chairman's Report

a) Monthly Update:-

- Trust Activities

The Nominations Committee is scheduled to meet on the 24th July to agree the short-listing for the additional Non-Executive Director post. The interviews are planned for Monday 5th August. The majority of Board members will have now had the opportunity to meet with the newly appointed Non-Executive Director, Jim Edney.

Board members will be aware of the two recent Executive Director appointments; namely Nicky Ingham and Tim Bennett as the Director of HR & OD and the Director of Finance respectively. I would like to place on record my thanks and appreciation to Feroz Patel, Acting Director of Finance, and Jacqui Bate, Interim Director of HR and OD, for all of their hard work in leading these important areas over the past few months.

Tony Shaw deputised at an Appointments Advisory Committee for a Care of the Elderly Consultant on the 8th July and Dr Gopalakrishnan Deivasikamani was appointed.

I chaired an Appointments Advisory Committee for a Consultant Paediatrician on the 11th July and Dr Gordon Morris was appointed.

I chaired an Appointments Advisory Committee for a Consultant in Trauma & Orthopaedics on the 16th July and Mr Amit Shah and Mr Vishwanath Shetty were appointed.

I chaired an Appointments Advisory Committee for a Consultant Ophthalmologist on the 19th July. Unfortunately, no appointment was made.

The Chief Executive and myself met with two Staff Side Representatives, Lynne Bentham and Margaret Heaton, on the 19th July. A request was made at the meeting for a Non-Executive Director representative to attend future JNCC meetings and this request is currently being addressed.

- Governors and Membership

In addition to those Governors that have recently resigned or have previously indicated their intention not to stand for re-election in 2013, the following Governors have subsequently advised that they will not be standing for re-election:-

- Anne Smith
- Eric Allcock
- Mark Chapman

I would like to take this opportunity to thank them for the contribution they have made to the Trust.

These Governors will be replaced as part of the current election process which is progressing as follows:-

- Staff Governor (Clinical Support) – Ashok Khandelwal elected unopposed.
- Staff Governor (Community Health Services) – Mike Phillips elected unopposed.
- Public Governor (North of England) – Sam Henderson Wallace elected unopposed.

There were no nominations received for the following constituencies:-

- Public – Lancashire & South Cumbria (one vacancy)
- Public North Lancashire (one vacancy)

Elections are to be held in the following constituencies:-

- Public – Blackpool
- Public – Fylde
- Public – Wyre
- Staff – Nursing & Midwifery

The results will be notified to the Trust on the 23rd August 2013 and the successful candidates will join the Council of Governors following the Annual Members' and Public Meeting on the 23rd September 2013.

- External Relations

The Chief Executive and myself met with Gordon Marsden, MP, on the 28th June.

Karen Crowshaw deputised at the launch of Healthwatch Lancashire on the 8th July.

I met with Dr Alex Gaw, Chairman at Lancashire North CCG, on the 16th July.

The Chief Executive and myself attended a meeting with Blackpool Council on the 23rd July to discuss shared services.

- Future Meetings

Looking forward, I am attending the following events/meetings:-

AAC for a Consultant Breast Surgeon – 25th July.

Judging Panel for the Celebrating Success Awards – 2nd August.

Ian Johnson
Chairman

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

31st July 2013

Confirmation of Chairman's Action

The Directors are requested to confirm the action taken by Karen Crowshaw, Non-Executive Director, on behalf of the Board of Directors as follows:-

Number	Date	Project Details
1	16.4.13	Midwife Led Unit *
2	10.6.13	Continuation of the Provision of Continence Products *
3	28.6.13	Consumables and Equipment
4	28.6.13	Colourflow Duplex Ultrasound Service
5	8.7.13	Maintenance Contract – Critical Trust IT Network Infrastructure

* Received Audit Committee approval on 25.6.13

Judith Oates
Foundation Trust Secretary

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

31st July 2013

Affixing of the Common Seal

The Board of Directors is requested to confirm the affixing of the Common Seal as follows:-

Number	Date	Contract Details
1	24.5.13	Section 38 Cycle Track Dedication Agreement: Lytham St Annes

Judith Oates
Foundation Trust Secretary

Board of Directors Meetings – Attendance Monitoring
1st April 2013 to 31st March 2014

Key: **G- Attended** **Y- Apologies** **R-No Apologies** **Blue- N/A**

* Extraordinary Board Meetings

Attendees	24.04.13	23.5.13*											
Ian Johnson (Chairman)	G	G											
Paul Olive	G	G											
Tony Shaw	G	G											
Karen Crowshaw	G	G											
Doug Garrett	G	G											
Alan Roff	G	G											
Jim Edney	B	B											
Gary Doherty	G	G											
Marie Thompson	G	G											
Dr Mark O'Donnell	G	G											
Robert Bell	Y	Y											
Pat Oliver	G	G											
Wendy Swift	G	G											
Feroz Patel	G	G											
Janet Benson	G	G											
Jacqui Bate	B	B											