Board of Directors (Part 1) meeting in public

Date **3 March 2022**

Time **9.30am**

Location **Teams**

Blackpool Teaching Hospitals NHS Foundation Trust

Time		*Topic*	*Lead*	*Process*	*Purpose / Expected Outcome*
9.30	1	Welcome and Introductions	Chairman	Verbal	
9.31	2	Declarations of Interests	Chairman	Verbal	To note
9.32	3	Apologies for Absence	Chairman	Verbal	To note apologies
9.33	4	Minutes of the Previous Meeting	Chairman	Report √	To approve the previous minutes
9.37	5	Matters Arising and Action Matrix	Chairman	Report √	To note progress on agreed actions
9.40	6	Patient Story	Deputy Director of Nursing	Presentation √	
9.50	7	Chairman's Update	Chairman	Verbal	To receive an update
10.00	8	Chief Executive's Report	Chief Executive	Report √	To receive an update
Quality					
10.10	9	Quality & Clinical Effectiveness Minutes and Update	Committee Chair	Report √	To receive for assurance
10.20	10	Maternity	Divisional Director of Nursing / Head of Midwifery & Divisional Director of Operations	Report √	To receive an update
	10.1	Ockenden Report Update			
	10.2	CQC National maternity survey results			
	10.3	Maternity Incentive Scheme Year 4.			
10.50	11	Quality Improvement Update	Associate Director of Quality Improvement	Report √	To receive an update

Board of Directors (Part 1) meeting in public

Date **3 March 2022**

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Blackpool Teaching Hospitals NHS Foundation Trust

Time		*Topic*	*Lead*	*Process*	*Purpose / Expected Outcome*
Performance					
11.00	12	Operations Committee Minutes and Update	Committee Chair	Reportv	To receive for assurance
11.10	13	Elective Recovery and Restoration	Chief Operating Officer	Report √	To receive for assurance
11.20	14	Integrated Performance Report Executive Summary	Chief Operating Officer	Report √	To receive for assurance
Strategy					
11.30	15	Strategy Sign Off and Key Objectives	Chief Executive	Report √	To approve
11.40	16	Emergency Village Update	Medical Director	Report √	To receive an update
Governance					
11.50	17	Audit Committee Minutes and Update	Committee Chair	Report √	To receive for assurance
Closing matters					
11.55	18	Any Other Business	Chair	Verbal	
12.00	19	Date and time of the next meeting: Thursday 5th May at 9.30am	Chair	Verbal	To note

Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting (held in public)

on Thursday 6 January 2022 at 9.30am

via Microsoft Teams

Present

Mr S Fogg	Chairman	
Mrs T Armstrong-Child	Chief Executive	
Mrs J Barnsley	Executive Director of Integrated Care and Performance	Non-voting
Mr M Beaton	Non-Executive Director	
Mr A Carridice-Davids	Associate Non-Executive Director	Non-voting
Mr K Case	Non-Executive Director	
Mr M Cullinan	Non-Executive Director	
Dr J Gardner	Medical Director	
Mrs N Hudson	Chief Operating Officer	Non-voting
Mrs S McKenna	Non-Executive Director	
Mr P Murphy	Director of Nursing, AHPs and Quality	
Mr F Patel	Director of Finance	
Mr A Roach	Non-Executive Director	
Mr J Wilkie	Non-Executive Director	
Miss S Wright	Joint Director of Communications	Non-voting

In Attendance

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/Company Secretary	
Miss K Ingham	Acting Head of Corporate Governance	Minutes
Mrs E Steel	Director of Corporate Governance, Bolton Hospitals NHS Foundation Trust	Observer

Apologies

Miss F Eccleston	Non-Executive Director
Mr K Moynes	Joint Director of HR and OD

BOD/2022/001 Chairman's Welcome and Introductions

Mr Fogg welcomed Directors to the meeting.

BOD/2022/002 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 Moynes is also appointed as Director of HR and OD at East Lancashire Hospitals NHS Trust.

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

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

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

BOD/2022/003 Apologies for Absence

Apologies were received as recorded above.

BOD/2022/004 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 clarifications:

Mrs Armstrong-Child confirmed that the strategy that she had referred to in section 84/21: Patient Story was in fact the Patient Engagement Strategy as opposed to the patient Quality Strategy.

In response to a comment that Mrs Armstrong-Child made about an action to better involve Governors in the work of the Board, Mr Fogg suggested that the Board give further consideration to the ways in which this could be done.

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

BOD/2022/005 Action List

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

RESOLVED: Directors noted the position of the action list.

BOD/2022/006 Patient Story

Mr Murphy introduced the patient story and provided an overview of the wrap-around care that the patient and their mother received throughout their stay at the Trust. He confirmed that the story illustrated the way in which both the patient's medical care and the emotional support offered to them and their family were catered for. A link to the story can be found here.

Mr Fogg sought feedback from the Directors on the story that had been shared. Mr Murphy commented that the part of the story that resonated with him the most was the service that the patient and their family received during the most difficult of times, particularly the compassion shown to their parents.

Mr Case shared his personal experience of receiving care at the Trust and shared the views of Mr Murphy, as did Mr Fogg.

Mr Beaton agreed with the comments shared and that it emphasised the importance of the staff in services, and the role of the Board was to help facilitate them doing their jobs.

RESOLVED: Directors noted the content of the patient story.

BOD/2022/007 **Chairman's Update**

Mr Fogg paid tribute to the commitment of the Trust's staff during the difficult circumstances that the Trust and wider NHS were currently in and stated that he hoped that the coming year would be one of positive change.

RESOLVED: Directors noted the update provided.

BOD/2022/008 **Chief Executive's Report**

Mrs Armstrong-Child referred Directors to the previously circulated report and highlighted the numerous awards that the Trust and its teams/staff had been shortlisted for in recent weeks. She provided an overview of the recruitment to Executive and senior leadership positions across the Trust and confirmed that Mrs Steel had been recruited to the post of Company Secretary in advance of Mrs Bosnjak-Szekeres' departure in mid-January. She confirmed that an appointment had been made to the post of Executive Director of Strategic Transformation, but that the recruitment to the post of Executive Director of HR and OD had been unsuccessful and would be readvertised after some revisions to the job title.

She went on to provide Directors with an update on the current Level Four incident that had been declared across the NHS and confirmed that the two main priorities set by NHSE/I at the beginning of December were to maximise discharges and increase vaccination uptake.

In response to Mr Wilkie's question about the implementation of mandatory vaccinations for staff and the potential impact that this would have on the workforce, Mrs Armstrong-Child confirmed that there was in excess of 800 staff who had no record of their COVID-19 vaccination status and that she had written to each individual to seek confirmation of this and to encourage them to take up the vaccination if they had not already done so.

Directors noted the work that had been undertaken to improve the discharges across the Trust and Mrs Armstrong-Child confirmed that the Trust had been able to close the escalation areas as a result of these efforts, despite not achieving the national requirement.

Mrs Armstrong-Child went on to confirm that the Trust had declared an internal critical incident over the most recent weekend and provided an overview of the current situation, including the current levels of staff sickness, which were noted to be around 13%.

Directors noted the Trust specific news, including the involvement in s piece of research to identify lung cancer via saliva testing as opposed to more traditionally invasive methods.

Directors were informed that Mr Steve Farley, Medical Photography Manager, had sadly passed away following an illness. Mr Farley was a well-loved and greatly missed member of the Blackpool Team.

RESOLVED: Directors received the report and noted its contents.

BOD/2022/009 **Performance**

a) Integrated Performance Report Executive Summary

Mrs Barnsley referred Directors to the previously circulated report and confirmed that there had been two Never events reported for the year to date and the Trust continued to achieve the IAPT standard. Directors noted that the name of the IAPT service was currently being reviewed and changed as a result of information being made available to the Trust that another company owned the trademark for the service's name.

Mrs Barnsley went on to report that there had been one case of MRSA and seven cases of E-coli recorded in December 2021. She went on to confirm that cases of COVID-19 were increasing and as a result there was additional pressure on the Trust's inpatient wards.

In addition, whilst the number of open care pathways had reduced, they remained above the accepted trajectory.

Directors noted that the number of patients waiting in excess of 52 weeks for surgery had increased, but patients on these lists were being contacted for assessment and where harms were identified multi-disciplinary team (MDT) meetings were arranged to consider care options.

Directors were informed that although staff sickness had improved in November 2021, there had been a deterioration in December, with the numbers of staff self-isolating/testing positive for COVID-19 had increased. Mrs Barnsley reported that staff turnover remained above target but had decreased in the reporting month and there had been a continued reduction in the use/cost of temporary and agency staffing.

Mr Cullinan commented that there seemed to be good reporting information about staff sickness and asked whether there was anything further that the Board could do to support staff. In response, Mrs Adams reported that the Trust had begun to review those individuals who were off sick with COVID-19 to see whether they were able to return to work under the new isolation guidelines

Mr Carridice-Davids commented that there was a lot of information within the report that registered as limited assurance but was not linked to the Corporate Risk Register (CRR) or Board Assurance Framework (BAF). He asked how the Trust could progress from limited assurance to assurance via implementation of action plans etc.

Mrs Barnsley confirmed that the detail that Mr Carridice-Davids referred to was provided through the two Board committees and a summarised version of the IPR was presented to the Board.

Mr Case suggested that the Trust may be under reporting work related injuries and that it may be affecting the Trust more than initially thought.

Mr Beaton provided an overview of the way in which the committees reviewed performance/gained assurance. He also commented that significant work had been carried out to develop and revise the BAF and commented that the document was a constantly developing/changing document.

Mr Murphy agreed that there was further work to do on representation of information and performance across the year rather than month on month comparisons, he suggested that there was a need to refine the SPC charts used within the IPR.

Mr Patel provided an overview of the financial performance of the Trust and confirmed that as of November 2021 the Trust was slightly ahead of the projected year end position, however this may be eroded as a result of the current situation. He went on to confirm that he was working with medical directors to work on medical staffing spend, particularly in terms of locum staffing costs.

Mr Fogg asked Executive Directors to devise a plan to structurally move through the current issues and move the Board to a better place. he suggested that he would be happy to hold some sessions with the Executive Directors to facilitate this work

RESOLVED: Directors received the report and noted its contents.

b) Elective Recovery and Restoration

Mrs Hudson confirmed that the performance against elective care recovery was strong in November 2021 and had reached 102% of the performance in the same month in 2019. She went on to confirm that performance in outpatient services was also around 101%, with diagnostics performing at 108% of the 2019 figures. Directors noted that there had been a continued reduction in patients waiting in excess of 52 and 104 weeks for treatment.

Mrs Hudson confirmed that the Trust was working under the current level 4 arrangements and had stood up the Trust's incident control processes to manage the urgent and emergency care pathways, and demand for services.

Mrs Hudson provided an overview of the work being undertaken to manage care and flow throughout the Trust particularly the work to increase medically appropriate discharges.

RESOLVED: Directors received the update provided.

c) Winter Plan Update

Mrs Hudson confirmed that the schemes agreed at the previous Board meetings had been enacted, but the Trust had struggled to recruit to some of the temporary posts required.

RESOLVED: Directors received the report and noted its content.

d) Green Plan

Dr Gardner introduced the item, provided a brief overview of the content and confirmed that the request was for the Board to approve the plan for roll out across the Trust for socialisation.

In the interests of time, Mr Fogg suggested that the item be taken as read and sought questions and comments from the Board members. There were no comments of questions from Board members.

It was agreed that the Plan be approved by the Board.

RESOLVED: Directors received the report, noted its contents and approved it.

BOD/2022/010 Engagement

a) National Guardian Office Action Plan

Mrs Adams presented the report to Directors and confirmed that many of the actions within the document had already been completed. She highlighted that a small number remained open, for instance the roll out of the Freedom to Speak Up (FTSU) training for staff and managers and the development of a robust strategy.

Mr Carridice-Davids commented that he had undertaken some reading following the last Board meeting and noted that a number of Trusts had FTSU Guardian reporting via their the Audit Committees and asked whether this would be considered by the Trust to ensure adequate floor to Board flows. Mr Fogg suggested that this matter be considered outside the meeting and brought back at a future date.

Mrs Armstrong-Child provided an overview of the work that was taking place across the Trust's staff networks, including the way in which Executive Directors and other senior leaders were engaging with the teams to identify leaders and develop the wider Trust's understanding of leadership.

Mr Carridice-Davids picked up on the points raised by Mrs Armstrong-Child and asked that the Non-Executive Directors be involved in this work too.

Mr Fogg asked for regular updates on this work to be provided to the Board.

RESOLVED: The reporting from the Trust's FTSU Guardian to be considered to ensure adequate reporting through from floor to Board.

b) BTH Staff Health & Wellbeing Action Plan 22/23

Mrs Adams referred Directors to the previously circulated paper, which was presented for information and approval. She confirmed that Mrs Sarvista, who was in attendance at the meeting for this item, would be able to provide additional information to the Board should this be required.

Mrs Sarvista provided a presentation which covered a number of points, including the alignment of the plan to the Trust's Vision and values, how the plan was developed, an overview of the Health and Wellbeing Framework and the high impact actions for 2022.

Mr Cullinan commented that one of his observations was, that a number of years ago, the view of the Board regarding staff wellbeing was relatively ambivalent, but as times had changed, they had gained a greater focus.

He went on to suggest that one of the objectives within the plan could be to become the leader of staff health and wellbeing across the ICS.

Mr Carridice-Davids thanked Mrs Sarvista for the report and that he shared the view of others about the pace of change required and the achievability of the work.

Mrs Adams confirmed that some of the actions within the plan presented had already been enacted, but that others would be carried out/overseen by other departments/teams within the Trust.

Mr Fogg thanked Mrs Sarvista for her attendance and wished her well in the work and that if she needed support, he would be happy to provide it.

RESOLVED: Directors received the report and lent their support to the recommendations set out within it.

BOD/2022/011 Governance

a) Corporate Risk Register (CRR)

Mr Murphy referred Directors to the previously circulated report and confirmed that the document continued to be developed and revised following the feedback gained at meetings, particularly the Board.

He went on to confirm that around 12 months ago the Trust was in the early stages of developing their risk registers and that the progress shown to date was positive. He highlighted the development of the document, particularly the work undertaken to review and refine the document from having in excess of 200 risks on it to the current version of the report and thanked both the Clinical and Corporate Governance Teams for their efforts in developing and refining the document, along with the Board Assurance Framework.

Directors noted the changes that had been made to the CRR since the last meeting, particularly in relation to the risks around stroke services and the potential mandatory vaccinations for NHS staff.

In response to Mr Wilkie's question regarding mandatory vaccinations for staff, Mr Murphy confirmed that there had been an uptake in the number of unvaccinated staff who had taken up the offer of a vaccination. He also reported that there had been some correspondence into the Trust from those staff still unwilling to be vaccinated and the Trust was working through the responses at this time. He went on to report that there would be a need to consider redeployment of these staff into non patient facing areas.

RESOLVED: Directors received the report and noted its content.

b) Board Assurance Framework (BAF)

Mrs Bosnjak-Szekeres referred Directors to the previously circulated report and confirmed that as per the agreement at the last meeting Risk 5.2 had been removed from the BAF with any elements that were relevant to other risks within the document being moved into the other risks. Directors noted the content of the report.

Directors briefly discussed the document and it was agreed that the BAF would be reviewed in the new financial year in order to better align its contents with the Corporate Risk Register.

RESOLVED: Directors received the report, noted its contents and approved the updated document.

It was agreed that the BAF would be reviewed in the new financial year with a view to better alignment with the Corporate Risk Register.

c) Governance Review Documents

i. Trust Constitution

Mrs Bosnjak-Szekeres referred Directors to the previously circulated document and confirmed that, whilst it was not yet due for review, there were a number of sections within the document that required amendment in order to bring them in line with the wider NHS constitution and best practice. She went on to highlight the areas that had been updated and sought feedback from Board members on the revisions.

In response to Mr Fogg's question about the voting majority of the Council of Governors, Mrs Bosnjak-Szekeres confirmed that it was a simple majority vote as opposed to a certain threshold of the vote being cast in a specific way.

In response to Mr Wilkie's query, Mrs Bosnjak-Szekeres confirmed that a Company Secretary was not a member of the Board and in her role as a Chartered Governance Professional she was in attendance at Board meetings to provide advice to the Board and to ensure parity it was not appropriate for such a role to be a Board member.

Mr Patel commented on the section of the document that referred to non-NHS income and asked for clarification that this section remained relevant. Mrs Bosnjak-Szekeres confirmed that this section remained a requirement of the document.

Directors approved the document for presentation to the Council of Governors.

RESOLVED: Directors received the document and approved it for submission to the Council of Governors for ratification.

ii. Standing Orders

Mrs Bosnjak-Szekeres referred Directors to the previously circulated document and asked that the Board delegate authority to the Audit Committee for approval of the Standing Orders. She provided an overview of the proposed changes to the document and confirmed that if the Board were minded to approve the suggested changes she would hand the work over to Mrs Steel for completion as further work would be required on the document in readiness for the new financial year.

RESOLVED: Directors agreed to delegate authority to the Audit Committee for the approval of the Standing Orders.

iii. Scheme of Delegation (Financial Limits)

Mr Patel referred Directors to the previously circulated document and confirmed that they were presented to the Board for approval and would be incorporated into the wider SFI's. He provided an overview of the changes made and the rationale for them.

Following a brief discussion Directors approved the changes to the financial limits contained within the Scheme of Delegation.

RESOLVED: Directors received the updates financial limits section of the Trust's Scheme of Delegation and approved them for inclusion within the overarching document.

d) Board Committee Assurance

i. Audit Committee Minutes and Update

Directors received the minutes of the previous meeting and Mr Cullinan had confirmed that he had nothing else to raise under the item.

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

ii. Quality and Effectiveness Minutes and Update

Mrs McKenna referred Directors to the previously circulated documents and confirmed that she too had nothing further to add.

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

iii. Operations Committee Minutes and Update

Mr Beaton confirmed that the December meeting had been stood down as a result of the operational pressures being experienced across the Trust. He suggested that the ongoing operational pressures would be an ongoing focus for the Trust and the Committee seemed to be well focused on the operational performance.

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

BOD/2022/012 Any Other Business

Mr Fogg thanked Ms Bosnjak-Szekeres for her time and efforts at the Trust and thanked her for her support.

BOD/2022/013 Formal Meeting Review

Mr Fogg invited feedback and comments from Directors outside the meeting due to the time constraints on the session.

BOD/2022/014 Date of Next Meeting

The next meeting will take place on Thursday 3 March 2022, 9.30am, via MS Teams.

Board of Directors Action List (Part 1)

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
010a	06.01.22	National Guardian Office Action Plan	The reporting from the Trust's FTSU Guardian to be considered to ensure adequate reporting through from floor to Board.	Esther Steel			Quaterly FTSU included on new workforce committee work plan	G
010b	06.01.22	Board Assurance Framework (BAF)	It was agreed that the BAF would be reviewed in the new financial year with a view to better alignment with the Corporate Risk Register.	Esther Steel	30/04/2022			
90/21b	04.11.21	Governance Corporate Risk Register (CRR)	A proposal to be prepared for reporting of assurance etc to the Board for review in the new year	P Murphy/ L Cheung	01/03/2022		Action covered in review of committees	G
84.21	04.11.21	Patient Story	Meet up outside the meeting with Mr Cullinan (NED) to further discuss dissemination of information to staff	Mr Walton-Pollard	06.01.2022		Mr Walton Pollard is in the process of arranging this meeting.	A
75/21a	02.09.21	Corporate Risk Register (CRR)	Divisional Directors will be invited on rotation, in the new year, to Board meetings to present their risks.	Corporate Governance Team	06.01.2022	01.04.22	The Divisional Directors will be invited to attend starting with the new financial year 2022/23.	A
43/21b	06.05.2021	Reciprocal Mentorship Criteria	A further update on the selection criteria for the programme will be provided when available.	Mr Moynes	01.07.2021	06.01.22	Update 31.12.21 - the Trust is still awaiting information from the NHS Leadership Academy. A meeting will be arranged prior to the Board meeting in March 2022, when an update will be provided.	R

RAG Rating	
Green	Completed
Amber	Ongoing
Red	Overdue
Blue	Agenda item

Blackpool Teaching Hospitals NHS Foundation Trust

Formal Board of Directors Meeting

3rd March 2022

Chief Executive's Report

Author of Report:	Trish Armstrong-Child, Chief Executive	
Executive Director Sponsor:	Trish Armstrong-Child, Chief Executive	
Date of Report:	22nd February 2022	
Executive Summary (to include, where appropriate, the level of assurance and position on trajectory) The attached briefing paper provides some high-level updates on activities within the Trust since the previous meeting of the Board of Directors. These include: • Awards and Recognition • News and Developments • Trust News • Reportable Issues Log • Risk Register and Board Assurance Framework		
For Information/Assurance: ✓	**For Discussion:**	**For Approval:**
Recommendations: Board members are requested to receive the report and note the information provided.		
Sensitively Level:		
Not Sensitive: **(for immediate publication)** ✓	**Sensitive in Part:** **(consider redaction prior to release)**	**Wholly Sensitive:** **(consider application exemption)**

Blackpool Teaching Hospitals NHS Foundation Trust

Chief Executive's Report

3rd March 2022

1. Awards and Recognition

Celebrating Success Awards Launched

The Trust was delighted to start the year launching the Celebrating Success Awards. The last time the awards were held was back in 2019. Since then, the hugely popular annual event has been postponed, keeping everyone safe during the pandemic. This year the awards will return in a new, virtual format.

The purpose of the awards is to recognise and share the best in our organisation, from projects and services to people who are passionate, innovative and committed to providing excellent care.

This year the awards feature new categories to provide even more opportunities to showcase our excellent colleagues and services. Almost 300 entries have been received, shortlisted and judged, with the event itself taking place online on Thursday, 10th March.

Thank you to everyone who has taken time to nominate and good luck to all those who have been shortlisted.

Dr Sharran Grey receives OBE

Congratulations to Dr Sharran Grey who has been awarded one of the country's highest honours after being made an OBE for services to Blood Transfusion and Patient Care.

Dr Grey, Haematology Consultant Clinical Scientist in the Lancashire Haematology Centre was honoured in 2021 New Year's honours list but didn't receive the OBE until recently due to Covid restrictions. Dr Grey attended the ceremony at Windsor Castle and accompanied by her family was awarded the honour by Prince Charles.

This is not the first time that Dr Grey has received national acclaim. In 2017 she was awarded the NHS England Chief Scientific Officer's Healthcare Science Award for her doctoral research on Accelerated Red Cell Transfusion for Selected Patients. This research also led to the development of a red cell dosage calculator app which improves the achievement of a patient's haemoglobin target. This is now a registered medical device and available to other NHS organisations.

Joint Advisory Group (JAG) Annual Review

The Joint Advisory Group (JAG) accreditation is awarded to endoscopy services which have demonstrated they meet best practice quality standards. Following the submission of the Trust's annual review we successfully met all the required JAG accreditation standards, resulting in our accreditation being renewed until 1st October 2022.

The JAG assessors congratulated the team for the high standard of achievement and for their hard work during the accreditation process. Accreditation is awarded for 5 years, subject to successful completion of an annual review. In the fifth year a full reaccreditation assessment is undertaken to renew accreditation.

National Lung Cancer Audit Annual Report

The National Lung Cancer Audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme. HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

Its aim is to promote quality improvement in patient outcomes and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. This year the report includes learning from the Cancer Alliance with high curative intent treatment rate, work carried out by Dr Anju Mirakhur, Consultant Respiratory Physician at the Trust.

It highlights how the Blackpool lung MDT introduced new ways of working to ensure patients referred with suspected lung cancer received prompt care as close as possible to the pre-pandemic state. The report recognises how, despite the constraints imposed by the pandemic, the lung MDT worked extremely hard together as a team across all its sub-specialties to ensure treatments were compromised as little as possible. Combined with new ways of working, including virtual MDTs, video and telephone consultations and facilitating patient and colleague vaccinations, the measures allowed continued treatment of patients. Central to this was the dedication and hard work of the lung cancer nurse specialists.

2. News and Developments

Care Quality Commission Report

The Care Quality Commission (CQC) published its report following a series of inspections at the Trust in September and October last year. Overall, the CQC rating for Blackpool Teaching Hospitals NHS Foundation Trust remains as Requires Improvement (RI). The Trust remains committed to becoming an outstanding organisation and everyone's continued efforts over recent years have been recognised.

In the report there are more detailed ratings for themes in individual hospital settings, but are as follows:

- Blackpool Victoria Hospital is rated as inadequate overall and whilst the caring element is again highlighted as good, particular concern is flagged around responsiveness and being well led
- Fleetwood Hospital is rated as requires improvement overall. This has not changed as the areas did not form part of the last inspection
- Clifton Hospital is rated good. This has not changed as the areas did not form part of the last inspection

Within the report there is acknowledgement of some of the fundamental changes that have been made at the Trust since the last inspection in 2019.

Why not home, why not today

Following the successful 'Home for Christmas' campaign, the Trust launched an extension campaign 'Why not home, why not today.' Colleagues continue to work extremely closely with everyone across the health and social care system to ensure a collaborative and responsive approach to prevent any potential delays. However, the urgent care pressures remain and continue to put significant pressure on our Emergency Department.

Trust celebrates LGBTQ History Month

The Trust marked the UK's official lesbian, gay, bisexual and transgender (LGBTQ+) by taking part in a series of events held across the NHS in Lancashire and Cumbria. The overall aim of LGBT History Month is to promote equality and diversity for the benefit of the public. Held every February since 2005, LGBT+ History Month aims to raise awareness of - and combat prejudice against - the LGBT+ community and highlight its achievements and diversity. This year's theme "The Arc is Long" is inspired by a Martin Luther King quote: 'The arc of the moral universe is long, but it bends towards justice.'

National Apprentice Week

The national awareness week provided an opportunity to recognise the positive impact apprenticeships can bring to organisations and the individuals. Throughout the week, personal stories were shared by current apprentices, celebrations of those completing their apprenticeship and information on how people can apply for apprenticeships at the Trust.

The Trust is heavily invested in its Apprenticeship programme and is currently supporting hundreds of new and existing colleagues both clinical and non-clinical gain the skills, knowledge and behaviours to thrive in their job roles and meet their career ambitions.

Tackling the NHS Backlog

The new national delivery plan sets out how the NHS will address backlogs built up during the COVID-19 pandemic and tackle long waits for care.The plan focuses on four areas:

1. Increasing health service capacity
2. Prioritising diagnosis and treatment
3. Transforming the way we provide elective care
4. Providing better information and support to patients

The plan sets out ambitions, guidance and best practice to help systems address key issues, ensuring there is consistent focus on elective recovery for years to come. Supporting staff is also a key part of the recovery of elective services, recognising staff need to be looked after so they can look after patients. The Chief Operating Officer and her teams continue to focus on reducing the backlog.

Independent Non-Executive Members appointed for new NHS organisation

Five new non-executive members have been appointed as designate members of the Lancashire and South Cumbria Integrated Care Board as the Lancashire and South Cumbria Integrated Care System prepares to continue to build partnership working across health and care in our area.

Subject to passage through Parliament, the Health and Care Bill is set to create a new NHS organisation and a statutory local Health and Care Partnership. Their purpose will be to:

- Improve outcomes (population health and care)
- Tackle inequalities in outcomes and access
- Enhance productivity and value for money
- Support broader social economic development

The NHS Lancashire and South Cumbria ICB is set to be established in July 2022. David Flory CBE, the ICB Chair Designate has named five critical designate appointments to the new Board. The appointments are Professor Ebrahim Adia, Sheena Cumiskey, Jim Birrell (Audit Committee Chair), Professor Jane O'Brien and Roy Fisher (Renumeration Committee Chair).

3. Trust News

Changes to the Executive Team

Deputy Chief Executive and Director of Strategic Partnerships Professor Nicki Latham will formally leave the Trust at the end of March, she is currently out on a three-month secondment supporting the Provider Collaborative Board (PCB).

Esther Steele will be formally joining the Trust from the 14th March 2022 and take up the post of Director of Corporate Governance.

The Director of People and Culture post is currently out to recruitment, interviews are anticipated around the middle of March. In the meantime, Louise Ludgrove joined us this month as the Interim Director.

The Trust's Executive Medical Director Dr Jim Gardner has been successfully appointed to a similar post at Liverpool University Hospitals NHS Foundation Trust. Jim has been a valued member of the Trust Board and Executive Team for two years, a great colleague to work with and his contribution during one of the most difficult moments in NHS history has been significant.

A leaving date has not been identified at this time, however, the Trust will begin the process of appointing a successor.

New Head of Emergency Department

Dr Anthony Kearns will shortly be stepping down as Head of the Emergency Department at Blackpool Victoria Hospital. Dr Kearns has led the department through the challenging days of the pandemic and the recent CQC inspection. Dr Simon McKay has been appointed as the new Head of Department and will join the Trust as a new consultant colleague.

Meanwhile, Dr Sam Guest has been appointed as Deputy Head of Department. Sam is already a respected and well-known figure in the Trust. Simon and Sam will lead the department as it continues its important work including the development of the new Emergency Village.

Mental health support in schools

A new service to support young people on the Fylde Coast who are struggling with their mental health and emotional wellbeing has been launched.

The new Mental Health Support Teams are available to pupils at secondary schools, specialist schools and pupil referral units in Blackpool and Wyre, as well as students at Blackpool and the Fylde College (up to their 19th birthday). The Teams will support those who are experiencing emotional or wellbeing issues such as low-level anxiety, low mood, or friendship or behavioural difficulties, to ensure they don't escalate to more serious mental health issues.

The Fylde Coast CCGs were successful in bidding for NHS England funding to create the new teams in July last year and have since been planning the service, which is provided by the Trust. Young people from some of the schools involved have helped shape what the service will offer and how they will work with young people.

Our Five-Year Strategy

Our five-year strategy is an important document which plots our journey as a Trust, provides a framework for the development of services for our patients and underlines our commitment to continuous improvement.

As part of the development of the plan, a series of dedicated engagement events were held throughout January to support colleagues, patients, relatives and carers to have their say on the what the strategy should include. The virtual listening events provided an opportunity for people to have their say and also to gather valuable feedback about what works, what's missing and what could be improved at the Trust.

A central hub was also created for anyone requiring further details about the strategy, or for those unable to attend the sessions, a helpful video and links to a survey could be utilised. The short sessions outlined the Trust's strategic aims and asked for input on how the organisation can meet the objectives set. All the contributions have been anonymised, collated and will be used to inform our draft plan, with the intention to launch the Trust's five-year strategy in Spring 2022.

New Ward to Support Demand

The Trust received funding to install a 24-bedded modular ward which will be placed on the Woodlands car park on the Blackpool Victoria Hospital site.

The modular ward will provide additional in-patient beds enabling elective surgery programme to continue. This will particularly help elective orthopaedic surgery to continue, as in previous years these patients have often had their surgery delayed due to pressures within the Trust.

Outside the winter pressure months, the modular ward will support the Emergency Village development, creating additional clinical space to support enabling works to be completed across the Blackpool Victoria Hospital site. The modular ward will be ready to receive patients by the end of March 2022 and a full implementation programme is underway.

4. Reportable Issues Log

Issues occurring between the last Trust Board (25.12.21 – 21.02.22)

Serious Incidents and Never Events

Eight STEIS reportable serious incidents were reported during this timeframe.

Two of these incidents were identified as meeting the criteria for Wrong Site Surgery Never Events.

All these incidents are being investigated as Serious Incidents in line with Trust policy and NHSE's Serious Incident Framework.

High Risk Complaints

There have been no high-risk complaints received since the last Trust Board meeting. For information there are 22 low risk, 3 moderate risk and 21 still ongoing.

Regulation 28 Reports

No formal regulation 28 reports have been received during this period.

5. Risk Register and Board Assurance Framework

No significant changes to report.

Trish Armstrong-Child
Chief Executive
Date 22nd February 2022

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Quality & Clinical Effectiveness Committee Meeting
held on Tuesday 25 January 2022 at 1.00 pm
via Microsoft Teams

Members

Mrs Sue McKenna	Non-Executive Director	Chair
Mr Keith Case	Non-Executive Director	
Mr Peter Murphy	Director of Nursing, Allied Health Professionals (AHPs) and Quality	

In Attendance

Mrs Simone Anderton	Deputy Director of Nursing & Quality	
Mrs Margaret Bamforth	Appointed Governor, Blackpool & The Fylde College	Observer
Ms Rebecca Bond	Director of Pharmacy - Divisional Director of Clinical Support Services	
Mrs Louise Cheung	Deputy Director of Quality Governance	
Ms Charlie Cookson	Nurse Consultant, Community Frailty Service	For item 4b
Dr Peter Curtis	Divisional Director	
Dr Lynn Douglas	Consultant Surgeon/Divisional Director for SACCT	
Ms Clare Ellis	Divisional Director of Clinical Professionals – Clinical Support Division	
Dr Gavin Galasko	Director of Research, Development & Innovation	
Mrs Katharine Goldthorpe	Associate Director of Quality Improvement	For item 8a
Dr Grahame Goode	Deputy Medical Director/Director of Clinical Effectiveness	
Mr Andrew Heath	Assistant Director of Nursing Quality	For item 5d
Mrs Lisa Horkin	Divisional Director of Nursing	
Miss Lauren Kavanagh	Corporate Governance Officer	Minutes
Mr David Kay	Divisional Director of Nursing-Tertiary	
Mrs Clare Lewis	Fylde Coast Clinical Commissioning Group (CCG) Manager	
Mrs Jo Lickiss	Divisional Director of Nursing, Surgery, Anaesthetics, Critical Care and Theatres	
Mr Stuart Logan	Head of Quality Governance	
Mrs Sharon Mawdsley	Infection Prevention Nurse Consultant	
Mrs Nicola Parry	Divisional Director of Nursing/Head of Midwifery	
Mr Jed Walton-Pollard	Deputy Director of Nursing	
Mrs Esther Steel	Director of Corporate Governance	

Apologies

Mr Michael Chew	Divisional Director
Dr Shajil Chalil	Tertiary Divisional Director
Dr Jim Gardner	Medical Director
Mr Nick Lane	Chief Allied Health Professional

1. Welcome/Apologies for Absence

Mrs McKenna welcomed members to the meeting and in the interests of time asked presenters to assume that the papers had been read and provide short summaries of key matters only.

Apologies were received as recorded above.

It was noted that there were no declarations of interest made.

2. Minutes of the Previous Meeting held on 21 December 2021.

Members, having had the opportunity to review the minutes of the previous meeting, agreed that any requests for revisions would be forwarded to the Corporate Governance Team outside the meeting and once received, the minutes would be approved as a correct record.

RESOLVED: The minutes of the previous meeting held on 21 December 2021 were approved as an accurate record subject to any amendments being sent to the Corporate Governance Team.

3. Matters Arising

a) Action List

Mrs McKenna requested that all actions that change their original date of delivery were agreed with the Chair going forward. It was noted that the restructure of the Committees would commence in the next financial year (2022-23).

It was agreed that actions that were scheduled on the agenda for the next meeting were amber until they were completed after the meeting.

CARING

4. a) Patient Story

It was noted that the patient story related to a staff nurse and her son who was brought into the Children's Assessment Unit after his sugar levels went dangerously low. The patient talked about the wrap around care that was put in place for both her son and their family as he was diagnosed with Type 1 diabetes. She praised the High Dependency Unit, the Children's Ward staff, the Dieticians and the Paediatric Diabetes Team for their compassion and support through this worrying time, educating them on how to live with this long-term condition.

Members welcomed such a positive patient story and conveyed their thanks to all the staff involved.

b) Celebrating Brilliance

Members welcomed Ms Charlie Cookson and her update on Community frailty services to the meeting. The following key points were noted: -

- 35% of 70-year-old patients experienced functional decline during hospital admission
- 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed
- 39% of people delayed in hospital could have been discharged using different pathways & services.
- The service covers the entire Fylde coast footprint: based at Moor Park & South Shore
- Support patients to live well alongside their existing long-term conditions.
- Multi-disciplinary team (MDT) of health professionals, including consultant, GP, non-medical consultants, advanced clinical practitioners, care co-ordinators, assistant practitioners, health care assistants and pharmacists.
- Maximum weekly Comprehensive Geriatric Initial Assessment (CGA) appointment capacity for the service is 45 appointments per week

The following friends and family feedback was noted by the Committee: -

"Excellent service which I couldn't have managed without, helped me to regain my independence & cope with my long-term illness, the nurse went over and above to care for all my needs"

"Outstanding care and response in an emergency situation, really don't know how we would have coped, staff brilliant"

Members thanked Ms Cookson and the Community Frailty team for all their hard work to mature such a high-quality service.

It was noted that work was on going with the Quality Improvements, last 1000 days collaborative to avoid patients coming into hospital and identifying patients as early as possible.

Dr Goode reported that the Community Frailty Service had received positive national recognition.

Mrs McKenna requested an update on the current situation at the Trust to ensure the members were aware of the high-level risks. Mr Murphy reported that the CQC Section 29a report outlined the key risks and actions that were being taken currently. It was reported that the Ophthalmology Department was a concern due to a Never Event and two Serious Incidents (SI's). Mr Murphy assured members that work was ongoing to ensure the services were safe and was implementing an action plan to mitigate incidents going forward.

Members noted that the Trust was still in high escalation and staffing continued to be an issue.

5. a) Elective waiting list management, prioritisation and review

Dr Goode provided the following update: -

- The Trust had issues with regards to Referral to Treatment (RTT) and the 18-week pathway.
- The ongoing Covid-19 pandemic was causing issues for patients waiting for treatment.
- NHS England had provided a Standard Operating Procedure (SOP) and all patients waiting longer then 52 weeks for treatment had to be contacted for a harms review.

It was confirmed that the Trust was continuing to harm review patients and all severe and high harm patients were being overseen by the Chief Operations Officer, Director of Integrated Care and Deputy Medical Director. Members noted that actions had been put in place to improve pathways to ensure patients could access treatment in a timely manner.

My Murphy advised that waiting lists had been a concern highlighted in the CQC Section 29a warning notice and the Trust was working on ensuring patients were accessed and followed up.

In response to Mrs McKenna query regarding ensuring the Trust was capturing all patients awaiting treatment, Dr Goode advised that that an additional resource had been provided to ensure the Trust was capturing all these patients regardless of speciality.

It was noted that additional work was on going with regards to the Trust's HISS system to ensure extra validation of data.

Members questioned the reliability of the systems and it was noted that it was the paper-based data that was causing the challenges and that an Electronic Patient Record (EPR) would help address this issue.

Mr Murphy confirmed that the Trust was undertaking further reviews and cleansing of the waiting lists.

Members noted that the Trust had made positive changes with regards to the systems and were applying a more robust way of reporting going forward.

b) Infection Prevention Control Report and Board Assurance Framework

Mrs Mawdsley highlighted the key points from the Infection Prevention Control Report: -

- One case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia was recorded for the Trust in December 2021 and that this was a Community Onset Healthcare Associated (COHA) case linked to recent hospital care.
- Seven cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia were recorded in December 2021.
- The Infection Prevention team had undertaken a root cause analysis of all Hospital Onset Healthcare Associated (HOHA) MSSA and Gram-negative blood stream infections for Q1 & Q2.
- Seven cases of Clostridioides difficile (CDI) were reported in December 2021 and this brought the total number of cases so far this year to 89.
- The Divisions continued to implement their CDI reduction action plans.
- The Trust CDI policy had been revised and ratified and incorporated new National Institute for Health and Care Excellence (NICE) treatment recommendations for treating CDI.
- One HOHA case was reported in December 2021 and this brings the total number of cases for the year so far to 15.
- At the time of writing the report, the Covid-19 prevalence in Blackpool was 2210 but had reached 2550 cases per 100,000 of the population earlier this month, which was the highest level seen since the start of the pandemic.
- At the time of writing the report, ten outbreaks were ongoing at Clifton and Blackpool Victoria Hospitals.
- The visiting at the Trust had still been restricted due to the number of positive cases of Covid-19.

Members noted that a new version of the IPC Board Assurance Framework would be provided to next meeting containing a new list of key lines of enquiry.

Mr Case raised concerns regarding the increase in MSSA cases and Mrs Mawdsley advised that all plans were in place to address this issue and regular root cause analysis were undertaken.

Members requested a more detailed front sheet outlining they key points that the Committee required to be sighted on to seek assurance on the actions being taken.

ACTION. Provide a more detailed front sheet outlining they key points that the Committee required to be sighted on to seek assurance on the actions being taken.

c) Medicines Management Quarterly Report

Mrs Bond advised that it was requirement that the Committee received reports on the use, optimisation and risks associated with medicines and that the pharmacy continued to intensively monitor the entire journey of all controlled drugs through the Trust to provide robust oversight.

Members noted significant workforce pressures remain and the department was working hard during unprecedented times to sustain safe service provision for the patients we serve, to remain a fit for purpose medicines optimisation service.

Members questioned whether work would commence to ensure a 7-day service within the pharmacy to improve medicines reconciliation compliance and Mr Murphy advised that the Trust would continue to pursue this and make reasonable improvements.

Mr Murphy highlighted the great improvements that had been made through Mrs Bond's leadership within the Pharmacy Department.

Mrs Bond highlighted the key points with regards to the controlled drugs audit.

- 36 areas had improved results compared to the Quarter 2 CD audit.

- 99% compliance was achieved for the standard of the Nurse in Charge or nominated deputy being in possession of the CD keys.

Members advised that going forward, this report should focus on a small number area in more details including information on risk and assurance. It was noted that it would be helpful if the report focused on areas of concern within the risk register and issues and good practice that the Committee were required to have oversight on.

ACTION: Future reports should focus on areas of concern within the risk register and issues and good practice that the Committee were required to have oversight on.

Members drew attention to the Controlled drugs incidents and sought assurance that there were no major concerns. Mrs Bond reported that she had full oversight of all these incidents and a high percentage relate to poor record keeping.

d) Complaints Report

Members noted the following key points from the report: -

- There had been a 6% increase in formal complaints this quarter, and a 2% increase in informal concerns with 385 cases recorded on the Ulysses platform.
- There had been a considerable decrease in general enquiries, with 238 less enquires (38% less) recorded than in Quarter 2.
- There had been an increase in cases reported by patients and their relatives in relation to access.
- There had been a rise of 275% in cases during Quarter 3 via a concern or complaint.
- 100% of complaints had been acknowledged within 3 working days since October 2021.

A question was raised around the learning from complaints and Mr Heath confirmed that complaint reviews panels and forums were taking place to enable a deeper dive into complaints. It was noted the importance of managing concerns in a timely manner to ensure they do not progress into a formal complaint.

Members noted the significant improvement in complaints compared to the previous year but requested more information going forward with regards to the learning from complaints and the impact on patient care.

e) Clinical Safer Staffing Report

Mr Walton-Pollard provided the following updates: -

- The report provided the Board with ward-level information relating to nursing and midwifery staffing levels.
- In December 2021 42 wards were reviewed, 7 wards were able to demonstrate a fill for both, qualified and unqualified, of 90% or over of the planned hours worked for both the day shift and the night shift.
- 35 wards demonstrated a fill for both, qualified and unqualified, of fewer than 90% of the planned hours worked for both the day shift and the night shift.

Members were made aware of the significant staffing issues in January 2022 due to staff sickness and isolation from the Omicron variant of Covid-19. It was noted that the data would be provided at the February 2022 meeting.

Mr Walton-Pollard reported that staff sickness for bands 2 and 3 was currently at 14.5% which was approximately 107 whole time equivalents.

It was noted that the Trust was increasing enhanced rates and ensuring agency rates were matched with other Trusts.

Members noted that Ward Managers and Matrons were being calculated in the numbers for each ward. And that the Deputy Directors of Nursing were chairing staffing meetings and making decisions based on the risks within the wards each day.

Members were assured that the Trust was taking the necessary actions with regards to staffing.

Mrs Lewis welcomed such a pro-active approach to the staffing issues but emphasised the importance of ensuring Clifton Hospital was included in plans to address staffing. Mr Walton-Pollard advised that the professional judgement report had included extra support workers at Clifton Hospital.

Members discussed the mandatory Covid-19 Vaccinations and it was highlighted that the Trust currently had 279 substantive staff currently 'in scope' although 1:1 interview had to take place to establish if they were exempt due to medical reasons. It was noted that a percentage of the staff in scope were on maternity leave, long term sick or career breaks. Members noted this significant risk to staffing numbers and that this was scored on the risk register as 20.

Mrs Anderton highlighted the following key points from the recruitment and retention section of the report: -

- The main recruitment pipeline continued to be via our overseas nurse recruitment programme.
- Further OSCE dates were accommodated in November and December leading to a further 11 overseas nurses successfully passing their OSCEs.
- There were currently 27 overseas nurses in the Trust working as adaptation nurses and preparing for their OSCE examinations.
- The Trust planned to continue recruiting 10-15 OSN per month throughout 2022.
- Student nurses due to qualify in March 2022 would be mapped into the registered nurse workforce planning going forward and be aligned with the OSN recruitment programme.
- The Trust had undertaken a recruitment drive for HCAs which had resulted in appointing around 40 to substantive posts and this was planned to continue monthly until sufficient numbers were recruited to fill vacancies from the template uplift.
- The Trust was working with the Prince's Trust to bring individuals from the local community in for work experience and eventually into a full-time job.

Members agreed that the mandatory vaccinations and staffing issue should be escalated to the Board of Directors. It was agreed that Mr Murphy would provide the wording to update the Board on the staffing pressures the Trust was currently experiencing.

f) Serious Incident Report/Duty of Candour Report

Mrs Cheung provided the following update: -

- There was one new Serious Incident (SI) reported to StEIS in December 2021 compared to four new SIs reported to StEIS in November 2021.
- As of 3 January 2022, there were a total of 1,943 open incidents, including 254 which had breached their timescales for closure and 678 were ongoing investigations.
- A new Standard Operating Procedure (SOP) had been finalised which further standardised the process for clinical review of reported incidents, both at a divisional and corporate team level, to ensure correct grading of harm and close management of closure of incidents.
- The Covid incidents identified within our ongoing investigations had been investigated and levels of harms agreed and were in the process of being closed. A Duty of Candour (DoC) letter had been agreed, and we had commenced the process of writing to Next of Kin (NOK) where DoC applies.

- Following concerns raised by the Care Quality Commission (CQC) in the received section 29a warning notice, and a subsequent review of the audit undertaken to assess DoC compliance across the Trust the Quality Governance team was currently undertaking a detailed review of the 2021/22 evidence of compliance against the DoC requirements. A definitive position will be reported to the next Committee meeting, along with any issues identified, and subsequent actions.

Mr Murphy confirmed that further work was ongoing with regards to the Ophthalmology Department, and an update would be provided at the 22nd February meeting.

ACTION: Provide an update on the Ophthalmology Department at the next meeting.

It was confirmed that all SIs and never events were being reviewed through the appropriate channels and actions were being taken to prevent reoccurrences.

Members agreed that a better understanding of the delays in reporting was required and what actions were being taken to correct this challenge.

ACTION: Ensure an update on the delays in reported Sis and actions being taken was provided at the next meeting.

It was acknowledged that there were challenges with regards to the Duty of Candour process and Mrs Cheung advised that the Trust was focusing on revisiting all the DoC and SI data systems and processes to ensure all areas were compliant. Members agreed that an update om this would be provided at the March 2022 meeting.

ACTION: Provide an update on the DoC and SI data systems at the March 2022 meeting.

g) Health & Safety Report

Mrs Cheung highlighted the key points from the report: -

- The top three causes of staff incidents reported in December 2021 were: exposure or contact with harmful substances (40), contact with clinical sharps (7) and unsuitable working conditions (7).
- Seven incidents were reported to the Health and Safety Executive (HSE) under Reporting of Diseases, Injuries, and Dangerous Occurrences Regulations, 2013 (RIDDOR) in December: Over 7-day Incapacitation of a Worker (1), Case of Disease (5) and Dangerous Occurrence (1)
- A total of 41 Violent and Abusive incidents were reported in December 2021, a 14.5% decrease over the same period last year.
- A Health and Safety Lead had been appointed by the Trust and a work plan for them was being developed.

Members noted that Musculoskeletal (MSK) data would be provided at the next meeting.

Mrs McKenna requested more details of key areas of concern and actions going forward to address the health and safety issues.

ACTION: Ensure more details of key areas of concern and actions going forward to address the health and safety issues.

h) COAST Accreditation Programme

Members noted the COAST Accreditation Programme report.

j) Getting it Right First Time (GIRFT) Update

Dr Goode advised that the report provided described the challenges, issues, and potential future position of the GIRFT programme within the Trust and also demonstrated the latest progress in relation to the GIRFT specialty reviews and provided a summary table. It was noted that the GIRFT Oversight Group had been established with a Non-Executive Director Chair. Members noted the challenges of lack of engagement from certain specialities but noted that this could be due to staffing levels and the Covid-19 pandemic.

It was noted the importance on changing the culture of the organisation which would help resolve the issues with engagement.

Mrs Mckenna requested that competing factors as described, that the clinicians were dealing with day to day which would be affecting their ability to deliver improvements within their specialty, be escalated to this committee for greater understanding.

Dr Goode advised that many specialities had shown good improvements and transformation but work had to be undertaken to expand the Trust's specialities to encourage new motivated clinicians.

Members were assured that a mature successful process was in place for the GIRFT and positive results were being seen but noted that engagement had to be improved.

RESPONSIVE

6. a) CQC Action Plan Update

i) Section 29a CQC warning notice and response

Members noted that it had been agreed to provide the Section 29a warning notice action plans to the Committee for oversight before a response was submitted on the 31st January 2022. It was noted that the CQC concerns centred around 3 main areas:

- Harms reviews/waiting lists
- ED performance and safety
- Incidents – reporting, grading and associated learning

It had been agreed there would be some further action taken with regards to time to be seen and these actions were being agreed and will incorporate, amongst other areas, addressing the Emergency Care Improvement Support Team (ECIST) observations, and escalation when time to be seen had not been met.

Mrs Cheung advised that within the CQC section 29a warning notice there was an example of a histology SI and concerns raised by the CQC and that there was on-going work to have an interim IT fix whilst awaiting the EPR. It was noted that it would be incorporated into the incident workstream action plan and that the Trust was currently reviewing the SI and the issues raised to be clear the current waiting list work will rectify concerns whilst awaiting the new IT fix.

Members noted that the Executive Team had reviewed the action plans and had agreed the communication actions to ensure all members of the senior leadership team were sighted on the key issues identified in the warning notice, and the subsequent actions taken.

Mrs Louise advised members that a Never Event that occurred in the Tertiary Division had been turned into a learning video which had received positive feedback and this exercise would be used going forward.

Members agreed that a deep dive into certain areas would be beneficial going forward to ensure they were assured. This would be an issue picked up, following the introduction of the new work programme for Governance.

ACTION: Provide a deep dive into certain areas within the CQC action plan.

Mr Murphy informed members that the Trust were working closely with the CQC with regards to the action plan to ensure the Trust had time to implement sustained changes and improvements.

b) Safeguarding Quarterly Report

Mrs Anderton outlined the key points from the recent three regulatory visits with regards to safeguarding: -

Ofsted Monitoring Visit

- Services at front door were providing effective and co-ordinated response to vulnerable families in Blackpool.
- Risk of harm was recognised and responded to in a timely way - strong collaborative partner presence.
- Agencies contribute to info gathering, conversations with parents are detailed and info in the detailed management notes ensures history is fully considered and impact on children explored.

HMICFRS, Ofsted, CQC and Probation Services are jointly Inspecting the Violence Reduction Unit

- How efficient and effective Violence Reduction Units are at reducing serious youth violent crime.
- How effective and efficient the police are at working with partners to implement the serious violence strategy, including a public health approach

Youth Justice Inspection May – June 2021

- Awarded Good with three areas of outstanding practice in court disposals reviewing, out of court disposals assessment and out of court disposals joint working.

Training

Safeguarding Adults training compliance at 5 January 2022

Level 1 - 1878 trained (93.62%)
Level 2 - 2152 trained (89.51%)
Level 3 - 2268 trained (82.23%)
Level 4 - 4 (75%)
Level 5 - 1 trained (100%)

Safeguarding Children training compliance

Level 1 - 4520 trained (87.94%)
Level 2 - 943 trained (82.14%)
Level 3 - 760 trained (86.46%)
Level 4 - 3 trained (75%)
Level 5 - 1 trained (100%)

It was noted that Deprivation of Liberty Safeguards (DOLS) assurance procedures had been enhanced to provide assurance for the unauthorised DOLs within the Trust; this was escalated weekly on an individual and cumulative basis. The additional measures included the safeguarding team and clinical staff reviewing patients at the onset then, day 7, day 14 and then day 28. In addition to the ongoing reviews by the clinical teams, it was apparent in the data and audits that the understanding and application was enhanced across the organisation.

Members thanks Mrs Gregory and her team for all the good work and noted areas of improvement.

EFFECTIVE

7. a) Quality and Clinical Effectiveness Indicators from the Integrated Performance Report (IPR)

Members noted that numerous areas from the IPR had been covered throughout other agenda items. Mrs McKenna requested that maternity and mortality were areas that had to be covered within the IPR going forward.

It was noted that the IPR was due to be reviewed and would be an improved more effective report going forward.

b) Managing Patient Safety and Flow though the Emergency Department

It was noted that this item was discussed earlier in the meeting.

WELL-LED

8. a) Quality Improvement Update

Members noted the Quality Improvement Update.

Mr Murphy reported an increase in pressure ulcers within the ED Department but advised that a Quality Improvement Lead was based within the department improve on this.

b) Annual Work Plan 2020-21

The Annual Work Plan was noted by the Committee.

Members noted that the Board Committee structure was being reviewed which would include the Annual Work Plans.

c) Items Recommended for Escalation to the Board

Members agreed that the staffing pressures and mandatory vaccinations would be escalation to the Board of Directors.

It was noted that the competing factors that the clinicians were dealing with day to day would be affecting their ability to deliver improvements within their specialty, be escalated to the Board of Directors.

CLOSING MATTERS

8. a) Any other Business

There were no other matters of business raised.

b) Formal Meeting Review

Members agreed that contributions by staff had been great, open and transparent.

c) Date of the Next Meeting:

The next meeting will take place on Tuesday 22nd February 2022 at 1.00 pm via MS Teams.

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board

Maternity Assurance, Ockenden, Morecambe Bay, CNST, HSIB, MBRRACE

Author of Report:	Nicola Parry Divisional Director of Nursing / Midwifery Louise Dowell Associate Director of Nursing
Executive Director Sponsor:	Mr Peter Murphy Executive Director of Nursing, AHP, Midwifery and Quality
Date of Report:	03/03/22

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

To update the Board on: -

- The progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance
- Maternity services workforce plans

This report and presentation will ensure that the Trust Board has an overview of the local maternity services as identified as a key element of the Ockenden review and will include an update on the Morecambe Bay (Kirkup Report), Maternity Incentive Scheme, HSIB and MBRRACE, providing assurance of review and action. This progress must be shared and discussed with the LMS and ICS. Progress must also be reported to the regional maternity team by 15 April 2022.

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

Recommendations:
The meeting is asked to take note of the reports and assurance given

Sensitivity Level:

Not Sensitive: **(For immediate publication)**	**Sensitive In Part:** **(Consider redaction prior to release)**	**Wholly Sensitive:** **(Consider applicable exemption)**
	✓	

Ockenden Report

1.1 Overview

The Ockenden Review is the initial report in respect of 250 cases from Shrewsbury & Telford NHS Trust Maternity Services. The Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and newborn harm' following efforts made by parents whose babies died in 2009 and 2016 respectively. A total of 1862 cases are being reviewed and a further report is anticipated next year.

The report highlighted several themes which were identified and shared with all Maternity Services urgently following the publication of the report on 10th December 2020.

There were seven Immediate and Essential Actions including

- Enhanced Safety
- Listening to Women and Families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring Fetal Wellbeing
- Informed Consent

1.2 Actions Taken

Evidence was submitted to the Ockenden portal prior to the closing date on 15th July 2021. The evidence was scrutinised, and feedback given to the Trust. Full Trust action plan below.

1.3 Ockenden One Year on

Ockenden review of maternity services – one year on

In response to the Trust submission to the Emerging Findings and recommendations from the Immediate and Essential Actions (IEAs) NHSE has asked that progress is discussed at the Trust public Board before the end of March 2022 ad that the report discusses: -

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance

- Maternity services workforce plans

The local system should ensure oversight of maternity services and ensure progress is shared and that this is discussed with the LMS and ICS. Progress must also be reported to the regional maternity team by 15 April 2022.

Detailed below is the Maternity Services action plan and status report.

Section 1							
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g., through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months							
What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement ?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	**RAG**
BTH Maternity Dashboard	Improvements in outcome data Reported at Divisional Quality Meeting, Trust Quality and Clinical Effectiveness Committee reported in the minutes of these meetings	Further action is taken at the MatNeo Quality Improvement Forum and outcomes monitored using QI methodology (run charts)	Local dashboard is being converted into run charts, work ongoing Implement the Perinatal Clinical Quality Surveillance Model	Quality Improvement Manager Maternity Matron Obstetrician / Risk Lead	Increase in staff training in QI methodology – developing this approach across the Division	This is improvement work; ongoing controls mitigate the risk	
LMS Dashboard	Improvements in outcome data demonstrated	Dashboard is reviewed at MatNeo Quality Improvement	Further development of LMS dashboard and presentation at the Divisional Quality	Quality Improvement Manager	Increase in staff training in QI methodology – developing this	This is improvement work; ongoing controls mitigate the risk	

	on the LMS dashboard and compared to peers	Forum and outcomes monitored using QI methodology (run charts)	and Clinical Effectiveness Committee	Maternity Matron Obstetrician / Risk Lead	approach across the Division		
Divisional MatNeo Quality Improvement Forum - monthly meeting **Current projects** ➢ Continuity of Carer ➢ OASI ➢ PPH ➢ 48 hr breast feeding rate NNU	Quality Improvement Programme is continuation of National programme and Trust direction. It is a recognised methodology to inform and improve outcomes The forum reports to the Divisional Quality and Clinical Effectiveness Meeting and discussions recorded in the minutes of this meeting	The QI Forum links with the Trust ambition to improve quality by QI methodology	MatNeo Quality Improvement Forum to continue to meet monthly QSIR practitioners being accredited within division	Quality Improvement Manager Maternity Matron Delivery Suite Lead Consultant	Increase in staff training in QI methodology – developing this approach across the Division	This is improvement work; ongoing controls mitigate the risk	
Reporting to HSIB, PMRT and NHSR	All qualifying incidents have been reported There is external scrutiny for all PMRT and HSIB incidents	All cases that are reported receive an initial Divisional review Final reports are scrutinised, actions implemented and shared with staff	The way in which case reviews are conducted is being reviewed – ensuring staff are counselled and prepared prior to the case review. External specialist reviewers to attend case review.	Associate Director of Nursing	Governance support to ensure all cases are reported, investigated and lessons shared	This is improvement work; ongoing controls mitigate the risk	

	This is reported to the Divisional Quality and Clinical Effectiveness Committee by way of the Patient Experience Report. This report is included in the minutes	Individual and group lessons are shared Newsletters, individual case-based discussion and Professional Midwifery Advocate feedback mechanisms are used Family involvement in the review is carried out Cases are reported to the Divisional Quality and Clinical Effectiveness Committee, Trust Quality and Clinical Effectiveness and the Trust Safety Champion	Availability rota to be maintained by LMS. All maternity serious incidents are to be shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB				
Data reported to the Maternity services dataset	Data is reported to the maternity data set via the Euroking System A monthly data score card is produced to inform compliance	The data from the system is used to populate the Divisional and LMS dashboard	To ensure that the Euroking system can provide the correct data for the dataset and Maternity Incentive Scheme reporting Implementation of the Badger Net system in line with the LMS ambition	Divisional Director of Nursing and Midwifery Matron/Digital Midwife	Digital Midwife Project support for the implementation of Badger Net	The Euroking system can provide the data for the maternity data set	

Serious Incidents are reported to the Safety Panel	All serious incidents are reported to the Trust Safety Panel and recorded in the minutes. All serious incidents are discussed at the Divisional Quality and Clinical Effectiveness Committee and recorded in the minutes	The lessons identified are shared at a Trust level	All maternity serious incidents are to be shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Divisional Director of Nursing and Midwifery	Trust governance support to ensure incidents are added to the agendas and reported accordingly	Lessons are already shared the actions will make this more robust	
Implement the Perinatal Clinical Quality Surveillance Model	A Perinatal Clinical Quality Surveillance Forum has been implemented and will meet on a monthly basis	The Perinatal Clinical Quality Surveillance Forum will report to the Trust Quality and Clinical Effectiveness committee and the Maternity Safety Champions will be part of this group	The forum will ensure that all reporting requirements are achieved and that the Trust Board are appraised of the Perinatal Clinical Quality Surveillance Model	Divisional Director of Nursing and Midwifery April 2021	Trust governance support to ensure agendas and minutes and reported accordingly	This will enhance current reporting structures	
There will be regular reviews of the existing maternity dashboard at Safety Special Interest Group and the Board	Data will be scrutinised for best practise as well as outliers / areas for concern in order to spread practise across the LMS.	Improved outcomes Shared learning bulletin	Establish Quality and Safety Forum Write SOP Regular agenda item on Alliance Board agenda	LMS SRO / Chair / HOM April 2021	Increased governance resource within LMS team	Utilise existing team members, data analysts from CSU and support through the clinical network	
The LMS will develop a Quality Surveillance and Concerns Forum	Ensure correct skills and	Improved outcomes	LMS Quality surveillance meeting	LMS SRO / Chair / HOM	Increased governance	Utilise existing team members, data analysts from	

to receive SIs and other qualitative and quantitative reporting and escalate to the Regional Perinatal Board in a proportionate manner according to the SOP (also being developed)	competencies on the forum to scrutinise the information. Clear roles and responsibilities and escalation	Shared learning bulletin Reduce duplication of reporting – single version of the truth Reporting in a timely manner	now set up since Nov 2021		resource within LMS team	CSU and support through the clinical network	
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.							

• Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.							
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements ?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	
Service User feedback is gathered from various sources, complaints, PALS, MVP, Facebook live	Patient Experience Report, reported to Divisional Quality meeting and recorded in the minutes	Patient feedback is positive	The Trust must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Director of Nursing and Quality April 2021	The appointment of an independent senior advocate role Regional/National team need to appoint to Independent senior advocate role – still awaited	This role is currently carried out within the Divisional Governance function	
The Trust Board has identified a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions	Trust Board Minutes Minutes of the Safety Champions Meeting that will include the Non-Executive Director Minutes of the Perinatal	The non-executive director will have oversight of maternity services and report to the Trust Board The Divisional Director of Nursing and Quality will have direct access to raise concerns	Develop the role of the non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the	Director of Nursing and Quality	The ongoing development of the non-executive role	Safety Champion Meetings are held monthly Divisional Director of Nursing has direct access to the Executive Director of Nursing and Quality	

	Clinical Quality Surveillance Forum		voices of service users and staff are heard Develop a Perinatal Quality Forum to ensure all reporting requirements are adhered to				
NPMRT	All qualifying cases are reported to the NPMRT tool to the required standard and reported to the Divisional Quality and Clinical Effectiveness Committee	External scrutiny is undertaken on all NPMRT cases, and they are added to the National database	Continue to report MPRT cases according to protocol	Director of Nursing and Quality	Governance support to ensure the incidents are reported	There is external scrutiny on NPMRT reports	
Trust safety champions (obstetric, neonatal and midwifery) are meeting bimonthly with Board level champions to escalate locally identified issues	Trust Safety Champions meeting on a bimonthly basis Safety Champion walkabout BAME Q&A Weekly newsletter / monthly newsletter	The Executive Safety Champion seeks active feedback from staff on walkabouts The Divisional Safety Champions have an open-door approach to safety discussions. All concerns are raised appropriately using recognised reporting systems	The non-executive will be invited to the meeting to support maternity safety and bring a degree of independent challenge to the oversight Develop a Perinatal Quality Forum to ensure all reporting requirements are adhered to	Director of Nursing and Quality	The ongoing development of the non-executive role	Safety Champion Meetings are held monthly Divisional Director of Nursing has direct access to the Executive Director of Nursing and Quality	

Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.							
What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	
A multidisciplinary training schedule is in place Structured skills drills (unannounced) carried out on a regular basis	There is a Training Needs Analysis (Training Needs Analysis (TNA) for Specialist Training in the Maternity Service OBS/GYNAE/ POL/005) in place which identifies the training required, staff group and frequency	The compliance with training is reported to the Divisional Quality and Clinical Effectiveness Meeting held monthly and recorded in the minutes of this meeting MIS compliance Safety Action 8 (90%)	Ensure that training continues and that all staff groups achieve 90% Implement the further guidance when this is published MIS compliance Safety Action 8 (90%)	Assistant Divisional Director of Nursing Head of Department	Clerical support to facilitate effective working from the PD Team	Training is ongoing and attendance monitored. Non-attendance / compliance is followed up	
Better Births Better training, is provided across all four providers in the LMS	The training is externally validated through the LMS, 3 times a	The training evaluation will be reported to the LMS Board 3 times per year	The training needs to continue and develop despite the COVID pandemic	Divisional Director of Nursing and Midwifery	The training needs to continue and develop despite the COVID pandemic	The training is reported to the LMS Board 3 times per year	

	year this is currently under review due to the COVID pandemic		No update yet due to COVID. Funding now transferred to LMS				
There are (physical) ward rounds twice a day, Monday to Friday at 8 am and at 6pm and remotely via telephone at 2200 hours There are regular (physical) ward rounds on Saturday and Sunday at 8 am and remotely via telephone at 2200 hours	There are currently no monitoring mechanisms	Compliance will be reported to the Divisional Quality and Clinical Effectiveness Meeting	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward Further discussion required to ensure weekend implementation. This would involve a change in job plan	Head of Department April 2021	Change in work plan to facilitate weekend consultant-led and present multidisciplinary ward rounds on the labour ward	There are twice daily ward rounds, but the consultant is not present on a weekend at 22.00 hrs for the rest of the time there is compliance	
Any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	This is monitored at the LMS Board on a quarterly basis The Trust Director of Finance has confirmed by way of e-mail dated 07/01/21 that this is the case	This is reported to the LMS Board on a quarterly basis	No further action required	Divisional Director of Nursing and Midwifery Ongoing	Ensure any further monies are allocated accordingly and monitored and reported to the LMS Board	The risk is mitigated by regular reporting and monitoring to the LMS Board	

Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team							
What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Women with complex pregnancies must have a named consultant lead	Clinical audit	Divisional Clinical Audit meeting	Ensure spot audit of 30 cases is undertaken to ensure there is a named consultant for women with complex pregnancies	Divisional Director of Nursing Obstetrician / Risk Lead	Resource to complete the audit	All women with complex pregnancies should be allocated a named consultant. The audit of managing complex pregnancies concluded that 100% of women had their level of care risk factor correctly identified at booking and 96% of high-risk women were referred to a consultant	
Where a complex pregnancy is identified, there is early specialist involvement and management plans agreed between the woman and the team There are specialist clinics in place for diabetes, twins perinatal mental health, complex social needs and preterm (rainbow clinics) Within these clinics individual management plans are developed There is confidence that this is place, an audit will give the required assurance	Clinical audit	Divisional Clinical Audit meeting	Ensure spot audit of 30 cases is undertaken to ensure there is an individual management plan	Divisional Director of Nursing and Midwifery Obstetrician / Risk Lead	Resource to complete the audit	Where a complex pregnancy is identified, there is early specialist involvement and management plans agreed between the woman and the team The audit of managing complex pregnancies concluded that 100% of women had their level of care risk factor correctly identified at booking and 96% of high-risk women were referred to a consultant	

Saving Babies Lives 2 compliance is monitored on a regular basis.	SBL2 monitoring meeting and action plan	Divisional Quality and Clinical Effectiveness Meeting	Ongoing review of actions and implementation of policy documentation MIS audit completion	Divisional Director of Nursing and Midwifery	Resource to complete the audits	All elements of the SBL2 bundle are in place. Audits still to be undertaken	
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.							
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Women are formally risk assessed at every antenatal contact to ensure that they have continued access to care provision by the	Clinical Audit	Divisional Clinical Audit Meeting	Ensure spot check audit of 30 cases is undertaken to ensure that the risk	Divisional Director of Nursing and Midwifery	Resource to complete the audits	Women are formally assessed at every antenatal contact	

most appropriately trained professional The risk assessment includes ongoing review of the intended place of birth, based on the developing clinical picture			assessment is undertaken at every antenatal contact and to assess PCSP compliance.	Obstetrician / Risk Lead		There is confidence that this is place, an audit will give the required assurance	
Saving Babies Lives 2 compliance is monitored on a regular basis	SBL2 monitoring meeting and action plane	Divisional Quality and Clinical Effectiveness Meeting	Saving Babies Lives 2 compliance is monitored on a regular basis.	Divisional Director of Nursing and Midwifery	Ongoing clinical support and engagement	Saving Babies Lives 2 compliance is monitored on a regular basis.	

Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.							
What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
A senior Lead Midwife has been appointed to lead best practice, learning and support. There is regular training and review of cases	The Senior Lead midwife is integral to the governance structure of the Division. Training figures will be monitored	Divisional Quality Meeting Safety Champions Meeting	Ensure a second lead is identified so that the unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support	Divisional Director of Nursing and Midwifery Maternity CTG Lead Consultant Obstetrician	Allocation of a Lead Obstetrician	There is already a Lead Midwife in place, and dedicated consultant staff who support training	
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019	The Lead midwife will provide a report to the Divisional Quality and Clinical Effectiveness Committee	Divisional Quality Meeting Safety Champions Meeting	Ensure training figures for all professions is greater than 90%	Divisional Director of Nursing and Midwifery Head of Department	Fetal monitoring Consultant lead – Mr. Karl McPherson	There is already a Lead Midwife in place, and dedicated consultant staff who support training	

	Competency assessments will be undertaken						
Saving Babies Lives 2 compliance is monitored on a regular basis. Obstetrician Lead for SBL2 who works in close liaison with the midwifery teams	SBL2 monitoring meeting and action plan	Divisional Quality and Clinical Effectiveness Meeting	Ongoing review of actions and implementation of policy documentation MIS audit completion	Divisional Director of Nursing and Midwifery	Resource to complete the audits	All elements of the SBL2 bundle are in place. Audits still to be undertaken	
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected							
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
The Community Midwife will provide information to enable the woman to have an informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Exceptions reported via incident reporting	Women are satisfied with their care. Friends and Family Results	Ensure spot check audit of 30 cases is undertaken to ensure women are provide with information to enable them to have an informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Assistant Divisional Director of Nursing	Resource to undertake the audit	The Community Midwife provides information to enable the woman to have an informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery There is confidence that this is place, an audit will give the required assurance	
Women are provided with accurate and contemporaneous	Exceptions reported via	Women are satisfied with their	Ensure spot check audit of 30 cases is undertaken	Assistant Divisional Director of Nursing	Resource to undertake the audit	Women are provided with accurate information	

evidence-based information as per national guidance Information leaflets are available on the Trust internet site and women are signposted appropriately	incident reporting	care. Friends and Family Results				There is confidence that this is place, an audit will give the required assurance	
Women are enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Exceptions reported via incident reporting	Women are satisfied with their care. Friends and Family Results	Ensure spot check audit of 30 cases is undertaken	Assistant Divisional Director of Nursing	Resource to undertake the audit	Women are enabled to participate equally in all decision-making processes and to make informed choices about their care	
The Trust has pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website	Exceptions reported via incident reporting	Women are satisfied with their care. Friends and Family Results	Ensure all information on the Trust website is up to date	Assistant Divisional Director of Nursing	Resource to undertake the audit	There is up to date information on the Trust web site and provided by medical and midwifery teams	
There is a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Reported monthly to the Divisional Quality and Clinical Effectiveness Committee by way of a Patient Experience Report	Feedback is received with positive comments. Complaints are responded to, and actions implemented	MVP meeting have been irregular due to COVID Implement virtual complaints meetings to ensure resolution	Women are enabled to participate equally in all decision-making processes and to make informed choices about their care	Ensure active participation of MVP with dates and minutes of meetings. Comments from Facebook Live	Feedback is collated and reported at the Divisional Quality and Clinical effectiveness Committee	
Continuity of Carer Ensuring that those who are most vulnerable (BAME, social deprivation) are on a continuity pathway	Reported to the LMS CoC work stream monthly	Achievement of 35% on a pathway by March 2021 and in receipt of pathway 51% by March 2022	Engagement of women and families via MVP and Facebook Live Engagement with all maternity staff Ensure data is submitted correctly to the EPR	CoC Project Board Currently on hold	Support of the Trust Board	Feedback is collated and reported at the Maternity Patient Safety Champions Continuity of carer (Ocean Team) is currently on hold	

Funding for investment in Maternity Workforce and Training

In line with Ockenden a request for additional funding to invest in maternity workforce and training was submitted.

The bid has been reviewed and maternity services will be awarded a total allocation of £261,476 for 2021/22. This will be paid in 2 tranches, £172,574 initially with a further £88,902 based on review of progress in November to help meet the gap in establishment of midwifery and obstetrician workforce and implement MDT training.

In addition (April 2021) maternity services undertook a Birthrate plus workforce assessment considering acuity and midwifery workforce. The results showed a 11.38 WTE shortfall of Registered Midwives. The funding detailed above provided Midwifery Workforce (inc. MDT provision) 6.5 WTE and Obstetric Workforce (inc. MDT provision) 0.3 WTE leaving a deficit of 4.88 WTE to enable Birthrate plus compliance.
Next steps

- The Maternity Service will develop a Workforce action plan to recruit and retain midwives
- A Business case detailing the current need for maternity staffing will be developed which will include a Consultant midwife (as recommended in the Ockenden report) a specialist midwife and 2.88 WTE band 5-6 midwives

Morecambe Bay (Kirkup Report)

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH).

Covering January 2004 to June 2013, the report concludes the maternity unit at FGH was dysfunctional and that serious failures of clinical care led to unnecessary deaths of mothers and babies.

The Investigation Panel also reviewed pregnancies at other maternity units run by University Hospitals of Morecambe Bay NHS Foundation Trust. It found serious concerns over clinical practice were confined to FGH.

The report makes 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.

The investigation report details 20 instances of significant failures of care in the FGH maternity unit which may have contributed to the deaths of 3 mothers and 16 babies. Different clinical care in these cases would have been expected to prevent the death of 1 mother and 11 babies. This is almost 4 times the frequency of such occurrences at the Trust's other main maternity unit, at the Royal Lancaster Infirmary.

The report says the maternity department at FGH was dysfunctional with serious problems in 5 main areas:

- Clinical competence of a proportion of staff fell significantly below the standard for a safe, effective service. Essential knowledge was lacking, guidelines not followed and warning signs in pregnancy were sometimes not recognised or acted on appropriately.

- Poor working relationships between midwives, obstetricians and paediatricians. There was a 'them and us' culture and poor communication hampered clinical care.
- Midwifery care became strongly influenced by a small number of dominant midwives whose 'over-zealous' pursuit of natural childbirth 'at any cost' led at times to unsafe care.
- Failures of risk assessment and care planning resulted in inappropriate and unsafe care.
- There was a grossly deficient response from unit clinicians to serious incidents with repeated failure to investigate properly and learn lessons.

The report says proper investigations into serious incidents as far back as 2004 would have raised the alarm. It was not until 5 serious incidents occurred in 2008 that the reality began to emerge.

2.1 Actions Taken

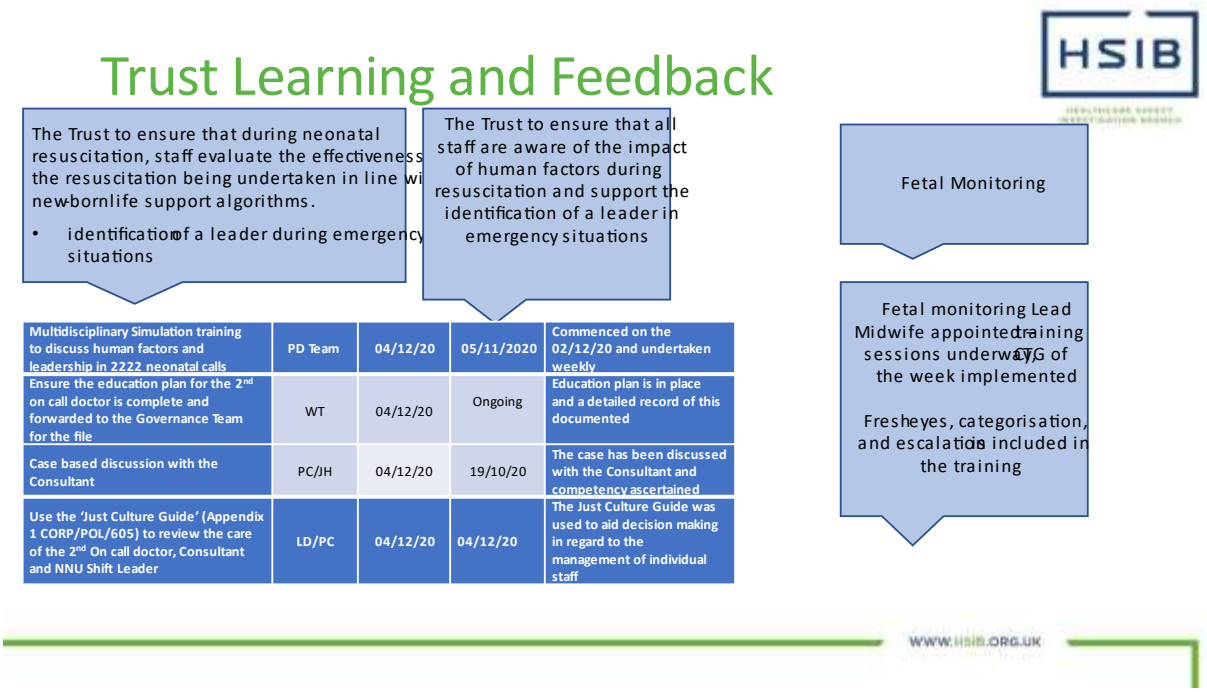
The safety recommendations from the Morecambe Bay Review were reviewed in April 2015, March 2016, February 2020 and December 2021. The recommendations from the published UHMB CQC report are currently being reviewed and the original recommendations revisited.

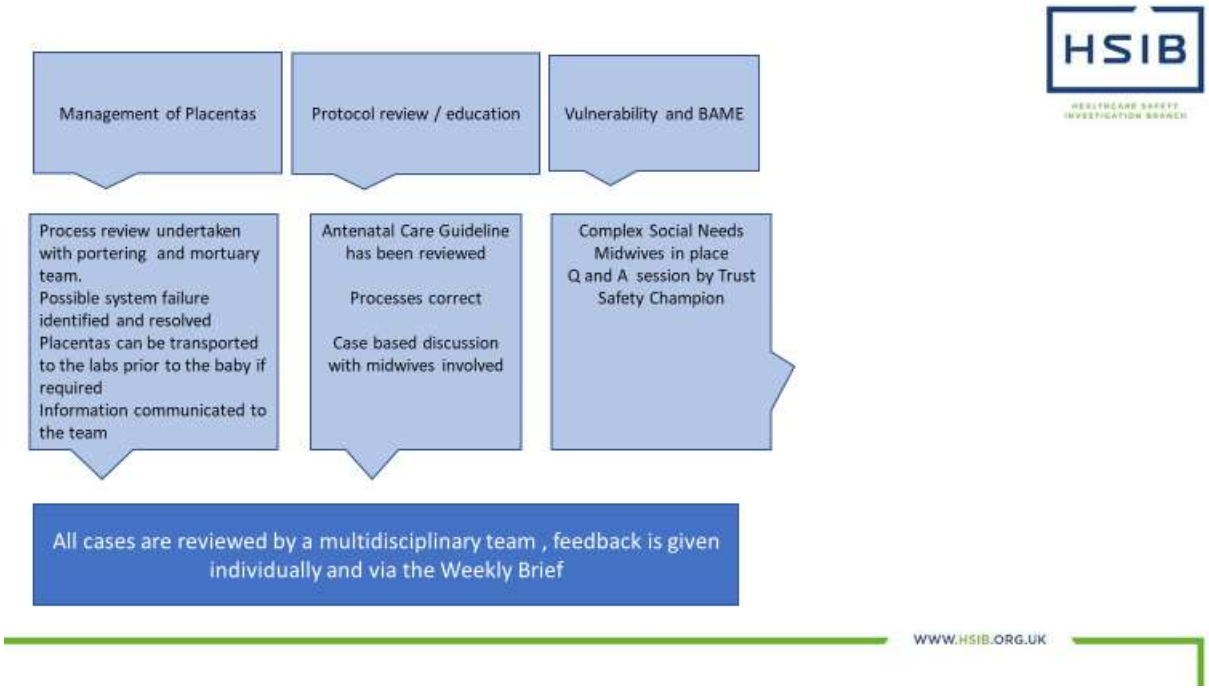
Kirkup Report - Updated August 21.

3.0 Healthcare Safety Investigatory Branch (HSIB)

Cases to date	
Total referrals	17
Referrals / cases rejected	6 cases in total. 3 cases rejected as duplicates. 3 cases rejected due to COVID-19 triage criteria: 2002-1691 / 2004-1877 / MI-003262.
Total investigations to date	11
Total investigations completed	10
Current active cases	1
Exception reporting	0

HSIB Maternity National Newsletter





3.1 Actions Taken

The Trust maternity Team work closely with HSIB, receiving monthly updates, participating in quarterly local and national incident reviews. The team participate in all qualifying incidents providing case notes, statements and any other information required by HSIB. Once the report is generated a tripartite meeting with HSIB, Trust and family is held. All HSIB reports are reported to the Safety Panel and Trust Board.

4.0 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)

The MBRRACE-UK programme of work involves the national Confidential Enquiry into Maternal Deaths (CEMD)and national surveillance of late fetal losses, stillbirths and infant deaths.

In addition, the programme includes a series of themed topic-based confidential clinical reviews of serious maternal and infant morbidity, and stillbirths. As near-miss events and cases of serious morbidity are more numerous than deaths, lessons can be learned quickly and improvements in care can be instituted more rapidly following their investigation.

4.1 Actions Taken

The MBRRACE report on Twin Pregnancies was reported to the Audit Meeting on the 8th April 2021. Dates are being arranged to discuss the MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18 and the Rapid report: Learning from SARS-CoV-2-related and associated maternal.

Families Division – Morecambe Bay Report Exercise April 2015 – updated February 2020

Review of Kirkup, Ockenden and Maternity Incentive Scheme Year 3

Theme	Divisional Action	Evidence	Responsible Peron	RAG
Patient Safety Recommendation 6, 7, 12, 16, 17 Kirkup IEA 3 Ockenden	Antenatal Care Obs/gynae/prot/008 • All women will have a booking Risk Assessment (see Appendix 1) completed by the midwife and documented in the handheld record • On-going review of clinical risk continues throughout the pregnancy as outlined in Appendix 2 • Any risks identified must be documented in the handheld record. • Place of birth should be assessed according to risk	• Documentation of risk assessment and management plan • Clear documentation of individualised management plan • Revised antenatal notes and policy • FCBC operational plan • Audit of standards	Community Midwifery Manager Audit Lead	
	Update February 2020 • Antenatal guideline regularly updated and is due a full update May 2020 • All incidents are discussed at the divisional weekly incident review meeting • Multidisciplinary Case reviews • 72-hour reviews on all incidents entered as moderate harm • Divisional weekly briefing • Message of the week • Involvement with PMRT, NHS resolutions, HSIB • CNST – incentive scheme Year 3	**Update February 2020** • 72-hour review 72 hour Rapid Review- AE57060.doc • Weekly Briefing Weekly Brief 07 02 2020.pdf • Message of the week	Clinical Governance and Quality Manager Clinical Governance Officer Patient Experience Coordinator	

	• Theatre environment appropriate			
Patient Experience Recommendation 1, 11, 13 Kirkup	• Review risk Families Division Risk Management Strategy • Respond to all complaints within timescale, promote meetings and ensure that duty of candour is followed • Ensure that the Trust process for Duty of Candour is followed • Coordination between Supervision and Management and the current letter should be reviewed. • A meeting with a patient / family must be followed up with a letter	• Incident Review meetings • Case review • Weekly brief • Trust training • Duty of candour • Complaint's performance and minutes • Letters are sent to all patients involved in level 3 and above incidents • Evidence of meetings with patients • Complaints Review Panel	Clinical Governance and Quality Manager	
	Update February 2020 • Daily walk about to the ward • FFT • Family Friendly Dashboard • Maternity Voices partnership • Birth afterthoughts	**Update February 2020** • Family Friendly Dashboard  Maternity Dashboard December 2019.pptx • Discussed at Divisional Quality Committee, Divisional Board and Maternity Pathways Meeting		

Governance Escalation and Assurance Recommendation 15 Ockenden, 16	• Maternity Safety Champions • Perinatal Surveillance Forum	Champions flow chart		
Clinical Quality	• Audit programme to include • Risk assessment protocols, place of delivery, transfer, and management of care • Discuss with audit lead re including in audit programme • Promotion of attendance of MDT • attendance at audit meetings • Ensure quality is discussed as a priority and meetings	• Annual audit programme and presentation at the MDT meeting • Maternity pathways meeting with the CCGS	Head of Department, Clinical Audit Lead Head of Service Head of Midwifery/Associate Director of Nursing	

	Update February 2020
	• Clinical activity monitored monthly via the maternity dashboard
	• Annual audit calendar reflects national guidance and local themes
	• CNST – maternity incentive scheme Year 3
		Update February 2020
		• Themed clinical quality reviews
		  • PPH
		  • 3rd and 4th Degree Tears
		  • Emergency LSCS
		• Spot audits
		  • VTE
		  • Still birth review
			Head of Department
			Quality manager	

Leadership Recommendation 14 Kirkup	• MDT skills drills to continue • MDT live drills to take place • Continue CQC mock visits	• Annual skills and drills programme • CTG training and Midwife • Attendance monitoring • Team Leader meetings • Staffing Meetings • HCA meetings • Annual appraisal • Families Management Team Structure	Practice Development Midwife	

	Update February 2020 • Attendance at leadership development programmes • Senior members of the Families division visibility	**Update February 2020** • Development of accreditation programme for the Families division	Head of Midwifery/Associate Director of Nursing Practice Development sisters	
Workforce and Education Recommendation 8 Kirkup Ockenden Workforce and leadership	• Review of medical skill mix • One Family engagement • Divisional review of the TNA annually • Compliance with national standards to ensure competencies • Individual training should be identified in the annual appraisal • Development of a Divisional training forum that would report into Governance • MDT skills drills to continue • MDT live drills to take place • Assurance report to be sent to governance meeting	• TNA • Attendance at skills drills • Doctors' competency documentation • Incident review/ raising concerns • Audit of policies • Training programmes • Completion of annual appraisal • Live drills • Assurance report	Head of Midwifery / Delivery Suite Lead	

	Update February 2020
	• Multidisciplinary training (BTH & LMS)
	• Workforce development
	  • Advanced clinical practitioner
	  • Physician associate
	  • Nursing associate
		Update February 2020
		• Better Births/ Better Training
		• PROMPT
		• Human factors training
			Head of Department,
			Head of Midwifery/Associate Director of Nursing	

Local Maternity Service and collaboration Recommendation 10, 18 Kirkup	Collaborative implementation since 2017			
Wider NHS issues Recommendation 19, 20, 21, 22, 23, 24	Regulatory Bodies Rural environments Education in smaller hospitals Review of recommendations Regulatory standards for investigation of serious incidents Regulatory duty of candour			

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

HSIB National Maternity Newsletter - Trust Template

The HSIB maternity newsletter is an initiative to support shared learning from trusts across the country. It allows trusts to share the changes made as a result of the findings and recommendations from maternity investigations done by HSIB.

Please use the template below to describe the learning that you would like to share.

Date of next newsletter	September 2021
Date needed by HSIB	30 July 2021

Trust	Blackpool Teaching Hospitals NHS Foundation Trust
Title of learning	Supporting Staff in Systematic Approach to CTG Interpretation and Fresh Eyes Review
We heard from HSIB… the evidence	To ensure staff are supported to systematically categorise CTGs and undertake fresh eyes review in line with guidance
We did this and it worked for us… the change	Our CTG Lead Midwife is undertaking regular multidisciplinary CTG training for staff and has encouraged them to participate in the “Monitoring May” CTG training by Mid Yorkshire NHS Trust. A literature search has been undertaken to review ‘Fresh Eyes’ evidence, and revised guidance has been given to staff via the divisional weekly newsletter.

	Our protocol for “ Intrapartum Fetal Monitoring and Fetal Blood Sampling” is being updated following these recommendations and to meet SBL2 standards.

Blackpool Teaching Hospitals NHS Foundation Trust

Trust Board of Directors
3rd March 2022

Quality Improvement (QI) Strategy Report

Author of Report:	Katharine Goldthorpe - Associate Director of QI Paryaneh Rostami - Senior QI Manager/ Patient Safety Specialist
Executive Director Sponsor:	Peter Murphy Director of Nursing, AHP & Quality
Date of Report:	03.03.2022

Executive Summary (to include, where appropriate, the level of assurance & position on trajectory):
This report provides brief updates on the progress of each of the Trust's main QI programmes. All programmes are currently on track. It should be noted that all aim statements are currently under review and will be updated in line with Trust 5-year strategy. Where improvements have been achieved and sustained, plans are underway to ensure monitoring is undertaken through the Divisional team structures.

Eliminating Pressure Ulcers Collaborative – Recent increase in Emergency Department pressure ulcers due to recent increase in length of stay in the department. Adaptive measures have been taken. Community teams have also experienced a number of data points outside the control limits, in line with recent increases in pressure. Teams have met with Senior Clinical Advisor from NHS England to share knowledge and help to create reliable systems during a difficult period.

Identification and Management of the Deteriorating Patient –Positive progress, with 9 out of 12 data points below the mean for the rate of cardiac arrests per 1000 admissions since the start of the collaborative and a statistically significant increase of 50% in the number of days between cardiac arrests.

Improve the Last 1000 Days Collaborative –In the month of January there were 2 #NOF within the collaborative teams. One of the #NOF was a resident from participating care home with a covid break out. The second #NOF was from a non-participating care home. Hospital admissions have significantly reduced during the period of the collaborative.

Safety Culture Programme –Safety culture survey data, and other safety data, have been incorporated into plans for a programme to be initiated with a specific team within Surgery, Anaesthetics, Critical Care & Theatres Division. The first Trust-wide Safety Newsletter was launched in January. The Learning from Excellence initiative has now been upscaled to the entire Trust and is available to be used on the Trust incident reporting system.

Clinical Quality Academy –Session on 23rd February will be attended by Dr James Mountford, Director of National Improvement Strategy, NHS Improvement. Planning for the second cohort of the CQA is underway with plans to launch announce the CQA2 teams at a celebration event on the 14th July 2022.

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

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

Sensitivity Level:

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

Quality Improvement Strategy: Update for Trust Board of Directors
3rd March 2022

1. PURPOSE

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

2. BACKGROUND

2.1 QI Strategy
The BTHFT QI Strategy [1] describes an approach to achieving the Trust's QI goals which includes how improvement capability is being built within the Trust. The report provides brief updates for the three breakthrough series collaboratives that the Trust is delivering to achieve the high-level aims outlined in the BTHFT QI Strategy (2019-Nov22) [1], the Safety Culture Programme and general building of improvement capability within the Trust.

It should be noted that all aim statement goal dates are currently under review and will be updated in line with Trust 5 year strategy. Feedback from the recent Care Quality Commission (see Appendix A for examples), will be considered when making these updates. Where improvements have been achieved and sustained, plans are underway to ensure monitoring is undertaken through the Divisional team structures.

3. COLLABORATIVE PROGRAMME DELIVERY

3.1 Reduce Avoidable Harm – Eliminating Pressure Ulcers
3.1.1 Executive Sponsor: Director of Nursing, Midwifery AHP and Quality

3.1.2 Specific Aims - for collaborative teams to achieve the following by March 2022:
- 50% reduction category 2 hospital acquired pressure ulcers
- 50% reduction in community acquired pressure ulcers
- 80% reduction in category 3 and 4 hospital acquired pressure ulcers

3.1.3 Assessment - for collaborative teams

- 62% reduction category 2 hospital acquired pressure ulcers
- 43% reduction in community acquired pressure ulcers
- 47% reduction in category 3 & 4 hospital acquired pressure ulcers (76% increase in time between)

The Acute hospital collaborative teams have seen a recent increase in the number of category 2 and 3 hospital acquired pressure ulcers (Figures 1 and 2). As highlighted in January's board report, patients attending the Emergency Department (ED) have experienced the majority of harms. The ED team have needed to adapt their process for avoiding pressure harm, due to a recent increase in length of stay in the department. Work has been undertaken to further improve the timeliness of first skin assessment and to ensure patients are repositioned as per their care plans. Early identification of high-risk patients attending ED, using a new pressure risk assessment tool, is currently being tested and suitable pressure relieving equipment has been identified. Early indications show that these new interventions are producing positive results and the team will continue to rapidly test, monitor and adapt their practice.

A recent visit from the NHS England and NHS Improvement Emergency Care Improvement Support Team (ECIST) to the Trust has identified opportunities to improve flow in ED. Work to address this will be supported by QI team using lean methodology.

Community teams have also experienced recent increases (Figure 3), with a number of data points outside the control limits. This mirrors a regular increase in escalation management solution (EMS) level to level 4, extreme pressure, throughout the months of November and December. Community teams met in February with Jacqui Fletcher OBE, Senior Clinical Advisor Stop the Pressure Programme / National Wound Care Strategy, NHS England and NHS Improvement to share expertise and knowledge which will help them create reliable systems during a difficult period.

3.1.4 Data

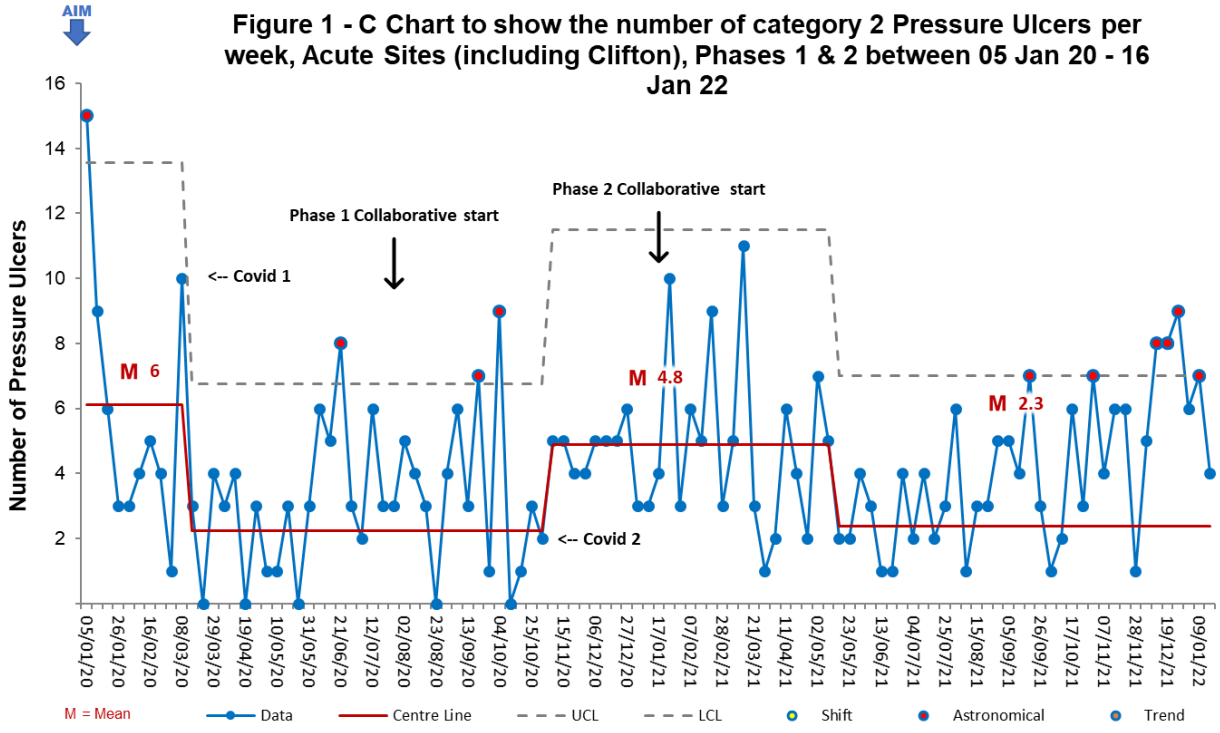


Figure 1 - C Chart to show the number of category 2 Pressure Ulcers per week, Acute Sites (including Clifton), Phases 1 & 2 between 05 Jan 20 - 16 Jan 22

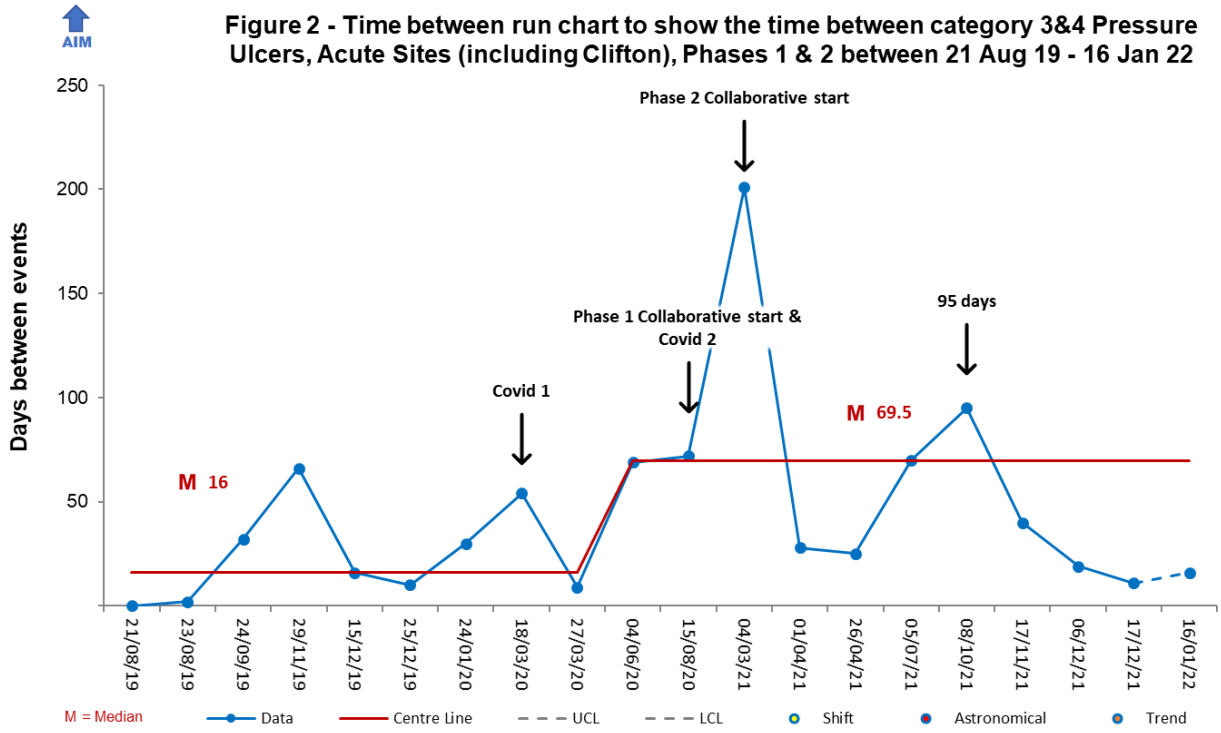


Figure 2 - Time between run chart to show the time between category 3&4 Pressure Ulcers, Acute Sites (including Clifton), Phases 1 & 2 between 21 Aug 19 - 16 Jan 22

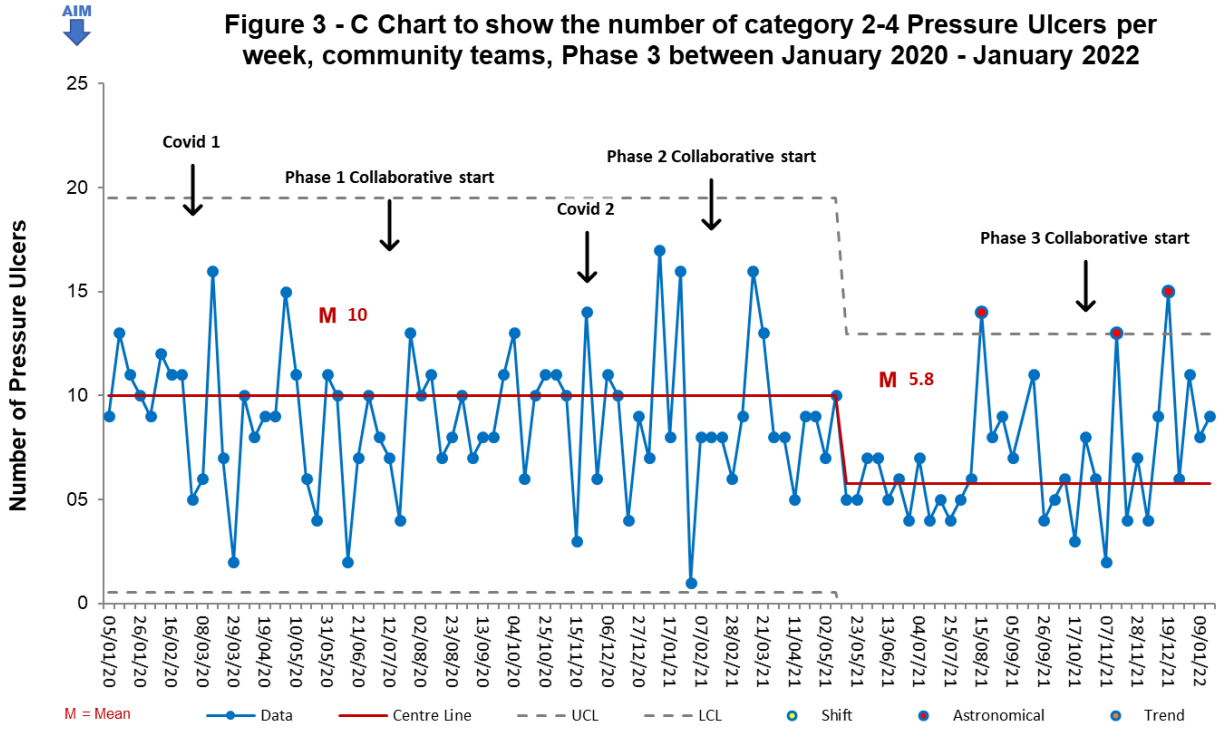


Figure 3 - C Chart to show the number of category 2-4 Pressure Ulcers per week, community teams, Phase 3 between January 2020 - January 2022

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

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

3.2.2 Specific Aim: Reduce the number cardiac arrests (outside of critical care units) by 50% by February 2022.

3.2.3 Assessment

The QI Hub supports a number of related projects across the Trust, some of which sit outside the collaborative teams. The results are positive, with 9 out of 12 data points below the mean for the rate of cardiac arrests per 1000 admissions since the start of the collaborative (Figure 4) and a statistically significant increase of 50% in the number of days between cardiac arrests (Figure 5).

Monthly virtual drop in cafés are open to any Trust member of staff to join, to support the continued use of improvement methodology and the spread of interventions through shared learning.

Interventions developed by some of the collaborative teams were referenced in January's CQC report and examples of these references have been provided in Appendix A.

3.2.4 Data

The cardiac arrest rate per 1000 admissions has been below the mean in January. The median number of days between events occurring in the combined collaborative inpatient teams has been sustained. This data is shared weekly to the collaborative Microsoft Teams channel and is available to all collaborative teams.

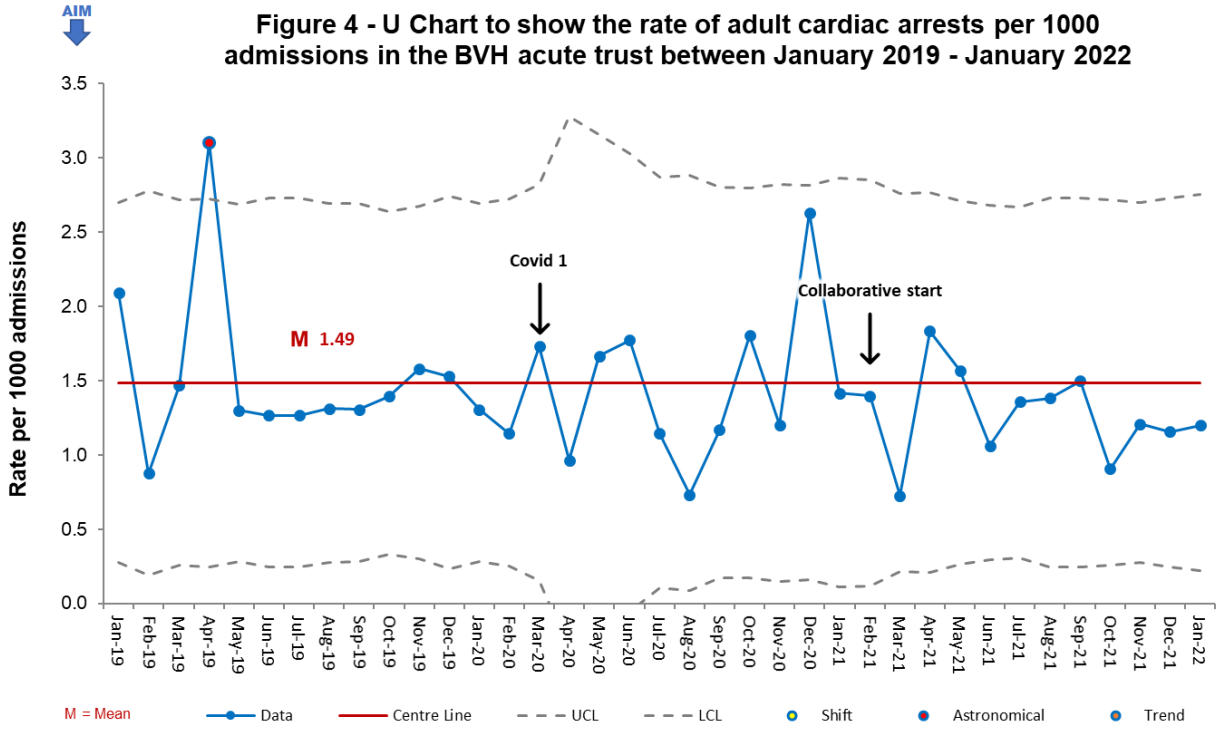


Figure 4 - U Chart to show the rate of adult cardiac arrests per 1000 admissions in the BVH acute trust between January 2019 - January 2022

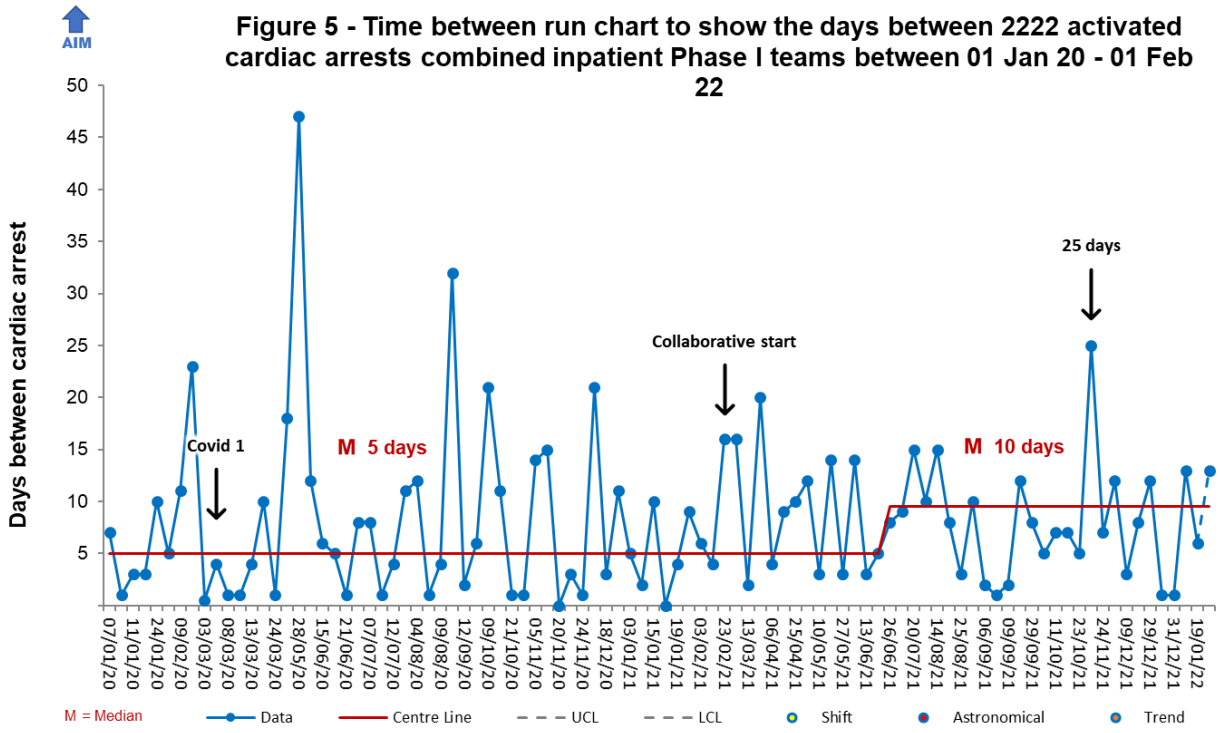


Figure 5 - Time between run chart to show the days between 2222 activated cardiac arrests combined inpatient Phase I teams between 01 Jan 20 - 01 Feb 22

3.3 Improve the Last 1,000 days of life: Reducing Fracture Neck of Femur (#NOF)

3.3.1 Executive Sponsor: Director of Nursing, Midwifery, AHP and Quality

3.3.2 Specific Aim (under development):
70% reduction in the number of fracture neck of femur which occur in identified care homes by March 2022.

3.3.3 Assessment
In the month of January there were 2 #NOF (Figure 6) within the collaborative teams. One of the #NOF was a resident from participating care home with a covid break out. The second #NOF was from a non-participating care home. Admissions have statistically significantly reduced during the period of the collaborative (Figure 7).

The eight care homes partnered remain divided in participation in the collaborative programme, it is however evident that the pressures last month are alleviating and 5 out of the 8 care homes attended coaching sessions to continue their improvement efforts. During the reporting period four care homes have been closed due to the covid variant meaning their residents were confined to their bedroom, which in turn increases risk. At present, only one of these homes is now closed.

The QI facilitator remains sensitive during this period as both residents and staff have had many challenges over the past month due to covid related pressures. Coaching and support is provided in person and a weekly drop in is available via MS teams.

Figure 8 shows data for resident “Jean”. This data helps the staff, resident and coach to discuss and understand challenges, reasons for her falling and plan future tests together. This learning will be spread across the teams and will form part of the in-depth evaluation.

3.3.4 Data

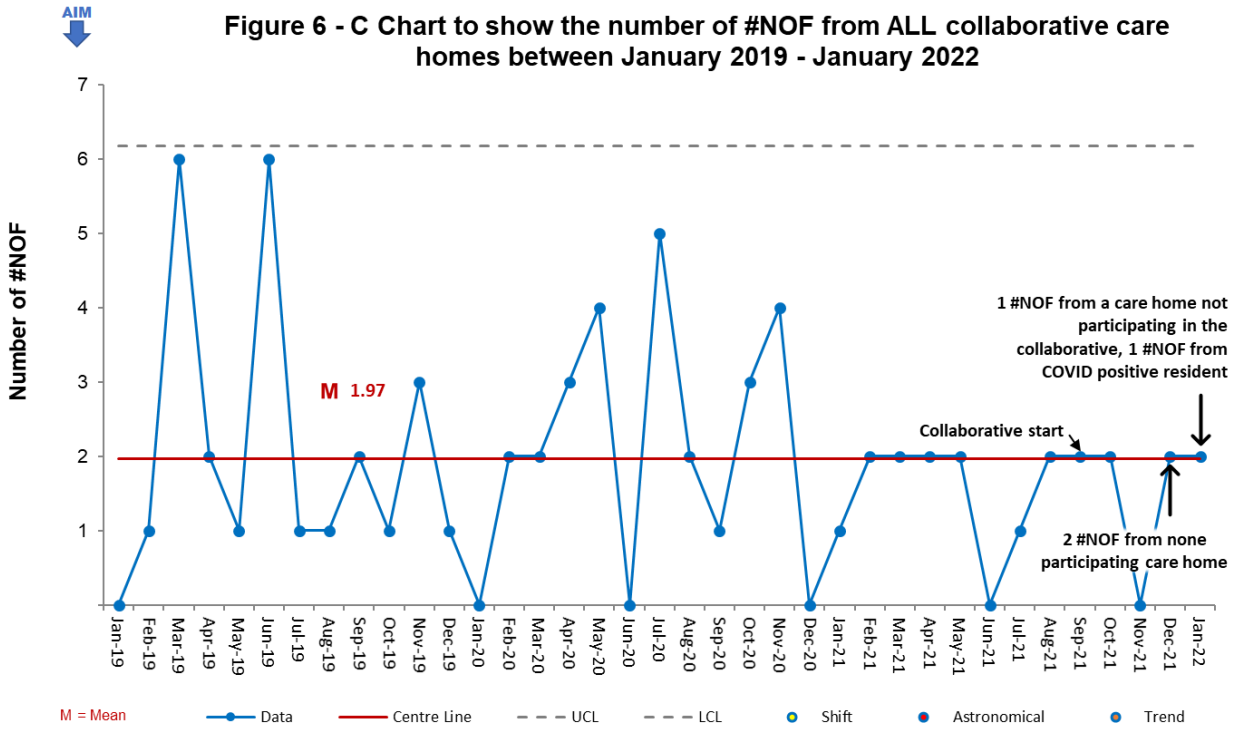


Figure 6 - C Chart to show the number of #NOF from ALL collaborative care homes between January 2019 - January 2022

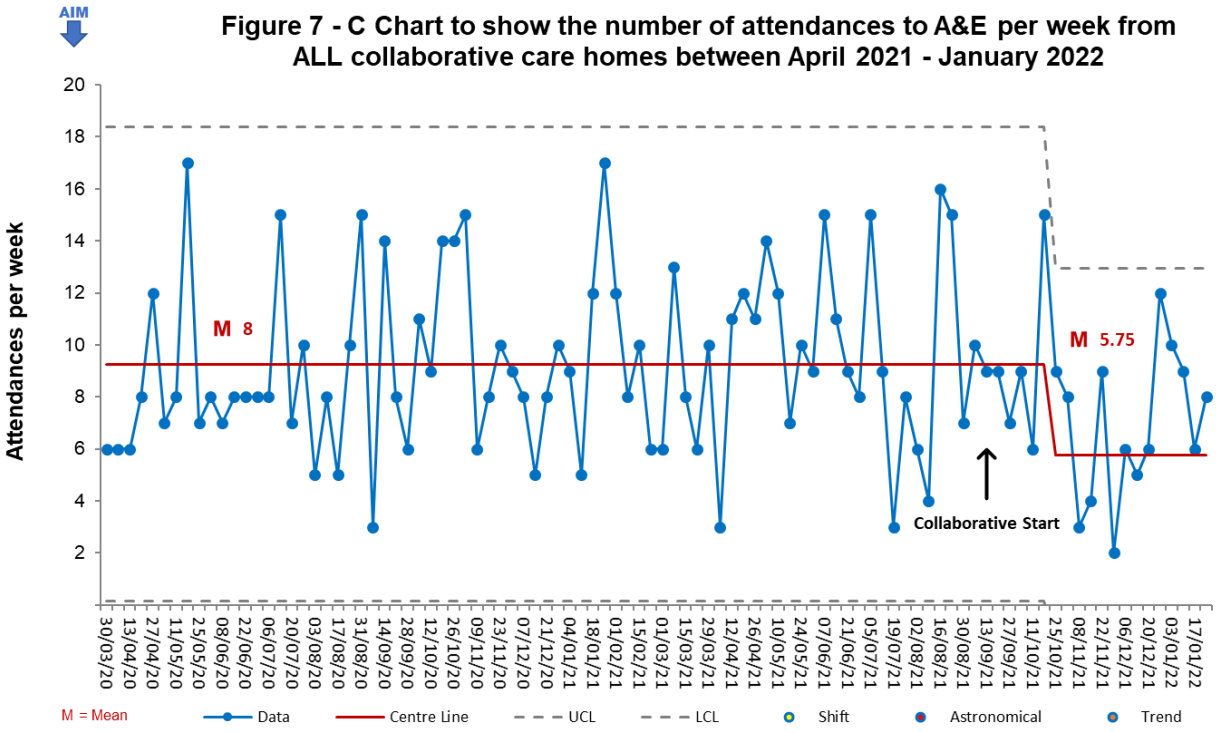


Figure 7 - C Chart to show the number of attendances to A&E per week from ALL collaborative care homes between April 2021 - January 2022

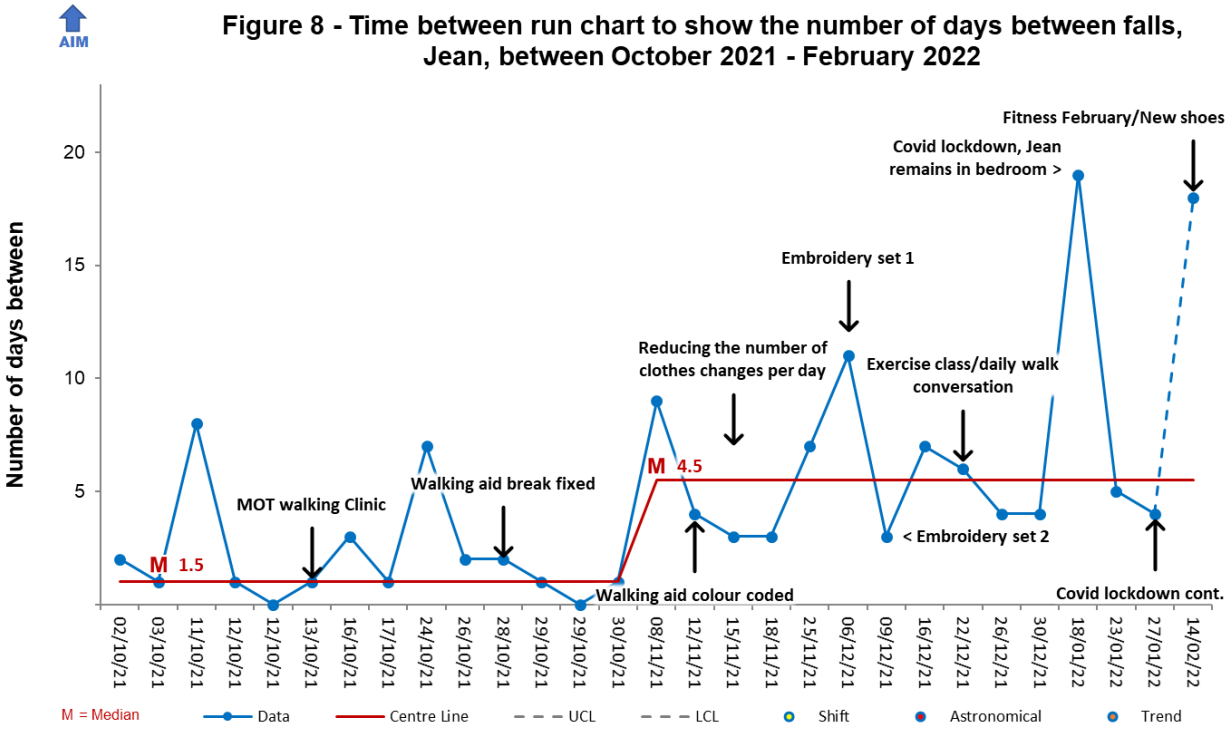


Figure 8 - Time between run chart to show the number of days between falls, Jean, between October 2021 - February 2022

4. SAFETY CULTURE PROGRAMME

4.1 Executive Sponsor: Joint between Medical Director & Director of Nursing, Midwifery, AHP & Quality

4.2 Specific Aims: This programme is split into 'patient safety pillars' based on the aims of the national patient safety strategy, [2] sections 4.3 – 4.6 highlight the progress of each one.

4.3 Insight
The Safety Culture Survey results that were presented to Board in November have been shared with SACCT Division teams and the survey will be repeated towards the end of the year to help monitor whether improvements in safety culture are occurring. The safety culture survey data, and other safety data, have been incorporated into plans for a programme to be initiated with a specific team within Surgery, Anaesthetics, Critical Care & Theatres Division in the first instance. This programme has started to be developed based on the NHS' Patient Safety Strategy and using the latest thinking in safety science. Other resources include the IHI blueprint, research publications and QI publications. A number of interventions to help improve safety culture, that are evidence based will be tested including the use of a ward level safety dashboard, the Blackpool Safety Barometer. A mock-up of the dashboard has been developed and is currently being reviewed by the expert faculty. The expert faculty will advise to help ensure the dashboard is in line with other initiatives, such as the "how are we doing boards" and will also help with stakeholder engagement.

4.4 Involvement
The QI hub have collated feedback on the first safety focus newsletter (see Appendix B), which was launched on the 19 January 2022, in line with the CQC Section 29a notice action plan. Engagement with the newsletter will be monitored over time and survey responses continue to be collected with feedback that will be used for improving the next newsletter. The reach of the newsletter is also being monitored via COAST visits and random spot checks.

4.4 Involvement
A change package for the safety culture collaborative programme is being developed to be used with specific teams in Surgery, Anaesthetics, Critical Care & Theatres Division, as mentioned in the previous report. This work will link to the aforementioned Blackpool safety Barometer, as well as Learning from Excellence mentioned below.

4.5 Inspiration
In line with the CQC Section 29a Warning action plan, Learning from Excellence has now been upscaled to the entire Trust and is available to be used on Ulysses. Further work is required to ensure all staff are aware.

5. IMPROVEMENT CAPABILITY

5.1 Dosing strategy
As per the Trust's Building Capability Dosing plan, presented to Board in March 2021, the QI Hub have continued to deliver improvement training and coaching across the Trust. At time of writing, 560 staff have received formal improvement training in the current financial year. QSIR virtual training continues with the next cohort of QSIR practitioner commencing in March. Staff who have already completed the five-day QSIR practitioner training are currently being offered the opportunity to progress through the national faculty QSIR college to become accredited associates and join the Trust QSIR faculty to support delivery of QSIR.

Following response to requests from staff having attended the Everyday Improvement and QSIR V programmes, the QI Hub have arranged for a more in-depth measurement and data training session to be delivered. Entitled "Measurement Jam" over 50 staff members requested to attend within 24 hours of the invitation being circulated.

5.2 Clinical Quality Academy
The next learning session is scheduled for Wednesday 23rd February, the session will be hosted by Brandon Bennett, Institute for Healthcare Improvement (USA) Associate. Guest speaker Dr James Mountford, Director of National Improvement Strategy will join the session to talk to the teams about the latest on the national agenda. Planning for the second cohort of the CQA is underway with plans to launch announce the CQA 2 teams at a celebration event on the 14th July 2022.

5.3 Quality Improvement Projects
There are currently 106 quality improvement projects (QIP's) logged by divisions with the QI Hub. Themes are identified and project leads are offered networking opportunities, training and coaching.

6. RISKS

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

7. FINANICAL AND LEGAL IMPLICATIONS

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

7.2 Legal Implications
There are no legal implications.

8. RECOMMENDATIONS

Trust Board of Directors are asked to consider the matters raised in this report for assurance.

REFERENCES

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

APPENDICES: Appendix A – Examples of QI mentioned in the CQC inspection 2021 report

QI area/ programme	Quotes
General QI	*… The trust was beginning to invest in continuous learning and improvement within the organisation…There was knowledge of improvement methods and the skills to implement improvement was beginning to be shared among the organisation…QI collaborative programmes showed that the trust was supporting improvements that focused on the outcome for the patients. The trust's QI journey was in its infancy but effective foundations were being built.* *(ED) Staff had a good understanding of quality improvement methods and had the skills to use them.* *(Medical care) service collaborated with partner organisations to help improve services for patients. Staff were committed to continually learning and improving services. They understood quality improvement methods and had some skills to use them. Leaders encouraged innovation and participation in research.* *(Surgical care) service collaborated with partner organisations to help improve services for patients. Staff were committed to continually learning and improving services. They understood quality improvement methods and had some skills to use them. Leaders encouraged innovation and participation in research.*
Eliminating Pressure Ulcers	*The eliminating pressure ulcers programme where 20 teams participated in the programme (included six community teams). The progress from Phase 1 in October 2021 was that the programme had achieved 53% reduction in category two hospital acquired pressure ulcers. There had been a 47% reduction category three and four pressure ulcers and an 84% increase in days between reporting grade three and four pressure ulcers. There had been a 43% reduction in community acquired pressure ulcers.*
Improving the identification and management of the deteriorating patient (DP)	*As part of the DP collaborative, the acute medical assessment unit (AMU) had developed, and introduced into practice in July 2021, 'medical escalation' stickers for use in patient records to indicate when a staff member had escalated a deteriorating patient to medical staff. These were then rolled out for use in other wards. This was to help with record keeping and audit trails as it had been identified by the trust that due to the urgency of the actions, nursing staff could forget to record their actions at the time. They then could not prove what actions had been taken and when. The stickers were like those used for cardiac arrest recording. We saw evidence of the use of these stickers…where patients had been escalated for assessment. In the AMU we (also) observed each bay had NEWS2 boards in place, which we were informed had been in place for around two months. This recorded each patient's current NEWS2 score, how often they should be checked, whether the latest score was better or worse than the last and when the next assessment was due. This allowed staff to see at a glance whether patients were at risk of deteriorating. We saw that all boards had been completed and updated appropriately…. if a patient had a NEWS score of above five then a trolley was put at the end of their bed, or outside their room so that the patient could have hourly observations recorded.* *We observed, at handover and safety huddles, that key information was passed between teams. Information relating to a patient's psychological state was noted where applicable. We observed on ward 23 that a new handover sheet had been developed which used the acronym 'FORCES' to remind staff of the key information that should be relayed at handover. This was: Fluids, Observations, Risk assessment, Care, Escalation and Social."* *We saw examples of innovative products and processes which had been designed by staff and those staff were proud to discuss their projects and were happy these were later acknowledged and integrated into normal practice. These included a 'shortness of breath kit' developed by a staff member. This consisted of a box containing all the emergency kit that might be required when a patient was suddenly short of breath…this meant that in the case of an emergency any member of staff could immediately find the required equipment in one place."*
Last 1000 days	*The reducing fracture neck of femur in care home collaborative programmes aim was to reduce the number of fractured neck of femurs (the joint at the top of the hip) in care homes by 70% by March 2022. The trust had reached out to system partners, local council and the local Clinical Commissioning Group, and eight care homes have joined the collaborative programme. The first learning session took place in September 2021. The programme was due to be completed in March 2022. This programme showed a positive multidisciplinary initiative to work across the NHS and partners to make foundations for positive changes to patient safety.*
CQA	*The Trust was starting an academy for clinical leaders. The academy consisted of eminent leaders of quality improvement, including associated of the Institute for Healthcare Improvement (IHI) and were partnered with a local university. Staff that participated in the programme would have an opportunity to achieve continuing professional development points, which could be used towards a higher education qualification. During the inspection the programme was in its early stages, the trust had received 27 applications and 10 teams had been successful. The equality and diversity team assisted with adapting the application process to support staff from black and minority ethnic backgrounds; over half of the successful applicants were from BaME consultants or SAS doctors (includes staff grade doctors and associate specialist doctors).*

Appendix B - Safety Focus Newsletter Issue 1

Meeting	Operations Meeting		
Time	2pm		
Date	27th January 2022		
Venue	Via MS Teams		
Present: -			
Mr M Beaton	Non-Executive Director	Chair	MB
Trish Armstrong-Child	Chief Executive		TAC
Mrs J Barnsley	Executive Director of Integrated Care & Performance		JB
Mrs Hudson	Chief Operating Officer		NH
Mr F Patel	Executive Director of Finance		FP
Mr J Wilkie	Non-Executive Director		JW
Mr A Carridice-Davids	Non-Executive Director		ACD
Mr A Roach	Non-Executive Director		AR
Attendance: -			
Mrs E Steel	Executive Director of Corporate Governance		ES
Mr S Barrow	Deputy Director of Finance		SB
Mrs S Adams	Operational Director of Human Resources		SA
Mrs S Crouch	Public Governor		SC
Miss F Roberts	Corporate Governance Officer	Minutes	FR
Miss L Kavanagh	Corporate Governance Officer		LK
Mrs L Smith-Payne	Deputy Director of Workforce		LSP
Mr J Walton-Pollard	Deputy Director of Nursing		JWP

Five observers in attendance including members of the Council of Governors.

Declarations of Interest

Mr J Wilkie	Non-Executive Director on the Board of Atlas

Apologies for Absence

Mrs L Cheung	Deputy Director of Quality Governance
Mr K Moynes	Executive Director of HR & OD

1. Welcome

Mr Beaton welcomed members and attendees to the meeting. Mr Beaton briefly spoke about the challenging circumstances the Trust were facing at the present time and gave his heartfelt gratitude to everyone for their dedication and hard work.

2. Minutes of the Previous Meeting on 23rd December 2022

Members had the opportunity to review the Minutes of the previous meeting held on 23rd December 2021. Mrs Crouch pointed out that in item 11 the minutes stated she was a Non-Executive Director when she is a Governor, with this amendment the Members approved the minutes as a true and accurate record.

3. Action Sheet

Members noted the position of the Action List. The following updates were provided:

Actions 261, 260 & 259 were confirmed as cleared.

Action 258 was updated and added to the Board Objectives Session next week and will be covered in the planning for next year.

Action 255 was amended and brought forward to after the Board Strategy Meeting in February.

Action 256 no information in the papers circulated but can be discussed.

All other Actions were confirmed as cleared or for future meetings.

Matters Arising

Mr Carridice-Davids and Mr Wilkie reminded Mr Patel about a separate informal workshop to be planned to follow on from the 16th December 2021 meeting they had. They agreed that the workshop should be separate from other meetings to allow the required time and to be solely to discuss the wider financial challenges for the Trust and the Operational Planning for the next financial year. This will take place before the next Operational Committee and all board and committee members will be invited.

It was noted that Mr Kevin Moynes last day as Executive Director of HR & OD would be the 31st January 2022 and Mrs Louise Ludgrove would be joining the meeting next time as the interim Executive Director of HR & OD.

Resolved: Corporate Governance Team and Mr Patel to arrange informal financial workshop.

4. Operational Performance

Operational Performance Presentation including Performance Metrics.

Mrs Hudson advised that she would be reviewing the performance information pack with Mrs Steel the new Director of Corporate Governance, so next month the information provided would be presented differently. Mrs Hudson went on to confirm all the key metrics were included in the circulated papers and highlighted these key points within them not in pack order.

- A&E and non-elective urgent and emergency pathways – nationally for Type 1 performance we are medium level. All other performance Types we are in the top 20.
- Main issues for concern are the length of stay in A&E majors department (12 hours plus waits from decision to admit) and A&E admission to discharge (12 hours plus waits).
- Over the last two weeks Ambulance hand over delays over 60 minutes has had significant improvement.

- Delays in Emergency department triage is improving.
- Not meeting criteria to resided patients has increased. There are still major pressures however, Pathway 1 patients awaiting packages of care has improved. Pathway 2 patients awaiting nursing/care homes or rehabilitation placements are delayed due to closed nursing/care homes due to covid outbreaks and covid leading to staffing issues.
- Increased covid in-patients' numbers.

Mrs Hudson reported on the continuing plans in place to address these key points.

- Continue with Ambulance and Emergency Department escalations policies and new patient flow structure.
- Continue to engage with ECIST to improve daily ward flow, emergency department and same day emergency care pathways and facilities. This will formulate into a formal improvement plan and will go to the A&E Improvement Board in February.

Mr Wilkie pointed out that some of the difficulties the Trust is facing is not completely within the Trusts control and enquired if the pressures being exerted on to the Trust were reasonable. Mrs Hudson acknowledged that although there was pressure to achieve the challenges presented to the Trust, for example the Home for Christmas campaign and to micromanage our discharge position, the Trust did achieve some of the challenges. Where the Trust was unable to meet the challenges, the Trust did show significate improvement and we could provide confident assurance that as a Trust we are doing everything we can internally to move forward. Mrs Hudson was proud to share with the Members that ECIST have been impressed with the effectiveness of some of improvements the Trust had implemented, for example the discharge processes and the Transfer of Care Hub, and they would like to share the idea with other hospitals. Mrs Hudson went on to explain there is now pressure on the external partners to have a 30% reduction in place to help the Trust with the not meeting criteria to resided patients, keeping in mind they are also struggling with the same ICT constraints as the Trust. Mrs Hudson confirmed she will be attending the Joint Cell Meeting where the focus will be on how the Trust can help the external partners with their challenges which in turn will assist the Trust further.

Mrs Hudson drew the Members attention to some points in the Cancer Performance which is based on November's submission.

- The 2 Week Wait target for first appointment is expected to deteriorate for December's report, partly due to pressures in breast regarding increased referrals and radiology support. However, the main contributing factor has been colorectal' s major increase in demand and vacancies within the team.
- Faster Diagnosis Standard has improved from November into December and will be expected to start achieving targets moving forward.
- 62-day Referral To Treatment will be a challenge due to previously noted delays in the 2 Week Wait standard for first appointment which will have a knock-on effect on the remainder of pathway and therefore on the January and February's performance.

Mrs Hudson reported on the continuing plans in place to address these key points.

- Additional radiology support has been secured in breast.
- New breast consultant triage process has been put in place.
- All patients waiting for colorectal for 2 Week Wait appointments have now been dated.
- Moving to a Straight To Test pathway in colorectal to aid faster diagnosis.

- New weekly cancer PTL meetings have been put in place for all sites including colorectal and breast where individual patients will be tracked and pre-empted along their pathway and escalated to higher management levels for action.

Mrs Hudson confirmed for Mr Beaton it is a reasonable expectation that by February the 2 Week Wait and 28 Faster Diagnosis Standard will be within national targets. Mr Carridice-Davids questioned if it is sustainable to keep improving on the 62-day Referral To Treatment standard? Mrs Hudson advised that Lancashire and South Cumbria are in a similar position and went on to explain that work is already ongoing to pre-empt and modal the future treatment requirements like extra theatre lists, staffing, appointments etc with regards to the already delayed 2 Week Wait patients that could get a cancer diagnosis and are already further along the 62-day pathway than expected.

Mrs Hudson confirmed that the 62-day standard is going to continue to be a challenge.

- Increased referrals now from pre-covid across all cancer sites.
- Reliance on one or two specialist consultants or surgeons.
- Tertiary patients to East Lancashire and Lancashire Teaching Hospitals.

Mrs Hudson gave assurance that 62-day performance is going to start to improve once we are through the back log of the colorectal patients, but cannot give assurance that the Trust will meet the national standard immediately. There will need to be a lot of demand and capacity work on a tumour group level to be undertaken first. Mr Carridice-Davids enquired if it was possible to forecast when the Trust expects to be more in line with national guidance. Mrs Hudson explained the national guidance is to aim for the February 2020 levels. Mrs Hudson is currently working on a modal with the teams to identify were we currently stand with that metric in mind.

Mrs Crouch asked for clarity on the deprived quintile columns in the first performance slide. Dr Catt advised that this was based on the Fylde Coast population only. Mr Beaton, Mrs Hudson and Dr Catt discussed that although it is important to capture this data and it is now a national requirement, is it information relevant to the Operation Committee. Mrs Hudson and Dr Catt agreed that when the performance pack is reviewed with the Director of Corporate Governance they will take into consideration if there is a more suitable way to present this information.

Mrs Hudson drew the Members attention to some points in the Elective waits.

- There is a national ask that there should be no patients on the waiting list at 104 weeks or over by the end of March.
- Patients waiting over 52 weeks has significantly improved.
- The main concern is a cohort of out-patients still waiting for the first appointment particularly in gastroenterology.
- Endoscopy capacity.
- CQC's concerns regarding data quality and the impact it is going to have on performance.

Mrs Hudson reported on the continuing plans in place to address these key points.

- Plans are in place to date the 15 patients at 104 weeks.
- Collaborating with ICS and options are being explored to triage patients still waiting for outpatient appointments and gastroenterology appointments.
- In contact with companies for additional support for gastroenterology.
- Formal report will be presented at the next Operational Meeting after MBI's validating report of the data quality is complete.

Operational Restoration Presentation

Mrs Hudson confirmed the key metrics were in the papers circulated and highlighted these points.

- Restoration is going very well despite the extra pressures over Christmas and New Year.
- To be granted funding, we now need to close a target of 89% of pathways within a month, which we are achieving easily in November and December.
- Main focus now is to free up as much bed space as possible to maximise our elective input.
- The Harm Review of all the 1122 patients waiting over 52 weeks will be complete within the next two weeks and a formal report is going to Quality Committee.

Mr Wilkie asked about the portfolio changes within the executive team. Mrs Armstrong-Child emphasised some of the changes are interim only and she would present the changes at the Board Strategy Meeting next week.

Pathology Collaboration Update

Mrs Barnsley confirmed the relevant papers have been circulated and were based on the November report due to the December meeting being stood down.

- TUPE process has paused and will commence in June. (Transfer of staff within the scope).
- Concerns from pathology staff and some specialities regarding delays in reporting and the Cancer MDT leads are concerned regarding HOT reporting.
- Waiting for the Pathology Collaborative to come to a decision of which in scope services are going to remain at BTH or move to HUB at Samlesbury.
- Awaiting full Business case.

Mrs Barnsley outlined her plan to propose to the Pathology Collaborative which in scope services we as a Trust felt was best to remain on site at BTH and which we felt was safe to transfer to the HUB.

Laboratory Information Management System (LIMS) Pathology Collaboration Business Case

Mrs Barnsley confirmed the Business Case has been included in the papers circulated and highlighted these relevant points.

- The current LIMS at BTH needs replacing very urgently before June 2023.
- The Pathology Collaboration Board has proposed a single LIMS covering across the four acute providers and the Pathology Collaborative at a cost of 1 million pounds over 15 years.
- One LIMS will be more flexible.
- No funding identified at this stage, but the Director of Finance will incorporate it into the financial planning requirements going forward.

Mr Wilkie asked for clarity on reconciling the finances in the report and on the cover page. Mrs Barnsley verified the £15.8 million pounds is the total cost to Lancashire and includes the costs already being incurred and the additional cost. The £909 thousand pounds is Blackpool's share of the cost. Mr Wilkie also asked for confirmation if the cashable savings from year four onwards are going to offset the additional cost and are we able to make sure the cashable savings are identified and held and not lost. Mr

Patel declared the £15.8 million pounds over the 15 years is the cost to the whole of Lancashire and assumes a cashable release benefit and it is a net figure. Mr Petal went on to advise that he will continue to engage with the national team to not only try to secure funding for Blackpool but hopefully the whole of Lancashire. Mr Carridice-Davids enquired what is our allocation/what are we looking to invest in this as Blackpool? Mr Petal directed Mr Carridice-Davids to section 6.1 page 81 of the papers circulated illustrating a table showing the maintenance cost of our current LIMS against the cost of implementing the single LIMS system. Mr Patel went on to confirm Blackpool will be taking advantage of the new LIMS earlier than the other three provides and that is why our costs are showing as higher but we are benefiting sooner. Members approved the business case.

Mr Wilkie enquired if with all the digitisation we are about to undergo, are we creating more problems? Mrs Hudson clarified the MBI data quality validating will aid in the installation of the new Electronic Patient Register (EPR). Mr Patel advised the EPR will be for the Trust only and there are 2 further meetings before finalising in March. Mrs Armstrong-Child emphasised that the Trust is going to be mindful to select a system that does not rule out possible integration in the future, but it is necessary to implement a new EPR now. Mr Beaton expressed the merits of a full time IT leader especially someone who has previous experience of EPRs. Mr Patel confirmed he is currently reviewing potential candidates.

Resolved: Mrs Armstrong-Child to present the current management portfolio at the Board Strategy Meeting.

5. HR & OD Development Performance

HR & OD Development Performance including Performance Metrics - Growing for the Future

Mrs Adams confirmed the information has been included in the papers circulated and highlighted these relevant points.

HR Dashboard

- Retention for December was consistent with the month before, 46 staff members left service.
- Agency spend for nursing is down in December. Deeper dive ongoing to establish why.
- Sickness/absence down compared to the previous month, and it rose in late December through January, the highest point was 13% of which half was related to Covid-19.
- Non-medical appraisal compliance rate is improving. A presentation and paper will be sent to the Executive Meeting on the proposed changes to appraisals to make them easier to complete.
- Core Skill compliance is consistent with the month before at just under 90%.

Staff Vaccinations and Condition of employment

- Of the 279 substantive staff and approximately 300 bank staff within scope without a vaccination recorded, 80 members of staff are not working (long term sickness/maternity/career breaks) so will only need to be vaccinated before they return to work.
- Using the Northwest framework to identify which roles are in or out of scope.
- Informal well-being conversations have begun with each individual staff member to ascertain if they intend to be vaccinated and provide information and guidance.

- 43 staff members over a range of disciplines and departments have confirmed that they do not intend to be vaccinated.
- First vaccine deadline is the 3rd February and second vaccine by the 31st March. (There is some specific flexibility by 21 days)
- The vaccination HUB is on stand-by for any last-minute surges.
- The abstainers are widespread across the specialities, departments, and areas.

Sue Crouch queried since the number of double vaccinated staff remained at 94% over two months, have we exhausted all persuasive methods? Mrs Adams reported that there are two groups of people: fear due to medical conditions/phobias and those taking a stand. From the staff members who have had well-being conversations so far ten have since been vaccinated which confirms the conversations are continuing to work.

Ongoing

- Wellbeing Conversations.
- Staff side colleagues encouraging vaccination.
- Vaccination area on the intranet with a telephone number to the hub.
- Vaccination area on the intranet with a link to the national Q&A sessions.
- Staff can be referred to a medic in the Trust for specific fears/questions.

Mrs Adams gave assurance that the Trust is doing everything it can to encourage and support staff with the decision to be vaccinated however staff members that are not vaccinated by the deadline and cannot be redeployed will have to leave the Trust.

Adrian Carridice-Davids asked if there was any corelation between the sickness absences due to stress over the mandatory covid vaccination and do we have things in place to help and do we track the demographic's including EDI? Mrs Adams confirmed that only one member of staff has declared stress because of the mandatory vaccination. Mrs Adams went on to say stress, anxiety and depression are the main reasons for sickness in the Trust and the Trust does have many systems in place to support staff with these issues, she felt that with recent pressures staff may feel they do not have time to partake in them. Weekly meetings take place, and the demographics are discussed as part of that meeting.

Nursing Staffing

Mrs Adams explained December showed a vacancy gap of 38% and although it looks on the chart like we will be at full establishment by March 2023 we do still have to the potential to perform another professional judgement review for quarter three and the winter pressures, winter planning and escalations plans will need to add to that new establishment to show us our position. Mr Beaton commented that the Trust has done very well and has come a long way in six months, but we do still have a lot of work to do. Mr Beaton also noted that the agency spend is coming down although it still a little high and with gaps. Mr Beaton enquired if Mr Patel had investigated the 5% extra discussed at last month's meeting and Mr Patel advised he is currently reviewing this and the modelling with Mr Murphy, and it will be included in the financial planning for next year. Mr Beaton pondered what the Trust felt the target should be and Mr Patel agreed to bring that back to the next meeting.

Medical Staffing

Mrs Adams reported there is a gap of 50 doctors which was on the CQC report and outlined the ongoing plans in place.

- 18 new doctors starting in the next few months.
- Working with an agency to recruit from abroad.

- CESR programme.
- Working with an agency to head hunt across the UK.
- Working on a dedicated Recruitment Strategy and action plan for hiring consultants and doctors.
- Workforce transformation and how the service is delivered.
- Workforce Agency Reduction Working Group.
- Grow our own strategy.
- Prioritising positions in gastroenterology, A&E, AMU, Haematology and CAMS.

Points raised during in the discussion.

- Can a registrar take on some of the roles rather than a full consultant?
- Do we need to accelerate to more than one staff employment a month to complete in 2 years?
- Are the adverts right place to draw candidates?
- How do we make roles more attractive? specialty verses general).
- How do we make BTH an attractive place to work?

Mr Roach had three queries; Do we have an informed understanding of what happened in November/December with agency spend, was it down due to covid in the agency and is coding a factor? Mrs Adams explained that the HR team are doing a deeper dive into the figures because there has been a high fill rate of agency staff. A sample has been done on the coding and there is still work to do on training.

Mark Beaton, Mrs Armstrong-Child and Mr Wilkie discussed what would it take to run a world class hospital with happy fully trained staff.

Points raised during the discussion.

- If we save money on agency staff, we can then use that money for the betterment of employed staff.
- If we are spending so much on agency, we obviously need to employee more staff.
- Without leadership and culture staffing levels can be irrelevant.

Members agreed to allocate 50 minutes to HR on next month's agenda to outline; what's the problem? Where is the problem? What are the numbers? What are we aiming to do? What is our long-term aim for agency?

Resolved:
Mr Patel to advise on the Trusts sickness absence recruitment percentage at the next Operational Meeting.

HR to bring a focused two-year plan to the next meeting.

Allocate 50 minutes for HR on the next meeting.

6. Finance Performance

Finance Performance Presentation including Performance Metrics

Mr Patel accepted the slides circulated with the papers as read and highlighted these key points on screen.

- The Trust is breaking even in line with the plan.
- Slightly behind on capital but will be caught up by March.

- BPPC has improved dramatically.
- Interim financial support is no longer required.
- QEP delivery has limited assurance due to non-recurrent measures.
- High assurance that we will deliver the year end forecast.
- Next year's financial performance is a limited assurance.
- Overall, £100 million run rate deficit.

Mr Carridice-Davids questioned what systems were put in place that improved the Better Payment Practice Code performance. Mr Patel informed the Members that there were agreements of payment within 30, 60 or 90 days. However, during Covid the Government changed the rules to 30 days, to bring this back in line there was two actions: - grip and control of invoices and enforcement of no purchase order, no pay policy.

Month 9 Position Report

Mr Beaton expressed a concern that the financial plan will not be achieved, so are we considering what we need to do?

The Members spent some time discussing the financial challenge.

Points raised during the discussion.

- There are some elements that finance will support short term.
- Workforce recruitment can be limited due to a small pool of suitable candidates.

The Members agreed that although it is essential to be able to generate and manage funding, key planning ahead and discipline is just as important. By coordinating demand & capacity, workforce and finance working together creates balance.

Medical Records Scanning Update.

Mr Patel confirmed the slides circulated with the papers as read and highlighted the key points on screen.

Points raised during the discussion.

- Governors will be happy there is a plan in place.
- Releases space.
- It is a safety issue/not an acceptable environment for staff to be working in.
- High risk in terms of operational strategy.
- Needs to happen very fast and planned well to avoid potential incidents of case notes/medical records being unavailable to access in an emergency.
- Medical records need to be stored for 25 years.

Members agreed and supported.

Resolved:

Agency payment system to be included in the financial update in the next meeting.

QEP to be included in the finance workshop.

Next planning cycle to be included in the financial update in the next meeting.

Members agreed and supported the Medical Record plan.

7. CQC Action Plan: Progress Update

Mr Beaton acknowledged Mrs Cheung absence due to ill health and asked Mrs Armstrong-Child to provide an update.

- The CQC can revisit the Trust at any time after the 31st January 2022.
- ECIST have started a review and the Trust is already working through the key safety indicators.
- Work has begun on actions to address recommendations relating to incident reporting and management.
- High level objectives will be decided at the Board meeting, then taken to the System Improvement Board and then placed on to the CQC Action Plan.

Mrs Armstrong-Child verified that so far it is not complete, but we are able to provide assurance to the CQC that we have made significant progress.

Resolved: Update was noted.

8. Integrated Performance Report (IPR)

No longer required on the agenda.

Resolved: **Remove this item from future agendas.**

9. Advanced Clinical Practice Paper

Mr Walton-Pollard agreed to take the papers as read and confirmed the items had been through the Clinical Effectiveness Committee and the recommendations were accepted. Mr Walton-Pollard elaborated on Advanced Clinical Practice role and its potential progression. Mr Walton-Pollard asked the members to consider the career structure, its governance and support for the medium and its long-term actions.

Points raised

- Potential solution to a number of medical vacancies.
- Financed by existing current medical vacancies.
- Career progression for the medical practitioner.
- Needs to be embedded into the surgical/medical speciality.
- Needs to have a strong, conclusive, accepted, and supported role.

Members agreed and supported.

Resolved: Members agreed and supported the ACP role.

10. Items Recommended for Escalation to the Board

Currently at limited assurance across the board.
A&E is still challenge.
21% of patient not meeting criteria to reside and the pathway 1 problems.
Colorectal delays.

Covid-19 occupancy.
Cancer year end targets needing to be adjusted.
Elective Waiting list delays.
MBI data quality validation and effect on performance.
Pathology Collaborative and the staff concerns.
Covid Vaccination Plan.
Nursing trajectory is improving and spending less on agency.
Medical staffing added to next meeting to decide a plan.

11. **Any Other Business**

Mrs Barnsley circulated the 2022/2023 Priorities and Operational Planning Guidance: Action & Outcome summary released on Christmas Eve, this morning before the meeting and Mrs Barnsley highlights the main points.

- There are 10 points of priority areas illustrated in the document.
- The first draft on the annual plan will be on next month's committee meeting for first draft submission at the end of February and final submission at the end of April.
- We have internal coordination with through the Transformation and Planning Team with a core group consisting of Heads of Performance, Contracting, Finance and Workforce to support the Divisional and Directorate Teams to formulate plans.
- The financial envelope is an unknown at this stage but will be worked in.
- We are working with the Provider Collaborative and linking with the CCG.

Mr Beaton instructed the Members who may not have chance to read the summary before the meeting to contact Mrs Barnsley via email with any questions or comments.

Mrs Armstrong-Child reminded the members the meetings and committees will be reviewed including structure, reports, papers, and agendas.

Resolved:

Mrs Steel to address the turnaround time of the minutes after a meeting.

Executives to update and re-forecast all reports/papers regularly.

12. **Formal Meeting Review**

- Has the Committee focused on the appropriate items? Are any items missing or not given enough time?
- Has the Committee challenged and received assurance (departmental/corporate/external) and when necessary ensured action is taken?
- Have the NEDs added value to the Committee?

No comments

13. **Date and Time of Next Meeting**

Thursday 24th February 2022 at 2.00.p.m

Blackpool Teaching Hospitals NHS Foundation Trust

Executive Directors Meeting

03 March 2022

Elective Recovery and Restoration

Author of Report:	Mrs Natalie Hudson
Executive Director Sponsor:	Mrs Natalie Hudson
Date of Report:	03.03.2022

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

Since 2019/20 the Trust has seen significant growth in the elective waiting list and the length of time patients are waiting for assessment and treatment due to the ongoing covid situation.

The Trust continues to focus on reducing elective waiting lists and those longest waiters with the aim of restoring activity levels to those undertaken pre pandemic in 2019/20.

This paper highlights the progress made with the elective waiting list and details the activity restoration levels achieved in January 2022.

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

Recommendations:

The Trust board are asked to review the report and acknowledge the progress made to date.

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

Trust Board Of Directors

3rd March 2022

Elective Recovery and Restoration

Restoration

In January the Trust has dealt with significant pressures with ongoing Urgent and Emergency demand combined with increased levels of staff sickness due to covid related absence and isolation.

This has impacted on the levels of elective activity that could be safely undertaken in January. Day case and Elective restoration for January was 84.1% compared to the same period in 2019/20. This is expected to improve in February with the reduction in sickness absence and isolation, whilst continuing to balance the on-site pressures with the ongoing winter non elective demand.

Restoration of Outpatients was 90.8% in January compared to the same period in 2019/20. This is less than previous months due to the need to cancel some outpatient clinics in January because of the sickness and isolation issues and reallocate the clinical teams to support the wards and Emergency Department. This is expected to be a temporary reduction in restoration rate and forecast to improve from March onwards.

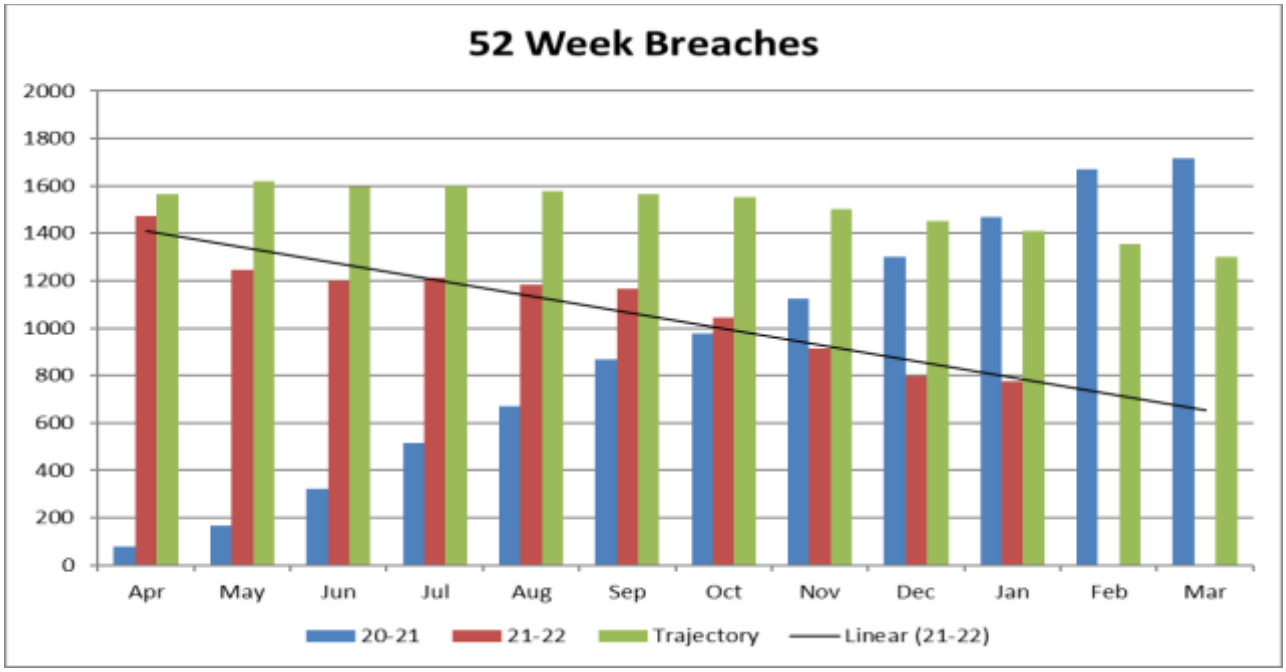
Jan-22

Point of Delivery	January Plan - Core	January 22 Actual	Diff	% Diff	January 19 Out-turn	Plan compared to Jan 19 out-turn	Jan 22 outum compared to Jan 19	% Restoration
Elective IP	362	420	58	16.1%	496	(134)	(76)	84.7%
Day Case	3,552	3,986	434	12.2%	4,584	(1,032)	(598)	87.0%
Outpatient Procedures	4,132	4,164	32	0.8%	5,110	(978)	(946)	81.5%
Total Elective Procedures	**8,046**	**8,570**	**524**	**6.5%**	**10,190**	**(2,144)**	**(1,620)**	**84.1%**
New Outpatient	6,361	8,284	1,923	30.2%	6,972	(611)	1,312	118.8%
Follow Up Outpatient	18,765	16,712	(2,053)	(10.9%)	20,569	(1,804)	(3,857)	81.2%
Total Outpatient Activity	**25,125**	**24,996**	**(129)**	**(0.5%)**	**27,541**	**(2,416)**	**(2,545)**	**90.8%**

Elective Waiting List

In February the national Delivery Plan for tackling Covid-19 backlog of Elective Care was published. This outlines the need to ensure all patients who have waited more than 104 weeks on an elective waiting list must be treated by the end of June. At the end of January 2022, the Trust is reporting 22 patients who have been waiting more than 104 weeks with plans in place to treat all patients in line with the June trajectory.

The Trust has focussed on restoring elective activity whilst balancing the pressures and bed requirements to manage the Urgent and Emergency demand over the winter period. The number of patients who are waiting on an elective waiting list over 52 weeks has been steadily reducing from a peak of circa 1,500 patients in April 2021 to 780 in January 2022.



Blackpool Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

January 2022

Integrated Performance Report

Author of Report:	William Wood - Head of Performance
Executive Director Sponsor:	Natalie Hudson – Chief Operating Officer
Date of Report:	21st February 2022

Executive Overview Summary:

Positive News

- No cases of MRSA bacteraemia were reported in January 2022. 2021. This means the total number of cases for 2021/22 increased to 6.
- FFT - Inpatients, 97% of patients said they would rate their care experience as very good or good.
- FFT - Maternity, 100% of patients said they would rate their care experience as very good against a trust target of 96%.
- FFT - Mental Health, 90% of patients said they would rate their care experience as very good.
- 22 inpatient wards reported zero falls in the month of January 2022.
- No incidents reported in January 2022 for over 7 day incapacitation of a worker.
- 96% of people referred to an IAPT service started treatment within 6 weeks of referral against the national target of 75%.
- 53% of people who completed treatment with Supporting Minds in January recovered against the national standard of 50%.
- The Trust's data quality index continues to be above national average.

Areas of Reporting Impacted due to COVID-19

- National VTE collection remains suspended. Case note reviews completed at the divisional level showing compliance ranging from 60% to 95%.
- Reporting of the Dementia Standard suspension continues. The Trust has submit 25 cases as part of a voluntary case note audit with the Royal College of Psychiatrists. Feedback from the audit will be shared at the Dementia Advisory board once published.

Areas of Challenge

- There were 2 Never Event incidents reported for the month of January 2022.
- 3 C.Difficile infections attributed to the Trust in January 2022 bringing the overall total for 2021/22 to 92. If the current rate is to continue there is a risk of exceeding the threshold of 104.
- 2 cases of E. coli were reported in January 2022. This brings the total number of cases for the year to 68. The E. coli case threshold for 2021/22 has been set at 105.
- There was 0 new patient safety alert received in January 2022 with 2 ongoing.

- Latest SHMI is at 103.47 (August 2021), HSMR is 103.66 (October 2021).
- The Trust received 28 formal complaints in January 2022, compared to 21 in December 2021.
- FFT – A&E, 80% of patients or their carers said they would rate their care experience as very good compared Trust target of 92%.
- FFT - Community, 95% of patients said they would rate their care experience as very good against a trust target of 98%.
- There was one mixed sex breach in January 2022.
- Emergency C-sections decreased to 15.3% of all deliveries in the month of January 2022.
- 109 new hospital acquired pressure ulcers reported in January 2022 compared to 106 in December, while Community acquired pressure ulcers decreased to 112.
- In January 2022 there was one incident relating to a Specified Injury to Worker.
- The Trust did not achieve the Referral to Treatment (RTT) open pathway standard in January, delivering 71.2% against the target of 92%. (December performance: 71.4%). There were 23,933 open pathways against the trajectory of 19,960.
- There were 776 patients waiting 52+ weeks in January which is a reduction from the previous month where 798 patients were reported and remains below the trajectory.
- The Trust failed to achieve the Cancer 62 Day Wait standard for all cancers in December with performance at 65.3%; a deterioration on November performance of 66.4%. There were 9 patients treated in November after day 104.
- 78.9% of patients received their diagnostic test within 6 weeks against a standard of 99%. This has decreased on December performance of 82.3%. Over 6 week breaches have increased from 840 in December 2021 to 1074 in January 2022.
- Staff sickness increased to 8.8% in January 2022 vs 7.1% in December 2021. Trust target is 4%. Anxiety and stress related absences remains the most common reason for long term absence, Infectious disease remains the top reason for short term sickness due to a rise in staff absent with covid related sickness.
- Staffing turnover is currently above the 11% target at 11.52% but still below the high seen in July 2021 of 12.42%.
- Temporary staffing levels increased to 7.6% following the increased sickness absence rates seen in month.
- Total agency spend increased for the first time in 5 months to £2.55 million, this has resulted from the increased sickness rates and rise in rate card.
- Type 1 performance for January was 41.75%, an improvement compared to December performance (40.1%). Total Economy Performance decreased to 78.3% (November: 78.9%)

Please note: Finance data not available.

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

Recommendations:

The Board of Directors are 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

January - 2022

Blackpool Teaching Hospitals NHS Foundation Trust

Safe

Never Events	KPIs
2	

VTE (%)	SPC
0.00	

C.Difficle	SPC
3	

MRSA	KPIs
0	

E.Coli	SPC
2	

Pat. Safety Alerts	SPC
0	

Effective

Crude Mortality (%)	SPC
1.79	

Caring

Complaints	SPC
28	

FFT Inpatients (%)	SPC
97.00	

FFT A&E (%)	SPC
80.00	

FFT Maternity (%)	SPC
100.00	

FFT Comm. %	SPC
95.00	

FFT Mental H. %	SPC
90.00	

Mixed Sex Breaches	KPIs
1	

Emerg. C Section %	SPC
15.30	

Responsive

RTT Incomp. (%)	SPC
71.17	

62 Day Cancer %	SPC
65.30	

6WW Diag %	SPC
78.88	

Dementia Std. %	SPC
0.00	

IAPT Wait %	SPC
96.00	

IAPT Rec. %	SPC
53.00	

DQMI (%)	SPC
93.00	

Efficient

Staff Sickness (%)	SPC
8.80	

Staff Turnover (%)	SPC
11.52	

Temp. Staffing %	SPC
7.60	

Capital Service	SPC

Liquidity	SPC

I&E Margins %	SPC

Agency Spd. (£M)	SPC
2.55	

EuR Rating	KPIs

Strategic

A&E + UCC	SPC
78.31	

SHMI	SPC
103.47	

Well Led

Financial Plan	SPC

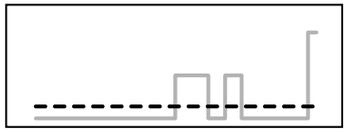
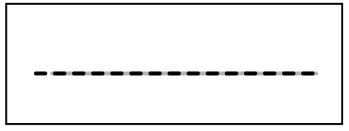
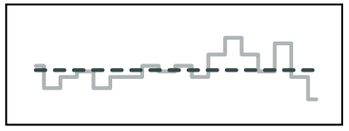
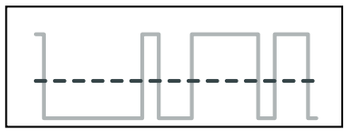
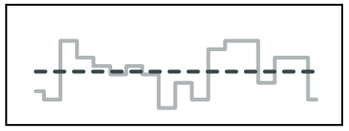
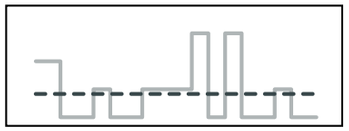
Spec. Injur. to Wrks.	KPIs
1	

Over 7 Day Inc Wrks	KPIs
0	

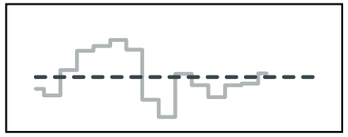
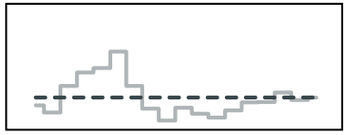
Definitions

Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

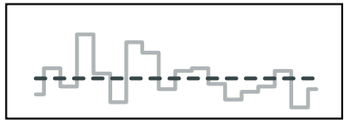
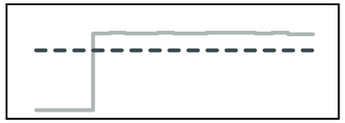
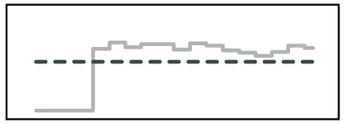
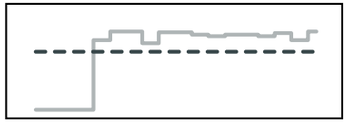
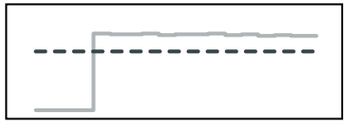
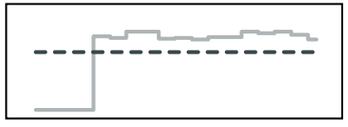
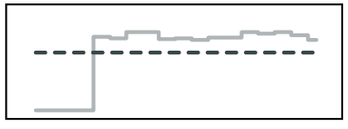
Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Never Event	Safe	2.00	0		Limited assurance
VTE (%)		0.00	0.00		Limited assurance
C.Difficile		3.00	0		Limited assurance
MRSA		0.00	0		Limited assurance
E.Coli		2.00	0		Limited assurance
Patient Safety Alerts		0.00	0		Limited assurance

Level 2: Domain Level Summary

Measure	Domain	Actual	Target	Trend Analysis & SPC		Assurance
HSMR	Effective	103.66	0			Assurance Not Recorded
Crude Mortality (%)		1.79	0.00			Assurance Not Recorded

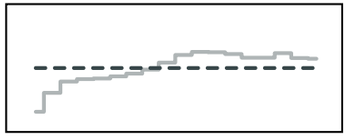
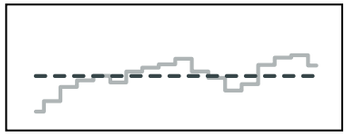
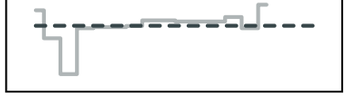
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Complaints	Caring	28	(Blank)		Limited assurance
FTT Inpatients (%)		97.00	96		Limited assurance
FTT A&E (%)		80.00	92		Limited assurance
FTT Maternity (%)		100.00	96		Limited assurance
FTT Community (%)		95.00	98		Limited assurance
FTT Mental Health (%)		90.00	(Blank)		Limited assurance
Mixed Sex Breaches		1.00	0		Limited assurance
Emerg. C Section		15.30	0		Full assurance

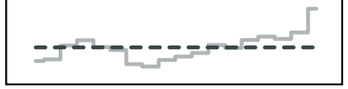
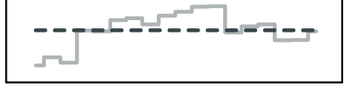
Level 2: Domain Level Summary

Blackpool Teaching Hospitals NHS Foundation Trust

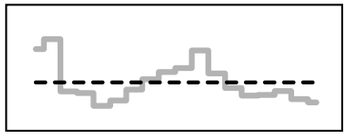
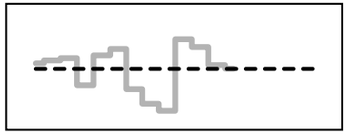
Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
RTT Incomplete (%)	Responsive	71.17	92.00		Limited assurance
62 Day Cancer (%)		65.30	85.00		Limited assurance
6WW Diag (%)		78.88	99.00		Limited assurance
Dementia Stds.		0	0		No assurance
IAPT Wait Times		96	75		Full assurance
IAPT Recovery		53	50		Full assurance
DQMI (%)		93.00	83		Full assurance

Level 2: Domain Level Summary

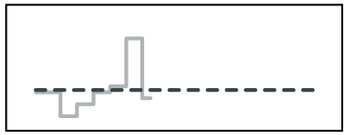
Blackpool Teaching Hospitals NHS Foundation Trust

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Staff Sickness (%)	Efficient	8.80	4		Limited assurance
Staff Turnover (%)		11.52	11.00		Limited assurance
Temp. Staffing (%)		7.60	0.00		Full assurance
Capital Service		(Blank)	0		Assurance Not Recorded
Liquidity (Days)		(Blank)	0		Assurance Not Recorded
I&E Margins (%)		(Blank)	0		Assurance Not Recorded
Agency Spend (Millions)		2.55	-1		Full assurance
EuR Rating		(Blank)	0.00		Assurance Not Recorded

Level 2: Domain Level Summary

Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
A&E + UCC (%)	Strategic	78.31	95		Limited assurance
SHMI		103.47	100		Assurance Not Recorded

Level 2: Domain Level Summary

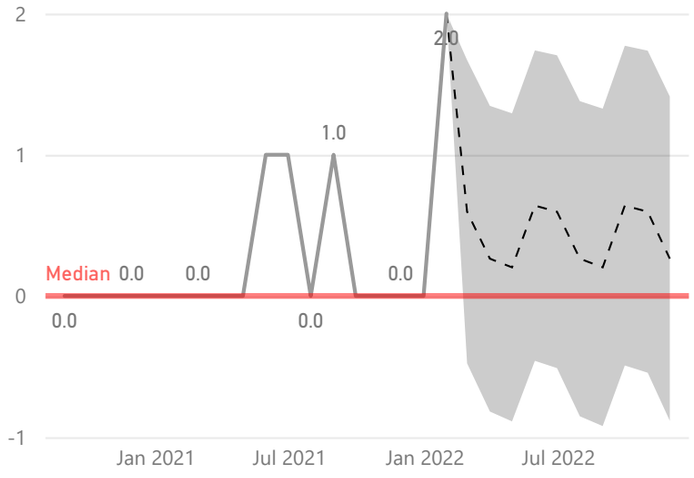
Measure	Domain	Actual	Target	Trend Analysis & SPC	Assurance
Financial Plan (%)	Well Led	(Blank)	0.00		Assurance Not Recorded
Specified Injuries to Workers		1.00	0.00		Limited assurance
Over 7 Day incapacitation of a Wrk		0.00	0.00		Limited assurance

Never Events

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
2	0

Key Risks, Mitigation & Assurance

Limited assurance

Issues

There were two new Never Event incidents reported in January 2022, one involved a wrong site surgery/intervention on the Intensive Therapy Unit (ITU) within the SACCT Division. This incident involved a patient who was receiving care on ITU for pneumonia. The patient was in a prone position and was rapidly deteriorating with oxygen saturations dropping to 60% within minutes. An ultrasound scan was performed at the bedside which identified a pneumothorax on the right side. The patient was then turned over, however the clinician remained on the same side of the patient and proceeded to perform a needle compression on the left side, instead of the right side. This was a time critical procedure as the patient was peri-arrest. The error was immediately recognised and the patient went on to have a needle compression performed on the correct side. This error resulted in the patient requiring a chest drain with its associated harm.
The second Never Event incident involved a wrong site surgery on the Medical Retina Unit in Ophthalmology, where a patient received intravitreal injections to her right eye on two occasions that were not medically required. The lady had been receiving treatment to her left eye, which had resolved and when the surgeon reviewed the scan of her right eye, he was interrupted and reviewed another's patient's scan by mistake and referred the original patient for treatment which was not required. The patient came to no harm, but had to undergo two unnecessary injections, with the associated risks involved. The patient received the appropriate treatment.

Actions

A Red Alert was distributed to all clinical staff across the Trust, with the initial identified learning. In regards to the incident in SACCT.
These incidents are undergoing investigation through the SI process.
The CCG and CQC have been informed of both incidents.

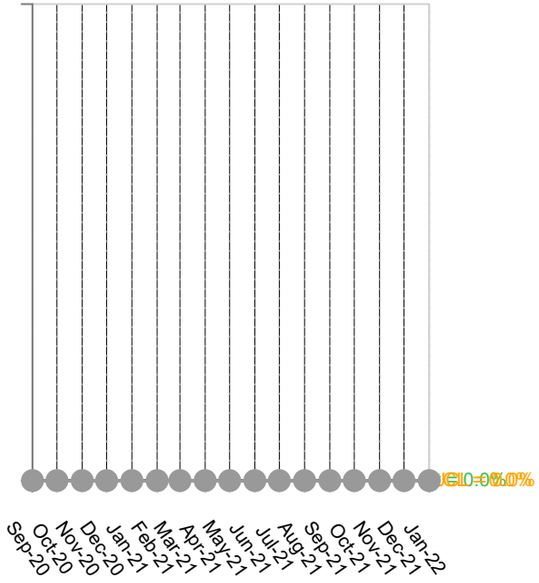
Risks	Mitigation

VTE

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
0.00	0.00

Key Risks, Mitigation & Assurance

Limited assurance

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 Jan-22 are as follows:

IMPF Wards Reviewed: AMU, SSU, 2, 3, 8, 25, 26, C - 86 identified, 9 out of 62 showing completed assessments on ward trackers. Case notes reviewed on same wards, 41 out of 51 completed assessments = 80.4%.

SACCT Wards Reviewed: 15A, 15B, 16, 34,35, SHCU, SAU, HDU, ITU - 12 identified, 27 out of 87 showing completed assessments on ward trackers. Case notes reviewed on same wards, 59 out of 62 completed assessments = 95.2%.

Tertiary Wards Reviewed: CDCU, CITU - 16 identified, 3 out of 16 showing completed assessments on ward trackers. Case notes reviewed on same wards, 8 out of 13 completed assessments = 61.5%.

Families: 11 identified, 0 out of 11 showing completed assessments on ward trackers. Case notes reviewed on same wards, 6 out of 9 completed assessments = 66.7%.

Actions

Overall some improvement across divisions compared to 12 months ago, both in terms of assessments completed as well as compliance to preventive measures. Working with IMPF leads to put in writing policy moving away from mechanical measures and have submitted new guidance for approval. Anticipate working on this but waiting for new appointments as there is currently no admin lead within governance for VTE. Working with Dr Goode and hopefully with Dr Laycock in the near future to get support for VTE related appointments and initiatives. Need their support to get ourselves a full time VTE specialist Lead Nurse or similar role. This has become URGENT now with the loss of the governance and admin lead for VTE for the trust. I have escalated this to Dr Goode and await some affirmative action. Keeping alive the message on VTE assessments and prophylaxis, especially on account of its correlation to COVID patients due to almost 20-70 percent increase in VTE related events in symptomatic critical COVID patients.
Many thanks to Margaret Forrest from Governance and Jenny Walters Pharmacist for help with rewriting assessments and policy changes!
Request regular and monthly communication from Medical and Nursing Leads to reiterate to wards and teams responsible for maintaining the accuracy of WARD TRACKERS
WE NEED A VTE ADMIN LEAD and a FULL TIME VTE LEAD NURSE please
Now working with Stockport to understand what VTE Exemplar STATUS means and how we could aspire towards this. Not achievable without a FULL TIME VTE NURSE LEAD in post. 3 in 4 trusts in the country have a full time VTE LEAD NURSE in post!!!, we are not one of them.

Risks	Mitigation

C.Difficile

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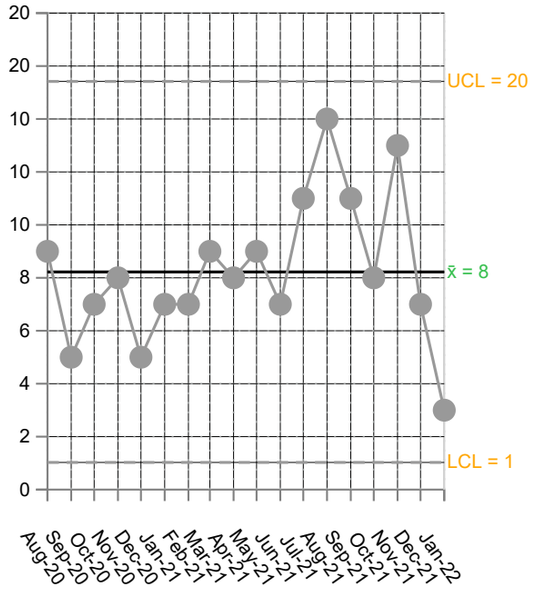
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
3	0

Key Risks, Mitigation & Assurance

Limited assurance

Issues

Three cases of CDI (2 HOHA & 1 COHA) were reported in January 2022. This brings the total number of cases so far this year to 92 (68 HOHA & 23 COHA). The NHS Standard Contract 2021/22 'Minimising Clostridioides difficile and Gram-negative Bloodstream Infections' document sets out the threshold of 104 CDI cases for BTH.

Actions

The Divisions continue to implement their CDI reduction action plans. Monthly (divisional) MDT CDI panel meetings also continue with respective CDI cases being presented and reviewed and any learning and actions identified are taken forward within division. Panel meetings are attended by IPC nurses and an antimicrobial pharmacist.

The Trust CDI policy has been revised and ratified and incorporates new NICE treatment recommendations for treating CDI and new PCR stool testing methodology has also been introduced in the pathology department which is thought to help reduce false positive results. A 'loose stool' care plan is also being trialled within the Integrated Medicine and Patient Flow and Surgery, Anaesthetics, Critical Care and Theatres Divisions.

Risks	Mitigation

MRSA

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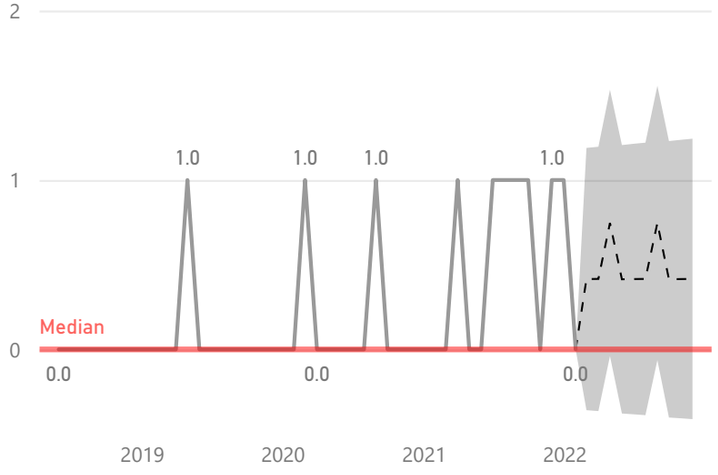
Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Issues	Actions
No cases of MRSA bacteraemia were recorded for the Trust in January 2022. Therefore, the total number of cases so far this year remains at six (2 HOHA and 4 COHA). Of note, four of the six cases relate to the same patient who has a complex deep-seated infection that is being managed by a multidisciplinary team.	Quality improvement activity is planned for Q4 relating to the insertion and ongoing care of vascular devices.

Actual	Target
0	0

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

E.Coli

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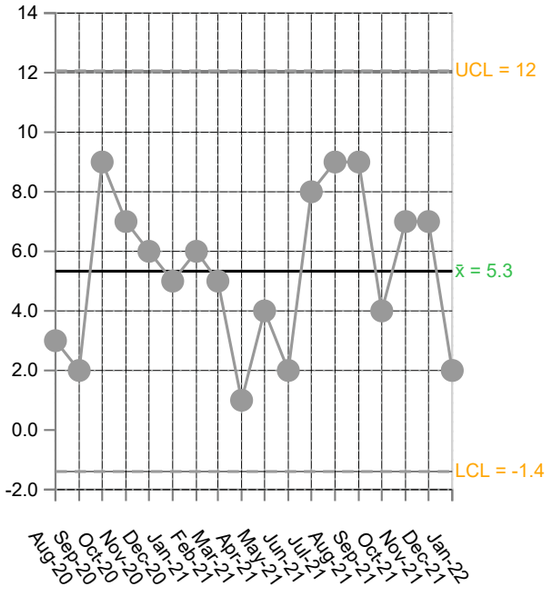
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
2	0

Issues

Two community onset cases of E. coli blood stream infections were reported in January 2022. This brings the total number of cases for the year so far to 68 (33 HOHA & 35 COHA). The NHS Standard Contract threshold for E. coli blood stream infections for 2021/22 has been set at 105.

Actions

Recent performance figures highlight an improvement although no change in process or practice has been implemented. It is thought however that a general improvement in hygiene as a consequence of the COVID-19 pandemic could explain the reduction in community onset cases.

Key Risks, Mitigation & Assurance

Limited assurance

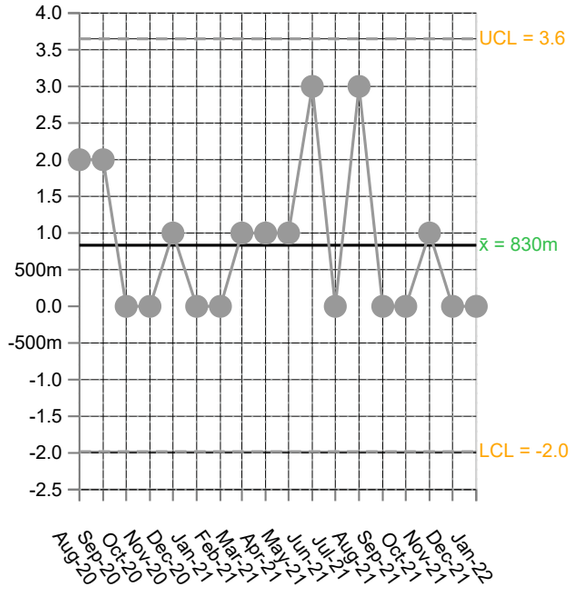
Risks	Mitigation

Patient Safety Alerts

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
0	0

Issues

There were 0 new patient safety alert received this month.

There are 2 ongoing patient safety alerts:

NatPSA/2021/005/MHRA - Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particle.
NatPSA/2021/008/NHSPS - Elimination of bottles of liquefied phenol 80%.

Actions

Due response date for the ongoing patient safety alerts:

NatPSA/2021/005/MHRA - 17/12/2021
NatPSA/2021/008/NHSPS - 25/02/2022

Key Risks, Mitigation & Assurance

Limited assurance

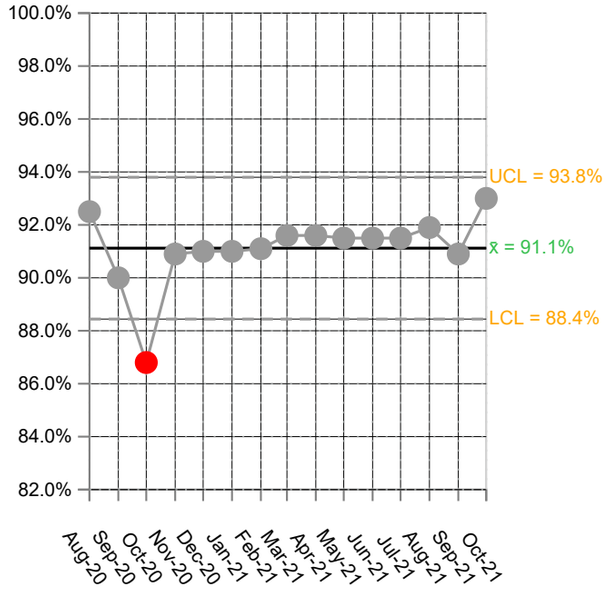
Risks	Mitigation

DQMI

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
93.00	83

Issues

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

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

Overall quality continues to remain consistent for the last 4 months recorded in the national report, with October value of 93%, 7.9% above national average.

Please note data refreshes can affect DQMI values going forward

Actions

None

Key Risks, Mitigation & Assurance

Full assurance

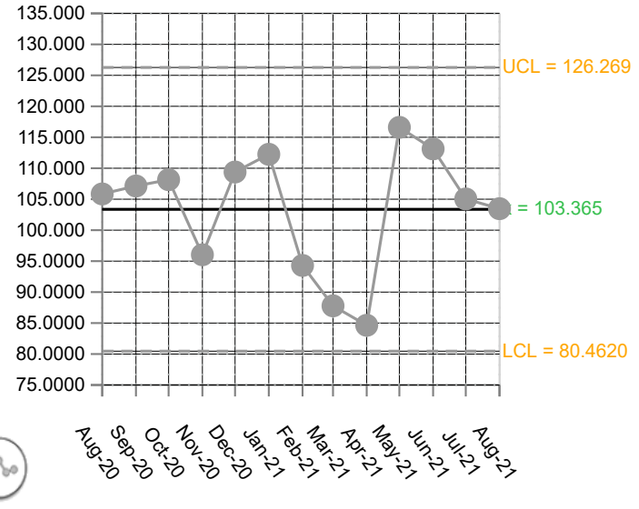
Risks	Mitigation
None	None

Mortality

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

SHMI Statistical Control Process



Actual (%)	Target
103.47	100.00

HSMR	SPC
103.66	

Crude Mortality (%)	SPC
1.79	

Key Risks, Mitigation & Assurance

Assurance Not Recorded

Issues	Actions

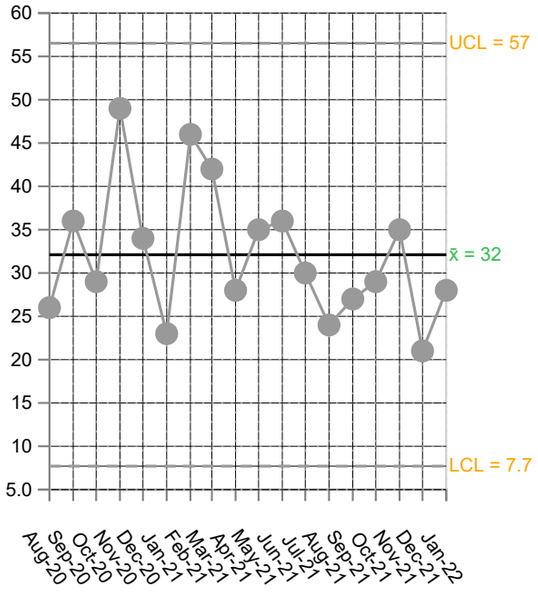
Risks	Mitigation

Complaints

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual	Target
28	(Blank)

Issues

In January 2022, 28 formal complaints were received which required investigation compared to 21 formal complaints in December 2021 representing a 25% increase. 100% of complaints were acknowledged within 3 working days in the Trust.

There were 19 complaints due to be responded to between the divisions in January. 15 were sent out in time (79%) with 4 cases breaching the local target of 25/40 working days. A breakdown for the divisions with complaints to respond to is below:

Clinical Support – N/A
Corporate – 0% (2 out of 2 not sent on time - 1 involving NWAS)
FAIC – 60% (3 out of 5 responses were sent on time)
IMPF – 100% (5 out of 5 responses were sent on time)
SACT - 100% (4 out of 4 responses were sent on time)
Tertiary - 100% (3 out of 3 responses were sent on time)

During January 2022, 3 complainants were dissatisfied with their first response from the Trust and requested further information. There were 2 second complaints due to be responded to all of which all were sent out on time (100%).

Actions

In January the Patient and Family Relations Team has corresponded with 195 patients and members of the public. 167 of these contacts were concerns and general enquiries. The main theme of enquiries related to appointments being cancelled last minute, and a duplicate booking system which was auto generating false appointment dates for patients in outpatients. This has been resolved with the appointment team. Work continues with the divisions to drive down the number of outstanding complaint actions plans for 2021-22. In January a meeting was held with the divisional complaint managers to discuss their individual complaint tracking systems, and the monitoring information they wish to receive from the corporate team.

Key Risks, Mitigation & Assurance

Limited assurance

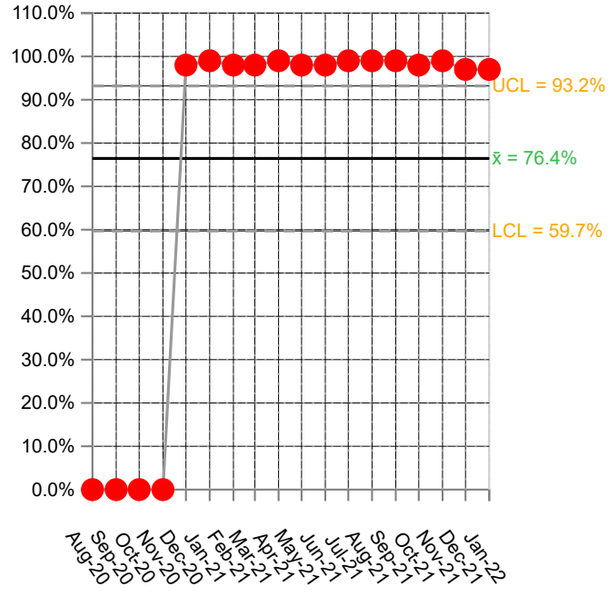
Risks	Mitigation

FFT Inpatients

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
97	96

Key Risks, Mitigation & Assurance

Limited assurance

Issues

In January, 636 inpatient FFT surveys were completed, by inpatients in either Clifton or Victoria hospital. This is a 6% increase from the previous month. 97% of the inpatients in January said they would rate their care experience as very good or good, the same score as the month previous.

Actions

In January the patient experience team has visited each ward in BVH to discuss their FFT distribution. With low staffing levels and hospital flow pressures the staff have said they are struggling to find time to hand out the survey. The patient experience team is working with Quality Improvement and the Clinical Improvement leads to get a QR code on patient discharge information. QR posters and handout sheets are also being trialled on the wards. The inpatient satisfaction score has also reduced over the past two months with issues being reported about co-ordination between services, long waits for treatment / scans, and general discomfort. Staff within the patient experience department are monitoring results and providing training and support to the ward managers to access their feedback daily. This has been ongoing throughout January.

Risks	Mitigation

FFT A&E

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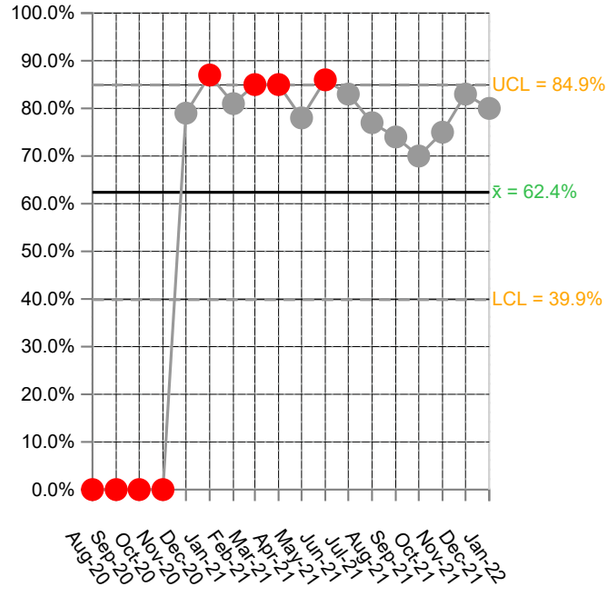
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
80	92

Issues

In January, 324 patients completed a FFT survey by SMS or paper after attending the Emergency Department. 80% of the patients or their carers said they would rate their care experience as very good or good, a 3% decrease in the satisfaction rate from last month.

Actions

Paediatric satisfaction scores remain high, but there continues be concerns expressed through the adult survey with 18% rating their experience as poor in January. Issues reported are around long waits for admission to a ward, pain management and the availability of emotional and physical support. 'Focus Days' have been implemented where in the huddle, the team focus on a specific area for improvement that was mentioned in the FFT.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

FFT Maternity

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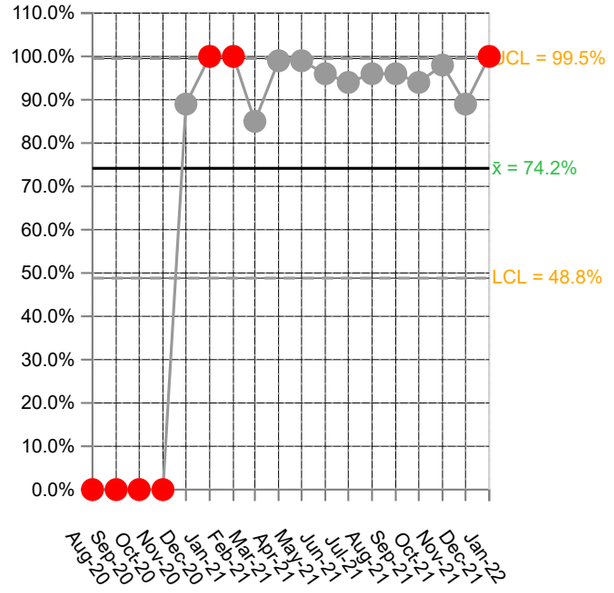
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
100	96

Issues

In January 61 FFT surveys were completed about maternity services, a 65% increase in their survey numbers from December. 100% of the patients or their carers said they would rate their care experience as very good, a increase of 11% from the previous month.

Actions

A meeting took place with the new Delivery Suite Manager in January, to discuss the importance of the FFT. QR code posters have been placed in each delivery room above the kettle's, so patients and/or their family can better access the FFT.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

FFT Community

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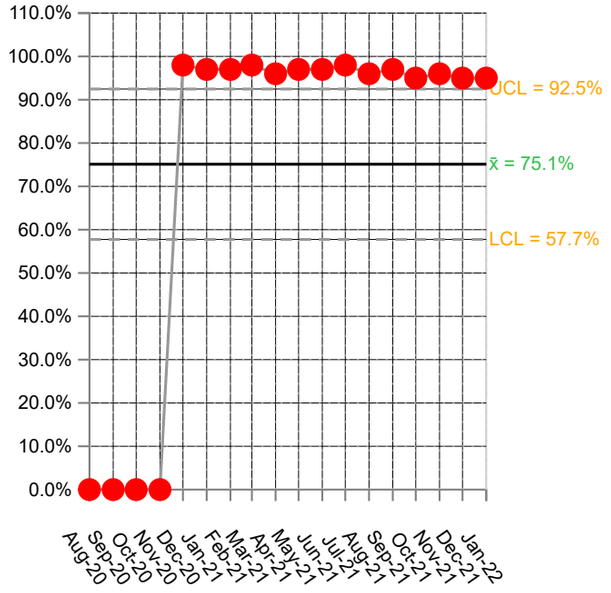
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
95	98

Issues

948 patients in the community completed a FFT survey at home or in clinic in January, a 48% increase in responses from December. 95% of the patients or their carers said they would rate their care experience as very good, the same score as the month previously.

Actions

QR code posters to complete an FFT are in use in all community services and are being sent via email when confirming appointment arrangements. Patient satisfaction levels remain the same, concerns expressed in January were around cancelled appointments, ongoing pain, and the difficulty of assessing this via virtual consultations. Staff within the patient experience department are providing training and support to the service managers to access their feedback daily. This has been ongoing throughout January.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

FFT Mental Health

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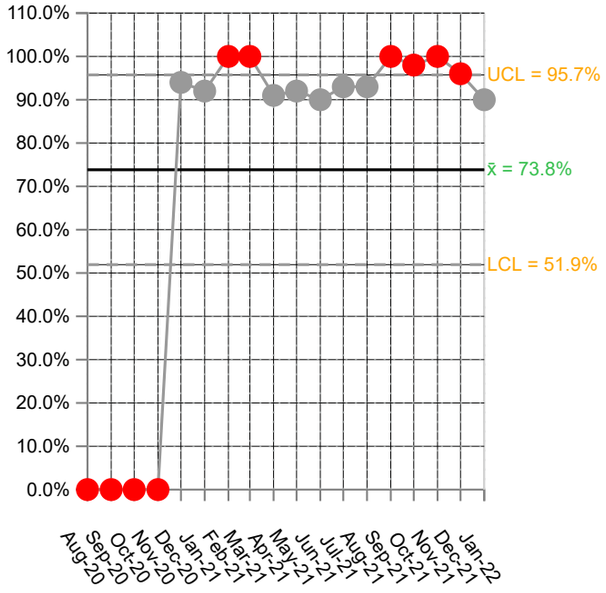
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
90	(Blank)

Issues

In January, 30 patients who require mental health support completed a FFT survey at home or in a clinic, a 15% increase in responses from December. 90% of the patients or their carers who used the services said they would rate their care experience as very good and good, a 6% decrease in satisfaction from last month.

Actions

The lower scores this month have come from the Primary Mental Health Team and YouTherapy about urgent referrals from the GP not being prioritised. Staff within the patient experience department are providing training and support to the service managers to access their feedback daily. This has been ongoing throughout January and the team will be contacting services in February to drive up their response rates, so their scores improve overall.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

Mixed Sex Breaches

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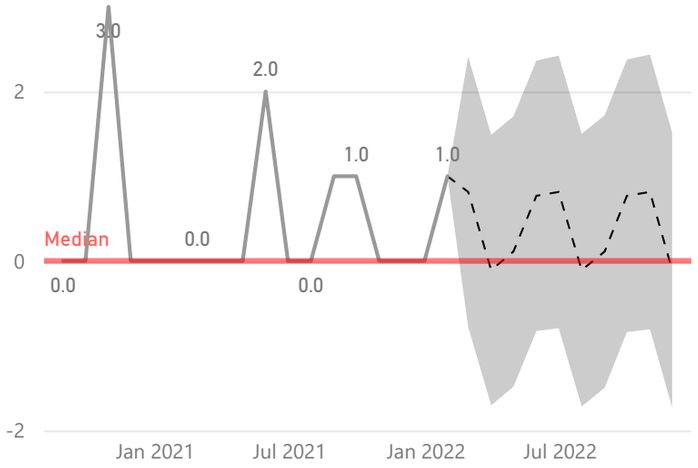
Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
1	0

Issues

There was one mixed sex breach in January which was upheld by our commissioners. This took place in ITU where the patient was waiting for a medical bed. This was escalated in every bed meeting, and discharges were monitored to create a bed for the patient to be transferred. There was no harm to the patient from this incident.

Actions

Dignity checks continue where EMSA concerns are reported to the patient experience team, on the COAST visits or via the incident reporting system.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

Emergency C Section

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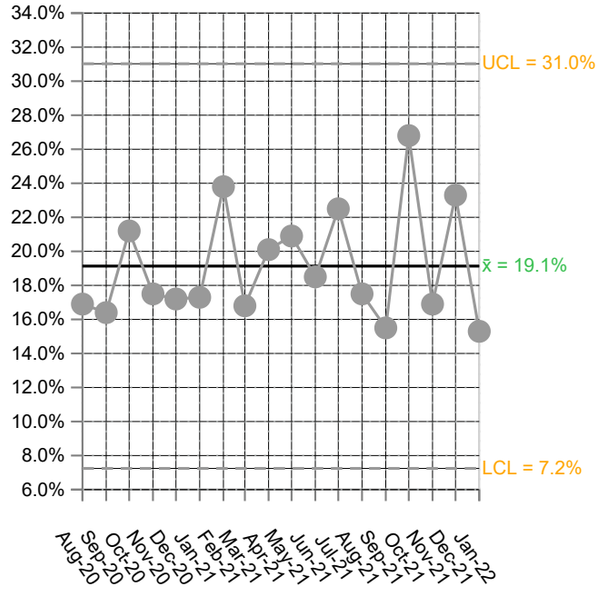
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
15.30	0

Issues

Medical complexity of pregnancies continues from month to month impacting on our emergency caesarean section rates.
A comparison with other areas in our region reflects a similar pattern.

Actions

Monthly review of emergency caesarean section rates is reported and monitored by the Quality, Patient Safety and Experience Team.

Key Risks, Mitigation & Assurance

Full assurance

Risks	Mitigation

RTT Incomplete Open Pathways

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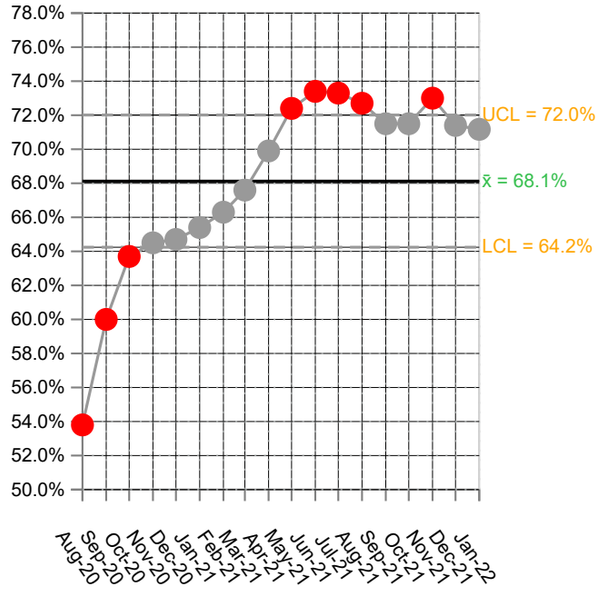
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
71.17	92.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

Performance for RTT incomplete pathways remains in non-achievement against the national standard of 92% at 71.2% for January 2022. This represents a 0.2% decrease against December 2021 at 71.4%. There were 23,933 open pathways against the H2 trajectory of 19,960. The Trust continued to reduce those waiting over a year with 22 fewer 52 week breaches at 776, while 104 week breaches remained the same at 18, both in line with H2 trajectories.

Actions

- Additional sessions have been put in place to deal with backlogs in outpatient services relating to General Surgery, ENT, Gastroenterology, and Paediatric Orthopaedics.
- Due to limited capacity the focus remains on urgent cancer surgery, urgent surgery, and long waiting patients.
- The business case for the modular gastrointestinal unit continues to progress.
- Endoscopy are still utilising insourcing solutions.
- Independent sector being used for Orthopaedics, General Surgery, and Gynaecological Surgery.

Risks	Mitigation
- A further wave of Covid-19 could reduce capacity by causing staffing shortages.| - Capacity vs Demand shortfall across a number of services.| - Emergency pressures can result in cancelled elective activity (non-admitted and admitted).| - Limited centralised tracking resource means not all administrative clock stops are recorded in a timely manner.	- Close monitoring of COVID-19 situation.| - Weekly review of activity plans, capacity and demand analysis to identifiy and mitigate shortfalls.| - Prioritisation of urgent and long waiting cases| - Plan to continue with some reduced Day Case capacity in the present HDU and Ophthalmology Day Case unit.| - Utilisation of external validation company to batch validate 15,000 pathways between January 2022 and March 2022.

62 Day Cancer Referrals

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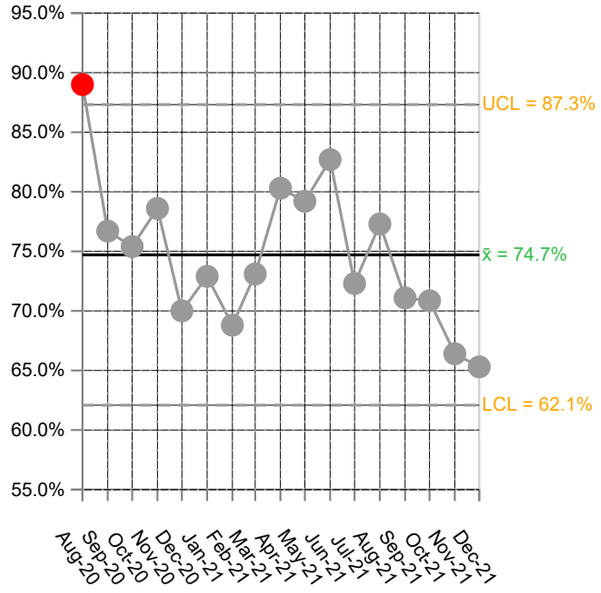
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
65.30	85.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

The Trust failed to achieve the Cancer 62 Day Wait for all cancers in December at 65.30%. This represents a decline in performance from previous months with November at 66.40%, October at 70.85%, September performance at 71.09% and August performance at 77.27%.
All patients who breach this target are monitored closely, subject to close review which also includes patients waiting over 104 days. The number of patients treated in December after day 104 is 9.

In December the Trust has not achieved the 2-week target at 71.03%, symptomatic breast has also not achieved for December at 77.32%. This continued deterioration in performance has been largely due to the increase in referrals, more notably in Lower Gastrointestinal and Breast Cancer services.

The Trust remains particularly challenged in relation to Upper and Lower Gastrointestinal Cancer Services which has attributed to the non-achievement of the 2 weeks wait metric.

For the Faster Diagnosis standard, the Trust did not achieve, with performance at 65.49% for December. Performance to this standard has stabilised and further work is on-going with all tumour sites to support improvement.

Day 31 First Treatment was achieved for December with performance at 97.07%. The Trust achieved the 31 Day subsequent treatment standard at 100%.

Actions

The following actions are being progressed to improve capacity:
- Additional 2-week rule clinics are continuing where possible
- Triage commenced and continues for Lower Gastrointestinal patients since December and is planned for breast patients in 2022.
- Options to increase capacity in Colorectal Surgery continue to be explored.
- Insourcing companies are being utilised to maintain capacity in Gastroenterology.
- The Trust has commenced a weekly Cancer Performance meeting from the beginning of November, with clear escalations at patient detail level for patients breaching the 62-day standard.

Risks	Mitigation
• Agency locums being utilised to support our challenged services can potentially leave with short notice|• High volume of Breast and Colorectal referrals are outstripping present capacity |• Bed availability could impact on Colorectal and General Surgical programme|	• The Trust continues to review CVs for appropriate Locums |• The 5th room in Gastroenterology and Insourcing will continue to increase activity |• Prioritisation is being given for Cancer patients |• Additional Fast Track activity is being put in place where feasible|• Straight to Test is being implemented for appropriate patients in colorectal|• Demand and Capacity work is being completed across challenged tumour groups.|

% Over 6 Week Wait Diagnostic

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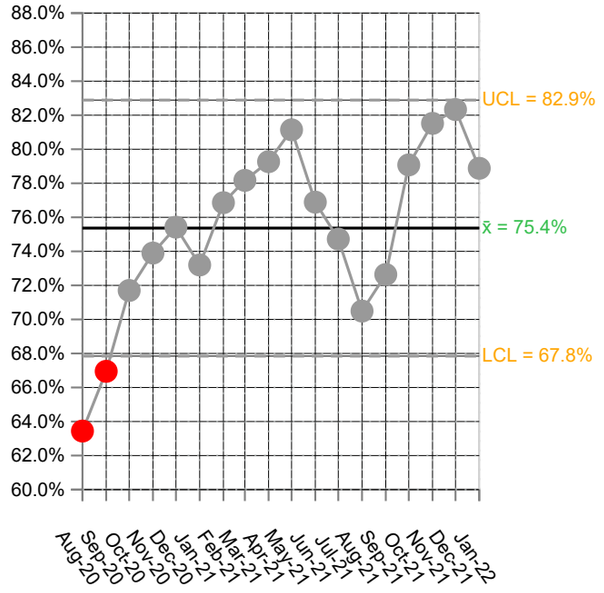
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
78.88	99.00

Issues

Performance against the 6 week remains in non-achievement against the national standard of 99% at 78.9% for January 2022. This represents a 3.4% decrease against December 2021 at 82.3% and the first month in the last 5 of deterioration.

The main modalities contributing to non-achievement are the endoscopies, however, in January 2022 the Trust has seen a spike in MRI and echocardiography breaches.

Although activity increased between December and January it remains low compared with the year to date average meaning the waiting list has grown.

Actions

- The Trust continues to utilise insourcing companies to improve gastroenterology diagnostic pathways.
- The case for the modular gastrointestinal unit continues to make progress.
- The Trust is still using modular CT scanners where apropriate
- Insourcing companies have provided additional activity for Echocardiography
- Additional sessions and overtime are being utilised where feasible
- An external company have completed a review into Cardiac Investigations offering solutions to improve systems, process, and data quality.

Key Risks, Mitigation & Assurance

Limited assurance

Risks	Mitigation

Dementia Standard

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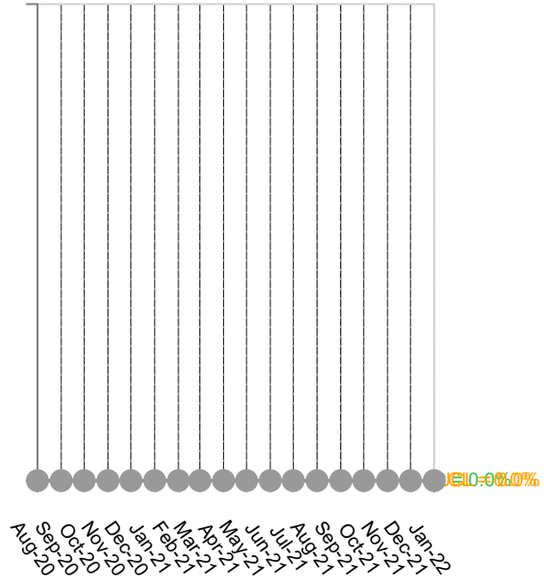
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
0	0

Issues

The analysis of the data collected from the 25 sets of case notes that was submitted as part of the Royal College of Psychiatrists (RCP) voluntary audit has yet to be completed. The findings will be considered in the dementia strategy workstreams and will also inform the basis of future reporting which has been identified as a requirement of the Dementia Strategy 2021/2025

Actions

The Dementia champions meetings continue to take place by TEAMS and a workplan for 2022 is being worked up.
Tier two dementia training continues through TEAMS with good attendance . The plan is to continue to deliver this training via TEAMS on a monthly basis, and the dates and booking requirements have been sent to ward Managers and Matrons. Dementia champions will also promote this training in their wards and departments.
The dementia strategy at a glance paper has been approved and work continues along the identified work streams for the dementia strategy with the leads for each identified workstream reporting back monthly on the progress of their agreed action plan.
Progress will be shared at the dementia advisory board on a quarterly basis.

Key Risks, Mitigation & Assurance

No assurance

Risks	Mitigation

IAPT Wait Times

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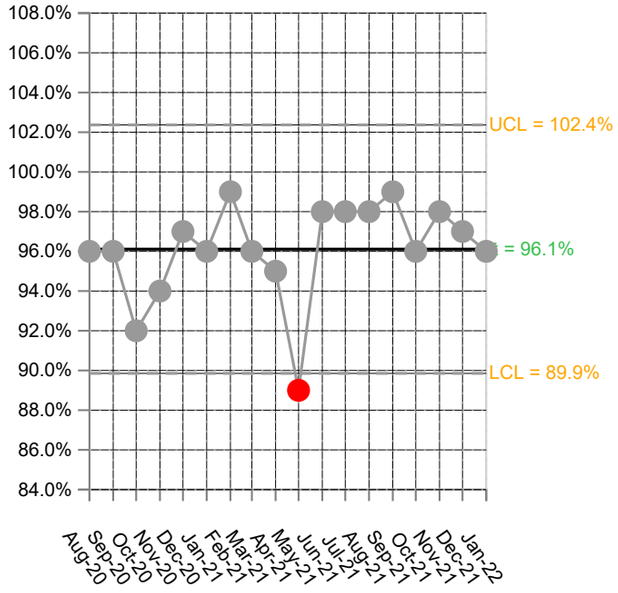
Blackpool Teaching Hospitals NHS Foundation Trust

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 December waiting times are within National Targets for IAPT services. The figure for Supporting Minds for January was 96%.
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, or if patients have very specific appointment requests regarding times, location, or gender of therapist.
However, we continue to work extremely hard to reduce our secondary waiting times, which are still being impacted upon by Covid-19 as plans to increase more face-to-face groupwork at Step 3 are still on hold.

Actions

• We are attempting to recruit additional CBT therapists to provide more out-of-hours therapy slots.
• Ensuring some groups are accessible on-line until face to face groups can commence. The compassion-focussed therapy group is due to run again online in February 2022. The Step 3 Anxiety Management Group has now been postponed due to poor take up of the online group offer. The online Step 3 Mindfulness Group is due to run again in January 2022.
• Working with staff to ensure that the DNA policy is adhered to, and monitoring DNA rates through caseload management supervision. This is 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. This is 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. This is ongoing.

Risks	Mitigation
• Anticipated increase in referrals due to COVID19.|• Increased waiting times for some - due to people needing or wanting to be seen face to face Limited room availability for socially distanced face to face therapy (insufficient rooms that are large enough to allow therapist and client to sit 2m away from each other).|• Due to the incidence of digital poverty in the locality some clients are unable to undertake online video link appointments due to either not having the required technology or data to have a weekly video link session for up to an hour a week. This leads to an increase in the number of clients who require face to face appointments.|	Ensuring as many groups as possible are accessible on-line due to current restrictions on group-work due to Covid-19. |Patients are still being actively encouraged to accept remote or online therapy wherever possible, unless face to face therapy is clinically indicated. Limited face to face working is continuing in a risk assessed socially distanced way for those patients who have a clinical need for face-to-face therapy or where difficulties accessing therapy remotely cannot be overcome. Staff are being flexible with their working hours to maximise room usage. We are ensuring that all planned groups are ready to go as soon as face to face group work possible|

IAPT Recovery

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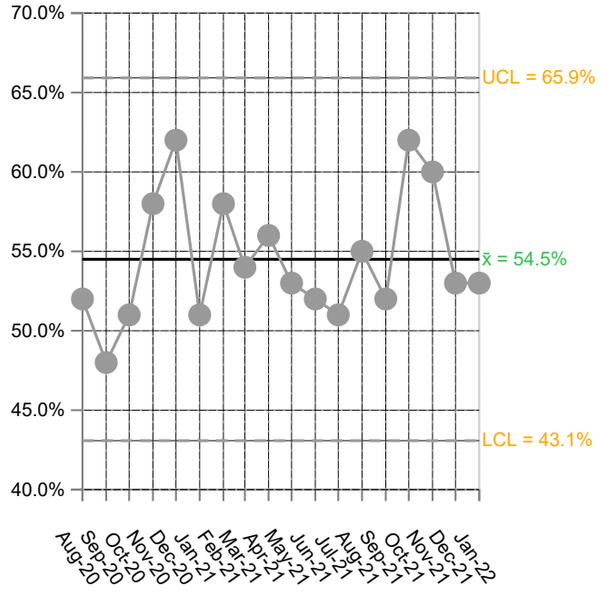
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
53	50

Issues

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

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

Actions

- We are working hard to safely increase the availability of face-to-face appointments for those patients where face to face therapy is clinically indicated by maximising use of available space.
- Administrators actively encouraging as many patients as possible to accept remote therapy to enable them to access therapy as quickly as possible and to ensure that those who need face to face therapy can access this in a timely way.
- 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 client's progress are 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) 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 which is 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 to maximise room usage.

Sickness

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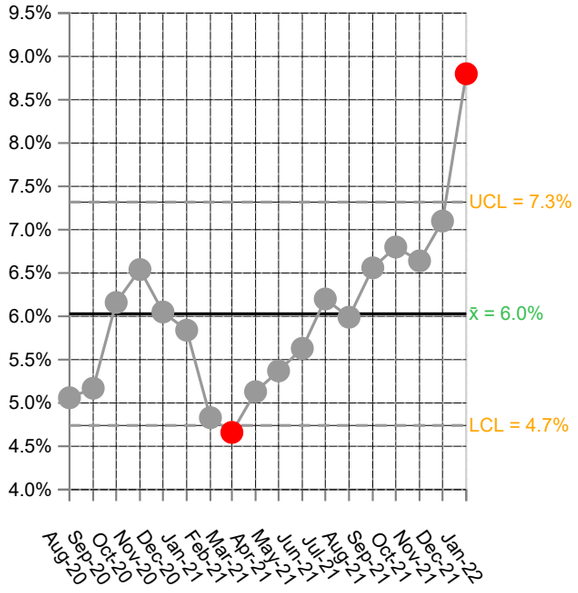
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
8.80	4

Key Risks, Mitigation & Assurance

Limited assurance

Issues

Sickness has been increasing month on month across the Trust and the spike in Covid sickness along with other sickness absence has resulted in the sickness % rising to 7.10% in December. We have seen a reduction in sickness across a couple of the divisions however there still remains high sickness percentage absence across all areas which has remained consistent over the last few months.
Current figures are: Families Division 8.22%, SACCT 5.92%: Tertiary Services 6.33%; Clinical Services 5.67%; Corporate Services 4.58%; IM&PF 9.30%; R&D 5.49% and Facilities 5.93%.
Anxiety and stress related absences remain the highest reason for long term sickness at 42.13% and infectious disease is the highest reason for short term absence at 26.17% as we have seen a rise in staff absent with covid related sickness. The other reasons for short term cases are anxiety and stress at 22.12% and cold/cough at 10.41%. Long term cases are injury/fracture at 10.74% and MSK at 8.28%.
As at the 18th January 22, the Workforce Advisory Service are supporting managers with 128 sickness absence cases which is a reduction of 17 compared to last month. 105 of which are long term cases which is a reduction of 11 compared to last month.
As expected we are continuing to report on staff absence due to covid and this is reported on a daily basis through silver command. This has caused significant staffing issues across the Trust as numbers have risen over 300 on a daily basis. Covid absence across the HCA, nursing and midwifery and medical staffing roles have been high across the Trust.

Actions

OH are continuing their provision with offerings from local mental health services, including Supporting Minds, the Resilience Hub which offers psychological support for the impact of Covid-19, Workplace Trauma Support Training for Line Managers and Wellbeing and Engagement Champions. Individual work is also continuing with OD and Wellbeing works to look at psychological safety for staff. OH are offering wellbeing checks for all staff and we are encouraging managers to undertake a health and wellbeing conversation with all staff.
We are continuing to encourage staff to have their flu vaccination as we are seeing the number of staff off sick with cold and flu rising along with the encouragement of covid booster vaccinations. Plans are also being developed following the mandating of vaccinations to help support staff who are yet to receive their vaccinations.
HR have been contacting all staff currently off with covid to remind them of the isolation rules and support available to try to ensure that staff can return to work as soon as they are medically fit. Covid absence is also being reported on a daily basis on silver/gold command.

Risks	Mitigation

Turnover - Staffing

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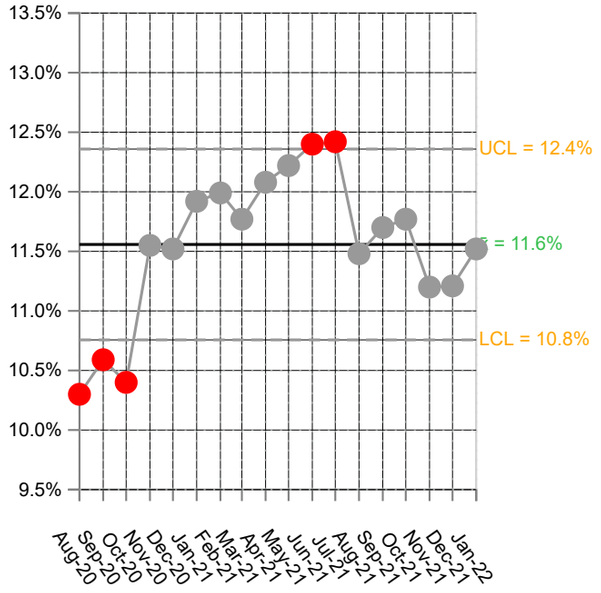
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
11.52	11.00

Issues

The Trust Turnover target is set at 11% however we are currently operating at 11.52% this is a slight increase from December but is still a reduction from the highest of 12.42% in July 2021, we are still above expectation by 0.52%.

Medical and Dental Turnover is set at 11% and is currently operating at 17.30% this is an increase on December's figure. It has been consistently over the 11% target over the last 12 months.

Medical and Dental recruitment has been impacted by overseas recruitment delays and the impact of coronavirus on travelling, issuing of visas etc. We are finding with the change in the Government Travel traffic light system, it is starting to help with overseas recruitment but there are still delays in the visas being produced in some of the overseas countries.

Nursing and Midwifery Turnover is set at 11% and is currently operating at 9.87% which is a 0.36% increase on December's figure and is still below target and remains consistently below the 11% target over the last year.

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

Actions

The Trust workforce dashboards have now been redeveloped to provide a more accurat vacancy figure and these now show 37.33 WTE registered nurse vacancies and 98.95 WTE unregistered nurse (HCA) vacancies. These vacancy figures are recorded at the point in time they were extracted from the latest workforce dashboards.

• The main recruitment pipeline continues to be via our overseas nurse recruitment programme. There are currently 36 overseas nurses in the Trust working as adaptation nurses and preparing for their OSCE examinations. The international nurse preceptorshi programme has commenced in January to support the overseas nurses who have registered with the NMC in the past 6 months to support retention.

• The Trust plans to continue recruiting 10-15 OSN per month throughout 2022 and has now received confirmation that the funding bid has been approved by NHSEI to allow this recruitment to continue. The Trust has commenced working with a second recruitment agency to ensure these numbers can be achieved.

• 9x student nurses due to qualify in March 2022 and 11x staff who have been trained and supported to undergo Registered Nurse Degree Apprentice qualification will be mapped into the registered nurse workforce planning going forward and be aligned with the OSN recruitment programme.

These strategies aim to allow the Trust to clear any RN vacancies, cover implementation

Key Risks, Mitigation & Assurance

Limited assurance

Risks

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

Mitigation

Other Recruitment and Retention work includes:||The HCA working group continues to meet to drive forward a focus on increasing retention of this staff group, and to mitigate the lead time between leavers and onboarding of new recruits through a redesign of the process for regular recruitment through temporary staffing. |The Trust has a rolling monthly recruitment drive for HCAs to recruit to substantive posts created from the recent establishment uplift, with 30 of the 47 recruited so far already in post and a further 5 interview panels planned in February. ||Ensuring the Trust is an 'employer of choice' by supporting local unemployed people into work, collaborative work has started to ensure strong links are being formed with both the DWP and job centre work coaches, and the local college who are delivering pre-healthcare courses to people in the community who wish to start a career in the hospital. The HCA Recruitment and Pastoral Lead post has been recruited to with a March start date and will support the

Temporary Staffing

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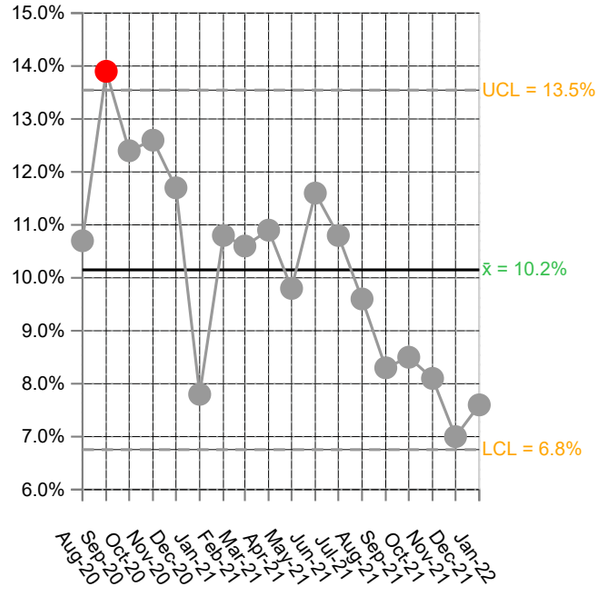
Blackpool Teaching Hospitals NHS Foundation Trust

Statistical Control Process



Actual (%)	Target
7.60	0.00

Issues

Increase in Temp staffing due to substantive staff sickness, enhanced rates agreed with Senior Nursing Team to continue pending a review until 31st Jan 2022

Actions

Reduction / removal of enhanced rates, reduction in Agency ratecard back to pre-Xmas levels to be agreed

Key Risks, Mitigation & Assurance

Full assurance

Risks	Mitigation
Enhanced rates / rate card escalation	Reduce where possible and safe - liaison with Senior Nursing team

Agency Spend

Click icons to Access other Levels

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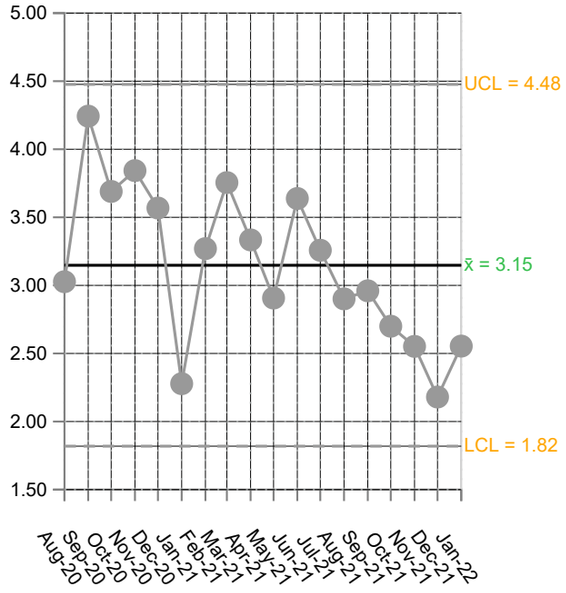

Actual	Target
2.55	-1

Issues

Spend increased due to rise in rate card to provide staffing to cover sickness absence

Actions

agency ratecard to be re-introduced when safe to do so

Key Risks, Mitigation & Assurance

Full assurance

Risks	Mitigation
Nursing staff levels falling	Rate card rise extended, to be reviewed 21st Feb

A&E + UCC Performance

Click icons to Access other Levels

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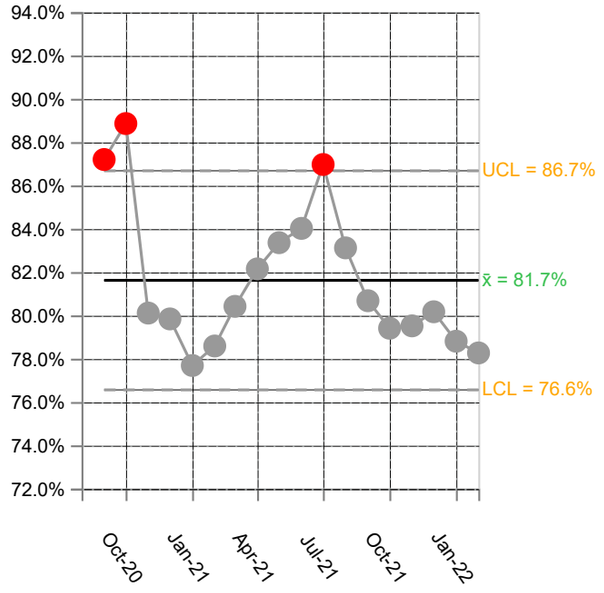
Statistical Control Process



Actual (%)	Target
78.31	95

Issues

ED performance for January was 41.75%. Total Economy Performance was 78.31%. The team continue to implement service improvements within the department that is monitored by the department action plan fully supported by the divisional triumvirate and the Executive Team.

We saw a slight decrease in attendances for the month however most days still remained over 200 attendances a day. These figures still remain higher than pre-covid putting extreme pressure on the dept. The attendance profile shows an increase in majors patients and surges in those attendances mean that the dept continues to struggle with social distancing. Triage times and Time to see a clinician has decreased slightly however it remains a challenge due to lack of capacity in dept due to limited admission beds being available. This has resulted in long lengths of stay for many patients.

The 111 First booked appts continue to be encouraged alongside streaming at Triage to the UTC and SDEC.

The dept reported at total of 837 DTA breaches which is a significant increase from the previous month.

Patients attending the dept with a Mental Health presentation increased in the month. 32% of these patients required admission. 11% of mental health presentations were transferred to the MHUAC.

The trust had the second highest ambulance attendances in the region (2509 conveyances). Arrival to handover was 28 mins and the total turnaround time reduced slightly to 39 mins. We have seen a reduction in the number of ambulance turnaround delays with 323, 30-60 min delays. Over 60-min delays reduced again this month to 158. This is linked to the lack of bed availability in the Trust resulting in capacity challenges in dept to take handover.

Actions

The team have developed an action plan to improve ED performance and reduce both admitted and non-admitted breaches. This is reviewed on a weekly basis now. Acute Medicine are also in attendance to support close working relationships.

The department has commenced an initial change to both nurse and medical staffing to support the triage area when the peaks in attendances occur. Escalation processes are now in place for nurse triage and Interventional triage areas and these are monitored on a daily basis and PDSA cycles continue.

NHS 111 First continues to encourage the public to use this service if they think they may need to go to ED. Although the numbers of patients that use this service remain low, the process sees patients spending less time in ED.

To reduce the number of patients experiencing ambulance handover delays the department continues to support the Rapid Handover and Fit to Sit processes. The Emergency Department has increased its capacity with an escalation area when ambulances are unable to offload, and the trust has opened an escalation area and implemented a full capacity protocol in response to ambulance delays.

Same Day Emergency Care commenced a NWAS Direct Access Pathway on 3rd November which supports the trust No Harm, No Wait, No Waste Strategy.

The patients waiting for a bed within the trust are monitored by the patient flow team and actions are put in place to maintain patient safety and reduce any delays.

ECIST are currently working closely with the ED and Patient Flow team to support improvements.

The medical team in reach to ED every day to ensure medical patients have a robust plan in place whilst waiting an admission and may be discharged wherever possible. The DTA escalation policy is in place to support early escalation through the division alongside the Trust Full Capacity Protocol.

Key Risks, Mitigation & Assurance

Risks	Mitigation
Delay to ambulance handovers during surges in attendances	This is monitored through the patient flow meetings with actions to de-escalate as asoon as possible. Rapid handover is in place at triage.
ED attendances continue to remain high. These numbers are overwhelming the department / Trust	NHS 111 advice given to all patients. Social distancing and covid pathways continue. Escalation and Surge Policy in place alongside Full Capacity Protocol
Nursing and Medical sickness / vacancies linked to covid and work-related stress	Support has been provided through the organisation and the recruitment team
Unbale to achieve consistent Triage and Time to Clinician performance	Performance reviewed daily. Escalation actions in place and review of nursing and medical processes at the front door has commenced.

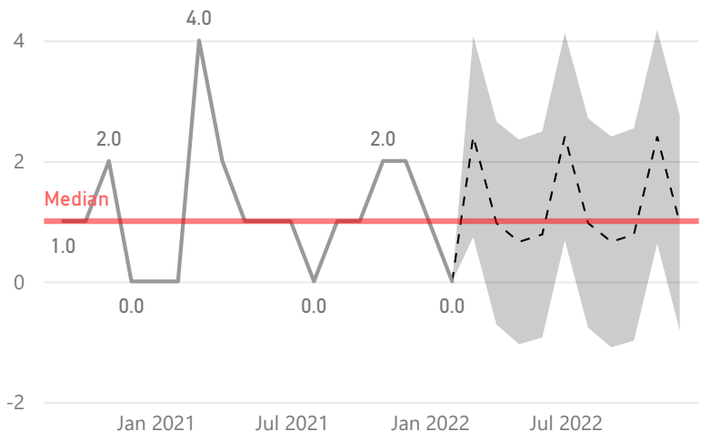
Limited assurance

Over 7 Day Incapacitation of a Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals
NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
0.00	0.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

No incidents reported to the HSE - RIDDOR Over 7 day incapacitation of a worker.

Actions

N/A

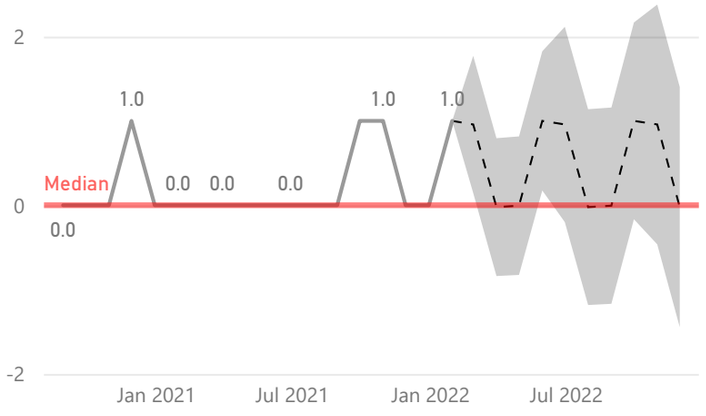
Risks	Mitigation
N/A	N/A

Specified Injury to Worker

Click icons to Access other Levels

Blackpool Teaching Hospitals NHS Foundation Trust

Historical & Future (Forecast) Performance



Actual	Target
1.00	0.00

Key Risks, Mitigation & Assurance

Limited assurance

Issues

One incident reported to the HSE - RIDDOR Specified injury to worker. Staff Incident - Slip, trip or fall: Staff member fell on the top floor of the multi storey car park due to icy conditions. Sustained injury to head, lost consciousness and was taken and admitted to A&E.

Actions

ATLAS have confirmed: The car park on this occasion was not gritted as the met office forecast indicated that the road surface temperature would not fall below zero and therefore did not trigger a gritting event. However, due to the impervious nature of the existing surface and the small amount (i.e. film) of standing water, in low temperatures there is the inherent risk of slipping.

There are warning signs indicating the risk of ice when entering the multi-storey car park.
A specialist contractor has been instructed to assess the existing surface with a view to improving the slip resistance of the surfacing material.
In view of the possibility of the temperature being lower on the 6th floor than on the surrounding roads, Atlas will raise the activation level for gritting this particular area.

Following the report from the specialist contractor, Atlas will review with the Trust (i.e. Car Park Management) whether the 6th floor parking area should be closed in adverse weather conditions. Incident, Risk and H&S team working with Estates and Facilities to ensure risk of slips, trips and falls included on departmental risk register.

Manager has confirmed: member of staff underwent CT scan of head. Discharged later that day. Visited GP following incident as experiencing muscle spasm in neck and prescribed medication to relieve this. Member of staff currently off work.

Risks	Mitigation
Risk Ref: 3106 - Low temperatures / snow (Current - Organisational)	Risk Refr: 3106 - ATLAS Severe Weather Plan / Snow and Ice Clearance|Risk Refr: 3106 - On request ATLAS have the ability to monitor/log temperature in specific areas over a period of time and advise on corrective action (There is no formal agreement on who would conduct temperature monitoring in advance of an incident)

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

Executive Directors

28th February 2022

Strategy Core Narrative

Author of Report:	Charlotte Walton, Director of Planning & Delivery
Executive Director Sponsor:	Trish Armstrong-Child, Chief Executive Officer
Date of Report:	25th February 2022

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

- In 2019, the Trust five year strategy ended. During the Covid-19 pandemic, the trust introduced a one-year strategy whilst a five year strategy was developed.
- The Board of Directors agreed a Strategic Framework and as part of the strategy development staff, patients, carers and external stakeholders have been consulted and engaged.
- As a result, the strategic framework has evolved through the co-production with staff and patients and a revised strategic framework, reflecting the feedback has been developed.
- Using the key themes alongside executive director one-to-ones, a strategy core narrative has been developed that sets out the aims, priorities, objectives, success measures and high level workplan for the next five years.
- The core narrative is presented for approval to progress to the design phase. This will involve engaging a design agency to create an easy-read, interactive version supporting the organisational re-brand.
- In March, a workplan will be developed for implementing the strategy, developing strategic plans and co-creating values and behaviours that will deliver the strategy.

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

Recommendations:

The Executive Directors are asked to:

- Review the core narrative and raise any concerns or edits
- Agree the QIA "As-Is" and "To-be" ratings for each domain based on the BAF
- Approve the core narrative to progress to design phase
- Note that further work on values, behaviours and strategic plans is needed.

Sensitively Level:

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

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

BLACKPOOL TEACHING HOSPITALS
NHS FOUNDATION TRUST
STRATEGY CORE NARRATIVE

PURPOSE OF THIS DOCUMENT

This is **not the strategy**.
The purpose of this document is to agree the core messages.

Blackpool Teaching Hospitals, have co-produced a new strategic framework that sets out the strategic intent for the Trust over the next five years. This framework has evolved through active participation and key engagement activities with our staff, patients and key stakeholders. We are ready to build on the framework to develop a larger strategic document to share with staff, patients, families, carers and wider stakeholders.

The core narrative has been co-developed with staff to support the production of the strategy and wider materials. This will enable the board to agree the language and messages behind the framework and ensure that any ambiguity is removed. The core strategic narrative will provide a structured approach to socialising the strategy and will be used to develop engagement material for staff, patients, and key stakeholders, including branding, design and communications.

The colours and the formatting presented in this document do not form part of the strategy and are for presentation purposes only. The design and structure will change following core narrative sign off at Board.

The Trust thanks the transformation and planning team for coordinating the core narrative through a newly established strategy task and finish group.

FOREWORD

The passion, hard work and dedication of our staff during the pandemic has been unparalleled #TeamBTH.

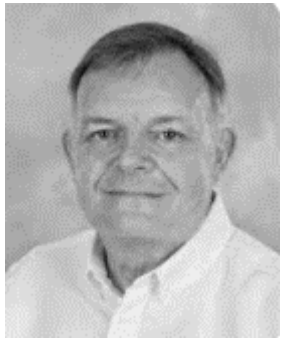
We are incredibly grateful for the contribution our people have made over the past two years; they are undoubtedly our greatest asset and at the heart of our future success. We know that healthy, happy staff provide the best patient care and this strategy sets out our vision for how we will achieve both. In doing so, we will make Blackpool Teaching Hospitals the local employer of choice.

We live and work in one of the most popular coastal areas in the country. Visitors are attracted to the Fylde Coast all year round; keen to explore our local landscapes, hospitality, and nightlife. Like all regions, ours is not without challenges; the Fylde Coast contains a number of extremely deprived areas with significant health and care challenges. We are committed to working with our partners to narrow health inequalities; developing new ways of working and utilising our collective resources to bring about positive change in the health and wellbeing of those we serve.

In developing this five-year strategy, we've been mindful that it's important to get the basics right. By focusing on our core business and providing the best possible care to our patients we will lay the foundations for wider transformational work. In doing so, we will rebalance the provision of services between community and hospital; integrating pathways and working with system partners to achieve the best possible outcomes.

We recognise that our strategy is a living document that will evolve over the coming years as we develop and grow as an organisation. We understand, too, that there is more work to be done to ensure the values and behaviours that reflect our strategic ambition are embedded within our operations, policies, and processes. What will not change, is our drive and commitment to realising our vision of improving the lives of the people who live, work and volunteer within the Fylde Coast and beyond.

Trish Armstrong-Child MBE
Chief Executive Officer



Steve Fogg
Chair

OUR VISION IS TO IMPROVE THE LIVES OF PEOPLE WHO LIVE, WORK AND VOLUNTEER WITHIN THE FYLDE COAST AND BEYOND

In January 2022, we invited staff, patients, carers, the community and key partners across the Fylde Coast to be involved in the development of our 2022-2027 strategy.

As a result of these engagement exercises we have developed the strategy to show a clear intent on improving the lives of people who live, work and volunteer in the Fylde Coast and beyond.

This approach was key and demonstrates our commitment to listening to our staff and actively engaging patients in how we deliver safe, effective sustainable care for everyone, everyday.

Our community told us that the following things were important to them:

- Being an employer of choice
- Recruiting and retaining staff, particularly from our local areas
- Growing excellence through training, education, research & innovation
- Health promotion and prevention
- Being a sustainable partner to improve our impact on the environment
- Having safe, healthy environments to work and receive care in

We invited staff and patients to attend virtual workshops led by our Chief Executive, Trish Armstrong-Child.

We invited all staff to participate in a virtual 24/7 online survey, using our Trust social media pages to promote this opportunity.

We actively engaged children and young people groups to understand what the strategy means to them, understanding what is important now to inspire future generations.

FEEDBACK FROM ENGAGEMENT SESSIONS

"I thought that within the time allotted and with contributors unknown it was planned and operated effectively and efficiently.

To have the CEO at the introduction and as a summariser was, I thought, an excellent indicator of commitment from the top to engage with individuals and representatives from the Community. And air time, at the start and at the end was allowed for certain individuals to have their say and they received full and meaningful responses."

"Really good session, great to hear that people are listening and want staff involvement and opinions plus service users/patients."

"These revisions make the strategy appear more complete and easier to understand, for people across a wider range of backgrounds. Great progress"

CHILDREN & YOUNG PEOPLE

We reached out to our education partners, schools and voluntary sector groups to understand what was important to children and young people.

Key themes included:

- Children friendly facilities, having more toys and games
- Digital, access to chargers, gaming consoles and electronic food ordering
- Improved communication to let them know what was happening
- Nicer Food
- Long waits for treatments and tests at community facilities
- Calmer waiting areas
- Careers guidance and information from year 8 onwards
- Flexible options for accessing healthcare including offsite facilities, drop in opportunities and accessing information through non-face to face means.

SUMMARY OF OUR STRATEGY

Our Mission
Why are we here?

We will deliver safe, effective sustainable care for everyone, everyday

Our Vision
What do we want to achieve?

We will improve the lives of people who live, work and volunteer within the Fylde coast and beyond

Our Aims
How we will achieve this?

Our People

We will widen access to job opportunities, becoming the **employer of choice** within our community with an empowered, diverse and engaged workforce

Our Population

We will work with our population to **co-produce high quality services** with a key focus on preventative care and reducing health inequalities

Our Responsibility

We will work with partners to deliver high quality, financially **sustainable services** and reduce our environmental impact

Our Priorities
What is important to us?

- Grow our Own
- Happy & Healthy Workforce
- Learning Culture

- Integrated Care
- Health Inequalities
- Prevention & Health Promotion

- Get the basics right
- New Ways of Working
- Investing in our Community (Anchor)

SUMMARY OF OUR PRIORITIES

Our People
We will widen access to job opportunities, becoming the **employer of choice** within our community with an empowered, diverse and engaged workforce

Our Population
We will work with our population to **co-produce high quality services** with a key focus on preventative care and reducing health inequalities

Our Responsibility
We will work with partners to deliver high quality, financially **sustainable services** and reduce our environmental impact.

Grow our own
Maximise the benefit of our diverse local community to grow our own future workforce and create local health and wealth.

Health Inequalities
Address inequalities in access, experience and outcomes of our care.

Get the Basics Right
Work collaboratively with our partners to improve quality of care and becoming a CQC Good Rated organisation.

Happy & Healthy Workforce
We recognise that the capacity to care for our patients is reliant on our staff wellbeing. We are committed to care for our people and support them in maintaining resilience and wellbeing.

Integrated Care
We will deliver on our commitment to co-produce integrated care, working with our health and social care partners and patients to influence neighbourhood plans.

New Ways of Working
Use Transformation, Digital, Innovation and Research to deliver new efficient models of care to widen access, enhance health promotion and improve our environmental impact.

Learning Culture
We will engage & empower staff in their education and learning. We will encourage the development of psychological safety and constructive challenge to improve patient and staff experience

Prevention & Health Promotion
Prioritise prevention, patient activation and early detection of illness in disadvantaged groups.

Investing in our Community (Anchor)
Choose to work collaboratively across the system with our partners and communities to positively impact beyond health care.

SUMMARY OF OUR OBJECTIVES

Our People
We will widen access to job opportunities, becoming the **employer of choice** within our community with an empowered, diverse and engaged workforce

Grow our own
Maximise the benefit of our diverse local community to grow our own future workforce and create local health and wealth.

- **Target opportunities to widen access to jobs for future generations**
- **Creating attractive innovative roles to reflect skills available and opportunities to recruit**
- **Create opportunities to develop, train and retain our staff**

Happy & Healthy Workforce
We recognise that the capacity to care for our patients is reliant on our staff wellbeing. We are committed to care for our people and support them in maintaining resilience and wellbeing.

- **Ensure all staff are treated equally with respect and have access to the same opportunities**
- **Create a health and wellbeing culture #TeamBTH**

Learning Culture
We will engage & empower staff in their education and learning. We will encourage the development of psychological safety and constructive challenge to improve patient and staff experience

- **Create a culture of improvement and education**
- **Create a culture that facilitates freedom to speak up and listening into action**
- **Build leadership through development**

SUMMARY OF OUR OBJECTIVES

Our Population
We will work with our population to **co-produce high quality services** with a key focus on preventative care and reducing health inequalities

Health Inequalities
Address inequalities in access, experience and outcomes of our care.

- **Embed equity into our delivery plans**
- **Build insights into health inequalities**
- **Build understanding of health inequalities**

Integrated Care
We will deliver on our commitment to co-produce integrated care, working with our health and social care partners and patients to influence neighbourhood plans.

- **Co-produce services improvements and redesign to improve access and timeliness to care**
- **Deliver as a system partner**
- **Enhance and integrate community services to support right care, right place, right time.**

Prevention & Health Promotion
Prioritise prevention, patient activation and early detection of illness in disadvantaged groups.

- **Make Every Contact Count (MECC)**
- **Actively support patients to improve health outcomes and reduce health inequalities**

SUMMARY OF OUR OBJECTIVES

Our Responsibility
We will work with partners to deliver high quality, financially **sustainable services** and reduce our environmental impact

Get the Basics Right
Work collaboratively with our partners to improve quality of care and becoming a CQC Good Rated organisation.

- **Strategically align the organisation**
- **Achieve Quality Standards and accreditations**
- **Deliver the financial viability programme**

New Ways of Working
Use Transformation, Digital, Innovation and Research to deliver new efficient models of care to widen access, enhance health promotion and improve our environmental impact.

- **Enhance our digital and data infrastructure**
- **Maximise the efficient use of estates**
- **Transform and Innovate**
- **Enhance Active participation in Research**

Investing in our Community (Anchor)
Choose to work collaboratively across the system with our partners and communities to positively impact beyond health care.

- **Deliver the Green Plan Priorities**
- **Co-design an Anchor Framework**

ABOUT US

Blackpool Teaching Hospitals NHS Foundation Trust is situated on the west coast of Lancashire, with its main services and settings covering the local authority areas of Blackpool, Fylde and Wyre. The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS) which as a whole includes a total population of about 1.6 million people. As well as acute services provided in three main hospitals to around 350,000 local residents, the Trust is a provider of specialist tertiary care for Cardiac and Haematology services across this region, delivers a wide range of community health services to over 445,000 residents including those in North Lancashire and hosts the National Artificial Eye Service across England. In addition, the Trust provides urgent and emergency care services to a further estimated 18 million people who visit the seaside resort of Blackpool each year.

Trust services are provided from the following main sites:

- Blackpool Victoria Hospital
- Clifton Hospital
- Fleetwood Hospital
- Whitegate Health Centre
- Lytham Road Primary Care Centre
- South Shore Primary Care Centre
- Fleetwood Primary Care Centre
- Moor Park Health and Leisure Centre
- National Artificial Eye Service

Atlas

We host a subsidiary company Atlas that provides Estate services and management across the Fylde Coast.

Blue Skies

We are the Corporate Trustee for the Blue Skies charity supporting the best in patient care and medical research for the Blackpool, Fylde and Wyre area.

ANNUAL STATISTICS

As a regional centre and key tourist hot spot, we provide care to a significant number of people both from within and outside our local area.

75,000 people seen in A&E
2,900 Urgent Care Visits
118,000 Walk in Attendances

800 beds across Blackpool Victoria and Clifton Community Hospital

400,000 Outpatients Supported
5,000 Elective Inpatients
50,000 Day Cases
50,000 Emergency Inpatients

400,000+ population across Lancashire & South Cumbria
354,000 Registered Fylde Coast Health and Care population

7,521 Staff
68 Nationalities

£475M Annual Turnover

OUR POPULATION

Approximately 333,000 people live in the Fylde Coast, making up the core population served by the trust. Demographic data highlights the older age of the population, with more than a quarter of the population in Fylde and Wyre aged 65 and over. This creates pressure for health services and will continue to do in the future as the population ages. By 2027, the population aged over 65 will be more than double that aged 0 to 15 years in Fylde and Wyre. By 2027 the population in Blackpool aged over 65 years will exceed those aged 0 to 15 years. There is little ethnic diversity across the Fylde coast; 97.4% of the population were recorded as white British at the last Census, compared with 85.9% nationally.

OUR KEY CHALLENGES

Health Inequalities

The Fylde Coast is an area of contrast; there are high levels of deprivation in Blackpool, which experiences the greatest deprivation of all of England's local authorities. There are pockets of deprivation in Wyre, notably Fleetwood, but also areas of affluence. Fylde is generally less deprived than other parts of the country. Deprivation has an impact across life, reducing life chances and leading to poor health outcomes. Inequalities begin from the start of life. In Blackpool, 21% of women smoke at the time of delivery, 13.3% in Fylde and Wyre, compared to 9.6% nationally. Babies born in Blackpool have the lowest life expectancy in England. The life expectancy of babies born in Wyre is also below the national average and is like the national average in Fylde. A quarter of children in Blackpool live in low-income families; if Blackpool had a similar rate to the national average, there would be 1,500 fewer children living in relative poverty . A lower proportion of children in Fylde and Wyre live in low-income families, but still 14.4% and 17.1% respectively.

Patterns of inequality persist through life, with lower than national rates of educational attainment in Blackpool but similar or better rates in Fylde and Wyre. The availability of social connection is an asset for health, with those who have social links less likely to become ill and more able to cope and recover if they are ill; 29.3% of adults experience loneliness in Blackpool, compared to 22.3% nationally. Again, inequalities are present as the rates of loneliness are lower in Wyre (23.5%) and particularly low in Fylde (16.9%).

Deprivation is linked to poor health behaviours and rates of obesity, smoking and alcohol consumption are high in Blackpool. In addition, people in deprived communities may find it more difficult to access health services, and this is shown in lower rates of screening and lower rate of early cancer diagnoses. Rates of obesity, smoking and alcohol consumption in Fylde and Wyre and like the England average, but rates of screening are low in both districts and the rate of early cancer detections is low in Wyre.

Inequalities experienced throughout life present in mortality rates; rates of early death from preventable causes such as cancers, respiratory and cardiovascular disease and alcohol and drug related deaths are higher than national rates in Blackpool and Wyre. Early death rates in the less deprived Fylde are in line with national averages.

OUR KEY CHALLENGES

Financial Challenge

In 21/22 the operating income and expenditure is circa £580m which means the Trust is forecasting financial breakeven. The 22/23 budget setting is in progress and discussions with the ICS and system partners continue to establish the share of system resources required to deliver a balanced financial plan but the estimated spend is similar to 21/22. An indicative cost savings target of £21m has been set but this may change should the Trust increase investment necessary to meet patient demand and reduce the elective waiting list. Delivery of the financial plan will ensure the Trust maintains a healthy cash balance and facilitates a planned capital investment of circa £34m but this is dependent the Trust receiving a share of system capital resources to support the proposed investment.

Across Lancashire and South Cumbria the health system is "over funded" which means system resource will gradually be reduced over the next few years to bring the system back in line with expected spend. The underlying deficit of the Trust is circa £150m which has been supported by non recurrent funding, this non recurrent funding will reduce over time.

It is expected that cost savings of around 3% to 5% will be required to bring the Trust back into financial balance and it is vital that we deliver a position of breakeven or better for the foreseeable future. Delivery of the financial plan will not require any further working capital loans and allow the Trust to continue to invest in capital developments.

The demand for services and the way services are delivered by the Trust and its partners will impact on the financial performance and its ability to achieve savings and invest in services. It is important that we deliver services as efficiently and effectively as possible, reducing waste and removing duplication.

OUR KEY CHALLENGES

Quality & Safety Challenge

In 2019, the Trust was placed in "challenged provider status" by its regulator due to safety concerns regarding mortality, staffing and patient access targets. The Trust has been working closely over the last two years with the regulator to undertake key actions for improvement. In July 2021, following the new NHS England and Improvement System Oversight Framework, the Trust was rated as SOF level 3 against five key themes:

1. Quality of care, access and outcomes
2. People
3. Preventing ill-health and reducing inequalities
4. Leadership and Capability
5. Finance and Use of Resources
6. Local Strategic Priorities

SOF level 3 identifies the Trust as having "significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the [Foundation Trust] license".

In December 2021, the Trust received an overall CQC rating of Requires improvement.

Since being placed in Challenged Provider Status the Trust has made significant improvements against key areas, including mortality but recognises that more work needs to be done. The Trust's five-year strategy focuses on partnership working, co-production of high-quality services whilst recognising that empowering staff is key to sustain and continue improving.

FACTS AND FIGURES

Indicator	Blackpool	Fylde	Wyre	England
Male life expectancy at birth	74.1	79.9	77.8	79.4
Female life expectancy at birth	79.0	82.9	82.3	83.1
Children in relative low income families (%)	24.9	14.4	17.1	19.1
Adult loneliness (%)	29.3	16.9	23.5	22.3
Under 18 conceptions (rate per 1,000)	31.1	12.0	18.7	15.7
Smoking status at delivery (%)	21.4	13.3	13.3	9.6
Prevalence of overweight and obesity (year 6) (%)	41.5	29.7	N/A	35.2
Excess weight in adults (%)	71.6	66.9	62.7	62.8
Physically active adults (%)	62.0	68.9	62.9	66.4
Smoking prevalence in adults (%)	19.8	5.5	7.3	12.1
Alcohol related harm (<18) (rate per 100,000 population)	722	493	521	456
Estimated diabetes diagnosis rate (%)	79.4	67.4	74.2	78
Early cancer diagnosis rate (%)	49.0	54.5	51.1	55.1
Bowel cancer screening coverage (%)	53.7	63.6	63.5	65.2
Infant mortality (rate per 1,000)	5.4	2.3	3.3	3.9
Under 75 mortality from preventable causes (rate per 100,000 population)	265.2	135.5	164.8	142.2
Hip Fractures in people aged 65+ (rate per 100,000 population)	588	548	520	529

FACTS AND FIGURES

Key Investments

Over the last five years, the Trust has invested circa £112m into capital developments covering buildings, equipment and IT. This has been funded both by the Trust through internally generated depreciation and capital allocations (Public Dividend Capital) from the Department of Health. This sustained investment has enabled services to maintain and enhance the delivery of high quality care .

Examples of Key Investments we have made:
Endoscope Decontamination development
Clinical Utilisation Reporting system
Obstetric Theatre development
Redesign A&E
Vanguard - Care Home connect
Wireless network Infrastructure
Beds
Cardiac Draeger Monitoring
IMS Maxims
Electronic Patient Management EPMA
Cardiac Heart Lung Machines
Theatre Equipment
MRI Machines
Endoscopy development
Cardiac Catheter Laboratory Emergency Village Modular Ward
Digitisation
Scanning

STRATEGIC CONTEXT

The Changing NHS Landscape

Blackpool Teaching Hospitals NHS Foundation Trust plays a key role as part of the Lancashire and South Cumbria Integrated Care System (ICS), Lancashire and South Cumbria Provider Collaborative Board (PCB) and Fylde Coast Place Based Partnership (PBP). Across England, 42 Integrated Care Systems have been established with the intention to achieve integration across health and care services to improve population health, reduce health inequalities, support productivity and sustainability of services and to support social and economic developments.

In February 2021, the Department of Health and Social Care put forward legislative changes to the Health and Social Care Bill that see Integrated Care Systems as statutory bodies from July 2022. This Bill sets out the new functions and responsibilities of the ICS including the ability to delegate to place based partnerships (PBPs) and provider collaborative boards (PCBs).

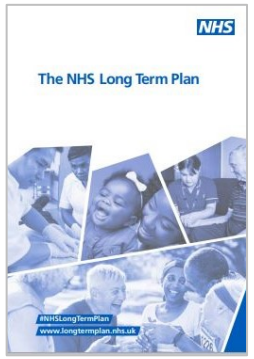
In response to the establishment of new statutory bodies, NHS England and NHS Improvement have introduced a new NHS System Oversight Framework (2021/22) for systems and NHS Trusts.

This means that over the next five years, as this landscape is formalised, we will need to think differently about how we deliver care for our local population

STRATEGIC CONTEXT

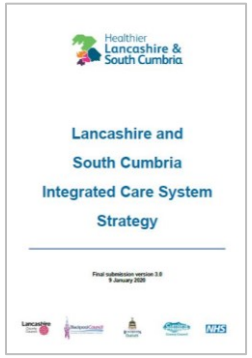
The Trust's five-year strategy should be considered in the context of the national and local strategies and the changing NHS landscape. We expect our five-year strategy to be organic and flexible to respond and re-prioritise where needed. We will review and refresh our strategy annually or sooner where needed.

Key National and Local Strategies



The NHS Long term plan (LTP)
Released in January 2019: sets out the national priorities that the NHS will deliver over the next ten years.

Our vision to "improve the lives of people who live, work and volunteer within the Fylde coast and beyond" naturally aligns to these key strategic documents.



Lancashire & South Cumbria Integrated Care System (ICS) Strategy
Released in January 2020: sets out how health and care partners across the ICS will work together to deliver a new way of working to achieve the vision of healthy local communities where people will have the best start in life, so they can live and age well.

Fylde Coast Integrated Care Partnership [now Place Based Partnership, PBP]
Released in August 2020: looks at the challenges we are facing across the Fylde Coast and how we will tackle them as a partnership so people in the Fylde Coast have longer, healthier lives.

STRATEGIC CONTEXT

Underpinning Strategies

We have developed three key strategic aims to support the delivery of our vision:

"We will improve the lives of people who live, work and volunteer within the Fylde coast and beyond"

A number of strategies already exist nationally and locally. It is important that our strategy aligns and we have plans that underpin the alignment to our local priorities.

Our People	**Our Population**
We will widen access to job opportunities, becoming the employer of choice within our community with an empowered, diverse and engaged workforce	We will work with patients to co-produce high quality services with a key focus on preventative care and reducing health inequalities
Underpinned by: • The NHS People Plan (2020) • Trust Quality Improvement Strategy (2019) • NHS Model Employer Strategy (2019)	**Underpinned by:** • The NHS Patient Safety Strategy (2019) • NHS Long Term Plan (2019) • NHS Food Standards (2014) • Integration and Innovation: working together to improve health and social care for all (2021)
Our Responsibility We will work with partners to deliver high quality, financially sustainable services and reduce our environmental impact	
Underpinned by: • Health Infrastructure Plan (2019) • Delivering a 'Net Zero' National Health Service (2020) • Lancashire and South Cumbria ICS Strategy (2020) • Fylde Coast ICP Strategy (2020) • NHS e-procurement strategy (2014) • Data Protection Act- a communications strategy and implementation plan (2018) • Prevent Strategy (2011) Counter-Terrorism and Security Act (2015)	

OUR PEOPLE

Priority 1: Grow Our Own

We want to maximise the benefit of our diverse local community to grow our own future workforce and create local health and wealth and we will do this through:

Target opportunities to widen access to jobs for future generations

Blackpool is ranked rank 313 out of 324 local authority areas against the index of social mobility. This means that young people living in deprived areas may miss out on the same opportunities offered in wealthier locations. The UK government identified Blackpool as an "opportunity area" to provide every child and young person in the area with the chance to reach their full potential in life. To benefit from our diverse local community, we need to:

- Improve the awareness of the diverse career opportunities and career progression we have to offer. Children and Young People who engaged in this strategy development said that from Year 8, they would like to start engaging in annual career conversations in health care.
- Ensure that staff and school leavers are aware of the diverse career opportunities in the NHS and the career progression we offer.
- Develop entry level opportunities and pathways in all areas of the organisation, from the staff restaurant to facilities and estates.

Creating attractive innovative roles to reflect skills available and opportunities to recruit

As a coastal community, Blackpool is challenged with recruiting and retaining health and social care staff. The Chief Medical Officers Annual Report (2021), shows that coastal communities, like the Fylde Coast, have 14.6% fewer postgraduate medical trainees, 15.0% fewer consultants and 7.4% fewer nurses per patient. To address this, we need to:

- Develop opportunities to incentivise qualified workers to come and work for Blackpool Teaching hospitals
- Develop new ways of working to fill existing vacancies through skill mix reviews, new models of care and applying flexible entry requirements.

Create opportunities to develop, train and retain our staff

We recognise that to grow and develop our staff, we need to equip them with the key skills and opportunities to fulfil their potential. To do this we need to:

- Develop career pathways from novice to expert across all clinical and non-clinical specialties
- Develop a talent and succession planning programme to identify future leaders
- Work with Universities and Higher Education Institutions to deliver courses closer to the Fylde Coast

We recognise that not all training opportunities to develop new skills are available locally. Staff will often move to areas where they can train and develop their skills. We will identify opportunities to deliver training and education closer, supporting trainees to establish roots in the local area. We will do this by working with local providers to understand what opportunities are available, particularly in harder to recruit areas.

Importantly, we also need to make sure our internal processes help and support staff to achieve their potential. We will improve our appraisal systems and align them to the Trust strategy and introduce all new starters to our Trust strategy, aims and priorities.

OUR PEOPLE

Priority 2: Happy & Healthy Workforce

We recognise that the capacity to care for our patients is reliant on our staff wellbeing. We are committed to care for our people and support them in maintaining resilience and wellbeing.

Ensure all staff are treated equally with respect and have access to the same opportunities

The principles of equality and inclusion are at the heart of everything we do and all that we stand for and we are committed to developing a workforce that is representative to the population we serve.

Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included.

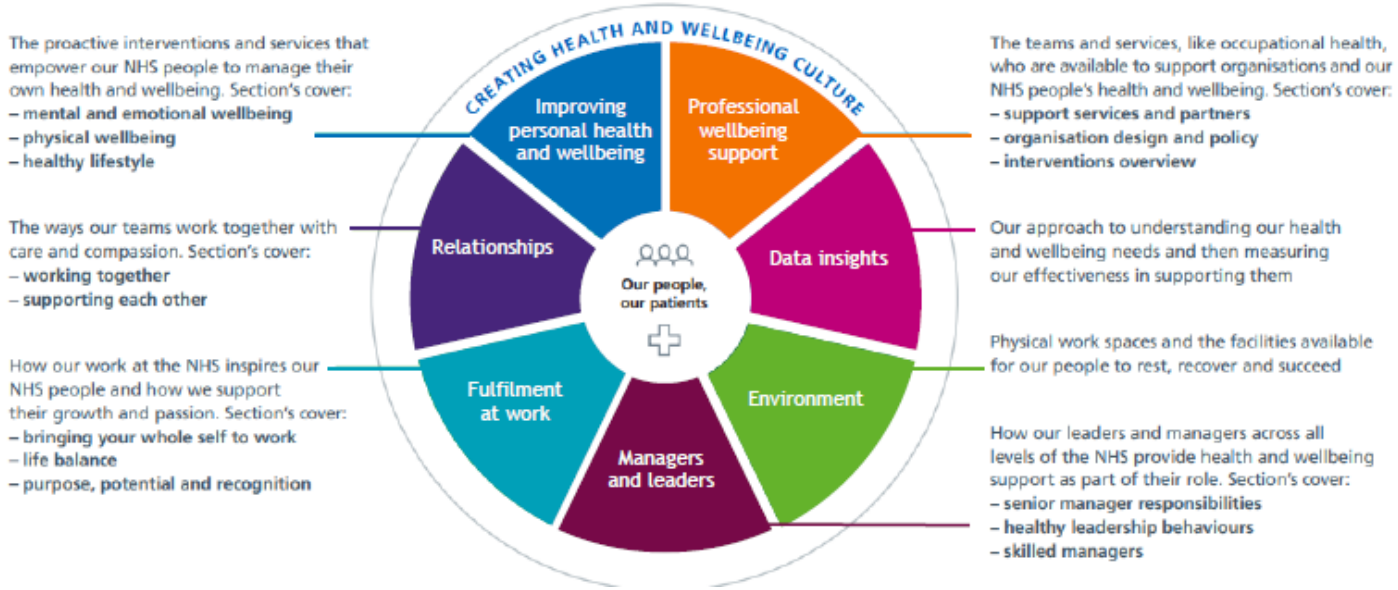
We want to ensure that Equality, Diversity and Inclusivity are considered in all our processes, procedures and interactions.

Create a health and wellbeing culture #TeamBTH

Our health and wellbeing model is rooted in psychological prosocial behaviour. Prosocial refers to an employee's helpful behaviour toward other individuals or the organisation. This behaviour is beneficial for the people to whom it is directed (individuals or the organisation) and is a great measure for organisational effectiveness. Prosocial psychology is a model we want to use to improve the health and well being of our staff to develop a safe, effective and sustainable organisation, for everyone, everyday.

The Trust has introduced a health and wellbeing model that sets out what we will focus on:

- **Improving personal health and wellbeing**, to support and encourage our people to manage their own health and wellbeing
- **Relationships**, focusing on the way our teams work together and support each other.
- **Fulfilment at work**, supporting growth and passion
- **Managers and leaders**, developing healthy leadership behaviours and skilled managers
- **Environment**, having a safe place to rest, recover and succeed
- **Data insights**, measuring how effective we are at improving health and wellbeing needs
- **Professional wellbeing support**, designing support services for staff



OUR PEOPLE

Priority 3: Learning Culture

We will engage & empower staff in their education and learning. We will encourage the development of psychological safety and constructive challenge to improve patient and staff experience

Create a culture of improvement and education

In 2019, the Trust launched its Quality Improvement Strategy that set out three key aims:

- To reduce avoidable harms
- To improve mortality
- To improve the last 1,000 days of life

These aims remain important to us as we build a culture of continuous improvement and equip staff with the skills so that they feel empowered to make key changes to how patient care is delivered.

As a Teaching Hospital, education is a priority to build the capability and skills in our workforce. To do this, we want to work with key staff groups to look at opportunities for entry level placements and to develop our existing workforce.

Create a culture that facilitates freedom to speak up and listening into action

To improve our services for patients and to ensure staff have a safe and effective working environment, it is important that they feel empowered to speak up about anything that gets in the way of doing a great job. To do this we need to strengthen our "Freedom to Speak Up" approach. The National Guardian's Office leads, supports and trains a network of Freedom to Speak Up Guardians who were created as a result of the Francis Report "The Freedom to Speak Up" (2015). This report suggested that NHS Culture did not always encourage or support workers to speak up.

To become a learning organisation, we will empower our staff to speak up and have the mechanisms in place to listen and take action. Speaking up not only improves patient care and safety but also helps to tackle bullying and discrimination, which is vital for the health and wellbeing of our workforce.

We will enable staff to have the confidence and skills to take ownership of and appropriately respond to concerns raised about their services alongside delivering continuous improvement.

Build leadership through development

Our Managers and leaders play a vital role in inspiring future generations, leading successful teams and improving organisational culture. In 2021, we changed our divisional structure and created new triumvirates. We have also invested in corporate deputy roles and now need to invest and develop these roles to improve operational performance, culture and patient outcomes.

Our People Success Measures

- Increase the number of staff employees at the Trust who live in the local area.
- All school leavers to have knowledge of career pathways in the NHS.
- Increased staff retention rates to above national average.
- Improved staff engagement survey results
- Improve patient experience satisfaction levels
- Substantively fill all our vacant positions
- All staff trained in Quality Improvement
- Achieve WRES Standard

OUR POPULATION

Priority 4: Health Inequalities

We will address inequalities in access, experience and outcomes of our care

Embed equity into our delivery plans

Addressing health inequalities is key to our elective delivery programme. We must ensure inclusive accessibility to care. We will reduce inequities in care experienced as a result of deprivation, disability and/or ethnicity.

Nationally, to support the reduction of health inequalities the CORE20PLUS5 programme has been established. Local systems are asked to define a target population cohort 'Core20PLUS' and target '5' focus clinical areas for accelerated improvement :

- Maternity
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding

We will work with our system partners to deliver the CORE20PLUS5 objectives. We will reduce health inequalities in the most deprived and excluded groups to tailor health services to improve access and outcomes to care.

Build insights into health inequalities

To embed equality into our delivery plans we need to make sure our services have access to health data. Over the next year we will develop ways to capture data and information on health inequalities to support action, measure improvement and provide assurance across the trust.

Using this data, we will be able to work with our system partners to develop an approach to population health. Using new data, we will build an understanding of health inequalities in relation to our population, services and staff and co-produce changes to improve health outcomes for all.

Build understanding of health inequalities

To reduce health inequalities across our services we will equip our staff with the knowledge and tools to address health inequalities in their services. To do this we will offer training to all staff on health inequalities and the use of methods such as Health Equity Assessment Tools to enable leaders and staff to apply a health inequalities lens to clinical areas and patient access, experience and outcomes.

Once we have built insights and an understanding of health inequalities we will co-produce improvement programmes to address them.

OUR POPULATION

Priority 5: Integrated Care

We will deliver on our commitment to co-produce integrated care, working with our health and social care partners and patients to influence neighbourhood plans.

Co-produce services improvements and redesign to improve access and timeliness to care

Across the organisation we have pockets of outstanding practice where staff and patients are actively engaged in service redesign and improvement. By developing a model of co-production we will equip staff and teams with the skills and knowledge to ensure patients, carers, volunteers, governors and the general public are active participants in care.

We know that we do not always engage with patients who are representative of the population we serve. We will develop ways to widen participation in designing services, including seldom heard groups.

We will listen to our patients to ensure that we design care to ensure that access is provided in the right way and use digital mean, where appropriate, or where needed.

Deliver as a system partner

The NHS landscape is changing, and we, as an acute and community service provider need to play our part as a system partner. Over the coming years the establishment of the Integrated Commissioning Board, Provider Collaborative Board and Place Based Partnership will create the opportunity to deliver improvements for population health.

Alongside our partners in Lancashire and South Cumbria we will participate in clinical and non-clinical transformation work that will support the delivery of safe, effective and sustainable high-quality care.

Enhance and integrate community services to support right care, right place, right time.

We know from feedback that health and social care needs to be more integrated, making it easier for our patients and their carers to navigate.

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It reduces traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

As an organisation, with our place-based partners we have committed to prioritising the redesign of four key pathways:

- Frailty
- Respiratory
- Urgent & Emergency Care
- Medical High Care

Over the next five years, we will commit to integrating these pathways to improve patient experience and outcomes.

OUR POPULATION

Priority 6: Prevention & Health Promotion

We will prioritise prevention, patient activation and early detection of illness in disadvantaged groups

Make Every Contact Count (MECC)

Our ambition is to train all staff to make every contact count. We will work with partners to increase the support available for people to manage and improve their own health and wellbeing. Making every contact count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that the NHS and people have with other people to encourage changes in behaviour to have a positive effect on the health and wellbeing of individuals, communities and populations.

Many long-term conditions are linked to behavioural risk factors. Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health.

The NHS Long Term Plan reminds us that every 24 hours the NHS comes into contact with more than a million people. This brings home the personal impact of ill health.

Actively support patients to improve health outcomes and reduce health inequalities

Health and wellbeing is determined by a range of factors, some are social, some are economic, and some are environmental. Sometimes, to improve health and wellbeing, NHS treatment is not the answer.

We will work with our partners to understand the activities available in our local communities to support staff to refer patients onto other services or support groups. For example, social prescribing is a term used to describe how health professionals can refer to local, non-clinical services such as housing, debt support, befriending, exercise or learning groups. Social prescribing supports those who are isolated, experience mental health conditions or have longer term health conditions.

As a health care provider, we will bring these local non-clinical services closer to health services and we will maximise the opportunities to do this with our partners, patients and local communities.

Our Population Success Measures

- All staff trained in MECC Conversations
- Increase referrals to social prescribing
- Increase referrals to lifestyle services
- Reduce Inequality to access for those from deprived localities
- Equivalent access to services across deprivation groups
- Equivalent outcomes from services across deprivation groups
- All staff trained in health inequalities
- Increase in specialties applying tools such as HEAT to inform improvements

OUR RESPONSIBILITY

Priority 7: Get the Basics Right

We will work collaboratively with our partners to improve quality of care and becoming a CQC Good Rated organisation.

Strategically align the organisation

For this strategy to be embedded we will align plans to achieve our aims and objectives, creating a golden thread throughout the organisation. Over the next year we will establish corporate and divisional plans that will set out the key actions to deliver the strategy. The Trust will embed an annual planning cycle to refresh these plans.

There are some key strategic plans we need in place to support delivery:

- Education, Research and Innovation Plan
- Estates Plan
- Digital Plan
- People plan
- Quality Improvement Plan
- Green Plan

Achieve quality standards and accreditations

The Trust is rated as "requires improvement" by the CQC with variation in ratings across our sites. Ongoing action plans are in place to address key concerns raised and our key objective is to achieve a minimum rating of "good" in the next five years.

We will focus on achieving key quality standards, benchmarks and accreditations:

- Implementing all actions aligned to Better Births, Ockenden and Continuity of Carer
- Quality accreditations in place across all wards and services, with key action plans in place to address any concerns
- Getting it Right First Time (GIRFT) plans in place for all identified specialties and included in regular performance reporting

The Trust will continue to monitor and benchmark itself against national data. We will work within our provider collaborative for peer support and reviews to facilitate the levelling up of service quality across Lancashire and South Cumbria.

Deliver the financial viability programme

Future Focus Finance (FFF) is a national programme designed to support staff by engaging everyone in improving NHS finance. It aims to recognise NHS organisations that have the best finance skills development practices in place.

At Blackpool Teaching Hospitals, we have been accredited, through peer review, with a level 1 FFF accreditation. Over the next five years we will achieve the highest level 3 accreditation.

As a system, Lancashire and South Cumbria is challenged financially. We need to work smarter and make better use of digital and partnership working to ensure we are sustainable and fit for the future. We will reduce our agency spend by improving our workforce design to deliver services with the skills available. We will work with partners to reduce duplication, transform and streamline services and maximise the use of community partners.

We will establish key transformation programmes, working collaboratively within the Lancashire and South Cumbria Provider Collaborative Board and the Fylde Coast Place Based Partnership Board.

OUR RESPONSIBILITY

Priority 8: New Ways of Working

We will use Transformation, Digital, Innovation and Research to deliver new efficient models of care to widen access, enhance health promotion and improve our environmental impact

Enhance our digital and data infrastructure

We will make our care pathways more streamlined and accessible by investing in our digital infrastructure. We will improve access to information for all, including patients, to improve experience and outcomes. To make improvements we will enhance our digital and data infrastructure by:

- investing in an electronic patient record, to enable us to share health care information
- Achieving a minimum level of digital maturity

We will develop different ways to deliver services. The NHS long term plan sets out the ambition to reduce face to face appointments. We will embrace technology, where appropriate, and work with patients and carers to deliver services such as virtual outpatients and wearable technology. We will offer ways to access health advice quickly by implementing patient initiated follow up (PIFU) and offer advice and guidance (A&G) via primary care providers.

Transform and innovate

As part of our strategy development, we will co-produce a vision for a clinical model and understand what this means to all services we deliver. We will design and embed a process to facilitate:

- Population health needs assessment
- Capacity and demand review of all our services
- Workforce reviews to understand the skill mix we have, vacancies and new workforce models

As part of this work, we will undertake deep dives into key services to understand challenges and opportunities. This will support the delivery of our strategy and set out a path to deliver our future clinical model.

Maximise the efficient use of estates

We know from feedback that access to our sites can be difficult and that there are more suitable local community facilities available.

We will rebalance our provision in the community, working with our patients and system partners. We will develop community diagnostic hubs, revise current pathways and review how and where care is provided through an estates review and co-produce and share an updated capital plan.

We know that access to our sites can be challenging and as part of our commitment to reduce health inequalities we will work with our Fylde Coast partners to make sure we have the right transport infrastructure to support access to services.

Enhance active participation in research

Clinical research is the backbone of healthcare innovation, improving the prevention, detection, diagnosis and treatment of disease, improving patient outcomes and saving lives. The treatment and support we provide our patients at Blackpool will, at some point, have been developed through clinical research.

Blackpool is one of five national NIHR patient recruitment centres set up to deliver late phase commercial trials. Each year we run over 100 high quality clinical research studies led by experienced research clinicians, overseen and supported by highly trained research nurses, administrators underpinned by an expert research management and governance team. The Trust is also a member of the NIHR Clinical Research Network Northwest Coast and the NIHR Applied Research

Collaboration, where together we work with academics and other health and social care providers to help tackle health inequalities through translating research into practice.
Over the next five years we want to:

- Make clinical research accessible to all
- Offer research addressing health inequalities
- Enable research through data and digital tools
- Develop and maintain a supported research workforce
- Work towards the attainment of University Hospital status
- Achieve recognition as a UK centre for research excellence

OUR RESPONSIBILITY

Priority 9: Investing in our Community (Anchor)

We will work collaboratively across the system with our partners and communities to positively impact beyond health care.

Deliver the Green Plan Priorities

The NHS has committed to a target of 'net zero' in less than 25 years. As one of the largest organisations and employers in the Fylde Coast we have a significant environmental impact. We have the opportunity to make a positive difference in both carbon emissions and population health.

Having a clear and intentional plan will allow us to focus on and manage our impact on the environment, whilst improving quality and access to services for those who need them.

Over the next five years we will set up the processes and governance to deliver our Green plan which aims to:

- Achieve net Zero by 2040 for direct emissions
- Contribute to all the UN sustainable development Goals, achieving 70% rating in our sustainable assessment tool by 2025

Co-design an Anchor Framework

"Anchor Institution" is a term used to describe organisations that are unlikely to relocate due to their connection with the local population, such as schools, councils and health care providers. Blackpool Teaching Hospitals is an anchor institution and as such, we have the opportunity to positively influence the social, economic and environmental conditions in our community to promote health, wealth and wellbeing.

To do this we will:

- Co-design an anchor framework to identify how the trust can generate social value to local communities and staff.
- Work with our partners across the Fylde Coast to identify opportunities to create local wealth and health

Our Responsibility Success Measures

- Reduce Agency Spend
- Deliver QEP Programme Targets
- Breakeven by 2025
- Achieve CQC Inspection Rating of Good
- Fully established accreditation system in all wards and services.
- Achieve national performance and improvement targets
- Achieve upper quartile performance against national benchmarks
- Achieve (HIMSS level 5)
- Pay suppliers in 90 days
- Achieve level 3 Future Focus Finance Accreditation
- Net Zero by 2040 for direct emissions
- Achieve 70% rating in our sustainable assessment tool by 2025

BRINGING THE STRATEGY TO LIFE

Stacie Johnson, Registered Nurse and Shortlisted Rising Star

Grow our own

Stacie joined the Trust in 2011 as a Health Care Assistant on Ward 10. Stacie really enjoyed her role and working as part of a close knit and supportive team though felt she had more to give. Supported by Ward Manager Lynette Reid and mentored by Tracy Turner and Gareth Burns, Stacie undertook Assistant Practitioner Training from 2015-17. Stacie loved the additional scope and responsibility that this role allowed – being able to cover all duties except medication. When she was recommended for a place on the Trust's first nursing apprenticeship cohort, Stacie accepted the opportunity and completed her university studies in December 2021 and receiving her PIN in March 2022. This was a great achievement not only for Stacie but for the Trust's ambition of "growing our own" to retain staff, develop talent and help ease staffing pressures.

Stacie has spent the whole of her Trust career working within the respiratory service and has paid tribute to the brilliant team she works alongside who have helped her to develop in ability, skillset and confidence; commenting: "The Trust has given me massive opportunities to undertake further training and progress in my career. I love my job and come to work happy every day."

BRINGING THE STRATEGY TO LIFE

Community Podiatry (George Rogers/ Emma Phillips)

Prevention & Health Promotion

Happy & Healthy Workforce

The Fylde Coast had the highest rate of foot amputations in the UK. In 2016 the Trust was subsequently awarded transformation funding to tackle this challenging issue. The original intent was to recruit more medics, however there were already vacancies for medical staff hence the Chief AHP suggested an alternative approach upskilling our podiatry workforce and developing a multidisciplinary team in line with NICE Guidance. Four Advanced Podiatrists were recruited (two externally and two through internal development), additional training was provided to all staff training and additional equipment was procured.

An MDT was developed including Consultant Diabetologists, Vascular and Orthopaedic Surgeons, Microbiologists, and Radiologists and a clinical pathway was subsequently developed to escalate and step-down patients between community and acute settings.
This initiative has been highly successful with data evidencing a significant reduction in amputations and waiting times from 11 weeks to 1 week.

An unexpected benefit was the improvement in the cultural climate. As an example; in the 2021 National Staff Survey; 100% of respondents agreed that their role makes a difference to patients and service users and feel trusted to do their job.

BRINGING THE STRATEGY TO LIFE

Community Sexual Health Services Digitisation

New Ways of Working

The pandemic accelerated the need to reach patients by a more accessible means; and the sexual health team responded by introducing 2 key initiatives:

i) Remote full STI screening kits

The team introduced completely remote testing kits which patients order online as an alternative to making an appointment in clinic. This approach has have proven to be really popular with15,500 self-test kits processed during 2020-21 and over 18,500 during 2021-22 YTD across the Lancashire wide sexual health footprint.

i) E-contraception

Sexual Health Services have undertaken a soft launch of e – contraception which currently enables existing patients to order repeat supplies of progesterone only contraception online to be delivered to their home address using tracked mail or collected from a clinic of their choice. The process allows the clinical information given by the patient online to be entered directly into their electronic patient records and onto the appointment screen using Blue Prism Technology. Benefits of the new system are that it improves access to contraception, reduces the complexity of the patient journey, and frees up consultations in clinic for new patients or those with more complex needs. Looking forward the service plan to increase the range of contraception available to request online.

A third initiative is in the pipeline – a Chatbot function which will be launched on the sexual health service website to enable patients to ask a range of questions about their sexual health and contraceptive needs.

OUR STRATEGY ROADMAP

Our Trust strategy sets out ambitious aims for the next five years. We must address our workforce, quality, safety and finance challenges by:

- responding to regulatory action
- aligning our strategy to address our biggest risks
- meeting national and local expectations

We recognise that first and foremost we need to get the basics right to deliver our Trust mission of delivering safe, effective and sustainable care for everyone, everyday.

The Trust has developed key actions plans and work programmes in response to the Care Quality Commission, national policies, operational planning guidance, challenged provider status (system improvement plan) and the Trust assurance framework. We have developed a delivery roadmap bringing together these programmes and laying the key foundations early to enable us to deliver our vision over the next five years.

We know that priorities change, and every year we will review and revise the strategy roadmap in line with national and local guidance and expectations.

The following Acronyms are used in the Road map to show alignment with the relevant action plans.			
SIP	Ops	BAF	CQC
System Improvement Plan	Operational Guidance	Board Assurance Framework	Care Quality Commission

OUR STRATEGY ROADMAP

Aim	Priority	Key Programme	22/23	23/24	24/25	25/26	26/27	SIP	Ops	BAF	CQC	Success Measure
Our People We will widen access to job opportunities, becoming the **employer of choice** within our community with an empowered, diverse and engaged workforce	**Priority 1** Grow our Own	Develop a school careers programme across the fylde coast for primary and secondary schools		✓	✓			●				Increase the number of staff employee at the Trust who live in the local area. All school leavers to have knowledge of career pathways in the NHS. Increase staff retention rates to above national average. Improve staff engagement survey results Improve patient experience satisfaction levels Substantively fill all our vacant positions All staff trained in Quality Improvement Achieve WRES Standard
		Develop career pathways from novice to expert across all clinical and non-clinical specialties	✓	✓	✓	✓	✓			●		
		Develop a talent and succession planning programme to identify future leaders.	✓	✓	✓	✓	✓		●	●		
		Develop an incentivised recruitment programme		✓	✓				●	●		
		Expand and develop our apprentice and school leaver workforce	✓	✓	✓	✓	✓		●			
		Work with local providers to understand opportunities to deliver new curricula.		✓	✓	✓						
	Priority 2 Happy & Healthy Workforce	Implement our People Plan and underlying plans on health and wellbeing	✓	✓	✓	✓	✓		●			
		Develop and maintain staff networks	✓	✓	✓	✓	✓	●			●	
		Develop an organisation prosocial model		✓	✓	✓	✓	●			●	
	Priority 3 Learning Culture	Implement a board development programme	✓					●			●	
		Trust values and behavioursal framework	✓								●	
		Expand our teaching hospital educational plan to deliver our strategic vision	✓									
		Implement a Triumvirate Development Programme	✓					●			●	
		All Staff to be trained in QI methodologies	✓	✓	✓	✓	✓	●				
		Develop a refreshed QI programme focusing on avoidable harm, reducing mortality and improving the last 1,000 days of life						●				
		Respond to key themes from national and local patient surveys and medical engagement surveys	✓		✓		✓	●				
		Review and improve our Freedom to Speak Up function for all staff groups	✓					●			●	

Aim	Priority	Key Programme	22/23	23/24	24/25	25/26	26/27	SIP	Ops	BAF	CQC	Success Measure
Our Population We will work with our population to **co-produce high quality services** with a key focus on preventative care and reducing health inequalities	**Priority 4** Health Inequalities	Capture data to make information available on health inequalities to support action, measure improvement and provide assurance across the trust.	✓	✓	✓				●			All staff trained in MECC Conversations Increase referrals to social prescribing Increase referrals to lifestyle services Reduce Inequality to access for those from deprived localities Equivalent access to services across deprivation groups Equivalent outcomes from services across deprivation groups All staff trained in health inequalities Increase in specialties applying tools such as HEAT to inform improvements
		Develop trust approaches to Core20Plus5 programmes, including participation in the hypertension community connector model pilot	✓	✓	✓				●			
		Develop opportunities for seldom heard groups to be active participants in service design and improvement	✓	✓	✓	✓	✓				●	
		Provide accessible information and communication support	✓	✓	✓	✓	✓		●		●	
		Provide training on health inequalities and the use of methods such as Health Equity Assessment Tools (HEAT) and Public Sector Equality Duty (PSED) tools.		✓	✓	✓	✓		●			
		Develop an approach to population health based on our understanding of health inequalities in relation to our population, services and staff, and implement with appropriate governance.		✓	✓	✓	✓		●			
	Priority 5 Integrated Care	Develop a toolbox for co-production for patients, carers, governors, staff and communities	✓	✓							●	
		Deliver wave 1 and wave 2 ambitions Community Diagnostic Hubs	✓	✓					●			
		Refine our directory of community services	✓						●			
		Contribute to the ambitions of the Provider Collaborative	✓	✓	✓	✓	✓	✓	●			
		Co-produce a child health strategy for our locality		✓								
		Deliver integrated care pathways for urgent and emergency care, respiratory, frailty, medical high care	✓	✓				●				
	Priority 6 Prevention & Health Promotion	Develop and implement a "Making Every Contact Count" programme		✓	✓	✓	✓		●			
		Develop person-centred, holistic models of care with a focus on prevention and self-care			✓	✓	✓		●			
		Provide proactive support for those on waiting lists to improve health and wellbeing and prevent harm	✓	✓	✓							
		Develop an Elective Care Patient Charter	✓						●			

Aim	Priority	Key Programme	22/23	23/24	24/25	25/26	26/27	SIP	Ops	BAF	CQC	Success Measure
Our Responsibility We will work with partners to deliver high quality, financially sustainable services and reduce our environmental impact	**Priority 7** Get the basics right	Develop annual strategy plans for divisions and corporate support teams with regular performance reporting	✓	✓	✓	✓	✓		●		●	Reduce Agency Spend Deliver QEP Programme Targets
		Make the changes required to deliver the CQC inspection action plan	✓	✓				●			●	Breakeven by 2025
		Implement all actions aligned to Better Births, Ockenden and Continuity of Carer	✓	✓					●			Achieve CQC Inspection Rating of Good
		Develop a supporting strategic plans for digital, estates and research and innovation that supports the implementation of the Trust strategy	✓									Fully established accreditation system in all wards and services.
		Establish an accountability and governance framework	✓					●			●	Achieve national performance and improvement targets
		Establish Improvement plans and oversight forums to achieve operational and transformation targets for outpatients	✓	✓				●	●	●	●	Achieve upper quartile performance against national benchmarks
		Work with teams and services to establish COAST accreditations	✓	✓	✓	✓	✓	●			●	Achieve (HIMSS level 5)
		Getting it Right First Time (GIRFT) plans in place for all identified specialties and included in regular performance reporting	✓	✓	✓	✓	✓				●	Pay suppliers in 90days Achieve level 3 Future Focus Finance Accreditation
		Develop and implement a medium term financial plan.	✓	✓	✓	✓		●		●		Net Zero by 2040 for direct emissions Achieve 70% rating in our sustainable assessment tool by 2025

Aim	Priority	Key Programme	22/23	23/24	24/25	25/26	26/27	SIP	Ops	BAF	CQC	Success Measure
Our Responsibility We will work with partners to deliver high quality, financially sustainable services and reduce our environmental impact	**Priority 8** New Ways of Working	Develop a new clinical model	✓									Reduce Agency Spend Deliver QEP Programme Targets Breakeven by 2025 Achieve CQC Inspection Rating of Good Fully established accreditation system in all wards and services. Achieve national performance and improvement targets Achieve upper quartile performance against national benchmarks Achieve (HIMSS level 5) Pay suppliers in 90days Achieve level 3 Future Focus Finance Accreditation Net Zero by 2040 for direct emissions Achieve 70% rating in our sustainable assessment tool by 2025
		Roll out capacity and demand planning across all specialties in both acute and community settings	✓	✓	✓	✓	✓		●			
		Ensure all staff who hold a patient case load have a standardised job plan	✓	✓	✓	✓	✓					
		Review and implement digital solutions to support patients in self-management and access to care.		✓	✓	✓	✓		●			
		Implement EPR		✓	✓	✓	✓		●	●	●	
		Deliver a high level of digital Maturity		✓	✓	✓	✓		●	●	●	
	Priority 9 Investing in our Community (Anchor)	Deliver the Green Plan Priorities	✓	✓	✓	✓	✓		●			
		Work with our partners across the Fylde Coast to identify opportunities to create local wealth and health	✓	✓	✓	✓	✓					
		Co-design an anchor framework to identify how the trust can generate social value to local communities and staff.	✓	✓								

IMPACT ASSESSMENT

	Impact		As-Is Risk Rating			Addressing the Risks	To-Be Risk Rating		
	What will the positive impact of this Strategy be in this area?	What will the negative impact of this strategy be in this area?	Consequence	Likelihood	Risk Score (C x L)	Mitigating Actions	Residual Consequence	Residual Likelihood Score	Residual Risk Score (C x L)
Patient Safety	The Trust strategy is underpinned by the National Patient Safety Strategy. This focuses on maximising the things that go right and minimising the things that go wrong. To key impact is to embed a learning culture throughout the organisation and refreshing our focus on quality improvement to reduce avoidable harms, reduce mortality and improve the last 1,000 days of life.	None Identified	5	3	15	Each division and corporate team will develop underpinning strategic plans that align to the organisational strategy, demonstrating a golden thread to ensure a positive impact is seen.	5	2	10
Clinical Effectiveness	Clinical effectiveness is doing the right thing, at the right time for the right patient. The Strategy commits to developing a new clinical vision and achieving the quality and accreditation standards to deliver high quality care.	None Identified	5	3	15	The Trust will roll out GIRFT plans for identified specialties and conduct service deep dives to identify areas for improvement, transformation and innovation.	5	2	10
Patient Experience	Patients will be more engaged in service change and will feel like there voice is heard and acted upon. They will be treated holistically with access to resources which will have a positive impact on the wider determinants of health, for example social prescribing.	None Identified	5	3	15	The Trust is developing a model of co-production to ensure that patients, carers and governors are involved in the production and design of services during service change.	5	2	10

IMPACT ASSESSMENT

	Impact		As-Is Risk Rating			Addressing the Risks	To-Be Risk Rating		
	What will the positive impact of this Strategy be in this area?	What will the negative impact of this strategy be in this area?	Consequence	Likelihood	Risk Score (C x L)	Mitigating Actions	Residual Consequence	Residual Likelihood Score	Residual Risk Score (C x L)
Staff Experience	The Strategy will create an environment where staff will have the freedom to speak up without the fear of reprisal. They will have access to health and wellbeing resources and a clear career development pathway across clinical and non-clinical areas.	None Identified	4	3	12	The Trust key priority is for a happy and healthy workforce and to develop a learning culture. Delivering against these priorities will improve staff experience which will be measured through staff satisfaction surveys, retention and our ability to recruit.	4	2	8
Targets/ Performance	The Strategy sets out the priority to build key leadership capability across the organisation. Leadership is key to delivering high performing organisations. The strategy sets out the priority to create new ways of working, using innovation, research and integrated care as means to improve services, which will have a positive impact on performance.	None Identified	5	4	20	The Trust will develop improvement plans to deliver the national performance targets and improvement targets.	5	2	10

IMPACT ASSESSMENT

	Impact		As-Is Risk Rating			Addressing the Risks	To-Be Risk Rating		
	What will the positive impact of this Strategy be in this area?	What will the negative impact of this strategy be in this area?	Consequence	Likelihood	Risk Score (C x L)	Mitigating Actions	Residual Consequence	Residual Likelihood Score	Residual Risk Score (C x L)
Inequalities	The purpose of the strategy is to actively identify, eliminate and/or reduce inequalities in access, experience and outcomes. We will do this in relation to the protected characteristics, geography and deprivation.	None Identified	4	4	16	The Trust will collect data to understand our inequalities, create population health plan and work with our partners to improve the social determinants of health. This will be supported by an anchor framework	4	2	8
Sustainability	The Trust strategy commits to reducing its carbon emissions and adapting to climate change whilst delivering on high quality financially sustainable services.	None Identified	4	4	16	The Trust has a Green Plan with key actions to address carbon emissions and climate change that the strategy commits to delivering. The workplan identifies the development of a medium term financial plan to support the delivery of financially sustainable services.	4	2	8

Meeting Committee

Date

Title of Report

Author of Report:	Clare Boyd, Emergency Village Programme Lead.
Executive Director Sponsor:	Jim Gardner, Executive Medical Director and SIRO for the Emergency Village Programme.
Date of Report:	22 February 2022

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

- The Emergency Village build, as approved through the original business case, is on time and target.
- Following a succesful Same Day Emergency Care (SDEC) Summit meeting in November 2021, the clinical pathways are being refined and the staffing and governance models being worked through.
- The temporary medical SDEC in the modular build in Car Park D is proving a good testing ground for new models of care.
- A new Frailty Assessment Area has been established over the winter to create additional capacity. This development has proven successful and has formed the basis for a new business case to support the introduction of a larger Frailty Assessment Unit, which would form part of a remodelled Emergency Village portfolio.
- Planning is well underway for a series of sequential moves to develop aspects of the scheme once the new critical care unit becomes available in August 2022 and the new modular ward is operational – expected to be April 2022.

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

Recommendations:

The Board is asked to note the content of the Report and receive assurance that the Emergency Village Programme, as approved by the Board, is on time and target.

New challenges and opportunities have emerged, and these are identified in the paper. The Board is asked to note these.

Sensitively Level:

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

Emergency Village and Critical Care Update March 2022

Blackpool Teaching Hospitals NHS Foundation Trust

1 OVERVIEW

1.1 CLINICAL READINESS PROGRESS

This paper updates the Board on progress towards building our new Emergency Village and Critical Care Unit. The programme includes and extensive rebuild and refurbishment of our Emergency Department, some of which has already been completed. A new integrated Same Day Emergency Care Unit and a new C16-bedded Critical Care Unit. Over the last year, partly in response to on-going clinical and operational debate, referencing national best practice, and partly in response to acute bed-pressures, the Trust has established a Frailty Assessment Area. This development is considered to be working well and there is now a new business case in development to support an improved Frailty Assessment Unit as part of an extended Emergency Village footprint. In addition, space created by the various planned developments enables further improved clinical areas such as Medical High Care. Finally, the complex series of decants required to enable the work is supported by a new modular 24-bedded ward which is arriving on site in March 2022 and due to open in April 2022.

There has been an extensive amount of clinical engagement over the past 12 months in readiness for both the new environments of Critical Care (CrCU), Same Day Emergency Care (SDEC) and new ways of working across the Emergency Village.

This has seen to date:

- **Interim Medical Same Day Emergency Care (SDEC**) unit opened in September 2021, enabling the trialling of new pathways, workforce opportunities, internal departmental links, and opening times. Whilst there have been challenges with its external location (Car Park D) both logistically and requiring some limitations on patient inclusion criteria, there has been an opportunity to trial new pathways and begin to adopt and explore new ways of working.
- **Interim Surgical SDEC** has also commenced expansion of its services after gaining additional space following the reconfiguration of Surgical Assessment Unit (SAU) and Acute Medical Unit (AMU) in September 2021, enabled by the interim SDEC move.
- The **interim Frailty Assessment Area (FAA**) opened as part of escalation needs prior to Christmas 2021 and has facilitated the development of pathways, workforce identification and processes that are forming the basis of the long-term Frailty Assessment Unit (FAU). The FAU will be a 48-hour bedded unit that focuses on adopting the Frailty SDEC pathways with an extended stay area for those needing longer care but with the aim of avoiding admission.
- **SDEC Summit** - In November 2021, Blackpool hosted the SDEC National team where the SDEC programme of delivery and challenges were debated with significant attendance and support from across the Trust. The National team praised the progress to date and next steps proposed.

Recent demands upon clinical services during December 2021 and January 2022 have impacted on the opportunity to progress as initially planned with all scheme elements, including implementation of certain pathways, user engagement on design elements and momentum in general.

Clinical teams are now finalising their needs, benefits and risks and submission is planned for early March 2022.

The build elements have continued on plan throughout, with key leads identified for this specific purpose who have ensured their availability for engagement and decision to ensure the programme key milestones have been delivered.

1.2 Business Case Needs

As part of the service transformation completed to date it has been identified that there is a need for additional investment to deliver the wider Emergency Village needs, past those detailed in the EV&CC business case that was approved in 2020. These business cases are in development with the clinical and operational teams and will be completed in early March 2022, they are:

- **SDEC Workforce needs** – to support the SDEC unit extended opening times from 7.30am to 12MN across both the medical and surgical specialties to create one integrated SDEC Unit. The workforce needs were not considered within the original business case as SDEC did not feature extensively within the original case.
- **Frailty Assessment Area Unit (FAA) needs** – it is intended that this will be a 16-bedded 48-hour unit, these beds do not exist within the current bed base and the service when benchmarked as acknowledged to be under funded, additional funding is therefore required.
- **Frailty Assessment Unit Capital Needs** – whilst the current FAA (previously Physiotherapy) is being utilised, (this is a temporary measure, with only 10 patient spaces) the environment, despite interim works, remains non-compliant. Significant investment circa £3m + VAT is required to create a suitable Frailty area with 16 beds, appropriate support accommodation and that includes a 14-space discharge lounge.

1.3 Build Programme

- The construction of the 3 storey SDEC and Critical Care new build began on site on 24th May 2021. The scheme has continued to progress in line with the agreed programme and remains comfortably on track.
- The Emergency Department refurbishment commences on occupation of the new build (August 2022), at which point the current Intensive Treatment Unit (ITU) relocates to the new build and the first phase of the ED refurbishment can begin. The current phased plan will see ED delivered in 4 phases and the full department refurbished and operational in August 2023.

1.4 Next Steps

The new Critical Care Unit and the Same Day Emergency Care Unit are planned to be ready for patient occupation in August 2022. At this point the refurbishment of the existing Emergency Department (ED) will commence, currently planned to take 12 months. Overall completion for August 2023.

1.4.1 Critical Care

The Critical Care team are focusing on the merging of the current Intensive Treatment Unit (ITU) and High Dependency Unit (HDU), its workforce implications, opportunities for staff development and its standard operational policies.

1.4.2 Same Day Emergency Care

The reinvigoration of the SDEC 2022 workstream will see a focus on:

- **Workforce**:
  - **Staffing model**: A lead clinician and lead ACP across both medical and surgical needs, common ground staff, specialist emergency team to come in when needed.
  - **Recruitment & Retention –** known recruitment challenges and opportunities
  - **Education and training** support
- Agreeing the clear **Governance structure** - to ensure functioning as a multi-specialty unit
- **IT and System Needs**: Booking system, Counting and coding-admissions or attendance, and a common e-PR, support for data analysis
- **Business Case approval**
- **Hot clinics -** Numbers, physical space/location and how it would function.
- **Support services** - Radiology, Pathology, Microbiology, Pharmacy, Porters, and wider stakeholder networking with GPs, NWAS etc.

1.4.3 Frailty Assessment Unit

The future of the long-term Frailty Assessment Unit depends on approval of the business cases for both workforce needs, and the capital funds required to create a suitable and safe environment for patients.

If approved, there will be a requirement to decant the current interim Frailty Assessment Area and Discharge Lounge for approximately 6 months to enable the refurbishment. This also requires relocation of the Orthotic, Surgical Appliances and 2 administration offices. This will deliver an increase of 6 frailty assessment beds (10 currently) and 4 additional discharge spaces (10 currently).

There will be a significant increase requirement in specialist workforce needs and it is known that there are recruitment challenges. The clinical and medical teams are exploring all options available as part of their workforce planning strategy.

1.4.3 Emergency Department

A final review of the ED refurbishment design was due to commence on 8th February 2022. This has been delayed by 2 weeks to enable wide review of environmental needs following the ECIST (NHS Emergency Care Improvement Support Team) visit and recommendations. This is now planned to start week commencing 28th February 2022. It will be clinically led and ensure that all clinical and support accommodation needs are optimised and any newly identified 'bottle necks' are addressed.

There will be extensive planning required on the decant and phased plan of the construction works, loss of current clinical spaces and how this can be mitigated. It is currently planned that Ward 1 will be utilised from August 2022, with the Ward 1 beds being reprovided within the new modular ward, currently arriving on site.

2 GOVERNANCE

- Project governance is embedded and has been revised to include Atlas Board and EV programme developments following transfer in October 2021 and is illustrated in Figure 1 below, this includes as a minimum:
    - SDEC 2022 Working Group (Medical and Surgical) and associated subgroups such as workforce, IT and systems, pathway development, NWAS
    - Frailty Working Group and associated subgroups such as workforce, IT and systems, pathway development, NWAS
    - User Engagement Sessions across all departmental areas to ensure a clinically led design
    - Monthly Client Progress meetings and 2 weekly progress and issues review meeting with IHP
    - Monthly programme interrogation and approval with IHP
    - Weekly internal Progress & Issues meetings with senior Atlas Management team
    - Monthly joint Atlas and Trust finance review meeting
    - Monthly P22 Construction Board – Dashboard update presented
    - Monthly EV&CC Programme Board – Dashboard update presented
    - Quarterly risk review meeting with IHP

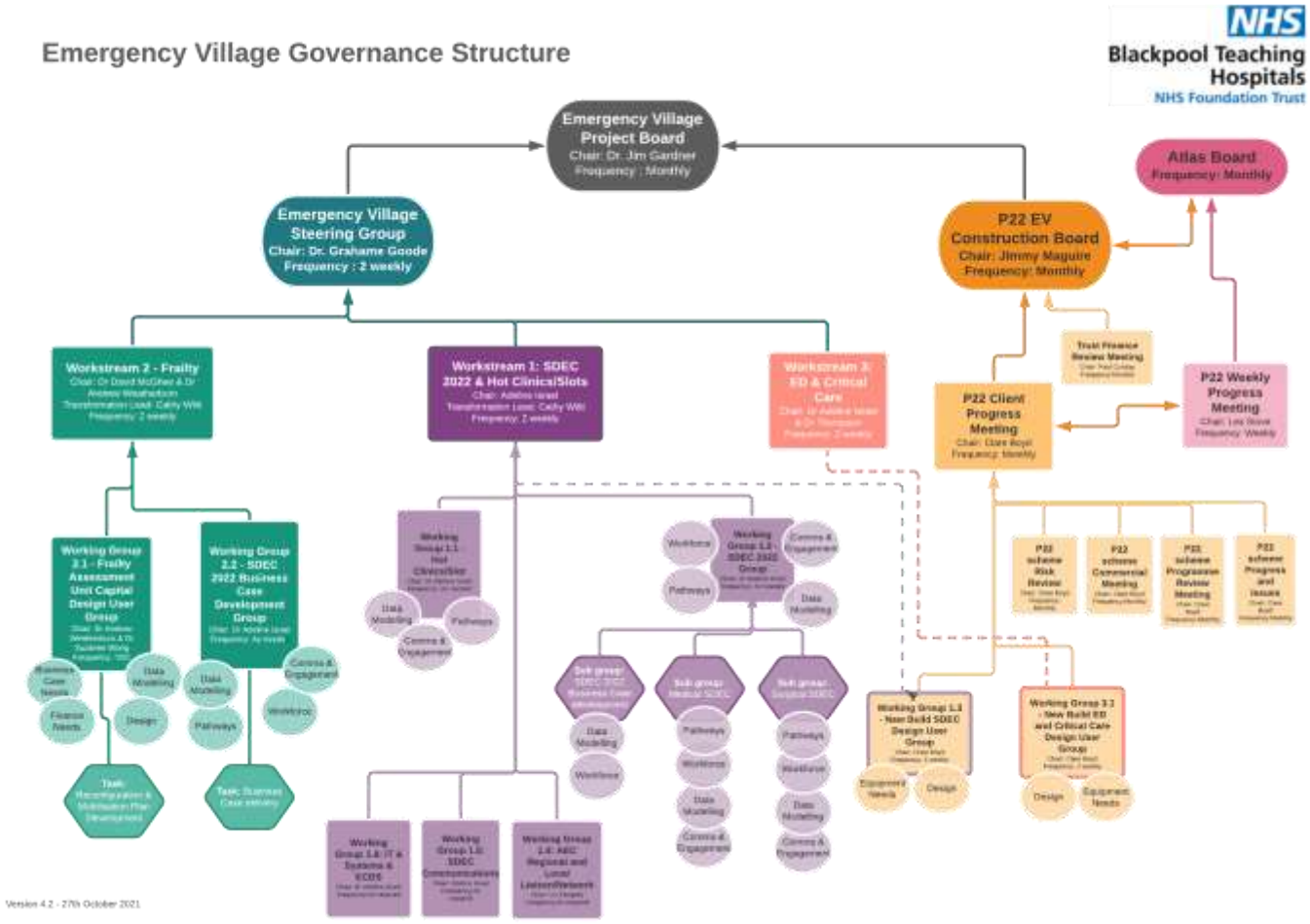


Figure 1: Ratified Emergency Village Governance Structure

3 FINANCE OVERVIEW

Baseline finance overview has been determined with Trust finance and agreed baseline for monitoring of the scheme included within the P22 Construction Dashboard (Table 1 below).

Element	FBC Cost inc. VAT (£)	Actual/ Forecast (£)	Variance (£)
GMP (IHP contract costs net of VAT)	**21,226,955**	**21,226,955**	**0**
Assumed Gain share	0	-43,300	-43,300
Additional CE's not yet instructed	0	174,000	174,000
VAT pre novation works	746,467	1,272,922	526,455
Recoverable VAT	0	-1,222,922	-1,222,922
Contractor Totals	21,973,422	21,407,655	-565,767
Fees	**704,215**	**1,335,159**	**630,944**
Non-works cost	150,000	150,000	0
Equipment cost (including CEs)	**975,000**	**1,121,518**	**146,518**
Trust risk pot (including £22k difference)	**1,175,828**	**-13,074**	**-1,188,902**
Inflation	310,016	310,016	0
Other Costs Total	3,315,059	2,903,619	-411,440
Business Case Total	**25,288,481**	**24,311,274**	**-977,207**

Table 1: Confirmed EV&CC Finance Baseline

£977,207 was the remaining budget available within the FBC scheme value to be utilised for risk/contingency following transfer to Atlas – this is considered a very reasonable sum given the current stage of the programme.

4 KEY ISSUES, CONCERNS AND RISKS

Risk/Issue	Mitigation Progress
Amendments to GMP design required to meet current clinical needs and decisions not made in a timely manner resulting in programme and cost impacts this includes:	• All concerns identified to date have been escalated to both the P22 Construction Board and the Emergency Village and Critical Care Programme Board – timescale for final decision have been communicated – if required/approved design to be amended by 31st March 2022 to ensure programme is not impacted • Design team currently working through existing GMP design to highlight any areas for concerns, wall protection review meeting scheduled • User group review sessions scheduled with key operational and clinical ED leads to determine any areas for concern

NHSE&I £12.9m financial year spend may not be achieved	• All possible spend options have been determined:
	  ○ Early equipment orders identified and placed
	  ○ IHP programme bring forward spend instructed
	• To be monitored through P22 Construction Board
	• To be monitored monthly at the Atlas and Trust finance review meeting
	• Trust is exploring other options to achieve spend

Completion of ED refurbishment elements and loss of clinical space during construction	• Draft decant phased plan has been developed to determine phases and impact on clinical space • Key clinical leads to review and agree plan for presentation at EV Steering Group • Escalated to EV Programme Board the need for suitable decant space – Ward 1 has been identified as a possibility
Key Trust personnel availability to attend design meetings to ensure programme needs due to operational pressures	• Escalated to EV Steering Group for action and support • Trust reviewing resource availability, secondment opportunities and potential external support to assist

Blackpool Teaching Hospitals NHS Foundation Trust

Minutes of the Audit Committee Meeting
held on Monday 24th January 2022 at 12.30 pm
via Microsoft Teams

Members:		
Mr Mark Cullinan	Non-Executive Director	Chair
Mr Mark Beaton	Non-Executive Director	
Mrs Sue McKenna	Non-Executive Director	
Mr Adrian Carradice-Davids	Non-Executive Director	
In Attendance:		
Mr Steve Barrow	Deputy Director of Finance	
Ms Laura Cross-Hunter	Head of Financial Services	
Mr Paul Cunday	Associate Director of Finance	
Ms Lizzie Ferdani	Assistant Manager, MIAA	
Miss Lauren Kavanagh	Corporate Governance Officer	Minutes
Mr John Marsden	Counter Fraud Specialist	
Mr Feroz Patel	Director of Finance	
Mrs Esther Steel	Director of Corporate Governance	
Mrs Jayne Wainwright	Engagement Manager, MIAA	
Ms Nicola Wright	External Auditors, Deloitte	
Apologies		
Miss Fiona Eccleston	Non-Executive Director	

1. Welcome/Apologies for Absence

Mr Cullinan welcomed members to the meeting and it was noted that the meeting was quorate.

Apologies were received as recorded above.

2. Declaration of Interests

There were no declarations of interests.

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.

RESOLVED: **The minutes of the previous meeting held on 25 October were approved as a true and accurate record subject to the amendments above.**

4. Matters Arising and Action Matrix

Members noted the position of the action list. The following updates were provided:

5a: Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Assurance Report (Reference 25): - Mrs Steel confirmed that the BAF and risks processes would be aligned with the developing strategy and that this would be actioned under the upcoming review of the BAF.

Mrs McKenna highlighted the importance of ensuring the Trust was managing the risks mentioned within the action lists. Members noted that a review of the Board Committees was taking place and this would be discussed formally at the next Board of Directors Meeting.

7a: External Audit Progress Report (Reference 28): - Mrs Wright requested feedback from Members regarding whether a session to discuss the Value for Money process and report was required or whether narrative around this could be provided to the next Committee on this matter. Members agreed that no session was required and the update on the Value for Money process and report could be provided at the next Committee.

ACTION: Ensure that Value for Money is included on the March 2022 Committee agenda.

9a: Counter-Fraud Progress Report (Reference 32): - Mr Marsden advised the members that Ms Hobson from Human Resources (HR) was available to answer any questions on the Counter Fraud Mandatory Training and that this action would be picked up later on in the agenda.

11: Workplan (Reference 34): - Mr Cullinan confirmed that he had been included in the Trust Constitution discussions, however, the constitution needed further review.

Mr Cullinan requested that all items on the action list were only turned green as completed if there was confirmation that the action had been completed.

5. <u>Internal Audit</u>

a) Internal Audit Progress Report

Mrs Wainwright advised members that Ms Sandra Cudlip had stood down from her role at MIAA and Ms Louise Cobain would be taking over that position going forward.

Members noted that the progress report covered the period November 2021 – December 2021. Mrs Wainwright reported that the Emergency Department (ED) Bed Allocation review had been finalised with substantial assurance being provided. It was noted that the Inventory Counting Procedures, Key Financial Controls and ESR Data Quality reviews were all currently at the draft report stage. It was further noted that the following reports were currently in progress: -

- Sickness Absence Management
- Cyber Controls
- COAST
- Disclosure & Barring Service Checks
- Risk Management

Mrs Wainwright reported that MIAA were currently planning the following reviews: -

- ATLAS Governance
- DSPT
- Assurance Framework
- Freedom to speak up

Members noted at that the last Audit Committee in October 2021 members were asked to approve changes to the audit plan and these were agreed in principal but further information was requested on alternative sources of assurance.

Mrs Wainwright stated that the Freedom to Speak Up review was to replace System Improvement Plan delivery. It was noted that the CQC assessed a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led domain of inspection. Mrs Wainwright added that recent guidance which aligned to this had been published jointly by NHS Improvement and the National Guardian Office and that this review would seek to evaluate the effectiveness of the FTSU arrangements which had been put in place at the Trust.

Mrs Wainwright advised members that the Trust System Improvement Plan would need to be updated to reflect the latest inspection by the CQC and it was therefore proposed to delay the internal audit review of this area until early 2022/23 so that they could include reviewing any new systems and controls designed to aid delivery of the improvement plan.

Members noted the second proposed change to the audit plan was that DBS Checks / Overpayments would replace Quality Efficiency Programme (QEP). Mrs Wainwright confirmed that this was the request of the Director of HR and the CEO and was in response to a previous incident, MIAA had been asked to perform an urgent review of the systems that the Trust had in place for performing DBS checks.

It was noted that QEP financial performance was reported to the Operations Committee and in December 2021 a QEP Oversight Group had now been set up who would in turn report to Quality and Clinical Effectiveness Committee on performance.

It was noted that these proposed changed had been agreed with the Chief Executive. Members approved the updated changes to the Audit Plan.

Members noted the Emergency Department Bed Allocation report.

b) Internal Audit Follow Up Summary Report

Mrs Wainwright explained that the Corporate Governance team maintain a follow-up tracker and the team request updates from action owners prior to each Audit Committee and that the action owners were required to provide evidence that any critical or high-risk recommendations have been addressed.

It was noted that once all recommendations had been completed, reviews from previous years will be removed from the tracker once presented to Audit Committee. Mrs Wainwright informed members that she was meeting with Mrs Steel on the 25th January 2022 to discuss improving the process and would report back to the Committee with the proposed recommendations.

ACTION: Ensure the proposed recommendations to improving the Internal Audit Recommendations process is provided to the Committee.

Members noted that Mrs Wainwright presented a paper outlining the proposed MIAA approach to developing the 2022-23 Internal Audit Plan for the Trust as well communicating indicative timescales. It was noted that the aim was to agree a process with the Trust to ensure we work closely with the Executive Directors to design and implement risk-based programmes of work.

In response to Mrs McKenna's query regarding Clinical Audit, Mrs Wainwright advised that Internal Audit was separate from Clinical Audit as it was clinical led by the Medical Director. Mrs Steel advised members that from September 2022 the Audit Committee would be having oversight of Clinical Audit.

6. External Audit

a) External Audit Progress Report

Mrs Wright reported that she was working closely with Atlas and the Charity to ensure their Annual Accounts had been completed and signed. Members noted that the issue with regards to stock counting had been resolved and PWC had confirmed they were happy with the Trust's closing stock position.

Mrs Wright advised that Deloitte were now working on risk assessments and planning for their second year working with the Trust. It was noted that work was ongoing regarding capital money that was required to be spent by the end of this financial year (2021-22).

Mrs Wright highlighted that due to the recent CQC report, the risks had to be considered and details of the audit plan would be provided at the next meeting.

ACTION: Ensure the audit plan taking into accounts the CQC report was provided at the next meeting.

Members noted the ongoing situation with regards to the mandatory vaccinations and that the Trust would be facing some legal challenges on this matter.

Mr Patel advised that the Trust current had 279 substantive staff currently 'in scope' although 1:1 interview had to take place to establish if they were exempt due to medical reasons. It was noted that a percentage of the staff in scope were on Maternity Leave, Long Term Sick or Career Breaks.

In response to Mr Beaton's question regarding legal advice, Mr Patel reported that the Trust was awaiting legal advice. In response to Mrs McKenna's query regarding data analysis from each department within the Trust, Mr Patel advised that this information was not provided at this time but a detailed update would be provided at the next Board of Directors Meeting to include staff per speciality and effects to services.

Members noted that the Chief Executive had written all those staff that were not vaccinated and the Trust had seen the number of unvaccinated staff decrease. It was noted that the issue was discussed weekly at team brief and managers were conducting 1:1 session with their unvaccinated staff. Mr Patel advised that this risk was going to be incorporated into the annual accounts.

Members agreed that this item had been escalated to the Board of Directors to include a break down on the total number of staff from each department were provided.

ACTION: Ensure an update on the Mandatory Covid-19 vaccinations is provided to the Board of Directors outlining how many staff this affected from each department and more details of the risk.

7. Financial Focus

a) Losses and Compensations

Ms Hunter-Cross referred members to the previously circulated report and confirmed that in quarter 3 of the year (Q3), there had been a total of £7,000 in value of losses and special payments which increased the value for the period to 31st December to £30,000. It was noted that there were two losses totalling £2,989 and 5 special payments totalling £4,044.

b) Waivers

Mr Burrow referred members to the previously circulated report and confirmed that for Q3, there had been 11 waivers with a total value of £310,266. It was noted that one of the waivers at a cost of £92,100 was in relation to additional capacity and expertise required for a short period of time to enable a focused data quality assurance of pathways on the PTL's, which was approved by the Board of Directors.

8. Counter Fraud

a) Counter-Fraud Progress Report

Mr Marsden reported that in the October 2021 Audit Committee meeting the question of counter fraud training being mandatory for all staff was raised and the Non-Executive Directors agreed that there was a strong need for such training and the Mr Marsden requested the support of the Audit Committee to achieve mandatory status for counter fraud training.

It was noted that Mr Marsden had spoken to the Trust's Organisational Development & Leadership Manager, who provided a rationale for the rejection, which included the risk of setting a precedence, the financial element (in regard to staff time) and the actual time it would need for all staff to complete the counter fraud e-learning module (on a three-year renewal basis).

Members were in agreement that this matter had to be escalated this to the Board due to the number of incidents that were taking place with regards to fraud.

Mr Patel agreed to take action on this matter and escalate appropriately.
Members noted that a test phishing email exercise took place and the email was circulated to 4816 staff. The results from this exercise were the following: -

No action taken – 3794
Opened the message only – 460
Opened the message and linked the link – 297
Opened the message, clicked the link and posted credentials - 265

Mr Beaton expressed concerns with regards to this data and advised that these phishing emails should be circulated regularly to ensure staff were learning.

ACTION: Commence conversations with the IT Department to ensure phishing emails are circulated regularly.

9. Items Recommended for Escalation to the Board

It was agreed that the following items would be escalated to the Board of Directors: -

Mandatory vaccinations
Counter Fraud mandatory training
Regular phishing email Exercises

Mrs Wainwright advised that an Internal Audit would take place looking into cyber security and that MIAA offer cyber security training if the Trust required it.

ACTION: That Mandatory vaccinations, Counter Fraud mandatory training and Regular phishing email Exercises were escalated to the Board.

10. Formal Meeting Review

Mr Cullinan sought feedback from members on the meeting that had taken place. Members provided no feedback.

11. Any Other Business

Mr Patel advised that at the Executive Directors Meeting on Monday 24th January 2022, it was suggested that the executive lead and manager to attend with the Internal Audit Report.
Members agreed with the proposal to ensure the Audit Committee was in all the executive directors diaries.

There were no further matters of business raised.

12. Declaration of Confidentiality

Members were reminder that all items were declared confidential unless they were already in the public domain.

13. Date and Time of Next Meeting

The next meeting will take place on 28th March 2022 at 1.00pm, via MS Team.