Blackpool Teaching Hospitals
NHS Foundation Trust

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30 April 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 6 May 2021 at 9.00 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 (34/21)	Chairman's Welcome and Introductions	Chairman	Information
02 (35/21)	Declarations of Interest	Chairman	Information
03 (36/21)	Apologies for Absence	Chairman	Information
04 (37/21)	Minutes of the Board of Directors Meeting held in public on 4 March 2021. (Enclosed)	Chairman	Approval
05 (38/21)	Matters Arising: a) Action List (Enclosed)	Chairman	Information/ Assurance
06 (39/21)	Patient Story	Executive Director of Nursing	Information/ Assurance
07 (40/21)	Chairman's Update (Verbal)	Chairman	Information
08 (41/21)	Chief Executive's Report (Enclosed)	Chief Executive	Information/ Assurance
09 (42/21)	Performance: a) Integrated Performance Report (Enclosed) i. Executive Summary b) Health and Safety Metrics Update (Verbal) c) Covid-19 Vaccine Update (Enclosed)	Deputy Chief Executive Deputy Chief Executive Chief Executive	Information/ Assurance Information/ Assurance Information/ Assurance
10 (43/21)	<u>Engagement:</u> a) NHS National Staff Survey Results (Enclosed) b) Reciprocal Mentoring Criteria (Verbal)	Executive Director of HR and OD	Information/ Assurance
11 (44/21)	<u>Improvement:</u> a) Care Quality Commission (CQC) Unannounced Visit Report (Enclosed) b) Quality Improvement Update (Enclosed) *(Mrs Katharine Goldthorpe, Associate Director of Quality Improvement) to join the meeting for this item).* c) Ockenden Report Update (Enclosed)	Executive Director of Nursing Executive Director of Nursing Executive Director of Nursing	Information/ Assurance Information/ Assurance Information/ Assurance
12 (45/21)	<u>Governance:</u> a) Corporate Risk Register (Enclosed)	Executive Director of Nursing	Assurance/ Approval

Item Number	Agenda Item		Purpose/ Expected Outcome
	b) Board Assurance Framework (Enclosed)	Director of Corporate Governance	Assurance/ Approval
	c) Board Committee Assurance: • Audit Committee Minutes (1 February 2020) and update (22 March 2021) (Enclosed/Verbal).	Committee Chair	Information/ Assurance
	• Quality & Clinical Effectiveness Minutes (23 February 2021 and 23 March 2021) and update (27 April 2021) (Enclosed/Verbal).	Committee Chair	Information/ Assurance
	• Operations Committee Minutes (25 February 2021 and 25 March 2021) and update (22 April 2021) (Enclosed/Verbal)	Committee Chair	Information/ Assurance
13 (46/21)	Any Other Business a) Planning for Board BAME Session (Verbal)	Chairman	Discussion
	b) NHSE/I Review of Disciplinary Policies and Procedures (Verbal)	Executive Director of HR and OD	Discussion
14 (47/21)	Formal Meeting Review	Chairman	Discussion
15 (48/21)	Date of Next Meeting: 1 July 2021 at 9.30am		Information

Minutes of the Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting (held in public)

on Thursday 4 March 2021 at 9.30am

via Microsoft Teams

Present

Mr S Fogg	Chairman	
Mr Kevin McGee	Chief Executive	
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	Non-voting
Mr P Murphy	Director of Nursing, AHPs and Quality	
Mr F Patel	Interim Director of Finance	
Mr J Wilkie	Non-Executive Director	
Professor T Warne	Non-Executive Director	
Miss S Wright	Joint Director of Communications	Non-voting

In Attendance

Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Miss K Ingham	Interim Head of Corporate Governance	Minutes
Mrs K Goldthorpe	Associate Director of Quality Improvement	For item 27/21
Mr P Rao	Associate Specialist Urologist	For item 22/21

Apologies

None to record

17/21 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.

18/21 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 confirmed that he was also appointed as Chief Executive of East Lancashire Hospitals NHS Trust and was also a Board member of Atlas

b) Mr Moynes confirmed that he was also appointed as Director of HR and OD at East Lancashire Hospitals NHS Trust

c) Mr James Wilkie confirmed that he was a Non-Executive Director on the Atlas Board.

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

19/21 Apologies for Absence

Apologies were received as recorded above.

20/21 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 correction:

Item 09/21: Integrated Performance Report (Finance) - Mr Patel reported that the financial years mentioned in the minutes were incorrect and that they referred to the 2020/21 year rather than 2019/20.

Item 09/21: Integrated Performance Report (Operational Performance) - Mr Case confirmed that the comments that he had made related to health and safety metrics rather than health and wellbeing metrics.

RESOLVED: Directors approved the minutes of the previous meeting, held on 7 January 2021 as a true and accurate record.

21/21 Action List

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

RESOLVED: Directors noted the position of the action list.

22/21 Staff Story

Mr Rao gave a short presentation to Directors which provided an overview of his personal history, including his childhood in South India and the emigration of his family from India to the United States of America, medical training, previous work in the NHS and his work since joining the Trust in 1994.

He highlighted the limited scope for progression as a middle grade doctor at the Trust that he had experienced, but noted that this was no longer an issue due to the developments within the department since 2017. He went on to highlight the work that the department was now involved in, including the focus on education, mentorship, leadership, audit and research work.

The Chairman thanked Mr Rao for his open and honest presentation and commented that it was good to hear the views and experiences of staff as well as patients. He commended Mr Rao for his clear commitment and enthusiasm for the Trust.

In response to Mr Case's question about the key leadership changes that had helped in 2015, Mr Rao confirmed that the change in leadership assisted the department to move away from purely being seen as a provider of services and enabled the department to take a greater role in the Trust.

Mr Wilkie agreed with Chairman's comments around the importance of including more staff stories at Board meetings. He went on to suggest that there was a role for existing Trust staff to play in the recruitment of new staff, particularly in terms of being ambassadors for the Trust. Mr Moynes agreed that this was a good point, and confirmed that whilst this did happen, it was not consistent across the Trust.

Mr McGee thanked Mr Rao for sharing his story and for his continued leadership within the Trust. He went on to state that the story emphasised the work taking place and that it was the bedrock on which the Trust is founded, particularly the education work that is taking place.

Mr McGee went on to ask how the Trust could work better with other organisations across the Integrated Care System (ICS) for the benefit of the whole ICS region. In response, Mr Rao confirmed that the department had considered what the service could offer to the ICS region that was not provided in other Trusts.

Mr Rao left the meeting at this point (9.55am)

RESOLVED: Directors noted the presentation given by Mr Rao.

23/21 Chairman's Update

Mr Fogg confirmed that it was a pleasure to have been selected as the Chairman of the Trust. He went on to say that having been in post for around three weeks, he had already discovered that the Trust was a warm and welcoming place to work. He confirmed that the challenges faced by the Trust would be worked through methodically and correctly and that he planned to continue to develop the Board.

Directors noted that a strategic view was key to the success of the Trust in the future and that there was a need to consider the long-term future of the Trust, both internally and as part of the ICS.

RESOLVED: Directors noted the update.

24/21 Chief Executive's Report

Prior to commencing the presentation of the main report, Mr McGee provided Directors with an overview of the events of the previous day in relation to the ongoing Police investigation into the incident within the Trust's Stroke Service. Directors noted that the police enquiry had progressed and confirmed that their thoughts were with the patients involved and the staff working within the affected service. Mr McGee went on to confirm that the Trust was working closely with the Police in relation to the investigation and that he will be keeping Board members and the teams involved informed as appropriate.

Mr McGee referred Directors to the previously circulated report and highlighted a number of items at national, regional and local levels, particularly the excellent work that the NHS as a whole and the Trust specifically had carried out in relation to the COVID-19 mass vaccination programme.

He went on to highlight the increase in applications for both nursing and medical education places at national level and the move towards restoration or services across the NHS. Directors noted the comments referenced in the report made by NHS Providers in relation to the likelihood of restoration of services taking longer than planned due to the need to support staff who are extremely tired.

Directors noted the update provided in the report relating to the New Hospitals Programme and were informed that the plan was to ensure that the benefit was for the ICS region as a whole.

Mr McGee highlighted a number of local matters contained within the report, including Dr Sharon Grey of the Lancashire Haematology Service being awarded an MBE and Dr Steve Williams being appointed to the role of Deputy Medical Director for Professional Standards.

Mr McGee invited Mr Murphy to provide an overview of the Collaborative Organisational Accreditation System for Teams (COAST) accreditation system for the Trust. Mr Murphy confirmed that the Trust had launched the programme in a pilot form in December 2020 and rolled out the system in quarter four of the 2020/21 year. He confirmed that to date there were two areas which had received gold accreditation with three silver and ten bronze accredited areas. Directors noted that positive feedback had been gained on the process. Mr Murphy briefly outlined a number of areas where the need for improvement had been identified, including the quality of documentation and cleanliness in some areas.

In response to Mr Case's query, Mr McGee confirmed that the Trust had received the draft CQC report relating to the unannounced inspection for factual accuracy checking. He went on to confirm that although the report had not been finalised, it made reference to the progress made in the Trust, particularly in relation to the Trust's Emergency Department and flow from general medial wards. It also highlighted that whilst progress had been made there remained much work to do.

Professor Warne asked whether the uptake of COVID-19 vaccinations from Trust staff was representative of the population and what work was being undertaken to encourage everyone to have the vaccine. Mr McGee confirmed that all means possible were being undertaken to identify and engage with staff who had not yet taken up the offer of vaccination. Mrs Barnsley confirmed that as of 3 March 2021 in excess of 17,000 first and second dose vaccinations had been administered and of those, 7,500 were to Trust staff. She went on to confirm that 2,100 of the vaccinations were administered to people over the age of 80, and 1,200 were provided to staff working within care homes. Directors noted that there had been an increase in the 'fail to attend' rate for second dose vaccinations.

RESOLVED: Directors received the report and noted its contents.

25/21 Performance

a) Integrated Performance Report

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.

Directors noted that COVID-19 infection rates within the Trust continued to reduce and bed capacity was being moved to restoration of services where appropriate. Critical care was an area of challenge in terms of demand and capacity.

Professor Latham went on to confirm that the Trust remained challenged in terms of matching capacity and demand in the Emergency Department, as the number of presentations continued to increase. She reported that the Trust had experienced good performance in relation to ambulance handovers in the reporting month and this was due to the combined efforts of the Trust and the North West Ambulance Service (NWAS).

Directors were informed about the positive progress made in relation to addressing delayed transfers of care. It was noted that, following a piece of work by Mrs Hudson, the Trust was performing well for discharges over the weekend period. Professor Latham went on to confirm that the Trust remained in the middle of the reporting pack for patient flow and highlighted the issues that had been identified with point of care testing which had impacted flow in the reporting month.

Directors were informed that there was a continued increase in the number of patients incurring a wait in excess of 52 weeks for surgery and noted that work was taking place at national level to validate these numbers.

Directors noted the mortality standards for the Trust continued to be addressed and that work was taking place with the national team around the Trust's Structured Judgement Reviews (SJR's) as they had been recognised as a mechanism for good practice.

Professor Latham went on to provide an overview of the national expectations in relation to the Phase Four Planning Guidance and confirmed that the first draft of the response was required by mid- March for submission to the ICS, which would then be incorporated in the first draft of the ICS submission to

NHS England/Improvement (NHSE/I) at the end of March 2021. Following feedback, a further iteration would be developed at Trust and then ICS level for submission in quarter two of the 2021/22 year.

Mr Case thanked Professor Latham for the overview and commented that the Trust seemed to continue to move in the right direction. He went on to highlight the need for a set of health and safety specific metrics at Board level, as the Trust had a duty to ensure that staff and visitors to the sites were safe. It was agreed that Professor Latham would liaise with Mr Case and Mr Verstraelen outside the meeting and develop specific metrics. It was also agreed that an update on health and safety and the metrics would be provided to the next meeting of the Board in May 2021.

Professor Warne suggested that there was a need to consider the long-term effects of the COVID-19 pandemic on staff and how any resultant issues could be identified and addressed.

Directors briefly discussed the need to ensure that the restoration of services was closely monitored and actioned as quickly as practicable across the ICS, particularly in relation to the management of patients waiting in excess of 52 weeks for treatment.

Dr Bedi stated that she was encouraged by the system level working that was taking place and the positive effect it was having on the services. She asked whether there were plans in place to move towards an ICS level IPR. In response, Mr McGee confirmed that the CQC had shared their intention to move away from individual organisation monitoring and move towards monitoring at ICS level. Directors noted that there would also be a drive towards monitoring financial performance at ICS level and systems, rather than individual organisations would be held to account.

RESOLVED: Directors received the report and noted its contents.

Professor Latham to liaise with Mr Case and Mr Verstraelen outside the meeting and develop specific metrics which, along with a health and safety update would be presented to the next meeting of the Board in May 2021.

ii. Quality

Directors noted the information provided in the IPR relating to quality.

iii. Finance

Directors noted the information provided in the IPR relating to finance.

iv. Operational Performance

Directors noted the information provided in the IPR relating to operational performance.

v. Workforce

Directors noted the information provided in the IPR relating to workforce.

RESOLVED: Directors received the report and noted its content.

b) COVID-19 Vaccine Update

Directors noted that this matter had been discussed under item 24/21: Chief Executive's Report.

26/21 <u>Engagement</u>

a) Reciprocal Mentorship Programme

Mr Moynes provided an overview of the programme and confirmed that it linked closely to the work being carried out by the staff engagement team, which was aligned to the Workforce Race and Equality Standard (WRES) and staff survey programmes. Directors noted that the programme was funded by the NHS North West Leadership Academy (NWLA) and that there was a requirement to set up a Programme Board which would be chaired by the Chief Executive.

Mr Moynes sought expressions of interest from Board members to act as mentors and confirmed that over the course of the programme it was envisaged that there would be around 20 pairs of mentors and mentees put together. He went on to confirm that an implementation team was being developed along with an implementation plan. The client group was noted to be made up of staff from underrepresented groups.

Directors noted that the selection criteria was currently being developed and would be presented to the next meeting of the Board in May 2021.

Mr Cullinan and Mr Case expressed their interest in being involved in the programme in any way appropriate. Mr Beaton reported that the Operations Committee had already briefly discussed this programme and were supportive of it.

Directors gave their support to continuing with the Reciprocal Mentorship programme.

RESOLVED: Directors gave their support to continuing with the Reciprocal Mentorship programme.

Mr Moynes will present the selection criteria to the next meeting of the Board in May 2021.

27/21 <u>Improvement</u>

a) Quality Improvement Update

Mr Murphy introduced the item by stating that the Trust's Quality Improvement Programme commenced in 2019 and was scheduled to run until at least 2022.

He addressed the comments made by Mr Beaton earlier in the meeting around managing staff welfare by confirming that there was a need to invest in staff, as they were a key component of the success of the Trust.

Mrs Goldthorpe attended the meeting to provide an update on the programme and confirmed that consideration was being given to moving into a distributed leadership model. The model would focus on supporting the clinical teams through an academy type arrangement for 12 months, including access to external and internal experts to progress their learning.

Directors were given an overview of the collaborative programmes that were being developed within the Trust, including the 'deteriorating patient programme' and 'pressure ulcer collaborative'. Mrs Goldthorpe confirmed that Dr Gardner and Mr Murphy were in attendance at each learning session and had regularly gave presentations to front line staff groups about the programme.

Directors noted that the next programme which would be launched would be the 'last 1,000 days of life programme' and it would be launched in May 2021.

Mr Wilkie queried to what extent the Trust embedded the improvement working within policies and staff development. Mrs Goldthorpe confirmed that a working understanding of the improvement programme was included within each job description and was incorporated within the recruitment and selection process for all roles within the Trust.

Professor Warne highlighted the discussions that had taken place at the most recent Quality and Clinical Effectiveness Committee meeting in relation to this work, particularly the need to formalise it across the Trust.

Mrs Goldthorpe confirmed that the Trust was about to test the live Quality Improvement (QI) programme which allows people to share their work across a wider audience.

Mr McGee shared his enthusiasm and optimism for the programme and confirmed that once fully embedded, it would become the accepted way that business was carried out across the organisation and would be linked through from 'ward to Board'.

It was agreed that regular updates would be provided to the Board on the programme.

Mr Fogg confirmed that he was pleased to see the report being presented to the Board and encouraged Mrs Goldthorpe and the team to undertake visits and discussions with non-NHS organisations and was happy to explore possible links with the team, if they wished.

Dr Gardner highlighted the work that the Trust carried out with academic institutions, such as UCLan and Lancaster University and encouraged the Quality Improvement team to explore closer working relationships with these institutions too.

RESOLVED: Directors received the report and noted its contents.

It was agreed that regular updates would be provided to the Board on the programme.

Mrs Goldthorpe to liaise with Mr Fogg and Dr Gardner in relation to exploring external learning opportunities within the private and education sectors.

28/21 Governance

a) Corporate Risk Register

Mr Murphy referred Directors to the previously circulated report and confirmed that it was a further iteration of the documents provided to the previous two Board meetings following input from the Good Governance Institute (GGI).

He went on to confirm that risk management training had been implemented across the Trust since the last meeting.

Directors noted the ongoing commitment to ensuring a 'ward to Board' link and the need to embed this through the divisions, departments and ward areas.

Mr Fogg suggested that it may be beneficial to look outside of the sector at other similar registers to improve the simplicity of the document. Mr Murphy offered to meet with Mr Fogg outside the meeting to provide an overview of the CRR and explain how it linked to the wider Trust work.

In response to Professor Warne's question, Mr Murphy confirmed that the ultimate direction of travel was for Trusts within the ICS to have a shared risk register but in the meantime there was a need to ensure that the Trust's CRR was embedded and utilised properly throughout the divisions.

Mrs Bosnjak-Szekeres reported that the process of considering risks across the ICS had commenced through the Board Assurance Framework (BAF) and the future iterations of the BAF would begin to inform the CRR.

RESOLVED: Directors received the report and noted its content.

Mr Murphy will meet with Mr Fogg to provide an overview of the CRR and its links to the wider Trust work.

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 no movement in the scoring of any risks since the last report.

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.

c) EU Exit Plan

Mrs Barnsley confirmed that the internal EU Exit Planning Task and Finish Group had started meeting again in November 2020 in order to share the guidance and business continuity plans for the UK's exit from the EU. Directors noted that the frequency of the meetings had increased to weekly in January 2021 with any issues being reported through the Trust's escalation processes and linked closely to the COVID-19 briefing, as well as daily situation reporting. These meetings have since been stepped back and take place monthly, although escalation continues where appropriate.

Mrs Barnsley reported that there had only been one potential issue as a result of the exit which related to the delivery of some haematology supplies which had been delayed, although this may not be entirely as a result of the UK's exit from the EU.

RESOLVED: Directors received and noted the update provided.

d) Board Committee Assurance

i. Audit Committee Minutes and Update

Mr Cullinan presented the minutes of the previous meeting for information and highlighted the progress made in relation to governance systems, although this was not at the pace that had been initially planned. He went on to confirm that the core financial controls for the Trust were good.

Directors noted the recommendations from the Committee, those being the request to continue the current meeting cycle and for the Board to undertake Cyber Security training. Mrs Bosnjsk-Szekeres confirmed that the training would take place later in the day.

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

ii. Quality and Effectiveness Minutes and Update

Professor Warne referred Directors to the previously circulated minutes and highlighted the Trust's response to the Ockenden review which had been presented to the Committee for information. The report was accompanied by an action plan which will be monitored through the Committee.

He went on to provide an overview of the discussions held at the Committee since the last Board meeting, including the duty of candour compliance, concerns over the respiratory services prioritisation by primary care within PCNs and health and safety issues that were presented as part of the SIRI report. Dr Gardner commented that work would continue between the Trust and the PCNs to move forward the respiratory services agenda.

Directors noted that the Committee had received the Guardian of Safe Working Hours report at the last meeting and had requested further information about annual leave and rotas. The Committee also agreed the annual workplan.

Mr McGee commented that a summary of the Ockenden report was presented to the ICS Board meeting that had been held earlier in the week and commented that there was a good amount of cross-organisational working taking place.

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 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.

Mr Patel confirmed that the financial guidance for the 2021/22 year was not yet available in its entirety, but some aspects of the planning had been communicated to Trusts from NHS England/Improvement (NHSE/I).

In response to Mr Cullinan's question about the possibility of an improved funding envelope from NHSE/I, Mr McGee confirmed that it was not yet possible to determine the funding envelope that would be received from NHSE/I, nor was it possible to confirm that the allocations would come directly to Trusts, as it was likely that funding would be allocated at ICS level then filtered down to Trusts/systems.

Mr Beaton went on to confirm that from an operational performance point of view there had been an improvement in referral to treatment performance along with a reduction in the number of patients on 62-day cancer waiting lists. The performance against the four-hour emergency department standard continued to be difficult, as did the number of patients with long length of stays. In addition, the restoration programme continued, but remained challenging.

Mr Beaton confirmed that from a workforce perspective, the results of the National Staff Survey were encouraging, despite the response rate remaining below 50%. He went on to report that nurse staffing gaps were continuing to reduce, and the next area of focus would be medical staffing.

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

29/21 Attendance Monitoring Form

The attendance monitoring form was provided for information.

30/21 Any other Business

Meeting of the Corporate Trustee

Mrs Bosnjak-Szekeres confirmed that there would be a requirement for the Board members to meet as the Corporate Trustee of the Charity at the end of the meeting to discuss and agree an item about the use of funds.

31/21 Formal Meeting Review

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

Mr Wilkie stated that he felt that the meeting had gone well and had progressed at a good pace with effective discussions where required. Mr Cullinan agreed, but suggested that the volume of papers received could be reduced.

32/21 Date of Next Meeting

The next meeting will take place on Thursday, 6 May 2021.

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
Item 25/21(a)	04.03.2021	Performance - Integrated Performance Report - Executive Summary	Develop a specific metric and present alongside a health and safety update at the Board meeting in May 2021.	Professor Latham / Mr Case / Mr Verstraelen	06.05.2021		On agenda for May 2021 meeting.	Green
Item 26/21(a)		Engagement - Reciprocal Mentorship Programme	Present the selection criteria to the Board meeting in May 2021.	Mr Moynes	06.05.2021		On agenda for May 2021 meeting.	Green
Item 27/21(a)		Improvement - Quality Improvement Update	Lease with Mr Fogg in relation to exploring external learning opportunities within the private and education sectors.	Mrs Goldthorpe	06.05.2021		Mr Fogg and Mrs Goldthorpe met on 29.04.2021 to discuss this matter	Green
Item 28/21(a)		Governance - Corporate Risk Register	Meet with Mr Fogg to provide a better understanding of the CRR.	Mr Murphy	06.05.2021		A meeting is to be arranged for May 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	31.1.21		The Board Strategy Sessions commenced on 1 April 2021. Ths work will be picked up as part of the ongoing Board Strategy Sessions.	Amber
			Develop an indicator for health and well-being for inclusion in the KPIs/IPR.	Nicki Latham	21.1.21	06.05.2021	Update: on agenda for May 2021 meeting. Action sent to performance team with delivery expected for April meeting.	Green

RAG Rating	
Green	Completed
Amber	Pending
Red	Overdue

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

6 May 2021

Chief Executive's Report

Author of Report:	Kevin McGee, Chief Executive
Date of Report:	6 May 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

May 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

More than 32 million people have received their first vaccine dose, with more than 8.9 million receiving their second. The number of first doses administered each day is now averaging around 96,000 - a drop from an average of about 500,000 in mid-March - as the schedule of second doses kicks in. An average of more than 340,000 second doses are now being given a day. The country is on track to offer a first does to all adults by the end of July 2021.

Due to evidence linking the Oxford-AstraZeneca vaccine to rare blood clots, those aged under 30 are to be offered the Moderna or Pfizer-BioNTech jabs as an alternative.

The progress made in the UK so far means the country continues to be among those with the highest vaccination rates globally. Figures on vaccination uptake for the UK are published on a weekly basis on the PHE coronavirus data dashboard along with other COVID-19 information.

NHS achieves key commitment to roll out integrated care systems across England

Patients will have better, more joined up care as Integrated Care Systems (ICSs), which require all parts of the NHS to work with each other and their partners, are rolled out across the country from April.

NHS chief executive Sir Simon Stevens confirmed that the final 13 areas, serving 14.9 million people, will be formally designated "integrated care systems" (ICSs) from April 1, hitting a major milestone in the NHS Long Term Plan. A total of 42 ICSs, which bring together hospital, community and mental health trusts, GPs and other primary care services with local authorities and other care providers will cover the whole of England.

Integrated Care Systems are central to the delivery of the **NHS Long Term Plan** by bringing together local organisations to redesign care and improve population health, creating shared leadership and action. ICSs exist to improve the health of all residents, better support people living with multiple and long-term conditions, preventing illness, tackling variation in care and delivering seamless services while getting maximum impact for every pound. They bring together the NHS, local government and other organisations including the Voluntary, Community and Social Enterprise (VCSE) sectors.

NHS urges sex crime and abuse victims to seek help

Women who have experienced domestic abuse and sexual assault are being urged to contact the NHS for support. The move comes after the number of people receiving help from NHS Sexual Assault Referral clinics halved after the first lockdown compared with the previous year despite official figures showing that domestic abuse and sexual assault increased.

The specialist clinics offer people who have been raped or assaulted a range of help including medical examinations, emergency contraception, emotional support and pregnancy testing. The clinics are run by specially trained NHS doctors, nurses and support workers who can provide the appropriate care for victims.

NHS COVID treatment saves a million lives

Dexamethasone, an inexpensive and widely available steroid, has saved around one million lives worldwide since its discovery as an effective treatment for COVID-19 in a clinical trial in the NHS.

Newly published figures show that use of the drug has so far saved 22,000 lives in the UK and an estimated one million worldwide.

Since the RECOVERY trial, led by University of Oxford scientists and involving tens of thousands of patients and 175 NHS hospitals, announced the results just nine months ago, dexamethasone has been used to treat millions of seriously unwell patients with COVID.

The RECOVERY researchers found that dexamethasone cut the risk of death by a third for COVID patients on ventilators and for those on oxygen it cut deaths by almost a fifth.

Learning disability mortality review to be updated

Autistic people will now be specifically included in an improved and expanded LeDeR programme to drive improvements in care. The move is part of changes to the **learning from life and death reviews programme (LeDeR)** which aims to make improvements to the lives of people with a learning disability.

The NHS has worked with stakeholders including bereaved families, people with a learning disability and autistic people over the past 12 months to develop the **new policy** which will focus not only on completing reviews but on ensuring that local health and social care systems implement actions at a local level to improve and save lives.

‘COVID-friendly’ cancer care at home extended

Thousands of people with cancer will benefit from ‘COVID friendly’ treatments from home. More than 30 different drugs are now available to treat patients, offering benefits such as fewer hospital visits or a reduced

impact on their immune system. Around 8,000 people have already benefitted from the treatment ‘swaps’ during the pandemic, helping to maintain cancer treatment in the face of coronavirus. More than 250,000 people have started their treatment for cancer since the start of the pandemic.

The NHS is funding effective and less risky treatment ‘swaps’ for patients. Access to these drugs has been improved and is being extended until summer 2021, with the potential to extend further, until the end of March 2022.

Roll out of new capsule cameras to test for cancer

Miniature cameras which patients can swallow to get checked for cancer are being trialled across the NHS. The imaging technology, in a capsule no bigger than a pill, can provide a diagnosis within hours. Known as a colon capsule endoscopy, the cameras are the latest NHS innovation to help patients access cancer checks at home.

Traditional endoscopies mean patients need to attend hospital and have an invasive procedure, whereas the new technology means people can go about their normal day. An initial group of 11,000 NHS patients in England will receive the capsule cameras in more than 40 parts of the country.

Thousands to benefit from new 5-minute breast cancer treatment

Injections that reduce the length of hospital stay for breast cancer patients from two and a half hours to just five minutes are being rolled out nationwide.

Breast cancer patients receiving chemotherapy will be offered a new combination therapy called PHESGO. It is injected and takes less than 5 minutes to prepare and administer, compared to two injections that take up to two and a half hours.

The injection will be offered to eligible patients with HER2-positive breast cancer, which accounts for 15 percent of all breast cancers. More than 3,600 new patients each year will benefit from the treatment, as well as others who will switch from the treatment they are on to the single injection. It can be given alongside chemotherapy or on its own.

‘Nightingale effect’ sees thousands of healthcare support workers join the NHS

The NHS has boosted support for patients, their families and staff by recruiting 10,000 healthcare support workers in the first three months of the year. In November 2020, NHS England and NHS Improvement launched their latest **We Are the NHS** recruitment campaign. This followed a record rise in nursing students joining the NHS this academic year, with UCAS figures from August 2020 showing a 22% increase from the same point in 2019.

The new staff will support the workforce and assist nurses, midwives and other healthcare professionals to perform health checks, update patient records, help patients wash, dress and move around, and care for women and families in maternity services. They will also support people with mental health conditions, learning disabilities, and autism.

NHS sets out COVID-19 recovery plan for patient care and staff wellbeing

The NHS is accelerating the delivery of operations and other non-urgent services as part of a £8.1 billion plan to help the health service recover following the intense waves of COVID.

The money, which is set out in the **NHS Operational Planning and Contracting Guidance**, will also fund more support for staff who may be effected by their experiences during the coronavirus pandemic. The guidance stresses that NHS staff "need to be at the heart of plans for recovery and transformations" and that any plans should "reflect the need for staff to get the support, rest and recuperation that they need".

Maternity services will also be boosted by an additional £95million this year, including by creating new midwifery and obstetrician roles and providing more training and leadership programmes for midwives.

Trusts, who do more operations and other elective procedures, will qualify for a share of a £1 billion pot. Average waiting times for non-urgent surgery have dropped by almost 40% since the summer, and the NHS will continue to increase the number of non-urgent operations it does.

Every **Integrated Care System** is drawing up plans to ensure all hospitals maximise their capacity to do as many non-urgent operations as possible. Trusts are also expected to reduce the number of patients waiting for longer than 62 days for cancer procedures to pre-pandemic levels over the coming months.

New Office for Health Promotion will improve the health of the nation

A new Office for Health Promotion will lead national efforts to improve and level up the health of the nation by tackling obesity, improving mental health and promoting physical activity.

The office's remit will be to systematically tackle the top preventable risk factors causing death and ill health in the UK, by designing, implementing and tracking delivery policy across government. It will bring together a range of skills to lead a new era of public health polices, leveraging modern digital tools, data and actuarial science and delivery experts.

It will enable more joined-up, sustained action between national and local government, the NHS and cross-government, where much of the wider determinants of health sit. More information can be found here.

Headache-busting gadget to roll out across the country

A small, portable device that can zap away excruciating headaches is now available to anyone who needs it on the NHS. The gadget is held against the neck and delivers a low-level electric current to block pain signals, relieving pain from people suffering from 'cluster' headaches.

NHS England is expanding the use of gammaCore after successful trials held over the last two years. Around 11,000 people are set to benefit from the device when they have the debilitating headaches.

New dedicated mental health services for new expectant and bereaved mums

Thousands of new, expectant or bereaved mothers will receive help and support for mental health problems through dozens of new dedicated hubs which are being set up across the country.

The 26 new hubs will bring together maternity services, reproductive health and psychological therapy under one roof as part of the NHS Long Term Plan.

Around 6,000 women will receive care and treatment for a wide range of mental health issues from post-traumatic stress disorder (PTSD) after giving birth to others with a severe fear of childbirth.

NHS Facebook campaign helps 40-plus men prevent Type 2 diabetes

The NHS is using Facebook to reach millions of men aged 40 and over who are at risk of developing Type 2 diabetes, to help them to change their lifestyle and avoid the condition.

The Facebook adverts will highlight the increased risk among white men of this age and encourage them to sign up for support from the Healthier You NHS Diabetes Prevention Programme.

Research shows that men over 40 are particularly at risk of getting Type 2 diabetes and this risk increases with age. The world leading programme, which supports those who are at risk of developing the condition to lose weight and adopt healthier habits, has already helped hundreds of thousands of people.

The NHS will post a series of sponsored Facebook ads which will let users click through to a quiz by Diabetes UK. If their score is moderate or high, they can refer themselves to a local service for support remotely or online, without having to go through a healthcare professional.

The NHS has fast-tracked access to the Healthier You programme after research found that people are twice as likely to die from COVID-19 if they have Type 2 diabetes.

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.

Vaccination programme update

Across Lancashire and South Cumbria, more than 876,000 people have been vaccinated. This is more than two-thirds of our adult population. This is an incredible achievement, and we couldn't have done it without the strong partnership working across NHS, local authorities, public sector, health and care staff, volunteers, and wider stakeholders.

The Government has reported that there will be a significant reduction in weekly vaccine supply available from manufacturers beginning the week of 29 March, meaning volumes for first doses will be significantly constrained. It is predicted this will continue for a four-week period, as a result of reductions in national inbound vaccines supply. During this period, vaccination services will continue to give first and second doses to eligible people in cohorts 1-9. People will continue to be able to book appointments at vaccination centres and community pharmacies via the national booking service online or by calling 119. GPs will also continue contacting eligible patients and vaccinating them throughout April.

However, fewer appointments will be available for first doses as the bulk of available supplies are used to vaccinate people with a second jab. Our vaccination delivery programme has been designed to be flexible, scaled up and diversified in line with fluctuating international vaccine supplies. Vaccination Centre opening hours will be reviewed on an ongoing basis as more information becomes available about future allocations of vaccine supply.

Lancashire and South Cumbria ICS partners are working together to ensure that vulnerable communities such as people with Learning Disabilities and Autism, Gypsy, Roma and Irish Traveller communities and homeless people are able to easily access Covid-19 vaccinations. LSCFT staff have used the HARRI bus, a multi-use clinical and teaching space, to deliver vaccinations to homeless people in Preston and Blackpool, and a significant piece of research is currently underway to understand the barriers and challenges to vaccine uptake in ethnic minority communities. This will help us understand how best to support our communities' needs.

New Hospitals Programme

Further details have been published regarding the Lancashire and South Cumbria New Hospitals Programme, which will see hospital Trusts work together with the government to build new, centrally funded hospital facilities locally.

The Lancashire and South Cumbria New Hospitals Programme aims to address inequalities and improve health outcomes for communities across the region and will result in new, world-class facilities for local people. New hospital designs will be led by expertise and evidence from doctors, nurses and other clinical staff, from across the Lancashire and South Cumbria footprint, to ensure the best possible levels of patient treatment and care.

Local people, staff and stakeholders will be encouraged to input into proposals with ongoing collaboration with patients, communities, GPs and partners a central part of developing plans, and public consultation planned for the end of the year. Further information can be found on the **New Hospitals Programme website**.

Healthwatch Lancashire 'Mood of the Public' project

During the first wave of COVID-19 in spring 2020, hospitals across the country paused routine and non-urgent care, ensuring enough staff and beds were free to look after COVID patients, as well as people who needed urgent or emergency care.

Now, Trusts across the Lancashire and South Cumbria footprint are working with local Healthwatch organisations to help to understand the views of local people who are waiting for a routine or non-urgent appointment. Healthwatch are calling this project The Mood of the Public. This targeted group are being invited to complete a survey to share their views on different ways NHS organisations can work together to improve services. Analysis of the feedback will also help the NHS organisations know how to manage waiting lists better and consider how to provide support when and where it is needed.

Military medical support Covid-19 vaccination programme

The NHS has once again joined forces with the Army, RAF and Navy to give COVID-19 vaccinations to some of the most vulnerable people in Blackpool, Fylde and Wyre.

Military medics visited housebound people living across the Fylde Coast to give them their second dose of the COVID-19 vaccination. The partnership's joint efforts have helped to provide vaccinations to nearly 2,000 housebound people in the area and as quickly as possible.

The latest round of military-supported vaccinations follows the success seen in north Blackpool and Fleetwood earlier this year, when teams from the Armed Forces first joined the Fylde Coast COVID-19 vaccination programme.

Act FAST to fight strokes

Residents in Lancashire and South Cumbria are being urged not to delay seeking help if they have signs of having a stroke and to 'Act F.A.S.T' to save lives – the NHS is open. Data from the lockdown period of the coronavirus (COVID-19) pandemic last year show that admissions to hospital for stroke fell – a 12% drop between March and April 2020.

NHS staff have been working together to ensure that stroke care and urgent treatment can safely continue while responding to the pandemic.

The main signs of stroke can be remembered with the word FAST:

- Face – has their face fallen on one side? Can they smile?
- Arms – can they raise both their arms and keep them there?
- Speech – is their speech slurred?
- Time – time to call 999.

Suicide prevention campaign award

The Lancashire and South Cumbria Integrated Care System (ICS) Suicide Prevention Team has received a Health Service Journal Award in the category 'Connecting Service and Information Award' for their work on setting up the real time surveillance system.

The award recognises NHS initiatives where data sharing has made a real difference to local people. Judges look for successful implementation of systems and technologies which have enabled improvements to patient care – improving outcomes, experience and supporting patients to look after themselves better while at the same time delivering efficiencies for staff.

Sharing information, resources and learning at every opportunity is integral to prevent suicides and improve the outcomes of people in Lancashire and South Cumbria. The Suicide Prevention Team plan to share their local solution and operating model nationally to support more innovative and positive work around suicide prevention.

Campaign stresses the importance of supporting each other

Everyone across Lancashire and South Cumbria is being encouraged to talk to friends and family members, helplines and debt support services as lockdown restrictions ease.

As the third national Coronavirus lockdown comes to an end, and people take stock of their lives, the local health and care partnership has launched the next phase of its Let's Keep Talking campaign.

People furloughed, unemployed or coping with a drop in self-employed work are being asked to start a conversation with loved ones, or reach out to telephone counselling services to address any concerns, take practical steps, and get help with their mental health.

It is more important than ever for people to reach out to local and national services for help as they battle the effects of the pandemic – particularly health and care workers and those who have taken an active role in supporting communities through the effects and challenges of the pandemic over the past 12 months.

"Long'' Covid service launched across the Fylde coast

A service supporting patients who have been diagnosed with a post-COVID-19 syndrome known as 'long Covid' has launched. Although most people recover well, some may experience longer term effects including a range of symptoms such as fatigue, breathlessness, a cough, 'brain fog', anxiety, low mood and poor sleep. Long Covid is when these symptoms last 12 weeks or more. It can affect a wide range of people from the young fit and active to the older person.

The Long Covid Team is made up of different healthcare professionals including a Doctor, Clinical Specialist Occupational Therapist, Psychological Wellbeing Worker and a Rehabilitation Support Worker. The Team will complete a holistic assessment, talking through the care and support available, setting goals and helping patients to manage and recover from Long Covid symptoms.

To be referred to the Long Covid Service, patients are asked to contact their GP who can refer them into the service. Patients may be able to self-manage some of their symptoms and there are lots of useful resources and guidance to support their recovery at www.yourcovidrecovery.nhs.uk

Locality Model Redesign Launch

Since January, Lancashire and South Cumbria NHS Foundation Trust has worked tirelessly to ensure the smooth implementation of the new locality model for clinical operational services, which will see the introduction of five new localities.

These are:

- The Bay
  South Cumbria and North Lancashire
- Fylde Coast
  Blackpool, Fylde and Wyre
- Pennine Lancashire
  Blackburn with Darwen, Burnley, Hyndburn, Ribble Valley, Pendle and Rossendale
- Central and West
  Greater Preston, Chorley and South Ribble, and West Lancashire
- Specialist Services
  Dental, Perinatal, Forensic Inpatients, Forensic Community, Eating Disorder Services (EDS), CAMHS and Learning Disability and Autism services

Led by a new clinical leadership structure, the model officially launched on 1 April 2021, an exciting move for LSCft and all involved.

The Locality Model Redesign has been led by Deputy Chief Executive and Chief Operating Officer, Chris Oliver and Network Director of Operations for Fylde Coast, Joanna Stark, with support of Project Manager Michelle Nicklin, and the Trust's new leadership Triumvirates.

The new model will offer additional support and leadership at a locality level with the senior leadership teams being closer to the teams delivering services.

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 **22 April 2021** the seal was applied to the Agreements For Lease and Underlease Relating to 'The Bungalow', Civic Centre, Breck Road, Poulton Le Fylde, Lancashire between NHS Property Services Limited And Blackpool Teaching Hospitals NHS Foundation Trust. The documents were signed by Mr Stephen Fogg, Chairman and Mr Kevin McGee, Chief Executive.

Show of appreciation

In recognition of the incredible effort and hard work put in as part of our response to the pandemic over the last year, all BTH colleagues will receive a £50 voucher and an extra day's leave. In making the announcement, Kevin McGee, CEO, expressed how proud he was to have been part of the BTH team which has gone above and beyond over the past year to provide safe, personal and effective care to patients, supporting their families and each other, whilst dealing with the restrictions and challenges of the pandemic too.

The extra day's leave has been agreed in conjunction with the Union. All parties are keen that the extra time and money is used to do something that supports recovery and health and well-being. It is hoped the voucher will be spent locally to support the Lancashire economy which has suffered so terribly in the past year.

Joy as COVID baby, Ruby, celebrates her first birthday

A baby girl born with COVID-19 at Blackpool Victoria Hospital while her mum was fighting for her life, turned one-year-old in April. Ruby Dawson weighed only 4lb 12oz when she arrived by emergency caesarean while mum Kathrine was sedated and, on a ventilator, fighting for her life with the virus.

One year on and Ruby is thriving – she goes to nursery with her sister Ava and mum Katherine has started a new job.

Katherine commented: "I've been given a second chance at life and it's one I will live without regrets. All the Blackpool Victoria staff involved with our care have been in my thoughts. Without them, we wouldn't be here."

Patients benefiting from new cancer triage unit

The new Acute Oncology Triage Unit, within the Oncology and Haematology Unit, is a dedicated facility for supporting local patients who are going through – or have already been through – treatment for cancer.

These patients are often especially vulnerable because of compromised immune systems due to their treatment, which can make them more susceptible to infections. Previously they would have had to attend the Emergency Department. At the triage unit, patients are able to avoid a visit to the Emergency Department and receive fast, personal treatment in a dedicated space with staff they are familiar with.

The dedicated unit is up-and-running, thanks to fundraising efforts from Rosemere Cancer Foundation which, along with the hospital's own charity Blue Skies Hospitals Fund, raised more than £100,000 to convert what was formerly a disused operating theatre at the rear of the hospital's Oncology and Haematology Day Unit. It is estimated it will help more than 500 cancer patients annually.

Covid patient praises world class care

A Blackpool man who spent 84 days in hospital with COVID-19 has praised the "world class'' NHS teams who helped him return home. For Mr Tushar Das, the opportunity to continue his rehabilitation at home after falling ill was a welcomed relief. Tushar had spent almost three months in Blackpool Victoria Hospital, including three weeks in an induced coma before being recommended for the Home First pathway and being discharged to his home.

Mr Das admits that though he was initially a little anxious at the prospect of finally going home after such a long time, he was delighted with the care he received across the board, from every element of the hospital.

Cardiac consultant urges public to recognise the signs of a heart attack

A leading cardiac surgeon is urging Fylde coast residents to recognise the signs of a heart attack, so they don't miss out on potentially lifesaving treatment. Dr Billal Patel, consultant cardiologist at the Lancashire Cardiac Centre based at Blackpool Victoria Hospital believes a significant number of heart attack cases are going untreated as patients are not recognising the symptoms or are staying at home so as not to be a burden on the NHS. By doing this, patients could be risking significant long-term damage.

As some NHS Trusts in the UK have seen a 50 per cent drop in patients presenting for cardiology and heart problems, Dr Patel has called on the Fylde coast community to recognise the symptoms of a heart attack and ensure they call a doctor or get themselves checked out as the NHS is definitely open for business.

NHS Staff Survey results welcomed

The latest NHS Staff Survey has revealed high levels of staff satisfaction at the Trust despite the pressures of the pandemic. The results of the annual survey carried out across hundreds of organisations and involving millions of NHS staff members have now been made public.

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

even during the immense pressures of the pandemic, record numbers took the time to engage with the survey and share their thoughts.

This year, the Trust's response rate was 49.5 per cent, which means 3,548 staff members took the opportunity to have their say and influence the way the Trust is run. This compares to 46.9 per cent for the 2019 survey.

Primary Care Network team wins national Health Heroes Award

The Trust's South Neighbourhood Primary Care Network (PCN) has been named Integrated Team of the Year at the fifth Our Health Heroes Awards, for their commitment to improving healthcare in one of the most socially deprived areas of Blackpool.

The team staved off competition from more than 200 other applicants for the award with Team Leader, Kay Dalton, presented with the honour by Erika Bannerman, Managing Director of NHS Shared Business Services (NHS SBS) at the awards.

South Neighbourhood PCN covers the South Shore area of the resort. It is a Multi-Disciplinary Health and Wellbeing Team that brings together community nurses, matrons, case managers, mental health and wellbeing staff, occupational therapists and physiotherapists, with representatives from four local GPs, Blackpool Council Adult Social Care, Blackpool Community Groups, including the Carers Centre, a Lottery-funded social prescribing team, and Blackpool Police. The team works closely together to improve patient care by improving engagement

Staff benefit from national NHS Charity fundraising

Donations from the nation's fundraising, including the late Captain Sir Tom Moore, have been used to give staff rooms at the Trust a new lease of life.

The Trust's charity Blue Skies has used funding from NHS Charities Together to transform staff rooms and break areas into relaxing and welcoming spaces. Over a series of grants, the £180,000 worth of funding has been used to create wobble rooms and wellbeing packs for staff and mementoes for bereaved families.

The charity also used the opportunity to revamp areas with new appliances, décor and furniture. More than 80 staff rooms in both clinical and administrative areas in hospitals across Blackpool, Fylde and Wyre have received new furnishings.

Cardiac centre receives global attention

The Lancashire Cardiac Centre at Blackpool Teaching Hospitals was the focus of global attention following pioneering work which reduces the risk to those who are suffering underlying severe kidney disease and require angioplasty. Led by Dr Billal Patel, the team at Lancashire Cardiac Centre has developed a procedure which requires much less dye to be used when performing angioplasty to insert a stent. The use of dye, known as contrast, can be harmful to kidneys for those who are at higher risk of kidney disease.

Dr Patel presented his ground-breaking work to medical faculties across South East Asia, including Hong Kong, Singapore, Indonesia and the Philippines. Dr Tawfiq Choudhury, part of the team, presented the technique at the European Bifurcation Club meeting and won the first prize for the best presentation.

Trust takes a moment to mark Covid anniversary

March saw the one year anniversary of the Trust's first reported Covid-positive patient, and sadly its first death. To mark the occasion, a series of events took place around the Trust allowing staff the opportunity to 'Take a Moment' and reflect on the past 12 months,

Among the activities included a tree planting ceremony outside the Women and Children's Unit, a range of virtual wellbeing sessions for staff, and visits by Executive Directors and Senior Managers to spend time with colleagues and express their thanks for their hard work.

Cardiac team benefits from new pioneering technology

The Lancashire Cardiac Centre at the Trust is once again leading the way with pioneering heart surgery techniques with the aim of providing better outcomes for patients in the region.

The cardiac electrophysiology team at the Lancashire Cardiac Centre, led by Dr Khalid Abozguia, has received new catheter technology which will help patients who are diagnosed with irregular heart rhythms.

The Intellanav Stablepoint Ablation Catheter is a brand new tool that treats the heart for irregular rhythms. Treating the heart for irregular rhythms involves burning millimetre-wide areas of the heart using a catheter. This new catheter provides physicians with immediate feedback on how hard they are pushing into the heart tissue and how the tissue is responding to the treatment.

The physician can now diagnose, burn and validate the success of intricate changes to the heart during the procedure.

Speaking about the use of the pioneering Stablepoint catheter, Dr Khalid Abozguia, the clinical lead for cardiac electrophysiology (EP) service at the Lancashire Cardiac Centre, said: "We are pleased that our centre is one of few hospitals in the UK able to offer this new technology, to provide significantly better outcomes for our patients undergoing catheter ablation for heart rhythm disorder."

Trust helps promote bowel cancer awareness

April is Bowel Cancer Awareness Month, and throughout the month the Trust shared a series of videos specially produced to help raise awareness of the disease.

These videos included details on all aspects of bowel cancer, including how to spot signs and symptoms of the disease, what a patient can expect in an investigation in gastroenterology, and what would happen if you needed surgery.

Covid vaccination clinic for cancer patients praised

A special Covid clinic to vaccinate cancer patients across the Fylde coast has been praised. The weekly clinic, which takes place in the Macmillan Unit at Blackpool Victoria Hospital, sees local cancer patients invited to receive their vaccinations in a safe and comfortable environment away from the main vaccination hub at the hospital.

This helps to reduce the risk of infections for patients, who may be more vulnerable because of their condition, while at the same time providing a calm space for patients.

COAST accreditation scheme update

The Trust's COAST ward recognition scheme is well underway with many wards having received a visit from the assessment team.

Launched in January 2021, the Collaborative Organisational Accreditation System for Teams (COAST) aims to raise standards and celebrate best practice of teams across the hospital.

The framework is designed around the Chief Inspector of Hospitals', 5 Key lines of enquiry (KLOE) which are: SAFE, EFFECTIVE, CARING, RESPONSIVE and WELL LED.

The assessment team includes colleagues from all divisions and all grades and acts as 'critical friends', helping to point out things that are going un-noticed. Initially, the COAST team are assessing adult inpatient areas with plans to assess all of Blackpool Teaching Hospital services including ED, Theatres, community services and maternity services.

Medical Trainee receives international recognition

A Blackpool Teaching Hospitals medicine trainee has won international acclaim after his work was feature on an influential platform in partnership with the Academy of Medical Educators.

Jhiamluka Solano-Velasquez, an Internal Medicine Trainee on Ward 25, used his experiences of working in the NHS in the UK to publish a first ever training survey in his home nation of Honduras. Jhiamluka's work was so well received that he was encouraged to put together elements of his publication and produce a poster for an event called Interrobang 2021.

The Honduran Medical College were so impressed with his work they made Jhiamluka their ambassador. The idea was to create a knowledge bridge between the UK and Honduras. Trying to get the good things that the NHS and the GMC has, try to learn from everyone and see what can be replicate in Honduras.

International Day of the Midwife and International Nurses Day

"**Follow the data, invest in midwives**" is the theme of the 2021 International Day of the Midwife held on 5 May. It is through this lens that International Confederation of Midwives (ICM) will lead the on-going and growing efforts to highlight the midwives role as fundamental in ending preventable maternal and new-born deaths.

This year's theme is timely because International Day of the Midwife will coincide with the launch of the 2021 State of the World's Midwifery Report. Co-led by UNFPA, WHO and ICM, the report will provide updated evidence base and detailed analysis on the impact of midwives on maternal and new-born health outcomes

and the return on investment in midwives.

International Nurses Day is celebrated on 12 May as it is the anniversary of the birth of Florence Nightingale, the founder of modern nursing. Following on from previous years, the overarching theme for the day is Nurses: A Voice to Lead with a sub-theme for 2021 of "**A Vision for Future Healthcare"**.

While there has been significant disruption to healthcare during the pandemic, there has also been significant innovation that has improved access to care. In 2021, the International Council of Nurses will focus on the changes to and innovations in nursing and how this will ultimately shape the future of healthcare.

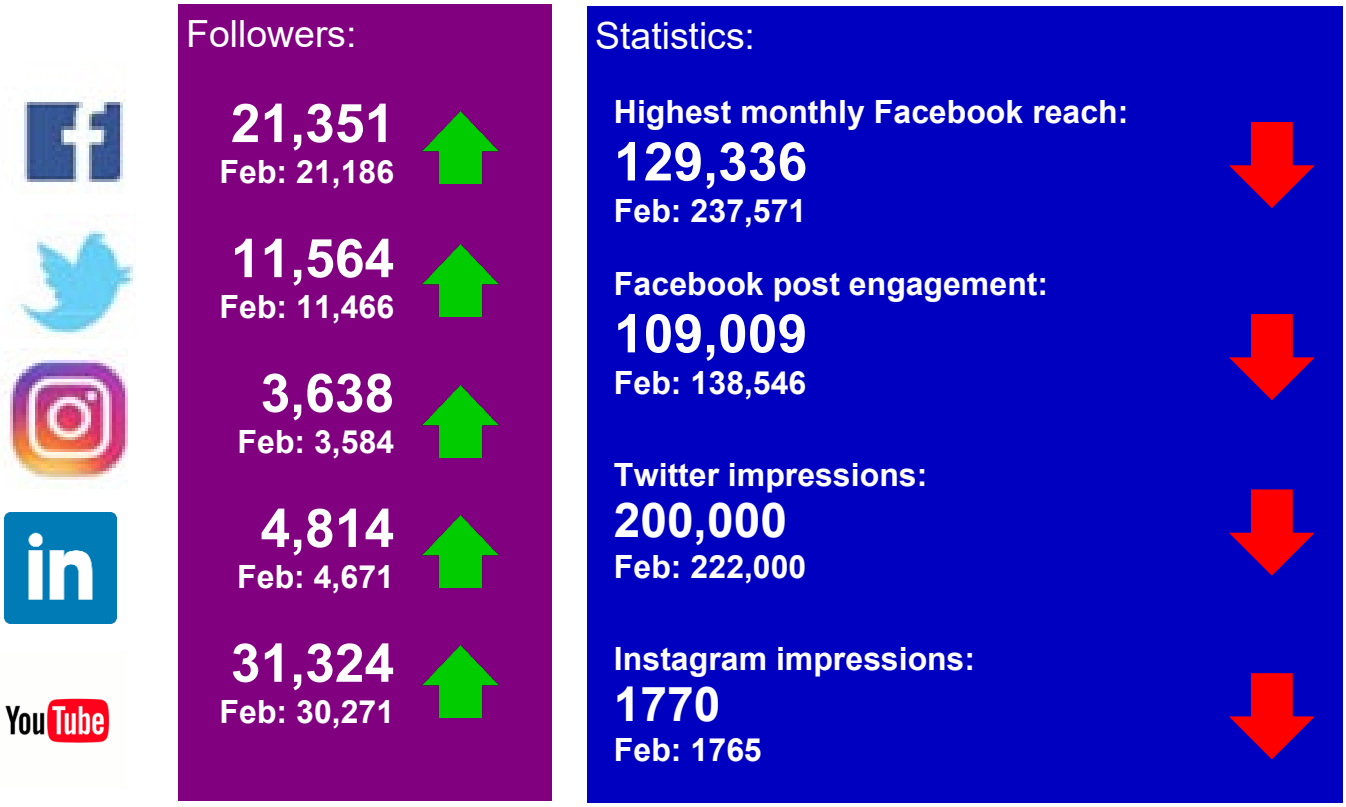
Appropriate events are being prepared to celebrate and honour all the midwives and nurses who have worked tirelessly, conscientiously and diligently throughout the pandemic and continue to do so each and every day.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

Monthly Media Update – February and March 2021

Social Media and Digital



Most talked about on social networks

Biggest engagement content Facebook:

- Jim Gardner update 17.2 21 (video) –Reach –88.5k
- Jim Gardner update 10.2.21 (video) Reach – 75.2k
- Jim Gardner update 24.2.21 (video) Reach – 72.2k
- Jim Gardner update 10.3.21 (video) –Reach –42.1k
- Jim Gardner update 3.3.21 (video) Reach – 35.5k
- Grahame Goode update 17.3.21 (video) Reach – 35.3k

Biggest engagement content Twitter

- Cardiac Centre global attention (text/pic) **15.2k** impressions

Top social media posts

Engagement insight

Facebook review score	4.1 out of 5 based on opinion of 201 people
Facebook Messenger	161 messages answered
Facebook staff group	1457 members

Page	Total Page Likes	From Last Week	Posts This Week	Engagement This Week
YOU 1 Blackpool Teaching Hos...	21.4K	▲100%	45	31.9K
2 East Lancashire Hospita...	15.8K	▲100%	62	4.2K
3 University Hospitals of ...	12K	▲100%	24	6K
4 Lancashire Teaching Ho...	9.7K	▲100%	93	6.4K
5 Blackpool Teaching Hos...	614	▲100%	3	550

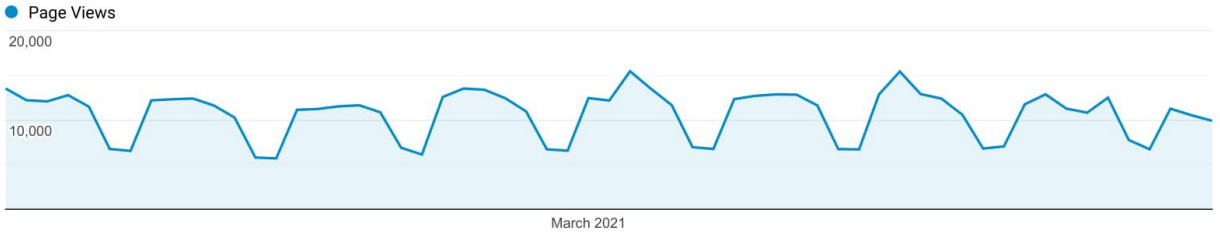
Web page hits

Overview

All Users
100.00% Page Views

1 Feb 2021 - 31 Mar 2021

Overview



Page Views	Unique Page Views	Avg. Time on Page	Bounce Rate	% Exit
628,797	507,046	00:00:56	53.88%	33.82%

	Page	Page Views	% Page Views
1.	/	73,305	11.66%
2.	/working-for-the-trust/current-vacancies/	36,666	5.83%
3.	/job_list/s7/Administrative_Services?_ts=1	16,283	2.59%
4.	/job_list/s1/Nursing_Midwifery?_ts=1	12,291	1.95%
5.	/our-services/	9,542	1.52%
6.	/working-for-the-trust/	9,146	1.45%
7.	/onehr/employee-staff-record-esr/employee/	8,729	1.39%
8.	/hospitals/blackpool-victoria/map-of-the-hospital/	6,392	1.02%
9.	/select_sector	6,243	0.99%
10.	/contact-us-2/	5,879	0.93%

Five - Chief Executive's Meetings

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

March 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
3 March	Formal Independent Care Sector Board (Formal ICS)
4 March	Formal Board of Directors – Blackpool
4 March	Chorley ED Checkpoint
5 March	Atlas Board of Directors Event
11 March	Fylde Coast A&E Delivery Board
11 March	NHSEI Chief Executives Advisory Group
12 March	Clinical Haematology Working Group
13 March	Take a Moment Event
14 March	New Hospitals Programme
17 March	System Leaders Executive

17 March	ICP Development Peer-to-Peer review
17 March	Council of Governors
17 March	Adult Social Care and Health Scrutiny Committee
18 March	Combined meeting of the Fylde Coast ICP Steering Group and Executive Strategy Group
18 March	Take a Moment Events
19 March	A&E System Lead Call
24 March	Atlas Board of Directors
29 March	Cardiac Network Meeting
29 March	Teams Brief
30 March	Interview Panel – Atlas
31 March	Health Education England Visit

April 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
1 April	Board Strategy Session

7 April	Informal ICS Board
8 April	Blackpool System Improvement Board
13 April	ICS Development Oversight Group
15 April	Strategic Commissioning Committee
19 April	Chief Executive Advisory Group
20 April	NHSEI CEO Advisory Group
21 April	System Leaders Executive Meeting
21 April	ICP Development – System Wide Workshop
22 April	Board Strategy Session
22 April	Medical Staff Committee
23 April	Clinical Haematology Working Group
23 April	HIP2 Strategic Oversight Group
26 April	Vital Signs Transformation Guiding Board
27 April	Health Education England Roundtable Discussion
28 April	Provider Collaborative Board Development Programme
29 April	Diagnostics Programme Board
29 April	Extraordinary New Hospitals Programme Strategic Oversight Group
29 April	Teams Brief
30 April	Pathology Collaboration Board

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

May 2021

Integrated Performance Report

Author of Report:	Charlie Walton
Executive Director Sponsor:	Nicki Latham – Deputy Chief Executive/Director of Strategic Partnerships
Date of Report:	29 April 2021

Executive Overview Summary:

The IPR contains two new metrics under the "Well Led" category, these are:

- Over 7 Day Incapacitation of a Worker (Page 41) and;
- Specified Injury to Worker (Page 42)

Positive News

- IAPT waiting times continue to improve their 75% target, with 96% of people referred to IAPT services starting treatment within 6 weeks of referral.
- The Trusts continues to perform above target on its Data Maturity Quality Index, achieving 90.6% against a target of 83%.
- There were no Never Events reported in March.
- There were no mixed sex breaches in March.
- FFT - Inpatients, 98% of patients said they would rate their care experience as very good.
- FFT – A&E, 85% of patients or their carers said they would rate their care experience as very good.
- FFT - Maternity, 85% of patients said they would rate their care experience as very good.
- FFT - Community, 98% of patients said they would rate their care experience as very good.
- FFT – Mental Health, 100% of patients said they would rate their care experience as very good.

Areas of Reporting Impacted due to COVID-19

- Reporting of patients who have received a VTE Risk Assessment was suspended, in order to move audit capacity on to Covid-related issues. However, this has now restarted using a digital solution from the wards and retrospectively reviewing patient notes.
- Reporting of the Dementia Standard suspension continues.

Areas of Challenge

- There is special cause concern for Referral to Treatment (RTT) for patients waiting over 18 weeks, delivering 67.6% against a target of 92%. There are currently 18,808 open pathways, 2,304 patients above the 16,500 target. 1,717 patients are waiting over 52 weeks. Insourcing and Independent Sector support is being considered as part of the restoration planning.
- The Trust did not achieve the Cancer 62 Day Wait from urgent referral to treatment for all cancers in February at 68.8% against the 85% standard. The current size of the backlog over 62 days is 88%

higher than the 2019/20 position, nationally this is 86% higher. The number of patients waiting over 104 days for treatment is 14, this is 136% higher than 2019/20 backlog, nationally this is 291% of the 2019/20 backlog. The Trust is continuing its improvement programme with the cancer alliance with a new Cancer Manager due to join the team in May.

- The national 6WW diagnostic standard of 99% was not achieved, with the March position showing 78.2%. This has predominantly been driven by endoscopy capacity and echocardiography. As part of the restoration programme endoscopy insourcing is being considered, with additional capacity expected in June 2021.
- The Type 1 performance for March was 55.83% and total economy performance was 82.19%. This represents a 3rd month of improvement. Continued improvement programmes are underway supported by the Trust PMO and Changeology.
- Staff Sickness in month is at 4.66%, a 4th month of improvement with the top reasons relating to anxiety/stress and Injury/fracture.
- 10.60% of staff are temporary staff, above the target of 5.56%. This has increased in month in line with the increase in agency spend.
- Agency spend has increased again this month, due to an increase in fill rates and off framework staffing.
- In month 12, the Trust has reported an adverse I&E margin performance of (0.1%), with a £6m worsening position due to NHSEI agreement to clear financial risk. As a consequence, the risk rating has remained at 4.
- There was one case of MRSA bacteraemia in March, with a post infection review indicating this could have been a community acquired infection.
- There were 9 C.Difficile infections detected during March.
- There were 5 E.Coli cases reported in March, a 7% reduction on the same reportable period last year.
- The rolling 12-month SHMI remains within statistically normal parameters with SHMI at 96.03 for March and HSMR at 128.8.
- The Trust received 42 formal complaints which require investigation in March, compared to 46 in February.
- 183 Non-hospital acquired pressure ulcers were reported in March and 98 Hospital acquired pressure ulcers. The Phase 1 collaborative teams are testing new wound care software for medical photography.
- Two members of staff have been incapacitated over 7 days.

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

March - 2021

Blackpool Teaching Hospitals NHS Foundation Trust

Safe

Never Events	KPIs
0	

VTE (%)	SPC
0.00	

C.Difficle	SPC
9	

MRSA	KPIs
1	

E.Coli	SPC
5	

Pat. Safety Alerts	SPC
1	

Effective

Crude Mortality (%)	SPC
1.41	

Caring

Complaints	SPC
42	

FFT Inpatients (%)	SPC
98.00	

FFT A&E (%)	SPC
85.00	

FFT Maternity (%)	SPC
85.00	

FFT Comm. %	SPC
98.00	

FFT Mental H. %	SPC
100.00	

Mixed Sex Breaches	KPIs
0	

Emerg. C Section %	SPC
16.80	

Responsive

RTT Incomp. (%)	SPC
67.60	

62 Day Cancer %	SPC
68.80	

6WW Diag %	SPC
78.17	

Dementia Std. %	SPC
0.00	

IAPT Wait %	SPC
96.00	

IAPT Rec. %	SPC
54.00	

DQMI (%)	SPC
90.60	

Efficient

Staff Sickness (%)	SPC
4.66	

Staff Turnover (%)	SPC
11.77	

Temp. Staffing %	SPC
10.60	

Capital Service	SPC
-0.30	

Liquidity	SPC
-19.30	

I&E Margins %	SPC
-4.00	

Agency Spd. (£M)	SPC
3.76	

EuR Rating	KPIs
4.00	

Strategic

A&E + UCC	SPC
82.19	

SHMI	SPC
96.03	

Well Led

Financial Plan	SPC
-0.10	

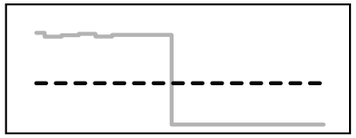
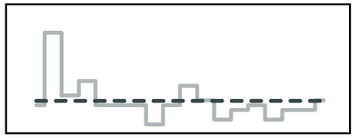
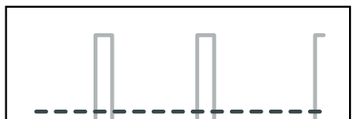
Spec. Injur. to Wrks.	KPIs
0	

Over 7 Day Inc Wrks	KPIs
2	

Definitions

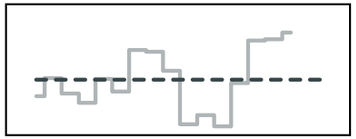
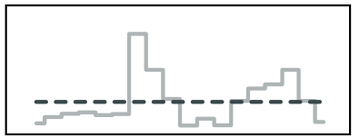
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Never Event	Safe	0	0		Full assurance
VTE (%)		0.00	0.00		Limited assurance
C.Difficile		9	0		Full assurance
MRSA		1	0		Full assurance
E.Coli		5	0		Full assurance
Patient Safety Alerts		1	0		Limited assurance

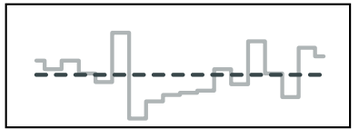
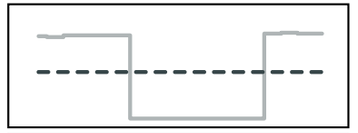
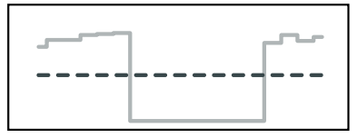
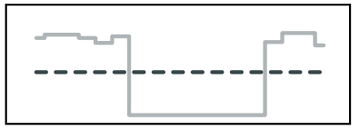
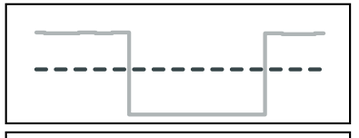
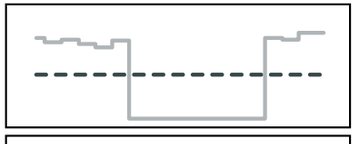
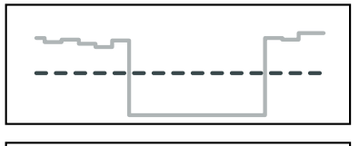
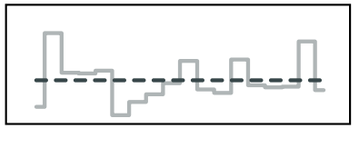
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC		Assurance
HSMR	Effective	128.88	0			Limited assurance
Crude Mortality (%)		1.41	0.00			Limited assurance

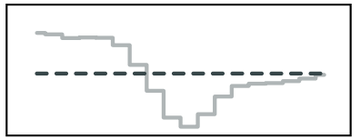
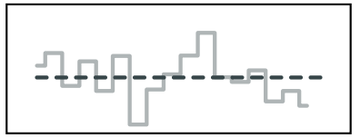
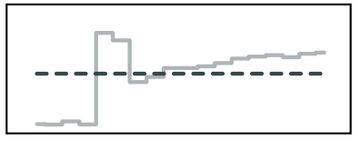
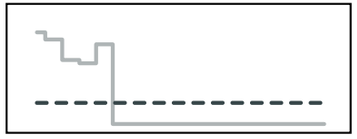
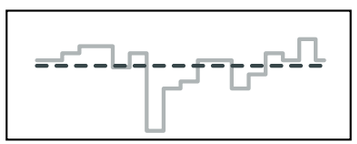
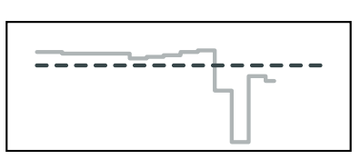
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Complaints	Caring	42	0		Limited assurance
FTT Inpatients (%)		98	96		Limited assurance
FTT A&E (%)		85	92		Limited assurance
FTT Maternity (%)		85	96		Limited assurance
FTT Community (%)		98	98		Limited assurance
FTT Mental Health (%)		100	95		Limited assurance
Mixed Sex Breaches		0	0		Full assurance
Emerg. C Section		16.80	0		Full assurance

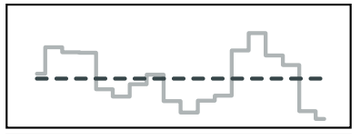
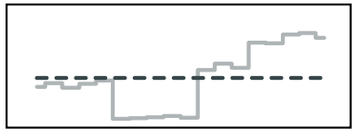
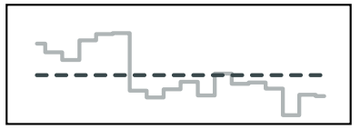
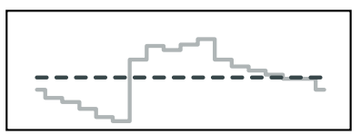
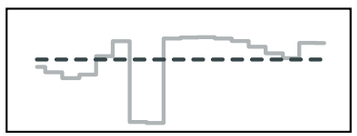
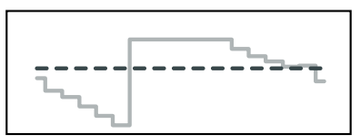
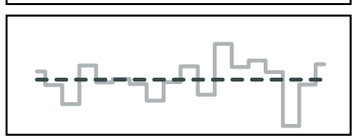
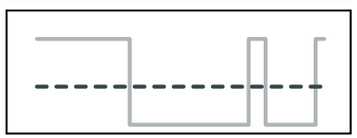
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
RTT Incomplete (%)	Responsive	67.60	92.00		Limited assurance
62 Day Cancer (%)		68.80	85.00		Limited assurance
6WW Diag (%)		78.17	99.00		Limited assurance
Dementia Stds.		0	0		No assurance
IAPT Wait Times		96	75		Full assurance
IAPT Recovery		54	50		Full assurance
DQMI (%)		90.60	83		Full assurance

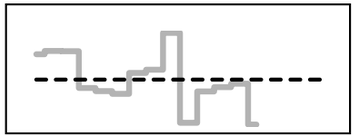
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Staff Sickness (%)	Efficient	4.66	4		Limited assurance
Staff Turnover (%)		11.77	11.00		Limited assurance
Temp. Staffing (%)		10.60	0.00		Limited assurance
Capital Service		-0.30	0		Limited assurance
Liquidity (Days)		-19.30	0		Limited assurance
I&E Margins (%)		-4.00	0		Limited assurance
Agency Spend (Millions)		3.75	-1		Full assurance
EuR Rating		4.00	(Blank)		Limited assurance

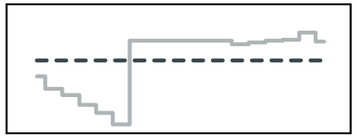
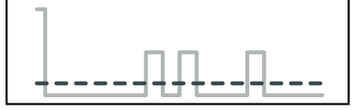
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC		Assurance
A&E + UCC (%)	Strategic	82.19	95			Limited assurance
SHMI		96.03	100			Limited assurance

Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

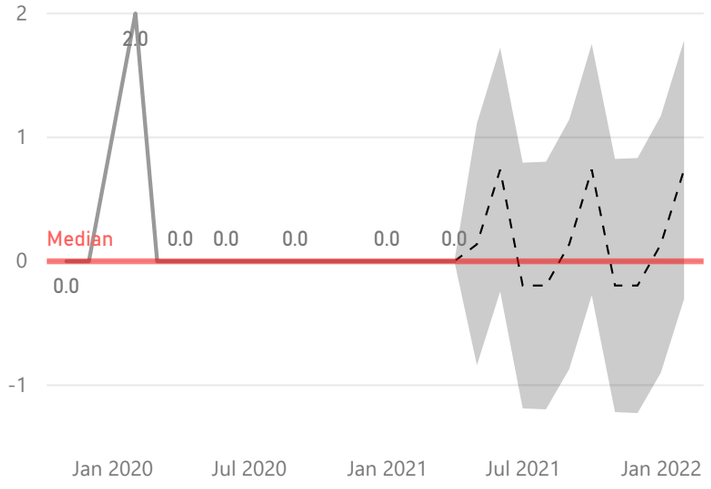
Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Financial Plan (%)	Well Led	-0.10	0.00		Limited assurance
Specified Injuries to Workers	Well Led	0.00	0.00		Full assurance
Over 7 Day incapacitation of a Wrk	Well Led	2.00	0.00		Full assurance

Never Events

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

Never Events: There were 0 Never Events reported this month.

Actions

There have been no Never Events this financial year.

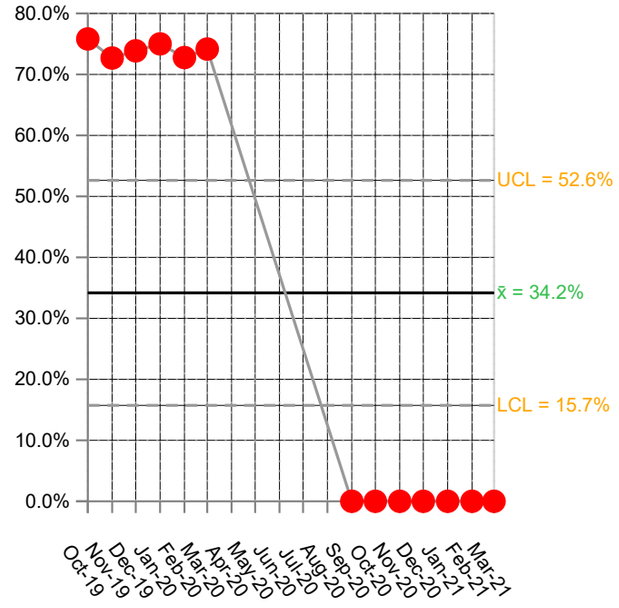
Risks	Mitigation

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 March 2021 are as follows:

Unscheduled care wards reviewed : AMU,AEC, 2, 3, 8, 25, 26, C, DS ITU
105 identified, only 12 out of 105 showing completed assessments on ward trackers. Case notes then reviewed on the same ward, 86 out of 96 completed in case notes reviewed. i.e approx. 90% compliance

Scheduled care wards reviewed : 34,35,15A, 15B, 16, SHCU, SAU, CDCU, CITU, HDU, ITU
117 identified on base tracker, 25 out of 117 showing completed assessments on ward trackers. Case notes reviewed on same wards, 94 out of 108 Reviewed notes showing completed assessments, i.e approx. 87% compliance

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.
STILL Awaiting feedback from Unscheduled and Families Divisions on whether they wish for policy to change to indicate moving away from mechanical measures!?
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
Have set up a help group with Dr Rostami and Jayne Thomas 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

Key Risks, Mitigation & Assurance

Limited assurance

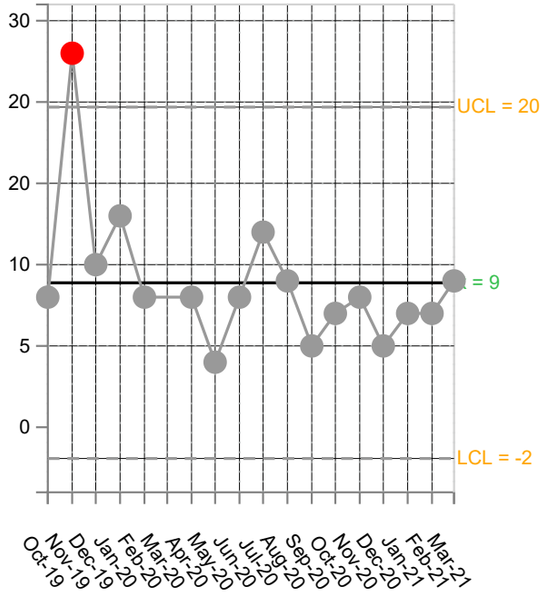
Risks	Mitigation

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 seven CDI cases were attributed to the Trust in March 2021. This brings the overall total for 2020/2021 to 89 which is a 29.9% reduction on the 127 cases that were reported the previous year. No objective was set for 2020/2021.

Actions

The Divisions undertake a root cause analysis of all cases. The outcome of these investigations determines which actions are required and forms the basis of a Divisional action plan. The Infection Prevention team undertakes commode cleanliness audits and the results also factor in to the Divisional action plans. Each Division then reports their progress against their CDI action plans at the Whole Health Infection Prevention Committee meeting.

A new cleaning checklist has also been developed for ward staff and updated cleaning schedules are displayed in all inpatient areas. Ribotyping is undertaken wherever two or more cases are reported on the same ward and outbreak meetings are convened as required. The Trust also has an antimicrobial formulary, which aims to prevent the use of antibiotics that can precipitate CDI.

Key Risks, Mitigation & Assurance

Full assurance

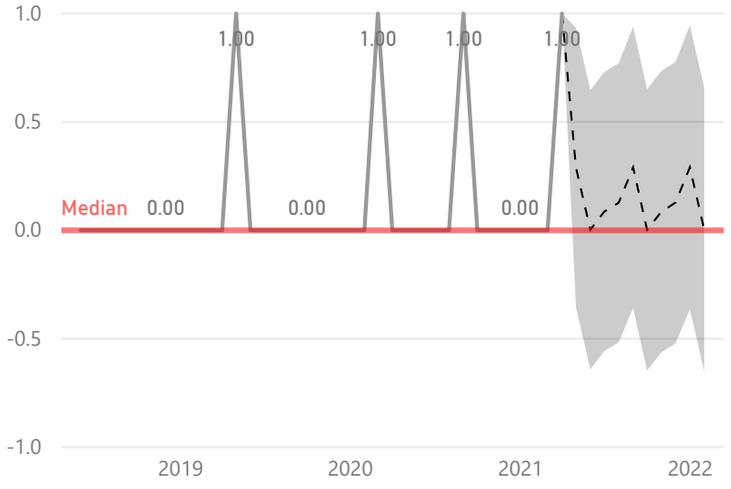
Risks	Mitigation

MRSA

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
1	0

Issues

One case of MRSA bacteraemia was reported in March. This brings the total for 2020/2021 to two cases which is the same number as the previous year. The Post Infection Review for this case is ongoing but preliminary investigations indicate that the cause was community acquired urosepsis. Therefore neither of the cases reported were linked to lapses in care.

Actions

A Post Infection Review meeting has been arranged with our commissioners and the Divisions will develop an action plan should any lessons be learned as a result of this process.

Key Risks, Mitigation & Assurance

Full assurance

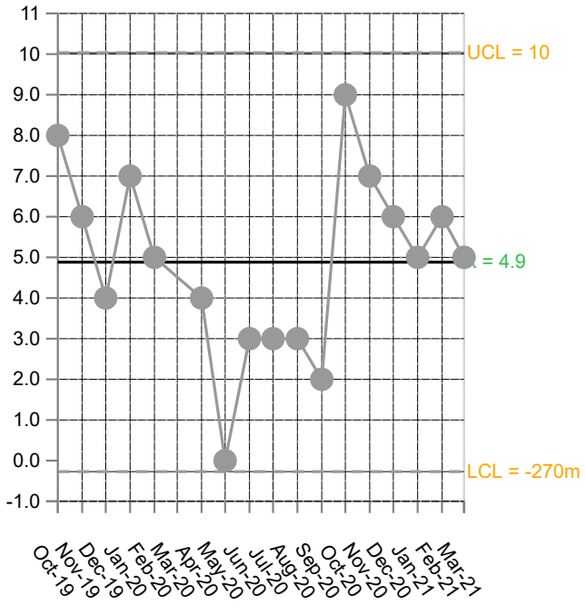
Risks	Mitigation

E.Coli

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
5	0

Issues

A total of five cases were reported in March 2021. This brings the total number of cases for 2020/2021 to 53 which is a 7% reduction on the 65 cases reported the previous year. No objective was set for 2020/2021.

Actions

Urinary tract infections (UTI) are the primary source of E. coli blood stream infections (BSI) . The trust has promoted the importance of hand hygiene and hydration and policies regarding the treatment of UTIs as well as catheter insertion have been reviewed and updated. Plans are in place to establish an ICS wide working group in relation to the reduction of E. coli and other Gram negative BSI.

Key Risks, Mitigation & Assurance

Full assurance

Risks	Mitigation

Patient Safety Alerts

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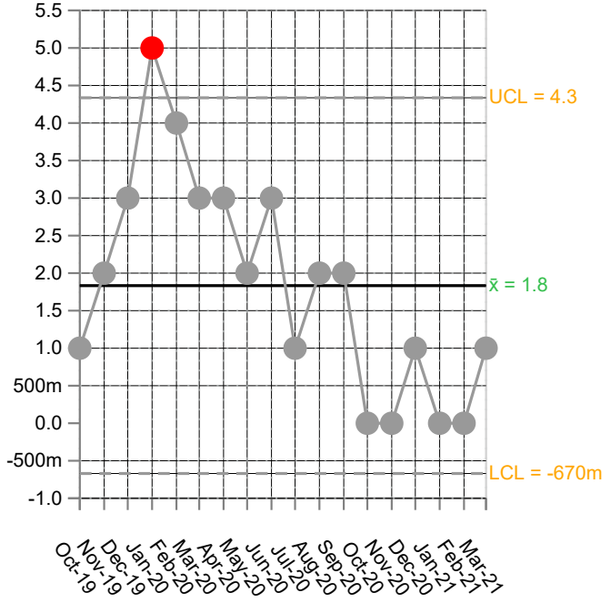
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
1	0

Issues

There was 1 new patient safety alerts received this month:

NatPSA/2021/001/MHRA - Supply disruptions of sterile infusion sets and connectors manufactured by Becton Dickinson (BD). The due response date for this alert is 31st Mar 2021. This has now been actioned and closed.

There are currently three patient safety alerts still ongoing: NatPSA/2020/005/NHSPS Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults. The due response date for this alert is 13th May 2021.
NatPSA/2020/006/NHSPS: Foreign body aspiration during intubation, advanced airway management or ventilation. The due response date for this alert is 1st June 2021.
NatPSA/2020/008/NHSPS, Deterioration due to rapid offload of pleural effusion fluid from chest drains. The due response date for this alert is 1st June 2021.

Actions

Due response date for the ongoing:

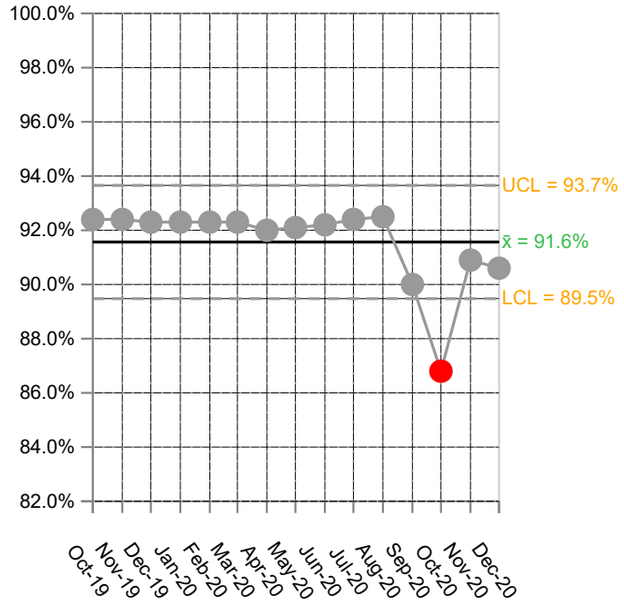
NatPSA/2020/005/NHSPS - 13/05/2021
NatPSA/2020/006/NHSPS - 01/06/2021
NatPSA/2020/008/NHSPS - 01/06/2021

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

Statistical Control Process



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 Decembers value of 90.6%, 8.8% above national average.

Please note data refreshes can affect DQMI values going forward

Actions

None

Actual	Target
90.60	83

Key Risks, Mitigation & Assurance

Full assurance

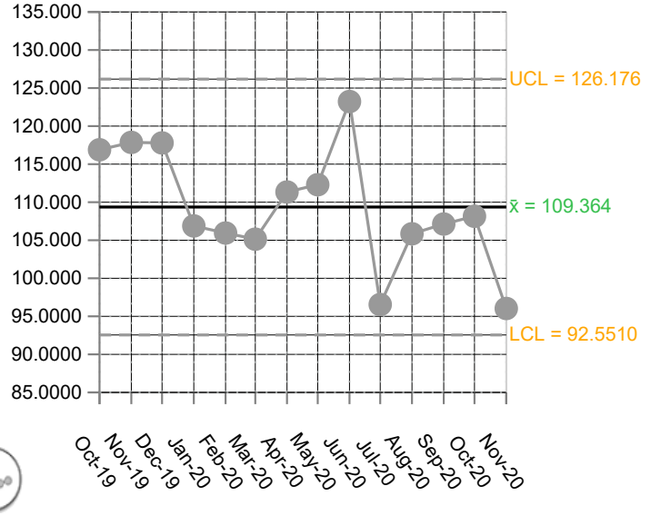
Risks	Mitigation
None	None

Mortality

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

SHMI Statistical Control Process



Actual (%)	Target
96.03	100.00

HSMR	SPC	Crude Mortality (%)	SPC
128.88		1.41	

Issues

Cumbersome current manual system for trust wide Learning from Deaths and mortality monitoring.
• Outstanding review of deaths of patients dying within 30 days of discharge from hospital.
• 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.
• Fragmented trust engagement with national and local LeDeR program.
• 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 to be 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 trustwide engagement with the LeDeR program including Learning from Deaths.
• Learning from Deaths Grand Round, in conjunction with NHSI Mortality Reduction Lead, planned for 12th May 2021.
• 12 month rolling averages for SHMI and HSMR smooth out variation and allow comparison across trusts.

Key Risks, Mitigation & Assurance

Limited assurance

Risks

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.

Mitigation

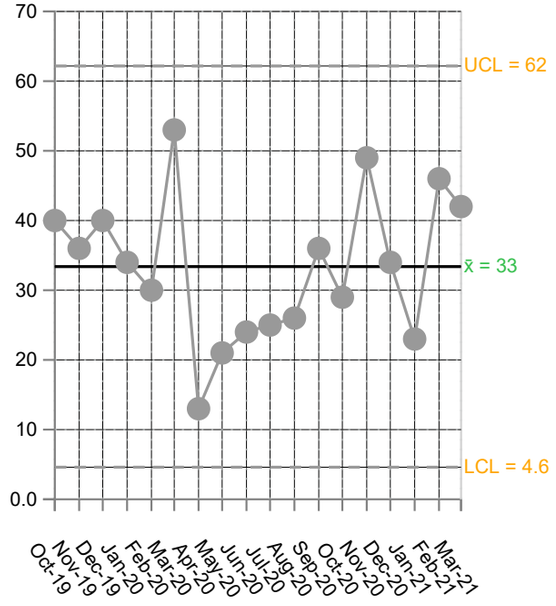
Speciality mortality governance leads and HOD's to be responsible for fair and even distribution of case record review workload within each speciality. • Medical Director is part of Regional Team considering aspects of nosocomial covid mortality reviews. Reviews underway across Trust using newly developed pro forma. Impact of the reviews on individual consultants minimised through allocating cases across an approved list.. Review of the case records 10 patients dying with 30 days of discharge to be undertaken to help guide on further proforma design. • LeDeR working group to continue working towards full trust engagement with the LeDeR program.

Complaints

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
42	(Blank)

Issues

In March 2021 42 formal complaints were received which required investigation compared to 46 in February 2021, a 8.5% decrease.

100% of complaints were acknowledged within 3 working days in the Trust. There were 41 complaints to be responded to between the divisions. 22 were sent out in time (54%), a 37% increase from February 2021. 19 breached the local target of 25/40 working days.

A breakdown for the divisions with complaints to respond to is below:
- ALTC Divisional response rate was – 67%. 2 out of 3 cases went out on time (7% increase from February) - Families Division response rate was 33.33%. One out of 3 went out on time (33.33% increase from February)
- Scheduled Care response rate was 73%. 8 out of 11 went out on time (53% increase from February)
- Unscheduled Care Division response rate was 55%. 11 out of 20 went out on time (30% increase from February)

Actions

Recruitment continues for the Patient Relations Team. The final posts, three Band 4's (2.8 WTE) and a Band 7 (1.0 WTE) will be interviewed and appointed by April. NHS England and Improvement have stated that NHS organisations must ensure they are answering all complaint responses in less than 6 months following the 30th April 2021, with normal service resuming if possible. Divisions will be reminded of this and to ensure complaint performance is still being discussed within the divisions monthly board and governance meeting and any anticipated delays are being escalated. The complaints received are often long and complex in nature. Whilst face-to-face meetings are not possible, the use of virtual meetings as an option is being encouraged.

Key Risks, Mitigation & Assurance

Limited assurance

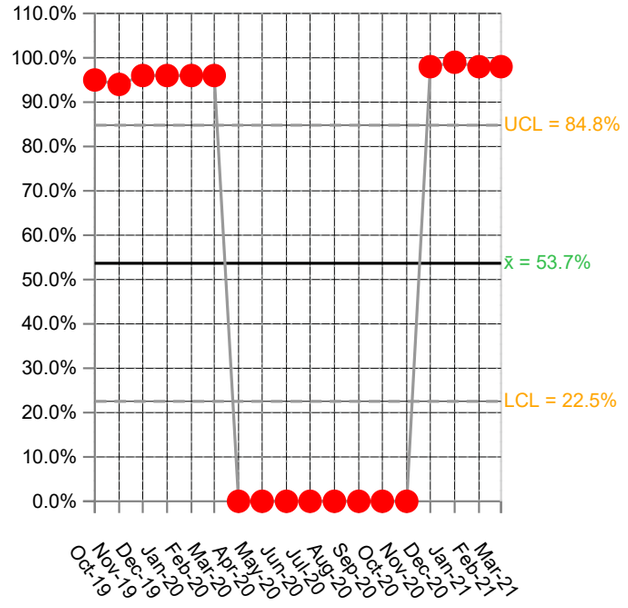
Risks	Mitigation

FFT Inpatients

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
98	96

Key Risks, Mitigation & Assurance

Limited assurance

Issues

In March 792 Inpatients completed a FFT survey whilst they were in either Clifton or Victoria hospital. A 197% increase from last month. 98% of the inpatients said they would rate their care experience as very good or good, a 1% increase from last month.

Actions

Reminders continue to be sent to the Ward teams to ensure they are offering the FFT survey at all opportunities throughout a patients stay. A list of areas with zero responses is collated monthly and sent out to senior nursing teams from inpatient areas, there is also a regular FFT article in the weekly newsletter with tips on how to engage with patients during the pandemic, giving examples from high performing areas.

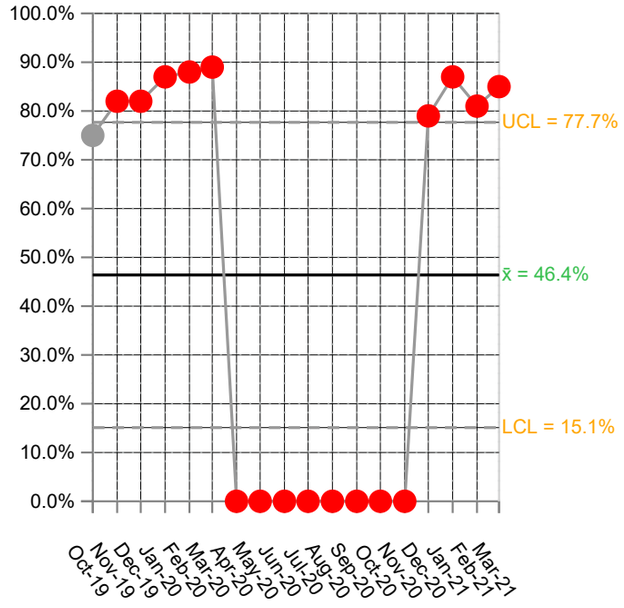
Risks	Mitigation

FFT A&E

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
85	92

Issues

In March 300 patients completed a FFT survey by SMS or paper after attending the Emergency Department. A 74% increase from last month. 85% of the patients or their carers said they would rate their care experience as very good, a 4% satisfaction increase from last month.

Actions

Feedback needs to be captured via the FFT paper survey as the surveys received this month were via electronic methods only such as SMS or online. The Patient Experience department will continue to support the staff with this method and assist with collections. Notification alerts and push reports are being sent to the departmental managers and Directors of Nursing overseeing A&E who can monitor the negative comments as they come in and act upon them.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

FFT Maternity

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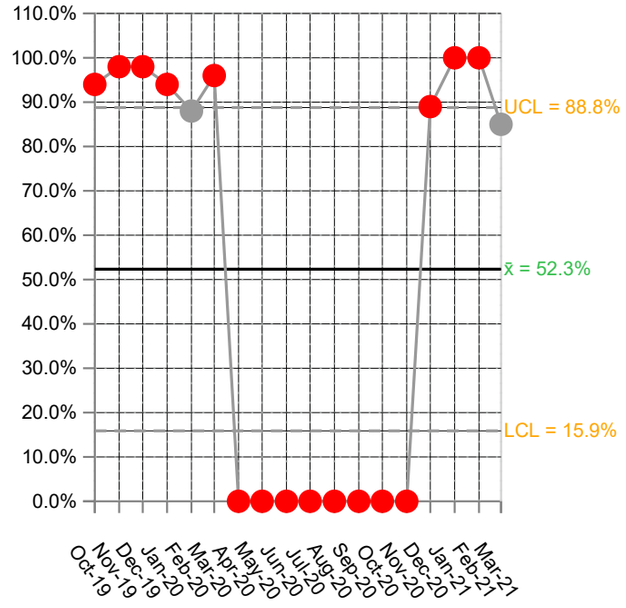
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
85	96

Key Risks, Mitigation & Assurance

Limited assurance

Issues

In March 13 maternity patients completed a FFT survey by SMS after the birth of their child, a 18% increase from February. 85% of the patients or their carers said they would rate their care experience as very good or good. One patient responded that the service they received was poor, which related to care and treatment, this has been escalated to the Ward Manager.

Actions

No paper surveys were submitted from maternity services in March. The Patient Experience department has made contact with the service managers to support the team in re-embedding the FFT into their daily practice of capturing the women's experience at all stages of their pregnancy. The SMS scripts are being changed for patients to offer feedback on antenatal, or post natal episodes alongside the standard birth question, due to pressures within the Health Informatics team this is taking longer than anticipated.

Risks	Mitigation

FFT Community

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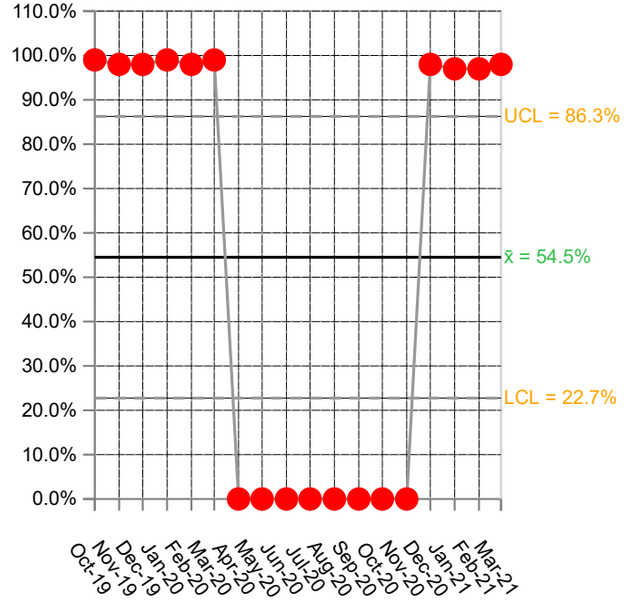
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
98	98

Key Risks, Mitigation & Assurance

Limited assurance

Issues

In March 614 patients in the community completed a FFT survey at home or in clinic. A 48% increase from last month. 98% of the patients or their carers said they would rate their care / experience as very good, 1% higher than the previous month.

Actions

The FFT question will be asked via SMS for MSK in the community. Sexual Health services are texting the online link to their patients via their Lilie system. If the SMS option yields a high response it will be rolled out for community services across the Fylde Coast. 268 patients chose to complete the survey via online option.

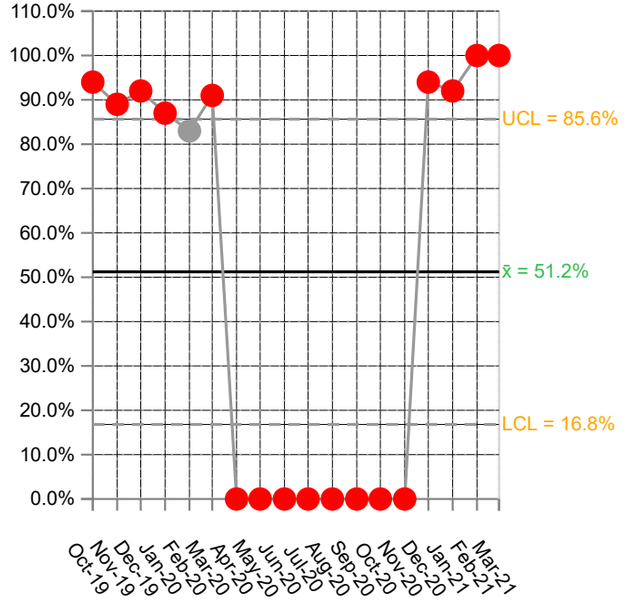
Risks	Mitigation

FFT Mental Health

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
100	95

Issues

In March 19 patients who require mental health support, completed a FFT survey at home or in a clinic. A 58% decrease from last month. 100% of the patients or their carers who used the services said they would rate their care experience as very good, the same as last month.

Actions

Online surveys within services such as Supporting Minds survey which includes the FFT question are the central feedback method. With no paper surveys being submitted in March staff will be encouraged to ask the FFT question via paper at different service points.

Key Risks, Mitigation & Assurance

Risks	Mitigation

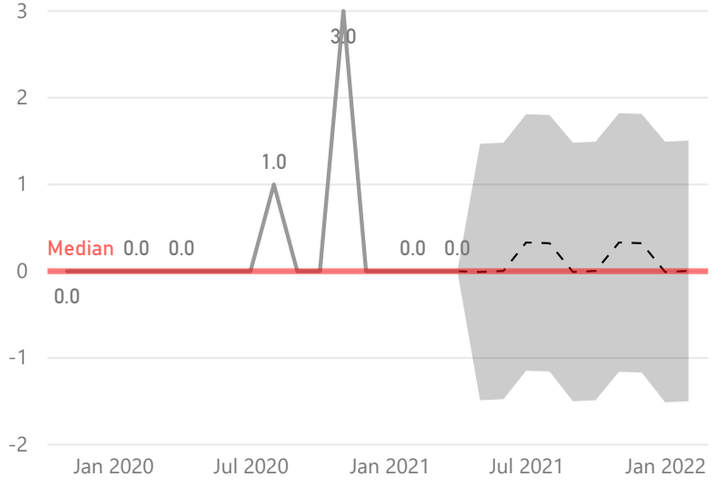
Limited assurance

Mixed Sex Breaches

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

There were no mixed sex breaches in March 2021.

Actions

We are using a new template to report the breaches to the CCG in line with the new guidelines and when permitted quarterly Eliminating Mixed Sex Audits will commence around the Trust with our Commissioners and senior nursing staff.

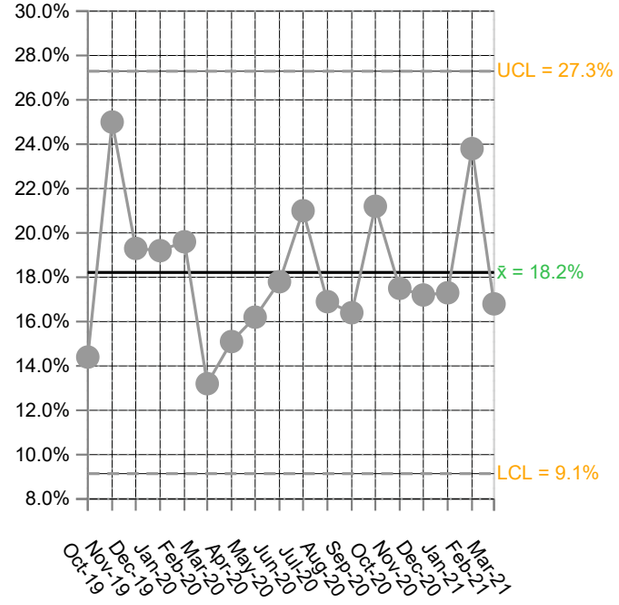
Risks	Mitigation

Emergency C Section

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
16.80	0

Issues

Medical complexity of pregnancies has resulted in the present monthly rate. A comparison of all emergency Caesarean section rates across the region (2018-19 and 2019-20 and the current year 2020-21) indicates that Blackpool Teaching Hospitals is not an outlier.

Actions

Metrics are reported and monitored through the families division; Quality, Patient Safety, and Experience Team.

Key Risks, Mitigation & Assurance

Full assurance

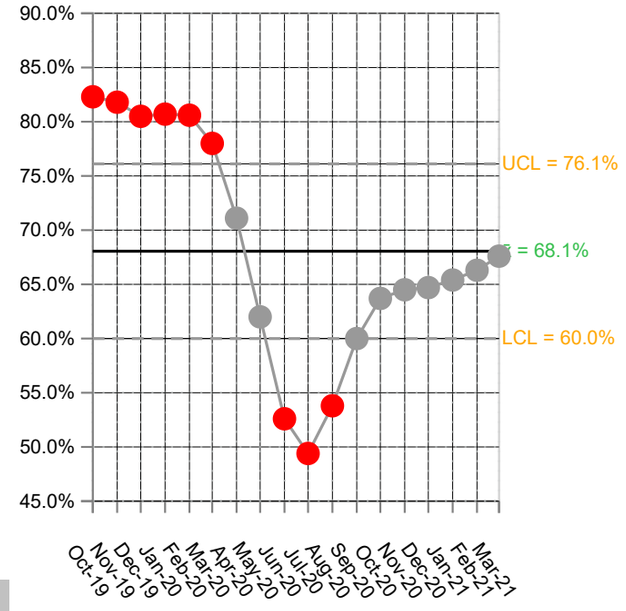
Risks	Mitigation

RTT Incomplete Open Pathways

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
67.60	92.00

Issues

The Trust did not achieve the RTT open pathway standard in March with performance at 67.6%. This represents a slight improvement from previous months (February 66.3%). There were 18,808 open pathways against the target of 16,500. The difference to target this month is 2,308 which has increased compared to the previous month of 1,951, the volume of RTT waiters is also above the monthly trajectory by 2,304. The Trust has 1,717 patients waiting 52+ weeks, a further increase from last month and against a target of 0, but slightly below the internal forecast trajectory of 1,800. This is a result of a reduced elective programme and also some patients wishing to defer surgery at this time.

The Outpatient activity for March was 126.6% for new patients and 123.6 % for follow up patients, however March 2019 activity was lower due to the on-set of Covid and the step down of clinical services, especially face to face OP appointments. Additional clinics were performed to assist with clearing the backlog in some specialities during Clinician's annual leave. Virtual consultations for new appointments remains stable at 29% compared to the benchmark of 25% and further work is currently ongoing to ensure remote consultations are embedded within business as usual.

Actions

- The Trust has negotiated contract with Spire hospital and BMI Ramsay to undertake 40 cases per week within each organisation.
- Additional Capacity at the weekends has been negotiated for Gastroenterology on site
- 2 Insourcing companies have been approached to undertake surgical procedures at the weekend through the Trust's Surgical Day Case Unit
- A Modular Gastrointestinal unit is being considered to increase Endoscopy and Colonoscopy activity
- Further theatre capacity coming on-line in May

Key Risks, Mitigation & Assurance

Limited assurance

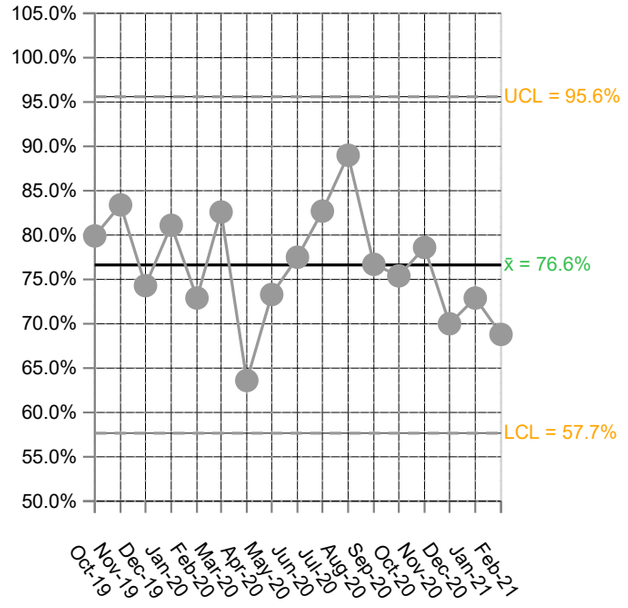
Risks	Mitigation
• Patients potentially reluctant to transfer|• Protracted procurement process could result in delay in contracts being agreed|• Insufficient theatre Gastroenterology and Anaesthetic manpower to increase capacity |• Potential overload in preadmission|• High level of emergency presentations impacting on elective bed provision and potential elective cancellations|	• Insourcing companies being utilised to mitigate preadmission risk and staffing risks|• Additional procurement staff are being recruited through restoration funds|• Dedicated manager being utilised to assist in persuading patients to transfer and managing the IS and outsource contracts|

62 Day Cancer Referrals

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
68.80	85.00

Issues

The Trust failed to achieve the Cancer 62 Day Wait for all cancers in February at 68.80%. This represents a slight decline from previous months with January's performance at 72.90%. All patients who breach this target are monitored closely, subject to a harm review which also includes patients waiting over 104 days. The number of patients treated in February after day 104 was 8, the number of patients waiting over 104 days (diagnosed and not diagnosed) is 14. 62 day screening performance has seen a decline from 80.00% in January to 63.60% in February.

The main areas for delay, 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.

The breast screening programme has recommenced and the Trust is maintaining the symptomatic breast target at 98.10% however due to poor availability of Consultant Radiologists the Trust is unlikely to achieve the 2 week target for breast treatment.

Actions

The following actions are being considered to improve capacity:

- Increasing Endoscopy capacity at the weekend from 2 rooms to 4 rooms from the end of April 2021
- Discussions are taking place with a company to install a Modular Gastroenterology Unit to undertake diagnostics at an off-site location, potentially Wesham
- Discussions are taking place with 2 insourcing companies which would allow more minor surgery to be undertaken at the Trust site at the weekend on the Day surgery unit thus releasing capacity for more major cases.
- Spire Independent Sector and BMI Ramsay have been asked to undertake 40 minor procedures per week (80 per week in total). Contracts are in the process of being finalised. This again will allow the Trust to increase the capacity of more complex cases.
- The Trust has appointed an Independent Sector Manager to facilitate transfer of patients to the above described companies.
- The Trust has been in discussions with the Cancer Alliance and other organisations from across the ICS to gain Radiologists support for Breast Services.
- A review of double reporting in mammography is also being undertaken by the Alliance to assist with reducing the diagnostic waiting time in Breast Services.
- Additional breast clinics are being secured at weekends to deal with the anticipated shortfall in capacity due to Radiology shortages

Key Risks, Mitigation & Assurance

Limited assurance

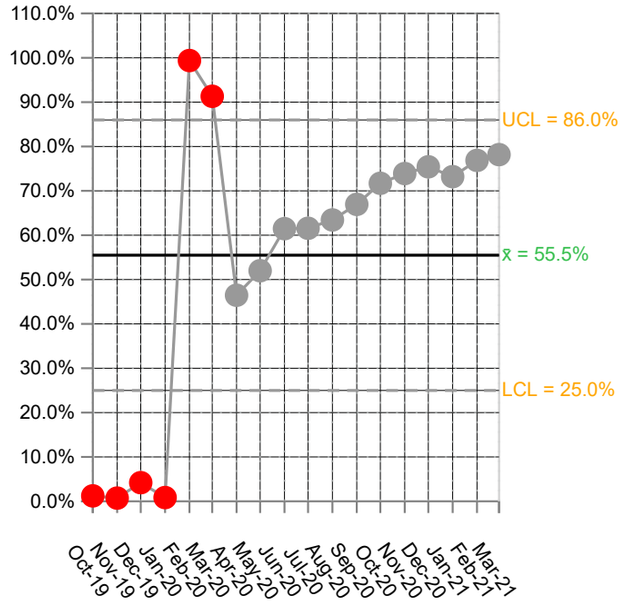
Risks	Mitigation
• Protracted procurement process|• Competition for resources across ICS|• Patients declining to transfer to other providers/Insourcing companies|• Preoperative assessment could be overwhelmed thus creating a backlog prior to procedure being performed|• Theatre staffing and Anaesthetic team appears to be a limiting factor|	• Trust have appointed a dedicated manager to discuss transfers to other organisations with patients directly |• Some insourcing companies provide preoperative assessments |• Additional staffing is being funded for procurement via Covid funding|• Locum Radiologist for Breast secured from May, some capacity gaps remain due to sickness in the Radiology team.|

% Over 6 Week Wait Diagnostic

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
78.17	99.00

Issues

The impact of Covid has resulted in non-delivery of this standard, reporting 78.69% of patients receiving their diagnostic within 6 weeks which represents a slight increase from last month's position which was 76.86%. The over 6 week breaches have increased slightly this month to 924 (March 2021) from the previous month of 907 (February 2021).

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

Actions

- In Echocardiography the Insourcing project is awaiting contractual sign-off and it is anticipated this will commence imminently
- Gastroenterology are increasing capacity at the weekends to 2 rooms to 4 from the end of April
- Insourcing companies are being approached to establish whether they can undertake additional Gastroenterology procedures
- A Modular option at Wesham Hospital is being considered to increase Gastroenterology capacity
- We have additional NHSE funded scanner in operation, running 7 days per week with substantive & locum staff permitting.
- Continued use of NHSE funded scanners
- Use of Independent Sector capacity
- Additional WLI sessions on existing MRI scanners
- Maintenance of additional MR mobile scanners

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation
• A significant lead time to introducing Modular site at Wesham|• 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 |• Poor availability of Radiologists |• Radiographer staffing |	• Additional funding secured to increase procurement capacity to assist with Insourcing and Outsourcing models |• Revised recruitment strategy being developed for Gastroenterology|• Recruitment of additional Radiologists |• Use of Locum staff where appropriate|• Use of Mobile scanning facilities where appropriate|

Dementia Standard

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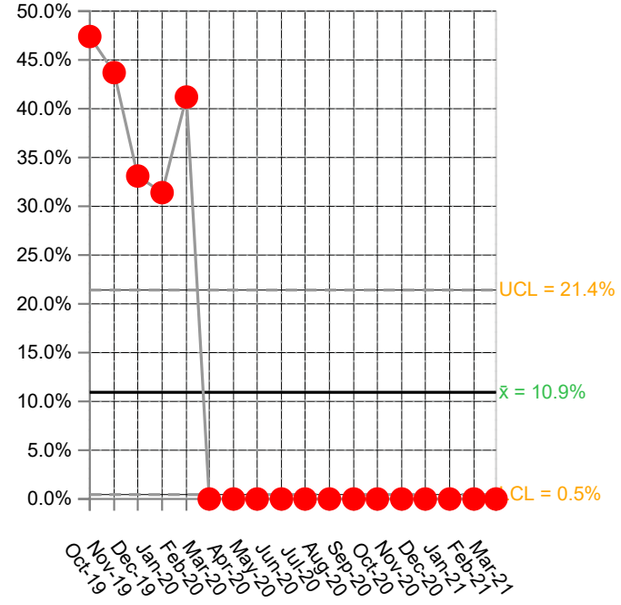
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
0	0

Key Risks, Mitigation & Assurance

No assurance

Issues

Due to the ongoing COVID-19 pandemic and in line with national guidance, this was not audited this month. Plan to ressume audit in April 2021.

Actions

Dementia Tier 2 training has continued virtually with further dates for the remainder of 2021. April is fully booked and the following dates are currently fully booked.
Dementia Champions monthly meetings continue with good attendance, the focus for April and May is Dementia Action week (17th - 23rd May) and planning for this is underway.
The Butterfly scheme relaunch continues with clinical areas now actively using the butterfly symbols correctly, this has been reflected in COAST assessments outcomes, however pictorial/dementia friendly signage is a theme for improvement through COAST assessments.
The dementia lead continues with to review the previous dementia strategy and commence preparatory work in producing an updated strategy. The dementia advisory board recommenced in March and will support the development of the new strategy and the other associated improvement work.

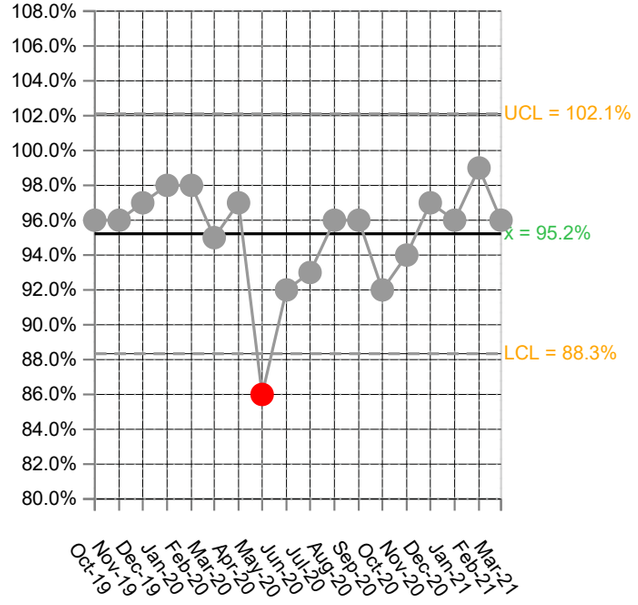
Risks	Mitigation

IAPT Wait Times

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
96	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 March was 96%, which is 2% above the 2020/2021 average monthly performance of 94%.
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 have recently recruited into 1 X CBT and 1 x PWP post.
- Ensuring some groups are accessible on-line until face to face groups can commence – work in progress – plans to launch two new online groups in January 2021 are now to commence in March as we have extended the recruitment phase. One group has started (Compassion-focussed group). The Stroke wellbeing group has been delayed as we are still negotiating a start date with the Stroke Association.
- We have now converted 2 x qualified PWP posts into additional trainee posts due to difficulties in recruiting qualified staff. Therefore 2 additional trainees have started with the service in March.
- 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

- 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).|

Mitigation

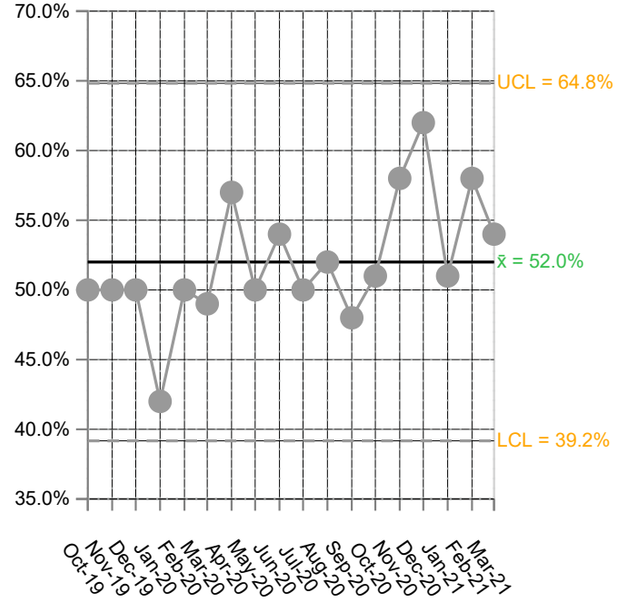
Ensuring some groups are accessible on-line due to current restrictions on group-work due to Covid-19. |Patients are being actively encouraged to accept remote or online therapy wherever possible, unless face to face therapy is clinically indicated. Limited face to face working is continuing in a risk assessed 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
54	50

Issues

National standards state that at least 50% of people who complete treatment should recover. The figure for Supporting Minds for March was 57%, which is 3% above the 2020/2021 average monthly performance of 54%.
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.

Key Risks, Mitigation & Assurance

Full assurance

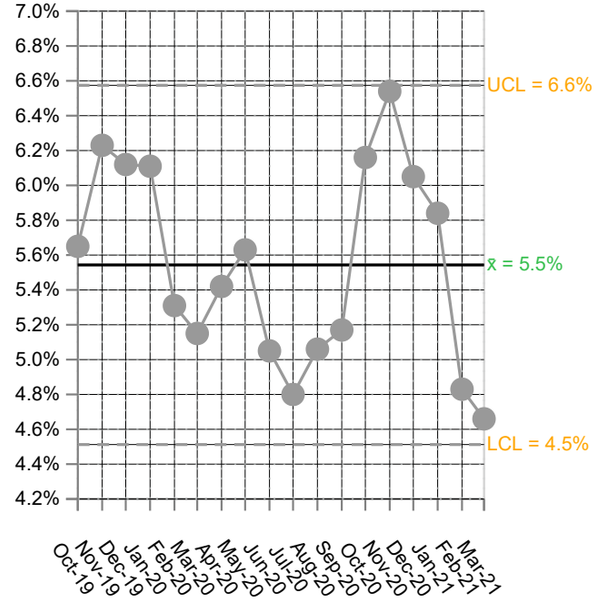
Risks	Mitigation
• Increased waiting times due to people needing or wanting to be seen face to face; Some patients choosing to wait for a face to face appointment where no clinical need for this identified, potentially increasing the risk of their mental health difficulties further deteriorating. Patients 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
4.66	4

Key Risks, Mitigation & Assurance

Limited assurance

Issues

Sickness continues to reduce month on month across the Trust ending quarter four at 4.66%. ATLC has reduced from 5.49% to 5.09%; Clinical Services from 2.70% to 2.68%; Corporate from 3.32% to 3.22%; Facilities has seen a slight increase from 3.60% to 3.68%; Families from 4.34% to 3.50%; R&D from 2.45% to 2.06%; Scheduled Care has seen a slight increase from 4.96% to 5.05% and Unscheduled a reduction from 5.85% to 5.70%. The number of staff currently off with covid has reduced significantly, however we have seen small numbers of staff reporting in sick following their vaccination although absence is minimal. Shielding has now ended and we are supporting staff back into the workplace. Reviews of risk assessments are taking place along with vaccination discussions and support from OH were applicable. As previously reported, we anticipate stress related absences following the pandemic therefore work is continuing ongoing to enhance psychological support for staff. Anxiety is the highest reason for short term absence at 29.6%, fracture injury at 10.5% and Gastrointestinal 9.30%.

Actions

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. The Risk Assessment has been amended to incorporate discussions with staff regarding the importance of the vaccination along with LAMP testing and guidance has been provided to all line managers. As at the 13th April 2021 the Trust has vaccinated 25,803 individuals. 14,138 of these are Trust staff and the remainder include over 80's, care homes and social care.

Risks

Mental Health issues will continue as Anxiety/Stress continues to be the highest reason for absence both short term and long term. Continued risk of staff refusing vaccination.

Mitigation

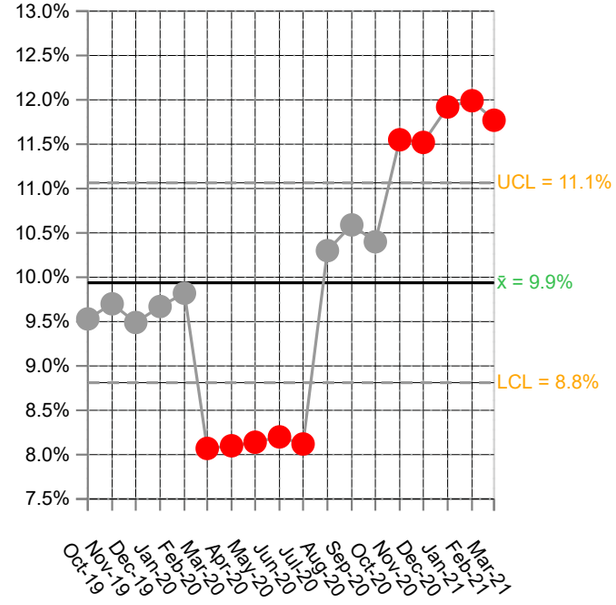
Occupational Health are continuing their support for staff along with offerings from local mental health services, including Supporting Minds, the Resilience Hub which offers psychological support for the impact of Covid-19, Workplace Trauma Support Training for Line Managers. Guidance and a flowchart has now been issued to managers to enable conversations to take place with staff to support the uptake of the vaccination. Risk Assessment has also been revised to incorporate vaccination and LAMP testing.

Turnover - Staffing

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
11.77	11.00

Issues

The Trust Turnover target is set at 11% however we are currently operating at 11.77% therefore above expectation by 0.77%

Medical and Dental Turnover is set at 11% and is currently operating at 18.76% which is considerably higher than target, this has been consistent over the last 8 months.

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

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.

Since the beginning of the Covid-19 pandemic, recruitment activity had steadily increased across the Trust compared to the same period last year, however the last 3 months have seen slight reductions with the HR and OD team recruiting 1310 new starters, 318 of these are Bank new starters in various roles (12 month period).

Actions

The Trusts new Nurse and AHP retention lead is now in post and working with the Recruitment and Retention Lead. Options are being explored to support staff around 'Flexible Working' including alternative hours, purchasing Annual Leave role change and other initiatives.

Provision of pensions advice via Pengage which will provide overall information and then offer individual sessions at cost to the individual (personal pensions advice)

Continuous recruitment via bank and agency as well as substantive.

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

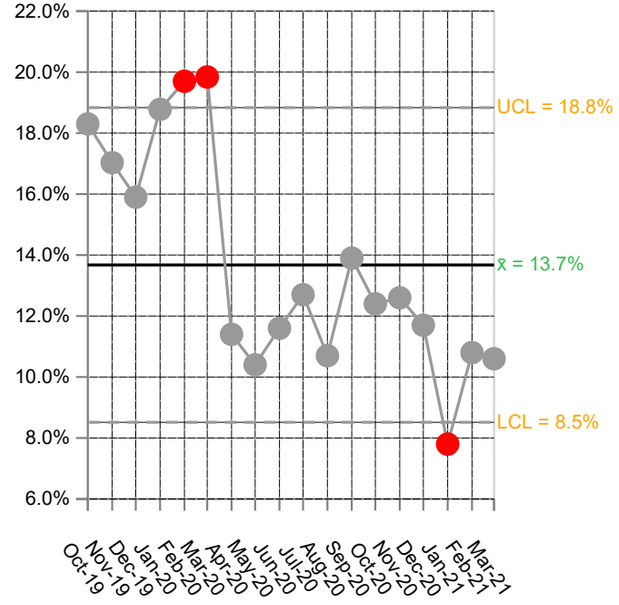
Continued support for the retention work streams and investment in the further clinical post to support with this work.

Temporary Staffing

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
10.60	0.00

Issues

There has been a very slight decline for % of temp staffing this month. Although the bank teams are undergoing recruitment drives they are now waiting for these candidates to go through the Recruitment process.

Actions

Bank expansion projects are running throughout the workforce, agency to bank conversion projects are also commencing this month. Work ongoing to review staff vacancies and establishments along with the retention project will contribute to longer term staffing solutions. The non medical bank are set to take on 100 new HCAs over the next month along with 40 administration staff over the next 2 months.

Key Risks, Mitigation & Assurance

Limited assurance

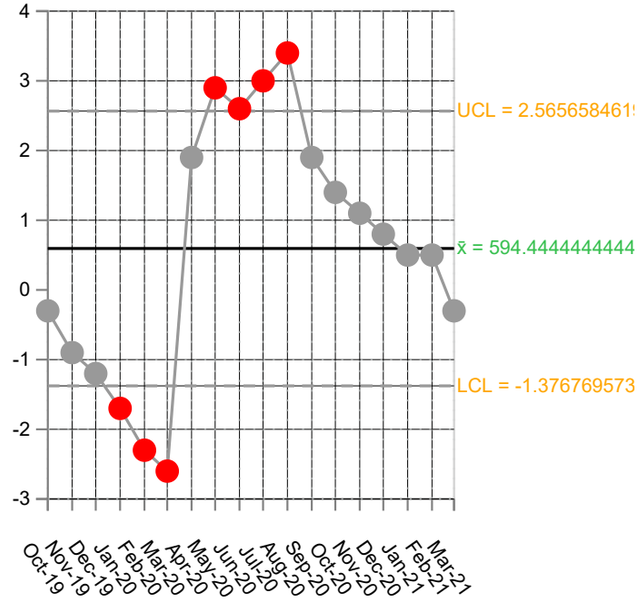
Risks	Mitigation
Lack of engagement for agency to bank conversion for Medical and Non Medical	re visitation of bank rates across the ICS including Nursing harmonisation meetings that are running every 2 weeks

Capital Service

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
-0.30	0

Issues

The Trust has reported capital service cover of -0.3x at M12 which scores a capital service cover rating of 4, consistent with M11.

In the phase 3 plan refresh for the last five months of 2020/21 submitted to NHSE/I on 18th November the Trust forecast an operating deficit of £15.7m (equating to an adjusted overall deficit of £20.6m after finance costs).

The financial plan for the remainder of the 2021/22 (submitted to the ICS in November) is a deficit of £20.6m after accounting for system resources. A further financial stocktake was undertaken in January to deliver a £29m improvement in the aggregate ICS forecast. The Trust has subsequently been set a target of delivering a "best case" deficit of £17.3m. Risk ratings however, will continue to monitor against the £20.6m.

The capital service cover has reduced as expected across the second half of the year as a result of the Trust having a planned deficit. In addition, variances from the plan will also impact on capital service cover.

Actions

As capital service costs are predominantly linked to existing borrowings which are fixed, the ability to improve the score against the metric is mainly restricted to improving operating financial performance.

In order to deliver the maximum currently available score, given the current level of borrowings, the Trust will need to deliver performance in line with the planned level of deficit. This will therefore require the restoration, winter and SIP plans to be delivered in line with the plan submitted to NHSE/I.

Key Risks, Mitigation & Assurance

Limited assurance

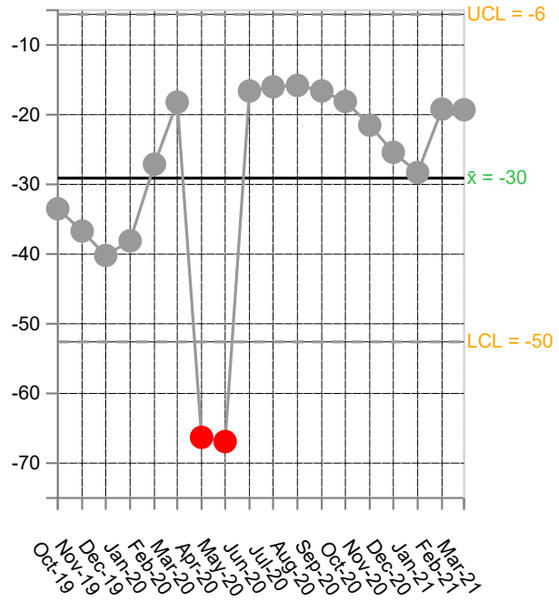
Risks	Mitigation
The Trust has insufficient cash to meet its financing obligations.	The delivery of the benefits associated with System Improvement Plan (SIP) schemes and delivery of QEP schemes will partly mitigate the underlying financial performance.||In addition, the Trust has indicated that there is a cash shortfall at the end of March in the plan submitted to NHSE/I which will require emergency revenue support. This was quantified in February and £15.7m revenue support fuinding was received in March, with a further £2.8m received in April..

Liquidity

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
-19.30	0

Issues

The Trust has reported liquidity of -19.3 days at month 12 and the liquidity rating remains in the lowest category (level 4).

The Trust has consistently been rated in the lowest category for a number of years as as consequence of weak I&E performance.

In the phase 3 plan refresh for the last five months of 2020/21 submitted to NHSE/I on 18th November the Trust forecast an operating deficit of £15.7m (equating to an adjusted overall deficit of £20.6m after finance costs).

The financial plan for the remainder of the 2021/22 (submitted to the ICS in November) is a deficit of £20.6m after accounting for system resources. A further financial stocktake was undertaken in January to deliver a £29m improvement in the aggregate ICS forecast. The Trust has subsequently been set a target of delivering a "best case" deficit of £17.3m. Risk ratings however, will continue to monitor against the £20.6m.

Liquidity has been reducing across the second half of the financial year as a result of the Trust having a planned deficit.

Actions

Improvements in liquidity performance will require the Trust to either reduce operating expenses or increase operating performance to generate a margin that improves net current assets.

In order to deliver the maximum currently available score, the Trust will need to deliver performance in line with the planned level of deficit. This will therefore require the restoration, winter and SIP plans to be delivered in line with the plan submitted to NHSE/I.

Key Risks, Mitigation & Assurance

Limited assurance

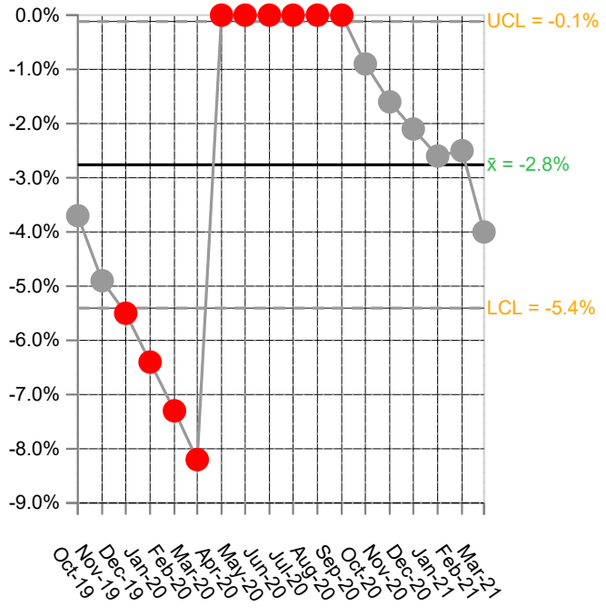
Risks	Mitigation
The Trust has insufficient cash to meet its liabilities.	The delivery of the benefits associated with System Improvement Plan (SIP) schemes and delivery of QEP schemes will partly mitigate the underlying financial performance.||In addition, the Trust has indicated that there is a cash shortfall at the end of March in the plan submitted to NHSE/I which will require emergency revenue support and is currently discussing this requirement with NHSE/I in advance of this need.

I&E Margin

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
-4.00	0

Issues

During the first six months of the 2020/21 financial year all Trusts delivered break even positions in months 1 to 6 by claiming additional retrospective top-up funding in accordance with Covid-19 financial guidance published in March 2020, and subsequently extended from July to September. From October 2020 Trusts have moved to a revised financial framework and are required to deliver a nationally set financial target.

The Trust submitted to NHSE/I an update to the forecast on 18th November for the remainder of the 2020/21 financial year. This is worse than the nationally set financial target of break even.

The financial plan for the remainder of the 2021/22 (submitted to the ICS in November) is a deficit of £20.6m after accounting for system resources. A further financial stocktake was undertaken in January to deliver a £29m improvement in the aggregate ICS forecast. The Trust has subsequently been set a target of delivering a "best case" deficit of £17.3m. Risk ratings however, will continue to monitor against the £20.6m.

In month 12 the Trust has reported an adverse I&E margin performance of minus (4.0%) against a plan of minus (3.9%). As a consequence of the increasing planned and actual financial performance deficit the risk rating remains at 4.

Actions

The Trust submitted to NHSE/I an update to the forecast on 18th November for the remainder of the 2020/21 financial year. This is worse than the nationally set financial target of break even. The Trust is incurring expenditure on Covid virus testing and vaccination programme and is seeking re-imbursement for these costs outside of the Covid envelope.

Key Risks, Mitigation & Assurance

Limited assurance

Risks

From October 2020 Trusts have moved to a revised financial framework and are required to deliver a nationally set financial target. The removal a retrospective top up funding in place for the first six months of the financial year, allocation of Covid envelopes and requirement to deliver a nationally set financial target represents a risk to financial performance across the remainder of the 2020/21 financial year.

Mitigation

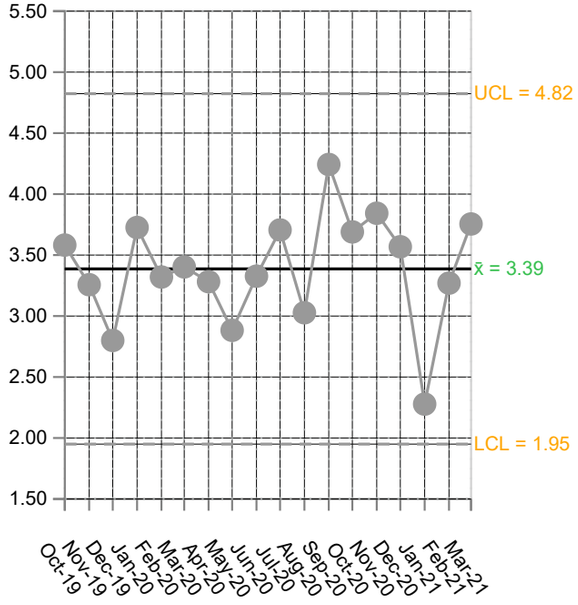
The Trust is incurring expenditure on Covid virus testing and vacination and is seeking re-imbursement for these costs outside of the Covid envelope.||While systems will be expected to deliver their plans, it may be possible for organisations within them by mutual agreement to deliver worse and better positions provided these are neutral overall.

Agency Spend

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
3.75	-1

Issues

This month has seen a spike in agency spend compared to February. This is due to a number of factors which include the increased fill rate from the new neutral vend solution for Nursing which is a positive from a safe staffing point of view. The month has also unfortunately seen an increase in off framework spend mostly in ITU and ED. March has seen a continued demand for ITU and Emergency Department nurses who attract higher rates of pay than general nursing wards.

Actions

Between March and April we should see a reduction in spend from the new financial year as the placement of adaptation nurses should be on the rise.
The Bank team for both medical and non medical are carrying out Bankpool recruitment drives for Trust's bank expansion which is seeing a positive effect.
Although the neutral vend solution is now in place close monitoring is to continue to follow trends with spend and fill rates.

Key Risks, Mitigation & Assurance

Full assurance

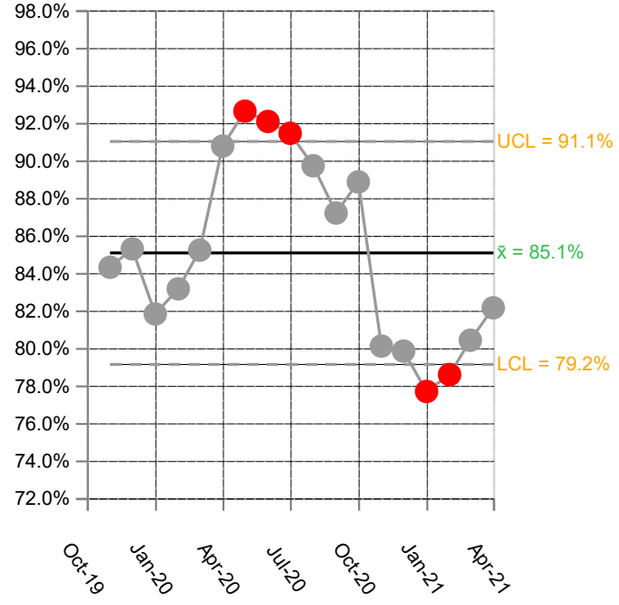
Risks	Mitigation
A third wave of COVID 19 is a current risk that needs to be planned for	Frequent staffing meetings diarised to keep a handle on trends and themes with staffing.

A&E + UCC Performance

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
82.19	95

Issues

ED performance for March was 55.83 % which is a 1.14% improvement from last month. Total Economy Performance was 82.19% which is a consistent improvement month on 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.

The department reported at total of 9 DTA breaches compared to 22 from the previous month. The 9 breaches consisted of 6 Mental Health and 3 Medical.
Whilst the medical DTA breaches saw a decrease for March the increase in Mental Health DTA breaches reflected an increase in patient attending the department with a Mental Health presentation.

The trust is one of the top 3 for highest ambulance conveyances in the region. Ambulance delays remain a cause for concern with 47 delays over 60 minutes for March, however this has decreased by 44 from February.
Peaks in attendances and congestion within the department of patients waiting for admission means that the triage area becomes overcrowded with delays to being seen by a doctor.

Sub-optimal streaming to the Urgent Treatment Centre meant non ambulatory primary care patients were being seen in ED due to logistical problems with the temporary location.

Actions

Action plan in place to support improvement of ED performance through the sustained reduction of admitted and non-admitted breaches.

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 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 Mental Health Urgent Assessment Unit is due to open by the end of April 2020. The ED is working closely with LSCFT to ensure the pathway is ready for implementation and will monitor the impact once in use.

The department has developed a Standard Operating Procedure in collaboration with NWAS which has been implemented as a trial this week, the results of this will be monitored by the ED management team. Further Emergency Village building works will create 2 further triage rooms and a Mental Health assessment room by the end of April. this will increase capacity in the triage area and should reduce congestion and delays to be seen at peak times.

the Urgent Treatment Centre has moved back to its co-located area w/c 12/04/21 This will mean that ED can return to its streaming of all patients suitable for primary care.

Key Risks, Mitigation & Assurance

Risks	Mitigation
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.
Risk of both medical and nursing staff shortages due to enlarged footprint and sickness due to isolation	Daily staffing meetings and completed to manage the medical / nursing workforce across the division. Staff work extra to cover short notice sickness. All gaps are out to agencies.
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.

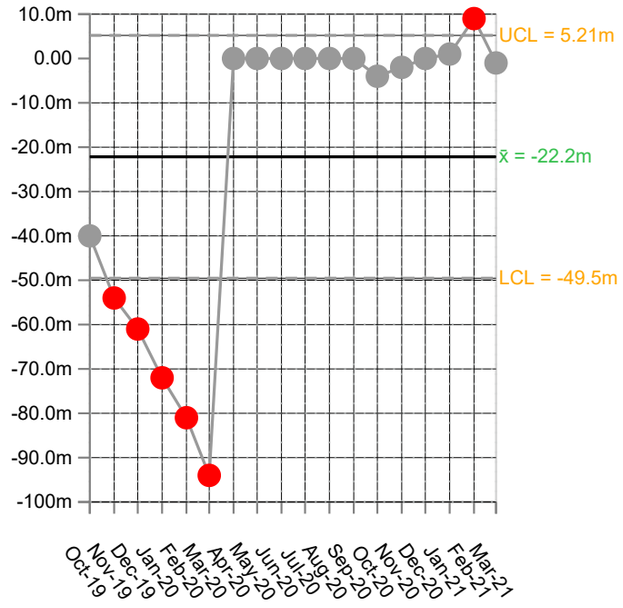
Limited assurance

Financial Plan

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
-0.10	0.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

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In month 12 the Trust has reported performance of 0.1% behind the financial plan following the £6m worsening of financial position agreed by NHSI to clear financial risks. This is a worsening from the position in month 11 (+0.9%). As a result the risk rating for distance from financial plan has fallen from a 1 to a score of 2. This has moved the overall use of resources score from a 3 to a 4.

Actions

The Trust submitted to NHSE/I an update to the forecast on 18th November for the remainder of the 2020/21 financial year. This is worse than the nationally set financial target of break even. The Trust is incurring expenditure on Covid virus testing and vaccination programme and is seeking re-imbursement for these costs outside of the Covid envelope.

Risks

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Mitigation

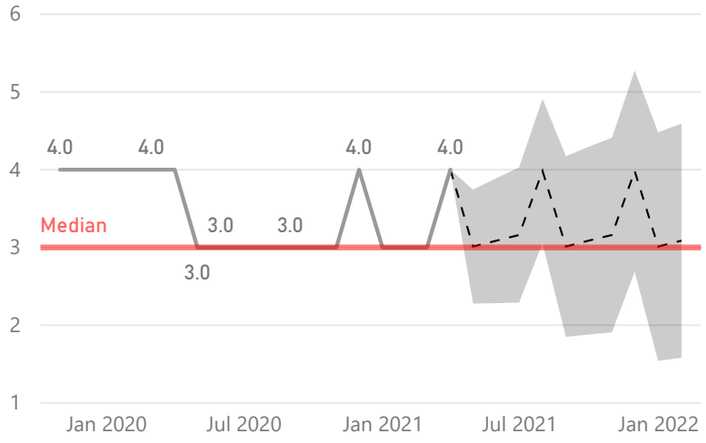
The Trust is incurring expenditure on Covid virus testing and vacination and is seeking re-imbursement for these costs outside of the Covid envelope.||While systems will be expected to deliver their plans, it may be possible for organisations within them by mutual agreement to deliver worse and better positions provided these are neutral overall.

EuR Rating

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



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In March the Trust has scored a Use of Resources rating of 4. This has worsened from February (rating of 3) as the Trust has been allowed by NHSI to deteriorate it's financial position by £6.0m to clear a number of known risks. As a result financial performance is now worse than original plan causing the movement in UoR score.

As the Trust has scored a rating of 4 (lowest) for the liquidity and agency cover metrics the Trust is unable to achieve a Use of Resources rating better than 3.

Actions

The Trust submitted to NHSE/I an update to the forecast on 18th November for the remainder of the 2020/21 financial year. This is worse than the nationally set financial target of break even. The Trust is incurring expenditure on Covid virus testing and vaccination programme and is seeking re-imbursement for these costs outside of the Covid envelope.

Actual	Target
4.00	(Blank)

Key Risks, Mitigation & Assurance

Limited assurance

Risks

From October 2020 Trusts have moved to a revised financial framework and are required to deliver a nationally set financial target. The removal a retrospective top up funding in place for the first six months of the financial year, allocation of Covid envelopes and requirement to deliver a nationally set financial target represents a risk to financial performance across the remainder of the 2020/21 financial year.

Mitigation

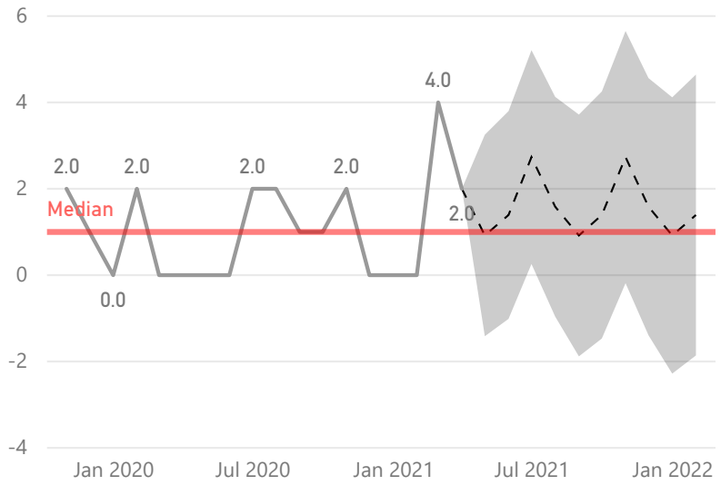
The Trust is incurring expenditure on Covid virus testing and vacination and is seeking re-imbursement for these costs outside of the Covid envelope.||While systems will be expected to deliver their plans, it may be possible for organisations within them by mutual agreement to deliver worse and better positions provided these are neutral overall.

Over 7 Day Incapacitation of a Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
2.00	0.00

Key Risks, Mitigation & Assurance

Full assurance

Issues

In the theatre 7/10 storage area, there are case notes strewn along the aisles. These should be either filed appropriately or in the designated overflow boxes in the rooms.
Member of staff had reached up high to get notes which are double-stacked on the top shelf (there are no steps available in that area to avoid over-reaching) and then tripped over notes on the floor as she turned to leave.

Staff member had difficulty getting the wheel chair into the taxi due to the taxi flooring having a lip on it where the ramp comes out. the driver did not know how to secure the wheel chair using the securing straps.
Member of staff was standing bent over the patient and trying to pull the wheelchair over this lip, when they felt a pulling sensation in their lower back/hip.

Actions

A review of the area needs to be undertaken
- There need to be steps available in order to reach the highest shelves.
- Discussed with medical records manager to ensure that all areas are tidy and all into the H&S guidelines

Deputy Head of Planned Care to organise some training for his drivers so they all know how to secure wheel chairs correctly.
- Emailed head of therapies to voice my concerns over the use of this type of transport for wheel chair patients
- Staff to be responsible for booking onto mandatory training.

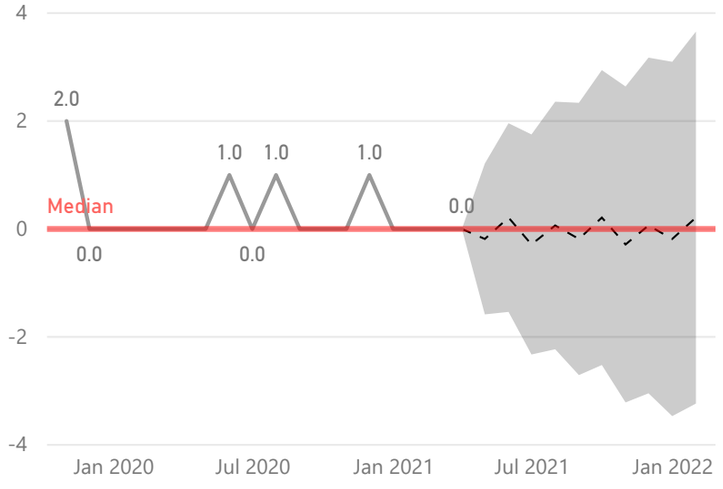
Risks	Mitigation

Specified Injury to Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
0.00	0.00

Key Risks, Mitigation & Assurance

Full assurance

Issues

There are zero injuries to report this month.

Actions

N/a

Risks	Mitigation

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

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors

Thursday 6th May 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:	Thursday 29th April 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)**

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

COVID Update – Vaccination and Asymptomatic Testing

All data has been captured as at Thursday 29 April 2021.

1. Vaccination Totals:

Data Set	First Doses	Second Dose	Overall
Over 80s	1560	1522	3082
Trust Staff	7325	6077	13402
Other NHS staff	1177	789	1966
Social Care Workers	4483	3605	8088
Care Home Workers	1180	930	2110
Others	1102	422	1524
Total	**16539**	**13633**	**30172**

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	263	205	78%	164
Clinical Services	2620	1807	69%	1241
Admin and Clerical	1898	1501	79%	1143
AHP	596	448	75%	335
Estates and Ancillary	362	326	90%	249
Healthcare Scientists	221	197	89%	166
Medical and Dental	1414	952	67%	620
Nursing and Midwifery	2523	2081	82%	1495
TOTAL	9897	7517	76%	5413

Staff group – Substantive	Headcount	Vaccinated First Dose	Percentage First Dose	Vaccinated Second Dose
Prof, Scientific and Technical	244	193	79%	159
Clinical Services	2009	1492	74%	1094
Admin and Clerical	1682	1363	81%	1076
AHP	490	389	79%	313
Estates and Ancillary	362	307	85%	236
Healthcare Scientists	217	187	86%	158
Medical and Dental	531	527	97%	372
Nursing and Midwifery	2249	1788	80%	1374
TOTAL	7784	6246	80%	4782

2. Staff Asymptomatic Testing (LAMP)

Data Set	Current Position
On-boarded staff	4269
Total samples submitted since launch	24564
Compliance (Test in last 7 days)	1650 (41.2%)
Current Positive Samples	32
Positives in last 7 days	2

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

Janet Barnsley
Executive Director of Operations - Planned Care

Thursday 29 April 2021

Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Director's Meeting

6th May 2021

2020 National Staff Survey report and findings

Author of Report:	Lee Barnes, Associate Director Staff Wellbeing & Engagement BTH and ELHT
Executive Director Sponsor:	Kevin Moynes, Executive Director of HR & OD
Date of Report:	11th March 2021

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

The Board of Directors is asked to note the 2020 National Staff Survey report and the key findings identified. The Board of Directors is also asked to discuss, support and approve the outlined recommendations.

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

Recommendations:

The Board of Directors is asked to support and approve the recommendations and improvements cited in section 11 of this paper.

Sensitivity Level:

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

Board of Director's Meeting

6th May 2021

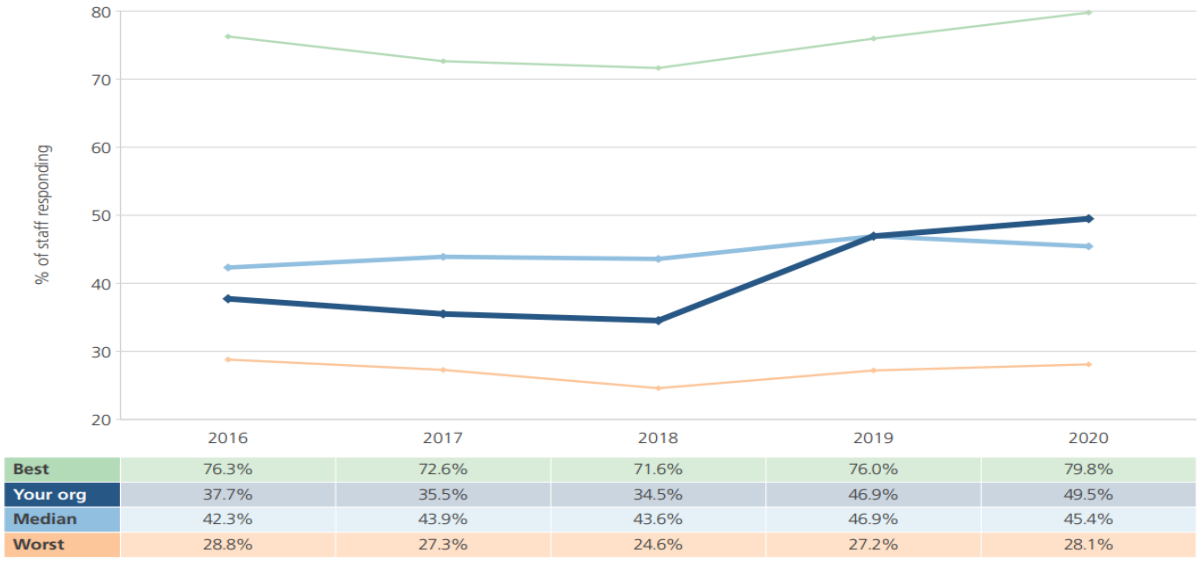
2020 National Staff Survey report and findings

1. Introduction

1.1 The Trust undertook a full census in 2020 and a total of 7169 staff were eligible to complete the survey. 3548 staff returned a completed questionnaire, giving a response rate of 49.5% which is above average for Combined Acute and Community Trusts in England, and compares with a response rate of 47% (3150) in the 2019 survey.

1.2 This is an increase of 2.5% from the previous year's response rate and an indicator that staff engagement through employee voice has improved within the last 12 months and taking a longer term analysis it can be seen that the response rate has significantly improved as a trend over the last 3 years by 15%.

Figure 1 below details the response rate trend over the last 5 years.



	2016	2017	2018	2019	2020
Best	76.3%	72.6%	71.6%	76.0%	79.8%
Your org	37.7%	35.5%	34.5%	46.9%	49.5%
Median	42.3%	43.9%	43.6%	46.9%	45.4%
Worst	28.8%	27.3%	24.6%	27.2%	28.1%

1.3 Figure 2 below details the return rate by division/directorate and compares with 2019 response rates.

Figure 2: Return rate by division/directorate

Locality	Response rate 2019	Response rate 2020
Trust Headquarters (Office of CEO)	76.9	73.7↓
Adults and Long Term Conditions	47.2	49.7↑
Clinical Support Services	54.8	48.6↓
Corporate Services	74.5	68.1↓
Facilities Management	44.6	57.1↑
Families Division	47.9	55.7↑
Finance	82.8	70.0↓
Human Resources & Organisational Development	77.6	78.5↑
Research and Development	79.5	64.4↓
Scheduled Care	38.5	46.8↑

Unscheduled Care	45	42.7↓
Overall	**47**	**49.5↑**

2. Summary of Themes

2.1 The National Staff Survey Benchmark report for Blackpool Teaching Hospitals NHS Foundation Trust contains results for themes and questions from the 2020 NHS Staff Survey, and historical results back to 2016 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations (see appendix 1 for the full report and appendix 2 for the summary report). The report is presented in the form of ten themes to provide a high level overview of the results for an organisation. The themes are as follows:

a) Equality diversity and inclusion.

b) Health and wellbeing.

c) Immediate managers.

d) Morale.

e) Quality of care.

f) Safe environment- Bullying and harassment.

g) Safe environment- Violence.

h) Safety culture.

i) Staff engagement.

j) Team working

*The 11th theme: “Appraisals” was not included in the 2020 census.

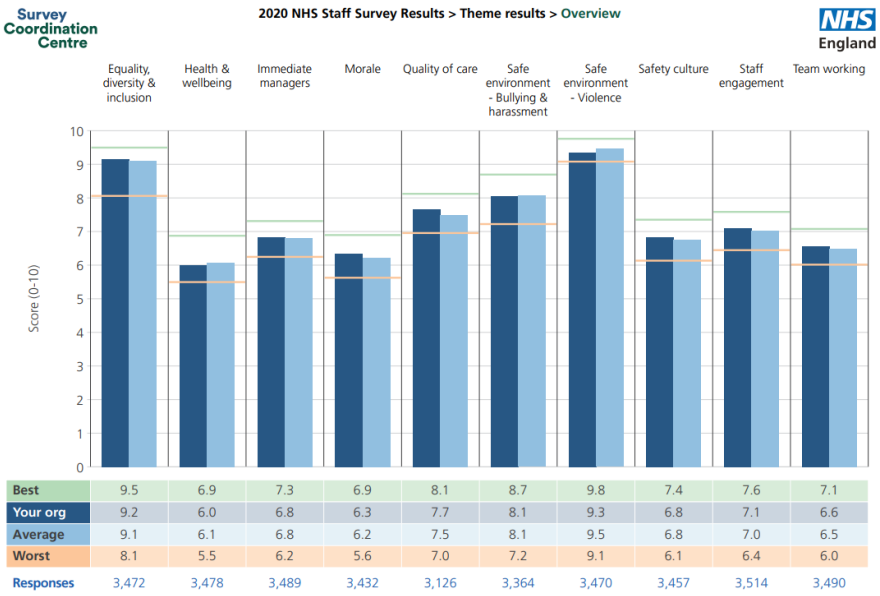
2.2 The ten themes are scored consistently on a 0-10pt scale with 10 being the best possible score. As in previous years the question level data is presented in percentage scores.

2.3 The Trust staff satisfaction responses scored above average for 5 of the 10 themes when compared with all Combined Acute and Community Trusts. The 5 themes BTH scored above average were: equality diversity and inclusion, morale, quality of care, staff engagement and team working.

2.4 The Trust staff satisfaction responses scored average for 3 of the 10 themes when compared with all Combined Acute and Community Trusts. The 3 themes BTH scored average were: immediate managers, safe environment- bullying and harassment, and safety culture.

2.5 The Trust staff satisfaction responses scored below average for 2 of the 10 themes when compared with all Combined Acute and Community Trusts. The 2 themes BTH scored below average were: health and wellbeing and safe environment- violence.

Figure 3 below outlines the theme results



3. Statistically significant improvements

3.1 Figure 4 below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the organisation's theme scores for both years and the number of responses that each of these are based on. The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's. Whereas: ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

3.2 The table below demonstrates three themes with statistically significantly higher scores when tested using a two-tailed t-test with a 95% level of confidence. The themes demonstrating the significantly higher scores compared to last year are: Health and Wellbeing, Safe Environment (Bullying and Harassment) and Safety Culture.

3.3 BTH has maintained scores in seven themes: Equality, Diversity and Inclusion, Immediate Managers, Morale, Quality of Care, Safe Environment (Violence), Staff Engagement and Team Working. No themes have deteriorated.

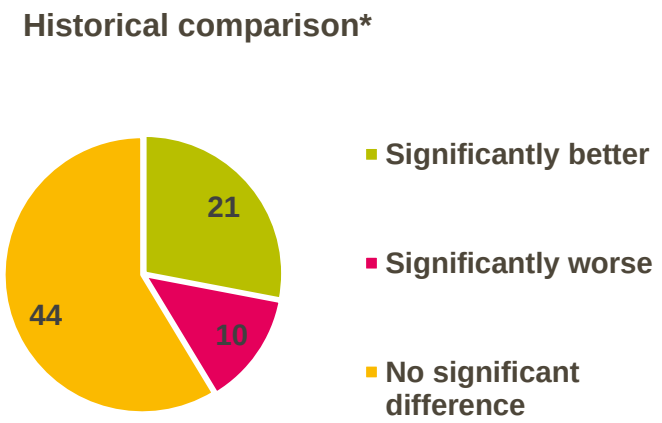
Figure 4: Significance testing – 2019 v 2020 theme results

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.2**	3081	**9.2**	3472	Not significant
Health & wellbeing	**5.8**	3100	**6.0**	3478	↑
Immediate managers †	**6.9**	3100	**6.8**	3489	Not significant
Morale	**6.3**	3039	**6.3**	3432	Not significant
Quality of care	**7.6**	2767	**7.7**	3126	Not significant
Safe environment - Bullying & harassment	**7.9**	3066	**8.1**	3364	↑
Safe environment - Violence	**9.4**	3073	**9.3**	3470	Not significant
Safety culture	**6.7**	3071	**6.8**	3457	↑
Staff engagement	**7.0**	3139	**7.1**	3514	Not significant
Team working	**6.6**	3094	**6.6**	3490	Not significant

4. Question level comparisons

4.1 75 questions can be compared historically between 2019 and 2020. The pie chart below demonstrates that 21 questions scored significantly better, 44 questions no significant difference and 10 questions significantly worse when compared with 2019.

Figure 5: Question level historical comparison



5. Overall indicator for staff engagement at Blackpool Teaching Hospitals NHS Foundation Trust

5.1 The staff engagement indicator score is 7.1. Please note: the staff engagement score is still calculated using the same questions as in prior years but has been adjusted to a scale of 0-10 with 10 being the best possible score.
The Trust's score of 7.1 is above average when compared with all Combined Acute and Community Trusts (Combined Acute and Community Trust average 7.0) and has improved on the previous year's overall indicator for staff engagement score of 7.0.

5.2 The overall indicator of staff engagement is calculated using 9 questions which focus on advocacy, motivation and involvement.

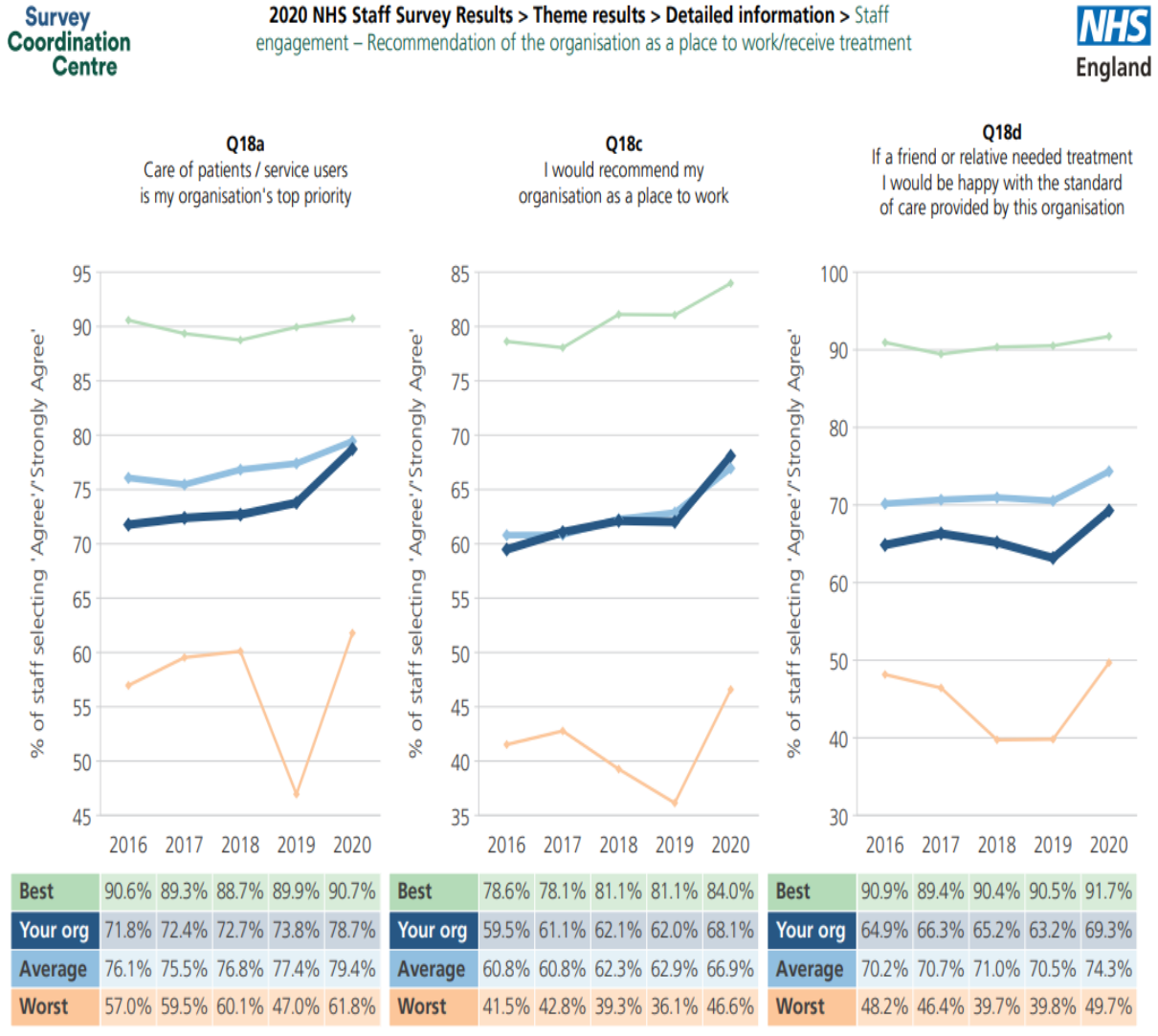
6. Staff advocacy

6.1 Staff belief that care of patients/service users is the organisations top priority (Q18a): this response is below average for Combined Acute and Community Trusts. Staff recommendation of the Trust as a place to work (Q18c): is above average.

If a friend/relative needed treatment I would be happy with the standard of care provided by this organisation (Q18d): is below average when compared with other Combined Acute and Community Trusts.

Historic comparisons demonstrate that responses to all 3 advocacy questions have significantly improved from the previous year.

Figure 6: Staff advocacy questions



	Q18a				
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	71.8%	72.4%	72.7%	73.8%	78.7%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

	Q18c				
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	59.5%	61.1%	62.1%	62.0%	68.1%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

	Q18d				
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	64.9%	66.3%	65.2%	63.2%	69.3%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

7. Staff motivation

7.1 I look forward to going to work (Q2a) I am enthusiastic about my job (Q2b) and Time passes quickly when I am working (Q2c) scores are all above average when compared with other Combined Acute and Community Trusts.

Historic comparisons demonstrate all three questions have deteriorated from the previous year and are at the lowest levels for the past five years.

Figure 7: Staff motivation questions

8. Staff involvement

8.1 There are frequent opportunities for me to show initiative in my role (Q4a), I am able to make suggestions to improve the work of my team/department (Q4b) and I am able to make improvements happen in my area of work (Q4d) scores are above average when compared with other Combined Acute and Community Trusts. Historic comparisons demonstrate questions 4b and 4c have deteriorated from the previous year while question 4a has improved slightly.

Figure 8: Staff involvement questions

9. Workforce Race Equality Standard (WRES) Indicators

9.1 Four of the WRES indicators are drawn from the national NHS staff survey. Within the last 2 years; BAME staff have been engaged in meaningful and sustained ways to start exploring why there are such differences between the treatment and experiences of white and BAME staff, and importantly, how the existing gaps can be closed.

9.2 In the spirit of continuous learning and transparency, the Trust has initiated a number of engagement activities to improve the experience of our BAME community including: Big Conversations, training

and communications which in turn have given confidence to BAME colleagues to have their say by voicing their concerns in the staff survey.

a) **WRES Indicator Five** - *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*. This has reduced among all staff groups year on year. The most significant decrease is a reduction of 31% for BAME staff to 26.6% which is below the national average of 28%. While white staff also reported a decrease of 6% year on year to 26.7%, this is still higher than the national average of 25.4%.

b) **WRES Metric Six -** *Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months*. This has decreased by 7.8% for white staff and 24% for BAME staff year on year. At 24.9%, white staff are still reporting higher levels than the national average of 24.4% while the experience of BAME staff, at 26.7% is significantly better than the national average of 29.1%.

c) **WRES Metric Seven-** *Percentage believing that the Trust provides equal opportunities for career progression or promotion*. BAME staff remain less likely than white staff to believe that BTH provides equal opportunities for career progression. However for BAME staff this figure has increased from 72.3% in 2019 to 78.6% in 2020. Likewise there has been an increase for white staff from 87.6% in 2019 to 88.9% in 2020. The gap between white and BAME staff on this indicator has reduced from 17% in 2019 to 12% in 2020.

d) **WRES Metric Eight-** Q17B. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues?

BAME staff remain significantly more likely to experience discrimination at work from colleagues and their managers. 13.7% of BAME staff reported personally experiencing discrimination at work from staff in the last 12 months compared to 6.4% of white staff. This does, however, represent a 23% decrease when compared with the previous year for BAME staff. White staff reported an 8% increase year on year. When compared to the national average, BTH data is below the national average of 16.8% for BAME staff though above the national average of 6.1% for white staff working in a Combined Acute and Community Trust.

10. Conclusion

10.1 It is inevitable that staff sentiment and engagement has been impacted by the ongoing pandemic and factors largely outside our control have changed the way we work in a short period of time, however we remain committed to improving our employee experience through robust actions plans and taking the opportunity to ensure staff voice is heard at every level; continuing to build on previous years' work and encouraging the appetite from staff to share their experiences and together make BTH a great place to work. Given the extraordinary year it is pleasing to see the areas of progress demonstrated despite the very challenging context.

10.2 These are by far, the best staff survey results that the Trust has received. However, the results clearly identify a number of areas where improvements are needed. Areas requiring improvement and recommended actions are cited below. It is hoped that the Board of Directors will support and approve all of these recommendations and following this together we will mobilise each strand of this essential priority to support recovery, restoration and transformation.

11. Recommendations

It is recommended that the Board of Directors support the following: -

11.1 Given the below average score of safe environment- violence it is recommended all leaders champion staff safety by reviewing, highlighting and utilising the mechanisms in place to protect staff from unacceptable behaviour.

11.2 Whilst a statistically significant improvement has been made over the last year in staff satisfaction around health and wellbeing the score is still below the national average. Therefore it is recommended the staff health and wellbeing strategy and services are reviewed and were necessary re-modelled to ensure restoration and recovery is enabled. Many staff will need additional support

following the Covid 19 pandemic and it is important early intervention is facilitated where appropriate for all staff.

11.3 The evidence base is clear that a high quality relationship with line managers is critical to supporting staff with their health and wellbeing. However we also know that line managers have been stretched significantly over the last year due to competing priorities due to the extraordinary year and their resilience may need addressing as compassionate leadership cannot flourish without self-compassion. With this in mind it is recommended that all line managers are trained in workplace trauma support and wellbeing to support themselves and their teams.

11.4 It is recommended there is a specific focus from all leaders to restore and champion the benefits of timely feedback including regular 1:1s and high quality appraisals/personal development reviews/plans. This includes the implementation of health and wellbeing conversations with all staff across the Trust on an annual basis.

11.5 All teams should develop a set of shared objectives aligned with the Divisional National Staff survey action plans and should be encouraged to meet regularly to discuss the teams' effectiveness and, where relevant, champion new ways of working that have evolved from the Covid pandemic (e.g. Microsoft teams) that support our agile workforce.

11.6 BTH should design and deliver training and development which enables managers to model compassionate and inclusive management practices thereby ensuring staff have opportunities to show initiative, are able to make suggestions to improve the work of their team and are involved in deciding changes that affect their work.

11.7 Continued collaboration between the Board of Directors/Senior Management and the Staff Guardian to embed the culture of speaking out safely. Further promotion of the "If You See Something, Say Something" campaign to raise awareness and assure all staff that the Trust encourages and supports staff who raise concerns if they feel safety is at risk. Further education and communication should be deployed to ensure all staff know how to report unsafe clinical practice and understand how concerns raised by service users are acted upon.

11.8 It is recommended that there is a continued focus and effort to increase visibility and communication from senior managers on all sites at Blackpool Teaching Hospitals and include a structured programme of: Back to the Floor visits; meet the Board events and patient safety walkabouts on sites questions and answer sessions with divisional leads beyond the BVH site.

11.9 Given the disparities of staff satisfaction from staff with protected characteristics it is recommended BTH progress the Trust wide action plan on equality, diversity and inclusion to ensure all staff have equal opportunities.

11.10 Divisions should make time to better understand and action their divisional data, particularly divisional strengths and areas for improvement. This will be supported by feedback workshops facilitated by the Staff Engagement Team and scheduled to take place during March and April 2021. It is recommended that as many line managers as possible along with the senior management team of all divisions/directorates attend these sessions.

11.11 Divisions should utilise this year's Big Conversations; specifically focusing on staff experience and engagement as a mechanism to discuss the current climate and culture at BTH. Sessions will focus on supporting staff health and wellbeing and the recovery and restoration work in the Trust as the Covid Pandemic continues to prevail. Using a participative approach; divisions will work with their staff base to formulate bespoke action plans that target areas of improvement and celebrate successes, with an agreed communications campaign plan '*you said, together we did'* for each division which will be supported by the Staff Engagement Team HRBP'S and Divisional management.

11.12 It is recommended that there is development of a transparent and measurable corporate action plan with supporting Divisional action plans facilitating a joined up approach to addressing staff satisfaction and engagement in 2021 with oversight and support of these plans on a quarterly basis to the board or appropriate committee.

11.13 It is recommended that if any directorate teams that were identified as hot spots for poor staff experience in the 2019 National Staff Survey remain hotspots in the 2020 National Staff Survey; further diagnostics, support and interventions are agreed and implemented.

11.14 Given the successfully increasing response rate over the years at BTH, it is recommended that the vast majority of 2021 staff surveys are sent via electronic survey rather than paper survey. This has

proven to be more successful in Trusts that have consistently maintained high response rates across their organisations and has proven successful in increasing our response rate.

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

6 May 2021

Care Quality Commission Unannounced Inspection - January 2021

Author of Report:	Stefan Verstraelen, Deputy Director of Quality Governance Louise Cheung, Head of Quality Governance
Executive Director Sponsor:	Peter Murphy, Director of Nursing, AHPs and Quality
Date of Report:	26 April 2021

Executive Summary:

This summary report provides the Board of Directors with an overview of the Care Quality Commission (CQC) inspection findings of the January 2021 unannounced inspection carried out of Urgent and Emergency Services, and Medical Care (including older people's care), what this means for the Trust and the next steps.

Key points of the report:

- The focused inspection of medical care (including older people's care) was because they had concerns about the safety and quality of the services.
- The inspection did not focus on all key lines of enquiry and therefore the Trust rating of 'Requires Improvement' remains unchanged.
- There are a number of MUST and SHOULD actions for the Trust to address; these have been incorporated into the overall CQC action plan.
- Whilst areas of outstanding practice were identified, a number of areas of concern were also flagged.

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

Recommendations: None

Sensitivity Level:

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

Board of Directors Meeting

6 May 2021

Care Quality Commission Unannounced Inspection - January 2021

1. Purpose of Report

The purpose of the report is to provide the Board with an overview of the key findings from the January 2021 Care Quality Commission (CQC) unannounced inspection. The report will also include an outline of what this means for the organisation and the next steps.

2. Background

The CQC made an unannounced inspection visit to the Trust from 11 January to 14 January 2021. It was a focused inspection of Blackpool Victoria Hospital, and included an inspection of the urgent and emergency care service as part of their winter pressures programme. As part of the inspection the CQC considered nationally available performance data, and data and intelligence provided by ourselves. They inspected against the safe, responsive, and well-led key questions; and inspected key lines of enquiry relevant to the winter pressures programme.

The CQC also carried out a focused inspection of medical care because they had concerns about the safety and quality of the services. That focused inspection covered; is the service safe, effective and responsive? The CQC visited the Acute Medical Unit (AMU) the Stroke Unit, Ward 10 and Ward 12. They also remotely reviewed Ward 23.

The CQC did not inspect all the key lines of enquiry or domains, and therefore did not provide a rating. Our Trust CQC rating of 'Requires Improvement' remains unchanged.

3. Key Findings:

Outlined below are the key findings from the CQC inspection.

Urgent and Emergency Care:

The inspection team found many positives during their inspection including; that staff understood how to protect patients from abuse; they managed infection control risks well; they completed and updated risk assessments for each patient; there was enough nursing and support staff with the right skill mix; and that leaders had the skills and abilities to run the service, including understanding the additional pressures faced due to the Covid-19 pandemic. However, patients did not always receive the right care promptly, and waiting times were not in line with national standards.

Within urgent and emergency care the CQC identified the following areas of outstanding practice:

- 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 had 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 the department.

Medical Care (including older people's care):

The CQC identified a number of areas for improvement including; infection control risk was not always managed well, insufficient medical staff with the right qualifications, skills and experience; inconsistencies in the approach to the completion of patient records; not all patient records were stored securely; fluid balance charts were not always fully completed; national guidance regarding patient consent was not always followed; best practice and national guidance was not always followed regarding the Mental Capacity Act

(MCA) and Deprivation of Liberty Safeguards (DoLS); and the CQC found examples of delayed or omitted antimicrobial medications.

The CQC did, however, identify a number of areas of good practice including; effective use of Personal Protective Equipment (PPE), completion and updating of risk assessments for patients; regular review of staff skill mix; medicines were stored, prescribed, and administered, appropriately; and patients were provided with enough food and drink to meet their needs.

Within medical care (including older people's care) the CQC identified the followed example of outstanding practice:

- Due to the National issue of DoLS authorisations not being reviewed by the Local Authority in a timely way, the Trust had implemented a DoLS 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.

4. Key areas of action for the Trust:

The CQC identifies actions the Trust either MUST or SHOULD take. Any action the Trust MUST take is necessary to comply with its legal obligations. Actions a Trust SHOULD take is because it was identified as not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Urgent and Emergency Care:

Action the service MUST take to improve:

- The Trust must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. (Regulation 12 (1)).

Action the service SHOULD take to improve:

- The Trust should ensure the planned Standard Operating Procedure (SOP) is implemented to guide staff when patients are in ambulances waiting for their care to be handed over. (Regulation 12).
- The Trust should continue to work to recruit a Paediatric Emergency Medicine consultant. (Regulation 18).

Medical Care (including older people's care):

Actions the trust MUST take to improve:

- The Trust must ensure that patient records are complete, legible and kept securely at all times, so that they are up to date, clear and only accessed by those authorised to do so. (Regulation 17 (1) (2) c).
- The Trust must ensure that medical staffing is sufficient to meet the needs of patients and ensure actual staffing meets with, or is close to, the planned numbers. They should continue work to improve the recruitment and retention of medical staffing to reduce vacancies. (Regulation 18 (1)).
- The Trust must continue to progress and implement improvement work in relation to the timely administration of antimicrobials in line with how they are prescribed and increase the awareness of antimicrobial stewardship. (Regulation 12 (1) (2) b).
- The Trust must make sure that when a patient is unable to consent to their care and treatment, staff follow Trust policy and the requirements of the MCA 2005. Patients and/ or their families should be involved in decisions made about their care and treatment. (Regulation 11 (1)).
- The Trust must continue to progress work and focus on making improvements to flow through the hospital, so that patients receive appropriate care and treatment in the right place when they need it and that discharges happen safely in line with national standards. (Regulation 12 (1) (2) a i).

Action the service SHOULD take to improve:

- The service should consider a review of the signage on wards in relation to Covid-19 so that it is clear to staff, patients and visitors where there are patients who have tested positive or those who are isolating for Covid-19. Where wards had a mix of negative and contact patients the signage for the segregation of facilities should be reviewed so that it is clear to patients to prevent any potential transmission of the virus. (Regulation 12)

- The service should continue to review nurse staffing to ensure that it is in line with national guidance, meets the needs of the patients and keeps them safe from avoidable harm. (Regulation 18).

5. What this means for the Trust and next steps

The additional findings and subsequent actions from this most recent CQC inspection means the Trust has a number of additional actions and areas of focus which require attention and addressing prior to the next CQC visit. It is worth noting that it is expected that the next CQC inspection will be imminent. In order for the Trust to aim to move out of a 'Requires Improvement' rating and into a 'Good' rating, it is imperative that robust and effective actions plans are developed relating to these new actions, and that they are completed in a timely manner and/or have responsive and timely deadlines set.

The Quality Governance team has been working with the Divisions to develop robust and comprehensive action plans in response to these latest action areas; these are to be incorporated into the wider CQC action plan to aid complete oversight and management. There is also preparation underway to support all divisions to be able to clearly describe their key complaints, incidents (including serious incidents) and risks, and they are being alerted to the fact we are expecting a CQC visit shortly. In addition, Trust-wide communications have been set up for key urgent messages with all staff being required to sign off they have read and understood the message via a message centre. This gives the Trust additional assurance and evidence regarding important information sharing to all staff, and as far as we are aware it is not something other Trusts have been able to achieve. We propose to also use this method of communication for key CQC preparation messages.

Accompanying this document is the full CQC inspection report for your review and information.

Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Inspection report

Whinney Heys Road
Blackpool
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Tel: 01253655520
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Date of inspection visit: 11 January 2021 14 January 2021 20 January 2021
Date of publication: 26/03/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Blackpool Victoria Hospital

Inspected but not rated

We carried out a focused inspection of Blackpool Victoria Hospital on 11 January 2021. This included an inspection of the urgent and emergency care service at Blackpool Victoria Hospital as part of our winter pressures programme.

We considered nationally available performance data and data and intelligence provided by the trust. We inspected against the safe, responsive and well-led key questions; we inspected key lines of enquiry relevant to the winter pressures programme.

We also carried out a focused inspection of medical care because we had concerns about the quality of services.

The focused inspection of medical care covered elements of three key questions; is the service safe, effective and responsive.

We did not inspect all the key lines of enquiry or domains and therefore have insufficient evidence to rate the services.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Urgent and emergency services

Inspected but not rated

Key facts and figures

The urgent and emergency care department at Blackpool Victoria Hospital provides emergency care for adults and children, 24 hours a day, seven days a week. The hospital is not a major trauma centre; however, it is the regional cardiothoracic centre and as such, patients with penetrating chest wounds are treated here. Annual attendances at the department are about 67,000 which includes 11,000 attendances for children and young people.

Following the outbreak of COVID-19, the department has designated three entrances and designated areas in the department, one for walk-in patients, one for ambulance drop-off and one for COVID-19 positive patients. The COVID-19 positive department is in the building that previously housed the primary care urgent treatment centre. The urgent care treatment centre has been moved to a building in the car park in front of the urgent and emergency care building. The COVID-19, or high-risk area, was designated as a red zone and the other areas of medium risk of COVID-19 were designated as amber zones.

The red zone had four assessment rooms and an ambulance handover space. There was an escalation area of eight cubicles with doors. There was not a separate resuscitation cubicle in the red zone but there was a resuscitation trolley and equipment that could be moved into cubicles as necessary.

In the amber area there was an assessment area with 13 bays and two additional bays which could be observed from the nurses' station. The ambulance drop-off had a triage area with a cubicle and two ambulance bays. There was a rapid assessment treatment area with five cubicles. There was a resuscitation area with four cubicles.

There was an assessment area which had a waiting area, four cubicles and three treatment chairs. This area was for lower acuity ambulatory patients and patients waiting for treatment before discharge.

Walk-in patients were triaged from a reception desk in the main reception area. There was a seating area adjacent to this for patients to wait, with appropriate social distancing measures in place.

The children's emergency department had a separate entrance with an intercom system to control entry. There was a waiting area for children and young people with controlled access to two triage cubicles and five treatment cubicles. One of the cubicles was suitable for patients with mental health problems and was ligature free.

We spoke with 18 staff during the inspection, including registered nurses, paramedics, consultants, middle grade doctors, flow matrons, pharmacy staff, senior managers from the emergency department and from the trust. We reviewed 23 records, including nursing records, doctors' records, risk assessments and prescription charts. During the inspection we attended a bed meeting, we observed a safety huddle and two handovers from ambulance staff to emergency department staff. We also observed the care and treatment of patients in the department.

Overall summary

Our findings were:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Urgent and emergency services

- The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks once they were in the department. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm, and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.
- Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and treatment including during periods of heavy demand. The service had an open culture where staff could raise concerns without fear.
- The service's senior clinical leadership team were able to describe the current issues that were impacting on the service's performance and response times. These included factors outside the service's control within the wider hospital and the community across the Blackpool, Wyre and Fylde Coast as a result of pressures from the COVID-19 pandemic that were leading to increased demand on the service and directly impacting on waiting times and performance.

However:

- People could access the service when they needed it but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times and took remedial action but could not always ensure that patients did not stay longer than they needed to.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- We reviewed the trust's safeguarding training rates. For safeguarding of children and young people, completion rates for level one training were 86.8%, level two 89.4% and level three 75.7%. For safeguarding of adults, training rates for completion rates for level one training were 92.3%, for level two 89.4% and for level three 55.7%. Prevent training rates were at 90% for levels one and two and 91.2% at level three; this is training to the risks of radicalisation and the roles involved in supporting those at risk. Training rates for the mental capacity act were 78.5%.

- In the adult emergency department, there was a safeguarding navigator who supported the department 25 hours a week. Safeguarding support was available 24 hours a day, seven days a week. The trust's safeguarding team developed a COVID-19 safeguarding package to support staff during the pandemic. The trust had an independent domestic violence advisor who would support any patients attending the emergency department.
- The paediatric ward had developed a safeguarding trigger tool. A form was completed for every child who attended the department. Information collected included: details of the child, if they were known to a social worker and information about who had accompanied the child to the department. If a young person between 16 and 17 years attended the main emergency department the same information was collected, and the paediatric staff would support the main department in the collection of this information. All the information was sent to the trust's safeguarding team.
- Following several difficult incidents there had been a debrief for all staff in the paediatric emergency department. There was learning from the incidents and a review of what could have been done differently. The nurse manager said that there had been good feedback from staff about the session. There was safeguarding supervision for all the paediatric nursing staff every three months.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The department was visibly clean. Throughout the inspection we saw cleaning staff working around the department and staff told us that the teams were responsive when areas needed to be cleaned. We saw that staff were cleaning trolleys and mattresses between patients and deep cleans were completed as necessary. There was a cleaning crew outside the hospital to decontaminate ambulances once a patient had been handed over to hospital staff.
- There were plentiful supplies of personal protective equipment (PPE) and we saw that staff used it. There was information on the walls of the department about appropriate PPE usage. There were sinks around the department with hand wash and alcohol gel and we saw that staff washed their hands and followed guidance on hand washing. Chairs in the waiting areas were made of wipeable material. Chairs were cordoned off to allow two-meter distancing between patients.
- Due to COVID-19 the department was divided into non-COVID-19 (amber) and COVID-19 (red) zones which had separate entrances which allowed patients to be segregated from each other. There was good signage in the department between the different areas. Patients could not be moved from the red zone until they had been swabbed for COVID-19. This allowed them to be placed in an appropriate area in the hospital for their treatment according to their COVID-19 status. This helped to reduce nosocomial infections in the trust.
- On the day of the inspection there was a delay in COVID-19 swab results. This was due to a machine failure and test results were taking up to five hours. We were told that usually results were available in two hours. The department was starting to use point of care testing on 14 January and those test results would be available in 15 minutes.
- In the children's emergency department there were two nurses on duty, one of them was designated for COVID-19 positive patients and one was for COVID-19 negative patients. This was displayed on the wall in the department.
- However, at the nurses' station in the adult emergency department, we observed that doctors and nurses did not always observe social distancing rules. We also saw that there were significant numbers of staff moving between the amber and red zones, although all staff that we observed followed appropriate infection control practices.

Environment and equipment

Urgent and emergency services

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However due to the size of the department and the lack of space due to building work it was cluttered.

- There was extensive building work ongoing in the department at the time of the inspection. This building work was part of the emergency village development and was due to be completed in two weeks. There were large areas of the department that were screened off to allow building work and this had reduced available space in the department. The department had made best use of available space for maximum patient capacity and separation of areas for COVID-19 and non COVID-19 patients.
- The size of the corridors made social distancing difficult but in assessment areas we saw that hospital staff and ambulance staff managed to maintain social distancing. In the ambulance triage area, there was space for four trolleys, and we saw that ambulance crews worked with hospital staff to maintain social distancing in this area.
- The cubicles in the red zone were equipped with a defibrillator and patients could be intubated in these cubicles as necessary. There was an X-ray unit in the amber zone of the department and a mobile X-ray facility in the red zone of the department.
- Resuscitation trolleys and sepsis trolleys in the department were checked and this information was documented. Equipment had "I am clean" stickers and we saw that equipment was cleaned between patients.
- In the paediatric emergency department, there was an assessment room for children and young people with mental health problems. This was ligature free.
- However, the department's corridors were cluttered with trolleys and equipment.
- The emergency department pharmacist was involved in the 'emergency village' to ensure provision for medicines was appropriate. However, they had identified that the fluid store was not temperature controlled and hence may not maintain a suitable temperature for the safe storage of medicines.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

- The trust's audits showed that standards for the administration of antimicrobials for sepsis within one hour were met.
- A specialist pharmacist and technician provided weekday support to the emergency department, working as part of the multi-disciplinary team, focusing on medicines quality and safety. The pharmacy team also ensured that when patients were admitted, any medicines the patient had brought with them went to the correct ward. A business case for extended pharmacy hours was in development.

Assessing and responding to patient risk

- **Once patients were in the department staff completed and updated risk assessments and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- The ambulance service used a pre-alert form provided by the trust to highlight any patient risks to the emergency department identified during the journey to the department. The form contained information about the patient's history and clinical observations. There was a process so that patient information from the ambulance service was transferred into the emergency department's electronic record for patients and could be reviewed by clinicians.

Urgent and emergency services

- Information provided by the trust following the inspection stated, patients were prioritised using the details recorded on the pre-alert form. On arrival the Consultant or Senior Coordinator in the department would link in with the Ambulance Liaison Officer (ALO) to confirm if the pre-alert details were still correct and if there were any immediate safety concerns. Following this a joint agreement as to the priority order for patient transfer was made between the trust and the ambulance service.
- At the time of the inspection there was no written guidance for staff on managing patients waiting in ambulances. However, we were told that a standard operating procedure was being developed between the trust and the ambulance service. This was due to be completed by the end of January 2021.
- The paramedics reported that it was easy to ask for help or for a medical review of the patient when in the ambulance. During the inspection we saw consultants going out to ambulances if concerns about patients were highlighted. Delays in handover meant there was an increased risk to patients in the local community who were waiting for an ambulance.
- During the inspection we observed that there were two ambulances waiting outside the hospital in the afternoon. By the evening this had increased to four. On the day of the inspection performance data showed that the longest wait for handover to urgent and emergency care staff from ambulance arrival times was 2 hours and 24 minutes.
- We observed that the handover of two patients from the ambulance crew to the triage nurse was of good clinical quality. Triage of all patients was by a nationally recognised tool. There was a COVID-19 clinical triage support tool for patients showing symptoms of the disease.
- The department used an early warning score system as a guide to determine the degree of illness of a patient. We saw that was used to identify patients at risk of deterioration and that their care was escalated appropriately.
- There were safety huddles every two hours or more frequently if required. These were led by the nurse in charge of the department and the doctors in attendance. There was a set agenda with prompts. At the 2.00pm meeting on the day of the inspection, the overall numbers of patients were discussed, the plans for each patient were reviewed and issues or requests for tests and diagnostics were escalated. The huddle we observed was supportive of staff and their well-being and ensured that staff had taken breaks.
- All patients in the rapid assessment treatment area, who had been brought in by ambulance, had observations completed, COVID-19 swabs taken, and appropriate tests completed on arrival in the department.
- The resuscitation room appeared well-equipped and we observed that two seriously ill patients were seen to and received immediate care and treatment that was consultant-led.
- There were clinical guidelines available on the intranet and these were easily accessible; all guidelines were up-to-date, and all had been reviewed and revised as necessary within the last two years. In the paediatric department, there were laminated sheets for the most common pathways used in the department and these were easily accessible by staff.
- Records which included doctors, nurses and medicine administration records were fully completed. Risk assessments for pressure ulcers, falls and venous thromboembolism were started when the patient had been in the department for two and a half hours. This was in line with trust policy. We saw that patients who were in the department for a long time were transferred to trolleys with pressure relieving mattresses.
- In the paediatric emergency department, we reviewed triage times. In December 2020, there were 703 paediatric attendances, an audit of triage times examined 155 cases randomly. There was 89% compliance with the 15-minute standard from the Royal College of Paediatrics and Child health that an initial clinical assessment of the child occurs within 15 minutes of arrival in the department. A number of these breaches of the 15-minute triage standard were due to children receiving immediate medical intervention on arrival in the department. In September 2020 there was an

86.6% compliance with the 15-minute triage standard. There was CCTV in the paediatric waiting areas so that the staff could observe children and young people in the department to see any deterioration and act immediately if necessary. Staff could also monitor the access to the department from the adult area of the emergency department. The department was using the COVID-19 triage trigger tool which staff said provided consistency in care.

- Staff in the paediatric department told us that they had a good relationship with staff on the children's ward and senior nurses would come down to the department if requested. There were regular meetings between the two departments. Reviews and learning from incidents, including COVID-19 related incidents took place and we saw examples of change in practice following incidents in the department.
- There was simulation training around the unwell child and study days including a pre-alert study day for the receiving of an unwell child into the department. We also saw evidence of staff competency training. All staff in the department were in date for their advanced paediatric life support training. An annual update for paediatric immediate life support training was planned and the band 7 nurses from the adult emergency department were included in the training to support the paediatric staff if necessary.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

- Managers told us that the nurse staffing in the department was at the establishment, as determined by the trust. The trust was using a staffing model which looked at acuity and risk. Staffing was reviewed daily across the division so that any gaps in staffing could be identified. Managers said that they supported staff, who may not have been in their comfort zone, if transferred from another area of the hospital to work in the department.
- There was a co-ordinator (band 7), 24 hours a day, seven days a week, to oversee the staffing in the department. The resuscitation area had two registered nurses for four beds and these nurses had undergone advanced life support training. In the triage area there was a registered practitioner from the local ambulance service, a streaming nurse and a triage nurse. The rapid assessment triage area had five bays with a co-ordinator, two registered nurses and three health care assistants. The Majors area had 13 beds with a co-ordinator, four registered nurses and four health care assistants. The COVID-19 red area had a co-ordinator, a registered nurse and a health care assistant.
- The clinical matron for the department told us that they were using between six and eight agency nursing staff every day to cover gaps in staffing through sickness and annual leave. Fill rates for registered nurses in December 2020 were 81.2% for day shifts and 100.4% for night shifts. In November 2020 fill rates for registered nurses were 82.3% for day shifts and 87.3% for night shifts and in October 2020 fill rates for registered nurses were 77% for day shifts and 83.3% for night shifts. For unregistered staff fill rates were about 80% for day and night shifts in December 2020. In November 2020 fill rates were 80.4% for day shifts and 86.6% for night shifts and in October 2020 fill rates were 77% for day shifts and 83.3% for night shifts for unregistered staff. All the bank and agency staff were known to the co-ordinators and had experience in the areas that they were allocated to. There was a thorough induction for agency staff, which included infection control processes and information governance.
- There were housekeepers in the department to help to provide patients with drinks and refreshments.
- In the paediatric emergency department, the nursing establishment was two registered children’s nurses for each shift supported by an emergency department assistant. In the period 1 December 2020 to 15 January 2021 there were six night shifts which were covered by one registered children’s nurse. This almost met the “Facing the Future Standards for Children in Emergency Care Settings” (Royal College of Paediatrics and Child Health 2018) that states

that there should be two registered children's nurses on every shift. To mitigate the risk the registered children's nurse on shift was supported by a registered nurse from the adult department so that there were two registered nurses in the paediatric department. Band seven nursing staff in the adult emergency department had received training in paediatric life support skills to support staff in the paediatric department if necessary.

Medical staffing

The service had mitigating actions in place to ensure enough medical staff with the right qualifications, skills, training and experience were in place to keep patients safe from avoidable harm and to provide the right care and treatment.

- At the last inspection in 2019, one of the actions for the trust was to increase medical staffing numbers at the trust to 18 consultants. There was currently a business case to uplift the numbers of consultants as part of the trust improvement plan and was waiting for approval following some changes to the business case.
- There were 12.5 consultants who worked in the department and no consultant vacancies. There was a consultant available in the department for 16 hours every day. There were three during the day until 5pm and then two until midnight. From midnight to 8.00am, the department was covered by an ST4 doctor or above.
- There was a shortage of middle grade staff. There were gaps in middle grade staffing with four vacancies at ST4 (two had been recruited to) and four at ST3 (two had been recruited to). There was one shift between 1 December 2020 and 15 January 2021 which did not meet the Royal College of Emergency Medicine standards on medical staffing of the emergency department. This was because agency staff were used to cover the staffing gaps.
- The culture of the department was very supportive across grades and professional groups.
- Feedback from staff was that their on-going educational needs should be considered and that this may support recruitment of further middle grade staff.
- The trust had been unsuccessful in the recruitment of a Paediatric Emergency Medicine consultant. However, there was a senior specialty doctor who had taken a lead role with an interest in paediatric medicine and there was access to the specialty paediatric team, 24 hours a day, seven days a week. There was an advanced nurse practitioner (ANP) for paediatrics and a business case to recruit and train an additional two ANPs for the department to provide cover 24 hours a day, seven days a week.
- The emergency department pharmacist supported junior doctor induction, providing education sessions and promoting sharing of learning through a monthly 'lessons learnt' newsletter that focused on medicines incidents and near misses within the emergency department.
- The emergency department pharmacist clinically checked and prescribed medicines supporting patient flow through the department, enabling the admitting doctor to focus on clinical history taking and clinical examination of the patients.

Is the service responsive?

Inspected but not rated

Access and flow

Urgent and emergency services

People could access the service when they needed it but did not always receive the right care promptly. Waiting times, arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times but could not always ensure that patients did not stay longer than they needed to.

- The urgent and emergency care service was available 24-hours a day throughout the year.
- The average attendance by ambulance was 79 patients per day in the week beginning 11 January 2021. On the day of the inspection performance data showed that the longest wait for handover to ED staff from ambulance arrival times was 2 hours and 24 minutes. This was the highest handover time for the week. The next longest handover time was on the following day and was 52 minutes. The average handover time for the trust was 19 minutes 47 seconds; the average for the region was 21 minutes and 37 seconds in this week. There were 56 patients with an extended turnaround time of one to two hours and five patients with an extended turnaround time of two to three hours in this week beginning the 11 January 2021.
- On the day of the inspection the trust had their highest number of COVID-19 positive patients being admitted since the start of the pandemic. There were 12 patients who were COVID-19 positive, with seven patients arriving by ambulance in a time period of 90 minutes. The small number of cubicles in the red area (five), combined with the delayed wait for the results of a COVID-19 swab, contributed to the ambulance handover delays.
- The service's performance data showed that in October 2020 the percentage of ambulances remaining at the hospital for more than 60 minutes was 4.3%, this compared with an England average of 7.3%. Time from arrival by ambulance to initial assessment was six minutes (October 2020) and time to treatment was 65 minutes (October 2020). The percentage of patients who spent less than four hours in the department was 51.2% compared to the England average of 72% (December 2020).
- The percentage of patients in the department spending more than 12 hours from decision to admit to admission was 51% in December 2020. Admissions waiting four to 12 hours from decision to admit to admission were 60% (December 2020) and were worse than the England average of 24% for the same period.
- There were daily bed meetings at 8.30 am,12 am, 4pm and 8pm. The meetings had a set agenda and were well-structured. Issues and concerns were raised at the meetings from each department in the hospital. There was representation from the emergency department at the meeting and there was an ambulance liaison officer who attended meetings. Following the meeting, a dashboard was produced highlighting information about flow in the emergency department and across the trust. Information for the emergency department included current patient numbers, breach times of current patients with a decision to admit and waiting times for ambulance handover. The dashboard provided the bed status of the trust in each speciality, current and forecasted and capacity at other sites. The operational pressures escalation level (OPEL) was included in the dashboard for the emergency department and the hospital. The bed meetings were chaired by more senior managers as the OPEL level increased.
- We observed the 4pm bed meeting on the day of the inspection. There had been 91 attendances during the day and there were 45 people in the department. Performance against the four-hour standard was 72.4% with 25 breaches of this standard. The average wait to be seen was two hours 16 minutes. There were 23 patients who had a decision to admit, 14 of these patients were for a medical bed, six for a surgical bed, one for an orthopaedic bed and two for a cardiology bed. Ten patients had waited for four to eight hours in the department and there was one patient who had waited for eight to 12 hours.
- There were clinical flow matrons who worked across the trust twenty-four hours per day, seven days a week. These were senior nursing staff who had oversight of patient flow, clinical oversight and had overarching management of the hospital out-of-hours. There were two matrons on duty out-of-hours. They looked at capacity and demand,

infection control and staffing and ensured quality and safety around flow and were the escalation point for the emergency department. The matrons produced an overnight summary report for the bed meeting. Senior nursing staff in the emergency department told us that they had a good relationship with the matrons and that they provided support to the department.

- All patients in the department who required an admission, needed a review by a senior clinician and a care plan in place, before they were transferred to a ward. Staff reported that the waiting time to see the medical admission team and be clerked by them was often several hours. They said that there were some consultants who would not see patients on the post-take ward round. This negatively impacted on flow through the department, with a delay for patients who needed a bed in the hospital. It was noted by the inspection team that there was marked repetition between the emergency department and admitting team, which could be reduced with a single clerking system.
- We were concerned that there could be a lack of consultant oversight of patients, because of the delays to see the medical admission team following a decision to admit the patient and that some of the consultants would not see patients on the post-take ward round. This could impact on the 14-hour quality standard from the National Institute for Health and Care Excellence, that patients should be reviewed by a consultant within 14 hours of their admission to hospital. There was a risk to patients, as there was no consultant responsible for their care.
- There were some medicine and surgery direct admission pathways into the trust and a cardiac arrhythmia clinic had been set up which took direct referrals.
- There was a hospital discharge team who reviewed patient pathways and looked for issues that could be preventing discharge. They met twice daily and information from this meeting was fed into the bed meetings.
- There was open access to the children ward for appropriate patients so that they did not have to go through the paediatric emergency department.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.

- Most senior managers and executive directors at the trust had been recent appointments and had worked to change and improve the culture and the quality of care in the emergency department. Managers said that changes had been implemented and embedded because staff from the department had been involved in the implementation of the change. Senior managers said that when they arrived at the trust it was evident that the staff were caring and compassionate and that they wanted to shape change to improve services for patients. Senior managers described the pace of change as rapid.
- There was effective senior leadership of doctors and nurses in the department. Junior doctors stated that they were supported and that consultants were open and easy to speak with.
- A senior nurse in the department told us that there was strong support from their manager and from the director of unscheduled care. They said that there had been massive leaps in patient care and patient safety following the appointment of the executive team.

- Staff told us that senior staff were visible in the department including the executive team.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, including during periods of heavy demand. The service had an open culture where staff could raise concerns without fear.

- Staff felt that they were at the centre of operations in the department and that they had been involved in the governance and processes of the department. It was their knowledge and expertise that was driving improvement and we were given examples of staff chairing meetings and how their ideas had been implemented.
- Managers told us that the freedom to speak up guardian role had been important because it had allowed staff to speak up, in confidence, about any issues with change that might directly impact on them, and this had helped to improve the culture.
- The atmosphere in the department, whilst busy, was calm and staff were aware of their roles and what they needed to do. Despite the pressures on the department, staff were appeared very supportive of each other.

Managing risks, issues and performance

The service's senior clinical leadership team were able to describe the current issues that were impacting on the service's performance and response times. These included factors outside the service's control within the wider hospital and the community across Blackpool, Wyre and the Fylde Coast as a result of pressures from the COVID-19 pandemic that were leading to increased demand on the service and directly impacting on waiting times and performance.

- There were systems and processes in place so that senior leaders were aware of the issues in the department. The report produced after each bed meeting was comprehensive and provided information across the trust to support access and flow. There was also oversight of the trust, 24 hours a day, seven days a week from the flow matrons. The appointment of these staff, who were dedicated to access and flow and patient safety, allowed the other hospital matrons to focus on the clinical issues in their areas.
- There was executive oversight of the issues and risks that impacted on the emergency department, including patient flow and patient discharge.
- The trust held a clinical command meeting every morning, which was chaired by the director of nursing and the medical director. This provided oversight of the trust and partner organisations at an executive level in the organisation.
- There was ongoing work to improve the flow through the department. Some of this was reliant on the imminent opening of the emergency village. There would be a same-day emergency care (SDEC) facility as part of this development. There was work to develop hot clinics and a review of GP pathways to look at direct admission of patients on appropriate pathways. The medical director told us that there was a meeting planned in January 2021 to look at frailty models and how these could be implemented. These interventions will provide alternatives to the emergency department and the hospital and help ensure timely intervention for patients in an appropriate and safe environment. The department was using quality improvement methodology to implement these changes.
- We saw that there was a departmental risk register and the main risk identified was about the ambulance delays, their causes and mitigating actions. Each incident with a delayed ambulance was incident reported and the deputy director of nursing was conducting a root cause analysis of the issues around these delays.

Urgent and emergency services

- There was evidence of strong partnership working across the emergency department and this was particularly evident with the local ambulance trust. The two organisations had worked to support and maintain patient safety during their journey to the hospital and through their handover processes.
- The trust had developed strong processes in the emergency department to support safeguarding including the safeguarding navigator role, an independent domestic violence advisor. They had won an award for their work for victims of rape who attended their department.

Outstanding practice

- 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.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. (Regulation 12 (1))

Action the service SHOULD take to improve:

- The trust should ensure the planned standard operating procedure is implemented to guide staff when patients are in ambulances waiting for their care to be handed over. (Regulation 12)
- The trust should continue to work to recruit a Paediatric Emergency Medicine consultant. (Regulation 18)

Medical care (including older people's care)

Inspected but not rated

The medical care service at Blackpool Teaching Hospitals NHS Foundation Trust provides care and treatment for:

- General medicine
- Care of the older person
- Diabetes and endocrinology
- Infectious diseases
- Gastroenterology
- Stroke and tertiary haematology

There are 443 medical inpatient beds located at Blackpool Victoria Hospital across 21 wards or units. The division has an ambulatory emergency care unit (AEC) and a short stay unit, with the primary aim that patients admitted to these areas can be typically discharged within 72 hours.

The trust had 55,058 medical admissions from October 2019 to September 2020. Emergency admissions accounted for 24,544, 1,992 were elective, and the remaining 29,522 were day case. Admissions for the top three medical specialties were: General medicine, gastroenterology and clinical haematology. The average length of stay was 7.1 days.

We carried out an unannounced focussed inspection of the medical care core service at Blackpool Victoria Hospital on 11 January 2021, because we received information that gave us concerns about the safety and quality of the services.

We looked at parts of the safe, effective and responsive domains. We did not rate the service because this was a focussed, unannounced inspection in response to specific areas of concern.

We observed care and treatment and specific documentation in 15 patient records, including risk assessments, do not attempt cardiopulmonary respiratory (DNACPR), mental capacity and Deprivation of Liberty Safeguards (DoLS) documents. We reviewed 19 prescription charts. We interviewed key members of pharmacy, nursing and medical staff along with the senior management team who were responsible for leadership and oversight of the service. We spoke with 43 members of staff in and five patients.

We observed patient care, infection control management, a ward handover and trust level staffing and flow meetings.

On this inspection we were limited to the wards we could visit due to the COVID-19 infection risk. We visited medical wards which included the acute medical unit (AMU), the stroke unit, Ward 10 and Ward 12. We reviewed prescription charts and patient records remotely from Ward 23.

Our findings were:

- The service did not always control infection risk well; especially in relation to a lack of clear signage in place to indicate COVID-19 risk areas.
- The service did not always have sufficient medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed staffing levels and skill mix.

Medical care (including older people's care)

- We found that there was an inconsistent approach to the completion of patients' care and treatment records and we found that not all patient records were stored securely on the wards we visited.
- We found examples of delayed or omitted antimicrobial medications. The trust antimicrobial stewardship group was sighted on this and was focusing on raising the profile of antimicrobial stewardship.
- Fluid balance charts were not always fully completed; out of the 15 records we reviewed we found three patients had incomplete fluid balance charts for each day they had been admitted.
- Staff did not always support patients to make informed decisions about their care and treatment or follow national guidance to gain patients' consent. Staff had received training and understood how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always follow best practice and trust policy around the Mental Capacity Act and deprivation of liberty safeguards.
- People could not always access the service when they needed it and receive the right care promptly. Arrangements to admit, treat and discharge patients were not always in line with national standards and flow through the hospital was a challenge.

However:

- Staff used equipment to protect themselves and others from infection and they kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Although at the time of inspection there were a number of nursing staff vacancies, managers regularly reviewed and adjusted staffing levels and skill mix, and there were recruitment plans in place. Nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Medicines were mostly stored, prescribed, administered and reviewed appropriately and patients had their allergy status recorded.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene.

The service did not always control infection risk well, especially in relation to a lack of clear signage in place to indicate COVID-19 risk areas. Other control measures were in place and staff used equipment to protect themselves and others from infection and they kept equipment and the premises visibly clean.

- Signage to indicate areas where there were COVID-19 positive patients was poor. We did not see evidence of signage at the entrance to the wards we visited, to inform staff or visitors of the COVID-19 status of the area. There was a risk that staff and visitors could enter these areas and be at risk of transmission of the virus or not be wearing the appropriate personal protective equipment.
- Staff rooms had maximum numbers of people that could be inside at any one time; this was to enable social distancing. On Ward 10 we were told they had increased the number of staff rooms to three, and there was a maximum of three staff allowed in at a time. We were told staff were aware of the maximum allowance, however, we saw that there was no signage to support this. There was a risk that staff who were unfamiliar with the ward would not be aware of this.
- Some wards which were identified as COVID-19 negative areas had isolated bays containing patients who had been in contact with COVID-19 positive patients. We observed that most of the side rooms and isolation bays where patients were being treated, who either had an infection or were at risk of infection, had doors which could be closed; we found that these were closed to prevent the spread of infection. However, two of the bays on Ward 12 did not have doors and were being used for patients who were isolating after being in contact with COVID-19 positive patients, there was a risk that infection could spread outside of these areas.
- We found that not all wards we visited had handwash basins located at the entrance and exits. We observed some of these were only located within patient bays. However, antibacterial gel dispensers were available. Domestic staff checked and refilled hand gel dispensers.
- Entrances and exits to the wards had stations which contained masks, hand sanitiser and visors, these were known as ‘donning and doffing’ stations. This is an area where staff and visitors can change their personal protective equipment when entering and leaving the ward. Staff advised that the side rooms on the entrance to two of the wards, had been initially allocated as ‘donning and doffing’ areas. However, at the time of our inspection these were being used to accommodate patients.
- We observed clinical waste bins located at the stations to dispose of personal protective equipment. However, on Ward 12 the bin was labelled as ‘general waste’ and contained a clinical waste bag with discarded personal protective equipment.
- All areas we visited were visibly clean and tidy. We observed planned cleaning taking place following the transfer of patients. Staff kept equipment clean and we saw ‘I am clean’ stickers used to indicate when it had been cleaned.
- We observed staff using personal protective equipment (in particular, masks) and we saw that they adhered to ‘bare arms below the elbow’ guidance. Staff had access to personal protective equipment at the entrance to the wards and to each bay, and we saw that they used it when providing patient care. Each bay contained facilities for staff to wash their hands and we saw staff washing their hands and using hand gel before and after contact with patients.
- Patients were encouraged to wear masks if they could tolerate them. We observed some patients wearing masks when they moved from their bedside.
- There was a process in place to identify and isolate patients who were at risk of or had a suspected or confirmed infection.
- We reviewed nationally published weekly nosocomial COVID-19 infection data from 1 November 2020 to 17 January 2021 (these are COVID-19 infections which have been acquired in hospital). The trust had reported 297 nosocomial infections in total, this was the fifth highest total number across the North West. The highest number of infections reported in one week was 50, this was in the week ending 15 November 2020.

- We noted that the number of nosocomial infections at the trust had in the main been higher than the average for North West hospitals. The data had shown a decrease in infections from the middle of November 2020 to the beginning of January 2021, when the infection rates came in line with the North West average. There has been a rise in infections since the start of January 2021, which had also been seen across the North West.
- Information showed that the trust was in the bottom 25% of trusts for E.Coli and Clostridium difficile rates per 100,000 bed days for the last three months. This was based on data from October 2020 to December 2020.
- The trust's infection prevention and control team conducted audits to monitor compliance with infection prevention controls. This included observational assessments of staff washing their hands and feedback was provided to the ward managers. Matron audits monitored environmental and equipment cleaning and staff adherence to the use of personal protective equipment and hand hygiene. Following the inspection, the trust provided details of hand hygiene audits covering the unscheduled care division for October to December 2020. These showed that overall compliance for the audit completed by the ward was 98.3% and the covert audit completed by the infection prevention and control team was 64.3%. These had shown improvement from the previous quarter. We observed quality boards on individual wards containing infection control rates and hand hygiene compliance were consistently updated.
- We were told that staff were offered weekly routine COVID-19 testing using the Loop-mediated Isothermal Amplification (LAMP) tests.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Comprehensive risk assessments were carried out for patients who used the service and risk management plans were implemented for patients who were identified as 'at risk' these were in line with national guidance.

- The service used national early warning scores (NEWS2) to assess the health and wellbeing of patients. This tool supported staff to identify if the clinical condition of a patient was deteriorating and required early intervention or escalation to keep the patient safe. We observed that the tool was electronic or paper-based, dependent on the area we visited.
- Staff received training to support them to recognise deteriorating patients; this was called 'recognise and act'. In November 2020 the service reported that 80% of staff had received the training. The trust had a planned "deteriorating patient collaborative" to improve the management of deteriorating patients. This was due to start in February 2021.
- We reviewed 15 patient records and found appropriately completed NEWS2 assessments. We saw evidence that staff had escalated NEWS2 scores in line with policy and that care plans had been updated. Records showed that patients at risk of sepsis had been identified and sepsis pathways were in place.
- Staff had access to a critical care outreach team 24 hours a day, seven days a week, where they could escalate concerns and seek support for patients who were showing signs of deterioration.
- Matrons monitored the completion of NEWS2 monthly as part of the matron audits. They checked that staff were appropriately monitoring patients and taking the required action dependent on the scores and that this was documented. Audit data provided prior to the inspection from February to November 2020, demonstrated that compliance with completion of NEWS2 across the service was between 92% and 100%.
- Matrons were ward based and did regular walkarounds. Staff told us that matrons were supportive and that they felt comfortable escalating concerns if needed.

Medical care (including older people's care)

- All patients were assessed using an acute admission nursing assessment document. Risk assessments were completed for falls, skin, moving and handling, malnutrition universal screening tool (MUST), and bed rail assessments. Records showed that these were well completed, and care plans were in place as a result. There was evidence of referrals to speciality teams such as dieticians where necessary. However, we found that there was an inconsistent approach to the completion of venous thromboembolism (VTE) assessments, six out of the 15 records we reviewed did not have these completed.
- Staff on the Acute Medical Unit told us they used a COVID-19 triage assessment tool. The document contained a patient bedside checklist which covered checks such as the nurse call bell and that oxygen and suction was working. Records showed these assessments had been completed.
- We saw evidence that patients received a consultant review within 14 hours of admission and there were regular medical reviews and clear care plans in place.
- Patient visiting had been suspended, in line with government guidance. As a result, patients reported feeling isolated and relatives/carers were concerned about a lack of patient improvement or deterioration. In response, the communication clinic was commenced, which shared information about patients' care and treatment with their families or carers. Senior nursing teams carried out spot checks to make sure that patients, relatives and carers had been communicated with. The Swan team (the hospitals palliative care team) provided the families of patients who were at the end of their lives with additional communication and support.
- We saw that the stroke unit had access to an electronic device where patients could contact family or carers with assistance from a member of the team. The unit had also introduced a daily communication call, in agreement with the patient and their relatives, to update them on key developments of the patients progress and care pathway. Staff told us that they received positive feedback as a result.

Nurse Staffing

Although at the time of inspection there were a number of nursing staff vacancies, managers regularly reviewed and adjusted staffing levels and skill mix and there were recruitment plans in place. Nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- At the time of our inspection there were 145 whole time equivalent registered nurse vacancies across the Unscheduled Care Division. Leaders told us that the highest vacancy rates were within the elderly care division. There were 106 whole time equivalent nurses who were going through the recruitment process, 62 of these had been recruited from overseas and so required additional training upon arrival and 44 were registered and working in the UK.
- Senior leaders told us there was a rolling programme of overseas recruitment ongoing and that it was expected the service would recruit an additional 120 nurses up until October 2021. Nurses who were recruited from overseas had to undertake a structured training programme over a three-month period and they remained supernumerary on the ward throughout this time.
- There was a 'grow our own programme' in place which introduced additional supporting and development roles to supplement the nursing workforce, these roles were apprentice nurses and assistant nurse practitioners.
- The sickness rate for the service was 7.32% which was higher than the trust's average of 6.58%. The leadership team identified the main reasons for absence were COVID-19, staff who were shielding and those suffering from stress related illness. It was recognised that this was a difficult time for staff and there was support from the Swan team (palliative care team) with de-briefs, access to clinical psychologists, human resources and well-being huddle rooms.

Medical care (including older people's care)

- The trust had recently implemented the 'safe care' staffing tool to monitor staffing skill mix, this was based on national guidance. At the time of our inspection the use of this across the service was in its infancy; it had been fully rolled out in December 2020. Ward managers added information about planned and actual staffing into the tool, with information about the acuity of the patients on the ward three times a day. The tool was reviewed for each ward twice daily as part of the 'safe care' staffing meetings. The tool highlighted red flag areas as a result of the information inputted into the system.
- 'Safe care' staffing meetings were held twice daily, in the morning and in the evening, and it was chaired by a divisional director or above. We observed one of the meetings. We saw that red flags were discussed, these included areas where there were patients with complex care needs, patients subject to a deprivation of liberty safeguard, patients requiring continuous positive airway pressure and areas where there were staffing shortages. Matrons and ward managers at the meeting, were asked to give their professional judgement on the staffing in their area and any mitigation in place to ensure staffing was safe. Divisional nursing leads sought assurance about red flag areas and identified where additional staff, such as bank or agency staff were needed.
- We heard a discussion relating to deprivation of liberty safeguard applications and the actions taken to ensure patients were safely cared for. Staff confirmed completion of appropriate paperwork, involvement of the safeguarding team and security on the ward where needed.
- Weekend staffing was planned on a Thursday. At the time of our inspection there was no formal process for review of the tool during the weekend. This was currently being done informally led by a divisional director of nursing or above, who dialled in at an agreed time in order to support and lead the staffing call. We were told there were plans to implement the staffing tool at the weekend in the future.
- Matrons told us they had good oversight of staffing for their areas and had regular walkarounds. Ward managers could escalate concerns with staffing throughout the day to the 'matron of the day' via a bleep system.
- The service had access to bank and agency staff to fill gaps in rotas based on the establishment. This could be exceeded if the acuity of the patients on the ward required it at that time, and if staff were available. We were told that due to the pandemic, and the demand for agency staff across the region, they often struggled to get cover and as a result, the trust had to pay enhanced rates to secure staffing. A concern was raised that the trust's bank service was only available Monday to Friday within working hours, which meant they could not access the team to allocate bank staff outside of these hours.
- Staff told us that the service relied heavily on registered agency staff to support and cover vacant shifts.
- We reviewed the planned versus actual staffing whilst we were onsite for the acute medical unit, the stroke unit and Ward 12. We found that actual staffing was in line with or close to the planned figures.
- The stroke unit was working towards the status of a hyper-acute stroke unit (HASU) to treat patients who required thrombolysis, which is a time critical procedure. There was work ongoing to increase the establishment of registered nurses to care for stroke patients, in line with national guidance. Although at the time of our inspection the trust had not achieved the HASU status they were providing services for acute stroke patients. We saw that planned staffing on the unit was not consistently met and staff told us there was often a shortfall in qualified staff to manage the acute stroke beds, which was not in line with national guidance.
- The service provided average fill rates for nursing and care worker staffing covering October to December 2020, for wards C,1, 3,11, 23, 24 and 25. The data demonstrated that in the main, fill rates were maintained across all wards for day and night staff. However, we noted that in October 2020 the average fill rate for care worker staff on the day shifts on Ward 23 was 61.2% and in December 2020 the registered nurse average fill rate for day staff on Ward 11 was 69%.

- Between October and December 2020, we saw that the service had reported 19 incidents relating to nurse staffing shortages. In the main we saw that these were categorised as “low harm”. Common themes reported within these as a result of the limited staffing, were around missed and delayed medication including critical medicines, the inability to provide enhanced care to patients who needed it and delayed observations. There had been four patient falls and one of these had been categorised as “moderate harm”.
- There had been a registered nurse staffing review of all establishments across the service which resulted in an increase of planned levels. We were told that the new establishments would be in place from April 2021. However, staff told us that health care assistant establishment did not meet with the needs of the service and had not been altered for over two years this was due to high agency expenditure. Following our inspection, the trust told us that there was a planned uplift of 62.5 whole time equivalent healthcare assistant staff as part of the establishment review.
- Ward staff used handovers to communicate information about patients care and needs. We observed a handover on the stroke unit which was thorough. The stroke unit had introduced a daily safety huddle and were able to evidence these through audit practice. The safety huddle template had been developed by the team which included patient updates, issues/concerns, risks, falls/slips and trips and equipment checks. There was a section which included important messages to share with staff regarding wellbeing, staffing concerns, COVID-19 update, discharges, delayed transfers of care and daily patient communication clinic for patient relatives/carers.

Medical Staffing

The service did not always have sufficient medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed staffing levels and skill mix.

- At the time of our inspection there were 26 whole time equivalent consultant vacancies across the service. We were told that the area with the highest consultant vacancies was care of the elderly. We were told that these areas were the most difficult to recruit to.
- The service used locum medical staff to fill gaps on rotas, which we were told was a challenge. The service used a high number of locum consultant staff to support the general medicine rotas. The senior leadership team recognised this was not ideal and were monitoring the impact on the wards which were locum-led.
- The service provided fill rate data for medical staff broken down into consultants, senior and junior medical staff for wards C, 1, 3, 11 and 23. In the main, we saw that fill rates were lower than planned. We saw that wards 3, 11 and 23 had the lowest reported fill rates. The average total fill rates overall for medical staff on these wards, for October to December 2020, were 74.93% on Ward 3, 86% on Ward 11 and 68.19% on Ward 23. We noted that the lowest fill rates were 50% for consultants, 40.91% for senior medical staff and 41.67% for junior medical staff.
- Staff we spoke with told us the medicine service still had gaps in medical staffing, they felt this was because of national shortages in certain specialities. Staff told us that advanced nurse practitioners worked closely with the medical team to provide medical cover including the out-of-hours service. The stroke unit had an establishment of four advanced nurse practitioners. At the time of our inspection there were two vacancies for this post on the unit.
- Rota coordinators highlighted medical staffing rota gaps to the senior clinical teams in advance, to assist in the planning of rotas and securing additional staff.
- Daily staffing meetings were held to review medical staffing across the service. The meeting looked at each ward to ensure that there was medical cover in place, escalate any concerns in relation to medical staffing and to monitor that all patients had received a medical review. Leaders felt assured that all patients across the service received a medical review daily.

- Patient flow meetings monitored assurance of medical review, medical cover and that ward and board rounds had taken place.
- The senior leadership team told us there was a planned review of the general medical rotas to align them with other specialities and update the job plans in order to attract recruitment of medical staff. There were links with the local commissioners to support this.
- There was ongoing work to introduce alternative specialist roles to support the medical workforce such as advanced nurse practitioners, physician associates and non-medical consultants.
- All specialities we visited had medicine consultant cover Monday to Friday (consultant of the week), with on call 24 hours a day, seven days a week for weekends and out-of-hours. The trust had a policy for the identification of the responsible consultant.
- All the services we visited had a daily consultant review and multi-disciplinary team meetings (MDTs).

Patient records

We found that there was an inconsistent approach to the completion of patients' care and treatment records and we found that not all patient records were stored securely on the wards we visited.

- There was an electronic patient tracking system which was used alongside the paper-based records. The tracker recorded vital information about patients, including their presenting complaint, past medical history, plan of care and estimated date of discharge. The tracker could be accessed by ward staff and specialist staff. Staff told us that there was poor completion of the electronic tracker and that staff often just updated the paper case notes; there was a risk information could be missed. Matrons confirmed that the tracker was not audited for completion.
- Staff told us that admission documentation was lengthy and there was often duplication of information, however there was work ongoing to improve this.
- We reviewed 15 patient records in total. We found there was an inconsistent approach to the completion of patient records in line with trust policy. We found that patients' identifiers were not always present on each page. There were missing dates and times of some assessments, which meant we could not always judge if assessments were made in a timely manner. Not all entries were legible, we found that in some records there was missing documented evidence of care planning discussions with patients or their families and whilst some entries had been signed the name had not always been printed and dated.
- We found three patients had incomplete fluid balance charts for each day they had been admitted. For two of the patients, staff had recorded 'inaccurate' on the charts for the balance carried over and for one of the patients the total balance was not always recorded. One of these patients was on a fluid restriction and the urine output was not measured. There was no documented evidence in the patients records to show that staff had reported the inaccuracies that they found, or that any changes had been made to improve this.
- Weekly matron audits covered different aspects of documentation on different weeks. We saw that this included risk assessments, bedside checklists, admission documentation, care plans, fluid balance charts, Malnutrition Universal Screening Tool (MUST) risk assessments, intentional rounding charts, NEWS 2, pressure care and the security of records. The audits provided a red, amber or green rating, to demonstrate which areas were non-compliant, partially complaint or compliant. We were told by a matron that there had been an improvement in the completion of risk assessments and fluid balance charts on the wards they covered since the start of the audits.

- We reviewed the matron audit data for the completion of fluid balance charts and Malnutrition Universal Screening Tool (MUST) risk assessments, which covered January 2021 for wards C, 11, 23, 24, 25 and 26. The results demonstrated an inconsistent approach to the completion and documentation of fluid balance and MUST assessments and highlighted areas of non-compliance. The audit identified that wards 24 and 25 were red, Ward C and 11 were amber and wards 23 and 26 were green.
- We reviewed matron audit data for these wards for January 2021 covering admission documentation, care planning, all risk assessments and intentional rounding. We saw that the wards were not all compliant with the completion of admission documentation and care plans, and that the wards were mostly red for these indicators. However, wards were compliant with the documentation and completion of risk assessments and intentional rounding.
- Patient records were not always stored securely. We observed the storage of patient records in unlocked note trollies on both the acute medical and stroke units. The security of patient records was monitored as part of the matron audits. We reviewed the results covering November and December 2020 for wards C, 11, 23, 24, 25, and 26. We saw that each ward scored red on both audits (except Ward 11 which did not provide a score for November), which meant that they were not compliant with the security of patient record requirements.

Medicines

Medicines were mostly stored, prescribed, administered and reviewed appropriately and patients had their allergy status recorded. However, we found examples of delayed or omitted antimicrobials. The trust antimicrobial stewardship group was sighted on this and was focusing on raising the profile of antimicrobial stewardship.

- The trust continued to show good compliance with choice of antibiotic but poor compliance with recording of 48-hour treatment reviews (54% in September 2020). A trust audit of reported antimicrobial incidents (August 2019 to September 2020) showed that missed doses were most common, followed by delayed doses. We similarly found delayed or omitted doses in five of the eleven prescription charts we reviewed, where antimicrobials had been prescribed. We also saw one example, of an inappropriate switch from an intravenous to an oral antibiotic that works only in the intestines and will not treat infections in other parts of the body.
- A delayed business case for increased support for antimicrobial stewardship remained in development.
- The trust showed good compliance with standards for safe and secure storage of medicines (Audit February 2020). Funding for probes to facilitate monitoring of fridge temperatures was in place. New lockable medicines storage had been rolled out to wards.
- Prescription charts were clearly presented, and allergy status was recorded for most records we reviewed. The trusts self-administration policy had been re-drafted and was ready for review and approval.

Is the service effective?

Inspected but not rated

Nutrition & Hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

- Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. The Malnutrition Universal Screening Tool (MUST) tool was used to identify adults who were malnourished or at risk of malnutrition. Patients had their nutritional needs assessed and these were recorded in care plans.
- We reviewed 15 patient records and we saw that most Malnutrition Universal Screening Tool risk assessments and food and rounding charts had been completed appropriately. We saw that patients were referred to the dietician for additional advice and support if required. However, matron audit results demonstrated an inconsistent approach to the completion of Malnutrition Universal Screening Tool risk assessments.
- Individual and multicultural patient needs were catered for, this included vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. Patients assured us that the food was warm, fresh and of good quality. We observed food being distributed to individual patients; the food looked appetising and fresh.
- The service had protected mealtimes and we saw patients were supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking. Staff we spoke with, were aware of the patients on the ward who required support with eating and drinking and shared the responsibility to support these patients. We observed housekeepers offering wet wipes to patients before meals so that patients could wipe their hands prior to eating.
- Most patients said the food was good and that the menus were varied. The quality and quantity of food was monitored through patient-led assessments of the care environment (PLACE) which showed an overall satisfaction with food provided. The PLACE scores for 2020 demonstrated that ward food scored 96.90%, which was higher than the national average of 92.62%.
- We saw records in the notes for patients who received nutrition via nasogastric tubes, including the date and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained. Nurses completed initial swallow assessments at the point of admission with appropriate referral to the speech and language therapists (SALT) if concerns were highlighted.
- The service used bowel charts to monitor patient's bowel movements. We saw evidence that these were completed, and staff had responded appropriately to the information recorded.

Mental Capacity Act and Deprivation of Liberty

Staff did not always support patients to make informed decisions about their care and treatment or follow national guidance to gain patients' consent. Staff had received training and understood how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always follow best practice and trust policy around the Mental Capacity Act and deprivation of liberty safeguards.

- Staff did not always carry out an assessment of a patient's capacity to consent to decisions about their care and treatment when it was indicated, in line with best practice and trust policy.
- We found that there was limited documented evidence of patients or their families being involved in decisions relating to do not attempt cardiopulmonary resuscitation (DNACPR) decisions. We reviewed 11 records and found that for two patients' staff had recorded "cognitive impairment" as a reason for not discussing the DNACPR decision with the patient. However, we could not find evidence that capacity assessments had been completed for these patients and there was no record of the patients' families being involved in the decisions. One of the forms did not have a clear reason listed for the DNACPR decision and there was no entry in the medical notes to support this.

Medical care (including older people's care)

- We reviewed 10 deprivation of liberty safeguard documents; two out of the 10 records evidenced that a Mental Capacity Act assessment had not taken place. Record entries were inconsistent, some had been signed but the name of the signatory had not been printed and dated. One of the deprivation of liberty safeguard documents had expired three days earlier. We raised this with staff at the time of our inspection.
- 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.
- DNACPR forms were clearly visible and stored in the front of the medical notes.
- Staff recorded the DNACPR status of patients on the staff handover form and were able to identify patients subject to a DNACPR order.
- Mental Capacity Act and deprivation of liberty safeguards documentation was audited monthly. It had been identified that improvements were needed and staff on the ward were being supported by the safeguarding team with the completion of documentation and review of patients. There was bespoke training with real life examples being provided. We were told that deprivation of liberty safeguard applications being sent to the local authority had increased as a result.
- Matron audits of mental capacity and deprivation of liberty safeguards documentation covering wards C, 11, 23, 24, 25 and 26, demonstrated compliance across all wards in January 2021.
- The trust provided figures which demonstrated that as of 31 December 2020, 78.53% of staff across the trust had received training in the Mental Capacity Act.
- Staff we spoke with had attended mandatory training for Mental Capacity Act and deprivation of liberty safeguards training, and understood capacity was decision and time specific. They also understood that it was everyone's responsibility to assess capacity.

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Arrangements to admit, treat and discharge patients were not always in line with national standards and flow through the hospital was a challenge.

- Patients accessed the service from various routes, such as the accident and emergency department, referral from their GP and sometimes following outpatient appointments. All patients admitted through the accident and emergency department who required inpatient care, were admitted through the acute medical unit and the ambulatory care unit. Patients were not routinely admitted directly to inpatient medical wards.
- The hospital had an acute medical assessment unit. The unit was open 24 hours a day, seven days a week and had access to medical cover. The assessment unit allowed patients to be streamed quickly from the emergency department and helped reduce hospital admissions.

Medical care (including older people's care)

- During our inspection we saw the assessment units were well supported by therapists and specialist support teams. The units had access to a dispensing pharmacist as well as rapid access therapists. The quick response to meet patient needs helped to support flow throughout the hospital.
- We were advised that due to access and flow pressures, it was not always possible for patients to be matched to speciality wards. For example, some patients admitted with respiratory conditions were cared for on wards other than the respiratory wards and some medical patients were placed on non-medical wards such as surgical wards. This was due to pressures for medical beds, these patients were referred to as 'outliers'. We were advised it was very unlikely that these patients would be repatriated to more suitable beds due to the ongoing pressures within the hospital.
- We reviewed the bed capacity list on the day of inspection on the Acute Medical Unit (AMU) which evidenced that 21 out of 35 patients had been admitted and cared for on the acute medical unit between two to three days. Staff told us that hospital capacity was stretched due to the current pandemic which impacted on bed availability. Patients who had a length of stay of seven days or more were referred to as "stranded" patients. Stranded patients were reviewed regularly to assess the potential to transfer to specialty wards so that beds could be made available for emergency admissions to the unit.
- Bed meetings were held four times per day. We observed a teleconference trust bed meeting which covered aspects surrounding, review of actions from the previous day, updates for all speciality areas, patient flow within the trust, bed capacity position, emergency department position, update from the discharge team, community beds update, infection control update relevant to patient flow within the hospital and an ambulance update.
- The trust used a business intelligence tool which tracked medical patients who were being cared for on wards which were not the speciality they required. 'Outlier' lists were generated daily, which identified where patients were, when the patient had last received a consultant review and a summary of their care plan. The 'manager of the day' had oversight of the medical allocation for these patients between the specialities. There were two medical escalation teams (dependent on staffing) who supported the review of these patients.
- Medical staff on each ward looked after the medical outliers with input from the specialist medical team concerned. They could track patients using the trust's electronic patient record system. Staff we spoke with on the stroke unit reported concerns about the number of medical outliers on the unit, they felt it impacted on patient safety and outcomes. We saw that an incident had been reported in September 2020 where an urgent stroke patient had a delayed admission of eight hours and 45 minutes to the unit, from the emergency department, due to the availability of a bed. The incident was graded as low harm.
- There were two winter escalation wards in use, which we were told had been open for two years. Staffing was provided by a substantive nursing team and supported by the medical escalation team.
- The senior leadership team told us the biggest challenges to discharging patients were those who had tested positive for COVID-19 and required ongoing care in a nursing home. There was difficulty in accessing providers who could accept these patients. The service utilised the Clifton Hospital site for some of these patients, however there was only access to two wards which we were told was a challenge.
- There were designated beds available in the local area which were identified to take COVID-19 positive patients requiring step down care. However, we were told due to the acuity of the patients, the beds were not always suitable, particularly those where accommodation was provided in side rooms. Therefore, these beds in the local area, could not be utilised.
- Staff told us there were twice daily board rounds attended by the nursing and medical teams. The second board round focussed on patient discharge. We were told that discharge planning started from the point of admission.

- Delayed discharges were escalated to the ward manager and then to the matron in the morning staffing meetings; these were then raised with the bed management team.
- We were told that out-of-hours discharges only occurred for those that had been planned.
- At the time of our inspection, we were told that there were five delayed transfers of care across the service.
- We reviewed daily discharge data and found that overall, from 1 November 2020 to 10 February 2021, of the patients who were medically unfit for discharge, 4.9% had stays of 21 days or longer. Of the patients who were medically fit for discharge, 39.3% had stays of 21 days or longer. The percentage of patients who were medically unfit for discharge had been a consistent level of around 5% from November 2020 to February 2021. The percentage of patients who were fit for discharge fluctuated between 31% and 48%. There was a trend where the percentage of patients increased towards the end of each month, before declining through the first couple of weeks of the month.
- There had been 14 incidents reported relating to discharges for medical specialities between September and November 2020. Four of the incidents reported issues with missed referrals for ongoing care and treatment, these were categorised as low harm incidents.
- There were a number of incidents relating to patients, where concerns had been raised about discharges. These related to discharges from the hospital between January 2020 and December 2020. Examples included, discharge information and medication not being sent with patients; information on wounds or pressure area damage not being accurate or shared with relevant services and COVID-19 guidance not always being followed when patients were discharged.
- Further information related to these incidents was requested and provided by the trust when we were made aware of them. The trust shared actions which had been put in place in response to the incidents.
- Staff had access to teams who provided support for discharging patients, there was the ‘hospital discharge team’, the ‘single point of discharge team’ and the ‘patient first team’ who were community based.
- Staff utilised the single point of discharge team to support complex discharges. We were told that prior to the COVID-19 pandemic, the team would regularly attend the board rounds. Currently they had access to the team via telephone and a bleep system, and they described the team as supportive.
- There was mixed feedback about the effectiveness of the hospital discharge team, we were told that communication with the team was limited and there was poor visibility on the wards and at board rounds. The senior leadership team told us that there was work ongoing to improve the structure and functions of the teams and to improve discharge pathways.
- By being close to the ward areas, the dedicated pharmacy discharge team supported improved discharge times through their involvement in writing-up and dispensing take home medicines for the acute medical unit and care of the older person services.

Outstanding practice

- 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.

Medical care (including older people's care)

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must ensure that patient records are complete, legible and kept securely at all times, so that they are up to date, clear and only accessed by those authorised to do so. (Regulation 17 (1) (2) c)
- The trust must ensure that medical staffing is sufficient to meet the needs of patients and ensure actual staffing meets with or is close to the planned numbers. They should continue work to improve the recruitment and retention of medical staffing to reduce vacancies. (Regulation 18 (1))
- The trust must continue to progress and implement improvement work in relation to the timely administration of antimicrobials in line with how they are prescribed and increase the awareness of antimicrobial stewardship. (Regulation 12 (1) (2) b)
- The trust must make sure that when a patient is unable to consent to their care and treatment staff follow trust policy and the requirements of the Mental Capacity Act 2005. Patients and/ or their families should be involved in decisions made about their care and treatment. (Regulation 11 (1))
- The trust must continue to progress work and focus on making improvements to flow through the hospital, so that patients receive appropriate care and treatment in the right place when they need it and that discharges happen safely in line with national standards. (Regulation 12 (1) (2) a i)

Action the service SHOULD take to improve:

- The service should consider a review of the signage on wards in relation to COVID-19 so that it is clear to staff, patients and visitors where there are patients who have tested positive or those who are isolating for COVID-19. Where wards had a mix of negative and contact patients the signage for the segregation of facilities should be reviewed so that it is clear to patients to prevent any potential transmission of the virus. (Regulation 12)
- The service should continue to review nurse staffing to ensure that it is in line with national guidance, meets the needs of the patients and keeps them safe from avoidable harm. (Regulation 18)

Our inspection team

The team comprised of five inspectors, two pharmacist specialist inspectors and three specialist advisors. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

6 May 2021

Quality Improvement Strategy Report

Author of Report:	Katharine Goldthorpe - Associate Director of Quality Improvement Paryaneh Rostami - Senior Quality Improvement Manager / Patient Safety Specialist
Executive Director Sponsor:	Peter Murphy, Director of Nursing, AHP & Quality
Date of Report:	26 April 2021

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

This report focuses on our Trust's patient safety culture measurement plan, as well as providing brief updates on the progress of each Quality Improvement (QI) programme outlined in the Trust's QI Strategy (2019-22).

Patient Safety Improvement Strategy – Part 1 of this report provides a summary of the Patient Safety Improvement strategy and the four "patient safety pillars" to ensure the Trust has strong foundations for good patient safety; insight, involvement, improvement and inspiration.

As with any improvement work, one of our initial priorities is to have the correct measurement systems, as without measurement it is impossible to know whether improvement is occurring. Therefore, this report, outlines our patient safety culture measurement plan, which is a key indicator of whether patient safety overall is improving. The report outlines the suitability of different safety culture surveys and recommends the US Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture as most suitable. Furthermore, this initial review highlighted that whilst safety culture surveys are vital for obtaining an understanding of our Trust's patient safety culture and our trajectory of improvement over time, it is also important to have a second step with a framework that helps us to focus on the results of the survey to get a more in-depth understanding of areas for improvement.

Pressure Ulcer Collaborative – Phase II teams are now in Action Period 3 and continue to test ideas and some are moving towards a statistically significant change. Learning Session 3 took place on 1st of April.

Deteriorating Patient Collaborative – Teams met for Learning Session 2 on 15 April and are now in Action Period 2 and all teams have had access to improvement coaching and subject specific masterclass training.

Improve the Last 1000 Days Collaborative – Work continues with the expert faculty each week to ensure the focus of this work is correct and will be reported to the Quality and Effectiveness Committee as this develops.

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

Recommendations:
The Board of Directors is 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		

Board of Directors Meeting

6 May 2021

Quality Improvement Strategy Update

1. PURPOSE

This report's purpose is to provide assurance to Public 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 outline plans for the next phase of work.

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. This report focuses on the Trust's proposed safety culture measurement plan (Part 1) and provides brief updates for each QI programme (Part 2).

Part 1:

3. SAFETY CULTURE MEASUREMENT: PROPOSED PLAN

In line with the national NHS Patient Safety Strategy [2] and the Trust's local Patient Safety Strategy, plans have been developed to understand the current Safety Culture and to monitor improvement over time. One of the main values of doing this, will simply be that it will raise the profile of patient safety and promote related conversations, which can help improve safety culture [3]. Therefore, the exact tool used may be less important than how it is implemented and how feedback is collated and used [4]. However, it is important that the measurement approach works for all of the Trust, including both acute and community divisions and for the wider Integrated Care Partnership (ICP), as it is likely the measurement approach will be extended for our partners to use also.

The following sections will; describe how safety culture measurement fits within the wider patient safety strategy (Section 3.1), define safety culture within this context (Section 3.2), review the most widely used safety culture surveys and tools (Section 3.3), provide recommendations for a safety culture measurement plan (Section 3.4), and finally outline well the next steps for testing and implementing the recommended safety culture survey (Section 3.5).

3.1 The Patient Safety Strategy

3.1.1 Executive Sponsor: Joint sponsors Director of Nursing, AHP and Quality and Medical Director

3.1.2 Background of the patient safety strategy

The NHS' Patient Safety Strategy [2] highlighted that good patient safety within organisations requires building; a strong patient safety culture foundation and a strong patient safety system foundation, which involves focussing on three strategic aims:

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (*Insight*).
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (*Involvement*).
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (*Improvement*).

3.1.3 Overall aims of BTHFT's Safety Strategy

The aforementioned national NHS strategy emphasised that the improving patient safety within organisations is not a "one size fits all" approach, and that the national strategy should only be used as guide. Building on this information and the aforementioned national aims, BTHFT's local Patient Safety Strategy has been divided into four areas, each with a specific aim. The four areas, described as "Patient Safety Pillars" are summarised in Table 1. The first three Patient Safety Pillars align with the national aims, the fourth, "inspiration", has been developed locally.

The Inspiration Patient Safety Pillar aim was developed to address the fact that BTHFT has more room for improvement than other organisations in some areas of patient safety, for example, pressure ulcers. Furthermore, local data and anecdotal feedback has highlighted that there are "pockets of excellence" within the Trust. The Inspiration Patient Safety Pillar focuses on learning about the best patient safety practices, both internally within the organisation and externally.

Table 1 – Blackpool Teaching Hospitals Foundation Trust's (BTHFT) Patient Safety Pillars

BTHFT's Patient Safety Pillars	**Aim**	**Potential national & local activities/initiatives**
1.Insight	Improving understanding of safety by drawing intelligence from multiple sources of patient safety information	- Safety Culture Survey - Safety Measurement Dashboard *(The Blackpool Safety Barometer)* - Digital technologies - New Safety Learning System - Patient Safety Incident Response Framework
2.Involvement	Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system	- Patient Safety Specialists - The Safety Movement Group - Patient Safety Partners
3.Improvement	Designing and supporting programmes that deliver effective and sustainable change in the most important areas	- QI Strategy - Patient Safety Syllabus - National Patient Safety Improvement Programme - Maternity and Neonatal Safety Improvement Programme - Medicines Safety Improvement Programme - Mental Health Safety Improvement Programme
4.Inspiration	Sharing knowledge, celebrating success & learning from the best.	- Learning from Excellence - Masterclasses - Partnerships - Networks

The specific aims and programme theory for each Patient Safety Pillar will be developed over time with the Safety Movement Group, who act as the expert faculty for this programme of work. The four Patient Safety Pillars work together to uphold and sustain the strong aforementioned foundations that are needed to ensure patient safety. For example, in order to evaluate the whether the aims of the Patient Safety Pillars are being achieved (improvement), it is vital to identify a plan for measuring safety culture (insight) because without measurement it is impossible to know whether safety is improving and what the priorities for improvement of safety are.

As measurement is one of the first priorities, this report will focus on the Insight Patient Safety Pillar. More specifically, it will look at a plan to measure and understand BTHFT's safety culture and improvement over time.

3.2 Safety Culture

Safety culture refers how patient safety is thought about and implemented within an organisation and the structures and processes in place to support a safe an organisation to become a safer health system [5]. Safety improvement requires that healthcare systems have ready access to information that supports learning from experience in order to promote systems that both prevent errors and mitigate the impact of errors that occur [6]. Having a good safety culture is of paramount importance and without a good safety culture, it is unlikely that

improvements will be sustained [7]. In order to know whether the trust is becoming a safer health system, safety culture must be measured.

3.3 Safety Culture Measurement Surveys and Frameworks

Measuring safety culture is important because the culture of an organisation and the attitudes its teams have, have been found to influence patient safety outcomes and these measures can be used to monitor change over time [8]. Assessing safety culture allows organisations to gain a basic understanding of the safety related perceptions and attitudes of its managers and staff.

Safety culture measures can be used as diagnostic tools to identify areas for improvement. As there are many potential starting points for improvement efforts, a safety culture assessment can help an organization to identify areas that are considered more problematic than others. Cultural issues that are identified as problematic can provide material for further analysis of underlying “root causes” and for generating improvement ideas from staff directly involved in the issues.

An important characteristic of safety culture assessment tools is whether they take a managerial or staff perspective, or combine elements of both. Some tools allow responses to be broken down according to the various staff groups who have responded. This allows collected data to be used to pin-point issues faced by particular staff groups. As most tools collect non-identifiable, anonymous data, this can be particularly useful for staff groups who feel less comfortable to raise concerns, for example, trainee staff.

3.3.1 Initial Assessment

3.3.1.1 Literature Review

An initial assessment highlighted that there are multiple safety culture survey instruments used within healthcare settings [8]. Those with the largest quantity of empirical evidence about their use have been summarised in Table 2, which also highlights the facilitators and barriers towards using each tool within the Trust. When considering the barriers and facilitators for each tool, the long-term plan for use of the tool has been considered. The long-term plan, in terms of using the tool across different settings includes being able to use the tools across all settings in the wider Integrated Care Partnership (ICP), including general practice, pharmacy, dentistry etc. This has started to be discussed with our colleagues from the Clinical Commissioning Group as the Trust moves towards working more closely as an ICP to help our patients to receive more continuous care [9].

Table 2. – Properties of most commonly used & rigorously tested safety culture measurement tools

Name of tool	Description of tool	Facilitators for using at BTHFT	Barriers to using at BTHFT
US Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture [10]	This tool was developed for hospitals, nursing homes and primary care. The main tool tested to date is the Hospital Survey on Patient Safety Culture (HSOPSC) which has 12 safety culture dimensions and 42 items.	• This is one of the most widely used surveys globally. • It has used to make comparisons between different industries and countries suggesting external reliability. • It has been used to collect data from a wide multi-disciplinary range of staff. • It has been extensively evaluated independently & evaluations have found that most items have acceptable psychometric properties. • It has been greatly improved over time and version 2.0 was released in 2019. • The tool assesses safety culture at the individual, unit and organisational levels. • The trust has access to extensive support to implement this as AQuA have a license for the tool. • Possibility to slightly adapt for community use. • Can be done on an app or paper and less time-consuming than tools that need a discussion facilitator.	• Some evaluations have suggested that some items included in the tool are valid, reliable and generalizable [8]. • Evaluations have concluded that the survey's items and dimensions overall are psychometrically sound at the individual, unit, and hospital levels of analysis but that further work is needed in some areas– however the tool has been improved since these evaluations were published. • The Survey can help to point out differences in attitudes between groups but does not explore why this is - it is not in-depth enough to really understand the issues causing problems in different areas of patient safety culture.
Safety Attitudes Questionnaire [11]	This was derived from the Flight Management Attitude Questionnaire & focuses on safety climate and asks healthcare teams to describe their attitudes to six domains, using a Likert scale to score.	• The tool has been adapted for use in many settings including medical & surgical wards, Intensive Care units, ambulatory clinics/primary care and nursing homes. • One of the most commonly used and rigorously validated tools for measuring safety climate in healthcare. • Higher scores on this survey have been associated with positive patient and staff outcome data [12]. • Allows comparisons between industries as well as identification of common human factors issues. • It can also be used to compare the attitudes of different types of staff within healthcare • It is relatively short and quick to complete.	• Focuses on Safety climate as a subset of safety culture. • Has not been implemented extensively in the UK. • Has been found to have modest response rates. On average about half of staff respond to the survey. • The Survey can help to point out differences in attitudes between groups but does not explore why this is.
Safety Climate Survey [13]	Developed by academics to measure the attitudes & perceptions of frontline staff regarding safety structures & processes.	• It can also differentiate the views of various types of staff. • It has been compared with other scales and found to have good reliability and validity. • It also tends to have quite high response rates. • Was endorsed by the Institute for Healthcare Improvement	• This tool was developed some time ago and may not include all the factors and features of newer tools. • It has largely been tested in North America so its transferability to other environments is uncertain. • No longer freely available online – difficult to get hold of.
Patient Safety Climate in Healthcare Organisations [14]	This survey was developed by academics & was sponsored by the US Agency for Healthcare. The tool drew from five existing survey instruments. Items from each were reviewed and	• The tool has been used in many countries. • Was one of the first tools developed that aimed to measure safety climate among all hospital personnel and across multiple hospitals of different types. • The development drew on lessons learned from tools	• Focuses on Safety Climate as a subset of Safety Culture. • Has mainly been used in the US. • The response rate has been found to be average, with around half of invited staff completing the tool.

	modified for application to hospitals. Additional questions were generated where gaps were apparent.	used in other industries. • Structured into 9 constructs -38 items spread over nine constructs, three organisational factors, two unit factors, three individual factors and one additional factor.	
Manchester Patient Safety Assessment Framework [15]	This tool helps NHS & healthcare teams assess their progress in the tool lists five levels of increasingly mature organisational safety culture across various domains. It is based on a theoretical framework and defines safety culture according to 10 dimensions.	• Can be used to get in-depth understanding about Safety Culture. • The tool is evidence-based and was developed from literature reviews & expert input and was promoted by the National Patient Safety Agency. • The tool is freely available. • Has been used by ambulance service, mental health organisations, community pharmacies and hospitals. • Can be applied at an organisational or team level. • It is more in-depth than the safety culture surveys. • It can be used to help teams reflect on safety culture, reveal any differences in perception between staff groups, help understand what a more mature safety culture might look like and help monitor changes over time and the benefits of specific interventions.30 Another strength is that it is one of the few tools that focuses on safety culture in its broad form and it also examines organisational maturity, thus signposting organisations and teams to areas for improvement. Has been adapted for various settings such as pharmacy, general practice etc. • The trust has support for using this via academic links with the University of Manchester.	• The tool has largely been used in the UK although some validation has taken place in North America. • Although the tool is purportedly used widely, little has been published about its use. Most organisations that use it have not published the results. • Could be adapted for social care, for example was used across various settings for Safer Salford [16]. • Requires facilitators to use - time consuming and labour intensive. • Difficult to use for measuring improvement over time.
NHS Education for Scotland Safety Discussion cards [17]	These cards are an adapted version of Eurocontrol safety discussion cards and were developed by healthcare professionals, academics and Eurocontrol and focus on different culture elements. Each card introduces a different issue for reflection or discussion by the Team.	• Can be used to get in-depth understanding about Safety Culture. • Compact set of cards, easy to use. • Cards are there to build on what you know already about safety culture and open up discussions within your teams. And could be used to build on what the survey finds. Has been used by mental health organisations, community pharmacies and hospital and social care. • Potential to arrange training sessions with developers via Q community. • Our contacts at AQuA have also worked with Leads from NHS Scotland so could AQuA could possibly support us with this.	• Newer tool so has not been widely evaluated independently. • Has mainly been used in Scotland. • Requires facilitators to use – time consuming and labour intensive. • Difficult to use for measuring improvement over time.

3.4 Recommended tools to monitor Safety Culture over time
Based on the review in Section 3.3, learning from Safety Culture events and discussions with experts, it is recommended that the Trust takes a two-pronged approach to monitoring safety culture. This is because evaluations of the safety culture and climate surveys have highlighted that often data is collected and findings are not actioned. Therefore it is important that our plan goes one step further than just measuring safety culture and not actioning what the measurements are telling us. The two steps of the plan should be to:

- Firstly, the figures (quantitative data) are needed to understand what the Trust is doing well in terms of patient safety culture and where improvements are required. This will be collected using a safety culture survey. For instance, the tool can identify differences in the perceptions or nurses and doctors or between clinicians and managers, but does not explore why these differences may exist or how to alleviate them.
- Secondly, as the figures only tell us which area of safety culture are good or bad, further exploration and collection of qualitative data (i.e. case studies, interviews and appreciative enquiry) are required to get an in-depth understanding of why the different areas of safety culture are good or bad. This will allow us to understand how we can learn from and spread positive practices and to improve negative practices.

As the quantitative data will inform the priority areas for the collection of qualitative data, the safety culture survey will be implemented first. Considering the facilitators and barriers listed in Table 2, the survey that would be most suitable for the trust to test is the AHRQ Safety Culture Survey (see Appendix A for questions listed in survey).The main reasons for recommending the use of this Survey this are that:

- It focuses on safety culture as a whole, unlike the tools that focus on safety climate only (as a subset of safety culture).
- It has been evaluated, validated and continuously been developed since the first version.
- It has been used by other organisations in the North West who recommend it.
- It has been used within a range of healthcare settings and there may room for slight adaptation if needed.
- It is free for us to use via our AQuA membership and AQuA have agreed to help us use this tool on a three monthly basis.

The main barrier for use of the AHRQ survey was that it does not allow a more in-depth understanding of what we are doing well and provide ideas for tackling priority areas of improvement. This is compared to the Manchester Patient Safety Framework (MaPSaf) and Safety Discussion Cards as these help to facilitate structured discussions with frontline staff to gain this more in-depth information. To overcome this barrier, it is proposed that one of these tools is also used to help with the second step involving qualitative data collection. However, as the collection of qualitative data is far more time and resource intensive and requires a facilitator this may be done on a less frequent basis


Image 1 – Safety Discussion Cards

For collecting the qualitative data it is recommended that we use the Safety Discussion Cards (see Image 1), this is because:

- A concise and generalizable set of cards, easily accessible and understandable by all.
- They have been tested in a range of settings, including community, acute, general practice and pharmacies.
- We have access to support for use via the Q Community (which is a network for improvers managed by the Health Foundation).

3.5 The next steps for testing the tools
The next steps focus on implementing the Safety Culture Survey, once Safety Culture Survey data are collected, they will be used to plan how the Safety Discussion Cards should be used.

3.5.1 Training
The Trust has access to AHRQ Safety Culture Survey training. This has been attended by the patient safety specialist. It is advisable for those leading the implementation of the Safety Culture Survey in different Divisions to also attend this training. This we will be encouraged via the Safety Movement Group.

3.5.2 When will Survey be tested?
We plan to test use of the Survey in May and will give teams a 3 week period to complete the form, based on recommendations from AQuA.

3.5.3 Who will the Survey be tested with?

Discussions are currently taking place to identify a suitable department for testing the safety measurement plan. The Patient Safety Specialist is attending departmental meetings to discuss this further. AQuA have advised that to get the most out of this survey a minimum of 300 responses from a range of healthcare professionals are required, and therefore a department with a large and varied staff group should be the first place we test the tool on. The staff groups will be divided into the groups listed in Table 3, these groups are based on recommendations from AQuA and conversations with a range of colleagues from within the trust including representatives from Medical, Nursing, AHP, Pharmacy, Clinical Governance and Organisational Development teams.

3.5.4 How will data be collected

Safety Culture Data will be collected over a 3 week period every 3 months. This has been provisionally agreed with AQuA who have formulated the survey into an online form. The QI Hub and Communication team will work with AQuA to send the survey on a three monthly basis. The survey will be shared using a platform called Smart Survey which we have been assured is suitable for use within the NHS. AQuA will also collate the data and present it in a report for us. To encourage engagement from staff, incentives for engagement will include a prize draw for those who enter the survey for book tokens or charity donations, as has been discussed with members of the executive team.

3.5.5 Evaluation of use

Use of the survey will be constantly evaluated by gaining feedback through short semi-structured interviews with purposely sampled staff. This will be face-to-face or via phone/teams and this will be done with representatives from the various staff groups. Areas of focus for the evaluation will focus on the four constructs of the Normalisation Process Theory [18]. This widely research and used implementation theory describes the four themes that are required to help normalise tools into practice successfully, these are:

- *Coherence* - understanding of the tools.
- *Cognitive Participation* - engagement with the tools.
- *Collective Action* - how the tools are being scaled-up in different areas.
- *Reflexive Monitoring - w*hether use of the tool and its data is being reviewed.

3.5.6 How will data be used?

The data collected using the safety culture survey will be triangulated with other data to get an in-depth understanding of the safety culture within BTHFT and associated improvement over time. The safety culture survey will be part of a dashboard called the Blackpool Safety Barometer, mentioned previously. The data from the safety culture survey, will be used alongside other data from the Barometer, to recognise and spread good practice, identify areas that require improvement, and to open up conversations about safety culture using the Safety Discussion Cards.

*Table 3 – Staff group categories for organising survey responses**	
Category	**Sub-category****
Medical team	Consultants
	Registrar level doctors
	Speciality & Associates
	Overseas locally employed Drs
	Junior doctors in HEE recognised programmes
	Student Doctors
Nursing team	Senior Nurses
	Registered Nurses
	Trainee Nurses
Healthcare Assistants	Healthcare assistant
Pharmacy	Pharmacists
	Pharmacy Technicians
	Dispensers
	Pre-registration Pharmacists
	Pharmacy students
Physicians Associates	Physicians Associates
Patient Safety Team/ Support workers	Patient Safety Team member
	Dedicated Support worker
Allied Healthcare Professionals	Physiotherapists
	Occupational Therapists
	Path Lab
	Technical
Corporate	Risk
	Quality Improvement
	Clinical Audit
Administrative	Secretary
	Receptionist
	Ward Clerk
*(All groups include Locum and Agency staff) **Sub-categories may be merged over time but we have been advised to separate them out and then merge if needed as this is more achievable.	

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Part 2:

4. PROGRAMME DELIVERY

4.1 Reduce Avoidable Harm – Eliminating Pressure Ulcers

4.1.1 Executive Sponsor: Director of Nursing, AHP and Quality

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

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

4.1.3 Assessment – Phase I

Phase I progress is provided in Appendix B and the aim has been extended to 31st May for these teams. Phase I have "held the gains" since last reported. The teams are still working on improvement efforts and continue to receive weekly data and support from their improvement coach. An event is planned for May to bring the Phase I teams back together to ensure they continue to improve (to eliminate harm) and offer support to sustain improvement.

4.1.4 Assessment – Phase II

Phase II commenced 14th January 2021. The 10 Phase II teams, that have joined the collaborative, are the teams with the next highest prevalence of pressure ulcers after the Phase I teams, therefore, the data below shows that the hospital teams have a lower starting point than the first phase. Learning Session 3 took place on April 1st for Phase II teams, this was attended by representatives from each team. The session was supported by Executive Sponsor and focused on sharing knowledge, revisiting PDSA cycles and testing it was an opportunity for teams to present their change ideas. Half of the teams are now achieving a statistical significant improvement the remaining 5 teams are either nearly achieving or starting to move towards a statistically significant improvement. The Pressure ulcer summit is scheduled for the 13th May. In the meantime, further work will be undertaken to address attribution of pressure ulcers in the community setting.

4.1.5 Phase II Data

The charts below show the patients in both the acute and community are still experiencing pressure ulcers. Progress will be monitored against the aims as described above (*4.1.2) The teams are yet to achieve a statistically significant improvement but are approaching their work in the right way, undertaking multiple tests of change.*

Figure1 – Hospital Acquired Category 2-4 Pressure Ulcers in Phase II Collaborative areas

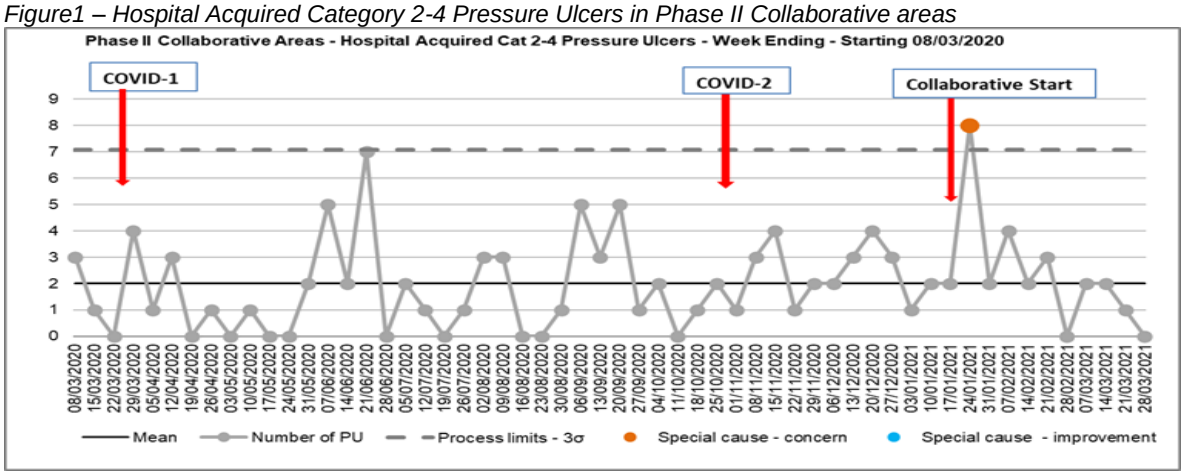
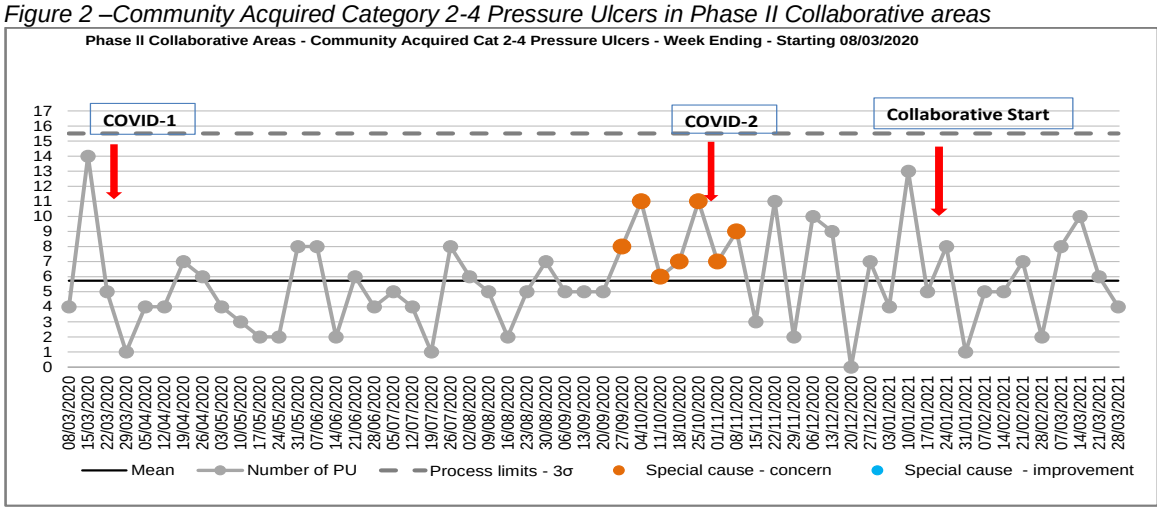


Figure 2 –Community Acquired Category 2-4 Pressure Ulcers in Phase II Collaborative areas



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

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

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

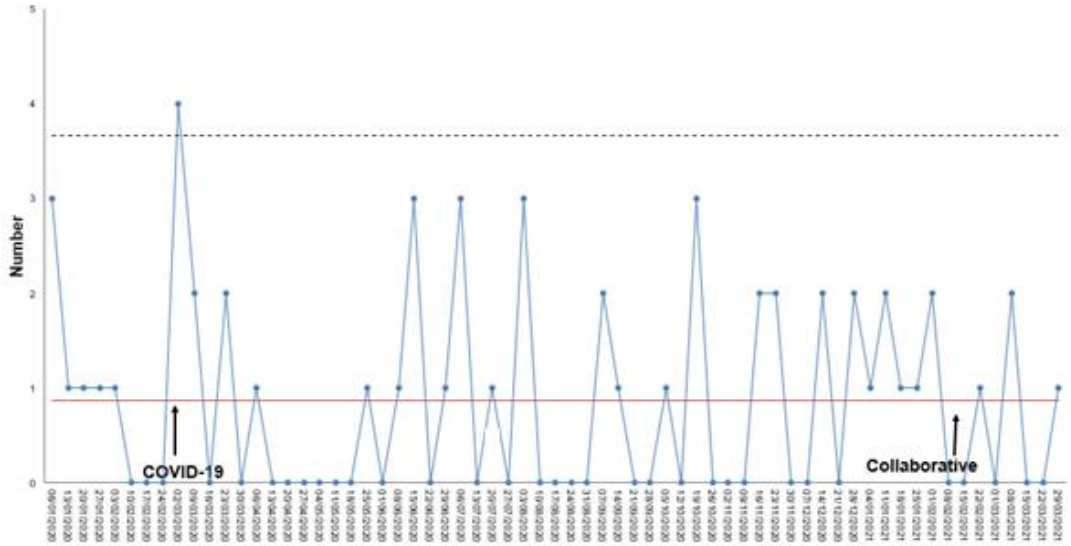
4.2.3 Assessment

The second learning session was held on 15th April 2021, with 42 attendees, from 9 teams including Acute Medical unit (AMU), Ward 37, Physiotherapy team, Clifton Ward 3, Ward 14, Speech & Language Therapy/Dietetic team, Ward 12, Ward 23, Ward 11 and presenters. The collaborative teams presented their understanding of root causes and improvement work undertaken to date. The teams have accessed improvement coaching and subject specific masterclasses during the action period.

4.2.4 Data

The data shows the number of weekly cardiac arrests where a 2222 call was activated on the acute site inpatient collaborative areas.

Figure 3 - 2222 activated Cardiac Arrests VS933 completed. Collaborative acute inpatient areas (Weekly data from 06/01/20 – 04/04/21)



4.3 Improve the Last 1,000 days of life

4.3.1 Executive Sponsor: Director of Nursing, AHP and Quality

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

4.3.3 Assessment (planning phase)
The aspiration of this programme is to give our patients back the gift of time and to ensure patients to live as well as possible until they are dying, and then allowing patients to die with dignity. This will be achieved by working with our patients, system partners and the community to improve services and enable patients to be in the place they love, longer. Work continues with the expert faculty each week to ensure the focus of this work is correct and will be reported to Quality and Effectiveness Committee as this develops.

5. Risks

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

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

6. Financial and Legal Implications

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

6.2 Legal Implications
There are no legal implications

7. Recommendations

The Board of Directors is asked to consider the matters raised in this report for information and to support commencement of the safety culture insight proposals.

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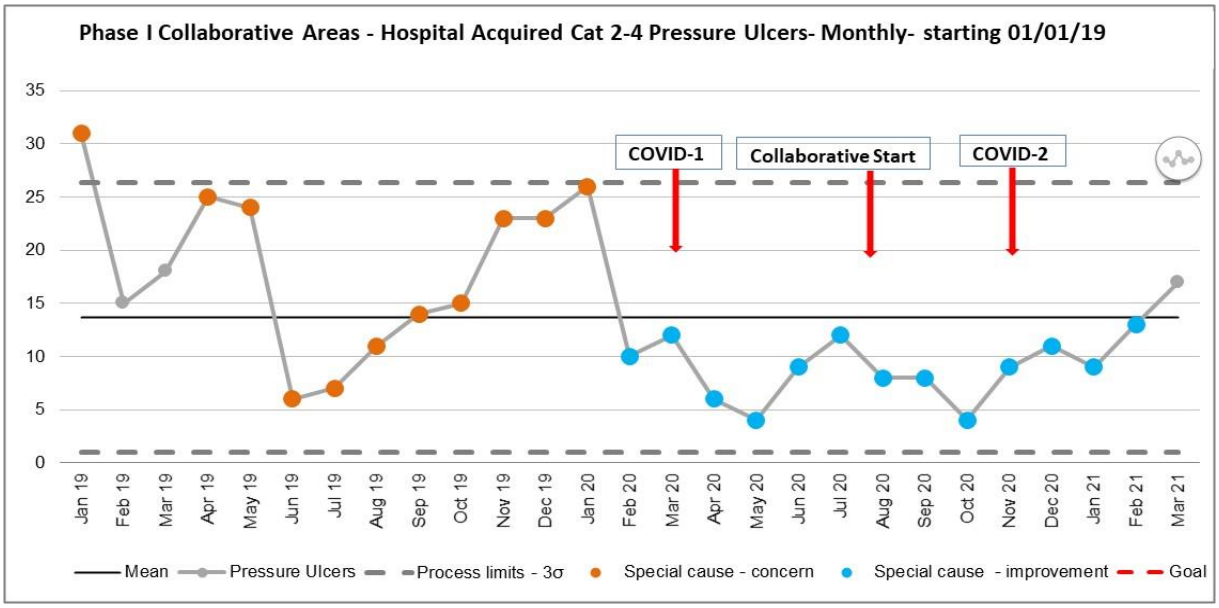
Appendix A – AHRQ Safety Culture Survey Measures & Questions

Code	Measure	Questions
IIA	Frequency of Event Reporting	• When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? • When a mistake is made, but has no potential to harm the patient, how often is this reported? • When a mistake is made that could harm the patient, but does not, how often is this reported?
IIB	Overall Perceptions of Safety	• Patient safety is never sacrificed to get more work done • Our procedures and systems are good at preventing errors from happening • It is just by chance that more serious mistakes don't happen around here • We have patient safety problems in this department
IIIA	Supervisor/manager expectations & actions promoting safety	• My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures • My supervisor/manager seriously considers staff suggestions for improving patient safety • Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts • My supervisor/manager overlooks patient safety problems that happen over and over
IIIB	Organisational Learning—Continuous improvement	• We are actively doing things to improve patient safety • Mistakes have led to positive changes here • After we make changes to improve patient safety, we evaluate their effectiveness
IIIC	Teamwork Within Organisational Units	• People support one another in this department • When a lot of work needs to be done quickly, we work together as a team to get the work done • In this department, people treat each other with respect • When one area in this department gets really busy, others help out
IIID	Communication Openness	• Staff will freely speak up if they see something that may negatively affect patient care • Staff feel free to question the decisions or actions of those with more authority • Staff are afraid to ask questions when something does not seem right
IIIE	Feedback and Communication About Error	• We are given feedback about changes put into place based on incident reports • We are informed about errors that happen in this department

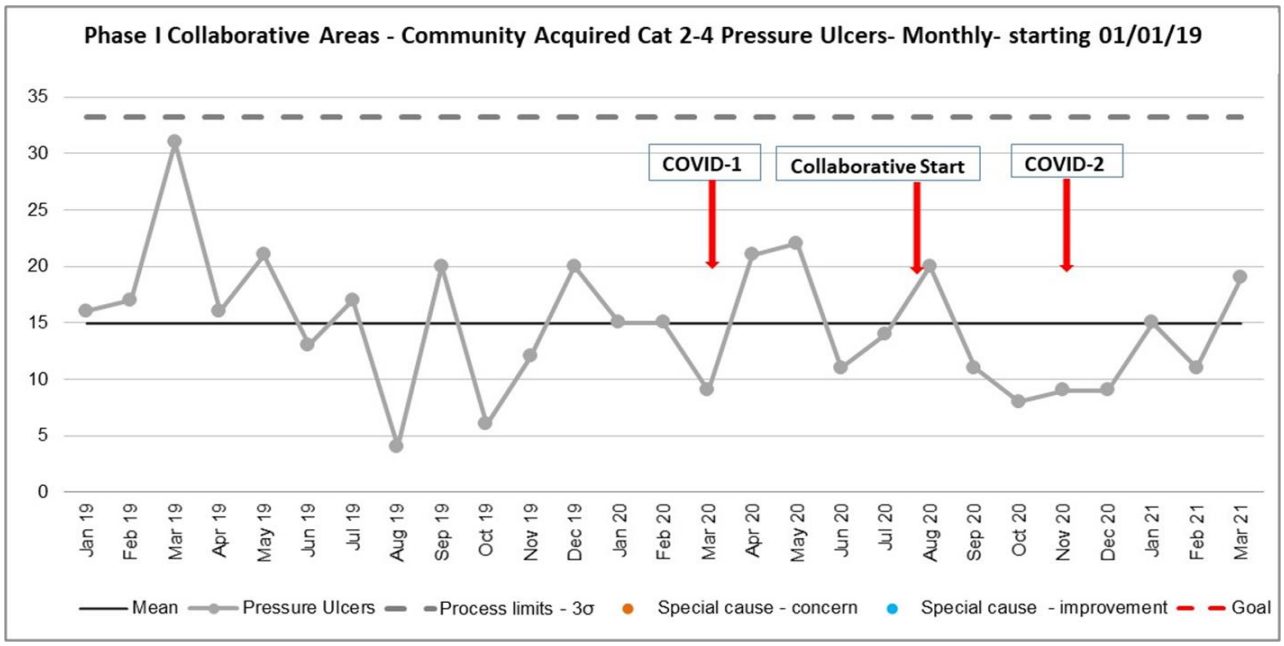
		• In this department, we discuss ways to prevent errors from happening again
IIIF	Nonpunitive Response To Error	• Staff feel like their mistakes are held against them • When an event is reported, it feels like the person is being written up, not the problem • Staff worry that mistakes they make are kept in their personnel file
IIIG	Staffing	• We have enough staff to handle the workload • Staff in this department work longer hours than is best for patient care • We use more agency/temporary staff than is best for patient care • We work in "crisis mode" trying to do too much, too quickly
IIIH	Organisational Management Support for Patient Safety	• Management in this organisation provides a work climate that promotes patient safety • The actions of management in this organisation show that patient safety is a top priority • Management in this organisation seems interested in patient safety only after an adverse event happens
IVA	Teamwork Across Organisational Units	• There is good cooperation among departments that need to work together • Departments in this organisation work well together to provide the best care for patients • Departments in this organisation do not coordinate well with each other • It is often unpleasant to work with staff from other departments in this organisation
IVB	Organisational Handoffs & Transitions	• Things “fall between the cracks” when transferring patients from one department to another • Important patient care information is often lost during shift changes • Problems often occur in the exchange of information across departments in this organisation • Shift changes are problematic for patients in this organisation

Appendix B - Eliminating Pressure Ulcer data for Phase 1 Teams

Aim: achieve a 50% reduction category 2 hospital acquired pressure ulcers- monthly: Continuous improvement efforts are needed to further eliminate pressure ulcers. A Phase 1 suststaining improvement learning session has been arranged for the 11th of May 2021. This is an opportunity for Phase 1 teams to come together and present lightening talks to highlight their success and challenges in a group setting, this will be supported by Executive Sponsors.



Aim: achieve a 50% reduction in community acquired pressure ulcers further improvement efforts are required to achieve a sustained change for these teams.



Aim: to achieve 80% reduction in Category 3 and 4 hospital acquired pressure ulcers: Since the collaborative started, there has been one hospital category 3 pressure ulcer recorded in August, and a Community acquired category 4 pressure ulcer recorded in January 2021 which is under investigation.

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

Board of Directors Meeting

6 May 2021

Ockenden Report Update

Author of Report:	Nicola Parry, Divisional Director of Nursing / Head of Midwifery
Executive Director Sponsor:	Peter Murphy, Executive Director of Nursing, Allied Health Professionals and Quality
Date of Report:	29/04/21

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

To give an update of the current position against the implementation of the Ockenden Report and provide assurance of effective implementation to the Board.

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

Recommendations:

The Trust Board is asked to take note of this update and approve that all serious incidents are to be shared with Trust boards at least monthly

- Serious Incidents to be reported to Trust Board
- Perinatal Surveillance Forum commenced
- Continuity of Carer Project Board in place and commenced

Sensitively Level:

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

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Date	Assurance Timetable
10.12.2020	Ockenden Emerging Themes – published
14.12.2020	NHSI/E letter to all CEO (outlining actions and responses from Trusts)
21.12.2020	Letter of compliance from each Trust, signed by CEO and Local Maternity System (LMS), returned to the Regional Chief Midwife (RCMO).
11.01.2021	Completed Assessment Assurance Tool to be forwarded LMS with Trust sign off
15.01.2021	Assessment Assurance Tool forwarded to RCMO by LMS. (now the 15.02. 21)  Assessment and assurance tool PDF 1
22.01.21	Reported to Quality and Clinical Effectiveness Committee – submission of the Assurance Tool confirmed
15.02.21	Review at Regional Quality Meeting and forwarded to the National Maternity Transformation Board
23.02.21	Reported to Quality and Clinical Effectiveness Committee – full report presented and confirmation of review at Regional Quality Meeting
23/03/21	Reported to Quality and Clinical Effectiveness Committee – update given
27.04.21	Reported to Quality and Clinical Effectiveness Committee – key items to consider discussed

05.05.21	Reported to Trust Board that all actions and audits identified within the tool are within timescales. All evidence will be uploaded to a portal (awaiting national guidance) when available Items to consider: - • All maternity serious incidents to be reported to Trust Board • Perinatal Surveillance Forum commenced (16.03.21) – nonexecutive maternity safety champion presence required. Next meeting 13.05.21 • Continuity of Carer (COC) Project Board in place (Jan 2021), first COC Team established and first baby born within the continuity of care structure. The Project Board continues to develop further COC Teams taking into consideration the associated risks

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

6 May 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:	22 April 2021

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

Outlined below are some key points for the Board of Directors to consider from this report:

- Part A of the Corpoarte Risk Register (CRR) is enclosed for noting.
- A new CRR report template, Policy, SOP and Strategy have been created and ratified in March. The SOP and Strategy have been operationalised and communicated to Trust staff. The Policy is due to be uploaded to SharePoint over the coming weeks.
- The Risk Assurance Meetings (RAM) are held bi-monthly and are attracting good attendance from divisions and departments which is monitored by an attendance register.
- KPMG have drafted their report after commencing an Internal Audit review to test the operating effectiveness of the Trust's procesess to manage risk. They gave assurance ratings of:
  - Design of the Risk Management Framework: Significant assurance with minor improvement opportunities.
  - Operating Effectiveness of the Risk Management Framework: Partial assurance with improvements requires.
- The Risk Manager is working with the divisions to review their Divisional Risk Registers.

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	

Blackpool Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting

6 May 2021

Corporate Risk Register

Background:
The Corporate Risk Register (Part A) continues to evolve and is now at its final template state, which provides the Board with a detailed overview of the currently recorded corporate risks. Nonetheless, as is appropriate, the Corporate Risk Register (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. BTH has worked in partnership with the Institute of Good Governance to roll out a comprehensive training programme. The Risk Manager will continue 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.

The Risk Manager is working closely with Ulysses, our system provider, to create a risk movement report, action monitoring report, risk dashboard report and the risk register, which are being launched in May. This will provide departments, divisions and corporate services with a clear overview of risk management and the effectiveness of the system and its use.

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.

Risks for highlighting but not yet populated onto the CRR

- Meetings are being set up with various areas to discuss the potential risk(s) to the Trust, service, staff and patients due to the new Trust divisional restructure.

New Risks for agreement to be escalated onto the CRR

Ref No.	Risk Title	Current Score (L x I)	Reason
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.	(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.
2699	There is a risk to the Trust that the Incident and Risk Management Team could fail to identify serious patient harms or risks to the organisation, and fail to meet national standards to manage and upload incidents to the National Reporting and Learning System (NRLS) on a weekly basis. This is due to the low levels of staffing and banding for this team, due to underfunding for this critical service.	(4 x 4) 16	This has the potential to cause reputational damage because of the inability to learn from incidents or raise risks in a timely manner. This could cause harm to both patients and staff.

New risks agreed

Ref No.	Risk Title	Current Score (L x I)	Reason	Agreed by
5	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.	(4 x 5) 20	Due to the impact this could cause across the Trust if the risk occurred.	Director of Strategic Partnerships

Risks increased and decreased

Ref No.	Risk Title	Previous Current Score (L x I)	Increased Current Score (L x I)	Reason	Agreed by
3037	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.	(4 x 3) 12	(4 x 5) 20	A full review of the risk and scoring was undertaken due to weak controls in place.	Director of Finance
3095	There is a risk that our endoscopy department continues to suffer delays and lack capacity, impacting on our cancer and referral to treatment pathways.	(3 x 3) 9	(4 x 4) 16	A full review of the risk and scoring was undertaken due to inadequate controls in place.	Director of Operations
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**		Medical Director

Risks removed from the Corporate Risk Register

Ref No.	Risk Title	Current Score (L x I)	Reason	Agreed by
3097	There is a risk that the uncertain implications of moving to single commissioning could result in funding changes that affect service provision.	**(4 x 3) 12**	Amalgamated into risk 3044	Director of Strategic Partnerships
3045	There is a risk that the Trust may not be financially sustainable due to the deficiency of income in comparison to expenditure.	**(4 x 3) 12**	Amalgamated into risk 3037	Director of Finance
3040	There is a risk that the Trust could encounter system failures with IT systems.	**(3 x 3) 9**	The score has been reduced below 15 and is now being managed within the division/s.	Director of Strategic Partnerships
3041	There is a risk that the Trust could not meet the green targets due to exceeding our carbon footprint due to waste management and additional waste from Personal Protective Equipment (PPE).	**(3 x 3) 9**		Director of Strategic Partnerships
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.	**(2 x 4) 8**		Director of Strategic Partnerships
3046	There is a risk to patient safety and experience of not replacing unsupported Medical Devices across the Trust.	**(3 x 4) 12**		Director of Strategic Partnerships

NB: All risks removed from the CRR are being managed at divisional level.

Recommendations:

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

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
						Risk Description										
Ref.	Linked to Part B	Date Identified	Risk Category / Type	Risk Sub- Category / Type	Accountable Director (Risk Sponsor)	Risk of	Impact / Consequences	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	Response-ibility of	Target Risk Rating (L x I)	Progress since last update
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. • Council storage facility secured and now full to capacity • Regular assessment by the Fire Officer and the Health and Safety Officer • Some additional storage space has been acquired by the Trust to house Closed Volumes of records • Utilising NHS BSA offsite scanning bureau and other spaces in mean time	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 • To procure a service to scan health records on our behalf in order to create space. This procurement is complete and the contract is being examined by Trust staff. It is anticipated that the contract will be signed of at the end of April 2021.	18.03.22	Chief Information Officer	(2 x 5) 10	• EDMS roll out is due to be complete by March 2022 • A service specification was written and a mini competition was initiated on 24 February 2021 to procure an outsourced scanning partner • It is estimated to take between 6 – 12 weeks to remove approximately 12,000 health records from Theatres 7-10. This will enable the work to start on fitting the Scanning Bureau.
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	Partially Effective/Partially Adequate	(3 x 5) 15	• The Trust will deliver 3 large scale programmes, as described in the Quality Improvement Strategy, that aim to deliver measurable improvements in patient quality and safety. This will be supported by the newly appointed Quality Improvement Hub. 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	31.08.21	Associate Director of Quality Improvement	(2 x 5) 10	• The System Improvement Board has requested that the Trust presents an update to the original System Improvement Plan by identifying any variances and explaining what has driven these • Deputy Medical Director appointed for professional standards and due to recruit DMD for Public Health expected Q2 21/22 • Check and challenge for CQC action plan • Revising system improvement plan • Elimination of pressure ulcers – 20 teams have now completed the Pressure Ulcer Collaborative with the summit for the second phase to be held in May 2021. The first phase have sustained their improvement and both teams are being supported to continuously improve. • Identification and management of the deteriorating patient – Collaborative commenced in February with 9 teams 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 in line with NHS Patient Safety Strategy. Safety culture survey identified (insight) Safety Movement Group formed, undertaking review of safety culture activities and access to them (involvement).
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	• All Infection prevention policies and procedures and training sessions are provided for all staff • Process in place to manage outbreaks and an escalation process in place • Inspections undertaken both formal and regular informal audits • A post infection review process (PIR) is embedded • Evidence based Antibiotic formulary which is regularly updated • Monitor of Daily Defined Dosage of antimicrobials and managing any antimicrobial supply problems • Infection Prevention team use ICNet which is designed to assist with the management of alert organisms and conditions	Partially Effective/Partially Adequate	(3 x 5) 15	• Monthly reports to the Quality and Clinical Effectiveness Committee to provide information and assurance • Resource has been allocated for dedicated improvement support to work with ward teams using a collaborative approach and The Model for Improvement. Teams are brought together for learning sessions, where they can share ideas, understand data for improvement and learn how to utilise improvement tools • A new business case is being developed for this role although no completion date has been set as yet	30.06.21	Head of Infection Prevention	(2 x 5) 10	• IPC Team enhanced during Covid • ICP implemented actions in line with Covid Guidance • 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 People 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 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 including attracting new talent • Working with International recruitment agencies • Working with 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	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	31.05.21	Operational Director of HR and OD	(3 x 4) 12	• Change of model for agency fill including contractual change. Gaps now better filled but issues with skills mix being monitored. • Bid successful to help with pastoral support and Objective Structural Clinical Examination (OSCE). At present there are 2000 nurses in post • Improved staff survey results • Long term effects on covid-19 on staff sickness and staff availability • Working carers initiative with ELHT progressing
3038	2778, 2440, 2821 & 1734	17.11.20	People and workforce	Staffing	Director of People 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	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 (April 2021) • Big Conversation 'listening into action' sessions • Identify candidates to participate in the Shadow Board Programme (Q1 2021) • Exploring additional options from partners as part of People recovery	30.04.2021	Operational Director of HR and OD	(3 x 2) 6	• As part of long term plan, fit for purpose service reconfiguration and new ways of working to be established ahead of both tertiary division set up in April 2021 and at system level in the longer term • Refresh of establishment in light of new roles – Q1 2021 • ICS working group on health and wellbeing national initiatives to decide what toe retain

3027	**2608 & 2761**	**17.11.20**	**People and workforce**	**Staffing**	**Director of People 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 (April 2021) • Big Conversation 'listening into action' sessions to be re-established • Identify suitable candidates to participate in the Shadow Board programme (Q1 2021) • Fit for purpose service reconfiguration and new ways of working to be established ahead of both tertiary division set up in April 2021 and at system level in the longer term • Refresh of establishment in light of new roles (Q1 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 HSWAs • Equality and diversity inclusion workshop with BAME clinical leaders. Assurance - Improved staff survey results • Working carers initiative with ELHT progressing	30.06.21	Operational Director of HR and OD	**(3 x 4) 12**	• 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 • Charity bid funding for staff rooms and recreational facilities • Long term effect on covid-19 on staff sickness and staff availability • Performance reviews for divisions restarted
3028		**17.11.20**	**Performance**	**Strategy**	**Deputy CEO**	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	**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	**31.03.21**	Directors of Operations	**(3 x 4) 12**	• EU Exit preparations update provided to Board in March 2020 • Material updates to be provided at future meetings • The Board have been updated on Brexit. The Trust have experienced no issues in relation to Brexit. • Escalation process in place for the divisions to report any issues on the daily ICC call • Meetings to be booked with HR 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	**Partially Effective/Partially Adequate**	**(5 x 4) 20**	• Demand and capacity modelling undertaken for phase 3 restoration • Exploring collaborative approach to management of P2 cancer patients in breast, urology and gynaecology via the IS • Integrated Care System (ICS) transformation programmes for theatres, outpatients and cancer • A further review of Cancer action plan	**31.05.21**	Cancer Manager	**(3 x 4) 12**	• Monthly – 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	**Partially Effective/Partially Adequate**	**(5 x 4) 20**	• CSU focus on frailty and respiratory pathways to improve flow and length of stay • Redesign bed management reports and produce bed management performance dashboard. • Integrated Care Partnerships (ICP) transformation programmes for respiratory, frailty 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 • Deliver Trust part of ICP transformation programme on frailty, cancer and outpatients • Divisional and corporate review of flow and discharge • Working with UCLAN for minor dental surgery as additional capacity	**31.05.21**	Divisional Director of Operations for Unscheduled Care	**(3 x 4) 12**	• Monthly – 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, elective Orthopaedics restarted in March 2021 • ICS transformation programmes for theatres, outpatients and cancer. • Further roll out of advice and guidance • IS contract agreed and elective work being transferred
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 • Administration support in place from February 2021 • New patient flow team started and revised patient flow meetings	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	• Undertaken a review of the patient flow team • Business case is being submitted for Executive approval for April 2021 • Review of frailty and respiratory pathways • Bed management reports and performance dashboards	**30.04.21**	Divisional Director of Operations for Unscheduled Care	**(3 x 4) 12**	• CSU focus on frailty and respiratory pathways to improve flow and length of stay • Divisional supernumerary managerial and clinical teams to support flow • Emergency village; Minors completed and Mental Health assessment unit due by April 2021 • The Urgent treatment centre in alternative location which will be co-located with Emergency Department by end of March 2021 • Hospital discharge ward has been established. • Concentrate on making improvements to discharge pathways • New bed management reports and performance dashboards created to be launched in April 2021
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 • 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	**Partially Effective/Partially Adequate**	**(5 x 3) 15**	• Plans to transfer patient with senior emergency department team • Joint Ambulance improvement plan to be created	**30.04.21**	Divisional Director of Operations for Unscheduled Care	**(5 x 2) 10**	• Ambulance diverts taking place agreed across provider collaboration and NWAS • Designed a new bed management report to be launch in April • Standard Operating Procedure at system level has been agreed and is in place • Joint Ambulance improvement plan being created which will be monitored at the Urgent and Emergency Care oversight committee

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	**Partially Effective/Partially Adequate**	**(4 x 4) 16**	• Run three session days • Recruiting for additional Endoscopes' utilising national campaign initiatives • Prioritisation in relation to post COVID • Increase endoscopy capacity and monitor through the endoscopy action plan • Endoscopy action plan and trajectory (End March 2021)	**30.06.21**	Divisional Director of Operations for Unscheduled Care	**(3 x 4) 12**	• Creating endoscopy trajectory and action plan for recovery including national bowel screening programme plan by March 2021 • Capital provided for increasing estate and department capacity including recovery area to better utilise endoscopy (End June 2021) • Exploring options to insource and outsource • The incentivised shifts for waiting list initiatives is in place which is helping to attract staff
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**	Divisional Director of Operations for Unscheduled Care	**(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 • Mental Health assessment unit due by April 2021 • QIP project to be undertaken	**30.04.21**	Directorate Manager for the Acute and Emergency Department	**(3 x 3) 9**	• Delivering Urgent and Emergency Improvement Plan actions • Mental Health unit to be completed by April 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	**Insufficient**	**(4 x 5) 20**	• Financial plan for rest of 20/21 and 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 • Agreement to manage a joint CIP/QIPP programme across the ICP. Further update to be provided in before the end of March 2021. • 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	**30.06.21**	Deputy Director of Finance	**(4 x 3) 12**	• 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
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**	Chief Information Officer	**(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 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	**30.06.21**	Deputy Director of Finance	**(2 x 4) 8**	• Work with the Divisional Directors of Operations to provide updates on actions
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 • Property risk sub group established • 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	**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 • 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 • Prepare detailed register of leases and prepare contract variation to ensure funding in place	**30.09.21**	Head of Facilities / Atlas	**(2 x 2) 4**	• Interim Head of Estates advises that all Pathology work is ongoing over the next two years • A big clean-up has been done in the basement and lighting and other measures fitted to reduce flooding • Filing now needs to be kept in the basement
5		**31.10.18**	**Partnership Working**	**Health and Safety**	**Mark Wrigley**	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 7th August 2020 • There are some 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 • Meet with Atlas (30th April) • Create an action plan with Atlas	**01.06.21**	Acting Pathology Director Manager	**(1 x 2) 2**	• 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. • Awaiting written feedback & meeting from Atlas on how to proceed

Board of Directors

6 May 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:	Nicki Latham, Deputy Chief Executive
Date of Report:	28 April 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 has been no risk movement for the BAF risks relating to Quality and Clinical Effectiveness, People and Workforce, Finance and Performance since the last Board report on the BAF, progress has been made with many of the actions
- The risk scores for the Partnership Working risks (5.1 and 5.2) are recommended for increase following the discussions at the Operations Committee meeting from 12 to 16 based on the increase to the likelihood scores from 3 to 4. The rationale for the increase is 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 at this time 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.
- 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 Risk appetite statements have also been included following agreement at the last Trust Board meeting.

The Board is asked to:

- Note the latest updates to the Board Assurance Framework (highlighted in Green)
- Agree the recommended increase to the Partnership Working BAF risks from 12 to 16 based on the increased likelihood.

Next steps:

- Recognising the strategy development process, BAF to be refreshed to reflect strategic objectives, once developed
- Define and express Trust Board's risk appetite for inclusion in the BAF

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

Sensitivity Level:

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

Introduction

The Trust Board's main focus is strategic. Board members must understand the business objectives and be able to identify the principal risks that may threaten the achievement of these objectives.

The purpose of the Board Assurance Framework (BAF) is to bring together in one place all of the relevant information on the risks to the Board's strategic objectives. It is an essential tool for the Boards seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Board can have confidence that they are providing thorough oversight of strategic risk.

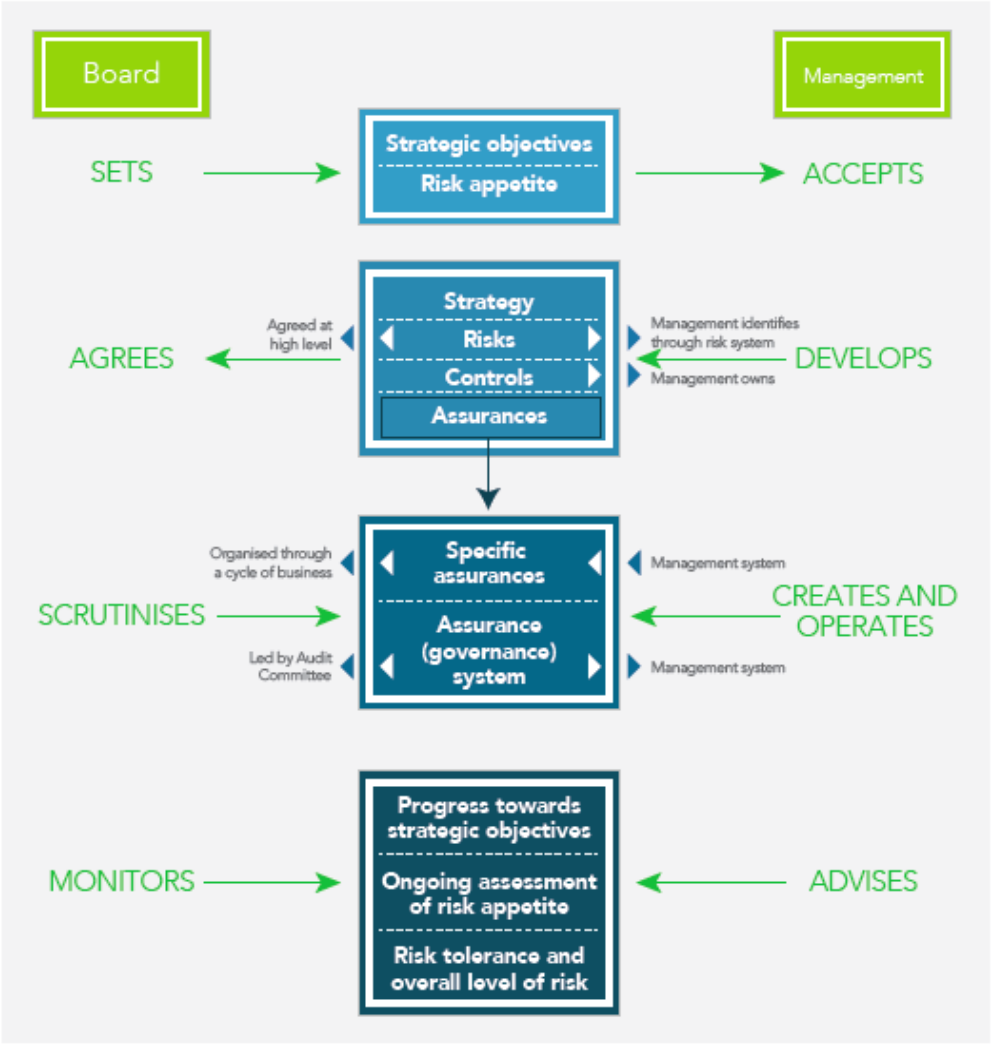
In simple terms:

"An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect."

The development of Board assurance arrangements should be a logical extension of an organisation's existing risk management arrangements. It is important therefore that you are satisfied with how the Board and the Audit committee understands and implements risk management, and that an informed engagement with the risks and opportunities that it faces. It is important that these arrangements are effective as they will help in understanding the process and control environment, and help you answer the following core questions:

- What do we want assurance over?
- How much assurance do we need?

Governance and reporting arrangements are vital aspects of any effective Board Assurance Framework. The Trust have defined clear lines of accountability and roles and responsibilities for the management and the Board (illustrated overleaf).



Context

1. This paper is the latest version of the Board Assurance Framework following the handing over of the document by the Good Governance Institute (GGI) in April 2021. The GGI were commissioned in in February 2020 to review the Risk Management of the Trust and then subsequently commissioned in Summer 2020 to support the implementation of a new Board Assurance Framework, culminating in the current form of the BAF that was approved by Board in September 2020.

2. As of 1 April 2021 the GGI handed over the BAF to the Trust and work continues to ensure that the BAF remains a live tool to drive the agendas of the committees and the Board, and monthly updates of the BAF continue with the Executive Team.

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

Update

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

5. Although there has been no risk movement since the last Board report on the BAF, progress has been made with many of the actions.

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

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 also asked to approve the recommended increase to the Partnership Working risk to XX based on the increased impact.

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

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
							optimal value 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	• **Operations Committee**	20	20	12	-	The Trust has an OPEN risk appetite for any risk which has the potential to

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

Strategic Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
	patient harm or reduced patient outcomes.						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.
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
	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 Priorities/ Domain	Strategic Risks	Assurance Committee	Risk Score and Profile				
			Initial Risk Score	Current Score	Target Score	Risk Movement	Risk Appetite
							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

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
							our risk appetite is CAUTIOUS. The Trust will AVOID any risk which has the potential to compromise data security.

QUALITY AND CLINICAL EFFECTIVENESS

ACCOUNTABILITY:	Lead –Medical Director/Director of Nursing	Committee – Quality and Clinical Effectiveness Committee and 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 Trend — ⇧ ⇩	
Last update	**Current**
—	—

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

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
- 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)

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 June and September.
  Reducing avoidable harm - Pressure ulcer collaborative commenced in March 2020, Phase 1 acute teams have shown sustained improvement, community progressing well. Phase 2 launched January 2021, with 10 teams engaged. ~~-~~
  Improving the last 1,000 days of life –Currently in preparation phase, programme launch May 2021. Vital signs methodology and value stream analysis approach to be used as well as ensuring community stakeholder engagement.
- Safety Culture Programme – Safety movement group created, exploring best tool for measurement in acute and community.
- As per 8 March 2021, of the 249 actions on the exiting CQC action plan 197 completed. Action plan to be revised and consolidated into an improvement programme following the report of the most recent inspection (January 2021) of A&E and general medicine.
- Discussion to the revised system improvement plan taken place. The revised plan will be presented to a future SIB. Deputy CEO linking with NHSI/E Improvement Director on step down plan to be presented to the SIB in July.
- Simplified assessment forms. E-Prescribing (EpR) coming into place pilot commencing in Cardiac Care, training rolled out (see BAF 3.2)
- COAST accreditation visits taking place on a weekly basis. First report presented February 2021 and to be reported quarterly to the Q&CE Committee. Currently focused on bed areas, working on a programme for non-bedded areas. Three assessment visits are taking place per week.
- Draft Clinical Strategy version 1.9 gone through New Hospitals Plan, discussed at Informal Board in April. The Board will receive a briefing update on Clinical Strategy Development on 6 May 2021.
- Developing senior leadership visibility templates to support services walkabouts during Q3-Q4. On pause due to COVID-19 wave three. Currently on pause but developing a plan to enable walkabouts to recommence safely. Limited numbers of informal walkabouts take place with Executive Medical Director, Executive Director of Nursing and Quality and Safety Management in person and also take place through MS Teams where necessary.
- Completion of RCP action plan by end of Q4. Report to Q&CE Committee on cultural piece.
- Ongoing programme with NHSI on mortality reduction. Focus on implementation of mortality app and training of SJR reviewers. Initial 4-week pilot phase complete 12 March 2021, further piloting to evidence SJR input flow to 9 April 2021 Rollout Plan being developed for Trust wide implementation Apr/May-21. NHSE/I supporting Grand Round organised

		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 • Mortality Reduction Programme and Learning from Deaths • No nosocomial outbreaks, and as at 16 April 2021 there are 3 COVID-19 positive inpatients. **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.		for 12 May 2021. NHSE/I are attending the Medical Leadership Forum planned for May 2021 to support SJR reviewers in extracting key action learning to enable improved learning from deaths. • Mass roll out of vaccination programme (see BAF 2.1) and is ongoing. Ongoing LAMP testing programme also in place. • Agreement at SIB to re-run the Medical Engagement Survey (MES) by end of Q2. • HEENW action plan in development triangulates with Emergency Village and Same Day Emergency Care (SDEC) Programme. Action plan will be presented to Q&CE Committee at the end of May.

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	• 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	**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) **External** • National Staff survey results – improvement in overall results 2020 • Staff Friends and Family Test • Pulse survey on People Plan	• Gaps in unscheduled care 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 inc new shielding requirements • Need for increased engagement in relation to rota issues with junior doctors • Risk to funding from Health Education Funding 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 in May 2021. • 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- ongoing • Roll out of Allocate roster system in progress –To be fully completed by April 2021. • Collaborative bench across ICS and refreshing rates to reduce contingent labour – Natalie Hill paper on rates circulated, awaiting provider agreement to rates • ICP workforce transformation discussions have commenced for hard to fill roles, utilising new or enhanced roles using Clear and Star workforce tools in respiratory and looking at other areas – two workshops on programme started and internal capacity to run programmes in future. Utilising for respiratory pathway. Ongoing work, People Board at ICS level now set up. • 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 • Grow your own scheme in progress – talent management approach in place and working with ELHT on joint/secondment roles. Nursing templates being reviewed to look at capacity for this scheme. Review of timeframe may be required as unlikely to be ready by the end of Q1. Now projecting Q2. • ICP review of workforce plans across the place to improve collaboration. Director of HR Strategic Development in place to produce workforce plan for ICP. Local People Board and Workforce Planning Group set up for ICP and ICS took place March 2021 and meeting bi-monthly. • Internal audit on recruitment and employee life cycle and nursing bank agency and rosters in reporting is ongoing and recommendations will be reported to the to the audit committee when

Risk Score		
Initial	**Current**	**Target**
16 **4 Impact** **4 Likelihood**	**16** **4 Impact** **4 Likelihood**	**12** **4 Impact** **3 Likelihood**

Risk Trend	
— ⇧ ⇩	
Last update	**Current**
—	—

	• 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 **How effective overall these controls are (tick one)?** ☐ **Effective** ✓ **Partially Effective** ☐ **Insufficient**			complete. Operations Committee will monitor implementation of actions. • National guidance on People Plan targets expected by Q3. People Plan has been socialised, KPI's awaited. • Visit from Health England Education North West (HENW) in November 2020. Action plan from previous visit ongoing. Quality and Clinical Effectiveness to received preparedness report October 2020 which showed feedback was positive. GMC visit in January 2021 which was also positive. • A further visit to discuss quality visit and the report has been arranged for 31st March 2021. • Planned corporate review of workforce by April 2021 • Linking into Healthier Lancashire, NHSE and NHS Employers to fast track international recruitment additional support preparing a bid – bid successful to help with pastoral support and OSCE (objective structural clinical examination). Pastoral support team implemented, and they work with the Trust's Professional Development Sisters to support the overseas nurses qualify into RCN registered nurses. 165 nurses as adaptation nurses, 105 more arrivals expected. 19 nurses passed OSCE. 204 overseas nurses, 22 due to qualify March, 36 in April, 52 May, 7 June (137 coming in between March and October). Now 2000 nurses in post. • 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 in process of signature and ensuring resources in place to undertake the work.

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

Risk Score		
Initial	**Current**	**Target**
16 **4 Impact** **4 Likelihood**	**12** **4 Impact** **3 Likelihood**	**9** **3 Impact** **3 Likelihood**

Risk Trend — ⇧ ⇩	
Last update	**Current**
—	—

- 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
- 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
- OH 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)?

	Effective
✓	**Partially Effective**
	Insufficient

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
- Staff vaccination programme

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

- 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
- COVID-19 second/third wave and shielding impact on sickness and staff attendance
- Temporary funding of some national wellbeing initiatives. Need to urgently identify whether any relevant former national health wellbeing initiatives funded by NHSE can be secured and funded on an ICS, ICP or Trust level though being funded during COVID-19
- Working carers passport to be implemented
- Occupational Health involved in COVID vaccine roll-out

- Monitoring and managing the number of non-medical appraisals undertaken in the appraisal window to ensure 100% compliance by April – window was deferred due to COVID and extended as part of restoration. Current compliance is relatively low as there has been no mandate in place due to COVID-19. As recovery phase continues and confident that appraisals will come back online with the appraisal window re-opening in Q1/2 of 2021/22.
- Behaviour framework is in development and needs to link to the revised Trust Values when agreed.
- Big Conversation 'listening into action' sessions to be re-established from Q1 2021/22 – deferred from Q3 due to COVID-19 pressures will link to the findings of the NHS National Staff Survey.
- Organisational Development Manager to work with Execs to identify suitable candidates to participate in the Shadow Board programme – by Q1 2021 - ongoing
- As part of long-term plan, fit for purpose service reconfiguration and new ways of working to be established ahead of both tertiary divisions set up in April 2021 and at system level in the longer term. Restructure taken place, live from 1 April 2021.
- 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 to be progressed with Communication team. Health and Wellbeing national initiatives circulated and updated regularly and targeted for staff. Exploring additional options from partners as part of People recovery (ongoing)
- Health and well-being conversations for all staff as appropriate and will be linked to the appraisal process upon recommencement.
- Advert for 100 HSWAs onto bench as part of long-term plan to fill HCA perm vacancies via talent pool programme
- 75% of substantive staff vaccinated.
- ICS CEO group to get stock take of all wellbeing initiatives to review what to retain and any new initiatives.
- Charity bid funding for staff rooms and recreational facilities
- Equality and diversity inclusion workshop with BAME clinical leaders.

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 Trend** — ⇧ ⇩ **Last update:** — **Current:** —	• 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 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 **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 • The financial envelope for COVID expenditure in the ICS is lower than the forecast. • Significant shortfall in substantive staff and therefore increased spend of agency and bank staff. Nursing position improving, but medical staffing remains a concern **Sustainability** • 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	**Income, Expenditure and Cash** • The Trust has agreed a financial plan for the remainder of 2020/21 based on the Phase 3 Planning requirements and agreement with the ICS. Financial plan being developed for 2021/22 based on newly released planning guidance. Updates to be given to future Operations Committees on a monthly basis incorporating latest NHS E/I guidance. • The Organisations have been given a share of the resource for COVID and will report against this value in the year-end financial position report • 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. • 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. NHSI/E deferred operational planning round for 21/22. Current financial regime to continue for Q1 and 2 21/22. Continuing with financial planning process internally. • Review of the Operational and Clinical Management Structure undertaken.

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- 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 NHS I/E contractual regime approved for Q3 and 4 of 21/22.

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<td>

- Review the Strategic Estates Infrastructure within the ICS to be picked up as part of ICS Strategic Estates Group.
- Re-establish the Quality and Efficiency Programme plan for saving requirements in 21/22.
- Agreement to manage a joint CIP/QIPP programme across the ICP, update to be provided when available.

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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

<table>
<tr><th colspan="3">Risk Score</th></tr>
<tr><th>Initial</th><th>Current</th><th>Target</th></tr>
<tr><td>15
5 Impact
3 Likelihood</td><td>15
5 Impact
3 Likelihood</td><td>8
4 Impact
2 Likelihood</td></tr>
</table>

<table>
<tr><th colspan="2">Risk Trend
— ⇧ ⇩</th></tr>
<tr><th>Last update</th><th>Current</th></tr>
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<td>

- 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)?

<table>
<tr><td></td><td>Adequate</td></tr>
<tr><td>✓</td><td>Partially Adequate</td></tr>
<tr><td></td><td>Insufficient</td></tr>
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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
- Vacancy Chief Clinical Information Officer role recruited to
- Quarterly report to Operations Committee on Health Informatics

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

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- 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 plan but is awaiting resource Old digital infrastructure such as Patient administration system (PAS)
- Although Electronic patient record (EPR) procurement started aligning with the ICS, the trust 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
- 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

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- Emergency funding for Health Informatics projects acquired for 2021 part offset due to funding not released from 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.
- Procurement on 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 will be presented to the Exec Team on 19 April.
- 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.
- 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. Mini tender /procurement for March 2021 temporary scanning bureau space. Work commencing imminently on first area (theatres 7-10). Contract negotiations are ongoing with procurement re external scanning facility.
- 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.

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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, 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. **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 Trend** — ⇧ ⇩ Last update: ⇧ Current: -	**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. **External**	• Managing elective and non-elective pressures – often competing due to no cold site facilities • Insufficient capacity – i.e. diagnostics • Infection prevention and control requirements resulting in reduced throughput compared to performance pre-COVID-19. • 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 – ongoing due to further pressure on services from the current COVID wave. • 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 • Priority targets and trajectories to be agreed – Some focus on trajectories of recovery in phase 3 • Patient choice and confidence • 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 • Vacancy of breast radiologist potentially resulting in 2-week symptomatic standards	• Ring fencing of key elective provision –ring fencing on hold due to COVID pressures • Endoscopy insourcing model started in October 2020 plans for expansion of the programme being developed and further work scoping outsourcing potential to be completed by the end of April 2021. Business case has been approved for capital required to enhance diagnostic capacity, on track for June 2021. • Temporary CT scanner (3 months) in place in addition to the nationally funded replacement CT scanner that was commissioned in March 2021. • Elective orthopaedic work resumed March 2021, plans in place to increase this programme from the end of April when medicine winter plans cease, and the ward handed back to scheduled care. • Resumed further theatre sessions and day surgery has been de-escalated, however due to ongoing non-elective pressures the programme has not been fully recommenced. • Initial restoration plan submitted, further work to refine and resubmit in May 2021, including completion or bed modelling to match demand with capacity. Insourcing option for weekend day case work being progressed by procurement. • Phase 1 of Divisional restructure completed to enable streamlined reporting going forward. Scoping of business intelligence requirements to take place – To be incorporated into divisional restructure phase 2 for May 2021 • ICS transformation programmes – adapt and adopt – theatres, OP, endoscopy, diagnostics, cancer – PMO to support work on theatres diagnostic to define improvement plan by end of Q4 2020/21. Outpatients focus on virtual appointments and advice and guidance. • Utilising locally agreed Independent Sector capacity via the National Contract with Spire and Ramsey.

		• 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.	• Large vacancies in AMU/ambulatory care middle grade doctor rota	• Emergency Village: GP Urgent Care moved back to co-location with ED. Mental Health assessment unit delayed due to estates issues, planned to open by end of April 2021. • Awaiting PAS supplier enabling recording of new royal college of surgeons' prioritisation codes for elective work. • Business case for to establish 24/7 Trust wide patient flow team to be reviewed by Exec Team in April 2021. • Ambulance handover improvement plan completed and being reviewed at April Urgent and Emergency Care Oversight Board. • Secured locum breast radiologist from May 2021. Substantive recruitment being progressed, to date no suitable candidates. WLI sessions in place to address capacity in April and May 2021. Working with the Cancer Alliance to review dual radiology reporting for Breast Symptomatic. • Peer review of the MU model, including medical rotas utilising ELHT clinical colleagues to take place in April/May 2021 to evaluate current model and support development of future vision. • Interim Divisional Directors of Operations in place for all Divisions and substantive recruitment underway.

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	• 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 **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 in 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. Meeting 18/2/21 for future direction of ICP and ICS. Initial meeting on governance of ICPs • Developing ICP provider collaborative • System reform across ICS ongoing. Provider collaborative board developed. CEO playing key role on Provider collaborative board. • ICS funding model to be agreed Q1 21/22 • New Director of Communications in place. • Board Strategy Session held on 1 April and agreed a further 5 sessions to develop a five-year strategy to align to the ICS.

Risk Score		
Initial	**Current**	**Target**
16 **Impact 4** **Likelihood 4**	**16** **Impact 4** **Likelihood 4**	**9** **Impact 3** **Likelihood 3**

Risk Trend — ⇧ ⇩ **Last update**: - **Current**: -				
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 **Risk Score** **Initial**: 16 Impact 4 Likelihood 4 **Current**: 16 Impact 4 Likelihood 4 **Target**: 12 Impact 4 Likelihood 3	• 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 • Shareholder Board **How effective overall these controls are (tick one)?** [ ] **Effective** [✓] **Partially Effective** [ ] **Insufficient**	**Internal** • Trust governance and board committees • Internal Respiratory Programme • RCP Board chaired by Dr G Goode. • Performance management quarterly Review meetings • Executive team meetings • Delivery roadmap for transformation of corporate services • Divisional review completed by 1st April 2021. • Tertiary services division set up. • Strategy for Atlas approved March 2021. **External** • ICP Respiratory Programme Board • ICP Frailty Programme Board (to be developed) • ICP outpatients programme board	• Limited resources in the system due to COVID19 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 • Lack of capacity to manage Atlas client side. • 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.	• Deputy Medical Director appointed for professional standards and recruited DMD for Public Health expected ~~Q12 21/22~~ • Frailty Programme Director had been identified, Establishment of ICP frailty programme Board and Delivery Roadmap by January 2021 to Frailty programme Board. • Atlas recruitment programme in place inc MD and senior team – recruitment by Q1/2 2021/22 • Agreed KPIs with Atlas, New ATLAS CEO appointed to commence in post on 1 May 2021. • Director of Estates to be in place Q1 2021/22

Risk Trend — ⇧ ⇩ **Last update** / **Current** — / —				

Blackpool Teaching Hospitals NHS Foundation Trust

AUDIT COMMITTEE MEETING

Minutes of the Audit Committee Meeting
held on 1 February 2021 at 1.30 pm
via Microsoft Teams

Present

Mr M Cullinan	Non-Executive Director	Committee Chair
Mr M Beaton	Non-Executive Director	
Professor T Warne	Non-Executive Director	

In Attendance

Mrs A Bosnjak-Szekeres	Director of Governance/ Company Secretary
Mr P Cundy	Associate Director of Finance
Ms H Fisher	Internal Auditors (KPMG)
Miss K Ingham	Corporate Governance Manager (ELHT)
Mr R Jones	Internal Auditors (KPMG)
Miss L Kavanagh	Corporate Governance Officer
Mr J Marsden	Counter Fraud Specialist
Mr F Patel	Executive Director of Finance
Mr N Seddon	Head of Financial Services
Ms T Squires-Evans	Associate Director of Finance
Ms H Taylor	External Audit (Deloitte)
Ms N Wright	External Auditors (Deloitte)

Apologies

None

1. Declarations of Interest

There were no declarations of interest made.

2. Apologies for Absence

None.

3. Minutes of the Previous Meeting

Members, having had the opportunity to review the minutes of the previous meeting approved them as a true and accurate record apart from the job titles of the external auditors in attendance, which will need to be updated.

RESOLVED: The minutes of the previous meeting were approved as a true and accurate record subject to the above correction in relation to the job titles of the external auditors.

4. Matters Arising

The action list was noted by the Committee.

RESOLVED: That the revised structures, including names, would be shared with Board members once completed.

5. Review of Internal Audit Progress (KPMG)

a) Internal Audit Progress Report and Recommendation Follow Up.

Mr Jones confirmed that the report detailed the work that had taken place since the last meeting in November 2020 and confirmed the issuing of final reports for the Core Financial Controls (significant assurance with minor improvement opportunities) and Medical Records (significant assurance) reports and the issuing of the draft report for the CQC Follow-Up audit. Mr Jones suggested that, in the interests of time, rather than go through the findings of each report separately, he would be content to take questions or comments on them from members.

Members were informed that the medical records audit allocation had been divided in two to allow the scanning section of the audit to be completed whilst retaining time for the IT legacy work to be completed at a later date.

Members noted that the work undertaken to date and planned to conclude before the end of the financial year would be sufficient to complete the Head of Internal Audit Opinion.

Ms Fisher reported that the mortality review which was initially scheduled for the previous reporting year would commence in March 2021 with the intention that it would be completed in the current financial year.

She went on to confirm that there had been an improved position in terms of management/Trust responses to previous audit recommendations, however several actions had been given revised dates for completion.

Mr Cullinan commented that it was assuring to see the responses to internal audit recommendations being received and thanked those responsible for providing responses for their efforts. Mr Patel confirmed that a considerable effort had been required to ensure that

responses were provided and thanked the Corporate Governance team for their efforts in encouraging and assisting teams to provide updates. It was agreed that the next report to the Committee would include more detail on the recommendations made and the responses received, including the analysis of the responses in relation to the low/medium/high recommendations.

In response to Mr Warne's comments about the CQC audit report and the need for assurance that the 'must do' actions had been addressed and an update being available in relation to any actions that were ongoing, Mr Jones confirmed that the internal auditors had focused their attention on seeking assurance on the tracking and closing off of the old actions from both the overall CQC inspection visit and the focused Emergency Department inspection. It was noted that the information gained from the 'check and challenge' sessions that had been held to complete the actions would be reported through the Trust's Quality and Clinical Effectiveness Committee. It was agreed that clarification would be sought about how systematic the 'check and challenge' sessions were and how it could be ensured that they covered the areas that were most pressing.

In response to Mr Warne's query as to whether the medical devices audit included those held within the community services, Ms Fisher confirmed that they had not been excluded, but had not been specified within the scope, however they could easily be incorporated.

Mr Beaton asked whether there was clarity within the Trust's retention policy as to the retention of scanned documents. Mr Patel agreed that a review of the Trust policy would be carried out and revisions made if required.

RESOLVED: Members received the report and noted its contents.

It was agreed that the next report to the Committee would include more detail on the recommendations made and responses, including analysis of the responses to the low/medium/high recommendations received.

Clarification will be sought about how systematic the 'check and challenge' sessions were and how it could be ensured that they covered the areas that were most pressing for the organisation.

A review of the Trust's document retention policy would be undertaken to ensure that reference was made to the retention of scanned documents and revisions made if required.

b) Health Technical Update

Members received the information in the update and noted its contents. There were no questions raised.

RESOLVED: Members received the information presented.

c) NHS Digital Data (NHSD) Security and Protection (DSP) Toolkit Benchmarking 2019/20.

Ms Fisher referred members to the previously circulated document and confirmed that the five core themes within the document reflected the NHSD returns that were required. Members received an overview of the complexity of the phishing attacks and it was confirmed that the current iteration of the NHSD toolkit did not account for this level of sophistication; however it is possible that the next toolkit may be revised to include such matters.

Following a comment from Mr Cullinan it was agreed that Mr Patel, along with internal auditors, would consider ways in which the content of the toolkit could be incorporated into the Audit Committee workplan.

Mr Warne expressed his concern in relation to the lack of knowledge and understanding of the digital world and the risks that this presented to the Trust.

Mr Beaton commented that digital security requires specific knowledge and could not effectively be carried out by general IT services and suggested that there may be more that the Trust could do to educate staff about cyber security risks.

Mr Jones suggested that the Trust's Board members may benefit from a cyber security specific training session. It was agreed that Mrs Bosnjak-Szekeres would raise this matter with the Trust Board Chairman for consideration.

RESOLVED: **Mr Patel agreed to consider ways in which the content of the toolkit could be incorporated into the audit committee workplan.**
Mrs Bosnjak-Szekeres will liaise with the Trust Board Chairman in relation to the suggestion of a Board training session on cyber security.

6. <u>External Audit Report</u>

Ms Wright referred members to the previously circulated report and confirmed that since the last meeting they had undertaken the first of the two virtual visits to plan the work on the annual accounts. On those visits they had reviewed various pieces of information and had undertaken a number of virtual 'walk-throughs' of documentation in preparedness for the year end audit work. The next virtual visit was planned for the week commencing 8 February 2021 and following that visit the formal audit plan will be developed and circulated to members in advance of the next meeting of the Committee.

Ms Taylor reported that the auditors were currently finalising the work that had taken place in December 2020 and would commence testing for the year end audit work. She went on to provide an overview of the work that was planned in advance of the end of the financial year and confirmed that a separate report would be provided to the Committee on this work.

Members were informed that the production of the Quality Account had been paused for 2020/21 due to the ongoing pandemic and the need to release capacity within the workforce to support areas in need. Ms Taylor confirmed that the deadline for the completion, audit and submission of the annual accounts had been moved out to mid-June 2021.

Mr Warne commented that whilst he understood the need to pause the production of the Quality Account, he suggested that it would be useful to understand whether the document would be required in 2022 and to ensure that there was sufficient data/information available for the current year to include in the next version of the document. Mr Patel confirmed that whilst there was no requirement for the document to be produced, the Trust could still prepare the document, even though it was not required for submission.

RESOLVED: Members received the report and noted its contents.

7. Governance Assurance Framework

a) Standing Financial Instructions (SFIs): Review of Delegation Arrangements (April to December 2020)

Mr Patel reported that there had been an agreement at the last Trust Board meeting to extend the time limits of the revised SFIs during the ongoing COVID-19 pandemic.

In response to a question from Mr Beaton regarding the number of times that the revised SFIs had been utilised during the pandemic, Mr Patel confirmed that whilst there had been a number of high value/risk items procured, such as ventilators, there had not been any breaches of the SFIs as these items had been procured centrally for the NHS as a whole.

RESOLVED: Members received the report and noted its contents.

8. Reference Folder

The items circulated in the Reference Folder were received for information. No questions, queries or decisions were made in relation to the items presented.

RESOLVED: Members received the documents for information and noted their content.

9. Items Recommended for Discussion/Decision by the Board of Directors

It was agreed that a meeting would be arranged for Committee members to meet with Mr Murphy, Director of Nursing to discuss the CQC inspection audit.

10. Attendance Monitoring

Members noted the attendance monitoring information that was provided for information.

11. Any Other Business

a) Next meeting

Mr Patel highlighted that the date of the next meeting fell during the Easter holiday period and suggested that it could be rearranged for late March to ensure that the meeting would be quorate and be able to consider items such as the going concern report, external audit timetable, etc. Members agreed that the next meeting would be held on Monday 22 March 2021 at 1:30pm.

RESOLVED: The Corporate Governance Team will revise the date and time of the next meeting as recorded above.

b) Internal Audit Contract

Mrs Bosnjak-Szekeres suggested that members of the Committee and Mr Patel remain in the meeting when all others had left so that an update could be provided on the process for the appointment of internal auditors.

12. Meeting Review

Mr Cullinan sought the views of the members on the meeting and whether there had been sufficient discussion on matters reported.

Professor Warne commented that he had felt that there had been sufficient challenge during the course of the meeting and confirmed that he had gained assurance around a number of matters, through the questions asked and the responses provided. He went on to confirm that he found the intelligence reporting from auditors to be particularly informative and interesting.

13. Declaration of Confidentiality

That all items be declared confidential unless they were already in the public domain.

14. Date and Time of Next Meeting

The next meeting will take place on Monday 22 March 2021, 1.30pm, via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Quality & Clinical Effectiveness Committee Meeting
held on Tuesday, 23 February 2020 at 1.00 pm
via Microsoft Teams

Members: Professor Tony Warne - Non-Executive Director (Chair)
Dr Sheena Bedi - Non-Executive Director
Mr Keith Case - Non-Executive Director
Dr Jim Gardner - Executive Medical Director
Professor Nicki Latham – Deputy Chief Executive/ Director of Strategic Partnerships
Mr Peter Murphy - Executive Director of Nursing, AHPs and Quality

In Attendance: Mrs Sharon Adams - Interim Operational Director of Human Resources and Organisational Development
Mrs Simone Anderton - Deputy Director of Nursing & Quality
Mrs Margaret Bamforth - Appointed Governor (Blackpool & The Fylde College) (Observer)
Mrs Rebecca Bond – Director of Pharmacy
Mrs Angela Bosnjak-Szekeres - Director of Corporate Governance
Mr Geoff Burrow - Assistant Director of Strategic Planning & Business Support (for item 7b)
Dr Peter Curtis - Divisional Director (Families and Clinical Support Divisions)
Mr Steve Fogg – Chairman
Mrs Katharine Goldthorpe - Associate Director of Quality Improvement (for item 8a)
Dr Grahame Goode - Director of Clinical Effectiveness/Deputy Medical Director
Mr Andrew Heath - Associate Director of Nursing & Quality (for item 5e)
Mrs Amy Hirst - Corporate Governance Administrator (minutes)
Mrs Lisa Horkin - Assistant Director of Nursing (Unscheduled Care Division)
Mr David Kay - Interim Assistant Director of Nursing (Adult and Long-Term Conditions Division)
Mrs Jo Lickiss - Assistant Director of Nursing (Scheduled Care Division)
Mrs Sharon Mawdsley - Infection Prevention Nurse Consultant
Dr Andy Ng – Guardian of Safe Working (for item 5d)
Mr Martyn Pugh - Corporate Governance Officer, East Lancashire Hospitals (Minutes)
Mrs Nicola Parry - Assistant Director of Nursing (Families Division)
Mr Stefan Verstraelen - Deputy Director of Quality Governance
Mr Jed Walton- Pollard – Deputy Director of Nursing
Ms Michelle Wong – Lead Antimicrobial Pharmacist

1. Welcome/Apologies for Absence

Professor Warne welcomed members to the meeting. He noted that the papers, which had been received in advance of the meeting should be taken as read. He asked presenters to advise the Committee about the implications of their reports and to provide an update on the levels of assurance.

Apologies were received from Mr Lee Tarren, Associate Director for Resourcing and Transformation, Mrs Joanne Bark, Divisional Director of Operations – Unscheduled Care and Mrs Claire Lewis, Head of Quality, Fylde Coast Clinical Commissioning Groups.

2. Minutes of the Previous Meeting held on 26 January 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 26 January 2021 were approved as a true and accurate record.

3. Matters Arising

a) Action List

It was noted that updates would be provided throughout the meeting to cover some of the outstanding actions. The following updates were provided:

NURSING & MIDWIFERY SAFE STAFFING EXCEPTION REPORT – Mr Murphy advised members that the decision had been taken to pause and review the report, ensuring that accurate fill rates, including agency workers are taken into account and a new report will be provided at future meeting.

MEDICINES MANAGEMENT ANNUAL REPORT – Mrs Bond advised members that the Duthie Audit feedback will be provided at the next meeting of the Committee (March 2021). She went on to confirm that it was difficult to undertake the Self-Administration of Medicines audit at the present time, as there was a need to revise the current policy first.

ANY OTHER BUSINESS: 106 – Mr Gardner advised that formal feedback from Health Education England North West (HEE NW) was still awaited.

BOARD ASSURANCE FRAMEWORK: COMMITTEE SPECIFIC RISKS – Mr Gardner advised that he would be talking with the National Medical Examiners and would produce a quarterly report to be shared with the Medical Examiner's Office. It was agreed that the action could be RAG rated as green. Professor Warne noted he had heard from NHSE/I Regional Office that a new mortality dashboard will be released shortly, which may also feed into the quarterly report.

i) Ockenden Review Update

Mrs Parry informed members that the completed document had be endorsed by Maternity services and sent to the region for review, with formal feedback expected within the next two weeks. Furthermore, she advised that the service had already collated a substantial amount of the evidence required.

Dr Bedi asked what the operational impact has been on the Trust's maternity services, particularly on resource implications and changes to practice. In response, Mrs Parry confirmed there was a potential resource implication regarding senior clinician time which will require discussion with the divisional finance team and would be reviewed through the Divisional Performance Reviews.

Dr Bedi further sought assurance regarding any checks and balances at system level and how external regulatory checks would work. Mrs Parry confirmed that monthly maternity meetings are in place with the four main providers and that the Ockenden report would be included as an item on the monthly oversight and bi-monthly meetings in the regional system.

Mr Case agreed that it is right that there is a significant focus on maternity services and asked how the focus would be kept on the quality of care and how any learning from the Ockenden Review can be applied to other areas. Mrs Parry responded that training and specific elements would be looked at for application elsewhere.

Dr Gardner added that divisional reviews will take place to make sure they are right for what is being asked of them and they would work to improve the organisation at every level.

Professor Warne noted that this was an important discussion and would like some thought given to how progress will be tracked.

RESOLVED: Consideration to be given to how progress will be tracked with specific issues to come back to the Quality and Clinical Effectiveness Committee.

CARING

4. a) Patient Story

Mr Murphy introduced the patient story, advising it was related to the Covid-19 pandemic. It was noted that this patient story praised the contribution made by staff, particularly within the Critical Care services and showed the professionalism of staff and use of technology to enable patients to communicate with family.

Following the patient story video, Professor Warne expressed thanks to everyone involved in the excellent care that is being provided to patients. Members noted that, often, it was the small non-clinical things which matters the most to a patient and the family.

Dr Gardner added that many of the staff involved would not have been in their substantive role due to the pandemic and it was reassuring to see they maintained their professionalism and patients did not notice a difference in the care provided.

SAFE

5. a) Mortality Data

i) Royal College of Physicians (RCP) Report Action Plan Update

Professor Warne expressed disappointment that this matter had not moved at the pace expected and asked that efforts be made to ensure actions have revised deadlines that were achievable for completion.

Dr Goode apologised for any disappointment, explaining that a discussion had taken place with Dr Gardner where it was decided not to change the timescales in order to facilitate a robust and honest discussion. Continuing, he advised that positive steps had been made with staffing with Medical High Care now having sufficient staffing capacity to cover shifts and rotations. He went on to confirm that work was ongoing to increase the number of consultants, and informed members that two new consultants were expected to commence in post by the end of April 2021.

It was noted that respiratory services were no longer a priority for all the Primary Care Networks (PCNs) and has been replaced with a focus upon mental health services due to the impact of the pandemic. Members noted that the Covid-19 pandemic had had a positive effect on multidisciplinary working and the launch of Covid Virtual Wards and the imminent start of a Long-Covid Clinic. Dr Goode finished by asking the Committee what they would expect to see in future updates

Mr Case sought clarification on the priority that the Trust places on this work and expressed disappointment that it is no longer seen as a priority by some PCNs. Dr Gardner responded that the business cases had been signed off to enable investment into the Trust's respiratory infrastructure and had been running some Respiratory High Care during the pandemic, noting that changes in direction would not prevent the Trust from moving forward with their own schemes of work.

Dr Bedi queried the rate limiting steps, asking if these were operational pressures such as time, staffing or physical constraints and what is affecting the timeline. Dr Goode responded that the issues were a combination of all of the factors above with particular issues being constraints on the clinicians' time and a focus on the Covid and Cancer pathways. He advised that there is substantial work taking place to revise the pneumonia pathways and consideration must be taken as to how hard to push staff to complete this work whilst undertaking other priorities. Once the pressures of Covid-19 have eased, the work will be prioritised. In addition, education will be reviewed due to the risks being mitigated following immunisation and it will be easier to get people together as time goes forward.

Professor Warne advised that as a provider organisation, there is the need to be more assertive and what could and should happen and he would be interested in seeing this reflected in a revised action plan, noting that the (Integrated Performance Report (IPR) features concise explanations regarding Summary Hospital Mortality Indicators (SHMI) and it would be useful to see something similar with risks and mitigating actions for this work.

Dr Gardner commented that there is a lot in the RCP report regarding medicine in general and the Emergency Village review and the Getting it Right First Time (GIRFT) review, along with other aspects which will have an impact on this and agreed to incorporate additional details into the next iteration of the report.

Dr Bedi queried the system priorities, commenting that she thought this was an agreed ICP priority. Dr Gardner responded that although still important, there has been a shift in primary care over the previous year due to Covid-19 and the development of the ICS.

Professor Latham added that she wished to reassure the Non-Executive Directors that along with Kevin McGee, Chief Executive, she would be meeting the new Trust Board Chairman, Stephen Fogg to discuss work with the Integrated Care Partnership (ICP). Instructions are awaited from NHSE/I regarding ICPs. Professor Warne responded that he believes this information will be shared with Trusts soon.

RESOLVED: Dr Gardner and Dr Goode to provide an updated version of the report for the March meeting.

b) Serious Incident and Duty of Candour Report

Mr Verstraelen highlighted the incidents and investigations and confirmed that there had been two new serious incidents reported on the Strategic Executive Information System (StEIS) in January 2021, in addition, there were no 'Never Event' incidents reported. He went on to confirm that as of 16 February 2021, the Trust had 14 on-going StEIS reported serious incidents. Drawing attention to the graph on page three of the report, Mr Verstraelen informed members of the consistent reduction in the number of serious incidents reported and advised that he will be meeting with the CQC to discuss them, as they had suggested that there may be an issue of under reporting. He added that upon review, the actual number reported had not reduced but the severity of harm had, due to improved staffing, better systems and processes, learning and management over the previous year. He highlighted the implementation of 72-hour reviews to see if further investigation was required.

Mr Verstraelen noted that there had been a steady rise in the number of breach incidents, but they remained within control limits. He went on to comment that he expected to see a reduction in correlation with pressures in the Trust due to Covid-19. He added that he intends to look at themes around low/no harm incidents to try and prevent them happening and will include this in future reports. In addition, the Health and Safety report will be expanded in the coming months and he is collaborating with the Head of Safety and Risk at East Lancashire Hospitals NHS Trust on this.

Professor Warne noted that the Health and Safety report provided the number of colleagues who had contracted Covid-19 at work, whilst the report from Mrs Mawdsley listed the number of patients, commenting that at present it felt like a disconnect between the two. Mr Verstraelen acknowledged the comment and responded that the number of staff needs to be reported to the Health and Safety Executive as per their guidance. However, if a Trust has appropriate access to PPE, staff training and processes and procedures are in place then the Health and Safety Executive would likely not see such cases as being outside the regulatory requirements.

Mr Case commented that the report showed the outcomes and outputs were moving in the right direction and starting with the RIDDOR reports was useful, but added that he would like to see the over 3 day accidents included to enable root causes analysis to take place. Mr Case also offered to assist with reviewing based on his experience in other industries.

Mrs Mawdsley commented there was a disconnect with the information from Occupational Health as the reports she receives do not align with the figures contained in this report and suggested liaising with Mr Verstraelen and Occupational Health outside the meeting for continuity.

Dr Bedi questioned the learning and monitoring, querying how this is taking place. Mr Verstraelen responded that work is still in the early stages of linking quality governance to quality improvement and he is looking to link to big ticket items where the impact on patients is serious. Professor Warne commented that this made sense, but suggested to the need to find a joined-up approach. He highlighted the excellent work being undertaken with regard to pressure ulcers through quality improvement strategy and improvements being fed through.

Mr Murphy commented on the quality improvement strategy, noting it was developed to tackle ingrained issues in the organisation such as pressure ulcers, where the Trust was a national outlier. The strategy allowed for creative thinking to problem solving and feeds into learning.

Dr Bedi raised a question regarding the tolerance level for incidents to be reported within 24 hours and also what happens when there are situations of abuse towards staff members.

Mr Verstraelen responded that there is no national guidance on a set tolerance level, and this is something that needed to be agreed as an organisation. He added that historically, the level is around 84% for the Trust, but although it is important to have a metric to perform against, context needs to be taken into account, so that members of staff can identify the urgency of reporting. He added that issues regarding staff abuse would be looked at by the Security Manager and work is ongoing to reduce instances of staff abuse through updated guidance and a review of the current policy.

Mr Murphy added that abuse towards staff members is taken seriously by the Trust and that he had signed a number of applications for court action since starting his role and will take it to the highest level, if required. Professor Warne reiterated that abuse and violence was not tolerated whether it is a member of the public or a colleague. He queried the current level of the Duty of Candour compliance. Mr Verstraelen confirmed there were 3 incidents, with the Duty of Candour carried out 100% of the time.

RESOLVED: Mrs Mawdsley to work with Mr Verstraelen and Occupational Health to ensure continuity in reporting.

c) Infection Prevention Control Report including Update on Nosocomial Infections, NHS England Actions and Board Assurance Framework

Mrs Mawdsley advised members that as the number of Covid-19 infections reduces over the coming months, she planned to revisit other key infections including MRSA and C-Difficile and that future reports would have a focus on these areas, including the actions taken to address the issues. Continuing, she advised that the Covid-19 figures were starting to reduce although not as fast as hoped and this is reflected across the North West as a region.
Mrs Mawdsley informed members that the number of nosocomial infections had fallen, although there had been a brief spike the previous week with two new outbreaks in addition to the two listed in the report. She reported that, although there has since been a reduction, with only one new in case in the previous five days. In addition, work was ongoing to reduce the number of community infections. In general, between 40 and 50 patients test positive in the first 7 days. Mrs Mawdsley confirmed that work is ongoing to reduce the number of cases with improvements to patient flow and management of pathways to reduce exposure to potential positive patients as a key step.

An update was provided on the Board Assurance Framework with most elements categorised as green due to works ongoing. Mrs Mawdsley noted that Infection Prevention and Control (IPC) training is currently at 91.5% and would like to see an improvement in this area.
Professor Warne thanked Mrs Mawdsley for the comprehensive reports, commenting that he noticed in the work plan the continuation of regular IPC updates and there is the need following the pandemic to continue safeguarding colleagues in daily practice.
Mrs Mawdsley agreed that it is appropriate for IPC to be on the agenda and she would continue to attend whilst required.

RESOLVED: Members noted the update provided.

d) Guardian of Safe Working Quarterly Report

Dr Ng provided an overview of the report and confirmed that it covered the three months prior to October 2020.

He highlighted the issue of annual leave requests for junior doctors, where some issues had been raised and confirmed that they were the result of issues that have now been dealt with directly by the rota co-ordinators.

The second issue raised related to the redeployment of junior doctors, noting that the Trust was fortunate to not require mass redeployment during the current wave of the pandemic and the small number of foundation doctors who were redeployed to acute specialities was with the consent of their supervisors and with all existing study leave and annual leave honoured. Dr Ng informed members that there is the requirement to give a minimum of 2 weeks' notice when changing the junior doctor rotas and it is important to give as much support as possible and provide a safe and personal environment.

Dr Ng advised that the third issue relates to vaccination and will be included within the next report, as February is when junior doctors rotate posts and there was some concern that they would need to travel back to the original location to receive the second dose of the vaccination. Dr Ng noted that the North West Deanery had produced guidance on this which has been shared with the doctors.

Mr Case queried if a future report could include the degree of excess hours worked and if this should be regularly reviewed by the Committee.

Professor Warne agreed with the points raised, adding that discussions about this and other details that could be provided needed to be undertaken, including HR matters and communication issues. Professor Warne asked for some of this detail to be provided in the next report showing what is being done to help support colleagues.

Dr Bedi raised a question regarding the reputation of Blackpool as a good place to train and work and queried if it would be possible to find out what the view on this is. Dr Gardner responded that, at present, it was not possible to provide assurance in this matter, however he confirmed that he regularly meets with doctors to seek their feedback.

Mr Murphy referred members to the previous point raised regarding metrics and the impact on quality and safety, noting that, as an organisation it would be useful to understand where people want to train and work.

Dr Ng informed members that he has more granular detail and would provide this in the next report, adding that as a trainee at the Trust, he knew this was where he wished to work and he tries to share his experience with the new students.

ACTION: Dr Ng to provide further details in the next report.

e) Collaborative Organisational Accreditation System for Teams (COAST) Accreditation

Mr Murphy informed members that the COAST accreditation programme was proceeding with two silver wards and the Coronary Care Unit being awarded a gold status. He advised that the progress of COAST was working well and providing good evidence of the work in relation to the safe, effective and well-led domains. Mr Murphy added that he hoped platinum status would be introduced in the next two years for wards that have maintained gold status for 3 consecutive reviews. In addition, weekly learning has been established with the mandate that matrons and ward managers, along with their deputies all attend and learn together.

In response to the question raised by Dr Bedi, Mr Murphy confirmed that the scheme had not uncovered anything that was not already known, but had enable a planned programme of work to take place and will enable high levels of assurance to be provided going forward.

RESOLVED: Members noted the update provided.

f) Antimicrobial Stewardship Report

Dr Gardner informed members of the importance regarding good governance in the usage of antibiotics and was encouraged by the attendance at the antimicrobial stewardship meetings. He added that although there is a lot of work to be done, the introduction of electronic prescribing will assist with progress.

Ms Wong informed members of the key activities that have taken place including the creation of guidance for appropriate usage and increased education via Teams and the creation of videos. In addition, with the emerging Covid-19 treatments, guidance is be created and monitored through regular six-monthly audits.

Continuing, Ms Wong updated members on the review of the choice of antimicrobials, advising that previously the 48 hours review date has often not been completed, but pharmacists are being encouraged to review this with different tactics being used, including highlighters and the trialling of new review stickers.

Ms Wong finished her update by informing members that through the monitoring of antibiotics, it can be seen that there is a slight increase, potentially due to Covid-19, however the Trust is performing well in comparison to other Trusts and work is continuing to ensure antibiotics are used appropriately.

Professor Warne thanked Ms Wong for the comprehensive report and explanation, noting that it was important to understand why the omissions happen. He requested a further update once the action plans had been implemented.

ACTION: Ms Wong to update the committee at a future meeting once the action plans have been implemented.

6. EFFECTIVE

a) Quality and Clinical Effectiveness Indicators from the Integrated Performance Report

Professor Warne noted that the report was starting to become more like the dashboard that the Committee is aiming for and when mortality was mentioned earlier in the meeting, this is a good example of what should be aimed for to provide assurance and confidence about the indicators, before transferring to the Integrated Performance Report. Professor Latham responded that she had given a timeline to the Performance team for this to be achieved and was expecting it to be in place for the next Board meeting.

Mr Case advised it would be beneficial to work with the Health & Safety representatives at East Lancashire Hospitals NHS Trust and offered to meet with the Performance team to work with them on developing the Health and Safety indicators.

RESOLVED: Mr Case to meet with Jane Rowley from the Performance team to work together on the Health and Safety indicators for the IPR.

7. RESPONSIVE

a) Complaints and Friends and Family Test

Mr Murphy noted that the indicators were poor; however recruitment is ongoing which will help the team and improve the performance indicators. He advised that cross-organisational learning with in-depth reviews will also be taking place.

Dr Gardner notified members that the quarter three mortality report would be presented at the next meeting and a large piece of work was underway regarding patients who may have acquired Covid-19 whilst in hospital and subsequently died, which will be useful for subsequent meetings.

Professor Warne commented that David Levy has undertaken some comprehensive work in this area which shows the impact of Covid-19 on the expected and unexpected mortality rate and would feed into this work.

Dr Gardner confirmed he had been invited to the regional mortality cell and would be attending in the future.

RESOLVED: Mr Murphy to bring an update, including performance indicators to the Committee in the future. Dr Gardner to present the quarter 3 mortality report at the March meeting.

b) Informatics Contribution to Covid-19

Mr Burrow provided a presentation to members on the work undertaken by the Informatics Department during the Covid-19 pandemic, highlighting the development and deployment of new systems and technologies including support for the mass vaccination programme and the creation of a Covid Dashboard for the Trust.

Professor Warne thanked Mr Burrow for the demonstration and commended the Informatics department for their hard work during the pandemic.

8. WELL-LED

a) Quality Improvement Update

Mrs Goldthorpe informed members that one of the charts in the report was incorrect. She noted that improvement was being seen in the Community teams for the first phase of the pressure ulcer work, but this chart was not included in the report. She informed members as part of her update about the Building Capability programme and how the dosing strategy had been developed using evidence and redesigned for the Trust, so it works for the organisation.
Professor Warne queried the data on pressure ulcers due to a difference with the information presented in the earlier report by Mr Verstraelen. Mrs Goldthorpe advised that the collaborative work currently involves a small number of teams and acknowledged that there are still instances of harm and pressures ulcers generally, as per Mr Verstraelen' s report.

Mr Murphy acknowledged that the methodologies are working and showing an improvement, but context is also needed when reporting the information.

Dr Bedi queried how the organisation would know when a difference had been made. Mrs Goldthorpe responded that tools had been developed to measure improvement and the staff survey also has questions regarding improvement capability and whether staff member feels enabled and supported to deliver improvements.

A discussion regarding the "Last 1000 days of life" project took place with Dr Bedi querying if the title was appropriate and if it would work better as a system initiative. Mr Murphy appreciated the comments, noting that this work is a test of what the ICP should be doing and that 'dying well' was one of the indices

included. Mr Case agreed, noting that this is a large piece of work which may have multiple work streams that could be passed on to other partners at a suitable time. Professor Warne agreed that there needs to be an agreed position as a Board and consideration given to how others in the system assist on the journey.

Dr Bedi expressed her concern about the changes to system priorities and the need for the project to have joint ownership and outcomes. Mr Murphy noted that weekly conversations are taking place whilst preparing this work and there are many partners with a vested interest in it.

RESOLVED: Members noted the update provided.

b) Corporate Risk Register (CRR)

Mr Verstraelen presented the CRR to members for approval, noting it would help drive good risk management in the organisation and assist with gaining a favourable audit opinion from the Trust's internal auditors. He noted that Mrs Bosnjak-Szekeres had worked with Board members on the Risk Appetite Statement and the work on the CRR had taken place with the Good Governance Institute (GGI).

Dr Bedi queried how the process is tested to ensure that the risk ratings are correct. Mr Verstraelen responded that the Risk Manager was in the process of setting up a training programme for all staff in the Trust, in addition to a Board session around risk management. He added that the draft documents still required some fine tuning to link in with other processes for full assurance.

Mrs Bosnjak-Szekeres added that work was ongoing to improve the document and when complete, it will provide a good measure as to whether the organisation was getting the levels of risk right.

Mr Verstraelen informed members that there are currently twelve risks, of which two are new risks and three risks have been de-escalated. He highlighted the work that was taking place to determine what details could be added to the risk system, so that members were able to see the effective management of risks and gain sufficient assurance.

c) Board Assurance Framework: Committee Specific Risks

The Committee noted the updates on the Corporate Risk Register and Mrs Bosnjak-Szekeres noted that it was good to see some of the connectivity between the IPR and the updates in the sources of assurance and actions with timelines for completion identified.

d) Items Recommended for Escalation to the Board

It was noted that the Risk Management Policy and Risk Management Strategy would be submitted to the Board for ratification.

ACTION: Mr Verstraelen to submit the Risk Management Policy and Strategy to the Board.

e) Annual Work Plan 2021-22

Professor Warne stated he felt fairly confident regarding the majority of the mandatory requirements and the work plan was accepted.

RESOLVED: Members noted the updates provided and accepted the work plan.

9. CLOSING MATTERS

a) Any other Business

Professor Warne notified members that he was keen for bi-monthly Divisional Quality Reports to be developed from April 2021.

Professor Warne also requested that a reference file be created, as lot of information that would be useful to the Committee is available elsewhere.

RESOLVED: Bi-monthly Divisional Quality reporting to commence at the April meeting.
A reference file to be created from the April meeting onwards.

i) Risk Management Policy & Risk Management Strategy

This item was discussed earlier in the meeting.

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.

Professor Warne added that the questions raised during the meeting were important and felt a suitable amount of time had been given to these for discussion.

c) Date of the Next Meeting

It was noted that the next meeting would take place on Tuesday, 23 March 2021 at 1.00 pm.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Quality & Clinical Effectiveness Committee Meeting
held on Tuesday 23 March 2021 at 1.00 pm
via Microsoft Teams

Members

Professor T Warne	Non-Executive Director	Chair
Mr K Case	Non-Executive Director	
Dr G Goode	Deputy Medical Director/Director of Clinical Effectiveness	
Mr P Murphy	Executive Director of Nursing, AHPs and Quality	

In Attendance

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)	
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Ms N Briggs	Divisional Head of Clinical Effectiveness	
Dr P Curtis	Divisional Director (Families and Clinical Support Divisions)	
Mrs K Goldthorpe	Associate Director of Quality Improvement	for item 8a
Mrs A Hirst	Corporate Governance Officer	Observer
Mrs L Horkin	Assistant Director of Nursing (Unscheduled Care Division)	
Miss L Kavanagh	Corporate Governance Officer	Minutes
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	Assistant Director of Nursing (Scheduled Care Division)	
Mr J Mannion	Lead Nurse Infection Prevention	
Dr R Morgan	Mortality Lead	for item 5ai
Mrs N Parry	Assistant Director of Nursing (Families Division)	
Ms V Schofield	PA to Senior Business & Delivery Manager	
Ms J Thomas	Senior Business & Delivery Manager	
Mr S Verstraelen	Deputy Director of Quality Governance	

Apologies

Mrs S Adams	Interim Operational Director of Human Resources and Organisational Development
Dr S Bedi	Non-Executive Director
Dr J Gardner	Executive Medical Director
Professor N Latham	Deputy Chief Executive/Director of Strategic Partnerships

Apologies cont.

Mrs S Mawdsley	Infection Prevention Nurse Consultant
Dr S Wiggans	Divisional Director – Scheduled Care

1. Welcome/Apologies for Absence

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 level of assurance. Apologies were received as recorded above.

2. Minutes of the Previous Meeting held on 23 February 2021.

Members, having had the opportunity to review the minutes of the previous meeting held on 23 February 2021 approved them as a true and accurate record, pending the following amendment: Mrs Lewis's apologies should have been noted to the previous Committee.

RESOLVED: The minutes of the previous meeting held on 23 February 2021 be approved as an accurate record, subject to the amendment 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 108: Ockenden review - the action was reported as completed and the full response would be reported back to the April Committee meeting.

Mrs Lewis raised a matter to Committee that NHS England/Improvement (NHSE/I) had highlighted for the Trust's attention, which was the quality of reporting for the 72-hour reviews. It was noted that insufficient evidence had been provided to gain assurance. It had been agreed for the Clinical Commissioning Groups (CCGs) colleagues to work with all Trust's to improve on the quality of reporting for these reviews to ensure all actions and risks were being captured.

Mr Verstraelen advised that he had created a work plan for the new Deputy Director of Quality Governance, which included a review of the quality of evidence of the 72-hour reviews. It was agreed to provide an update on the improvements of reporting to the June Committee.

RESOLVED: Members noted the position of the action list.

ACTION: Mrs Parry to present the full response of the Ockenden review to the April Committee meeting.

Mr Verstraelen to provide a progress report on the improvements of reporting to the June Committee.

CARING

4. a) Patient Story

Mr Murphy introduced the patient story and advised that it was related to a patient with learning difficulties. It was noted that this patient story highlighted the positive aspects of the patients care, as well as improvements that could be made by the Trust to provide personalised care.

The Committee members highlighted the importance of the patients understanding the feedback and content that was being fedback to them in hospital.

Mrs Anderton reported that the Trust had identified 50 members of staff to become Learning Difficulties/Dementia Champions and the training for this role would commence in April 2021.

Professor Warne informed members that NHS England / Improvement (NHSE/I) had agreed that there would be a focus on ensuring members of the public with learning difficulties received their Covid-19 vaccinations. Mrs Lewis advised that the Winter Gardens Vaccination Centre was providing dedicated slots to fulfil this focus.

SAFE

5. a) Mortality Data

i) Quarterly Summary and Learning from Deaths Report

Dr Morgan provided the Committee with the latest nationally validated Trust-wide Summary Hospital Mortality Indicator (SHMI) (12 month rolling-average) figure for Blackpool Teaching Hospitals NHS FT, which was 109.

In relation to the previous agenda item, Dr Morgan confirmed that, when a patient with learning difficulties died, the Trust was required to report this death to the national platform and had to ensure that a case review took place. It was noted that a comprehensive review of 15 deaths of patients with learning difficulties had taken place and an action plan had been created to highlight improvements.

It was noted that the digital Learning from Deaths application was currently undergoing pilot testing in four specialities, with a view to a Trust-wide roll out at the beginning of the new financial year.

Dr Morgan stated that the Trust was undertaking reviews of deaths as a result of nosocomial COVID-19 infections. He went on to confirm that there was a need to provide reassurance to the families, particularly to assure them that their loved ones had received safe care. It was further noted that undertaking these reviews provided the Trust with the opportunity to learn lessons and put processes in place to avoid such deaths.

In response to Professor Warne's question, Dr Morgan confirmed that reporting would be via the Trust's Mortality Governance Committee. It was noted that the findings of the review would be circulated to all relevant areas of the Trust to ensure actions were implemented. Dr Morgan advised that the Trust was required to review a minimum of 20 cases from across the Trust.

Mr Case noted that the Trust had made improvements in relation to its mortality data and sought assurance on what had contributed to these improvements. Dr Morgan responded that a number of aspects had contributed to the improvements, including; ensuring accurate recording of co-morbidities, timely and appropriate responses to CQC requests, and adequate nurses/doctors to patient ratios.

It was noted that the Trust had three areas that required improvement; stroke, sepsis and pneumonia. It was agreed that a report would be provided to the May Committee meeting which includes an overview of the actions and improvements to be undertaken.

ACTION: Dr Morgan to provide a report on stroke, sepsis and pneumonia to the May Committee meeting.

ii) Royal College of Physicians (RCP) Report Action Plan Update

Dr Goode advised that following the discussions at the last meeting, the action plan had been revised, particularly in relation to the inclusion of timescales and action owners. It was noted that there were 22 actions, 11 of which had been completed, seven were overdue and a further five were in progress.

Dr Goode reported that good progress had been made with regards to the actions on the Respiratory Assessment Unit, reducing the length of stay and recruitment within Medical High Care. It was noted that a review of the Terms of Reference would take place to ensure it reflects accountability.

Members commented that it was encouraging to see the good progress and that a good level of assurance had been gained.

b) Serious Incident Report, Duty of Candour Report and Health and Safety Report

Mr Verstraelen confirmed that there had been five new serious incidents reported on Strategic Executive Information System (StEIS) in February 2021. It was noted that as of 9 March 2021, the Trust had 16 on-going StEIS reported serious incidents that would all be reviewed within the prescribed timescales. It was reported that Duty of Candour (DOC) compliance remained at 100%.

Mr Verstraelen reported that the Quality and Safety team would undertake a review of the reporting template, to ensure 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.

Mr Case confirmed that Mr Verstraelen and his team were looking into the health and safety reporting and thanked them for their help with regards to this.

c) Infection Prevention Control (IPC) Report Including an update on Nosocomial Infections and Board Assurance Framework

Mr Mannion reported that a total of 7 Clostridium Difficile infection (CDI) cases were attributed to the Trust in February 2021 and this brought the overall total for the year to date to 80. Members noted that this was a 31% reduction on same period last year. It was noted that no CDI objectives had been set for 2020/21 by NHS Improvement due to the ongoing COVID-19 pandemic, however, it was anticipated that a new objective would be set for 2021/22.

Mr Mannion informed members that the Trust currently had a total of 12 COVID-19 positive inpatients, which was a significant reduction since the peak in January 2021. It was noted that the Trust currently had 1 COVID-19 outbreak, but work was underway to manage this issue.

Mr Mannion reported that it had been recommended that a permanent Corporate Fit Testing Team be established to oversee the fit testing programme and the co-ordination of clinical fit testers within the divisions.

Members were informed that National Institute for Health Protection (NIHP), formerly Public Health England, had launched a new “Every Action Counts” campaign to support infection prevention and control behaviours. Members noted that key IPC messages were regularly communicated to staff.

Mr Case commented that he had received assurance from the report and queried what the Committee could do going forward to support the IPC team. Mr Mannion responded that support had been received from the Board and the IPC team had robust forums to report into.

Professor Warne addressed the ventilation issues at the Trust, and it was noted that Mrs Barnsley was leading on this issue.

Mr Murphy reported that with the guidance and support from NHSE/I, the IPC team had expanded its staffing resource which had had a significant impact on the positive work that had taken place.

Professor Warne congratulated Mr Mannion and his team for keeping the Trust safe at this difficult time and asked for his thanks to be conveyed to the IPC team.

ACTION: Mr Mannion to convey Professor Warne’s thanks to the IPC team.

d) Getting It Right First Time (GIRFT) Update

Dr Goode provided an overview of the GIRFT programme and highlighted that it had been designed to reduce unwarranted clinical variation and provide a peer review tool. It was noted that since the last report submitted to the Committee there had been two further GIRFT deep-dive events, one in Gastroenterology and the second in Acute and General Medicine. Members noted that both events had been well attended and supported by a multi-professional audience. A further event for Neurology was scheduled for 30 March 2021.

Dr Goode reported that since the first GIRFT review took place in June 2014 there had been 32 deep dives recorded on the NHS Future Platform.

It was noted that a GIRFT Oversight Group was being established and it was suggested that it would be beneficial to include a Non-Executive Director (NED) on the group. Professor Warne and Mr Case agreed to raise this suggestion at the next NED meeting and provide Dr Goode with an update.

ACTION: Professor Warne and Mr Case liaise with NEDs to establish a NED to attend the GIRFT Oversight Group.

e) Learning from Community Acquired Pressure Ulcers (ATLC)

Mr Kay reported that the Adult Long Terms Conditions (ATLC) division had recently seen an increase in category three and four pressure ulcers within Community Services. He confirmed that an improvement plan had been developed and was linked to the quality improvements collaborative.

Ms Briggs drew members attention to the Pareto charts on pages five and seven, which showed 24 themes. Committee members were in agreement that any improvements in the reduction of pressure ulcers had to be system-wide and linked closely with the quality improvements collaborative. Members were informed that the Trust was aware of the themes, and an improvement plan would be developed to address the issues.

Mr Murphy advised that the Trust had only experienced an increase of 2 pressure ulcers in comparison to last year which was within the parameters of normal variation.

f) Duthie Audit Feedback

Mrs Bond advised that the report was a summary of findings from the annual Safe and Secure Handling of Medicines Audit (Duthie) for 2021 and confirmed that the full audit would be provided to the Committee upon completion. Members noted that 132 areas were audited in February and March 2021, which included wards, theatres, clinics and satellite pharmacy areas.

Mrs Bond reported that during this year's Duthie Audit, an 'Anaesthetic room standards book' was viewed by pharmacy staff in theatres 6-12. The document contained fridge and room temperature monitoring sheets that were checked as part of the audit and had been incorporated into other checks required to be undertaken in a theatre setting. It was noted that the record keeping displayed in this area was of such a high standard that the practices within the theatres would be rolled out across other theatre areas.

It was noted that there was a marked improvement in medication storage across the Trust and this improvement had been supported by the recent introduction of Collaborative Organisational Accreditation System for Teams (COAST) inspections of clinical areas.

Mr Case questioned whether there was an audit that looked into the culture of administration of medicines and how this was being managed. Mrs Bond confirmed that the Trust completes an 'omissions audit' which covered culture and why medicines were not administered. It was noted that staff were benefiting from tidy and organised handling of medicines and were assured that all medicines were in the correct place.

EFFECTIVE

6. a) Quality and Clinical Effectiveness Indicators from the Integrated Performance Report

Dr Goode reported that a number of the points covered in the report had already been addressed during the course of the meeting. It was noted that the Venous Thromboembolism (VTE) data was not being reported nationally due to the ongoing COVID-19 pandemic, although case reviews were still being undertaken to enable data to be analysed for trends and improvements.

Dr Goode drew the Committee's attention to the data relating to cardiac arrests, which had increased, but confirmed that work was ongoing to improve the treatment of deteriorating patients by working with the Deteriorating Patient Collaborative.

Mr Murphy referred to the patient experience section of the report and highlighted the importance of providing individualised care for each patient. Members were informed that the staffing capacity within the Patient Experience team had been increased over recent months.

RESPONSIVE

7. a) CQC Action Plan Update

Mr Verstraelen reported that 91% of the 117 actions within the CQC Action Plan had been completed, however 10 of the actions were overdue. He went on to confirm that the divisions had developed plans to mitigate the risks and manage the outstanding actions.

It was noted that the Trust had recently received an unannounced visit from the Care Quality Commission (CQC). members were informed that the Trust would be provided with a series of recommendations following the visit, and these would be incorporated into the Trust's overarching CQC action plan. It was agreed that the Committee would be sighted on the progress with the review of the CQC action plan.

WELL-LED

8. a) Quality Improvement Update

Mrs Goldthorpe highlighted the importance of Quality Improvement being threaded through a number of the other reports presented to the Committee.

She went on to report that, with regards to the Pressure Ulcer Collaborative, the 'phase 2 teams' were now in the 'action period 2' phase, which included testing of ideas and some were noted to be moving towards a statistically significant change.

Mrs Goldthorpe also reported that teams were now in the 'action period 1' phase for the Deteriorating Patient Collaborative and would be meeting for their Learning Session 2 on 15 April 2021.

It was noted that there were plans being developed for a "Stakeholder Council" to meet in March and April 2021 to support the 'improve the last 1000 days' programme and ensure it had the correct focus. Mrs Goldthorpe informed the Committee that the Quality Improvement team were looking at carrying out a safety culture survey that was relevant to both hospital and community settings. She agreed to provide an update on this at the next meeting.

Mr Case highlighted the importance of ensuring NED colleagues understood the importance of Quality Improvement, particularly in relation to cultural change and it was agreed to addressed this with the Trust's Chairman.

It was agreed that Mrs Goldthorpe would liaise with Mrs Lewis outside of the meeting to discuss the Safety Culture survey.

ACTION: **Mrs Goldthorpe to provide an update at the next meeting with regards to the Safety Culture survey.**

ACTION: **Mrs Bosnjak-Szekeres to commence conversations with the Chairman to ensure NEDs were aware of the quality improvements in terms of the cultural changes.**

ACTION: **Mrs Goldthorpe to liaise with Mrs Lewis outside of this meeting to discuss the Safety Culture survey.**

b) Corporate Risk Register (CRR)

Mr Verstraelen reported that he had met with KPMG, the Trust's internal auditors to discuss the outcomes of the internal audit review of the operating effectiveness of the Trust's risk management processes. It was noted that KPMG had drafted their report and had given an assurance rating of significant assurance and had identified some minor improvement opportunities around the design of the Risk Management Framework.

Mr Verstraelen advised that a comprehensive risk management training programme had commenced for staff. Members noted that the team was working on providing a live Corporate Risk Register to future Committee meetings.

It was noted the importance of ensuring the CRR linked in with the Board Assurance Framework (BAF) and Mr Verstraelen confirmed that the Trust's Risk Manager had now met with the Executive Directors regarding the CRR during the BAF review sessions.

It was agreed for ease that the report would be provided in an A3 format going forward.

ACTION: **Mr Verstraelen to provide the report in a A3 format going forward.**

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

It was noted that there were no items to be escalated to the Board.

e) Annual Work Plan

The Annual Work Plan was noted by the Committee.

CLOSING MATTERS

9. a) Any other Business

104-Week Breaches

Mrs Lewis advised that it was a national priority to review any 104-week breaches and informed the Committee that the Trust currently had four of these. It was noted that clarity was required about where the reviews of harms would be reviewed and tracked. Professor Warne agreed he would provide clarity on where harm reviews would be reported.

ACTION: **Professor Warne to seek clarity of where harms reviews would be reported to.**

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, 27 April 2021 at 1.00 pm via MS Teams.

Blackpool Teaching Hospitals
NHS Foundation Trust

Minutes of the Operations Committee Meeting held on Thursday 25 February 2021 at 2.00 pm via Microsoft Teams

Members:	Mr Mark Beaton	Non-Executive Director (Chair)
	Dr Sheena Bedi	Non-Executive Director
	Mr James Wilkie	Non-Executive Director
	Mrs Janet Barnsley	Director of Operations (Planned Care)
	Professor Nicki Latham	Deputy Chief Executive/Director of Strategic Partnership
	Mr Kevin Moynes	Joint Director of Human Resources & Organisational Development (HR & OD)
	Mr Feroz Patel	Interim Director of Finance
In Attendance:	Mrs Sharon Adams	Deputy Director of Workforce, Education and OD
	Mrs Jo Bark	Deputy Director of Operations
	Mrs Angela Bosnjak-Szekeres	Director of Corporate Governance
	Mr Paul Cunday	Associate Director of Finance – Operational Finance
	Mr Steve Fogg	Chairman of the Trust Board
	Mr Steve Gratrix	Governor Observer (Public) – Fylde Constituency
	Mrs Sharon Robson	Director of Procurement, Lancashire Procurement Cluster (for item 12)
	Mrs Tracey Squire-Evans	Associate Director of Finance – Financial Planning & Commissioning
	Mr Stefan Verstraelen	Deputy Director of Quality Governance (for items 4 & 5)
	Mrs Jacinta Gaynor	Membership & Governors Officer (minutes)

1. Welcome/Declarations of Interests/Apologies for Absence

The Chair welcomed members and attendees to the Operations Committee meeting. The Chair noted, for the context of the meeting, the extremely difficult circumstances NHS staff were currently working under and thanked all staff for their work.

It was noted that Mr Wilkie declared his role on the Board of Atlas.

Apologies were received from Mrs Natalie Hudson, Interim Director of Operations (Urgent & Emergency Care).

2. Minutes of the Previous Meeting

The minutes of the previous meeting held on 25 January 2021 were presented for approval.

It was noted that the updates provided by Mr Gratrix, Public Governor for Fylde had been incorporated into the minutes, which had been circulated to the Committee.

Mrs Squire-Evans requested that Miss McNeill's name be amended from O'Neil within the minutes.

RESOLVED: The minutes of the previous meeting held on 25 January 2021 were agreed as a correct record subject to the aforementioned amendments.

3. Matters Arising

a) Action List

It was noted the majority of actions had been completed, a number of actions had been included on the agenda for discussion, and further actions were due to be discussed at the April meeting.

4. Care Quality Commission (CQC) Action Plan: Progress Update (items relating to Operational and HR & OD matters)

Mr Verstraelen drew attention to the highlight report in respect of the Care Quality Commission (CQC) action plan and confirmed that good progress had been made regarding the operational actions with 90% of all actions being completed. It was noted that from the wider CQC action plan of 249 actions, 233 had been completed and the 16 overdue actions had been discussed with CQC during the review session on 24 February 2021. Mr Verstraelan reported that no concerns had been raised by CQC and they had been assured about the process and that the risks were being robustly managed.

There was a short discussion in relation to Internal Audit (IA) review and their perspective that there had been a lack of progress with risk management. It was agreed that Mr Verstraelan liaise with Internal Audit and provide a progress update on risk management before the next Audit Committee Meeting.

ACTION: Mr Verstraelan to provide and update Internal Audit with progress on risk management prior to the next Audit Committee Meeting.

Mr Wilkie commented on the outstanding red actions and queried what plans were in place to ensure that these would be resolved in the near future. Mr Verstraelan confirmed that some of the work had been put on hold due to the pandemic, however, there was good progress being made with the action plan overall and assured members that all actions were being well managed through the 'confirm and challenge' sessions.

The Chair commented that the Committee needed to see a systematic and structured approach to future CQC inspections going forward.

5. Corporate Risk Register (CRR)

Mr Verstraelen referred to the ongoing development of the CRR and the development of the Risk Management Policy (RMP) and the Risk Management Strategy (RMS). It was noted with these documents in place, it would enable greater links with the Divisional Risk Registers and the CRR, which in turn would connect with the Board Assurance Framework (BAF). He confirmed that appropriate processes were in place and Internal Audit was auditing the risk management processes. He requested the Committee to approve the RMP and the RMS in order that it be presented to the Board of Directors for ratification next week.

In response to Mr Wilkie's question relating to reference 3046 – Medical Devices risk and whether there was sufficient financial provision on a rolling basis, Mr Patel confirmed there had been significant investment over the past 18 months in relation to replacing equipment and managing service/maintenance contracts and ensuring that work was ongoing to identify correct funding contracts.

Mrs Bosnjak-Szekeres informed the Committee that funding was also being secured via the Blue Skies Charity through charity fundraising campaigns, such as for the MRI scanner for the Emergency Village.

In response to Dr Bedi's query on whether the document was a safe, workable document whilst work was ongoing, Mr Verstraelan confirmed that apart from a few caveats around the accuracy of the scoring process, which were being addressed through an ongoing training programme and storyboard, the document provided a good oversight of where the main risks were and how the Trust managed those risks.

Mr Verstraelan sought approval of both the RMP and RMS documents to be taken to the Board of Directors meeting for ratification.

RESOLVED: The RMP and RMS were approved by the Committee.

6. 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 attention to the previously circulated reports and highlighted the key areas below. It was noted Mr Patel presented a slightly updated version of the presentation slides.

Key Financial Risks

Cash Position and Forward View - only **limited assurance** could be given that the Trust would not need further interim revenue support in 2020/21.

Deliverability of the Forecast – only **limited assurance** could be given to the end of January 2021.

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.

Deliverability of Forecast

Mr Patel reported there were concerns with the use of agency staff on escalation wards and the lack of restoration/elective activity. Mr Patel presented the pay and non-pay information and stated that he would be happy to take questions from members.

2020/21 Financial Forecast

Mr Patel reported that the financial plan and trajectory indicated a deficit of £20.6M by the end of January 2021. However, a target had been set for the Trust of a 'best case' deficit of £19.5M, and good progress was being made towards that target.

Cash Position

Mr Patel confirmed that as a result of a revenue submission, the Trust would receive revenue funding for March 2021. He confirmed that the cash pressure was expected to continue into April 2021.

The Chair requested whether a Divisional cash breakdown was available and for this to be brought to the next meeting. Mr Patel confirmed this was available.

ACTION: Mr Patel to bring a divisional cash breakdown to the next meeting.

Financial Planning

It was noted that Mr Patel was due to take part in a national call for Finance Directors at 4 pm. Mr Patel confirmed that financial planning had been deferred to the end of quarter 1 in 2021/22, and no current guidance had been published. He confirmed that the Trust would continue to base assumptions on the financial planning arrangements prior to the onset of the pandemic.

Mr Patel stated that any further updates would be reported to the Board of Directors Meeting on 4 March 2021.

ACTION: Mr Patel to report any further updates to the Board of Directors Meeting on 4 March 2021.

Business Cases & Developments - Emergency Village/Critical Care (EVCC) Update

Mr Patel confirmed that following review by the NHSE/I team and their request for a full business case to be produced, the business case was due to be discussed at the Board of Directors Meeting on 4 March 2021. Mr Patel informed the Committee about the conditions in relation to the funding and advised that the £12M funding was required to be drawn down and spent by March 2022. Mr Patel assured the Committee that there were no concerns

about this and that the capital monies could be deferred into the Integrated Care Services (ICS) support for the next year. He confirmed that seeking Blue Skies funding for the MRI scanner had been approved by the regulator. Mr Patel informed the Committee that a workshop was due to take place on 5 March 2021 with the Board of Atlas to discuss the formal proposal for the Emergency Village and the capital transfer.

In response to Mr Wilkie's query in relation to the conditions set by NHSE/I, Mr Patel confirmed the conditions were; Atlas Board agreement, letter of support for Blue Skies funding of the MRI scanner and the drawing down and spending of the funding by March 2022.

In response to Mr Wilkie's query in relation to Appendix A of the Finance report, Mr Patel confirmed that the figures indicated in the appendix did not include the number of substantive international recruits and that agency usage would reduce significantly, however, this did not correlate with the substantive staff fill rate. It was noted that as recruitment was increased it would be expected to see a significant change. Mr Patel agreed to provide a further update at the April meeting.

ACTION: Mr Patel agreed to provide a further update at the April meeting.

There was a short discussion in relation to financial planning and what guidance the Trust was using to base its financial forecasting assumptions on. Mr Patel confirmed that in the absence of any agreement, the Trust continued to financially plan based on pre-pandemic guidance.

The Trust Chairman queried whether all costs drivers had been identified and requested a meeting be arranged to further discuss, and to include Mr Patel, Mr Moynes and himself.

ACTION: The Corporate Team to arrange a meeting between Mr Patel, Mr Moynes and the Trust Chairman to discuss financial forecast planning.

c) Month 10 Position

It was noted that this item has been discussed as part of the finance report under the cash position.

ACTION: Items for escalation/reporting to the Board:

- **Overall limited assurance for finances; deliverability of forecast, cash position and sustainability.**
- **Forecast deficit of £20.6m at the end of January 2021.**
- **Target of £19.6m deficit.**
- **Funding requirement from March 2021.**
- **The EVCC full business case update**

7. Operational Performance Update

a) Performance Metrics and BAF Update

Mrs Barnsley reported that the planned and unplanned care performance metrics referred to BAF item 3.1, and the score remained at 20, with a target of 12; it being noted that the main drivers were the continued high bed occupancy levels due to Covid-19 and the affected restoration programme.

b) Operational Performance Presentation (Planned Care)

Mrs Barnsley drew members' attention to the presentation and provided a detailed update on the planned care activity, including referral to treatment (RTT), 52-week breaches, cancer performance, diagnostic performance, elective and non-elective re-admissions, and cancelled operations. It was noted there had been slight improvement in RTT volumes and cancer waiting times. Members were informed that there had been a further increase in 52-week waiters and diagnostics, and overall performance remained below the target.

Limited assurance was provided for:
Referral to treatment (RTT) performance,

52-week breaches,
62-day cancer waiting times and
6-week diagnostics.

Mrs Barnsley reported there had been some good work within the Children's Ward accommodating adolescent day case unit and bringing services back on-line.

Mrs Barnsley referred to the previously circulated report and highlighted that outpatient activity data was currently being investigated and a further update would be provided once this was completed. It was noted the national validation work had been completed for elective pathways and harm reviews were being undertaken for patients waiting in excess of 35 weeks.

In response to Dr Bedi's query on the impact of the cancer trajectory not improving, Mrs Barnsley confirmed the issue has been around staffing which had now been addressed. It was noted that Mrs Bark would provide a further update in relation to endoscopy.

In response to Dr Bedi's query regarding the impact of the advice and guidance provided to colleagues, Mrs Barnsley confirmed there had been a positive impact and she would be happy to share a detailed paper on this with the Committee.

ACTION: Mrs Barnsley to share the comparative data pack with regards to advice and guidance.

a) Operational Performance Presentation (Urgent & Emergency Care)

Mrs Bark provided a detailed update on urgent and emergency activity, including Accident & Emergency (A&E) breaches, performance and bed occupancy.

- Accident & Emergency (A&E) Performance - **moderate assurance** provided
- Length of Stay (LoS) **- moderate assurance** provided

It was noted that although the Emergency Departement type 1 performance had slighted improved, it had not met the trajectory due to continued issues with bed occupancy and patient flow. It was noted there had been de-escalation to medium risk wards, however, there were still challenges in relation to patient safety being maintained due to Covid-19.

It was noted during January there had been 16 'Decision To Admit' (DTA) breaches, which had been an improvement over the previous two months.

Mrs Bark stated that an agreed process with North West Ambulance on the hand over process was showing a positive impact.
]
Mrs Bark informed the Committee that Endoscopy continued to present challenges and confirmed the action plan was due to be presented at the next Executive Directors' Meeting.

There was a short discussion in relation to the NHS 111 programme and how this should be an important part of the process of the A&E patient pathway. The Chair stated that the Committee needed to understand the impact and numbers involved and requested that a trajectory would be useful for the Committee. Mrs Bark confirmed this work was being undertaken.

In response to the Chair's query in relation to central discharging, Mrs Bark confirmed this was progressing well, but still needed some work.

ACTION: Items to be escalated/reported to the Board of Directors in relation to planned and urgent and emergency care:

- **Improvement in RTT,**
- **Decrease in 62-day cancer waiting times,**
- **National targets not being achieved but stable performance,**
- **Endoscopy action plan – staffing work with HR underway**
- **Note plan for restoration 2019/20 and 2020/21 expected targets**
- **Reduction of 12 hour breaches – good news**
- **Discharge team working better**

- **Length of stay on hold**

8. Human Resources & Organisational Development Performance Update

a) Performance Metrics and BAF Update

Mrs Adams referred to the presentation slides and reported on the BAF, People Plan update, Growing for the Future, Looking after our People, Flu Campaign, Staff Survey, Health and Wellbeing update and Belonging to the NHS – Reverse Mentoring.

It was noted that the assurance level remained as **partial assurance.**

b) HR & OD Performance Presentation

Mrs Adams confirmed that an update on the People Plan would be provided at the Board of Directors' meeting in May 2021 and confirmed that the ongoing work at the Trust was being undertaken in-line with both national and regional requirements.

Mrs Adams drew members' attention to the trajectory within the presentation slides and confirmed that the target of 2000 new nurses had been achieved and confirmed the a total of 204 overseas nurses were currently working within the Trust, 22 of whom were due to qualify as NMC registered nurses, with a further 36 in April, 52 in May and 8 in June 2021. A further 137 would be due to arrive between March and October 2021.

The Chair acknowledged the ongoing, hard work being undertaken to achieve the trajectory targets and stated the he was assured about the progress made.

In response to Mr Wilkie's query in relation to the £1.1M increase in budget funding and whether this was within the existing budget, Mrs Adams confirmed the recruitment of overseas nurses was nationally funded and was claimed back once the nurse was fully qualified. Mr Patel commented that Task and Finish Group is monitoring the staffing budgets.
The Chair stated that in order to complete the graph it would be helpful to understand the impact of sickness on the budget/he staffing funding.

ACTION: That Finance and HR work together to produce data on the impact of sickness on budget/funding.

Mr Gratrix commented that he had recently spoken to a nurse who had been in Year 3 of her studies and had indicated that she was unsure whether she would remain. He queried whether information was gathered in connection with reasons for staff not remaining at the Trust. Mrs Adams confirmed that work was being undertaken to gather this information. Mr Moynes confirmed that a total of 96% of students who qualify remain with the Trust. It was noted that senior leaders needed to have the time and skills to enable supportive conversations to take place.

Mrs Adams informed the Committee that there was a lot of work being undertaken with regards to a national workforce recovery taskforce across Lancashire and South Cumbria and a bid had been submitted to NHS Charities for £185k to refurbish staff facilities.

The Committee noted the ongoing work in relation to the flu campaign and Covid-19 vaccinations, and it was confirmed that a Grand Round would be undertaken to heighten awareness and encourage participation. Mrs Adams reported that the National Staff Survey update was due to be reported at the Board of Directors on 4 March 2021 with a full report at the meeting in May 2021.

Mrs Adams reported that the Trust had been successful in an application to the NHS Leadership Academy Reciprocal Mentorship Programme and an update would be provided to the Board of Directors on 4 March 2021. She stated that this would be a joint initiative across the Trusts in Blackpool and East Lancashire and Dr Bedi was the NED lead for the Trust. The Chair suggested that this initiative should be linked into succession planning and not just the mentoring role.

ACTION: Items to be escalated/reported to the Board of Directors:

- **Safe staffing levels and 2000 new nurses target achieved**
- **Staff health and well-being - good news story**
- **Staff Survey initial results encouraging**
- **NHS Leadership Academy Reciprocal Mentorship Programme**
- **Next step to undertake work on a medical staff trajectory**
- **Flu and covid-19 vaccinations**

9. System and Partnership Working

a) Board Assurance Framework Update

It was noted there was no significant changes to the BAF score and assurance levels.

b) System and Partnership Working Update

Professor Latham drew the Committee's attention to the previously circulated report and provided a detailed update in relation to the ongoing work across the ICS and the oversight governance groups being set up and acknowledged that the Trust needed to ensure the right people were involved at the right levels.

There was a detailed discussion about the collaborative work being undertaken across Lancashire & South Cumbria (L&SC) and the remit of the Trust within this. Professor Latham stated that she would welcome input from the Non-Executive Directors. It was agreed that a meeting be arranged to include Professor Latham, Dr Bedi, and the Trust Chairman.

ACTION: The Corporate Assurance Team to arrange a meeting to include Professor Latham, Dr Bedi, and the Trust Chairman to discuss.

The Chair and Mr Wilkie commented on the importance of getting this right and the Chair agreed to escalate to the Board of Directors.

c) Operational Priorities Presentation

Mrs Latham referred to the previously circulated paper and asked the Committee to note the Trust's response to the operational priorities letter from NHS England and NHS Improvement published in December 2020.

ACTION: Items to be escalated/reported to the Board of Directors:-

- **Ongoing work being undertaken as part of the ICS.**
- **The importance of the role of the Board of Directors within ICS developments.**
- **Trust response to the Operational Priorities report from NHSE/I.**

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

For the purposes of the minutes, it was noted this item was presented and discussed following the Finance Update – agenda item 6.

Mr Patel provided some background on the LPC and invited Mrs Robson to present the update. Mrs Robson informed the Committee that following feedback from the Chair of the Committee, the presentation that had previously been circulated with the papers, had been updated with comparative data against the trajectory. Mrs Robson referred to the updated presentation and provided a detailed update on the savings made across the cluster versus the trajectory. She informed the Committee members that LPC had achieved medium scale savings in excess of £32M, which ranked the LPC in the top quartile in relation to the 'model hospital' metrics across the country.

There was a short discussion on how to achieve improvements in volume in order to drive up savings and it was noted that work was ongoing to liaise with other functions, such as Estates and Facilities. The Chair stated that it would be useful to understand levels of compliance and asked for an update within future reports.

ACTION: Mrs Robson to include data on levels of compliance in future updates to the Committee.

In response to Mr Wilkie's query of how to capture efficiency programmes and savings, Mr Patel confirmed there were two elements; no budget for inflation pressures and where savings were made these were taken out of the budget.

In response to Dr Bedi's query, Mr Patel confirmed that everything was validated by the Finance Department. Mrs Robson added none of the budgets belong to the LPC and that they work hand in hand with the Trust staff to bring budgets into line.

13. Annual Workplan 2021/22

The document was noted and agreed by the Committee members.

14. Items Recommended for Escalation to the Board

It was noted that the items recommended for escalation to the Board of Directors had been identified during the meeting, with the exception of agenda items 4 and 5 noted below.

ACTION: Items to be escalated/reported to the Board of Directors:-

Agenda item 4 - CQC action plan:-

- **good progress was being made.**
- **system plan needed for future inspections.**

Agenda item 5 – Corporate Risk Register

- **CRR noted and accepted.**
- **RMP and RMS approved.**

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15. **Any other Business**

a) Risk Management Policy and Risk Management Strategy

It was noted this item has been discussed and approved under agenda item 5 – Corporate Risk Register.

RESOLVED: The RMP and RMS were both approved by the Committee.

16. Formal Meeting Review

The Chair asked Committee members for feedback in relation to the questions posed as part of the meeting review.

Mr Gratrix commented that he completes a feedback form which is reported to the formal Council of Governors and he provides significant assurance on the Committee. He clarified to the Committee this was based on how the Committee was run and the information discussed and shared at the Committee, and not the levels of assurance provided during the Committee meeting.

The Chair commented that the meeting had gone very well and thanked Committee members for their time and input in terms of the preparation for the meeting and expressed thanks to the staff working in the Trust, for their excellent commitment shown in these extremely difficult circumstances.

17. Date of Next Meeting

It was noted that the next meeting would take place on Thursday, 25 March 2021 at 2 pm.

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Operations Committee Meeting

held on Thursday 25 March 2021 at 2.00 pm

via Microsoft Teams

Members		
Mr M Beaton	Non-Executive Director	Chair
Mr J Wilkie	Non-Executive Director	
Mrs J Barnsley	Director of Operations (Planned Care)	
Mrs H Hudson	Director of Operations (Emergency & Urgent Care)	
Professor N Latham	Deputy Chief Executive/Director of Strategic Partnership	
Mr K Moynes	Joint Director of Human Resources & Organisational Development (HR & OD)	
Mr F Patel	Interim Director of Finance	
In Attendance		
Mrs S Adams	Deputy Director of Workforce, Education and OD	
Mrs A Bosnjak-Szekeres	Director of Corporate Governance	
Mr P Cunday	Associate Director of Finance – Operational Finance	
Mr S Gratrix	Governor Observer (Public) – Fylde Constituency	
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		
Dr S Bedi	Non-Executive Director	

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.

He referred to the media broadcast the previous evening and commented that it had been a very powerful piece. He assured the Executive Directors (EDs) that in the context of the meeting, the role of Non-Executive Directors (NEDs) was to be supportive and constructive. Mr Moynes agreed and commented that it was a stark reminder that workforce restoration would facilitate service restoration, but only at a rate that staffing levels would allow.

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.

RESOLVED: The minutes of the previous meeting held on 25 January 2021 were agreed as a correct record.

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.

4. **Care Quality Commission (CQC) Action Plan: Progress Update (items relating to Operational and HR & OD matters)**

Mr Verstraelen drew attention to the highlight report in respect of the Care Quality Commission (CQC) action plan and confirmed that good progress had been made, with 92% of workforce actions and 98% of performance actions being completed. Mr Verstraelen reported that following the CQC inspection report, due to be published on 26 March 2021, there were a number of actions to add to the action plan and a number of recommendations that needed to be addressed. He confirmed that work was being undertaken to consolidate the action plan and it would be presented in a different format to future meetings.

Mr Verstraelen stated that work was being undertaken in conjunction with the Good Governance Institute (GGI) to prepare for the next round of CQC inspections.

The Chair referred to the previously published interim inspection report, and queried that of the six 'must dos', three had already been included on the action plan and had been marked 'green'. He requested that a verbal update be provided to the next meeting as to why these had not been captured, why this happened and what plans were being put in place to prevent this happening again.

ACTION: Mr Verstraelen to provide a verbal update to the next meeting in relation to the three 'must dos' not captured last time round and the plans to be put in place to prevent this happening again.

5. Corporate Risk Register (CRR)

Mr Verstraelen provided an overview of the ongoing development of the CRR. He confirmed that work was being undertaken with the Ulysses system provider to create a simple reporting template which would enable real time reporting. Members were informed that the Trust's internal auditors, KPMG, had notified the Trust that the required improvements had not been seen at the pace or scale required in terms of the systems and processes for the management of operational risks.

6. 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 activity, including Accident & Emergency (A&E) performance, Length of Stay (LoS)/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, due to a revised set of metrics being introduced through the A&E Oversight Board, there would be a need to revise the urgent and emergency care operational performance presentation for future meetings and that members would be able to compare the Trust's performance with other Trusts.

Members noted that although the Emergency Department type 1 performance achieved 84.4%, it had not met the required trajectory. It was further noted that the 12-hour trolley wait standard had seen a gradual decline between October 2020 and March 2021, with 7 breaches reported in March 2021, six of which were noted to be mental heath related breaches and one physical health breach. Mrs Hudson reported there would now be a focus on the 4-hour ED standard and forecasted an improvement in performance from April 2021 onwards. She confirmed that a 12-month A&E action plan would be presented to the next meeting.

Following a brief discussion, it was agreed that there needed to be an agreed set of words used within reports and that this needed to be standardised across the Committee and Board reporting.

In response to Mr Beaton's query relating to the 12-month action plan, Mrs Hudson confirmed that, in previous years, this would have formed part of the annual planning guidance, against which the Trust would be held to account, however due to the ongoing pandemic, this had been deferred to May 2021. Mrs Hudson informed the Committee that further work be undertaken to produce revised trajectory.

Mr Beaton sought clarity around the management control tools used to monitor progress and the frequency with which monitoring took place. Mr Patel confirmed that under normal circumstances, this would have been achieved through the operational plan, but had been paused in order to focus on restoration of services. He confirmed that the operational plan was due to be submitted in May 2021 and that the EDs monitored progress on a weekly basis through their meeting cycle.

Mrs Hudson commented that the Committee would begin to see a standardisation in performance reporting in conjunction with the previously mentioned metrics reported to the A&E Oversight Board.

Mr Wilkie drew attention to page 24 of the full papers and stated that the Committee needed to have confidence in the data presented. He questioned whether the decrease in the number of patients presenting through A&E was driving the increase in performance or was it as a result of the improvement interventions that had been put in place? Mrs Hudson confirmed that work was being undertaken to revised the trajectory for 2021/22.

Mr Gratrix referred to the discussions held at the previous meeting regarding the NHS 111 pilot and queried whether the scheme was being promoted locally. Mrs Hudson confirmed that the scheme was being well used and confirmed she would make enquiries with the national team with regard to media communications.

RESOLVED: Members received the report and noted its contents.

ACTION: Mrs Hudson to present the 12-month A&E action plan to the next meeting.

Mrs Hudson to make enquiries with the national NHS 111 team with regard to media communications.

c) Hospital Discharge Programme

In response to Mr Gratrix's query around the definition of discharge, Mrs Hudson referred to the previously circulated report and confirmed that the Trust's Hospital Discharge Board (HDB) fed into the overall Integrated Care System (ICS) Discharge Board to ensure compliance with national data.

She drew attention to the key performance indicator (KPI) data regarding discharge pathways and provided an example of pathway 1 criteria, that had the aim 'to discharge back home 24 hours after being declared medically fit'. She reported that within the last 12 months the average time taken to discharge patients' home after being declared medically fit had been 2.5 days. Mrs Hudson confirmed that work was being undertaken to achieve the LoS targets.

In response to Mr Wilkie's query whether the work undertaken had identified where the blockages were, Mrs Hudson confirmed that a mapped pathway had been identified and was being piloted on Ward 23 and, assuming it proved effective, it would be rolled out across the Trust.

d) Operational Performance Presentation (Planned Care)

Mrs Barnsley provided a short presentation, which included a detailed update on the 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 improvement 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 relation to critical care and confirmed that de-escalation had been able to take place. She reported that there had also been an increase in theatre activity, especially with the re-introduction of the paediatric list and confirmed that an agreement had been made with the independent sector (IS) to continue support in 2021/22.

It was noted that the majority of cancer targets had been achieved during February 2021, apart from 62-day screening performance and maximum 62-day wait from urgent referral to treatment for all cancers, and it was noted that the Trust had been the best performer across the Lancashire & South Cumbria Integrated Care System (ICS). 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, and 70% of Trust staff had also received their first vaccination. Members noted that the second phase of the 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.

e) Restoration Update

Mrs Barnsley provided a detailed update on restoration plans and confirmed that the national planning guidance was due to be published shortly. She reported that a regional submission had been made for elective restoration plans. Mrs Barnsley stated that a system-wide plan would be in place to address the backlog of 52-week waiters and additional funding would be required/sought. She confirmed that an update would be presented to the next meeting of the Board of Directors.

In response to Mr Wilkie's query about how the additional £4m funding requirement would be met, Mr Patel confirmed that the funds would come from the £1bn restoration fund and that the ICS had been allocated around £100m. Members noted that of the £100m, the Trust had been allocated around

£15m. He confirmed that, should the Trust meet the required activity levels for the current year, there was the possibility of accessing additional funds.

In response to Mr Wilkie's further query in relation to outsourcing and whether the Trust would have the staff in place, Mr Patel confirmed this would be part of ICS plan. Mrs Barnsley confirmed that staff would be either insourced or outsourced to operate day cases on a 7-days per week basis.

In response to Mr Beaton's query about when the Committee would receive information about the costing and budget, Mr Moynes confirmed that an update from the Task and Finish Group was due to be reported to the Committee meeting in June 2021, as per the action plan.

Members briefly discussed the actions being undertaken to encourage the 30% of staff who had not had their first vaccination. Mr Beaton stated that it may be useful to look at what level of Black, Asian and Minority Ethnic (BAME) staff had not been vaccinated and determine the reasons for this. Mrs Barnsley confirmed that the Occupational Health department were currently contacting unvaccinated staff to understand the reasons why they had not taken up the offer of a vaccination and to address any concerns they may have.

Mr Beaton suggested that it may be useful for the next meeting for the EDs to consider the use of league tables to compare the Trust's performance against other Trusts.

RESOLVED: Members received the report and noted its contents.

ACTION: The EDs to consider the use of league tables for the next meeting, to compare the Trust's performance against other Trusts in relation to the COVID-19 vaccination programme.

Items to be escalated/reported to the Board of Directors in relation to planned and urgent and emergency care were noted to be: performance against other Trusts; A&E type 1 performance improvement; slight LoS improvement, but still remains challenging; restoration in progress, but still remains challenging with limited assurance; and endoscopy and echocardiogram action plans.

7. Human Resources & Organisational Development Performance Update

a) Performance Metrics and BAF Update

Mrs Adams provided a short presentation which included the following updates: the Board Assurance Framework (BAF); a 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 continued good work in closing the vacancy gap. She confirmed that discussion had taken place with Staff Side colleagues. Mr Patel drew attention to a caveat in the trajectory in relation to the assumed sickness level of 5%. A short discussion took place in relation to the current nurse staffing gap and how it was affected by sickness levels. Mr Patel confirmed that the Board of Directors had agreed that until agency spend was down and full recruitment was achieved, the agency spend would be re-established on 1 August 2021.

ACTION: Mr Patel/Mr Moynes to provide an update on the retirement profile at the June 2021 Committee meeting.

The Chair acknowledged the hard work being undertaken to achieve the trajectory targets and stated the he was assured about the progress made.

c) Looking after our People

Mrs Adams informed members that there was a lot of work being undertaken with regards to a national workforce recovery taskforce. She highlighted the four themes that were being considered; time and space to recover; preventative HWB; delivery of effective support to staff; and maintaining the existing HWB offer. Mrs Adams confirmed the Task and Finish Group would conclude at the end of the month and that an update would be provided to the next Committee meeting.

ACTION: An update to be provided from the Task and Finish Group to the next Committee meeting.

d) National Staff Survey Result 2020

Mrs Adams provided a detailed update on the National Staff Survey results for 2020. It was noted that these had been the best results over the last seven years of the survey. Members were informed that a 'deep dive' into particular areas highlighted by the survey results. Mrs Adams confirmed that an action plan would be developed to address the areas that require improvement.

e) Belonging to the NHS

Mrs Adams reported that the Board of Directors had supported the NHS Leadership Academy Reciprocal Mentorship Programme and there had been a lot of interest from both the NEDs and EDs to take part in the programme.

Mrs Adams reported that a summit had taken place on 5 March 2021, supported by NEDs and EDs, the Freedom to Speak Up Guardian and 25 SAS and IMG doctors had attended. Members noted that the summit had been successful and well received by those attending.

Mr Wilkie referred to a previous discussion at the Committee, where it had been agreed to set up a Board of Directors session to discuss and understand BAME staff issues and stated that this needed to be actioned.

Mr Beaton stated that work needed to be undertaken on a medical staffing trajectory and that this should be the focus for the next Committee meeting.

RESOLVED: Members received the report and noted its contents.

ACTION: Mr Moynes /Mrs Adams to ensure a Board of Directors session is arranged with regards BAME staff issues.

Mr Moynes/Mrs Adams to present the medical staffing trajectory to the next Committee meeting.

Items to be escalated/reported to the Board of Directors were noted to be: Ongoing work to reduce nursing vacancy gap; improvement in Staff Survey results, summary of highlights; actions to address percentage of staff not completing Staff Survey; focussed Health and Wellbeing programme – Take a Moment, Executive Team support; and actions to increase the number of staff being vaccinated.

8. 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 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.

Deliverability of the Forecast – significant assurance could be given to the end of February 2021.

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.

2020/21 Financial Performance

Mr Patel reported that an updated financial forecast of a £18.6m deficit was submitted in March 2021, following the receipt of additional funding to cover the loss of non-NHS income. He confirmed that this would continue to be monitored against the £20.6m planned deficit.

Mr Patel confirmed that significant work was being undertaken and that an operational plan would be presented to the next Committee meeting.

In response to Mr Wilkie's query relating to the 2021/22 budget contingency assumption to eliminate divisional vacancies, Mr Patel confirmed that in the absence of a financial framework, the paper had described the steps being taken to ensure budget holders reduced agency spend.

RESOLVED: Members received the report and noted its contents.

ACTION: Mr Patel to present an operational plan to the next Committee meeting.

Cash Position

Mr Patel confirmed that the Trust would need to borrow a further £3m. He confirmed that supplier payments terms would be extended.

Business Cases & Developments - Emergency Village/Critical Care (EVCC) Update

Mr Patel provided a detailed update on the EVCC project and confirmed that the outline business case (OBC) had been approved by NHS England/Improvement (NHSE/I) and the full business case (FBC) had been submitted. He confirmed that work was ongoing in conjunction with Atlas to transfer the EVCC project.

Members briefly discussed the funding for the EVCC and the plans that were in place to ensure the funding was utilised. Mr Patel confirmed that a Task and Finish Group had been set up between the Trust and Atlas to monitor and progress. Mr Wilkie referred to the recent Atlas Board of Directors Meeting and stated that considerable work was being undertaken by both organisations to progress the project. Mr Beaton requested an update be provided to the next Committee meeting.

ACTION: **Mr Patel to provide an update on the EVCC project to the next meeting.**

c) Month 11 Position

It was noted that this item has been discussed as part of the finance report under the cash position.

RESOLVED: **Members received the report and noted its contents.**

ACTION: **Items for escalation/reporting to the Board were noted to be: overall limited assurance for finances; cash position and sustainability; slight improvement in assurance for deliverability of forecast; forecast deficit of £18.6 at the end of February 2021; EVCC project update; and forecast update in June 2021.**

9. System and Partnership Working

a) Board Assurance Framework Update

It was noted there was no significant changes to the BAF score and assurance levels.

b) System and Partnership Working Update

Professor Latham provided a detailed update in relation to the ongoing work across the ICS. She confirmed that discussions about the Trust's future strategy would be taking place at the next informal Board of Directors Meeting on 1 April 2021.

Members discussed the collaborative work being undertaken across the ICS and Professor Latham referred to the previous discussion in relation to standardisation of data and confirmed this was a system-wide initiative

RESOLVED: **Members received the report and noted its contents.**

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

It was noted that the items recommended for escalation to the Board of Directors had been identified during the meeting.

Members briefly discussed the HWB offer to staff and Mr Gratrix offered his support. Mr Beaton acknowledged his support but stated that formalisation was required in relation to the Governors' role. Mr Beaton stated that staff health and wellbeing should form part of managers' objectives and their appraisals.

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.

Mrs Bosnjak-Szekeres commented that she had noticed a vast improvement in the running of the meeting and the content presented at the meeting, including the assurance about the governance of the Committee.

Mr Gratrix commented that he had recently feedback to the Council of Governors Meeting that he was very supportive of the Committee and he had provided his assurances to the Governors.

Mr Beaton commented that the meeting had improved and had become more standardised, although there were a few areas, such as terminology that still required some work. He referred to the Quality and Clinical Effectiveness Committee format and requested that the EDs give some thought to whether divisional staff should be invited to attend the meetings.

Members briefly discussed the purpose of inviting divisional staff to the meeting and whether there was a remit within the talent management programme to provide reporting experience to Board committees for divisional staff. It was suggested that one way could be 'deep dive' sessions with various divisions.

Mr Wilkie commented that the purpose of the meeting was to provide assurance in a succinct manner and that long presentations were not what the Committee required. He stated the Committee needed to be clear on the objective for inviting divisional staff.

Mr Beaton also noted that in order to gain a better understanding of the workings and content of the committee's business, it may require staff to attend on more than once occasion.

Mrs Bosnjak-Szekeres commented that she attended the Q&CE Committee and confirmed that senior nursing leaders attended, but provided update on a rotational basis.

ACTION: That the EDs give some consideration to inviting divisional staff to the Committee meeting.

15. Date of Next Meeting

The next meeting will take place on Thursday, 22 April 2021 at 2.00pm via MS Teams.