Blackpool Teaching Hospitals
NHS Foundation Trust

Corporate Governance Team
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
Lancashire
FY3 8NR

Telephone: 01253 951505
bfwh.corporate.governance@nhs.net

25 June 2021

Dear Board Members

Blackpool Teaching Hospitals NHS Foundation Trust – Board of Directors Meeting

The next meeting of the Board of Directors of the Blackpool Teaching Hospitals NHS Foundation Trust will be held in public on Thursday 1 July 2021 at 9.30 am via Microsoft Teams.

Members of the public and media are welcome to observe the meeting via Microsoft Teams, but are advised that it is a meeting held in public, not a public meeting. If you wish to join the meeting, please email the Corporate Governance Team at:
(bfwh.corporate.governance@nhs.net)

Any questions relating to the agenda or reports should be submitted in writing at least 3 days (72 hours) in advance of the meeting. The Board shall endeavour to respond to the submitted questions, either in the meeting or outside of the meeting, dependent upon the number of questions received.

Enquiries should be made to the Corporate Governance Team on 01253 951505 or bfwh.corporate.governance@nhs.net.

Yours sincerely

Corporate Governance Team

Blackpool Teaching Hospitals
NHS Foundation Trust

A G E N D A

Item Number	Agenda Item		Purpose/ Expected Outcome
01 (49/21) *9.30*	Chairman's Welcome and Introductions	Chairman	Information
02 (50/21) *9.31*	Declarations of Interest	Chairman	Information
03 (51/21) *9.32*	Apologies for Absence	Chairman	Information
04 (52/21) *9.33*	Minutes of the Board of Directors Meeting held in public on 6 May 2021 (Enclosed)	Chairman	Approval
05 (53/21) *9.35*	Matters Arising: a) Action List (Enclosed)	Chairman	Information/ Assurance
06 (54/21) *9.37*	Patient/Staff Story	Executive Director of Nursing	Information/ Assurance
07 (55/21) *9.45*	Chairman's Update (Verbal)	Chairman	Information
08 (56/21) *9.55*	Chief Executive's Report (Enclosed)	Chief Executive	Information/ Assurance
09 (57/21)	<u>Performance:</u>		
10.05	a) Integrated Performance Report (Enclosed) i. Executive Summary	Deputy Chief Executive	Information/ Assurance
10.15	b) Elective Recovery and Restoration (Enclosed)	Chief Operating Officer	Information/ Assurance
10.20	c) Covid-19 Vaccine Update (Enclosed)	Executive Director of Integrated Care and Performance	Information/ Assurance
10 (58/21)	<u>Engagement:</u>		
10.30	a) Freedom to Speak Up Report (Enclosed) *(Mrs Jane Butcher, Freedom to Speak Up Guardian)*	Joint Director of HR & OD	Information/ Assurance
11 (59/21)	<u>Improvement:</u>		
10.35	a) Health Education England North West Feedback Report (Enclosed)	Executive Medical Director	Information/ Assurance
10.40	b) Care Quality Commission (CQC) Update i. CQC Unannounced Visit Update (Enclosed) ii. Care Quality Commission Inspection Preparation	Executive Director of Nursing	Information/ Assurance
10.45	(Enclosed)	Executive Director of Nursing	Information/ Assurance

Item Number	Agenda Item		Purpose/ Expected Outcome
	c) Quality Improvement Update (Enclosed) *(Mrs Katharine Goldthorpe, Associate Director of Quality Improvement) to join the meeting for this item)*		
12 (60/21)	<u>Governance:</u>		
10.50	a) Corporate Risk Register (Enclosed)	Executive Director of Nursing	Assurance/ Approval
10.55	b) Board Assurance Framework (Enclosed)	Director of Corporate Governance	Assurance/ Approval
11.00	c) Provider Licence Self Certification (Enclosed)	Director of Corporate Governance	Approval
11.05	d) Board Committee Assurance: • Audit Committee Minutes (22 March 2021) and update (11 June 2021) (Enclosed/Verbal)	Committee Chair	Information/ Assurance
	• Quality & Clinical Effectiveness Minutes (27 April 2021 and 25 May 2021) and update (22 June 2021) (Enclosed/Verbal)	Committee Chair	Information/ Assurance
	• Operations Committee Minutes (22 April 2021 and 27 May 2021) and update (24 June 2021) (Enclosed/Verbal)	Committee Chair	Information/ Assurance
13 (61/21) *11.15*	Any Other Business a) Maternity Incentive Scheme Year 3	Chairman Executive Director of Nursing	 Approval
14 (62/21) *11.20*	Formal Meeting Review	Chairman	Discussion
15 (63/21) *11.25*	Date of Next Meeting: 2 September 2021 at 9.30am		Information

Minutes of the Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting (held in public)

on Thursday 6 May 2021 at 9.30am

via Microsoft Teams

Present

Mr S Fogg	Chairman	
Mrs J Barnsley	Director of Operations: Planned Care	Non-voting
Mr M Beaton	Non-Executive Director	
Dr S Bedi	Non-Executive Director	
Mr K Case	Non-Executive Director	
Mr M Cullinan	Non-Executive Director	
Dr J Gardner	Medical Director	
Mrs N Hudson	Interim Director of Operations: Urgent and Emergency Care	Non-voting
Professor N Latham	Deputy Chief Executive / Director of Strategic Partnerships	
Mr K Moynes	Joint Director of HR and OD	
Mr P Murphy	Director of Nursing, AHPs and Quality	
Mr F Patel	Interim Director of Finance	
Mr J Wilkie	Non-Executive Director	
Miss S Wright	Joint Director of Communications	Non-voting

In Attendance

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/Company Secretary	
Miss K Ingham	Interim Head of Corporate Governance	Minutes
Mrs K Goldthorpe	Associate Director of Quality Improvement	For item 44/21b
Mrs N Parry	Associate Director of Nursing	For Item 44/21c

Apologies

Mr Kevin McGee	Chief Executive

34/21 Chairman's Welcome and Introductions

Mr Fogg welcomed Directors to the meeting and suggested that, as the agenda was rather large the papers be taken as read.

35/21 Declarations of Interests

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

It was noted that the following declarations applied:

a) Mr McGee is also appointed as Chief Executive of East Lancashire Hospitals NHS Trust and was also a Board member of Atlas.

b) Mr Moynes is also appointed as Director of HR and OD at East Lancashire Hospitals NHS Trust.

c) Mr Wilkie is also a Non-Executive Director on the Atlas Board.

d) Miss Wright is also appointed as Director of Communications at East Lancashire Hospitals NHS Trust.

RESOLVED: Directors noted the position of the Directors Register of Interests and the declarations made at the meeting.

36/21 Apologies for Absence

Apologies were received as recorded above.

37/21 Minutes of the Previous Board of Directors Meeting held in Public

The minutes of the previous meeting were approved as a true and accurate record, pending the following corrections to the minutes: Mr Moynes is a voting member of the Board and the spelling of Dr Wiggins' name.

RESOLVED: Directors approved the minutes of the previous meeting as a true and accurate record pending the aforementioned corrections.

38/21 Action List

Directors noted that items on the action list were either completed, or on the agenda for this and future meetings.

RESOLVED: Directors noted the position of the action list.

39/21 Patient Story

Mr Murphy introduced the patient story, which took the form of a video, and confirmed that the timing of this particular story was interesting as the previous day had the International Day of the Midwife. He went on to suggest that the story reflected the care and compassion that the patient had received whilst an inpatient in the maternity unit of the Trust.

The patient reported that she had been admitted to the Trust to be induced after experiencing reduced movements of her baby. She confirmed that whilst the team was under pressure due to the demands within the department and the ongoing COVID-19 pandemic, they worked hard to provide a calming and safe environment.

She praised the night staff who had shown a great deal of empathy towards her whilst she was at her lowest. She went on to pass her thanks to the other members of the team who had been involved in her care, for their professionalism and support shown to her and the other expectant mothers on the unit.

Mr Murphy commented that setting this particular story within the context of the COVID-19 pandemic was crucial as there were a number of additional processes in place to ensure mothers and babies were kept safe and at the lowest possible risk of contracting COVID-19 whilst staying on the unit.

He went on to thank the team involved in the care of the patient and commended the teamwork and leadership within the unit, particularly in relation to each member of the team knowing their role and carrying it out to the full.

Mr Fogg stated that he very much looked forward to these stories at the Board meetings as it gave the opportunity to hear from a range of areas which he had, as yet, been unable to visit.

In response to Mr Wilkie's suggestion of running these types of stories on a loop through the publicly accessible monitors around the Trust, Miss Wright confirmed that the stories were shared both internally and externally and the Communications Team were currently reviewing the possibility of sharing the stories through social media platforms too.

RESOLVED: Directors noted the content of the patient story and extended their thanks to the team involved.

40/21 Chairman's Update

Mr Fogg reflected on his first three months in the post of Chairman and confirmed that whilst there were a number of improvements that needed to be made across the Trust, he had been pleased to see the general happiness of the staff at the Trust, and the well-structured organisation that existed.

He reported that he had recently undertaken a number of walk-rounds and had been particularly pleased to go on a visit to the Swan Bereavement Centre where he saw the great work that was being done on supporting families. Another visit that he had undertaken was to the Trust's Fleetwood site, where it was pleasing to see the work being carried out there.

Directors noted that Mr Fogg was working with the Trust's Governors, who recognised the difficulties that were being experienced by the Trust, a number of who were newly elected whilst the others had a wealth of experience in the role. Mr Fogg went on to confirm that he was working with Mrs Bosnjak-Szekeres to develop a suitable training programme for the Council of Governors, to determine and embed the right skills for the group and to help them undertake their statutory duties.

Mr Fogg went on to report that the Trust would be setting up Shadow Committees for the Operations and Quality and Clinical Effectiveness Committees which would allow the Committee Chairs to feedback to the Governors and allow them to gain a good understanding of the work that was being carried out through the Committees and enhance the Governors' interactions with the Non-Executive Directors.

Mr Fogg confirmed that the Trust was in the process of recruiting two new Non-Executive Directors, one with a clinical background and the other with a finance/audit background.

Mr Patel temporarily left the meeting at this point (9.30am)

RESOLVED: Directors noted the update provided.

41/21 Chief Executive's Report

Professor Latham referred Directors to the previously circulated report and confirmed that she would present the report on behalf of Mr McGee. She confirmed that there were currently no patients being treated for COVID-19 in the Trust.

Professor Latham highlighted a number of national, regional, local and Trust specific items from the report. From a national and regional perspective she highlighted the roll out of the national COVID-19 vaccine programme, which had been a great success; the system reform work that was taking place at Integrated Care System (ICS) level, including the submission of the ICS level planning documentation; the increase in the numbers of applications for student nurses and the nationally agreed show of appreciation for staff in the form of an additional days annual leave and a £50 voucher.

Directors noted that the vaccination centre at the Winter Gardens would be closed, but the centre that was in operation at the Trust would remain open to continue to provide staff and the general population with vaccinations. Professor Latham confirmed that there were national plans in place to vaccinate the vast majority of the population of the UK by July 2021, with the potential for a booster programme to commence in September 2021.

In relation to the ICS system reform work that was taking place, Professor Latham confirmed that Mr David Flory, Independent Chair of the ICS, had made explicit references to the requirement to collaborate and work together across partner organisations to address the ICS financial deficit. In addition, Professor Latham agreed to share some newly published documentation with Board members in relation to the work that was taking place at ICS and Integrated Care Partnership (ICP) level.

Mr Fogg confirmed that he had met with Mr Flory the previous day and the message had been clear that there was a requirement for performance across the ICS to be as high as possible whilst releasing sufficient savings to reduce the overall ICS financial deficit position. He went on to suggest that the two were linked, and that the improvements in performance and quality would drive out cost efficiencies.

In response to Mr Case's comment regarding the funding of the NHS, Professor Latham explained that Mr Flory had a clear vision of where the ICS needed to get to in terms of the financial position.

Mr Cullinan asked whether there was any possibility of working together across the ICS to share the workforce to ease pressures in some areas. Mr Fogg confirmed that there was a recognition that not all of the Trusts were starting off on an equal footing across a range of areas, including staffing and finances.

Mr Beaton suggested that consideration needed to be given to the whole of the ICS in relation to ensuring that adequate quality levels were maintained and enhanced where possible, whilst also managing the financial issues faced by the ICS and there was a risk of tipping the balance in favour of one at the expense of the other.

Directors briefly discussed the requirement of a 3% savings programme and whilst this would be difficult to achieve, all organisations within the ICS were committed to achieving the required savings. It was agreed that the Executive Directors would develop a simple performance dashboard relating to costs, investments, performance, quality and patient experience.

Professor Latham concluded by providing an overview of the work that was taking place across the Trust, including the significant amount of improvement and innovation work that was taking place and had been included within the Chief Executive's report.

RESOLVED: Directors received the report and noted its contents.

It was agreed that the Executive Directors would develop a simple performance dashboard relating to costs, investments, performance, quality and experience.

42/21 <u>Performance</u>

a) <u>Integrated Performance Report</u>

i. Executive Summary

Professor Latham provided Directors with and overview of the Integrated Performance Report (IPR) and highlighted a number of matters for the Board's attention. She confirmed that the Operations Committee had discussed the need to improve performance reporting and suggested that the current IPR provided the detail for discussion at the Operations Committee and the Quality and Clinical Effectiveness Committee, but a more streamlined/high level version would be presented to the Board in the future.

Directors noted that the Trust had a number of areas of outstanding practice, including the Improving Access to Psychological Therapies (IAPT) service.

Professor Latham referred Directors to the positive feedback gained through the Trust's Friends and Family Test responses, and whilst it was necessary to acknowledge the immense strain that staff were under, the feedback provided about staff members continued to be positive.

Professor Latham went on to highlight areas of challenge for the Trust, including the restoration of services and the accelerator programme, which would be discussed in more detail in the part 2 Board

meeting later in the day. She went on to confirm that cancer performance remained an area of increased focus and confirmed that Mrs Hudson, Mr Murphy and Dr Gardner were working on modelling at divisional level to improve performance in this area.

Professor Latham referred Directors to the newly developed health and safety metrics and confirmed that further development would take place following feedback from Directors. She highlighted the requirement by the Health and Safety Executive for the Trust to report on certain incidents, including deaths and injuries to staff who had consequently been off work for seven days. She went on to confirm that there were two staff members who had been off work for more than seven days as a result of specific injuries. One related to a fall in theatres and the other related to a member of staff injuring themselves whilst moving a patient. In both cases immediate actions were identified and implemented, and refresher training provided.

Mr Fogg asked Mr Case whether he was more confident that matters of health and safety were being identified and addressed following the implementation of the health and safety indicators. Mr Case confirmed that whilst he was pleased to see the indicators being developed, he was not yet sufficiently assured, as more work was required to develop them further. He went on to confirm that he would be in attendance at the next Health and Safety Committee meeting in June 2021. Mr Fogg suggested that the Board have a 'stop and check' review on this matter at a future meeting.

In response to Mr Wilkie's suggestion of adding a metric to confirm the number of days since the last accident, Professor Latham suggested that the Trust were currently reporting on the fundamentals of health and safety but that further developments and innovations now needed to be considered and embedded throughout the Trust.

RESOLVED: Directors received the report and noted its contents.

The Board will undertake a 'stop and check' review on health and safety at a future meeting.

b) Health and Safety Metrics

This matter was covered as part of the Executive Summary above.

c) COVID-19 Vaccine Update

Directors noted that the majority of the item had been discussed under the earlier parts of the meeting.

In response to Dr Bedi's question, Mrs Barnsley confirmed that the Trust was focused on providing staff with their second doses of the COVID-19 vaccination. Once completed, the focus would switch back to vaccinating the general population. She went on to confirm that the Trust was working with the regional vaccination team regarding the vaccination of pregnant women and people over the age of 12, who required vaccination prior to a booster programme being rolled out.

In response to Mr Wilkie's comment about the number of staff who remained unvaccinated, Mrs Barnsley confirmed that 80% of substantive staff had received their vaccinations, but the final 20% of staff were proving difficult to reach or were unwilling to have their vaccination. She went on to report that the Trust's Occupational Health department were in the process of determining the reasons for staff not wishing to receive the vaccination and would be developing a thematic review of the reasons.

RESOLVED: Directors received the update and noted its content.

43/21 Engagement

a) NHS Staff Survey Results

Mr Moynes referred Directors to the previously circulated report and confirmed that the results of the survey had been discussed at the previous closed session, due to the results being under embargo at the time.

He confirmed that the survey had been offered to all substantively employed staff and despite the ongoing effects of the COVID-19 pandemic there had been a response rate of 49.5%, which was above average for a combined acute and community Trusts and an increase of 2.5% on the previous year.

Mr Moynes provided an overview of the results of the survey, and confirmed that out of the 10 key areas, the Trust had scored above the national average on half of them, was in line with the national average on three and below the national average on two.

Directors noted that the staff engagement score for the Trust was 7.1, which was above the national average. The scores for patient care being a top priority and staff recommending the Trust as a place to receive treatment indicators had both improved from the previous year. This is showing positive progress, despite these indicators remaining below the national average.

Mr Moynes went on to provide a summary of the recommendations and the actions being taken to address them, including the appointment of a Clinical Psychologist, workforce trauma support and the implementation of a compassionate leadership programme for line managers.

In response to Mr Fogg's question regarding the feeling of staff in the Trust matching with the views expressed in the survey, Mr Moynes confirmed that there were clear examples of areas where the findings of the survey matched the feelings within teams, however there were also areas where the findings were less aligned. He went on to confirm that the Big Conversations were in the process of being completed and they provided an opportunity to explore in more detail in some of these areas, to understand the issues within certain teams and target actions that would best benefit them.

Mr Cullinan asked whether there was any correlation between the availability of staffing and the areas where there had been lower response rates. Mr Moynes confirmed that this was the case for some of the areas, for example, posts within unscheduled care services were difficult to recruit to and retention of staff had been an issue in the past.

RESOLVED: Directors received the report and noted its contents.

b) Reciprocal Mentorship Criteria

Mr Moynes confirmed that the Directors had agreed to provide support to the Reciprocal Mentorship Programme at the last Board meeting in March 2021. Unfortunately, the NHS Leadership Academy had delayed the commencement of the programme and a meeting will now take place on 18 May 2021 to determine and agree the terms of reference and selection process for the programme.

Directors agreed that an update will be provided on the selectin criteria when it becomes available.

RESOLVED: A further update on the selection criteria for the programme will be provided when available.

44/21 Improvement

a) CQC Unannounced Visit Report

Mr Murphy referred Directors to the previously circulated report and confirmed that the Trust had received an unannounced CQC inspection of the Urgent and Emergency Services and Medical Care (including older people's care) department in January 2021, at the time when the Trust had its largest number of COVID-19 admissions.

Directors were informed of the key points from the report and noted that the report was relatively positive and had not highlighted any issues that the Trust was not already aware of. Mr Murphy also summarised the work that was taking place to improve the experience of patients presenting as a result of mental health crisis.

Directors recognised the improvements that had been made and noted that the action plan relating to the 'must and should do' recommendations was due to be submitted to the CQC on or before 14 May 2021.

Mr Murphy provided an overview of the required actions, including those related to medical recruitment, patient flow and safeguarding. He confirmed that the Trust was making improvements on daily basis, but some of the actions would take place over a longer term.

Dr Gardner commented that the visit had presented the Trust with a lot of opportunities, and many of the issues identified could be traced back to the flow of patients through the Trust and therefore there was a need to make changes in a systematic and logical way.

In response to Mr Beaton's question, Mr Murphy confirmed that there had been one action which had appeared on this inspection report that was also included on the previous list of recommendations and it related to staffing levels.

RESOLVED: Directors received the report and noted its contents.

b) Quality Improvement Update

Mrs Goldthorpe attended the meeting for this item and referred Directors to the previously circulated report and provided a summary of the progress that had been made with regard to the various quality improvement schemes since the last meeting.

She highlighted the vision around developing the patient safety culture and Directors noted the ambition to ensure that the changes made resulted in improvements. Mrs Goldthorpe confirmed that the Trust was keen to be able to measure the safety culture within the Trust to show continued improvements and embedding of the culture. She went on to confirm that an appropriate toolkit had been identified and work was taking place to implement it. She went on to confirm the current development of the Blackpool Patient Safety Barometer, which would include surveys amongst other measures.

In response to Mr Fogg's question about how the improvement work would be driven across the Trust, Mr Murphy confirmed that this work was ongoing and there was a need to develop it at pace. It was agreed that Mr Murphy would provide a report to a future Board of Directors meeting regarding the Last 1,000 Days of Life programme.

RESOLVED: Directors received the report and noted its contents.

Mr Murphy agreed to provide a report to a future Board meeting in relation to the Last 1,000 Days of Life programme.

c) Ockenden Report Update

Mr Murphy introduced the item and handed over to Mrs Parry, Associate Director of Nursing to present the report.

Mrs Parry confirmed that the report provided an overview on the progress being made to implement the recommendations set out in the Ockenden Report into Maternity Services at The Shrewsbury And Telford Hospital NHS Trust.

She went on to provide a presentation to Directors, which included: headlines from the report and key dates, reporting requirements, summaries of the seven immediate and essential actions, the ways in which the Trust and wider ICS were responding to each of the recommendations and how evidence was being provided. She went on to confirm that the Trust and CCG had both been having difficulties with the Perinatal Mortality Review Tool but were working together to address these issues.

Directors noted that the recommendations from the Ockenden report were enhanced safety, listening to women and families, staff training and working together, managing complex pregnancy, risk assessments throughout pregnancy, monitoring foetal wellbeing and ensuring informed consent. Mrs Parry confirmed that significant work was being undertaken to address the educational difficulties that some members of the Trust's population had in order to address the recommendation around informed consent and managing complex pregnancies.

Mrs Parry went on to highlight two specific areas for consideration as they would have the biggest impact on the ability to deliver the seven recommendations; they were noted to be workforce and leadership. Directors noted that the service was currently well staffed and succession planning and development of managers was being undertaken at both Trust and regional levels.

Directors were informed that the next steps would be to finalise the collation of evidence prior to submission through an electronic portal. Mrs Parry stated that additional resources would be required to develop and maintain the recommendations and confirmed that these had been determined and a request for the resources had been completed which amounted to around £449,000 recurrently, and it covered both workforce and educational requirements.

Mr Case commented that the Quality and Clinical Effectiveness Committee had been receiving progress updates and through the reporting to the Committee he had received sufficient assurance that things were being managed well.

RESOLVED: Directors received the report and noted its contents.

45/21 Governance

a) Corporate Risk Register (CRR)

Mr Murphy referred Directors to the previously circulated report and confirmed that it was a further iteration of the documents provided to the previous Board meetings following input from the Good Governance Institute (GGI) in late 2020. He went on to confirm that Divisional level reporting would be recommencing following the easing of the COVID-19 pandemic.

Mr Wilkie commented that the Operations Committee had discussed *Risk ID 3044: There is a risk that Trust does not engage with the Integrated Care Systems (ICS), Integrated Care Provider (ICP) and provider collaborative and there are uncertain implications of moving to single commissioning* and whilst he was pleased to see the actions being taken in the Board Assurance Framework (BAF) in relation to the partnership working risks, could not understand the rationale for the removal of the risk from the CRR.

In response, Mrs Bosnjak-Szekeres confirmed that the CRR was concerned with the operational risks of the Trust rather than the strategic risks, which was the remit of the BAF. In this vein the two documents considered different facets of the risks and whilst a strategic risk remained, the specific operational risk had reduced to a level where it no longer met the threshold for being included on the CRR report, which reports on risks that score 15 or over on the risk score. However, the risk would likely remain on the Trust-Wide Risk Register.

Mr Case stated that he was pleased to see the continued development of the document and how the risks were being managed.

Mr Murphy provided an overview of the various ways in which the CRR could be managed in the future, including regular reviews at Divisional level and through additional quarterly Divisional reviews.

RESOLVED: Directors received the report and noted its content.

b) Board Assurance Framework (BAF)

Mrs Bosnjak-Szekeres presented the BAF to Directors and confirmed that the document had been reviewed and updated prior to the meeting and presented to the Quality and Clinical Effectiveness Committee and the Operations Committee. She highlighted the changes made and confirmed that

there had been a recommendation to increase the risk scores for the Partnership Working risks (5.1 and 5.2) following the discussions at the Operations Committee meeting. She confirmed that both risks had been recommended for increase from 12 to 16 based on the increased likelihood scores moving from 3 to 4.

Directors noted that the rationale for the increases related to the briefing paper that was issued by the ICS Senior Leaders Executive Meeting held on 21 April 2021 which specifically referred to potential changes to ICP boundaries, which would introduce a significant level of risk in delivering on existing large-scale change programmes. In addition there is uncertainty about how ICSs will develop the leadership, capabilities and governance required to deliver in 2021/22 and take on their anticipated statutory responsibilities from April 2022 and develop an implementation plan for managing their organisational and people transition into the future arrangements.

Following a brief discussion, Directors approved the revision to the scoring of BAF risks 5.1 and 5.2.

Directors noted that the document continued to be used to drive the agendas of the Committees. Mrs Bosnjak-Szekeres reported that many of the actions were progressing and those that had been completed since the last presentation to the Board had been moved under the 'potential sources of assurance' section.

RESOLVED: Directors received the report, noted its contents and approved the updated document, including the revised risk scores for BAF risks 5.1 and 5.2 (partnership working).

c) Board Committee Assurance

i. Audit Committee Minutes and Update

Mr Cullinan presented the update from the previous meeting for information and highlighted the effect that COVID-19 had had on the way in which the Trust's auditors were working. He confirmed that the Committee had received an update on the follow-up actions from internal audit reports and thanked the Executive Directors and their teams for their efforts in following up the reviews and addressing the recommendations.

Mr Cullinan confirmed that the Committee had accepted the recommendation from the Audit Panel to appoint Mersey Internal Audit Agency (MIAA) as the Trust's new internal auditors.

RESOLVED: Directors received the minutes of the previous meeting and noted the update provided.

ii. Quality and Effectiveness Minutes and Update

Dr Bedi referred Directors to the previously circulated minutes and provided a brief overview of the discussions that had taken place. She confirmed that the Committee had been informed of the improvements noted as a result of the mortality collaboration and the continued work that was taking place in relation to the out of hospital deaths.

Directors noted that the number of complaints had increased slightly, and work was taking place to review these in more detail.

RESOLVED: Directors received the minutes of the previous meetings and noted the update provided.

iii. Operations Committee Minutes and Update

Mr Beaton referred Directors to the previously circulated minutes and confirmed that the majority of the Committee's discussions had been reflected in the discussions that had taken place throughout this meeting. He confirmed that the Committee had spent some time discussing the results of the

NHS Staff Survey and the work being carried out to close the vacancy gaps for both nurse and medical staffing.

Mr Beaton went on to confirm that the Committee had been updated on the Trust's financial position, which remained pressured and therefore the Committee members had limited assurance about the financial position.

In addition, Mr Beaton reported that operational performance had also been discussed at the meeting, and despite the Trust not meeting the four-hour standard, performance was good when compared to peer organisations in the ICS area.

Directors noted that there had been positive discussions at the Committee in relation to restoration of services and that plans were in place to increase normal activity. Mrs Hudson confirmed that both performance and restoration were difficult at the moment, as there were significant operational issues and informed Directors that part of the part 2 Board session later in the day would be used to discuss elective recovery.

RESOLVED: Directors received the minutes of the previous meetings and noted the update provided.

46/21 Any Other Business

Planning for Board BAME Session

Mr Moynes suggested that there was a feeling amongst the Directors that a Board session should be developed to consider the BAME workforce. He went on to confirm that there was considerable work underway across the Trust, but notwithstanding that work there was evidence to suggest that colleagues from BAME heritage backgrounds have a different experience at work than their White British colleagues. He suggested that he, Dr Bedi and Mrs Bosnjak-Szekeres would work together to develop a session.

In response to Mr Fogg's suggestion, Mr Moynes agreed that the session would include a number of staff members from BAME heritage backgrounds.

Mr Beaton agreed that the session would be helpful and encouraged consideration to be given to how the Board could ensure that participants were open and honest with the Board.

NHSE/I Review of Disciplinary policies and procedures

Mr Moynes reported that NHSE/I had contacted Trusts to request the review of Trust policies and processes relating to matters of staff disciplinary policies and for them to be brought to a future Board meeting for review and approval.

Mr Cullinan suggested that, in the past, the Trust may not have managed staff disciplinary matters in a compassionate way but that had seemed to change in the last year.

Question to the Board

Mrs Bosnjak-Szekeres confirmed that the Board had received the following question from a member of the public prior to the Board meeting:

"Can you please explain if the Trust has a process to ensure implementation of NICE guidance? With particular reference to NG196, NICE guidance Atrial Fibrillation: diagnosis and management, published 27 April 2021?"

Mrs Bosnjak-Szekeres informed Directors that the Corporate Governance Team had liaised with the relevant departments within the Trust to ensure that an answer was provided. She confirmed that the Trust does have a process in place to ensure the implementation of The National Institute for Health and Care Excellence (NICE) guidance. She went on to state that the Trust has a NICE Committee, which is Chaired by the Director of Clinical Effectiveness/Deputy Medical Director to provide further

assurance to the Board of Directors that the Trust's specialties are adhering to NICE guidelines or have mitigation that we are working towards specific guidance. Specifically, the Trust does have a Tertiary Cardiology Electrophysiology (EP) service, which provides the full range of Atrial Fibrillation (AF) procedures outlined within the NICE guidance and works collaboratively with the Integrated Care System (ICS) Cardiac Network and the ICS Stroke network.

47/21 Formal Meeting Review

Mr Fogg sought feedback from Directors about the effectiveness of the meeting.

Mr Cullinan stated that he felt that the meeting had gone well and had progressed at a good pace, covering the important issues and had drawn together the issues that had been discussed throughout the Board Committees.

Professor Latham agreed and commented that there had been a good level of challenge throughout the meeting. She went on to suggest that the Board could work to develop the narrative and culture that was being framed across the ICS.

Mr Beaton commented that there had not been a great deal of decision making at the meeting, which he would have expected at a meeting of this nature, but there had been a great deal of assurance provided throughout the meeting. Mrs Bosnjak-Szekeres confirmed that there are couple of decision items on the part 2 Board agenda.

48/21 Date of Next Meeting

The next meeting will take place on Thursday 1 July 2021, 9.30am, via MS Teams.

Board of Directors Meeting
Action List

Minute Ref/No	Date Of Meeting	Agenda Item Heading	Action To Be Taken	Person Responsible	Date To Be Completed	Change Of Date	Progress	RAG Status
41/21	06.05.2021	Chief Executive's Report	It was agreed that the Executive Directors would develop a simple performance dashboard relating to costs, investments, performance, quality and experience.	Executive Directors	Nov-21		Discussions are taking place with Board members to determine the content requirements. Scoping will commence and be supported by Value Circle. Once Head of Performance is in place (September 2021) the scorecard will be developed and presented to the Board in November 2021	Amber
42/21a		Integrated Performance Report: Executive Summary	The Board will undertake a 'stop and check' review on health and safety at a future meeting.	Professor Latham	Sep-21		Agenda Item September 2021	Amber
43/21b		Reciprocal Mentorship Criteria	A further update on the selection criteria for the programme will be provided when available.	Mr Moynes	Jul-21		The Trust is still awaiting further information from the Leadership Academy.	Amber
44/21b		Quality Improvement Update	Mr Murphy agreed to provide a report to a future Board meeting in relation to the Last 1,000 Days of Life programme.	Mr Murphy	Sep-21		Agenda Item September 2021	Amber
Item 09/21(a)	07.02.2021	IPR - Quality	Organise an informal Board session to enable detailed discussion to take place regarding the arrangements post Covid-19.	Corporate Governance Team	Jan-21		The Board Strategy Sessions commenced on 1 April 2021. This work will be picked up as part of the ongoing Board Strategy Sessions.	Amber

RAG Rating	
Green	Completed
Amber	Pending
Red	Overdue

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

1 July 2021

Chief Executive's Report

Author of Report:	Kevin McGee, Chief Executive
Date of Report:	1 July 2021

Executive Summary (to include, where appropriate, the level of assurance and position on trajectory):

The report provides a summary of national, health economy and internal developments.

For Information/Assurance:	**For Discussion:**	**For Approval:**
X		

Recommendations:

Board members are requested to receive the report and note the information provided.

Sensitivity Level:

Not Sensitive: (for immediate publication)	**Sensitive In Part:** (consider redaction prior to release)	**Wholly Sensitive:** (consider applicable exemption)
X		

CEO Report

July 2021

This report is divided into five sections. Section one details major national headlines, section two reports news from across Lancashire and South Cumbria, and section three notes Trust news and initiatives which are aligned to the Trust's values. The fourth section shows the external communications and engagement interactions with the final section summarising the Chief Executive's diary.

One - National Headlines

Top news reports gathered from NHS England, NHS Improvement, NHS Providers and other reputable news sources.

UK COVID-19 vaccine programme

The NHS in England has now delivered more than 60 million vaccinations with nearly 36 million adults, in England, receiving their first vaccine dose, and over 26 million having their second jab.

More than one million jab appointments were booked since the NHS vaccination programme opened for every adult in England. People rushed to book 1,008,472 appointments in just two days – an average of more than 21,000 every hour, or six every second over the weekend of 19 and 20 June. The figure does not include appointments made through local GP-led vaccination services or people getting jabbed at walk-in centres.

The figures do reveal that four in five adults have now received their first dose of the jab, and three in five already fully vaccinated after receiving two doses.

The NHS is contacting people aged 40 and over to bring forward their second dose in line with updated JCVI advice with the NHS booking service now showing earlier time slots available for those who are eligible to rebook.

All adults can book at one of the 1,600 vaccination centre, pharmacy or general practice sites across the country that are available through the national booking service. Vaccination centres are also available in convenient locations such as mosques, museums and football stadiums.

Record number of people seen in March following urgent cancer referrals

New figures have shown that hard working NHS staff saw a record number of people, who were referred for urgent cancer checks, in March.

Almost quarter of a million people with suspected cancer were seen as NHS services began to bounce back after the peak of the winter COVID-19 wave.

More than 230,000 people were checked in March, alongside rapid progress by the NHS delivering the COVID-19 vaccination programme and providing care to 12,000 seriously ill patients with COVID requiring hospital treatment.

The latest statistics, published in May, also confirm that for every COVID patient cared for by the NHS between January and March 2021, 18 other patients got treatment for non-COVID conditions, while NHS staff carried out 300,000 more diagnostic tests in March than in February.

NHS ahead of target in recovery of elective care, and mental health services

The latest NHS figures show operations and other routine care are ahead of ambitions set out in April, with mental health services back at pre-pandemic levels.

Despite the extensive disruption to care caused by the pandemic, it's encouraging that the figures show routine operations, cancer and mental health care are rebounding. Average waits for non-urgent care have fallen to 11 weeks, and the number of people waiting over 52 weeks fell by more than 50,000 in April. Mental health services are back at pre-pandemic levels, and treatment rates for cancer are also now back to usual levels, with nearly nineteen out of twenty people starting treatment for the disease within one month.

The NHS is committed to restoring services to pre-pandemic levels and has recently invested £1 billion in elective recovery. The Elective Accelerator programme will see a dozen Trusts and five specialist children's hospitals receive a share of £160 million to increase the number of elective operations they deliver.

The NHS also faced one of its busiest months on record in terms of emergency care in May, with staff responding to more than 800,000 incidents – an increase of over 70,000 from two years previously.

In addition to increased demand, staff in emergency departments are having to work differently from how they did pre-pandemic, with extra time needed for applying personal protective equipment and performing rapid COVID-19 tests on patients. Social distancing and enhanced infection prevention control measures have also meant fewer beds and less clinical space.

Wide support for more comprehensive urgent care indicators

Patients, clinicians and the public have welcomed proposals for a comprehensive set of indicators for urgent care. The updated standards aim to capture what matters clinically to patients, end hidden waits and reduce the risk of spreading COVID-19.

The proposed bundle of 10 measures takes account of changes in the way that urgent and emergency care is delivered such as the roll-out of Same day Emergency Care and strengthening of NHS 111.

Hospitals will be expected to see and assess patients within 15 minutes, one of 10 indicators which also include 111 performance, ambulance response times, through to time spent in Emergency Departments.

Developed with clinical leaders, the proposed measures – which come 15 years after the existing targets were introduced – aim to improve patient flow to prevent crowding and ensure A&Es work more efficiently and effectively than the current standards.

Thousands of lives to be saved by making every contact count

Health MOTs at NHS vaccination services, pharmacies and clinics are set to save thousands of lives.

Chief Operating Officer, Amanda Pritchard has set out how the health service will make 'every contact count' by rolling out opportunities for health checks at times when patients already have other appointments.

The NHS will offer a range of targeted tests including blood pressure, heart-rhythm and cholesterol checks when people drop in for top-up covid jabs or flu vaccinations this autumn.

With one stroke prevented and 37 people with irregular heart rates diagnosed for every 5,000 people offered heart checks at vaccination centres, it is estimated that more than 1,000 strokes could be prevented every year if everyone over 65 was offered an annual heart rhythm check.

First patient treated with the 'world's most expensive drug'

A five-month old baby has become the first patient to receive a potentially life-saving drug on the NHS that can prevent paralysis and prolong the lives of children with Spinal Muscular Atrophy (SMA). Arthur Morgan, who was diagnosed with SMA, received the one-off gene therapy at Evelina London Children's Hospital on 25 May 2021.

Untreated SMA is the leading genetic cause of death for children, and until two years ago there were no treatment options available for youngsters diagnosed with the cruel disease. But now gene therapy can potentially give babies the ability to sit, crawl and walk.

The NHS Long Term Plan committed to using cutting edge treatments and therapies to save and improve patients' lives.

Zolgensma, which has a list price of £1.795 million per single dose, was made available on the NHS following a landmark deal struck with manufacturers Novartis Gene Therapies in March this year.

Patients with type 1 diabetes to get artificial pancreas on the NHS

An 'artificial pancreas' designed to revolutionise the life of people with Type 1 diabetes will be provided by the NHS, 100 years after the discovery of insulin. Up to 1,000 patients will benefit from a pilot of the innovative 'closed loop technology', which continually monitors blood glucose and automatically adjusts the amount of insulin given through a pump. It can eliminate finger prick tests and prevent life-threatening hypoglycaemic attacks.

This means the NHS is going above and beyond its Long Term Plan goal on non-invasive glucose monitoring, with two in five people with Type 1 diabetes already now benefiting from this technology.

Up to 1,000 patients from around 25 specialist diabetes centres in England will benefit from the pilot programme. Participating centres will submit data via the NHS's world-leading National Diabetes Audit and the results will feed into the evidence assessment undertaken by the National Institute for Health and Care Excellence (NICE).

£52 million investment to fast track online maternity records

Every mum to be will be able to access their maternity records on their smart phones. Bulky paper records would soon be a thing of the past as pregnant women will be able to access information on their pregnancy at their fingertips on phones or other electronic devices if they choose to. Although, women can also choose to keep paper records, depending on their preference.

The NHS investment of £52 million is to fast track its Long Term Plan commitment to ensure that all women will have access to all of their maternity notes and information through a smart phone or other device by 2023/24.

Giving women easy access to their maternity records, whether on a smart phone or online, allows them to take full control of their pregnancy journey by having all the information and decisions about their care at their fingertips. Midwives, GPs, and other clinicians caring for a pregnant woman will also have easy access to information, no matter where or when the mum-to-be is seen. Not only will this help improve the experience for women by reducing the burden of repeating information to each healthcare professional that they see throughout their pregnancy, but it will also improve safety.

It will help NHS maternity professionals to ensure the best health and care outcomes by preventing important details from being missed.

While some Trusts have some form of digital maternity records in place, the new system will be the gold standard and ensure that there are no variations in quality of platform across the country.

Anne Longfield appointed to help transform care

The NHS has appointed former Children's Commissioner Anne Longfield OBE to help transform the care of children and young people with a learning disability and autism.

As the new independent chair of the Learning Disability and Autism Children and Young People's Steering Group, Anne will champion the rights of children and young people to ensure they get the support they need at the right time and work closely with the Ministerial led 'Building the Right Support Board'.

Rise in NHS annual health checks for people with a learning disability

Three quarters of people with a learning disability aged 14 and over have received an annual health check two years ahead of an NHS Long Term Plan target.

Every year, people with a learning disability die sooner than they should and many from potentially avoidable conditions, such as constipation or aspiration pneumonia. Despite the pandemic, the NHS has ensured that three quarters of people over the age of 14 with a learning disability have received their annual health check, two years ahead of the Long Term Plan target – the health MOT's from local GPs are crucial in identifying and tackling major health conditions and preventable causes of early death.

The news comes as the fifth annual learning disability review and action report are published. Most recent data shows that 97% of eligible reviews were completed within six months, a rise of a third compared to the previous year.

This important report reminds us why improving the health of people with a learning disability is a priority for the NHS and it is vital we use this to make real and lasting change to help close the health inequality gap seen throughout society.

Funding boost for young people's mental health services

Children and young people will benefit from a cash injection to mental health services which includes addressing the increasing demand for the treatment of eating disorders.

An extra £40 million has been allocated to address the COVID impact on children and young people's mental health and enhance services across the country.

One way the additional money will be spent is to support ensuring the right type of beds are in the right places, or that alternatives to admission are in place, supporting parts of the country that have more challenges in their range of bed capacity.

This pandemic has hit our young people hard and while services have remained open throughout, there has been an increase in the numbers of children and young people seeking help from the NHS for their mental health.

This additional funding is in recognition of the rising demand. It also supports the NHS's continued commitment to provide the best care as early as possible and the work involved to prevent children and young people needing hospital treatment. And if they are in hospital that they receive the right treatment before being supported back at home.

England's top NHS nurse says volunteering surge can be positive COVID legacy

Increased volunteering across the NHS and beyond can be a positive legacy of COVID. New research showed that giving up time for the health service or other good causes can significantly boost quality of life.

Speaking at the start of Volunteers Week, Chief Nursing Officer for England Ruth May thanked hundreds of thousands of volunteers across the country who have played their part in the fight against COVID and urged them to stick at it as the country recovers.

New figures released show that 436,000 people from the NHS Volunteer Responders Programme, set up at the start of the pandemic, have so far carried out almost two million tasks for those who needed to stay at home during the pandemic. Roles range from phone calls to the isolated to delivering medicines and medical devices, while thousands have given up their time to steward vaccination sites as part of the biggest jabs drive in NHS history.

NHS kicks off 'CPR Army' following footballer's collapse

England's National Medical Director, Professor Stephen Powis, is sending out an army of volunteers to teach CPR after international footballer Christian Eriksen was saved by quick thinking medics during the Euro 2020 match.

With only one in three people in England giving CPR when they witness someone going into cardiac arrest, Professor Powis says thousands more lives could be saved if more people knew what to do.

A new partnership with St John Ambulance has been launched to deliver an NHS programme encouraging everyone to learn CPR and how to use defibrillators. The health and first aid charity recently trained 27,000 vaccination volunteers in these lifesaving skills and will seek to train an additional 60,000 people as part of this new programme.

Two - Lancashire and South Cumbria Headlines

Important updates and information reflecting work being carried out across Healthier Lancashire and South Cumbria and Healthier Fylde Coast.

New Role for Kevin Magee

BTH and ELHT's Chief Executive, Kevin McGee, has been appointed as Chief Executive of Lancashire Teaching Hospitals NHS Trust. Kevin has agreed to take up the role following the departure of their current Chief Executive Karen Partington later this year. Kevin will continue with his work as lead Chief Executive for the Provider Collaborative Board

It is an incredibly important time for the Lancashire and South Cumbria Integrated Care System and there is no doubt that improved collaboration across NHS organisations, and specifically providers through the Provider Collaborative Board, will be key to our future success.

Both BTH and ELHT will be recruiting new Chief Executive Officers to focused on the individual Trusts.

It's important to know that our direction of travel remains unchanged. The Trust remains committed and focused on providing sustained improvement in the quality of safe and effective clinical services and all providers across Lancashire and South Cumbria remain committed to working together to improve the system as a whole for our communities.

In the meantime Kevin remains actively engaged and visible across both organisations. Whilst his start date at LTHTR has not been confirmed, there will be work ongoing across all three Trusts to ensure a smooth handover is in place for staff and patients.

COVID-19 update

In the North West community COVID-19 infection rates have started to rise across the whole of the region, which significant challenges in Lancashire. It is notable that cases are high in younger people. Health care providers are continuing to urge people to come forward for vaccinations as soon as they become eligible, particularly as cohorts open up to those younger groups to ensure protection for families, friends and communities.

In response to some of the areas in Lancashire where higher rates of prevalence are being seen, the Government, the DHSC, and PHE have made surge testing available to those communities to help to break the cycle of transmission.

While hospitalisation rates have been gradually rising, it is too early to tell whether the rise in cases will lead to any more significant impact on the NHS. As the vaccination offers some level of protection, there is reason to be optimistic that the impact will not be on the same scale as the previous waves of the virus. Many of those hospitalised in recent weeks are younger people, some who have not received one or both doses of the vaccine yet, and some with other underlying health conditions. It is also the case that those patients who are being hospitalised are recovering quicker and spending less time in hospital.

The variants of concern are being closely monitored to look out for any increasing levels of sickness in those infected, any growth in hospital admissions and any cases that develop in people who have been vaccinated.

At this time, we continue to see lower numbers of patients being treated for COVID-19 in our hospitals and intensive care units, and thankfully lower rates of hospital acquired infection as well.

Given the rise in rates of community and as restrictions continue to ease, it is now more important than ever that we resist complacency and wasting the gains we have made in the past few months. It is important to continue to follow the protective measures learnt over the last year, and encourage our staff, patients, and communities to do the same, to ensure we minimise the risk of the infection rates rising again.

Where areas are seeing rising rates of community transmission again, we will ensure we are focusing our support and monitoring efforts on those areas that continue to see significant challenges.

The vaccine continues to be our best route out of the pandemic. We are ensuring work is done with communities in areas where vaccine uptake has been lower to understand any reasons for this and ensure those who are eligible for vaccines are encouraged to do so at the first opportunity. We are urging anyone who qualifies for a jab but has not yet received one to not delay and book an appointment.

Virtual COVID-19 wards have now been rolled out across the system, providing an effective way of monitoring people recovering from Covid in their own homes, using pulse oximetry technology to remotely monitor blood oxygen levels.

The NHS and its workforce have worked under immense pressure now for over a year and their heroic efforts should be a point of pride to everyone across the country, but especially in Lancashire and South Cumbria, where that pressure was greater and lasted longer. Colleagues went above and beyond the call of duty over and over again to ensure the NHS was able to continue to treat patients, including those requiring care for reasons unrelated to COVID-19. It is vital that we continue to concentrate significant efforts, including plans for the long term, to support their health and wellbeing, physically and mentally, ensuring colleagues are aware of the support available to them, and taking every opportunity to celebrate the herculean efforts we have seen from them to date, while understanding the impact the last year is likely to have had on individuals.

The Government continues to consider the next steps on its roadmap out of lockdown lifting most legal restrictions on meeting others outdoors, and updating guidance on social distancing measures, with more businesses reopening, and the numbers of people able to attend weddings, receptions, funerals, and wakes rising to 30.

Vaccination programme update

More than 1 million people in Lancashire and South Cumbria have now had at least 1 dose of the COVID-19 vaccine as part of the largest vaccination programme in NHS history – and over 50 million people have been vaccinated across the UK.

In the first three months of 2021, volunteers gave more than 50,300 hours of their time as marshals at over 30 different community vaccination clinics and 7 mass vaccination centres across Lancashire and South Cumbria. Marshals help patients navigate through the site, from directing them to a parking space, checking they have an appointment, managing the queues and helping them to exit sites safely after their vaccination.

People aged 18 and over are now being invited to come forward and book appointments to receive their vaccinations, people over 16 who live with adults with weakened immune systems are also being offered a vaccine. Anyone aged 45 and over or who has a learning disability, is clinically vulnerable, clinically extremely vulnerable (at high risk from coronavirus) or an unpaid carer is also being invited to book their appointment.

Elective Care Recovery

Recovery continues to be a primary focus of our work and it is vital we stand back up as much of our elective care programme as possible, while at the same time working to ensure those who have already waited for considerable time for care are treated as soon as possible. Mutual aid is proving an invaluable tool to ensure the sickest patients are treated as quickly as possible in the most appropriate place, including cancer patients who, where necessary are being treated through our surgical hubs.

Where appropriate, online outpatient appointments and innovative ways of delivering surgery are helping to ensure people get the care they need in a timely way.

In addition to working as one NHS across Lancashire and South Cumbria (and the North West) to provide mutual aid to deliver vital services, we continue to work with the private sector to provide resource to address the backlog in our elective care programme and get patients treated as quickly as possible.

This area of work must remain a priority for the NHS in the coming months so we can begin to address the substantial growth in our waiting lists with thousands of patients now waiting more than a year for non-covid treatment.

Some services are already back up and operating at more than 110% in comparison to the 2018/2019 baseline numbers which means we are not just back up and operational in those areas, but also starting to make some inroads into the backlog and those patients who have waited for some time for care.

In May, the NHS announced a £160 million initiative to tackle waiting lists and develop a blueprint for elective recovery as early reports show the health service is recovering faster after the second wave of the coronavirus pandemic. This includes an 'elective accelerator' pilot led by Lancashire and South Cumbria ICS, which will see BTH along with East Lancashire Hospitals NHS Trust, Lancashire Teaching Hospitals NHS FT, Lancashire and South Cumbria NHS FT and University Hospitals of Morecambe Bay NHS FT working together to make significant inroads into our collective waiting lists over the next three months. The programme has already exceeded its April ambitions and is progressing well.

As we continue the work of restoring services impacted by the pandemic, it is vital that we ensure this is balanced with the recovery and resilience of our colleagues. Supporting colleagues who have been going above and beyond the call of duty now for more than a year is a crucial piece of the jigsaw and putting all of our efforts into that principle is the only way we will prepare the NHS for the work we will need to do as we start to move away from the most intense moments of the pandemic.

The impact of the third wave meant unfortunately some elective activity had to be paused, although emergency and cancer procedures continue to be delivered. These measures were in line with our surge planning and allowed us to ensure the most urgent operations and cancer care could go ahead despite the pressures, as well as ensuring that we had capacity to treat COVID-19 patients in our hospitals.

NHS pelvic health clinics to help tens of thousands of women

Tens of thousands of pregnant women and new mums will receive support to prevent and treat incontinence and other pelvic floor issues, thanks to new clinics being set up. Lancashire and South Cumbria will be one of 14 areas in the country where this will be initially piloted with up to 17,000 women set to benefit from the additional support every year

Clinics will offer a one stop shop for women with symptoms, bringing together midwives, specialist doctors and specialist physiotherapists under one roof. It is understood that many women don't report issues with incontinence because they are embarrassed about seeking help. Bringing together experts in pelvic health in one place will offer women a way of seeking help quickly and easily, as well as sending the message that postnatal incontinence is nothing to be ashamed of and can be treated.

Every woman receiving maternity care in the pilot sites will be able to access the service throughout their pregnancy. Being supported by physiotherapists from the start means exercises can provided to help to prevent problems from developing in the first place.

Queen's Birthday Honours

One of Lancashire's leading Consultant immunologists, Professor Anthony Rowbottom, has been awarded an MBE in The Queen's Birthday Honours List 2021 in recognition of his services to Pathology during the Covid-19 pandemic.

Dr Rowbottom is Professor of Clinical Immunology and Laboratory Director for Immunology at Lancashire Teaching Hospitals. He is also the Clinical Director for the Lancashire and South Cumbria Pathology Service and has most notably been instrumental in part leading the Covid-19 swabbing programme across Lancashire and South Cumbria.

In just a short space of time, the Covid-19 testing programme has grown considerably and is now able to offer tens of thousands of tests to the population per day across Lancashire and South Cumbria.

An MBE is an appointment to the Order of the British Empire and are handed out twice a year - in the New Year Honours List and The Queen's Birthday Honours List. MBEs are awarded for an outstanding achievement or service to the community which will have had a long-term, significant impact and stand out as an example to others.

Dare to Care

An innovative pilot scheme, which supports unpaid carers to pursue a career in local care homes, will be launching in Lancashire and South Cumbria in June this year.

'Dare to Care' is a free 12-week training programme that provides unpaid carers – including young carers aged 16-18 years – an opportunity to develop new skills, receive training certificates and build confidence to become a volunteer and potentially job-ready for a career in the care sector.

The 'Dare to Care' programme has been developed by the Integrated Voluntary Services Project in partnership with the Health Innovation Campus at Lancaster University, Lancashire County Council and Healthwatch in Blackpool (Empowerment Charity) and Healthwatch Lancashire and is a brilliant example of organisations working in partnership across Lancashire and South Cumbria

Transforming Pathology Services

The transformation work for pathology services is continuing. The Lancashire and South Cumbria Pathology Collaboration is currently developing models, with one of the models including a new Pathology Hub. However, each hospital will continue to retain emergency pathology services within the hospital site.

A robust and transparent process was put in place for choosing a location for a Pathology Hub, and Leyland, near Centurion Way, was endorsed as the preferred clinical option. An independent review of available sites in Leyland and the wider South Ribble area was undertaken by NHS Improvement in April 2021 and this identified that the Enterprise Zone site in Samlesbury as the most suitable location for the Hub. This was endorsed by the Pathology Collaboration Board on 28 May 2021.

The Pathology Hub will provide a purpose-built environment bringing together highly qualified clinical and scientific staff from across the network who will drive adoption of new technology, maximise future investment and increase our ability to continue providing a high-quality pathology service.

The Outline Business Case was submitted to NHS England and NHS Improvement in March 2021 and work is now progressing on the Full Business Case by September 2021.

LSC Together

Health and care partners across Lancashire and South Cumbria have agreed to run an 'LSC Together' initiative between 21 – 25 June. Traditionally called a 'Perfect Week' the work will ensure the whole health and care system focuses on building from the learning of responding to the Coronavirus pandemic, test new ways of working and ensuring people have the best possible experience of our health and care services which includes primary care, hospital care, mental health, social care or the community care sector.

With significant pressures and challenges across the health and care system it is extremely challenging operationally to deliver the kind of care we want to for all our patients whenever they present. This initiative aims to help us to capture learning and build on the experiences of COVID-19 to improve our services for our 1.8million population across Lancashire and South Cumbria.

Three – BTH Headlines

Important news and information from around the Trust which supports our vision, values and objects.

Use of the Trust Seal

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

- On 23 June 2021 the seal was applied to the Licence to Underlet and Alter relating to the Clifton Dialysis Unit at Clifton Hospital, Lytham St Annes between Orchard Ltd, Fresenius Medical Care Renal Services Ltd, Fresenius Medical Care Holdings Ltd and Blackpool Teaching Hospitals NHS Foundation Trust.
- Also on 23 June 2021 the seal was applied to the supplemental lease relating to the land to the side and rear of the Clifton Dialysis Unit at Clifton Hospital, Lytham St Annes between Orchard Ltd and Blackpool Teaching Hospitals NHS Foundation Trust. Both documents were signed by Mr Stephen Fogg, Chairman and Mr Feroz Patel, Executive Director of Finance.

Tangerine army of volunteers returns

Blackpool Teaching Hospitals Trust welcomed back their dedicated cohort of volunteers in May, perfectly timed to coincide with National Volunteers Week.

The 400-strong group are returning to duty in phases due to ongoing Covid restrictions, however the so-called ‘tangerine army’ are already being welcomed back by grateful patients and staff, with their presence missed over the last 15 months.

The volunteers are really well loved and well-liked within the Trust. Twenty-nine different roles cover almost everything from giving out directions, ward helpers, wheel-chair distribution, blood runners and supporting the volunteer shop. They are hard to miss in their bright orange uniforms.

Clifton Hospital launch new End of Life mouthcare packs

Clifton Hospital’s End of Life training team have created a new mouth care pack for patients who are receiving end of life care. The versatile pack will also be used for any patient requiring mouth care.

Practice Development Sister Donna Hargreaves and Trainee Advanced Clinical Practitioner (ACP) Harriet Matichecchia identified a gap and put together a 24-hour grab pack to keep patients’ mouths clean and hydrated.

The packs contain disposable soft tooth cleaners, enough to clean the mouth every four hours or more if needed, a gentle tongue scraper, mini toothpaste, moisturising lip balm and a basic dressing pack containing a bin bag and tray to enable ‘Taste for Pleasure’ by giving patients their favourite drink as mouth care.

These can be used along-side the suction toothbrush grab packs for the patients in the last few days of life.

Trust's Asthma Pathway praised for reducing admissions

A bespoke service for asthma patients in the Blackpool and Fylde region has been celebrated as a success after the pathway reduced hospital admissions.

The Trust has implemented a number of additional pathways to ensure that patients receive safe and effective care, particularly by utilising the Trust's Same Day Emergency Care (SDEC) teams. The aim of SDEC is to ensure patients get seen earlier and receive treatment within a day, and this has been particularly effective in helping asthma patients.

The specialist Asthma pathway sees patients arrive in the Emergency Department for initial checks, before being fast-tracked to SDEC, where the patient's asthma history and background is investigated, a specialist asthma clinician can then assess and decide the right course of treatment for the patient, with the aim of getting them home on the same day – reducing the need for a hospital bed.

One of the key advantages of seeing asthma patients early is that where possible, specialist care can often reduce the requirement for the patient to use a nebuliser. By getting the patient into the SDEC earlier, they can be seen by a medic earlier and make a different treatment plan, and this can improve their outcomes.

New Blackpool Mental Health Urgent Assessment Centre opens for patients

Lancashire and South Cumbria NHS Foundation Trust (LSCFT), in collaboration with Blackpool Teaching Hospitals, has launched a new Mental Health Urgent Assessment Centre (MHUAC) in Blackpool.

The MHUAC is located next to the A&E department at Blackpool Victoria Hospital, where work is underway to create an Emergency Village, enhancing and expanding emergency care.

It has been established as a safe and calm assessment space for service users who are experiencing urgent mental health needs and have no coronavirus symptoms or physical injuries.

The centre has three purpose-built assessment rooms for service users and their carers. With access to highly trained mental health nurses, consultant psychiatrists, support workers, and trainee nursing associates, service users will be assessed, supported and treated as required. This new mental health model being developed to provide an alternative pathway for patients accessing emergency departments is a milestone in transforming emergency mental health care.

Daughter raises funds to say thanks for lifesaving treatment

A daughter who ran 5k a day for 30 days has raised almost £2,000 for the Blue Skies charity as a thank-you for the hospital saving her mother's life.

Danielle Wade, 42, saw her mum Lynette Ward admitted to Blackpool Victoria Hospital earlier this year after being diagnosed with Covid-19. Lynette, who had worked at Blackpool Victoria as a Waiting List Manager for 30 years, was admitted to the critical care unit for lifesaving treatment and now Danielle has set herself the challenge of raising funds as a mark of appreciation.

"It was the biggest rollercoaster ever. They warned us about the blood clots, infection, and a phone call to say she probably wasn't going to make it," Danielle said. "Critical care were amazing, just unbelievable. Phone calls to update us and even wheeling her out to the garden one day!"

Blackpool Teaching Hospitals sets up new Medical Examiner team

A new department has been set up at Blackpool Victoria Hospital in order to scrutinise all hospital deaths. The Medical Examiner System is a national system being rolled out across England and Wales.

The Medical Examiner team, led by senior doctors, ensures that all patient notes are reviewed, and a cause of death agreed between the reporting doctor and the Medical Examiner.

Dr Brack, a Trust consultant cardiologist at Blackpool Victoria Hospital who is one of the Trust's three Medical Examiners, said: "Not only are we responsible for independently inspecting all the medical notes leading up to the passing of a patient, we also act as a point of contact for the bereaved family."

Medical Examiners (MEs) agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death with the doctor completing it. If there are any concerns, the Medical Examiner's team will escalate these to Divisional Quality and Governance Leads and contact the Coroner, regional and national MEs teams when appropriate.

As well as the team of medical examiners: Mr Heath, a general surgeon and Dr Gulfam, consultant endocrinologist, there are a team of three medical examiner officers (MEOs). The new service ensures accuracy and identifies areas for improvement across the Trust.

Health Informatics team praised by inspectors

Blackpool Teaching Hospitals NHS Foundation Trust is 'leading the way with staff development' according to inspectors who visited recently to carry out an assessment of the organisation's Health Informatics team.

Health Informatics (HI) includes around 220 employees, from seven departments: Clinical Coding, Digital Transformation, Health Informatics Support, ICT, Information Governance and Health Records, Information Management and Programme Management.

In 2015 the team attained Level 1 of the Excellence in Informatics accreditation, followed by Level 2 in 2017. The accreditation is awarded by the Skills Development Network, which works within NHS organisations in England to improve leadership and professional development skills.

The Level 2 accreditation followed the successful integration of a professional development department within Health Informatics, and the instruction of a skills management system designed to improve Learning and Development for the HI workforce.

In 2020 the team applied for reaccreditation to showcase the progress made. Inspectors met with staff and in their report praised HI for its 'happy and well-motivated workforce.'

Orthoptic department receives new equipment

Hospital charity Blue Skies provided funding to purchase extra equipment for the Orthoptic Department, so they can increase their capacity to see children in a community setting rather than bringing them to the hospital eye department.

Having the extra equipment available has helped the Trust to see more patients by adding more community clinic sites, where they can be examined locally.

This has been extremely beneficial during the Covid pandemic as it enabled the service to move the children away from the hospital site and will also benefit them in the longer term. Children are more comfortable in a local environment, and it is generally more convenient for the parents to attend.

This followed £18,000 worth of funding to purchase an ultrasound machine for the Haematology Ward at Blackpool Victoria Hospital.

Celebrating International Nurses Day

A host of events took place across the Trust to celebrate International Nurses Day and International Day of the Midwife recently.

Virtual event were held, during which Pete Murphy, Director of Nursing, took the opportunity to thank colleagues for their tireless hard work.

Pete led a team of senior colleagues on a walkabout around the Trust, visiting areas including Outpatients where a special Nurses Day display had been put up. Meanwhile, an art competition designed to encourage children to draw a picture representing what nursing or midwifery means to them, was held, and a competition held to share positive experiences as a nurse. The Outpatient Department won the Maintaining Positivity Award which was presented by Pete Murphy.

Donations support BTH wards

A local resident whose son was cared for by Blackpool Victoria Hospital has donated two ‘Dementia boxes’ to say thank you. Gillian Hesketh, of Little Thornton, praised the teams who cared for her son Matthew who was seriously injured in a fall.

He was cared for on Ward 34, which along with Ward 35, is an Orthopaedic Trauma Ward. Many of those being cared for on the wards have dementia, and when Gillian spent time visiting her son, she was determined to say thank you.

Gillian, who also runs a small local business called Happy Days Dementia Workshop which supplies items to organisations including hospitals, was keen to help.

The boxes will help the care staff engage with people and keep them calm when they may be distressed and worried.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

Monthly Media Update – May 2021

TOP STORIES

- Blackpool Teaching Hospitals set up new medical examiner team
- Emergency department doctors urge people to use services wisely
- Clifton Hospital launch new end of life mouthcare packs
- New Blackpool Mental health Urgent Assessment Centre opens for patients
- Accelerating care across Lancashire and South Cumbria

Dr Adeline Israel at the new Mental Health Urgent Assessment Unit

15 External news articles created (press & web)

2 Media enquiries / statements issued

8 Pieces of media coverage*Google

24 Videos shot and edited

20 bulletins:

8 staff
4 CQC
4 Weekly News
4 stakeholder

Campaigns supported:

ED pressure
LAMP testing
Staff vaccinations
Covid-19
Health & Wellbeing
CQC inspection
Restoration of services
Trust restructure
£50 voucher and day off

Our website received **302,478** page views from **61,095 users**. The most viewed page was **Current Vacancies**.

4 Podcasts shared

Social media and digital update

Social media **followers**

21,690

11,659

3,698

5,084

32,592

121,284
Highest monthly Facebook reach

98,803
Facebook post engagement

296,000
Twitter impressions in May

1,770
Instagram impressions

The most talked about issues on our social networks...

Biggest engagement content, Facebook:

- MHUAC 11.5.21 (text/pic)–Reach – 29.7k
- BVH Vaccination Hub 25.5.21 (video) Reach – 23.3k
- Grahame Goode update 21.5.21 (video) Reach – 23.1k

Biggest engagement content, Twitter

- ED busy use the right service (text/pic) **14.2k** impressions

Facebook review rating:
4 out of 5

Facebook Messenger messages answered:
192

Staff Facebook group
1,503 members

Monthly Media Update – June 2021

TOP STORIES

- ⇒ Trust's asthma pathway praised for reducing admissions
- ⇒ Tangerine army of volunteers return to Blackpool Teaching Hospitals
- ⇒ Meet the volunteers
- ⇒ Opportunity to lead the Trust as 'inspiration' non-executive directors
- ⇒ Susan to star in her very own Thelma and Louise
- ⇒ Jane retires after 'long and fantastic' career at the Trust

Asthma pathway: Advanced Clinical Practitioners Mary Erica Diaz-Santos and Liam Duffy.

12 External news articles created (press & web)

5 Media enquiries / statements issued

3 Pieces of media coverage*Google

18 Videos shot and edited

27 bulletins:

8 staff
2 CQC
4 Weekly News
4 stakeholder
4 #ICYMI
5 Perfect Week

Campaigns supported:

ED pressure
LAMP testing
Staff vaccinations
Covid-19
CQC inspection
Restoration of services
Volunteers return
Perfect Week
Staff engagement
Recruitment—FB live

Our website received **233,754** page views from **44,079 users**. The most viewed page was **Current Vacancies**.

4 Podcasts shared

Social media and digital update

Social media **followers**

21,736	↑
11,689	↑
3,713	↑
5,132	↑
33,049	↑

110,289
Highest monthly Facebook reach ↓

98,320
Facebook post engagement ↓

233,000
Twitter impressions in May ↓

1,538
Instagram impressions ↓

The most talked about issues on our social networks...

Biggest engagement content, Facebook:

- Jim Gardner 9.6.21 (video) Reach – 27.1 k
- Jim Gardner 16.6.21 (video) Reach – 24.6k
- Vaccinations 21+ 16.6.21 (text/ photo) Reach – 23.1k

Biggest engagement content, Twitter

- Attendances in ED are continuing to rise (text/pic) **4989** impressions

Facebook review rating:
4.2 out of 5

Facebook Messenger messages answered:
159

Staff Facebook group
1,509 members

Five - Chief Executive's Meetings

Below is a summary of the meetings the Chief Executive has chaired or attended since the last Board meeting.

May 2021 Meetings

Date/Frequency	Meeting
Weekly – Monday	Lancashire and South Cumbria (LSC) Out of Hospital and Hospital Cell Touchpoint
Weekly – Monday	North West Hospital Cell Gold Command Escalation
Weekly – Monday	Executive Team
Weekly – Tuesday	David Flory, Independent Chair, (LSC) Integrated Care System
Weekly – Wednesday	LSC Chief Executives Briefing
Weekly – Wednesday	North West Regional Leadership Group
Weekly – Thursday	Chairman/Chief Executive Briefing
Weekly – Friday	North West Capacity Oversight Group
Weekly – Monday and Wednesday	LSC Hospital Cell Team
Bi-weekly - Tuesday	COVID-19 STP Hospital Cell – Bill McCarthy
Bi-weekly – Wednesday	North West Coast Vaccine Alliance Steering Group
Monthly – Tuesday	ICS Development Oversight Group
11 May	CEO Advisory Group
11 May	New Hospitals Programme
13 May	Specialised Commissioning Leadership Team
13 May	Strategic Commissioning Committee (Formal)
17 May	Good Governance Institute (GGI)
17 May	Quality Improvement Executive Visioning Event
18 May	Cardiac Network Meeting
19 May	Lancashire and South Cumbria Finance Meeting
20 May	Atlas Board

20 May	Team Brief
21 May	New Hospitals Programme – Offline SOG meeting
24 May	Vital Signs Transformation Guiding Board
25 May	Louise Robson, Provider Collaboration
27 May	Lancashire and South Cumbria Diagnostics Programme Board
28 May	Lancashire and South Pathology Collaboration Board
28 May	Provider Collaboration Board
28 May	HIP2 Strategic Oversight Group

June 2021 Meetings

Date/Frequency	Meeting
Weekly – Monday	Lancashire and South Cumbria (LSC) Out of Hospital and Hospital Cell Touchpoint
Weekly – Monday	North West Hospital Cell Gold Command Escalation
Weekly – Monday	Executive Team
Weekly – Tuesday	David Flory, Independent Chair, (LSC) Integrated Care System
Weekly – Wednesday	LSC Chief Executives Briefing
Weekly – Wednesday	North West Regional Leadership Group
Weekly – Thursday	Chair/NED Weekly Briefing
Weekly – Thursday	Chairman/Chief Executive Briefing
Weekly – Friday	North West Capacity Oversight Group
Weekly – Monday and Wednesday	LSC Hospital Cell Team
Bi-weekly - Tuesday	COVID-19 STP Hospital Cell – Bill McCarthy
Bi-weekly – Wednesday	North West Coast Vaccine Alliance Steering Group
Monthly – Tuesday	ICS Development Oversight Group
10 June	Strategic Commissioning Committee (Informal)
11 June	NHS System Oversight Group (Informal)

14 June	Interviews – Director of Finance
15 June	Accelerator Follow Up Group
16 June	David Flory, Independent ICS Chair
17 June	CONFED21 Roundtable
17 June	CEO Advisory Group
17 June	Patient Food Testing
23 June	Provider Collaboratives – Good Practice Event
24 June	Lancashire and South Cumbria Diagnostics Programme Board
24 June	Estates site visit
25 June	Lancashire and South Cumbria Pathology Collaboration Board
25 June	Provider collaboration Board
25 June	LSC Mental Health Improvement Board
28 June	Vital Signs Transformation Guiding Board
29 June	Bill McCarthy, North West Regional Director
29 June	Cardiac Network Meeting
30 June	Team Brief

Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting

1 July 2021

Integrated Performance Report

Author of Report:	Jessica Kozakiewicz
Executive Director Sponsor:	Janet Barnsley - Executive Director of Integrated Care and Performance
Date of Report:	17th June 2021

Executive Overview Summary:

Positive News

- There were no cases of MRSA bacteraemia reported in May
- There were 9 C.Difficile infections detected during May bringing the 2021/22 total to 14
- 4 cases of E.coli reported in May compared to 1 case in April
- FFT - Inpatients, 98% of patients said they would rate their care experience as very good
- FFT - Maternity, 99% of patients said they would rate their care experience as very good
- FFT - Community, 97% of patients said they would rate their care experience as very good
- FFT - Mental Health, 92% of patients said they would rate their care experience as very good
- 89% of people referred to an IAPT service started treatment within 6 weeks of referral, compared to 95% in the previous month. The national target is 75%

Areas of Reporting Impacted due to COVID-19

- National VTE collection remains suspended. Retrospective case note review taking place with May findings indicating 63% compliance although this audit is not yet complete. 68 casenotes reviewed so far
- Reporting of the Dementia Standard suspension continues. Case note audit due to take place between June and September

Areas of Challenge

- There was one Never Event incident reported this month involving misplacement of an NG tube whereby Trust policy was not adhered to
- There was 1 patient safety alert in May
- Latest SHMI is at 109.39% (December 2020), HSMR is 83.16 (March 2021) and Crude Mortality for May 2021 is 1.46%
- The Trust received 35 formal complaints in May, compared to 28 in April 2021
- FFT – A&E, 78% of patients or their carers said they would rate their care experience as very good compared to 85% last month with 13% less respondents

- There were 2 mixed sex breaches in May 2021
- The Trust did not achieve the Referral to Treatment (RTT) standard in May, delivering 72.4% against the target of 92%. This is a slight improvement from April performance (69.9%)
- There were 1,244 patients waiting 52+ weeks against a target of 0 and below the trajectory of 1,620. This is an improvement compared to 1,471 patients in April
- The Trust failed to achieve the Cancer 62 Day Wait standard for all cancers in April with performance at 80.3%; an improvement from March performance at 73.10%
- 81.1% of patients waited less than 6 weeks for a diagnostic test against a standard of 99%, slight improvement on the previous month (79.3%)
- The Type 1 performance for May was 59.47% and Total Economy Performance improved by 2.28% from the previous month to 86.34%
- There were 89 ambulance delays over 60 minutes for May compared to 109 for the previous month**.** The Trust is one of the top 3 for highest ambulance conveyances in the region with 42% of ED attendances brought to hospital by ambulance
- 139 non-hospital acquired pressure ulcers reported in May compared to 158 in April. 58 hospital acquired pressure ulcers reported in May compared to 62 in April
- Staff Sickness in month has risen slightly from 5.13% in April to 5.37% in May against the Trust target of 4%. Increase in sickness across all Divisions apart from Tertiary.
- Staffing turnover currently exceeding the 11% target at 12.22% with the highest turnover observed in Medical and Dental which is currently operating at 17.71%
- Slight decrease in the proportion of staff that are temporary staff, from 10.9% to 9.8%
- Total agency spend has decreased this month from £3.33m to £2.90m due to bank expansion (medical and non-medical), competitive neutral vend provider and overseas/recruitment uptake. The use of off framework agencies has also ceased

Please note: Finance data not available.

For Information/Assurance:	**For Discussion:**	**For Approval:**
	x	x

Recommendations:

The Board of Directors is requested to note and approve the Integrated Performance Report.

Sensitivity Level:

Not Sensitive: **(for immediate publication)**	**Sensitive In Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider applicable exemption)**
x		

Level 1: Domain/Trust High Level Summary

May - 2021

Blackpool Teaching Hospitals NHS Foundation Trust

Safe

Never Events	KPIs
1	

VTE (%)	SPC
0.00	

C.Difficle	SPC
9	

MRSA	KPIs
0	

E.Coli	SPC
4	

Pat. Safety Alerts	SPC
1	

Effective

Crude Mortality (%)	SPC
1.46	

Caring

Complaints	SPC
35	

FFT Inpatients (%)	SPC
98.00	

FFT A&E (%)	SPC
78.00	

FFT Maternity (%)	SPC
99.00	

FFT Comm. %	SPC
97.00	

FFT Mental H. %	SPC
92.00	

Mixed Sex Breaches	KPIs
2	

Emerg. C Section %	SPC
20.90	

Responsive

RTT Incomp. (%)	SPC
72.40	

62 Day Cancer %	SPC
80.30	

6WW Diag %	SPC
81.14	

Dementia Std. %	SPC
0.00	

IAPT Wait %	SPC
89.00	

IAPT Rec. %	SPC
53.00	

DQMI (%)	SPC
92.10	

Efficient

Staff Sickness (%)	SPC
5.37	

Staff Turnover (%)	SPC
12.22	

Temp. Staffing %	SPC
9.80	

Capital Service	SPC

Liquidity	SPC

I&E Margins %	SPC

Agency Spd. (£M)	SPC
2.91	

EuR Rating	KPIs

Strategic

A&E + UCC	SPC
84.06	

SHMI	SPC
109.39	

Well Led

Financial Plan	SPC

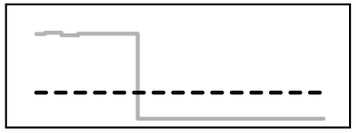
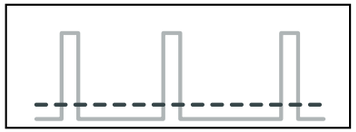
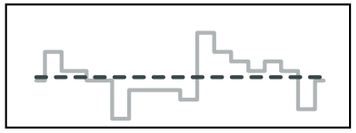
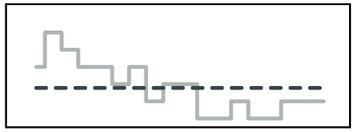
Spec. Injur. to Wrks.	KPIs
0	

Over 7 Day Inc Wrks	KPIs
1	

Definitions

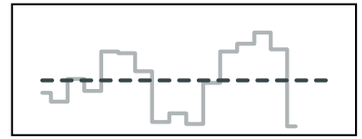
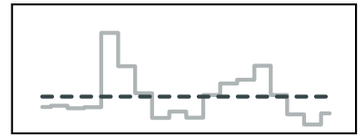
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Never Event	Safe	1.00	0		Limited assurance
VTE (%)		0.00	0.00		Limited assurance
C.Difficile		9.00	0		Limited assurance
MRSA		0.00	0		Full assurance
E.Coli		4.00	0		Limited assurance
Patient Safety Alerts		1.00	0		Limited assurance

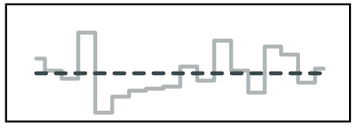
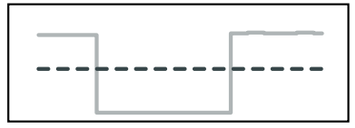
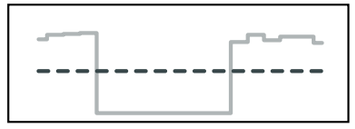
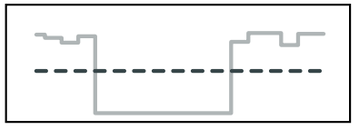
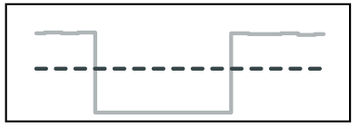
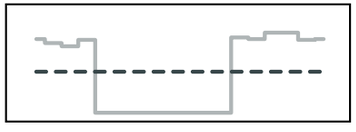
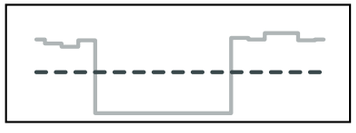
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
HSMR	Effective	83.16	0		Limited assurance
Crude Mortality (%)		1.46	0.00		Limited assurance

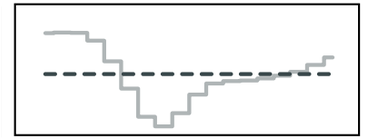
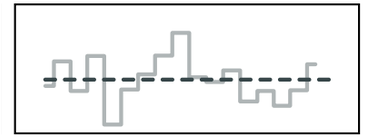
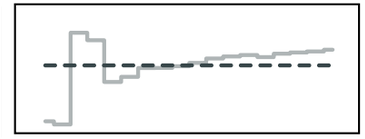
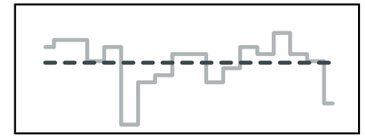
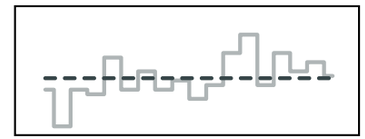
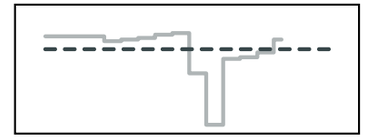
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Complaints	Caring	35	(Blank)		Limited assurance
FTT Inpatients (%)		98.00	96		Limited assurance
FTT A&E (%)		78.00	92		Limited assurance
FTT Maternity (%)		99.00	96		Limited assurance
FTT Community (%)		97.00	98		Limited assurance
FTT Mental Health (%)		92.00	(Blank)		Limited assurance
Mixed Sex Breaches		2.00	0		Limited assurance
Emerg. C Section		20.90	0		Full assurance

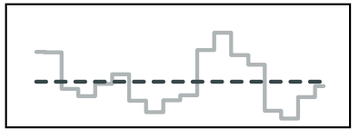
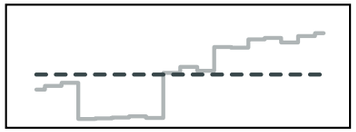
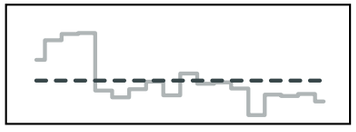
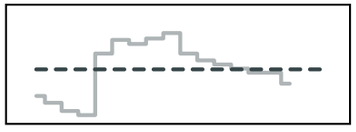
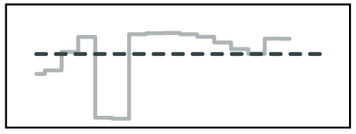
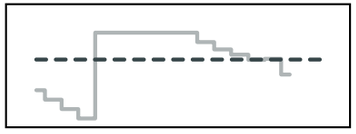
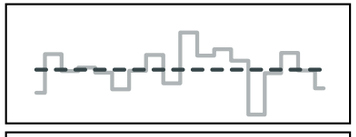
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
RTT Incomplete (%)	Responsive	72.40	92.00		Limited assurance
62 Day Cancer (%)		80.30	85.00		Limited assurance
6WW Diag (%)		81.14	99.00		Limited assurance
Dementia Stds.		0	0		No assurance
IAPT Wait Times		89	75		Full assurance
IAPT Recovery		53	50		Full assurance
DQMI (%)		92.10	83		Full assurance

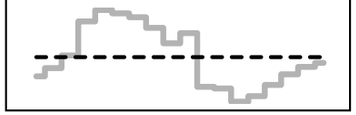
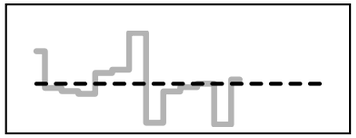
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Staff Sickness (%)	Efficient	5.37	4		Limited assurance
Staff Turnover (%)		12.22	11.00		Limited assurance
Temp. Staffing (%)		9.80	0.00		Full assurance
Capital Service		(Blank)	0		Assurance Not Recorded
Liquidity (Days)		(Blank)	0		Assurance Not Recorded
I&E Margins (%)		(Blank)	0		Assurance Not Recorded
Agency Spend (Millions)		2.91	-1		Limited assurance
EuR Rating		(Blank)	0.00		Assurance Not Recorded

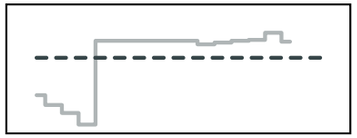
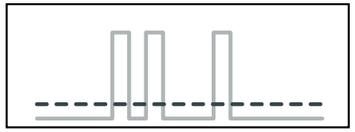
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC		Assurance
A&E + UCC (%)	Strategic	84.06	95			Limited assurance
SHMI		109.39	100			Limited assurance

Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

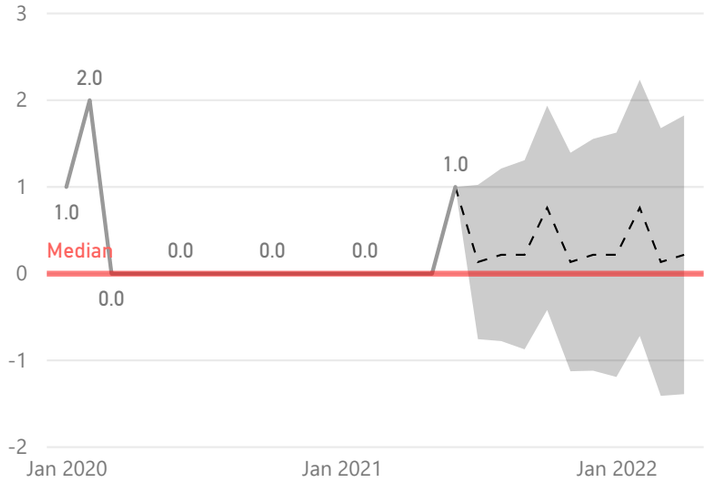
Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Financial Plan (%)	Well Led	(Blank)	0.00		Assurance Not Recorded
Specified Injuries to Workers		0.00	0.00		Limited assurance
Over 7 Day incapacitation of a Wrk		1.00	0.00		Limited assurance

Never Events

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
1	0

Issues

There was one Never Event incident reported this month. The incident involved the misplacment of an NG tube on CITU on 28/05/2021. Trust policy was not adhered to.

Actions

Immediate actions identified: chest x-rays to be reviewed by a senior clincian if there is any doubt in the position of the NG tube. Staff must alert medical staff if no aspirate obtained following a period of rest from NG feeding. Staff to note the length of NG tube at each check and document on the SAS chart. Medical and Nursing staff will be made aware of this incident through safety huddles, governance meetings and unit meetings. Policy for Fine Bore Nasogastric Feeding Tube for Adults to be disseminated to HoD's and Matrons for cascade to clinical teams and to be discussed at handover for 7 days. Red Alert produced and distributed through Communications to all staff.

Key Risks, Mitigation & Assurance

Limited assurance

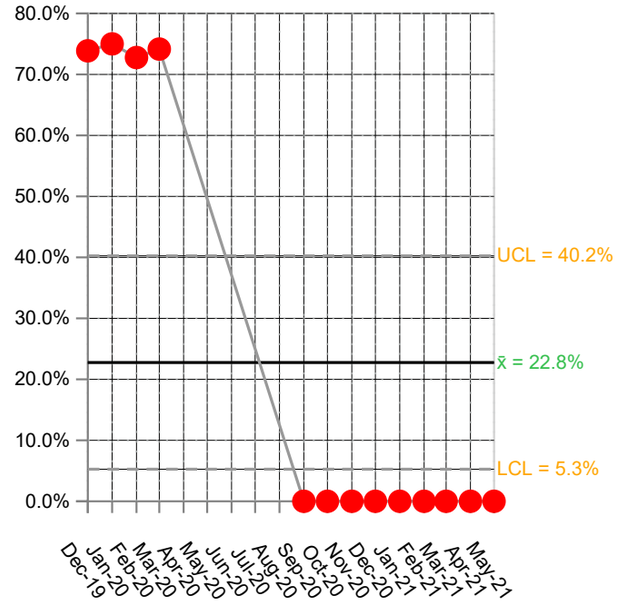
Risks	Mitigation

VTE

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
0.00	0.00

Issues

The national VTE collection is currently suspended. Using the ward and base trackers as a starting point, to try and understand true compliance we are retrospectively reviewing case notes as currently unable to send audit teams to all wards. There are challenges around compliance and accuracy. The base trackers always show 100% compliance (mandatory field requiring completion before moving to other assessments)
For VTE assessments, the data from the ward trackers and/or case note reviews is being used to understand true compliance. Although the sample sizes are small, the findings from the case note reviews in May 2021 are as follows:
Unscheduled Care (Integrated Medicine and Patient Flow care) wards reviewed : AMU, AEC, 2, 3, 8, 25, 26, C, DS ITU-91 identified, only 14 out of 76 showing completed assessments on ward trackers. Case notes then reviewed on the same ward, 14 out of 17 completed in case notes reviewed. i.e approx. 82% compliance
Scheduled care wards reviewed : 15A, 15B, 16, 34,35, SHCU, SAU, HDU, ITU -101 identified on base tracker, 29 out of 94 showing completed assessments on ward trackers. Case notes reviewed on same wards, 27 out of 29 Reviewed notes showing completed assessments, i.e 93 % compliance
Additional Tertiary wards this month : CDCU, CITU-21 identified. No base tracker, 2 out of 21 completed on ward tracker, 2 out of 22 completed in case notes reviewed so far(incomplete Audit)

Actions

Great and promising improvement from unscheduled care both in terms of assessments completed as well as compliance to preventive measures
New advice from NICE might mean a divergence between different divisions especially for mechanical prophylaxis.
Unscheduled Division appearing to indicate moving away from mechanical measures and their lead is currently working on submitting new guidance for approval. Anticipate working on this over the next month or two.
Have set up a help group with Dr Rostami and Jayne Thomas and Dr Goode to be guided better in improving VTE for the Trust. Also to help plan how to get ourselves a full time VTE specialist Lead Nurse or similar role. This has become URGENT now with the loss of the governance and admin lead for VTE for the trust. I have escalated this to Jayne and Dr Goode and await some affirmative action
Keeping alive the message on VTE assessments and prophylaxis, especially on account of its correlation to COVID patients due to almost 20-70 percent increase in VTE related events in symptomatic critical COVID patients.
Request regular and monthly communication from Medical and Nursing Leads to reiterate to wards and teams responsible for maintaining the accuracy of trackers
Can I get Dr Gardner/ Dr Goode/Dr Wiggans to use their good offices to get all divisions to engage more with VTE for both assessments and prophylaxis efforts

Key Risks, Mitigation & Assurance

Limited assurance

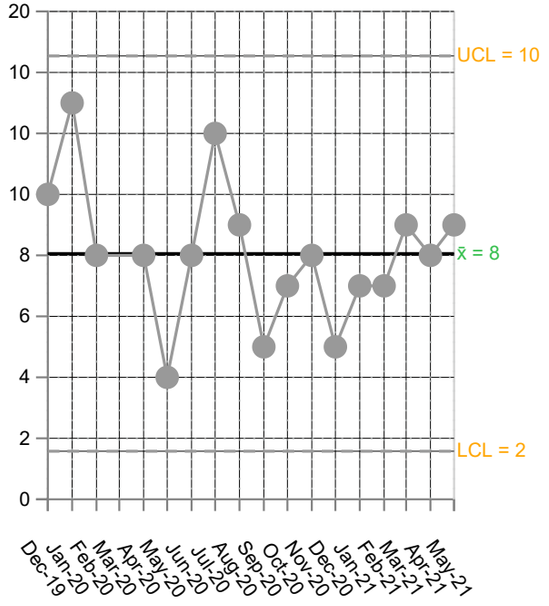
Risks	Mitigation

C.Difficile

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
9	0

Issues

A total of nine cases were attributed to the Trust in May 2021. This brings the total number of cases so far this year to 14. NHS England & NHS Improvement (NHSE&I) has yet to publish any objectives for 2021/2022.

Actions

The Divisions provided assurance that actions were being taken to address CDI at the WHIPC meeting on June 8th. This includes the development and trial of a care plan for patients with diarrhoea. Of note, compliance with commode cleanliness has also improved significantly from 64% in Q4 2020 to 98.9% in May 2021.

Key Risks, Mitigation & Assurance

Risks	Mitigation

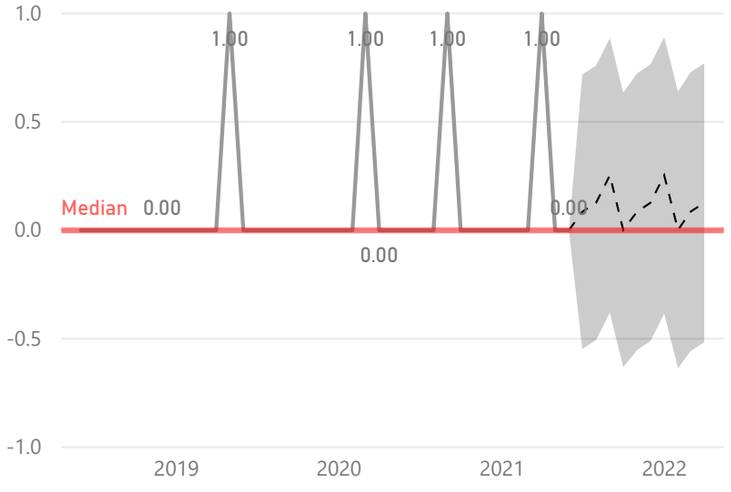
Limited assurance

MRSA

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
0	0

Key Risks, Mitigation & Assurance

Full assurance

Issues

No cases of MRSA bacteraemia were reported in May 2021.

Actions

No new actions to report.

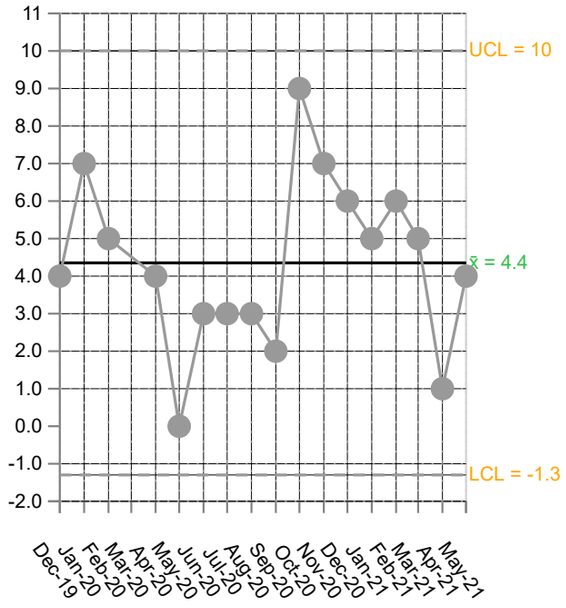
Risks	Mitigation

E.Coli

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
4	0

Issues

Four cases of E. coli blood stream infection were reported in May 2021. This brings the total so far this year to five. As with CDI, NHSE&I have yet to set any E. coli objectives.

Actions

As reported last month, plans are in place to establish an ICS wide action plan to tackle Gram Negative Blood Stream Infections which include E. coli.

Key Risks, Mitigation & Assurance

Risks	Mitigation

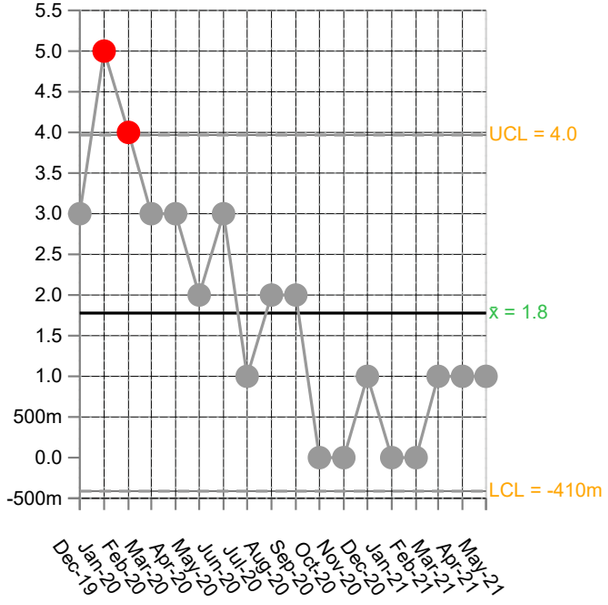
Limited assurance

Patient Safety Alerts

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
1	0

Issues

There was 1 new patient safety alert received this month:

NatPSA/2021/002/NHSPS - Urgent assessment/treatment following ingestion of 'super strong' magnets.

Actions

Due response date for the new patient safety alert:

NatPSA/2021/002/NHSPS - 19/08/2021

Key Risks, Mitigation & Assurance

Limited assurance

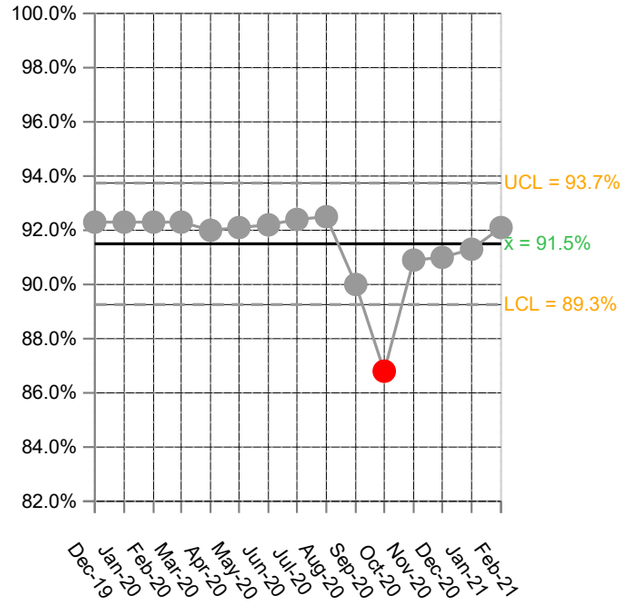
Risks	Mitigation

DQMI

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
92.10	83

Issues

The Trust's data quality index continues to be above national average overall for the past 5 reporting periods including the latest and also above average in each of the 7 distinct minimum data sets submitted :-

Accident and Emergency (AE)
Admitted Patient Care (APC)
Community Services (CSDS)
Improving Access to Psychological Therapies (IAPT)
Mental Health Services (MHSDS)
Maternity Services (MSDS)
Outpatient (OP)

Overall quality continues to remain consistent for the last 4 months recorded in the national report, with February's value of 92.1%, 7.3% above national average.

Please note data refreshes can affect DQMI values going forward

Actions

N/A

Key Risks, Mitigation & Assurance

Full assurance

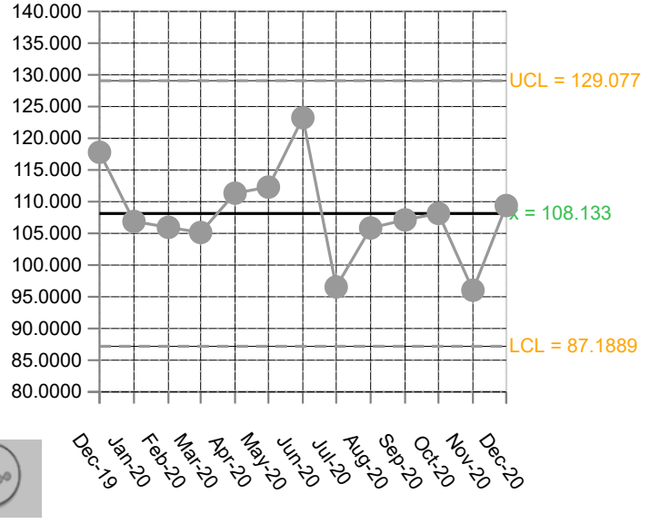
Risks	Mitigation
None	None

Mortality

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

SHMI Statistical Control Process



Actual (%)	Target
109.39	100.00

HSMR	SPC	Crude Mortality (%)	SPC
83.16		1.46	

Issues

- Review of deaths of patients dying within 30 days of discharge from hospital nearing completion.
- Specific diagnostic groups with apparent excess mortality as identified by HED system in need of retrospective case record review.
- Standard Structured Judgement Review process is not well suited to analysing covid deaths where hospital acquisition is implicated. Modified SJRs underway.
- SHMI and HSMR potentially distorted by Covid-19.

Actions

Trust-wide roll out of digital mortality (Learning from Deaths - LfD) application to expand the pool of competent SJR case record reviewers and streamline processes now underway.

- Customised proforma designed to facilitate retrospective case record review of patients dying from hospital acquired COVID infection approved and underway.
- Case records distributed across the whole consultant body in order to avoid individual overload in the review of care of patients dying from hospital acquired COVID infection.
- Formation of a small working group, including community and trust representation, to work on full Trust wide engagement with the LeDeR program including Learning from Deaths.
- Learning from Deaths Grand Round, in conjunction with NHSI Mortality Reduction Lead took place on 12th May 2021. National Lead also attended Medical Leadership Forum.
- 12 month rolling averages for SHMI and HSMR smooth out variation and allow comparison across trusts.

Key Risks, Mitigation & Assurance

Limited assurance

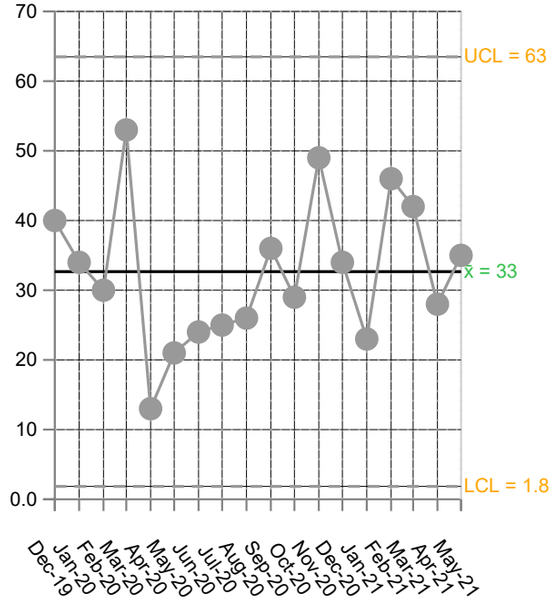
Risks	Mitigation
Learning from Deaths Application may not be utilised as expected. • Retrospective case reviews of nosocomial covid deaths may be difficult to interpret • Challenges with the ease of access to Primary and Community Care digital records by case record reviewers engaged in the evaluation of patients dying within 30 days of discharge from hospital. • Absence of a validated review proforma for the evaluation of continuing care post hospital discharge. • Details of all deceased LD patients across the trust may not always forwarded to LeDeR medical lead to ensure that SJR takes place in all cases. New Divisions establishing fresh Learning from Deaths processes.	Speciality mortality governance leads and HOD's to be responsible for fair and even distribution of case record review workload within each speciality. • Medical Director is part of Regional Team considering aspects of nosocomial covid mortality reviews. Reviews underway across Trust using newly developed pro forma. Impact of the reviews on individual consultants minimised through allocating cases across an approved list.

Complaints

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
35	(Blank)

Issues

In May 2021, 35 formal complaints were received which required investigation compared to 28 in April 2021, an increase of 20%.
100% of complaints were acknowledged within 3 working days in the Trust. There were 32 complaints due to be responded to in May 2021. 13 complaints were sent out in time (41%), a 35% decrease from the previous month. 19 breached the local target of 25/40 working days. The individual divisions response rate is below:

Clinical Support 13% (1 out of 8)
FAIC 50% (3 out of 6)
IMPT 37% (4 out of 11)
SACT 80% (4 out of 5)
Tertiary 0% (0 out of 1)
Corporate 100% (1 out of 1)

During May 2021, 9 complainants were dissatisfied with their first response from the Trust and requested further information from the division. There were no second complaints which were due to be responded to in May but there are 24 outstanding cases from the reporting year April 2020 to March 2021. Of these 24 3 cases have breached the 6 month timeframe, which have been escalated to senior management to ensure a swift resolution.

Actions

NHS England Improvement have now withdrawn the flexibility around complaint times introduced during COVID 19. From May 1st 2021 we must now adhere to the 25/40 working day timeframes and ensure all complaints are responded to within 6 months in line with the national target. A weekly tracker is sent to all divisions identifying outstanding first or second responses. A universal escalation procedure is to be agreed for the divisional complaint managers to get timely, high quality statements from staff to support the investigation process. There will be further Trust wide scrutiny on the standard of complaint responses with the commencement of the Complaint Review Panel in June 2021, this is expected to reduce the number of second responses required and also the overall complaint response time.

Key Risks, Mitigation & Assurance

Limited assurance

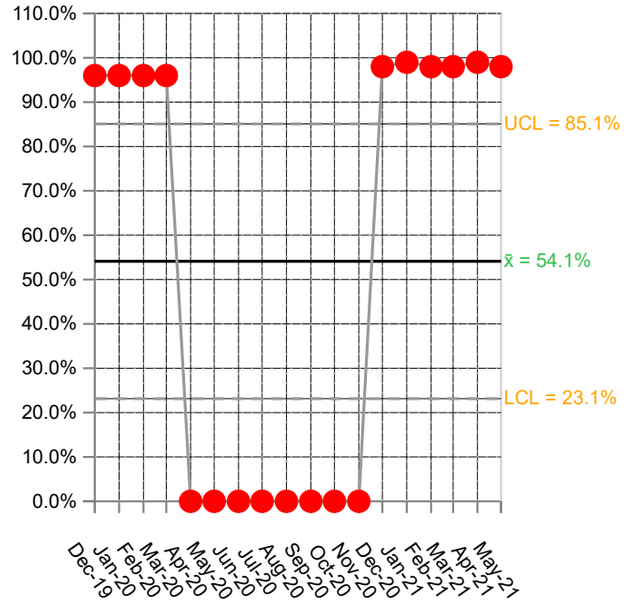
Risks	Mitigation

FFT Inpatients

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
98	96

Issues

In May 733 inpatient FFT surveys were completed, by inpatients in either Clifton or Victoria hospital. This is a 43% increase in the number of responses when compared with last month. 98% of the inpatients in May said they would rate their care experience as very good or good, a 1% decrease from last month.

Actions

Service managers continue to receive regular updates and alerts from the Experience platform when action is required on the back of a low scoring survey. The COAST ward inspections are supporting promotional activities around the FFT, with more staff requesting access to the platform to display their results and actions taken at a ward level.

Key Risks, Mitigation & Assurance

Risks	Mitigation

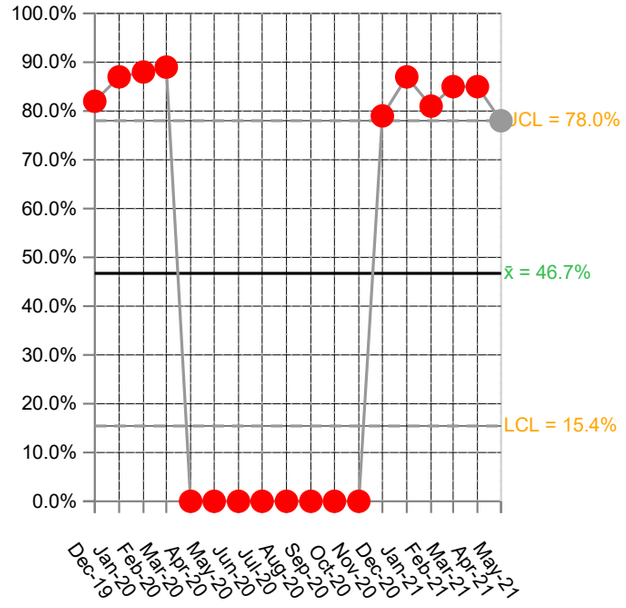
Limited assurance

FFT A&E

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
78	92

Issues

In May 310 patients completed a FFT survey by SMS or paper after attending the Emergency Department. A decrease of 13% from last month. 78% of the patients or their carers said they would rate their care experience as very good, a 7% decrease in the satisfaction rate from last month. Issues reported were around staff attitude, and long waits waiting for treatment and diagnosis.

Actions

28% of the surveys this month were in paper format, which is a 14% improvement from last month as previously feedback had been captured in electronic format only. Notification alerts and push reports are being sent to the department managers and Directors of Nursing overseeing A&E. They are actively responding to any negative concerns on the Experience platform.

Key Risks, Mitigation & Assurance

Limited assurance

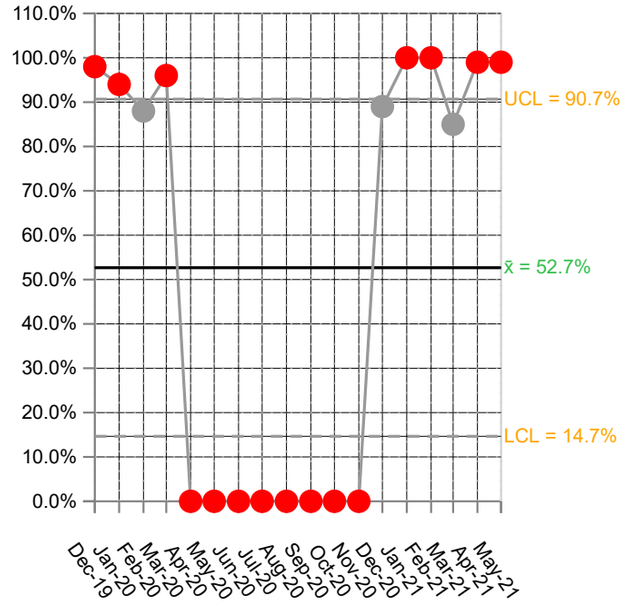
Risks	Mitigation

FFT Maternity

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
99	96

Issues

In May 74 of these surveys were for maternity services, a 24% decrease in their survey numbers from last month. 99% of the patients or their carers said they would ranbnte their care experience as very good, the same score as April.

Actions

There is a new Ward Manager on Ward D who has championed the FFT and promoted the established into service again. 65 paper forms were submitted compared to 9 SMS surveys this month. The SMS is being reviewed with informatics and the FFT provider to drive up responses across the maternity pathway.

Key Risks, Mitigation & Assurance

Limited assurance

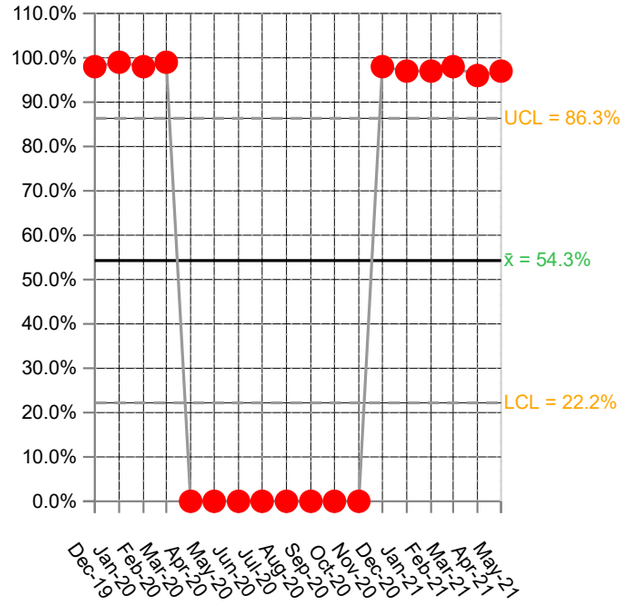
Risks	Mitigation

FFT Community

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
97	98

Issues

1123 patients in the community completed a FFT survey at home or in clinic, a 20% increase from last month. 97% of the patients or their carers said they would rate their care experience as very good, a 1% increase from the previous month.

Actions

The FFT question is now being asked via SMS for MSK in the community, and Sexual Health services are texting the online link to their patients via their Lilie system. 136 surveys were completed via SMS in May.

Key Risks, Mitigation & Assurance

Risks	Mitigation

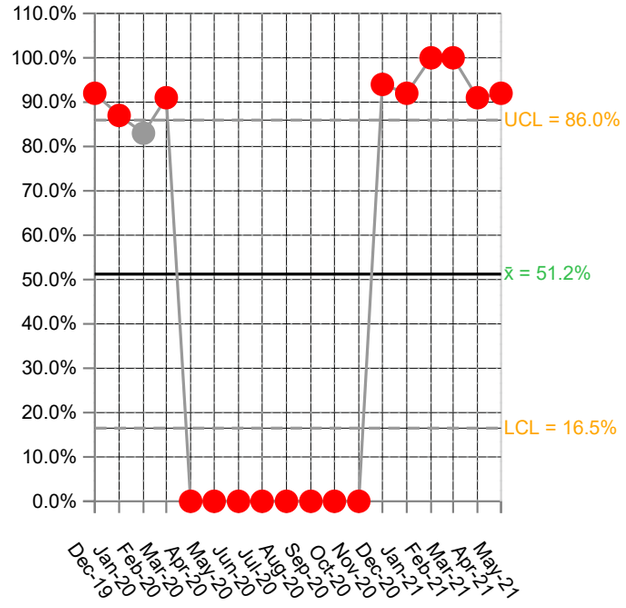
Limited assurance

FFT Mental Health

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
92	(Blank)

Issues

In May, 26 patients who require mental health support completed a FFT survey at home or in a clinic, a 42% decrease in responses from April. 92% of the patients or their carers who used the services said they would rate their care experience as very good, a 1% increase from last month in patient satisfaction.

Actions

1 paper survey was completed this month, all other data was entered online surveys, through the Supporting Minds and You therapy survey. Service leads will be reminded to hand out paper surveys at every opportunity to ensure there is more feedback about their services.

Key Risks, Mitigation & Assurance

Limited assurance

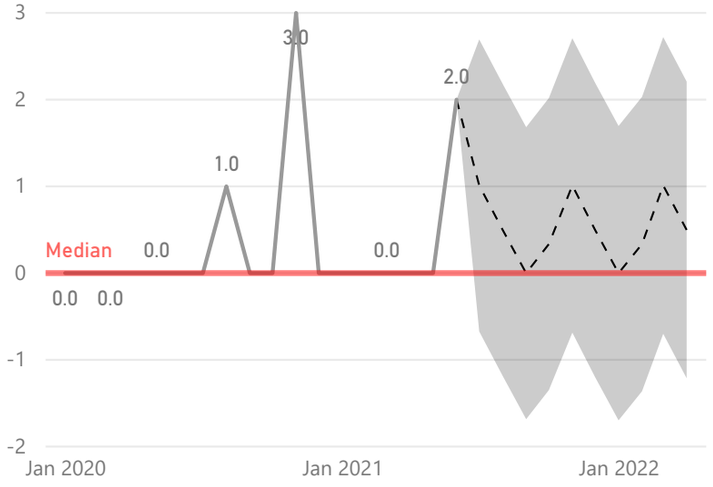
Risks	Mitigation

Mixed Sex Breaches

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Issues	Actions
There were 2 mixed sex breaches in May 2021. One took place on AEC, where a patient was in a mixed sex area beyond the 4 hours. The other took place on HDU where no suitable bed could be found to step them down when ready for discharge from the unit.	We are using a new template to report the breaches to the CCG in line with the new guidelines. The COAST Team are raising any privacy and dignity issues which breach the new guidelines to the patient experience department when they conduct ward inspections.

Actual	Target
2	0

Key Risks, Mitigation & Assurance

Limited assurance

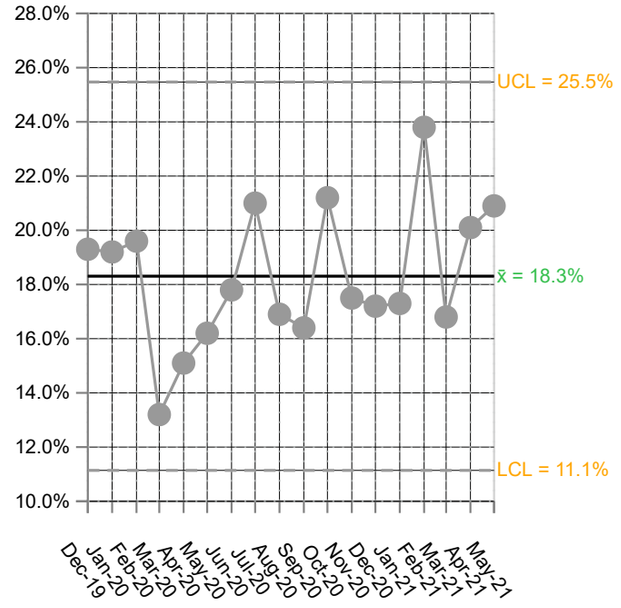
Risks	Mitigation

Emergency C Section

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
20.90	0

Issues

Medical complexity of pregnancies has resulted in the present monthly rate. A comparison of all Emergency Caesarean Section rates across the region from 2018/19 to 2020/21 indicate that Blackpool Teaching Hospitals are not an outlier.

Actions

Metrics are reported and monitored through the divisional Quality, Patient Safety and Experience Team

Key Risks, Mitigation & Assurance

Full assurance

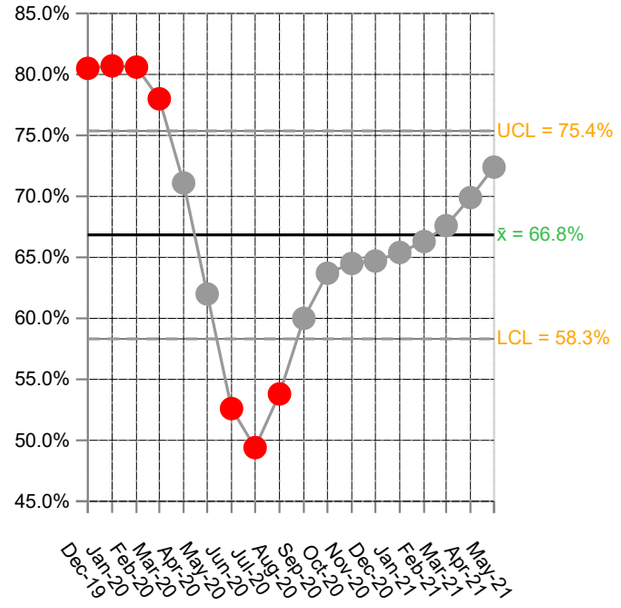
Risks	Mitigation

RTT Incomplete Open Pathways

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Issues

The Trust did not achieve the RTT open pathway standard in May with performance at 72.4%. This represents an improvement from previous months (April 69.9%). There were 18,913 open pathways against the trajectory of 19,000. The Trust has 1,244 patients waiting 52+ weeks, which is a reduction on last month reported at 1,471 and below the trajectory of 1,620.

Restoration of elective work compared to the same period in 2019 was 93.2% for IP and 88.1% for DC, with overall elective at 88.6%. The Outpatient activity for May was 101.4% for new patients and 103.5% for follow ups. 29.4% of all outpatient activity was delivered virtually. Diagnostic restoration was 117.1%

Actions

- The Trust has contracts with Spire hospital to undertake General Surgery, Orthopaedics and Gynaecology procedures.
- It is anticipated that Medinet will provide an insourcing service at the weekend for minor surgical procedures from mid June/early July.
- Additional capacity at the weekends has been negotiated for Gastroenterology on site with three session days having commenced at the end of May
- A Modular Gastrointestinal unit is being discussed with Remedy Healthcare and Vanguard with the potential start date from the beginning of September/October 2021.
- Additional support for pre-operative services is being put in place through overtime, filling vacancies, consideration of agency staff and Insourcing teams.
- Initiatives under the accelerator plan are being progressed.

Actual (%)	Target
72.40	92.00

Key Risks, Mitigation & Assurance

Limited assurance

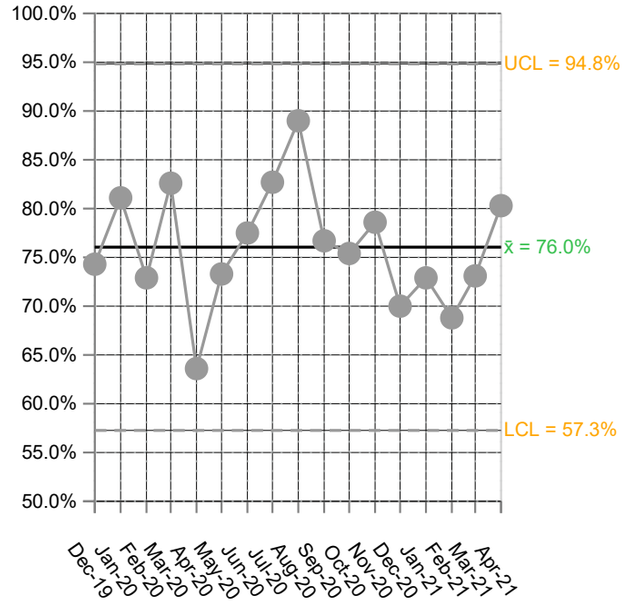
Risks	Mitigation
• Achieving the IS target is problematic due to administrative issues and the acceptance criteria at Spire hospital prioritising only low risk patients. Patients potentially reluctant to transfer.|• Protracted procurement process could result in delay in contracts being agreed|• Insufficient theatre Gastroenterology and Anaesthetic manpower to increase capacity |• Potential lack of capacity in pre-admission.|• Reluctant in patients to transfer to external or Insourcing providers|• Further spike in Covid-19 cases	• Insourcing companies being utilised to mitigate preadmission risk and staffing risks|• Additional procurement staff are being recruited through Covid funds|• Dedicated manager being utilised to assist in persuading patients to transfer to other providers.|• Waiting list initiatives being undertaken at the weekend to maximise minor case capacity.|• Project manager has been installed to assist with procurement processes.

62 Day Cancer Referrals

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
80.30	85.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

The Trust failed to achieve the Cancer 62 Day Wait for all cancers in April at 80.3%. This represents an improvement from previous months with March's performance at 73.1%. All patients who breach this target are monitored closely, subject to close review which also includes patients waiting over 104 days. The number of patients treated in April after day 104 is 2; the number of patients waiting over 104 days (diagnosed and not diagnosed) is 17.

Due to poor availability of Consultant Radiologists the Trust has failed to achieve the 2-week target for breast treatment. Symptomatic breast has reduced from 65% (March 2021) to 40.5% in April 2021 and we anticipate significant improvements between May & June as new recruits take up post.

The main areas for delay outside of breast services are resulting from capacity issues which have been exacerbated by the backlog due to Covid are within Endoscopy, Gastroenterology and Colonoscopy. This is then placing pressure on colorectal surgery at the end of the pathway.

Actions

- A locum Consultant Radiologist commencing in mid-May will improve breast performance from mid-May, expected to recover by the end of June.
- Additional breast clinics are being secured at weekends to deal with the anticipated shortfall in capacity due to Radiology shortages.
- Following discussions with the Insourcing provider for endoscopy, capacity will be increased for the end of May to three session days at the weekends.
- Discussions are taking place with Remedy Healthcare & Vanguard to install a Modular Gastroenterology Unit at Preston Business Centre with a target date for commissioning of September/October 2021. These agreements still need to be finalised.
- The Trust is attempting to source locum consultants to increase the compliment of Gastroenterologists from the present 3.5 WTE to the establishment at 7 WTE.
- Medinet have been identified as a potential provider from late June early July to undertake more minor procedures allowing the Trust internal team to focus on surgical cancer cases.
- Spire Independent Sector are being utilised to undertake more minor day case and inpatient procedures however issues regarding these lists remain problematic.
- One-stop clinic for prostate being piloted

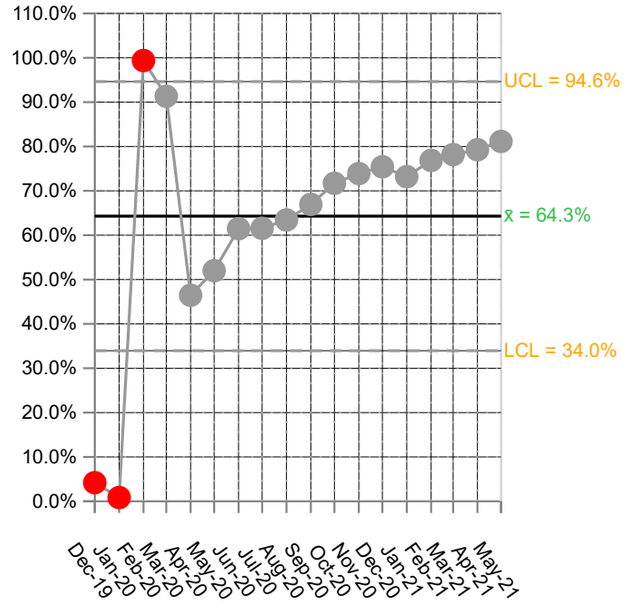
Risks	Mitigation
• Protracted procurement processes|• Competition for insourcing and outsourcing across ICS|• Patients declining to transfer to other providers/Insourcing companies|• Preoperative assessment is presently overwhelmed with the present workload|• Theatre staffing and Anaesthetist availability is a potential limiting factor|• Risks of patients coming forward for surgery as lockdown eases and/or unwillingness to follow isolation rules.	• New Cancer Manager is post from mid June |• Cancer patients prioritised for listing|• Trust have appointed a dedicated manager to discuss transfers to other organisations with patients directly |• Project manager has been installed to work with procurement to ensure time scales are met|• Some insourcing companies provide preoperative assessments |• Review of banding of difficult to fill posts for preoperative assessment may attract more candidates for vacant posts|• Additional staffing is being funded for procurement via Covid funding

% Over 6 Week Wait Diagnostic

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
81.14	99.00

Issues

The impact of Covid has resulted in non-delivery of this standard, reporting 81.1% of patients receiving their diagnostic within 6 weeks which represents an increase from last month's position which was 79.2%. The over 6-week breaches have reduced this month to 771 (May 2021) from the previous month of 852 (April 2021).

The highest volume areas of breaches are Gastroscopy, Sigmoidoscopy, Colonoscopy and Echocardiography.

Actions

- Additional capacity at the weekends has been negotiated for Gastroenterology on site with three session days commenced at end of May.
- The Trust is working to increase the number of Gastroenterology from 3.5 WTE to 7 WTE by sourcing additional Locum staff and working on long term recruitment.
- A Modular Gastrointestinal unit is being discussed with Remedy Healthcare and vanguard with the potential start date from the beginning of September/October 2021.
- NHSE scanner remains in situ 7 days per week supported by private sector locum agency capacity.
- To assist the wider ICS, 1 MRI scanner is now operational with 3rd party staffing solutions to address their backlog.
- Additional overtime sessions continue for Echocardiography at the weekends but unfortunately the insourcing team have been unable to commence their programme because of staffing difficulties.

Key Risks, Mitigation & Assurance

Limited assurance

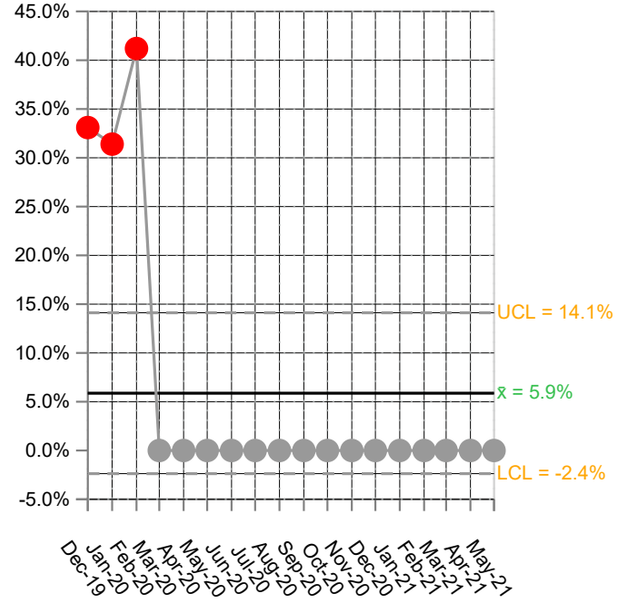
Risks	Mitigation
• A significant lead time to introducing Modular site at Preston Business Centre (September/October)|• Potential increase in diagnostics being required due to additional referrals from primary care |• Relatively low numbers of Senior Clinicians in Gastroenterology will reduce internal capacity |• Limited availability of Radiologists for additional MRI work|• Radiographer staffing	• Additional acceleration funding secured to increase procurement capacity to assist with Insourcing and Outsourcing models |• Revised recruitment strategy being developed for Gastroenterology and the use of locum Gastroenterologists being implemented. |• Recruitment of additional Radiologists, ICS wide reporting ask for additional MRI work|• Use of Locum staff where appropriate|• Use of Mobile scanning facilities where appropriate

Dementia Standard

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
0	0

Issues

Due to the ongoing COVID-19 pandemic and in line with national guidance the dementia audit did not take place during May 2021. The Royal College of Psychiatrists(RCP) has invited trusts to volunteer to participate in a case note audit between June and September 2021. We expect to participate in this. Feedback from the RCP National audit of Dementia report on the impact of COVID 19 pandemic on hospital care for people with dementia was shared at the Dementia Advisory Board. The RCP has asked for participation in the following carer survey: audit.https://wh1.snapsurveys.com/s.asp?k=162074814780

Actions

Dementia Tier 2 training has continued virtually during May 2021 with 45 people attend this training.
Dementia Champions monthly meetings also continue with good attendance. Dementia Action week, despite restrictions took place in May, with pledges from staff to people with dementia and their families. The week was also used to promote Johns Campaign, Paint me a Picture, the Butterfly scheme and our Dementia Champions . A raffle raised £254.00 for the Blue Skies Dementia Fund during this week.
Preparatory work in producing an updated dementia strategy has commenced with a consultation event arranged for 23rd June 2021 with key stakeholders, including staff, 3rd sector organisations, patients, families and carers of those living with dementia. This will include a reveiw of the recent RCP audit.

Key Risks, Mitigation & Assurance

No assurance

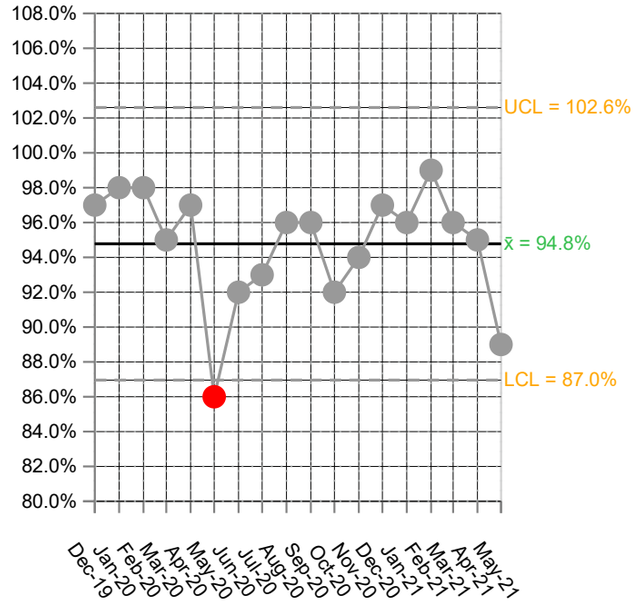
Risks	Mitigation

IAPT Wait Times

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
89	75

Key Risks, Mitigation & Assurance

Full assurance

Issues

National standards state that 75% of people who are referred to an IAPT service should start treatment within 6 weeks of referral. Supporting Minds March waiting times are within National Targets for IAPT services. The figure for Supporting Minds for May was 89%.

Regarding those patients who have waited for more than 6 weeks, this is mostly due to patients booking a place on a group intervention and then electing to postpone this until the next group.

However, we continue to work extremely hard to reduce our secondary waiting times, which are still being impacted upon by Covid-19 as plans to increase more face to face groupwork at Step 3 are still on hold.

Actions

- We are attempting to recruit additional CBT therapists to provide more out-of-hours therapy slots.
- Ensuring some groups are accessible on-line until face to face groups can commence – our new psychological well-being group for stroke survivors has commenced and is receiving good feedback. This is being delivered in conjunction with the Stroke Association. The pilot compassion-focussed group has now completed with positive feedback and recruitment has commenced for the next group.
- Working with staff to ensure that the DNA policy is adhered to, and monitoring DNA rates through caseload management supervision - ongoing
- Monitoring and reviewing the number of sessions offered at Step 3 to ensure that these are aligned to, and in keeping with, NICE and IAPT guidance - ongoing
- Review individual practitioner's targets at Step 3 and how they meet these and ensuring overbooking is kept to a minimum but is used when necessary to ensure targets are met – ongoing.

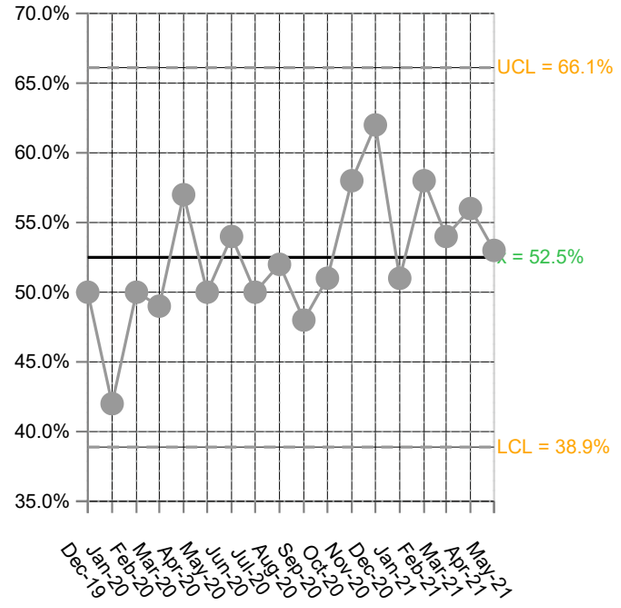
Risks	Mitigation
• Anticipated increase in referrals due to COVID19.|• Increased waiting times for some - due to people needing or wanting to be seen face to face Limited room availability for socially distanced face to face therapy (insufficient rooms that are large enough to allow therapist and client to sit 2m away from each other).	Ensuring as many groups as possible are accessible on-line due to current restrictions on group-work due to Covid-19. |Patients are still being actively encouraged to accept remote or online therapy wherever possible, unless face to face therapy is clinically indicated. Limited face to face working is continuing in a risk assessed socially distanced way for those patients who have a clinical need for face to face therapy or where difficulties accessing therapy remotely cannot be overcome. Staff are being flexible with their working hours in order to maximise room usage. Ensure that all planned groups are ready to go as soon as face to face group work possible

IAPT Recovery

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
53	50

Key Risks, Mitigation & Assurance

Full assurance

Issues

National standards state that at least 50% of people who complete treatment should recover. The figure for Supporting Minds for May was 53%.
There are issues impacting on service delivery that we continue to monitor to ensure they do not impact on Recovery.

- Reduced face to face appointments due to Covid-19. We have limited room availability for socially distanced therapy (insufficient rooms that are large enough to allow therapist and client to sit 2m away from each other) and some GP surgeries declining use of the rooms usually used by our service.
- Covid -19 exacerbating pre-existing mental health difficulties
- Some referrals received fall outside the remit of an IAPT service (a service for people with mild to moderate mental health difficulties) in terms of their complexity. These have the potential to impact on recovery.

Actions

- We are working hard to safely increase the availability of face to face appointments for those patients where face to face therapy is clinically indicated by maximising use of available space.
- Administrators actively encouraging as many patients as possible to accept remote therapy to enable them to access therapy as quickly as possible and to ensure that those who need face to face therapy can access this in a timely way.
- In order to maintain recovery rates at over 50% fortnightly enhanced caseload supervision monitors individual practitioner's recovery scores and supports the monitoring and reviewing of the client's progress. The number of sessions offered is monitored to ensure that these are aligned to, and in keeping with, NICE and IAPT guidance and so that the patient receives the optimum amount of therapy. In addition, any barriers to clients progress is discussed. This is ongoing and meetings with staff occur twice per month.
- Complex cases that potentially fall outside the remit of the service are routinely discussed at the interface meeting between Supporting Minds and IAPT so that the most appropriate service can be identified. We are currently liaising with the CCG regarding the management of those patients who do not meet the criteria for either service. This is ongoing. Cases are logged so that we can demonstrate the wider impact of this to the service.

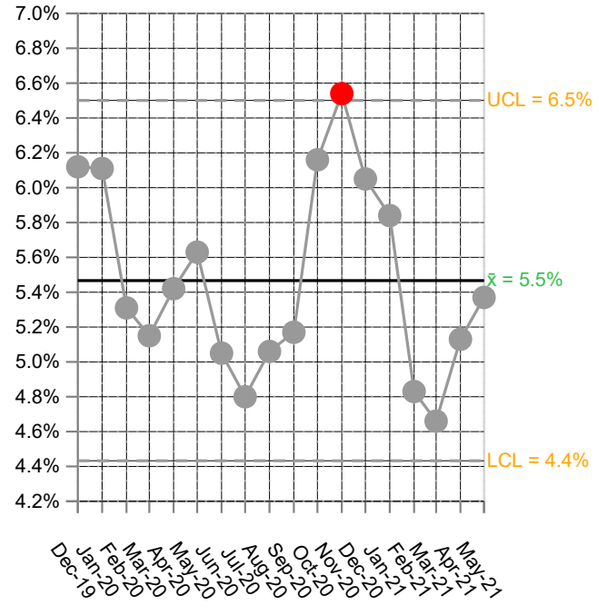
Risks	Mitigation
• Increased waiting times due to people needing or wanting to be seen face to face; Some patients choosing to wait for a face to face appointment where no clinical need for this identified, potentially increasing the risk of their mental health difficulties further deteriorating. Patients who have been seen face to face initially are being encouraged to transfer across to remote therapy once they have settled into therapy (if their needs can be met in this way) in order to free up capacity for others.	Patients are being actively encouraged to accept remote or online therapy wherever possible, unless face to face therapy is clinically indicated. |Limited face to face working is continuing in a risk assessed and provided in socially distanced way for those patients who have a clinical need for face to face therapy or where difficulties accessing therapy remotely cannot be overcome. |Staff are being flexible with their working hours in order to maximise room usage.

Sickness

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
5.37	4

Key Risks, Mitigation & Assurance

Limited assurance

Issues

Sickness continues to remain high and we have seen an increase in sickness across divisions apart from Tertiary where their figures have reduced slightly. Clinical Services have increased to 4.25%; Corporate has seen a small increase to 3.45%; Facilities has seen a minimal increase to 4.36%; Families and ICC has risen to 5.90%; IM&PF has increased to 6.99%; R&D has risen significantly from 0.97% to 3.67% in the month; SACCT has increased to 5.38% however Tertiary has seen a reduction from 4.73% to 4.11%. The overall sickness % for May was 5.37%. This is still high and a long way from the Trust target of 4% but is not unexpected given the fact we have seen an increase in staff off with stress related absences and a high number of long term sickness cases. The number of staff currently off due to covid is reducing slowly although we do still have a number of staff off with long covid. Anxiety and stress related absences remain the highest reason for both short and long term. Short term this is reported at 29.86% with Injury/fracture at 13.95% and gastrointestinal at 9.43%. Long term, anxiety and stress is reporting at 44.68%, then injury/fracture at 11.07% and back problems at 7.86%.

Actions

Actions remain the same as last month and Occupational Health are continuing their support for staff along with offerings from local mental health services, including Supporting Minds, the Resilience Hub which offers psychological support for the impact of Covid-19, Workplace Trauma Support Training for Line Managers and Wellbeing and Engagement Champions. Individual work is also ongoing with OD and Wellbeing works to look at psychological safety for staff in Critical Care.
As at the 14th June 2021 the Trust has vaccinated 33,976 individuals. 16,415 of these are Trust staff and the remainder include over 80's, care homes and social care. Work continues between HR/OH and the long covid clinic to support staff currently off and returning to work with long covid.

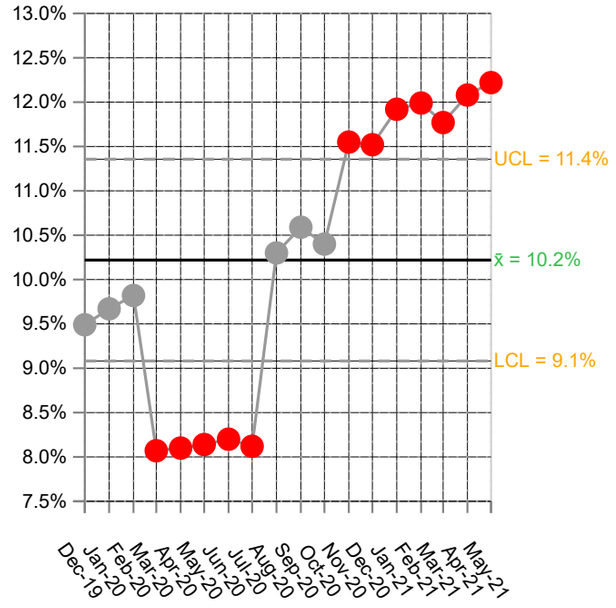
Risks	Mitigation
Stress and Anxiety continues to be our highest reason for absence for both short term and long absence. Risk of failure of all staff to take up vaccination. Staff unable to return to work following long covid.	Health and wellbeing offer to continue. Investment in psychological support to be made for the next 12 months. Risk assessment and discussions continue with staff unwilling to have the vaccination.

Turnover - Staffing

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
12.22	11.00

Issues

The Trust Turnover target is set at 11% however we are currently operating at 12.22% therefore above expectation by 1.22%.

Medical and Dental Turnover is set at 11% and is currently operating at 17.71% which is considerably higher than target, but this has reduced slightly from last month. It has been consistently over the 11% target over the last 10 months.

Medical and Dental recruitment has been impacted by overseas recruitment delays and the impact of coronavirus on travelling, issuing of visas etc.

Nursing and Midwifery Turnover is set at 11% and is currently operating at 8.71% which is 2.29% below target which is good and remains consistently below the 11% target over the last year.

There has been a considerable amount of recruitment taking place during the pandemic, with bring back staff, students and trainees taking up temporary posts since April 2020. This has a negative impact on turnover as once hired they are counted in the establishment.

Actions

The main recruitment pipeline continues to be via our overseas nurse recruitment programme up to and including Oct 21. There are currently 127 overseas nurses in the Trust working as adaptation nurses and preparing for their OSCE examinations. Of these, 53 have confirmed OSCE dates booked in May, 6 in June and 66 in July.
The recent change in restricted entry requirements to the UK with countries placed on the red list due to Covid has affected the numbers able to arrive in April and May. The Trust has worked with the regional and national team to negotiate suitable quarantine arrangements, and plans are in place for this to be on-site for up to 15 nurses at a time for the 10 day quarantine period supported by our international recruitment team starting with the first cohort in June.
There are 80 student nurses due to qualify in Sept 20, 30 of these are on the child health pathway as part of our regional education commitment. The Trust is currently working with the 50 student nurses on the adult nursing pathway to confirm job offers and ensure retainment of this cohort upon qualification. These will be mapped into the registered nurse workforce planning going forward and be aligned with the OSN recruitment programme. 34 of these students are on paid placements working as aspirant nurses mostly in their agreed substantive area to support the covid staffing challenge and to enhance their preparation for starting work in their preferred area once qualified.
These strategies aim to allow the Trust to clear current RN vacancies, cover implementation of agreed new uplifted templates and offset turnover for the year based on current turnover rates.

Key Risks, Mitigation & Assurance

Limited assurance

Risks

Care needs to be taken to ensure we commit to the completion and roll-out of the retention work and we continue to monitor and review to ensure it remains effective, currently we are making excellent progress and we need to explore new initiatives to continue the progress we have made.

Mitigation

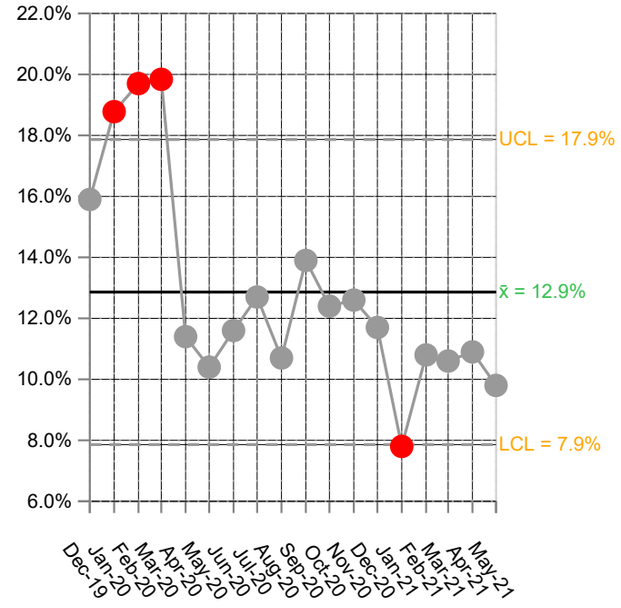
Other Recruitment and Retention work includes:||The HCA working group continues to meet to drive forward a focus on increasing retention of this staff group, and to mitigate the lead time between leavers and onboarding of new recruits through a redesign of the process for regular recruitment through temporary staffing. Smaller task and finish groups are meeting to work up the new processes.||The Working for Longer working group has met to review and plan retention strategies around our later career staffing group and will meet monthly to identify gaps in support for the older workforce. Flexible working has been identified as an initial priority to feed into this workstream.||

Temporary Staffing

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
9.80	0.00

Issues

Proportion of temporary staffing has decreased slightly this month. Although the temporary staffing establishment is increasing due to recruitment drives the recruitment activity has also meaning more substantive roles filled. This correlates with agency spend.

Actions

The non medical deployment team are continuing to promote bank working via various models to ensure agency spend is constantly decreasing across divisions. The Medical Deployment team are due to bring the medical bank in house from July 2021 where they can monitor temporary staffing in house rather than via a managed service. This will allow for more transparent and instant reporting. Agency to bank recruitment continues. The non medical bank have taken on 100 new HCAs this along with 40 administration staff over the next month.

Key Risks, Mitigation & Assurance

Full assurance

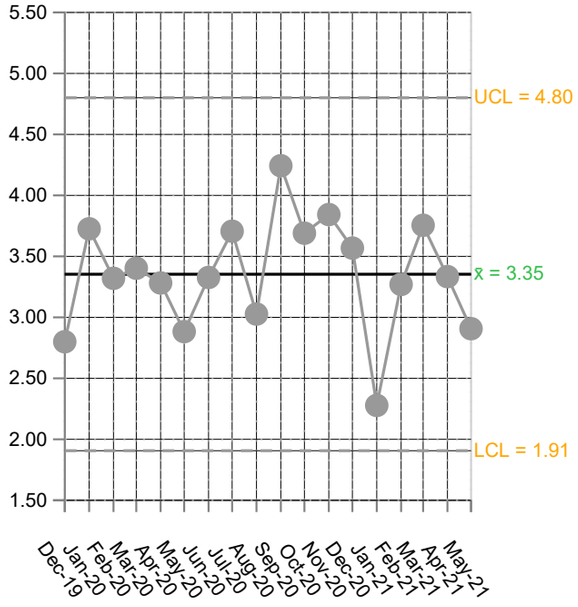
Risks	Mitigation
Lack of engagement for agency to bank conversion for Medical and Non Medical	re visitation of bank rates across the ICS including Nursing harmonisation meetings that are running every 2 weeks

Agency Spend

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
2.91	-1

Issues

This month showed a reduction in agency spend from 3.33mil to 2.90mil. This is reflective of a few factors including bank expansion (medical and non medical), competitive neutral vend provider and overseas/recruitment uptake. The Non Medical team have also eliminated the use of off framework agencies which is due to continue.

Actions

Agency spend should continue to drop over the next few months. The non Medical team have agreed a rate card reduction that will come in to play over the next few months and also a rate drop for preferred workers for priority booking. The Medical team are awarding Retinue a neutral vend contract for their medical supply which will mirror the process currently used for non medical. This will allow competitive rates across more agencies and the potential for a rate card reduction programme. Recruitment continues to pick up which will show with agency spend over the next few coming months.

Key Risks, Mitigation & Assurance

Limited assurance

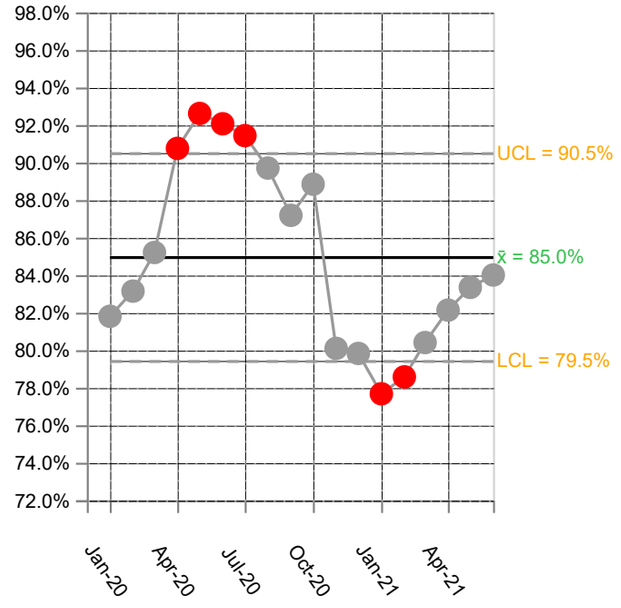
Risks	Mitigation
Neutral vend programmes add extra work to the deployment teams as no more managed service	business cases to be reviewed looking at manages service cost savings
Added pressure on the Recruitment team with current recruitment drives and new starters	Recruitment meetings to start up again for divisional support.

A&E + UCC Performance

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
84.06	95

Issues

ED performance for May was 59.47 % Total Economy Performance was 86.34 % which is a 2.28% improvement on last month. The division have developed an action plan to support a sustained improvement in ED performance, this is reviewed on a daily basis with the ED team.

Attendances are now increasing back to pre-covid levels with regular daily attendance figures of 250 and above. There were 6837 attendances for May compared to 4771 for May 2020.

The attendance profile is seeing an increase in "walk-in" patients and surges in those attendances mean that the department can struggle with social distancing. Triage times and Time to see a clinician is also then delayed.

The department reported at total of 31 DTA breaches compared to 36 from the previous month. The 31 breaches consisted of 15 Mental Health, 15 Medical and 1 Surgical. Patients attending the department with a Mental Health presentation increased by 15% with 7.34% of those patients being referred to LSCFT.

The trust is one of the top 3 for highest ambulance conveyances in the region, 42% of ED attendances were brought to hospital by ambulance. Ambulance delays over 60 minutes were 89 for May compared to 109 for the previous month. Whilst ED is improving to reduce ambulance handover delays they still remain a cause for concern.

Actions

The team have developed an action plan to improve ED performance and reduce both admitted and non admitted breaches - the ED team is currently meeting the trajectories set and this is reviewed on a bi-weekly basis.
NHS 111 First continues to encourage the public to use this service if they think they may need to go to ED. Although the numbers of patients that use this service remain low, the process sees patients spending less time in ED.
The department has commenced an initial change to both nurse and medical staffing to support the triage area when those peaks in attendances occur. An escalation process is being completed for the triage and Interventional triage areas.
The patients waiting for a bed within the trust are monitored by the patient flow team and actions are put in place to maintain patient safety and reduce any delays. The medical team in reach to ED every day to ensure medical patients have a robust plan in place whilst waiting an admission and may be discharged wherever possible.
The DTA escalation policy is in place to support early escalation through the division.
The Mental Health Urgent Assessment Unit is now open, the early data is not available yet but the initial view is that the impact will be minimal due to the strict exclusion criteria.
The NWAS Delay to Transfer Standard Operational Policy has been in place since the 19th April 2021 to support early escalation of any NWAS delays.
The Rapid Handover process was commenced on 4th May 2021 and early data is showing a significant improvement in the 30-60 min and over 60 minute delays.

Key Risks, Mitigation & Assurance

Risks	Mitigation
Both nursing and medical sickness rates have increased due to Isolation guidelines and work related stress.	Support from Workforce and Organisational Development has been given to the department to support staff.
Due to congestion in department and / or surges in ambulances there may be ambulance handover delays	This is monitored at all bed meetings with actions to de-escalate as soon as possible. SOP is being trialled to support safety with NWAS.
The easing of lockdown may mean a surge in attendances which overwhelm the ED/trust	NHS 111 advice given to all attending patients. Public communications to increase. Social distancing and COVID-19 pathways continue in place. Escalation and Surge policy is updated and regularly reviewed.

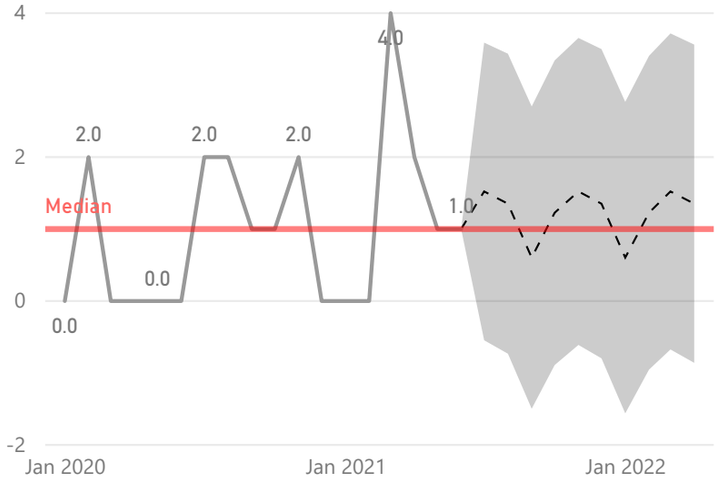
Limited assurance

Over 7 Day Incapacitation of a Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Issues

Staff incident - Injured whilst handling patient: staff member hurt their back and leg assisting a bariatric patient to go to the toilet. The patient requires regular assistance and normally two people are required to assist the patient. The staff member didn't request assistance as everyone else was busy supporting other patients/completing drug rounds.

Actions

Awaiting completion of the manager's form from Ward 5 (respiratory)

Actual	Target
1.00	0.00

Key Risks, Mitigation & Assurance

Limited assurance

Risks

There is a generic risk within the division as follows, the potential risk of injury when completing moving and handling of patients. This has the potential to cause injuries to both staff and patients due to the lack of suitable equipment or number of people. The risk score is moderate (L3 X S2) 6.

Mitigation

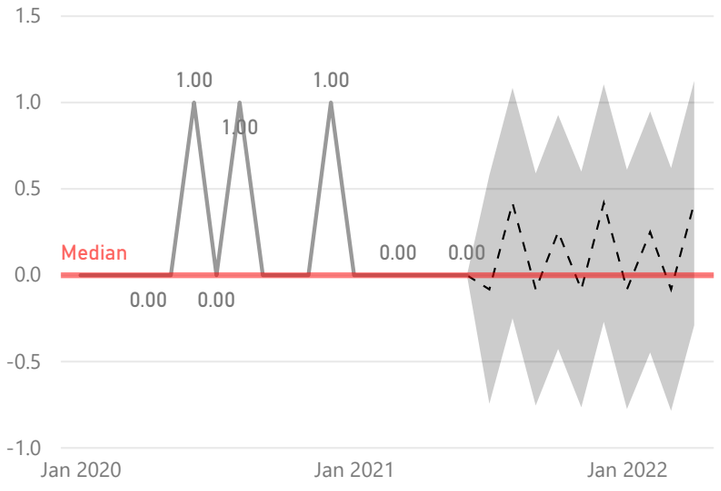
There are a number of controls in place to reduce the risk these are for staff to attend training, staff to inform managers of lack of equipment, to risk assess any injuries, policies and procedures in place. The risk is due to be reviewed annually and the next review is August 2021.

Specified Injury to Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Issues	Actions
There are 0 (nil) incidents reported to the HSE under RIDDOR - Specified injury to worker	N/A

Actual	Target
0.00	0.00

Risks	Mitigation
N/A	N/A

Key Risks, Mitigation & Assurance

Limited assurance

Definitions

Blackpool Teaching Hospitals NHS Foundation Trust

This links you back to the Main iPR page - Level 1

This links you back to the Safe page - Level 2

This links you back to the Effective page - Level 2

This links you back to the Caring page - Level 2

This links you back to the Responsive page - Level 2

This links you back to the Efficient page - Level 2

This links you back to the Strategic page - Level 2

This links you back to the Well Led page - Level 2

This denotes that a metric is not compatible to be analysed using a statistical process control

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Directors – Recovery & Restoration

Blackpool Teaching Hospitals
NHS Foundation Trust

Restoration – activity and financial value

May-21

Point of Delivery	May Plan - Core	May 21 actual	Diff	% Diff	May 19 Out-turn	Plan compared to May 19 out-turn	May 21 outurn compared to May 19	May 21 out-turn compared to May 2019	NHSEI Financial Baseline (£)	Financial Threshold (75% of Baseline)	Draft May 21 Actual (£)	Variance (£)
Elective IP	362	481	119	33.0%	530	(168)	(49)	90.8%			2,238,873	
Day Case	3,557	4,116	559	15.7%	4,738	(1,181)	(622)	86.9%			2,442,422	
Outpatient Procedures	3,654	4,640	986	27.0%	4,543	(889)	97	102.1%			525,658	
Total Elective Procedures	**7,573**	**9,237**	**1,664**	**22.0%**	**9,811**	**(2,238)**	**(574)**	**94.1%**	**4,582,140**	**3,436,605**	**5,206,953**	**1,770,348**
New Outpatient	6,161	6,526	365	5.9%	7,093	(932)	(567)	92.0%			1,117,684	
Follow Up Outpatient	16,042	18,810	2,768	17.3%	18,331	(2,289)	479	102.6%			1,547,351	
Total Outpatient Activity	**22,203**	**25,336**	**3,133**	**14.1%**	**25,424**	**(3,221)**	**(88)**	**99.7%**	**2,366,938**	**1,775,204**	**2,665,035**	**889,831**
Diagnostics	12,103	12,007	(96)	(0.8%)	10,330	1,773	1,677	116.2%				
Total	**41,879**	**46,580**	**4,701**	**11.2%**	**45,565**	**(3,686)**	**1,015**	**102.2%**	**6,949,078**	**5,211,809**	**7,871,988**	**2,660,179**

Blackpool Teaching Hospitals
NHS Foundation Trust

Key Points to Note

- 94.1% restoration of elective work compared to 92.6% in April. Most improvement on elective IP at 90.8% compared to 81.3% in April
- Slight reduction in OP at 99.7% restoration compared to 101.2% last month
- Slight reduction in diagnostics at 116.2% compared to 120.2% last month
- Financial variance improved from £2,049K to £2,660K and should be noted the threshold value has increased by 5% to 75%.
- Overall financial value of £7,872K compared to £7,253K in April
- Cancer restoration targets re-set to 115% of previous activity

Blackpool Teaching Hospitals
NHS Foundation Trust

Key Activities

- Bid for funding for schemes / enablers for acceleration submitted (where tariff doesn't apply)
- Recruitment of locum gastroenterologists
- Endoscopy capital works completion in early July, review of green/amber pathways
- Expansion of endoscopy in-sourcing
- Day case insourcing on track for late June/early July
- Scoping exercise for cold elective Orthopaedic surgery at Clifton

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors

1 July 2021

Vaccination Update

Author of Report:	Jamie Harrop, Vaccination Programme Support	
Executive Director Sponsor:	Janet Barnsley, Executive Director of Integrated Care and Performance	
Date of Report:	25 June 2021	
Executive Summary (to include, where appropriate, the level of assurance and position on trajectory) This paper provides an updated in terms of the hospital Covid vaccination programme and asymptomatic testing for Staff.		
For Information/Assurance: x	**For Discussion:**	**For Approval:**
Recommendations: The Board is asked to note the position on vaccination for both first and second dose and are asked to promote and support the asymptomatic testing programme.		
Sensitively Level:		
Not Sensitive: **(for immediate publication)** x	**Sensitive in Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider application exemption)**

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

COVID Update – Vaccination and Asymptomatic Testing

All data has been captured as at Thursday 23 June 2021

1. Vaccination Totals:

Data Set	First Doses	Second Dose	Overall
Over 80s	1523	1570	3094
Trust Staff	7438	6886	14226
Other NHS staff	1232	950	1282
Social Care Workers	4507	4132	8641
Care Home Workers	937	1202	2135
Others	2917	1710	4630
Total	**18554**	**16450**	**34008**

a. Staff Group Totals – All Staff (Including Bank/Agency):

Staff group – all staff	Headcount	Vaccinated First Dose	Percentage First Dose	Vaccinated Second Dose
Prof, Scientific and Technical	262	213	81%	183
Clinical Services	2606	1931	74%	1629
Admin and Clerical	1962	1560	80%	1381
AHP	593	467	77%	408
Estates and Ancillary	423	393	93%	344
Healthcare Scientists	223	205	92%	182
Medical and Dental	1433	1008	70%	755
Nursing and Midwifery	2536	2192	86%	1807
TOTAL	10039	7969	79%	6689

Staff group – substantive	Headcount	Vaccinated first dose	Percentage first dose	Vaccinated second dose
Prof, Scientific and Technical	246	197	80%	172
Clinical Services	1980	1606	81%	1386
Admin and Clerical	1716	1398	81%	1264
AHP	486	396	81%	368
Estates and Ancillary	422	365	87%	329
Healthcare Scientists	217	189	87%	170
Medical and Dental	528	528	100%	456
Nursing and Midwifery	2284	1921	84%	1706
TOTAL	7879	6600	84%	5851

Staff group – BAME	Headcount	Vaccinated first dose	Percentage first dose	Vaccinated second dose
Prof, Scientific and Technical	23	19	83%	12
Clinical Services	327	267	82%	205
Admin and Clerical	54	45	83%	36
AHP	33	30	91%	21
Estates and Ancillary	24	22	92%	20
Healthcare Scientists	23	21	92%	17
Medical and Dental	267	214	80%	168
Nursing and Midwifery	272	221	81%	191
TOTAL	1023	839	82%	667

2. Staff Asymptomatic Testing (LAMP)

Data Set	Current Position
On-boarded staff	4801
Total samples submitted since launch	36147
Compliance (Test in last 7 days)	1806 (45.62%)
Current Positive Samples	12
Positives in last 7 days	2

* Data accessed from the Nexus / Hi-Pres portals.

Janet Barnsley
Executive Director of Integrated Care and Performance

Thursday 23 June 2021

Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting

1 July 2021

Freedom to Speak Up Report

Author of Report:	Jane Butcher – Interim Head Freedom to Speak up Joint Guardian Office jane.butcher@nhs.net / 07909 116153
Executive Director Sponsor:	Kevin Moynes, Director of Human Resources & Organisational Development Kevin.Moynes@nhs.net / 01253 956782
Date of Report:	1st July 2021

Executive Summary

This report provides a summary of the Freedom to Speak Up activities from April 20 – March 21 and future plans for the service at Blackpool Teaching Hospitals.

Following the departure of the previous Freedom to Speak up Guardian, and instructions taken from the National Guardian office, the data held in relation to details of staff speaking out and raising concerns has been limited due to information governance and access constraints specifically in relation to the lack of explicit consent to access previous data held by the Staff Guardian Service. Therefore, elements of the data contained within this report for Q1, Q2 and part of Q3 have been taken from figures reported on the National Guardian database and past Board papers.

1 [X]	2 [X]	3 [ ]
For information	**For Discussion**	**For Approval**

Recommendations:

The Board of Directors are asked to:

- Continue to support the development of the Trust's Freedom to Speak Up strategy
- Agree that any lessons learnt from concerns raised across the Trust and community sites being embedded in the organisation

Sensitivity Level:

1 [X]	2 [ ]	3 [ ]
Not sensitive: (for immediate publication)	**Sensitive in part: (consider redaction prior to release)**	**Wholly sensitive: (consider applicable exemption)**

1. Background

The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged to do so and can do it safely in a protected environment. Sir Francis recommended that Trusts should appoint "someone to whom staff can go to, who is recognised as independent and impartial, has authority to speak to anyone within or outside the Trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role". This is now a requirement within the NHS standard contract.

2. Introduction

This report has been prepared to advise the Board of Directors of progress made and work undertaken between April 20 – March 21, the number of staff who have raised concerns, emerging themes, actions taken and the latest news from the National Guardian Office. This report also covers the latest figures published by the National Office under the FTSU Index.

3. Progress to Date

- Work to introduce and embed the Joint Office for Freedom to Speak across both BTH and ELHT has now commenced and we are currently in the consultation process of appointing the current Interim Head of Joint Freedom to Speak Office – Jane Butcher into the role on a permanent basis and we have also recruited a Deputy Staff Guardian – Lauren Staveley who will join the office in July 2021 based at Blackpool Victoria Hospital to work within the Office alongside the existing Deputy based at East Lancashire Teaching Hospitals. This will now ensure wider access to the service for all staff across both organisations, sharing good practice
- Presentation / promotion of the FTSU service shared with SAS Doctors as part of the Equality and Diversity Summit held in March 2021
- Presentation of the service given to the Clinical leaders forum late 2020
- Contact made with each FTSU Champion to re-introduce and re-establish the role and working to recruit a more champions from with the workforce from our BAME, LGBTQ + and Disability communities / networks.
- The launch of the "if you see something say something" campaign raising awareness through the organisation of the role and the new Guardian arrangements in place with plans to continue to embed.
- Design of a new leaflet to be shared with all staff now completed
- Successful implementation of the National Office approved national training for all staff and leaders (level 1 & 2) within the Trust via the ESR system available for all staff to access. Promotional material shared with staff.
- Discussion in place to embed the recommendation to all staff to undertake training to be included as part of the PDR /Appraisal Process for all clinical and non-clinical staff.
- Update to the Induction given to include reference to the FTSU training
- Working closely with the Retention Nurse to ensure that the service is understood and where it will be helpful to assist in the retaining of staff
- Communication plan in the process of being created for early July along with the Communication Team
- Attendance at JNCC by the Head of the Joint Office
- Further planned face to face visits to areas within the hospital and across community services (previously made difficult to COVID) to promote the service
- Planning taking place for the Freedom to Speak up months activities in October 2021
- Monthly meetings between the Freedom to Speak Up Guardian and HR colleagues
- Staff Guardian cultural review taking place within Gastroenterology sponsor by Mrs N Hudson, Director of Operations
- Working alongside Trust leaders in relation to the National Guardian Review and the recommendations

.

4. Blackpool Teaching Hospitals Raising Concerns Data

Concerns Raised

We have continued to support staff that raise concerns via the FTSU Guardian Joint Office and the FTSU Champions. This section of the report highlights the numbers of concerns raised between April 2020 – March 2021 (Q1, Q2, Q3 & Q4). It also provides a summary of the themes of concerns raised by the staff.

It is the responsibility of the FTSU Guardian to record and monitor all concerns raised and report them to the Trust's Board of Directors and the National Guardian's Office.

For the period of April 20 – March 21 a total number of 90 concerns have been raised. In the previous year the Trust reported a total number of concerns at 176 (data taken for the National Guardian Office portal), meaning a decrease in concerns of 51%.

The table below provides a summary of information provided by Blackpool Teaching Hospitals to the National Guardian's Office per quarter.

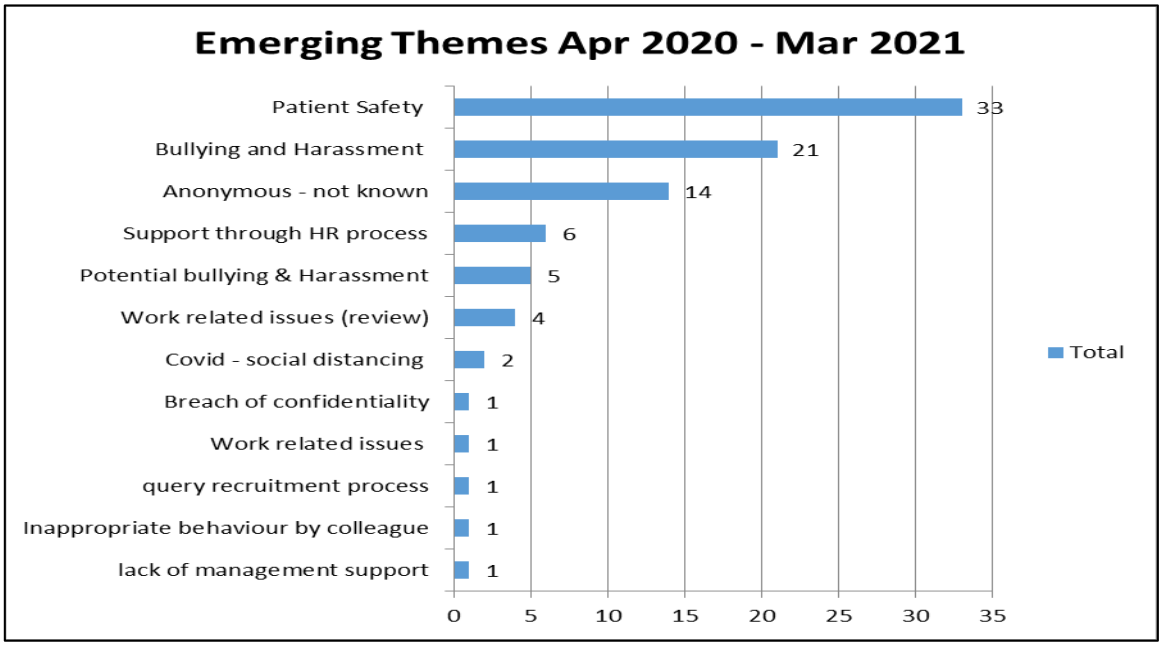
Table 1: Freedom to Speak Up Concerns raised April 2020 to March 2021

2020/2021	Q1	Q2	Q3	Q4
Total number of concerns raised	54	15	11	10
Number of those raised anonymously	54	14	0	0
Cases with elements of patient safety/quality	33	0	0	0
Cases related to behaviours including bullying & harassment (2) and poor attitudes & behaviour (19)	21	0	4	2
Cases where people indicate that they are suffering detriment as a result of speaking up	0	0	0	0
Received feedback from reporter	0	0	0	0
Asked from feedback 'Given your experience, would you speak up again?'* Yes = 31, Maybe = 1 No = 1	No data	No data	No data	No data

Emerging themes and actions taken to address

Of the 90 concerns that have been raised table 2 demonstrates which themes these concerns have been raised under, the highest amount at 33 have been related to Patient Safety, the second highest at 21 is (alleged) Bully and Harassment. Unfortunately, due the issues with accessibility to the data we have 14 concerns that have been raised that we have no knowledge what they were in relation to.

Table 2: Emerging Concerns



When a patient safety concern is raised the senior nursing teams or senior clinicians are directly involved as necessary. The staff are fully supported by the Guardian and will be offered an opportunity to discuss with the seniors directly their concerns or to allow for the Guardian to speak on their behalf if they wish to remain anonymous.

Staff are encouraged and have recently been reminded, that they are encouraged to raise concerns to management if feel able to do so. In some areas we will be looking at introducing an identifiable person on each shift who staff can raise concerns directly with during that shift. I this proves effective then we will look to role this across all patient areas.

FTSU Guardian Office works closely with the Senior HR Team, Occupational Health and Wellbeing team and is working towards building stronger working relationships with our Union colleagues to address some of the concerns raised under in relation to staff feeling either bullied or harassed.

This will allow us to ensure that there is a more collective approach to ensuring that staff are supported and that there are systems and policy in place to assist staff.

The Mediation service is also assisting with some of the issue that we are alerted to in relation to alleged concerns of Bullying and Harassment and can be there to address / resolve these concerns informally.

The fourth in the table with a number of 6 concerns is staff requiring support through a HR process and again we will gather further information to get a clearer understanding of how we can work alongside senior managers within HR to offer further support and to promote our services to staff who are wishing to be supported.

Since being in post the interim Head of Freedom to Speak up Joint Office has experienced excellent support and responses from senior leaders and Directors when raising concerns.

5. FTSU Index

Blackpool Teaching Hospitals Staff Survey

The annual NHS staff survey contains several questions that are helpful indicators of speaking up culture. The FTSU index is calculated as the mean average of responses to the following four

questions from the NHS Staff Survey that are themed around how staff feel they are treated when raising concerns and what the support offered (17a, 17b, 18a, & 18b)

The table below shows the increase in the FTSU index score over the past 3 year for BTH which demonstrates the improvements in speaking up culture at the organisation year on year.

Blackpool	2018	2019	2020
FTSU Index	79%	79.2%	79.7%

The table below shows the rank of BTH in comparison with some of our neighbouring Trusts and demonstrates a strong 2nd position. To note: The National average score is 79.2% and the average North West score is 79.9%.

Trust	Score	Ranking	Score	Ranking	Score	Ranking
	2018		2019		2020	
East Lancashire Hospital Trust	81%	1	81.9%	1	80.8%	1
Blackpool Teaching Hospitals	**79%**	**2**	**78.7%**	**2**	**79.7%**	**2**
Lancashire Teaching Hospitals	78%	3	78.7%	2	79.2%	3
Lancashire & South Cumbria FT	n/a	-	75.9%	3	78.9%	4
Morecambe Bay FT	79%	2	75.8%	4	76.7%	5
NW Ambulance Service NHS Trust	74%	4	73.8%	5	74.2%	6

Data source: Summary of Staff Survey responses from 2018 - 2020

6. National Guardian Office

Recently, BTH has undergone a review carried out by the National Guardian Office. A factually accuracy document has now been submitted by the Trust following the next step in the process and BTH await further guidance from the National Office regarding publication. Along with the review will be a set of recommendations which the Head of FTSU joint office will be working towards collectively with the Trust to ensure that the recommendations are implemented

The National Guardian Office have been an announcement that Dr Henriette Hughes OBE will be stepping down as the National Guardian after 5 years in post.

The Fourth National Guardians survey has been published and one of the headlines is that speaking up in the NHS is improving according to the result of the survey which has seen an increased from 80% to 86% of all guardians agreeing. The report is published in full on the National Guardian's website

The first module of the Freedom to speak up training - Speak Up – is now available for all workers, no matter what their contract terms, and was launched in October and has already been completed by 800 learners. The second model –Listen – has more recently been launched and is aimed at Managers at all levels a final module, Follow Up, for senior leaders – including executive and Non-Executive Directors, lay members and governors – will be launched later this year.

7. Prioritises over next 6 months

- To promote the "if you see something say something campaign" further throughout the organisation and embed the Joint Office approach across both organisations
- Work with the Trust to identify potential groups of staff that face barriers to speaking up, and work towards addressing those barriers – Networks
- Work with the organisation to re-visit the Freedom to Speak Strategy

- Work alongside the organisation to review the current Freedom to speak up policy
- Promote the training package for freedom to speak up to all staff and leaders
- Revisit the role of FTSU Champions

8. Conclusion

Although the service has seen a decrease in the amount of concerns being raised in the last two quarters, the office is currently experiencing an increase in cases and is confident that the embedding of the joint approach will encourage more staff to speak out freely and will have a positive impact on the further embedding of culture of openness, honesty and transparency.

9. Recommendations

The Board is asked to:

- Continue to support the development of the Trust's Freedom to Speak Up strategy
- Agree that any lessons learnt from concerns raised across the Trust and community sites being embedded in the organisation

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting – Part 1

1 July 2021

Health Education England North West (HEENW) Report and Action Plan

Report Prepared By:	Dr Jim Gardner, Executive Medical Director		
Contact Details:	Jim.gardner@nhs.uk		
Date of Report:	01 July 2021		
Purpose of Report: **To brief the Board on the 2021 Health Eduction England North West 'Qualiy review outcome report' and the Trust's subsequent Action Plan.**			
	For information	X **For Discussion**	**For Approval**
Risks Associated with Report on BAF or CRR: **The Report links to the BAF.**			
	x **BAF**	**CRR**	**Not Linked to Corporate Risk**
Assurance Level:			
	Full	x **Partial**	**No Assurance**
Recommendations: **The Board is asked to note the final 'Quality review outcome report' from Health Education England North West (HEENW), following their virtual visits to the Trust in early 2021.** **The Board is asked to note the Action Plans prepared in response to the report and submitted to HEENW.**			
Sensitivity Level:			
1 X **Not sensitive:** **For immediate publication**	**2** **Sensitive in part:** **Consider redaction prior to release**	**3** **Wholly sensitive:** **Consider applicable exemption**	

Introduction

This paper and attached action plans inform the Board of the 2021 assessment visits by HEENW (undertaken virtually through a series of interviews with doctors in training and Trust staff) and the Trust's response to on-going issues raised.

Background

HEENW undertake annual reviews of all NHS Trusts who host doctors in training. Following visits in 2019, HEENW identified a high number of concerns relating both to patient safety and to the experience of doctors in training. These concerns, particularly relating to emergency medicine and the acute medical pathway, led to a HEENW risk rating for the Trust of Level 3 (Serious Concerns). The Trust remains in enhanced monitoring from the General Medical Council as a consequence.

The Trust prepared detailed action plans in response to the HEENW Quality review outcome report in 2019 and has implemented many positive changes.

Due to COVID 19, the 2020 annual visit programme was delayed, but in early 2021 we were able to arrange interviews for 45 doctors in training with the HEENW review team. The virtual visits took place on 14th and 20th January 2021.

The 2021 report acknowledges improvements made and moves the Trust from Level 3 (Serious concerns) to Level 2 (Significant concerns). There is still more work to be done, and this is captured in the action plans attached at Appendices 1 and 2 of this paper.

Report Findings

In the Report, HEENW note a series of improvements:

- The increased staffing the Trust has put in place since the last visit has clearly improved the experience for trainees as the panel did not hear any incidences of them feeling overwhelmed due to workload as in 2019.
- • The middle grades in the acute medical take are working effectively. They suggested several innovative ways of making the service safer and more effective. HEENW recommend that this group is actively engaged with.
- • The trainees were appropriately progressing with their competency developments in both specialties of medicine and emergency medicine.
- • There is positive education team support, including the Medical Director.
- • The Clinical Educator role in the emergency department is viewed as positive by trainees.
- • There is excellent switchboard support.
- • There are supportive education and clinical supervisors in the specialties and in emergency medicine.
- • There is a positive incident reporting culture in emergency medicine.

But the Report notes that:

There is still an issue with the interface between the AMU and emergency medicine with limited leadership and ownership which is impacting on the learning environment. Problems with senior support, handover, induction and workplace-based assessments are still evident from HEENW's previous visit.

There was one patient safety concern identified which was fed back to the Medical Director and Director of Medical Education on the day of the intervention. A patient safety action plan was sent to the Trust with a return date of 9 February 2021. The completed action plan was comprehensive (Appendix 2), and HEENW were impressed with the speed of which corrective action was taken.

There are 5 requirements following the visit, 4 of which are rated at Level 1 and one at Level 3.

The level 3 concern is a pre-existing issue regarding senior support on AMU which will continue to be monitored as the issues are persistent. Level 1 concerns will be monitored by the HEENW patch Associate Dean at their regular meetings with the Trust.

The level 3 concern will continue to appear on HEE's Executive Risk Register and be reported to the NHSE/I Quality Surveillance Group and monitored via the GMC Quality Reporting System. In addition, regular monitoring will be undertaken by the patch Associate Dean.

Requirement 1. Level 3.

The Trust must ensure that consultant support is more easily accessible to specialty and foundation trainees in medicine placements in the Acute Medical Unit (AMU).
The Trust must ensure that all specialty and foundation trainees in medicine receive feedback, especially on work undertaken in AMU.
The Trust must ensure robust systems are in place for the observation, care and onward journey of all patients, especially medical ones, located in the Emergency Department.
The Trust must ensure that trainees' responsibilities are clear.
The Trust must review and address medicine trainees' concerns in relation to handover.

Requirement 2. Level 1.

The Trust must ensure that trainees have opportunities to post-take with a consultant to ensure they receive the experience required to meet their curriculum needs.

Requirement 3. Level 1.

. The Trust must ensure there are processes in place allowing trainees to access study and annual leave more easily and that issues with the medicine rota coordinator are addressed to facilitate this.

Requirement 4. Level 1.

The Trust must look into the comments made by trainees regarding the pressure experienced from some nursing staff regarding achieving the 4-hour wait target.

Requirement 5. Level 1.

The Trust should consider their support provided to those trainees that are new to the NHS and the UK to see if this can be improved.

Actions Underway

The HEENW Requirements are acknowledged by the Trust and actions to address them are ongoing. There is regular dialogue between the Medical Education Team, led by Dr Kate Goldberg, Director of Clinical and Medical Education, and the patch Associate Dean for HEENW, Dr Aruna Hodgson.

The full HEENW Report has been reported through the System Improvement Board and has, therefore, been seen and discussed with the Care Quality Commission, NHS England (NHSE)/NHS Improvement (NHSI) and the combined Fylde Coast Clinical Commissioning Groups (CCGs).

Over and above the action plans presented in the appendices, the Trust is paying a lot of attention to the acute medical pathways through the governance of the Emergency Village

Programme and through enhanced operational support of the Emergency Department and AMU, with weekly meetings chaired by the Chief Operating Officer and attended by the Medical Director and Director of Nursing and Allied Health Professionals, in addition to senior clinical and operational leads from the Division.

The Board is asked to receive the Report for assurance and note the Action Plans.

Because of the ongoing Level 3 concern and the four Level 1 concerns, the Board is recommended a level of **partial assurance**.

Health Education England

APPENDIX 1
ACTION PLAN – POSTGRADUATE EDUCATION REVIEW

Trust:	Blackpool Teaching Hospitals NHS Foundation Trust
Programmes/Specialties:	Foundation Emergency Medicine, IMT trainees, GP trainees, Higher trainees Acute Care Pathway
Date of Visit:	14th and 20th January 2021
Date Action Plan sent to Trust:	1 March 2021
Deadline date for completion:	4 June 2021
Action Plan Updated:	22 June 2021 – Kate Stannard. AMD Clinical and Medical Education
Response compiled by:	Dr Kate Goldberg, Director of Clinical and Medical Education Dr Steve Davies, Associate Director of Medical Education Laura Orwin, Medical Education and Quality Manager Emily Croucher, Postgraduate Manager

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

(*) Green = Fully Achieved, Amber = Partially Achieved, Red = Not Achieved

CONCERN 1: LEARNING ENVIRONMENT AND CULTURE

There is still an issue with the interface between the AMU and emergency medicine with limited leadership and ownership which is impacting on the learning environment. Problems with senior support, handover, induction and workplace-based assessments are still evident from HEE NW's previous visit in 2019.

HEE NW has been monitoring the teaching culture, lack of senior support, handover, and opportunities to post take on the AMU since 2018. This has been monitored by HEE NW via an ISF level 3 concern.

As these issues persist this will continue to be a level 3 requirement. HEE NW are aware of the progress being made in this area and the patient safety action plan submitted following the virtual visit details plans to improve leadership on the AMU.

REQUIREMENT 1:

THE TRUST MUST ENSURE THAT CONSULTANT SUPPORT IS MORE EASILY ACCESSIBLE TO SPECIALTY AND FOUNDATION TRAINEES IN MEDICINE PLACEMENTS IN AMU.

*THE TRUST MUST ENSURE THAT ALL SPECIALTY AND FOUNDATION TRAINEES IN MEDICINE RECEIVE **FEEDBACK**, ESPECIALLY ON WORK UNDERTAKEN IN AMU.*

*THE TRUST MUST ENSURE ROBUST SYSTEMS ARE IN PLACE FOR THE **OBSERVATION, CARE AND ONWARD JOURNEY OF ALL PATIENTS,** ESPECIALLY MEDICAL ONES, LOCATED IN THE EMERGENCY DEPARTMENT.*

*IT MUST ENSURE THAT **TRAINEES' RESPONSIBILITIES** ARE CLEAR.*

*THE TRUST MUST REVIEW AND ADDRESS MEDICINE TRAINEES' CONCERNS IN RELATION TO **HANDOVER**.*

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
CONSULTANT SUPPORT				
Lack of senior support links in with our patient safety actions - SOPS/Educator role.	**See Patient Safety Action Plan**			
OBSERVATION, CARE AND ONWARD JOURNEY OF ALL PATIENTS				
Interim Divisional Director and Higher Medicine TSTL will be completing spot checks on several handovers in AMU to check they are working appropriately. Some of these have taken place already and the Medical Director has been present at an evening handover. IMT trainee leading on handover which will incorporate RCP toolkit as QI project. Higher Medicine TSTL and Interim Divisional Director have been in contact with trainee to pursue further.	Improvements recognised following changes to handover Continue to monitor through internal QA programme	Integrated Medicine and Patient Flow/ Medical Education	July 2021	Amber
TRAINEE RESPONSIBILITIES				

Associate DME has met with Dr Vipin Sharma (AMU Induction Lead) to discuss Induction. Dr Sharma has redesigned the AMU on call Induction and is planning for it to be available online including a virtual tour. The AMU Team will link in with the Rota Coordinators to ensure they are timetabled to attend Induction. A communication will be sent from Med Ed to all Supervisors in Medical Specialties asking them to ensure that trainees have accessed the AMU on call Induction.	Improved AMU on call Induction delivered to August trainees Continue to monitor through local induction forms and internal QA programme	Integrated Medicine and Patient Flow/ Medical Education	July 2021	Amber
HANDOVER				
See above - OBSERVATION, CARE AND ONWARD JOURNEY OF ALL PATIENTS				
FEEDBACK				
Med Ed will continue to highlight the importance of feedback and how this is communicated to our trainees with our Supervisors. This was discussed at our Medical Education Committee in June and TSTLS agreed to cascade to Supervisors. Higher Medicine TSTL and Internal Medicine TSTL will ensure widespread communication to Supervisors.	Include on the agenda with our Supervisors	Integrated Medicine and Patient Flow/ Medical Education	June 2021	Green
As part of our Educator Development programme, we have a session planned for 04/11/21 which will be geared to medical trainees and will cover topics such as changes with their curriculum and how to give effective feedback. This session will be attended by the Training Programme Director and Head of School. We will record the session so that this resource is available for anyone unable to attend.	Educator Development session delivered and available for Supervisor Monitor through local QA programme	Integrated Medicine and Patient Flow/ Medical Education	November 2021 January 2022	Amber

CONCERN 2: DELIVERING AND IMPLEMENTING CURRICULA AND ASSESSMENTS

Higher medical trainees commented that there is no system on the AMU for them to be able to post take with a consultant.

REQUIREMENT 2: THE TRUST MUST ENSURE THAT TRAINEES HAVE OPPORTUNITIES TO POST TAKE WITH A CONSULTANT TO ENSURE THEY RECEIVE THE EXPERIENCE REQUIRED TO MEET THEIR CURRICULUM NEEDS.

LEVEL 1

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
We have been given a target that 50% of an individual trainees ACAT's are to be completed with AMU related work. This has been communicated both with Consultants, Supervisors and Trainees.	50% of trainees ACATs completed with AMU related work – evidenced via portfolio and monitored through internal QA programme	Integrated Medicine and Patient Flow/ Higher Medicine & IMT TSTL's/ Medical Education	January 2022	Amber
Higher Medicine TSTL and IMT TSTL to complete 2 podcasts on completing ACATS - 1 aimed at trainees and 1 aimed at supervisors. Trainees will be involved in the content of the podcast.	Increased trainee awareness of how to complete ACATs	Higher Medicine & IMT TSTL's/ Medical Education	July 2021	Amber

CONCERN 3: LEARNING ENVIRONMENT AND CULTURE

The panel heard of problems trainees have had in obtaining annual/study leave.

REQUIREMENT 3: THE TRUST MUST ENSURE THERE ARE PROCESSES IN PLACE ALLOWING TRAINEES TO ACCESS STUDY AND ANNUAL LEAVE MORE EASILY AND THAT ISSUES WITH THE MEDICINE ROTA COORDINATOR ARE ADDRESSED TO FACILITATE THIS.

LEVEL 1

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
All annual leave / study leave requests will be reviewed weekly by the Rota Co-ordinator. The Directorate Support Manager also meets with the Rota Co-ordinator bi-weekly to look at leave and mop up any requests that have been missed. Last minute or urgent leave will be looked at straight away. For the IMPF division there is a weekly meeting between the division and the rota coordinators to review the requests for leave and agree.	Rota requests are dealt with in a timely manner which will be monitored through our local QA programme and Junior Doctors Forum.	Rota Team/ Medical Education	October 2021	Amber
Monthly meetings are taking place between Higher Medicine TSTL and Rota Team, mostly for troubleshooting and looking at particularly challenging leave requests or rota issues.	Continue to include on the agenda of monthly Med Ed/Integrated Medicine and Patient Flow meeting for discussion with Higher Medicine TSTL.	Rota Team/ Medical Education	April 2021	Green
Funding has been approved for an extra medical Rota Co-ordinator – there are now 4 Rota Co-Ordinators covering Medicine. The 4th has been put in place initially in a fixed term capacity until September. Enquiries have been made as to what will happen beyond this.	Improved processes and cover provided which will be monitored through our local QA programme.	Rota Team/ Medical Education	September 2021	Amber
Induction information sent to the trainees has been reviewed with clear instructions on how to contact the relevant Co-ordinators for annual leave and on call swaps added. This has taken place for all new trainees but will ensure it takes place for August changeover and onwards.	Trainees clear on who to contact regarding rota queries. Monitor through local QA programme.	Rota Team/ Medical Education	August 2021	Amber
Rota coordinator going through performance management stages and no longer managing medical/ED rotas although still within the team	Issues with individual team member dealt with which should no longer impact on trainees. Monitor through local QA programme.	Rota Team	March 2021	Green

Weekend working of coordinators to trouble shoot any rota issues. Process to make this a permanent arrangement is currently ongoing with HR.	Increased availability of Coordinators to deal with any issues Monitor through local QA programme.	Rota Team	October 2021	Amber

CONCERN 4: LEARNING ENVIRONMENT AND CULTURE

Foundation and GP trainees in emergency medicine said priorities can get skewed and patient flow issues are prioritised. Trainees said they have encountered pressure from some nursing staff to achieve the 4-hour wait target which has been inappropriate.

REQUIREMENT 4: THE TRUST MUST LOOK INTO THE COMMENTS MADE BY TRAINEES REGARDING THE PRESSURE EXPERIENCED FROM SOME NURSING STAFF REGARDING ACHIEVING THE 4-HOUR WAIT TARGET.

LEVEL 1

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
The Emergency Medicine Nursing Team will communicate with and ensure that the junior trainees due not feel pressured to make clinical decisions against the 4-hour standard. The process will be reiterated to trainees at Induction.	Continue to communicate to any new trainees Monitor through our local QA programme	Emergency Medicine Department /Medical Education	August 2021	Amber

CONCERN 5: SUPPORTING AND EMPOWERING LEARNERS

GP and foundation trainees that were new to the UK and the NHS felt that further support more specific to the trust would be helpful in addition to HEE NW support.

REQUIREMENT 5: THE TRUST SHOULD CONSIDER THEIR SUPPORT PROVIDED TO THOSE TRAINEES THAT ARE NEW TO THE NHS AND THE UK TO SEE IF THIS CAN BE IMPROVED.

LEVEL 1

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
As part of our communication with trainees prior to their start date, Medical Education will ensure we ask them if they are new to the UK. Our Lead Employer link will also actively request information from them in advance so that we are made aware of these trainees. Once identified as IMG/new to NHS, our IMG New Starter Handbook can be given to them before they arrive in the UK/local area. This includes information on accommodation, life in the UK, setting up a bank account and access to Dentists/Doctors etc.	Improved awareness of trainees new to the UK and NHS with appropriate information provided in advance. Closely monitor information provided and raise any concerns with Lead Employer where needed.	Medical Education/ Lead Employer Link	July 2021	Amber
Trainees to have access to specific IMG Induction as well as the normal Trust Induction. IMG specific Induction includes the following talks: Welcome to UK Practice from GMC, Introduction to Clinical Skills with the Simulation & Skills Team, Communication and DNACPR and a Careers Meeting with the DCME. The Rota team are made aware so that the trainees can be released to attend this as well as their Trust Induction.	Ensure trainees have opportunity to attend BVH IMG Induction sessions. This will be monitored by reviewing registers and linking in with the Rota Team.	Medical Education/ Rota Team	August 2021	Amber
Rota team made aware of IMG Trainees prior to them starting so that a shadowing period of two weeks can be given. Trainee buddy to be identified within department for them to work alongside.	Shadowing period offered and trainee buddy allocated to any trainees new to the UK/NHS. Regular communication between Med Ed and the Rota Team to ensure this is implemented. Monitor experience of this group of trainees through our local QA programme.	Medical Education/ Rota Team	August 2021	Amber

Make sure any Supervisors assigned to an IMG are aware it is their first job in NHS/UK and that extra support may be required. Ensure the Supervisors are aware of the TSSC meetings and that if needed, support is available should their IMG trainee require it. Medical Education to run specific events aimed at increasing the Supervisors awareness of IMG trainees – such as at the Supervisors Quarterly Update Meetings.	Communications sent out to Supervisors in advance of trainees starting. IMG Supervisor sessions planned & repeated where necessary.	Medical Education	September 2021	Amber

Health Education England

APPENDIX 2
PATIENT SAFETY ACTION PLAN – POSTGRADUATE EDUCATION REVIEW

Trust:	Blackpool Teaching Hospitals NHS Foundation Trust
Programmes/Specialties:	Higher trainees Acute Care Pathway
Date of Visit:	20 January 2021
Date Action Plan sent to Trust:	25 January 2021
Deadline date for completion:	9 February 2021
Report updated:	21 June 2021 – Dr Jim Gardner
Response compiled by:	Dr Jim Gardner, Medical Director Dr Kate Goldberg, Director of Clinical and Medical Education Mrs Kate Stannard, Associate Director of Medical and Clinical Education Mrs Laura Orwin, Medical Education and Quality Manager

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

(*) Green = Fully Achieved, Amber = Partially Achieved, Red = Not Achieved

CONCERN 1:

There were patient safety inferences heard from the discussion with medical and emergency medicine higher trainees. The panel heard trainees describe very sick patients in A&E who had been transferred to medical care with no senior oversight from AMU consultants. Trainees described disorganised AMU processes and explained that there is no consultant “ownership” of the patients still present in A&E. They described being frustrated by the need to “ring around” to gain advice which left them anxious about their decision making.

When asked to provide specific examples of patient safety incidences one trainee said that they were unable to provide specific examples as “it happens all the time, each shift”. One trainee described a situation when s/he was unclear if active or palliative care was required and felt unsupported in the decision making.

Several trainees gave examples of working at other busy hospitals where the AMU worked well and suggested learning could be taken from. Several trainees had suggestions on how the culture in AMU could be improved.

REQUIREMENT 1: THE TRUST MUST ENSURE

1. *OWNERSHIP AND LEADERSHIP BY AMU CONSULTANTS OF THE SERVICE INCLUDING THOSE PATIENTS TRANSFERRED TO AMU THAT ARE STILL IN THE EMERGENCY DEPARTMENT AREA*

How the concern is being addressed	*How improvement is monitored and sustained*	*Who is responsible*	*Timeline*	*RAG rating (*)*
The Medical Director has met with the Head of AMU to clarify supervision arrangements	Clear rotas easily available on the whiteboard in AMU Regular updates with Medical Director	Medical Director	February 2021	Green
A focus group took place on 08/02/21 with higher medical trainees in Medicine/Emergency Medicine to discuss their solutions for improving the AMU culture. The focus group was attended by the Medical Director, Director of HR & OD and the Director of Clinical and Medical Education	Solutions to be considered and acted upon where appropriate with an action plan being put in place We will be working with the Medical Director and Deputy Divisional Director around the issues and the action plan. We will keep them updated with any concerns raised via our QA work Continue to monitor through internal QA programme	Medical Education/ Integrated Medicine and Patient Flow	February 2021	Green
Medical Director has arranged for Dr Margaret Christian (AMU Consultant) and Lesley Gaw (Matron) both from ELHT to visit Blackpool to do some consultancy for us. They will look at both our clinical pathways and our human factors and resources. Dr Margaret Christian and Lesley Gaw have visited the Trust on 26th May and on the 16th June.	Recommendations made for improving quality and safety with an action plan being put in place	Integrated Medicine and Patient Flow	July 2021	Amber

Following the visits, we are expecting a formal report and will identify relevant operational improvements and educational actions.				
A GIRFT of Acute & Gen Med took place on 08/03/21. As a result of the GIRFT, daily board rounds have commenced to improve communications with nurses regarding patient scoring. Dr Grahame Goode Deputy Medical Director/Director of Clinical Effectiveness is the GIRFT Lead. NHSIE have been in contact with the Division to arrange to meet and agree a formal action plan.	Recommendations made for improving quality and safety with an action plan being put in place	Integrated Medicine and Patient Flow	July 2021	Amber
A SOP has been produced for Working on AMU. It outlines clear responsibilities of what is expected of the AMU Consultant supporting patients in ED and the OC Med Consultant. The SOP includes clarity on who trainees should contact when advice is required. A meeting took place on 26/05/21 with Senior Managers and Medicine Consultants to discuss the SOP as concerns had been raised. Dr Jeffries (Higher TSTL) is making amendments to the SOP on 27/05/21 before it is sent to Dr Qazi (Interim Divisional Director) for review. Trainee Rep will be consulted to ensure there are no omissions. A working group is to be set up which will include Dr Jeffries, Dr Qazi and the Medicine Consultants to discuss implementation of the SOPs.	Monitor through QA programme that SOP has been received and trainees are able to access senior support for advice Ensure document is distributed at Induction Ensure document is shared with all Consultants and new starters	Medical Education/ Integrated Medicine and Patient Flow	July 2021	Amber
An email has been sent to all trainees and Medical Consultants giving clarity on whom the higher medical trainees should contact when they require urgent advice regarding medical management of a patient on the take	Monitor through QA programme that all trainees have clarity on who should be contacted. Ensure there are no further issues	Medical Education	February 2021	Green
Daily board rounds on AMU have resumed. This involves regularly discussing patients and giving advice regarding management of patients as well as identifying those that should be referred to Palliative Care or suggesting patients that need escalation planning and DNACPR discussions. EOL teaching session delivered on 06/04/21.	Daily board rounds continue Records obtained of Consultant completion of Palliative Care teaching session and DNACPR Sim Sessions – evidenced via appraisal	Integrated Medicine and Patient Flow	July 2021	Amber

Recommendation that all AMU Consultants attend the DNACPR sim sessions. Dr Foy (AMU HOD) will inform Consultants of this expectation and this will be evidenced via appraisal.				
A new BTH Internal Professional Standards document which has been devised for medics will now be rolled out to all doctors upon starting at the Trust. This has been emailed to all current trainees and will be communicated with any new trainees	Monitor through QA programme that trainees are aware of and have received the document Ensure document is shared with all Consultants and any new Consultants joining the Trust	Medical Education/ Integrated Medicine and Patient Flow	February 2021	Green
Work with Integrated Medicine and Patient Flow and MD to support continuation of the Clinical Educator role in ED and support its development in AMU. Clinical Educator is now clearly identified on the white-board on AMU as well as the daily on call rota. Amendments made to rota meaning that every day there is a Consultant available from 8am-7pm. This gives the trainees an opportunity to complete acute ACATS and WPBA's before the 9am handover. Current staffing will not allow the Clinical Educator and the ED Link Consultant to be 2 separate people. Hope to rectify in the future which should be identified as part of AMU review.	Remain on the agenda of monthly meetings between Medical Education and Integrated Medicine and Patient Flow Clinical Educator continues to be clearly identified	Medical Education/ Integrated Medicine and Patient Flow	May 2021	Green
The Trust has appointed an RCP Chief Registrar in General Medicine who will focus on leadership & service improvement.	Monitor service improvements made once Chief Registrar is in post	Integrated Medicine and Patient Flow	Post to begin in August 2021	Green

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board Meeting

Date of meeting: 1 July 2021

CQC Unannounced Visit Update

Author of Report:	Stefan Verstraelen, Deputy Director of Quality Governance
Executive Director Sponsor:	Peter Murphy, Director of Nursing, AHP's and Quality
Date of Report:	23 June 2021

Summary:

This paper provides the Trust Board with:

1) A succinct overview of the findings of the unannounced and partly focussed Care Quality Commisson (CQC) inspection on 11 January 2021 of the Urgent and Emergency Services, and Medical Care (including older people's care), and
2) Assurance that the Trust is making good progress with the subsequent CQC action plan.

For Information/Assurance:	**For Discussion:**	**For Approval:**
x		

Recommendations:
The Board is asked to note the update provided.

Sensitivity Level:

Not Sensitive: **(for immediate publication)**	**Sensitive In Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider applicable exemption)**
x		

Unannounced CQC inspection - 11 January 2021:

On 11 January 2021, the Care Quality Commission (CQC) carried out an unannounced inspection of Urgent and Emergency Services, as part of the CQC's winter pressures programme, and a focussed inspection of Medical Care (including older people's care) at Blackpool Victoria Hospital – "*because of concerns about the quality of services*". The specifics of these concerns have not been disclosed to the Trust.

The CQC inspected the Urgent and Emergency Services against the safe, responsive and well-led key questions and the focused inspection of Medical Care (including older people's care) covered elements of three key questions: is the service safe, effective and responsive.

The CQC did not inspect all the key lines of enquiry or domains and therefore had insufficient evidence to rate the services. The inspection was unannounced (staff did not know they were coming) to enable the CQC to observe routine activity.

The final CQC inspection report was published on Friday 26 March 2021 and is available on the CQC website.

Key points:

- The inspection report is, overall, a positive report. Before the inspection, the Trust was aware of areas where improvements were needed and this had already been discussed in an open and transparent manner with the CQC prior to the unannounced inspection, for example at routine engagement meetings, through CQC enquiries and at the System Improvement Board. The inspection report makes no mention of anything the Trust was not already aware of and areas requiring improvement, as pointed out by the CQC, had already programmes of improvement work in place prior to the inspection.

- The report demonstrates that the Trust has made good improvements since the previous CQC inspection in June 2019.
- The inspectors recognised that staff had delivered through the extremely challenging Covid-19 pandemic and praised staff for their professionalism during the inspection, which took place during the peak of the second Covid-19 wave.
- The CQC issued a total of six MUSTs and four SHOULDs under four requirement notices (Regulation 11, 12,17 and 18):
    - Urgent and Emergency Services: one MUST and two SHOULDs
    - Medical care (including older people's care): five MUSTs and two SHOULDs
- The CQC highlighted a total of three areas of OUTSTANDING PRACTICE

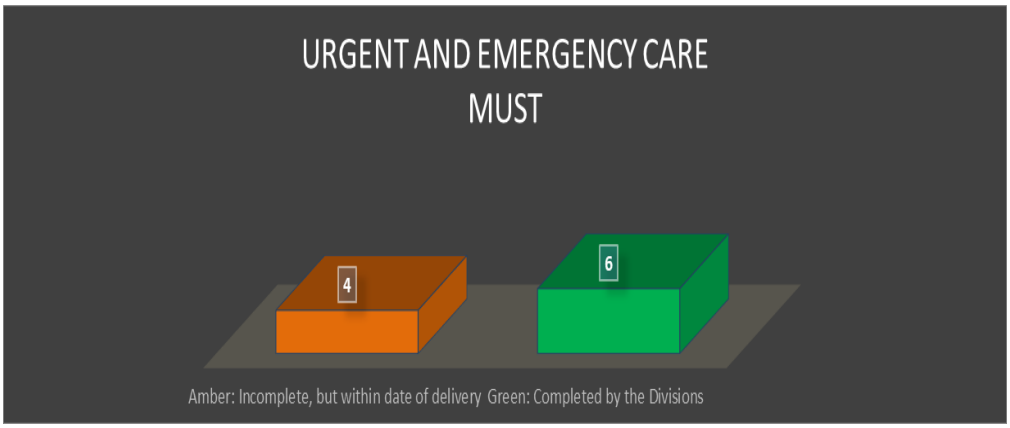
The CQC action plan:

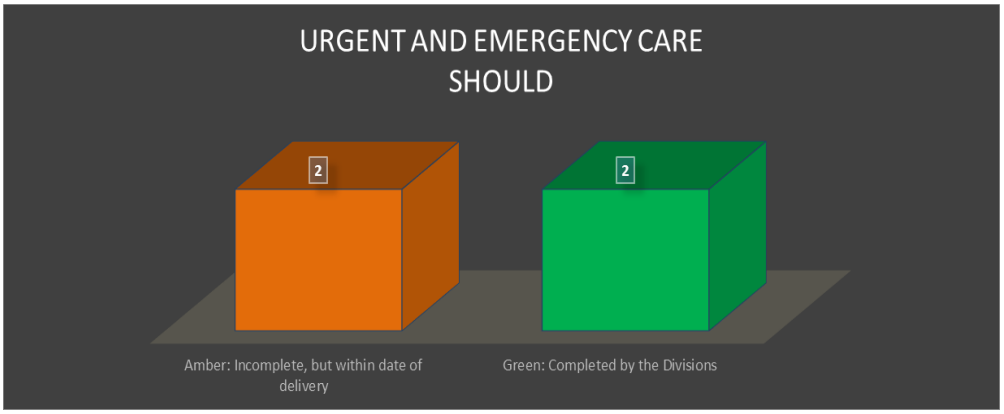
Following the publication of the inspection report on 26 March 2021, the Trust was required to submit a comprehensive action plan to the CQC by 14 May 2021; this action plan was been submitted accordingly and has been agreed by the CQC.

For the six MUST and four SHOULD requirements, the action plan comprises a total of 41 actions, of which 19 actions have been completed (= 46%):

Urgent and Emergency Services:

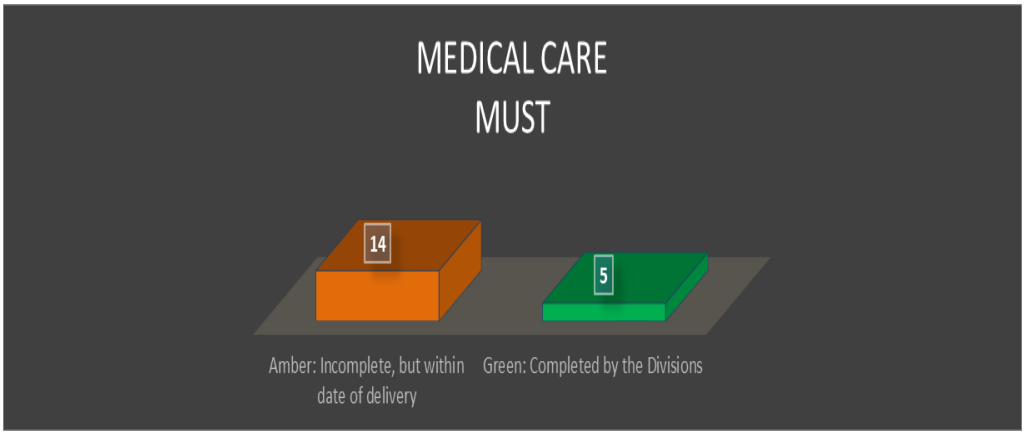
- One MUST: 10 actions, of which six have been completed (= 60%) and the remaining four actions are incomplete, but within date of delivery.
- Two SHOULDs: four actions, of which two have been completed (= 50%) and the remaining two actions are incomplete, but within date of delivery.

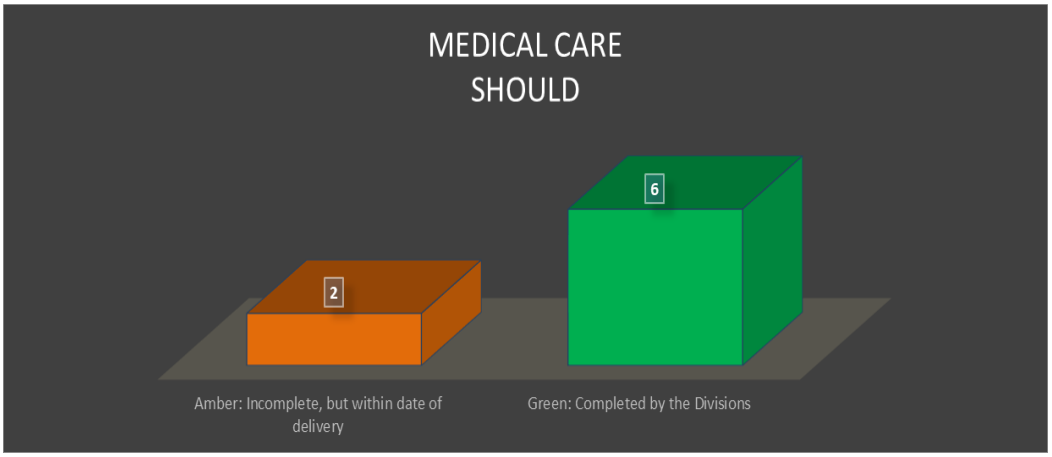




Medical care (including older people's care):

- Five MUSTs: 19 actions, of which five have been completed (= 26%) and the remaining 14 actions are incomplete, but within date of delivery.
- Two SHOULDs: eight actions, of which six have been completed (= 75%) and the remaining two actions are incomplete, but within date of delivery.





Outstanding practice:

In its inspection report, the CQC highlights three areas of outstanding practice:

Urgent and Emergency Services:

- There was an advanced paramedic who worked with the mental health liaison team to deflect admissions from the department to other services. Patients who requested an ambulance would be contacted by phone or visited by this team. This had been effective in reducing admissions to the department and shown a reduction in section 136 admissions to mental health services.
- The trust had developed strong processes in the emergency department to support safeguarding including the safeguarding navigator role and an independent domestic violence advisor. They had won an award for their work for victims of rape who attended their department.

Medical care (including older people's care):

- Due to the National issue of DoLS authorisations not being reviewed by the Local Authority in a timely way, the trust had implemented a deprivation of liberty safeguard assurance process where patients were reviewed every seven days. This allowed for professional challenge between colleagues over whether the application was still required, to ensure any deprivation of a patient's liberty was kept to a minimum.

Conclusion:

Following the unannounced and partly focussed CQC inspection on 11 January 2021 and the subsequent publication of the CQC inspection report on 26 March 2021, the Trust has implemented a comprehensive CQC action plan, comprising a total of 41 actions.

Out of these 41 actions, 19 have been completed (= 46%) and 22 actions are incomplete, but within date of delivery.

The Trust is making good progress with the CQC action plan following the January 2021 inspection.

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board Meeting

Date of meeting: 1 July 2021

Care Quality Commission Inspection Preparation

Author of Report:	Louise Cheung, Head of Quality Governance Stefan Verstraelen, Deputy Director of Quality
Executive Director Sponsor:	Peter Murphy, Director of Nursing, Quality & AHPs
Date of Report:	June 2021

Executive Summary

The Trust has taken a number of steps to prepare for the imminent Care Quality Commission (CQC) inspection, all of which are detailed in the report, but include:

- Establishment of CQC Hub
- Weekly CQC Preparation meetings held and walkarounds undertaken
- Focus on reduction of overdue risks and out of date policies/procedures
- Increase in activity on the COAST programme

Members of the Board are asked to take note of the preparations the Trust is undertaking for a CQC inspection.

For Information/Assurance:	**For Discussion:**	**For Approval:**
x		

Recommendations:

The committee is asked to note the improvements already made and those proposed for the forthcoming year.

Not Sensitive: **(for immediate publication)**	**Sensitive in Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider application exemption)**
x		

Blackpool Teaching Hospitals NHS Foundation Trust

Care Quality Commission Inspection Preparation Update Paper – June 2021

1. Introduction/Purpose

The Trust underwent a comprehensive, rated Care Quality Commission (CQC) inspection in June 2019 and the CQC published its inspection report in October 2019 and was rated as 'Requires Inspection' overall and 'Inadequate' in relation to 'Well-led' (Trust Leadership).

The Trust also underwent a focused (unannounced) inspection of Urgent and Emergency Services and Medical Care (including older people's care) in January 2021; the inspection report published was published in March 2021. This inspection did not cover all the Key Lines of Enquiry (KLOE) and therefore the overall rating remains unchanged.

In line with the current CQC inspection methodology, it is expected that it is imminent that the Trust will be subject to an announced, rated inspection.

It is also possible that the CQC may carry out further focused (unannounced) inspections, if they determine risk to patients is high.

This paper follows previous papers outlining the outcome of the January inspection and has a focus on outlining how the Trust has been preparing for an imminent inspection.

2. Key CQC Preparation arrangements

Outlined below are key actions/governance arrangements that have been put into place to prepare for an imminent upcoming CQC inspection:

- A CQC Hub has been established at the HPEC and is now staffed throughout office hours in the week. Divisional displays have been set up which includes a SWOT analysis and has the findings from the last CQC inspections clearly displayed as a focal point for staff and senior management to drop in to review evidence and raise any issues/queries.

- The CQC Hub has three staff who have a programme of CQC preparation visits to wards/clinics/pharmacy across the Blackpool Victoria Site. They have been identifying any quick wins or wider issues to be addressed and supporting the divisions in ensuring those issues are rectified prior to inspection.

- A weekly CQC preparation meeting is held with key individuals across the Trust and is chaired by the Director of Nursing, AHPs and Quality. The meeting focuses on risk, policies, Infection Prevention and Control (IPC), walkarounds, mandatory training compliance, and estates and facilities.

- In addition to the above preparation meetings the Deputy Director of Quality Governance chairs a weekly CQC preparation meeting with the Divisional Directors of Nursing, and a further one with the Quality Managers. These meetings focus more in-depth of those actions agreed and the weekly Trust meeting and overcoming any further challenges to implementation.

- There has been a focus on reducing the number of overdue risks across the Trust. At the 10 May the Trust had 603 risks which were overdue for review, in just over 2 weeks a total of 550 risks were reviewed and then in date, since then more have continued to be reviewed. The Trust currently has 14 risks overdue for review.

- There has been a concerted effort to reduce the number of policies which are past their review date which was of significant concern. As at 20 May 2021 the Trust had a total of 294 policies/procedures past their review date compared to 735 when reported to the CQC in October 2020. Previously the CQC had identified specifically 251 policies/procedures which they confirmed must be reviewed and in date, out of those 80 were past their review date on 20 May. Through the weekly Trust CQC Preparation meetings there has been a drive to review all out of date policies/procedures with a particularly focus on the 80. Additional support has also been sourced to assist the Policy co-ordinator in reviewing and approving the updated policies and procedures. Currently there are 121 policies/procedures out of date Trust wide out of over 1500 policies/procedures in use, and of the CQC identified 80, 29 remain overdue for review. Whilst significant progress has been made policies remains an area of focus and of some concern.

- The COAST programme remains a significant element of the assurance programme in preparing for the CQC inspection and the frequency of the visits has been increased to support Trust readiness.

- Monday walkarounds have been taking place to ensure areas and corridors are clean and free from clutter, and Friday senior team walkarounds are also taking place.

- A Monday SOP has been developed and implemented with key tasks/checks every week in preparation for a visit.

- Divisions and corporate teams have been asked to there is a push on mandatory training compliance and we as an organisation can articulate where reductions in compliance are due to Covid-19 and/or decisions taken nationally/regionally regarding training.

- The Good Governance Institute (GGI) and Deputy Director of Quality Governance have met individually with all Executive Directors and Non-Executive Directors to prepare for a ‘Well-Led’ review and agree appropriate actions.

- The CQC actions plans have been agreed with the CQC and merged.

- The Safety at a glance posters now include the Trust top three risks, and the recent never event red alert and have been issued to and displayed in all wards.

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board Committee
1st July 2021

Quality Improvement (QI) Strategy Report

Author of Report:	Katharine Goldthorpe - Associate Director of QI Paryaneh Rostami - Senior QI Manager/ Patient Safety Specialist
Executive Director Sponsor:	Peter Murphy Director of Nursing, AHP & Quality
Date of Report:	01.07.2021

Executive Summary (to include, where appropriate, the level of assurance & position on trajectory):
This report provides brief updates on the progress of each of the Trust's main QI programmes.

Pressure Ulcer Collaborative – The collaborative is moving into Phase III, which will focus on further reduction of pressure ulcers in community settings, where there is a higher prevelance of harm due to category 3 & 4 pressure ulcers. Phase I & II teams from acute, Clifton and community settings have achieved a statistically signficant improvement in the number of category 2 pressure ulcers.

Deteriorating Patient Collaborative – Teams in this programme are currently in Action Period 2. Learning Session 3 will occur on the 13th July. This is a complex programme, which has been affected by COVID recovery. However, teams are delivering targeted intitiatives and we should be optimistic that we will see improvement over the course of the collaborative.

Improve the Last 1000 Days Collaborative –The expert faculty have identified a cohort of the population who use acute services due to fracture of the femur (fractured hip) from falls. This was done by analysing a wealth of local public health and hospital data. A project initiation document (PID) relating to this work has been submitted to Quality & Effectiveness Committee and will be presented to Board in the next QI Strategy Report.

Safety Culture Programme - Directors of the division that was identified suitable for testing the AHRQ Safety Culture Survey have now been contacted and plans are underway to start the survey.

Improvement Capability – Planning for the Blackpool Clinical Quality Academy (BCQA) has commenced, including work with the University of Lancaster's Medicine School to enable BCQA participants to receive Continuing Professional Development (CPD) points for their work as part of programme. The BCQA is on track to launch its communications in June, with a view to commencing in October. A PID has been approved by the Quality & Effectiveness Committee and is attached for information.

For Information/Assurance:	**For Discussion:**	**For Approval:**
x		

Recommendations:
Trust Board are asked to consider the matters raised in this report for assurance.

Sensitivity Level:

Not Sensitive: **(for immediate publication)**	**Sensitive In Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider applicable exemption)**
x		

QI Strategy: Update for Board of Directors

1. PURPOSE

The purpose of this report is to provide assurance to Trust Board on progress made towards the goals outlined in Blackpool Teaching Hospitals NHS Foundation Trust's (BTHFT's) Quality Improvement (QI) Strategy (2019-22) [1] and to outline further plans.

2. BACKGROUND

2.1 QI Strategy

The BTHFT QI Strategy [1] describes an approach to achieving the Trust's QI goals. As a reminder, the Trust's high-level aims are; to reduce preventable deaths and avoidable harm and the Trust and its partners also have the system-wide aim of improving the last 1,000 days of life for patients. The Trust is delivering three breakthrough series collaboratives, each one focusing on one of the aforementioned high-level aims. This report provides brief updates for each of these collaboratives (Section 3). In addition to providing updates for the progress of the Safety Culture Programme (Section 4) and building improvement capability within the Trust (Section 5). As part building improvement capability, the "Blackpool Clinical Quality Academy" will be launched this year and a Project Initiation Document (PID) has been included in Appendix A.

3. COLLABORATIVE PROGRAMME DELIVERY

3.1 Reduce Avoidable Harm – Eliminating Pressure Ulcers

3.1.1 Executive Sponsor: Director of Nursing, AHP and Quality

3.1.2 Specific Aims - for Phase I & II teams to achieve the following by May 2021:

- 50% reduction category 2 hospital acquired pressure ulcers
- 50% reduction in community acquired pressure ulcers
- 80% reduction in Category 3 and 4 hospital acquired pressure ulcers

3.1.3 Assessment – Phase I

Phase I progress is provided in Appendix B and the date to achieve the aforementioned aims has been extended for Phase I teams. These teams previously achieved statistically significant improvement and continue to "hold the gains" since last reported.

3.1.4 Assessment – Phase II

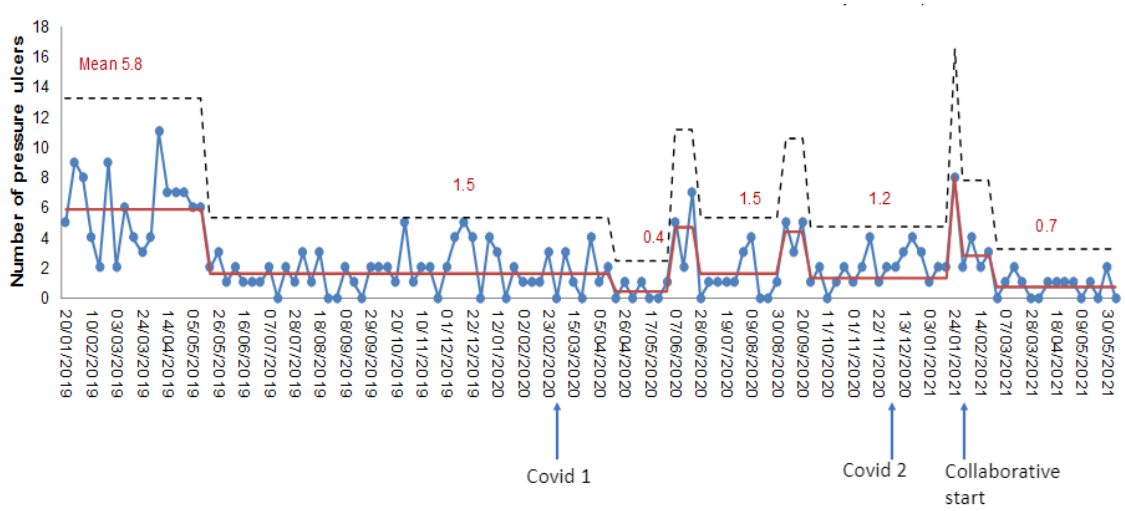
The Phase II teams continue their improvement efforts following the summit in May.

3.1.5 Phase II Data

The charts in Figure 1 and 2 show that acute and Clifton teams have achieved a statistically significant improvement in reducing category 2 hospital acquired pressure ulcers. However, there have been two category 3 and 4 pressure ulcers since March 2021, including one since the Phase II started. Community teams have achieved a statistically significant improvement in category 2 pressure ulcers, and there has been no special cause variation in category 3 and 4 pressure ulcers since September 2020. The expert faculty have recommended that Phase I and phase II community teams join together for the next phase (see Phase III below).

Aim: achieve a 50% reduction category 2 hospital acquired pressure ulcers- monthly:

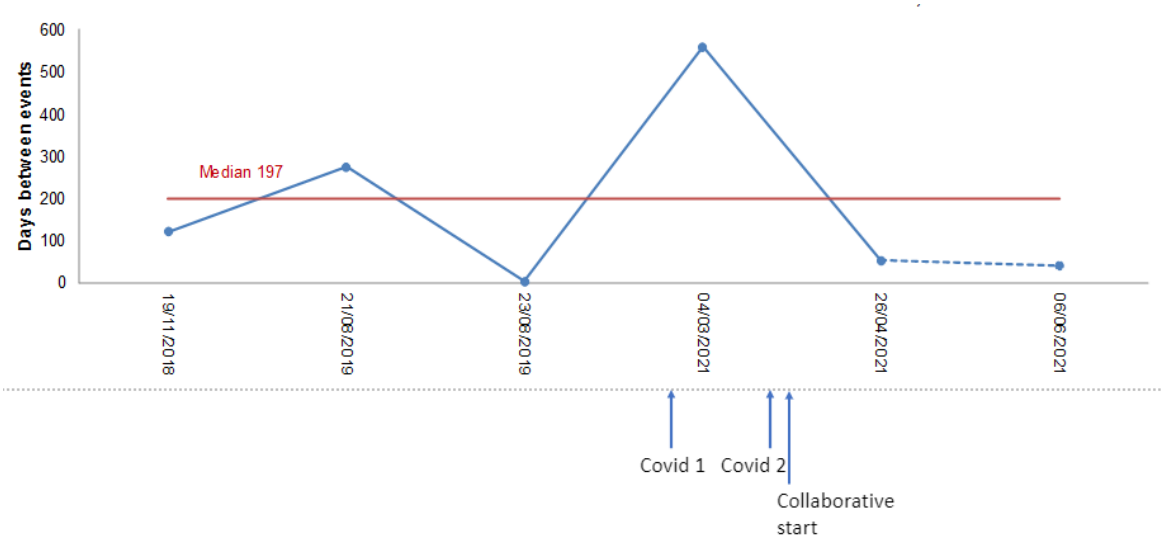
Figure 1 - C Chart to show Category 2 Pressure Ulcers in acute and Clifton BTH sites per week for Phase II teams



The chart in Figure 1 shows that teams achieved a statistically significant reduction in category 2 pressure ulcers.

Aim: to achieve 80% reduction in Category 3 and 4 hospital acquired pressure ulcers:

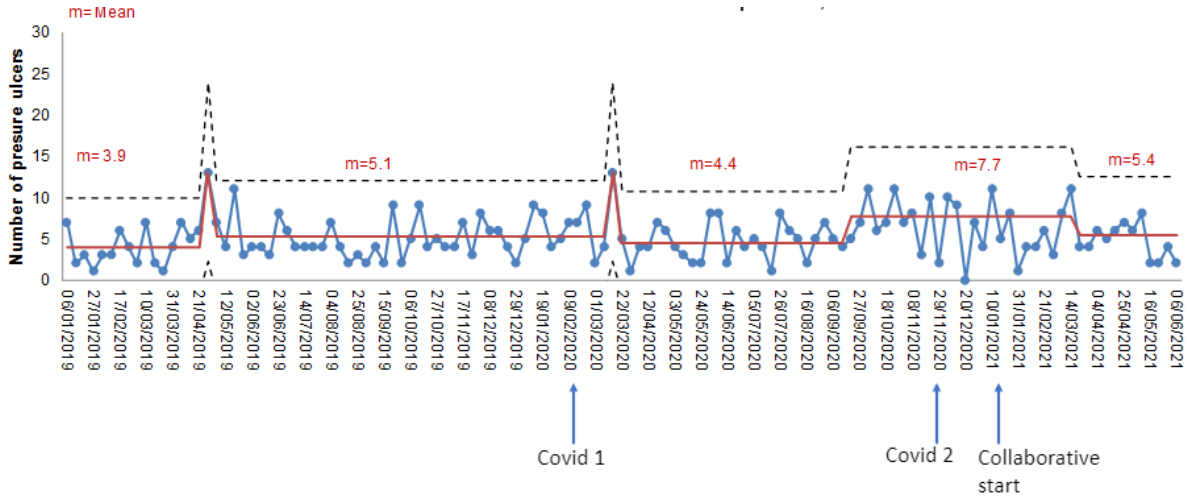
Figure 2 - Time between chart to show Category 3 & 4 pressure ulcers in acute and Clifton BTH sites for Phase II teams



There have been two category 3 and 4 pressure ulcers since March 2021, one since the collaborative started.

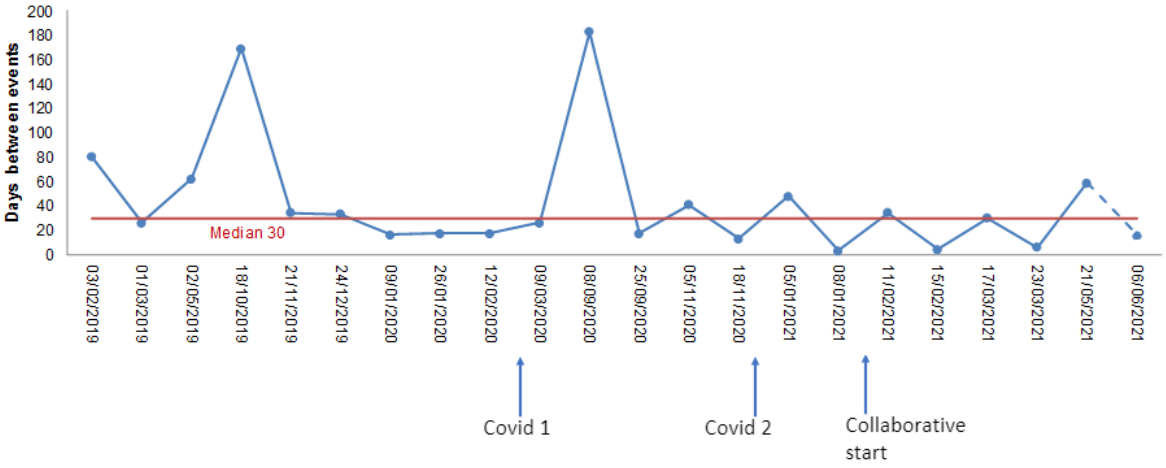
Community teams

Figure 3 - C Chart to show category 2 pressure ulcers across ALTC per week for Phase II teams



The chart above shows teams achieved a statistically significant reduction in category 2 pressure ulcers since the start of the collaborative.

Figure 4 - Time between run chart to show category 3 & 4 pressure ulcers across ALTC for Phase II teams



There has been no special cause variation in category 3 and 4 pressure ulcers since September 2020.

3.1.6 Phase III

As daily work to reduce pressure ulcers continues at the front line, several interventions have been identified that will further support the process:

- Phase III collaborative to launch for six Phase I & II community teams to continue their improvement work to achieve project aims.
- A discrete piece of work to understand how pressure ulcers are attributed in the community. This will create opportunities for learning and better working with our partners in social care.
- Wound photography promotes timely validation, a project to deliver this is underway.
- A peer review of the Tissue Viability Service has been undertaken, the results will help to improve categorisation and validation of harm.
- A full and formal evaluation of Phase I and II is currently underway, to consolidate learning from the collaborative process and inform the pressure ulcer policy going forward. An updated change package will be agreed.

3.2 Reduce Preventable Deaths – Identification and Management of the Deteriorating Patient

3.2.1 Executive Sponsor: Joint between Director of Nursing, AHP and Quality and Medical Director

3.2.2 Specific Aims:
To reduce the number of cardiac arrests outside of critical care units by 50% by September 2021.

3.2.3 Assessment
There are 9 teams participating in this collaborative, including ward and allied health professional -based teams. These teams are currently in Action Period 2 of the collaborative and are attending regular meetings with their QI coach. They are expected to attend and present their progress at Learning Session 3 on 13th July 2021. The teams used Action Period 1 to understand root causes of issues and to develop their measurement strategy and improvement plans, they are testing their ideas using PDSA cycles. They are expected to use the change package and learn from each other throughout the collaborative and a dedicated collaborative MS Teams channel has been introduced to aid the teams. The teams receive regular update newsletters and have access to QI methodology training.

The teams are currently testing interventions which aim to improve the identification and care of the deteriorating patient using PDSA cycles these include:

- Standardisation of effective safety huddles.
- Effective handover processes.
- Identification of patients at risk e.g. the use of NEWS2 boards and visuals.
- Use of NEWS2 trolleys.
- Clear documentation of escalation.
- Use of simulation training.
- Early signs of sepsis awareness in non-acute area.
- Standardisation of ward rounds.
- Use of electronic alerts and response to referral times.
- Effective debrief and learning from events.
- Oxygen management.
- Reduction in waiting times for review, referrals, and procedures.
- Standardisation of equipment state of readiness.
- Awareness of early signs of deterioration & confidence to escalate for staff levels.

3.2.4 Data
The data in Figure 5 shows that the number of weekly cardiac arrests where a 2222 call was activated within Phase 1 acute inpatient collaborative areas. We are yet to see a statistically significant change.

As cardiac arrests are relatively rare events, time between run charts are also being used to display data to understand if tests of change are having a desired impact – see Figure 6. A shift may take longer to appear in time between run charts therefore we would look for astronomical data points in the short term.

Figure 5 - 2222 activated Cardiac Arrests VS933 completed. Phase 1 Collaborative acute inpatient areas (Weekly data from 06/01/20 – 6/06/21)

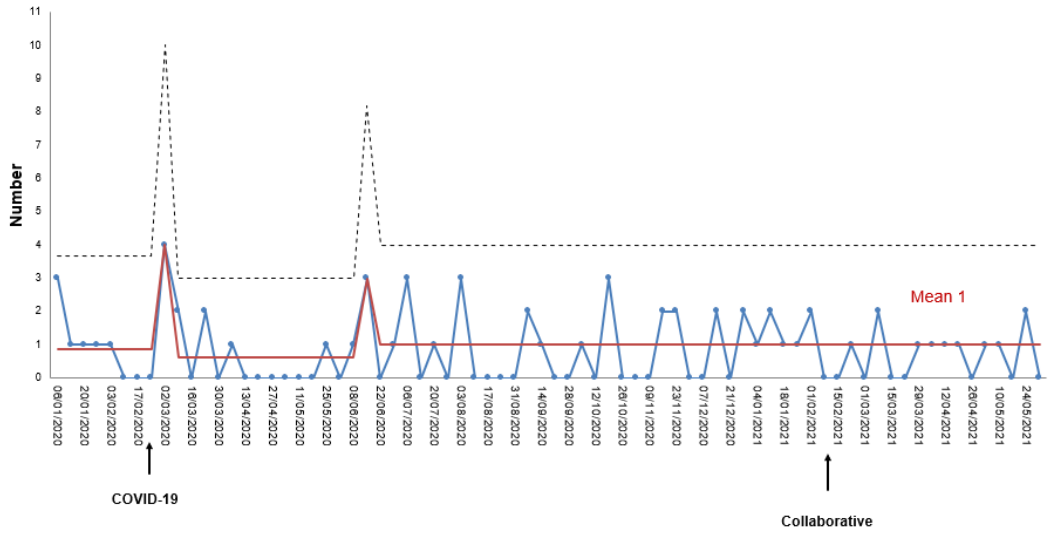
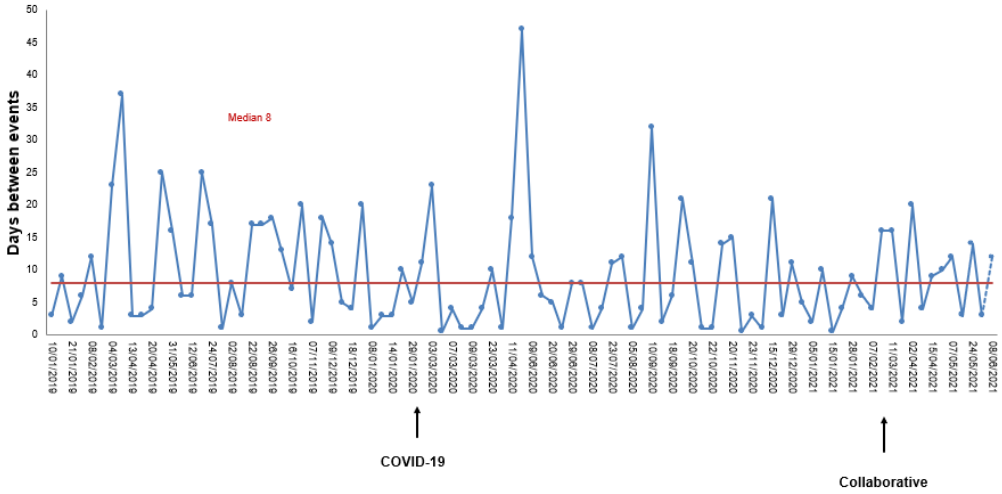


Figure 6 – Time between run chart showing days between 2222 activated Cardiac Arrests VS933 completed. Phase 1 Collaborative acute inpatient areas 10/01/2019 – 6/06/21)



Individual teams have developed measurement strategies including the use of time between run charts. The teams are encouraged to collect qualitative and quantitative data to inform their PDSA cycles.

3.3 Improve the Last 1,000 days of life

3.3.1 Executive Sponsor: Director of Nursing, AHP and Quality

3.3.2 Specific Aim (Under development):
To improve the last 1,000 days of life for our first cohort population by January 2022

3.3.3 Assessment (planning phase)
The aspiration of this programme is to give our patients back the gift of time. Much consideration has been given by the expert faculty as to how our population can live as well as possible until they are dying, and how we can then help to allow patients to die with dignity. Having analysed a wealth of local public health and hospital data, the expert faculty have been able to identify a cohort of the population who use our services due to fracture of the femur (fractured hip) from falls. A focus on preventing falls, has the potential to improve health outcomes and the risk of mortality for those that are most vulnerable. A project

initiation document (PID) has been developed, which describes the scale of the problem, the opportunity for improvement and a framework for delivery. This has been presented at Quality and Effectiveness Committee and will be presented to Board in September.

4. SAFETY CULTURE PROGRAMME

4.1 Executive Sponsors: Medical Director & Director of Nursing, AHP & Quality

The Safety Culture Programme has been split into four patient safety pillars, each with separate aims. Sections 4.2-4.6 provide updates for each pillar.

4.2 Insight
The Safety Culture Measurement plan to the Safety Movement Group on the 25th May 2021 has been approved by the Quality and Clinical Effectiveness Committee and a division has been identified as suitable for testing the Agency for Healthcare Research and Quality (AHRQ) Safety Culture Survey. Directors of the division have now been contacted and plans are underway to start the survey.

4.3 Involvement
The second Safety Movement Group meeting was held on the 25th May 2021. Feedback from this meeting highlighted that the meeting "provided a good overview of the direction of travel for patient safety" and that; "it gave an opportunity to have everyone involved in patient safety in one forum, for open discussion and collaborative working." Summaries from each meeting are also shared within team, divisional and departmental meetings, to help increase awareness of the patient safety strategy and its progress.

4.4 Improvement
The National Patient Safety Syllabus was published on 13th May 2021 and will be available for NHS staff in August or September 2021. The Patient Safety Specialist has met with colleagues from Organisational Development to plan how to launch this within the Trust with a view to launching this in September 2021.

4.5 Inspiration
The Maternity directorate within the Families and Integrated Community Care division has started to test "Learning from Excellence" focusing on capturing the positive practice related to postpartum haemorrhages and cardiotocography.

5. IMPROVEMENT CAPABILITY

The QI strategy describes how the Trust will empower workforces to improve efficiently, and one of the ways that this will be done is by delivering the "Blackpool Clinical Quality Academy" (BCQA). The BCQA is a programme that will educate clinicians within the Trust to close the gap between leadership and clinical practice by introducing and educating them to gain a deep understanding of improvement science. The BCQA will take place over the academic year and will consist of 9 teaching days led by experts in improvement science and leadership. The PID for the BCQA has been included in Appendix A.

BTHFT will work with the University of Lancaster's Medicine School to enable BCQA participants to receive Continuing Professional Development (CPD) points for their work as part of the BCQA. They will be able to use their CPD points towards various degrees as they choose. The offer being developed will most likely be based on a mixed-model, whereby upon completion of their projects, BCQA participants will be able to use their CPD points to retrospectively achieve a Level 7 educational award, which could either be a Clinical Practice in Education Management (CPEM) or a Masters of Research (MRes). If the participant chooses to obtain an MRes, the University of Lancaster could also support them

to apply to progress onto a Level 8 award with the choice of Doctor of Philosophy (PhD) by Publication, Traditional PhD or Doctorate of Professional Studies (DProf).

6. RISKS

6.1 Virtual learning sessions
Due to social distancing restrictions, the teaching and collaborative Learning Sessions continue to be held "virtually" using MS Teams. This deviates from the methodology and may result in less favourable results in some cases. To mitigate this, "Virtual Action Learning Sessions" and individual coaching is offered to teams and individuals.

6.2 QI Hub team space allocation
Space allocated for QI Hub team is not fit for business activities that lead to improvement and innovation (e.g. space to involve multiple employees, Kaizen suite). To mitigate this, space has been allocated and works will commence in the coming weeks.

7. FINANICAL AND LEGAL IMPLICATIONS

7.1 Financial Implications
The business case for funding has been presented and agreed.

7.2 Legal Implications
There are no legal implications.

8. RECOMMENDATIONS

Board are asked to consider the matters raised in this report for assurance and to support commencement of the building capability proposals.

9. REFERENCES

1. Blackpool Teaching Hospitals. *Quality Improvement Strategy 2019 – 2022*.; 2019.

2. NHS England, Colleges A of RM. *National Patient Safety Syllabus 2.0*.; 2021. https://healtheducationengland.sharepoint.com/Comms/Digital/Shared Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared Documents%2Fhee.nhs.uk documents%2FWebsite files%2FPatient Safety Syllabus%2FNational patient safety syllabus v2.pdf&parent=%2F

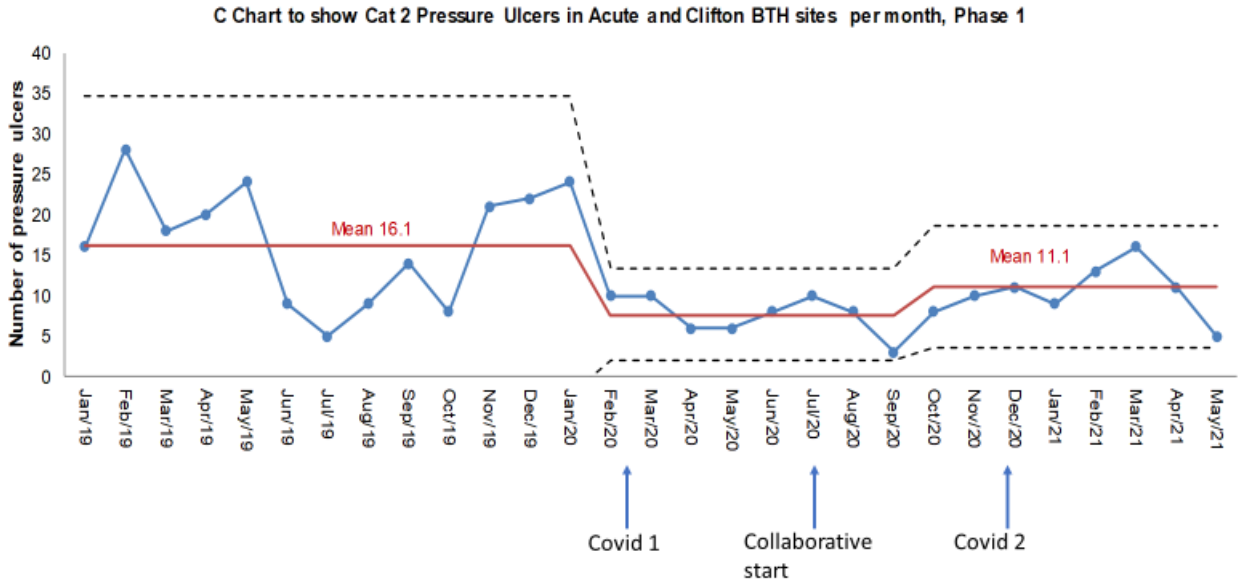
10. APPENDICES

Appendix A – Blackpool Clinical Quality Academy Project Initiation Document

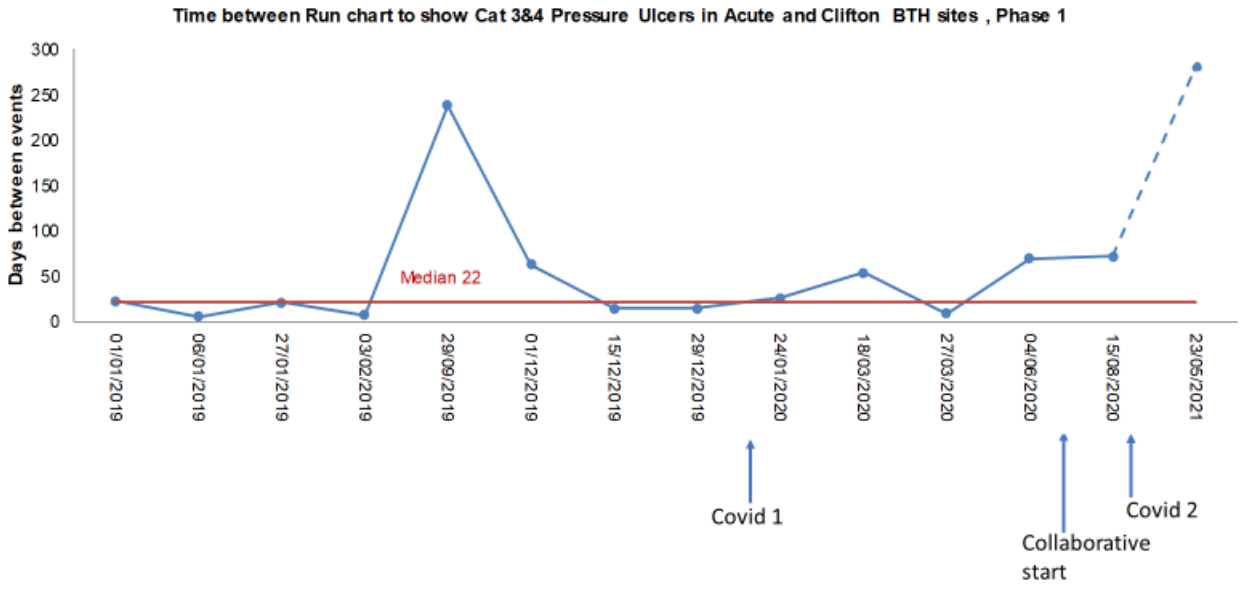
Please see separately attached document.

Appendix B - Phase I pressure ulcer data

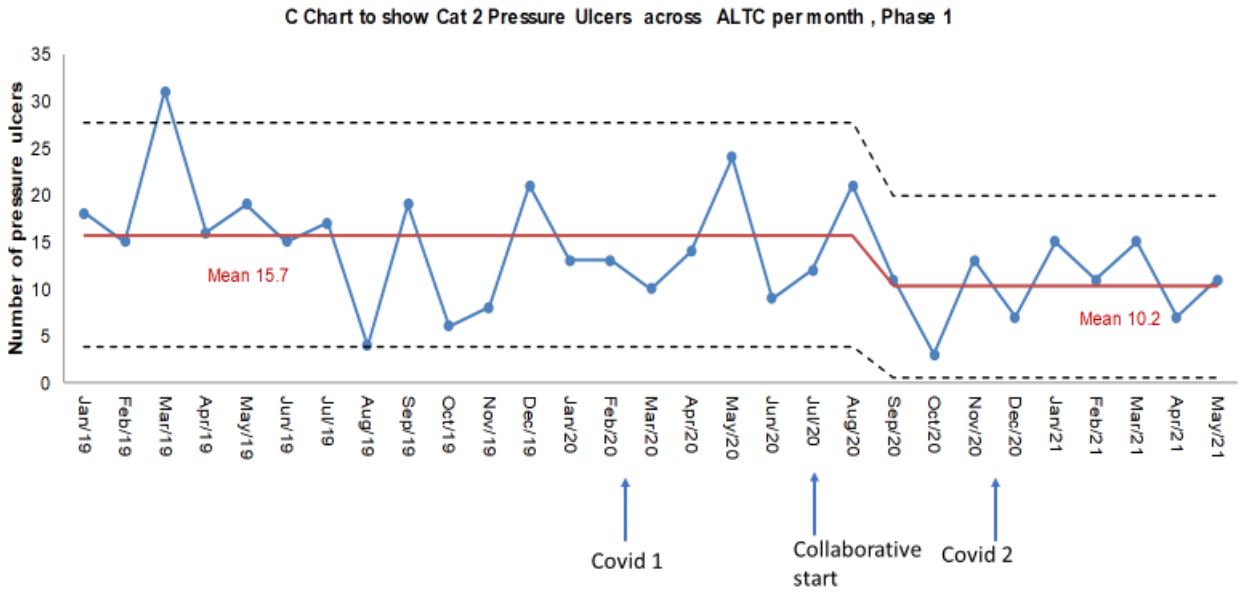
Aim: achieve a 50% reduction category 2 hospital acquired pressure ulcers- monthly:

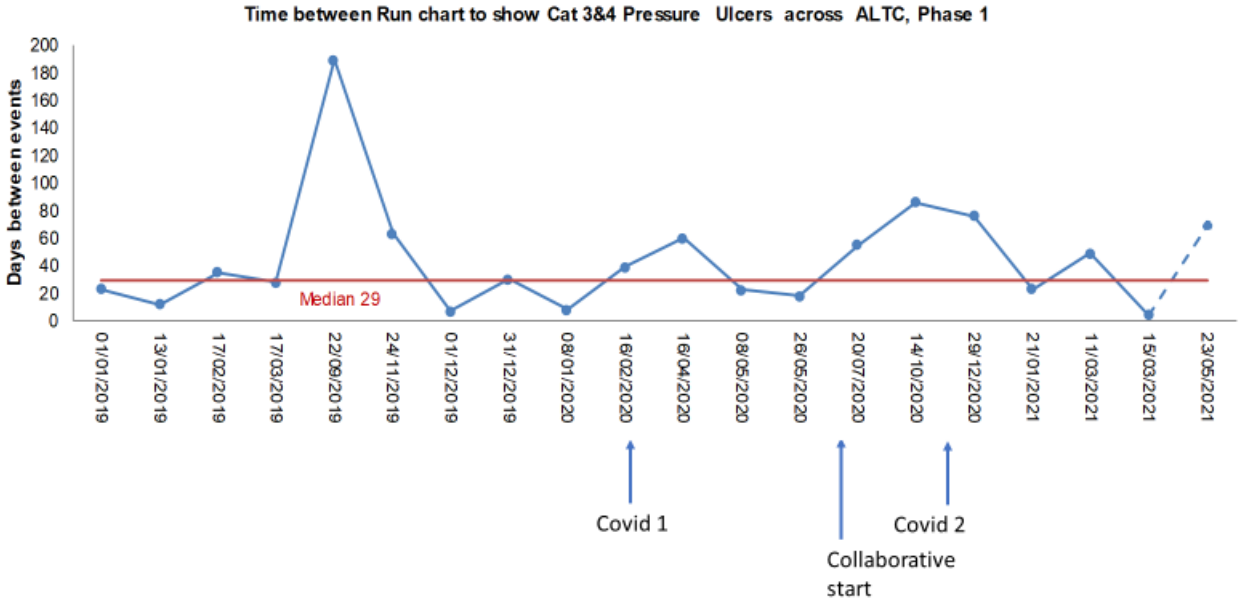


Aim: to achieve 80% reduction in Category 3 and 4 hospital acquired pressure ulcers:



Aim: achieve a 50% reduction in community acquired pressure ulcers





It should be noted that data presented in this report are not inclusive of deep tissue injuries or unstageable pressure ulcers, but the work the teams are doing will have an impact on those numbers as they progress.

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Project Initiation Document

Clinical Quality Academy

Document management

Revision history

Version	Date	Summary of changes
1	13.05.21	

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title/responsibility	Date	Version
Dr Jim Gardner	Medical Director		1
Pete Murphy	Director of Quality, AHP's and Nursing		
Dr Steve Wiggans	Director of professional standards and deputy medical director		
Kate Stannard	Associate Director Medical/Clinical Education		

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Dr Jim Gardner		Medical Director		1
Pete Murphy		Associate Director of Quality, AHP's and Nursing		1
Quality Committee		Chair		1

Related documents

Title	Owner	Location
Quality Improvement Strategy	Director of Nursing, AHP and Quality,	

Contents

1. Purpose and Background

1.1 Purpose of a Project Initiation Document

The purpose of the Project Initiation Document is to define the outline and scope of the new Trust Clinical Quality Academy, in order to form the basis for its management and an assessment of its overall success.

The Project Initiation Document has two main purposes:

- To ensure a sound basis for the Project Team to progress and;
- To provide a single source of reference about the project so that information can be placed in context and easily found.

1.2 Background and Content

It is the duty of everyone who works in the Trust to be involved in quality improvement and make appropriate changes that will lead to better patient outcomes, system performance, patient experience and professional development. As well as facilitating the large-scale change programmes, we aim to increase improvement capability and therefore knowledge in all staff groups and grades, in order to achieve service improvement at every level.

The Trust Quality Improvement “dosing strategy” describes how we will provide our people with the skills and opportunities to continuously improve. This includes a 12-month training programme for clinically led teams, known as Blackpool Clinical Quality Academy (BCQA).

Taking learning from other successful programmes, such as Salford’s Improvement Science for Academics (IS4A) and IHI Improvement Advisor programme, BCQA will design a programme that works for our people, to build a workforce empowered to drive improvement in their daily work. The academy will follow the IHI Breakthrough Series Collaborative framework and will deliver an intensive programme of teaching, action learning and coaching in the science of improvement. The programme will be delivered by eminent teachers and leaders in this field from both the UK and oversees. The course will be delivered virtually and, when this is possible, in person.

Applying for BCQA will be a competitive process and, following application, shortlisted teams will be interviewed, with 10 teams accepted onto the programme. We know effective and lasting improvement is usually brought about through a committed team effort, therefore applications will be open to consultant led, multidisciplinary teams of five individuals. These teams must describe a project that lends itself to a quality improvement approach to achieve our Trust aspiration of “no waits, no waste, zero harm”. The successful teams will deliver improvement over the course of the programme and will be supported to publish or present at a conference, allowing their work to be celebrated far beyond the walls of our organisation.

1.3 Purpose of the Project

BCQA is committed to helping teams to identify, plan and execute improvement projects throughout our organisation, deliver successful results and, where possible, spread changes across the system. Organisations that achieve multiple and sustained improvements have a number of individuals throughout the organisation to drive these initiatives. To effectively deliver improvement, these individuals need more than just an interest in improvement work. They need a solid foundation, advanced knowledge and skills in the art and science of improvement, plus the ability to engage their colleagues in achieving and maintaining successful improvement.

BCQA will provide the advanced knowledge and skills needed to excel in a collaborative learning environment with actionable ideas to achieve maximum results.

Blackpool Teaching Hospitals aim to have health and care services that are fit for the future, delivered by a skilled, motivated and resilient workforce (Appendix 1). Part of the commitment is 'Thriving Futures' which means the organisation will support staff in each step they take in their career journey as well as priding ourselves in nurturing the skills and leadership to help deliver the best care we can. BCQA will ensure that the organisations commitment and aim is focused on and addressed throughout

1.4 Aims and Objectives

BCQA aspires to maximise potential to move at pace and scale, creating a critical mass of "improvers" and create a culture for improvement across the Trust.

Aim: By 2022, ten clinically led teams will deliver projects to achieve "no waits, no waste, zero harm" outcomes, whilst developing advanced improvement science knowledge and skills.

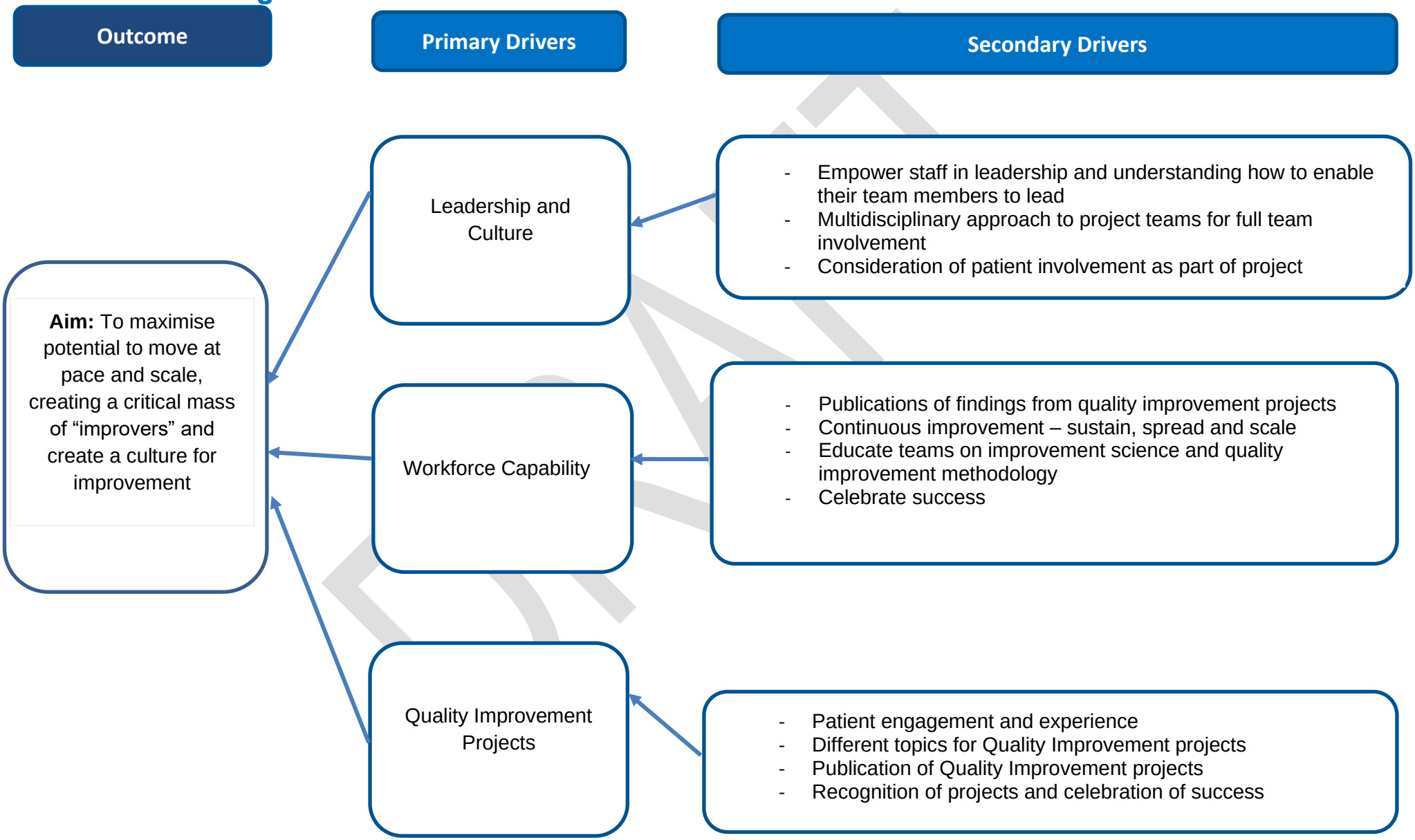
This will be measurable by:

- Number of projects achieving improvement in process and outcome measures using data for improvement (SPC)
- The Model for Understanding Success in Quality (MUSIQ)
- Team stories relating to the art and science of improvement
-

Objectives:

- Clinically led teams across the Trust will be supported to apply for a place on BCQA
- Successful teams will develop a deep understanding of improvement science to ensure their project goals are achieved and sustained how to use the QI methodology to ensure their projects are sustainable
- Graduates of the Academy will have attended the teaching sessions, presented their work at each session, submitted monthly progress reports, discussed their work with an executive sponsor and published or submitted a poster to a conference.

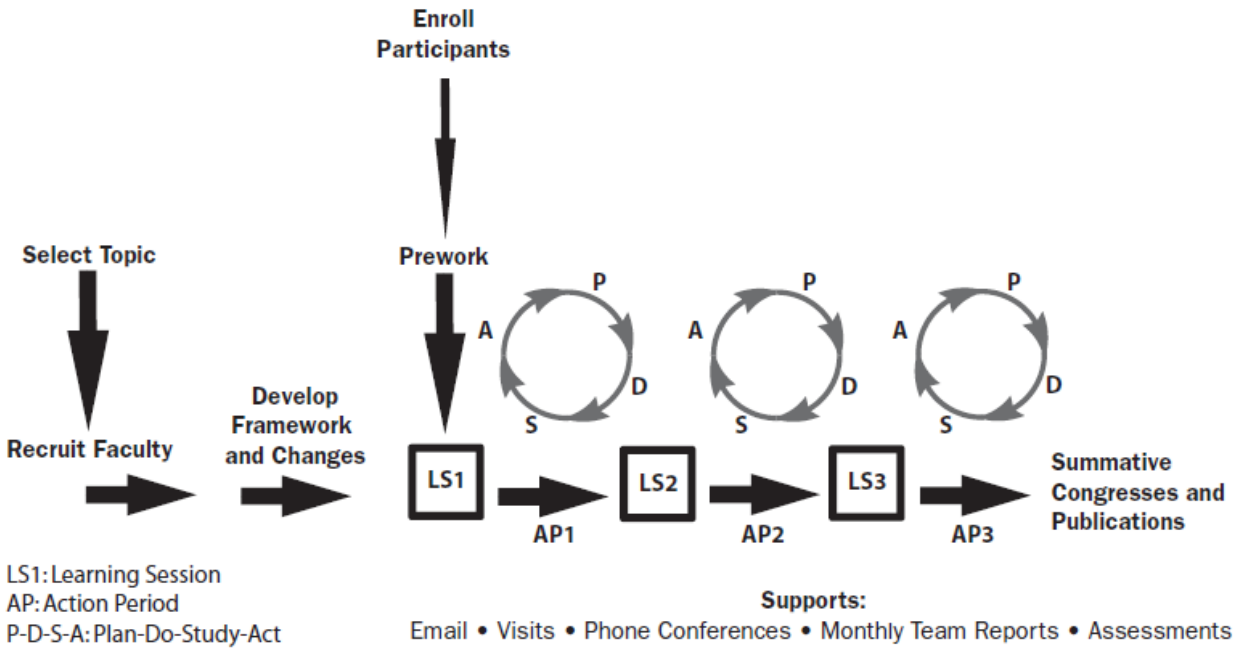
2. Driver Diagram



3. QI Approach and Project Plan

3.1 QI Approach

The Clinical Quality Academy will be structured in a similar way to the Breakthrough Series Collaboraive model developed by the IHI and will embody an “all teach all learn approach”. Throughout the Clinical Quality Academy the teams will be taught about the fundamentals of improvement, these include; History of Improvement Science, Deming’s Profound System of Knowlede, The Model for Improvement, Shewhart’s theory of variation and statistical process control (SPC), variation and interpretation of both qualitative and quantitative research.



Breakthrough Series Model[2]
Reference: IHI’s Collaborative Model for Achieving Breakthrough Improvement.
IHI Breakthrough Series White Paper 2003.

3.2 High Level Project Plan

Stage	Date
Communications Launched – Applications opened	June/ July 2021
Applications Deadline	August 2021
Interviews	September 2021
Notification of place on Academy	September 2021
Workshop 1	October 2021

Month	Topic	Presenter
Day 1 October 20th 2021	History and definition of improvement science - Deming's System of Profound Knowledge - Model for Improvement - How to develop, test and implement change (PDSA cycles) - Project aim and driver diagram	Brandon Bennett Institute for Healthcare Improvement faculty, USA
Day 2 October 21st 2021	- Shewhart's theory of variation and Statistical Process Control (SPC) - Rationale about monthly reporting - Sampling and stratification - Quantitative methods - Measuring for improvement and research - Data visualisation	Mohammed Mohamed has a chair in quality in healthcare at the University of Bradford
Day 3 October 22nd 2021	- Understanding systems and process - Process mapping - Psychology of change - Understanding personalities and leadership - Coaching for improvement	Zoe Egerickx Specialist in human psychology, behavioural insights, change management and improvement science. Zoe has a background in nursing.
Day 4 November	- Factorial Design (planned experiment) - Team presentations	Brandon Bennett
Day 5 January	- How to Publish Quality Improvement - Research using SQUIRE guidelines in improvement practice - Qualitative and Quantitative methodologies - Innovation and Creativity Techniques	TBC

	- Team presentations	
Day 6 February	- Holding the gains – sequence of improvement and spread - Difference between testing and implementing - Belief systems - Scaling and spread - Team presentations	TBC
Day 7 March	- Systems thinking and systems leadership - Team presentations	Mohammed Mohamed
Day 8 May	- Case studies - Harnessing the power of influence - Attention economy - Team presentations	TBC
Day 9 June	- Evaluation using film – lights, camera action - Team presentations	TBC
July	- Graduation and celebration event	TBC

BCQA PID References

1. Blackpool Teaching Hospitals. *Quality Improvement Strategy 2019 – 2022*.; 2019.

2. Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement (IHI Innovation Series white paper.) Boston: Institute for Healthcare Improvement, 2003

Appendices

Appendix 1

Board of Directors Meeting

1 July 2021

Corporate Risk Register

Author of Report:	Charlotte Mays, Risk Manager
Executive Director Sponsor:	Peter Murphy, Director of Nursing, AHPs and Quality
Date of Report:	21 June 2021

Executive Summary:

Outlined below are some key points for the Board from this report:

- Continue to improve risk management across the organisation with an increased focus on divisional risk review and visibility, and review of all risks on the registers
- Enhance systems for real-time risks visibility with a focus on completing actions and driving down risk scores
- Continue to ensure enhanced visibility of high score risks and the corporate risk register within the organisation, and training programmes to support effective risk management and challenge
- One new risk has been escalated after agreement to Part A of the Corporate Risk Register (CRR)
- Safeguard (Ulysses) has been re-configured for the new divisional structure
- The divisions have been working to review their risks and have reduced the risks to be reviewed from 603 to eight.
- The next phase in the programme is to focus on all actions that are overdue for review.

For Information/Assurance:	**For Discussion:**	**For Approval:**
X		

Recommendations:

For the Board to note the updates to the Corporate Risk Register (Part A).

Sensitively Level:

Not Sensitive: (for immediate publication)	**Sensitive in Part:** (consider redaction prior to release)	**Wholly Sensitive:** (consider application exemption)
	X	

Board of Directors Meeting

6 May 2021

Blackpool Teaching Hospitals
NHS Foundation Trust

Corporate Risk Register

Background:

The Corporate Risk Register (Part A) continues to evolve. The Corporate Risk Register (CRR) provides the Board with a detailed overview of the current recorded corporate risks. Nonetheless, as is appropriate, the CRR is a live document that has been further updated in the preceeding month, following discussions with Executive Directors and other senior staff.

As highlighted at the previous meeting, phase three of the improvement programme is in progress. The Risk Manager is continuing to hold training sessions for all staff across the Trust to ensure good risk management. A survey has been created to gain feedback from all staff after further improvements have been made.

The Risk Manager has worked closely with Ulysses, our system provider, to create various reports, to provide departments, divisions, and corporate services with a clear overview of risk management and the effectiveness of the system and its use.

The Risk Management Survey was completed by 142 members of staff and demonstrates positive results and room for improvement within key areas. Therefore, as a matter of priority, the Risk Manager is working with the divisions to ensure:

- Training is made available on the system
- All the Divisional Risk Registers are up to date including risk reviews and actions
- Departments, wards, and services are aware of their top 3 risks

In preparation for the CQC, the Risk Manager is working closely with the divisions. One of the actions is to communicate to all staff the top risks for the Trust, which are aligned to the Trusts 1-year vision

Summary:

The CRR (Part A), is comprised of divisional, departmental, and corporate service risks, which, if materialised (in part or full), have the potential to result in significant adverse consequences for Staff, Patients, Visitors and the Trust, therefore require executive input or overview.

Progress Update:

The Board is advised to note the material changes of the CRR. Meetings have been held with Executive Directors and Risk Owners to review and update their risks.

New Risks added to the CRR, since March 2021

Ref No.	Risk Title	Current Score (L x I)	Reason / Agreement
3317	The Trust is at risk of failing to meet the Accessible Information Standard (AIS), which became a legal requirement in 2016; this is due to not providing information in different formats to our patients.	**(3 x 5) 15**	The Trust is at high risk of disability discrimination and severe financial loss after complaints and claims continue to be made about not offering appointment and other information in other formats. If the Trust continues to take its current stance then there is a high possibility of further substantial financial claims being made. We are legally obliged to provide information in different formats to people who require it. This can be Braille, text messages, large font, Easy Read, emails, video, audio etc. We are not providing this nor do we have the systems to support this work, and this project has not moved any further since the AIS came into effect in 2016. This risk has been discussed and agreed to be escalated with the Executive Directors.
3120	There is a risk to the Trust that the Local Exhaust Ventilation (LEV) systems and fire dampers could cause unsafe levels of formaldehyde due to unsuitable fans and infrastructure. This could lead to staff exposure to formalin within Pathology.	**(3 x 5) 15**	This could result in significant health and safety breaches including an increased risk of unsafe levels which has the potential to cause harm to staff working directly with formalin.
3355	There is a risk that there is a lack of governance within the divisional structures to provide the correct level of assurance. This has the potential to impact the maturity of the divisions and the divisional triumvirates being held to account.	**(4 x 4) 16**	This has the potential to adversely impact on finance, quality, performance, and the quality of care provided to patients.
1370	There is a risk that the Pharmacy Dispensing Robot could fail as the system is no longer supported by the company (over 10yrs old) and a Capital replacement project is required. This could have a negative impact on medication supply to patients, impacting turn-around-time & patient- flow. This could then affect the service provided to our patients.	**(4 x 4) 16**	This risk could result in detrimental effect on the service provided to patients. There are issues with accountability and were the device (robot) sits. Therefore, this has been discussed and agreed to be escalated with the Executive Director of Integrated Care and Performance.

Risks increased and decreased since March 2021

Ref No.	Risk Title	Previous Current Score (L x I)	Increased Current Score (L x I)	Reason	Agreed by
2243	There is a risk that the Trust does not comply with infection control standards leading to hospital acquired and nosocomial infections.	**(3 x 4) 12**	**(3 x 5) 15**	A full review of the risk and scoring was undertaken.	Medical Director

3016	There is a risk that the Trust could breach fundamental standards required by its license.	**(4 x 5) 20**	**(3 x 5) 15**		

Recommendations:

For the Board to note the updates to the Corporate Risk Register (Part A).

Last Updated: 14/06/2021

Blackpool Teaching Hospitals
NHS Foundation Trust

Corporate Risk Register

Blackpool Teaching Hospitals NHS Foundation Trust

STEP 1 - IDENTIFY								STEP 2 - EVALUATE				STEP 3 - PLAN			STEP 4 - FOLLOW-UP
Ref.	Linked to Part B	Date Identified	Risk Category / Type	Risk Sub- Category / Type	Accountable Director (Risk Sponsor)	Risk Description		Inherent Risk Rating (L x I)	Controls in place	Assurance (RAG) rating for the strength of controls	Current Risk Rating (L x I)	Actions to address the risk	Action Deadline	Target Risk Rating (L x I)	Progress since last update
						Risk of	Impact / Consequences								
3014	2506, 2532& 2512	17.11.20	Quality	Information Governance	Medical Director	There is a risk that the Trust does not adhere to records management requirements due to the insufficient storage space.	This could cause; damaged folders, incomplete records and unable to locate records. This could lead to monetary penalties, regulatory action due to the General Data Protection Regulation (GDPR), loss of reputation and reduce the quality of care provided to our patients.	(4 x 5) 20	• Additional storage areas awarded: above old Laundry and Loft 2 • Availability of health record folders is monitored via: KPI's, audits and Incident reporting. • Regular assessment by the Fire Officer and the Health and Safety Officer • Utilising NHS BSA offsite scanning bureau and other spaces in mean time • Procured a service to scan health records on our behalf in order to create space. This procurement is complete and the contract has been signed.	Partially Effective/Partially Adequate	(3 x 5) 15	• Estates working on making Theatres 7 – 10 fit for purpose • Implementation of the scanning bureau will ease some of the storage areas • EDMS programme in place	18.03.22	(2 x 5) 10	• EDMS roll out is due to be complete by March 2022
3016	2836, 009 & 2711	17.11.20	Quality	Clinical	Director of Nursing	There is a risk that the Trust could breach fundamental standards required by its license.	The Trust could be at risk of not meeting regulatory requirements and not providing the correct level of care for our patients.	(4 x 5) 20	• Systems and processes in place to enable staff to deliver care and treatment in line with the fundamental standards • Trust's Quality Improvement Strategy is in progress • Deputy Medical Director appointed for professional standards • Check and challenge for CQC action plan	Partially Effective/Partially Adequate	(3 x 5) 15	• The Trust will deliver 3 large scale programmes, as described in the Quality Improvement Strategy. o Elimination of pressure ulcers o Identification and management of the deteriorating patient o Improving the last 1000 days o Safety Culture • CQC action plan • RCP action plan • HENW Action Plan • Reports submitted to the SIB on the improvement agenda •Due to recruit DMD for Public Health expected Q2 21/22 •COAST accreditation visits to the wards and programme	31.08.21	(2 x 5) 10	• Revising system improvement plan • Elimination of pressure ulcers – 20 teams have now completed the Pressure Ulcer Collaborative with the summit for the second phase held in May 2021. • Identification and management of the deteriorating patient – Collaborative commenced in February and the summit will be held in September 2021. • Improving the last 1000 days – Expert faculty have been recruited and plans are being developed to work with community partners • Safety Culture – Programme being developed
2243	2778	02.05.14	Quality	Clinical	Medical Director	There is a risk that the Trust does not comply with infection control standards leading to hospital acquired and nosocomial infections.	This could result in patient harm and regulatory action.	(4 x 5) 20	•Policies, procedures, and training sessions are provided for all staff •Process in place to manage outbreaks and escalation in place •A post infection review process (PIR) is embedded •Monitor of Daily Defined Dosage of antimicrobials and managing any supply problems •The Team use ICNet which is designed to assist with the management of alert organisms and conditions •IPC Team enhanced during Covid and implemented actions in line with Covid Guidance •Resource has been allocated for dedicated improvement support to work with ward teams	Partially Effective/Partially Adequate	(3 x 5) 15	• Monthly reports to the Quality and Clinical Effectiveness Committee to provide information and assurance • A new business case is being developed although no completion date has been set	31.08.21	(2 x 5) 10	• HENW risk assessment has moved from a Level 2 (Serious) to Level 3 (Significant)
3026	1208, 1438, 2833 & 2764	16.11.20	People and workforce	Staffing	Director of HR and OD	There is a risk that the Trust is unable to attract the appropriately skilled and representative workforce. **Linked to BAF 2.1**	This has the potential of adversely impacting the care provided to patients and sufficing the regulatory requirements under safe staffing.	(4 x 4) 16	• Operations Committee oversight on the action plan inc. attracting new talent • Working with International recruitment agencies and Health Education England on the Global Health Exchange programme • International Recruitment programme • Workforce panel reviewing if appointments can be converted into apprenticeships • Agency agreed to cover for gaps in rota • Bid approved for funding with ELHT to provide support for working carers with NHSE/I • People Plan has been socialised • Improved staff survey results • Bid successful to help with pastoral support and Objective Structural Clinical Examination (OSCE). At present there are 2000 nurses in post	Insufficient	(4 x 4) 16	• Arrange workforce panel to review of appointments • Convert locums into substantives staff • Measuring demand and capacity from a job plan and rotas perspective • Collaborative bench across ICS and refreshing rates to reduce contingent labour • ICP workforce transformation • Grow your own scheme • Planned corporate review of workforce • Identify staff for carers passport and legacy mentorship programme • Monitor skills mix through Safe Care tool • Identify staff for carers passport and legacy mentorship programme	31.03.22	(3 x 4) 12	• Change of model for agency fill including contractual change. Gaps now better filled but issues with skills mix being monitored. • There is a clear improvement on long covid-19 on staff sickness and staff availability. However, the Trust is yet to see the impact on long term effects due to covid-19. • Working carers initiative with ELHT progressing
3038	2778, 2440, 2821 & 1734	17.11.20	People and workforce	Staffing	Director of HR and OD	There is a risk that the Trust could be unable to provide the required care standard as a result of reduced or uncertain staffing numbers due to the impact of the Covid- 19 pandemic. **Linked to BAF Risk 2.2**	This could have an adverse effect on patient care, staff wellbeing and the delivery of the service.	(3 x 5) 15	• Workforce Transformation • Strategy including; education, training, support, health and wellbeing and development plans are in place • National Wellbeing initiatives in response to COVID pandemic • Wellbeing apps from NHS England • IAPT stress awareness training for staff •As part of the long-term plan, fit for purpose service reconfiguration and new ways of working have been established and at system level in the longer term	Partially Effective/Partially Adequate	(3 x 4) 12	•Review COVID guidance on a regular basis •National, Regional, and local initiatives •Health and well-being conversations for all staff as part of appraisal process •Behaviour framework •Big Conversation 'listening into action' sessions •Identify candidates to participate in the Shadow Board Programme (Q1 / Q2 2021) •Exploring additional options from partners as part of People recovery •Work is ongoing with the Good Governance Institute to look at staff across the divisions •ICS working group on health and wellbeing national initiatives to decide what to retain •Behaviour Framework is in progress and the Trust are in the process of reviewing the values	31.03.22	(2 x 4) 8	•Adverts are now live to recruit across the divisions for Divisional Directors and Deputy Directors
3027	2608 & 2761	17.11.20	People and workforce	Staffing	Director of HR and OD	There is a risk that the Trust is unable to retain and sustain the appropriately skilled and representative workforce. **Linked to BAF 2.1**	This has the potential of adversely impact on the health and wellbeing of staff, the care provided to patients and it has the potential for reducing training and education income into the Trust.	(4 x 4) 16	• Health Education England (NW) action plan • Workforce Service Improvement Plan • Health Education England (HEE's) STAR workforce planning and Clinically Led Workforce and Activity Redesign (CLEAR) programmes and tools • Medical Engagement Scale survey and associated working groups • Accountability and Performance Management Framework • Job planning activity for doctors • Piloting the NHS National Leadership Academy High Potential Scheme across the ICS • Workforce Transformation Strategy including education, training, support, health and wellbeing and development plans are in place • North West Regional Trauma Hub • National Wellbeing initiatives in response to COVID pandemic	Insufficient	(4 x 4) 16	• Monitoring and managing the number of non-medical appraisals undertaken and having health and well-being conversations with all staff • Behaviour framework • Big Conversation 'listening into action' sessions to be re-established • Identify suitable candidates to participate in the Shadow Board programme (Q1 / Q2 2021) • National, Regional, and local initiatives • Collaborative working to increase number of students next year • Ensure employees work at the top of their license • ICS working group on health and wellbeing national initiatives to decide what to retain • Advert for 100 HCAs • Equality and diversity inclusion workshop with BAME clinical leaders. Assurance - Improved staff survey results • Working carers initiative with ELHT progressing • Vaccination programme ongoing • Charity bid funding for staff rooms and recreational facilities • Work is ongoing with the Good Governance Institute to look at staff across the divisions	31.03.22	(3 x 4) 12	•As part of the long-term plan, fit for purpose service reconfiguration and new ways of working have been established and at system level in the longer term. This could affect staff due to the organisational change. •Adverts are now live to recruit across the divisions for Divisional Directors and Deputy Directors •Behaviour Framework is in progress and the Trust are in the process of reviewing the values •81% staff received their 1st vaccine and 53% staff received their 2nd vaccine (substantive) •72% staff received their 1st vaccine and 49.5% staff received their 2nd vaccine (all staff groups Inc. bank and agency) •ICS CEO Group to get stock of all wellbeing initiatives to review what to retain and any new initiatives •There is a clear improvement on long covid-19 on staff sickness and staff availability. However, the Trust is yet to see the impact on long term effects due to covid-19.

3028		**17.11.20**	**People and workforce**	**Staffing**	**Director of HR and OD**	Brexit deal poses a risk of interruption to service sustainability, provision and destabilising the Boards financial position.	This has the potential of adversely impacting the recruitment of staff and the care provided to our patients.	**(4 x 5) 20**	• Financial planning responsibility and oversight maintained at the operations committee of the Trust • Escalation process in place for the divisions to report any issues on the daily ICC call • EU Exit preparations update provided to Board in March 2020	**Partially Effective/Partially Adequate**	**(4 x 5) 20**	• A detailed discussion to be held with the relevant Board sub-committee and a paper to be presented to the Board • Material updates to be provided at future meetings	**31.08.21**	**(3 x 4) 12**	• Risk to be discussed with HR and transferred due to the risk around recruiting staff
3032		**17.11.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that the Trust could fail to deliver the National Access Targets for the 62 day Cancer Pathway. **Linked to BAF 4.1**	This has the potential of adversely impacting the time taken to diagnosis which could lead to poor patient outcomes which could have an impact on the reputation. This could impact on the achievement of National cancer targets, therefore, impacting the Trusts financial position.	**(4 x 4) 16**	• Local service accountability and reporting with escalation in place • Weekly – patient tracker list meetings for Cancer and RTT • Bi-monthly – Cancer Alliance Board • Cancer action plan and performance improvement plan in place • Bi-monthly - Trust Internal Cancer Board, Outpatient and Theatres Efficiency Programme and Elective length of stay reviews reported to Planned Care steering group • Monthly – Integrated care partnership level meetings for planned and unplanned care including A&E Delivery Board, NHSI/E monthly performance review, System Improvement Board • Cancer Board terms of reference and membership reviewed • Integrated Care System (ICS) transformation programmes for theatres, outpatients, and cancer	**Partially Effective/Partially Adequate**	**(5 x 4) 20**	• A further review of Cancer action plan • Ensure 105% recovery of cancer by monitoring demand to ensure its sufficient and flex accordingly	**31.07.21**	**(3 x 4) 12**	•Review of performance and improvements plans at Operations Committee and subsequent Integrated Performance dashboard provided to the Board. • Restoration plan in place and further elective work being undertaken
3034	**165**	**18.11.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that the Trust could fail to deliver the National Access Targets for 18 week RTT. **Linked to BAF 4.1**	This has the potential of adversely impacting the time taken to diagnosis which could lead to poor patient outcomes which could have an impact on the reputation. This could have a negative impact on patient flow, capacity and the care provided to our patients.	**(4 x 4) 16**	• Local service accountability and reporting with escalation in place • Outpatient steering group focusing on advice and guidance • Green pathways for elective patients agreed and in place although impacted due to trauma ward COVID outbreak • OPD – steering group membership agreed • Divisional supernumerary managerial and clinical teams to support flow • Plans for IS use for Q4 agreed Elective Orthopaedics restarted in March 2021 •Bed management reports and performance dashboards created and launched • IS contract agreed and elective work being transferred	**Partially Effective/Partially Adequate**	**(5 x 4) 20**	• CSU focus on frailty and respiratory pathways to improve flow and length of stay • Deliver Trust part of ICP transformation programme on frailty, cancer, and outpatients • Agreed new waiting list category who have agreed to defer due to COVID and exploring whether these can be removed from waiting list count • Demand and capacity modelling • Divisional and corporate review of flow and discharge • Working with UCLAN for minor dental surgery as additional capacity • Ensure 105% recovery of cancer by monitoring demand to ensure its sufficient and flex accordingly	**31.07.21**	**(3 x 4) 12**	•Review of performance and improvements plans at Operations Committee and subsequent Integrated Performance dashboard provided to the Board •Restoration plan in place and further elective work being undertaken •Further roll out of advice and guidance •Orthopaedics has returned to a 12 bedded elective ward •Suitable patients are being sent to our local IS provider and other NHS organisations
3036	**165**	**19.11.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that the Trust could fail to deliver the 4 hour and 12 hour targets, within the Emergency Department. **Linked to BAF 4.1**	This has the potential of adversely impacting the time taken to diagnosis which could lead to poor patient outcomes which could have an impact on the reputation. This could have a negative impact on patient flow, capacity and the care provided to our patients.	**(4 x 4) 16**	•Oversight and assurance reporting to the Operations Committee and Quality Committee •Local service accountability and reporting with escalation in place •Emergency village: Minors completed, Mental Health assessment unit opened, Urgent Treatment centre was co-located with the Emergency Department •Hospital discharge ward has been established •Concentrate on making improvements to discharge pathways •Bed management reports and performance dashboards created and launched	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	• CSU focus on frailty and respiratory pathways to improve flow and length of stay • Divisional supernumerary managerial and clinical teams to support flow	**31.07.21**	**(3 x 4) 12**	•Business case to support the expansion of the patient flow team has been approved •Recruitment to expand the patient flow team is in progress
3094		**05.01.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that the Trust cannot meet its required ambulance offloading time requirements due to a full emergency department.	This could result in reduced patient flow affecting quality and timeliness of care, reduced reputation and potential regulatory action.	**(5 x 4) 20**	• Covid and non-Covid split pathways • Previous work on footprint and ambulance handover to reduce ambulance waits • Electronic monitoring on Nexus system for ambulance arrivals • Standard Operating Procedure at system level has been agreed and is in place • ED senior clinician to review patients in event of backlog • Escalation procedure in place to Patient Flow Matron and on call manager • Ambulance handover discussed and escalated at each flow meeting • Standard Operating Procedure at system level in place • Serious incident reported, action plan agreed with ambulance service •Bed management reports and performance dashboards created and launched • Ambulance diverts taking place agreed across provider collaboration and NWAS	**Partially Effective/Partially Adequate**	**(5 x 3) 15**	• Plans to transfer patient with senior emergency department team • Joint Ambulance improvement plan to be created	**31.07.21**	**(5 x 2) 10**	• Joint Ambulance improvement plan being created which will be monitored at the Urgent and Emergency Care oversight committee • The division have worked with NWAS to produce a SOP to ensure full escalation of the ED and agreed a rapid handover process to ensure timely offloading of ambulance patients
3095		**06.01.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that our endoscopy department continues to suffer delays and lack capacity, impacting on our cancer and referral to treatment pathways.	This could result in patient harm from delays to treatment and regulatory action for not adhering to diagnostic standards.	**(4 x 4) 16**	• Maintaining P1 and P2 activity including GP fast tracks • All referrals clinically triaged and harm reviews for long wait patients (45 weeks) • Patient Tracker List (PTL) meetings to track cancer waiting lists • Nursing for endoscopy at establishment • Waiting list initiatives including insourcing sessions for weekends • Incentivised shifts for waiting list initiatives is in place • Consultant job plans reviewed to increase triage capacity • Endoscopy trajectory and action plan for recovery including national bowel screening programme plan in place	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	• Recruiting for additional Endoscopes' utilising national campaign initiatives • Prioritisation in relation to post COVID • Increase endoscopy capacity and monitor through the endoscopy action plan	**31.07.21**	**(3 x 4) 12**	•Capital provided for increasing estate and department capacity including recovery area to better utilise endoscopy (July 2021) •The incentivised shifts for waiting list initiatives is in place which is helping to attract staff •Single patient pathway is being embedded with support of IP •Insourcing companies are being used •Locum Gastroenterologists and a modular build is being considered from September 21
3096	**2764**	**07.01.20**	**Performance**	**Reputational**	**Executive Director of Operations**	There is a risk that COVID-19 continues to increase escalations to critical care, creating a backlog of scheduled work including day cases. **Linked to BAF 3.2**	This could result in patient harm from delays to treatment and regulatory action from not adhering to constitutional standards.	**(4 x 4) 16**	• Local service accountability and reporting with escalation in place • Critical care surge plan agreed at ICS level. Daily call in place with management of mutual aid in terms of critical care decompression. Transfer team established on daily rotation across the acute providers to enable swift decompression when required	**Partially Effective/Partially Adequate**	**(5 x 4) 20**	• Elective programme managed as part of RTT and Cancer risks • Being managed at ICS basis - to be de-escalated as critical care use reduces especially considering BTH critical care bed pressures. To be achieved by daily monitoring and forecasting of bed position going forward • Divisional leads creating an action plan in advance of confirmation from the ICS	**30.06.21**	**(3 x 4) 12**	• Waiting for the ICS to agree the reduction in bed base from 20 to 16 • Surgical lists to restart once confirmation from the ICS to reduce bed base
3015	**2616**	**17.11.20**	**Performance**	**Clinical**	**Executive Director of Operations**	There is a risk that patients with mental health issues will not be seen or treated in a timely manner. This is due to a lack of capacity to meet the service demands.	This could result in poor patient experience with potential impact on the patients long term condition as well as slow patient flow impacting on Emergency Department (ED) targets.	**(4 x 5) 20**	• Performance monitored through the operations committee • Improvements in place since April 2020 there has been a step-change in the level of documentation recorded for the escalation for these patients' waits • Senior clinicians remind doctors during hand over if there are patients in the department who need their capacity assessed • Mental Health delays escalated to gold command by the reginal teams	**Insufficient**	**(4 x 4) 16**	• Review and monitoring through the Audit Committee as part of the internal audit plan and recommendations • Re-design service provision • QIP project to be undertaken	**31.07.21**	**(3 x 3) 9**	• Delivering Urgent and Emergency Improvement Plan actions • Emergency village; Minors completed and Mental Health assessment unit opened on 5th May 2021 • Mental Health delays escalated to gold command by the reginal teams

3037	**242 & 2514**	**14.11.20**	**Finance**	**Financial**	**Director of Finance**	There is a risk that the level of funding the Trust is able to generate is insufficient to cover the costs of providing services in a safe and effective way.	This could result in a further risk that costs increase beyond what was planned driven by two main factors – shortage of an appropriately skilled workforce and / or significant changes in the way in which services are delivered.	**(4 x 5) 20**	• Weekly Cash Action Group, Finance deep dives, Reports on variances and forecasts and Medium term financial strategy • Quality and Efficiency Board • Standing Financial Instructions recently updated, Standing Orders and Scheme of Delegation • System Improvement Plan • ICP Cost Improvement/Quality Innovation, Productivity (CIP/QIPP) programme • Shareholder Panel • Articles of Association with Atlas • Counter fraud strategy • Capital programme • Long term plan • Submit 13 week cash flow forecasts to NHSI&E's Cash and capital Team • Financial plan completed for 20/21	**Insufficient**	**(4 x 5) 20**	• Financial plan for rest of 21/22 • Develop medium term financial strategy • Training for staff on financial management • To report against the winter plan and include progress against recruitment • Review of the Operational and Clinical Management Structure • Review the Strategic Estates Infrastructure within the ICS • Report against the share of resource for COVID in the financial forecast • The Trust will be part of ICS wide provider efficiency programme which is currently being developed in conjunction with the Provider Collaborative Board. • Work with the divisions to ensure they are all working towards financial sustainability • Maximise the planned activity and reduce the emergency admissions • Recruit to substantive posts across the Trust • Improve negotiations with Commissioners and ICS	**31.03.22**	**(3 x 5) 15**	• Refresher training on the financial processes to all budget holders and holders of management roles. This would include process of approving posts and procurement process by Q2 2021/22. • Reporting against winter plan going forward which includes progress against recruitment • Review of the Operational and Clinical Management Structure commenced • Review the Strategic Estates Infrastructure within the ICS. To be picked up as part of Health Infrastructure Plan 2. • The Trust has been given a share of the resource for COVID and will report against this value in the financial forecast • Financial plan completed for 20/21 • Financial plan for 21/22 is due to be submitted (June 2021)
3039	**2531**	**17.11.20**	**Finance**	**Cyber Security**	**Director of Finance**	There is a risk that the Trust could sustain a cyber-attack due to the increasing sophistication of attacks and failure to provide assurance that our IT systems are protected. **Linked to BAF 3.2**	This could have an effect on the delivery of services and care provided to our patients, financial loss due to fraud, regulatory action due to information governance breaches and reputational damage.	**(3 x 4) 12**	• Threat scanning software in place Signed up to national CareCert system • CIO network communications in place to rapidly escalate immediate threats	**Partially Effective/Partially Adequate**	**(3 x 3) 9**	• Trust to seek help on specific issues through NHS Digital team to ensure protection from any cyber threat • Any specific instances must be reported and escalated to the senior management	**30.06.21**	**(2 x 2) 4**	• Continuous daily monitoring and senior team twice weekly meeting on health informatics obligations and prioritisation • External resource available if necessary
3065		**16.11.20**	**Finance**	**Financial**	**Director of Finance**	The Trust is at risk of not understanding how effectively the use of resources is to provide high- quality, efficient and sustainable care for patients. This is due to not improving the use of resources assessment.	This has has the potential to impact the quality, efficiency and productivity of the service which could result in negatively impacting on the financial position.	**(4 x 4) 16**	• Tools in place to assess own efficiency i.e. model hospital, service line management and right care • Cost and engagement programme • Updated audit and Operations committees in previous months • System improvement financial forecast check and challenge for each business case since 2019	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	• Work with the divisions to ensure they are all using the use of resources assessment framework, to understand their current state • Work with the divisions ensure they are living in their budgetary allocation and delivering their services in the most efficient manner • Set up a Quality and Efficiency Programme • Set up monitoring meetings between divisions and ED's • The Trust is developing a quality efficiency and productivity improvement board to be implemented after the peak of COVID pandemic	**30.09.21**	**(2 x 4) 8**	• Work with the Divisional Directors of Operations to provide updates on actions • Budgetary allocation in process of being issued to budget holders, including requesting budget holders to sign off their start budgets. (Excluding; reserve, efficiency, and inflation). •Divisional Performance Reviews are conducted quarterly as per the performance management accountability framework •The material has been created for the Quality and Efficiency Programme. There will be a discussion with Clinicians and Executive Directors for approval. •Quality Efficiency and Productivity Improvement Board (QEP Board), to establish a Board for this. The Terms of Reference is being reviewed and once this has been completed there are plans to develop membership of the Board.
1370		**02.03.09**	**Performance**	**Clinical**	**Executive Director of Operations**	There is a risk that the Pharmacy's Dispensing Robot could fail as the system is no longer supported by the company (over 10yrs old) and a Capital replacement project is required.	This could have a negative impact on medication supply to patients, impacting turn-around-time & patient- flow. This could then effect the service provided to our patients.	**(4 x 4) 16**	•Service contract provides out of core hours engineer on-call •User manual available next to the interface p.c. •Twice weekly full system shutdown to ensure the system is working to optimum performance •Number of Pharmacy staff trained who can manage problems •Automation system has an internal UPS allowing 30-40 minutes run time in the event of power failure •Part packs of some products are available in Dispensary and some stock located within 3 satellite Pharmacies •Super users can output packs using the emergency output function •Purchasing team can purchase packs based on BCP •Senior Technicians can manage and prioritise workloads •Suppliers of emergency shelving units are identified in the BCP if shelving is required •Interface system has been upgraded to ARiM web-based system allowing greater access for Pharmacy staff	**Insufficient**	**(4 x 4) 16**	•Scenarios or Robot incidents to be written up as guides •All pre-preventative maintenance issues to be actioned and followed up •Business case to be planned for replacement robot	**01.09.21**	**(1 x 4) 4**	•New risk escalated from Part B of the CRR after agreement with Executive Director of Integrated Care and Performance •Contractor been on site to review scope and plans •Escalated to Chief Finance Officer to confirm funding stream for a replacement •Current issues with accountability and were the Robot should sit
3042		**17.11.20**	**Partnership Working**	**Health and Safety**	**Director of Strategic Partnerships**	There is a risk that, due to the ambiguity around the number of properties used and lack of capacity to meet the demand, the infrastructure and facilities could not be well maintained or built for purpose. **Linked to Atlas TRPR04 and TRPR12. Linked to Part A 005.**	This could result in potential financial penalties, breach of regulations and/or litigation.	**(4 x 5) 20**	• Health and Safety and Environmental Assessments and its related policies in place • Liaison has been undertaken with all service leads to identify properties in use • Access ceased with immediate effect to high-risk third-party properties • All schools have been contacted regarding assurance documentation • Property co-ordinator has been appointed • Letters issued to CEO's at LCC and BC regarding assurance documents • Handover procedure document being produced to ensure notification of change of use/ new builds etc. • Meeting held with insurance brokers and current year policy renewal being discussed • Information currently being gathered via the relevant operational teams regrading services occupying properties where NHS PS are the landlord • Filing now needs to be kept in the basement • A big clean-up has been done in the basement and lighting and other measures fitted to reduce flooding	**Partially Effective/Partially Adequate**	**(4 x 5) 20**	BTH Actions • Storage area to be reallocated will also incorporate the scanning bureau Limitations of electrical capacity within Pharmacy is beyond the remit of Clinical Support Division • An assessment into storage including basements must be complaint with the HSE regulation • All sites of storage to be planned for the relevant risk assessments in Q3 2021 ATLAS Actions •Set up Property Risk Subgroup •Re-circulate copies of the property spreadsheet and email issued to all Trust divisional staff & all relevant stakeholders to establish an exact list of which properties are used by the Trust •Prepare a compliance template for schools to gain documented assurance that the required regulatory checks are being undertaken •Establish List of Landlords •Prepare detailed register of leases •Prepare contract variation to ensure funding in place •Gain a full and detailed understanding of Trust occupancy across the various sites	**30.09.21**	**(2 x 5) 10**	•Atlas Property Team are now liaising closely with Trust operational staff to understand and finalise the NHSPS property templates, regarding actual usage/occupancy •Atlas to work with the Trust to establish formal processes for notifying the Trust of non-compliant properties so that relevant action can be taken •Meeting held with Director of Strategic Partnerships and Chief Operational Staff, from the Trust to agree focus on 43 NHSPS properties •Dedicated temporary additional resource in the form of a Property co-ordinator has been appointed •Several schools have now responded, and access is being arranged to Blackpool Council's database to provide assurance on a further 60 schools
3355		**26.04.21**	**Partnership Working**	**Staffing**	**Director of Strategic Partnerships**	There is a risk that there is a lack of governance within the divisional structures to provide the correct level of assurance. This has the potential to impact the maturity of the divisions and the divisional triumvirates being held to account.	This has the potential to adversely impact on finance, quality, performance, and the quality of care provided to patients.	**(4 x 4) 16**	•Blackpool teaching Hospitals have worked with the Good Governance Institute to devise a new divisional re-structure •Divisional Performance Reviews are conducted quarterly as per the performance management accountability framework •The divisions hold governance meetings on monthly basis divisions governance meetings •The divisions are required to report to various committees and meetings across the Trust	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	•Positions have been advertised to ensure the correct level of governance •GGI are working with the divisions to complete a self-assessment	**30.06.21**	**(2 x 4) 8**	•The divisions have now re-structured into the new 5 clinical divisions •The divisions are working closely with the Good Governance Institute to review their maturity models by carrying out self-assessments •The Good Governance Institute will be facilitating workshops on structures and processes for each division

3120		**18.02.21**	**Partnership Working**	**Health and Safety**	**Director of Strategic Partnerships**	There is a risk to the Trust that the Local Exhaust Ventilation (LEV) systems and fire dampers could cause unsafe levels of formaldehyde due to unsuitable fans and infrastructure. This could lead to staff exposure to formalin.	This could result in significant health and safety breaches including an increased risk of unsafe levels which has the potential to cause harm to staff working directly with formalin.	**(3 x 5) 15**	•Histology staff wearing powered respirators where necessary •Formalin vapour is monitored on weekly basis •Use of existing downdraft benches where possible •Work exposure limits of formalin calculated on annual basis as per requirements •Weekly airflow checks performed in all relevant areas •Fire doors operational, fire extinguishers in place and a weekly fire alarm check •Full evacuation of laboratory staff to assembly points in the event of fire alarm sounding •COSHH assessments in place •Compliance checks are carried out each month •SOPs and training, competency documents in place for processes in laboratories, CL3 room and the mortuary	**Partially Effective/Partially Adequate**	**(3 x 5) 15**	•Atlas to review the findings and work closely with Pathology •To relocate Pathology above the mortuary	**30.09.21**	**(1 x 5) 5**	•Project has been put in place to mitigate the risk •All staff are wearing respirators •Plans have been drawn up by the architect to re-locate Pathology
3317		**22.04.21**	**Quality**	**Clinical**	**Director of Nursing**	The Trust is at risk of failing to meet the Accessible Information Standard (AIS), which became a legal requirement in 2016, this is due to not providing information in different formats to our patients.	The Trust is at high risk of disability discrimination and severe financial loss after complaints and claims continue to be made about not offering appointment and other information in other formats. If the Trust continues to take its current stance then there is a high possibility of further substantial financial claims being made.	**(4 x 4) 16**	•Oversight team in place to monitor and update actions required to meet the AIS oThe oversight team includes heads of informatics, HR, Patient Experience, Legal, Operations and Programme Management.	**Insufficient**	**(4 x 4) 16**	•PMO have been selected to raise awareness at a service level around the AIS, ensuring that clear visual stickers / alerts are placed on the patients' medical notes, hardcopy and electronic. They are also putting a training package together for staff to collect, record and utilise information in generating patient correspondence. •Informatics are liaising with neighbouring Trusts and primary care services to understand how they meet the AIS requirements •Patient Experience has worked with N-Vision and sent a comms out to 2000 people with a visual impairment to see if they would like a VI flag placing on their record	**30.06.21**	**(2 x 4) 8**	•Update expected on the PMO/ informatic actions above by mid June 2021 when the oversight team next meet • The patient experience department has added 10 VI flags so far to patients records
2699		**07.06.21**	**Quality**	**Staffing**	**Director of Nursing**	There is a risk to the trust that the quality governance team could fail to effectively support effective quality governance requirements due to insufficient capacity and skill mix. This is due to vacant, soon to be vacant posts, and a lack of some senior/higher banded posts within the team.	This could have the potential to impact on the trust's ability to meet its responsibilities, and legal requirements across CQC regulations, incidents, serious incidents, risk, health and safety, coronial responses, clinical audit and clinical effectiveness, policies, and legal services; leading to a potential negative impact on patient and staff safety, and the reputation of the organisation.	**(4 x 4) 16**	•Temporary staff have / are being appointed to support various teams •Appointed to Head of Quality Governance post •Senior managers in team working to support team, especially where no managers in post, leading to less focus on improvement work •Team having to work in a priority/needs-based approach, less time to focus on improvement work	**Insufficient**	**(4 x 4) 16**	• Head of Quality Governance to draft an updated team structure and associated request for additional/different posts to address gaps/issues •Seek approval of amended team structure and posts •Seek support/funding/approval for full-time band 7 clinical audit and effectiveness post to replace now vacant 8a 0.4WTE post •Band 7 incident and risk post to be advertised •Head of Quality Governance to propose updated model for legal services provision in the trust •Due to commence recruitment process for band 7 in incident and risk team •Temporary band 4 policy support to commence work with the team	**31.07.21**	**(2 x 4) 8**	• Head of Quality Governance has started to review the team's structure • Advert to be posted for the Clinical Risk and Incidents Manager • Band 3 full time bench to be recruited to support Risk and Incidents •Band 7 clinical audit post JD is being drafted •Band 4 temporary policy support has been identified •Deputy Director of Quality Governance post has been advertised
5		**31.10.18**	**Partnership Working**	**Health and Safety**	**Director of Strategic Partnerships**	There is a risk that the Trust could encounter total loss of Pathology service due to age (>50 years old) of electrical components & lack of electrical capacity in Pathology.	The loss of service would have a significant impact on the Trust's ability to deliver emergency and critical care which would increase risk of patient harm or mortality.	**(4 x 5) 20**	• Escalated to the Divisional Performance Review Meeting (August 20) • Contingency plans in place at neighbouring laboratories & with POCT devices	**Insufficient**	**(4 x 5) 20**	• Explore opportunity to improve electrical capacity in current location or review possibility of alternative solutions • To work with Atlas to understand immediate and long-term mitigations for Pathology electrics and to create an action plan to treat the risk •Liaise with Atlas every time a new piece of equipment requires installation & also had to extend into adjacent area to accommodate new Covid testing platforms	**30.09.21**	**(1 x 5) 5**	•Awaiting written feedback & meeting from Atlas on how to proceed •The risk is unlikely to be reduced until Histology has been re-located (end of Q3)

Board of Directors

1 July 2021

Board Assurance Framework

Author of Report:	Mrs A Bosnjak-Szekeres, Director of Corporate Governance Miss K Ingham, Acting Head of Corporate Governance
Executive Director Sponsor:	Professor N Latham, Deputy Chief Executive
Date of Report:	24 June 2021

Executive Summary (to include, where appropriate, the level of assurance and position on trajectory):

- No additional risks have been added to the Board Assurance Framework (BAF)
- Although there have been no changes to the risk scores for the BAF risks since the last report to the Board, progress has been made with many of the actions and some actions have been completed and moved across to the controls/assurance sections.
- In the refreshing of the Corporate Risk Register, the BAF has also been updated to reflect this where appropriate at a strategic level.
- The Board Assurance Framework has continued to be used as a tool to drive the Committee agendas, with updates in the BAF reflecting committee papers.

The Board is asked to:

- Note the latest updates to the Board Assurance Framework (highlighted in Green)

For Information/Assurance:	**For Discussion:**	**For Approval:**
X	X	X

Recommendations:

The Board is asked to note the report including the changes to the BAF since the last update and the progress made in the utilisation of the BAF in driving the business of the Committees.

The Board is asked to approve the revisions made to the document as recommended by the Board Committees.

Sensitivity Level:

Not Sensitive:	Sensitive In Part:	Wholly Sensitive:
(for immediate publication)	**(consider redaction prior to release)**	**(consider applicable exemption)**
X		

Context

1. This paper is the latest version of the Board Assurance Framework following the review by the Committee's on 22 June and 24 June 2021.

2. The BAF will remain an item on Committee agendas each month, supporting a focus of agenda items and papers.

3. No additional risks have been added to the BAF since the last report to the Board.

4. Although there have been no risk score movements since the last Board report on the BAF, progress has been made with many of the actions.

5. In the refreshing of the Corporate Risk Register, the BAF has also been updated to reflect this where appropriate at a strategic level.

Recommendations:

6. The Board is asked to note the report including the changes to the BAF since the last update and the progress made in the utilisation of the BAF in driving the business of the Committees.

7. The Board is asked to approve the revisions made to the document as recommended by the Board Committees.

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
Quality and Clinical Effectiveness	1.1 There is a risk that the Trust does not meet fundamental standards of quality and care, does not learn from poor performance and does not continuously improve, resulting in patient harm and reputational damage.	• **Quality and Clinical Effectiveness Committee** • **Audit Committee**	20	15	10	-	The Trust has an OPEN risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has MINIMAL risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
							for money.
People and Workforce	2.1 There is a risk that the Trust is unable to attract, recruit and sustain appropriately skilled and representative workforce	• **Quality and Clinical Effectiveness Committee** • **Operations Committee**	16	16	12	-	We will value our people and equip them with the skills to provide the right care. However, we recognise that to achieve our necessary workforce objectives in terms of recruitment, training and culture, we need to have a SEEK appetite towards finance, innovation, reputation and compliance. Such actions and decisions would be subject to rigorous assessment and be signed off by the Board.
	2.2 There is a risk that the Trust fails to foster, grow and continuously nurture the right culture where everyone feels they belong, safe, healthy and well		16	12	9	-	
Finance	3.1 There is a risk that the level of funding the Trust is able to generate is insufficient to cover the costs of providing services in a safe and effective way. There is a further risk that costs increase beyond what	• **Operations Committee**	20	20	12	-	The Trust has an OPEN risk appetite for any risk which has the potential to reduce of cost base. We have a SEEK appetite for some

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
	was planned driven by two main factors – shortage of an appropriately skilled workforce and / or significant changes in the way in which services are delivered (e.g. due to the need for social distancing).						financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
	3.2 There is a risk that the Trust's digital systems and processes are unable to support clinical services and business functions		15	15	8	-	
Performance	4.1 There is a risk that the Trust is unable to manage demand caused by, insufficient resources, volume of attendances and referrals as well as fundamental process issues resulting in an ability to meet the regulatory requirements as required by the NHS Constitution and the potential of patient harm or reduced patient outcomes.	• **Operations Committee**	20	20	12	-	We will deliver the right care, at the right time, and in the right place for our patients. To achieve this, we will need to have a CAUTIOUS appetite towards financial decisions, regulatory compliance and innovation. However, we will have a SEEK appetite towards our reputation as an organisation.

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
							The Trust has MINIMAL risk appetite for risks which are non-clinical but affecting the day-to-day services the Trust provides.
Partnership Working	5.1 There is a risk of a lack of timely and effective integrated solutions emerging from system development and ICP modelling	• **Operations Committee**	16	16	9	-	The Trust has a MINIMAL risk appetite for risk, which may affect the reputation of the organisation. We will work with all our partners, including patients and the public, to deliver our strategy. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. Our appetite for risk in this area will be SEEK in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability.
	5.2 There is a risk that the Trust's systems and processes are unable to support the transformations in clinical services and business functions that emerge from more integrated working.	• **Quality and Clinical Effectiveness Committee**	16	16	12	-	

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
							A decision to take this level of risk would be based on a rigorous assessment and a review of the robustness of the controls and would require support of the Board. We will collaborate within the provider collaborative, integrated care system, integrated care partnership as well as with local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. In this regard our risk appetite is CAUTIOUS. The Trust will AVOID any risk which has the potential to compromise data

Strategic Board Assurance Framework – Board Overview

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
							security.

QUALITY AND CLINICAL EFFECTIVENESS

ACCOUNTABILITY: **Lead:** Executive Medical Director and Executive Director of Nursing, AHP and Quality. **Committees:** Quality and Clinical Effectiveness Committee; Audit Committee

Risk Appetite: The Trust has an OPEN risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation
The Trust has MINIMAL risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed.
We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

Principal Risk

Risk There is a risk that the Trust does not meet fundamental standards of quality and care, does not learn from poor performance and does not continuously improve, resulting in patient harm and reputational damage.

Impact
Patient harm
Reputational damage

Risk Score		
Initial	**Current**	**Target**
20 **5 Impact** **4 Likelihood**	**15** **5 Impact** **3 Likelihood**	**10** **5 Impact** **2 Likelihood**

Risk Score Trend — ⇧ ⇩	
Last update (May)	**Current (June)**
—	—

Key Controls

- Systems and processes to enable staff to deliver care and treatment in line with the fundamental standards, in order to deliver on the three quality aims as outlined in the Trust's Quality Improvement Strategy:
  - Reducing preventable deaths
  - Reducing avoidable harm
  - Improving the last 1,000 days of life
- System Improvement Plan has been submitted to the System Improvement Board (SIB) that includes all Care Quality Commission (CQC) actions which will be monitored by the Quality and Clinical Effectiveness Committee (Q&CE) and through CQC Engagement Meetings.

How effective overall these controls are (tick one)?

	Effective
✓	**Partially Effective**
	Insufficient

Potential Sources of Assurance

Internal
- Whole Health Economy Infection Prevention and Control Committee (WHIPC)
- Antimicrobial Governance Committee
- Mortality Governance Committee
- VTE Committee
- Blood Transfusion Committee
- Assurance via reports to the Q&CE Committee including:
  - Patient stories
  - Quality dashboard
  - Harms Report
  - Serious Incident/Duty of Candour Report
  - Safe staffing Reports
  - Learning from Deaths Report
  - Clinical Audit Reports
  - National Confidential Enquiry into Patient Outcome and Death Reports
  - National Safety Standards Invasive Procedures Report
  - Medical Engagement Survey updates
  - Ward and Community Team Accreditation Programme
  - Pressure Ulcer Collaborative
  - Care of the Deteriorating Adult Collaborative
  - Dissemination of learning to staff from newsletters
  - Patient Safety Walkabout Summary reports on a quarterly basis
  - Quarterly divisional reviews
- Medical Examiners fully functional and from March all deaths are being reviewed.
- Strategic objectives and strategic risks updated following the Board workshop in October 2020
- Royal College of Physicians (RCP) action plan is reported to the Q&CE Committee on monthly basis for maintaining the oversight and providing assurance to the Board
- Infection, Prevention and Control (IPC) Board Assurance Framework (BAF) at Trust and divisional level and checklist audits.
- Monthly report on infection control to Q&CE Committee highlighting board to ward approach. IPC BAF version 1.4 submitted to NHSE/I.
- Regular updates on nosocomial work to executives weekly, Q&CE Committee monthly and Board bi-monthly
- Mortality Governance Committee

Gaps

- Reoccurring themes in serious incidents such as poor documentation and record keeping
- Regulatory breaches per the CQC inspection report including person-centred care, safe and caring, equipment and premises, good governance, staffing
- High bed occupancy levels

Action, Timeline and Progress

- Delivery and implementation plan for the three quality aims in the Trust's Quality Improvement Strategy:
  Reducing preventable deaths - Deteriorating patient collaborative project initiation agreed by the Board, commenced February 2021, with 9 teams engaged. Most recent learning set took place on 15.04.21. Further two dates due in July and September.
  Reducing avoidable harm - Pressure ulcer collaborative commenced in March 2020, Phase 1 & 2 acute teams have shown sustained improvement, community progressing well. The programme will be evaluated June 2021.
  Improving the last 1,000 days of life –Currently in preparation phase, programme launch planning is nearing completion. The first phase will focus on reducing instances of fractured neck of femur in the community. This project initiation document is currently being prepared and will be presented to the Quality & Effectiveness Committee in the first instance.
- Safety Culture Programme – Safety Movement Group are meeting regularly to support the measurement strategy (insight) and co-create a syllabus of activities to improve the safety culture (involvement).
- As per 16 June 2021, 240 out of 249 actions on the existing (June 2019) CQC action plan have been completed (=96%). Divisions have plans in place to manage the remaining nine actions. An additional action plan has been agreed with the CQC following the inspection that took place in January 2021. As per 16 June 2021, 19 out of the 41 of the actions on the new action plan have been completed (= 46 %), the remaining 22 are incomplete, but within date of delivery (= 54 %).
- Discussion to the revised system improvement plan taken place. The revised plan will be presented to a future System Improvement Board (SIB). Deputy Chief Executive linking with NHSI/E Improvement Director on step down plan to be presented to the SIB meeting on 8 July 2021.
- Simplified assessment forms. E-Prescribing (EpR) coming into place pilot commencing in Cardiac Care, training rolled out (see BAF 3.2). Face to face E-Prescribing training delayed due to COVID-19 and pilot commencement delayed until 31 August 2021.
- As of 16 June 2021, 54 COAST visits have taken place (since 5 January 2021) with 37 areas having their first assessments and a further 17 having been reassessed. All adult inpatient areas, 'admitting' areas and the

		- Mortality Reduction Programme and Learning from Deaths - No nosocomial outbreaks since 16 April 2021. As of 10 June 2021, there are 2 COVID-19 positive inpatients. - Clinical Strategy version 1.9 gone through New Hospitals Plan, discussed at Informal Board in April 2021. The Board received a briefing update on Clinical Strategy Development on 6 May 2021. - Completion of RCP action by Q2 2021/22. The Respiratory Programme Board monitors the action plan going forward and reporting through to the ICP. - Governance process for the Emergency Village is driving the clinical developments. - Ongoing Mortality Reduction programme with NHSI. With one of the key actions being improved learning from deaths. A Mortality App has been developed and is in use, this is supported by NHSE/I. Training for Structured Judgement Reviews (SJRs) has taken place and the process commenced. - Mass roll out of vaccination programme (see BAF 2.1). Ongoing LAMP testing programme also in place. **External** - System Improvement Board - CQC reports - NHSI reports - Friends and Family Test - Inpatient survey - Quality Surveillance of tertiary services in relation to specialised commissioned services - The Trust SHMI was a persistent outlier. The Trust is now consistently within statistically normal limits and focus is on clinical sub-groups that are outliers. - HEENW Review completed final report received and risk status improved.	• Patient safety visits need to be relaunched • Using lamp staff screening not been able to roll out to extent of infection control standards. Improvements made in numbers of staff enrolled and reliability over the last month. • Latest HEENW report maintains focus on acute medical take and Acute Medical Unit (AMU)	Emergency Department have had at least one assessment. It is expected that visits to theatres, critical care, paediatrics, outpatient areas and maternity will begin in quarter 2 with revisits to all areas continuing depending on their outcome rating. The COAST PATH peer assessment tool will also be extended to community services during quarters 2 and 3. • Developed senior leadership visibility templates to support services walkabouts which have re-commenced in June 2021 and will be facilitated, they will take place on alternate weeks going forward. Regular informal walkabouts take place with Executive Medical Director, Executive Director of Nursing, AHP and Quality in person and also take place through MS Teams. • Key work is undertaking modified Structured Judgement Reviews (SJRs) regarding patients with nosocomial infections – completion due by 30 June 2021. Reporting will take place through the Quality and Clinical Effectiveness Committee (QCE) in July 2021. • Agreement at SIB to re-run the Medical Engagement Survey (MES) in Q1/2 of 2022/23. • HEENW action plan was submitted on 6 June 2021, along with the action plan and triangulates with Emergency Village and Same Day Emergency Care (SDEC) Programme. The action plan was presented to QCE Committee at the end of May and will be monitored through this Committee on a quarterly basis (next report on 31 August 2021).

PEOPLE AND WORKFORCE		
ACCOUNTABILITY:	**Lead – Director of Human Resources and Organisational Development**	**Committee – Quality and Clinical Effectiveness Committee and Operational Committee**
Risk Appetite:	**We will value our people and equip them with the skills to provide the right care. However, we recognise that to achieve our necessary workforce objectives in terms of recruitment, training and culture, we need to have a SEEK appetite towards finance, innovation, reputation and compliance. Such actions and decisions would be subject to rigorous assessment and be signed off by the Board.**	

Principal Risk	Key Controls	Potential Sources of Assurance	Gaps	Action, Timeline and Progress
Risk There is a risk that the Trust is unable to attract, recruit and sustain appropriately skilled and representative workforce **Impact** Staff motivation and morale Poor patient care Sustainability and delivery of services **Risk Score** Initial: 16, 4 Impact, 4 Likelihood Current: 16, 4 Impact, 4 Likelihood Target: 12, 4 Impact, 3 Likelihood **Risk Score Trend** Last update (May): — Current (June): —	• Operations Committee oversight on the action plan including attracting new talent • Close monitoring of sickness absence and use of agency staff • Work is being done to address the workforce supply by working with international recruitment agencies, offering retire and return programmes as well as working with Health Education England on the Global Health Exchange programme. • The Trust is engaged in cohort 4 of NHSI Retention Programme and also has a retention and recruitment board in situ, to address and mitigate risks wherever possible. • A recruitment microsite up and running. • A daily and weekly staffing report is available demonstrating clinical fill rates. • Staffing contract with Medacs has been agreed to ensure consistency and quality of care is delivered. • The Apprenticeship Levy is being used to develop clinical staff – Nursing Associates and RGNs commenced in March 2020 • Regular audits on returns to work • North West Reservist model programme in response to COVID-19 outbreak in relation to Bringing Staff Back initiative • Redeployment hub • Guardian of Safe Working • Clear project workforce transformation tools to support Emergency Village Programme • Flu programme • Work had been undertaken with the Director of Nursing, AHP and Quality to look at the total workforce; and monthly reviews of all vacancies, recruitment activity, time to hire and alternative recruitment measures were taking place. • Continuing Professional Development and Simulation skills as part of staffing training package • Fast track recruitment process for COVID-19 as part of Call to Action • Human Resources Directors working at system level to ensure we apply guidelines and policies consistently and we look for areas of mutual aid working with hospital cell process • HR Directors undertaking workforce planning activity at ICP including frailty pathway • Internal coordination centre in place responsive to second spike working till at least end of March • COVID-19 and emergency preparedness plan to ensure appropriate safe staffing levels • Mutual aid agreement in place across the system • Opportunistic recruitment in place, working with job centres and colleges to bring non-NHS staff into trust on appropriate schemes • Block booked agency staff for winter plan • International Recruitment programme • Workforce panel reviewing if appointments can be converted into apprenticeships • Change of model for agency fill including contractual change from February 2021 monitoring fill rates on a daily basis continues. • Corporate review of workforce has been completed and a new structure implemented from 1 April 2021	**Internal** • Annual & Quarterly Guardian of Safe Working Report • CQC Action plan on engagement and culture change • Recruitment dashboard in place with Statistical Process charts • Growing for the future Trajectories • Monthly safer staffing report to Operations Committee • Regular audits on returns to work • Recruitment, retention and re-design plans • Conversion rate of internal recruits • Divisional Performance reviews re-instated (assurance process re agency spend) • Pastoral support team implemented, and they work with the Trust's Professional Development Sisters to support the overseas nurses qualify into RCN registered nurses • 87 nurses passed OSCE in May and once PIN numbers are issued will commence in post. • Local People Board and Workforce Planning Group set up for ICP and ICS. Meetings are bi-monthly. **External** • National Staff survey results – improvement in overall results 2020 • Staff Friends and Family Test • Pulse survey on People Plan	• Gaps in Integrated Medicine and Patient Flow division of medical workforce • Retention/turnover of nursing workforce due to aging workforce profile. • Uncertainty about Integrated Care Partnership (ICP) progression and opportunities to share resources • Restoration phase three has highlighted gaps in workforce for delivery • Inability to grow our own at the pace required to meet gaps in professional roles- lead in educational time required and unfunded • Application of policies and procedures • Long term effect of COVID-19 impact on sickness and staff availability • Need for increased engagement in relation to rota issues with junior doctors • Risk to funding from Health Education England in relation to improvements to training offering in particular areas (emergency medicine) • National skills shortages in key professional groups • COVID-19 has had an impact on the pipeline for international recruitment due to the restrictions for travel.	• Plans to be drafted on conversion of locums to substantive staff, plan to be shared at Operations Committee in September 2021 linked to the Divisional Performance. Therefore, asking the Divisions to complete plans for conversions. Monthly recruitment meetings with Divisions are to commence in June 2021, and will be used to address staffing/recruitment agency and long-term locum use and what can be done to address areas of pressure, including hard to recruit to areas (workforce transformation filling gaps with alternate staff) and drive down spend. • Measuring demand and capacity from a job plan and rotas perspective to ensure job plans are accurate and staff are working to the top of their license. This work is ongoing, plan to conclude end Q1 2021/22 Medical director to sign off. • Roll out of Allocate roster system in progress. The Trust is currently 70% live with 2 areas ready to go live in the next few weeks. The project was due to be completed by April 2021, however due to COVID this has been extended until 30 September 2021. We are on track with timescales to have all areas live by the end of August / early September leaving the remainder of September for any reporting or technical issues to be resolved. • NHSE/I Capital funded project to set up an ICS AHP collaborative bank has commenced which will run until 31st March 2022. Currently in early implementation phase looking at supplier contract for system platform and preliminary discussions with digital passporting team to integrate the process. • Unfunded Bank and Agency Harmonisation for the ICS. There has been a financial audit and recommendations made by MIAA in January 2021. An options paper has been developed to harmonise bank pay across the ICS. The focus has shifted since this project commenced in 2019 from one of pure cost improvement to offsetting agency costs for nursing by incentivising Trust banks. Alongside the Bank harmonisation (pay and other elements such as mandatory training), an ICS ratecard for nurse agency will be set. The delivery on objectives expected by the end of the financial year 2022. • Recruited Chief AHP lead to review use of AHP roles to improve MDT working. Update to be provided at future date as part of workforce transformation agenda. This work is ongoing, funding for CLEAR project received from HEE. To feed into NHSI work on new divisional structure and workforce modelling due in Q1 2021/22.

	How effective overall these controls are (tick one)? ☐ **Effective** ✓ **Partially Effective** ☐ **Insufficient**			• Corporate review of workforce completed, now in the implementation phase. Recruited substantive to the Chief AHP on 7 June 2021. • Working through Divisional triumvirate vacancies and recruiting to them. Eg tertiary divisions is now being recruited to (3x Deputy Director of Operations – interviews 09.06.2021, Executive Director of Finance – interviews held 14.06.2021, successfully appointed to DOF role). • Grow your own scheme in progress – talent management approach in place and working with ELHT on joint/secondment roles. Nursing templates have been reviewed with a view to signed off/approved in Q3, they will then be implemented. • 100 HCAs to bench (recruitment) anticipated that these staff will be able to fast-track into substantive roles when they occur, this is ongoing. • ICP review of workforce plans across the footprint to improve collaboration. Executive Director of HR and OD is the lead. and plans are in place to develop a workforce plan for ICP. • The final internal audit reports on recruitment, employee life cycle and nursing bank agency and rosters have been received and will be reported to the to the audit committee along with the associated action plans which have been developed. The Audit Committee will monitor implementation of actions. • National guidance on People Plan targets expected by Q3. People Plan has been socialised, KPI's awaited. 2020/21 people plan rolled over into 2021/22. • Following the meeting with HEENW on 31st March 2021, HEENW met internally to discuss the Level 3 concerns. HEENW were reassured by the progress made both in terms of staffing levels on AMU and with the plans that are in place to address the AMU issues which are affecting the learning environment. Both issues were being monitored by HEENW and were rated level 3 (major concerns) as per HEE's Intensive Support Framework (ISF). HEENW have now downgraded the level 3 concerns to level 2 (significant concerns) to reflect the progress that has been made. They will continue to monitor these issues and will review the ISF level on a quarterly basis to ensure that the correct ISF level is attached to the concerns. If improvement is not continuous there is the potential for these concerns to be upgraded again to ISF level 3. They will visit the Trust again to speak to trainees around April/May 2022. HEENW have recommended to the GMC that enhanced monitoring measures continue until they are reassured that improvement is sustained. • Linking into Healthier Lancashire, NHSE and NHS Employers to fast-track international recruitment additional support and a bid for funding has been successful to help with pastoral support and OSCE (objective structural clinical examination). 195 nurses as adaptation nurses, 86 going through the training. 109 nurses passed OSCE in May. 6 due to take their OSCE in June, 66 in July and 69 in July

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 1 in August (104 coming in between July and October). Adaptation nurses (pre-June 2020 intake) 170 in post, with 3 loses, (post-June 2020 intake) 284 Adaptation Nurses since June 2020 and no leavers.
• Bid for funding with ELHT to provide support for working carers with NHSE/I. Bid approved. Next to identify staff for carers passport and legacy mentorship programme. MOU now signed off, additional funding of around £50k awaited, to recruit a temporary member of staff to progress this work.</td>
</tr>
<tr>
<td>Risk
There is a risk that the Trust fails to foster, grow and continuously nurture the right culture where everyone feels they belong, safe, healthy and well

Impact
Patient harm
Staff motivation and morale
Loss of staff and their skills

<table>
<tr><th colspan="3">Risk Score</th></tr>
<tr><th>Initial</th><th>Current</th><th>Target</th></tr>
<tr><td>16
4 Impact
4 Likelihood</td><td>12
4 Impact
3 Likelihood</td><td>9
3 Impact
3 Likelihood</td></tr>
</table>

<table>
<tr><th colspan="2">Risk Score Trend
— ⇧ ⇩</th></tr>
<tr><th>Last update (May)</th><th>Current (June)</th></tr>
<tr><td>—</td><td>—</td></tr>
</table>
</td>
<td>• Health Education England North West (HEENW) action plan
• Workforce Service Improvement Plan
• Health Education England (HEE's) STAR workforce planning and Clinically Led Workforce and Activity Redesign (CLEAR) programmes and tools
• Compassionate Leadership and Just Culture strategies presented at the January Board. Implementation plan in progress.
• Inviting staff identifying as future senior leaders via the succession planning process to participate in the Senior Collaborative Leadership programme
• Trust values and behaviours framework
• Medical Engagement Scale survey and associated working groups
• Close monitoring of disciplinary and grievance cases
• Trust appraisal process
• Close partnership working with Staff Side colleagues
• Big Conversation 'listening into action' sessions
• NHS North West Leadership Academy (NWLA) Shadow Board programme
• Accountability and Performance Management Framework
• Trust succession planning and talent management processes
• Job planning activity for doctors
• Piloting the NHS National Leadership Academy High Potential Scheme across the ICS
• Workforce Transformation Strategy including education, training, support, health and wellbeing and development plans are in place.
• A buddy ward system is n in place for senior managers.
• COVID-19 BAME focus groups held in June 2020 led by CEX, MD, DON & HRD to check in with staff and ensure they understood reasons for completing risk assessments.
• People Pulse surveys completed fortnightly
• Employee Assistance Programme for all staff to access
• Occupational Health services including self and management referrals for counselling and MH practitioner support fully recruited to
• People Plan to become a standing agenda item on all divisional management meetings
• North West Regional Trauma Hub
• National Wellbeing initiatives in response to COVID pandemic
• Wellbeing apps from NHS England
• IAPT stress awareness training for staff
• Staff encouraged to work from home
• Wobble rooms for staff to relax
• Shiny Mind app
• Flu campaign and flu plan
• Health and wellbeing induction in staff handbook
• Staff risk assessments for COVID and DSE
• Part of NHS Leadership mentorship programme

How effective overall these controls are (tick one)?
<table>
<tr><td></td><td>Effective</td></tr>
<tr><td>✓</td><td>Partially Effective</td></tr>
<tr><td></td><td>Insufficient</td></tr>
</table>
</td>
<td>Internal
• Regular monitoring and assurance through the relevant committee(s)
• Monthly monitoring of appraisal compliance rates
• Number of disciplinary and grievance cases
• Number of people promoted
• Executive, divisional and occupational succession plans
• Trust Board, with its new leadership to engage with front line staff – 4Ss walkabout in place
• Occupational Health (OHD) KPI's to measure and monitor performance
• Sickness absence levels
• Employee Sponsor Group for improving culture
• Charitable funding utilised to continue wobble rooms
• Associate Director of Health and Wellbeing
• NED champion for Health and Wellbeing
• Wellbeing directory in place and champions in place across the Trust.
• Staff vaccination programme
• Occupational Health involved in COVID vaccine roll-out
• Temporary funding of some national wellbeing initiatives to continue in 2021/22.
• The number of staff shielding has reduced significantly as people return to work onsite.

External
• Health Education England (NW) action plan
• CQC inspection – Well Led Domain
• NHS NSS results
• Annex 23 of Agenda for Change pay deal
• NHS People Pulse survey results
• SEQOHS accreditation
• Internal Auditor report on sickness</td>
<td>• Staff who do not have an appraisal
• Staff unclear of the responsibilities and accountabilities
• Identifying candidates to attend the Shadow Board programme
• Lack of fully developed internal plan and response to the NHS People plan
• Lack of succession planning within divisions
• Better marketing of the health and wellbeing offer
• Working carers passport to be implemented</td>
<td>• Monitoring and managing the number of non-medical appraisals undertaken in the appraisal window to ensure 100% compliance by April 2021– window was deferred due to COVID and extended as part of restoration. Compliance for 2020/21 was below the norm at 52% as there has been no mandate in place due to COVID-19. As recovery phase continues there is confidence that appraisals will come back online with the appraisal window re-opening in Q1/2 of 2021/22. The compliance for non-medical appraisal at the end of May 2021 was 8.53% vs 0.78% for the same period in 2020/21.
• Health and well-being conversations for all staff as appropriate and are be linked to the appraisal process.
• Behaviour framework is in development and needs to link to the revised Trust Values when agreed.
• Big Conversation 'listening into action' sessions have concluded and link to the findings of the NHS National Staff Survey. Actions are to be completed in Q2 and 3 prior to next staff survey (November 2021).
• Organisational Development Manager to work with Execs to identify suitable candidates to participate in the Shadow Board programme – by end of Q2 2021 (September 2021).
• As part of long-term plan, fit for purpose service reconfiguration undertaken. Consultation completed and new structure implemented as of 1 April 2021, working to fill staffing gaps/newly identified roles at senior manager level within Divisions.
• Refresh of establishment in light of new roles – Q1 2021 (ongoing).
• National, regional and local initiatives. 5 ways to health and wellbeing guide. Signposting in place. Other communication of health and wellbeing campaign measures are being progressed with Communication team on an ongoing basis. Health and Wellbeing national initiatives circulated and updated regularly and targeted for staff. Exploring additional options from partners as part of People Recovery (ongoing) Once completed this will influence future HWB work/planning of activities.
• Advert for 100 HCAs onto bench as part of long-term plan to fill HCA permanent vacancies via talent pool programme. Linked to actions in risk above. These will be included in the talent pipeline as preliminary work will have been undertaken whilst on bench.</td>
</tr>
</table>

				• 83% of substantive staff vaccinated against COVID-19. With a 71% having had both vaccinations. • Plans are in progress for an equality and diversity inclusion workshop with BAME clinical leaders (provisionally programmed for October 2021), SAS Dr workshop was held in March 2021.

FINANCE		
ACCOUNTABLITY:	**Lead – Director of Finance**	**Committee – Operations Committee**
Risk Appetite:	**The Trust has an OPEN risk appetite for any risk which has the potential to reduce of cost base.** **We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.**	

Principal Risk	Key Controls	Potential Sources of Assurance	Gaps	Action, Timeline and Progress
Risk There is a risk that the Trust is not able to generate sufficient resources to cover the costs of providing services in a safe and effective way. There is a further risk that costs increase beyond what was planned driven by two main factors – shortage of an appropriately skilled workforce and / or significant changes in the way in which services are delivered (e.g. due to the need for social distancing). **Impact** Financial sustainability Regulatory intervention and enforcement **Risk Score** **Initial:** 20 – 4 Likelihood, 5 Impact **Current:** 20 – 4 Likelihood, 5 Impact **Target:** 12 – 3Likelihood, 4 Impact **Risk Score Trend** — ⇧ ⇩ Last update (May): — Current (June): —	• Weekly Cash Action Group • Quality and Efficiency Board • Standing Financial Instructions updated, Standing Orders and Scheme of Delegation • Operational Plan • Medium term financial strategy • System Improvement Plan • ICP Cost Improvement/Quality Innovation, Productivity (CIP/QIPP) programme • Shareholder Panel • Articles of Association with Atlas • Contract reviews • Counter fraud strategy • Capital programme • Finance deep dives • Long-term plan • Business case process • Reports on variances and forecasts • Divisional performance reviews relaunched **How effective overall these controls are (tick one)?** [ ] Effective/Adequate [✓] Partially Effective/Partially Adequate [ ] Insufficient The key factor in which the effectiveness of the controls remains partial is due to the uncertainty of the funding streams and how the ICS distributes system funding.	**Internal** • Integrated Performance Report • Counter Fraud report • Losses and Compensation report • Annual Report and Accounts • National cost collection report • Waivers report • Financial forecast including cash forecasting that is stress tested • Financial flash results • Financial performance report includes: High level pay/non-pay trajectory forecasting Cashflows Stress testing • Operations Committee • Winter plan 20/21 • Financial forecasts to ICS • Workforce planning group • The Trust has significantly invested in the replacement of medical equipment in the previous 18 months. This will be monitored on an ongoing basis through capital replacement programme. • Current financial regime to continue for Q1 and 2 21/22. Continuing with financial planning process internally. Internal budgets are in the process of being set and issued for 2021/22. • Current COVID-19 costs have been met within the ICS system resource. **External** • CQC Use of resources assessment • External audit • Internal audit • NHSI Report • The System Improvement Board has ratified an investment programme to meet the CQC actions from the visit in June 2019	**Income, Expenditure and Cash** • Failure to manage cost pressures and / or new investments (including capital) and agency expenditure within the affordability envelope agreed with the ICP. • Lack of clarity on future financial regime does not support good financial decision making beyond end Q2. • Unclear cash position post COVID-19. • Unclear deficit position post COVID-19 but likely to have worsened. • Potential for the recurrent services badged as 'winter' created an increasing deficit. • Significant shortfall in substantive staff and therefore increased spend of agency and bank staff. Nursing position improving, but medical staffing remains a concern. **Sustainability** • NHSI/E deferred operational planning round for 2021/22. • Lack of appropriate tertiary service offer nor exploitation of current tertiary services. Tertiary Services Division now established. • No cold elective site. • Current funding regime is not needs led meaning it does not support the population demographic or activity that Trust currently serves. • Quality and Efficiency (Cost Improvement) Programme requires refresh. • Business cases are financially assessed from an economic perspective rather than an affordability one. • Pressure to respond to quality and safety issues leads to circumstances of operating outside financial control procedures. • Further rigour and scrutiny needed of current financial management. • No agreed ICS financial regime approved or agreed for Q3 and 4 of 21/22 • No agreed NHSE/I contractual regime approved for Q3 and 4 of 21/22.	**Income, Expenditure and Cash** • Financial plan being developed for 2021/22 based on the most recent planning guidance. Updates continue to be provided to the Operations Committees on a monthly basis incorporating latest NHS E/I guidance. Plans for the first half of the year (H1) have been agreed with the ICS via the submission on 6 May 2021 which was shared with the Operations Committee at its meeting in May 2021. Planning guidelines for H2 are as yet unknown (estimated to receive in Q2 of 2021/22). • The Organisation has been given a share of the resource for COVID and will report against this value in the monthly financial position reports – ongoing for at least the first half of 2021/22. • The Trust is in receipt of revenue support and will continue to submit 13-week cashflow forecasts to NHSI/E's Cash and Capital Team and will continue in 2021/22. • Refresher training on the financial processes to all budget holders and holders of management roles. This would include process of approving posts and procurement process by Q2 2021/22 (ongoing). **Sustainability** • Developing a medium-term (1-5 years) financial strategy to include a costed, resourced and affordable plan to ensure the Trust meets all safety requirements and can achieve operational performance standards and go beyond 2021 to return to at least a financial balance in the future. This will require both transformational change which reduces costs and / or recurrent additional income to support the cost base and will be reported to the Operations Committee when agreed. • Review the Strategic Estates Infrastructure within the ICS to be picked up as part of ICS Strategic Estates Group which has been re-established following it being stood down due to COVID-19. • We are in the process of re-establishing the Quality and Efficiency Programme for saving requirements in 2021/22, planned to be re-established by end June 2021. • Agreement for an ICS wide Provider Efficiency Programme, which is currently being developed in conjunction with the Provider Collaboration Board.

Risk
There is a risk that the Trust's digital systems and processes are unable to support clinical services and business functions

Impact
Poor patient care
Poor service delivery
Reputational damage
Financial performance and efficiency

Risk Score		
Initial	**Current**	**Target**
15 5 Impact 3 Likelihood	**15 5 Impact 3 Likelihood**	**8 4 Impact 2 Likelihood**

Risk Score Trend — ⇧ ⇩	
Last update (May)	**Current (June)**
—	—

- Seeking system level resource to improve digital infrastructure
- Health Informatics Committee – engagement with Trust on informatics
- Health Informatics strategy
- Electronic Document Management Project (EDMS)
- Electronic Prescribing and Medicines Project (EPMA)
- Health Informatics programme team
- Utilised capital to improve health informatics infrastructure
- 5-year plan for informatics on 'rainbow model'
- Continuous daily monitoring and senior team twice weekly meeting on health informatics obligations and prioritisation. External resource available if necessary.

How effective overall these controls are (tick one)?

	Adequate
✓	**Partially Adequate**
	Insufficient

Internal
- Ongoing tracking and assurance through the Operations Committee with escalation and exception reporting to the Board.
- Health Informatics Committee reporting to Operations Committee
- Information governance report and data quality to Health Informatics Committee
- Chief Clinical Information Officer in post, Chief Nursing Information Officer job description developed
- Quarterly report to Operations Committee on Health Informatics.
- Commenced the Directorate Risk Assurance Meeting cycle, allowing more time for discussion of items than in the past.

External
- Internal and External audit report findings
- Active involvement by Chief Information Officer at ICS level, regional and national events to ensure the trust implementing the health informatics infrastructure for the future

- Trust is well placed with technology architecture to meet current national and regional standards and the trust has a well-developed route to digital maturity however not yet implemented due to funding constraints
- 5-year financial forecast for requirements but is dependent on resources being made available
- Old digital systems infrastructure such as Patient administration system (PAS) reaching end of life needs careful planning to replace.
- Although Electronic patient record (EPR) procurement started aligning with the ICS, the Trust's financial position may mean we cannot implement the EPR within the stated timeframes.
- In addition, other resource constraints may mean more focus is placed on operational delivery rather than strategic development.
- Physical location of the scanning bureau delayed due to requirement to change location. There is significant pressure in relation to the current storage locations for records, specifically the main records storage area in the basement of the Blackpool Victoria Hospital site which was flooded on 10 May 2021. this is thought to be as a result of the building work currently being undertaken in the Emergency Department.
- Board only assured every six months of Health Informatics progress
- Potential for digital support for COVID impacting on other strategically significant projects in the short term.
- Capital allocation for 2021/22 received which falls short of calculated requirement and will have an impact on programmes of work.

- Emergency funding for Health Informatics projects acquired for 2021 part offset due to funding not released from the centre for COVID related purchases. Informal confirmation that COVID funding component will be received, timeline to be confirmed.
- Funding from HLSI available across ICS to move digital system roadmap forward. However, this has been revised and is at a more reduced level than anticipated.
- Procurement of EPR started aligning with ICS – RFIs received, now analysing RFIs across ICS (discovery phase) as ELHT and Lancashire have signed separate agreements. Next step is OBC - August 2021 and was presented to the Exec Team on 19 April. Full business case and mini competition initiated to determine BTH best suited supplier.
- Agreement reached with current PAS supplier to trigger two-year extension to support as per SBS framework agreement. Long-term discussions taking place for PAS future. Issues remain with underlying database and support arrangements that need a clear mitigation plan.
- Market analysis of electronic observation procurement project. Specification in place. Q1 decision on whether to start procurement exercise. Remain on course for decision in Q1
- Scanners for electronic document management project have been delivered – full move into Parkwood was expected completion by February however to be demolished so changed to old Theatres 7 to 10. Estates working on making area fit for purpose. Of the three areas where scanners are to be located, one is complete with the remaining areas anticipated to be complete by July 2021. Contract now in place with external scanning facility to enable faster scanning of paper records.
- Health Informatics Strategy to be reviewed to ensure alignment with the ICS – ongoing looking both over the next 12 months and 5 years. Agreement reached with East Lancashire Health Informatics Service to produce a combined Health Informatics Strategy (2021-2026).
- Stepped down daily call to weekly on COVID as improving picture.
- Review of IG processes and culture to be undertaken. Progress to date includes: Review of current structure and requirements to meet demand with IG senior management, completion of a draft paper supporting restructure to be agreed at the Health Informatics Divisional Board. In addition, discussions are being undertaken around Information Governance risk reports and approvals of information requests with Caldicott Guardian, Chief Clinical Information Officer (acting as Trust responsible Clinical Safety Officer) and Senior Information Risk Owner to determine a way forward.

PERFORMANCE		
ACCOUNTABILITY:	**Lead – Directors of Operations**	**Committee – Operations Committee**
Risk Appetite:	**We will deliver the right care, at the right time, and in the right place for our patients. To achieve this we will need to have a CAUTIOUS appetite towards financial decisions, regulatory compliance and innovation. However, we will have a SEEK appetite towards our reputation as an organisation.** **The Trust has MINIMAL risk appetite for risks which are non-clinical but affecting the day-to-day services the Trust provides.**	

Principal Risk	Key Controls	Potential Sources of Assurance	Gaps	Action, Timeline and Progress
Risk There is a risk that the Trust is unable to manage demand caused by, volume of non-elective attendances insufficient resources and capacity, and the national ask to restore activity to pre-COVID levels resulting in an inability to meet the regulatory requirements set out in the NHS Constitution and the potential of patient harm or reduced patient outcomes. **Impact** Regulatory scrutiny and enforcement Poor patient care Reputational damage **Risk Score** Initial: 20 Impact 4 Likelihood 5 Current: 20 Impact 4 Likelihood 5 Target: 12 Impact 4 Likelihood 3 **Risk Score Trend** — ⇧ ⇩ Last update (May): - Current (June): -	**Internal** • Operations Committee – focus on Trust-wide performance and reporting to Board • Operational Delivery Plan and Restoration plan • CQC Action Plan focus on operational issues • Daily – Emergency Department reporting, Referral to treatment (RTT) over 30-week position, delayed transfers of care etc • Weekly – patient tracker list meetings for Cancer and RTT, weekly performance dashboards and forward view • Monthly – Review of performance and improvements plans at Operation Committee and subsequent Integrated Performance dashboard provided to the Board. • Bi-monthly – Trust Internal Cancer Board, Outpatient and Theatres Efficiency Programme and Elective length of stay reviews reported to Planned Care steering group **External** • Monthly – Integrated care partnership level meetings for planned and unplanned care including A&E Delivery Board, NHSI/E monthly performance review, System Improvement Board • Bi-monthly – Cancer Alliance Board • Provider collaboration including mutual aid support • ICS wide programmes for restoration and recovery **How effective overall these controls are (tick one)?** Effective ✓ Partially Effective Insufficient	**Internal** Ongoing tracking through various reports, including: • Patient tracker actions escalated • Weekly performance report and forward view subject to scrutiny by Executives with actions noted • Reporting to Cancer Board Quarterly Divisional Performance Reviews. • Internal Audit reviews • Integrated Performance Report • RTT improvement plan – monthly monitored at division and operational management group and monthly Patient Tracker List (PTL) • Integrated care system wide agreement to enhanced pay rates for non-medical staff to support additional sessions • Monthly meetings of A&E delivery board • Deliver all actions from Urgent and Emergency Care Improvement Plan - update reports to ICP Oversight Board and Ops Committee at each agenda. • Working with UCLAN for minor dental surgery for additional capacity • Flow team in place with administrative support, revised patient flow meetings and reporting. • Supernumerary managerial and clinical teams in each division supporting flow • COVID-19 virtual ward led by primary care • Nursing home for positive Covid patients who meet criteria to reside • Cancer action and performance improvement plan in place and subject to ongoing refinement –Cancer Board terms of reference and membership reviewed. • Ring fencing of key elective provision (ward 16 currently only ward area that has been ringfenced). Agreed escalation plan and side-room management of COVID patients to maximise elective capacity. • Expanded insourcing of endoscopy programme expected to commence June 2021.	• Managing elective and non-elective pressures – often competing due to no cold site facilities • Insufficient capacity in some areas – i.e. diagnostics • Infection prevention and control requirements resulting in reduced throughput compared to performance pre-COVID-19. • Concerns re potential increases in COVID-19 presentations following observations at other ICS providers. • Workforce issues – as well as ongoing recruitment and retention (link to BAF risk 2.1) • Resources to fulfil extra sessions due to COVID - 19 that may have an impact on staff wellbeing and maintaining a healthy work life balance • Understanding current and future demand and capacity to plan and utilise resources effectively • Business intelligence capacity not sufficient to support operational delivery. • Lack of understanding or ability to utilise performance data at divisional level • Service transformation has not kept up with demand • Patient choice and confidence. As lockdown lifts there is a reluctance to self-isolate prior to planned surgery/admission. Concerns re ongoing COVID from the population as current lockdown measures extended. • Inability of the Trust to directly affect the capacity of external organisations which impairs ability to discharge patients in a timely fashion. • The existing estate configuration is not 'fit for purpose' in some areas i.e. outpatient suites, inpatient wards • Non-Covid non-elective work has returned to pre Covid levels. • Ambulance handover delays • Large vacancies in AMU/ambulatory care middle grade doctor rota.	• We are exploring options of cold site elective provision at Clifton Hospital (Ward 2b and a modular theatre). • Endoscopy capital works continue and are on track for completion in early July 2021. Appointed locum gastroenterology consultants. Increase in restoration programme in hand. Agreed a green pathway for Endoscopic Retrograde Cholangiopancreatography ERCP. • Recruitment is underway for Head of Performance (interviews to be held 15.06.2021). • Initial restoration plan submitted, further work to refine, resubmitted in May 2021, work is ongoing regarding right-sizing of elective and non-elective bed provision, anticipated completion of end Q2.. • Insourcing option for weekend day case - site visit is to take place w/c 14.06.2021 with pre-op insourcing commencing by end of June 2021 with surgery recommencing in early July 2021. An accelerator programme funding request for those schemes/ enablers that do not attract tariff – a response is awaited. • Phase 1 of Divisional restructure completed to enable streamlined reporting going forward. Scoping of business intelligence requirements to take place with a paper to Exec Team in late-June 2021. • Transformation programme recommenced in line with national restoration programme. It is anticipated that this will move to a source of assurance at the next review. • Utilising locally agreed Independent Sector capacity via the National Contract with Spire. • MHAU opened early May 2021, It is anticipated that this will move to a source of assurance at the next review. • Validation programme underway to update prioritisation codes. • National validation programme for diagnostics to commence in June 2021 • Recruitment is underway for patient flow restructure (ongoing). • Ambulance Handover Improvement plan in place and monitoring is ongoing to measure improvements. • Locum breast radiologist in post from 24 May 2021. Substantive recruitment being progressed, to date no suitable candidates. WLI sessions in place to address capacity issues, with an expectation for recovery by the end of June

		• Resumed further theatre sessions and day surgery has been de-escalated and elective programme recommenced. **External** • Minutes and action notes for integrated care provider meetings and Cancer Alliance Board • Integrated Care Provider performance review with NHSI/E – key lines of enquiry and action notes • Oversight Framework report • Emergency Care Improvement Programme report • Working with external partners to support delivery of reduction in LoS and improved flow system wide Hospital Discharge Board in place focusing on national criteria to reside and streamlining of discharge pathways.		2021. ICS agreement to extend the WLI overtime payments. • Peer review of the MU model, including medical rotas utilising ELHT clinical colleagues to take place in May 2021 to evaluate current model and support development of future vision with findings to be reported in June 2021. • Substantive appointments made to the Divisional Directors of Operations; all posts covered awaiting start dates for the permanent staff.

SYSTEM AND PARTNERSHIP WORKING

ACCOUNTABILITY:	Lead – Director of Strategy and Innovation and Director of Finance	Committee – Operations Committee

Risk appetite:

The Trust has a MINIMAL risk appetite for risk, which may affect the reputation of the organisation.

We will work with all our partners, including patients and the public, to deliver our strategy. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. Our appetite for risk in this area will be SEEK in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. A decision to take this level of risk would be based on a rigorous assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate within the provider collaborative, integrated care system, integrated care partnership as well as with local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. In this regard our risk appetite is CAUTIOUS.

The Trust will AVOID any risk which has the potential to compromise data security.

Principal Risk	Key Controls	Potential Sources of Assurance	Gaps	Action, Timeline and Progress
Risk There is a risk of a lack of timely and effective integrated solutions emerging from system development and ICP modelling. **Impact** Future commissioning of services Reputational damage The future system configuration may result in not fit for purpose and misaligned incentive schemes within the system Trust sustainability Unclear role in design and delivery of placed based modelling **Risk Score** Initial: 16 Impact 4 Likelihood 4 Current: 16 Impact 4 Likelihood 4 Target: 9 Impact 3 Likelihood 3 **Risk Score Trend** Last update (May): ⇧ Current (June): -	• ICS system reform and engagement with the Trust • Fylde Coast strategy development programme in place • Interim governance arrangements are in place • Fylde Coast executive group and Fylde coast steering group in place, regular meetings • Fylde Coast ICP strategy 2020 – 2025 in place • Focused discussion through boards on ICP priorities Respiratory, Frailty and Outpatients • Partnership Boards such as A&E Delivery Board • Regular reporting on ICS and ICP decisions to Trust Board • Provider Collaboration Board CEO representation **How effective overall these controls are (tick one)?** Effective ✓ Partially Effective Insufficient	**Internal** • Trust Board and sub-committees reports • Systems partnerships report to Board • CEO update including ICP and ICS developments • ICP strategy in place • ICS Strategy in place • ICP development group meeting monthly • MD and DCEO on provider collaborative within ICP • Director of Communications • ICP work programmes and strategic narrative in place • Joint Executive Director of Communications in place. • Substantive Executive Director of Finance appointed on 14.06.2021. **External** • Regular meetings with Fylde Coast (Monthly meeting papers)	• Need to develop the Trusts input and engagement into ICP development. • Unclear place-based population health modelling is specific to the needs of each of the five ICPs. • Refined programme management approach to the delivery • Further developed collaborative and partnership framework that is agreed with all partners • Need for strengthening stakeholder engagement • Potential changes to ICP boundaries, which at this time would introduce a significant level of risk in delivering on existing large-scale change programmes.	• Active engagement in the development of the collaborative framework and ICP development process with focus on delivery through robust programme management, partnership and relationship development to influence the developments – ICP Development Group in place which reports to ICS Board. Next meeting scheduled for 17 June 2021 where discussions will continue on the future direction of the ICP and ICS. • System reform across ICS ongoing. Provider Collaboration Board in place. CEO playing key role on Provider Collaboration Board. • ICS funding model agreed for Q1 and 2, further information required for Q3 and 4. • Three Board Strategy Sessions have taken place with a further three planned to develop a five-year strategy to align to the ICS.
Risk There is a risk that the Trust's systems and processes are unable to support the transformations in clinical services and business functions that emerge from more integrated working. **Impact** Staff recruitment and retention Lack of strategic delivery Quality of care	• Divisional and corporate restructure plan including creation of tertiary division • Internal clinical transformational plan • Trust working closely with Health Education England and other strategic partners before COVID to address some of the gaps in the workforce and System wide approach to workforce issues and Robust workforce plan and close working with the strategic partners and local workforce plan and succession planning for key roles • Clinical leadership • Imbedding performance management assurance framework • Quality Improvement and Vital Signs • Atlas Shareholder Board	**Internal** • Trust governance and board committees. • Internal Respiratory Programme • RCP Board chaired by Dr Goode. • Performance management quarterly Review meetings • Executive team meetings • Delivery roadmap for transformation of corporate services • Divisional review completed by 1st April 2021.	• Limited resources in the system due to COVID-19 and required rate of response to address the challenges faced in workforce. • Lack of leadership capacity and oversight to ensure delivery. • Lack of permanent staff at Atlas. • Uncertainty about how ICSs will develop the leadership, capabilities and governance required to deliver in 2021/22 and take on their anticipated statutory responsibilities from April 2022 and develop an implementation plan for managing their organisational and people transition into the future arrangements.	• Recruited Deputy Medical Director for Public Health expected to commence in post at the end of June 2021. • Atlas recruitment programme in place, Director of Finance post is currently being advertised, closing date 16.06.2021. • Development of organisational True North and embedding QI – Exec Team session held 17.05.2021 with D Fillingham (Executive Sensei) and will undertake a Board session, details of which are to be agreed (July 2021).

Risk Score **Initial** / **Current** / **Target** 16 Impact 4 Likelihood 4 / 16 Impact 4 Likelihood 4 / 12 Impact 4 Likelihood 3 **Risk Score Trend** — ⇧ ⇩ **Last update (May)**: ⇧ / **Current (June)**: -	**How effective overall these controls are (tick one)?** ✓ **Partially Effective** **Effective** / **Insufficient**	• Tertiary services division set up. • Strategy for Atlas approved March 2021. • Deputy Medical Director appointed for professional standards • Joint Director of Estates in post from 4 May 2021. • New MD in place for Atlas, commenced on 4 May 2021. • Agreed KPIs with Atlas and monitoring taking place. **External** • ICP Respiratory Programme Board • ICP Frailty Programme Board (to be developed) • ICP outpatients programme board • ICP Frailty Programme Director in post, ICP Frailty Programme Board and Delivery Roadmap in place.		

Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting

1 July 2021

Annual Self-Certification 2020/21

Report Prepared By:	Angela Bosnjak-Szekeres, Director of Corporate Governance
Contact Details:	angela.bosnjak-szekeres@nhs.net
Date of Report:	25 June 2021

Report Summary:

NHS providers need to self-certify after the end of the financial year as to whether they have:

1. Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have a regard to the NHS Constitution.

2. Complied with governance arrangements.

3. The required resources available if providing Commissioner requested services.

The attached documents contain the draft self-certification by BTHFT for the financial year 2020/21 against the above conditions.

It is recommended that the Trust self-certifies as confirming compliance with the conditions.

The Board is asked to review the draft self-certification and agree for it to be signed by the Chairman and the Chief Executive before its publication on the Trust website.

1 ☐ **For information**	**2** ☐ **For Discussion**	**3** X **For Approval**

Recommendations:

To Board is asked to agree the annual self-certification for signing by the Chairman and the Chief Executive before its publication on the Trust website.

Sensitivity Level:

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

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2020/21** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Head of Internal Audit Opinion for the 2020/21 year has increased to substantial assurance with minor improvements from limited assurance in 2019/20. Improvements to the control framework and risk management systems have been implemented during the year. Work is ongoing to refine and embed processes. The Board has a full complement of substantive members, with the exception of two Non-Executive Director vacancies which are currently in the process of being recruited to and the Trust has continued to make significant improvements in order to further strengthen the overall governance framework and control systems to ensure the delivery of sustained improvements across the organisational spectrum. The actions from the enforcement action and the CQC inspections are incorporated into a system-wide improvement plan that is regularly monitored.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board receives and considers guidance on good corporate governance issued by the Regulator. The Trust has employed a Chartered Governance Professional since September 2019 to support the Board and to provide assurance on the effectiveness and robustness of the organisation's corporate governance framework.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	In response to COVID-19 the Trust had streamlined its Committee structures to release capacity and the revised Committee structure has been in place since June 2020. The Committees meet regularly and work against an annual workplan and report to the Board of Directors through bi-monthly reporting through the Committee Chairs providing assurance and updates on the Committees. The Committee effectiveness review is being carried out in quarter 1 and any resultant action will be monitored through the Board and Committees. The Trust continued to implement the System Improvement Plan and it has been monitored through the Board Committees, the Blackpool System Improvement Board and the Executive Directors.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust's control framework can be evidenced as operating effectively based on the outcome of the Head of Internal Audit Opinion which was significant assurance with minor improvements. Work is ongoing in the areas requiring the improvements in order to strengthen performance, especially regarding the effectiveness of managing and embedding strategic change. Considerable improvement in the design of plans and monitoring systems to drive and secure change continued in 2020/21. These efforts have resulted in a number of revised processes being put in place and embedded as part of the control framework. We are continuing to work on the recommended minor improvements to ensure that they are properly implemented and embedded into the day-to-day working of the organisation, so that they continue to deliver sustained performance improvement in 2021/22 and in future years.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	As per the statement under section 4, the Board is satisfied that considerable improvement has been made in the designs of the improvement plans and monitoring system to drive and embed change and it receives regular updates and assurance about the continuing work to implement the new systems and to ensure delivery of sustained improvement.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	All Executive posts are now filled on substantive basis and there are two NED vacancies on the Board which are currently being recruited to with succession planning in place for all posts. The Board has a good mix of skills and has welcomed its newly appointed Chairman in post from 1 February 2021. The Trust applies the compassionate leadership ethos and the HR&OD department continued to support the succession planning and talent management programmes across the organisation.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name Steve Fogg	**Name** Kevin McGee

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2020/21 Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed Please fill details in cell E22

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

On the 15 June 2021, the Trust's Audit Committee considered the Going Concern Assessment. In accordance with the requirements of the DHSC Group Accounting Manual ("GAM"), the Trust has prepared its accounts on a going concern basis, applying the 'continuing provision of services' approach. After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future and the directors have adopted the going concern basis in preparing the accounts.

Operational guidance was issued by NHSE&I on 25 March 2021 stating that financial arrangements from H2 of 2020/21 would continue into H1 of 2021/22. The financial arrangements are based on system financial envelopes consisting of nationally calculated block payments from commissioners, system top-up to support delivery of a system break even position, system growth funding and a system COVID funding allocation. The financial plan for H1 of 2021/22 is break even, which includes:
1.The income and costs to deliver the restoration of planned activities;
2.A 3% efficiency target in H1 plans (£8.7m).

At the time of this declaration, the key financial risks facing the Trust in this declaration are:
• There is no further guidance on the financial arrangements for H2 of 2021/22 impacting on the 12 month view;
Elements of the System resource is non-recurrent in nature;
The drive to restore planned activities is impacting upon the Trust's management attention on the efficiency requirements for the year;
• The Trust does not have formal agreement in place for revenue support during 2021/22. The Trust will continue to share 13 week cashflows with NHSE&I to ensure a swift response to a forecasted negative cash balance.
These key risks with associated assurance levels were discussed at the Operations Committee in June 2021.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve Fogg	**Name**	Kevin McGee
Capacity	Chairman	**Capacity**	Chief Executive
Date	01 July 2021	**Date**	01 July 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | **2020/21** | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve Fogg	**Name**	Kevin McGee
Capacity	Chairman	**Capacity**	Chief Executive
Date	01 July 2021	**Date**	01 July 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A During the year the Trust had organised a variety of training and development events for individual Governors and groups on topical matters (eg induction, refresher courses, recruitment of Non-Executive Directors, access to a suite of training materials on the Trust Learning Hub). The Trust has organised expert advice for the last recruitment campaign for the Chair from the specialist recruitment agency and several briefing sessions were organised to enable Governors to understand the recruitment process and to enable them to fully participate in the process and fulfil their statutory duties.

Under the leadership of the new Chairman the Trust is working on refreshing the Governors training and development offer and a presentation was given to the Council of Governors on 16 June 2021. The Trust is currently working with the Trust's Organisational Development team to develop a Training Needs Analysis tool and are also preparing a training session with the Mersey Internal Audit Agency (MIAA) on 30 June 2021. The refreshed training offer will be developed based on the training needs analysis and the results of a survey. The survey is designed to assess the skills base and the training needs of the Council of Governors as a group and those of individual Governors. This will be followed up by the Council of Governors effectiveness survey which the Governors agreed to carry out on an annual basis going forward. The next Council of Governors Effectiveness Survey, based on the GovernWell model is due in September 2021.

Blackpool Teaching Hospitals
NHS Foundation Trust

Minutes of the Audit Committee Meeting
held on Monday 22, March 2021 at 1.30 pm
via Microsoft Teams

Members:		
Mr M Cullinan	Non-Executive Director	Chair
Mr M Beaton	Non-Executive Director	
Professor T Warne	Non-Executive Director	
In Attendance:		
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Mr P Cundy	Associate Director of Finance	
Ms H Fisher	Internal Auditors (KPMG)	
Mr R Jones	Internal Auditors (KPMG)	
Miss L Kavanagh	Corporate Governance Officer	Minutes
Mr J Marsden	Counter Fraud Specialist	
Mr J McManus	Interim Head of Financial Services	
Mr F Patel	Interim Director of Finance	
Mr M Pugh	Corporate Governance Officer (ELHT)	Minutes
Ms H Taylor	External Auditors (Deloitte)	
Ms N Wright	External Auditors (Deloitte)	

Apologies
None

1. Welcome/Apologies for Absence

Mr Cullinan welcomed members to the meeting. Members noted that Professor Warne would be late for the meeting. Mr Cullinan confirmed that a request had been received to defer item 6 until after 14:00 due to the availability of the external auditors. Apologies were received as recorded above.

2. Declaration of Interests

Mr Cullinan informed members that he had now been appointed Chair of the Charitable Funds Committee.

3. Minutes of the Previous Meeting held on 1 February 2021.

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

RESOLVED: The minutes of the previous meeting held on 1 February 2021 were approved as a true and accurate record.

4. Matters Arising

Divisional Structures: It was noted that the divisional structures were still to be finalised and the action should be kept as amber until fully approved next week.

Review of Retention Policy: Members were informed that Information Governance had been consulted and this would be reviewed as part of on-going work for the Data Security and Protection Toolkit (DSPT) and through audits. Mr Patel raised the issue of what happens to scanned documents that are held in the cloud and how the policy is applied. Mr Cullinan suggested that checks are made to ensure that the policy is being followed, especially in relation to records that may be kept for a longer period.

RESOLVED: Consideration to be given to how the Document Retention Policy is being followed, in particular for records that may be kept for a longer period.

5. Internal Audit Reporting

a) Internal Audit Progress Report

Mr Jones presented the previously circulated report, referring members to the progress of the reviews and noting that most have progressed to at least 50% completion or further. Mr Jones informed members that the mortality review had commenced, and it was expected to be completed by year-end. It was explained to members that any delays to the reviews were due to issues including the implementation of new Trust processes, at the request of management and, for one review, the change of scope from Medical Devices to Payroll.

Mr Jones updated members on the follow-up to the Care Quality Commission (CQC) report into the Emergency Department, noting that this was a long report and had taken significant time to be completed, with the initial CQC visit taking place in January 2019. Members were informed that due to the length of time that had passed, the management response and actions dovetailed into what the initial CQC report had highlighted. Director of Nursing, Mr Peter Murphy wished this to be brought to the Audit Committee for review and hoped that the members felt appraised of the progress of the work to address the CQC recommendations.

Mr Cullinan commented that the report was comprehensive, provided assurance to the Committee and highlighted the importance of getting things right and the cross-over with CQC inspections. He added that this area of activity is a top priority for the Trust and wished for the report to be presented to the Trust Board.

A question was raised by Mr Jones regarding the members preference for receipt of subsequent reports and suggested releasing them in batches as they are finalised prior to the year-end meeting to allow members time to read in advance. It was agreed that this would be a useful approach.

Mr Patel noted that the CQC action plan should be presented to the Quality Committee prior to being presented to the Trust Board. Professor Warne responded that he was happy for this to be the case.

RESOLVED: **Subsequent reports to be distributed to members as finalised prior to the year-end meeting. The report and CQC action plan is to be presented to the Quality Committee prior to submission to the Trust Board.**

6. External Audit Report

a) External Audit Progress and Work Plan 2020/21

Ms Taylor referred members to the previously distributed paper, noting that it outlined the initial view on significant risks as part of the audit this year. Members were advised that assessments are still ongoing and Deloitte had set out their initial views on property and management matters. Ms Taylor advised that there is a risk of fraud around revenue and that there will be substantial guidance from NHS England/Improvement (NHSE/I) and the National Audit Office expected to be published in the coming week. Members noted that an update would be provided to members when available. Additionally, members were advised of the work undertaken on property valuation this year, which due to the new auditing standard requiring more detail, has resulted in the need for liaising with specialists in this field, Cushman and Wakefield. It was noted that there had been a requirement to produce a separate report on value for money this year and further details, including the expected fees for the report, were included within the plan. Ms Taylor advised that the intention is to complete as much work as possible before the audit of the financial statements.

A query was raised by Mr Cullinan, asking when the review of PriceWaterhouseCoopers (PWC) files from 2019/20 would be completed. Ms Taylor responded that all PWC files for the Trust had been reviewed in the previous week, including for Atlas and the Trust's charitable fund.

Mr Beaton raised concern around a potential swing in property valuations and asked if this would have a significant impact. Mr Patel advised that there is the potential for revenue impact and should there be a significant upswing, a funding arrangement will be instigated by the national team. He went on to confirm that, at present, there is uncertainty as to whether there will be an increase or decrease in valuation. Mr Beaton highlighted the need to maintain close oversight due to the impact other organisations have experienced in this area.

Ms Taylor drew member's attention to a difference in how Deloitte and PWC calculate the materiality level, noting that Deloitte calculate this based on 2% expenditure whilst PWC calculate based on income. She went on to confirm that there was no significant difference to the final value.

Mr Patel informed members he had agreed with Deloitte that they would be able to work with Trust staff in order to undertake stock takes.

Members were advised that the Going Concern paper would be discussed later in the agenda, however it was noted that guidance was still awaited from the centre. Ms Taylor also highlighted the need to agree a date for the Audit Committee to reconvene in order to sign off the accounts before the deadline of June 15 and proposed meeting the week before (week commencing 7 June 2021). Mr Cullinan agreed to discuss this matter outside of the meeting.

RESOLVED: Committee members approved the plan.
Mr Cullinan to liaise with Ms Taylor on a date for the Audit Committee to reconvene to sign off the annual accounts.

7. Counter Fraud Reporting

a) Counter Fraud Service Report

Mr Marsden presented the report to members, assuming that it had already been read and noting that this is a compilation of previous papers. Mr Cullinan queried one of the values listed in the investigations, asking for further information around the £269,851 figure. Mr Marsden advised that this was based on the hourly rate of £125. He added that he was in consultation with the Police and should this not lead to joint action with the Police, he would refer the matter to the Counter Fraud Authority. Members noted that there was the potential for the matter to progress to prosecution, dependant on the outcome of the formal interview.

Mr Cullinan asked if there had been any actions to prevent a similar situation from occurring again. Mr Marsden advised that there would be a number of recommendations attached to the report. Continuing, he advised that there were flaws in observations of the Trust procedures. Mr Cullinan requested that when the report is completed, he would like a short summary to be presented to the Audit Committee, including comments from the Chief Executive on management action for the future.

Professor Warne queried an incident listed in the report and asked if there has been the assurance that none of the patients in this case came to harm. In response, it was noted that just over 100 patients were affected and the Trust took swift and comprehensive action to contact every patient. Mr Marsden advised that two patients have since died, although this was unrelated to the examination and one refused to come back to the Trust for further examination. He confirmed that the remainder have been re-examined with nothing untoward being found in the second examination and the cost involved in rectifying the situation currently totalled around £18,000.

Mr Beaton referred back to the earlier incident that had been discussed, commenting that the value would equate to approximately 2,000 hours at £125 per hour and asked what period this covered. In response, Mr Marsden noted the period covered was from early 2015 to summer 2019. Mr Beaton raised a concern that checks needed to be made to ensure this is not happening elsewhere in the Trust.

Mr Marsden noted that one issue related to managers often being unaware of staff activity, particularly when they are based on different sites and there is a pattern of rosters being authorised 'blind' as a result. Mr Patel commented that there is the need for greater assurance that timesheets were being checked before being authorise. He advised that he would discuss this further with HR as a matter of urgency.

Mrs Bosnjak-Szekeres agreed with the comments regarding escalation and noted that she had also escalated this to HR. Mr Beaton highlighted the need for some concession to provide trust and enable a flexible workforce. He made it clear that he was not criticising staff or advocating the use of 'clocking in/out', but within a large workforce there will always be some potential for advantage to be taken.

RESOLVED: **Mr Marsden to present a summary to the committee of the final report, including Chief Executive comments and management actions.**

Mr Patel to discuss with HR how timesheets are being checked.

b) Counter Fraud Work Plan 2020/21

Mr Marsden informed members that the work plan had been revised to take into account the Government standards and that although the self-assessment submission for this year will be based on the Government standards, the existing standards would be accepted during this transitional year.

He advised that the submission date was the end of May 2021 and he would liaise with Mr Cullinan and Mr Patel for approval and present the plan to the Committee at the July meeting.

RESOLVED: Members received the update and noted its contents

8. Governance and Assurance Framework

a) Losses and Compensations

Mr Patel commented that this is an opportunity to clean up the balance sheet and there were a number of invoices of considerable age and where their chance of recovery was diminished. Mr McManus informed members that the report covered months 10 and 11 and the low level of run rate has continued with a total of nine compensation payments totalling less than £4,000. He advised that the background work should be completed by year-end.

RESOLVED: Members received the update and noted its contents

b) Accounting Policies

Mr McManus informed members that the usual processing in accounting policies had been followed and he had not identified any new standards that required adoption. He advised that the implementation of International Financial Reporting Standard (IRFS) 16 had been deferred to April 2022, and that the key sources of estimation and uncertainty remain the land and building valuation and the valuation of stock. He informed members that the policies will continue to be reviewed and an updated set will be brought to the next meeting.

RESOLVED: Members approved the draft policies.
Updated versions of the policies will be brought to the next meeting.

c) Draft Going Concern Statement

Mr Patel commented that he was seeking approval from the Committee to prepare the 2020/21 statement as a going concern. He advised that under normal circumstances he would have presented the income streams for the following year to the Committee, however operational planning has been deferred to quarter one of 2021/22, and at present, there are no definitive streams to present, but money is available to the Trust as

required. He noted that new guidance will be produced from the centre regarding going concerns and hoped that later in the week, there would be some communication regarding the incomes streams for the new financial year and any associated deficit, and what could be done to combat this.

Professor Warne queried how, as an independent Foundation Trust, the Trust could be described as a going concern when the system has to take responsibility for all organisations. Ms Wright explained that when looking at a going concern, they would review cash flow and contracts and in light of the pandemic, the approach taken by Deloitte was to look at the funding of services and not necessarily signed contracts. She advised that it is important to consider what is in the annual audit report and the work undertaken including value for money.

Mr Beaton responded that value for money was dependent on the inputs and outputs and although the Trust may be in deficit, it did mean they are not providing value for money. Ms Wright accepted that this is a valid challenge and as an auditor there is the need to understand why there is a deficit.

Mr Beaton commented that it was easier to say the organisation is not a going concern when there is a substantial deficit and it would be preferred to be declared not a going concern rather than not value for money.

Mr Cullinan queried the value for money changes and approach, asking if this is to be looked at via the Operations Committee or the Audit Committee. In response, Mr Patel advised that the Audit Committee would be the preferred forum, as its remit was to consider management controls and processes.

Mr Cullinan advised this should be an agenda item going forward, with discussion, linking into the Operations Committees, so that this is not just a technical exercise.

RESOLVED: Members received the update and noted its contents.
The Going Concern statement to be added as an agenda item for future meetings, linking into the Operations Committee.

d) Draft Annual Governance Statement

Mrs Bosnjak-Szekeres informed members she was preparing the Annual Governance Statement and had scheduled a meeting with Ms Fisher and Mr Jones to finalise the report, adding that she would be grateful for any comments and feedback on the current version and will circulate the draft document for feedback before submission.

Professor Warne noted the report successfully captured the recent governance structures that had been implemented and it was a good first draft. Mr Cullinan agreed and provided feedback, noting that in relation to the Integrated Care Partnership (ICP) it felt that there had been little involvement or information with the progress of the Fylde Coast

which felt at odds with comments made further in the statement. He added that he understood that the last 12 months were focused more on the operational matters in the Trust. Mr Cullinan advised that the Terms of Reference (T.O.R) for the Committees showed some inconsistency between the T.O.R and practice and was unsure how feedback would be provided in the Annual Report. Mrs Bosnjak-Szekeres agreed to ensure the points raised would be addressed.

Mr Patel queried if there would be any sessions scheduled for the Annual Governance Statement or the Annual Report in order to provide feedback. In response, Mrs Bosnjak-Szekeres advised that last year this was provided via e-mail, however should a session be desired, this can be arranged. It was agreed that email would be suitable.

RESOLVED: Members received the update and noted its contents

9. Attendance Monitoring Report

Members noted the attendance monitoring report was provided for information.

10. Any Other Business

No other business was raised.

11. Declaration of Confidentiality

Mrs Bosnjak-Szekeres reminded members that all items be declared confidential unless they were already in the public domain.

12. Formal Meeting Review

Members agreed that the meeting had been well focused and that good levels of assurance had been received from the reports.

13. Schedule of Meetings 2021/22

The next meeting is scheduled for Friday 25 June, time to be confirmed. A meeting will be scheduled to sign off the Annual Accounts.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Quality & Clinical Effectiveness Committee Meeting
held on Tuesday 27 April 2021 at 1.00 pm
via Microsoft Teams

Members

Professor T Warne	Non-Executive Director	Chair
Dr S Bedi	Non-Executive Director	
Mr K Case	Non-Executive Director	
Dr J Gardner	Executive Medical Director	
Mr P Murphy	Executive Director of Nursing, AHPs and Quality	

In Attendance

Mrs S Adams	Interim Operational Director of Human Resources and Organisational Development	
Mr P Allanson	Good Governance Institute	Observer
Mrs S Anderton	Deputy Director of Nursing & Quality	
Mrs M Bamforth	Appointed Governor (Blackpool & The Fylde College)	Observer
Mrs J Bark	Divisional Director of Operations (Integrated Medicine and Patient Flow)	
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Ms N Briggs	Divisional Head of Clinical Effectiveness	
Mr S Chalil	Interim Divisional Director (Tertiary)	
Ms L Cheung	Head of Quality Governance	
Mrs K Goldthorpe	Associate Director of Quality Improvement	For item 8a
Dr G Goode	Deputy Medical Director/Director of Clinical Effectiveness	
Mr A Heath	Associate Director of Nursing & Quality	For item 5f & 7a
Mrs A Hirst	Corporate Governance Officer	Observer
Mrs L Horkin	Divisional Director of Nursing (Integrated Medicine and Patient Flow)	
Miss K Ingham	Acting Head of Corporate Governance	Observer
Miss L Kavanagh	Corporate Governance Officer	Minutes
Mr N Lane	Chief Allied Health Professional	
Mr D Kay	Interim Assistant Director of Nursing (Adult and Long-Term Conditions Division)	
Mrs C Lewis	Head of Quality, Fylde Coast Clinical Commissioning Groups	
Mrs J Lickiss	Divisional Director of Nursing (Surgery, Anaesthetics, Critical Care and Theatres)	
Mrs S Mawdsley	Infection Prevention Nurse Consultant	
Mrs N Parry	Divisional Director of Nursing/Head of Midwifery (Families)	

Dr P Rostami	Senior Quality Improvement Manager/ Patient Safety Specialist	For item 8a
Mrs J Rowley	Interim Divisional Director of Operations (Tertiary)	
Mr S Verstraelen	Deputy Director of Quality Governance	
Mr J Walton-Pollard	Deputy Director of Nursing & Quality (Interim)	

1. Welcome/Apologies for Absence

Professor Warne welcomed Mr Allanson from the Good Governance Institute (GGI) to the meeting and advised the Committee that he would be observing the meeting in preparation for the forthcoming Care Quality Commission (CQC) Well-Led inspection.

Members were informed that as the papers had been received in advance of the meeting, they would be taken as read. Report authors and presenters were asked to advise the Committee about the implications of their reports and to provide an update on the levels of assurance.

No apologies were received.

2. Minutes of the Previous Meeting held on 23 March 2021.

Members, having had the opportunity to review the minutes of the previous meeting held on 23 March 2021 approved them as a true and accurate record, pending the following amendments:

Mrs Lewis advised that all Clinical Commissioning Groups (CCGs) were required to raise with all Trusts, the robustness of the 72-hour reporting.

It was noted that reference to Clostridium Difficile within the minutes should be amended to Clostridioides Difficile. It was further noted that NHS Improvement was expected to issue objectives for 2021/22 for Clostridioides Difficile not NHS England.

RESOLVED: The minutes of the previous meeting held on 23 March 2021 be approved as an accurate record, subject to the amendments above.

3. Matters Arising

a) Action List

Members noted the items on the action list were either completed, or on the agenda for this or future meetings. The following updates were provided:

Action reference 106: Health Education England North West (HEENW). It was agreed to provide an update on the HEENW report to the 25 May 2021 meeting, as the final report had to be presented to the System Improvement Board (SIB) on 13 May 2021.

RESOLVED: Members noted the position of the action list.

CARING

4. a) Patient Story

Mr Murphy introduced the patient story and advised that it was related to a patient who had given birth to her third child. It was noted that this patient story highlighted the positive aspects of the patient's care provided by the maternity team, especially the midwives and student nurses.

In response to Mr Case's comment regarding whether the positive care shown within the patient story related to any actions within the Ockenden report, Mrs Parry advised that it related to 'listening to the voice of the family' action point.

Mr Murphy highlighted the excellent piece of work being undertaken by Ms Fitzgerald, Matron, who was leading a weekly Facebook live event which was focused on answering questions from expectant mothers. The Committee noted the patient story.

SAFE

5. a) Mortality Data

i) Royal College of Physicians (RCP) Report Action Plan Update

Members noted the positive improvements within the action plan update. Dr Goode reported that the Trust was continuing to complete and close off the outstanding actions within the timescales. It was noted that a new consultant had been recruited by the Trust, which would allow the release of the current consultant to enable them to support Respiratory High Care.

Is response to Mr Case's query regarding the 30% deaths outside of hospital, Dr Gardner advised that CCG/SIB colleagues were working together to address this matter. Mrs Lewis reported that an informal review of these cases was due to commence with General Practitioners (GP) and Dr Morgan would provide relevant cases to be reviewed.

Dr Gardner advised that the Summary Hospital-level Mortality Indicator (SHMI) data within the Integrated Performance Report (IPR) contained only in-hospital data and that the various components of SHMI would be provided at the next meeting.

ACTION: Dr Gardner to provide the various components of SHMI at the next meeting.

b) Serious Incident Report, Duty of Candour Report and Health and Safety Report

Professor Warne commented on the detailed comprehensive report and asked that a more concise report be provided to the Committee in the future. It was agreed that the next report would be more streamlined and would provide only information for the members in order to gain assurance.

Mr Verstraelen confirmed that there had been 5 new serious incidents (SIs) reported on Strategic Executive Information System (StEIS) in March 2021, bringing the total number of ongoing serious incidents on StEIS to 18.

Mr Verstraelen advised that the Trust had reported a total of 2,521 incidents in March 2021 which had shown that staff were understanding the reporting process for incidents.

In response to Professor Warne's query regarding the reason why the current open and breached incidents were not being closed, Mr Verstraelen reported that the Incident and Risk Team were continuing to work with the divisions to close the incidents but the recent divisional restructure had temporarily impacted the ability to close off these incidents.

Mr Verstraelen advised that the Health and Safety section of the report was under continuous review and confirmed the data within the report had been analysed to understand the top 3 staff related incidents for the Trust, these being: unsuitable working conditions; slips, trips, and falls; and contact with clinical sharps. It was noted that mitigations were in place to reduce the risk to staff.

It was noted that in March 2021, 44 violent & abusive incidents were reported in comparison to 45 reported in the same period the previous year and work was on-going with the Security Team to reduce the number of such incidents. Members noted that Duty of Candour performance had deteriorated from 100% in February 2021 to 91% in March 2021. Work is ongoing to recover performance in this area.

In response to Mr Case's query regarding whether staff were provided with feedback if they had input an incident into the system at the wrong level of harm, Mr Verstraelen confirmed that staff were provided with feedback.

Mr Murphy reported that as patient visiting had been reintroduced in some areas it was likely that the number of incidents relating to violent and abusive behaviour towards staff should begin to decrease.

Dr Bedi requested that a breakdown of the 24-hour reporting time data would be provided within the next report.

ACTION: **Mr Verstraelen to provide a more streamlined report for the next meeting.**

Mr Verstraelen to provide a breakdown of the 24-hour reporting data to the next meeting.

c) Infection Prevention Control (IPC) Report Including an update on Nosocomial Infections and Board Assurance Framework

Mrs Mawdsley reported that Nosocomial or Hospital Onset Covid Infections (HOCI) (i.e. patients who test positive 8 or more days after admission) had reduced significantly with only 1 case being reported in the past 5 weeks. It was noted that this case related to an asymptomatic patient who had previously tested positive in October 2020 and was borderline in terms of whether the case should have been classed as a genuine re-infection.

It was reported that a total of 9 Clostridioides difficile infection (CDI) cases were attributed to the Trust in March 2021, which brought the overall total for 202/21 to 89. Members noted that this was a 29.9% reduction on the previous year's total. Members were informed that there had been no CDI objectives set for 2020/21 by NHS Improvement yet. It was further noted that the Trust was also awaiting guidance regarding the current COVID-19 restrictions across the NHS.

Mrs Mawdsley advised that the Corporate Fit Testing now sits with the Organisational Development Team.

d) Ockenden Review Update

Mrs Parry provided an update on the current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provided assurance of effective implementation; Local Maternity System (LMS) and NHS England and NHS Improvement (NHSE/I) regional teams.

Members noted that the assessment tool and all serious incidents were to be shared with the Trust's Board of Directors at their next meeting.

Mrs Parry reported that an IEA was that the safety in maternity units across England must be strengthened by increasing partnerships between Trusts and local networks. It was noted that neighbouring Trusts must work collaboratively to ensure that local investigations into serious incidents (SIs) had regional and Local Maternity System (LMS) oversight. It was noted that the Trust had plans to implement a Perinatal Clinical Quality Surveillance Model and introduce continuation of care for mothers.

In response to Mr Case's query regarding having a Non-Executive Director (NED) lead for maternity, Mrs Bosnjak-Szekeres confirmed that this was being addressed with the Chairman.

It was agreed that an Ockenden Review update, including a summary of the points discussed at this Committee, would be provided to the Public Board of Directors Meeting on the 6 May 2021.

ACTION: **Mrs Parry to provide a Ockenden Review update to the Board of Directors for the meeting on 6 May 2021.**

e) Clinical Safer Staffing Report

Mr Heath advised that the report provided members with an overview of the nursing workforce during March 2021 and that it was set out in-line with the National Quality Board (NQB) Standards and expectations for safe staffing.

It was noted that out of the 41 wards reviewed, 32 wards were able to demonstrate a fill for both qualified and unqualified staff and 90% of the planned hours were worked for both the day and night shift. It was further noted that the Trust currently had 126.58 registered nurse vacancies, and the Trust's main recruitment pipeline continued to be via the Overseas Nurse Recruitment Programme. Mr Heath reported that there were 180 overseas nurses in the Trust working as adaptation nurses and that they were preparing for their exams. Mr Heath reported that the Trust had 75 student nurses who were due to qualify in September 2021 and the Trust was working with them to obtain substantive roles.

Mr Heath advised that the Trust had developed a new working group to enhance the Health Care Assistant (HCA) recruitment, with a focus on increasing retention of this staff group and to reduce the time between leavers and the onboarding of new recruits.

Mrs Adams commented that due to the COVID-19 pandemic there continued to be a delay in the overseas recruitment but confirmed that work was on-going with regards to the "grow our own" programme.

In response to Dr Bedi's query regarding ensuring that overseas nurses were welcomed and comfortable with cultural changes, Mrs Adams provided assurance that additional pastoral care was provided for these nurses as well as preceptorships to support them in their first 12 months of being qualified.

Mr Case questioned the governance process surrounding the agreement that all staff would have an extra day's annual leave and how the risks have been mitigated. Mrs Bosnjak-Szekeres agreed to provide information about the governance process around this decision and provided assurance that all risks including financial have been considered and mitigated. Professor Warne agreed that further discussion regarding this was to be taken to the Board.

ACTION: Mrs Bosnjak-Szekeres to confirm the governance process regarding the decision to grant an extra day's leave to all staff.

ACTION: Members requested a Board discussion regarding the governance of delegated decision making.

f) Collaborative Organisational Accreditation System (COAST) Accreditation Programme Update

Mr Heath advised that the Trust had undertaken 34 visits to date, with some wards being awarded Gold Awards. Members noted that 10 revisits had taken place with 7 of those showing improvements. It was noted that the team planned to visit all wards across the Trust by 10 June 2021.

Mr Heath commented that the teams were looking at developing COAST pathway peer reviews for both inpatient and community services.

Mr Murphy acknowledged the positive progress made and the high number of Golds Awards. He stated that this was a testament to the system and it provided the opportunity to focus on those wards that had received a Bronze Award.

It was agreed that Ms Maria Jennings would attend a future meeting to provide the Committee with an overview of the excellent work she had completed within her ward.

ACTION: Mr Murphy to invite Mrs Maria Jennings to a future meeting.

EFFECTIVE

6. a) Quality and Clinical Effectiveness Indicators from the Integrated Performance Report

Professor Warne questioned why the venous thromboembolism (VTE) section of the IPR contained no figures but provided a detailed narrative. Dr Gardner advised that currently the Trust was not reporting the VTE data to the national database due to the ongoing COVID-19 pandemic and advised that the Trust was awaiting National Institute for Health and Care Excellence (NICE) guidance on this matter.

Professor Warne drew attention to the pressure ulcers figures and requested an update on the position. Mr Murphy advised that a full review and analysis would take place on pressure ulcers and a report would be provided to a future meeting.

Mrs Lewis advised that within the report, it had been agreed that the indicators to be monitored would be the 108-hours breaches and the harm review process. It was noted that further guidance on this would confirm the additions of these indicators within the IPR. Mr Murphy confirmed that the 108-hours breaches were reported through the Operations Committee and the harms reviews would be reported through this Committee.

Mr Case conveyed his thanks to the team for providing the health and safety data and it was noted that full assurance was not given as the standards and metrics were still under development. Ms Cheung responded to Mr Case's comment and advised that within the IPR the risks associated with the health and safety data would be included and addressed going forward.

ACTION: **Mr Murphy to provide an update on pressure ulcers at a future meeting.**

Mrs Cheung to ensure the risks relating to the health and safety data are provided within the IPR.

RESPONSIVE

7. a) Complaints Report (Themes and Learning)

Mr Heath drew the members' attention to the report and advised that there had been an increase in complaints in the final quarter of the year.

Mr Heath advised that the Patient Relations Teams were currently undertaking a recruitment exercise to increase the team's capacity, and this would be reflected in the data going forward.

In response to Professor Warne's question regarding the Trust being sighted on the responses from the Ombudsman, Mr Heath advised that the responses were shared with the Trust.

Mr Murphy advised that it would be helpful for the Patient Relations Team to have a breakdown of the pathway and timeframes as this would allow them to see clearly where the time-lapses fell and why the Trust was not compliant with responding to complaints within the required timescale.

It was agreed that the divisions would provide their action plans on dealing with complaints and providing responses to complaints at a future meeting.

Dr Bedi requested more detail on the 'staff attitude' themes that were appearing in complaints and whether it was relating to the stress staff were experiencing. Mr Heath responded that several matters related to patients not wearing masks whilst on Trust property and confirmed that communication would be circulated advising of specific exemptions.

Dr Bedi commented on the importance of understanding the cause of some of the themes within complaints and drew the members' attention to page 177 of the report, which stated that administration was an area of concern. Mr Heath advised that this was a multi-factorial issue and communication with patients was just one aspect. Mr Murphy highlighted the importance of appropriate communication with patients and advised that the Customer Care Programme would support this.

Mrs Horkin commented that an increase was due to social media and guidance on managing this would be circulated to the ward managers and heads of department.

ACTIONS: **Divisions to provide their actions plans on dealing with complaints and providing responses.**

b) Safeguarding Quarterly Report

Mrs Anderton provided a brief overview of the report and highlighted an update on the Trust's CQC Regulation 11, regarding consent which was included on the Trust's CQC action plan.

It was noted that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) compliance had improved. Mrs Anderton advised that divisions had released staff to attend adult and child safeguarding and Prevent training sessions.

It was noted that funding to continue and extend the Independent Sexual Violence Advisors (ISVA) service had been secured and an application for Independent Domestic Violence Advisors (IDVA) funding had been made. Mrs Anderton reported that there had been a significant increase in DOLS applications with 171 submitted in March 2021. It was noted that this was an improvement and provided assurance that divisions had recognised when DOLS and MCA applications were required.

It was agreed that a thank you would be conveyed from the Committee to the Safeguarding Team for all their hard work.

ACTION: Mrs Anderton to ensure the Committee's thanks were conveyed to the Safeguarding Team.

WELL-LED

8. a) Quality Improvement Update

Professor Warne commented on the detailed, comprehensive report and asked that a more concise report be provided to the Committee in the future. It was agreed that the next reporting would be more streamlined and would provide only information for the Committee to gain assurance.

Dr Rostami provided an update on the Safety Culture Survey and advised that the survey had provided the Trust with the opportunity of learning. It was noted that the United States (US) Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture Survey was used locally and nationally. It was noted that the data from the Safety Culture Survey, would be used to recognise and spread good practice, identify areas that require improvement and to open up conversations about safety culture using the Safety Discussion Cards.

ACTION: Mrs Goldthorpe to provide a more concise report to the next meeting.

b) Annual Audit of Effectiveness Programme

Dr Gardner provided a brief update of the report and it was noted that outcomes, reflections and improvements were necessary within the report going forward to provide assurance. It was agreed that this would be included in the next report.

ACTION: Dr Gardner to include outcomes, reflections and improvements within the next Annual Audit of Effectiveness Programme report.

c) Corporate Risk Register (CRR)

Professor Warne commented on the great work with regards to the CRR. Mr Verstraelen highlighted the work that had commenced with linking the SIs, CRR and Board Assurance Framework (BAF). Members were all in agreement that this was now a reliable system and a great mechanism to manage risks going forward.

In response to Dr Bedi's comment regarding the practical use of and feedback from staff on the CRR, Mr Verstraelen reported that the Risk Manager had circulated a survey to staff to enable them to provide feedback on Risk Management. It was agreed that an update on the outcome of the Risk Management survey would be provided to the next meeting.

ACTION: Mr Verstraelen to provide an update on the outcome of the Risk Management survey.

d) Board Assurance Framework: Committee Specific Risks

Members noted the revised BAF and updates that were provided. None of the risk scores increased, but the BAF risk in relation to the ICS will be reviewed at the request of the Operations Committee and presented to the May Board.

e) Items Recommended for Escalation to the Board

It was noted that a summary of the Ockenden Review Report and the governance around decision making would be escalated to the Board.

ACTION: Mrs Parry to provide a summary of the Ockenden Review Report to the Board of Directors Meeting on 6 May 2021.

f) Annual Work Plan

It was agreed by the members that pressure ulcers would be added to the Annual Work Plan.

ACTION: Corporate Governance team to ensure that pressure ulcers were added to the Annual Work Plan.

CLOSING MATTERS

9. a) Any other Business

Mr Murphy conveyed thanks on behalf of the Committee to Professor Warne for his contributions and stewardship that had been provided to this Committee.

b) Formal Meeting Review

Members agreed that the meeting had been well focused and that good levels of assurance had been received from the reports.

c) Date of the Next Meeting:

The next meeting will take place on Tuesday, 25 May 2021 at 1.00 pm via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Quality & Clinical Effectiveness Committee Meeting
held on Tuesday 25 May 2021 at 1.00 pm
via Microsoft Teams

Members

Dr S Bedi	Non-Executive Director (NED)	Chair
Mr K Case	Non-Executive Director	
Dr J Gardner	Executive Medical Director	
Mr P Murphy	Executive Director of Nursing, AHPs and Quality	

In Attendance

Mrs S Adams	Interim Operational Director of Human Resources and Organisational Development	
Mrs S Anderton	Deputy Director of Nursing & Quality	
Mrs M Bamforth	Appointed Governor (Blackpool & The Fylde College)	Observer
Mrs R Bond	Director of Pharmacy/Divisional Director of Operations (Clinical Support)	
Ms L Cheung	Head of Quality Governance	
Miss L Douglas	Interim Divisional Director (Surgery, Anaesthetics, Critical Care and Theatres)	
Mr A Heath	Associate Director of Nursing & Quality	For item 5g & 5h
Mrs A Hirst	Corporate Governance Officer	Observer
Mrs L Horkin	Divisional Director of Nursing (Integrated Medicine and Patient Flow)	
Miss K Ingham	Acting Head of Corporate Governance	Observer
Ms M Jennings	Clinical Matron	For item 4b
Miss L Kavanagh	Corporate Governance Officer	Minutes
Mr N Lane	Chief Allied Health Professional	
Mr D Kay	Interim Assistant Director of Nursing (Adult and Long-Term Conditions Division)	
Mrs C Lewis	Head of Quality, Fylde Coast Clinical Commissioning Groups	
Mrs J Lickiss	Divisional Director of Nursing (Surgery, Anaesthetics, Critical Care and Theatres)	
Mrs S Mawdsley	Infection Prevention Nurse Consultant	
Dr R Morgan	Mortality Lead	
Mrs N Parry	Divisional Director of Nursing/Head of Midwifery (Families)	
Dr P Rostami	Senior Quality Improvement Manager/ Patient Safety Specialist	For item 8a
Ms J Thomas	Senior Business & Delivery Manager	
Mr S Verstraelen	Deputy Director of Quality Governance	
Mr J Walton-Pollard	Deputy Director of Nursing & Quality (Interim)	

Apologies

Mrs A Bosnjak-Szekeres	Director of Corporate Governance
Mrs K Goldthorpe	Associate Director of Quality Improvement
Dr G Goode	Deputy Medical Director/Director of Clinical Effectiveness
Dr S Wiggans	Divisional Director – Scheduled Care

1. Welcome/Apologies for Absence

Dr Bedi introduced herself as the new Chair of the Committee and thanked members for joining the meeting.

Members were informed that as the papers had been received in advance of the meeting, they would be taken as read. Report authors and presenters were asked to advise the Committee about the implications of their reports and provide an update on the levels of assurance.

Apologies were received as recorded above.

2. Minutes of the Previous Meeting held on 27 April 2021.

Members, having had the opportunity to review the minutes of the previous meeting held on 27 April 2021 approved them as a true record, pending the following amendment:

Mrs Lewis advised that on page 9 of the minutes it should read 104-day Referral to Treatment (RTT) and not 108-day breaches.

RESOLVED: The minutes of the previous meeting held on 27 April 2021 be approved as an accurate record, subject to the amendments above.

In response to Mr Case's question whether any formal feedback had been received from the Good Governance Institute (GGI) following their observation of the last meeting, Dr Gardner and Mr Murphy confirmed that no feedback had been received. It was agreed that the GGI would be contacted to gain feedback.

ACTION: Dr Gardner/Mr Murphy to chase the GGI to gain feedback from their observation of the last meeting.

3. Matters Arising

a) Action List

Members noted the items on the action list were either completed, or on the agenda for this or future meetings.

RESOLVED: Members noted the position of the action list.

CARING

4. a) Patient Story

Mr Murphy introduced the patient story and advised it had been produced for International Nurses and International Midwives Day and highlighted the importance of celebrating these days across the Trust. It was noted that the patient story was entitled: "These are the Hands", which highlighted the day to day care provided by nurses and midwifes. Mr Murphy conveyed his thanks to Mr Heath who had helped produce this patient story.

b) Celebrating Brilliance

Mr Murphy introduced Ms Jennings, Clinical Matron, to the meeting and advised that she had undertaken extraordinary work on the Care of the Elderly wards. Ms Jennings reported the challenges the wards had experienced during the Covid-19 pandemic and conveyed thanks to her team for all their hard work during this extremely challenging time. She confirmed that the patient was at the forefront of everything within the Care of the Elderly wards, and that they were hoping for a gold Collaborative Organisational Accreditation System for Teams (COAST) accreditation. Ms Jennings thanked Mr Murphy and Mrs Horkin for the guidance and support that she had received during her time at the Trust and confirmed she would continue to welcome senior teams visiting the wards.

Members conveyed thanks to Ms Jennings for attending this meeting and for all the hard work her and her team were doing.

SAFE

5. a) Mortality Data

i) Mortality Report

Dr Gardner advised that this was Dr Morgan's last meeting due to retiring in June, and took the opportunity to convey his thanks to him for all the work he had done for the Trust and patients in relation to the Learning from Deaths agenda. It was noted that it was fitting that Dr Morgan was due to leave as the nationally reported 12-month rolling average Summary Hospital-level Mortality Indicator (SMHI) was at its lowest ever reported in the Trust of 106.

Dr Morgan referenced specific pathway work relating to sepsis, respiratory diseases (pneumonia and chronic obstructive pulmonary disease (COPD) in particular) and stroke.

It was noted that the stroke data was improving steadily and this was reported in two different ways: one is recording SMHI and the other is the Sentinel Stroke National Audit Programme (SSNAP). SSNAP data for the Trust was in Band C at 66 with a national average of 72. The Trust had also improved on the SMHI which was currently 109.

Dr Morgan referenced the unusually high HSMR in the report which was at 132. It was noted that it was thought that the main reason was due to a distortion of the data due to Covid-19. Dr Gardner advised that further analysis would be undertaken over the coming months in order to update the Committee further.

In response to Mr Case's question about the establishment of the Medical Examiner role, Dr Morgan confirmed that there was a working group looking at how to improve the Medical Examiner role.

It was noted that the Medical Examiner can review deaths that carry an opportunity for learning.

Mr Murphy commented on the great work undertaken by Dr Morgan to reduce the overall SHMI and Hospital Standardised Mortality Ratios (HSMR) figures.

ii) Royal College of Physicians (RCP) Report Action Plan Update

Dr Gardner introduced the report and advised that currently this report was provided monthly to this Committee. It was suggested that going forward, a report would be provided on completion of all actions or exception reports if any problems occurred that the members had to be sighted on. Dr Gardner highlighted the importance of maintaining internal focus on the RCP Action plan, especially with regards to Acute Medical Pathways and Respiratory. Members agreed with the proposal from Dr Gardner.

RESOLVED: An update on RCP Report Action Plan would be provided on completion of all actions or by exception if the members had to be aware of any issues.

Dr Gardner advised that RCP action 01 was being actioned within the Emergency Village and Advancing Quality Alliance (AQuA) work, therefore, the narrative within the report would be updated to reflect this**.** It was noted that RCP action 12 was ongoing with work commencing to ensure processes were consistent.

b) Getting It Right First Time (GIRFT) Update

Dr Gardner provided an overview of the GIRFT programme and highlighted that a GIRFT Oversight Group had been established with Mr Case being the NED representative on this group.

c) Serious Incident Report, Duty of Candour Report and Health and Safety Report

Mr Verstraelen confirmed that there had been 2 new serious incidents reported on Strategic Executive Information System (StEIS) in April 2021. It was noted that as of 30 April 2021, the Trust had 19 on-going StEIS reported serious incidents that would all be reviewed within the prescribed timescales. It was also reported that Duty of Candour (DOC) compliance had increased back to 100%.

Mr Verstraelen reported that the Quality and Safety Team were undertaking a review of the reporting template, to ensure that it provided the correct level of assurance to the Committee. Members agreed that a review was necessary to provide assurance that the Trust was learning from the key themes within the report.

It was reported that as of 10 May 2021, there were a total of 1056 incidents (including 268 ongoing investigations) that had breached their target timeframes for closure, compared with 948 outstanding incidents on 12 April 2021. Mr Verstraelen requested members to note that this figure included 171 incidents which had been reported retrospectively by the Risk and Incident Team for the hospital-acquired Covid-19 deaths, which were under investigation through the Serious Judgement Review (SJR) process.

It was further noted that the majority of these breached incidents were no harm or minimal harm incidents (97.4%) and that the divisions were currently working to review and reduce the breached incidents in their areas.

It was agreed that Mr Verstraelen and Ms Cheung would meet with Dr Bedi to discuss the contents of this report going forward to ensure the members were assured.

ACTION: Corporate Governance Team to arrange a meeting between Dr Bedi, Mr Verstraelen and Ms Cheung to discuss the contents of the report.

It was noted that the Health and Safety section had been removed from the risk report and was now a standalone report. Mr Verstraelen reported that in April 2021, a total of 54 violent and abusive incidents had been reported. Mr Verstraelen confirmed that the Trust's Security Manager would provide a violence prevention and reduction standards report to the Trust Board, which would outline a comprehensive action plan to reduce the number of violent and abusive incidents.

Mr Verstraelen advised that the Trust had circulated a communication via a message centre with regards to understanding risk reporting and reported that 6697 members of staff had signed to state that they had read and understood the communication.

In response to Mr Case's query regarding the number of incidents reported incorrectly at moderate harm, Mr Verstraelen advised that this was due to staff reporting the incident at a higher level of harm than required. It was agreed that an update on this issue would be provided to the August 2021 meeting to enable members to gain assurance that the gap was closing.

ACTION: Mr Verstraelen and Ms Cheung to provide an update of the incorrect reporting level of incidents at the August 2021 meeting.

It was agreed to provide more detailed analysis of the recurring incidents and how these could be prevented in future reports.

ACTION: Mr Verstraelen and Ms Cheung to provide more detailed analysis of the recurring incidents and how these could be prevented in future reports.

Dr Bedi requested that an update on the increased number of breached incidents be provided at the next meeting.

ACTION: Mr Verstraelen and Ms Cheung to provide an update on the increased number of breached incidents and work commencing to resolve this issue.

d) Infection Prevention Control (IPC) Report Including an update on Nosocomial Infections and Board Assurance Framework

It was noted that the case numbers with regards to Covid-19 had reduced significantly over recent weeks and NHS England had advised that lockdown lifting guidance for the NHS was due to be published.

Mrs Mawdsley reported that the overall Trust compliance rate for IPC training as of 5 May 2021 was 92.63% which was an increase on last month. It was noted that a new location for the fit testing pod was an issue and it had been raised at the Incident Coordination Centre Meeting on 12 May and had been escalated to the Head of Facilities. It was agreed that an update on the fit testing pod would be provided to the next meeting.

ACTION: Mrs Mawdsley to provide an update on the fit testing pod location issues to the next meeting.

Mrs Mawdsley advised that the Trust had received a Covid-19 Health & Safety Executive (HSE) Spot Check visit and that the report provided a summary of the key control measures and arrangements detailed in the HSE Spot Check Inspection Findings Report. It was noted that a main area of concern related to the ventilation issues in the Trust, however, on-going work with Atlas was being undertaken to ensure all wards and departments had a full ventilation assessment and that a plan had commenced to improve ventilation systems across the Trust.

It was agreed that Mr Case would meet with Mr Verstraelen and Ms Cheung to discuss how the Trust reported on Health and Safety.

ACTION: Corporate Governance Team to arrange a meeting between Mr Case, Mr Verstraelen and Ms Cheung to discuss how the Trust reported Health and Safety.

e) Clinical Safer Staffing Report

It was noted that this report provided an overview of the nursing workforce during the month of April 2021 and was set out in line with the National Quality Board (NQB) Standards and Expectations for safe staffing published in 2016 and further supplemented in 2018. Mr Heath advised that the report provided assurance to the members that arrangements were in place to safely staff the inpatient wards with the correct number of nurses with the right skills and at the right time.

Mr Heath reported that the main component of the recruitment pipeline continued to be the overseas nurse recruitment programme and that there were currently 177 overseas nurses in the Trust working as adaptation nurses and preparing for their Objective Structured Clinical Examinations (OSCE). It was noted that 75 student nurses were due to qualify in September 2021 and that the Trust was currently working with them to confirm job offers and ensure retainment of this cohort upon qualification.

f) Guardian of Safe Working Quarterly Report

It was noted that this report provided an overview and assurance of the Trust's compliance with safe working practices for junior doctors and highlighted any areas of concern.

It was agreed to circulate the Medical Staffing Trajectory that was presented to the Operations Committee to this Committee.

ACTION: Corporate Governance Team to circulate the Medical Staffing Trajectory that was presented to the Operations Committee to this Committee.

Members commented on the lack of narrative within the report and requested that this and a high-level summary were provided within the next report.

ACTION: Dr Ng to provide more narrative within a composite report including a high-level summary.

g) Learning Difficulties Update

Mr Heath advised that the report provided an overview of information and data on the Trust's performance in the national benchmarking exercise 2019, measuring performance against the learning disability improvement standards. It was noted that in December 2020 the Trust appointed a Learning Disability and Dementia lead nurse.

Mr Heath advised that the benchmarking report and data published in March 2021 was being used to form the development of a Learning Disability Strategy and action plan. It was noted that the report findings would be shared with service users through the Learning Disability Partnership and that progress against the areas identified would be reported at the October 2021 meeting.

h) Dementia Strategy

It was reported that preparatory work had now been undertaken to review and plan the next 3 years of the Dementia Strategy, as this had not been undertaken during 2020 due to the Covid-19 pandemic. Mr Heath reported that 7 key commitments had been identified, which would build on the key actions set out in the 2016–2019 strategy and current national drivers. It was noted that the proposed strategy would go out for consultation with stakeholders and partners prior to a final formulation and that the stakeholder event was due to take place on 23 June 2021. It was agreed an update on the Dementia Strategy would be provided to the November 2021 meeting.

ACTION: Mr Heath to provide an update on the Dementia Strategy to the November 2021 meeting.

i) Health Education England North West Feedback Report

Dr Gardner reported that Health Education England (HEE) North West had commenced a review in Autumn of 2020, which had been placed on hold due to the Covid-19 pandemic, but advised that it had now been concluded and made available to the public. It was noted that this report had already been provided to the System Improvement Board and that the Trust was required to complete an action plan from the report.

In response to Dr Bedi's query regarding whether this would be reported to the Trust Board, Dr Gardner confirmed it would be reported to the July Board.

ACTION: Dr Gardner to provide a summary to the Trust Board on the 1 July 2021.

j) Medicines Management Annual Report

Mrs Bond advised that it was a requirement that the Committee received reports on the use, optimisation and risks associated with medicines. It was highlighted that the key notes within the report were maintaining robust governance via the Drug and Therapeutics Committee and Medicines Management Committee; ensuring Trust-wide compliance with Care Quality Commission essential standards for medicines management; ensuring a competent workforce with regards to medicines; improving medication incident reporting and trust wide learning; and optimising effectiveness and efficiency within the Pharmacy Service.

Mrs Bond provided a brief update on the Medicines Management Committee (MMC), Fylde Coast Medicines Group, Research and Development and Commissioning for Quality and Innovation (CQUIN)s which were all reported in detail within the report. It was noted that in 2020/21, a total of 233 documents were approved by the MMC and that this was made up of 81 Patient Group Directives (PGD), 49 new documents, 93 renewal documents and 10 patient information leaflets.

Mrs Bond reported that in an average year, Pharmacy initiate and support over 50 clinical trials, however, in early 2020 all new trials were put on hold due to the pandemic and only urgent trials were considered. It was noted that a total of 9 clinical trials were initiated by Pharmacy during 2020/21.

It was noted that for the year of 2020/21, all (CQUINS) were put on hold until further notice in light of the Covid-19 pandemic.

Mrs Bond reported that the CQC report from 2019 detailed the lack of antimicrobial ward rounds across the Trust due to shortages of Consultant Microbiologists. It was noted that Public Health England

Guidance, Start Smart - Then Focus 2015, recommended that the Trust had a ward-focused antimicrobial team to review antimicrobial prescribing. Mrs Bond advised that a business case for the recruitment of additional Antimicrobial Pharmacists and Technicians had been developed and approved and that the department were currently in the process of recruiting.

In response to Mr Case's comment regarding adding full benchmarking data within future reports, Mrs Bond confirmed that she would provide this data going forward.

ACTION: Mrs Bond to provide benchmarking data within the next report.

EFFECTIVE

6. a) Quality and Clinical Effectiveness Indicators from the Integrated Performance Report

Mr Murphy advised that the Trust was commencing an independent review of the systems and processes around pressure ulcers and that a report with the findings would be presented to the Committee once received.

Dr Gardner advised that currently the Trust was not reporting the Venous Thromboembolism (VTE) data to the national database due to the ongoing Covid-19 pandemic.

RESPONSIVE

7. a) CQC Action Plan Update

Mr Verstraelen advised that 46 out of 47 "MUST" actions had been completed (98%) and 63 out of 70 "SHOULD" actions had been completed (90%). It was noted that in total, 8 actions were overdue and that the divisions / departments / services had plans in place to risk manage these outstanding actions. Mr Verstraelen reported that actions for 6 "MUST" and 4 "SHOULD" following the January 2021 CQC inspection had been added to the CQC action plan.

WELL-LED

8. a) Quality Improvement Update

Dr Rostami reported that the Pressure Ulcer Collaborative Phase 1 Teams had attended a learning session on the 11 May 2021, and that this session had demonstrated that teams were progressing with their improvement efforts and highlighted areas for further work. It was noted that Phase 2 Teams had attended a summit event on the 13 May 2021, where the results of their 5-month project had been presented.

Dr Rostami advised that 9 teams participating in the Deteriorating Patient Collaborative were currently in action period 2 and that they were due to attend and present their progress at learning session 3 on 13 July 2021. It was noted that teams used action period 1 to identify root causes of issues, develop their improvement plans and continue to test ideas using Plan, Do, Study Act (PDSA) cycles.

It was noted that the Improve the Last 1000 Days Collaborative work was ongoing with the expert faculty each week to ensure that the focus of this work was correct and that updates are reported to the Quality and Clinical Effectiveness Committee as it develops.

Dr Rostami reported that the last report had highlighted the safety culture measurement plan, which would be presented to the Safety Movement Group on the 25 May 2021 and that the aim was to start testing in September 2021.

It was noted that the National Patient Safety Syllabus was published on 13 May 2021 and would be available for NHS staff in August or September 2021. Dr Rostami advised that over the next few months, the Patient Safety Specialist would work with the Associate Director of Quality Improvement and Organisational Development colleagues to plan how to launch this.

In response to Mr Case's suggestion regarding including some non-NHS views on how Quality Improvement can add value, Dr Rostami advised that the team were planning on looking into this and that the chosen safety culture survey was used by both the public and private sector. It was agreed to arrange a meeting between Mr Case and Dr Rostami to discuss this in more details.

Dr Bedi asked that this also form part of Health and Safety reporting.

ACTION: **Corporate Governance Team to arrange a meeting for Mr Case and Dr Rostami to discuss Quality Improvement adding value and to ensure that safety aspects of QI are incorporated into Health and Safety reporting**

b) Corporate Risk Register (CRR)

Mr Verstraelen requested that members note the material changes to the CRR and that meetings had been held with Executive Directors and Risk Owners to review and update their risks. It was noted that a total of 603 risks had yet to be reviewed, however, 1656 had been reviewed and updated by the divisions.

Mr Verstraelen reported that the Risk Management Survey had been completed by 142 members of staff and highlighted room for improvement within key areas. It was noted that the Risk Manager was working with the divisions to ensure that training was made available on the system, all the Divisional Risk Registers were up to date, including risk reviews and actions, and that departments, wards, and services were aware of their top 3 risks.

c) Board Assurance Framework: Committee Specific Risks

The Committee noted the revised Board Assurance Framework and the updates that were provided.

d) Items Recommended for Escalation to the Board

A summary of the Health Education England North West Feedback to be provided to Board

e) Annual Work Plan

The Annual Work Plan was noted by the Committee.

CLOSING MATTERS

9) a) Any other Business

There was no other business.

b) Formal Meeting Review

Members agreed that the meeting had been well focused and that good levels of assurance had been received from the reports presented.

c) Date of the Next Meeting:

The next meeting will take place on Tuesday, 22 June 2021 at 1.00 pm via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Operations Committee Meeting

held on Thursday, 22 April 2021 at 2.00 pm

via Microsoft Teams

Members

Mr M Beaton	Non-Executive Director	Chair
Dr S Bedi	Non-Executive Director	
Mr J Wilkie	Non-Executive Director	
Mrs J Barnsley	Director of Operations (Planned Care)	
Mrs N Hudson	Director of Operations (Emergency & Urgent Care)	
Professor N Latham	Deputy Chief Executive/Director of Strategic Partnership	
Mr F Patel	Interim Director of Finance	

In Attendance

Mrs S Adams	Deputy Director of Workforce, Education and OD	
Mr P Allanson	Good Governance Institute	Observer
Mr S Bloor	Chief Information Officer	for item 9c
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Mr P Cunday	Associate Director of Finance – Operational Finance	
Mrs A Hirst	Corporate Governance Officer	Observer/minutes
Mrs L Horkin	Divisional Director of Nursing – Unscheduled Care	for items 4 & 5
Mrs K Ingham	Acting Head of Corporate Governance	Observer
Mrs J Lickiss	Associate Director of Nursing	for items 4 & 5
Mrs L McNeill	Patient Level Information & Costing Systems (PLICS) & Statutory Liquidity Ratio (SLR) Accountant	for item 7g
Mrs T Squire-Evans	Associate Director of Finance – Financial Planning & Commissioning	
Mr S Verstraelen	Deputy Director of Quality Governance	for items 4 & 5
Mrs J Gaynor	Corporate Governance Officer	minutes

Apologies

Mr S Gratrix	Governor Observer (Public) – Fylde Constituency
Mr K Moynes	Joint Director of Human Resources & Organisational Development (HR & OD)

Mrs Bosnjak-Szekeres informed members that in preparation for the forthcoming Care Quality Commission (CQC) Well-Led inspection, the meeting would be observed by Mr Peter Allanson from the Good Governance Institute (GGI). It was also noted that divisional staff had joined the meeting in

relation to agenda item 4. It was further noted that Miss Ingham, Acting Head of Corporate Governance had joined to observe the meeting.

1. Welcome/Declarations of Interests/Apologies for Absence

Mr Beaton welcomed members and attendees to the meeting and noted, for the context of the meeting, the extremely difficult circumstances NHS staff were currently working under and thanked all staff for their work.

Mr Wilkie declared his role as Non-Executive Director on the Board of Atlas.

Apologies were received as recorded above.

2. Minutes of the Previous Meeting

Members having had the opportunity to review the minutes of the previous meeting held on 25 February 2021, approved them as a true and accurate record, pending the following amendment: Mrs Hudson to be added to the attendance list.

RESOLVED: The minutes of the previous meeting held on 25 January 2021 were agreed as a correct record, pending the above amendment.

3. Matters Arising

a) Action List

Members noted the position of the action list and were informed that the majority of actions had been completed or were on the agenda for this or subsequent meetings.

The following updates were provided:

Action Reference 145: Operational Performance Update (Urgent & Emergency Care) - NHS 111 Communications - Mrs Hudson reported that a national launch had commenced, however, the feedback from the team working within the Trust's Emergency Department (ED) had not been positive. Members briefly discussed how improvements around local communications could be made and how to ensure there was a consistent strategy across primary care. Mrs Hudson confirmed that this would be monitored through the Accident & Emergency (A&E) Improvement plan.

Mr Beaton stated that it would be helpful for members to understand the position of Trusts across the region and the actions being undertaken to promote the NHS 111 Service. Mrs Hudson confirmed that this work would be included as part of the National Restoration Emergency plan which would be reported at the next meeting.

ACTION: Mrs Hudson to provide the National Restoration Emergency plan to the next meeting and to include the NHS 111 position and actions.

4. **Care Quality Commission (CQC) Action Plan: Progress Update (items relating to Operational and HR & OD matters)**

Mr Verstraelen drew members attention to the highlight report in respect of the CQC action plan and confirmed that good progress had been made. Members noted that 57 of the 59 actions had been completed, which equated to 97%. Mr Verstraelen stated that divisional colleagues had joined the Committee in order to provide updates on the outstanding actions. He went on to inform members that a business case had been submitted in relation to the consultant staffing and that the divisions had actions in place to address the robustness of the cancellation policy. He confirmed that CQC had requested and updated action plan by 15 May 2021.

Mr Verstraelen stated that work was ongoing in conjunction with the Good Governance Institute (GGI) and divisional colleagues to prepare for the next round of CQC inspections.

In response to Dr Bedi's query about the lack of change of actions from green to blue, Mr Verstraelan confirmed that the Confirm and Challenge sessions held at divisional level continued to take place, and where insufficient evidence had been provided, work continued to be undertaken to ensure adequate assurance could be gained that actions were being completed.

Mr Beaton sought clarification in relation to the 'must do' actions that remained outstanding following the recent CQC inspection. Mr Verstraelan confirmed the action which remained open in relation to medical staffing/services had an underpinning divisional action plan, which was being progressed. Mr Beaton noted the urgency of the medical staffing trajectory to be in place and Mrs Adams confirmed that it would be presented to the next meeting.

ACTION: Mrs Adams to present the medical staffing trajectory to the next meeting.

5. Corporate Risk Register (CRR)

Mr Verstraelen referred members to the previously circulated document and provided an overview of the ongoing developments to it.

Mr Wilkie sought clarity on the *risk 2699: 'Management failing to identify serious patient harms or risk and fail to meet national standards to manage and upload incidents to the national system on a weekly basis'* and whether this meant that there was insufficient capacity within the Risk Management Team to manage the risk or that the escalation system in place was not effective. Mr Verstraelen confirmed that whilst staffing within the team remained a challenge, actions were in place to address this matter. In response to Mr Wilkie seeking further assurance about the systems that were in place regarding the Trust's risk escalation processes, Mr Verstraelen confirmed that the systems that were in place were robust and highlighted the general increase in the number of incidents being reported.

In response to Mr Wilkie's query about why *risk 3044: 'Engagement with the Integrated Care System (ICS)'* was to be deleted from the CRR, Mr Verstraelen reported that the risk was being de-escalated from the CRR back to the divisional risk register and would be monitored by the System Improvement Board. Members had a detailed discussion regarding the de-escalation of *risk 3044* from the CRR, including the methodology used to score risks, the ever changing landscape of the ICS, the impact of this on the Trust and the importance that the Board of Directors continue to have oversight of this risk.

Professor Latham provided a summary to members of the discussions undertaken earlier that day at the Board Strategy Session relating to partnership working and the ICS. It was agreed that *risk 3044* would be reviewed on the basis of these discussions and remain on the CRR. Committee members requested for the BAF risk relating to the ICS to be reviewed before presentation to the May Board meeting.

ACTION: Professor Latham to review the scoring based on earlier discussions and increase the risk to high and keep the risk on the CRR.

ACTION: Mrs Bosnjak-Szekeres and Professor Latham to review the ICS BAF risk.

ACTION: Mr Verstraelen to circulate the scoring mechanism used to score risks.

6. Human Resources & Organisational Development Performance Update

a) Performance Metrics and BAF Update

Mrs Adams informed members that work had been undertaken on the medical staffing trajectory, but due to operational pressures had not yet been completed and reconfirmed that it would be presented to the next meeting. It was noted there was no change in the number of medical staffing vacancies, which stood at 61. Members noted that of the 61 vacancies. 5 were at the interview stage and 29 were currently under offer.

Mrs Adams provided a short presentation which included the following updates: Board Assurance Framework (BAF) monthly review; recruitment update, nursing trajectory and overseas nursing programme; health and wellbeing (HWB) update; national staff survey results 2020; sickness update; reverse mentoring scheme; equality and diversity summit for specialty and associate specialist doctors (SAS) and international medical graduate (IMG) doctors update.

It was noted that the assurance level remained as **partial assurance**.

b) Growing for the Future

Mrs Adams drew members' attention to the trajectory within the presentation slides and the work that was ongoing to close the vacancy gap. She stated that further improvements to the overall staffing position in July/August 2021, when a number of posts which were under offer, would be filled.

Members briefly discussed the establishment figure for the Trust and the number of variables which may affect the organisation. Mr Beaton acknowledged that many variables existed and suggested these be presented along with the trajectory in the following format: 'attrition rate of x / should have been y / was z'.

Dr Bedi's commented that it was good to see change, however, this opened up other cultural challenges in relation to staff. Mrs Adams confirmed that there was a national strategy based on looking at the type of new dynamics being faced and how to address these. Dr Bedi acknowledged the strategy and noted that it needed to be worked on in collaboration with overseas nurses. Mrs Adams confirmed that the Trust was to review the onboarding of overseas nurses with their input and feedback.

The Chair acknowledged the hard work being undertaken to achieve the nursing trajectory targets and stated the he was assured about the progress made and this was now required to address medical staffing issues.

ACTION: Mrs Adams to set out the variables on the trajectory in the format suggested above and report back to the next meeting.

c) Looking after our People

Members noted the update provided in relation to the overseas nursing programme.

Mrs Adams provided an overview of the health and wellbeing package available to all staff and it was noted that the response from the ICS was to provide all NHS staff with a £50 voucher and a one off additional day's annual leave to show their appreciation for the efforts of staff during the pandemic. This information will be communicated across the whole ICS jointly. Mr Patel confirmed the costs involved had been covered in the month 12 position.

Members received an update on the vaccination programme and noted that 80% of substantive staff had received their first dose of the COVID-19 vaccination and work was underway to ensure second doses were being administered in the relevant timelines.

Members briefly discussed the actions being taken to encourage the 20% of staff not yet vaccinated and it was agreed that an update would be provided at the next meeting on this matter, with particular attention paid to the reasons why staff had not taken up the offer and the actions that were being undertaken to address them.

In response to Dr Bedi's question regarding whether or not there was any indication of the vaccine being made mandatory for healthcare workers, Mrs Adams confirmed that nothing had been discussed at a national or regional level.

ACTION: Mrs Adams to provide an update on the reasons and actions being taken to encourage the 20% of staff not yet vaccinated.

d) National Staff Survey Result 2020

Mrs Adams provided a detailed update on the planned next steps following the National Staff Survey results for 2020, which included a schedule of 'Big Conversations' throughout April/May 2021. She confirmed that planning work would commence in September for the next National Staff Survey due in October 2021. Members noted the improved survey results.

e) Belonging to the NHS

Mrs Adams reported that the development of a Board of Directors session in relation to addressing Black, Asian, and Minority Ethnic (BAME) matters had been added to the agenda for the meeting on 6 May 2021.

Mrs Adams reported that the Reciprocal Mentoring for Inclusion Programme was due to commence in June 2021. She went on to provide a summary of the recent joint campaign between the Trust and Blackpool Council titled 'It Stops Here' which relates to a campaign against attacks on females.

Members discussed the possibility of embedding Health and Wellbeing conversations within appraisal conversations.

In response to Mr Wilkie's query about how the new restructure was being received, it was noted that overall feedback had been positive, but that there was always room to improve. Professor Latham informed members that the functional part of the process had been received well by staff. She confirmed that that there had been no redundancies made and that work was being undertaken to provide the right cultural oversight. She confirmed that the next steps would be in relation to governance, financial and HR support.

7. Finance Performance

a) Performance Metrics and BAF Update

It was noted that there had been no significant changes to the BAF or the overall assurance rating and risk score.

b) Finance Performance Presentation

Mr Patel drew members attention to the previously circulated reports and highlighted the following key areas:

Key Financial Risks

Cash Position and Forward View - only **limited assurance** could be given that the Trust will not need further interim financial support in the 2021/22 financial year.

Sustainability – only **limited assurance** could be given.

Based on current performance and latest guidance, only an **overall limited level of assurance** could be provided at this stage.

Draft March 2021 Financial Position

Mr Patel reported that after 12 months of the financial year, the Trust had incurred a deficit of £96.1m (including additional funding) against a forecast deficit year end position of £93.9m. Following top-up funding, a deficit of £16.2m had been reported against a forecast deficit of £16.3m. He reported that it had been agreed with NHS England /Improvement (NHSE/I) that this could be reduced by a further £0.6m. Members noted that the additional day's annual leave and £50 voucher for all staff had been accrued in month 12.

Cash Position

Mr Patel confirmed that the Trust's cash position was low and there may be a requirement to borrow further funding. He confirmed that supplier payments terms would be extended.

Sustainability

Mr Patel reported that there was a risk that the level of funding the Trust was able to generate in 2021/22 would not be sufficient. He confirmed this was as part of the ICS and that ongoing discussions were being undertaken at that level.

2021/22 Financial Planning

Mr Patel confirmed that the financial planning guidance had been issued on 25 March 2021 and that systems had been issued with financial envelopes based on the last six months of 2020/21.

Business Cases & Developments - Emergency Village/Critical Care (EV/CC) Update

Mr Patel drew members attention to the presentation slides and provided a detailed update. He confirmed that work was progressing well on the project, but that a number of queries had been received from NHSE/I in relation to differences between the full business case and the outline business case. He went on to confirm that work was being undertaken to address these queries with the use of external legal advisors.

Members noted that a paper was to be submitted to the Board of Directors of both the Trust and Atlas in May.

Mr Wilkie commented that he had recently attended a walkabout around the EV/CC project. During the visit discussions had been undertaken around valuable lessons being learnt from the whole business case process. Mr Wilkie suggested that Mr Fort be invited to a future meeting of the Committee.

ACTION: Mr Patel to liaise with the Corporate Governance team to invite Mr Fort to a future meeting of the Committee.

c) Month 12 Position

It was noted that this item has been discussed as part of the finance report under the cash position. However, Mr Patel drew attention to the table on page 75 of the full papers and it was noted that the difference in percentage achieved in March 2021 compared to March 2020 was as a result of the COVID-19 pandemic taking effect in mid-March 2020.

RESOLVED: Members received the report and noted its contents.

d) National Cost Collection Report

Mrs McNeill referred members to the previously circulated report and highlighted the good progress being made by the Patient Level Costing team and the internal developments in Patient Level Costing, including Service Line Reporting, Clinical Engagement and Data Quality. It was noted that an annual submission to NHSE/I is being prepared.

Members acknowledged the good work being undertaken.

8. Operational Performance Update

a) Performance Metrics and BAF Update

Members were informed that the planned and unplanned care performance metrics were related to BAF item 3.1, and that there had been no change in the scoring (20 against a target score of 12).

b) Operational Performance Presentation (Urgent & Emergency Care)

Mrs Hudson provided a detailed update on urgent and emergency care activity, including Accident & Emergency (A&E) performance, Length of Stay (LoS) and discharges. Members confirmed that in relation to both A&E and length of stay performance they had received **moderate assurance.**

Mrs Hudson informed members that work had been undertaken on the urgent and emergency care operational performance presentation and would be presented to the next meeting. She confirmed this would include the national submission for annual planning.

Members noted that although the Emergency Department type 1 performance achieved 82.2%, it had not met the required trajectory. It was further noted that there had been a significant decrease in the performance of the 12-hour trolley wait standard. Mrs Hudson confirmed that breaches had largely been related to patients awaiting input from/admission to mental health services. She went on to suggest that improvements would be seen in the coming months following the opening of the new mental health assessment unit.

Members noted the LoS presentation.

RESOLVED: Members received the report and noted its contents.

ACTION: Mrs Hudson to present the revised operational performance presentation, including the annual planning submission to the next meeting.

b) Operational Performance Presentation (Planned Care)

Mrs Barnsley provided a short presentation, which included a detailed update on planned care activity, including referral to treatment (RTT), 52-week breaches, cancer performance, diagnostic performance, elective and non-elective re-admissions, and cancelled operations. Members noted there had been slight deterioration in RTT, cancer and diagnostic standards.

Members confirmed that **limited assurance** was provided in relation to RTT performance, 62-day cancer waiting times, 6-week diagnostics and 52- week waits.

Mrs Barnsley reported that there had been positive movement in restoration of activity with the Day Surgery Unit back online, with a planned increase in May 2021. She reported that outpatient activity had been restored to 124% for new appointments and 126% for follow-up appointments.

Mrs Barnsley reported an increase in the use of the Advice & Guidance programme from 91 to 164 calls, with further specialities due to come online in the coming weeks.

It was noted that the cancer targets for 31-day subsequent treatment; 2-week wait; 31 day wait and breast symptomatic; had been achieved during February 2021. It was noted that the other cancer targets continued to make improvements month on month. Mrs Barnsley confirmed that both endoscopy and echocardiogram had action plans in place to address the performance issues.

Mrs Barnsley reported that 20,000 people across Blackpool had received their first COVID-19 vaccination. Members noted that the second phase of the public vaccination programme was due to commence imminently.

In response to Mr Wilkie's query about the 11 patients currently on ventilators, Mrs Barnsley confirmed that none of the patients were in critical care.

c) Covid-19 Update

Mrs Barnsley referred to the previously circulated presentation and provided a detailed update on COVID-19 position.

Mrs Barnsley reported that the Incident Control Centre (ICC) was being managed at Level 3, with reduced operating hours. She reported that both the vaccination and LAMP testing programmes were progressing well and plans to stand down the ICC and the work to be included into business as usual.

d) Restoration Update

Mrs Barnsley provided a short presentation on the draft operational restoration plan and submission timescales for the period April 2021 to September 2021. She confirmed that this was to be presented to the Executive Directors Meeting on 26 April 2021 and would be presented back to the Committee in May 2021 with a final submission to the national ICS team on 6 May 2021.

There was a discussion around the assumptions and capacity targets, the plans in place to achieve these and whether the 105% target would be sufficient. Mrs Hudson confirmed that this would be closely monitored and would be reported back to each future Committee meeting.

Mrs Barnsley drew members attention to an additional slide in relation to contracts and sought support from the Committee for the pre-approval to engage with the contracts list as per the slide. She confirmed the submission would be for £28.4m with approval of £4.5m for the first six months. It was noted that the plans would be be presented to the Board of Directors on 6 May 2021 for a decision.

RESOLVED: The Committee agreed in principle and recommended the submission to the Board of Directors for approval.

9. System and Partnership Working

a) Board Assurance Framework Update

It was noted there were no significant changes to the BAF score and assurance levels in the report presented, however following the discussion undertaken at the Board Strategy Session that had been held earlier in the day, there was a need to review the scoring of BAF risks 5.1 and 5.2 (partnership working) with a view to increasing the risk scores.

b) System and Partnership Working Update

Professor Latham stated that the Board had held a strategy session earlier in the day and confirmed that a draft strategy had been drafted with a power map of stakeholder engagement and across provider collaboratives.

ACTION: Professor Latham to circulate the paper to members.

c) Health Informatics Update

Mr Bloor, Chief Information Officer provided a verbal update on health informatics. Members were informed of the risk in relation to the patient administration system, and Mr Bloor confirmed that an options appraisal paper was to be discussed at the Executive Directors (EDs) Meeting on Monday, 26 April 2021.

He further reported that work was being undertaken on the secondary uses of data performance reporting and that a draft outline would also be taken to EDs on Monday, 26 April 2021 and that both items would be formally reported back to the Operations Committee.

Mr Beaton requested that an update on how the digital technology of the Trust would integrate with that of the ICS be provided to members. It was agreed that the update would include what the Trust receives from the ICS and why, what the Trust undertakes itself and why and any plans for integration.

ACTION: Mr Bloor to formally submit both papers to the next Operations Committee.

ACTION: Mr Bloor to provide an update to the Committee on the integration of digital technology across the ICS in his next update to the Committee.

10. Board Assurance Framework (BAF)

This item was discussed under agenda items 6a, 7a, 8a and 9a.

11. Integrated Performance Report (IPR)

This item was discussed under agenda items 6a, 7a, 8a and 9a.

12. Items Recommended for Escalation to the Board

Mr Beaton confirmed the items for escalation to the Board for each area as:

HR & OD Performance Update

Overall partial assurance; ongoing work to reduce nursing vacancy gap; medical trajectory work required to close gap; focused Health and Wellbeing programme – good initiatives in place – still stressful time for staff, more expected with restoration and changes in culture and inclusion of staff, additional day leave and £50 voucher; and actions to increase the number of staff being vaccinated.

Financial Performance Update

Overall limited assurance for finances; issues with cash position and sustainability; forecast deficit on target at end of March 2021; EVCC project update; guidance mechanism still awaited, expected within 7 days and forecast to be reported to Board of Directors on 6 May 2021.

Operational Performance Update – Planned and Urgent & Emergency Care

Overall limited assurance: A&E type 1 performance numbers reported to Board of Directors; wait times for cancer treatment; restoration update and target of 105%, plus assumptions may not move and staff pressures; and endoscopy and echocardiogram action plans.

13. Any Other Business

There were no further items of business presented to the Committee.

14. Formal Meeting Review

Mr Beaton sought feedback from members in relation to the questions posed as part of the meeting review.

Mr Allanson commented that it had been a very busy meeting and noted there was a lot of work to be done in relation to cancer targets.

Mr Beaton commented that the meeting had improved and had become more standardised, although there was still work to be undertaken to refine this process.

Mr Wilkie commented that the most substantial and important part of the meeting from his perspective was the working dynamic between the EDs and the Non-Executive Directors (NEDs) and in view of the forthcoming CQC Well-led inspection. He suggested that a more open session be held to gain an understanding and whether the EDs felt value was provided by the NEDs to the meeting.

Mr Beaton suggested that feedback would be better received through one to one sessions rather than in a larger forum.

Mrs Bosnjak-Szekeres confirmed that there would also be an opportunity to feedback via the annual committee survey in June/July 2021.

15. Date of Next Meeting

The next meeting will take place on Thursday, 27 May 2021 at 2.00pm via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Operations Committee Meeting

held on Thursday, 27 May 2021 at 2.00 pm

via Microsoft Teams

Members

Mr M Beaton	Non-Executive Director	Chair
Dr S Bedi	Non-Executive Director	
Mr J Wilkie	Non-Executive Director	
Mrs J Barnsley	Director of Operations (Planned Care)	
Mrs N Hudson	Director of Operations (Emergency & Urgent Care)	
Mr K Moynes	Joint Director of Human Resources & Organisational Development (HR & OD)	Mr K Moynes
Mr F Patel	Interim Director of Finance	

In Attendance

Mrs S Adams	Interim Operational Director of Human Resources and Organisational Development	
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Ms L Cheung	Head of Quality Governance	for items 4 & 5
Mr P Cunday	Associate Director of Finance – Operational Finance	
Mr D Hill	Financial Improvement Director	
Miss L Kavanagh	Corporate Governance Officer	presentations
Dr D Kenny	Appointed Governor – Lancaster University	
Mrs S Robson	Director of Procurement, Lancashire Procurement Cluster	for item 12
Mrs T Squire-Evans	Associate Director of Finance – Financial Planning & Commissioning	
Mrs J Gaynor	Corporate Governance Officer	minutes

Apologies

Mr S Gratrix	Governor Observer (Public) – Fylde Constituency
Professor N Latham	Deputy Chief Executive/Director of Strategic Partnership
Mr S Verstraelen	Deputy Director of Quality Governance

1. Welcome/Declarations of Interests/Apologies for Absence

Mr Beaton welcomed members and attendees to the meeting and noted, for the context of the meeting, the difficult circumstances all staff were currently working under and thanked them for their work.

Mr Wilkie declared his role as a Non-Executive Director on the Board of Atlas.

Apologies were received as recorded above.

2. Minutes of the Previous Meeting

Members having had the opportunity to review the minutes of the previous meeting held on 22 April 2021, approved them as a true and accurate record.

RESOLVED: The minutes of the previous meeting held on 22 April 2021 were agreed as a correct record, pending the above amendment.

3. Matters Arising

a) Action List

Members noted the position of the action list and noted that the majority of actions had either been completed or were on the agenda for this or subsequent meetings.

Mr Beaton sought clarification about the closure of action reference 145: Operational Performance Update (Urgent & Emergency Care) - NHS 111 Communications. Mrs Hudson reported that there had been an increase in the numbers of people using the service, as reported to the recent Emergency Oversight Board. She went on to confirm that there had been an issue relating to the use of clinical codes, with only around 50% of the code sets being triaged through this service. Members noted that a piece of work was being undertaken to identify the reasons for this and to ensure that accurate recording was being undertaken. It was agreed that Mrs Hudson would provide a further update on this matter at the next meeting of the Committee.

Mr Beaton stated that it would be helpful for members to also gain an understanding of the actual versus target usage. He asked that the action list be updated to this effect and requested information be included in the operational performance metrics reporting to future meetings.

ACTION: The action reference 145 to be updated to include the inclusion of NHS 111 actual usage versus target usage in future performance metrics reporting.

Mr Beaton commented that the medical staffing trajectory action did not appear to be on the action list and requested the action list be updated to include this action.

ACTION: The action list to be updated to include the medical staffing trajectory action.

POST MEETING NOTE: Action reference 155 (22.04.21) indicates that the medical staffing trajectory be presented to the May meeting.

4. Care Quality Commission (CQC) Action Plan: Progress Update (items relating to Operational and HR & OD matters)

Ms Cheung drew members attention to the highlight report in respect of the CQC action plan. Members noted that; all 48 operational 'must do' actions had been completed, with 40 out of the 41 (98%) operational 'should do' actions having also been completed.

Members noted that of the 11 workforce 'must do' actions, 10 had been completed in addition to all 12 of the workforce 'should do' actions being completed. Members were informed that the outstanding 'must do' and 'should do' actions had been now been added to the Trust's CQC action plan.

Ms Cheung drew attention to the outstanding action reference A158 and confirmed that a business case to address the uplift in the number of consultants from 13.5 to 18 had been approved and that the action would be closed and submitted to CQC.

Mr Wilkie referred back to the previous CQC inspection, specifically, the marking down of the Trust regarding 'avoidable' issues, such as safety equipment checks, correct storage of equipment and

recruitment of staff. He sought clarity on the processes that had been put in place to address such matters. Ms Cheung confirmed that, as part of the preparation for the next inspection, a number of processes had been put in place, including the creation of the CQC hub and walkabout inspections were being regularly undertaken, which focused on a range of matters including, cleanliness, storage and equipment. Any concerns that were identified during these walkabouts are then able to be addressed quickly.

Members briefly discussed the need for a systematic step-by-step management process for CQC inspections, which had previously been requested. It was suggested that Mr Murphy would be the most appropriate Executive Director to provide the Board perspective on the preparations for the next CQC inspection. Mrs Bosnjak-Szekeres confirmed that CQC Inspection preparations were regularly discussed at the Trust's Quality and Clinical Effectiveness Committee and by the Executive team.

ACTION: To escalate to the Board the need for discussions around a trust-wide systematic step-by-step management process for CQC inspections.

5. Corporate Risk Register (CRR)

Ms Cheung referred members to the previously circulated document and provided an overview of the ongoing developments to it.

In response to Mr Wilkie's query about why the newly added risk *3120: The Trust that the Local Exhaust Ventilation (LEV) systems and fire dampers could cause unsafe levels of formaldehyde due to unsuitable fans and infrastructure. This could lead to staff exposure to formalin'* had been included under the partnership working risk category, Ms Cheung confirmed this was an error and would be amended for the next iteration of the report.

ACTION: Ms Cheung to amend the risk category of r*isk 3120*.

In response to Mr Wilkie's question regarding the type of PPE that was currently in use in the histology service, Mrs Cheung confirmed that the staff in the service were currently using powered respirators, however work was taking place to seek an alternative estates solution, which would be in place by February 2022.

Following a brief discussion, members agreed that this was not an acceptable timeframe for resolution of the matter and asked that Mrs Barnsley, as the Executive Director responsible prioritise the matter for rectification. It was agreed that an update would be provided by Mrs Barnsley to the Committee members within the week.

ACTION: Mrs Barnsley to immediately resolve the issue for histology staff and update the Committee members next week.

6. Finance Performance

a) Performance Metrics and Board Assurance Framework (BAF) Update

It was noted that there had been no significant changes to the relevant sections of the BAF or the overall assurance and risk scores.

b) Finance Performance Presentation / H1 21/22 Financial Planning

Mr Patel drew members attention to the previously circulated reports and highlighted the following key areas:

<u>Key Financial Risks</u>

Cash Position - only **limited assurance** could be given that the Trust will not need further interim financial support in the 2021/22 financial year.

Sustainability – only **limited assurance** could be given.

Based on current performance and latest guidance, only an **overall limited level of assurance** could be provided at this stage.

H1 Financial Position

Mr Patel referred members to the previously circulated slides and gave a detailed update on the H1 financial position and confirmed the finance and contracting arrangements for H1 2021/22. Members noted that the forecast plan for H1 2021/22 was a £6.9m deficit, including efficiency savings and top-up funding.

Members discussed the quality improvement efficiency savings target of 3% and stated that there should be a consistent approach across the Trust.

Cash Position

Mr Patel confirmed that the Trust's cash position was low and there may be a requirement for additional borrowing in Quarter 2.

Sustainability

Mr Patel reported that there was a risk that the level of funding that the Trust was able to generate in 2021/22 would not be sufficient. He confirmed that discussions were taking place at an Integrated Care System (ICS) level in relation to provider sustainability and financial requirements.

c) Month 1 Position Report

Mr Patel provided a detailed update to members regarding the financial position of the Trust at the end of the reporting month (April 2021), including confirmation that the month-end financial position was £255,000 worse than the planned position, with the main reason being an overspend in surgery.

Members briefly discussed the Quality, Efficiency & Productivity (QEP) program and the need to ensure recurrent savings were made, as opposed to non-recurrent savings, which had not been the case in previous years. Mr Wilkie suggested that recurrent QEP savings should form part of the day to day/business as usual work of the Trust. Members agreed that they would benefit from a better understanding of the QEP programme, including how it was determined, managed and where responsibility lay for the programme.

In response to Mr Beaton's query around QEP targets and whether plans had been shared with the Divisions, both Mr Patel and Mrs Hudson confirmed that this work was currently being undertaken. Mr Beaton requested that an update be provided to the next meeting detailing the top 5 targets, progress to date and the current levels of savings.

RESOLVED: Members received the report and noted its contents.

ACTION: Mr Patel agreed to provide an update on the top 5 QEP targets and the savings being made to the next meeting.

d) Emergency Village/Critical Care (EV/CC) Update

Mr Patel informed the Committee that the business case for the EV/CC programme had been approved by NHSE/I, as had the funding of £12.9m. Members noted that this would have to be spent within the 2021-22 financial year. It was further noted that Atlas had been informed and this would be discussed at Board on 3 June 2021. Mr Patel confirmed that work was also being undertaken by both the Trust and Atlas to address the legal issues.

7. Operational Performance Update

a) Key Performance Metrics and BAF Update

Members were informed that the planned and unplanned care performance metrics were related to BAF item 3.1, and that there had been no change in the scoring (20 against a target score of 12).

Mrs Barnsley drew attention to the previously circulated slide deck, which provided an overview of both planned and unplanned care activity, including:

- referral to treatment (RTT)
- 52-week breaches
- Performance against Cancer and diagnostic standards
- elective and non-elective re-admissions
- cancelled operations
- urgent and emergency care activity, specifically Accident & Emergency (A&E) performance, length of stay (LoS) and discharges.

Members noted there had been a slight improvement in RTT, cancer waiting times, diagnostic standards and both A&E and length of stay performance. Members confirmed that **moderate assurance** had been provided.

In relation to performance against cancer targets, members noted that, for the reporting month, all targets with the exception of three had been met. The three cancer standards that had not been met were noted to be: 2-week wait (breast symptomatic), 62-day referral to treatment and 62 day screening performance. Mrs Barnsley confirmed that a locum breast consultant had been appointed and an action plan was in place to address the backlog.

Mrs Barnsley reported that a validation and prioritisation exercise was to be undertaken for echocardiogram and endoscopy and that an update would be provided to the Committee at the next meeting.

ACTION: Mrs Barnsley to provide an update on the validation and prioritisation exercise for echocardiogram and endoscopy at the next meeting.

Mrs Hudson confirmed that A&E performance for type 1 attendances was 58% during March 2021 with overall performance against the four-hour standard being 84% for the reporting month. Members noted that performance against the four-hour standard for the previous week was 90%. Mrs Hudson confirmed that several challenges remained, in relation to A&E performance, particularly the increased number of attendances.

Members noted the summary provided and agreed that the revised format of the report provided greater clarity of the Trust's performance and performance against other Trusts. Mr Beaton requested that an additional column be included in future reports to show a month on month trend.

ACTION: Mrs Barnsley/Mrs Hudson to add an additional column to indicate month on month trends to the summary.

Members noted Mrs Hudson's concern in relation to cancer referrals and the future treatment capacity requirements. It was noted there would be an insourcing capacity at weekends and two further Gastroenterology locum consultants had been recruited. Mrs Hudson confirmed that she would discuss the recruitment issues within Gastroenterology with the Division.

ACTION: **Mrs Hudson will discuss the recruitment issues within Gastroenterology with the Division.**

RESOLVED: **Members received the report and noted its contents.**

b) Restoration

Mrs Hudson drew members attention to the previously circulated slide deck and provided a summary in relation to restoration of services. She confirmed that she and Mrs Barnsley were looking at volumes compared to target for core plan, core plus and the accelerator programme. Members noted that the total elective activity restoration rate was 92.6% and outpatient activity was 101.2%. Mrs Barnsley confirmed that the required restoration target for the month was 70%.

In response to Mr Wilke's query, Mrs Barnsley confirmed the restoration assumptions had been based on the national requirements.

There was a short discussion on the ongoing challenges for restoration and the impact of timely decisions and action. Members noted that an update on the ICS accelerator programme would be provided to the next meeting.

ACTION: **Mrs Hudson to provide an update on the ICS accelerator programme at the next meeting.**

8. Human Resources (HR) & Organisational Development (OD) Performance Update

a) Performance Metrics and BAF Update

Mrs Adams provided a short presentation which included the following updates: Board Assurance Framework (BAF) monthly review; recruitment update, nursing trajectory and overseas nursing programme; agency spend trajectory; medical staffing trajectory; health and wellbeing (HWB) update; sickness update; Covid-19 vaccination programme and an update on equality and diversity.

It was noted that the assurance level remained as **partial assurance**.

b) Growing for the Future

Mrs Adams drew members attention to the trajectory within the presentation slides and the positive work that was taking place within the Trust to close the vacancy gap. She confirmed that agency spend had been mapped into the trajectory, along with detailed variables and a reduction of approximately £1.4m monthly would be anticipated as the fill rate increased.

Mr Beaton acknowledged the hard work being undertaken to achieve the nursing staffing trajectory targets and stated the he was assured about the progress being made. He stated that the Committee would be interested to see the overall attrition rate and the target. He went on to ask that this be presented as y% versus x%.

ACTION: **Mrs Adams to include in the nursing trajectory, the overall attrition rate and the target attrition rate in the format of y% - x%.**

Mrs Adams drew attention to the medical staffing trajectory and reported that the Trust had a medical staffing establishment of 252 whole time equivalents (WTE), with a vacancy gap of 40 WTE consultants. Members noted that clarity was required on the actual establishment figures due to the various categories of doctors.

Mrs Hudson confirmed that Dr Gardner had commenced work in relation to the recruitment of medical staffing and this would be sighted at Board level.

Members briefly discussed the ways in which the recruitment packages for perspective consultants could be improved and address issues which were perceived as being negative.

c) Looking after our People

Mrs Adams provided an overview of the health and wellbeing package and the good work that was taking place.

Members received an update on the vaccination programme and noted that 76% of all staff and 81% of substantive staff had been vaccinated.

Members acknowledged the update provided as to the reasons why some staff had not taken up the vaccination offer. There was a detailed discussion around the actions that were being undertaken to address this and the need for a more comprehensive strategy.

d) Belonging to the NHS

Mrs Adams reported that a second onboarding meeting had taken place on 18 May 2021, in relation to the Reciprocal Mentoring for Inclusion Programme and extended an invitation to the Board members present at the meeting to take part.

Members discussed the variety of leadership and talent management programmes that were in existence and it was agreed that a Board level discussion would be sought to address succession planning.

ACTION: Corporate Governance Team to organise a Board session on succession planning.

9. System and Partnership Working

a) Board Assurance Framework Update

Mrs Bosnjak-Szekeres presented the document to members in the absence of Professor Latham.

Members noted that there had been no changes to the BAF risk scores and also noted the updates to the document.

b) System and Partnership Working Update

Mrs Bosnjak-Szekeres confirmed that there was a New Hospitals Programme case for change and that a final copy would be circulated to Board members outside the meeting.

Members noted that the Trust's Chairman had agreed to Chair the ICP level meetings, which provided the Trust with more positive inputs with the Clinical Commissioning Groups (CCGs).

c) Health Informatics Update

Mr Patel drew attention to the previously circulated business case for the patient administration system, and the options appraisal and sought approval for the recommendation within the paper.

There was a short discussion around the challenges and the major investment required for this business case. It was agreed that a specialist working group be set up and to include a member from another Trust who had recently been through this process. Mr Beaton agreed to be the Non-Executive Director lead.

ACTION: **Mr Patel to arrange a working group to address the challenges and issues presented by the options appraisal paper.**

10. Board Assurance Framework (BAF)

This item was discussed under agenda items 6a, 7a, 8a and 9a.

11. Integrated Performance Report (IPR)

This item was discussed under agenda items 6a, 7a, 8a and 9a.

12. Lancashire Procurement Cluster (LPC) Update

Mrs Robson referred members to the previously circulated presentation and provided a detailed update on the ongoing collaborative work of the LPC and the savings made across the cluster versus the trajectory. She informed the Committee of the key areas that LPC would focus on for efficiency savings, such as, mattress contracts and maintenance, focus on quality of care and eliminating waste, ICS approach to the standardisation of nursing terms and conditions and the trial of the re-use of single use items.

Members discussed the achievement of improvements as a system and that this needed to be driven by the Executive Team, especially in areas such as, Estates and Facilities. Members noted that the link to 'LPC way' was key to driving QuIPP efficiencies across the Trust and requested this data be included in the next update to the Committee.

Mr Beaton requested an understanding of the levels of compliance and expected volumes going through the system versus actual volume and requested data in the next quarterly update.

ACTION: **Mrs Robson to include the link with LPC to drive the Trust's QEP programme.**

Mrs Robson to provide data on levels of compliance, expected going through the system versus actual volume for the next quarterly update.

13. Items Recommended for Escalation to the Board

Mr Beaton confirmed the items for escalation to the Board for each area as:

<u>CQC Highlight Report</u>

Systematic step by step management process for CQC inspections.

<u>Financial Performance Update</u>

Overall limited assurance for finances; improved cash position – potential issues relating to cashflow and sustainability; forecast target deficit of £6.9m in H1; QuIPP target of £20m – risk of not achieving target and the need for investment; additional elective ask of 120%; EVCC funding approval.

<u>Operational Performance Update – Planned and Urgent & Emergency Care</u>

Overall limited assurance: continued pressures within A&E; restoration; cancer treatment: spikes in diagnostics and referral activity; potential issue with treatment; good news - diagnostics improving; risk of accelerator site and 120% restoration ask; ICS overall plan for accelerator status plan not agreed – addressed at next meeting.

HR & OD Performance Update

Overall partial assurance; nursing vacancy gap under control (risk of external staff abroad 48 gap over 200 – possible impact on restoration plans); medical trajectory work commenced 20% gap - strategies put in place; actions to encourage vaccination uptake in those staff who have not yet been vaccinated – Board leadership and engagement with process.

Lancashire Procurement Cluster Update

Board collaboration across the ICS and Board discussion in relation to Procurement.

14. Any Other Business

Pathology Collaboration

Mrs Barnsley highlighted the concerns of staff in relation to the Pathology Collaboration and the increased pace of change. She confirmed that support was being offered to staff and confirmed that members would have sight of the Board report.

There was a short discussion around the collaboration as a whole and how the Board need to influence discussions better.

15. Formal Meeting Review

Mr Beaton stated that he would be happy to have one to one feedback from the Executive Directors.

16. Date of Next Meeting

The next meeting will take place on Thursday, 24 June 2021 at 2.00pm via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board

01/07/21

Maternity Incentive Scheme Year 3

Author of Report:	Nicola Parry
Executive Director Sponsor:	Peter Murphy
Date of Report:	29/06/21

Executive Summary (to include, where appropriate, the level of assurance and position on trajectory)

NHS Resolution has launched the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions for a second year. The scheme supports the delivery of safer maternity care through an incentive element to the contribution to the CNST, rewarding trusts meeting ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. In this third year the scheme will further incentivise the ten maternity safety actions from the previous year with some further refinement.

For Information/Assurance:	**For Discussion:**	**For Approval:**
		✓

Recommendations:

The meeting is asked to note the Maternity Incentive Scheme Year 3 requirements, and the Trust Board responsibilities. The sign off date is 15/07/21 and all evidence will be accessible on the Shared Drive prior to the sign off date.

The Trust Board is requested to allow the Chief Executive to sign the declaration form if the evidence requirements are sufficient

The Trust Board are asked to approve the specific documents detailed in Appendix 1

Sensitively Level:

Not Sensitive: (for immediate publication)	**Sensitive in Part:** (consider redaction prior to release)	**Wholly Sensitive:** (consider application exemption)
✓		

Maternity Incentive Scheme Year Three

The Maternity Incentive Scheme is a national scheme to help maternity services in England deliver better care to mothers and their babies and has shown positive results in its first year.

NHS Resolution's maternity incentive scheme, rewards trusts meeting ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

.

The Ten Maternity Safety Actions

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

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

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Program?

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

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

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback and you work with service users through you Maternity Voices Partnership to coproduce local maternity services patient feedback mechanism for maternity services and that you regularly act on feedback?

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

- **The evidence will be made available on a shared drive for the Trust Board to access by Tuesday 29th June**

  \\fcvmsrv080\Organisation Data\BFW Hospitals\Women's & Children's Division\GOVERNANCE\CNST incentive scheme maternity safety actions\2021\Board Evidence

- **A check and challenge meeting has taken Place with the Director of Nursing and Quality on the 29th June. The Director of Nursing and Quality will provide assurance to the Trust Board that the evidence is adequate to ensure that the standards are met**

Assurance

Assurance and evidence can be provided for the majority of the standards the exceptions relate to: -

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

Neonatal medical GIRFT report showing non-compliance - there is an associated action plan in place to enhance the nursing workforce developing a blended workforce model. This standard is achieved with the action plan in place.

Neonatal Nursing Audit showing non-compliance, and the associated action plan. This standard is achieved with the action plan in place.

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback and you work with service users through you Maternity Voices Partnership to coproduce local maternity services patient feedback mechanism for maternity services and that you regularly act on feedback?

The Board are to note that the MVP Chair role has been vacant, and a new Chair has been appointed. Therefore, confirmation for this standard has come from the CCG (CCG commissioned service) rather than the MVP chair. The maternity service has continued to gather and act upon patient feedback.

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Compliance not at 90% however an action plan is in place to achieve this standard. This standard is achieved with the action plan in place the 90% target has been paused for this year.

Specific Evidence for Trust Board Approval (available on the Shared Drive)

Safety Action	**Specific Evidence for Trust Board Approval all included in the shared Drive**
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Quarterly Reports which include evidence that that the PMRT has been used to review eligible perinatal deaths and that the required standards from October 2020
Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?	Monthly score card showing compliance
Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Program?	Transitional care audit
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Neonatal medical GIRFT report showing non-compliance and associated action plan Neonatal Nursing Audit showing non-compliance and associated action plan

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Midwifery staffing oversight report 2020 /21
Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Preterm Delivery Prevention Antenatal Clinic OBS/GYNAE/GUID/112 Completion of audits as identified in the summary sheet
Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback and you work with service users through you Maternity Voices Partnership to coproduce local maternity services patient feedback mechanism for maternity services and that you regularly act on feedback?	The Board are to note that the MVP Chair role has been vacant, and a new Chair has been appointed. Therefore, confirmation for this standard has come from the CCG (CCG commissioned service) rather than the MVP chair
Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, MDT training when this is permitted
Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan
Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	All qualifying incidents have been reported