Board of Directors in Public Meeting (Part 1)
2nd March 2023
09.30 – 12.30
Boardroom

Time		Topic	Lead	Process	Purpose / Expected Outcome
09.30	1	Welcome and Introductions	Chair	Verbal	To note apologies
	2	Declarations of Interests	Chair	Verbal	To note
	3	Apologies for Absence	Chair	Verbal	To note apologies
	4	Minutes of the Previous Meeting	Chair	Report ✓	To approve the previous minutes
	5	Action List & Matters Arising	Chair	Report ✓	To note progress on agreed actions
	6	Patient Story	Director of Nursing	Video	To discuss the learning from a recent patient story
	7	Chair's Update	Chair	Verbal	To receive an update
	8	Chief Executive's Report	Chief Executive	Report ✓	To receive an update
Quality					
10.00	9	Quality Integrated Performance Report	Medical Director	Report ✓	To note
	10	Quality Assurance Committee Escalation report	Chair of Quality Assurance Committee	Report ✓	To receive an update
Finance and Performance					
10.20	11	Finance and Performance Integrated Performance Report	Director of Finance/Chief Operating Officer	Report ✓	To note
	12	Finance and Performance Committee Escalation Report	Chair of Finance and Performance Committee	Report ✓	To receive an update
Workforce					
10.50	13	Workforce Integrated Performance Report	Director of People and Culture	Report ✓	To note

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Time		Topic	Lead	Process	Purpose / Expected Outcome
	14	Workforce Assurance Committee Escalation Report	Chair of Workforce Assurance Committee	Report ✓	To update
	15	2021-2022 Annual Submission to NHS England Northwest Appraisal and Revalidation and Medical Governance	C Barben	Report ✓	To update
		**11.10 AM - COMFORT BREAK (10 MINUTES)**			
		Strategy and Transformation			
11.20	16	Reducing Health Inequalities Plan and Anchor Framework (Dr *Heather Catt to co-present*)	Deputy CEO / Director of Strategy & Transformation	Report ✓	To approve
	17	Digital Plan	Deputy CEO / Director of Strategy & Transformation	Report ✓	To note
		Governance			
12.00	18	Audit Committee Escalation Report	Chair of Audit Committee	Report ✓	To update
		Consent agenda for information *Papers in this section are provided for information and assurance. If you wish to raise a question in relation to one of the reports, please advise in advance of the meeting.*			
	19	New Hospitals Programme		Report ✓	For information
		Closing matters			
12.15	20	Any Other Business	Chair	Verbal	To note
	21	To respond to any questions from members of the public received in writing 24 hours in advance of the meeting			
	22	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.			

Date and time of the next meeting: Thursday 4th May 2023 at 9.30am

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Meeting	Board of Directors Meeting	
Time	11.00 am	
Date	12th January 2023	
Venue	MS Teams	

Members: -

Steve Fogg	Trust Chair	Chair
Trish Armstrong-Child	Chief Executive	
Chris Barben	Executive Medical Director	
Janet Barnsley	Executive Director of Integrated Care	
Mark Beaton	Non-Executive Director	
Adrian Carridice-Davids	Non-Executive Director	
Steve Christian	Deputy Chief Executive/Executive Director of Strategy & Transformation	
Carl Fitzsimons	Non-Executive Director	
Natalie Hudson	Chief Operating Officer	
Louise Ludgrove	Executive Director of People and Culture	
Sue McKenna	Non-Executive Director	
Feroz Patel	Executive Director of Finance	
Andrew Roach	Non-Executive Director	
Robert Ryan	Non-Executive Director	
Fergus Singleton	Non-Executive Director	
James Wilkie	Non-Executive Director	
Shelley Wright	Joint Executive Director of Communications	

In attendance: -

Esther Steel	Executive Director of Corporate Governance	
Simone Anderton	Deputy Director of Nursing (for Pete Murphy)	
Lynne Eastham	Director of Midwifery	
Jacinta Gaynor	Corporate Governance Officer	
Frances Roberts	Corporate Governance Officer	Minutes
Lauren Staveley	Freedom to Speak Up Guardian	

Observers: -

Margaret Bamforth	Appointed Governor for Blackpool and the Fylde College
Cllr Howard Ballard	Appointed Governor for Blackpool Council
Sue Crouch	Public Governor for Wyre/Lead Governor
Bill Gregory	Financial Improvement Director
Dr Ranjit More	Staff Governor for Medical and Dental
Shelagh Parkinson	Gazette Newspaper
Mark Singleton	Chief Information Officer
David Wilton	Public Governor of Northwest Counties

1.   Welcome and Introductions

The Chair welcomed the members to the meeting and thanked all the Trust staff and partners for their hard work through the current challenges and pressures.

2.   Declarations of Interest

There were no declarations of interest.

3.   Apologies

Apologies
Fiona Eccleston - Non-Executive Director
Peter Murphy – Executive Director of Nursing, Midwifery, AHPs and Quality

4.   Minutes of the Previous Minutes

The minutes of the meetings held on the 3rd of November 2022 were approved as a true and accurate reflection of the meeting.

Resolved: The previous minutes were approved.

5.   Action List

The Executive Director of Corporate Governance confirmed all the completed actions and that the remaining actions had a future completion date.

Matters Arising

There were no matters arising.

6.   Chair's Update

The Chair updated the members on a recent System Chairs Meeting and shared it was a positive meeting despite the current challenges, with the system looking towards the future.

Resolved: The members noted the update.

7. **Chief Executive's Report**

The Chief Executive provided a high-level update on the activities within the Trust and community included in the circulated papers, and elaborated on the following points: -

Acknowledgements
The Information Governance Team was awarded Team of the Year by the National Health Care Strategic Information Governance Network.

New Appointments
Bridget Lees will be joining the Executive Team from the 1st of April 2023 as the newly appointed Executive Director of Nursing, Midwifery, AHPs and Quality, succeeding Peter Murphy who will be joining East Lancashire Hospitals NHS Trust from the 17th of February 2023. Simone Anderton the Deputy Director of Nursing will be bridging the intervening gap.

Bill Gregory will be joining the Executive Team until the end of March 2023 as the Financial Improvement Director to support the Financial Sustainability Plan.

Operational Pressures
Unfortunately, despite all planning and investment, the Trust has been under intense pressure over the holiday season due to a number of factors, including the Northwest Ambulance Service (NWAS) industrial action, the bed capacity and flow for the increased numbers of type one urgent care patients, and covid and influenza A patients, resulting in the Trust declaring Operational Pressure Escalation Level (OPEL) to the highest level of four. Over this period the Executive Director Team were on-call and on-site every day to support the teams and community partners. The Chief Executive apologised to the public and the community, and paid personal tribute to all the clinical, operational and support staff both in the hospital and community who went above and beyond to ensure the Trust could provide care to the community under very challenging circumstances.

Strike Action Update
The Royal College of Nursing (RCN) are due to begin industrial action on the 18th and 19th of January 2023 and although the ballot result means the Blackpool Teaching Hospital Nurses will not be striking it will impact the surrounding Trusts.

The Northwest Ambulance Service (NWAS) industrial action on the 11th of January 2023 was managed successfully with the Business Continuity Plans and the Chief Executive praised all staff involved for their hard work.

The Royal College of Physiotherapists have indicated industrial action intent for the future and the Trust will be provided with dates in due course.

The Junior Doctors were balloted on the 9th of January 2023 and the outcome will be announced soon.

Initiatives

There are many great initiatives proceeding and in development, particularly the training programme for paediatric dentistry to increase the number of specialist paediatric dentists. The Trust's Frailty Assessment Area celebrated its first anniversary in November 2022, which supports patients with frailty needs and prevents long detrimental attendance in the Emergency Department. The Chief Executive paid tribute to the swiftness of the implementation of the frailty area and pathway, and all the Trust and community teams involved.

System News and Development

On the 23rd of December 2022, the Trust received the NHS Priorities and Operational Planning Guidance for the forthcoming business year. The Trust will have the draft plans available to share with the Integrated Care Board (ICB) in February 2023 for a system-wide approach.

The Specialised Commissioning Services will be transitioning from National Health Services England (NHSE) to the Integrated Care Board (ICB) and the Trust will continue to work closely with the ICB to ensure it has clarity moving forward.

Reportable Issues Log

Thirteen incidents have been logged on the Strategic Executive Information System (StEIS) and the Chief Executive noted that the reporting period was from the 21st of October 2022 to the 31st of December 2022, and the incidents themselves did not necessarily occur during that period. All the incidents have been sequenced in terms of themes and they are progressing through the serious incident framework.

Risk Register and Board Assurance Framework

The assurance mapping exercise has now been completed to assign to the appropriate assurance committees for robust oversight prior to Board review. Also, the corporate, divisional and departmental Risk Registers, which link to and run parallel to the Board Assurance Framework (BAF), have been reviewed to present to the Risk Management Committee.

In response to members' queries, the Chief Executive reassured the members that the Executive Team are acutely conscious of the effect the pressures and challenges have on all staff members and described the ongoing health and wellbeing team plan including psychological support.

The Chief Executive clarified for a member; the system-wide bank/agency staff collaboration is progressing through the Provider Collaboration Board (PCB) and the Lancashire Procurement Cluster (LPC), and all the providers have a designated lead involved in its development. Further information will be forthcoming shortly.

Resolved: The members noted the report and the update.

8. Quality Integrated Performance Report

The members noted the Integrated Performance Report (IPR) circulated in the papers, which provided an overview of all aspects of the Trust's performance, and it was accepted as read.

The Executive Medical Director and the Deputy Director of Nursing expanded on some of the key points, taking into account the December metrics that were not circulated in the papers:-

- There has been an increase in sickness and in the December IPR the fill rate dropped from the November 90% to 80% in December, so there has been a reduction in the availability of bank and agency staff. Corporate and nursing managers have been in practice, safe staffing levels are reviewed by senior nursing every twenty-four hours, and a financial incentive is in place.
- Many areas have been escalated, affecting staffing levels and increasing potential harms. There has been an increase in the number of falls.
- Despite the challenges, some Key Performance Indicators (KPIs) are showing a reduced level of some harms including pressure ulcers.
- The Trust has maintained good performance in dealing with complaints and Duty of Candour within target.
- Escalated areas have resulted in a lower rate of E-discharges, and ways to combat this are being explored.
- Clostridium Difficile infection rates have reduced.
- There has been an improvement in the rate of screened deaths.

In response to a question from a member regarding falls themes, the Deputy Director of Nursing, reported there is a higher prevalence of falls within the Integrated Medicine and Patient Flow (IMPF) division and at Clifton Hospital due to the larger number of Deprivation of Liberty Safeguards (DoLS) patients and mental health patients residing on those wards. A new Falls Collaborative is being formed to concentrate on the IMPF areas, Clifton Hospital, and the Stroke Ward.

The Chief Executive requested a change to the Friends and Family (FFT) response rate data in the IPR to provide improved clarity.

For members seeking further assurance on how the Trust monitors and manages safe staffing levels, the Deputy Director of Nursing and the Executive Medical Director described the Safe Care Tool and the Medical Dashboard, and how the senior staff use these tools to monitor and collect data to ensure safe staffing levels across the Trust. The Clinical Governance Committee and the Quality Assurance Committee have oversight of the staffing levels for assurance purposes.

The Executive Director of Strategy and Transformation informed the members that a tri-daily senior leadership team meeting was temporally established over the high-pressure holiday season to monitor staffing levels and escalate any other issues as they arose.

BOD/23.01 **Action:** The Chief Executive and Executive Director of Nursing, Midwifery, AHPs and Quality to meet to discuss the FFT data further.

9.   Quality Assurance Committee Chair's Report

The Quality Assurance Committee Chair accepted the Chair's Report circulated in the papers as read and provided a brief synopsis of the items in the report and noted two additional points: -

- There was a Quality Assurance Committee Workshop planned in December, which was stood down due to operational pressure, however, this will be rearranged for the New Year and will be to review possible improvements to the committee.
- The formation of the Clinical Governance Committee and the Risk Management Committee has been very beneficial and has enabled the Quality Assurance Committee to track the actions and improvements and receive assurance via the Escalation/Chair Report.

The Quality Assurance Committee Chair reflected that due to pressures the committee has had to be flexible on the timescale for papers to be submitted to the committee, leading to a delay in full papers being circulated for review prior to committee meetings.

The Chief Executive announced a full review of the year three (August 2021) submission to the Clinical Negligence Scheme for Trusts (CNST) has been completed and a letter stating the Trust believes at the time the Trust felt it was compliant has been sent to NHS Resolutions and the Trust is awaiting a reply. The Quality Assurance Team are aware and will keep the Board informed of any feedback received.

BOD/23/02   **Resolved:** Quality Assurance Team to update the Board on CNST submission feedback.

10.   Clinical Negligence Scheme for Trusts Submission

The Director of Midwifery accepted the Maternity Clinical Negligence Scheme (CNST) year four submission report circulated in the papers as read, which described the Trust position against the current CNST compliance and the action plan. Displaying a PowerPoint presentation, the Director of Midwifery guided the members through the key points of the report.

In response to a query from a member, the Director of Midwifery confirmed that some areas of non-compliance are due to the compliance evidence not being submitted to Board for review, and a reporting schedule/structure is being produced so this can be avoided in the future. The Chief Executive suggested that the required compliance information be included in the IPR so the committees and Board are sighted on the relevant data on a regular basis.

The Director of Midwifery clarified for a member, that the recommended band four and band seven administration support would be funded by NHS Resolutions in place of the compliance premium.

The Executive Director of Finance advised that there is a potential cost to the Trust of £800k if repayment is required in relation to previous CNST discounts – this is included on the risk register and within the accruals

The members expressed their gratitude to the Director of Midwifery for her due diligence and hard work since joining the Trust, and they are confident that robust plans are in place and compliance will be achieved.

BOD/23/03   **Action:** The Director of Midwifery to review the IPR and include the relevant compliance data.

11.   <u>**Learning From Deaths / Mortality**</u>

The Learning from Death/Mortality Report was deferred prior to the meeting starting, to allow time for further discussion through the assurance committees.

Resolved: The item was deferred.

12.   <u>**Finance and Performance Integrated Performance Report**</u>

The Chief Operating Officer noted the IPR Report included in the circulated papers, and accepting the report as read, she continued on to provide the members with a verbal update on the following points not included in the paper: -

- The December pressures and operational performance including risks and concerns.
- How the emergency pressures have affected the elective and non-elective waiting lists, and the plans to reduce the waiting times and process the increased number of referrals swiftly.
- The successful completion and delivery of the Winter Plan actions.
- The additional escalated areas opened to manage to the unanticipated increased pressure over the holiday season.
- The enhanced full-capacity protocol enacted across the Trust.
- The early deployment of the Respiratory and Cardiac In-Reach to the Emergency Department.
- The flexible on-call rota.
- The twenty-four hours a day, seven days a week support from the executive team.
- The continuing endeavours to reduce ambulance handover waiting times and support the Urgent Care Department.
- The monitoring of surge pressure costs.
- The providing and receiving of mutual aid for seventy-eight week waits for patients.

The Chair reported that feedback from the Northwest Ambulance Service (NWAS) was complimentary to the Trust, the Emergency Department, and the support staff for their exceptional efforts during the industrial action.

The Executive Director of Strategy & Transformation outlined the ongoing place based work and how it supports the Trusts discharge position and the patients not meeting the criteria to reside, including a tri-weekly place Tactical Forum meeting including all partners' and local health and care system representatives, and the Multi-Agency Discharge Events (MADE).

For the members who were seeking further assurance on the monitoring of the unanticipated emergency costs over the holiday season, the Executive Director of Finance and the Chief Operating Officer described the monitoring, executive approval and oversight, and the

limitation and review processes in place. The Executive Director of Finance confirmed for members, that there is a running/estimated surge pressure costs amount for forecast purposes and costs incurred due to industrial action are recorded separately from the challenges and pressures costs. The Chief Executive advised there is also a bespoke Risk Register with a decision-making tool identifying risk versus cost and productivity and this will be reported to the appropriate committees in the future.

In response to a member asking for clarification, the Chief Operating Officer shared that Mutual Aid has been sought for the Cardiac Department via the National Mutual Aid Tracker, and the initial assessment is Manchester, Liverpool and other suitable independent sector providers are not in a position to provide aid at this time.

The members had an in-depth discussion on the challenges and complexities of medical recruitment and retention and the themes across the Trust. The Chief Operating Officer and the Executive Medical Director shared; there is a programme of work progressing to map out speciality-focused targeted recruitment plans for all specialities, and the Medical Recruitment and Retention Committee commenced six months ago and is now beginning to evidence improvements and successes.

The Chief Executive acknowledged the difficulties and challenges the Trust's operational teams and clinical teams have to provide a safe balance between backlog and new demand, and emphasised in the longer term the Trust recognises the need to manage elective waiting lists on a system level. The individual Trusts are working with the ICB to focus on mutual aid and how to spread the risk across the system to ensure there is some capacity equity. This will likely affect the Trust's position in some negative and positive ways, however, overall it will be of benefit to all Trusts and will be retitled to System Support. The Chair requested to be notified when Mutual Aid (System Support) is next on the Finance and Performance Committee so he can be present.

The Executive Director of Finance reported that capital is slightly behind projections however this should catch up by the end of the financial year and there is money being received from the centre with a view to spend at the end of the year and will be high risk and this will be discussed with the Auditors. Further risks would be the high level of costs relating to agency spend either due to emergency pressures or high levels of sickness/absences within the Trust.

Action: The Chair is to be invited to the relevant Finance and Performance Committee.

13.   **Finance and Performance Committee Chair's Report**

The Chair of the Finance and Performance Committee accepted the Chair's Report that was circulated in the papers as read and elaborated on the main points for the members.

The Chair of the Finance and Performance Committee also stressed that although the pressures have been extremely high for the Trust and staff the KPI's show some improvements in some key areas.

The Executive Director of Finance added there is a resource to be received from the national team and a meeting is arranged with the Finance Directors to agree on the underlining forecast control total and the Board will be notified.

Resolved: The members noted the report.

14. **Workforce Integrated Performance Report**

The Executive Director of People of Culture noted the inclusion of the IRP report in the papers circulated and provided a brief synopsis of the key metrics for the members.

The Chief Executive thanked the Trusts staff members for their perseverance in improving the Appraisal metrics.

Resolved: The members noted the report.

15. **Workforce Assurance Committee Chair's Report**

The Workforce Assurance Committee Chair accepted the Chair's Report that was circulated in the papers as read, and highlighted the main points for the members, including some further points: -

- The appraisal completion rate has doubled in the last few months.
- The December Workforce Assurance Workshop has been deferred until February due to operational pressures and will focus on recruitment and retention.
- The Targeted Agency Control Panel Terms of Reference is on the 18th January 2023 Workforce Assurance Committee Agenda for review, so that will be moving forward to fruition and will be highly beneficial for agency oversight.

On reflection, the Workforce Assurance Committee Chair noted that papers are being submitted past the deadline delaying the full papers from being circulated and reviewed, and requested that if the deadline cannot be met, to please inform the Corporate Governance Team so the item can be deferred until the next meeting.

The Workforce Assurance Committee Chair praised the Trusts volunteers for all the roles they fulfil, and members thanked the volunteers for their dedicated service, particularly throughout the covid pandemic.

Resolved: The members noted the report and the update.

16. **Freedom to Speak Up Report**

The Freedom to Speak Up (FTSU) Guardian joined the meeting and confirmed the report which illustrated the progress made and work undertaken around the FTSU agenda had been circulated in the papers, and accepting the report as read, pointed out the key aspects for the members.

The Freedom to Speak up Guardian provided the members with some updates since the report was produced: -

- The National Freedom to Speak Up policy approved in July is now live in the organisation.
- There are now Forty-four FTSU Champions.
- FTSU are attending the Diversity Networks.

The FTSU Guardian confirmed for a member, that due to feedback and metrics, she has definitely felt a positive change across the Trust and the FTSU role is fully supported by the Trust.

The Chief Executive described the ongoing process to re-launch the Trusts valves involving the FTSU Guardian, the workforce team and the communication team.

Resolved: The members noted the report and the update.

17.	**Audit Committee Chair's Report**

The Audit Committee Chair presented the Chair's Report circulated in the papers and accepting the report as read, elaborated on the main points for the members.

Resolved: The members noted the report.

18.	**Standing Orders**

Deferred.

Resolved: The item was deferred.

19.	**Any other business**

There were no Any Other Business matters to discuss.

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

Thursday 2nd March 2023 at 9.30am in the Trust Board Room.

Board of Directors Action List

Minute Ref/No		Agenda Number	Date Of Meeting	Agenda Item Heading	Action To Be Taken	Person Responsible	Date To Be Completed	Change Of Date	Progress	RAG Status
BOD/23/09	BOD Strategy	4	02.02.23	Finance Peer Review Response	Financial update to be provided to Board in March 2023	F Patel	02.03.23		A financial update was provided at the Extraordinary Board meeting held on 23.02.23 . An item has been added to the agenda for 02.03.23 meeting.	Y
BOD/23/03	Part 1	10	12.01.23	CNST Submission	Review the IPR to ensure it details when the Trust is expected to be compliant.	P Murphy / L Eastham	31.01.23		PM/SA awaiting FICC data.	A
BOD/23/04	Part 1	10	12.01.23	CNST Submission	Ensure a further conversation with the Finance Team is undertaken and that measures are in place to ensure actions are completed.	P Murphy / L Eastham	31.01.23		PM/SA awaiting FICC data.	A
BOD/23/12	BOD Strategy	5	02.02.23	Strategy, Planning & Transformation	Circulate the 2023/24 operational planning guidance to Board members.	S Christian	09.02.23		Completed	G
BOD/23/13	BOD Strategy	5	02.02.23	Strategy, Planning & Transformation	arrange an Extraordinary Board of Directors meeting to further discuss the 2023/24 operational planning submission.	Corporate Governance Team	23.02.23		A meeting was arranged for 23.02.23 and a further one has been arranged for 30 .03.23.	G
BOD/23/01	Part 1	8	12.01.23	Quality IPR	To discuss the FFT response rate data narrative with P Murphy/ S Anderton.	T Armstrong-Child	02.03.23		Complete	G
BOD/23/02	Part 1	9	12.01.23	QAC Chair's Report	Ensure Board members are kept up to date with CNST submission feedback.	T Armstrong-Child	02.03.23		Complete	G
BOD/23/05	Part 2	8	12.01.23	Financial Recovery	Undertake a more detailed discussion with regards the Financial Management Review report by S Worthington in order to formulate an agreed response and action plan.	All	02.02.23		This has been added to the Board Strategy Agenda for the meeting on 02.02.23.	G
BOD/23/06	Part 2	9	12.01.23	Transformation	Create of a set of core demand assumptions from which a capacity, resourcing and financial plan is created, to underpin the transformation plan,aid improved financial and operational performance to achieve better patient outcomes and experience.	All	02.02.23		This has been added to the Board Strategy Agenda for the meeting on 02.02.23.	G
BOD/23/07	Part 2	9	12.01.23	Transformation	Attend the Monthly Chair/NED Meeting on 26.01.23 if available.	S Christian	26.01.23		S Christian on leave on 26.01.23 and unable to attend.	G
BOD/22/23	Part 2	9	07.07.22	Emergency Village - Phase 2 ED refurbishment plan update	To consider how to assure QA Committee that risks in relation to patient care are considered.	N Hudson	01.09.22	28.02.23	Monthly PFIP update to FAP Committee.	G
BOD/22/38	Part 1	8	03.11.22	Chief Executive's Report	Provide a draft enabling plan for R&D to a future Board Meeting.	T Armstrong-Child	01.06.23			B
BOD/23/08	BOD Strategy	1	02.02.23	Welcome and Introductions	Invite colleagues from Primary Care and Local Authorities to a future Board meeting.	Corporate Governance Team	01.06.23		This will be added to the agenda for the June meeting.	B
BOD/23/10	BOD Strategy	4	02.02.23	Finance Peer Review Response	Invite S Worthington to the Board Meeting in July 2023.	T Armstrong-Child	05.07.23		This will be added to the Board workplan.	B
BOD/23/11	BOD Strategy	5	02.02.23	Strategy, Planning & Transformation	An annual year end presentation to be presented to Board and a one page summary provided to Governors	S Christian	04.05.23		This will be added to the Board workplan.	B

RAG Rating	
Red	Overdue
Green	Completed
Blue	Future agenda item
Amber	rbal update in Action update ite
Yellow	On agenda

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Title	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	2 March 2023		Discussion	
Author	Trish Armstrong-Child Chief Executive		Decision	
Exec Sponsor			Confidential y/n	N

Summary *(what)*	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

Implications *(so what)*	This paper is for information and assurance.

Link to Strategic objectives	Our People	x
	Our Population	x
	Our Responsibility	x

Proposed Resolution *(What next)*	Board members are requested to receive the report and note the information provided.

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1. **Awards and Recognition**

   Professor Naqvi awarded MBE

   Congratulations to Professor Naseem Naqvi who has been awarded an MBE for services to emerging technologies in the 2023 New Year's Honours.

   Professor Naqvi, a Consultant Stroke Physician, is the first person worldwide to be awarded a National Honour in the field of Blockchain and Web3 Technologies.

   Support for Turkey/Syria earthquake victims

   Many of our community have been affected following the terrible earthquakes reported in Turkey & Syria, with many of our staff having close links through family and friends.

   We wanted to pay tribute to Steve Mannion, Orthopaedic Surgeon who has been out to Turkey supporting the medical aid charity UK Med following the earthquake.

   Steve has volunteered with aid agencies in conflict zones since the 1990s including Afghanistan, Cambodia, and Rwanda during the 1994 genocide. He returns regularly to practice in Malawi where he is involved in training and research programmes. Steve is also Clinical Senior Lecturer in conflict and catastrophe medicine at St George's Medical School, University of London.

   Long service honoured at BTH

   Colleagues who have served 20, 30, 40 and 50 years with the Trust and wider NHS are now being formally recognised.

   I have been delighted to host several events over recent months and hear stories from many staff who have worked for the Trust and the wider NHS community. In recent weeks, colleagues came together who have served more than 500 years between them across a number of different roles in both clinical and non-clinical areas.

   New Cultural Diversity Network leader

   Robert Yusay (Cultural Diversity Network Lead / Ambassador Equality, Diversity and Inclusion) has taken on this role and is supporting colleagues who have joined us from overseas to settle into the Trust.

   As leader of the Cultural Diversity Network, Robert will play a lead role in supporting and integrating colleagues from overseas and educate co-workers of the importance of being inclusive.

   On 3rd March the Trust is proud to be celebrating 'Overseas NHS Worker Day'. A big thank you to Robert and all his colleagues for the work they have put into planning this event.

   Celebrating Success awards receive more than 300 nominations

   Since the last Board we opened our nominations process for this year's Celebrating Success Awards. We have received more than 300 entries. Over the next few weeks we have arranged a series of judging panels to consider for all our key staff categories.

   Categories this year include a People's Health Hero Award chosen by members of the public, along with awards including Clinical Team of the Year, Chief Executive's Unsung Hero, Compassion in Action and – inspired by the NHS' 75th birthday this year a new category for Lifetime Achievement Award.

   The award will take place virtually on March 16, available to view via the Trust's YouTube channel.

   Chief Information Officer Appointment

   Mark Singleton has joined us as our new Chief Information Officer and is responsible for the Trust's data and digital systems and teams. Mark will lead digital and information transformation across the Trust and in collaboration with partners in the wider healthcare community.

Changes to the Divisional Director post for Families and Integrated Care Division

Congratulations to Mr Eric Mutema, Consultant Surgeon Obstetrics & Gynaecology has taken up the role as the new Divisional Director within FICC. Eric has taken over the role from Dr Peter Curtis, Consultant Paediatrician who has been the Divisional Director for 16 years. Peter has worked in the Trust for 29 years and will continue to work here. I wanted to take the opportunity to personally thank Peter for all his dedication to the post and wish him well for the future.

Community appeal delivers a new piano to Barry

Trust volunteer Barry Evans, 79, has been playing the piano for patients at Clifton Hospital for 20 years as well as making regular appearances at Blackpool Victoria Hospital.

Barry was on the search for a new piano for the Memory Corridor near BVH's Care for the Elderly wards after the old instrument he previously used tinkled its last tune.

After a public appeal for help, offers flooded in from the local community, with the volunteer team now working to take delivery of an appropriate piano.

Hospital charity welcomes singing legend as its new patron

Blue Skies announced a new, high-profile patron, Alfie Boe.

As a new patron, he called on the local community to support the good cause as it launched its 75th Anniversary Appeal to mark the NHS' birthday.

2. <u>**Trust News**</u>

Secretary of State tours BTH sites

The Secretary of State for Health, Steve Barclay, visited Blackpool Teaching Hospitals recently to receive a tour and hear about the work being done by the Trust.

During his visit Mr Barclay visited the Transfer of Care Hub, our new Same Day Emergency Care facility, the Emergency Department and Mental Health Urgent Assessment Unit.

He then spent time at the modular endoscopy unit operated by Trust partners Remedy Healthcare Solutions, before visiting the Assessment and Rehabilitation Centre (ARC) in Blackpool.

BBC reports some of shortest waiting times at Blackpool A&E

The Trust has been recognised as having some of the shortest A&E waiting times this winter, according to BBC analysis done for the broadcaster's online NHS winter tracker. This focuses solely on the four-hour standard and is a reflection on the work done within our Urgent Care footprint supported by our urgent care teams and also the impact of our new Same Day Emergency Care Unit. However, we recognise we still have significant work to do and this will continue to be a focus through our Patient Flow Improvement Programme

Ambulatory stroke unit opens

We recently opened our new ambulatory unit for stroke patients at the Blackpool Victoria site, this is a result of a three-year collaboration between the Trust and Lancashire and South Cumbria Integrated Care Board.

The unit was opened to support the acute stroke unit at the Trust, as a way of treating appropriate patients and discharging them on the same day.

Chief executive signs NHS smokefree pledge

I was privileged to play my part in supporting the Trust to commit to reducing the health disparities related to smoking in our community.

As part of the Trust's commitment to helping smokers quit and providing smokefree environments that support them, senior executives are re-signing the NHS Smokefree Pledge.

The pledge aims to be a clear and visible way for NHS organisations to show their commitment and supports the work of the Fylde Coast Smokefree Services. I have recently met with the smoking cessation team to start the conversation of how we practically and pragmatically work towards a smoke free zone site. The Trust is very lucky to have such a team of enthusiastic practitioners who are committed to supporting our communities and I look forward to providing regular updates to future board sessions

Proud of Community shines a light on BTH's community teams

The #proudofcommunity campaign launched recently, aiming to build a network of ambassadors from the Trust's community teams.

The campaign is led by the Trust's Well Team, working alongside community colleagues across BTH and supported by the Executive Team, Divisional Directors and colleagues.

It aims to help share successes, ideas, knowledge and to influence change particularly in areas specific to community settings.

3. **Reportable Issues Log**

From 1 January 2023 to 19 February 2023, 9 StEIS reportable incidents were reported during this period. Five related to treatment delay, two related to delay in diagnosis and two related to an unexpected death.

All these incidents are being investigated as Serious Incidents in line with Trust policy and NHSE's Serious Incident Framework. None of these incidents were identified as meeting the Never Event criteria.

Of the formal complaints that were 'due to be responded to' between 1 January 2023 to 19 February 2023; there were no high risk final grade complaints. For information there were 29 low risk, 1 moderate risk and 19 cases still ongoing

4. **Risk Register and Board Assurance Framework**

Following the last Risk Management Committee, risks scoring 20+ relating to capacity and demand have been escalated to assurance committees for consideration to include in relevant sections of the BAF.

5. **Wider System News and Developments**

The Lancashire and South Cumbria (LSC) Integrated Care Board (ICB)

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) met on 1st February 2023.

A recording of the meeting is available to watch online here: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/future-board-meetings/1-february-2023-board-meeting

The Chief Executive's Report submitted by Kevin Lavery as part of the meeting's papers provides a wider update and can be read here: https://www.healthierlsc.co.uk/download_file/7318/11530

Provider Collaborative Board (PCB)

The PCB met on 19th January 2023. It received updates on pressures within the acute and mental health trusts; finances; research and innovation; corporate services collaboration; the clinical programme board; workforce resilience and sustainability; Cancer services and pathology.

Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

The Joint Committee had been established to give the PCB a mechanism via which to make decisions on a number of areas as agreed with Trust Boards.

System pressures – Acute

Urgent and acute care services remain extremely busy, with a collective position of 71.5% on the A&E four hour waiting time target. This is above the regional average and during January the position had risen to 76%. There had been some extremely positive examples of mutual aid over the last four weeks, particularly in relation to ambulance diverts from Blackpool Teaching Hospitals to Lancashire Teaching Hospitals and Morecambe Bay.

The Royal College of Nursing (RCN) industrial action had been well handled with positive working with staff side to ensure that patients remained as safe as possible during the strike. Some elective activity had been stood down with a varied picture across Trusts and there was some best practice learning to be had.

Planning was already underway for the industrial action set to take place in March. This was likely to be more challenging than the January strikes as some of the North West Ambulance Service (NWAS) and RCN action was due on the same date. The possible Junior Doctors strike would also have a significant impact if it proceeded.

With the exception of a number of agreed exemptions, there are no patients waiting 104 weeks within the system. Collectively trusts are on track to meet the 78 week waiting time target by the end of March although challenges remain around this including the as yet unknown impact of ongoing industrial action.

The biggest risk sits with Lancashire Teaching Hospitals due to the volume of patients on their lists, however all Trusts are committed to working together to achieve the target. This meant that some Trusts would experience a worsening of their individual position on 78 weeks, however individual Boards were sighted and supportive of this. LTH also had some specific issues in relation to the waiting list initiatives which were under discussion and may need to be escalated to the ICB and regional teams as this presented a further risk to the 78 week target.

Colorectal cancer remained a challenge across most Trusts so proactive mutual aid would remain very important in ensuring that the target was met by the end of March 2023.

In summary, the system was exceptionally challenged due to the combination of winter, covid, flu. Urgent and Emergency pressures, industrial action, and the work on restoration. However, staff were rising to the challenge and L&SC were delivering well compared with other systems with great examples of mutual aid across all areas of work. This provides a strong platform to move into the next phase of restoration. Trusts were also committed to working towards having a joint Patient Treatment List (PTL) and a paper providing more detail on the specifics of this would come to a future meeting as part of a wider strategy for scheduled care.

System Pressures - Mental Health

The flow of people with Mental Health (MH) needs from Emergency Departments into the Mental Health Urgent Assessment Centres (MHUACs) had worked well over the Christmas period despite the pressures within the system. Acute Trusts had really noticed the difference that the MUACs had made within the last month or so. A report on the MHUACs was due to come back to the PBC in two months.

The phrase mutual aid within an acute setting applies to other providers within a local geographical area, however within MH this means other MH providers. It was important that the ICS and PCB were as sighted on issues relating to the wider MH system as they were on acute pressures. Secure and rehabilitation services nationally were under considerable pressure, with a number of closures of facilities providing these services both within the NHS and the independent sector.

Skylark, an eleven bedded MH facility was due to open on the Royal Preston site which would help reduce the numbers of out of area patients.

LCSFT were committed to tracking the outcomes of the activity they were undertaking and had now joined a group looking at excess mortality rates as part of that process.
Financial pressures

The system's financial position continues to be very challenged with ongoing conversations taking place with the regional and national teams about the likely year end position.

The current operational challenges including the industrial action would inevitably have a detrimental effect on finances. Unfunded beds remained an issue for some trusts due to a lack of out of hospital capacity – some short-term solutions had been found but these were high cost and unsustainable particularly in relation to temporary staffing premiums.

Changes to discount rates were contributing to technical gains and progress continues to be made across all trusts in terms of grip and control – it would be vital to sustain this throughout the remainder of the year.

Any deficit this year would be carried into the following year and was likely to impact on the ability to attract future capital. The next financial year 2023/20024 was set to be even more challenging with much scrutiny around efficiency and restoration of elective activity.

Research and Innovation (R&I)

An update was given on the current state of the National Institute for Health and Care Research (NIHR) Studies in the PCB Trusts, the interactions with local academia and industry, and innovation and the workforce in Research and Innovation (R&I).

A discussion took place on successes to date, opportunities and limitations and recommended ways to move this agenda forward.

Whilst much progress had been made, colleagues across Lancashire and South Cumbria were keen to ensure that they fulfilled their potential in both R&I and Education. In addition to the ongoing work of the networks it was important to develop a unique proposition for L&SC and fully integrated ways of working between different organisations and to focus on some specific areas of research (e.g., deprivation). The ICS were keen to work with the PCB to develop these areas of expertise particularly given the positive effect that involvement in R&I as part of people's job roles had on both recruitment and retention of staff.

Workforce Resilience and Sustainability Project

The Bank and Agency programme had been reset and renamed the Workforce Resilience and Sustainability Programme to reflect the scope of the work required.

A workshop in January including staff side and temporary staffing had been very positive and removed some of the potential barriers to the tender process proceeding at the end of March.

A general communications plan has been prepared and will be disseminated shortly. The Business Case would be coming back to the PCB in March.

Corporate Services Collaboration

Work around the Workforce Resilience and the Sustainability project had been extensive during December. Three workshops had taken place with HR, Finance and Communications with a further workshop to take place in February/March to finalise proposals for the Target Operating Model.

A clear procurement path has been put forward for Bank and Agency and the ELFs Shared Services proposal, and there was good progress on development of a single payroll and other initiatives such as the ledger for finance.

Clarity of leadership, governance and assurance would be essential to the success of the programme and learning had been taken on board from previous programmes to ensure that this was robust.

Work was taking place to align HR policies such as management of change and infrastructure for redeployment, and relevant processes were being put in place in advance of the development of the target operating model.

A forward plan with a clear decision-making timetable would be developed after the next workshop.

Clinical Programme Board

A positive meeting had taken place between the Clinical Services Programme Board and the ICS Medical Director to begin to agree priorities and milestones, particularly for the next year in relation to both the Clinical and Cancer Strategies.

The programme team had done a lot of work with Senior Responsible Officers on the programme plan milestones, decisions, benefit realisation, and the risk register and the forward look for 2023/24 would be firmed up further with the help of the ICS.

Engagement of staff, and interaction with the ICS team would be critical to the success of the clinical programmes– the ICS would be arranging a workshop in March to set out how and when engagement and consultation needed to take place in connection with any proposed service changes. A tool kit had been developed by the ICB and PCB communications and engagement colleagues to make the process as easy as possible and to ensure a consistent methodology.

There was a consensus that delivery of services needed to take place within the existing infrastructure of the ICS and PCB rather than waiting for the New Hospitals Programme (NHP) to come to fruition and that configuration of existing trusts would be a limiting factor that needed to be taken into account. Interdependencies between services would need to be considered when deciding where services should be located. A commissioning view would also be important for many of the projects, for example with regard to the location of regional centres.

Work is progressing in Pennine to review current community services, and this would inform the PCB considerations about the development and delivery of integrated care models. This would need to be closely integrated with the ICS work, as this was a commissioning responsibility.

Cancer Services

The system has experienced challenges in the delivery of some cancer services and some of them were noticeably fragile.

The findings of a deep dive have been reported to the ICS Board. These encompassed a range of issues and a Cancer Plan addressing these will return to IC Board in Q4.

The PCB and ICS now need to work closely with the specialist commissioning to address these challenges. Difficult decisions may need to be made by providers, informed by the PCB in the interest of the public and the best possible outcomes.

The ICS Board would initially be concentrating on a number of key changes within agreed priority specialties – Vascular, Head and Neck and specialist Urology cancer surgery - and NICUs and non-surgical oncology workforce.

Other clinical programmes need to develop robust networks and focus on delivering best practice pathways informed by Get It Right First Time (GIRFT) principles.

Pathology

Presentations have or will shortly be given to individual Trust Boards about the intention for the pathology collaborative to report into the Joint Committee. Meetings had taken place with Divisional Directors within Trusts.

Further discussions had taken place with Browne Jacobson to understand what might be in the Joint Committee Terms of Reference regarding this and the overall direction of travel, with the focus likely to be on ten key areas.

Trish Armstrong-Child
Chief Executive

Title	Integrated Performance Report (IPR) – Quality

Meeting:	Board of Directors in Public Meeting
Date:	2nd March 2023

Author	William Wood, Associate Director of BI				
Exec Sponsor	Natalie Hudson, Chief Operating Officer Peter Murphy, Executive Director of Nursing, Midwifery, AHP & Quality Chris Barben, Executive Medical Director				
Purpose	Assurance	Y	Discussion	Y	Decision	Y
Confidential y/n	N				
Summary *(what)*	SHMI – continued reduction to 106 which is within the expected range for risk adjusted hospital mortality Skin integrity committee established to support the divisional teams to continue to ensure prevention and management of skin and tissue damage. Dementia Tier 1 training is being reviewed and to be included in core mandatory training. Still birth and neonatal charts changed from count to rate charts pending further review by the Business Intelligence Unit and Divisional leadership team. Duty of Candour 100% 97% of complaints responded to within the 25/40-day standard. Safe staffing remains within normal variation despite several additional escalation areas remaining open.				

Previously considered by	Quality Assurance Committee

Implications *(so what)*	The non-achievement or deterioration of key performance indicators has a direct correlation with the quality of care the Trust delivers.

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	✓
Equality, Diversity and Inclusion (EDI) implications considered		
Proposed Resolution *(What next)*	The Board of Directors is asked to acknowledge and approve the Quality IPR.	

Integrated Performance Report

Quality Assurance Committee

January 2023

Caring · Safe · Respectful

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting ***https://www.england.nhs.uk/publication/making-data-count/***

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre dashed reference line (black) is the mean, and the two light grey dashed lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.

Executive Summary

		Assurance				Variation				
		P	?	F	(blank)	H●	L●	(●)	L●	(blank)
Quality	Harm Free	1	5	1	11		1	17		
	Patient Experience	4	8	1	1	1		11	2	
	Maternity	1	3		9	1	2	9		1
	Infection Prevention and Control		5		1			6		
	Mortality		1	2	3	1	2	3		

Measures the likelyhood of targets being met for this indicator.

Assurance

? Indicates that this indicator is inconsistently passing and falling short of the target.

P Indicates that this indicator is consistently **passing** the target.

F Indicates that this indicator is consistently **falling** short of the target.

Whether SPC rules have been triggered positively or negatively overall for the past 3 months.

Variation

Indicates that there is no significant variation recently for this indicator.

L / H Indicates that there is **positive** variation recently for this indicator.

L / H Indicates that there is **negative** variation recently for this indicator.

↗ Special cause variation where **UP** is neither improvement nor concern.

↘ Special cause variation where **DOWN** is neither improvement nor concern.

Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

Quality

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Harm Free

Cardiac Arrests

The resuscitation team at Blackpool Teaching Hospitals recorded 152 cardiac arrests between November 2020 and November 2021 with 108 of those occurring outside of critical care areas (ED, ITU/HDU, cardiology catheter labs, CCU and public spaces) where emergency calls were made to activate the team. As a comparison the figures between December 2021 and December 2022 are a total of 113 cardiac arrests, with 77 outside those areas previously listed. As described in the Trust QI Strategy, our approach to improvement is to use a Breakthrough Series collaborative, which launched in February 2021.

The aim of the Deteriorating Patient collaborative is to reduce patient harm as a result of failure to monitor, recognise and respond to a deteriorating patient.

9 multidisciplinary teams were involved in the first phase of the collaborative, which held a summit in September 2021. These teams undertook improvement projects related to the identification and care of the deteriorating patient. Individual time between run charts are used by the teams to display cardiac arrest data for the 6 inpatient areas. A combined time between cardiac arrest run chart is used to display data for the collaborative.

Patient Safety Alerts

In January, there were 2 Patient Safety Alerts:

NatPSA/2023/002/CMU - Supply of Licensed and Unlicensed Epidural Infusion Bags.

NatPSA/2023/001/NHSPS - Use of oxygen cylinders where patients do not have access to medical gas pipeline systems.

These were both closed within month and did not breach.

Dementia

The Royal College of Psychiatrists (RCP) National Audit for Dementia (NAD) started on the 20th of September, this includes audit of 40 case notes, patient and family feedback and an organisational statement. All 3 parts of the clinical audit have now been completed, initial findings were that the 4AT was not always completed and it was not always recognised that patients had delirium. A delirium awareness session has been delivered on the 17th January. The Dementia champions meetings have continued to take place via TEAMS with good attendance, future meetings will be face-to-face. Work has been carried out to ensure that the champions can be identified on Health Roster to ensure they can be more accurately monitored across the organisation. A request has been sent to the training department to ask that Tier 1 dementia training is made mandatory to all staff, the e-learning training is already available on ESR. Tier 2 dementia training has been reviewed, to ensure it is fully compliant with Health Education England (HEE) standards. The revised training is being carried out over 2 days, 2 sessions have taken place to date, with positive feedback reviewed from candidates. This training is currently non mandatory, it will continue to be delivered in partnership with LSCFT, safeguarding, dieticians, pharmacy and experts by experience, the training is now face-to-face. The dementia delivery plan and identified work streams continue with the identified themes of work, and the leads from each of these work streams reporting back on a monthly basis on the progress of their agreed action plan. A summary of the progress of each work stream will be delivered to the DAB.

Falls

In January, there were a total 62 harms recorded because of a fall, 60 of minimal or zero harm and 2 reported as moderate harm falls. In addition, there are a further 21 incidents that are currently under review within divisions and are awaiting categorisation. This is a decrease compared to the previous month, but within normal variation.

In January, 28 inpatient wards experienced zero falls and 26 areas recorded zero falls through December.

A steering group has reviewed and updated the intentional rounding tool (IR) - this will ensure that patients individual needs and risks are identified by staff and addressed to ensure risk of harm is mitigated. Relating to falls - this will ensure patients items are within reach, footwear is appropriate, patient discussions are taking place regularly regarding falls safety for example. Evidence supports a 50% reduction in falls through use of IR. Plans are to test the new tool across the bedded divisions in February 2023 – awaiting delivery from printers. The new falls policy has been ratified for use.

A working group to review and update falls practice has been commenced and this will include a review of the use of technology such as falls alarms, training, completion of risk assessments and bay-based care.

Harm Free

Pressure Ulcers

Acute

A total of 113 hospital acquired pressure ulcers were reported in January. The breakdown of this is: 38 at Category 2/ 4 at Category 3 / 0 at Category 4, with 17 unstageable and 54 Deep Tissue Injuries.

There were also 8 device related pressure ulcers. This was an increase from the previous month and reviewing the SPC chart shows special cause.

During January, 24 clinical areas within the acute site declared zero hospital attributable skin damage; this is an increase compared to December and of these areas - 9 have reported zero attributable skin damage in the last 6 months.

January has seen continued high pressures within the Emergency Department. The Tissue Viability Team continue to support the department daily, providing support to implement skin inspections and facilitate patient repositioning and early Tissue Viability plans if required.

A project to implement wound photography within the Emergency Department has commenced testing – this will support appropriate patient management and accurate pressure ulcer reporting.

A review of all training related to tissue viability has been completed leading to a streamlined and easy to access offer from the TV team supported by divisional PD training packages – although training within the acute setting was paused during January, this will recommence in February.

Community

A total of 140 non-hospital acquired (community) pressure ulcers were reported in January. The breakdown of this is: 48 at Category 2/ 2 at category 3/ 1 at Category 4, with 25 Unstageable and 64 Deep Tissue Injuries. There were also 5 device related pressure ulcers. This was a decrease from the previous month and reviewing the SPC chart shows data is back within normal variation.

The community Skin Surveillance Forum continues to monitor the pressure ulcer acquisition and prevention within the division.

A project for community validation of pressure ulcers is currently underway within two teams with spread to further teams planned; an audit to monitor this will be set up and managed by the Tissue Viability Team.

Pressure ulcer training for senior nurses has continued to be delivered to community staff in January with additional dates added due to demand.

Since the pressure ulcer collaborative ended, the skin integrity committee is in place to support the divisional teams to continue to ensure prevention and management of skin and tissue damage remains a focus. Each Divisional Director of Nursing represents their team through a review of data, performance and improvement plans bimonthly. This committee focuses on the use of the change package to support improvement.

eDischarge Compliance

This indicator will undergo further refinement over the next month to ensure accurate performance reporting.

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Cardiac Arrest		7	Jan 23	(variation)			14	Dec 22		79.00
IAPT Recovery	50%	53%	Jan 23	(variation)	(?)	50%	56%	Dec 22		
IAPT Wait Times	75%	98%	Jan 23	(variation)	(P)	75%	93%	Dec 22		
Over-seven-day incapacitation of a worker	0	0	Jan 23	(variation)	(?)	0	0	Dec 22	0	11.00
Specified injuries to workers	0	1	Jan 23	(variation)	(?)	0	1	Dec 22	0	3.00
New Community acquired pressure ulcers, trust attributable actual		140	Jan 23	(variation)			159	Dec 22		1201.00
New Hospital acquired pressure ulcers actual		113	Jan 23	(variation)			109	Dec 22		778.00
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days		1.39	Jan 23	(variation)			1.42	Dec 22		11.90
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days		0.14	Jan 23	(variation)			0	Dec 22		0.49
Patient Safety Alerts		2	Jan 23	(variation)			0	Dec 22		8.00
Number of SUI/StEIS incidents		5	Jan 23	(variation)			4	Dec 22		46.00
Number of never events	0	0	Jan 23	(variation L)	(?)	0	0	Dec 22	0	0.00
Number of falls		139	Jan 23	(variation)			146	Dec 22		1431.00

Quality

Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
		Latest					Previous		Year to Date	
Patient Falls resulting in harm (number)		62	Jan 23				64	Dec 22		759.00
Patient Falls - Moderate/Severe/Death - per 1,000 bed days		0.071	Jan 23				0	Dec 22		0.95
Safe Staffing	90%	90%	Jan 23			90%	87.2%	Dec 22		
eDischarges Compliance	95%	80%	Dec 22			95%	84%	Nov 22		
30 Day Emergency Readmissions (%)		7.23%	Sep 22				7.35%	Aug 22		

Quality

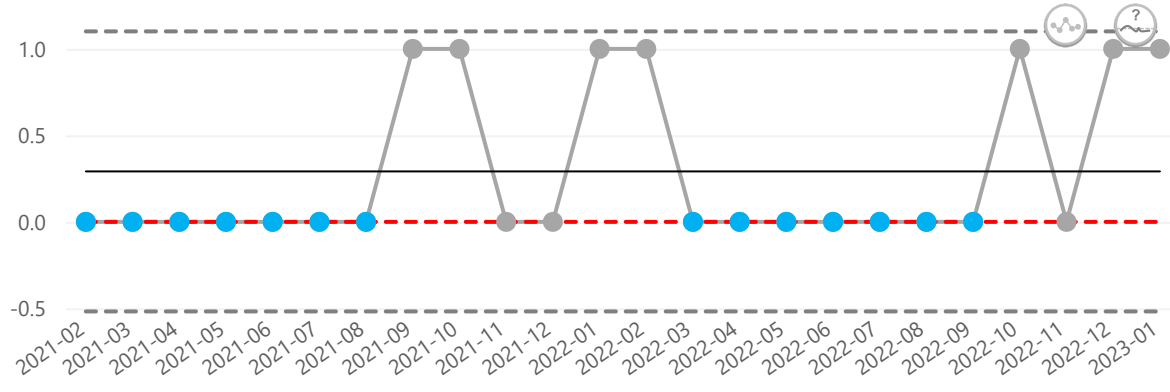**Quality**

Cardiac Arrest
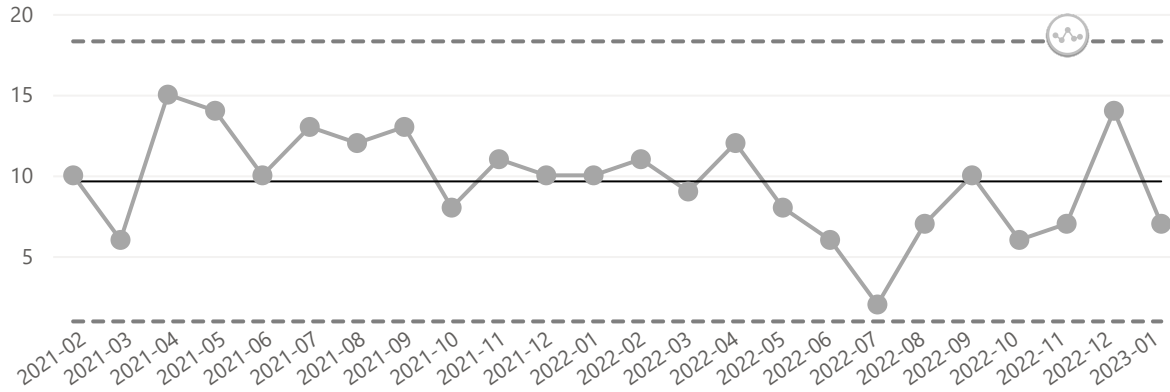
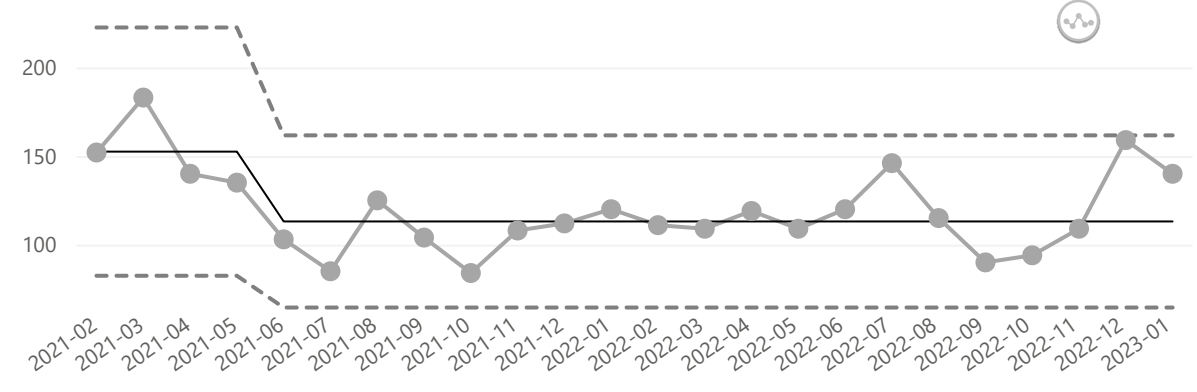**IAPT Recovery**
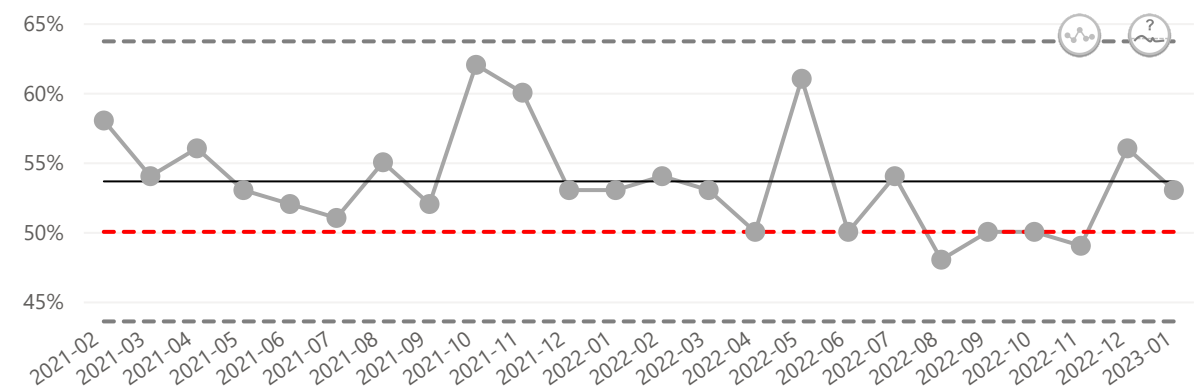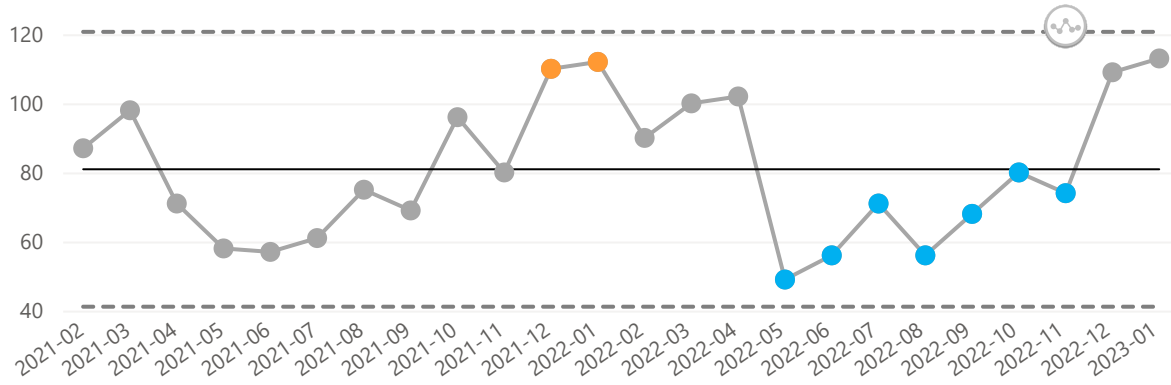
IAPT Wait Times
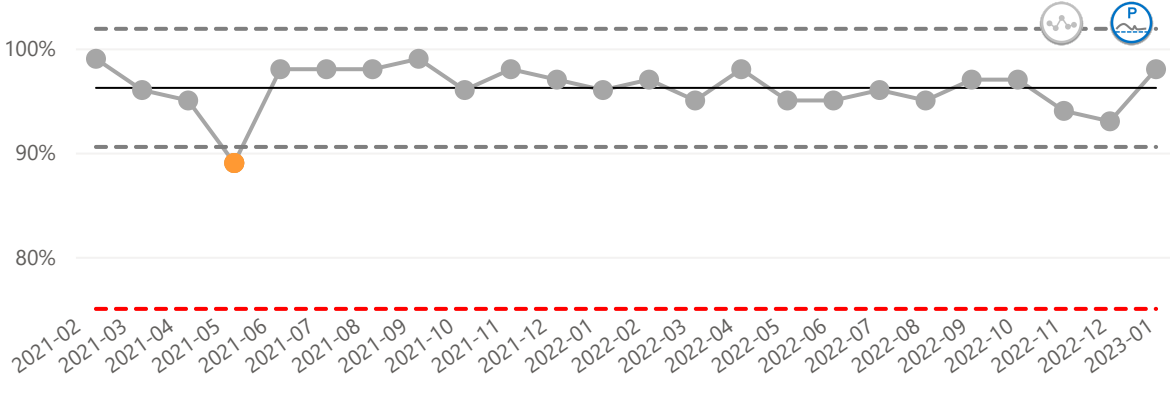
Over-seven-day incapacitation of a worker
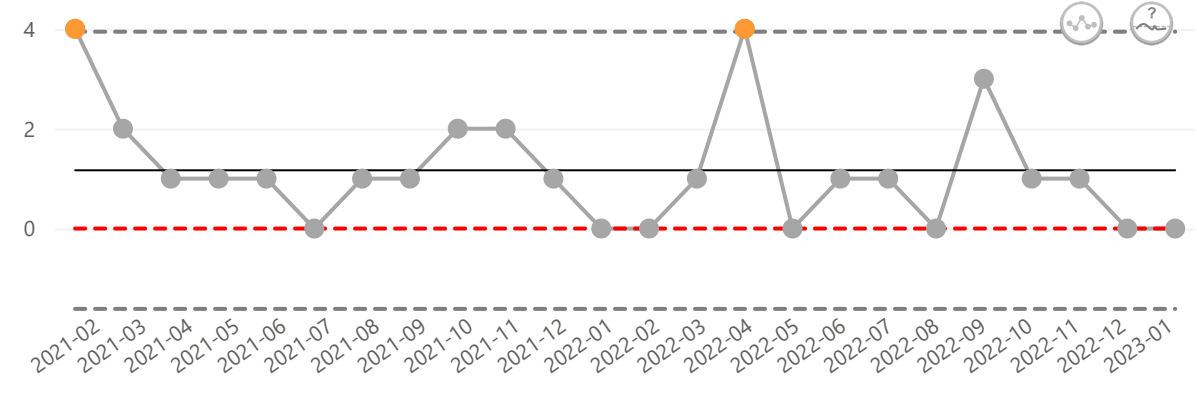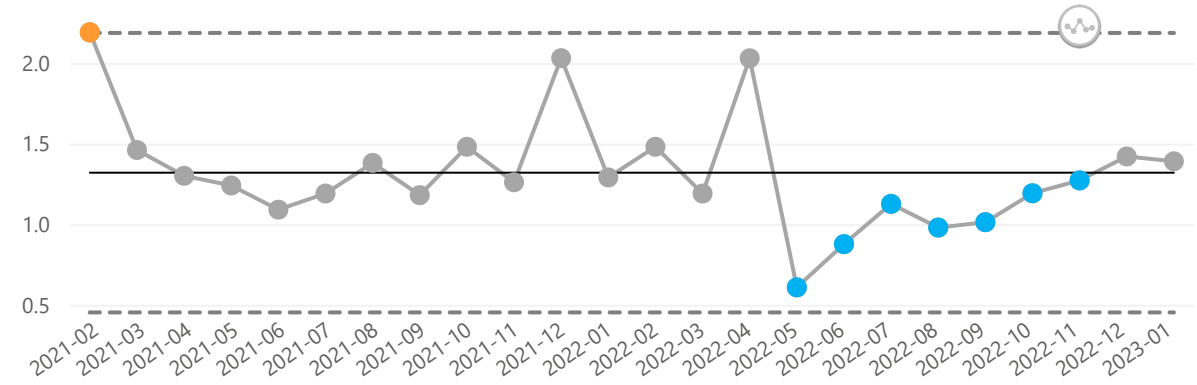
Specified injuries to workers

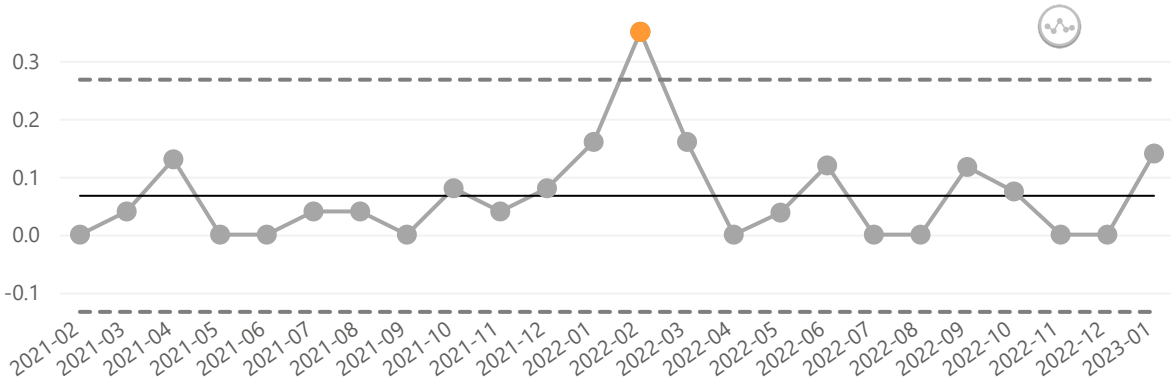**New Community acquired pressure ulcers, trust attributable actual**

Quality

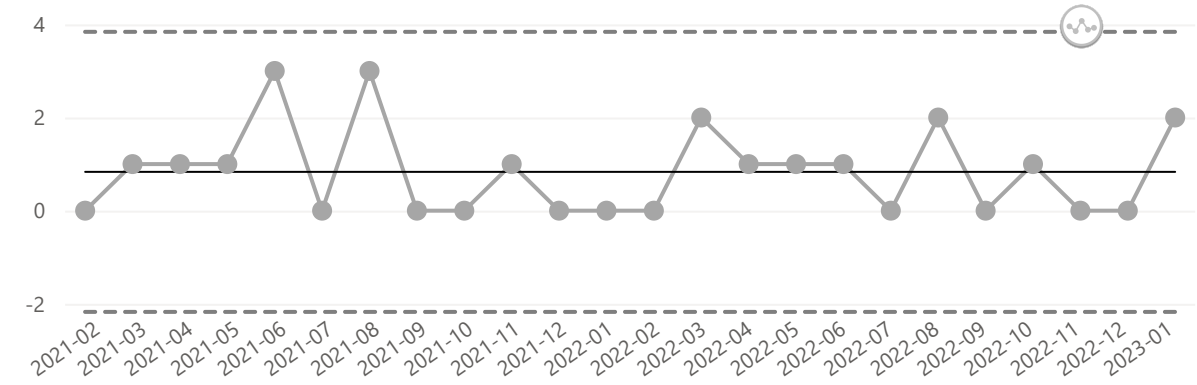**New Hospital acquired pressure ulcers actual**

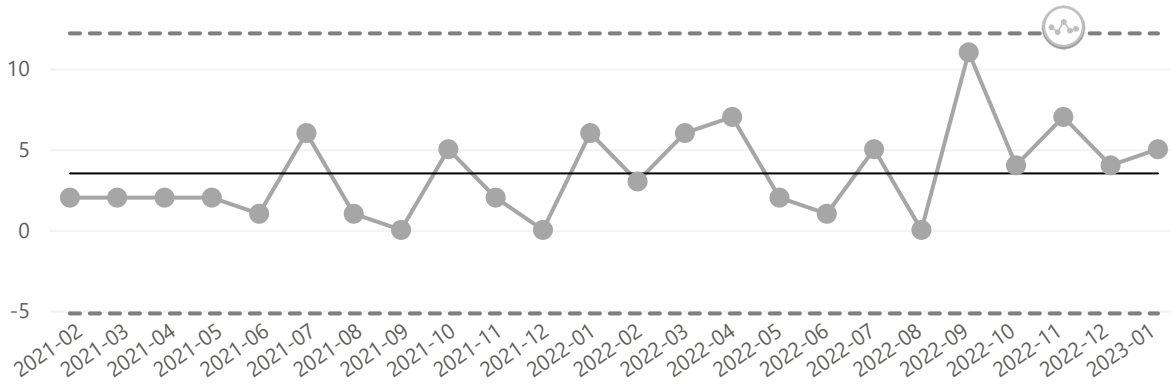**Hospital Acquired Category 2 Pressure Ulcers – per 1,000 bed days**

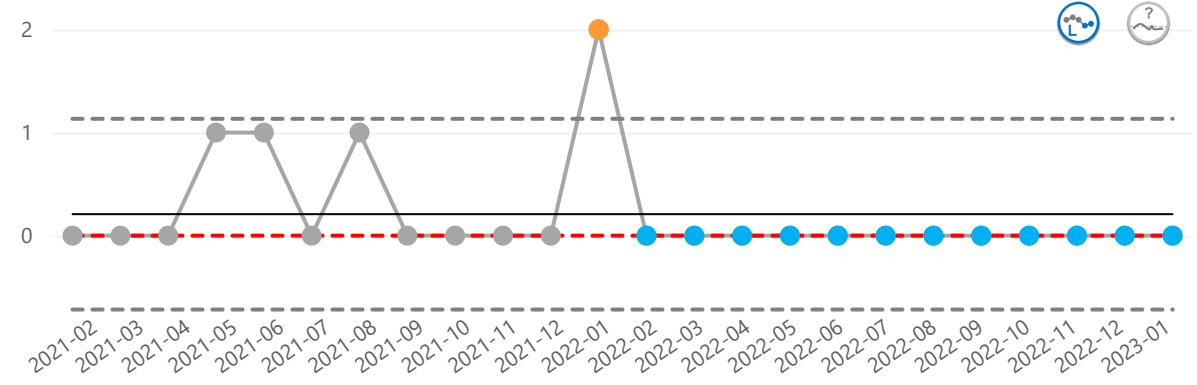**Hospital Acquired Category 3 & 4 Pressure Ulcers – per 1,000 bed days**

Patient Safety Alerts

Number of SUI/StEIS incidents

Number of never events
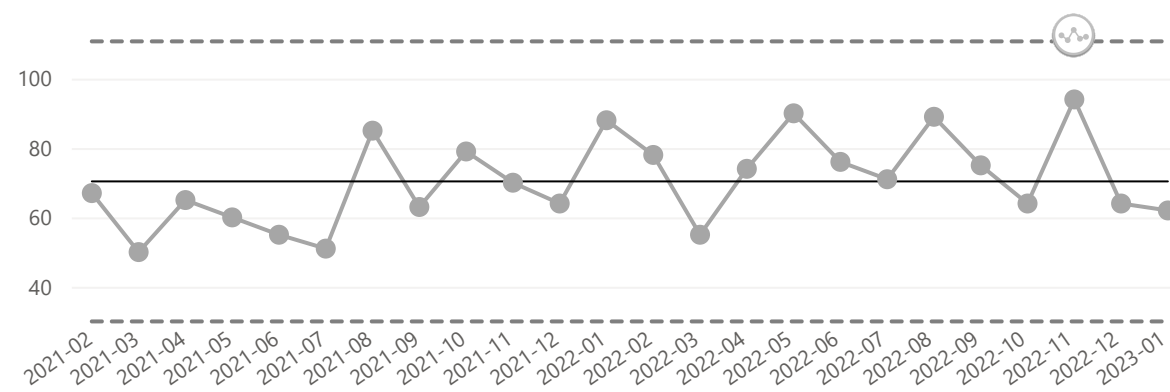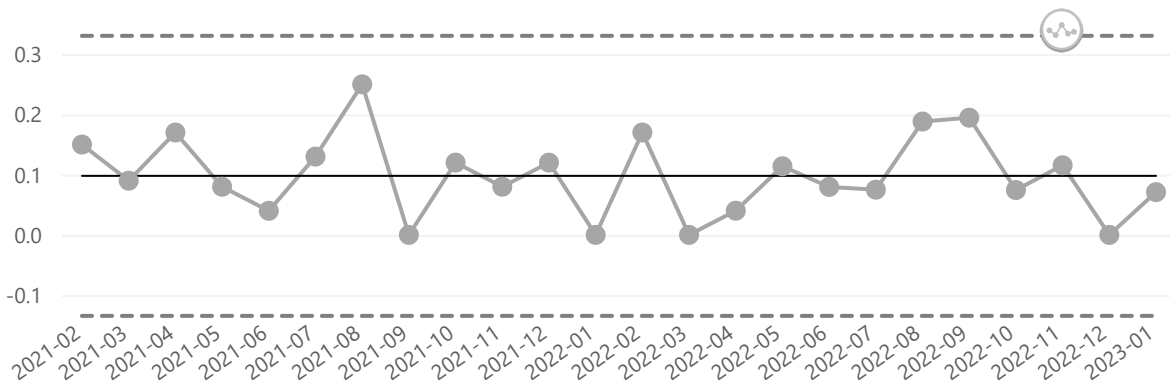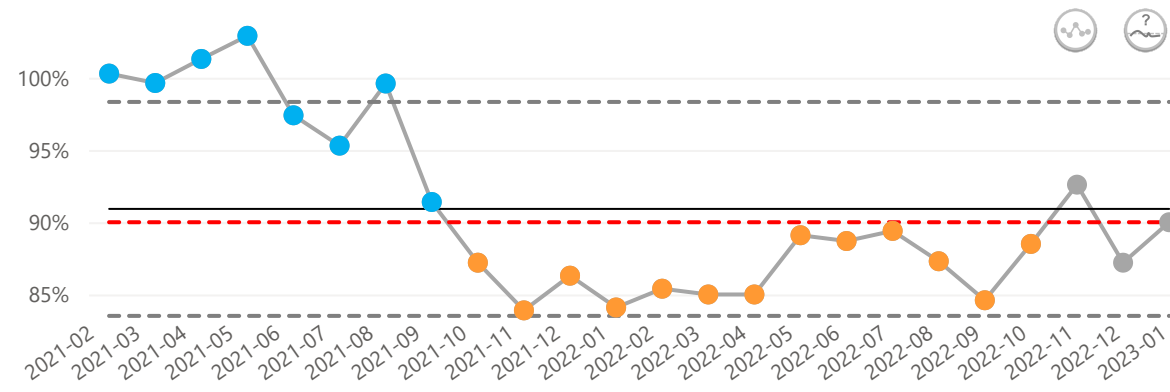
Quality

Number of falls
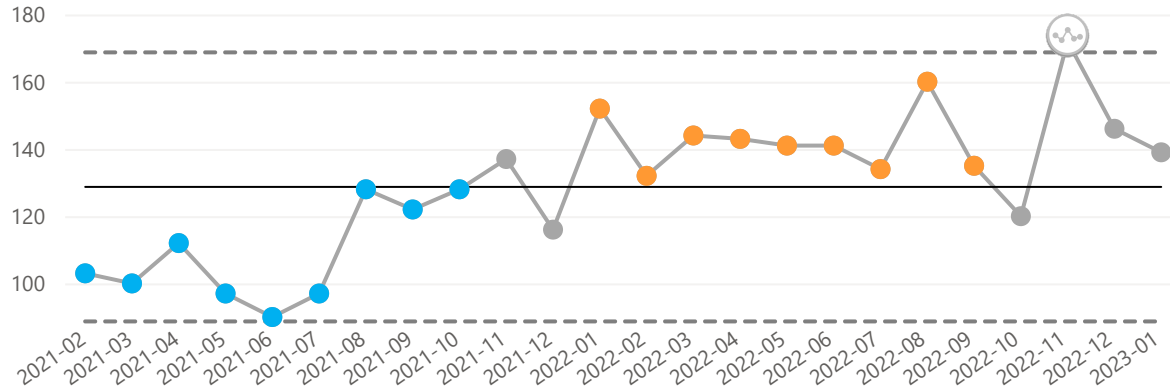
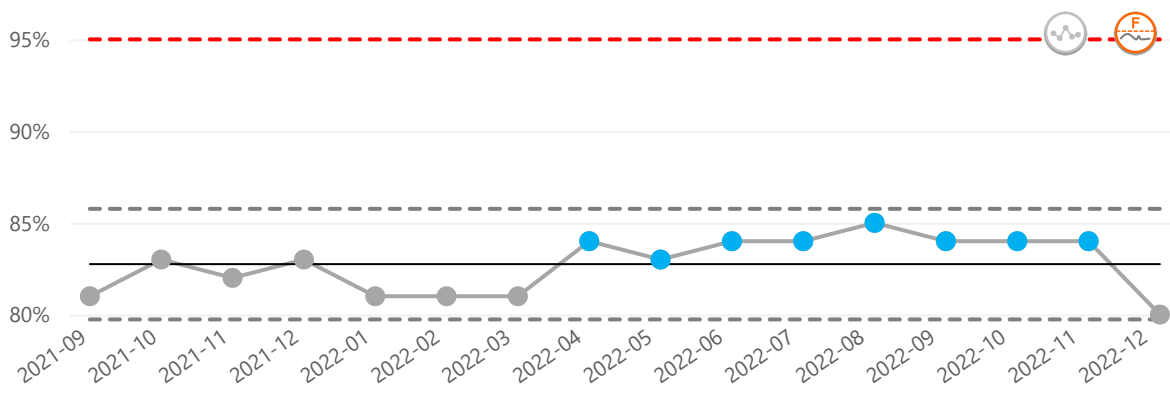**Patient Falls resulting in harm (number)**

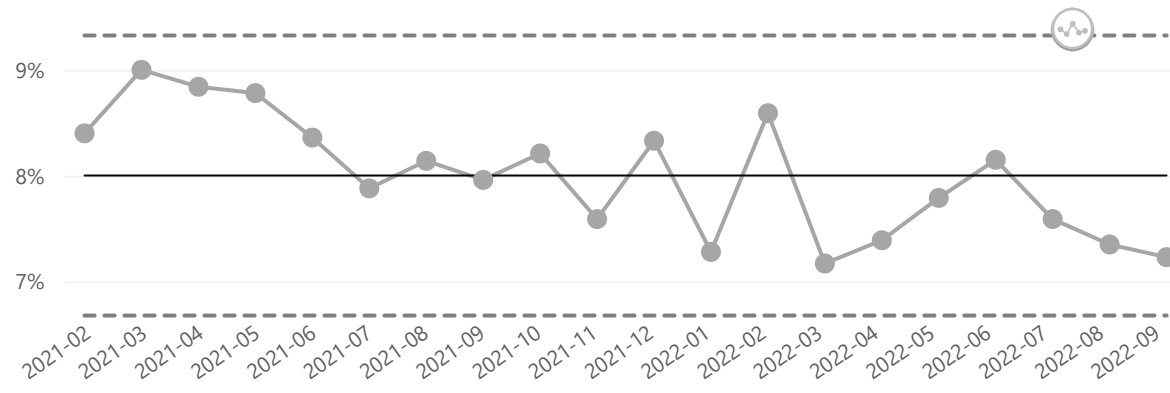**Patient Falls - Moderate/Severe/Death - per 1,000 bed days**

Safe Staffing

eDischarges Compliance

30 Day Emergency Readmissions (%)

Maternity

Induction Rate

The induction of labour is slightly higher than the regional average due to our complex population. We have a higher than national average smoking rate at time of booking and at time of birth. This leads to additional surveillance and the potential for fetal growth problems. We also have high pre-term births, women with raised BMI and high levels of social deprivation and mental health. These factors all increase the likelihood of induction of labour. The Consultant Midwife, Head of Midwifery, Director of Midwifery and Head of Department are reviewing the induction of labour pathway in conjunction with NHS England Quality Improvement team at the beginning of March. We plan to ensure more streamlined processes for induction of labour, and informed choice around the decision to proceed with an induction of labour. Although the aim is not necessarily to reduce induction of labour it is to ensure the women and family receive the right birth in the right place with the appropriate information and informed choice. We also want to improve the timeliness of transfer for induction of labour in line with our CQC Improvement Plan, this will improve the experience of women being induced in our unit.

Maternity Complaints as % of Deliveries

We have seen an increase in complaints. However, this is now on a downward trajectory and being monitored closely by the Matron and Head of Midwifery to ensure as many complainants as possible are seen face to face, and key themes are identified and worked on. A key theme identified is culture within the ward environment, and in particular how this impacts communication with patients. NHS England have provided training to help with personal and professional resilience and compassion in the workplace. This is being rolled out through March. Individuals identified through complaints are being managed as per policy and also supportive conversations with the Professional Midwifery Advocate team.

Induction of Labour - % within 4 hours

At present no chart is included as there aren't many data points available. Data is being collected each month and once sufficient data points are available a run chart will be included before moving to an SPC chart.

The Business Intelligence directorate are working with the clinical division to undertake a full review of the maternity indicators included in the Quality Integrated Performance Report. With a particular focus on the targets and whether these are still up to date and applicable to the organisation.

		Latest				Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Emergency C Section		21.2%	Jan 23	(common cause)			23.6%	Dec 22		
Caesarean Rates		35.4%	Jan 23	(common cause)			42.3%	Dec 22		
Breastfeeding Initiation	62%	67.3%	Dec 22	(common cause)	(?)	62%	70.9%	Nov 22		
Neonatal Mortality		0.005	Jan 23	(L)			0	Dec 22		0.01
Stillbirth		0	Jan 23	(L)			0	Dec 22		1.00
Number of Maternal Deaths	0	0	Jan 23	(common cause)	(P)	0	0	Dec 22	0	0.00
Induction Rate	38%	48%	Jan 23	(common cause)	(?)	38%	40.9%	Dec 22		
Maternity Complaints as % of Deliveries		5.1%	Jan 23	(common cause)			1.9%	Dec 22		
Percentage of Occasions 1:1 Care Provided		98.9%	Jan 23	(H)			98.6%	Dec 22		
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births		1.5%	Jan 23	(common cause)			0.8%	Dec 22		
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth		0%	Jan 23	(common cause)			0%	Dec 22		
Percentage of Women Booked by 12 weeks 6 days	90%	86.9%	Jan 23	(common cause)	(?)	90%	90.7%	Dec 22		
Induction of Labour - % within 4 hours		18.8%	Dec 22				41.6%	Nov 22		

Quality

Quality

Emergency C Section
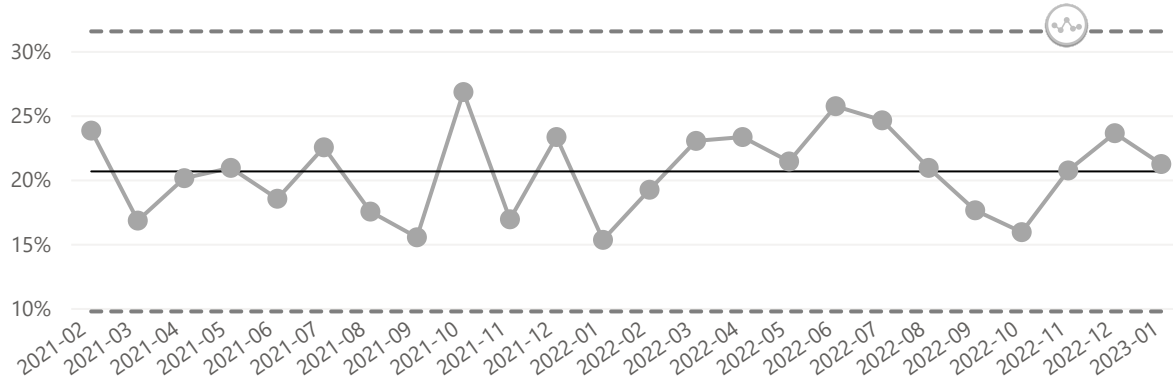
Caesarean Rates
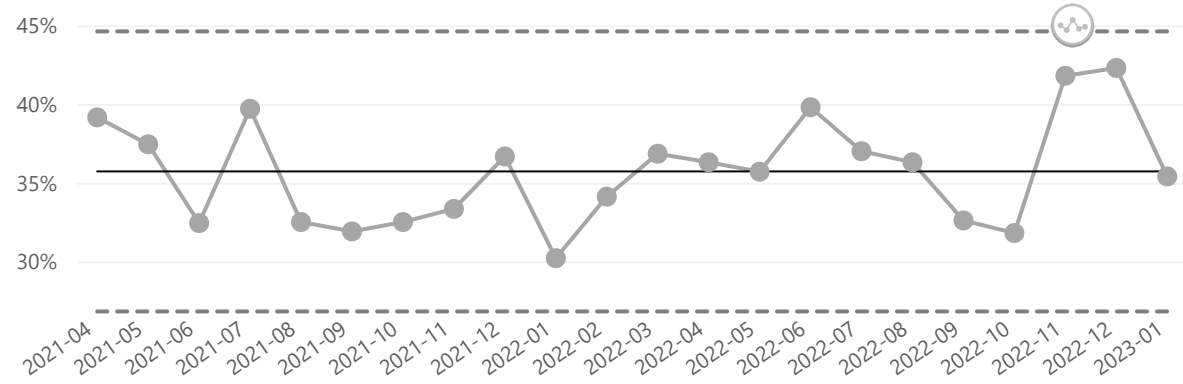
Breastfeeding Initiation
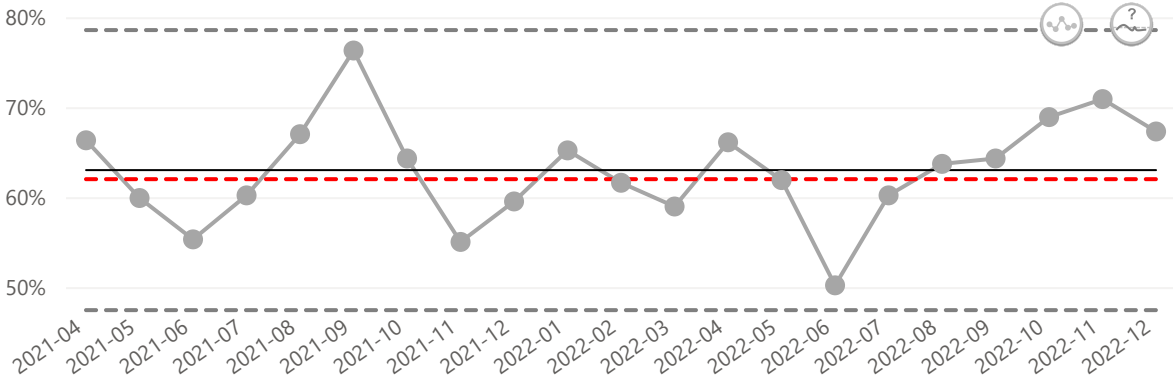
Neonatal Mortality
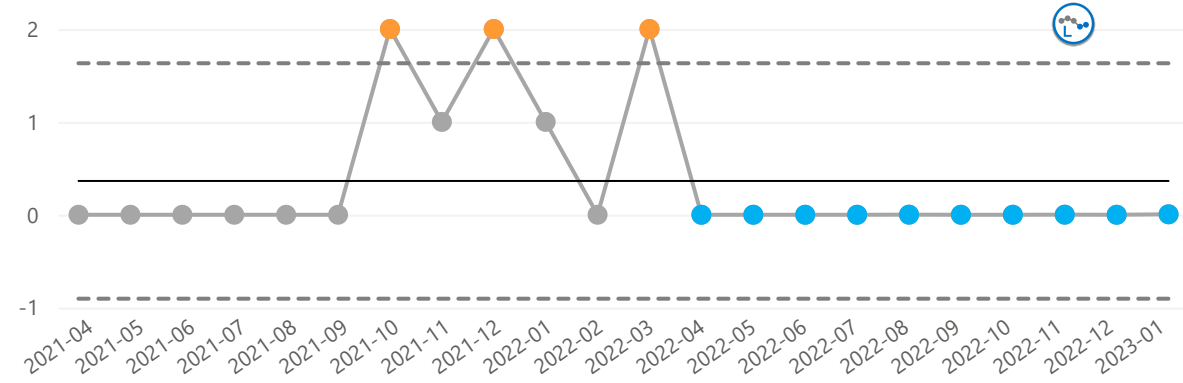
Stillbirth

Number of Maternal Deaths

Quality
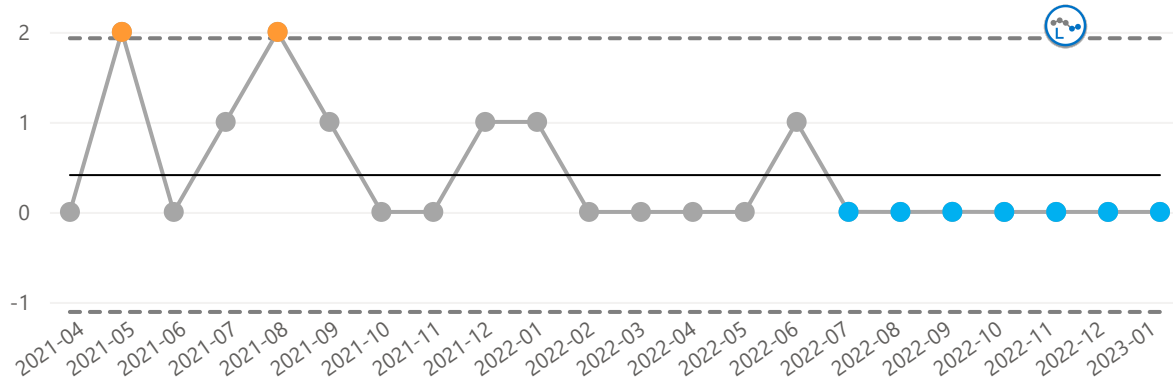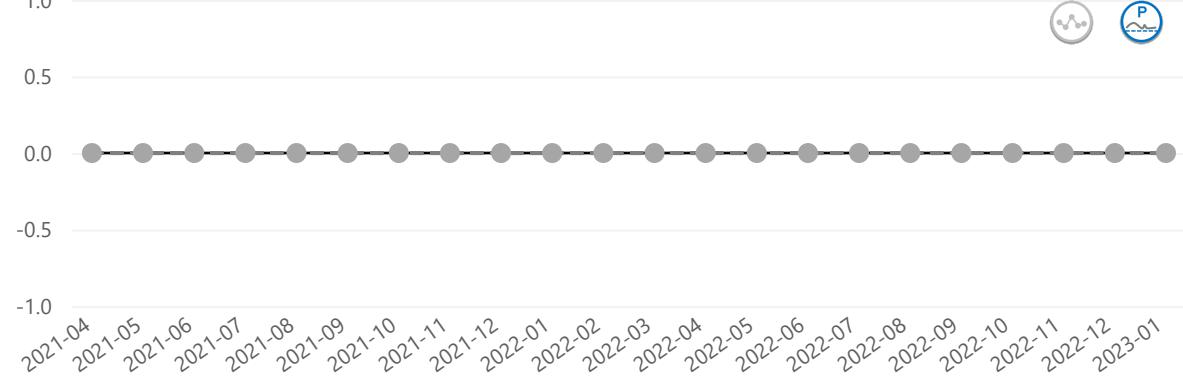
Induction Rate
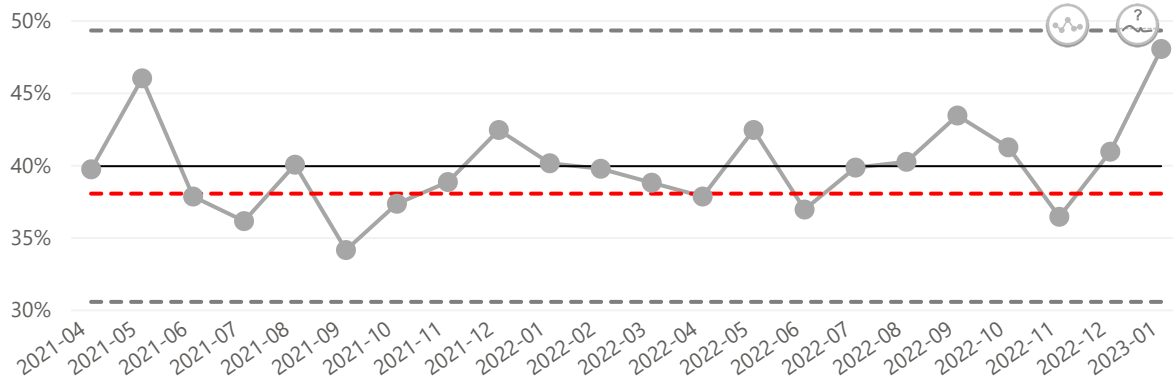
Maternity Complaints as % of Deliveries
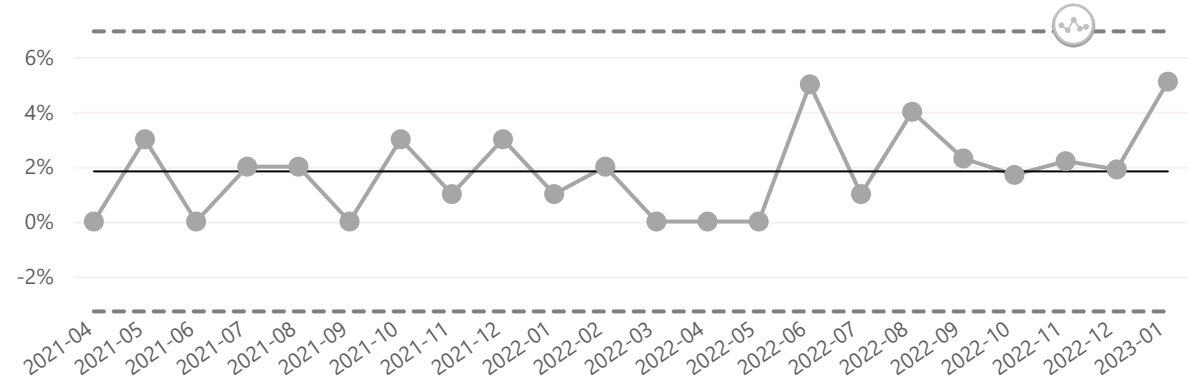
Percentage of Occasions 1:1 Care Provided
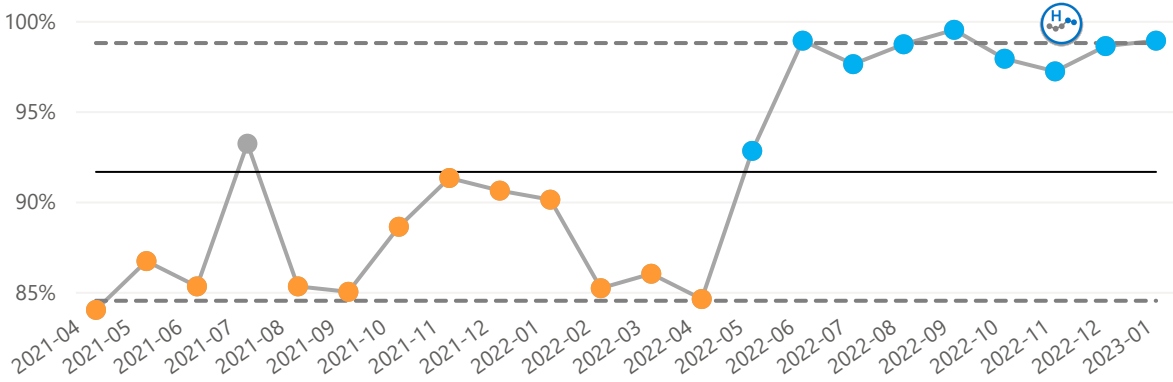
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births
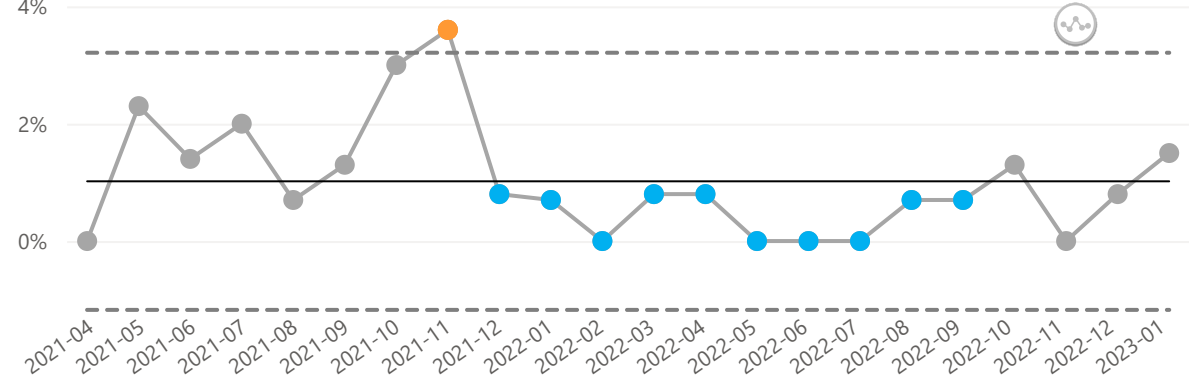
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth

Percentage of Women Booked by 12 weeks 6 days

Quality
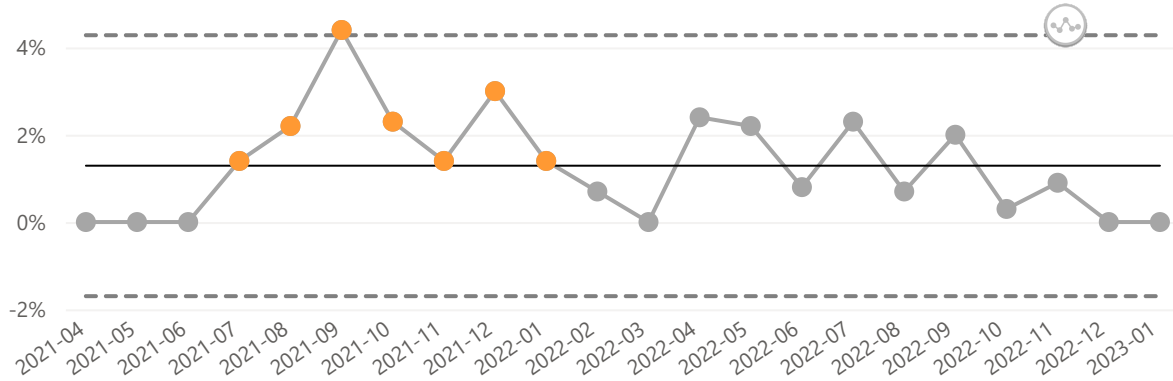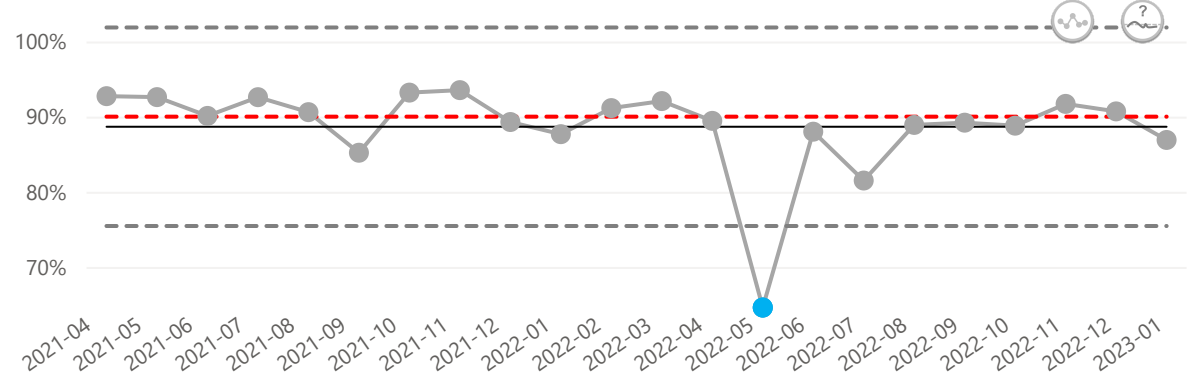
Patient Experience

Overall, Friends and Family Test

5157 FFT surveys were completed in January a 28% increase compared to December. Current pressures have eased slightly in the Trust, which has reflected in the FFT numbers. Additionally, the return of the patient experience volunteers on a regular basis has meant that we have also been able to survey patients directly using the Outpatient and Inpatient Listener Survey.

95% of our patients rated their care as good in January, a 2% increase. Monthly meetings continue with services to discuss their FFT feedback agreeing key priorities to improve the patient and carer experience. SMS is continuing to be rolled out across the Trust, with 48% (2493) of the feedback in January collected via SMS or online reducing cost on paper surveys and supporting the Trusts green plan. The patient experience team held a FFT event on the mezzanine at Victoria Hospital during January which was well received by staff and visitors.

Outpatients and Day Case

2092 FFT surveys were completed for outpatients and day case in January, a 26% increase compared to December. Overall satisfaction is 94%, a decrease of 1%.
Patient Engagement continue to meet with the outpatient clinical matrons to identify themes and define an agreed improvement plan. A new Sister has recently been recruited in the Outpatient area, as a co-ordinator to help with the pressures within the waiting areas and support improved communication. Both issues have been identified through FFT feedback.

Inpatient

1024 FFT surveys were completed, by inpatients at either Clifton or BTH sites a 15% increase. Overall satisfaction is 96%, a 1% decrease. SMS was introduced during quarter 3 and has helped towards this increase.

Emergency Department

219 FFT surveys were completed in January, a 11% decrease compared to December. Overall satisfaction is 77%, an 8% increase. The patient information poster/ leaflet is being updated to reflect the pathways for patient blood result, which is an area of concern from feedback. Recruitment for ED waiting area volunteers is being readvertised.

Maternity

106 FFT surveys were completed in Maternity in January, an 8% decrease compared to December. Overall satisfaction is 91%, an increase of 3%. A new welcome to the ward poster and information sheet has been produced, to improve patients understanding of the pathways and increase communication while on Ward D. The ward is also looking to source eye masks and ear plugs for patients who are antenatally admitted due to concerns over noise at night.

Community

1548 FFT surveys were completed in January in the community, a 39% increase compared to December. Overall satisfaction is 97%, an increase of 2%.

Paediatrics

487 FFT surveys were completed across paediatrics in January, a 50% increase compared to December. Overall satisfaction is 93%, a 3% increase. Patient Engagement continue to meet with the Children's Engagement leads, both in the community and acute. The new Patient Experience Community Officer has been actively meeting with the community leads, encouraging them to ask for feedback, as well as discussing where improvements can be made

Mental Health

168 FFT surveys were completed within mental health in January, a 600% increase compared to December. Overall satisfaction is 94%, a 7% increase. Patient Engagement continues to work with informatics to roll out and embed SMS surveys across the mental health services and are looking to have this in place for Spring 2023. This will drive up the FFT numbers and encourage consistent feedback across all mental health services.

Patient Experience

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Quality

Complaints

In January 2023 30 new formal complaints were received, 20% more than December. Additionally, we had 29 complaints 'Due to be Responded to' in January, 28 of which (97%) were completed within our 25/40-day timescales, our best monthly performance since the pandemic. The key themes reported in January's complaints were treatment / care issues, poor or lack of communication and staff attitude. The team meet monthly with divisional leads to discuss these themes and ways that they can be addressed. This team supported 28 informal concerns and 1,064 general enquiries as we seek to resolve concerns including communication problems at the earliest opportunity.
There were 7 second responses due in January – all 7 were delivered on time

Duty of Candour

The Trust has continued to demonstrate 100% compliance for the three stages of Duty of Candour (DoC) process for all incidents graded as Moderate and above for January 2023.

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
FFT Overall - % Rated Good or Very Good	95%	95%	Jan 23	(common cause)	(?)	95%	93%	Dec 22		
FFT AE - % Rated Good or Very Good	95%	77%	Jan 23	(common cause)	(F)	95%	69%	Dec 22		
FFT Community - % Rated Good or Very Good	95%	97%	Jan 23	(common cause)	(?)	95%	95%	Dec 22		
FFT Inpatients - % Rated Good or Very Good	95%	96%	Jan 23	(L)	(P)	95%	97%	Dec 22		
FFT Outpatients / Day Case - % Rated Good or Very Good	95%	94%	Jan 23	(L)	(?)	95%	95%	Dec 22		
FFT Maternity - % Rated Good or Very Good	95%	91%	Jan 23	(common cause)	(?)	95%	88%	Dec 22		
FFT Mental Health - % Rated Good or Very Good	95%	94%	Jan 23	(common cause)	(?)	95%	87%	Dec 22		
FFT Patients Response Rate	15%	14%	Jan 23	(H)	(?)	15%	12%	Dec 22		
Mixed Sex breaches	0	0	Jan 23	(common cause)	(?)	0	0	Dec 22	0	41.00
Duty of Candour – Stage 1a – Initial Verbal	100%	100%	Jan 23	(common cause)	(P)	100%	100%	Dec 22		
Duty of Candour – Stage 1b – Initial Written	100%	100%	Jan 23	(common cause)	(P)	100%	100%	Dec 22		
Duty of Candour – Stage 2 – Final DoC	100%	100%	Jan 23	(common cause)	(P)	100%	100%	Dec 22		
Complaints Formal (number)		30	Jan 23	(common cause)			25	Dec 22		380.00
Complaints - % closed within 40 working days	80%	97%	Jan 23	(common cause)	(?)	80%	74%	Dec 22		

Quality

FFT Overall – % Rated Good or Very Good
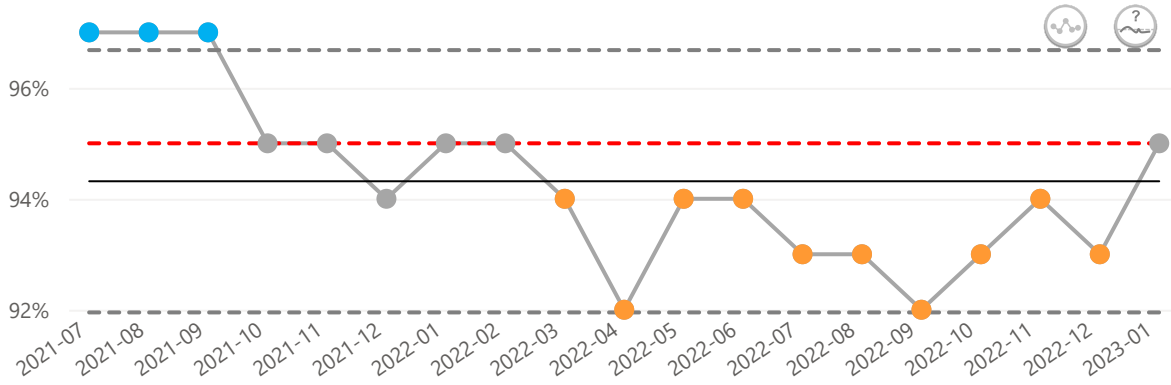
FFT AE – % Rated Good or Very Good
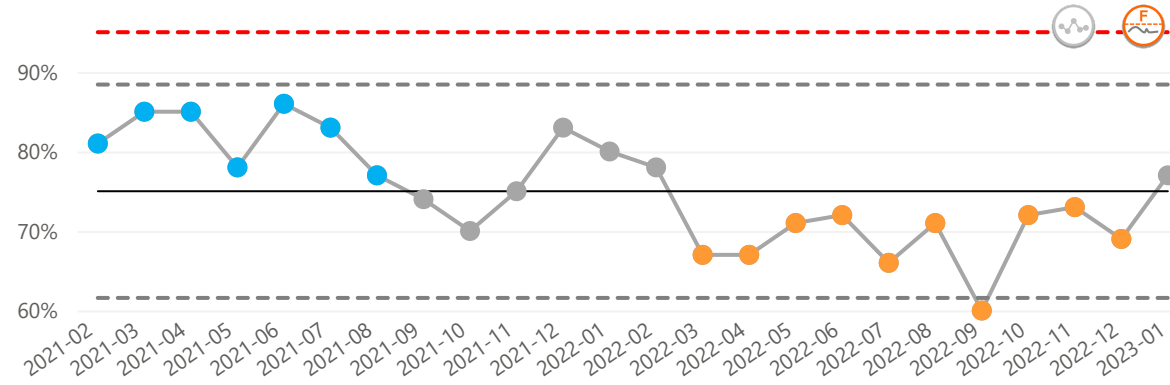
FFT Community – % Rated Good or Very Good
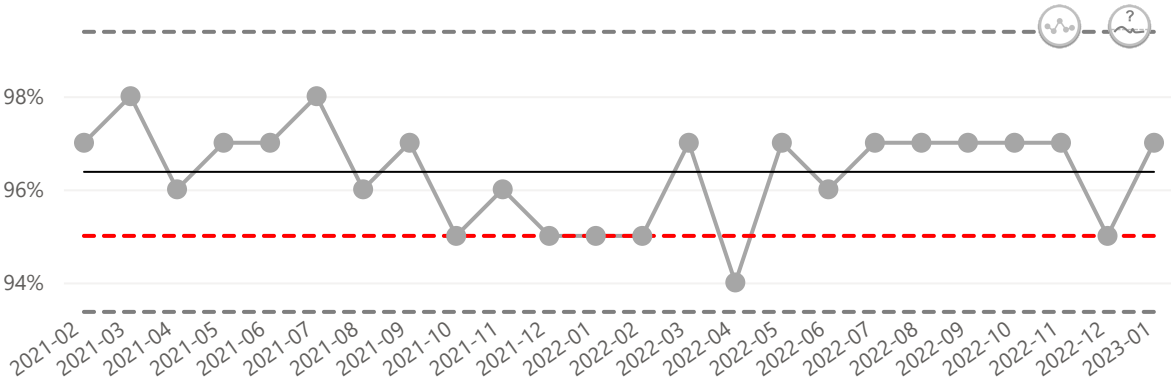
FFT Inpatients – % Rated Good or Very Good
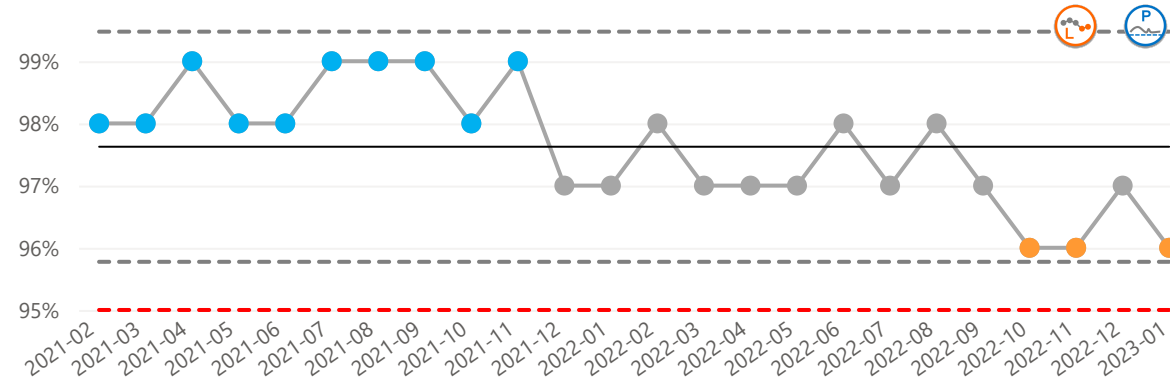
FFT Outpatients / Day Case – % Rated Good or Very Good

FFT Maternity – % Rated Good or Very Good

Quality

Quality
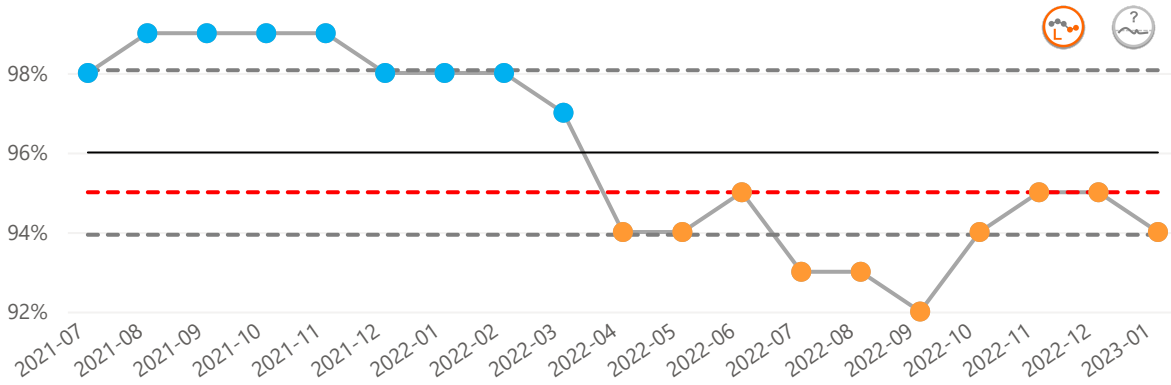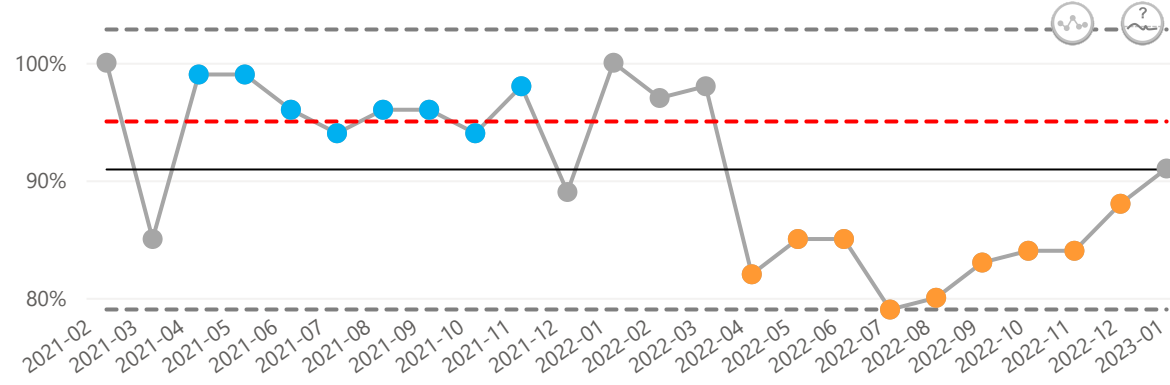
FFT Mental Health - % Rated Good or Very Good
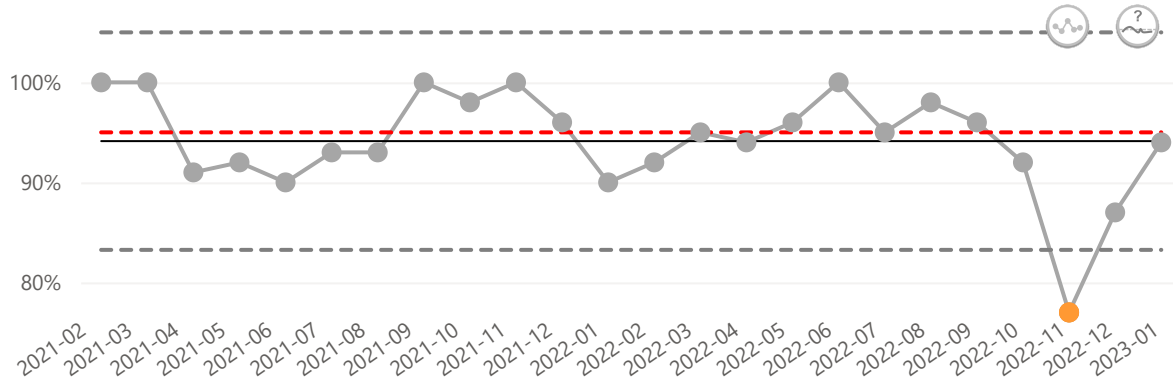
FFT Patients Response Rate
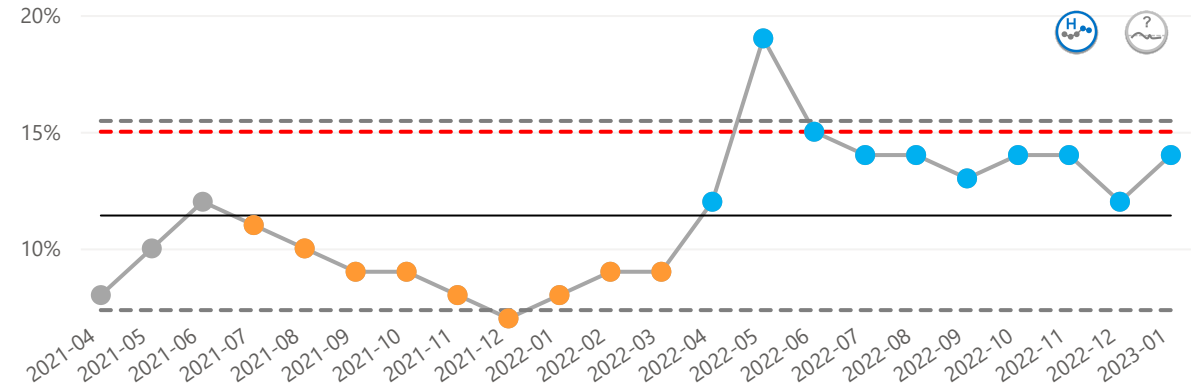
Mixed Sex breaches
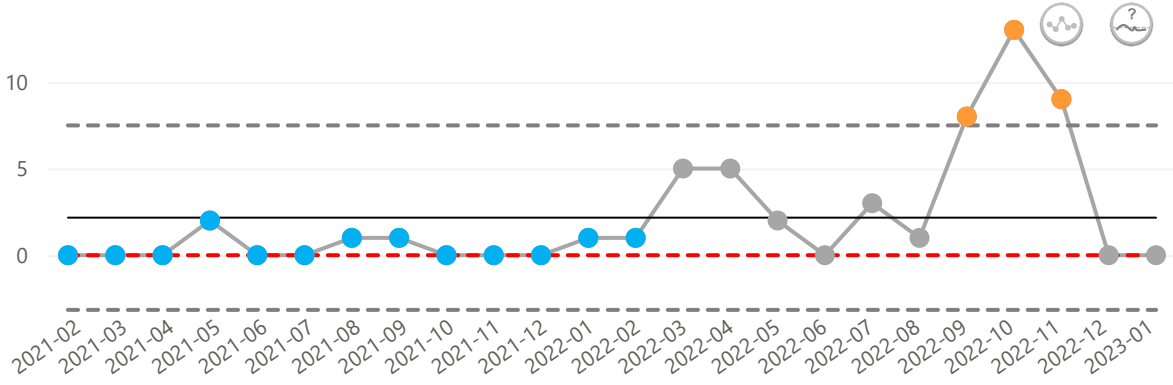
Duty of Candour – Stage 1a – Initial Verbal
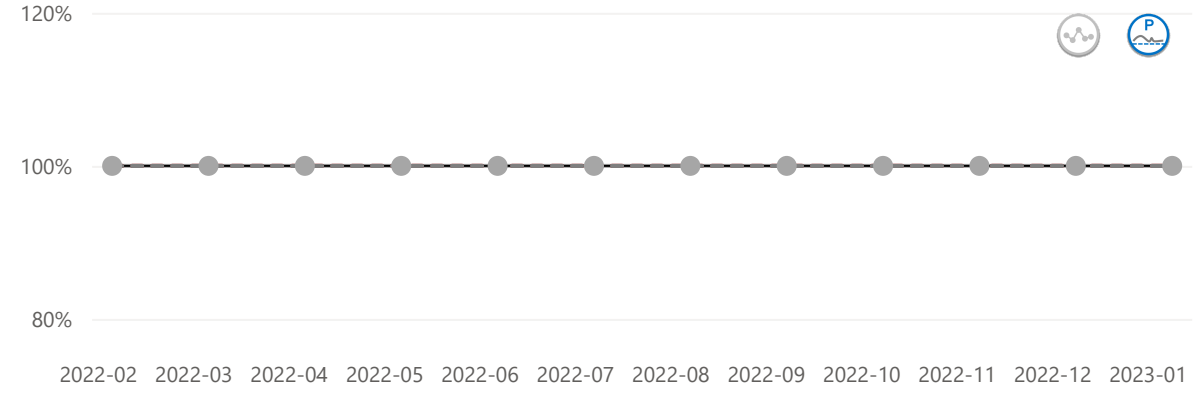
Duty of Candour – Stage 1b – Initial Written

Duty of Candour – Stage 2 – Final DoC

Quality
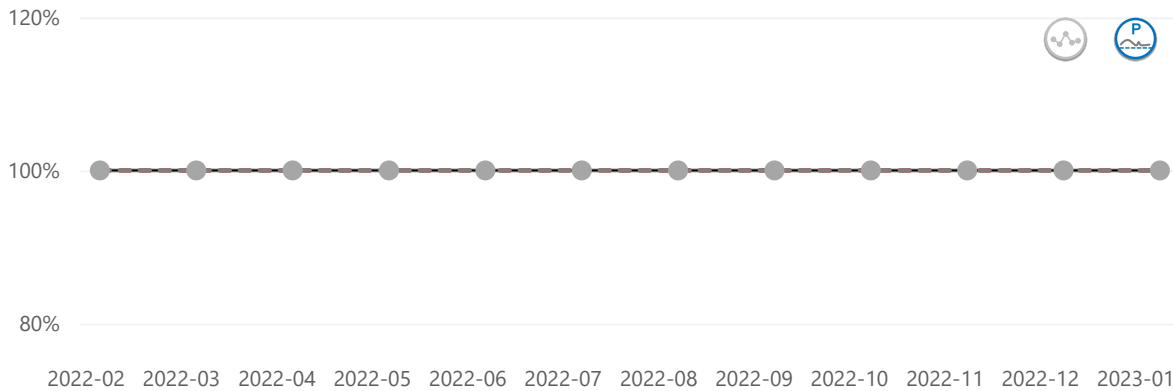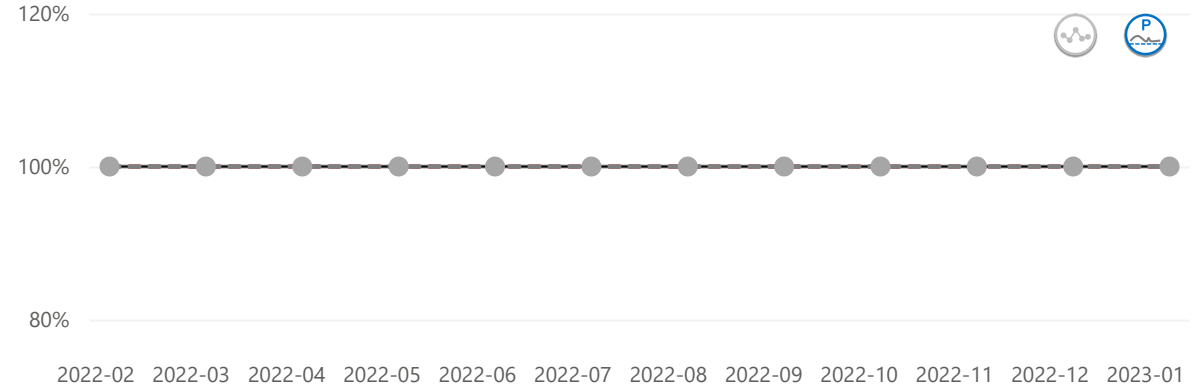
Complaints Formal (number)
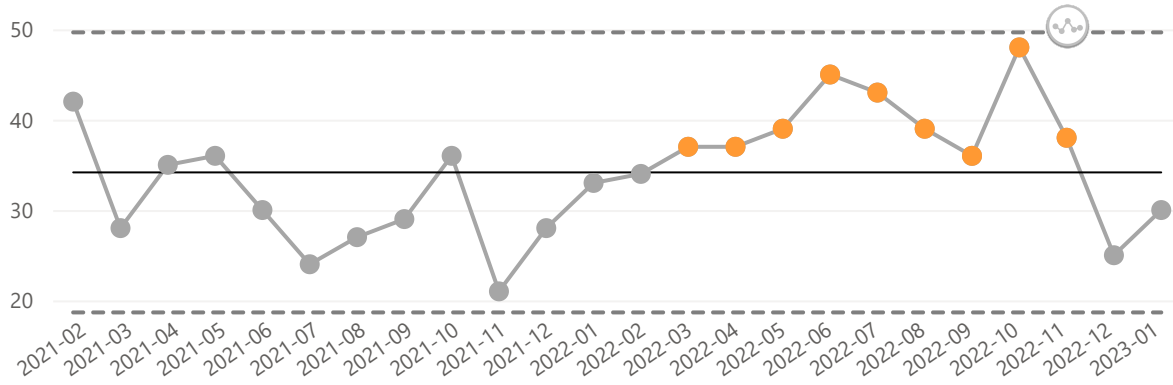
Complaints - % closed within 40 working days
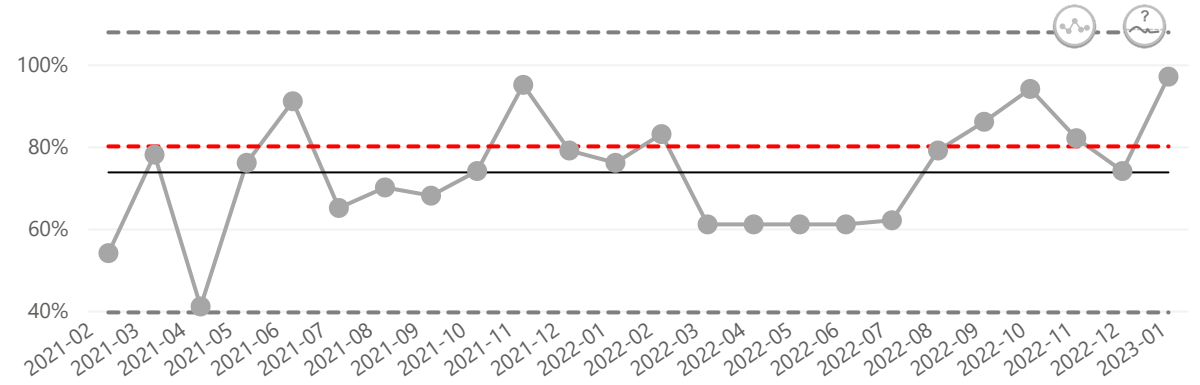
Infection Prevention and Control

MRSA

One Community Onset case of MRSA bacteraemia was attributed to the trust in January 2023. This brings to total number of cases for the year to three which is a 50% reduction on last year. The patient had recently attended the Same Day Emergency Care unit; hence the case has been attributed to BTH. However, a review of the case determined that no lapses in care occurred during this visit. A threshold of zero has been set for MRSA.

MSSA

Three cases were attributed to the trust in January bringing the total number of cases for the year to 41. This is a 10.8% increase on last year. Data provided by NHS England showed an increase in MSSA regionally and nationally, the cause of which is being investigated. Locally, case numbers rose last month to 13 due to several contaminated samples but are back within normal variation this month. No threshold has been set for MSSA.

CDI

Four cases of CDI were attributed to the trust in January bringing the total number of cases to 82 against a threshold of 109. 2022/23 data provided by NHS England shows that by the end of Q3, BTH was one of only seven of the 24 acute trusts in the Northwest, and the only acute trust in the L&SC ICB, to remain within the NHS Standard Contract threshold for Clostridioides difficile infections (CDI).

E. coli

Thirteen cases were reported in January. This brings the total, number of cases for the year to 93. The NHS Standard Contract threshold for E. coli blood stream infections for 2022/23 has been set at 91. Therefore, the trust has breached the annual threshold.

Pseudomonas aeruginosa

One case of Pseudomonas aeruginosa was attributed to the trust in January. This brings the total so far this year to 18 against an NHS Standard Contract threshold of 19. The trust is therefore currently above plan for this infection.

Klebsiella spp.

Six cases of Klebsiella spp. were reported in January. This brings the total number of cases this year to 40. The NHS Standard Contract threshold for 2022/23 was set at 36 and therefore the trust has breached the annual threshold.

Data provided by NHS England determined that most acute trusts in the Northwest are also above ambition for E. coli, Pseudomonas aeruginosa and Klebsiella spp., and UKHSA data shows an upward trend in cases nationally. Locally, a QI project which aims to reduce the number of GNBSI associated with IV-line infections has commenced. Learning from this project will be disseminated across the trust and the ICB. System wide collaboration is needed to tackle GNBSI as well as other HCAIs such as MSSA which are also increasing regionally and nationally. A provisional meeting to agree IPC priorities for L&SC took place on November 22nd, 2022, and it is anticipated that task & finish groups will soon be convened.

Indicator	Latest					Previous			Year to Date	
	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Clostridioides difficile	9.08	4	Jan 23			9.08	7	Dec 22	91	82.00
E. Coli	7.58	13	Jan 23			7.58	7	Dec 22	76	93.00
Klebsiella spp.	3.6	6	Jan 23			3.6	5	Dec 22	36	40.00
MRSA Bacteraemia	0	1	Jan 23			0	0	Dec 22	0	3.00
MSSA		3	Jan 23				13	Dec 22		41.00
P. aeruginosa	1.58	1	Jan 23			1.58	1	Dec 22	16	18.00

Quality

Quality

Clostridioides difficile
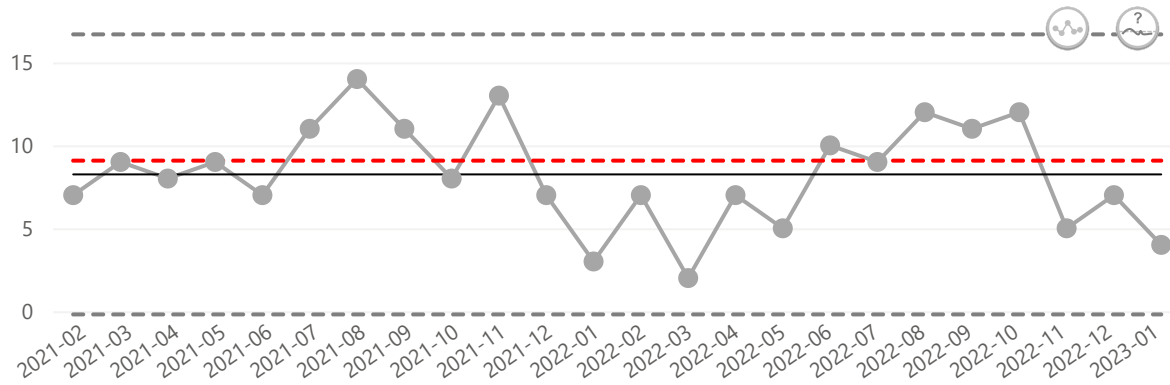
E. Coli
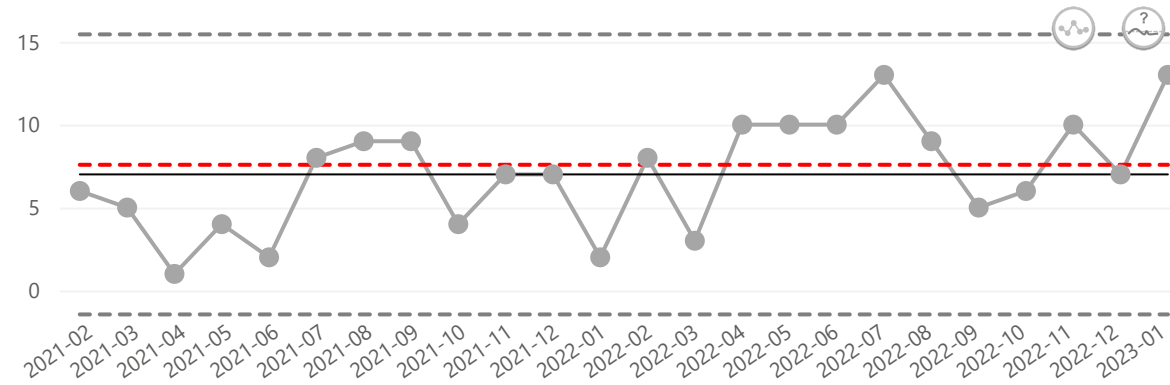
Klebsiella spp.
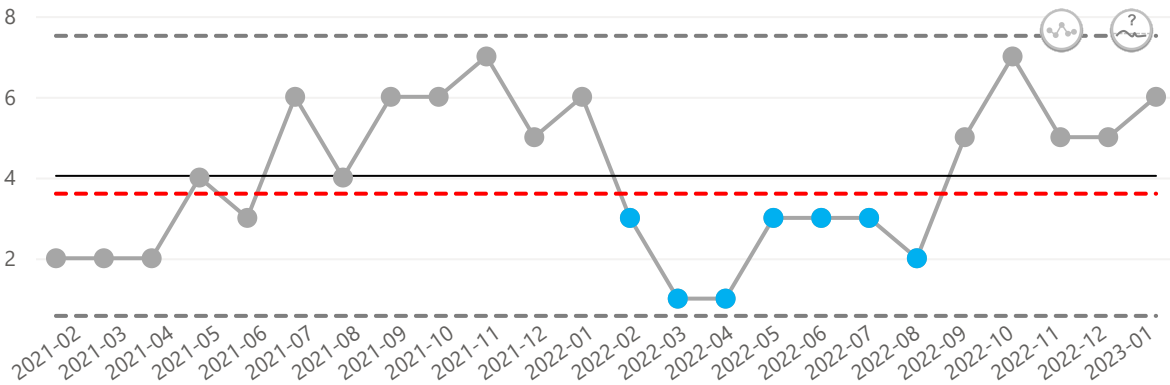
MRSA Bacteraemia
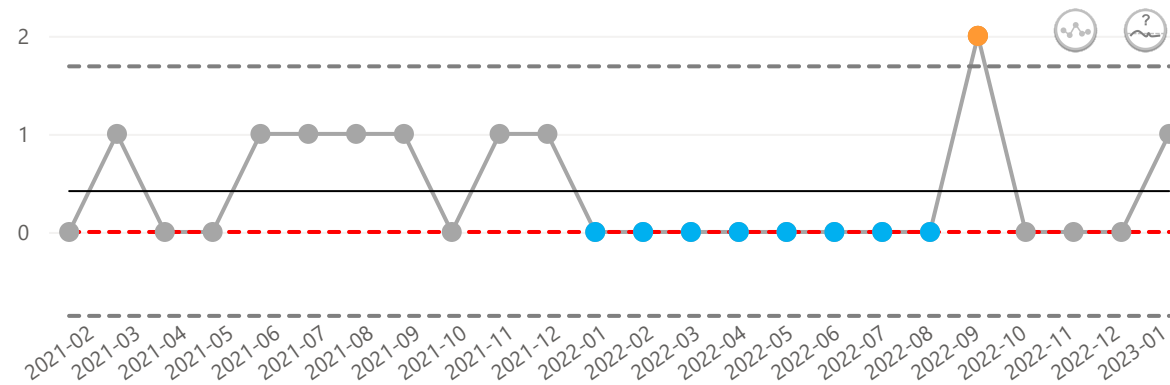
MSSA
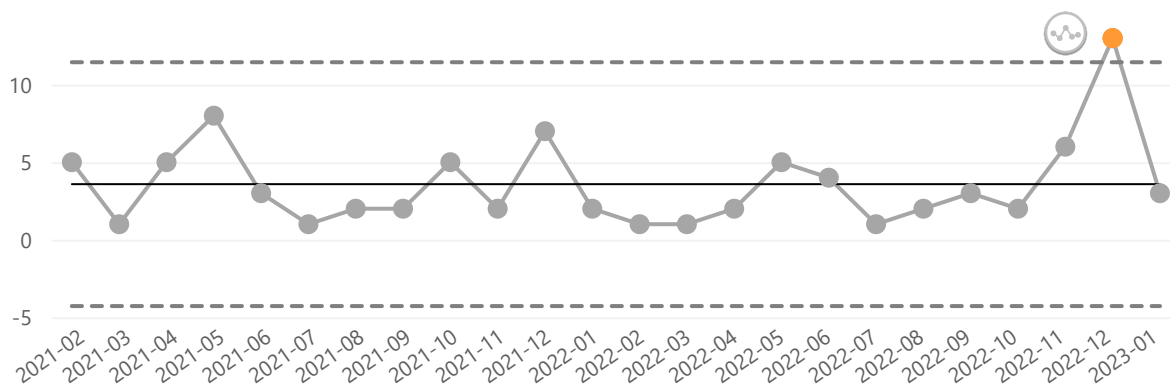
P. aeruginosa
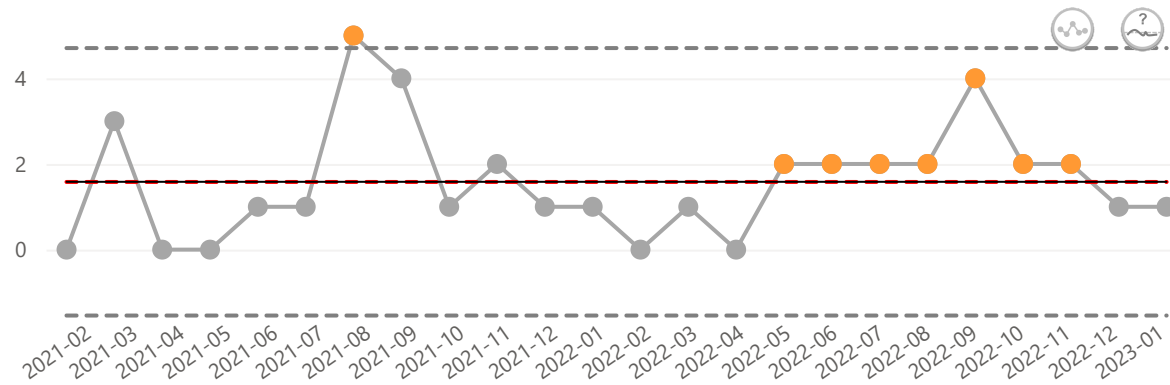
Mortality

SHMI – continued reduction to 106 which is within the expected range for risk adjusted hospital mortality.

Percentage of deaths screened – continued improvement with rates close to 95%.

Deaths registered within 5 days – reduction for last 2 months, having achieved 100% in October 2022. There is an escalation process in place for inpatient teams who are not responding to calls to complete death certificates, and this will be raised at the Medical Staff Committee to encourage compliance.

Referral to coroner within 24 hours – increase from 50 to 60% over last 7 months. Meeting being arranged with Coroner, Coroner's Officers, bereavement staff and Medical Examiners to improve compliance.

		Latest				Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
CRUDE Mortality Rate (Rolling 12 months)		1.46%	Jan 23	(L)			1.48%	Dec 22		
Referral to Coroner Within 24 Hours	100%	57.5%	Dec 22	(H)	(F)	100%	63.8%	Nov 22		
Death Registered within 5 Days	100%	86.9%	Dec 22		(?)	100%	92.5%	Nov 22		
SHMI – Rolling 12 months		106.04	Aug 22				107.24	Jul 22		106.04
HSMR – Rolling 12 months		93.99	Sep 22	(L)			94.16	Aug 22		93.99
Percentage of Deaths Screened	100%	92.6%	Dec 22		(F)	100%	93.1%	Nov 22		

Quality

Quality

CRUDE Mortality Rate (Rolling 12 months)
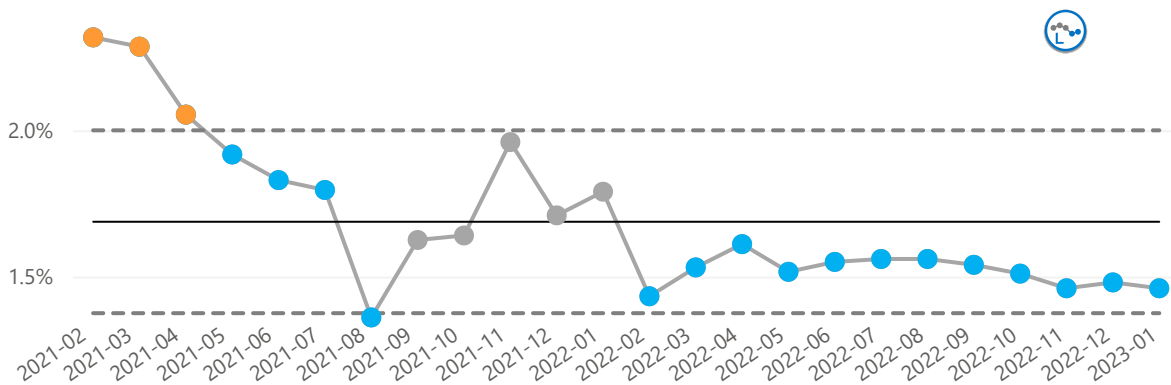
Referral to Coroner Within 24 Hours
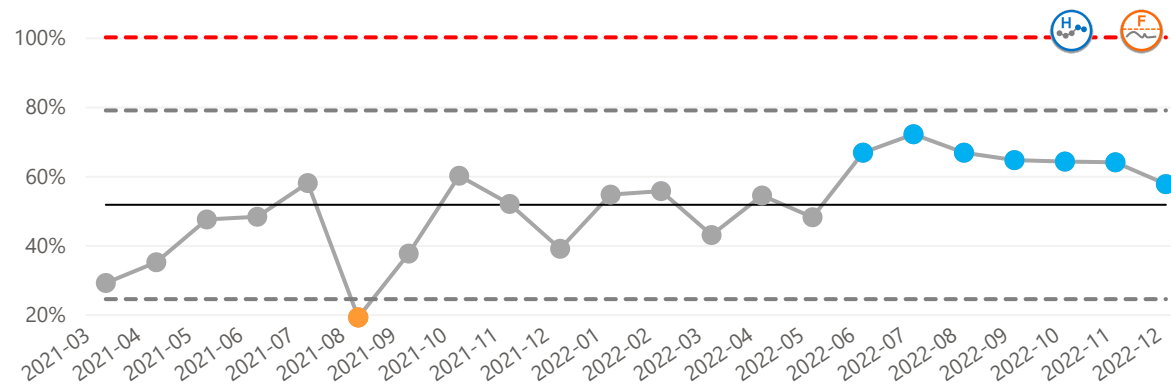
Death Registered within 5 Days
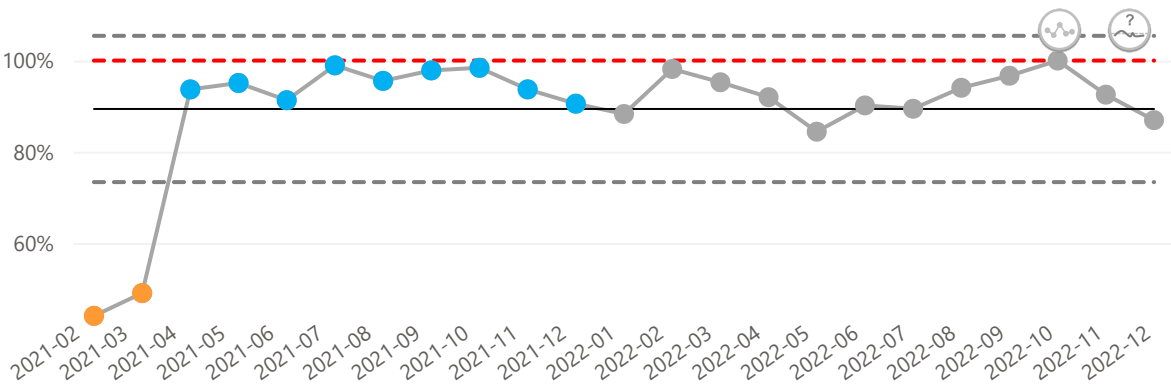
SHMI – Rolling 12 months
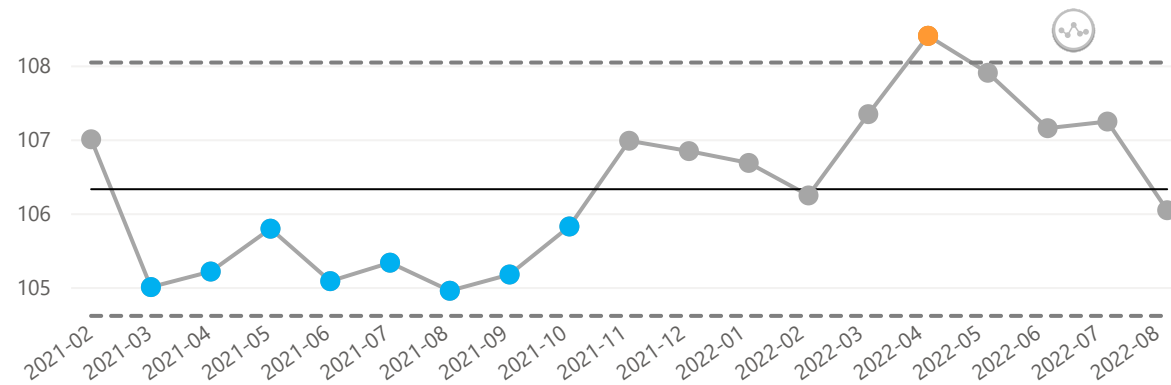
HSMR – Rolling 12 months

Percentage of Deaths Screened

Title	Quality Assurance Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	2nd March 2023

Author	Esther Steel, Director of Corporate Governance						
Exec Sponsor	Pete Murphy/Chris Barben						
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No						

Summary *(what)*	Report provided to update the Board on matters discussed at the Quality Assurance Committees on Tuesday 31st January 2023 and to provide a verbal update on the issues discussed on Tuesday 28th February 2023. Three areas were identified for escalation to the Board, these were in relation to neonatal mortality incidents, clinical record keeping and clinical audit compliance. The Committee also spent time considering how assurance is provided on the learning from incidents.

Previously considered by	N/A

Implications *(so what)*	Actions have been agreed through the QAC Committee

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications considered	Yes - no apparent EDI implications to the matters noted

Proposed Resolution *(What next)*	To note the QAC Committee Escalation Report and the proposed actions

Committee/Group Escalation Report

NHS Blackpool Teaching Hospitals
NHS Foundation Trust

Name of Committee/Group:	QA Committee	Report to:	Board of Directors
Date of Meeting:	31 January 2023	Date of next meeting:	28 February 2023
Chair:	S McKenna	Parent Committee:	Board of Directors

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations with areas for improvement recognised

Alert

What	So What	What Next
Patient Story Story highlighted issues with telemetry monitoring Investigation undertaken by tertiary with a number of actions to ensure there is a robust process for permanent monitoring of patients on telemetry and continuous cycle of monitoring including out of hours. The incident discussed was the subject of a coroner's inquest and there was positive feedback with regard to the actions taken.	Committee members discussed the incident and noted that this served as a reminder of the complex issues and human factors that might impact on patient safety. The report triggered a wider discussion about the learning and the role of the QA Committee in considering SI reports striking a balance to provide information to NEDs on incidents, our response to incidents and learning from incidents.	Committee to continue to discuss the role of the Committee in reviewing SI reports/PSRIF reports Consider the introduction of themed reviews of incidents. **Report back on incident themes**
Neonatal incidents – three incidents and a slight increase in neonatal mortality flagged to the committee. A Neonatal improvement Board has been established – chaired by the Medical Director with external representation to look at processes to ensure reporting is timely and accurate. Also considering issue of team working in neonates which was identified as a theme.	Committee members discussed the report considering the immediate actions taken officers were asked for assurance about the review process and the wider process to understand and address the concerns raised	Royal College of Paediatrics and Child Health invited to undertake an external peer review **External report to come back through Quality Assurance Committee** Request for all incidents a summary – themed review timeline and what has been done about it **Position statement for the next Committee**
Trauma Audit Research Network **TARN -** The Clinical Governance Committee escalated a concern regarding poor compliance with submission of data to the TARN	The Committee discussed the importance of clinical audit. It was noted that having an audit lead, who would be a single point of contact, would be beneficial for coordination of clinical audits.	Report to Audit Committee Audit Committee to have a role in the oversight of Clinical Audit

Committee/Group Escalation Report

Blackpool Teaching Hospitals
NHS Foundation Trust

Clinical Record Keeping	Committee members noted the work to improve the overall standard of record keeping and discussed the impact a full EPR would have in improving performance.	An update will be provided in six months, Actions to improve include:
The report provided a snapshot audit of the level of compliance with clinical record keeping.	The National team have now given the Trust authority to proceed with the EPR business case	• Record keeping will be included in medical induction with comms to support reminders • Picked up through COAST • Going forward monitor for improvement and identification of hot spots • Moving to monthly audit of 30 patients for each division

Assurance

What	So What	What Next
Clinical Governance Committee – Chair Report The Clinical Governance Committee had a detailed discussion about the safety in escalation areas. Committee members were assured that while the surge protocol was not ideal actions had been taken to protect the safety of our patients. Two wards have been deemed inappropriate for surge patients.	Other items discussed at Clinical Governance Committee have also been reported in full to the QA Committee and are picked up within the relevant section of this report	Lessons learned in terms of planning escalation areas
GIRFT Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variation. The report described the current position on GIRFT activity within Blackpool Teaching Hospitals NHS Foundation Trust (BTH) and demonstrated our involvement and performance at a speciality, Trust, and system level.	Members discussed the level of detail necessary for this committee and it was agreed assurance would be needed on the governance processes, progress, outcomes and clinical leadership engagement with regards to GIRFT	It was noted that any area of concern would be reported to the committee if required with an outcome paper to QAC on a regular basis
Waiting List harm assessment Significant progress has been made in ensuring that all patients with a long wait for elective care have a clinical harm assessment.	The main area of concern is in GI and Colorectal Members noted the current position and the actions being undertaken to reduce clinical risk including the use of a Chat Bot to streamline the review process.	Report back in two months

For patients waiting over 78 weeks, 100% have had an admin review and 88% have had a clinical review – the remaining 12% are scheduled in for review appointments No further severe harm identified however some moderate harm because of delays to treatment	Performance is on track with the reviews and clinical teams are considering the next steps to roll reviews out to patients waiting over 52 weeks	
Health and Safety Committee Chair report Report discussed in detail in the Clinical Governance Committee and covered through the CGC Chair report		MIAA undertaking an audit of Health and Safety Committee to report direct to QAC in future

Advise		
What	**So What**	**What Next**
Mortality and Learning from Deaths SHMI of 109 is within expected limits The level of scrutiny through the Mortality Governance Committee is improving , task and finish groups using QI methodology are being established for groups of conditions with the highest mortality including AKI (Acute Kidney Injury) Pneumonia, sepsis and heart failure The Medical examiner is now looking at community deaths – this will increase the demand on the team	Committee members noted the improvements made to improve outcome and the work done to improve the process to issue a death certificate	Update to be provided quarterly
IPC and IPC BAF **The following metrics were highlighted:** Currently above plan for MRSA, E. coli, Klebsiella spp. and P. aeruginosa blood stream infections. However, there was a reduction in CDI (12%), MRSA (60%), and Klebsiella spp. (21%) compared with the number of cases reported by the same time last year.	Committee members discussed the IPC BAF noting that this provided a comprehensive overview of the controls and mitigations in place for infection prevention and control	The Committee agreed to receive a gap analysis to provide an exception report rather than the full IPC assurance framework DIPC will move to the Director of Nursing from 1st April

No threshold had been set for MSSA. However, a total of 13 cases were reported in December 2022 which was a significant increase on previous months. Influenza case numbers peaked at the end of December and were now falling sharply. COVID-19, influenza and Norovirus infections continue to circulate in the community leading to nosocomial infections and outbreaks.		
IPR The following metrics were discussed in response to questions from Committee members: Falls - There was an increase on in the number of falls but assurance was given that these falls were low harm. IAPT (Improving Access to Psychological Therapies) Waiting Time - No concerns to be raised with regards to the IAPT data as this was due to individuals not meeting the prevalence criteria. E-discharges – there were issues with the data as different departments were using different systems and this was being addressed with the performance team to ensure more accurate data going forward.	Recognised progress made with more data but need oversight and view of leads to provide narrative on the work being done and the impact	Narrative to be reviewed to ensure supporting commentary provided Action to agree maternal indicators after next meeting to allow triangulation of concerns Provide the safe staffing report for information monthly in the end section
SI/duty of candour There were four new Serious Incidents (SIs) and no new Never Event incidents reported in December 2022. There was 1 Serious Incident which was delayed in November 2022, with agreement of an extension with the ICB. This incident was submitted in advance of the agreed extended deadline. The Trust had continued to demonstrate 100% compliance for the three stages of Duty of Candour	Committee members recognised the difference the team has made in addressing the backlog of incidents that the Trust is required to report to the National Reporting and Learning System (NRLS). This backlog had now been cleared and weekly monitoring is now in place. Committee members discussed the factors that might lead to the delay in reporting an incident noting that potentially there may be delays in reporting if an incident is investigated by the police or if there is a	Report noted

(DoC) process for all incidents graded as Moderate and above for December 2022 The Trust was involved in seven inquests held in December 2022, 3 in IMPF, 2 in Tertiary and 2 in SACCT.	delay in finding out about an issue – e.g. delay in diagnosis might not be found until presentation	
Maternity governance Update provided on the CNST submission: External review of CNST evidence was completed on 12 December 2022 which found non-compliance with some Safety Actions which were not recoverable prior to submission deadline of February 2023. Following further review of evidence two safety actions meet full compliance and partial on eight, however, they were not a patient safety risk.	Discussed previous process for the approval of year 3 and year 4 and submission of evidence and noted that in terms of compliance the previous declaration was made in good faith The Director of Midwifery confirmed that she was confident in terms of delivery time as set out in the report to Board	Audit support requested in preparation for year 5 Report will be signed by the CEO and submitted

Title	Integrated Performance Report (IPR) – Finance & Performance

Meeting:	Board of Directors in Public Meeting
Date:	2nd March 2023

Author	William Wood, Associate Director of BI Thomas Singleton, Performance Business Partner					
Exec Sponsor	Natalie Hudson, Chief Operating Officer Feroz Patel, Executive Finance Director					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					
Summary *(what)*	See the IPR summary pages for appropriate narrative.					

Previously considered by	Finance & Performance Committee

Implications *(so what)*	Inability to achieve national, regional, and local targets can be a driver of poor quality and experience for patients.

Link to strategic objectives	Our People	
	Our Population	
	Our Responsibility	✓

EDI implications considered	

Proposed Resolution *(What next)*	The Board of Directors is asked to acknowledge and approve the Finance and Performance IPR.

Caring · Safe · Respectful

Integrated Performance Report

Finance and Performance Committee

January 2023

Caring · Safe · Respectful

Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **_https://www.england.nhs.uk/publication/making-data-count/_**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre dashed reference line (black) is the mean, and the two light grey dashed lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.

Executive Summary

		Assurance				Variation				
		P	?	F	(·)	L	(·)	H	L	(·)
Operations	Access		5	10	6	2	11	4	2	2
	Activity		6				6			
	Cancer		8	2	1		9	1	1	
	Productivity	1	3	2	5	1	8	1	1	
Finance	Finance	2	9	1	4	3	7	2		4

Assurance

Measures the likelyhood of targets being met for this indicator.

? Indicates that this indicator is inconsistently passing and falling short of the target.

P Indicates that this indicator is consistently **passing** the target.

F Indicates that this indicator is consistently **falling** short of the target.

Variation

Whether SPC rules have been triggered positively or negatively overall for the past 3 months.

Indicates that there is no significant variation recently for this indicator.

L / H Indicates that there is **positive** variation recently for this indicator.

L / H Indicates that there is **negative** variation recently for this indicator.

Special cause variation where **UP** is neither improvement nor concern.

Special cause variation where **DOWN** is neither improvement nor concern.

Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

Access

UEC

A&E Performance – both type 1 and all type ED performance continue to trigger with continuous underperformance against the national standard and the rolling average.

Pressures have worsened recently with increased number of Type 1 attendances and surges in both Flu and Covid presentations as well as usual seasonal trauma and orthopaedic presentations. This has caused continued significant pressure in relation to Bed occupancy.

Percentage of Patients spending 12 plus Hours in ED increased to its highest point in the last 18 months with 1158 patients waiting 12 hours or longer from decision to admit. The lack of available beds in the hospital has continued to increase the length of stay in the Emergency Department and cause further issues with ambulance handover with a lack of physical space available to enable the handover of patients from NWAS to the ED teams.

Ambulance Handovers were a significant concern in month although improved from December..

Management Actions

The Trust is using the Patient Flow Improvement Programme to mobilise and monitor the improvement workstreams to address the Urgent and Emergency Care Performance. The details of the workstreams and their progress is included within the Patient Flow Improvement Programme presented to the Finance and Performance Committee.

Key Highlights from the report this month are:

The additional ED capacity and additional ambulance handover cubicles. The Trust have been trialling a trust appointed Ambulance Liaison Officer working between triage and NWAS to support improved handover processes.

Trust is engaged in regional ambulance handover collaborative and has commenced a QI programme in January with the introduction of 2 hourly huddles in ED to support and escalate issues regarding handovers, capacity and staffing in ED.

Frailty business case prepared and being presented to Executive team in February to propose the development of a combined Frailty Unit merging the current assessment area and wards creating an MDT frailty department and building on current interim arrangements.

Additional domiciliary care hours came online as planned at end of December 2022. Further bids have been formed and submitted to regional team to access the additional winter discharge funding and support further stepdown bed capacity.

The virtual ward capacity continues at 27 beds covering both respiratory and frailty with the aim to increase to 50 beds pending successful recruitment.

Access

Elective Care

Number of RTT incomplete pathways is continuing to rise with increased referral demand. The number of patients currently over 52 weeks has reduced in month to 964 for January submission with the growing waiting list being seen due to the rate of new referrals who are currently shorter waiting times but if not addressed may cause issues in later months.

RTT Incomplete pathways over 78 weeks – The numbers of longest waiters reduced to 101 for January submission. The Trust has formed a weekly speciality level trajectory to monitor the longest waiters in order to meet the zero target by March 2023. Gastroenterology and Cardiology are the specialities causing most concern who account for the majority of the 78 week waits. National Guidance has been received in January regarding specific asks on validation and booking of 78 week plus patients, monitored through weekly WLMDS submissions. An internal daily report is compiled and distributed to Divisional teams. A detailed analysis of the 78 week position, trajectory and further actions is included on the Finance and Performance Committee Agenda.

Diagnostics – Percentage of patients waiting over 6 weeks for a diagnostic test is triggering for consistent non-achievement of the standard sitting at 74.3% achievement in January against the 95% standard. This is still being largely driven by the demand and capacity shortfall in endoscopy and is expected to improve in future months with increased endoscopy capacity available but dealing with those patients on the urgent referral pathways will be our initial priority. This is a slight improvement from December's compliance.

Management Actions

The Trust is using the weekly Escalation and Assurance PTL and Divisional PIDA meetings to monitor the Elective Care Performance. The details of workstreams and their progress is included within the Elective Care and Data Quality report presented to the Finance and Performance Committee.

Diagnostics – Endoscopy is the main contributor to the underperformance. The 6th endoscopy room being delivered via a modular unit has gone live from December 2022 and once the urgent referral demand and backlog has improved focus will move to bringing down the routine waits and improving the current DMO1 position.

RTT long waits – The 2 specialities Gastroenterology and Cardiology have formed improvement plans to both reduce their waits to within 78 weeks in line with the national improvement trajectories and improve compliance against the RTT standards. The improvement plans are being monitored through the revised weekly PTL structures and monthly PIDA meetings. Detailed paper outlining further actions and progress is included in this month's F&P papers.

RTT Incomplete Pathways – External validation support has been sought to support validation of the elective waiting lists. Speciality level reviews are to be undertaken to understand current demand and capacity constraints and target those areas of concern before the increased patient cohorts become at risk of progressing to long waits.

Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
		Latest					**Previous**			**Year to Date**
Virtual Ward Occupancy		29.97	Jan 23				24.13	Dec 22		107
4 Hours from arrival to ADT - % within 4 hours	95%	80.7%	Jan 23		F	95%	78.9%	Dec 22		
A&E Type 1 Performance %	65%	52.4%	Jan 23		F	65%	52.0%	Dec 22		
Ambulance Handovers - % within 15 minutes	65%	24.3%	Jan 23		F	65%	16.5%	Dec 22		
Ambulance Handovers - % within 30 minutes	95%	73.7%	Jan 23	L	F	95%	58.9%	Dec 22		
Ambulance Handover 30-60 Mins		317	Jan 23				428	Dec 22		4261
Ambulance Handover Over 60 Mins	0	245	Jan 23		?	0	484	Dec 22	0	2866
Number waiting over 12 hours from DTA		999	Jan 23	H			1153	Dec 22		8952
Number of Patients spending 12+ Hours in ED - Trust		1580	Jan 23	H			1908	Dec 22		15347
% of Patients spending 12+ Hours in ED - Trust	2%	8.76%	Jan 23	H	F	2%	9.24%	Dec 22		
% of patients waiting less than 6 weeks for a diagnostic test	95%	74.3%	Jan 23		F	95%	73.8%	Dec 22		
Total RTT Waiting List - Trust	29485	33819	Jan 23	H	?	28360	32648	Dec 22	29485	33819
RTT Incomplete Pathways - % within 18 weeks	92%	64.4%	Jan 23	L	F	92%	65.9%	Dec 22		
2-Hour UCR	70%	84.6%	Dec 22			70%	81.4%	Nov 22	70%	84.6%

Operations

Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
		Latest					Previous		Year to Date	
RTT Incomplete Pathways - Over 52 Weeks	544	964	Jan 23	(variation)	F	565	1055	Dec 22	544	964
RTT Incomplete Pathways - Over 78 Weeks	26	101	Jan 23	L	F	39	152	Dec 22	26	101
RTT Incomplete Pathways - Over 104 Weeks	0	1	Jan 23	L	F	0	0	Dec 22	0	1
Total 52 week waits – completed		319	Jan 23	(variation)			211	Dec 22		2203
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days	0%	12.9%	Jan 23	(variation)	?	0%	25.5%	Dec 22		
TIA - High Risk Treated within 24Hrs	60%	66.7%	Jan 23	(variation)	?	60%	38%	Dec 22		
Stroke - 90% Stay on Stroke Ward	80%	51.2%	Jan 23	(variation)	?	80%	58.6%	Dec 22		

Operations

Virtual Ward Occupancy
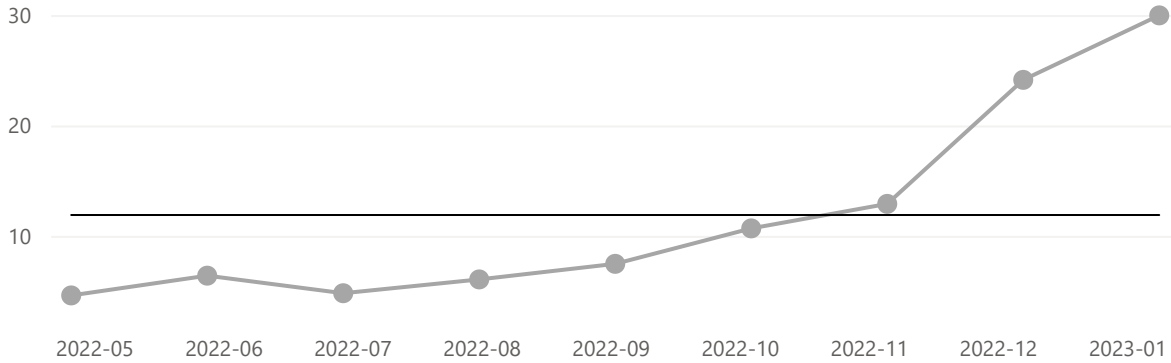
4 Hours from arrival to ADT - % within 4 hours
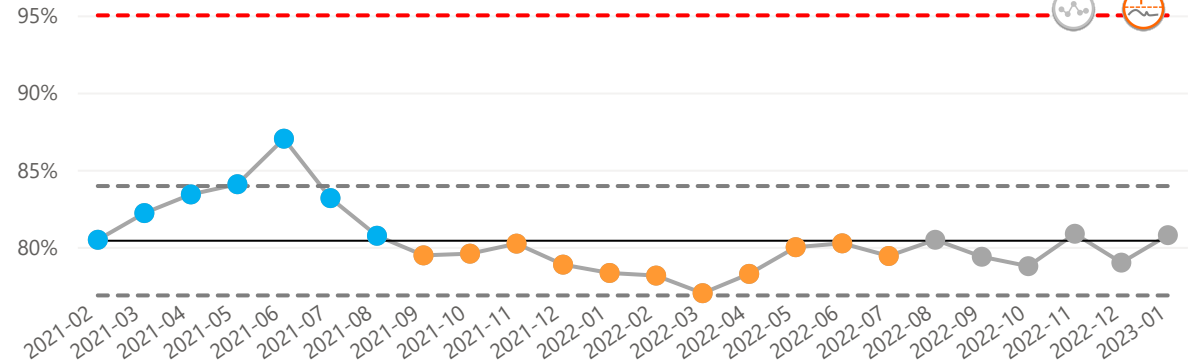
A&E Type 1 Performance %
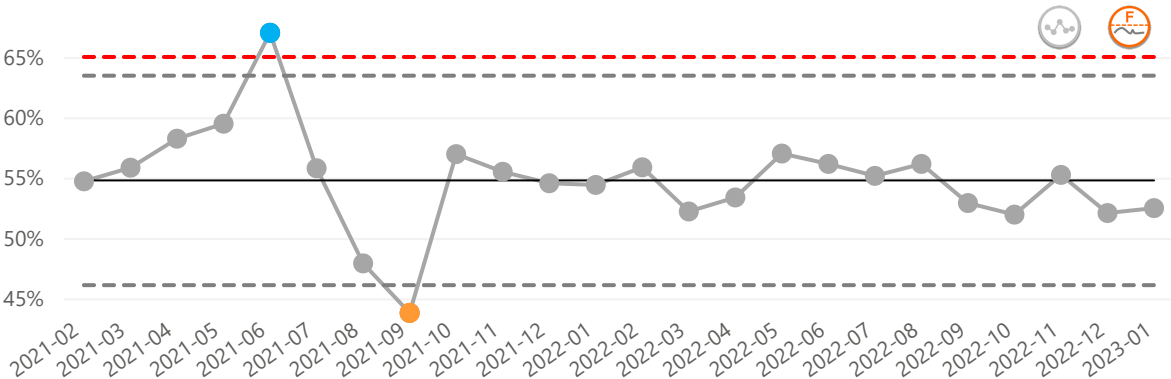
Ambulance Handovers - % within 15 minutes
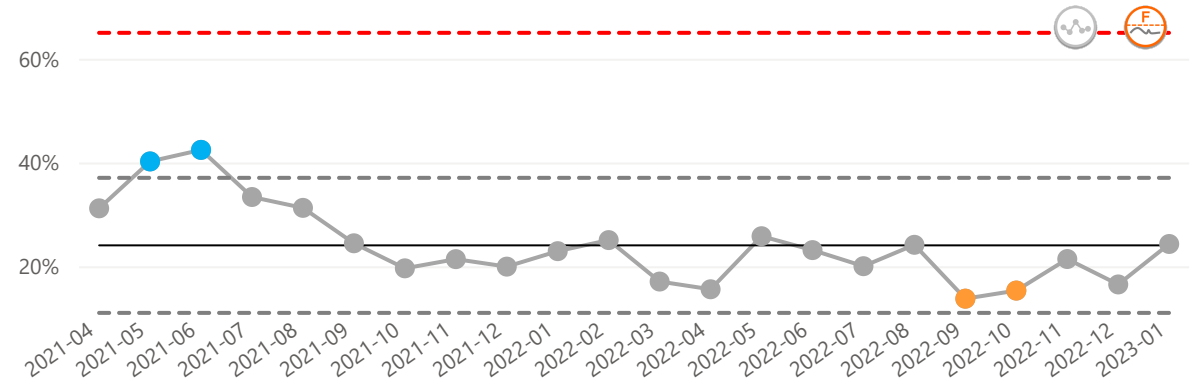
Ambulance Handovers - % within 30 minutes
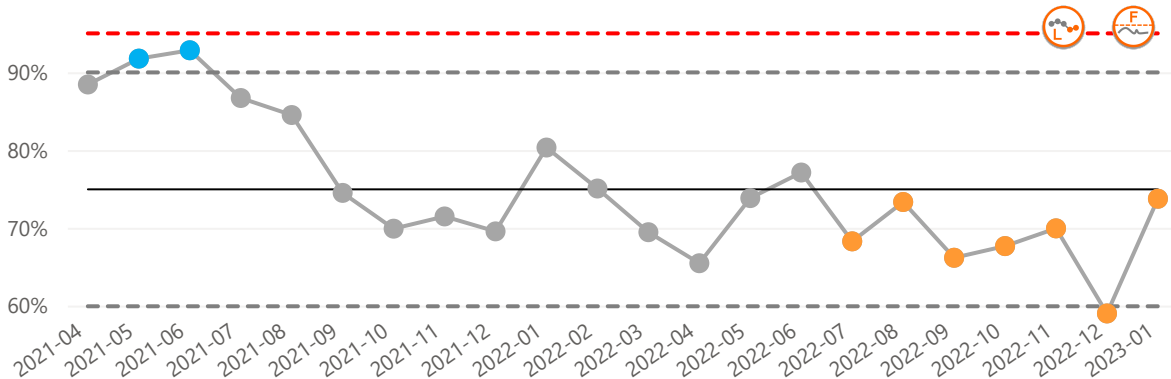
Ambulance Handover 30-60 Mins

Operations
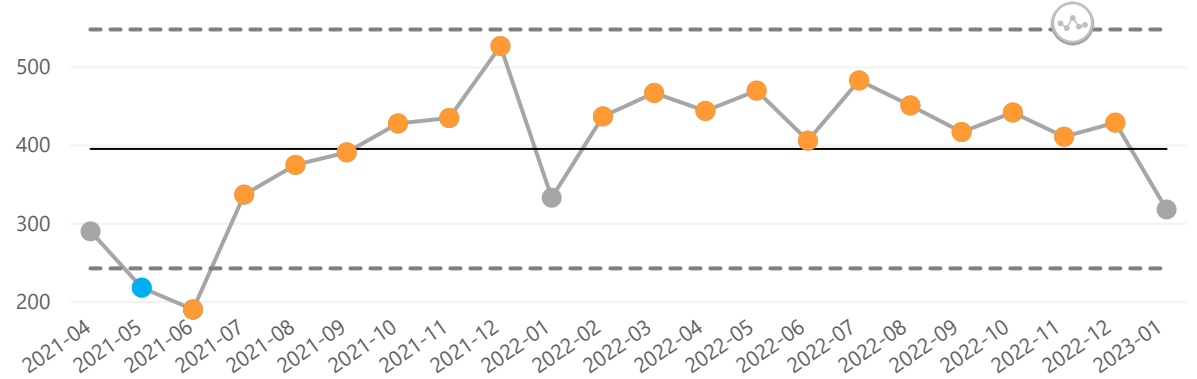
Ambulance Handover Over 60 Mins
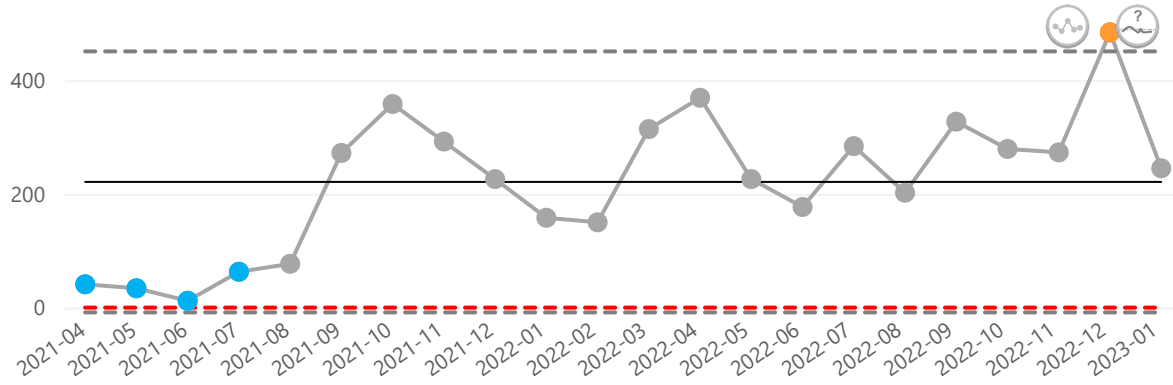
Number waiting over 12 hours from DTA
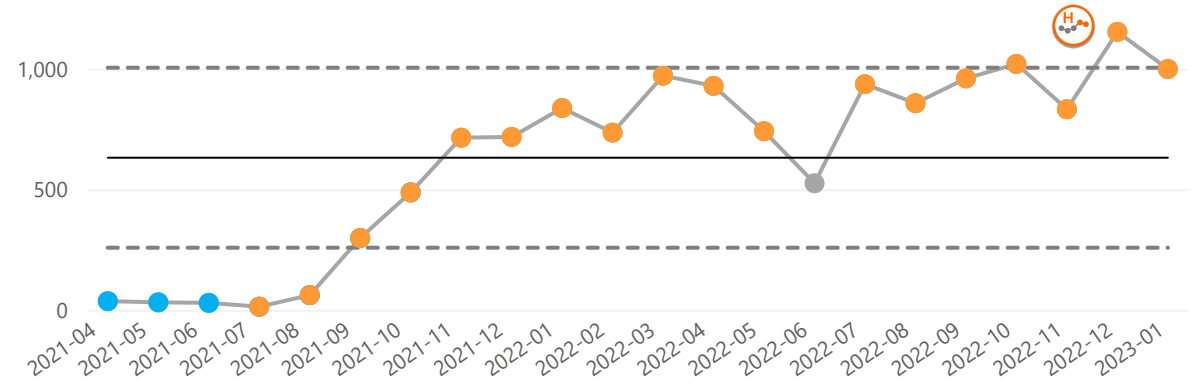
Number of Patients spending 12+ Hours in ED – Trust
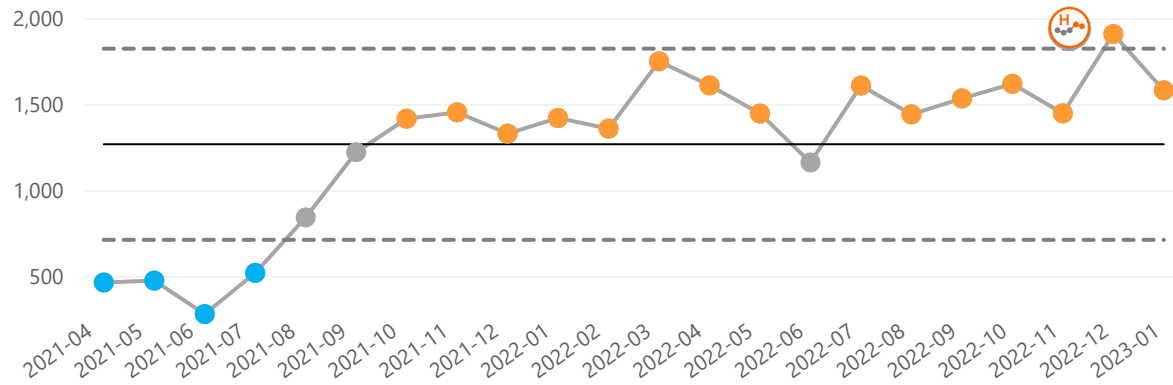
% of Patients spending 12+ Hours in ED – Trust
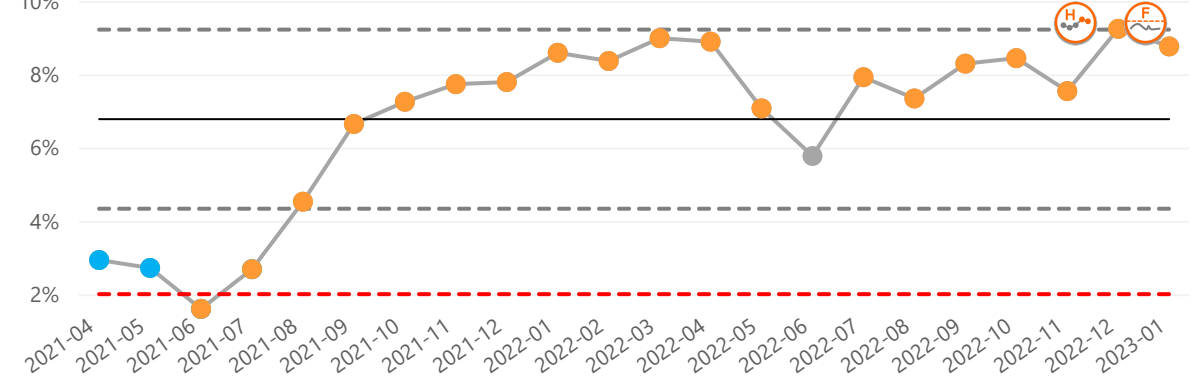
% of patients waiting less than 6 weeks for a diagnostic test

Total RTT Waiting List – Trust
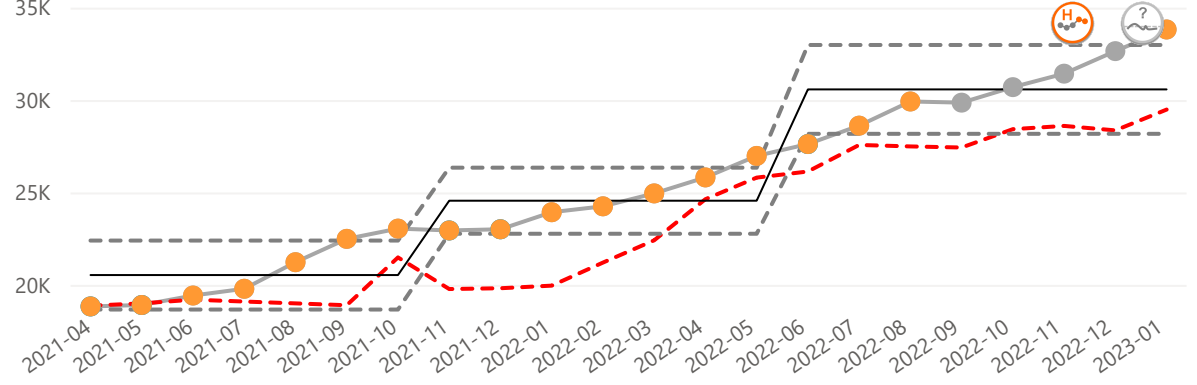
Operations

RTT Incomplete Pathways - % within 18 weeks
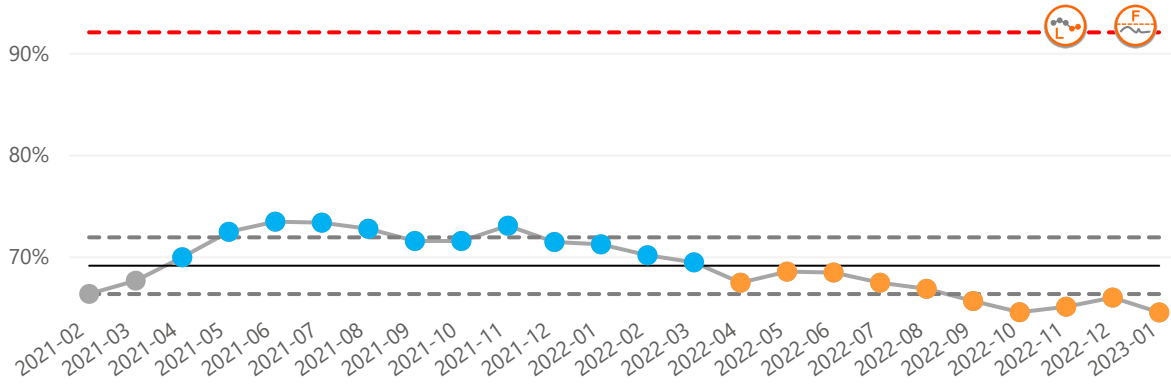
RTT Incomplete Pathways - Over 52 Weeks
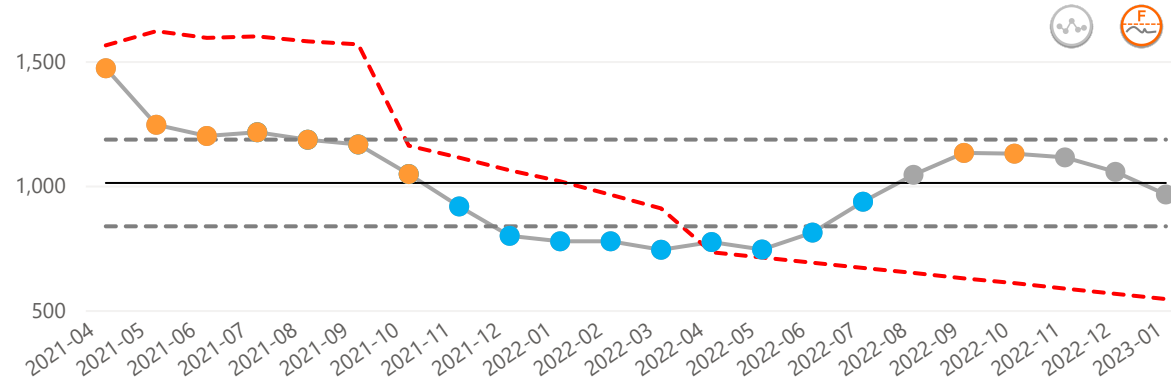
RTT Incomplete Pathways - Over 78 Weeks
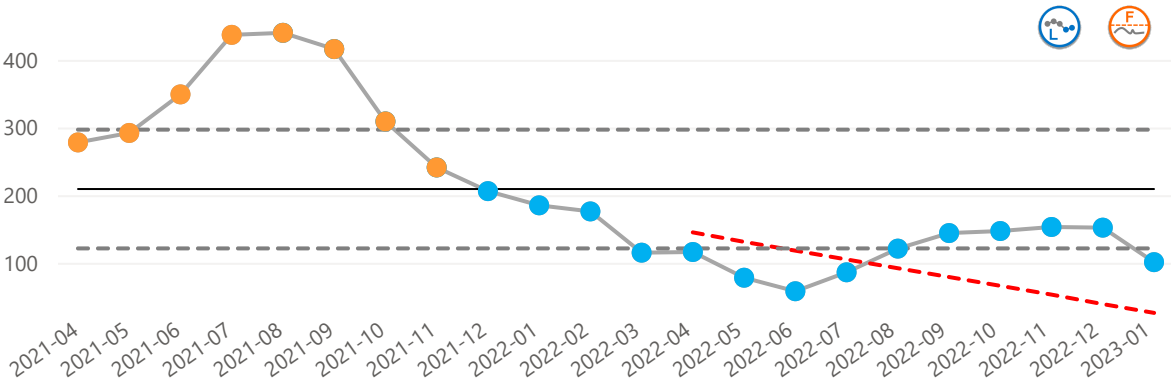
RTT Incomplete Pathways - Over 104 Weeks
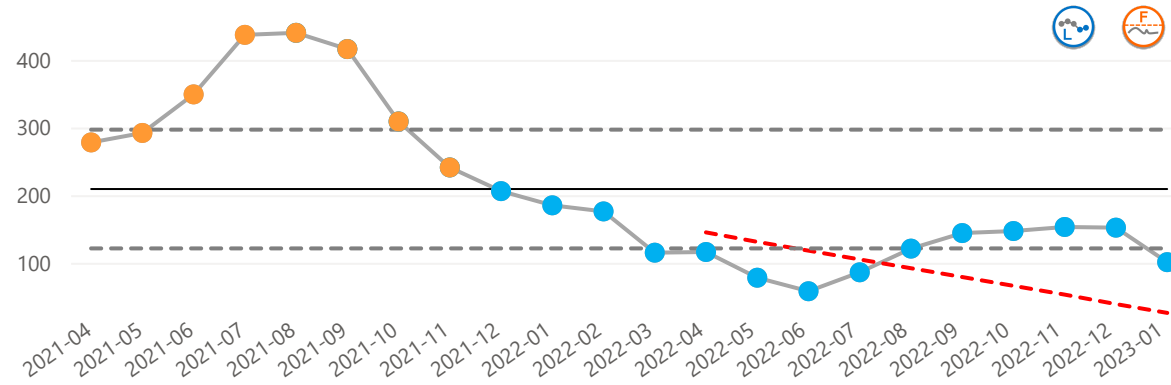
Total 52 week waits – completed
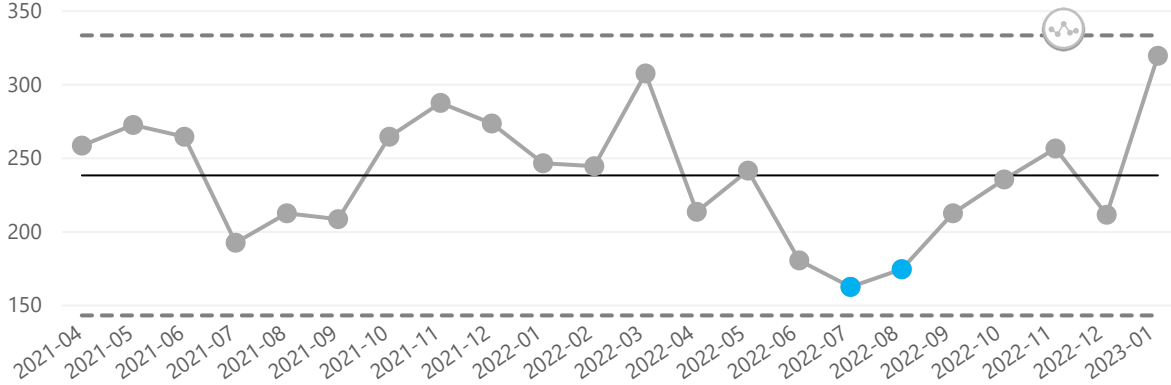
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days

Operations
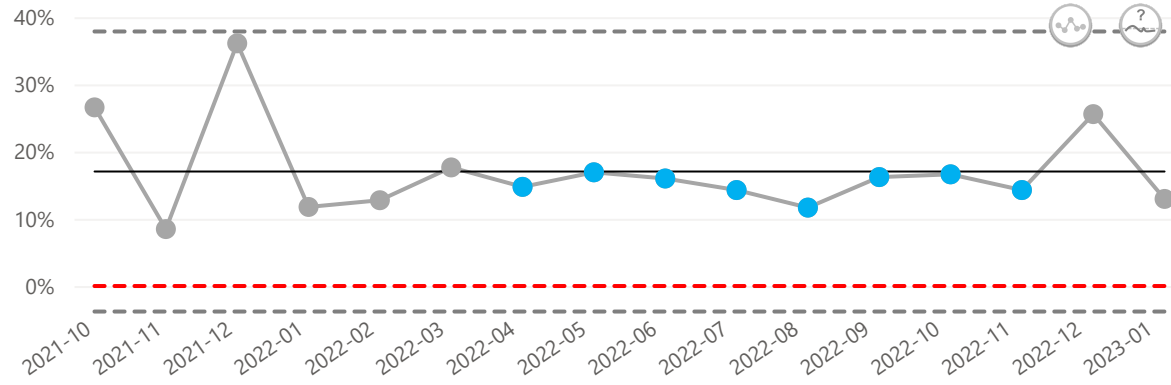
TIA - High Risk Treated within 24Hrs
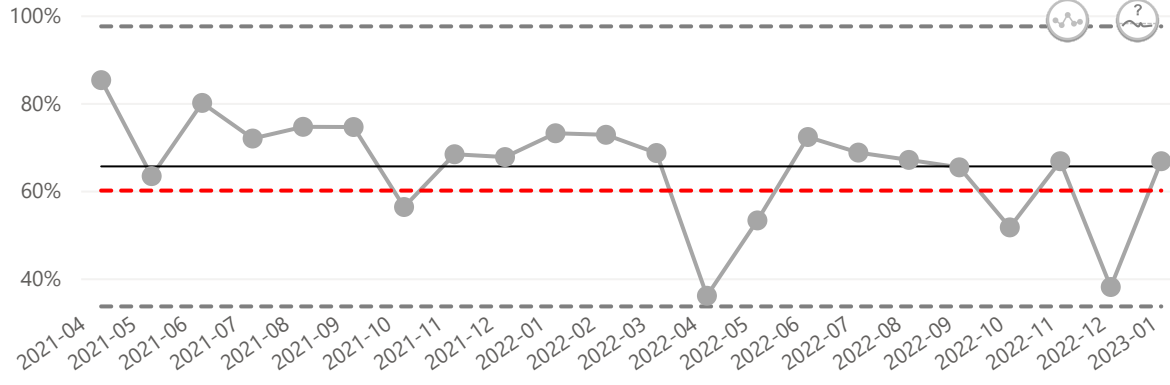
Stroke - 90% Stay on Stroke Ward
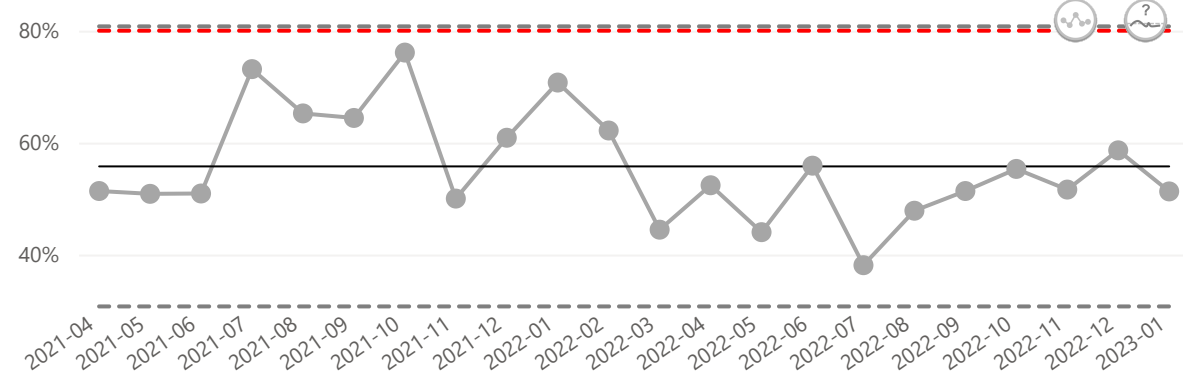
Activity

Operations

Indicator	Latest					Previous			Year to Date	
	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Outpatient New	9122	9272	Jan 23			8687	7823	Dec 22	90783	96630
Outpatient Follow Up	22998	22481	Jan 23			21903	19346	Dec 22	228888	219187
Day Case	4705	4854	Jan 23			4481	4129	Dec 22	46826	44768
Elective Inpatient	503	451	Jan 23			479	399	Dec 22	5003	4255
Non-Elective Inpatient	4458	4363	Jan 23			4458	4776	Dec 22	44004	42603
ED Attendances	6944	5777	Jan 23			6944	6286	Dec 22	68544	62735

Operations
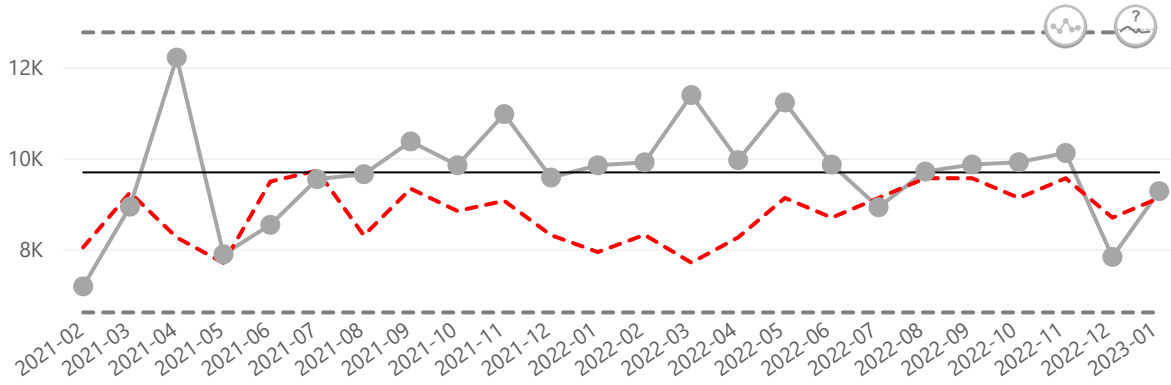
Outpatient New

Outpatient Follow Up
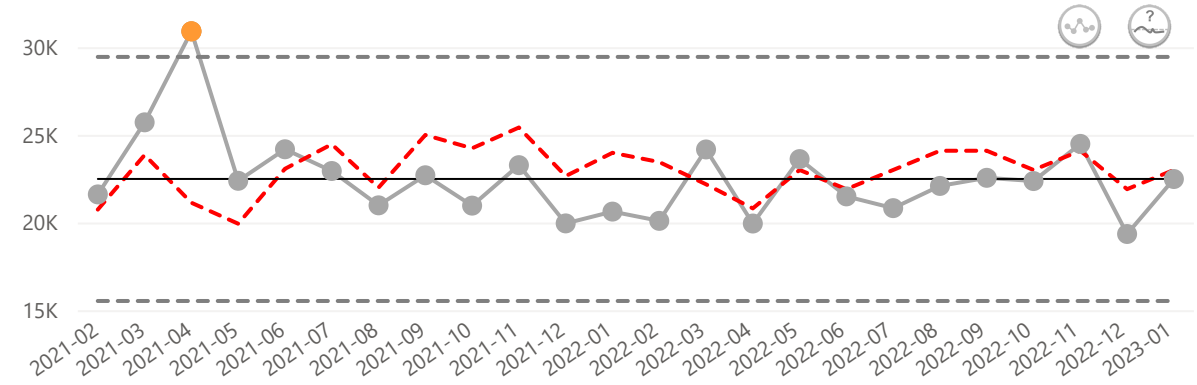
Day Case
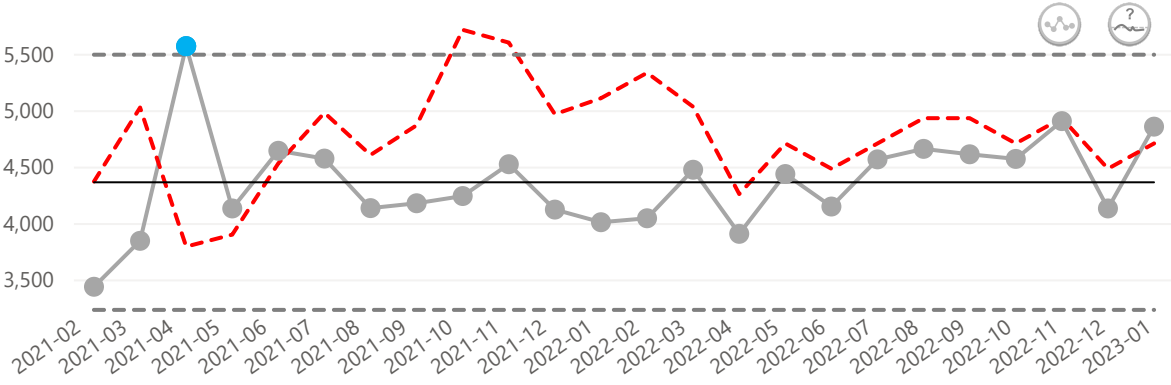
Elective Inpatient
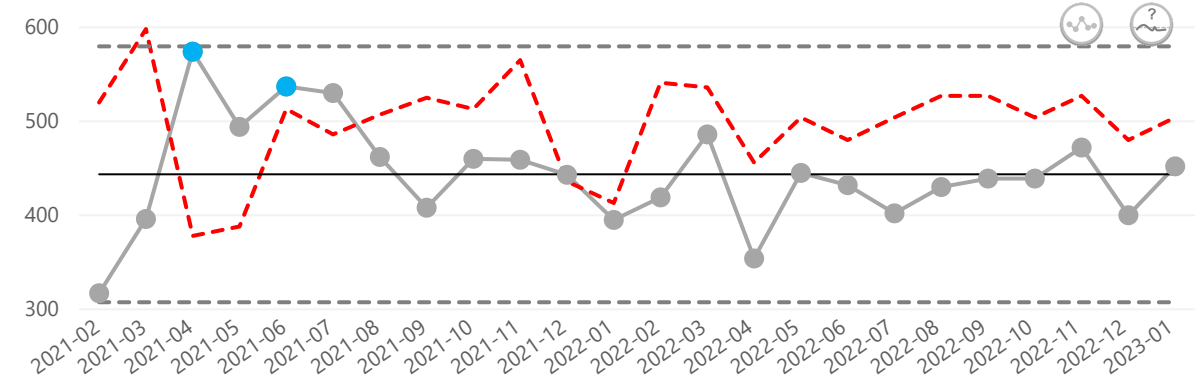
Non-Elective Inpatient

ED Attendances

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust
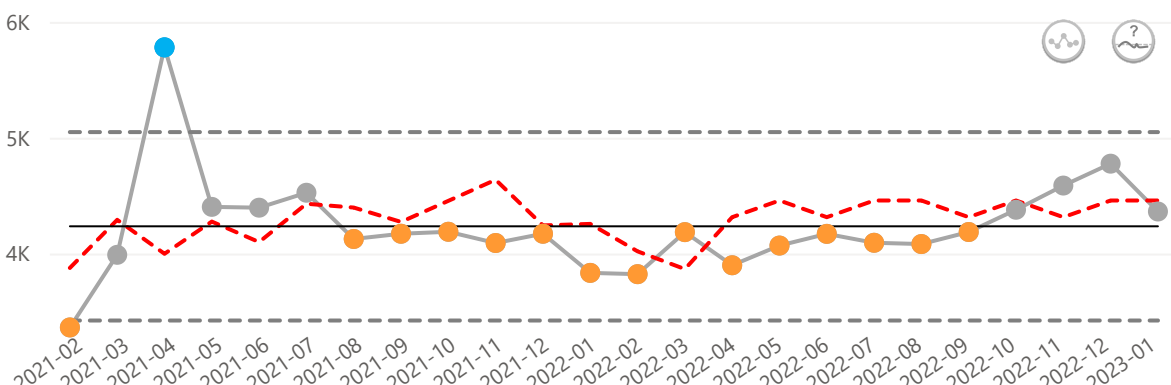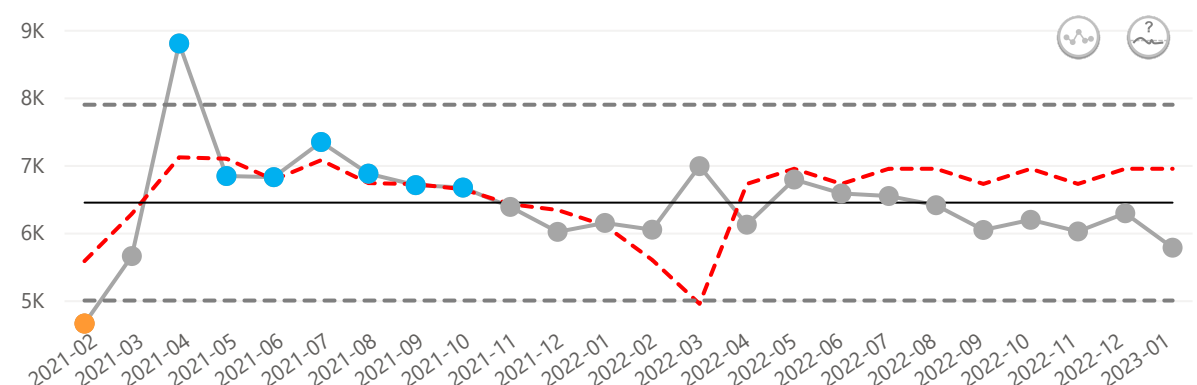
Cancer

Cancer Performance continues to be a key focus within the Trust with ongoing challenges to meet the national standards.

The 2WW standard is showing 93.1% achievement against the 93% standard. The performance has improved significantly since October 2022 with the ability to reinstate the straight to test pathway in Colorectal.

The 28 day Faster Diagnosis Standard has decreased in month to 66.2% (from 69%) against the 75% national target.

The Trust has consistently under achieved against the 85% 62-day treatment standard and in month performance did decrease to 67.9%. Performance is not expected to significantly improve until the 62-day backlog has been cleared. In January 234 patients remain on our cancer PTL over 62 days, this has improved but is still not meeting the monthly improvement trajectory due to the lack of capacity with services currently over reliant on agency and external support.

104 day breach metrics maintained for January from December.

Management Actions

The Trust is using the Weekly Cancer PTL meetings and Divisional PIDA meetings to monitor the Cancer Performance. The details of workstreams and their progress is included within the Cancer Performance report presented to the Finance and Performance Committee.

Further PTL scrutiny is being applied through the introduction of 104 day risk specific PTL meetings taking place three times a week to support the reduction of this backlog.

The increase in Endoscopy capacity has come online from the end of December 2022 with the opening of the Modular Unit. TIF capital funding has now been confirmed to enable the Trust to commence the building of a permanent 6th endoscopy room to come online in November 2023.

Increased validation of waiting lists taking place to ensure timely updates on pathways. MBI asked to provide some external scrutiny to Trust's cancer waiting lists in January and provide assurance that all PTL and breach reporting and validation is being optimised.

Indicator	Latest					Previous			Year to Date	
	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
TWW Suspected Cancer - %	93%	93.1%	Dec 22		?	93%	95.4%	Nov 22		
TWW Breast Symptomatic - %	93%	97.4%	Dec 22		?	93%	98.2%	Nov 22		
28 Days Faster Diagnosis Standard - %	75%	66.2%	Dec 22		?	75%	69.0%	Nov 22		
31 Days First Treatment - %	96%	89.7%	Dec 22	L	?	96%	93.5%	Nov 22		
31 Days Subsequent Treatment - Drugs - %	98%	100%	Dec 22		?	98%	100%	Nov 22		
31 Days Subsequent Treatment - Surgery - %	94%	100%	Dec 22		?	94%	92.3%	Nov 22		
62 Days GP Referred (Classic) - %	85%	67.9%	Dec 22		F	85%	80.2%	Nov 22		
62 Days National Screening - %	90%	58.6%	Dec 22		F	90%	44.1%	Nov 22		
62 Days Consultant Upgrade - %	85%	87.9%	Nov 22		?	85%	75%	Oct 22		
62 Days - GP Referred (Classic) Open Pathways >62 Days	125	237	Jan 23		?	140	261	Dec 22	125	237
62 Days - GP Referred (Classic) Open Pathways >104 Days		79	Jan 23	H			79	Dec 22		79

Operations

TWW Suspected Cancer – %
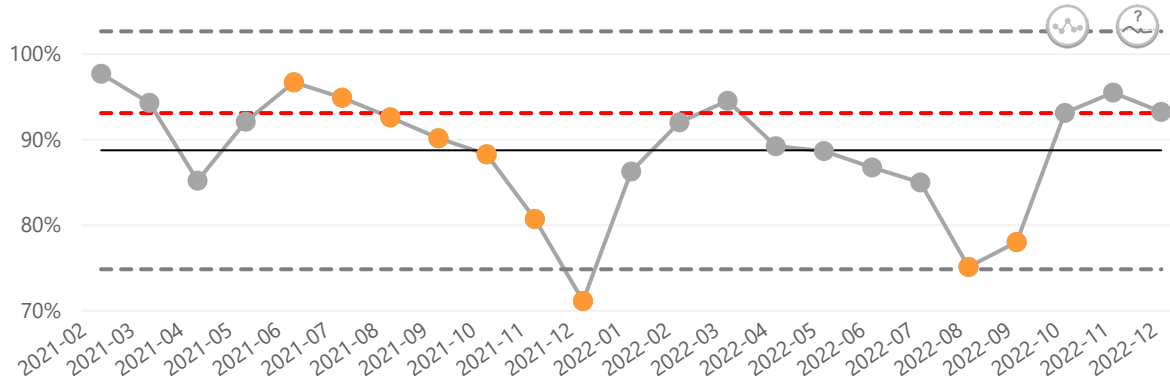
TWW Breast Symptomatic – %
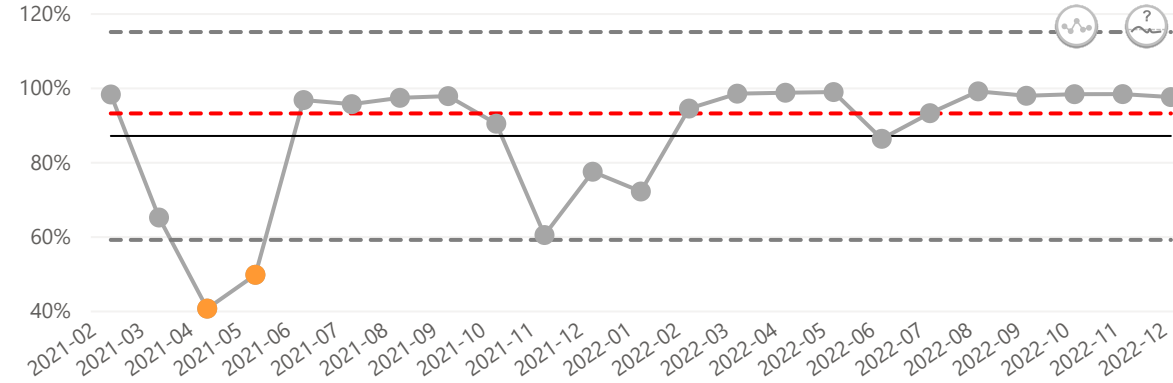
28 Days Faster Diagnosis Standard – %
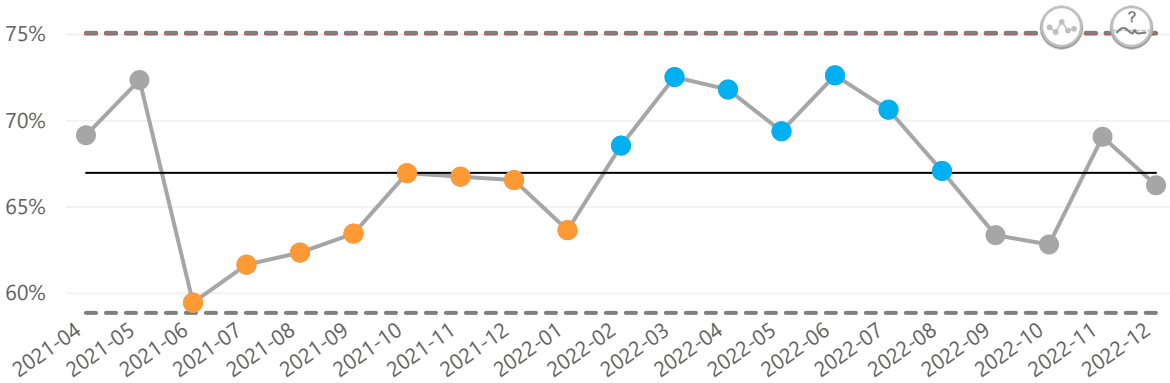
31 Days First Treatment – %
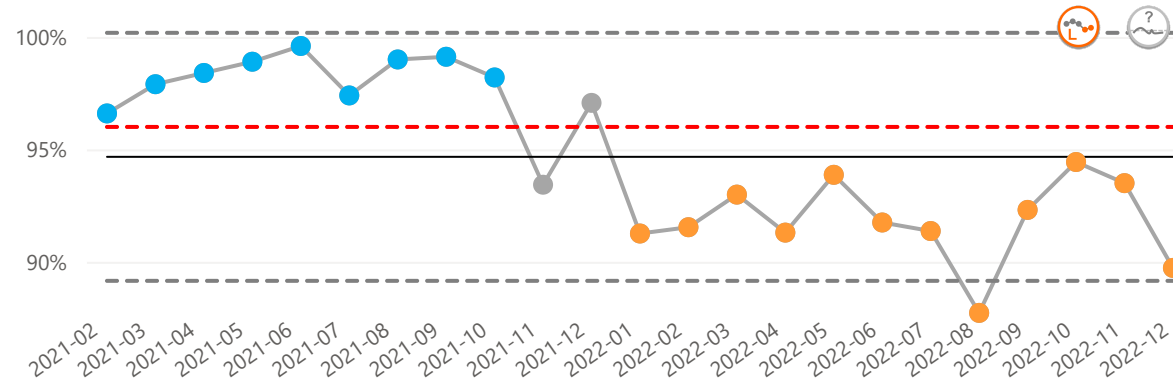
31 Days Subsequent Treatment – Drugs – %

31 Days Subsequent Treatment – Surgery – %

Operations
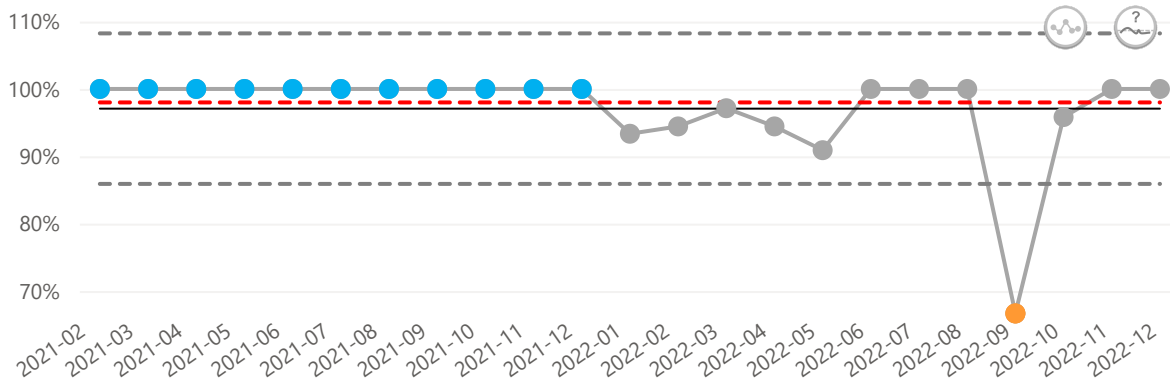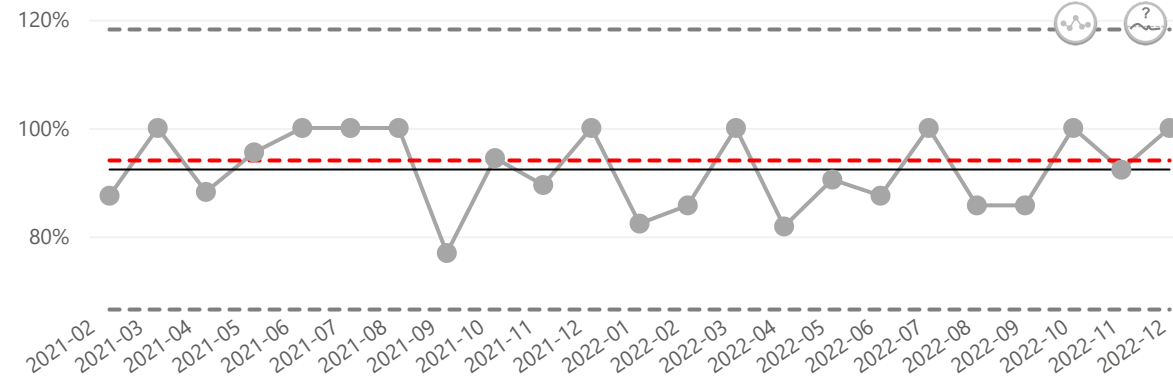
62 Days GP Referred (Classic) – %
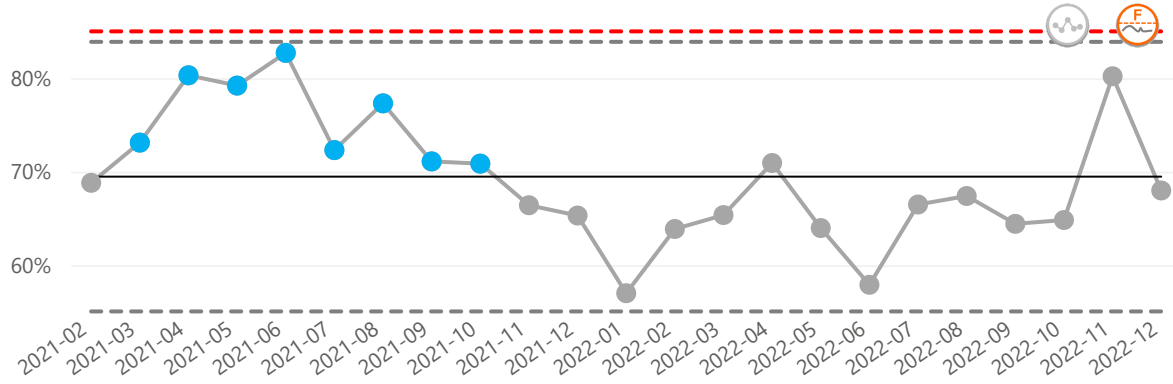
62 Days National Screening – %
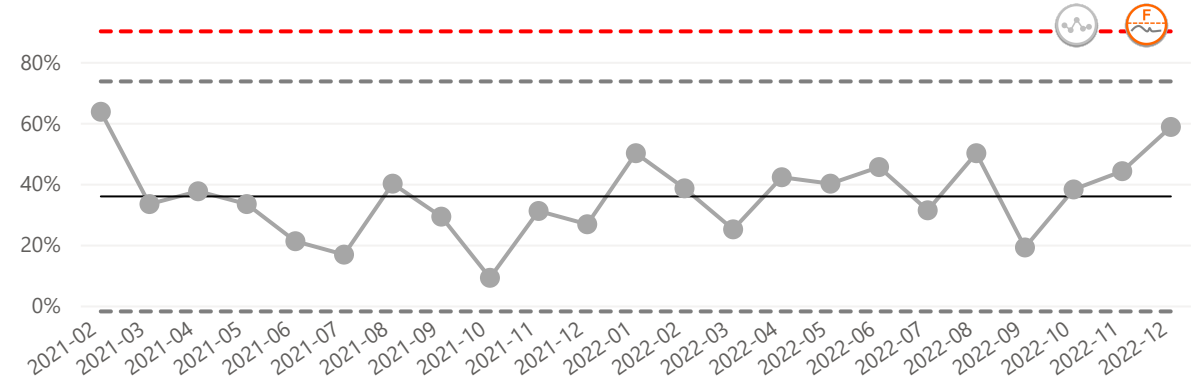
62 Days Consultant Upgrade – %
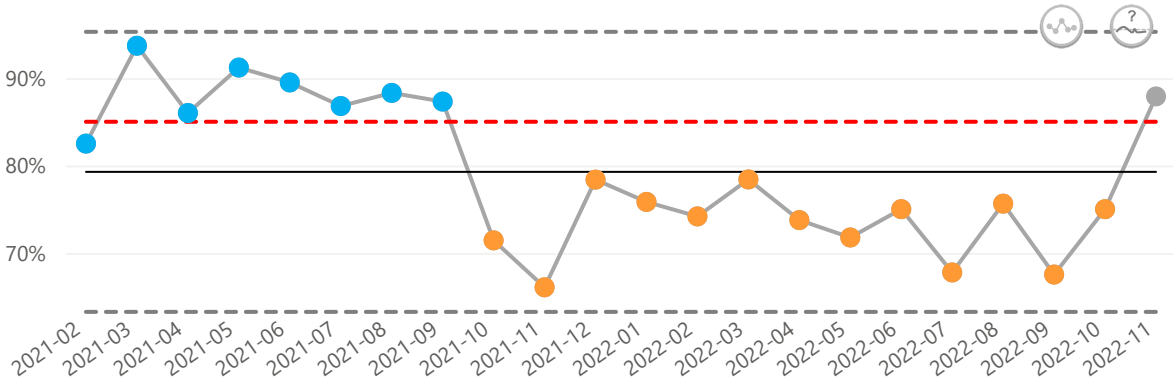
62 Days – GP Referred (Classic) Open Pathways >62 Days
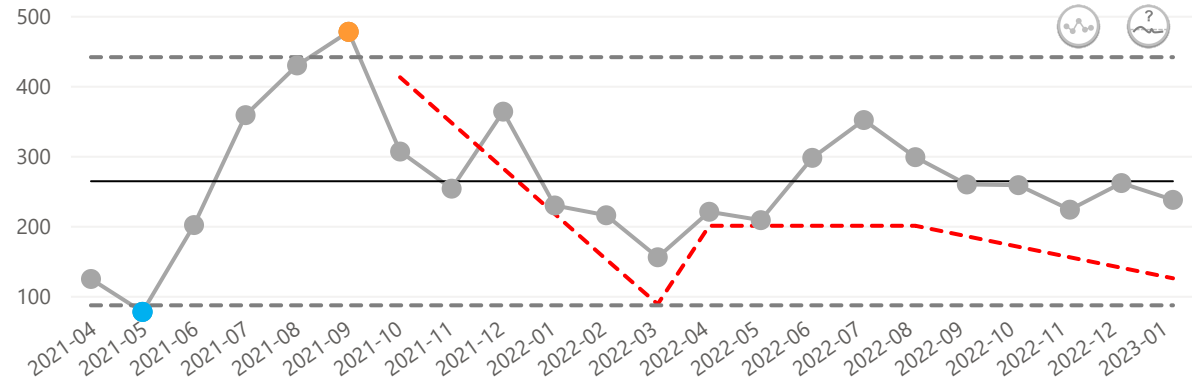
62 Days – GP Referred (Classic) Open Pathways >104 Days
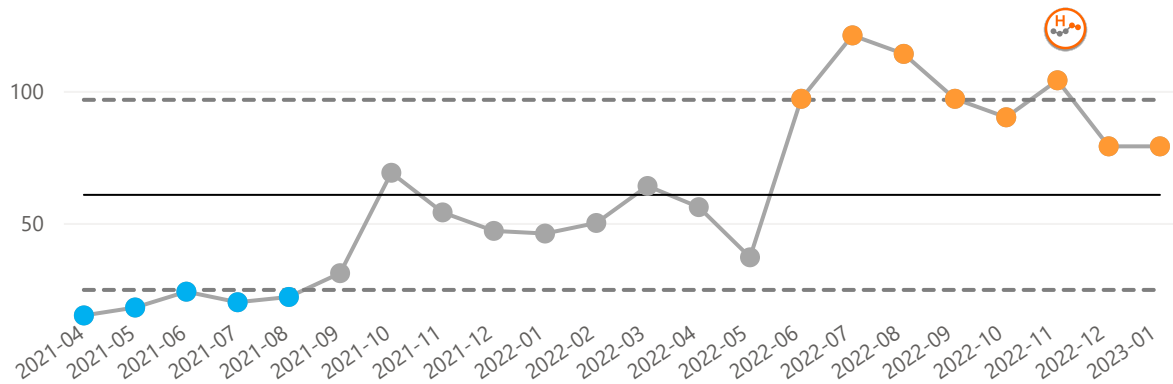
Productivity

Productivity

The IPR Productivity metrics currently provide a combination of key statistics across both Urgent and Emergency and Elective Care. The Trust is currently reviewing the governance and oversight of productivity metrics across the organisation and will be implementing a Trust Productivity Group commenced in January 2023 with formal reporting through to the Finance and Performance Committee including a revision of the metrics included in future IPR reports.

UEC productivity metrics – As mentioned in the access standards the Trust's bed occupancy and stranded patient metrics remain high with ongoing challenges and delayed discharges relating to those patients who no longer meet the criteria to reside in an acute hospital bed.

January saw a slight decrease in ED conversion rate from 41.5% in December to 40.6%.

Elective Productivity Metrics – Increases seen in January across both Outpatient and Theatre Utilisation month. The limited bed availability in January and need to escalate into the surgical and cardiac day case units has resulted in a larger than average number of patients cancellations with clinical teams moved to support UEC pathways and patients unable to have their procedures without inpatient beds available.

Operations

Indicator	Latest					Previous			Year to Date	
	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
DNA rate (OPD) %	7%	6.79%	Jan 23	(variation)	(?)	7%	8.1%	Dec 22		
New:Follow Up rate		1.95	Jan 23	(L)			1.95	Dec 22		1.95
OP Slot Utilisation	95%	91.8%	Jan 23	(variation)	(?)	95%	91.1%	Dec 22		
ED Conversion Rate		40.6%	Jan 23	(variation)			41.5%	Dec 22		
Bed Occupancy - BTH	85%	94.5%	Jan 23	(variation)	(F)	85%	89.4%	Dec 22		
Stranded Patients (>6 Days LOS)		389	Jan 23	(H)			378	Dec 22		389
Super Stranded Patients (>20 Days LOS)		132	Jan 23	(variation)			105	Dec 22		132
Theatre Utilisation, All Specialties, Urgent & Elective	85%	76.9%	Jan 23	(variation)	(F)	85%	75.1%	Dec 22		
Data Quality Maturity Indicator	82.5%	91.4%	Oct 22	(variation)	(P)	82.5%	91.4%	Sep 22		
Depth of Coding		5.2	Nov 22	(L)			6.84	Oct 22		5.2
PIFU Open Pathways	0.05%	0.3%	Jan 23	(variation)	(?)	0.05%	0.34%	Dec 22		

Operations

DNA rate (OPD) %
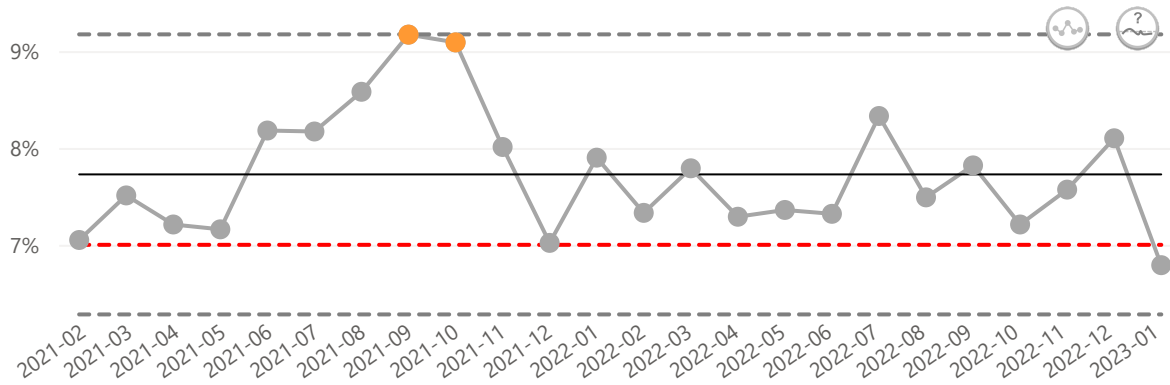
New:Follow Up rate
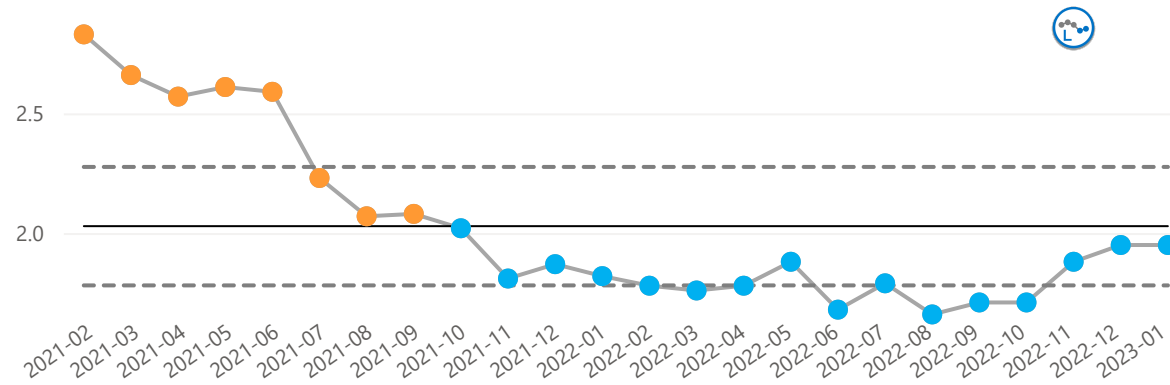
OP Slot Utilisation
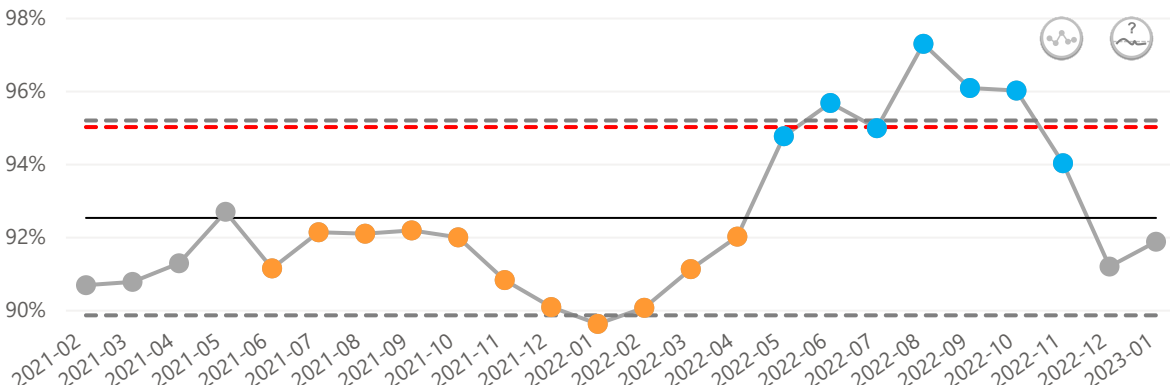
ED Conversion Rate
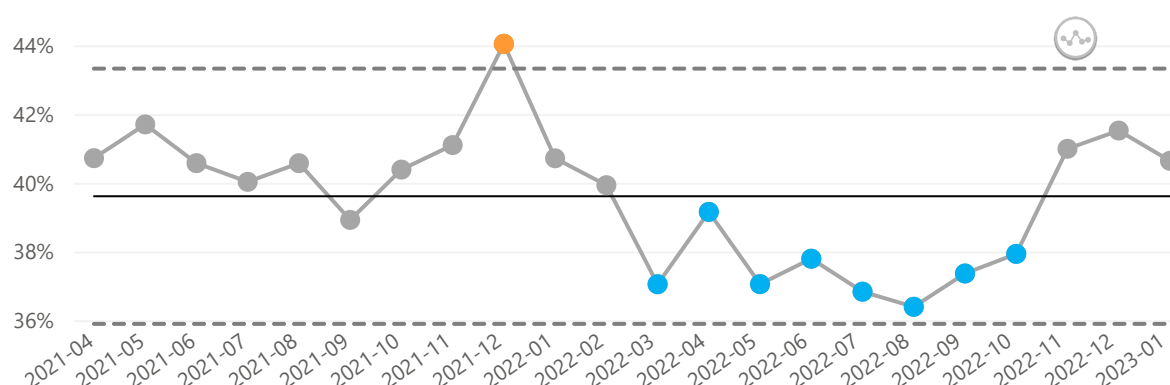
Bed Occupancy - BTH
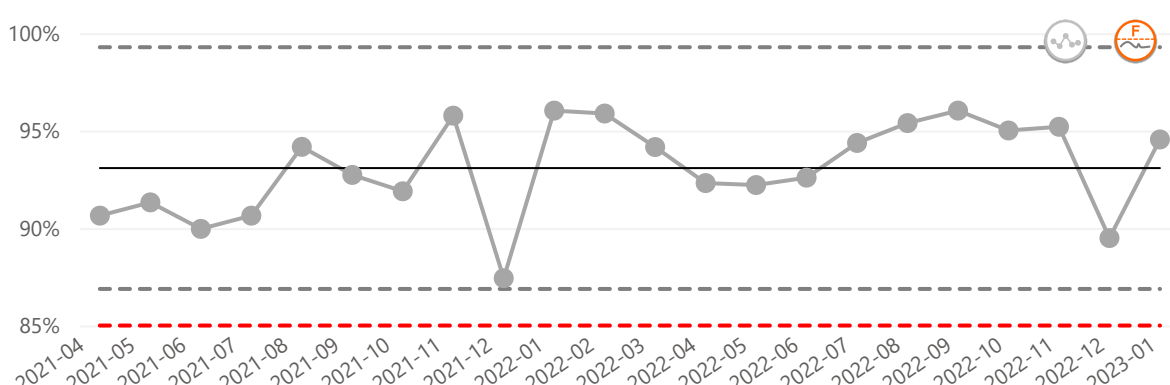
Stranded Patients (>6 Days LOS)

Operations
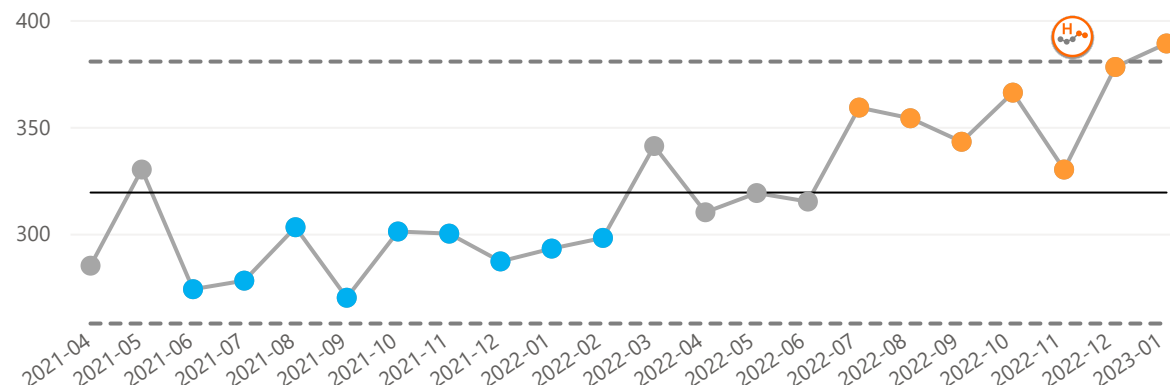
Super Stranded Patients (>20 Days LOS)
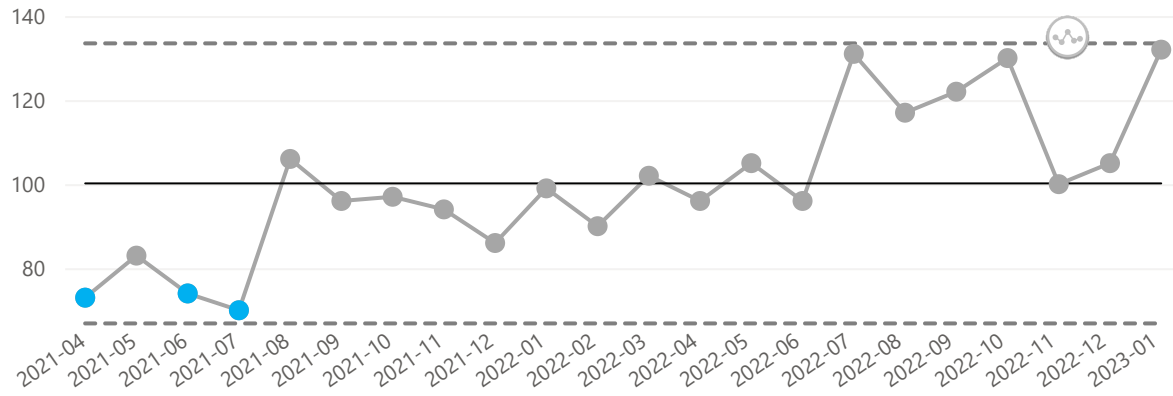
Theatre Utilisation, All Specialties, Urgent & Elective
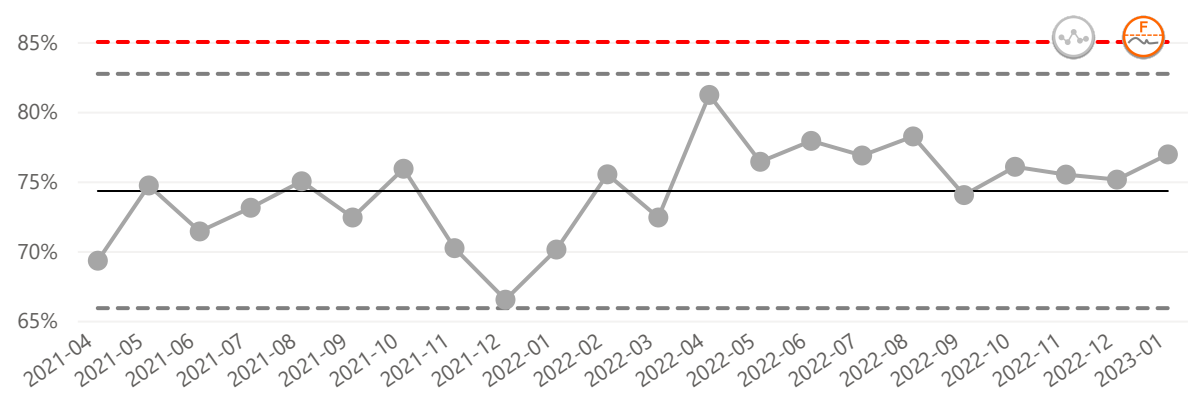
Data Quality Maturity Indicator
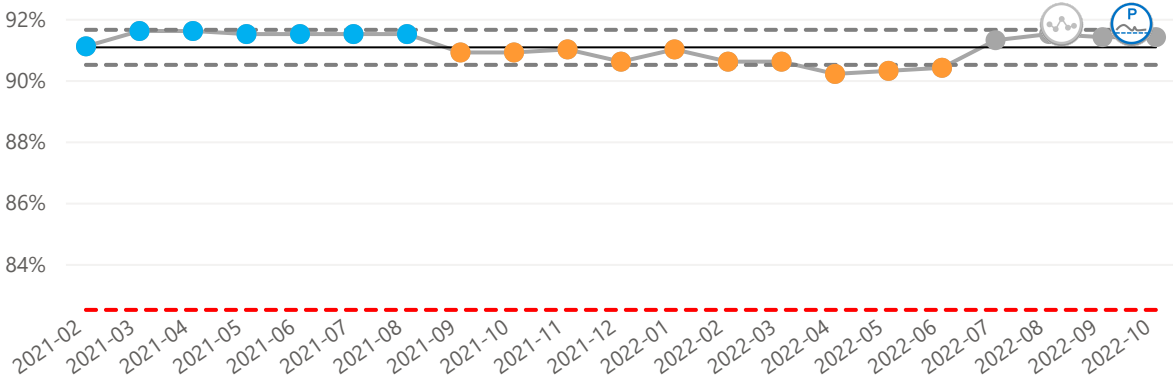
Depth of Coding

PIFU Open Pathways

NHS
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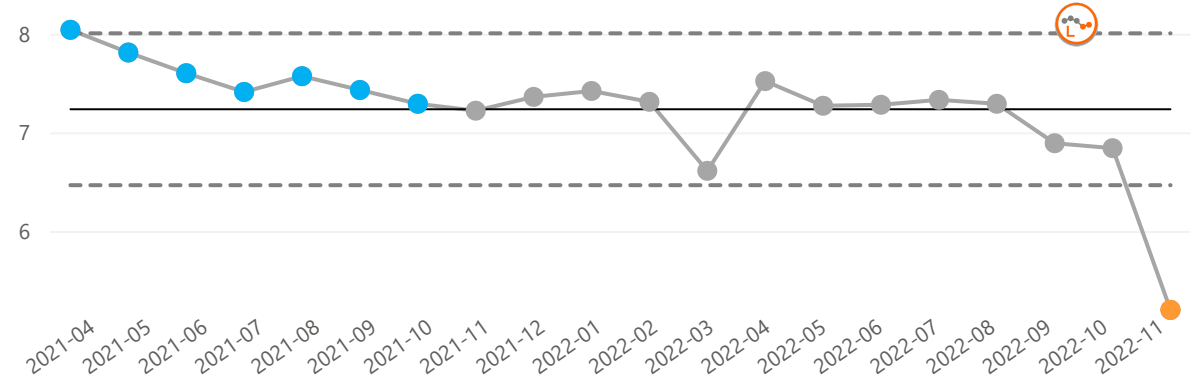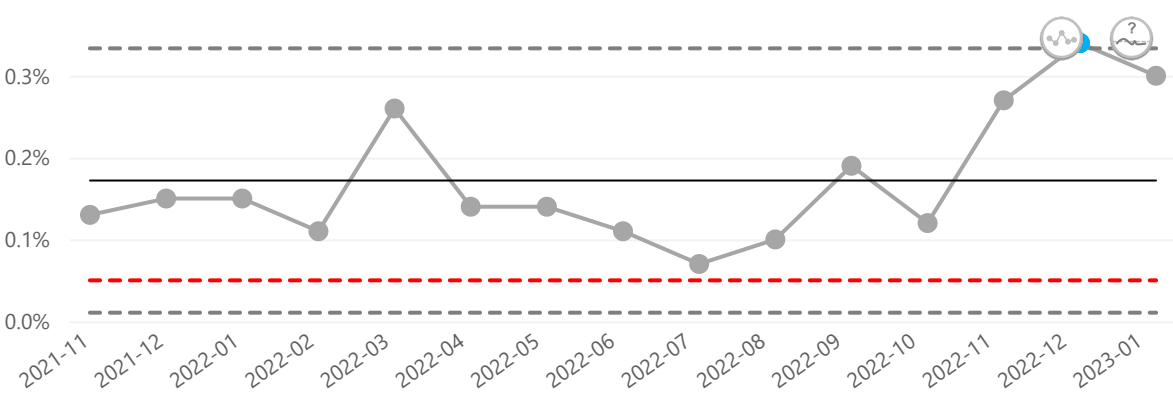
Finance

- Financial Position - year to date (£m) - Year to date position is an actual deficit of £14.5m which is £12.1m more than the planned deficit of £2.4m
- Pay Spend - year to date (£m) - Year to date position is an actual spend of £349.7m which is £23.6m more than the planned spend of £326.1m
- Agency Spend - year to date (£m) - Year to date position is an actual spend of £32.4m which is £12.5m more than the planned spend of £19.9m
- Bank Spend - year to date (£m) - Year to date position is an actual spend of £25.4m which is £16.6m more than the planned spend of £8.8m
- Bank and Agency Rate run (%) - Year to date 16.5% of the paybill is spent on bank and agency which is 7.7% more than the planned spend of 8.8%
- Non pay spend - year to date (£m) - Year to date position is an actual spend of £182.9m which is £1.7m less than the planned spend of £184.6m
- CIP - year to date (£m) - Year to date savings of £18.1m have been delivered which is in line with plan
- Capital spend - year to date - Year to date position is an actual spend of £16.8m which is £1.8m less than the planned spend of £19.1m
- Cash balance at month end - Cash balance as at 31st January 2023 is £32.7m which is £16.8m less than the planned cash balance of £49.5m
- Financial Position - forecast outturn (£m) - Forecast of £8.5m deficit which is £8.5m worse than the break even plan
- CIP - forecast outturn (£m) - Forecast savings which is in line with plan
- Capital spend - forecast outturn (£m) - Forecast spend of £38.8m which is in line with the planned spend of £38.8m (plan updated due to additional central funding)
- Cash balance - forecast outturn (£m) - Forecast cash balance of £38.0m as at 31st March 2023 which is £8.5m worse than plan (this is aligned to the I&E forecast deficit)

Indicator	Latest Plan	Latest Actual	Latest Period	Variation	Assurance	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual
Medical Consultant Agency Run-Rate (£m)	0.6	0.7	Jan 23	(variation icon)	(? assurance icon)	0.7	0.5	Dec 22	7.4	8.8
Medical Non Consultant Agency Run-Rate (£m)	0.4	1.2	Jan 23	(variation icon)	(? assurance icon)	0.4	0.4	Dec 22	4.9	10.9
Medical Consultant Bank Run-Rate (£m)	0	0	Jan 23	(L variation icon)	(? assurance icon)	0	0	Dec 22	0.0	0.0
Medical Non Consultant Bank Run-Rate (£m)	0	0.5	Jan 23	(variation icon)	(? assurance icon)	0	0.2	Dec 22	10.0	4.5
Nurse Agency Run-Rate (£m)	0.3	1	Jan 23	(variation icon)	(F assurance icon)	0.5	1.2	Dec 22	6.4	11.2
Nurse Bank Run-Rate (£m)	0.8	1.1	Jan 23	(variation icon)	(? assurance icon)	0.8	1.1	Dec 22	8.5	10.0
Pay Run-Rate (£m)	32.5	35.2	Jan 23	(variation icon)	(? assurance icon)	32.4	34.9	Dec 22	326.1	349.7
Non Pay Run-Rate (£m)	18.5	21.6	Jan 23	(variation icon)	(? assurance icon)	18.6	19.5	Dec 22	184.5	183.0
Capital Spend (£m)	3.1	2.6	Jan 23			2.4	1.4	Dec 22	19.1	16.8
Cash Balance (£m)	49.5	32.7	Jan 23			48.2	29.5	Dec 22	49.5	32.7
Surplus / Deficit Against Plan (£m)	1.3	-1.2	Jan 23			1.3	0.3	Dec 22	-2.5	-14.5
QEP Performance (£m)	2.95	2.95	Jan 23			2.3	2.3	Dec 22	18.1	18.1
BPPC (by value) - In Month	95%	94%	Jan 23			95%	93%	Dec 22		
BPPC (by volume) - In Month	95%	97%	Jan 23			95%	92%	Dec 22		

Finance

	Indicator	Latest			Previous			Year to Date	
		Plan	Actual	Period	Plan	Actual	Period	Plan	Actual
Finance	BPPC (by value) - Year to Date	95%	93.6%	Jan 23	95%	94%	Dec 22	95%	93.6%
	BPPC (by volume) - Year to Date	95%	93%	Jan 23	95%	92%	Dec 22	95%	93%

Finance

Medical Consultant Agency Run-Rate (£m)
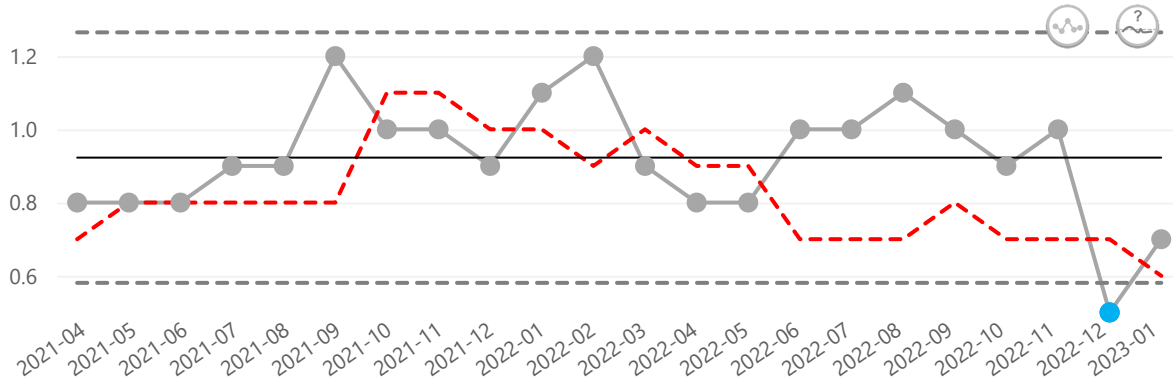
Medical Non Consultant Agency Run-Rate (£m)
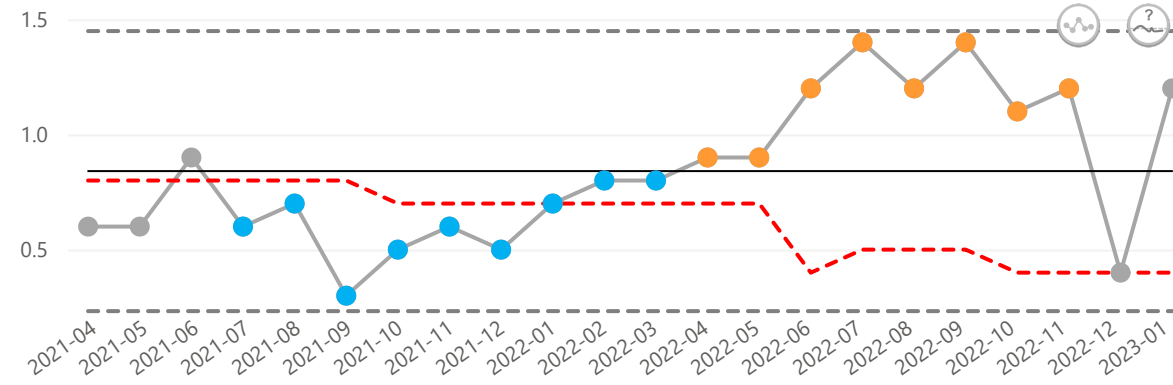
Medical Consultant Bank Run-Rate (£m)
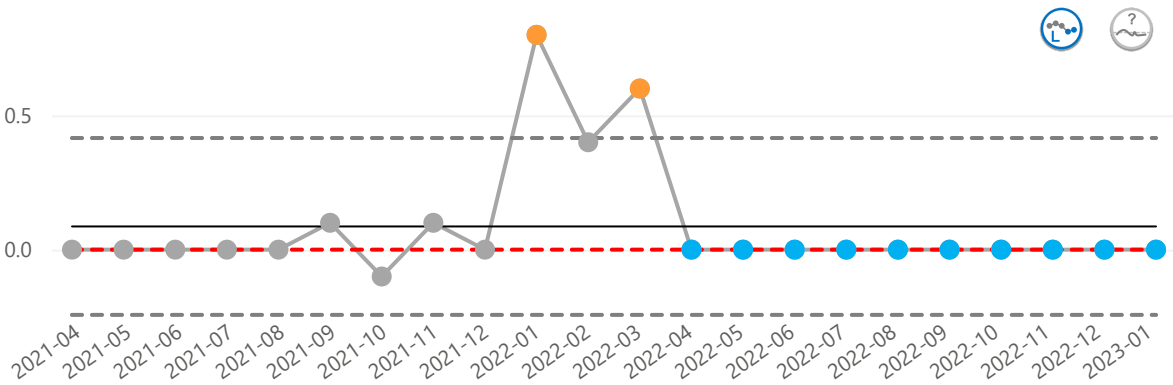
Medical Non Consultant Bank Run-Rate (£m)
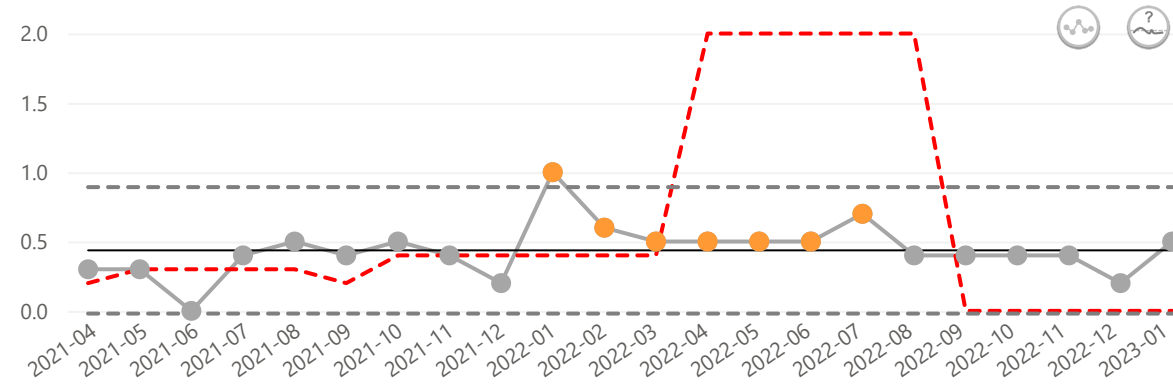
Nurse Agency Run-Rate (£m)

Nurse Bank Run-Rate (£m)

Finance
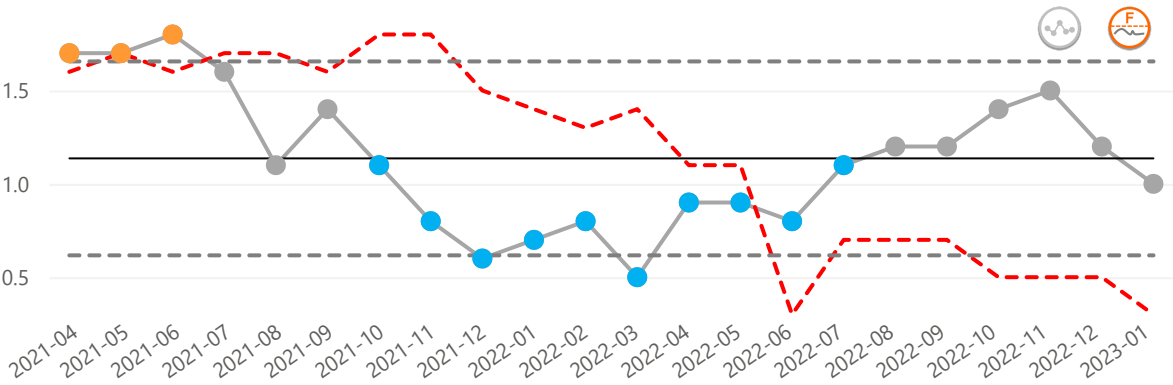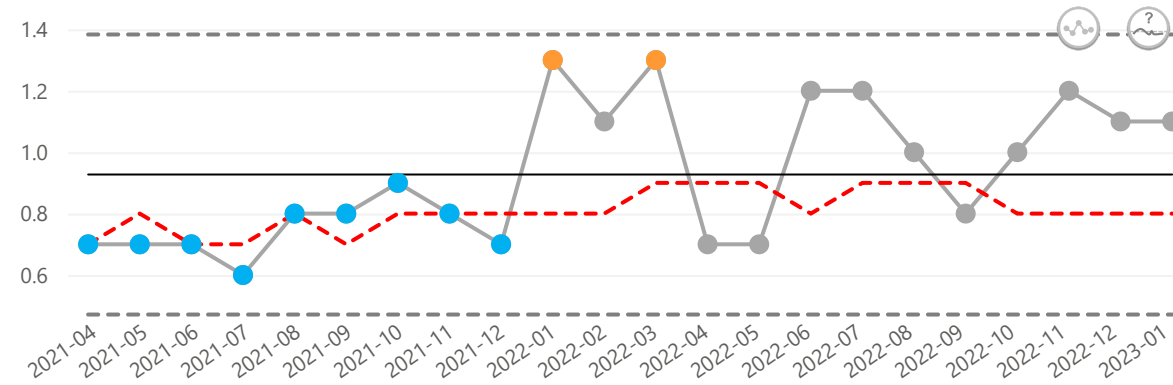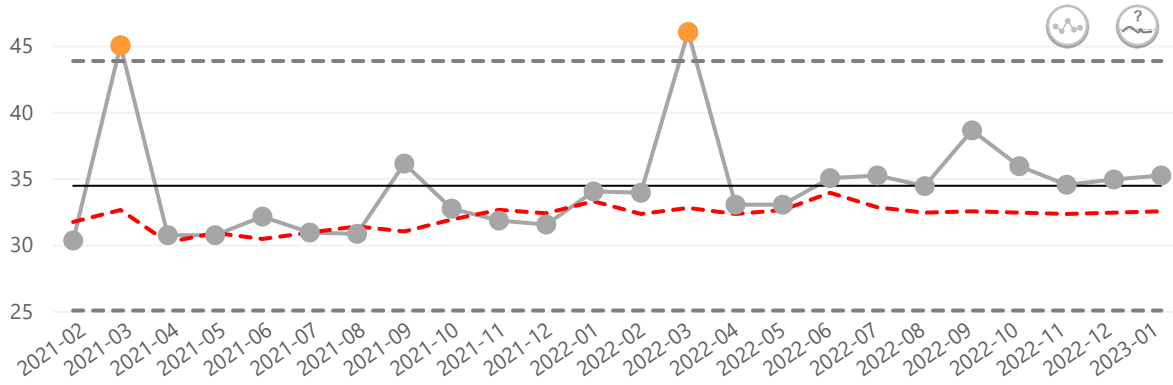
Pay Run-Rate (£m)

Non Pay Run-Rate (£m)
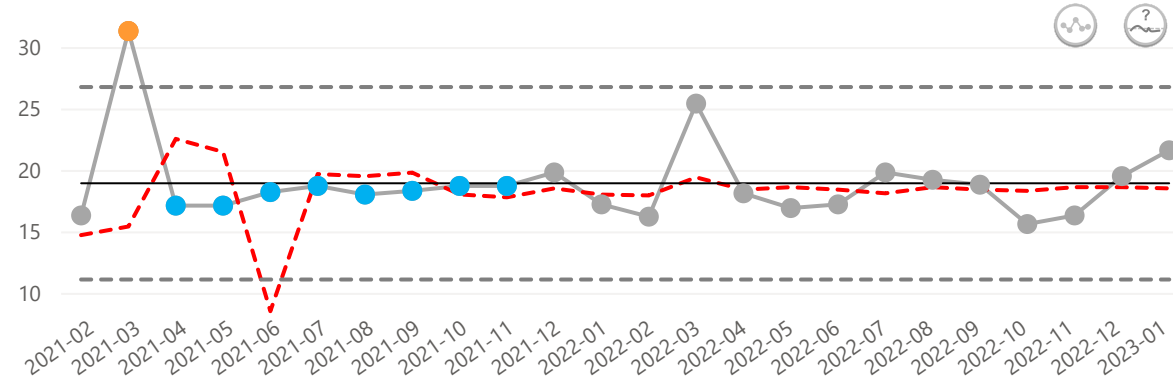
Capital Spend (£m)
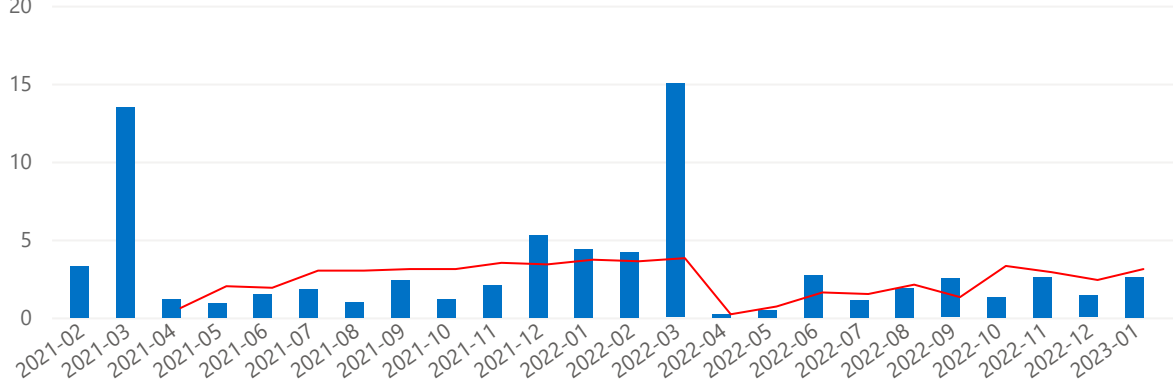
Cash Balance (£m)
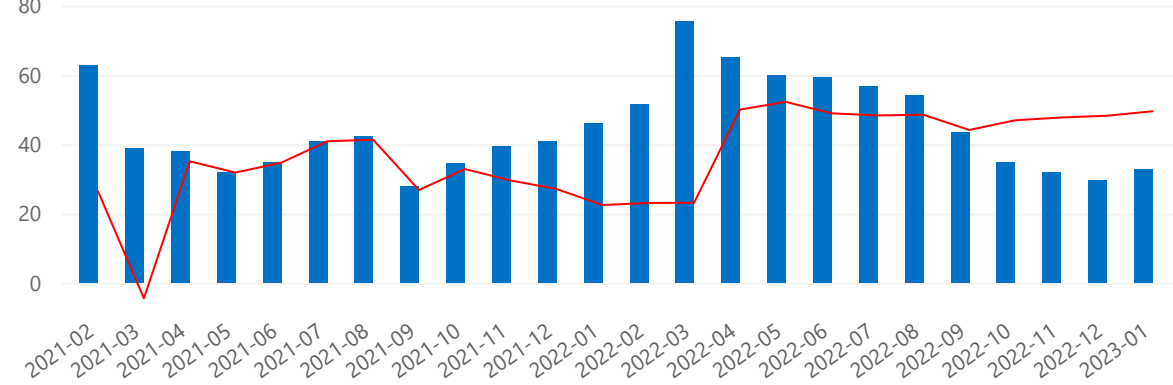
Surplus / Deficit Against Plan (£m)

QEP Performance (£m)
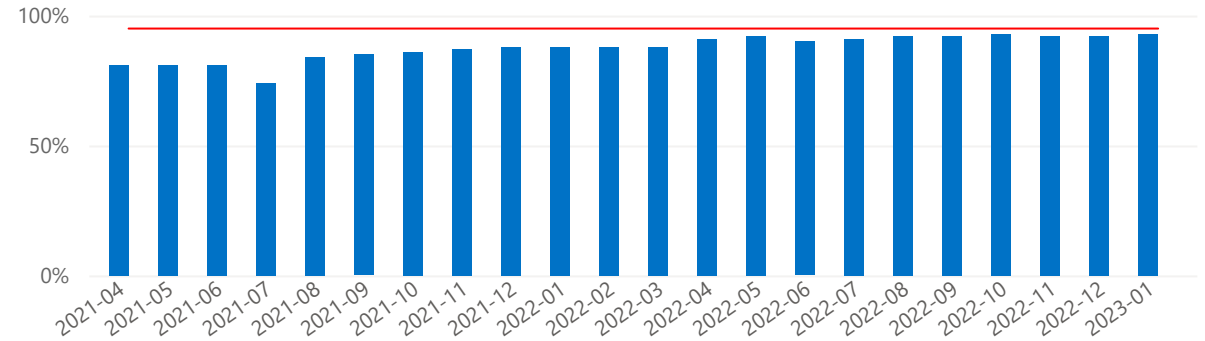
Definitions

Tier	Metric	Definition	MetricNumerator	MetricDenominator	MetricConstruction	DataSourceSystem
Access	% of Patients spending 12+ Hours in ED - Trust	The percentage of patients that have a wait of over 12 hours within the A&E Department . This includes Type 3 attendances. To achieve the Trust must have no patients waiting over 12 hours.	Attendances with time in department >=12 hours	Total attendances	(Numerator/Denominator)*100	Maxims
Access	% of patients waiting less than 6 weeks for a diagnostic test	% of patients waiting less than 6 weeks for a diagnostic test at month end. To achieve the Trust must have >= 95% of patients waiting < 6 weeks.	Number of patients waiting <6 weeks for a diagnostic test	Total number of patients waiting for a diagnostic test	(Numerator/Denominator)*100	HISS/RIS
Access	2-Hour UCR	The percentage of 2-hour urgent community referrals responded to within 2 hours. Target of 70% to come into effect from end of Quarter 3 22-23.	Number of referrals receiving response within 2 hours	Total number of referrals	(Numerator/Denominator)*100	NHSE
Access	4 Hours from arrival to ADT - % within 4 hours	The percentage of A&E attendances where the patient was admitted, discharged or transferred, where their waiting time within the department was within four hours, out of total number of A&E attendances where the patient is admitted, discharged or transferred. To achieve the Trust must have more than 95% of A&E departures within 4 hours of their A&E arrival time.	Number of attendances departing within 4 hrs	Total number of attendances	(Numerator/Denominator)*100	Maxims
Access	A&E Type 1 Performance %	The percentage of Type 1 A&E and UCC attendances where their waiting time within the department was within four hours, out of total number of Type 1 A&E and UCC attendances. To achieve the Trust must have more than 65% of A&E departures within 4 hours of their A&E arrival time.	Number of Type 1 attendances departing within 4 hrs	Total number of Type 1 attendances	(Numerator/Denominator)*100	Maxims
Access	Ambulance Handover 30-60 Mins	The number of ambulance handovers completed 30-60 minutes. Following the handover between the ambulance crew and the A&E staff.	-	-	Count	NWAS
Access	Ambulance Handover Over 60 Mins	The number of ambulance handovers completed over 60 minutes. Following the handover between the ambulance crew and the A&E staff.	-	-	Count	NWAS
Access	Ambulance Handovers - % within 15 minutes	The percentage of ambulance handovers completed within 15 minutes. Following the handover between the ambulance crew and the A&E staff. To achieve the Trust must have more than 65% of ambulance handovers completed within 15 minutes.	Number of handovers completed within 15 mins	Total number of handovers	(Numerator/Denominator)*100	NWAS
Access	Ambulance Handovers - % within 30 minutes	The percentage of ambulance handovers completed within 30 minutes. Following the handover between the ambulance crew and the A&E staff. To achieve the Trust must have more than 95% of ambulance handovers completed within 30 minutes.	Number of handovers completed within 30 mins	Total number of handovers	(Numerator/Denominator)*100	NWAS
Access	Number of Patients spending 12+ Hours	The number of patients that have a wait of over 12 hours within the	-	-	Count	Maxims

Title	Finance & Performance Committee Escalation Report

Meeting:	Board in Public Meeting
Date:	2nd March 2023

Author	Esther Steel, Director of Corporate Governance				
Exec Sponsor	To be presented by FAP Chair				
Purpose	Assurance	x	Discussion	x	Decision	

Confidential y/n	No
Summary *(what)*	To update the Board on the alerts, assurance and advise content, discussed at the Finance & Performance Committees on: - Thursday 26th January 2023 - Thursday 23rd February 2023. Both meetings focused on financial and operational challenges – areas for alert are identified in the reports. Board members are asked to note that although a number of items have been escalated there are also items to celebrate – the Trust is performing well against the new four hour target and attracted positive media coverage and good progress has been made with cancer performance and elective recovery

Previously considered by	n/a

Implications *(so what)*	Board members are asked to note Board members will also be asked to approve the new Digital Plan

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	Non noted

Proposed Resolution *(What next)*	To note the F&P Committee's Escalation Report

Caring · Safe · Respectful

Committee/Group Chair's Report

Blackpool Teaching Hospitals
NHS Foundation Trust

Name of Committee/Group:	Finance and Performance	Report to:	Board of Directors
Date of Meeting:	26 January 2023	Date of next meeting:	
Chair:	Mark Beaton	Parent Committee:	Board of Directors

Introduction

Quorate meeting held on MS Teams, good engagement in discussion with a focus on key operational and financial challenges

Alert

What	So What	What Next
Financial Performance Report The Director of Finance provided an update on month 9 financial performance – the Trust reported a deficit of £13.3m which is £9.6m worse that plan. Cash – the team are reviewing the latest guidance on liquidity – the cash balance has reduced and is lower than the planned cash balance Cost Savings – year to date programme has released savings of £15.2m however much of this is non recurrent	Committee members discussed the adverse variance noting the impact of escalation (£7.2m) mainly in relation to contingency staffing Committee members spent some time discussing the financial challenge with a focus on savings programme and the under delivery of QEP Agreed limited assurance on achievement of QEP and on achievement of the financial forecast and sustainability and noted that while cash balances remain sufficient this year there is limited assurance for next year	Requested more detailed understanding of QEP assumptions. Further discussion to take place with the full Board.
RTT incompletes – over 78 weeks Report provided on a deep dive into long waiters focusing on pathways over 78 weeks to deliver the national ask of eliminating these by March 2023	Committee members noted the work done to improve noting that the Trust has improved from the August position when five specialities were at risk to two specialities at risk in October – cardiac and GI MBI are undertaking validation and are on track to have validated 100% by the end of January Committee members noted that some of the current cost pressures are driven by our reliance on premium cost providers. Officers were challenged to ensure that teaks continue to give due consideration to costs/benefits	The Committee noted the update and noted the risk in Cardiac and GI while there was some assurance in GI more actions are required in Cardiac including potential mutual aid or additional capacity through in sourcing. As this is now monitored at system level we might also be asked to provide mutual aid in other specialities

Committee/Group Chair's Report

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Assurance		
What	**So What**	**What Next**
Cancer Performance two week wait and 62 day Two week wait cancer performance improved significantly towards the end of 2022 with full recovery achieved in November and maintained above the 93% standard during December. 62 day backlog continues to be a pressure primarily drive by colorectal and upper GI – main contributors to in month slippage was a reduction in capacity over the festive period and a limitation on the use of the modular unit while a licence was obtained for the use of controlled drugs	Committee members noted the fragility of capacity. The issue in relation to sedation is expected to be resolved in February	Additional PTL improvement plan for a period of 8 weeks to target all patients on prior PTL for colorectal and upper GI MBI to support a validation and assurance exercise to ensure accurate reporting
Atlas Client Performance meeting Progress made with renewal of appointments for Authorised Engineer and Approve Person Domestic tender now complete New contract for gas provision noted with increased costs – Board previously advised	The Committee noted the update	Improvement noted
Advise		
What	**So What**	**What Next**
Finance Improvement Plan The Financial Improvement Director provided an update on his work so far including work with the non pay group, the vacancy control group and the targeted agency control group	Committee members welcomed the update and the proposed plan	Further discussion with full Board on February 2nd 2023
Planning guidance Update provided on the 2023/24 planning guidance and process	Committee members noted the requirement to reduce agency expenditure and discussed the use of capacity and demand modelling to show demand by speciality	Timetable for submission noted – Committee members requested opportunity for oversight by the full Board ahead of submission

SEND update	Update noted	Improvement noted
Recap of action plan provided with an update on the progress made in each area		
Patient Flow Improvement Programme (PFIP)	Bed occupancy remains high	Regular updates provided through the bulletin
Update provided on the PFIP programme – work in December focused on the challenges over the seasonal period		
ICS Electronic Patient Record – Strategic Outline Case	New Chief Informatics officer welcomed to the Trust/Committee. Committee members discussed the operability of the strategy and tasked the new CIO to report back to provide assurance that the proposed strategy is operable	The Committee noted the update and supported the move to proceed to the next stage of the process
The EPR outline business case (OBC) has been approved by the National Frontline Digitisation Investment Board giving the go ahead to proceed with procurement		
Procurement Update	Discussed compliance with policy – noted that the Audit Committee receive a regular update on waivers	Committee members requested more detail on level of compliance and actions to maximise compliance with no PO no pay policy
The Committee received an update from a representative from the procurement hub		
PACS/RIS	The Committee previously approved in principle but had concerns about cost implications	The Committee agreed to recommend to the Board that the contract notice be issued and procurement commence
Following a paper to the Committee in November 2022, an update was provided on the infrastructure and deployment implications of a change to a new contract. The ICB have now confirmed that the costs associated with this will be covered centrally		

Committee/Group Chair's Report

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Name of Committee/Group:	Finance and Performance	Report to:	Board of Directors
Date of Meeting:	26 January 2023	Date of next meeting:	23 Feb 2023
Chair:	Mark Beaton	Parent Committee:	Board of Directors

Introduction

Quorate meeting held on MS Teams, good engagement in discussion with a focus on key operational and financial challenges.

The Trust continues to experience significant operational pressures with escalation areas incurring additional costs

Alert

What	So What	What Next
Financial Performance Report At 31st January 2023 the Trust has reported a deficit of £14.5m, which is £12.1m worse than the planned deficit of £2.4m. At the Board of Directors on 2nd February, the Board of Directors noted the unmitigated forecast of £35.8m and approved the submission of a mitigated financial forecast of £8.5m.	In the interim period since the Board of Directors approved the submission, the Trust's target mitigated outturn deficit has been increased marginally to £8.8m. This updated target has been discussed with and agreed by the Board in an extraordinary meeting earlier in the day. The year-to-date financial performance is £0.5m better than forecast predominantly due to improved divisional performances and less than forecasted surge.	The Committee noted the update There is significant assurance that the Trust will achieve the target £8.8m deficit There is low assurance on the long-term financial sustainability – action is required to reduce the reliance on contingent workforce. Workforce Assurance Committee seek assurance that we have sufficient ambition in our recruitment plans.
Cash Financing As of 31st January 2023 the Trust has a cash balance of £32.7m. The current and forecast deficit position combined with the utilisation of non-cash mitigations to minimise the deficit is resulting in a reducing cash balance. Whilst there will be no requirement for cash financing in the current financial year, an ongoing deficit in the 2023/24 financial year will put the cash position under pressure and therefore cash financing may be needed by the Trust.	Committee members noted the cash position and discussed the actions that would be required if cash support was needed	Limited assurance on the future cash position

Blackpool Teaching Hospitals
NHS Foundation Trust

Cancer 62-day performance – remains a challenge however the additional GI capacity should start to drive performance to reduce the backlog but not anticipated to achieve the target reduction of less than 77 cases	Committee members discussed the management actions taken and the implications of not achieving the reduction target noting that the 2023/24 planning target is to return to a pre pandemic position which for BTH is 128 by March 2024	Update to March F&P Committee
Elective Waits – cardiac outpatient capacity Although most specialities are on target to achieve the 78 week target the capacity to achieve this in cardiology outpatients is limited		Outsourcing and mutual aid will reduce the number of patients waiting over 78 weeks
Outpatients Committee members were alerted to a risk resulting from the current method of booking outpatient appointments	The issue will be addressed with the implementation of a partial booking system – this will reduce cancellations and give better management of capacity	The management of our outpatient lists will be a focus over the next 12 months overseen by a Productivity Group and Information Assurance Group
Patient Flow Improvement Programme (PFIP) Update provided on the PFIP programme – Specific Alert in relation to no criteria to reside numbers and the adverse impact on patient flows.	The Trust is engaging with partners on MADE events and reviewing extending winter schemes ICB agreed to extend additional domiciliary care hours winter scheme for F&W residents, until end of June.	A demand & capacity review has been conducted to determine the system gap in meeting increased demand for patient's needing additional support needs at discharge when returning to usual place of residence.

Assurance		
What	**So What**	**What Next**
Cancer Performance two week wait and 62 day Progress continues to be made however there was a decline in January due to consultant sickness which resulted in a number of clinics being cancelled		Update noted
Elective waits and data quality Update provided on progress made towards reducing the number of patients waiting – with the exception of cardiology, good progress has been made with no patients waiting more than 104 weeks.	Following an ask about validation confirmation was given the Trust is 100% compliant with actions to validate the waiting list	Update noted

Committee/Group Chair's Report

NHS Blackpool Teaching Hospitals
NHS Foundation Trust

Patient Flow Improvement Programme (PFIP) Assurance provided on the use of SDEC with an increase in the number of direct referrals SDEC continues to deliver the anticipated improvements	Committee members noted the update and discussed the recent media coverage of the Trust's achievement of the four-hour target. Agreed that while this is a great result it is important not to lose site of the type one A&E pressures that continue	Regular updates to continue
Atlas Client Performance meeting Authorised Engineers and Approved Persons now in place for all areas and fire safety concerns addressed	The Committee noted the update and the improvement in the management of the contract between Atlas and the Trust	Improvement noted
2023/24 Capital Planning Update provided on the 2023/24 capital planning exercise the Trust are using a risk-based approach that considers a number of factors to assess and prioritise the way capital resources are allocated. This ensures that the 2023/24 capital plan directs resources to the area of greatest need through a robust governance process.	Capital resources are extremely limited. For 2023/24 the total of externally funded and business critical scheme bids of £48.2m is currently £7.1m more than the funding of £41.1m available. Committee members discussed the approach and the prioritisation process used agreeing they had significant assurance with regard to the process	A number of potential solutions are available and will need to be examined in order to close the current "gap" of £7.1m.

Advise

What	So What	What Next
MBI update on recommendations Update provided on actions taken in response to MBI data validation review in 2021 – progress has been independently reassessed by MBI with six of the 14 actions complete and the other eight underway but with further work required – No actions rated red.	Actions taken following the review mean the Trust now has systems in place to provide oversight and control of our own data. Committee members discussed the importance of data validation noting the anticipated benefits of a full EPR and the need to maintain current systems until EPR is implemented	Audit Committee to commission a review of data quality for three high risk areas
Digital Plan First version of the Digital Plan presented for review by the Committee ahead of seeking Board approval	Committee members discussed need for an ambitious and flexible strategy aligned to the needs of the organisation and the wider ICS	Draft plan approved

Title	Integrated Performance Report (IPR) - Workforce		

Meeting:	Board of Directors in Public Meeting		
Date:	2nd March 2023		

Author	William Wood, Head of Performance		
Exec Sponsor	Natalie Hudson, Chief Operating Officer Louise Ludgrove, Executive Director of People and Culture		
Purpose	Assurance — Y	Discussion — Y	Decision — N
Confidential y/n	N		

Summary (what)	See the IPR summary pages for appropriate narrative.

Previously considered by	NA

Implications (so what)	The Trusts performance against the workforce KPIs have a direct impact on the finance, operational, and quality aspects of the organisation. Meaning negative trends here can cost the organisation more, reduce operational performance, and worsen the quality of care.

Link to strategic objectives	Our People	✓
	Our Population	
	Our Responsibility	

EDI implications considered	

Proposed Resolution (What next)	The Board of Directors is asked to acknowledge and approve the workforce IPR.

Caring · Safe · Respectful

Integrated Performance Report

Workforce Committee

January 2023

Caring · Safe · Respectful

Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **_https://www.england.nhs.uk/publication/making-data-count/_**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre dashed reference line (black) is the mean, and the two light grey dashed lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.

Executive Summary

		Assurance				Variation				
		P	?	F	(—)	H●	L●	●●●	H●	(—)
Workforce	Organisational Development			2	3	1		1		3
	Sickness, Vacancy and Turnover	5	4	5			3	3	8	

Measures the likelihood of targets being met for this indicator.

Assurance

? Indicates that this indicator is inconsistently passing and falling short of the target.

P Indicates that this indicator is consistently **passing** the target.

F Indicates that this indicator is consistently **falling** short of the target.

Whether SPC rules have been triggered positively or negatively overall for the past 3 months.

Variation

Indicates that there is no significant variation recently for this indicator.

Indicates that there is **positive** variation recently for this indicator.

Indicates that there is **negative** variation recently for this indicator.

Special cause variation where **UP** is neither improvement nor concern.

Special cause variation where **DOWN** is neither improvement nor concern.

Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

Organisational Development

- Core Skills Training Compliance % - triggering due to consistent non-achievement of the target.
- Appraisal Compliance % – triggering due to consistent non-achievement of the target, although a recent run of points above the upper control limit would suggest improvement.

		Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Core Skills Training Compliance %	95%	89.3%	Jan 23			95%	89.2%	Dec 22		
Appraisal Completeness %	90%	70.8%	Jan 23			90%	70.6%	Dec 22		

Indicator	2017-04	2018-04	2019-04	2020-04	2021-04
Staff Survey - Care of my patients / service users is my organisations top priority	72.40%	72.70%	73.80%	78.70%	77.20%
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	66.30%	65.20%	63.20%	69.30%	65.30%
Staff Survey - I would recommend my organisation as a place to work	61.10%	62.10%	62.00%	68.10%	64.30%

Core Skills Training Compliance % (top left chart, x-axis 2021-02 through 2023-01, y-axis 88%–94%)
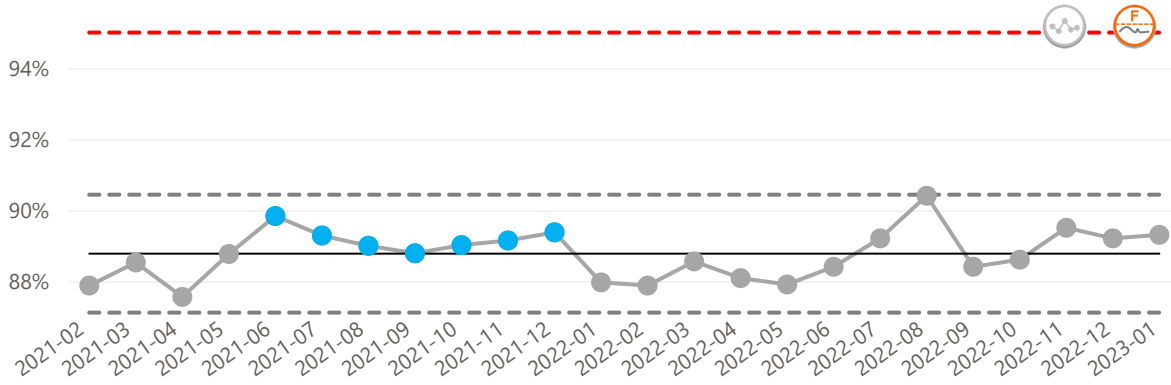
Staff Survey - I would recommend my organisation as a place to work (top right chart, x-axis 2017-04 through 2021-04, y-axis 62%–68%)

Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (middle left chart, x-axis 2017-04 through 2021-04, y-axis 65%–80%)

Staff Survey - Care of my patients / service users is my organisations top priority (middle right chart, x-axis 2017-04 through 2021-04, y-axis 74%–78%)

Appraisal Completeness % (bottom left chart, x-axis 2021-04 through 2023-01, y-axis 20%–80%)

Workforce
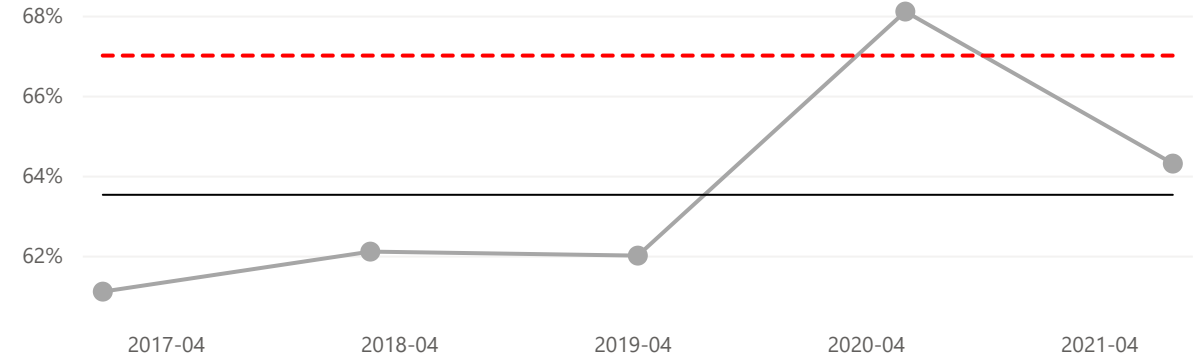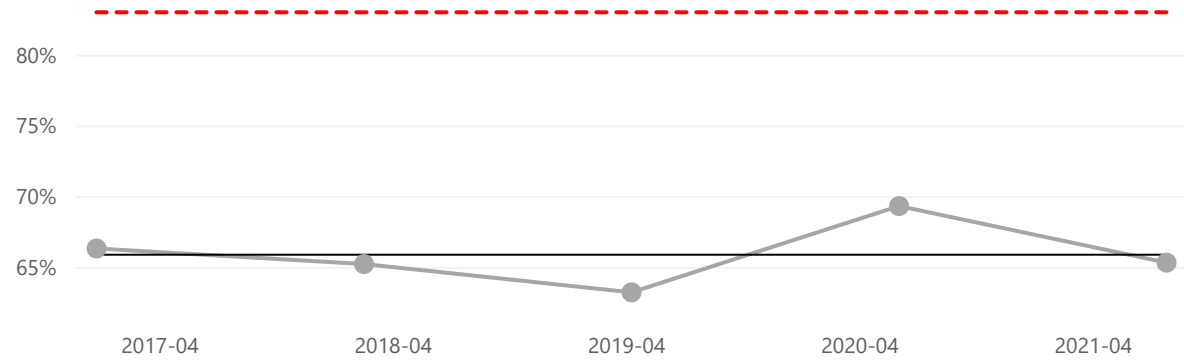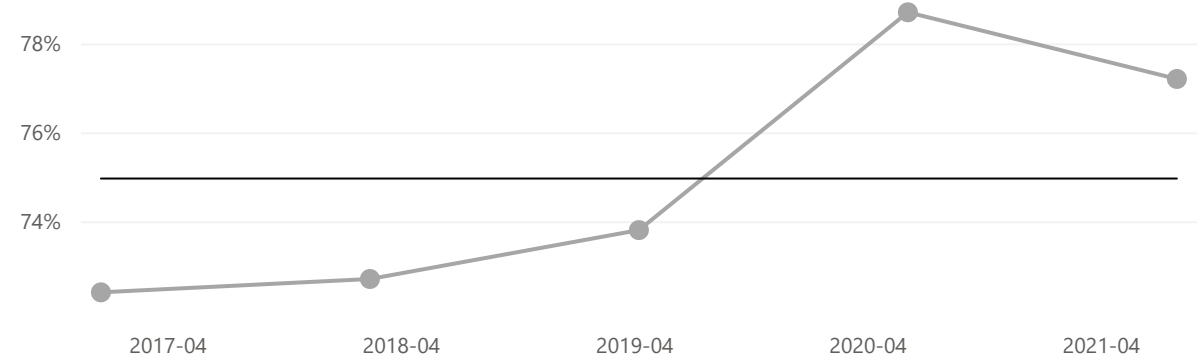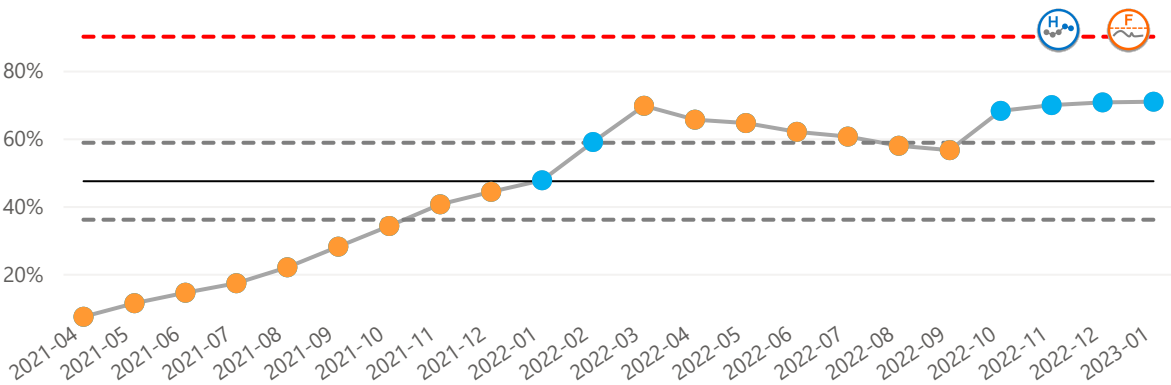
Sickness, Vacancy and Turnover

- Sickness % (Rolling 12 Months) – triggering due to consistent non-achievement of the target, consecutive points above the average, and points above the upper control limit.
- Sickness % - All Staff (In Month) – triggering due to consistent non-achievement of the target.
- Sickness % - Medical Staff (In Month) – triggering due to 2 out of 3 data points close to upper control limit (suggesting deterioration).
- Sickness % - Nursing Staff (In Month) – triggering due to consistent non-achievement of the target and single data point above the upper control limit.
- Sickness % - AHP (In Month) – triggering due to inconsistent achievement of the target (this is occurring because the target line is between the control limits and below the actual).
- Sickness % - not related to COVID-19 – Trust - triggering due to consistent non-achievement of the target and single data point above the upper control limit.
- Vacancy Rate % - All Clinical Staff – triggering due to consecutive points above the average, and multiple points outside of the control limits.
- Vacancy Rate % - Medical Staff (Excluding Deanery Drs) – triggering due to consistent non-achievement of the target, and consecutive points above the average.
- Vacancy Rate % - Nursing and Midwifery Staff – triggering due to inconsistent achievement of the target and consecutive points above the average.
- Vacancy Rate % - AHP – triggering due to inconsistent achievement of the target.
- Time to Recruit (Weeks) – triggering due to consecutive data points above the average.

Indicator	Latest					Previous			Year to Date	
	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Sickness % - Rolling 12 Months	4%	6.97%	Dec 22	(H)	(F)	4%	6.88%	Nov 22		
Sickness % - All Staff (In Month)	4%	8.15%	Dec 22	(common cause)	(F)	4%	6.78%	Nov 22		
Sickness % - Medical Staff (In Month)	4%	3.45%	Dec 22	(H)	(P)	4%	3.46%	Nov 22		
Sickness % - Nursing Staff (In Month)	4%	9.3%	Dec 22	(H)	(F)	4%	7.01%	Nov 22		
Sickness % - AHP (In Month)	4%	4.57%	Dec 22	(common cause)	(?)	4%	4.3%	Nov 22		
Sickness % - Not related to Covid 19 Trust (In Month)	4%	7.4%	Dec 22	(H)	(F)	4%	6.13%	Nov 22		
Turnover % - All Staff (Rolling 12 months)	11%	8.71%	Jan 23	(L)	(?)	11%	8.4%	Dec 22		
Turnover % - Nursing & Midwifery (Rolling 12 months)	11%	7.39%	Jan 23	(L)	(P)	11%	7.37%	Dec 22		
Turnover % - AHP (Rolling 12 months)	11%	6.62%	Jan 23	(L)	(P)	11%	7%	Dec 22		
Vacancy Rate % - All Clinical Staff	4.28%	3.53%	Jan 23	(H)	(P)	4.28%	3.56%	Dec 22		
Vacancy Rate % - Medical Staff (Excluding Deanery Drs)	4.28%	12.3%	Jan 23	(H)	(F)	4.28%	11.9%	Dec 22		
Vacancy Rate % - Nursing & Midwifery Staff	4.28%	4.67%	Jan 23	(H)	(?)	4.28%	4.94%	Dec 22		
Vacancy Rate % - AHP	4.28%	7.58%	Jan 23	(common cause)	(?)	4.28%	4.56%	Dec 22		

		Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Time to Recruit (Weeks)	12	10.08	Jan 23			12	9.74	Dec 22	12	10.08

Workforce

Workforce

Sickness % – Rolling 12 Months
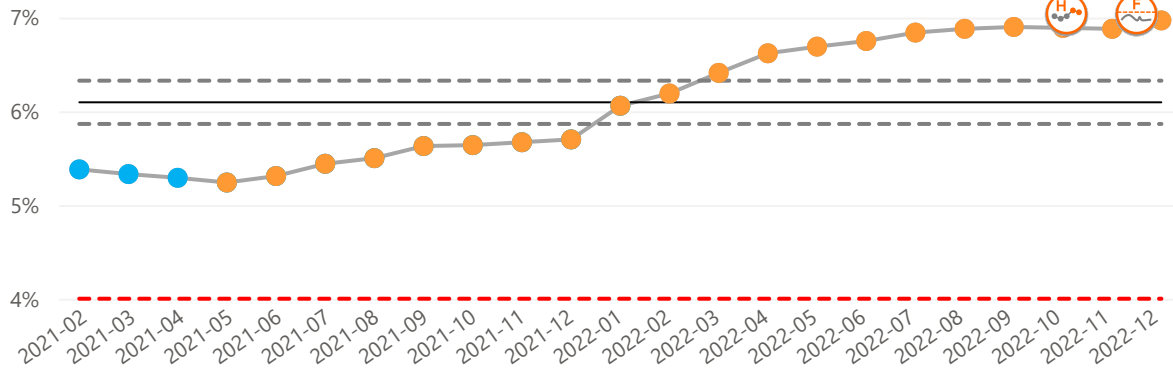
Sickness % – All Staff (In Month)
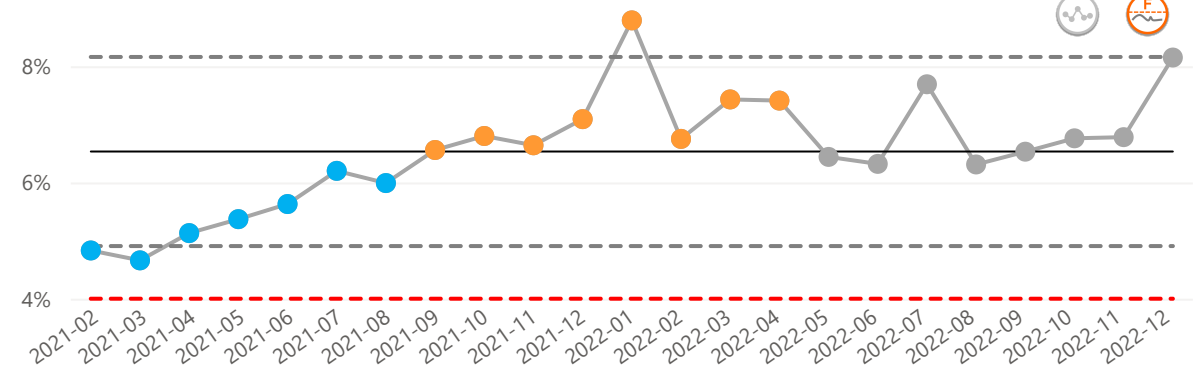
Sickness % – Medical Staff (In Month)
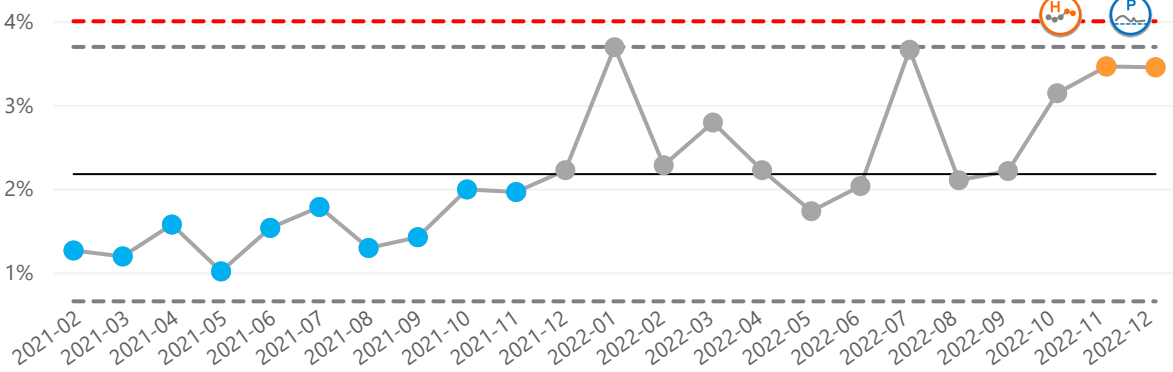
Sickness % – Nursing Staff (In Month)
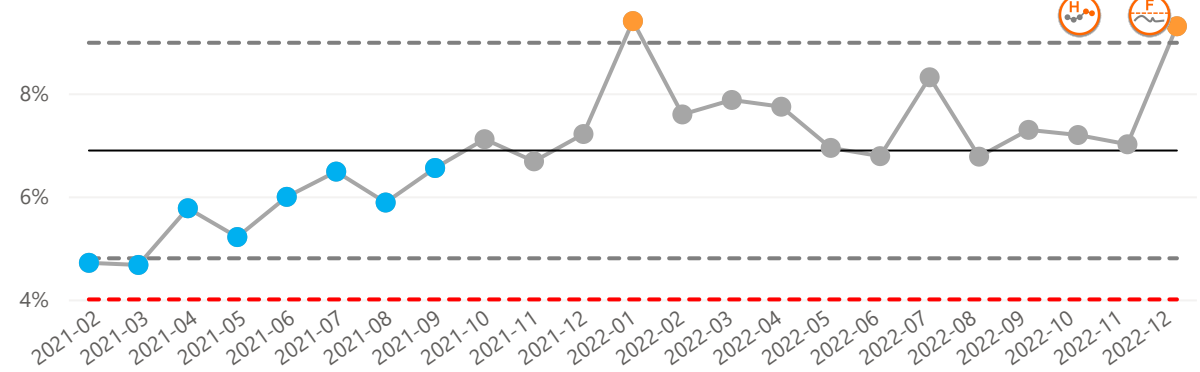
Sickness % – AHP (In Month)
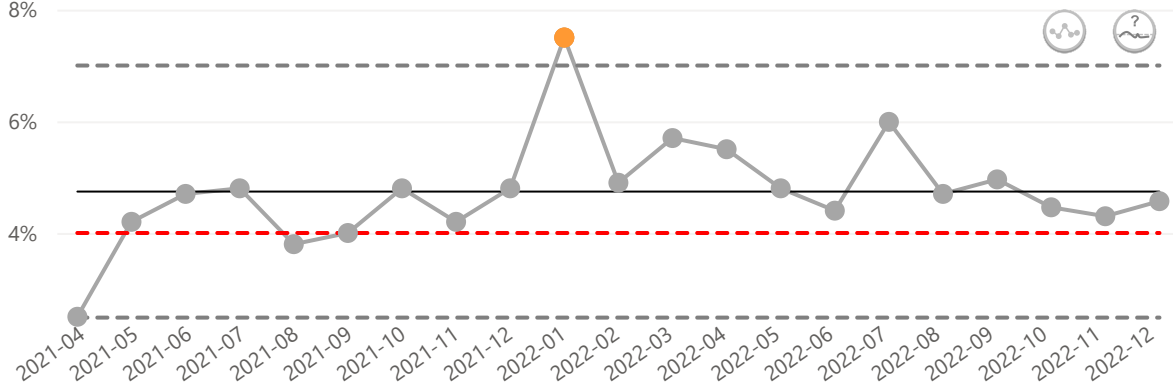
Sickness % – Not related to Covid 19 Trust (In Month)

Workforce
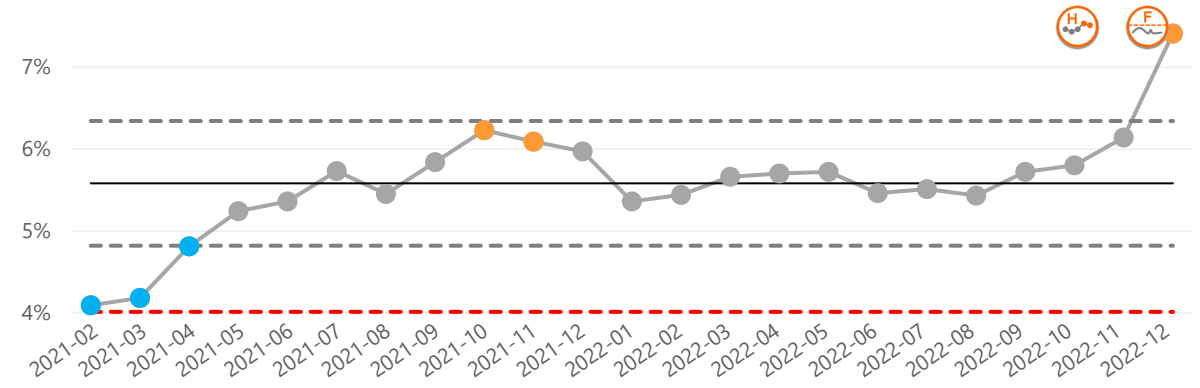
Turnover % – All Staff (Rolling 12 months)
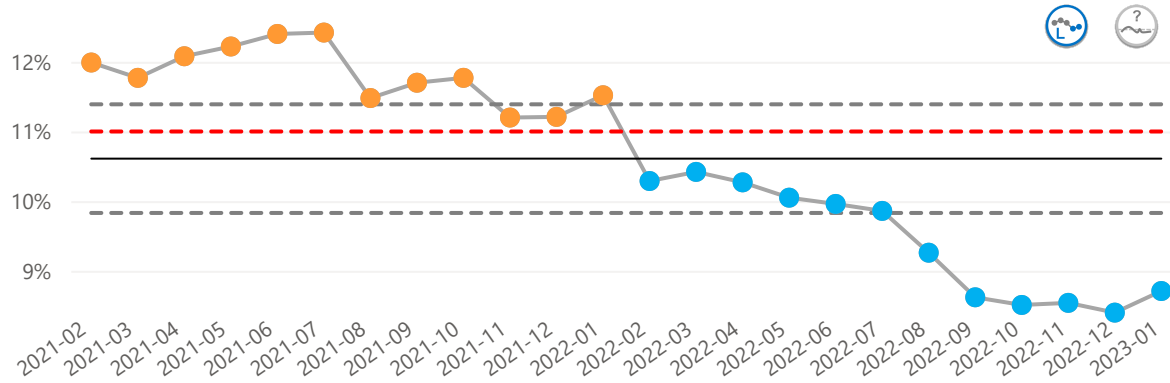
Turnover % – Nursing & Midwifery (Rolling 12 months)
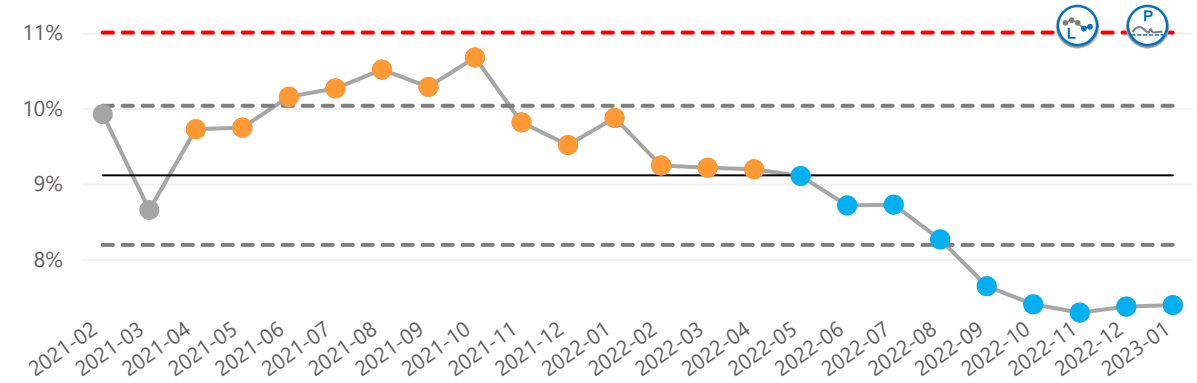
Turnover % – AHP (Rolling 12 months)
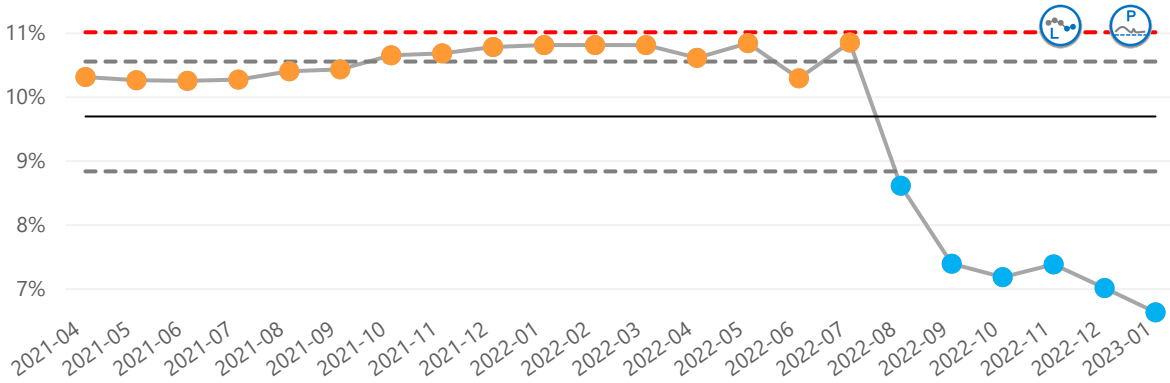
Vacancy Rate % – All Clinical Staff
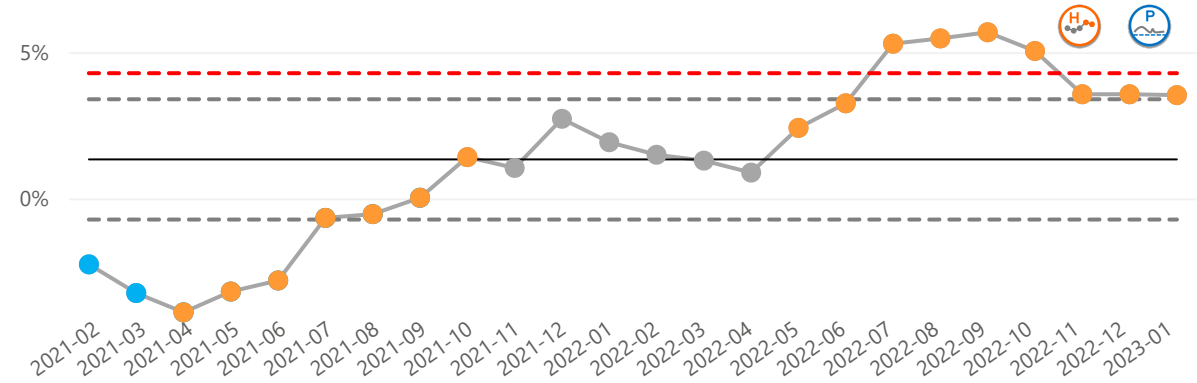
Vacancy Rate % – Medical Staff (Excluding Deanery Drs)

Vacancy Rate % – Nursing & Midwifery Staff

Workforce
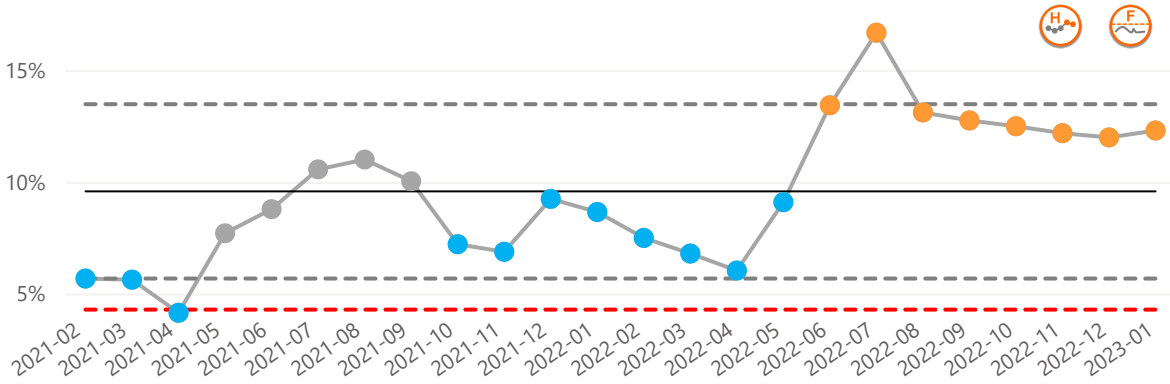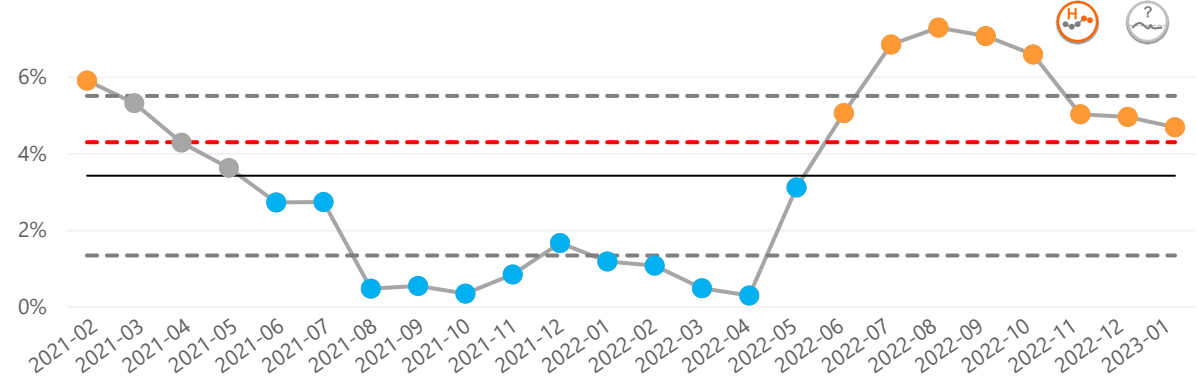
Vacancy Rate % – AHP

Time to Recruit (Weeks)

Title	Workforce Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	2nd March 2023

Author	Esther Steel, Director of Corporate Governance					
Exec Sponsor	Meeting Chaired by Carl Fitzsimons					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No					

Summary *(what)*	Chair report attached for the formal Workforce Assurance Committee held on Wednesday 18th January 2023. In addition to this the Committee met on Thursday 15th February 2023 for a focused workshop to consider recruitment and retention

Previously considered by	

Implications *(so what)*	The Workforce Assurance Committee will continue to focus on actions to support our staff, improve our quality and provide a cost effective service making best use of public monies

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications considered	EDI is within the remit of this committee and all papers are reviewed to ensure EDI implications are considered

Proposed Resolution *(What next)*	To note the Workforce Assurance Committee's Escalation Report

Committee/Group Chair's Report

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Board of Directors
Date of Meeting:	18 January 2023	Date of next meeting:	15 March 2023 2023
Chair:	C Fitzsimons	Parent Committee:	Board of Directors

Introduction

Meeting held on Teams, well attended by HR and divisional teams. The meeting was quorate. Good open discussion with member questions to Executive team, answered fully.

Alert

What	So, What	What Next
Sickness minimal increase to 6.8% – higher than target of Highest reason for sickness is stress and anxiety operational pressures create a difficult working environment	Do have strong health and wellbeing support but looking to increase psychologist support – system discussions in relation to withdrawal of central hub established for support in Covid – seeking to equalise the spread of psychology support across the system Now have 200 health and wellbeing support champions across the Trust	Review target to consider if achievable with regular review Continuing to work on financial support and guidance for staff
Multi- Professional Educational Governance Meeting Escalation Report The members confirmed they had reviewed the MEG report circulated in the papers and agreed the MEG Meeting should report to the Workforce Assurance Committee.	Challenge of accommodation raised	
Guardian of Safe-working (GOSW) Item deferred in the absence of the guardian	There is a mandated requirement for the report from the GOSW to be presented to Board members	Medical Director to meet with the Guardian to discuss attendance and reporting which is a key element of the role
Flu Vaccination Programme Update The Associate Director of HR provided a summary of the actions taken and progress made in relation to uptake of the flu vaccine – at the time of reporting 50% of staff had received the vaccine	Committee members discussed the actions being taken to encourage Flu vaccination uptake including: - • Enhanced communication programme. • Intranet shows weekly divisional performance.	Committee members noted the progress made and the actions proposed to maximise uptake by 28 February 2023 Verbal update to be provided on month end uptake

	• Evening, weekend, early morning, and community sessions around the trust. • Daily Roaming Peer Vaccinators who visit all areas and vaccinate staff in their place of work. • Roaming Wellbeing Champions to speak to staff. • Survey and myth-busting.	

Assurance		
What	**So, What**	**What Next**
Staff Story The Committee were shown a video capturing staff experiences of the Clinical Quality Academy	The members all agreed it was powerful to hear the benefits directly from the clinicians, and the Clinical Quality Academy is a great initiative and will improve the quality of service within the Trust.	Committee members felt the Clinical Quality Academy should be promoted as a recruitment tool.
Workforce Integrated Performance Report Report presented – workplan for the Committee now agreed to provide more detailed updates on key metrics Improvement made with metrics for core skills (mandatory) training – PIDA meetings with divisional teams are providing an opportunity to focus on this area.	Committee members focused on the narrative and recognised the benefits of regular reviews of targets whilst acknowledging that the majority of targets are determined by regulators Discussion focused on uptake in appraisals with recognition of the significant improvement achieved and a focus on the next steps for full compliance	Introducing more e-learning packages to give increased options to staff. Looking at a Committee to review the subjects included on the mandatory training list – future update to be provided. A trajectory for completion of appraisals will be included in the IPR
Workforce Operational Group Group established to look at operational issues – will provide regular updates to the WAC	In future the Workforce Operational Group will provide an escalation report	Terms of reference need to be approved at the next WAC
Culture Action Plan Update provided on the cultural action plan – the initial priority is to address any unacceptable behaviours and develop core values that all staff should uphold	Committee members discussed the measurement of success and while recognising the complexity of this area and the ongoing nature of the work felt it was important to monitor through agreed metrics	Ask for a cultural dashboard Update to be provided to the Board
Multi Professional Education Escalation Report The group provides a forum in which to agree the strategic delivery and quality of medical and non-medical education within the Trust. The meeting was	The escalated risks in relation to operational pressures and training room availability were noted.	Executive action required to address the risk escalated

attended by internal and external stakeholders including academic stakeholders. The group discussed the impact of operational pressures including the impact on training room availability. The group also received an update on the Health Education Northwest action plan and received positive assurance on encouraging learners to speak up.		
Revalidation Report The annual submission to NHSE for appraisal, revalidation and medical governance was presented and the Committee noted the actions in place to ensure robust appraisal support for all doctors employed by the Trust	The report is in a mandated format and provides a summary of appraisals and GMC recommendations. A refreshed approach is planned for 2022/23	The Committee noted the report
Health and Wellbeing Report The Head of Health and Wellbeing provided a comprehensive summary of actions taken to deliver the 2022 Health and Wellbeing plan	Committee members discussed access to support services. Committee members agreed that while the report provided useful information it would benefit from the inclusion of outcomes and effectiveness data	Progress noted Future reports to provide evidence of outcomes to give assurance on the effectiveness of the investment in health and wellbeing
Review of the Trust's approach to DBS checks Update provided on the agreed approach to improving the DBS checking system to provide assurance that the Trust is compliant with responsibilities in relation to patient and staff safety.	Good progress has been made to ensure the Trust has a comprehensive record of staff DBS checks enabling action to be taken where a DBS check is not recorded or is out of date.	Monthly monitoring continues
Board Assurance Framework Members reviewed the BAF and agreed that the agenda had provided the opportunity to discuss a number of the risks and controls included on the BAF	Committee members reflected on the discussions in the meeting and agreed that the BAF should be updated as below: A gap in assurance/controls to be added to reflect the omission of the GOSW report A gap to be added to reflect low uptake of flu vaccination	The BAF will be updated to reflect the debate – it will continue to be a standing item at the end of the agenda to be used as a tool to guide the meeting

Advise

Committee/Group Chair's Report

What	So, What	What Next
February Workshop Brief Committee members noted that the workshop on February 15th would focus on recruitment and retention.		
Targeted Agency Control Panel Members were advised that a panel has been established to monitor and control the use of agency staffing	Committee members discussed the remit of the panel and the need to balance the control of agency expenditure and the provision of safe staffing	The panel will report to the Workforce Operational Group

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	2021-2022 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	02.03.2023		Discussion	
Author	Nicola Di Vito		Decision	
Exec Sponsor	Chris Barben		Confidential y/n	

Summary *(what)*	To provide an update to the Board on the progress of Medial Revalidation and Appraisal. To offer assurance to prove that the organisation, Designated Body, is compliant with the Responsible Officer Regulations

Implications *(so what)*	• To support quality improvement at the Trust • To provide the necessary assurance to the higher-level Responsible Office • Acts as evidence of CQC inspections

Link to Strategic objectives	Our People Happy and Health Workforce – ensuring wellbeing, resilience, and respect through Medical Appraisal Learning Culture – Encouraging learning and building leadership through Development	
	Our Population Prevention and Health Promotion – Ensuring doctors are Fit to Practice and embedding equity into our delivery plans Integrated Care – Service Improvements and improvement of access/timeliness of care	
	Our Responsibility Getting the Basics Right – Achieving quality standards and working collaboratively New Ways of Working – Transformation and innovation and enhancing active participation in research	

Proposed Resolution *(What next)*	To confirm that Blackpool Teaching Hospitals is complaint with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and to enable the submission of the Statement of Compliance to NHSE&I Submission made to NHSE 15th September 2022

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:		
	Name	Contact information
Responsible Officer	**Mr Chris Barben**	**01253 953722**
Medical Director	**Mr Chris Barben**	**01253 953722**
Medical Appraisal Lead	**Prof Ravi Gulati**	**01253 957256**
Appraisal & Revalidation Manager	**Nicola Di Vito**	**01253 957256**
Additional Useful Contacts	**Dr Steve Wiggans**	**01253 958250**

Contents

Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

The board of Blackpool Teaching Hospitals NHS Foundation Trust can confirm that:

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

> 2021/2022 update: The Responsible Officer role has changed following the departure of Dr Jim Gardner and is now Mr Chris Barben (substantive Medical Director)
>
> Action for next year: Mr Barben is attending Responsible Officer Training on 14th September 2022.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Yes
>
> 2021/2022 Update: Further support from a senior perspective has been added to the Team. Dr Steve Wiggans has joined the Medical Revalidation Team as Director of Professional Standards/Deputy Medical Director and provides a link between the RO and Medical Appraisal Lead.
>
> Action for next year: An additional administrator is in the process of being recruited to further support the Medical and Appraisal Revalidation Team. A senior administrator who will be supported by two administrators in the future model (this is not whole-time support for any of the three administrators but will provide additional resource).

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> 2021/2022 update: Yes, a manual record of all prescribed links is kept in addition to an electronic software system (MYL2P)
>
> Action for next year: There is a continual review of prescribed links locally

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> List of relevant policies and date of last review: Appraisal and Revalidation for Medical Staff policy is currently under review
>
> 2021/2022 update: An updated policy has been written and negotiated with Staff Side colleagues; the policy is due to be ratified by the Joint Local Negotiating Committee on 22nd July 2022

> Action for next year: The policy is reviewed every three years and is continually monitored

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> 2021/2022 update: A full peer review of appraisal processes has not taken place this year, however, an annual peer review meeting took place on 21st July 2021. Full discourse took place around all issues within the Medical and Appraisal remit.
>
> Action for next year: A peer review meeting has been diarised for 17th October 2022 and a full review of process is to be planned.

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

> List of relevant policies and date of last review: To be developed
>
> 2021/2022 update: A focus on supporting agency locums within the organisation is being developed at present
>
> Action for next year: To implement the process that is currently being scoped and to ensure it is fit for purpose.

7. Where a Service Level Agreement for External Responsible Officer Services is in place

> Describe arrangements for Responsible Officer to report to the Board: No current SLA
>
> Date of last RO report to the Board: October 2022
>
> Action for next year:

Section 2a – Effective Appraisal

1.   All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

> 2021/2022 update: Clinical Governance data is requested by the Medical Appraisal and Revalidation Team and an updated approach to gathering complaints and incidents is being scoped.
>
> Action for next year: The Medical Appraisal and Revalidation Team provide robust support to all doctors to support all doctors at the Trust.

8.   Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

> 2021/2022 update: Reasons for any deferred or missed appraisals are recorded and data flow is continually reviewed.
>
> Action for next year: Continue to monitor annual appraisals and multi-source feedback exercises.

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

> List of relevant policies and date of last review: Appraisal and Revalidation policy for Medical Staff is in place – this policy is currently being reviewed
>
> 2021/2022 update: The policy has been reviewed by Staff Side colleagues and is due for ratification on 22nd July 2022
>
> Action for next year: To continually monitor the policy

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

> Number of available appraisers: There are enough Trust Recognised Appraisers at Blackpool Teaching Hospitals
>
> 2021/2022 update: The Trust has seen a decrease in the number of over the last 12 months due to retirement of a decision to step away from the role of Appraiser
>
> Action for next year: Medical Appraiser Training continues to be delivered at the Trust. A change to the Medical Appraisal and Revalidation policy has taken place to ensure that all Trust Appraisers go through a recruitment and selection process and are provided with SPA time for their role as a Trust Recognised Appraiser.
>
> This is to ensure robustness for Medical Appraisals going forward

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

> 2021/2022 update: Local Network meetings take place three times a year and are led by Prof Gulati. Attendance at LNWM is monitored to ensure participation by all Trust Recognised Appraisers.
>
> Action for next year: The format of these meetings is currently under review

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[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> List of relevant policies and date of last review: Appraisal and Revalidation for Medical Staff
>
> 2021/2022 update: The Quality Assurance process takes place outside the Medical Appraisal and Revalidation Team; the Excellence Tool is used locally.
>
> Action for next year: To continually review the process

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	440
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	338
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	65
Total number of agreed exceptions	37

Section 3 – Revalidation Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	77
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	23
Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	1
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	101

2.

> 2021/2022 update: All recommendations (or deferrals) were made timely
>
> Action for next year: To continue to ensure recommendations are made timely

3. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

> List of relevant policies and date of last review: N/A
>
> 2021/2022 update: Yes, Prof Gulati emails all recommendations to each doctor when a recommendation is made, and each email includes narrative as an update
>
> Action for next year: Continue this practice

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

> List of relevant policies and date of last review: N/A
>
> 2021/2022 update: The Medical Revalidation Team gather Clinical Governance (Claims/Incidents/Complaints) in advance of the annual appraisal meeting. Each doctor receives a notification from the team to update them regarding data place within their appraisal.
>
> Action for next year: Review the current process of gathering information internally

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> 2021/2022 update: The relevant HR Business Partner and Head of Department is contacted prior to annual appraisal meetings and prior to Revalidation Recommendations to understand conduct and performance. In

> addition, the Practitioner Support Group has now been implemented to understand any informal medical concerns across the Trust.
>
> Action for next year: A review of the Practitioner Support Group will take place in 2023 to ensure the group is effective and

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> List of relevant policies and date of last review: The Handling Concerns Procedure for Medical and Dental Staff
>
> 2021/2022 update: The Handling Concerns Procedure is under current review and has had input from the BMA and GMC. The procedure is due to be ratified at JLNC on 22nd July 2022.
>
> Action for next year: To ensure policies are monitored in line with the Medical and Dental Policy Group

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.   Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

> Outline arrangements and frequency for reporting to the Board: The Practitioner Support Group will provide a report to the Medical Workforce Committee annually which feeds into the Executive Team
>
> 2021/2022 update: The Trust now has a Director of Professional Standards and a Medical Professional Standards Manager who are reviewing the process flow of medical formal and informal cases within the Trust
>
> Action for next year: To provide analysis and data for the Board for insight

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other

---

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

> 2021/2022 update: The Peer Group Meeting is due to take place in October 2022 and further collaboration to be discussed at this meeting
>
> Action for next year: Discussion around effective transfer of information remain on going.

6.   Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

> 2021/2022 update: The Trust has an incident reporting system managed by the Risk Management Team. The Medical Appraisal Clinical Lead supports actions as required.
>
> Action for next year: The Practitioner Support Group are reviewing themes as a senior multi-disciplinary team

Section 5 – Employment Checks

1.   A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

> List of relevant policies and date of last review: Recruitment and Selection of Substantive Medical Consultants and Recruitment and Selection Policy (for non-consultant posts)
>
> 2021/2022 update: Recruitment is undertaken in line with Trust policies by the Recruitment Team
>
> Action for next year: None

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[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11:
http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail any additional information that you wish to highlight (the following provides a guide to information that you may wish to include):

- **General review of actions since last Board report – The Practitioner Support Group is in place to capture and support informal issues within the medical body. This group will identify themes and provide support as required.**

    The Director of Professional Standards has provided proactive support to the Medical Appraisal and Revalidation Team

- **Actions still outstanding – Data sharing between Blackpool Teaching Hospitals and other organisations including Private Practice and ICS/Peer Group (Blackpool, East Lancashire, Morecambe Bay and Preston).**

- **Any reflections of impact of COVID 19 on delivering service to patients – Difficulty in gaining patient feedback for colleagues**

    Undertaking annual appraisal has been delayed due to the pandemic

    The number of Recognised Trust appraisers has diminished due to pressures of delivering services and Consultant retirements

- **Current Issues – Remuneration for the role of Trust Recognised appraiser remain on going and a resolution is being discussed at JLNC as part of the updated Medical Appraisal and Revalidation Policy**

    Patient feedback for a small number of doctors (Critical Care) who are having difficult gaining patient feedback and this issue is affecting several Trusts

    The number of trained appraisers has reduced but Medical Appraiser training continues at the Trust and there has been a good take up of this training

- **New Actions: To work the Trust software company to support Service User Feedback for those who don't patients (pathology)**

    The Trust are introducing an electronic system to support the collection of feedback about clinical practice for agency locum doctors

Overall conclusion:

The Trust has recorded one non-engagement recommendation and this issue is now resolved

The Trust has implemented a new software system, moving from Allocate to MYL2P and the new system has been received well within the Trust

The Medical Appraisal and Revalidation Team continue to review processes on a bi-annual basis

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS Blackpool Teaching Hospitals NHS Foundation Trust

Ref No	Item	Action to be Taken	Person respon	Date to be Completed	Change of Date	Progress	RAG Status
1	Responsible Officer Training	CB to attend Training	Chris Barben	14.09.22		Course Attended	*Green*
2	Resources of the Revalidation Team	NDV to manage and recruit to vacant posts	Nicola Di Vito	31.03.23		A team leader has commenced in post and one administrator has been been sourced with a second currently undergoing pre-employment checks	*Amber*
3	Accurate record of Prescribed Links	Ensuring accurate records of Prescribed Links is kept	Nicola Di Vito	N/A		A series of data bases are kept by the team to ensure: 1. An accurate list of Prescribed links (those the Trust are responsible to Revalidate) 2. Clinical Governacre data collection is managed 3. Multi Source Feedback is gained timely	*Green*
4	Policy	To ratify an updated A&R policy	Nicola Di Vito	01.04.22		The policy was updated and ratified at JLNC on 22nd November 2022	*Green*
5	Peer Review of A&R	To participate in Peer Review activity for callibration and good practice	Steve Wiggans Nicola Di Vito	30.06.23		BTH have participated in annual Peer Review since 2017, one full peer review took place in 2017 where by organisations evaluate each others practice. Annual review meetings have taken place discussing any current issues and best practice annually. Full peer review to take place in May 2023 by UHMB, LTH, BTH, ELHT, Airdale, Lancs Care	*Amber*
6	Agency Locum Doctors	To understand practice issues	Steve Wiggans Nicola Di Vito	30.06.23		An electronic solution is being reviewed to enable insight into any practice issues whilst delivering DCC at Blackpool	*Amber*
7	Clinical Governace Data	Compliants, Claims and Incidents are required for annual appraisal and revalidation purposses	Steve Wiggans Nicola Di Vito	30.03.23		This is a statutory requirement for Medical A&R. There have been issues with the collection of this data due to lack of information being provided from Clinical Governace Teams which is causing a risk. Steve Wiggans and Nicola Di Vito are due to meet with Louise Chueng on 22nd February to review the process and improve data provision.	*Amber*
8	Number of Trust Appraisers/Remuneration for the role of Trust Appraiser	Ensure there are enough appraiers for the Trust's number of prescribed links and the role of Trust Recognised Appraiser is now within Job Plans	Nicola Di Vito	31.03.23		1. Regular Trust Training is in place for the role of Trust Recognised Appraiser and supported by Prof Gulati (Associate MD for A&R) 2. Trust policy now reflects remuneration for the role of Trust Recognised Appriaser 3. There are currently sufficent appraisers for the needs of the Trust but this remains under review	*Green*
9	Appraiser Education	Regular Appraiser Update Sessions	Prof Gulati	28.02.23		Local Network Meetings are held several times a year and it is a requirement for all Recognised Appraisers to attend at least one per annum	*Green*
10	Quality Assurance process	Quality of Appraisals to be reviewed	Nicola Di Vito Prof Gulati	30.04.23		The EXCELLENCE tool is used to ensure the quality of Appraisal summaries, however, the person undertaking this role has left the Trust and a replacement is commencing in April. Therefore, there is a slight delay in continuing this process	*Amber*
11	Local/HR Concerns	Gathering of data Practitioner Support Group	Nicola Di Vito Steve Wiggans	28.02.23		Data is gathered for annual appraisal and GMC revalidation PSG is in place and supporting informal concerns within a multi disciplinary team and reviewing themes	*Green*
12	Private Practice	Link with Spire	Steve Wiggans Nicola Di Vito	28.02.23		There is now an established reporing line between BTH and Spire	*Green*
13	Associate Medical Director for A&R	Recruitment	Steve Wiggans	30.04.23		Prof Gulati has resigned from the post and is due to leave on 31st March 2022, recruitment process are in place	*Amber*
14	Higher Level Responsible Officer Visit	NHS England Visit to Blackpool	Chris Barben Steve Wiggans Prof Gulati Nicola Di Vito	09.02.23		An NHS Engand took place on 9th February 2023 The visit went very well and no concerns were raised	*Green*

Title	Health Inequalities Plan and Anchor Framework

Meeting:	Public Trust Board
Date:	2nd March 2023

Author	Heather Catt, Consultant in Public Health						
Exec Sponsor	Steve Christian, Deputy CEO and Director of Strategy and Transformation						
Purpose	Assurance		Discussion		Decision		X
Confidential y/n	N						

| Summary *(what)* | The Board is asked to consider the attached Health Inequalities Plan which sets out the action that the Trust will take over the remaining four years of the Trust's five-year strategy. The Board is also asked to consider the attached Anchor Framework, which has been coproduced with our communities and stakeholder organisations to set out action we will take to tackle the social, economic and environmental conditions that influence health.

The accompanying presentation provides a high-level explanation of how health inequalities happen and what the Trust can do to tackle them. It also summarises the Health Inequalities Plan and Anchor Framework. |
|---|---|

Previously considered by	

Implications *(so what)*	

Link to strategic objectives	Our People	X
	Our Place	X
	Our Responsibility	X

Equality, Diversity and Inclusion (EDI)	

implications considered	

| **Proposed Resolution** *(What next)* | The Board is asked to approve our Health Inequalities Plan and Anchor Framework and agree the proposed governance arrangements. |

Purpose

The intention of this presentation is to:

1. Provide a high-level understanding of health inequalities, how they are caused and how BTH can tackle them

2. Outline the Trust's Health Inequalities Plan and the priorities for 2023/24

3. Present the Trust's Anchor Framework

Decision required - The Board is asked to:

1. **Approve** the Health Inequalities Plan goals and priorities for 2023/24

2. **Endorse** the Anchor Framework

3. **Agree** the proposed governance arrangements

Caring · Safe · Respectful

What are health inequalities?

The social determinants of health

Health inequalities are **preventable, unfair and unjust differences in health status** between groups, populations or individuals that arise from the **unequal distribution of social, environmental and economic conditions within societies**.

These determine the **risk of people getting ill**, their **ability to prevent sickness**, or **opportunities to take action** and access treatment when ill health occurs.
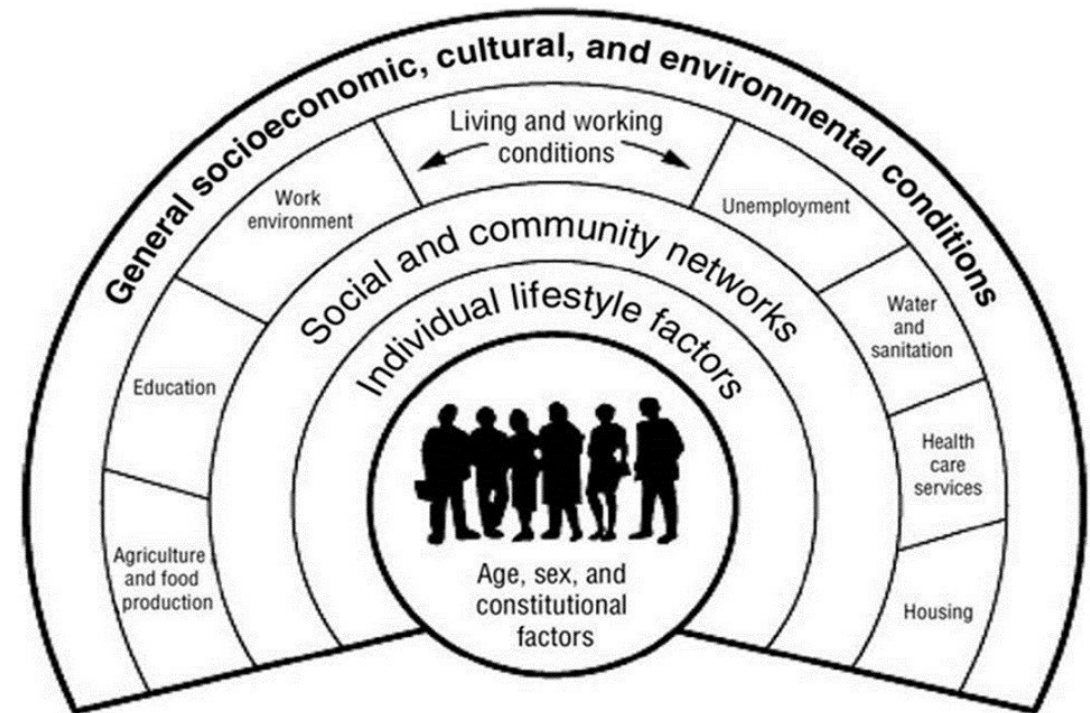
Source: Dahlgren and Whitehead (1991) Chapter 6: social determinants of health - GOV.UK (www.gov.uk)

System map of the causes of health inequalities

People do not have the same opportunities to be healthy.

Inequalities are driven by a range of factors, including variations in the wider determinants of health and the presence of, or access to, psycho-social mediating and protective factors
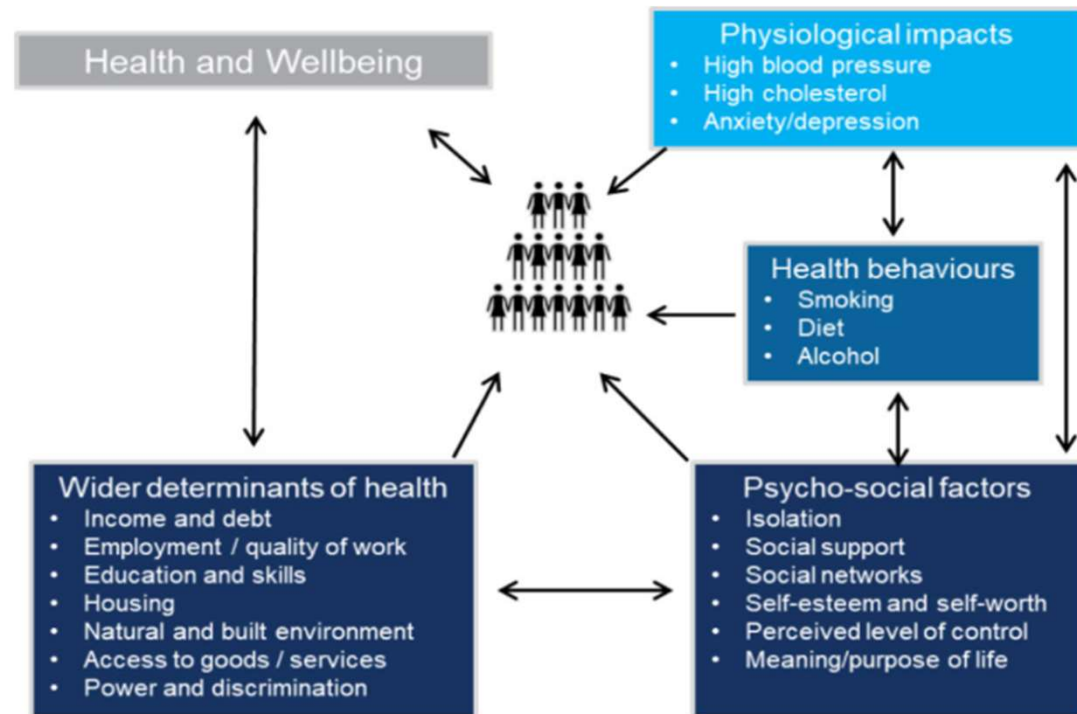
Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)

Health inequalities at BTH: life expectancy by deprivation score
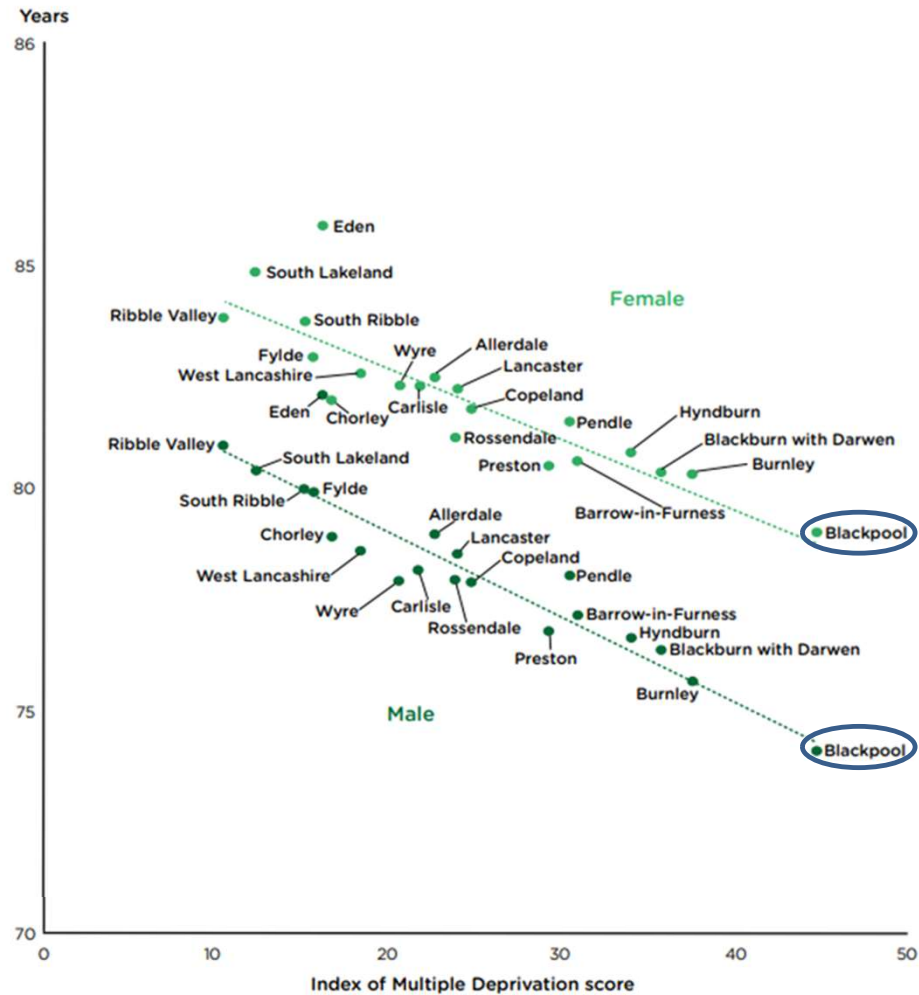
Source: Office for National Statistics (36)

Health_Equity_Commission_Lancashire_and_Cumbria_report_FINAL.pdf (healthierlsc.co.uk)

Health inequalities in health care: planned versus emergency care use by deprivation quintile (national data)
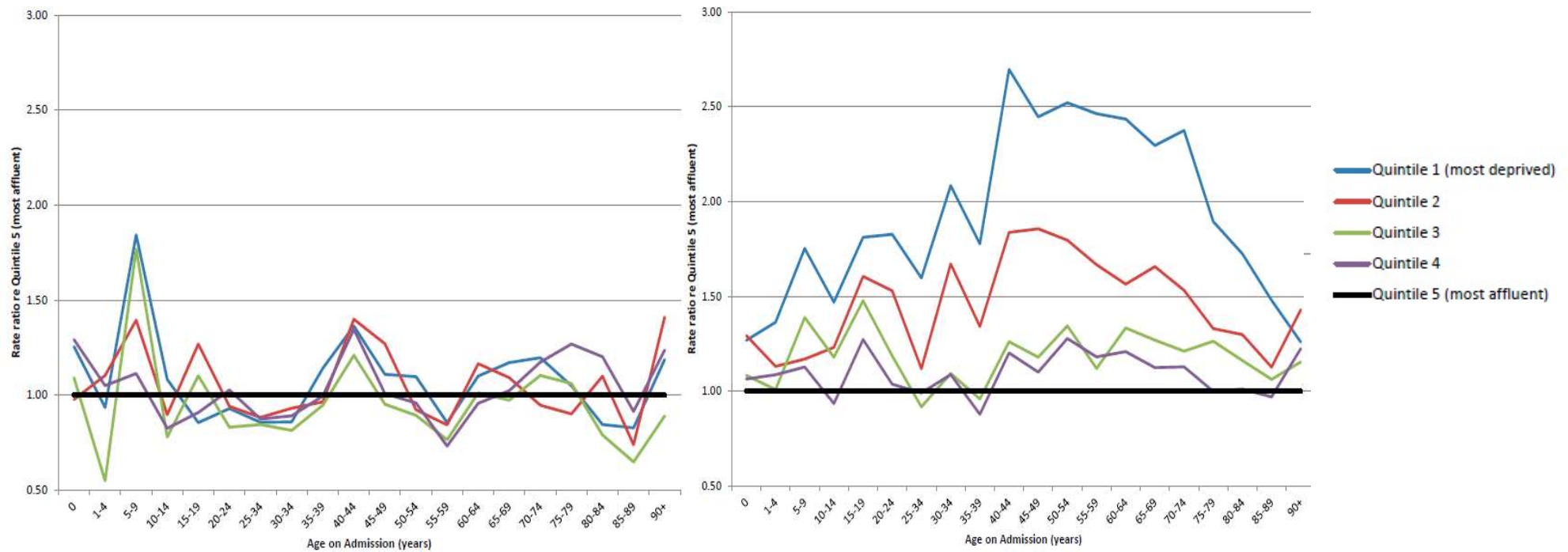
Why should we care about health inequalities?

MORAL case

FINANCIAL case

LEGISLATIVE case
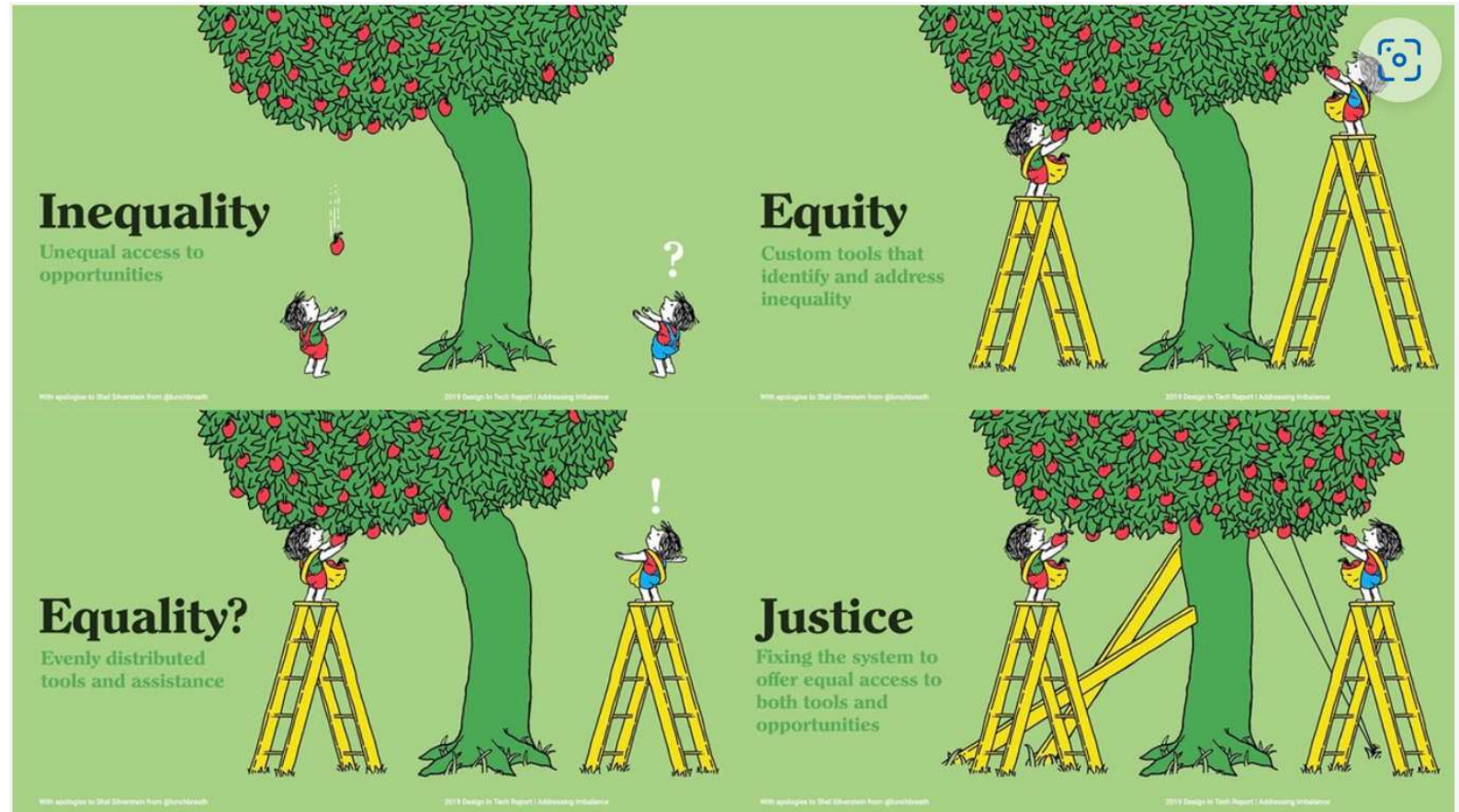
Defining: Equity, Equality and Justice | Achieve Brown County

The NHS role in prevention: what can we do?

Post-diagnosis: improve quality of life and reduce symptoms

Post-diagnosis: prevent reoccurrence

Pre-diagnosis: reduce risk factors for disease

Pre-risk factors: create conditions for good health

Tertiary prevention

Secondary prevention

Primary prevention

Social determinants of health
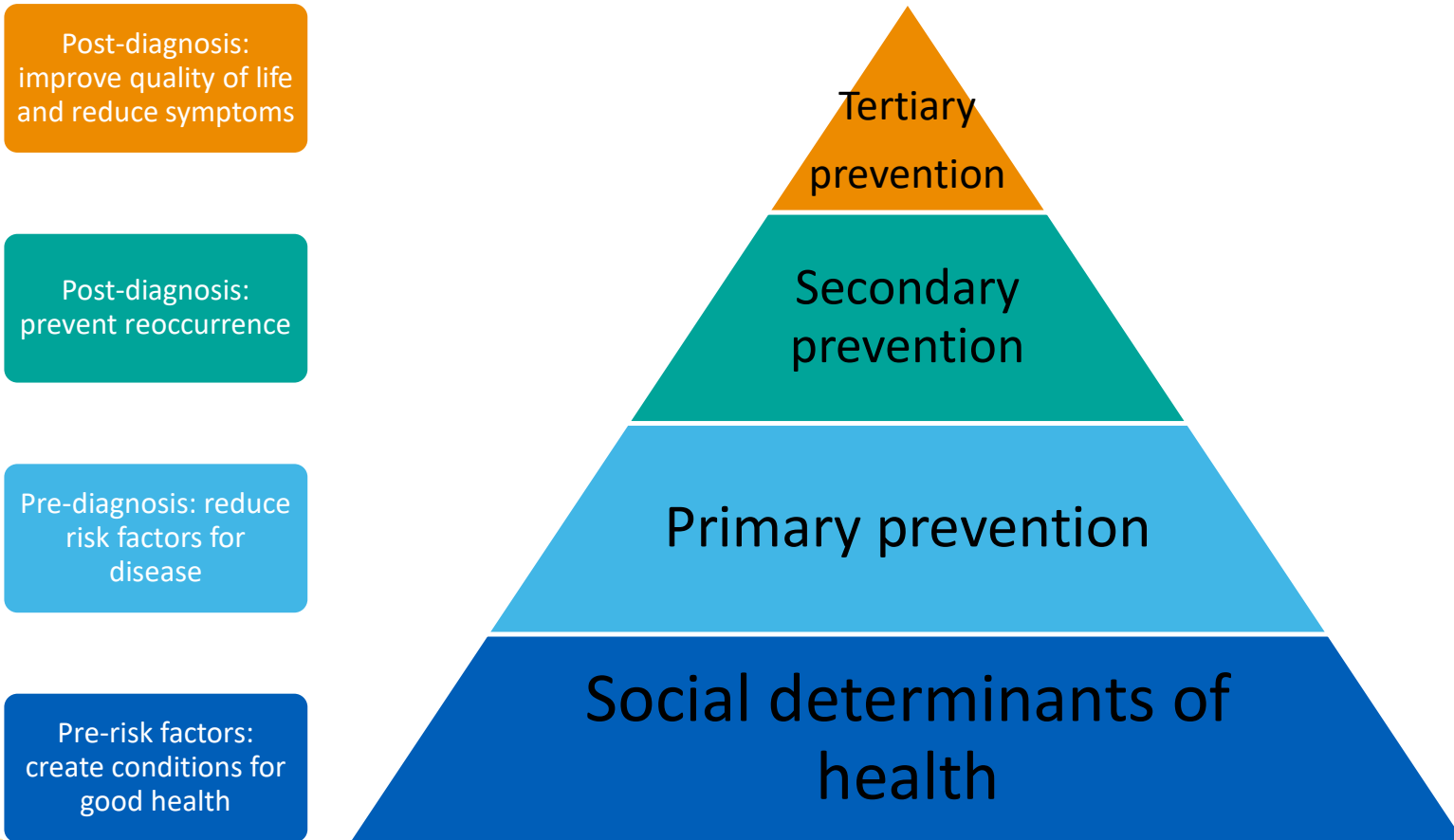
CORE20PLUS5 –national programme to reduce inequalities in healthcare
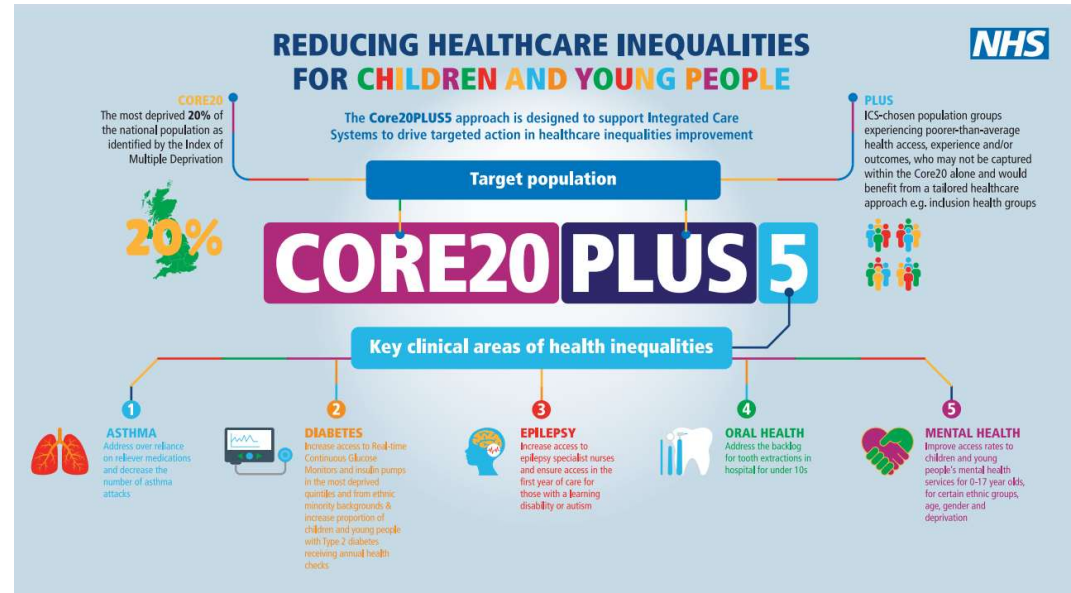
Framework for tackling health inequalities at BTH
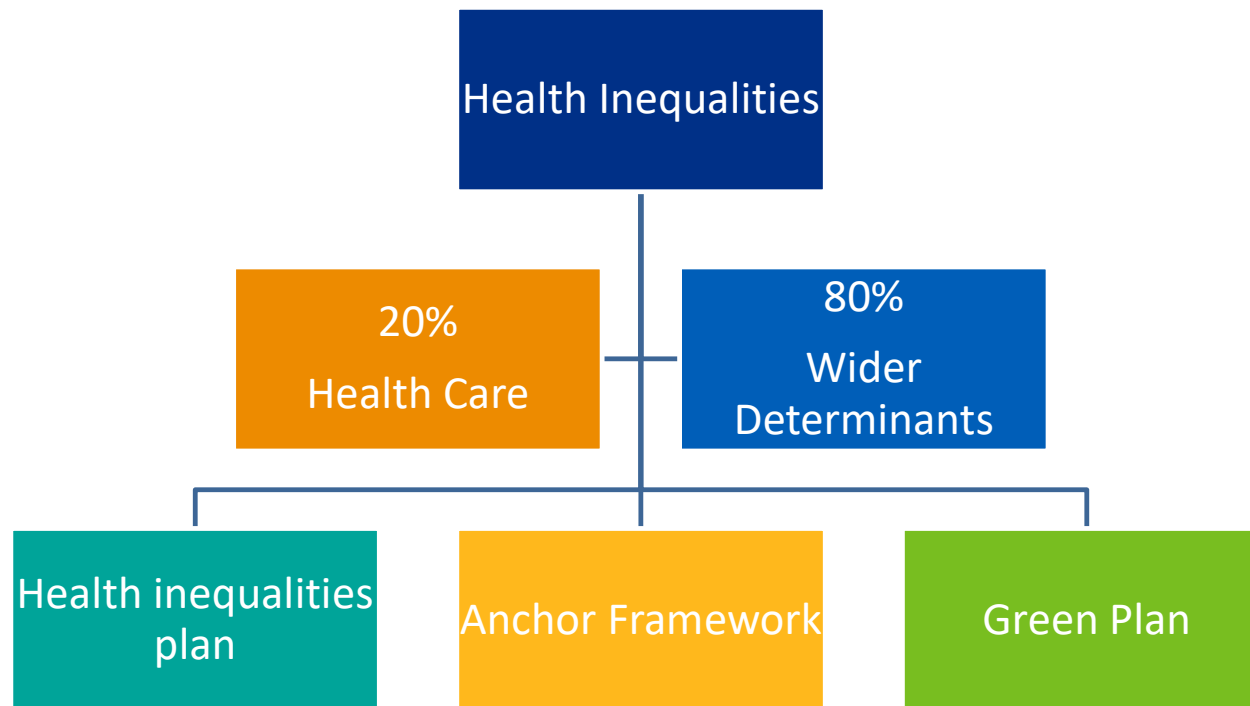
Our Health Inequalities Plan

- Priorities for 2023/24

Trust five-year strategy

Our mission Why are we here?	To 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 on the Fylde Coast and beyond.		
Our aims How will we 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 and healthy workforce • Learning culture	• Integrated care • Health inequalities • Prevention and health promotion	• Get the basics right • New ways of working • Investing in our community (Anchor)

Alignment with other plans and partner engagement

National:

- Health and Social Care Act 2022
- NHS Long term plan
- NHS Operational Planning
- NHS standard contract

Local:

- Health Equity Commission (Lancashire and Cumbria)
- Lancashire and South Cumbria Integrated Care Strategy (draft)
- Fylde Coast Prevention Strategy
- CQC action plan
- Quality improvement plan *(Draft)*
- Innovation plan *(Draft)*
- Green plan
- Digital Enabling Plan 2022-27
- Anchor Framework

Partner engagement:

- Blackpool Council
- Lancashire County Council
- Lancashire and South Cumbria NHS FT
- Lancashire and South Cumbria ICB
- Blackpool Citizen's Advice Bureau
- Empowerment Charity
- Blackpool Coastal Housing
- Marmot Team
- Trust colleagues

Example initiatives to tackle health inequalities

Strategic priority: Health inequalities

Engage in existing and emerging partnership networks beyond traditional health and social care providers to deeply listen and understand what our population requires. Engage with Health and Wellbeing Partnerships, Poverty Truth Commissions, HealthWatch, partner community conversations and staff engagement.

Strategic priority: Prevention and Health Promotion

Expand social prescribing referral process using learning from existing social prescribing offer. Review social prescribing to ensure it is addressing the social determinants of health.

Anchoring
on the coast

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Our Anchor Framework

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

The Health Foundation

References available at www.health.org.uk/anchor-institutions

© 2019 The Health Foundation.

Why we wanted to do this

Challenges in coastal communities

Anchor role not embedded in the Trust

To locate anchor approach in the community

What we did

- Embedded four community co-researchers in BTH working alongside the research team
- Engaged with communities in the Fylde Coast including those facing multiple disadvantage, through the VCFSE, to identify the important barriers to and opportunities for local wealth creation.
- Engaged with staff to understand their perspective on challenges and opportunities for BTH to discharge its anchor responsibilities.
- Engaged with partners to understand their perspectives on how BTH can deliver its anchor role and learn from their experience on social value and corporate responsibility work.
- Co-produced a framework to guide BTH and other coastal community anchors.

Steering Group:
- Community co-researchers
- BTH R&D Team
- BTH Consultant in Public Health
- BTH Executive Director of Strategy
- BTH Non-Executive Director
- Blackpool Council Director of HDRC
- Empowerment Charity CEO
- Blackpool Citizen's Advice Bureau CEO
- NIHR Research Ready Communities
- Applied Research Collaborative (ARC) North West Coast

How we did it

Project set up: January to June 2022
- Recruited 4 lived experience researchers
- Co-designed the research methods
- Community researcher induction
- Research ethics submission and approval

Analysis: December 2022 to January 2023
- Thematic analysis of data from qualitative research
- Conducted a literature review of other Anchor Frameworks
- Results synthesized to 50 statements for inclusion in the Delphi survey

Qualitative research: August to November 2022:
- Ran an initial survey (67 respondents)
- Held 3 stakeholder focus groups (25 participants)
- Conducted interviews with stakeholders (27 participants) and disadvantaged communities (12 participants)
- Achieved NIHR portfolio adoption

Agreeing the Framework: January to February 2023
- Delphi survey to agree statements for inclusion in the framework (138 participants across three rounds)
- Steering Group validation of final statements

Our Anchor Framework

Employment:

- Make **recruitment more local and inclusive** through supportive schemes
- Increase **apprenticeship offer for local people** to help keep them in the Fylde Coast
- **Reach out across our communities** to share information on roles and overcome barriers
- **Support fair pay and conditions of employment** for direct and contracted employees
- Make **the physical & mental health of staff** a priority

Procurement:

- Think creatively about funding to **shift spend** to **prevention, circular economy** and spending for **social value**
- **Engage local suppliers** and provide support to **join the list of suppliers**.
- Commit to **learning about the local business base**, shift spend locally and generate **local wealth**.

Environment:

- **Reduce waste:** paper, single use items and food
- Ensure **recycling of waste** including furniture and equipment
- Encourage and support **active travel** and use of **public transport** by staff and patients
- Include the **whole environmental cost** in purchasing decisions

Buildings and assets:

- Allow **local groups and organisations** to **use estates at little or no cost**
- **Co-locate** services in **community buildings** to create flexible and connected services
- Develop **good quality, accessible green spaces, for all to use,** particularly disadvantaged communities

Partnership Working:

- Deliver all **services in partnership** and **in local communities**
- Work with other anchors to **identify groups who need more support** and **test and scale** ways to provide it
- Funding and opportunity for **lived experience roles** to enable **coproduction and peer support**
- Work with other anchors to support **long-term stable VCFSE funding**

Proposed governance arrangements

The Health Inequalities Plan and Anchor Framework will report to the Board via the Strategic Delivery Group and the **Health Inequalities Steering Group**.

It is also proposed that the Anchor Framework be used to drive partnership activity and report to the **Blackpool Place Based Partnership Board**.
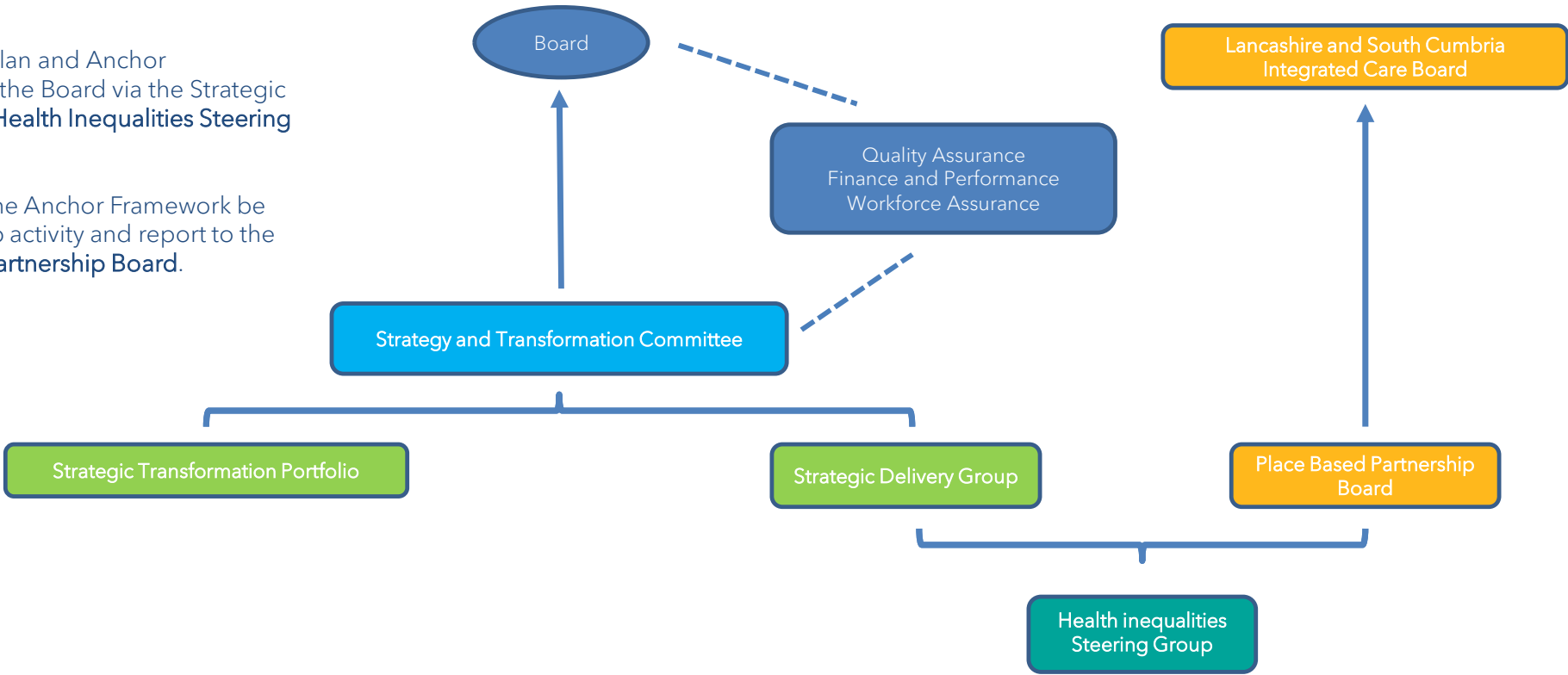
Next Steps

Next Steps

- Engage across BTH to assign Health Inequalities **leads for priority initiatives** and establish **SMART measures.**

- Establish **Health Inequalities Steering Group.**

- Health inequalities plan to be reviewed by **Coproduction Team** prior to design and publication.

- Seek **approval from Place Based Partnership Board** for adoption of the Anchor Framework.

- Seek **Board members to get involved** in the Health Inequalities Plan and Anchor Framework.

Our Health Inequalities Plan

2023 to 2027

Author: Heather Catt, Consultant in Public Health

Version: 1.0

Status:

Approved by:

Date Approved:

Contents

1. Foreword

It is unfair that an individual's postcode is a bigger determinant of their health than their genetic code.[1] The place where you are born determines when and how you are likely to die.

Individuals do not have the same opportunity to be healthy due to the circumstances into which they are born, then grow up, live, work and grow old. Any individual or organisation that can change this has a moral obligation to do so. Blackpool Teaching Hospitals NHS Foundation Trust take seriously our responsibility to our patients, staff, volunteers, and community. This commitment is indicated in our Five-Year Strategy vision:

"WE WILL IMPROVE THE LIVES OF PEOPLE WHO LIVE , WORK AND VOLUNTEER ON THE FYLDE COAST AND BEYOND"

As a provider of acute, community and tertiary health care services, we can look for and address inequalities in the access to, experience of and outcomes from our services. Ensuring we collect the data we need to be able to find and address inequalities is fundamental and will be supported by our digital transformation over the coming years. We can also be a listening organisation and take the time to understand what services our communities need and codesign those services with our communities so that they are fit for purpose and drive a reduction in health inequalities. We can look after and promote the health and wellbeing of our staff in the same way that we look after our patients.

As a large public sector organisation who employs lots of people, spends lots of money on goods and services and has a range of buildings and spaces in our estate we can influence the wider factors that influence poor health and health inequalities to prevent them from happening. This means providing our communities with access to quality, buying more goods and services locally to keep the Fylde Coast pound in the Fylde Coast, using our buildings and assets in a way that benefits local communities and organisation, working more closely with partner organisations to develop solutions to local challenges and reducing our impact on the environment. Our Anchor Framework and Our Green Plan are additional plans to tackle these social determinants of health and support our Health Inequalities Plan.

However, tackling health inequalities cannot be a side project if it is to be successful, it must be embedded in everything we do and we will work to achieve this during the delivery of this plan. It's too important to our communities and the sustainability of our NHS not to.

Steve Christian - Deputy CEO / Executive Director of Strategy and Transformation

Heather Catt – Consultant in Public Health

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[1] Graham GN. Why Your ZIP Code Matters More Than Your Genetic Code: Promoting Healthy Outcomes from Mother to Child. Breastfeed Med. 2016 Oct;11:396-7. doi: 10.1089/bfm.2016.0113. Epub 2016 Aug 11. PMID: 27513279.

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2. What are health inequalities?

Health inequalities are preventable, unfair, and unjust differences in health between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. These determine the chances of people getting ill, their ability to prevent illness, or opportunities to act and access healthcare when ill health occurs.[2]

Health inequalities ultimately means differences in health, but the term is also used to refer to differences in the care that people receive and the opportunities that people have to live healthy lives; but of which can contribute to their health. Health inequalities can therefore involve differences in:

- Health status, e.g., life expectancy and prevalence of health conditions
- Access to care, e.g., availability of services and treatments
- Quality and experience of care
- Behavioural risks to health, e.g., smoking, or healthy diet
- Wider determinants of health, e.g., quality of housing, employment opportunities, education, air quality [3]
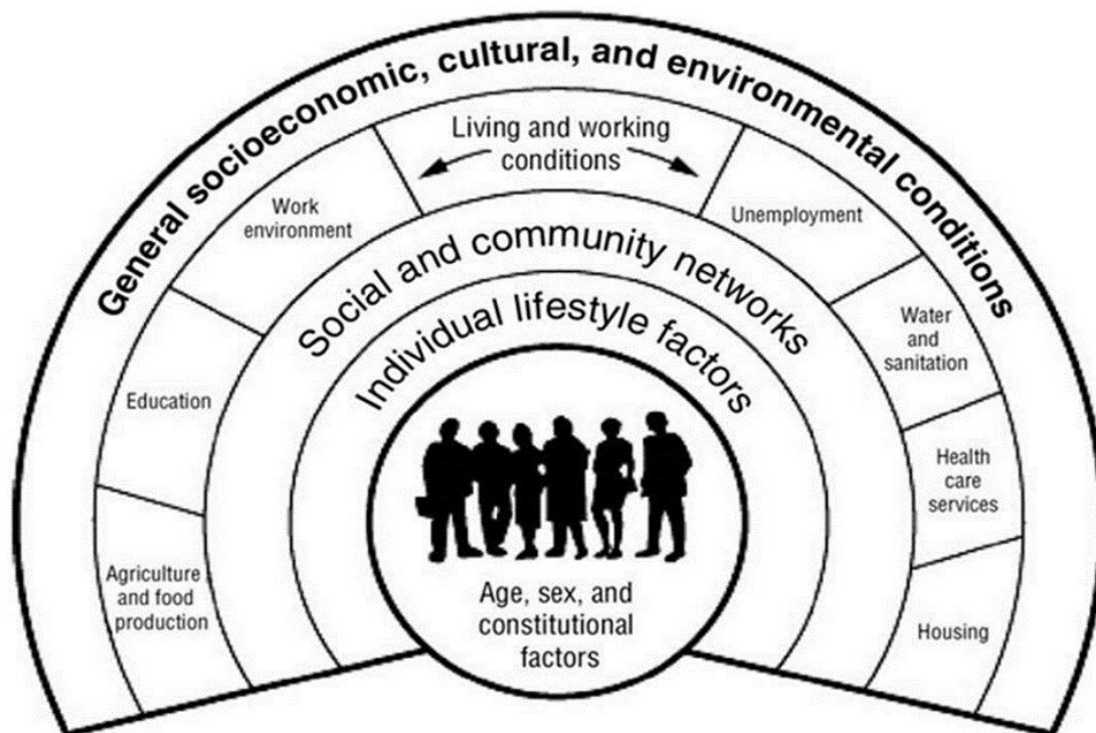
Figure 1: THE SOCIAL DETERMINANTS OF HEALTH[4]

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[2] NHS England and NHS Improvement: Reducing health inequalities https://www.england.nhs.uk/about/equality/equality-hub/resources/
[3] The King's Fund: What are health inequalities? https://www.kingsfund.org.uk/publications/what-are-health-inequalities
[4] Dahlgren and Whitehead (1991) Chapter 6: social determinants of health - GOV.UK (www.gov.uk)

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The ways in which social determinants impact on mental and physical health are complex and inter-related, often acting over a long period of time, even before birth. Inequalities are driven by many factors, including differences in the wider determinants of health and psycho-social factors, which can be protective for health. But health inequalities are not inevitable and can be reduced through targeted action on the determinants of health.
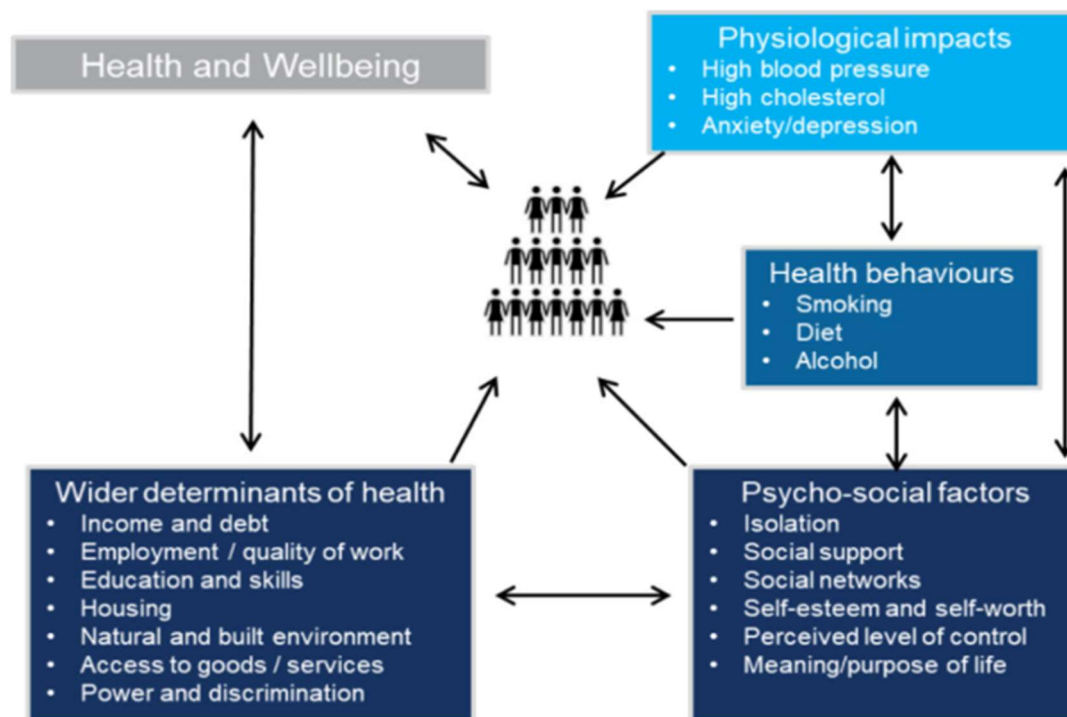
Figure 2: SYSTEM MAP OF THE CAUSES OF HEALTH INEQUALITIES[5].

Health inequalities are determined by social circumstances largely beyond an individual's control. The figure overleaf shows the different groups that are most vulnerable to health inequalities and how these dimensions of health inequalities overlap. Legislation underpinning efforts to reduce inequalities includes the Equality Act 2010 and the Public Sector Duty, which sets out key characteristics of communities that face inequalities. However, the Act does not include socio-economic status, which is a key contributor to inequalities in health and wellbeing outcomes, as well as other factors such as where people live.

Some groups in society are particularly disadvantaged. The concept of 'inclusion heath' (an approach which aims to address extreme health and social inequities) has typically encompassed groups including people experiencing homelessness; Gypsy, Roma, and traveller communities; vulnerable migrants; people leaving prison; and sex workers[6]; but other groups can also be included, such as care leavers. These groups can be socially

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[5] Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)
[6] v Department of Health 2010. Social Exclusion Task Force and Department of Health Inclusion Health: Improving the way we meet the primary healthcare needs of the socially excluded. Cabinet Office, Department of Health, London
https://webarchive.nationalarchives.gov.uk/ukgwa/+/http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf

excluded, which means processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions.[7]

The way these dimensions combine and interact also influences health inequalities. This is referred to as 'intersectionality'. For example, women experiencing homelessness have distinct health risks and needs compared to men experiencing homelessness.[8] Similarly, people living in deprived communities in urban areas experience different health inequalities to people living in deprived communities in coastal areas.
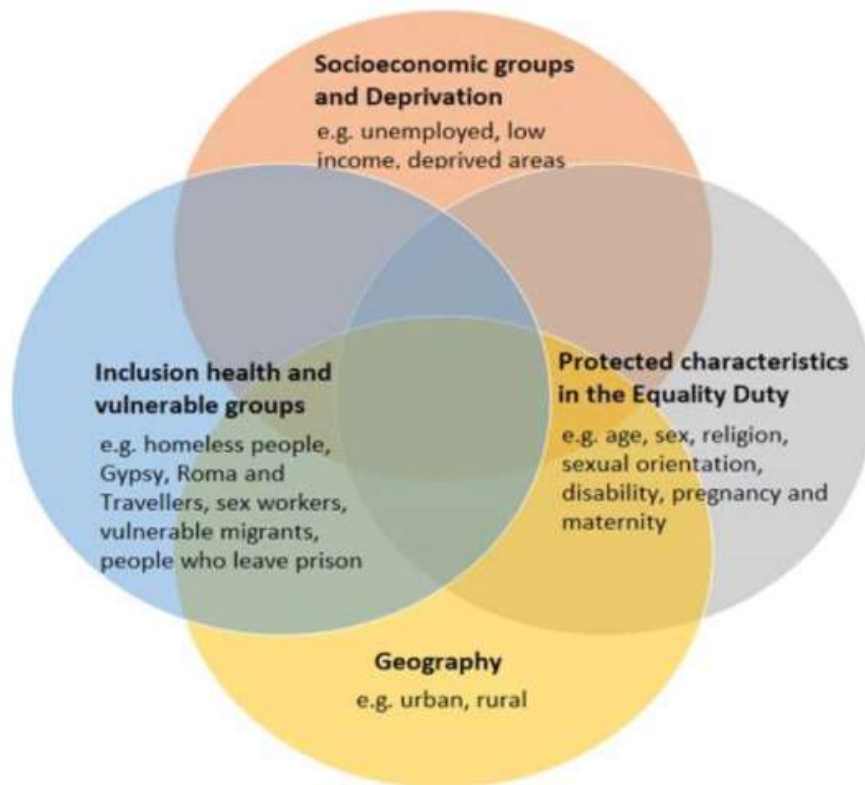
Figure 3: THE OVERLAPPING DIMENSIONS OF HEALTH INEQUALITIES[9]

[7] Popay J, Escorel S, Hernández M, Johnston H, Mathieson J, Rispel L (2008). Understanding and tackling social exclusion: final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network. World Health Organization, Geneva
https://www.researchgate.net/publication/244919409_Understanding_and_tackling_social_exclusion
[8] What are health inequalities? | The King's Fund (kingsfund.org.uk)
[9] Source: Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

3. National Context

The Health and Social Care Act 2022 asks NHS Trusts to reduce inequalities in health, wellbeing, and the quality of services. The NHS Long Term Plan[10] sets out how to tackle our greatest health challenges, including closing the gap in health inequalities in communities, recognising the important role the NHS has in addressing this in partnership with local authorities and the voluntary and community sector.

Health and care services worldwide have faced an unparalleled challenge in responding to and managing the impact of COVID-19. The disproportionate impact of the virus on different groups and communities has highlighted longstanding health inequalities. Recovery from the pandemic presents both a challenge and opportunity to address health inequalities.

While action on the behaviours and conditions affecting health is a necessary part of the solution to reduce health inequalities, these also need to be addressed within the context of their root causes: the conditions under which people are born, grow, work and live.

The CORE20PLUS5 approach

Core20PLUS5 is the NHS England and NHS Improvement approach to reduce inequalities in healthcare at both national and system level. Two programmes focus on adults and children and young people.

Target population

Core20 refers to the most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health: income, employment, education, health, crime, barriers to housing and services, and living environment.

The 'PLUS' element of the Core20PLUS5 approach refers to Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. These are groups who would benefit from a tailored health care approach and should be based on local population health data.

Inclusion health groups include ethnic minority communities; coastal communities; people with multi-morbidities; protected characteristic groups; people experiencing homelessness; drug and alcohol dependence; vulnerable migrants; Gypsy, Roma, and Traveller communities; sex workers; people in contact with the justice system; victims of modern slavery; young carers; and other socially excluded groups.

Key clinical areas of health inequalities

The final part of Core20PLUS5 sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes, with national and regional teams co-ordinating

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[10] NHS Long Term Plan https://www.longtermplan.nhs.uk/

local systems to achieve national aims. For adults, these areas of focus are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case finding, plus an overarching programme focused on tobacco reduction. For children and young people, these areas are asthma, diabetes, epilepsy, oral health, and mental health.
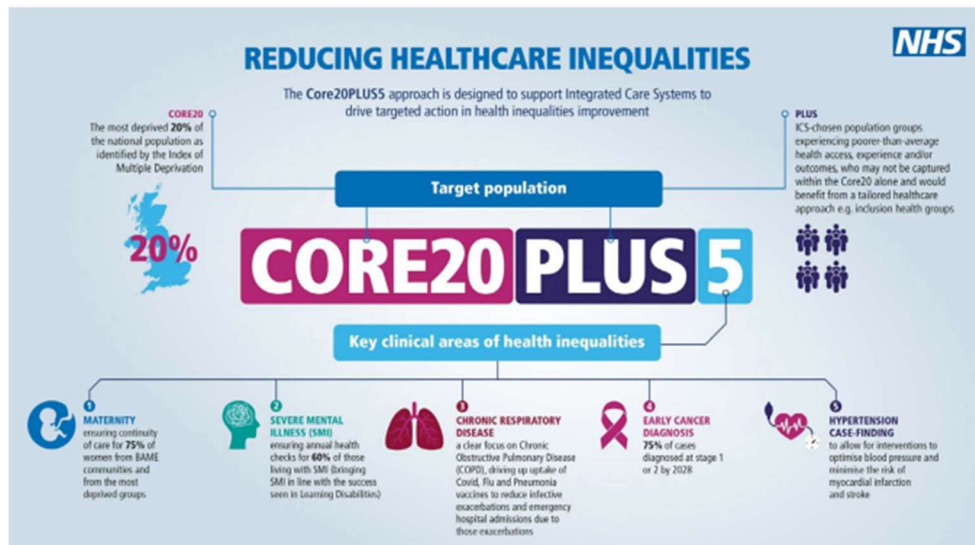
Figure 4: THE CORE20PLUS5 APPROACH TO REDUCING HEALTHCARE INEQUALITIES.
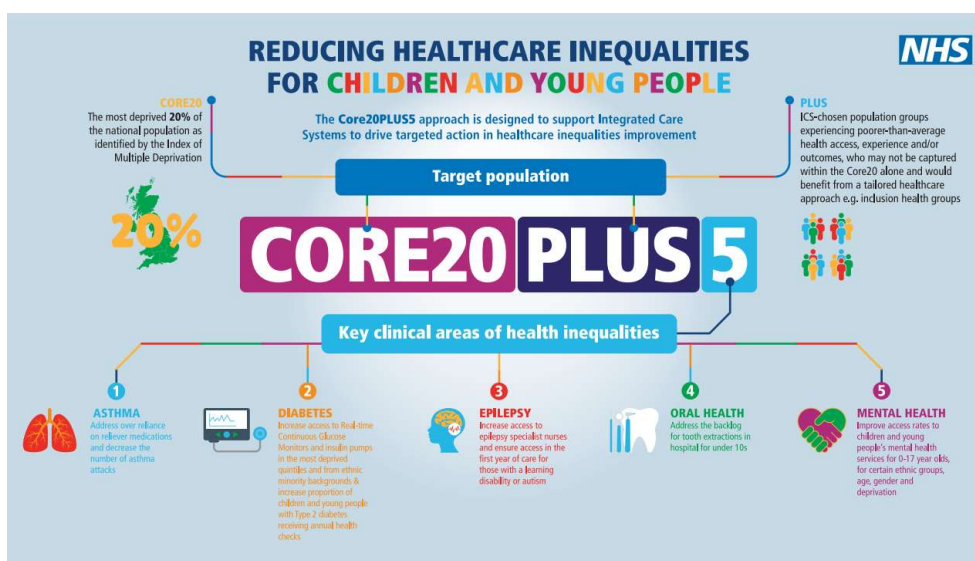
Figure 5: THE CORE20PLUS5 APPROACH TO REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE.

4. Local Context

Locally the Blackpool and Lancashire Place Based Partnerships and Lancashire and South Cumbria Integrated Care Partnership provide an opportunity for leadership to ensure that we work collaboratively across the system to understand and address health inequalities locally. Given the range of causes, a joined-up, place-based approach is necessary to tackle the complex causes of health inequalities.

The Lancashire and South Cumbria Integrated Care Strategy for 2023-28 (DRAFT) outlines a life course approach to describe their priorities for action to deliver their vision of a population that is healthier, wealthier, and happy.
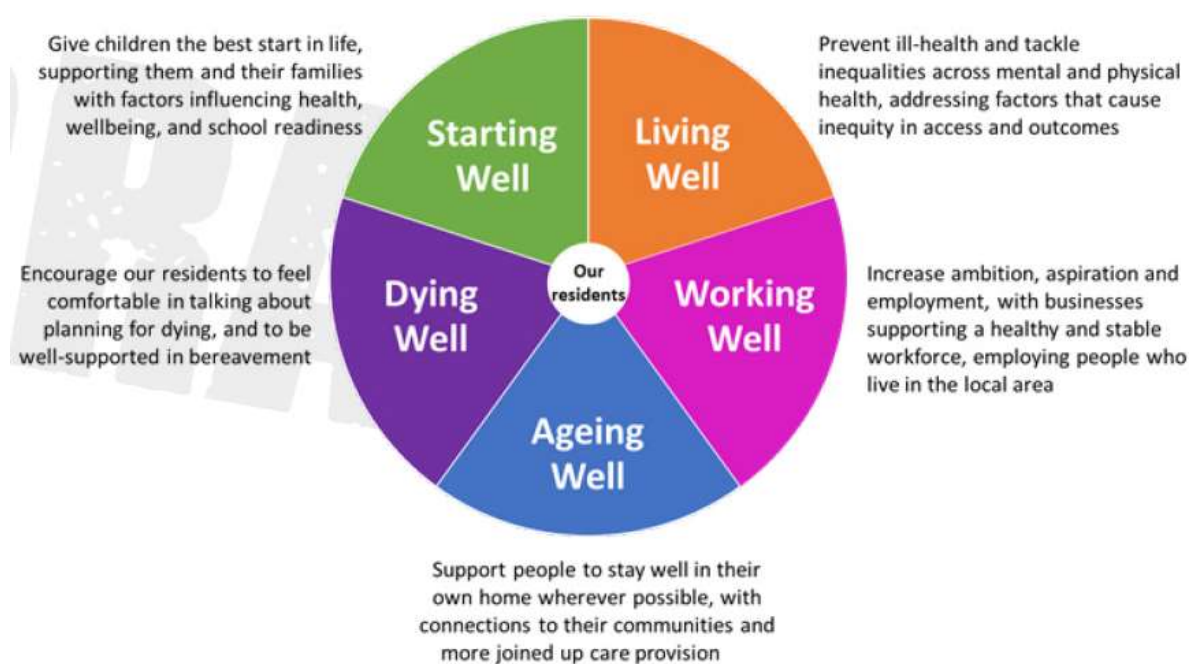
Figure 6: LIFE COURSE APPROACH TO PRIORITIES OF THE LSC INTEGRATED CARE STRATEGY

In preparing our Health Inequalities Plan we have considered all the local plans, reports, and recommendations to ensure that we align with and support existing work into tackling health inequalities. This includes the following documents:

- Health Equity Commission (Lancashire and Cumbria)
- Fylde Coast Prevention Strategy
- CQC action plan

We have also engaged extensively with our partners at place to ensure that they understand and agree with the approach we plan to take.

Our Health Inequalities Plan, together with Our Anchor Framework and Our Green Plan, will allow us to work effectively with our partners and ensure we support the achievement of the Integrated Care Partnership's vision.

5. Health Inequalities in the Fylde Coast

This section provides a summary of key demographics, deprivation and key indicators which have an impact on health inequalities. Further detail can be found in the links below:

fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)

Fylde-Coast-CCGs-demographic-profiling.pdf

Population of the Fylde Coast

The Fylde Coast has an older people than the national average and the average in Lancashire and South Cumbria ICS. Fylde district has one of the oldest populations in the integrated care system. An older people will have an impact on the prevalence of long-term conditions and need for health care services.
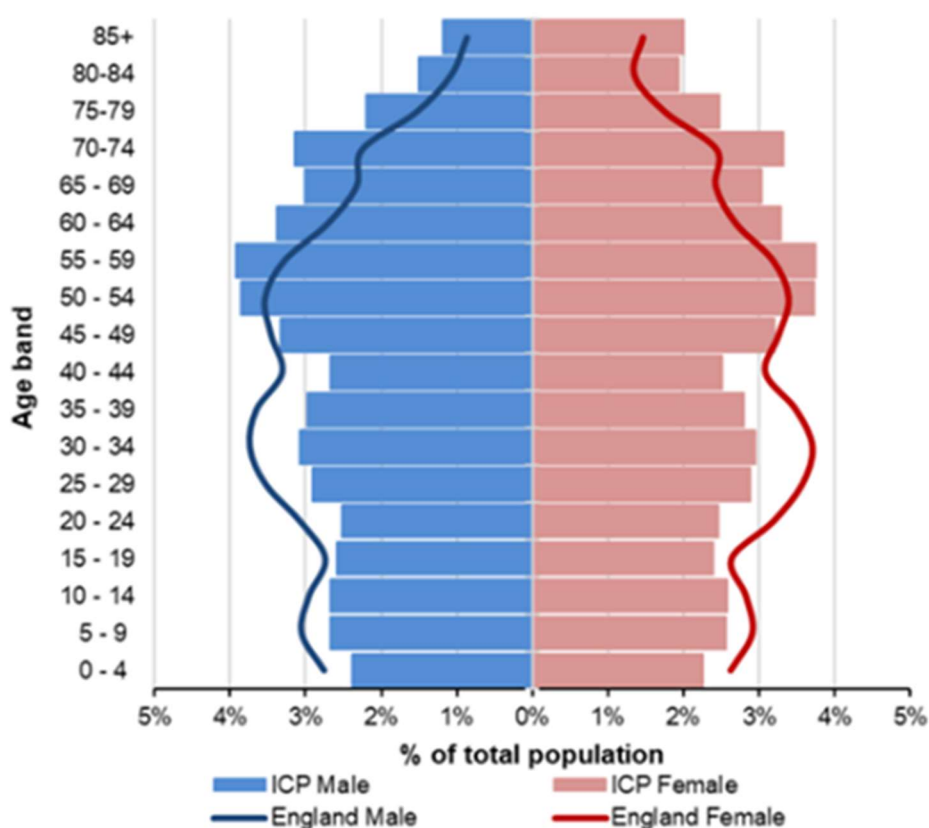
Figure 7:POPULATION PYRAMID FOR THE FYLDE COAST COMPARED TO LANCASHIRE AND SOUTH CUMBRIA, 2019[11]

Population projections

Fylde and Wyre districts are expected to have with more people moving into the districts than moving away. As a result, Fylde and Wyre are predicted to experience strong population growth over the next 20 years, a large proportion of which will be older people.

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[11] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)

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However, Blackpool is estimated to experience a reduction in resident population over the coming years and a modest increase by 2043. Of note, the working age population of Blackpool is predicted to reduce whilst the older population is predicted to increase. This has large implications in terms of the economy and the health sector.

Ethnicity

The Fylde Coast has less ethnic diversity in the population than either the Lancashire and South Cumbria ICS or England.
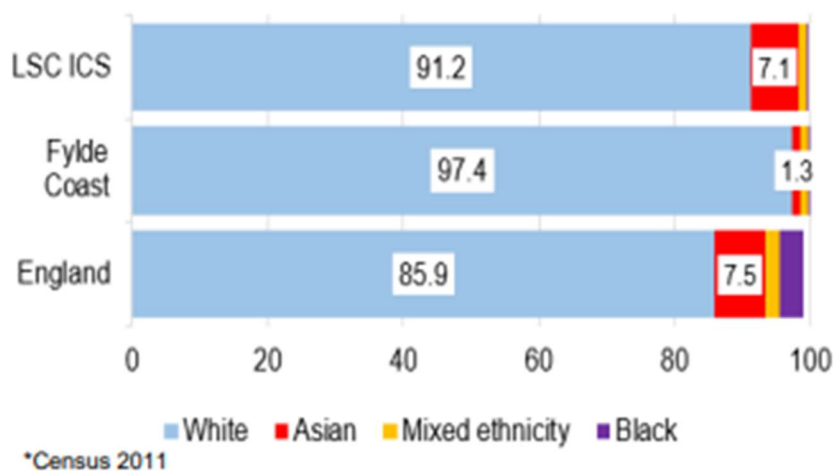
Figure 8: ETHNICITY BREAKDOWN FOR THE FYLDE COAST, COMPARED WITH LANCASHIRE AND SOUTH CUMBRIA AND ENGLAND[12]

Deprivation on the Fylde Coast

Deprivation and poverty can be the biggest risk factors for poor health and wellbeing. People living in deprived areas are more likely to have poorer health outcomes and a reduced life expectancy. They may face differences in the care they receive and their opportunities to live healthy lives, compared to their counterparts in less deprived areas.

The Fylde coast has clear concentrations of deprivation, shown as darker areas in the map below, but also very wealthy areas, shown as lighter areas. The darker the area, the more deprived. Concentrations of significant deprivation are found in key urban and coastal areas of Blackpool, Fleetwood and pockets across St Annes and Cleveleys.

A third of the Fylde coast is within the most deprived 20% of areas nationally (CORE20 population). Most are concentrated in Blackpool; half of the Blackpool population are in the CORE20 and eight out of the ten most deprived areas in England are within the town.

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[12] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)
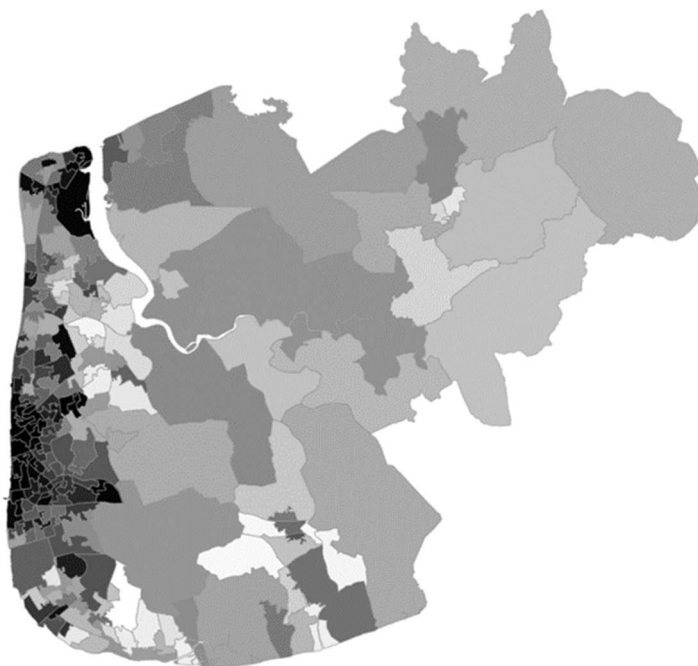
Figure 9: INDEX OF MULTIPLE DEPRIVATION 2015 MAP OF FYLDE COAST

Life expectancy gaps

The table below shows life expectancy overall and the gap in life expectancy between the local authorities in the Fylde Coast and England and within the Fylde Coast districts (for deprivation). The life expectancy gap with the national average is greatest for Blackpool and there are large inequalities across all three districts between the most deprived and least deprived areas.

Table 1: LIFE EXPECTANCY OVERALL AND THE GAP BETWEEN THE LOCAL AUTHORITIES IN THE FYLDE COAST AND ENGLAND AND WITHIN THE FYLDE COAST DISTRICTS (2015-17)[13]

Local authority	Absolute gap in life expectancy between local authority and England (years)	Life expectancy (years)-local authority	Life expectancy (years)-England	Absolute gap in life expectancy between most and least deprived quintile (years)	Life expectancy in most deprived quintile of local authority (years)	Life expectancy in least deprived quintile of local authority (years)
Males						
Blackpool	-5.4	77.2	79.6	-10	68.8	78.8
Fylde	-0.8	78.7	79.6	-9.5	74	83.5
Wyre	-0.7	78.9	79.6	-9.8	71.9	81.7
Females						
Blackpool	-3.6	81.1	83.1	-7.8	74.8	82.6
Fylde	-0.5	82.3	83.1	-6.7	80.2	86.8
Wyre	-0.7	82.4	83.1	-7.2	77.4	84.6

The table below shows the top six causes of death contributing to the gap in life expectancy between the most and least deprived areas in the Fylde Coast for males and females.

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[13] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)

Table 2: TOP SIX CAUSES CONTRIBUTING TO THE GAP IN LIFE EXPECTANCY BETWEEN MOST AND LEAST DEPRIVED AREAS OF THE FYLDE COAST[14]

Ranked cause of Life expectancy gap	Females	Males
1	Heart disease	Cirrhosis and liver disease
2	Chronic lower respiratory diseases	Heart disease
3	Other cancers	Accidental poisoning
4	Cirrhosis and liver disease	Other causes
5	Flu and pneumonia	Chronic lower respiratory diseases
6	Other causes	Lung cancer

A good start in life for young people in the Fylde Coast

A good start in life is vital: the experiences a child has in their early years can have an impact on their future health and wellbeing. Some children may experience educational, social and health disadvantages that follow them through life. These may include factors such as being born into a household experiencing poverty and / or being a low birth weight. Missing school through hospital stays or having excess weight can also affect a child's development. Protective factors, which promote wellbeing and mitigate risk, such as being school ready and performing well at school, can lead to opportunities to thrive in life.[15]

Positives for the Fylde Coast	Challenges for the Fylde Coast
• **A&E attendances** in under-5s are significantly better than nationally • Overall, significantly fewer **year 6 children are obese** in Fylde and Wyre than nationally (significantly more are in Blackpool) • The proportion of **year 6 children with excess weight** (obese and overweight combined) is significantly lower (Blackpool is significantly higher). • The percentage of **low birthweight** term babies, while not significantly different, is lower than England (although significantly higher in Blackpool)	• There are significantly more **deliveries to teenage mothers** than nationally. • **Emergency hospital admissions** for children under-five is significantly higher than the national average. • **Admissions for injuries** for those aged 15 - 24 is significantly higher than nationally in all districts. • The rates of **admissions for injuries** in children under-five and under-15 are significantly higher (Fylde is similar) • **GCSE achievement** is significantly worse (Wyre is significantly better, Fylde is similar)

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[14] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)
[15] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)

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Moving through life in the Fylde Coast

Moving through life, where a person lives, their health behaviours, their social connections and their economic position continue to have an impact on their physical and mental health, and wellbeing. Having these as positive influences increases the likelihood of having a healthier life (including a healthier and longer life expectancy). Conversely, a lack of these can lead to an increased risk of poorer health and wellbeing, which can be seen through higher levels of hospital admissions, illness, and premature mortality.

The Fylde Coast has many challenges, particularly in Blackpool, which performs badly on many indicators, and affects the Fylde Coast averages. Fylde has an older age profile and an ageing population, which brings other challenges around long-term conditions, limiting illnesses and increased need for health care.[16]

Positives for the Fylde Coast	Challenges for the Fylde Coast
• The Fylde Coast has a similar rate of **emergency admissions for stroke** compared to England (Wyre is significantly lower). • Incidence of **breast cancer** and **colorectal cancer** is similar across all districts. * • Incidence of **prostate cancer** is similar to England. • The Fylde Coast has a similar rate of **emergency hospital admissions for hip fractures in 65+** compared to England (Blackpool is significantly higher). *Lower incidence of disease may be due to lower health risk behaviours and/or screening, but equally it may be due to a gap in screening and diagnosis. Looking at this in respect of the local population is important.*	• There is a significantly higher rate of **hospital stays for alcohol-related harm** (narrow definition) than nationally. • **Alcohol-specific mortality for males** is significantly higher across Blackpool and Fylde than the national average. • The proportion of people with a **long-term illness or disability** is significantly higher than for England. • The rate of **deaths from all causes** is significantly higher than the national average. • The rate of **deaths from stroke** (all ages, all people) is significantly higher than for England.

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[16] fylde_health_and_care_partners_profile.pdf (lancashire.gov.uk)

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6. Our Trust Five-year Strategy

The Trust's five-year strategy was launched in 2022 and sets out the action we will take to improve the lives of people who live, work and volunteer on the Fylde Coast and beyond. Action across three strategic aims - our people, our population, and our responsibility - will be delivered through nine priorities.

Figure 10: Trust Five-year Strategy on a page

Our Health Inequalities Plan is one of the enabling plans for the strategy, setting out action against its nine priorities. Addressing health inequalities will be vital to ensure we can achieve the strategic vision, but it is important to recognise that tackling health inequalities is not an isolated programme and needs a public health approach to be embedded in other plans, priorities, and programmes.

7. Our Health inequalities Plan

Health inequalities result from a complex range of interrelated causes – and the causes of those causes, which are the conditions under which people grow, learn, work and live. It is estimated that 20% of health outcomes results from clinical interventions, whilst 80% is driven by the wider determinants of health.[17] Our Health Inequalities Plan is one part of our response to tackling health inequalities. We operate a framework approach with two other plans that align and complement each other: Our Anchor Framework to drive improvements in the wider determinants of health through our corporate functions such as recruitment, procurement, managing our estate and partnership working, and Our Green Plan to reduce our environmental impact and adapt our services to the changing climate.
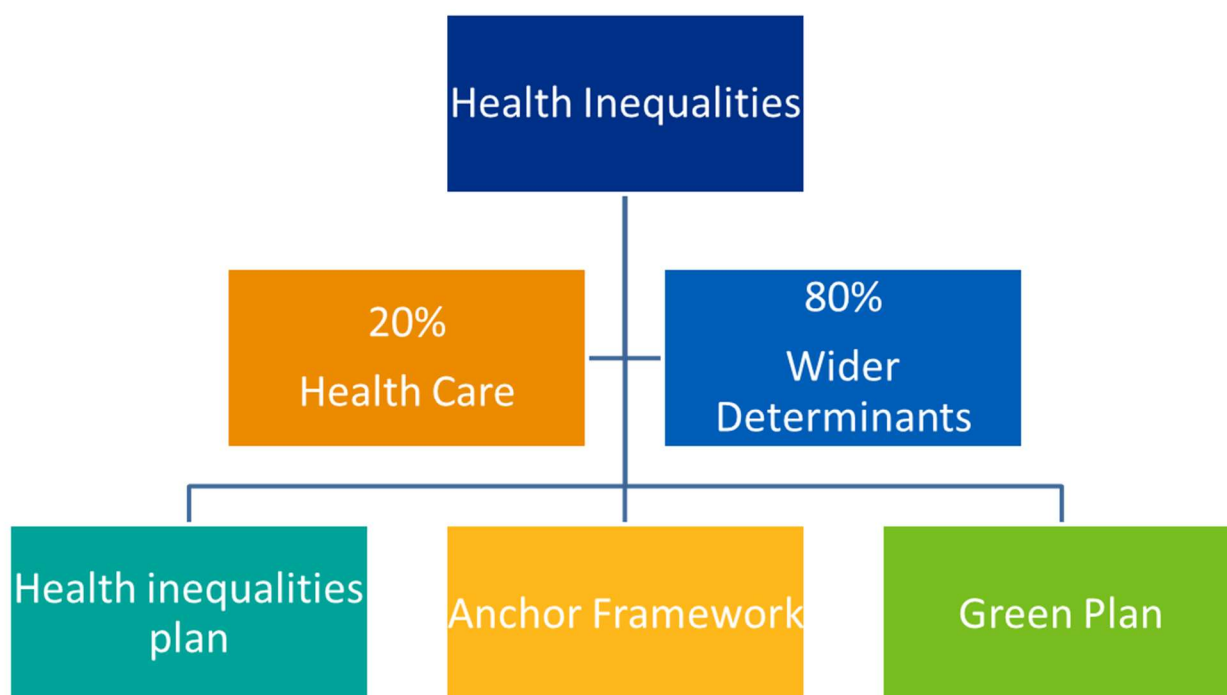
Figure 11: Our Framework for Tackling Health Inequalities

This plan sets out the strategic approach for how the Trust will reduce health inequalities, aligned to the aims and priorities of the Trust's strategy. We will work with our partners in the ICS, across the NHS, local authorities, the voluntary, community, faith and social enterprise sector, other anchor organisations and, most importantly, our communities to deliver our plan to reduce health inequalities.

Our goals describe our medium-term objectives and initiatives have been identified to achieve them. This plan is accompanied by an action plan document (see Appendix) which will be reviewed annually and sets out the priority initiatives we need to deliver. We will define SMART measures to monitor our progress against this plan.

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[17] New Local Government Network. Place based health: A position paper 2015 [Available from: http://www.nlgn.org.uk/public/2015/place-based-health-a-position-paper/

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Our people

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

Strategic priority: Grow Our Own

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

Goal – Increase understanding and uptake of the range of opportunities at BTH with a focus on equity groups

Goal - Increase opportunities for our diverse local community with a focus on equity groups

Goal - Increase opportunities for existing staff to develop with a focus on equity groups

Our people

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

Strategic priority: Happy & Healthy Workforce

Objective: Care for our people and support them in maintaining resilience and wellbeing. We understand that the capacity to care for our patients is reliant on our staff wellbeing

Goal – Improve the health and wellbeing of all staff working in the Trust, both directly employed and contracted to work in the Trust with a focus on equity groups

Goal - Acknowledgement of the social gradient with the NHS workforce and the impact on health and wellbeing

Our people

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

Strategic priority: Learning Culture

Objective: Engage and empower staff in their education and learning, encouraging the development of psychological safety and constructive challenge to improve patient and staff experience

Goal – Enhance strategic leadership in reducing health inequalities

Goal – Give staff the skills they need to understand health inequalities and address them

Figure 12: Our People Health Inequalities Goals

Strategic priority: Health Inequalities

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

Objective: Address inequalities in access, experience, and outcomes of our care

Goal – Ensure complete and high-quality data collection on all protected characteristics (staff and patients)

Goal – Use data to understand the local population and identify CORE20PLUS communities

Goal – Use data to understand in more depth and address ACCESS to care, EXPERIENCE of care and Health and social OUTCOMES

Strategic priority: Integrated Care

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

Objective: Continue our commitment to co-produce integrated care, working with health and social care partners and patients to influence neighbourhood plans

Goal – Take a partnership approach working with other health and social care providers and communities

Goal – Embed co-production and engagement in Trust work

Strategic priority: Prevention and health

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

Objective: Prioritise prevention and early detection of illness in disadvantaged groups. We will support patients in developing the skills, confidence and knowledge to manage their health

Goal – Create a culture of empowering and supporting people to take more control over their health and improve their wellbeing

Goal – Embed a population health and prevention approach among our workforce

Goal – Ensure the Trust's elective recovery plan identifies and addresses health inequalities

Figure 13: Our Population Health Inequalities Goals

Strategic priority: Getting the Basics Right

Our responsibility

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

Objective: Work collaboratively with our partners to improve quality of care and become a Care Quality Commission (CQC) 'Good' rated organisation

Goal – Ensure health equity is considered a core component of quality

Strategic priority: New Ways of Working

Our responsibility

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

Objective: Use transformation, digital, innovation and research to deliver new efficient models of care to widen access, enhance health

Goal – Develop and roll out of digital transformation with a focus on inclusion

Goal – Build recognition of digital inclusion as an essential health equity requirement

Strategic priority: Investing in Our Community

Our responsibility

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

Objective: Work collaboratively with our partners and communities to positively impact beyond healthcare

Goal – Make a positive difference in terms of carbon emissions and population health

Goal – Take collaborative action to improve the social, economic, and environmental conditions of the Fylde Coast

Figure 14: Our Responsibility Health Inequalities Goals

Appendix: Health Inequalities Action Plan

GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
OUR PEOPLE: We will widen access to job opportunities, becoming the employer of choice within our community with an empowered, diverse, & 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					
Increase understanding and uptake of the ranges of opportunities at BTH with a focus on equity groups

Increase opportunities for our diverse local community with a focus on equity groups

Increase opportunities for existing staff to develop with a focus on equity groups | Build relationships with schools and colleges across the Fylde Coast (particularly in most deprived areas) to encourage local young people to aspire to a career within BTH. | 2 | Staff survey results (monitored by equity groups)

Exit interviews

Vacancies

Uptake and success of career development (monitored by equity groups)

Uptake and success of school engagement (monitored by equity groups)

Annual completion of the NHS Equality Delivery System return | Widening Participation and Apprenticeship Lead | HR Occupational Health Local authorities Schools Colleges Universities Social care VCFSE services - particularly Blackpool Coastal Housing to work with care experienced young people/adults |
	Identify and capitalise on existing opportunities to increase recruitment and retention in programmes for entry level roles in areas of opportunity (e.g., HCA recruitment along key bus routes with travel offer provided by Blackpool Transport)	2		TBA	
	Provide funding and support for existing staff to access degrees and other opportunities along developed career pathways. Monitor equity in uptake	2		Widening Participation and Apprenticeship Lead	
	Ensure equality duties are met in recruitment and employment practices, including pay, progression, and terms.	3		Equality & Diversity Lead	
	Work closely with local schools and colleges in areas with higher levels of deprivation to provide apprenticeships, job training and employment shadowing with a guaranteed employment, apprenticeship, or training offer for 18–25-year-olds	3		Widening Participation and Apprenticeship Lead	
	Targeted programmes to support children in care and care leavers to gain skills and experience to apply for and work in NHS careers. (Other PLUS groups – LD?)	3		TBA	
	Strengthen equitable recruitment and retention practices, including the development of apprenticeships and in-work training, and recruitment from local communities and those underrepresented in the workforce.	3		TBA	
	Work with Higher Educational Institutions to develop supported nursing and midwifery programmes from Fylde Coast schools linked to employment at BTH.	3		TBA	

GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
HAPPY & HEALTHY WORKFORCE: Care for our people and support them in maintaining resilience and wellbeing. We understand that the capacity to care for our patients is reliant on our staff wellbeing					
Improve the health and wellbeing of all staff working in the Trust, both directly employed and contracted to work in the Trust Acknowledgement of the social gradient with the NHS workforce and the impact on health and wellbeing	Promote community finance institutions to supply credit, reduce levels of debt and provide financial management advice	2	Uptake of initiatives (monitored by equity groups) Staff survey results (monitored by equity groups) Policies reviewed for health inequalities impact and findings addressed	Head of Wellbeing & Inclusion	Agencies HR Occupational health Local authorities Staff VCFSE sector Citizens' advice Travel providers Private providers (food, physical activity offer)
	Work with the VCFSE sector to provide social welfare, legal and debt advice, including housing, fuel, and poverty support.	2		Head of Wellbeing & Inclusion	
	Review & expand health and wellbeing support offer to staff, and monitor uptake by equity group, including smoking cessation support available free of charge to all staff; availability of healthy food at Trust sites (day and night/weekends); mental health support (Crisis support and preventative offer) & suicide prevention; physical activity programmes; NHS Health checks for over 40s; and Flu/Covid vaccines.	2		Head of Wellbeing & Inclusion	
	Review travel policies and working practice to consider their impact on health inequalities, including fuel reimbursement to ensure staff are not out of pocket, inclusion of cycle and walking mileage, active travel policy, subsidised cycle schemes, annual travel pass schemes and hybrid working	3		TBA	
	Consideration to agencies working within the Trust – often lower status roles (domestics, porters, etc.). Using procurement process and contracts to ensure agency alignment with Trust in terms of OH, wellbeing policies and practices, etc. and pay a real living wage. Trust health and wellbeing support/services being made available to agency staff.	3		Director of Procurement	
	Commit to be a real living wage employer and ensuring wages meet the minimum income standard for healthy living	4		TBA	
LEARNING CULTURE: Engage and empower staff in their education and learning, encouraging the development of psychological safety and constructive challenge to improve patient and staff experience					
Enhance strategic leadership in reducing health inequalities.	Engagement with staff and develop understanding of population health through a health inequalities training package including the use of methods such as Health Equity Audit Tool (HEAT) and the Public Sector Equality Duty (PSED) tools.	2	Uptake of training by department and role	Public Health	Healthcare public health colleagues from local trusts across L&SC

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GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
Give staff the skills they need to understand health inequalities and address them.	Inclusion of health equity data as part of Board performance packs that include waiting lists broken down by ethnicity and IMD quintile focused on unwarranted variation	2	Health equity data reported at each Board meeting Health inequalities actions identified in divisional plans Communication plan developed	Associate Director of Business Intelligence	
	Coproduce methods for communicating local initiatives and services available to staff to support people (alongside training on health inequalities and trauma informed approaches). Ensure these are not only digital communication methods.	2		Public Health and Communications	
	Development of a holistic impact assessment tool (including both environmental and health inequality impact) to enhance and/or replace existing Business Case process.	2		Public Health and PMO	
	Embed principles of reducing health inequalities in Divisional plans across the Trust.	3		Public Health	

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

GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
Ensure complete and high-quality data collection on all protected characteristics (for both staff and patients). Use data to understand the local population and identify CORE20PLUS communities.	Develop plans to improve quality data collection on all protected characteristics (for both staff and patients), with an immediate focus on improving data collection on ethnicity.	2	Complete collection of data on protected characteristics (staff and patients) Core20PLUS communities identified, and profiles published Regular attendance at	Chief Information Office	EPR design team VCFSE sector Poverty Truth Commission Healthwatch Co-production team ICB leads Translation /advocacy services Health and wellbeing partnerships Divisions
	Engage in existing and emerging partnership networks beyond traditional health and social care providers to deeply listen and understand what our population requires. Engage with Health and Wellbeing Partnerships, Poverty Truth Commissions, Healthwatch, partner community conversations and staff engagement.	2		Public Health and Deputy Director of Strategy	
	Provide access to resources to reduce inequalities by providing accessible information and communication support (e.g., translators, LD resources). Ensuring that we communicate with our patients and community in a way that reflects literacy levels, digital capabilities, and communication needs.	2		Equality & Diversity Lead	
	Develop approaches to Core20PLUS5 programme: SMOKING - Smoking cessation positively impacts all 5 key clinical areas. Continue to provide Ottawa model smoking cessation support to all patients, and review impact, including by equity groups.	2		TBA	

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GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
Use data to understand in more depth and address: • ACCESS to care (including barriers, late presentation, low uptake of screening and preventative care) • EXPERIENCE of care (actively seeking patient feedback, particularly from deprived and vulnerable groups) • Health and social OUTCOMES	Develop approaches to Core20PLUS5 programme: CVD Hypertension case finding and optimal management; lipid optimal management	2	networks across corporate and divisions Inequalities dashboards published Standards for information and communication support developed and enacted Models for Core20PLUS programmes developed and success monitored	TBA	
	Develop approaches to Core20PLUS5 programme: CHRONIC RESPIRATORY DISEASE - A clear focus on Chronic Obstructive Pulmonary Disease (COPD) in integrated respiratory pathway - Increase uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions for COPD patients due to those exacerbations.	2		TBA	
	Develop approaches to Core20PLUS5 programme: EARLY CANCER DIAGNOSIS: - delivering earlier cancer diagnosis; Ensure equitable access to elective cancer care	2		TBA	
	Develop approaches to Core20PLUS5 programme: MATERNITY - Ensure continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely. - Improve equity of access for Core20Plus communities, including by monitoring late booking and poor engagement with antenatal care. - Consider other groups in the population that may benefit from continuity of care	2		TBA	
	Develop approaches to Core20PLUS5 for children and young people: ASTHMA: - Address over reliance on reliever medications and decrease the number of asthma attacks.	2		TBA	
	Develop approaches to Core20PLUS5 for children and young people: DIABETES: - Increase access to real-time continuous glucose monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds and increase proportion of children and young people with Type 2 diabetes receiving annual health checks.	2		TBA	

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GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
	Develop approaches to Core20PLUS5 for children and young people: EPILEPSY: - Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.	2		TBA	
	Develop approaches to Core20PLUS5 for children and young people: ORAL HEALTH: - Address the backlog for tooth extractions in hospital for the under 10s.	2		TBA	
	Develop approaches to Core20PLUS5 for children and young people: MENTAL HEALTH: Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation.	2		TBA	
	Use data to understand the local population and identify CORE20PLUS communities. Use information on health inequalities to support action, measure improvement and provide assurance across the organisation.	3		TBA	
	Develop approaches to systematically consider data on patient and community access, experience and outcomes and adapt as a result. Maintain a focus on deprived and marginalised groups.	3		TBA	
INTEGRATED CARE: Continue our commitment to co-produce integrated care, working with health and social care partners and patients to influence neighbourhood plans					
Take a partnership approach working with other health and social care providers and communities. Embed co-production and engagement in all work programmes.	Support the development of Integrated Neighbourhood Teams to ensure health inequalities, prevention and personalised care are embedded.	2	Co-production used in service design Lived experience in recruitment panels, decision making and peer support Health equity	Public Health and Personalised Care Programme Manager	Local authorities Co-production team at Blackpool LA Empowerment Charity Primary care Social prescribers VCFSE groups Patients Family/carers
	Ensure continued funding for lived experience roles as part of co-production and peer support, to fully utilise the wealth of lived experiences locally & address issues faced by the most disadvantaged. This should include recruitment processes, decision making, project and service design, etc	2		TBA	
	Develop a toolbox for co-production for patients, carers, governors, staff, and communities.	3		TBA	

GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
	Ensure that a health inequalities approach is embedded in the delivery of integrated care pathways for urgent and emergency care, respiratory, frailty and medical high care	3	assessment used in pathway developments with action plans to address unwarranted variation	TBA	
	Look into where care is provided and transport links with a view to overcoming barriers to access. Aim to provide care in people's own communities wherever feasible, with consideration to more deprived communities.	4		TBA	
	Work with partners at place to ensure our population has equitable access and support for key preventative interventions and that we align the available resources in the system. Focus areas: • Smoking / respiratory • Alcohol / liver • Healthy weight • Maternity and early years (first 1001 days) • Good mental health • Community-centred approaches for health and wellbeing	4	Reduced inequities in service access, experience, and outcomes	TBA	
PREVENTION AND HEALTH PROMOTION: Prioritise prevention and early detection of illness in disadvantaged groups. We will also support patients in developing the skills, confidence, and knowledge to manage their own health.					
Create a culture of empowering and supporting people to take more control over their health and improve their wellbeing. Embed a population health and prevention approach among our workforce.	Seize opportunities to encourage positive behaviour changes at all points of contact. Provide staff training on health coaching, Making Every Contact Count (MECC) and patient activation measures (PAMs)	2	Uptake of training by department and role	Personalised Care Programme Manager	Training providers Social prescribers Business Intelligence and corporate performance Personalised Care
	Accelerate preventative workstreams: Delivering the Tobacco Prevention Programme	2		Service Manager – LTCs	
	Accelerate preventative workstreams: Increasing screening and vaccinations, particularly in those populations with lowest uptake	2	Social prescribing referrals embedded in BTH services	TBA	
	Accelerate preventative workstreams: Delivering the HIV Prevention Programme	2		TBA	
	Accelerate preventative workstreams: Delivering Alcohol Care Teams	2		TBA	
	Introduce trauma-informed training to build staff empathy and engagement with most vulnerable populations to drive a trauma-informed approach to care.	2	Waiting lists by equity groups	Personalised Care	

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GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
Ensure the Trust's elective recovery plan identifies and addresses health inequalities				Programme Manager	
	Expand social prescribing referral process using learning from existing social prescribing offer. Review social prescribing to ensure it is addressing the social determinants of health.	2		Public Health	
	Have waiting list disaggregated and analysis undertaken of ethnicity and deprivation. Develop and publish elective recovery plans focused on addressing unwarranted variation. Regularly report on performance at ICB and Trust board level. Develop Health Equity Impact Assessments for elective recovery plans and develop SMART action plans to tackle any identified inequalities	2		Associate Director of Business Intelligence	

OUR RESPONSIBILITY: We will work with partners to deliver high quality, financially sustainable services and reduce our environmental impact.						

GETTING THE BASICS RIGHT: Work collaboratively with our partners to improve quality of care and become a Care Quality Commission (CQC) 'Good' rated organisation						

Ensure health equity is considered a core component of quality	Embed principles of health equity in the development of new approaches to: • education, research, and innovation • our estates • our digital infrastructure • our people • quality improvement and transformation • sustainability and environmental measures	2	Defined SMART actions in enabling plans	Public Health	

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						

Develop and roll out of digital transformation with a focus on inclusion	Make clinical research accessible to all and actively explore opportunities for studies that address the inequalities experienced by our population.	3	Proportion of patients with digital capabilities recorded (monitored by	R&D manager	VCFSE sector Local authorities EPR design team R&D
	A focus on digital inclusion, accurately recording patients' digital capabilities and access and working to optimise them by understanding, linking with, and shaping the wider system support offer.	4		Chief Information Officer	Research

GOALS	INITIATIVES	Year	MEASURES	BTH Lead	Partners
Build recognition of digital inclusion as an essential health equity requirement	Embrace opportunities presented by the implementation of an electronic patient record system to accurately capture equality data (protected characteristics, ensuring ethnicity data recorded, appropriate gender options, sexual orientation, LD, physical disabilities) and Core20PLUS criteria. Use of mandatory fields to ensure completion. Guidance on appropriate referral pathways for key groups. Patient information to explain purpose and value of providing such information.	4	equity groups) Uptake of digital services (monitored by equity groups)	Chief Information Officer	institutions /academics
	Consideration of digital inclusion in redesign of services (technology to reduce face-to-face appointments, virtual outpatients, etc.)	4	Population involvement in research (monitored by equity groups)	Chief Information Officer	
INVESTING IN OUR COMMUNITY: Work collaboratively with our partners and communities to positively impact beyond healthcare					
Make a positive difference in terms of carbon emissions and population health Take collaborative action to improve the social, economic, and environmental conditions of the Fylde Coast	Targeted and joined up action, in partnership with local authority and other stakeholders to help and support residents most at risk, from emerging situations such as the cost-of-living crisis.	2	Carbon emissions SDAT score	Public Health	
	Work to achieve the Green Plan ambition to reach net zero carbon by 2040 for direct emissions and contribute to the United Nations sustainable development goals, achieving a 70% rating in our sustainable assessment tool by 2025	4	Proportion of the workforce who live in the Fylde Coast	Public Health	Local authorities VCFSE sector Local businesses Other local Anchor institutions
	Taking our role as an Anchor institution seriously by codesigning an anchor framework and working with partners to improve the social, economic, and environmental conditions through how we employ people, buy goods and services, use our buildings and spaces, reduce our environmental impact and work in partnerships.	4	Proportion of procurement spend in the Fylde Coast	Public Health	

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Our Anchor Framework

Author: Heather Catt, Consultant in Public Health

Version: 1.0

Status:

Approved by:

Date Approved:

Contents

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What are Anchor Institutions?

Anchor institutions are large organisations rooted in and connected to their local communities. They can improve health through their influence on local social and economic conditions by adapting the way they employ people, purchase goods and services, use buildings and spaces, reduce environmental impact, and work in partnership.

What is Anchoring on the Coast?

Anchoring on the Coast set out to co-design an anchor framework for coastal communities and evaluate a model of coproduction. We embedded community researchers in the BTH research team to co-design an anchor framework for Blackpool Teaching Hospitals NHS Foundation Trust with the community, staff, and partners in other anchor institutions and the voluntary, community, faith, and social enterprise sector.

The research team, led by the Trust's Consultant in Public Health, co-designed and delivered the research between January 2022 and February 2023. Using these methods, the research team collaborated with stakeholders and communities facing multiple disadvantage across Blackpool and the Fylde Coast to understand the challenges faced in these communities and how the Trust can discharge its responsibility as an anchor institution to better the lives of those living in the Fylde Coast and working for the Trust.

The output of the project is an anchor framework that other areas wanting to reflect the needs of coastal communities can adopt.

Why was this important?

Coastal communities have different challenges to urban communities and existing frameworks on how anchor institutions can improve their social value may not be as relevant for coastal areas. Communities living on the Fylde Coast, which comprises Blackpool, Fylde and Wyre, experience wide inequalities in health and wealth. Blackpool is the most deprived local authority in England and eight of England's 10 most deprived small areas are in Blackpool. Being a coastal area adds additional dimensions to high levels of deprivation, due to longstanding challenges in the economy and employment.

The links between employment and health are well evidenced, and the role of Anchor institutions in this context is therefore important. This project led by Blackpool Teaching Hospitals NHS Foundation Trust (BTH) aims to develop a framework to allow BTH to use its economic power as an employer of 7,500 staff with turnover of £552 million to contribute to the economic, environmental, and social fabric of the Fylde Coast and reduce health inequalities.

What did we do?

Anchoring on the Coast looked at the key challenges and opportunities that BTH faces in increasing its social value as an Anchor institution. BTH's Research Team worked with four community researchers to co-produce an Anchor framework for our coastal community. These researchers with lived experience co-produced the research and took part in all elements. They designed the methods, including interview topics and communication pieces, led the focus groups, interviewed members of our community who are seldom heard from in typical consultations, took part in the analysis and refinement of statements, conducted in person consensus surveys in a community centre.

Through co-production with our community researchers, we decided to focus on how anchor institutions can help improve the socio-economic conditions of economically vulnerable groups within the Fylde Coast areas ranked as being in the 20% most deprived of all England's small areas.

This was a qualitative research study with research ethics approval and the project was adopted to the NIHR research portfolio. We engaged a wide range of stakeholders including members of the public from across our most disadvantaged communities, staff who work at the Trust, businesses, the local authority, community, and voluntary organisations, etc.

Our economically vulnerable groups
Young people who
- Have experience of being not in education, employment, or training
- Are care leavers or carers
People who are:
- Carers
- Insecurely employed
- Unemployed
- Experiencing homelessness
- Leaving prison
- Armed forces veterans
- Travellers
- From minority communities (Polish, Romanian, Hungarian and Italian)

Project set up: January to June 2022
- Recruited 4 lived experience researchers
- Co-designed the research methods
- Community researcher induction
- Research ethics submission and approval

Analysis: December 2022 to January 2023
- Thematic analysis of data from qualitative research
- Conducted a literature review of other Anchor Frameworks
- Results synthesized to 50 statements for inclusion in the Delphi survey

Qualitative research: August to November 2022:
- Ran an initial survey (67 respondents)
- Held 3 stakeholder focus groups (25 participants)
- Conducted interviews with stakeholders (27 participants) and disadvantaged communities (12 participants)
- Achieved NIHR portfolio adoption

Agreeing the Framework: January to February 2023
- Delphi survey to agree statements for inclusion in the framework (138 participants across three rounds)
- Steering Group validation of final statements

The final stage of our project was the conduct of a Delphi survey, which is a method for generating consensus. We developed statements in lay language so that we could fully engage our partner organisations and communities. We sent out our statements in three rounds to BTH staff, anchor institutions and VCFSE organisations, asking participants to vote on the statements they felt were most important. We conducted in person surveys in one of Blackpool's most deprived communities. Participants had the opportunity to suggest amendments to wording or alternative statements. Between each round we sent back the results showing how the separate groups voted. This allowed participants to reflect on their vote and the chance to change. The flow diagram for the survey is in the Appendix along with the presentation of the results by Anchor pillar.

Who delivered Anchoring on the Coast?

The community researchers were inducted to the Trust and provided with IDs, laptops, and emails. The entire research team engaged in mutual peer support through weekly research team meetings throughout the duration of the project.

Partnerships were crucial to delivery and the was enabled through monthly steering group meetings. These meetings provided guidance and support.

Members of the project team included key leaders form the local authority, VCFSE sector, the NIHR, and strategic leaders from the Trust, including the Deputy Chief Executive and a Non-Executive Director with community experience.

Our Steering Group
- Community researchers
- BTH R&D Team
- BTH Consultant in Public Health
- BTH Deputy CEO
- BTH Non-Executive Director
- Blackpool Council Director of HDRC
- Empowerment Charity CEO
- Blackpool Citizen's Advice Bureau CEO
- NIHR Research Ready Communities
- Applied Research Collaborative (ARC) North West Coast

What did Anchoring on the Coast identify?

A summary of the themes from the agreed Anchoring on the Coast statements are below. The detailed anchor framework showing the final nineteen statements for the Anchor Framework for Coastal Communities is in the Appendix.

Employment:

- Make **recruitment more local and inclusive** through supportive schemes
- Increase **apprenticeship offer for local people** to help keep them in the Fylde Coast
- Reach out across our **communities** to share information on roles and overcome barriers
- Support **fair pay and conditions of employment** for direct and contracted employees
- Make the **physical & mental health of staff** a priority

Procurement:

- Think creatively about funding to **shift spend** to **prevention, circular economy** and spending for **social value**
- **Engage local suppliers** and provide support to **join the list of suppliers.**
- Commit to **learning about the local business base**, shift spend locally and generate **local wealth.**

Environment:

- **Reduce waste:** paper, single use items and food
- Ensure **recycling of waste** including furniture and equipment
- Encourage and support **active travel** and use of **public transport** by staff and patients
- Include the **whole environmental cost** in purchasing decisions

Buildings and assets:

- Allow **local groups and organisations** to use estates at little or no cost
- **Co-locate** services in **community buildings** to create flexible and connected services
- Develop **good quality, accessible green spaces, for all to use,** particularly disadvantaged communities

Partnership Working:

- Deliver all **services in partnership** and in local communities
- Work with other anchors to **identify groups who need more support** and **test and scale** ways to provide it
- Funding and opportunity for **lived experience roles** to enable **coproduction and peer support**
- Work with other anchors to support **long-term stable VCFSE funding**

What next for Anchoring on the Coast?

This innovative and exciting project stuck to the principles of coproduction throughout. We intend to build on our experience of coproduction and take forward a new way of working in the Trust. The level of engagement from our system partners and Trust staff was humbling and we intend to sustain this momentum to deliver the actions identified in the framework.

The qualitative research identified ten statements in each pillar, which the Delphi survey prioritised to a list of nineteen. We intend to start to collaborate with our partners and community to develop detailed action plans for each of these statements. Over time we will review and will continue to work our way through the list of all fifty.

Now the Anchoring on the Coast project is complete, our next steps are:

- Return to our communities to tell them the results
- Ask the Trust Board to approve the framework for adoption
- Ask the Blackpool Place Based Partnership to approve the framework
- Work with other anchor institutions to deliver what is in the framework
- Co-design a method to continue collaborating with the community as we implement the framework
- Write and publish three research papers on the project:
    - One on the framework
    - One on the model of coproduction
    - One on our pragmatic Delphi survey method

Appendix: Our Anchor Framework

Employment
Make recruitment more local and inclusive, including changing roles to match the skills available in the community, removal of criteria requiring NHS experience, considering other qualifications (e.g. functional skills and lived experience), pre-employment schemes, training leading to guaranteed job trial, mentoring for early employment, support to transition from unemployment to employment, work placements and voluntary experience, to find or develop people with skills for specific jobs.
Work with local schools, colleges, and higher education institutions to offer apprenticeships for a range of frontline and non-frontline roles, making them available for local people, particularly young people, and those in disadvantaged communities, reducing hopelessness and helping them to stay living and working on the Fylde Coast.
Reach out across our communities (including schools and social housing providers), aiming to recruit locally and from diverse communities, share information on the different types of roles available, and support people to overcome any barriers to these jobs.
Support fair pay and conditions of employment including paying the real living wage and providing secure employment, which could be part time and flexible to support and attract people. Work with contractors to ensure their employees are offered the same fair pay and conditions.
Make the physical and mental health and wellbeing of staff a priority, provide facilities and support at work to do that, and develop a culture of care. Measure the uptake of health and wellbeing programmes by different staff groups and act on identified inequalities.

Procurement
Think creatively about the use of funding to shift spending towards services that stop people becoming ill (prevention), towards repair, reuse, and recirculation of goods like office furniture and mobility aids, and towards better and fairer use of spare money at the end of the financial year to create social value.
Encourage local suppliers to join the list of providers for anchor institutions and promote local suppliers in organisation sites. Provide sessions, tools, and information for potential local suppliers to increase their use.
Commit to learning about local businesses and where the organisation spends its budget and work towards increasing spend locally. Prefer suppliers who employ and generate wealth locally, who monitor their social, environmental, and economic benefits (social value) and work to improve them.

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Environment
Reduce paper, single use items and food waste. Replace single use items with items that can be used again (reusables) and identify ways to use food waste, such as food banks, where it is not possible to reduce.
Provide bins for recycling, in appropriate locations, programmes to support the reuse of furniture and equipment, and ensure people know what and how they can recycle.
Encourage and support active travel (e.g., walking and cycling) and promote and work with other organisations to increase access to and use of public transport (e.g., buses and trains) by staff and patients.
When purchasing, include the whole environmental cost from production, disposal, and replacements, to make decisions between, for example, disposable and reusable products and local and national or international providers.

Buildings and Assets
Allow local groups, charities, and businesses to use estates when they are not in use, at little or no cost, and advertise to raise awareness of this offer.
Create opportunities for shared access and locating services together (co-location) in community buildings to create connected and flexible that meet the needs of people living in the most disadvantaged communities.
Develop good quality, accessible green spaces to improve health and wellbeing, particularly for people who do not have access. Use these sites for community food growing to be used by anchor catering or made available for the community.

Partnership Working
Make working in partnership with other organisations the standard, particularly in preventing people from becoming ill. Consider how all services could be delivered using partnerships and in local communities through other anchors and the VCFSE sector.
Work with other anchors to identify groups in our community who need more support. Organisations should work together to understand what matters to these individuals and provide the right support. Test ways of doing this and use those that work for the whole community and all services.
Provide funding for lived (and living) experience roles to enable co-production and peer support, particularly with more vulnerable groups. This should include recruitment processes, decision making, project and service design, etc.
Work with other anchor institutions to investigate opportunities for long-term stable VCFSE funding, such as public sector funded community centres, enabling long term work to build the abilities of communities to support themselves and prevent illness. Where funding for VCFSE services stops, work together to coordinate continued support for people.

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Appendix: Delphi Flow Diagram

Round 1 (62 participants)				
50 statements (5 votes)	BTH (9)	Anchors (10)	VCFSE (8)	Community (35)

Round 2 (46 participants)				
7 statements updated and 1 added following qualitative feedback				
51 statements (5 votes)	BTH (8)	Anchors (7)	VCFSE (4)	Community (27)

Round 3 (30 participants)				
1 statement updated following qualitative feedback and 2 statements eliminated				
49 statements (3 votes)	BTH (6)	Anchors (11)	VCFSE (6)	Community (7)

Steering Group:

Consensus on 19 most important statements

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Appendix: Results of the Delphi Survey (ranking from 1 to 10 where 1 is most important)

EMPLOYMENT

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PROCUREMENT

Chart: Rank of average rank by procurement category for Round 1, Round 2, and Round 3.

Category	Round 1	Round 2	Round 3
Think creatively about the use of funding to shift spending towards services that stop people becoming ill (prevention), towards repair, reuse and recirculation of goods like office furniture and mobility aids, and towards better and fairer use of spare mo	1	1	1
Encourage local suppliers to join the list of providers for anchor institutions and promote local suppliers in organisation sites. Provide sessions, tools and information for potential local suppliers to increase their use.	3	2	2
Commit to learning about local businesses and where the organisation spends its budget and work towards increasing spend locally. Prefer suppliers who employ and generate wealth locally, who monitor their social, environmental and economic benefits (social	2	3	2
Simplify procurement processes, including ensuring payment terms do not impact the cash flow of smaller businesses, and lobby for changes to procurement frameworks to allow the preferred use of local suppliers of food and other goods.	6	6	4
Anchor institutions should group together with businesses, voluntary sector, community organisations and social enterprises and create opportunities for new business that mean things are made locally.	4	5	5
Identify a senior lead and designated board member for social value and sustainability to make sure the organisation is focused and works with other anchor organisations.	10	9	6
Monitor and make sure that contractors deliver the benefits that they said they would, and track and share good practice. Consider the use of a social value database tracker.	7	4	7
Work with other anchors to identify opportunities to procure together and hold awareness events offering local businesses the chance to speak to those procuring services or products so they understand the requirements.	9	10	8
Work with other anchors to develop a statement of what we expect our suppliers to do to increase their local social, economic and environmental benefits (social value charter). Share the charter with other smaller organisations. Use this charter as elemen	8	7	9
Increase the understanding by procurement teams and the wider organisation of social value and why and how anchor organisations should improve the social, economic and environmental conditions of the local area.	5	7	10

■ Round 1   ■ Round 2   ■ Round 3

ENVIRONMENT

BUILDINGS AND ASSETS

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NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

PARTNERSHIP WORKING

Rank of average rank

Round 1 Round 2 Round 3

Title	Digital Plan / Strategy

Meeting:	Trust Board		Purpose	Advise/Information	
				Assurance	
				Discussion	
Date:	Thursday 2nd March 2023			Decision	
Author	Mark Singleton, Chief Information Officer			Validate/Ratify	✓
Exec Sponsor if applicable	Steve Christian, Deputy CEO / Executive Director of Strategy and Transformation			Alert/Escalation	
				Confidential y/n	

Summary *(what)*	To support the delivery of the Trust Strategy a number of "enabling plans" were identified, this included Digital. Colleagues in Health Informatics started work on the plan last year, but has recently been reshaped by the Chief Information Officer over the last few weeks to better align it to the Trust Strategy. This is the first version of the Digital plan but by no means the last. As the NHS and Digital are both fast moving landscapes, we intend to do annual reviews of the strategy to ensure it remains aligned to the organisations, ICS & national needs. The Digital Plan was presented and approved by Finance and Performance Committee on Thursday 23rd February 2023.

Implications *(so what)*	No negative implications foreseen. Just positive in that it provides some focus to the team(s) and a starting point for conversations with our people and patients.
Risks	As the demand & need for digitisation continues, further investment maybe required to support the delivery of the strategy. This is being evaluated separately via a review of demand vs capacity.
Link to Organisational Strategic objectives	Our people	✓
	Our Population	✓
	Our responsibility	✓
Link to Divisional Strategic objectives	TBC	
Proposed Resolution *(What next)*	Trust Board are asked to: • Validate & ratify the current version of the Digital Strategy / Plan	

Caring · Safe · Respectful

Our Digital Strategy and Plan

2023–2026

Caring · Safe · Respectful

NHS

Blackpool Teaching Hospitals
NHS Foundation Trust

Contents

I am delighted to welcome you to the Blackpool Teaching Hospital NHS Foundation Trust's new Digital Strategy. I took on the role of Chief Clinical Information Officer in 2020 and am passionate about how we as clinicians can drive improvements in patient outcomes with the adoption of technology. Digital plays a key role in making patient care more efficient and safer. This allows us as clinicians to easily record and share information centered on the patient. It has the potential to make care more seamless and address the barriers between services and organisations. It also has a huge potential to free up clinician and staff time away from repetitive administrative tasks back into patient care. We understand from many of you, the frustrations you have with the current technology in the Trust. It is clear to me that we have a lot of scope to improve our digital maturity and to have the systems that we need to support our work, we should also keep in mind the huge opportunities that digital healthcare offers.

Delivering digital change is all of our responsibility and will require the collaboration of multiple teams and individuals. This strategy speaks to our collective vision, mission and principles for future development. It cannot be delivered by any one team in isolation, and we all have a role to play in making our Digital Strategy real.

Dr Jonas Eichhöfer
Consultant Interventional Cardiologist
Chief Clinical Information Officer

Virtually every aspect of modern life has been, and will continue to be, radically reshaped by digital and data and healthcare is no exception. Continuous advances in technology are constantly opening new possibilities for care. The growth in data and democratisation of information is driving choice and control throughout our daily lives and giving us heightened expectations around digital services.

The pandemic enabled us to expediate a level of digital transformation that might have otherwise taken several years but as we move into the recovery period it is crucial that we continue to build on this progress.

After taking another Trust on a similar journey from paper to digital and being named Europe's Best Data Powered Business, I'm looking to replicate that success at Blackpool and incredibly excited about what the future holds.

I was born in the hospital, grew up on the Fylde Coast and still have family and friends in the area, that's why I will personally strive to ensure we have the very best digital offering for Our People and Our Population.

Mark Singleton
Chief Information Officer

2. What is digital?

What do we mean by Digital?

Digital can have many different meanings and interpretations, in the Trust and in this strategy, digital includes data, technology, information and records both in structured data and scanned paper form.

How many different Digital systems does the Trust have?

The Trust has currently over 310 different IT systems, each with its own specific purpose and audience. Over the next three years we'll be looking to consolidate this number both within the organisation but also across the Integrated Care System (ICS). The number of systems however may remain static with the continuous arrival of new patient apps that support also our population.

What types of data do we have?

The Trust has a wealth of different types of data, whether that be structured data such as national diagnosis and treatment codes or unstructured data such as free-text notes, diagnostic scans or even old handwritten paper records.

Where do we get our data from?

The majority of our data is patient data which is obtained from patients during their care. This data is recorded in one of the Trust's many clinical systems. We also obtain and exchange data with other health and social care providers including GPs or support services such as pathology.

What do we do with our data?

Our biggest use of data is for the provision of health care. Good data is obtained through adhering to good clinical record keeping standards. Being able to view medical history at the time of patients' treatment is imperative for good care. Data is also utilised to measure and improve the care that we provide.

We also share limited data sets with our local and national partners for national statistics, benchmarking, and research, to name just a few uses.

More information is available via our Privacy Notices however we will be showcasing more uses via videos and webinars in the future.

Who regulates the use of our Digital?

The Trust has a number of different committees that oversee our use of Digital and Data, ultimately, we abide by the UK Data Protection Act and General Data Protection Regulations (GDPR). The Trust completes a Data Security Protection Toolkit (DSPT) assessment annually on how it meets the National Data Guardian's 10 Data Security Standards to evidence that personal information is handled correctly.

3. Feedback from engagement sessions

To support the develop this strategy, engagement sessions were held with Our People and Our Population. These sessions were well attended and have shaped the strategy in terms of ensuring that we find solutions to their existing challenges both clinical and workforce related.

The sessions highlighted that our staff want to be involved, we should get the basics right and ensure that everyone has access to the right information at the right time and in the right place.

Feedback also highlighted that people do not always feel confident with digital tools and with that in mind we must make sure that throughout the implementation of the strategy we develop the digital capability and confidence of both Our People and Our Population.

Further feedback made it clear that implementing such a plan is not a technical piece of work but involves a cultural change and an understanding that investment is needed in Our People.

Overall, the sessions confirmed that the direction of travel is supported by Our People and Our Population but that we must go on the journey together, always communicating.

4. Our mission

Our mission is:

"to enhance care through digital innovation and data-led decision making"

To do this our priorities are broken down into three key areas:

Digitise

We will transition from paper-based operations to digital systems, drastically improving the timeliness, utilisation and security of our information.

Connect

We will connect people and systems within our organisation and across the Health and Social Care system.

Inform

We will inform decision-making by providing real-time, insightful data and analytics.

5. Our priorities

	Our people We want to become an employer of choice	**Our population** We will work with patients to improve our services	**Our responsibility** We will develop new ways of working
Digitise	We will strive to ensure Our People have the right information, at the right time in the right place.	We will continue to invest in our digital services to make our care more accessible and improve patient experience and outcomes. Digitising our records will allow us to give our patients greater visibility of their data and ownership of their care.	We will continue to invest and enhance our digital and data infrastructure to ensure our clinicians have the best tools to provide the best care possible.
Connect	We will look at better ways we can connect our frontline to digital. This will include technically, improving our interoperability but more importantly culturally, how do we ensure digital is "Clinically led, Operationally Supported and Digitally Enabled".	We will use the same Electronic Patient Record (EPR) across Lancashire and South Cumbria to ensure information is accessible to the clinicians who need it and isn't duplicated or siloed.	We will grow our relationships with the frontline, industry and academic partners on research, innovation and skills and talent development.
Inform	We will help our workforce develop their digital skills, data literacy so they are capable and confident working in a digitally mature and data-led organisation.	We will work closely with our partners to understand and address Our Population's Health and any Health Inequalities using our data and analytics capability.	We will work towards having a high level of digital maturity, the pinnacle in healthcare often being seen as achieving Level 7 Healthcare Information and Management Systems Society (HIMMS) accreditation.

6. Our objectives

6.1 Our people

The next three years will probably be the most challenging the NHS has ever seen with staffing shortages, significant financial pressure and unprecedented demand for both planned and unplanned care.

Digital however will be a key enabler to addressing some of those challenges, whether it's using the same systems across the region to support patients and staff to moving freely, further automation of repetitive tasks to reduce the administrative burden from the frontline or using data science and predictive analytics to help the organisation plan its resources, these are just three of many possibilities for digital which are already in progress.

We have already scanned 50% of our legacy paper records to make them instantaneous to view; we have automated much of our staff onboarding processes using Robotic Process Automation (RPA); introduced remote working and have gained a level 2 accredited with the Service Desk Institute to name just a few recent successes.

Going forward we want all our colleagues to have the right information and tools to provide the best possible care. Information maybe via dashboards, mobile apps or embedded within the actual clinical systems. The tools could be anything from mobile devices to wearables.

In addition to information and tools, it is vital that people have the right skills to use them. To this end we are committed to supporting our colleagues through training, education and development.

We will develop a Digital Innovation Centre a modern and conducive place for our people to learn new digital skills but will also be a safe space for them to work with the Digital team and our partners on co-designing new digital solutions. We hope to create capacity in our workforce to do this by digitising and automating any manual and routine tasks.

We will continue to support our 'grow our own' workforce, working closely with our academic partners but will balance this by bringing in experience and specialist skills when and where needed.

These interventions will not just improve patient care, have a significant effect our staff's health and wellbeing and retention with the organisation but should help put Blackpool on the map for its innovation.

Fundamental to the successful delivery of this strategy and any digitisation project is the cultural and behavioural change. The transformation required is significant and will require everyone's involvement. That's why we want every digital project to be 'clinically led, operationally supported, digitally enabled'.

1 Inactive records - where the patient / records haven't been seen or updated in the last 18 months.

These are our objectives
to support **Our People** for the next three years:

Our people

To support the organisation being an employer of choice, with an empowered, diverse and engaged workforce.

Digitise
We will strive to ensure Our People have the right information, at the right time in the right place.

- We will transition from paper-based operations to digital systems, making it far quicker and easier for our workforce to record, find and view the information they need
- We will embed Digital Thinking into the organisational culture
- We will develop an innovation hub, to test, co-design and introduce new technologies that support the organisations

Connect
We will look at better ways we can connect our frontline to digital.

This will include technically, improving our interoperability but more importantly culturally, how do we ensure Digital is 'Clinically led, Operationally Supported and Digitally Enabled'

- We will ensure our digital transformation is clinically led, operational supported and digitally empowered
- We'll continue to work with our partners to ensure our digital infrastructure supports people and patients moving freely and easily across the region
- We will continue to connect the different digital systems to reduce the number of applications that have been referenced or entered into and provide more time to care

Inform
We will help our workforce develop their digital skills, data literacy so they are capable and confident working in a digitally mature and data-led organisation.

- We will continue our automation of routine processes in order to reduce the administrative burden on our workforce
- We will introduce and identify Digital Champions within the organisation to ensure the digital teams remain connected to the frontline
- We will work with and help our employees increasing their digital confidence and data literacy through education and support

6.2 Our population

Our local population of approximately 350,000 people is very diverse with significant variation in deprivation, age and life expectancy. This means that over the next three years, we will need to think differently about how we deliver care for our patients and local population.

To support this, we have already implemented video consultations and virtual wards so that patients can receive care in their own homes. We have invested in other remote clinical apps and videos to support self-care, self-check-ins and are currently looking to procure and implement a single Electronic Patient Record (EPR) across Lancashire and South Cumbria.

The EPR will provide our clinicians with more information at their fingertips to make better, more effective decisions. They will have automatic access to decision support tools, meaning their decisions will be made based on the best information available.

It will make our people and processes more efficient in order to create a smoother care journey for Our Population. It will enhance communication across clinicians and teams, reduce duplication and reduce some of the data burden by obtaining data from other systems or devices (such as wearables and RFID tags) or calculating results automatically.

Paper records will be replaced by digital records and there will be new ways of working introduced to take advantage of this digital approach. It will make a number of administrative tasks easier to manage as information will flow around the organisation more easily.

The EPR will also give us the foundation for a Patient Portal in the future to allow our patients have better visibility of their data and ownership of their health and wellbeing. This may include the ability to complete forms and assessments prior to appointments, book and re-arrange appointments, provide and view results or correspondence.

The EPR will also help us improve our data on our population's health inequalities. Using this data, we will be able to work with our partners to co-produce improvement programmes and digital solutions to help address them.

As procuring and implementing the Lancashire and South Cumbria Electronic Patient Record (EPR) is likely to take a number of years, we'll continue to develop our in-house developed Patient Record (Nexus) which currently supports our operational processes and patient care within the hospital. We'll also expand our use of other technologies such as scanning, automation and data science. We are fortunate that we have some very talented individuals within the digital team but whether we build or buy solutions depends on the specific use-case.

The North West has just been named one of three recipients of £25m to help develop a Trusted Research Environment (sometimes referred to Secure Data Environment) which will also be fundamental in understanding our populations needs. This may also present us with the opportunity to move our Data Warehouse (our Data Layer) to the Cloud in order to for us to refresh our data quicker and more frequently and easier to share with our partners.

The Data Layer will be the organisation's "single version of the truth" ensuring that data appearing on our operational dashboards is the same as the data being reported in our integrated performance report and that is shared with our external partners via our statutory submissions.

The Data Layer will also support our use of Data Science, a new profession that combines statistics, programming and the subject matter knowledge. This skill can help identify hidden insights from our data and help the organisation with some of its biggest challenges and questions, via predictive and what-if analytics, artificial intelligence and machine learning. Despite its complexity, we'll make the results easy for the frontline to consume via Data Visualisation, a technique that translates raw data into visual, easy to understand graphical forms using elements such as charts, maps and KPIs.

These are our objectives
to support **Our Population** for the next three years:

Our population

we will work with our population to co-produce high quality services with a key focus on preventitve care and reducing health inequalities.

Digitise
We will continue to develop in our digital services to make our care more accessible and improve patient experience and outcomes.

- We will work with our clinical services on where we can increase our remote care offering (such as video consultations and virtual wards)
- We will look for new ways to capture and share data to reduce the administrative burden on patients.

Connect
We will use the same Electronic Patient Record (EPR) across Lancashire and South Cumbria to ensure information is accessible to the clinicians who need it and isn't duplicated or siloed.

- We will look to procure and implement the same EPR as our acute care partners by 2025
- We'll continue to develop our in-house patient record (Nexus) until the Lancashire and South Cumbria EPR is ready

Inform
We will work closely with our partners to understand and address Our Population's Health and any health inequalities using our Data and Analytics capability.

- We will improve how we capture data needed to truly understand our population and health inequalities.
- We will work with our system partners on the development of a Secured Data Environment / Trusted Research Environment that can be used to better understand our populations needs
- We will increase our use of Data Analytics and Data Science to better inform our planning and allocation of resources

6.3 Our resonsibility

"We will work with partners to deliver high quality, financially sustainable services and reduce our carbon footprint."

6.3.1 High quality services

Moving from paper to digital systems not only brings big opportunities but also big responsibilities. Keeping our digital systems and data safe is, and will remain, our top priority. To evidence this each year the Trust must complete a Data Security Protection Toolkit to evidence its safeguards. We have achieved this for the last 17 years, however as cyber threats increase in number and sophistication, we need to ensure we continue to invest in this area.

It is our responsibility to keep all our systems up-to-date, updating, upgrading or decommissioning systems as and when required. Particular care and attention is required with our digital backbone consisting of our core Infrastructure, Patient Administration System and soon-to-be Electronic Patient Record. This backbone is critical to the organisation's operations and interfaces with so many of the Trust's other systems.

We want the very best for our patients which is why we will strive to have the best digital maturity possible. In healthcare this is often demonstrated by obtaining a Level 7 accreditation with the Healthcare Information and Management Systems Society (HIMMS). Once we've introduced our new Electronic Patient Record (EPR), we expect to achieve Level 5 but will continue to work towards a Level 7.

6.3.2 Financial sustainable services

As a public organisation, we have a responsibility to get the most value from our public funding. We already generate an income for the Trust by providing IT services to our local primary care and Integrated Care Board. We'll look to grow this service as well as collaborate with partners where possible.

Having a single EPR in Lancashire and South Cumbria is just one of many systems we are looking to consolidate across the locality. This will not only support Our People and Our Population moving freely across the region, but should also help us reduce cost.

As one of the largest employers on the Fylde Coast, we also have a responsibility to support our population and academic partners in raising the awareness of the different digital professions and to support the development of digital skills and future talent. We'll do this by providing lectures, work placements and collaborating on research and innovation.

We also want to grow our relations with our industry partners by exploring collaboration opportunities and identifying common goals which could form the basis of strategic partnerships.

6.3.3 Environmentally friendly services

To help reduce our carbon footprint we have introduced video consultations and virtual wards for patients and remote working for our staff; resulting in less travelling and carbon omissions. Our biggest milestone moving forward, will be the removal of paper when we introduce our Electronic Patient Record.

Digital's biggest impact on the environment is usually its data centres as they require significant energy to operate. We have already made significant progress to mitigate this by decommissioning our own data centres and consolidating with the local authority. We are now starting to take this to the next level by moving systems and services to the public cloud on a case-by-case basis where the benefits exceed the additional financial investment.

These are our objectives
to support **Our Responsibility** for the next three years:

Our responsibility

We will work with partners to deliver high quality, financially sustainable services and reduce our carbon footprint.

Digitise

We will continue to invest and enhance our digital infrastructure to ensure our clinicians have the best tools to provide the best possible care.

- We will continue to increase our remote care and working where possible to further reduce the organisations and our patients carbon footprint
- We will work with our clinical and operation colleagues to co-design solutions
- We will improve our governance to ensure it keeps both the organisation and its patients safe

Connect

We will grow our relationships with the frontline, industry and academic partners on research, innovation and skills and talent development.

- We will convert our relationships with our suppliers to strategic partnerships in order to increase our colloboration and co-design systems and services
- We will continue to work with our healthcare partners on consolidating the number of different digital systems being used across the region
- We will work with academic partners on innovation, research, training, career promotion and student placements to help develop our future workforce

Inform

We will work towards having a high level of digital maturity, the pinnacle in healthcare often being seen as achieving Level 7 Healthcare Information and Management Systems Society (HIMMS) accreditation.

- We will continue to invest in our cyber security to ensure we have the highest levels of protection for our data
- We will undertake annual Digital Maturity assessments to help shape and track our Digital Maturity journey

The delivery of our strategy will require a significant number of projects and programmes of work over the next three years. As the NHS and digital are both fast paced environments, planning for what we will be working on in three year's time might be difficult. Therefore, instead we will work closely with the organisation to understand its needs and priorities from a digital point of view on an annual basis and as part of its business planning.

These priorities should still align to both the Trust's Strategy and Digital Plan goals. However, the timing and ordering of the priorities will be determined by the organisation, and this adheres to our "Clinically Led, Operationally Supported and Digitally Enabled" mantra and ethos.

Below is a high-level plan for what we will be working on over the next 12 months:

Project	2022/23 Q4	2022/23 Q1	Q2	Q3	Q4	Q1	2024/25 Q2	Q3	Q4	Q1	2025/26 Q2	Q3	Q4
Implementation of the new PAS													
Implementation of the L&SC EPR	Evaluation & Procurement					Design | Test | Training | Go-Live							
Implementation of the new LIMS													
Development of Nexus Patent Record													
Implementation of the new PACS/RIS													
Upgrade to A&E system (Maxims)													
Increased internet connectivity													
Implementation of EPMS													
Implementation of EPMA													
Implementation of Virtual Wards													

Please note:
The Digital Programme is reviewed and prioritised on an annual basis and is therefore subject to change.
The priorities ofr 2024/25 and 2025/26 will be finalised in Q4 of the prior year.
Project durations are indicative and are not finalised until after the project discovery phase.

8. Digital governance

Delivery of the Digital Strategy requires strong and effective governance and leadership from the Trust Board through the entire organisation. Whilst the Trust Board is the overall accountable body for the Trust Strategy, the Digital Committee is responsible for the delivery of the Digital Strategy.

The figure on the following page shows how the Digital Committee relates to the Trust Board and the Governance structure which sits within this.

As the strategy is implemented various programme and project groups will need to be put into place and it is important that these fit within the overall governance structure.

The Trust also needs to make sure that the governance also fits with that of the Integrated Care System.

Digital Division

Board

- Board of Directors

Committee

- Finance & Performance Committee
- Digital Committee
- Risk Assurance Meeting

Division

- Divisional Governance
- Information Assurance Group
- Digital Divisional Assurance Group
- Digital Programme Assurance Group
- Digital Divisional Risk Assurance Group
- Better Information Meetings
- Project & Programme Boards
- Digital Cyber Risk Assurance Group

Directorate

- Business Intelligence
- ICT
- IG & Records
- Digital Programme
- Digital Education
- Digital Health

Departments and People

Key:
- Trust Governance
- Digital Division
- Other Divisions

9. Some of our successes to date

We introduced video consultations to support local care homes in 2016 and then extended to patients during the pandemic in May 2020.

Patients with Covid, Acute Respiratory and Cardiac conditions have been supported with remote monitoring from their own residence since 2020, we often refer to these as 'Virtual Wards'.

The Trust has developed its own Patient Record called Nexus which currently supports our operational processes and patient care within the hospital.

A specialist Electronic Patient Record was introduced in Maternity in June 2022.

£1.6m of external funding was secured to scan our paper case notes into the Trusts Electronic Documentation Management System (EDMS).

We automated the sharing of data and records with our healthcare partners in 2018.

We have collaborated with NHS England on the development on the NHS Digital Staff Passport, which has won numerous regional and national awards.

We retained Cyber Essentials accreditation in February 2022.

Since 2017, 61,761 staff have undertaken e-learning courses.

10. Strategic context

This Digital Strategy has been developed to align to the following strategic context:

10.1 NHS England

The NHS Long Term Plan sets out how the NHS will move to new service models, joining up care so that it can be provided at the right time and in the optimal care setting. The Long Term Plan can only be realised by providing widespread access to services using digital technologies. Digitally enabled care features prominently in The Long Term Plan and describes a future where patients and carers can better manage their health and condition online.

Clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support without the current administrative burden. The Plan points to predictive techniques to support local organisations and Integrated Care Systems to plan and optimise care for their populations. The practical priorities point to straightforward, secure and easily accessible technologies where data is captured as a by-product of care that empower clinicians and patients alike. The Long Term Plan commits to the NHS offering a 'digital first' option where patients want or need it and commits to making digital services interoperable and patient centred, which they have a right to expect.

The What Good Looks Like (WGLL) programme draws on local learning. It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. "This will improve the outcomes, experience and safety of our citizens". WGLL is included in both the ICS Design framework and the NHS Operational Planning and Contracting Guidance and has been used in the preparation of this enabling plan. It is predominantly focused at an ICS level and emphasises how clinical care pathways are supported by digital technologies across organisational boundaries; collaboration is key to the successful delivery of such initiatives and this digital strategy.

The NHS England National Director of Transformation has also announced a list of high priority initiatives that have a large dependency on digital transformation. These include increased uptake of the NHS App, Home Hospitals/Virtual Wards, Pathway redesign using digital tools and increasing diagnostic capacity through improved decision support for imaging. One of the main points in these priorities is the "managed convergence" of systems at an ICS level which means that the Trust must collaborate across the Integrated Care System on the most effective implementation of solutions such as the Electronic Patient Record (EPR). This work has already begun with Blackpool Teaching Hospitals taking a leading role on the EPR implementation across the ICS.

10.2 Department of Health and Social Care

As well as the Long Term Plan committing to full digitisation there has also been a recent announcement by the Secretary of State for health whereby the intention is to focus on personalised care, levelling up and harnessing the power of technology. The statement within the Secretary of State's speech that all Trusts must have an Electronic Patient Record (EPR) by December 2023, is of significant relevance to the Trust. This is in line with the Trust's strategic objective under 'New Ways of Working' to implement an EPR and is the corner stone of this Digital Strategy. To aid in this ambition, NHS England and Improvement has a digitising the frontline initiative with support and resources which Blackpool Teaching Hospitals is fully engaged with.

Data Saves Lives further emphasises the power of data in a modern health and care system and states that "putting this strategy into action will deliver better treatment for patients, better health results for people who need care and support, and better decision making, research, and support for our colleagues on the front line."

The Plan for Digital Health and Social Care sets out the Government's vision for digitally transformed health and care services. It is aimed at health and social care leaders across the system, and industry partners to help them plan for the future. It makes clear the priorities for digital transformation and begins to set out the support that will be available to local systems to enable the changes that are needed.

Other publications such as Joining up care for People, places and populations also have a dependency on digital and quality information.

As can be seen there are many initiatives which have to be considered in the context of this digital strategy. The Trust will continue to review the external landscape and ensure that this plan remains relevant in that context through constant refinement.

10.3 Health Infomatics Career Pathways Report (HEE)

The key to a successful digital enabling plan is to ensure digital transformation and employee engagement work together with our staff, citizens and patients so that they do not feel alienated or overwhelmed by complex, disparate systems that don't talk to each other. Instead, we want our workforce to feel empowered to work efficiently, creatively and productively with the help of technology at their fingertips. We will work in partnership with our clinical colleagues to ensure we have strong leadership and management, user engagement, information governance, resourcing and skills in place.

Digital literacy is defined as, "capabilities for living, learning, working, participating and thriving in a digital society". This is a wide area but is fundamental to delivering safe, effective and person-centred care. Best practice in developing the digital skills of our workforce involves more than simply producing or identifying training content, rather it requires a holistic approach to personal and organisational learning which creates an enabling environment for relevant and effective digital skills development across our communities. Therefore, we will develop education programmes which will ensure we get the right knowledge to the right people at the right time, ensuring Our People come first and that they feel comfortable, confident and are better equippedto work in a digital environment. We will identify skills gaps using HEE digital literacy model and will map digital programmes to the needs of the workforce.

"The focus on digital, technology and data within healthcare continues to rise. More than ever, there is a significant need to ensure we have a workforce who are both skilled and knowledgeable alongside creating the conditions to ensure individuals can put those skills and knowledge to good use and have the confidence they can progress with a career should they wish to do so. Without a better understanding of this, the NHS will continue to face recruitment and retention problems in this area, and individuals risk continuing to languish in unhelpful roles not putting their skills to good use."

Building the right workforce for a digitally enabled future

10.4 Local context

For local context, Blackpool Teaching Hospitals is part of the newly formed Integrated Care System (ICS) and plays a leading role in many provider collaborative initiatives including those within the digital agenda.

The ICS has developed a Digital Transformation and Investment Plan (DTIP) with the following Strategic Pillars:

- **Support the frontline**
- **Manage the system more effectively**
- **Integrate services**
- **Create the future, and**
- **Empower the person**

The DTIP describes a 'top ten' set of initiatives which are: shared care record; diagnostics; electronic patient record with convergence; cyber security; common systems and infrastructure under the "Northern Star"; remote monitoring and virtual wards; population health management; regulated care and digitising social care; elective recovery; process automation.

The Trust is collaborating with its partners and is also leading on some of these initiatives such as the procurement of a single Electronic Patient Record. The Trust has recently implemented the ICS wide maternity system and work continues on consolidating the region's diagnostics systems.

This strategy recognises that the Trust is part of the ICS collaborative and enables us to work to those goals in line with working towards the aims of the Trust Strategy.

11. Glossary

Abbreviation	Name	Description
	Automation	Also known as RPA, is the process of using digital to repeat set tasks.
BI	Business Intelligence	A technology-driven process for analysing data and delivering actionable insights to support decision making.
CCIO	Chief Clinical Information Officer	The CCIO provides clinical leadership and input on digital projects. Their presence within an organisation helps ensure that digital projects are designed with users firmly in mind.
CDS	Commissioning Data Set	Datasets we share with our national and regional partners for 'secondary uses' such as management information, payment, national statistics/reporting and research.
CIO	Chief Information Officer	The CIO oversee the people, processes and technologies within the Digital division to ensure they deliver outcomes that support the Trusts goals.
COW	Computer on Wheels	Computer on wheels which are in the clinical areas and can be easily moved and used by clinicians to access the Electronic Patient Record.
	Cloud	Cloud computing is the on-demand availability of computer system resources, such as data storage and computing power without organisation to procure and maintain their own physical servers.
CSO	Clinical Safety Officer	A current, qualified clinician responsible for assessing and overseeing the clinical safety of information assets and ensuring the systems and suppliers meet the required safety standards.
	Data Science	combines maths and statistics, programming, advanced analytics, artificial intelligence (AI), and machine learning with specific subject matter expertise to uncover actionable insights hidden in an organisation's data. These insights can be used to guide decision making and strategic planning.
	Data Visualisation	Data visualisation is the process of translating raw data into visual forms, such as KPIs, charts, maps to make data easier for people to understand.
DW	Data Warehouse	DWs are central repositories of integrated data from one or more disparate sources.
E OBS	Electronic Clinical Observations	A system that allows our clinicians to digitally record and monitor observations about a patient's health

Abbreviation	Name	Description
EDMS	Electronic Document Management System	A digital repository for saving, centralising and organising documentation
EPMA	Electronic Prescribing and Medicines Administration	EPMA systems allow doctors to prescribe, nurses to. administer medications, pharmacists to clinically review and reconcile. medications and pharmacy technicians to input drug histories and order medications
EPR	Electronic Patient Record	A system for recording clinical information, to make it easily available for use by doctors, nurses, allied healthcare professionals and patients.
ERS	Electronic Referral Service	NHS e-Referral Service (e-RS) provides an easy way for patients to choose their first hospital or clinic appointment. Bookings can be made online, using the telephone, or directly in the GP surgery at the time of referral.
ESR	Electronic Staff Record	A payroll system commissioned by the Department of Health and Social Care that NHS organisations are entitled to use free of charge. ESR is currently used by 99% of NHS Trusts and manages the payroll for over one million NHS employees.
IAA	Information Asset Administrator	Each information system also has an IAA to provide day-to-day administration and ensure the system and its information remain aligned to Trust policies and external regulation. The IAA reports to the IAO.
IAO	Information Asset Owner	Each information asset has an IAO, the IAO is a senior role responsible for ensuring their information asset(s) is managed appropriately and aligned to the Trust policies. An IAO is accountable to the Senior Information Risk Owner (SIRO).
ICB	Integrated Care Board	Each ICS has an integrated care board, which is a statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area.
ICS	Integrated Care System	Partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.
	Interoperability	Is the ability of two or more components or systems to exchange information and to use the information that has been exchanged.

Abbreviation	Name	Description
LIMS	Laboratory Information Management System	An IT system to manage samples and its associated data. A LIMS can automate workflows, integrate instruments, and manage samples and associated information.
MDT	Multi-Disciplinary Team	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users.
NPR	Nexus Patient Record	An IT system developed in-house to support patient flow and care with functionality such as visibility of our inpatient capacity and harmonising different clinical systems.
PAS	Patient Administration System	A key component of the hospital's digital backbone, an IT system that captures administrative and demographic data on the users of Trust services.
RFID	Radio Frequency Identification	Allow users to automatically and uniquely identify and track assets (such as medical equipment) using wireless radio frequency waves.
RPA	Robotic Process Automation	Software to automate routine tasks and processes to ultimately emulate a human interaction with a computer.
RTT	Referral to Treatment	An NHS Constitution standard that measures the time from a referral to treatment in an acute setting.
SRE	Secure Research Environment	Also known as a TRE, provides approved researchers with access to linked, de-identified data to quickly answer research questions.
TRE	Trusted Research Environment	Also known as an SRE, provides approved researchers with access to linked, de-identified data to quickly answer research questions.
	Virtual Ward	Virtual wards allow patients (with frailty or acute respiratory infections for example) receive the care they need at home (or care home) safely and conveniently, rather than being in hospital.
	Wearable	Devices that patients attach to bodies to collect health and fitness data. Examples include smart watches, fitness trackers, blood pressure monitors and biosensors/pulse oximeters.

Title	Audit Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	2nd March 2023

Author	Esther Steel, Director of Corporate Governance				
Exec Sponsor	To be presented by the Audit Committee Chair				
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No				

Summary *(what)*	To update the Board on the alerts, assurance and advise content, discussed at the Audit Committee on Wednesday 8th February 2023 Committee members noted the progress made to close outstanding actions and agreed to ensure all others closed by the end of the financial year.

Previously considered by	

Implications *(so what)*	The Audit Committee plays a key role in providing oversight of the assurance provided to the Board

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications considered	No EDI issues noted

Proposed Resolution *(What next)*	To note the F&P Committee's Escalation Report

Committee/Group Chair's Report

![NHS Blackpool Teaching Hospitals NHS Foundation Trust logo]

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	8 February 2023	Date of next meeting:	
Chair:	F Eccleston	Parent Committee:	Board of Directors

Introduction
Quorate meeting held on Teams with attendance from internal and external auditors with good engagement from all Committee members. The meeting was observed by two of our Governors

Alert		
What	**So What**	**What Next**
Internal Audit Follow up Report MIAA presented an update on the progress made to address recommendations made in previous Audit reports. Following discussion at the December meeting a formal process had been established to ensure evidence-based closure of medium, high and critical risk recommendations	Committee members noted the progress made with 16 recommendations closed since the previous meeting but expressed concern that nine recommendations from KPMG reviews undertaken in 2020/21	Committee members mandated action to close the remaining nine historic KPMG recommendations
NCEPOD and TARN briefing Further to discussion within the Clinical Governance Committee and the Quality Assurance Committee, Committee members were alerted to an issue in relation to compliance with submission of data to the Trauma Research Network (TARN) and the National Confidential Enquiries into Patient Outcome and Death (NCEPOD)	The Trust was alerted to a concern in relation to the submission of data to TARN and NCEPOD. Actions are in place to address the backlog and upload the required data.	Going forward the Committee will play an active role in the oversight of Clinical Audit

Assurance		
What	**So What**	**What Next**
Internal Audit Progress Report MIAA presented their regular update providing a summary of their work against the internal audit plan for the period 29 November – 31 January 2023. The finalised were included in detail within the agenda and are reported below:	Committee members noted the progress against the plan and assured members that they were on track to provide the Head of Internal Audit opinion	Update noted – see individual report lines for detail on the completed reports

The following reviews are at draft report stage: • Consultant Job Plans • ESR/Payroll • Freedom to Speak Up • Mental Capacity Act: Consent & Restraint		
Mobile Working and Devices review – final report This was reported as a substantial assurance report with 3 medium and 1 low risk recommendation for improvement. Overall, the review identified that there was a robust, pro-active and implemented system of control in place over the management and deployment of mobile devices. However some improvements could be made in respect of the risk management reporting of mobile device compliance,		
Two Hour Community Response Data Quality The report was commissioned after issues with reported data were identified resulting in under reporting of performance. The Trust currently measures response times for services employed by the Community rapid response team This was reported as a moderate assurance report with assurance that the Trust's position on full data integration is reasonable	The Executive Director of Integrated Care attended to provide a management response to the 4 recommendations identified in the report (1 high risk, 2 medium risk and 1 low risk) The recommendations in the report have been accepted and a follow up exercise will be undertaken to evaluate progress made. The auditors highlighted the complexity of the service model and the subjectivity of the data	Work is ongoing with the teams to provide a wider assurance on data collection and reporting. Report requested in June to provide an understanding of systems and weaknesses
Medical Staff Recruitment and Retention MIAA undertook an audit to provide assurance on the systems and controls in place in respect of recruitment and retention of permanent and fixed term medical staff. While it was found that overall the report provided moderate assurance that the Trust has an appropriate	The Executive Medical Director attended to discuss the actions agreed in response to the recommendations in the report. The Committee noted the action plan and discussed the challenges in relation to recruitment and retention – this will be the subject of a focused review at the February Workforce Assurance Committee	An action plan has been developed based on the management response within the report – this will be overseen through the Workforce Operational Group and reported to the Workforce Assurance Committee

system of control there were a number of recommendations for improvements to the controls and the operation of the controls (5 recommendations of which 1 was high risk and 4 medium)		
Compliance with NHS Code of Governance The report provided an overview of the Trust's compliance with the 2014 Code of Governance. Although it is the intent of the Trust to be fully compliant a number of areas for further work were highlighted as below: B.5.5 - Timely information noting that concerns have been expressed by NEDs that papers for meetings have been delayed or incomplete B.5.6 and E.1.6 - Governor engagement with members and the public noted that this was limited because of the Covid-19 pandemic with plans in place to refresh in 2023/24 B.6.2 - Recommendation for an external review every three years The last independent external review was undertaken in 2021 – an external review should be commissioned in 2023/24 B.6.5 - Governors' collective review of performance Not formally undertaken in recent years	Committee members discussed the review with a focus on the areas requiring further focus and the proposed actions. The Governor observers were invited to comment on the elements in relation to the Council of Governors, both agreed with the assessment and proposed actions. The two governors agreed that they would welcome a Committee members discussed the provision of timely papers for meetings and the need to support staff to provide clear and concise timely papers. A new Code has been published and comes into effect on 1 April	The Committee approved the proposed statement for inclusion in the Annual Report. A report on compliance with the new code will be provided for discussion in September 2023.
Register of Interests We have a duty to ensure that our business is conducted to the highest standard of integrity with our finite resources used in the best interests of our patients. On appointment/election all Board members, staff and governors are required to declare any potential conflict of interest and during the course of	While there is a high level of confidence that the registers are correct for Board members and Governors, an initial review of the interests held for all staff show that further work is required to ensure these are an accurate reflection of actual and potential conflicts of interest	The registers are published on our website and are available for inspection if required. A proactive review of compliance with the declaration process will be conducted in Q1 and Q2 of 2023/24 – this will include cross checking with companies house data and declarations made through the British Association of Pharmaceutical Industries (BAPI)

employment any changes to these or any additional conflict should be declared within 28 days.

Advise		
What	**So What**	**What Next**
Internal Audit Draft plan The MIAA internal audit lead presented the proposed internal audit plan for 2023/24. The plan has been drafted on a risk assessed base and will remain flexible to allow for responses to any emerging challenges	Committee members discussed the plan in the context of the current financial challenge and the recent financial governance review with agreement that the Trust would benefit from further assurance on the ambitious QEP programme required for 2023/24	MIAA will continue to engage actively with Executive and Non-executive Board members to develop and deliver a plan that remains focused and challenging and adds value Final version of the plan to be presented in April 2023 Committee members to take a proactive role in reviewing the scope of audits
External Audit Plan Deloitte provided the committee with an overview of the audit process and risks identified for the financial statement audit. Materiality levels are unchanged from last year and a full revaluation of property is planned for this year therefore.	Committee members discussed the implications of IFRS 16 changes and the key risks identified in relation to the audit noting that significant audit risks had been identified in relation to valuations, completeness of expenditure and management override of controls	Paper on IFRS leases and assumptions to the April meeting
Going Concern Statement The Committee reviewed the proposed Going Concern Statement noting that it had been prepared in accordance with the guidance/template	All entities are required to provide assurance that the financial statements have been prepared on a going concern basis.	The Committee approved the statement
Accounting Policies NHS England (NHSE) directs that the financial statements of all Foundation Trusts must meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), and therefore the requirements of HM Treasury's Financial Reporting Manual (FReM).	The main change for 2022/23 is the adoption of IFRS 16 – the implications of this in regard to leases have been considered and will be included in a paper to the next meeting	The Committee approved the draft accounting policies underpinning the preparation of the 2022/23 annual accounts

As part of the Annual Accounts process each year the Trust's accounting policies are updated and presented to the Audit Committee.		
Modern Slavery Statement It is a requirement under section 54 of the Modern Slavery Act 2015, that all organisations with a turnover of £36 million publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. The statement should be made on an annual basis, it must be approved by the Board and published on the Trust website – the Trust should also consider publishing on the modern slavery statement register	Committee members noted the content of the statement and the implications with regard to the local population.	The Committee approved the Annual Modern Slavery Statement – the proposed statement is appended to this report for approval by the Board.
Annual Report Plan Although the Annual Reporting Manual has not yet been published the preparatory work is underway for the publication of the Annual Report for 2022/23		The draft Annual Report will be shared with Committee members in due course.
Counter Fraud report The Counter Fraud Manager provided a summary update on recent Counter Fraud activity	The Committee discussed the detail within the report, noting the progress on investigations leading to the recover or avoidance of monies otherwise lost to the Trust. Committee members agreed the need for more understanding in relation to the risks relating to agency/timesheet fraud	Working group to be established to ensure robust controls in relation to the use of temporary workforce
Committee Workplan The workplan has been updated with reference to the HFMA handbook to ensure that all elements within the Committee's scope are covered	The Committee reviewed the workplan noting that it is an iterative process that will remain flexible to accommodate new and emerging issues during the course of the year	Draft workplan approved

Committee/Group Chair's Report

The following reports were received but not discussed in detail:

Losses and Special Payments

Waivers

Committee/Group Chair's Report

Appendix 1

Title	Modern Slavery Statement					

Meeting:	Audit Committee
Date:	8th February 2023

Author	Esther Steel					
Exec Sponsor	Esther Steel					
Purpose	Assurance		Discussion		Decision	✓
Confidential y/n	n					

Summary *(what)*	It is a requirement under section 54 of the Modern Slavery Act 2015, that all organisations with a turnover of £36 million publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains.
	The statement should be made on an annual basis, it must be approved by the Board and published on our website – the Trust should also consider publishing on the modern slavery statement register
	The attached statement sets out actions taken by Blackpool Teaching Hospitals NHS Foundation Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls in accordance with the Modern Slavery Act 2015.

Previously considered by	Trust Safeguarding lead

Implications *(so what)*	Failure to publish a statement would be considered a regulatory breach

Link to strategic objectives	Our People	✓
	Our Place	✓
	Our Responsibility	✓

EDI implications considered	The Trust must play its part in eradicating modern slavery

Proposed Resolution *(What next)*	Audit Committee members are asked to review the statement and recommend approval by the Board of Directors.

Modern Slavery Statement

Blackpool Teaching Hospitals NHS Foundation Trust is a provider of local health care services for the population of Blackpool and Fylde and Wyre, plus the tertiary centre for Lancashire Cardiac Services. The following statement sets out our commitment to, and efforts in, preventing slavery and human trafficking practices.

We fully support the Government's objectives to eradicate modern slavery and human trafficking and recognise the significant role the NHS plays in both combatting it and supporting victims. As the provider of health care services across the Fylde Coast, we believe there is no room in our society for modern slavery and human trafficking, we have a zero tolerance for modern slavery and breaches in human rights and will ensure this is built into the processes and business practices that we, our partners and our suppliers use. We are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

We are committed to raising awareness and providing training to ensure front line practitioners are aware of and able to respond to incidents of modern slavery.

Our Safeguarding Children and Safeguarding Adults policies incorporate sections on modern slavery. Modern slavery is referenced within the Safeguarding Children and Adult mandatory training from Levels 1-3, which applies to all staff employed by the Trust. The Trust has a Safeguarding Training Strategy which reflects the national Strategy.

Our staff must:

- Undertake Safeguarding training appropriate to their roles and responsibilities.

- Work with the Procurement Department when looking to work with new suppliers so appropriate checks relating to modern slavery can be undertaken.

- Follow the Local Safeguarding Boards Multi-Agency policies and procedures.

- Respond and work collaboratively to support the health of survivors of modern slavery.

Safeguarding is every staff member's responsibility including keeping present and potential future victims of modern slavery and human trafficking safe. All staff can access support in this regard by contacting the Trusts Safeguarding Teams and Professionals.

Our Commitment to Prevent Slavery and Human Trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business activity and in so far as is possible to holding our suppliers to account to do likewise.

Our Approach

Our overall approach will be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment and we will:

- Review our approach and publish this annual statement outlining the steps we are taking to tackle modern slavery.

- Continue to ensure that our recruitment processes are highly mature, requiring practices that adhere to safe recruitment principles. This includes strict requirements in respect of identity checks, work permits and criminal records. These practices will extend to any employment agencies used by the Trust.

- Our pay structure is derived from national collective agreements and is based on equal pay principles with rates of pay that are nationally determined. The Workforce Assurance Committee will hold the organisation to account in adhering to these standards and practices.

- ▪ Regular Freedom to Speak Up reports are provided to the Workforce Assurance Committee these include an overview of the concerns raised by staff and the category they fall into.

- ▪ Ensure our procurement processes provide assurance that organisations are taking relevant steps to adhere to the standards.

The Trust's Whistleblowing Policy, which applies to all employees, consultants, contractors and agency staff who work for the Trust is accessible via the Trust's intranet site. Alternatively, concerns can be raised with the Trust's Freedom to Speak Up Guardian.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending March 2023.

Confirmation

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Signed

On behalf of the Board of Directors
Blackpool Teaching Hospitals NHS Foundation Trust

Date

Title	New Hospitals Programme Quarter 3 Board Report		

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	2 March 2023		Discussion	
Author	Rebecca Malin, Programme Director Jerry Hawker, Programme SRO		Decision	
Exec Sponsor	Janet Barnsley, Executive Director of Integrated Care		Confidential y/n	N

Summary *(what)*	The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 3 period: October to December 2022. This quarterly report is presented to the following Boards: • University Hospitals of Morecambe Bay NHS Foundation Trust • Lancashire Teaching Hospitals NHS Foundation Trust • East Lancashire Hospitals NHS Trust • Blackpool Teaching Hospitals NHS Foundation Trust • Provider Collaborative

Implications *(so what)*	The report includes the progress against plan for October to December 2022, in particular providing an update on the technical analysis of the shortlisted options and the viability of potential new sites in terms of equality impact and travel and transport analysis. In addition, the feedback from stakeholders on the recommended options reported to Trust Boards in September and October 2022. It outlines next steps with the national New Hospital Programme business case and capital funding allocation.

Link to Strategic objectives		

Proposed Resolution *(What next)*	It is recommended the Board: • Note the progress undertaken in Quarter 3. • Note the activities planned for the next period.

<h1>NEW HOSPITALS PROGRAMME Q3 BOARD REPORT</h1>

1. Introduction

1.1 This report is the 2022/23 Quarter 3 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of Cohort 4 of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the ['Improving NHS infrastructure' website](#).

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

3 National New Hospital Programme

3.1 **Programme business case and early / enabling works** – the national programme business case has been presented to HM Treasury in December 2022. The outcome of this will determine the capital allocation and phasing for the L&SC NHP. The team are expecting confirmation of the outcome in Q4 and will then plan accordingly. The outcome of the national business case will also include the status of the L&SC bid for early works / investment at Furness General Hospital to improve the Critical Care Unit and Emergency Department.

3.2 **National guidance** – as part of cohort 4, L&SC NHP is expected to fully adopt the national NHP guidance including standard hospital design (Hospital 2.0), digital, demand and capacity modelling and the associated underpinning assumptions. Members of the NHP team and wider system colleagues have been proactively supporting the national team on developing some key components of this guidance. A briefing from the national team on the status and next steps is anticipated in Q4.

4 Progress against plan (for the period October to December 2022)

4.1 **Shortlist of options** – the focus of Quarter 3 has been on potential new site options for both Royal Lancaster Infirmary (RLI) and Royal Preston Hospital (RPH), which the Trust Boards of Directors approved at their meetings in September (UHMBT) and October (LTHTr) 2022.

4.2 The programme has made positive steps in understanding further technical and design details on potential new sites. Such analysis has included a review of the traffic impact in / around each new site, geographical surveys, and discussions with local authority planning and highways teams. All of this provides input to the deliverability of each site i.e., could a new hospital facility be accommodated on the site with sufficient supporting infrastructure.

4.3 Subsequently, the team continues to appraise potential sites against the agreed technical criteria as further details emerge. This will continue up to a future shortlisting of sites ahead of any business case submission and public consultation (if required).

4.4 In addition, several new sites have been identified to the team throughout Q3, these have been appraised against the pass / fail criteria and reported to the Strategic Oversight Group (SOG) in December 2022.

4.5 **Equality impact –** significant work has been undertaken to ensure equality, diversity and integration are at the heart of each option. During Quarter 3, the Communications and Engagement Oversight Group received a demographic insight report, outlining an overview of the demographics of L&SC and intelligence relating to protected characteristic groups, health inclusion groups and groups who may be more likely to experience health inequalities. Work has started on the equality and health inequalities impact of the communications and engagement strategy, model of care, digital strategy, and site selection and appraisal. This important work will continue throughout the process to enable the Programme to consider the likely impact of new hospital facilities on different groups of people.

4.6 **Travel and transport analysis for potential new sites –** another really important component part of any future business case has been completed this quarter. The travel and transport analysis seeks to understand travel through an equality-related lens and explores potential considerations for the Programme. The report considers accessibility to the potential new sites for patients, staff and the public. An update has been provided to the SOG in December 2022 and this work will feed into the future shortlisting of sites.

5   Public, patient and workforce communications and engagement

5.1 At the end of Quarter 2, the team launched a [milestone update announcing recommendations for preferred options and alternative options for Royal Lancaster Infirmary and Royal Preston Hospital](). Subsequently, a new open-access online survey was issued,

which captured 604 views on the proposals and on what was most important to people from new hospital facilities. The feedback positively supported the recommended options and explored the acceptable proximity to existing sites. Participants reported in even stronger proportions than at the shortlist survey that the key challenges they face in accessing existing hospital facilities revolve around the location of hospital sites, public transport links and parking. As in the shortlist survey, respondents felt that the most important considerations to ensure that future hospital facilities meet their needs were hospital sites being in accessible locations, futureproofing to meet future (not just current) healthcare needs and adequate car parking.

5.2 Several new blogs have been published on the New Hospitals Programme website during Quarter 3 and shared through NHP and partner external and internal communications channels. This includes two blogs by the ICB director of strategic estates, infrastructure and sustainability. The first [blog focuses on the improvements needed at RLI and RPH](), exploring the condition of the existing estate, associated backlog maintenance, the impact on the availability and suitability of space for clinical and operational activity. The second [blog explores the requirement for the NHS to achieve carbon neutrality by 2040]() and the targets set for hospitals.

5.3 The Medical Director at UHMBT has contributed a [blog regarding future plans for Westmorland General Hospital]().

5.4 The NHP Operational Lead for LTHTr has issued a [blog discussing the major benefits that new hospital facilities will bring to the care of patients](), such as co-locating clinical services next to each other in the most productive way, improved infrastructure around the hospitals, including car parking and access routes, the latest technology and equipment, and right environment for caring for patients.

6 Stakeholder management

6.1 Stakeholder engagement has continued, including webinar sessions for NHS staff during October and November 2022. The team hosted six sessions and key topics of discussion were the provision of car parking, the impact on Chorley and South Ribble Hospital, the impact on Westmorland General Hospital and engagement with stakeholders. Drop-in engagement sessions have also been held at Royal Preston Hospital and Chorley and South Ribble Hospital, following on from engagement at UHMBT sites earlier in the year.

6.2 Meetings have been held with a number of local MPs during Q3: Mark Menzies MP, Cat Smith MP and David Morris MP, as part of a rolling programme of engagement.

6.3   Furthermore, the team have continued their collaboration with Lancaster University to co-produce a report on the engagement of underrepresented people; identifying good practice, developing a framework for future engagement and providing evidence to inform the NHP's engagement practice. The findings of this will be reported in Q4 and will benefit not only the NHP but many other engagement initiatives across L&SC.

7   Programme governance and risk

7.1   During Quarter 3, the Programme has strengthen the approach to risk, aligning with the programme objectives and revising the risk appetite, as well as continuing to manage dependencies within the integrated care system and national team.

8   Next period – Q4 2022/23

8.1   Further work will be undertaken in Quarter 4 to continue to review and strengthen all aspects of the options pending the outcome of the national Programme Business Case. Upon this announcement the team will work with the national team to understand the outcome of the business case and what this means for new hospital facilities in L&SC.

9   Conclusion

9.1   This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 3 2022/23.

10   Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Quarter 3.
- Note the activities planned for the next period.

Rebecca Malin   **Jerry Hawker**
Programme Director   **Programme Senior Responsible**
January 2023   **Officer**