Board of Directors in Public Meeting (Part 1)
5th July 2023
09.30 – 11.30
Boardroom

Blackpool Teaching Hospitals
NHS Foundation Trust

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	Chair's Update	Chair	Verbal	To receive an update
	7	Chief Executive's Report	Chief Executive	Report ✓	To receive an update
	8	Anti-Racist Programme	Director of People and Culture	Report ✓	To discuss
Quality					
10.00	9	Quality Assurance Committee Escalation Report	Chair of Quality Assurance Committee	Report ✓	To note for assurance
	10	Quality Integrated Performance Report	Medical Director / Director of Nursing	Report ✓	To note
	11	Quality Accounts	Director of Nursing	Report ✓	To approve
	12	Quality Improvement	Associate Director of Quality Improvement	Report ✓	To note
	13	Maternity and Neonatal Report	Director of Nursing	Report	To note for assurance
Finance and Performance					
10.30	14	Finance and Performance Committee Escalation Report	Chair of Finance and Performance Committee	Report ✓	To note for assurance

Time		Topic	Lead	Process	Purpose / Expected Outcome
	15	Finance Integrated Performance Report	Interim Director of Finance	Report ✓	To note
	16	Performance Integrated Performance Report	Deputy Chief Executive	Report ✓	To note
Workforce					
10.50	17	Workforce Assurance Committee Escalation Report	Chair of Workforce Assurance Committee	Report ✓	To note for assurance
	18	Workforce Integrated Performance Report	Director of People and Culture	Report ✓	To note
Governance					
11.10	19	Audit Committee Escalation Report	Chair of Audit Committee	Report ✓	To note for assurance
	20	Provider Licence Declaration	Director of Corporate Governance	Report ✓	To approve
Closing matters					
11.25	21	Any Other Business	Chair	Verbal	To note
	22	To respond to any questions from members of the public received in writing 24 hours in advance of the meeting			
	23	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 7th September 2023 at 9.30am

Meeting	Board of Directors Public Meeting
Time	10.00 am
Date	4th May 2023
Venue	MS Teams

Members: -

Steve Fogg	Trust Chair	Chair
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	Executive Director of Strategy and Transformation/Deputy Chief Executive/Chief of Operations	
Fiona Eccleston	Non-Executive Director	
Carl Fitzsimons	Non-Executive Director	
Bridget Lees	Executive Director of Nursing, Midwifery, Allied Health Professionals (AHPs) and Quality.	
Louise Ludgrove	Executive Director of People and Culture	
Sue McKenna	Non-Executive Director	
Robby Ryan	Non-Executive Director	
Fergus Singleton	Non-Executive Director	
James Wilkie	Non-Executive Director	
Shelley Wright	Executive Director of Communication	

In attendance: -

Mark Brearley	Interim Finance Advisor	
Jacinta Gaynor	Corporate Governance Officer	
Frances Roberts	Corporate Governance Officer	Minutes
Mark Singleton	Chief Information Officer	
Esther Steel	Executive Director of Corporate Governance	

Observers: -

Margaret Bamforth	Appointed Governor for Blackpool and the Fylde Collage
Gaynor Jones	Corporate Governance Officer

Shelagh Parkinson	Local Democracy Report, Gazette
David Wilton	Public Governor for Northwest Counties

1. Welcome and Introduction

The Chair welcomed members to the meeting and acknowledged the current challenges and thanked all staff for their hard work.

2. Declarations of Interest

There were no declarations of interest.

3. Apologies for Absence

Trish Armstrong-Child – Chief Executive

4. Approval of Previous Minutes

The minutes of the meeting held on 2nd March 2023 were approved as a true and accurate reflection of the meeting.

Resolved: The minutes from the previous meeting 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 or were to be discussed during the meeting.

Matters Arising

There were no matters arising.

6. Chairs Update

The Chair expressed his appreciation to all Trust staff for their hard work during the ongoing challenges in the local and national healthcare system and praised the continued delivery of services. The Chair described for the members, the ongoing development of the Integrated Care System alongside the Trust to deliver safe, quality, sustainable services.

7. Chief Executive Report

The Deputy Chief Executive/Executive Director of Strategy and Transformation provided a high-level overview of some key items from the Chief Executive Report circulated in the papers including: -

- Children's Ward gaining the Platinum accreditation in COAST Assessment.
- Welcomed Bridget Lees as Executive Director of Nursing, Midwifery, Allied Health Professionals and Quality.
- Recognised all Trust staff and partners for their diligent planning and performance during the Industrial Actions.

- Thanked Blue Skies Charity for organising the activities to celebrate the 75th Anniversary of the NHS on the 5th of July 2023.
- Provided an update on the implementation of the Electronic Patient Record System.
- Provided an update on the Trust's work with the System Improvement Board and the next steps to refresh the exit criteria to ensure it is aligned with the 2023/24 Planning Guidance.

In response to a member's query, the Deputy Chief Executive/Executive Director of Strategy outlined the Engineering Better Care Programme, which applies Quality Improvement methodology to improve pathways and scale up good practice across the system and community to remove any inequality.

Resolved: The members noted the report and the update.

8. Quality Integrated Performance Report

The Executive Director of Nursing, Midwifery, AHPs and Quality advised the Integrated Performance Report (IPR) circulated in the papers, which provided members with an overview of all aspects of the Trust's quality and safety performance, will be reviewed in quarter one to set clear ambitions for improvement. The Executive Medical Director informed the members that due to feedback, a more detailed narrative regarding mortality will also be included in future IPRs.

The Executive Director of Nursing, Midwifery, AHPs and Quality highlighted two board requirement points from the IPR: -

- Safe staffing has been maintained at 90% over the last few months.
- There has been an improvement in one-to-one care in maternity to 96.7%.

The Executive Medical Director highlighted two key points: -

- Currently there is no quality marker for cardiac arrests, however, there is a Quality Improvement Programme to look at the Deteriorating Patient Programme which will produce some quality measures.
- The Summary Hospital Mortality Indicator (SHMI) level has further reduced to 103.88, so the Trust is no longer an outlier and is back in line nationally.

For a member seeking further information on the IPR review progress the Executive Director of Nursing, Midwifery, AHPs and Quality explained the Trust's standards will be based on national and regional standards, any changes will be brought to the Quality Assurance Committee for approval, and will continue to be reviewed yearly for standard changes and relevance.

The Executive Medical Director clarified for a member, that the low-performance metrics on the referral to the coroner and deaths registered metrics are mainly due to the recent challenges and there are now escalation processes in place, and the Mortality Improvement Group is investigating the timescales and where the delays are occurring.

For a member who was concerned the complaints metric had increased, the Executive Director of Nursing, Midwifery, AHPs and Quality stated there is a review of the management

of complaints as part of the Quality Improvement Programme, and she personally reads each complaint and incident report.

Further detail was sought by a member regarding themes on safe staffing levels, and the Executive Director of Nursing, Midwifery, AHPs and Quality replied that there is a Quality Improvement Programme working with staff not only on quality, but also looking at different ways of working.

Resolved: The members noted the IPR.

9. Quality Assurance Committee Escalation Report

The Chair of the Quality Assurance Committee drew the member's attention to the Quality Assurance Committee Escalation Reports circulated with the papers and summarised the alerts, and updated the members on the focus areas of the recent workshop.

Resolved: The members noted the report and the update.

10. Finance and Performance Integrated Performance Report

The Interim Finance Advisor confirmed the Trust's year-end performance a deficit of £12.9 million, which whilst above the planned deficit was agreed as acceptable by the Integrated Care Board and NHS England.

The Deputy Chief Executive/Executive Director of Strategy and Transformation guided the members through the key aspects of the Integrated Performance Report circulated in the papers, which detailed an overview of all aspects of the Trust's operational and financial performance.

For members who were concerned about data and narrative inconsistencies between reports and committees, the Deputy Chief Executive/Executive Director of Strategy and Transformation stated that the Executive Directors will perform a review of its quality assurance and due diligence and will report back to the Board.

The members discussed Atlas and agreed that decisions need to be made on how to ensure the Trust receives an appropriate return on its investment.

Resolved: The members noted the report and the update.
Action: Future discussion on Atlas to be scheduled for a part two meeting.

11. Finance and Performance Assurance Committee Escalation Report

The Finance and Performance Committee Chair provided the members with a synopsis of the alerts in the Finance and Performance Assurance Committee Escalation Reports circulated in the papers.

Resolved: The members noted the report.

12. Workforce Integrated Performance Report

The Executive Director of People and Culture encapsulated the key metrics from the Integrated Performance Report (IPR) circulated in the papers for the members, and provided some updates on some points not included in the report: -

- As a system, options are being explored to expand psychological support for staff after the current funding ceases at the end of the year.
- There is a trial at East Lancashire Hospitals Trust investigating links between staff postcodes and absence.

The Deputy Chief Executive/Executive Director of Strategy and Transformation also added that parallel to the Trust's enhanced recruitment plan, the Trust will be working in collaboration with partners and the Provider Care Board to explore network arrangements.

For a member, the Executive Director of People confirmed quality and quality of experience are going to be included in the new appraisal system and this will be evaluated at a later stage.

A member enquired if safe staff level themes could be analysed including regular areas with limited staff levels against planned staffing levels and the effect this has on staff members, absence, and performance.

A member requested that the planned target for agency staff is included in the Trust's progress towards achieving the target and the Chair requested further visibility for the Board on the alternative to recruitment plans and projects.

Resolved: The members noted the report.
Action: The Workforce Assurance Committee to receive assurance on safe staffing levels regarding themes and effects on staff members, absence, and performance.
Action: The Trust's planned target for agency staff and trajectory to be included in the Workforce IPR.
Action: Future Board discussion on the Trust's People Plan.

13. Workforce Assurance Committee Escalation Report

The Workforce Assurance Committee Chair summarised the Workforce Committee Escalation Report alerts, circulated in the papers, for the members and provided a verbal update on the recent Workforce Assurance Committee workshop and the areas of focus.

Members who had attended the Workforce Assurance Committee workshop commended the workshop as an open, positive, and productive experience with well thought out outputs to take forward in a programmed approach.

Resolved: The members noted the report and the update.

14. <u>Staff Survey</u>

The Executive Director of People and Culture provided a high-level overview of the Staff Survey Report circulated in the papers, which described the proposed new organisational approaches to addressing the key findings from the National Staff Survey reports.

The members had an in-depth discussion on the importance and benefits of the Staff Survey and the future focuses moving forward. All members agreed that this discussion would fit well in the scheduled programme of Workforce Assurance Committee Workshops

Board members discussed different models and programmes used for organisational development noting the wide range of programmes currently in place and the future plans for development for the divisional leadership teams – updates on Organisational Development have been included within the workplan for the Workforce Assurance Committee.

Resolved: The members noted the report.

16. Audit Committee Escalation Report

The Audit Committee Chair outlined the three alerts from the Audit Committee Escalation Report circulated in the papers.

The Deputy Chief Executive/Executive Director of Strategy and Transformation stated the Trust needs to drive the delivery of the action plans and recommendations, so we can provide assurance to the auditors and the Trust, and incorporate and embed the learning from them.

In response to a query from members, the Executive Director of People and Culture confirmed that staff members within the payroll department had returned to work, therefore, the Trust would monitor the impact on the services going forward.

The Executive Director of Corporate Governance drew the member's attention to the Audit Committees Terms of Reference circulated in the papers, which are unchanged from last year and the members agreed on their approval.

The members emphasised the significance of ensuring that all staff are paid on time and correctly and the Executive Directors were commencing work to rectify the challenges highlighted in the payroll report.

Resolved: The members approved the Audit Committee Terms of Reference.

17. <u>Any Other Business</u>

The Chair requested that for good governance the summary sheets at the beginning of reports submitted to committee and board meetings be completed appropriately and completely. The purpose of the summary sheet is to guide the members to focus on the important points in the report and to be clear on what the members are being asked to consider or action. The Executive Director of Corporate Governance advised there will be a report writing guide circulated shortly to educate on more pertinent report submissions in the future, and reports that are not to standard will be returned to the submitter for further work.

Some of the members were concerned that some actions are not followed up, particularly a previous action that related to arranging an Equality, Diversity and Inclusion (EDI) Board Session. The Chair agreed that once the Culture Plan has been presented to the Board, an EDI Board Session will take place.

The Chair referred to a number of actions that had been raised, but that had not been completed and requested the Executive Directors to reflect on this matter.

Action: An EDI Board Development Session is to be arranged once the Culture Plan has been presented to the Board.

Date and Time of Next Meeting

Wednesday 5th July 2023 at 9.30 am

Board of Directors Action List

Minute Ref/No	Meeting	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/23/18	Part 2	8	04.05.23	Strategy & Transformation Committee Escalation Report	Board members agreed that a more detailed report would be presented to the next Board meeting which would provide an overview on the projects	S Christian	03.08.23		This will be reported to the Board Strategy Session in August 2023.	B
BOD/23/19	Part 2	9	04.05.23	Medical Employee Relations Cases	Ensure that trends are included in this report going forward.	C Barben	07.03.24		This will be included in the next Medical Employee Relations Cases report.	B
BOD/23/20	Part 1	10	04.05.23	Finance and Performance Integrated Performance Report	Future discussion on Atlas return on investment to be scheduled for a part two meeting	E Steel	07.09.23		added to Board workplan	B
BOD/23/21	Part 1	12	04.05.23	Workforce Integrated Performance Report	The Workforce Assurance Committee to receive assurance on safe staffing levels regarding themes and effects on staff members, absence, and performance	L Ludgrove	19.07.23		Included on WAC forward plan	B
BOD/23/22	Part 1	12	04.05.23	Workforce Integrated Performance Report	The Trust's planned target for agency staff and trajectory to be included in the Workforce IPR.	L Ludgrove	19.07.23		Included on WAC forward plan	B
BOD/23/23	Part 1	12	04.05.23	Workforce Integrated Performance Report	Future Board discussion on the Trust's People Plan.	L Ludgrove	07.09.23		This will be discussed at the September Board.	B
BOD/23/24	Part 1	17	04.05.23	AOB	An EDI Board Development Session is to be arranged once the Culture Plan has been presented to the Board.	E Steel	07.09.23		EDI Board development session to be scheduled	B
BOD/23/16	Part 1	14	02.03.23	Workforce Integrated Performance Report	Update IPR to include recruitment targets, HR priorities and how these tied in with the financial plans.	L Ludgrove	05.07.23		IPR being updated to reflect requirements	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 strategy session.	Corporate Governance Team	07.09.23		has been discussed - formal invite to be offered from September	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	02.11.23		This will be reported to the AMM.	B
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.	B Lees	31.01.23		B Lees reviewing all maternity reporting - action to be closed	G
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.	B Lees	31.01.23	01.06.23	Business case approved.	G
BOD/23/17	Part 2	7	04.05.23	Culture Update	Board members agreed that the culture update would be reported to the Workforce Assurance Committee	L Ludgrove	17.05.23		Culture Update was presented to 17.05.23 Workforce Assurance Committee.	G

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

Blackpool Teaching Hospitals NHS Foundation Trust

Author	Trish Armstrong-Child, Chief Executive					
Exec Sponsor	N/A					
Purpose	Assurance	✓	Discussion		Decision	
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

Previously considered by	*N/A*

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

Link to Strategic objectives	Our People	✓
	Our Place	✓
	Our Responsibility	✓

Equality, Diversity and Inclusion (EDI) implications considered	Yes

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

1. Awards and Recognition

Simulation and Clinical Skills Re-accredited

Colleagues from the Simulation and Clinical Skills facility have proudly achieved re-accreditation by ASPiH - which stands for Association for Simulated Practice in Healthcare. This is particularly noteworthy as there are only a handful of Trusts nationally that have this accreditation.

The ASPiH accreditation award assures healthcare professionals, educators, regulators, and patients that a high quality of simulation-based education and technology-enhanced learning is provided by the organisation. It defines good practice, thereby assuring users that the provider has agreed and met the standards required of a high-quality simulation/technology-enhanced learning provider and encourages development. It is a baseline quality standard that helps guide providers to be the best they can be, for current and future users.

This demonstrates the level of hard worked contributed by the team to ensure they meet the standards required and their commitment to continue to deliver high quality education.

BTH given NHS Pastoral Care Quality Award for international recruitment

A team effort by the Trust's HR International Recruitment team and the Nursing International Recruitment team has helped secure the NHS Pastoral Care Quality Award.

Launched in March 2022, the award is a benchmark for recruitment of international nurses and midwives across England. Additionally, it provides the opportunity for Trusts to recognise their work in international recruitment and show their commitment to colleague wellbeing of potential and existing employees. So far, 53 Trusts have achieved this award, which is a quarter of the total Trusts in England.

Last year 172 international nurses and midwives were recruited at Blackpool, and with a target of recruiting 129 more by November this year, it's essential that BTH continues to prioritise the safe arrival, induction and support for new people joining us through our international recruitment programme.

Achieving the award involves meeting a set of standards for best practice pastoral care, which have been co-developed with regional and Trust international recruitment leads and international nursing and midwifery associations. By achieving the award, Trusts demonstrate a commitment to supporting internationally educated nurses and midwives at every stage of their recruitment and beyond. Enhanced pastoral support has a positive impact on both recruitment and retention and supports staff wellbeing.

HSJ Patient Safety Awards 2023

Seven BTH entries have been successfully shortlisted for this year's HSJ Patient Safety Awards.

The HSJ Patient Safety Awards help drive improvements in culture and quality across the NHS. These awards recognise and reward the hard-working teams and individuals who are striving to deliver improved patient care.

The shortlisted are:

Best Use of integrated Care and Partnership Working

- Blackpool Teaching Hospitals FT - Operation Provide - Reaching Out to Victims of Domestic Abuse
- Lancashire and South Cumbria ICB and Blackpool Teaching Hospitals FT - Reproductive Trauma Service

Improving Care for Children and Young People Initiative of the Year

- Blackpool Teaching Hospitals FT - ED Navigator Service
- Blackpool Teaching Hospitals FT and FCMS - Development of a Paediatric Virtual Ward across the Fylde Coast

Improving Health Outcomes for Minority Ethnic Communities

- Blackpool Teaching Hospitals NHS Trust - All Views Matter

Mental Health Safety Improvement Award

- Lancashire and South Cumbria ICB and Blackpool Teaching Hospitals FT - Reproductive Trauma Service
- Patient Safety Pilot Project of the Year Award
- Blackpool Teaching Hospitals FT - Preventing Hospital Acquired Pneumonia: Introducing the COUGH care bundle

You can see the full shortlist here: Shortlist 2023 | HSJ Patient Safety Awards (patientsafetycongress.co.uk) The winners will be announced in September and between now and then we will be sharing and amplifying our recognised success so far, as well as supporting teams with any next steps.

Nursing Times Awards 2023

The Trust has been shortlisted for the Nursing Times Award in the category of Critical and Emergency Care Nursing. The nomination of ED Project: Providing timely and responsive specialist palliative care assessment at the 'front door', will be presented to judges on 12 September. All finalists will find out if they have won a Nursing Times award on the Wednesday 25 October 2023 at the Grosvenor House, Park Lane, London. We will be sharing the shortlisting success and supporting the team with any next steps.

Research Team shortlisted for top award

A research team led by Professor Frank Martin, manager of our Research and Development Department, is shortlisted for the North West Coast Academic Health Science Awards. The nomination is for the 'Research Delivery Team of the Year' Award. Their project is a saliva 'dip' test for prospective lung cancer screening in a primary care population. The awards winners will be announced at the end of June.

Bristol Patient Safety Conference winners

An improvement project aimed at increasing feedback from patients who cannot provide it in English has been nationally recognised. Tina Dwivedi, (Consultant for Sexual Health) and Kellie Mason (on behalf of Patient Experience), attended the Bristol Patient Safety awards, representing a CQA project, All Views Matter, which was shortlisted in the category 'QI in Progress'. The team was asked to produce a poster, and give a short presentation, followed by questions from a judging panel which outlined the project. The pair were awarded first place, which means the project and all the team's hard work has been nationally recognised.

Finance Team wins technology award

The Trust's Finance Costing Team was part of the nomination that won the recent Healthcare Financial Management Association North West Embracing Technology Award. The annual award is presented to those teams that have used technology and/or digital solutions to support finance activities to improve financial processes and performance.

The judges were impressed with the collaborative approach used to develop an integrated care system patient-level cost benchmarking tool, which the teams now propose to share with the Trust's divisions to support the identification of system and Trust opportunities for cost reduction, service change and improvement.

Patient Flow Improvement Programme update

As we approach the first-year anniversary of our Patient Flow Improvement Programme, Flow Thinkers are being recognised and celebrated.

The programme has five key workstreams designed to support the delivery of safe and effective patient flow throughout the organisation. The workstreams are admission avoidance, emergency department, in-hospital patient flow, discharge planning and mental health. Networks have been developed to address difficult and complex challenges together, identify and apply areas of good practice and to enhance system resilience.

One of the networks created are the Flow Thinkers, who are colleagues identified as driving change and delivering improvements that are important to enhancing our patients' experience and outcomes, as well as colleague wellbeing.

Colleagues are encouraged to nominate those people who have shown their commitment to patient flow improvement. Celebrated Flow Thinkers receive a badge and are profiled on the Trusts internal SharePoint site and organisation wide bulletins, with the aim to raise the profile of the importance of flow and inspire others to consider how they too can make a difference.

Recently nominees have included:

- Dr Grahame Goode, Director of Clinical Effectiveness
- Michael Moran, Senior Information Analyst
- Suzy Churchill, Ward Manager, Ward 15a
- Vicky Gaskell, Discharge Assistant Lead
- Jordan Ashcroft, Transfer of Care and Patient Flow
- Ruth Wilson, Lead Discharge Facilitator
- Sonya Scott, Advanced Clinical Practitioner, Rapid Response Team
- Katrina Leach, Clinical Coordinator for Criteria to Reside, Transfer of Care Hub

DynaMed Award win for the Library Service

BTH's Library Service has won a top award which recognises the quality of clinical decision making. The DynaMed award is presented by EBSCO, a library technology company, and recognises organisations which use the most up-to-date evidence for their decision making for patient care.

Blackpool Teaching Hospitals won the award, and as a result Naomi Majek, e-Resources Librarian, was invited to give a presentation to NHS Library Managers on how the Trust achieved the award.

As a Trust, we accessed the DynaMed system 4,797 times and supplied 2,215 full text articles in five months - more than twice that of the next hospital users.

2. Trust Update

Changes to the Executive Team

The Trust's Executive Director of Finance Feroz Patel has moved to the Lancashire and South Cumbria Integrated Care System (ICS) to support with the system recovery board which will focus on specific transformational collaborative projects. Feroz has been a valued member of the Trust Board and Executive Team since his appointment in 2021. The Trust wishes Feroz every success in this new challenge and looks forward to continuing to work alongside him across the system. In the meantime, Mark Brearley will lead the finance team and function as Interim Director of Finance.

Industrial action

The Trust is managing the ongoing uncertainty of potential industrial action by professional groups and trade unions over pay disputes with the Government. This has led to multiple periods of industrial action, requiring careful planning to minimise the impact on patients, families, and colleagues.

Most recently, the British Medical Association (BMA) announced that junior doctors (also known as post graduate doctors and clinical fellows) would be taking industrial action at NHS organisations across England, including the Trust, from 7am on Wednesday 14 June to 6.59am on Saturday 17 June 2023.

To ensure service continuity and safety, the Trust's senior leadership took significant steps, including establishing an incident room and holding daily meetings both in the run up to, during and after the industrial action took place.

The Trust keeps colleagues informed through regular updates and directs them to important information, such as patient flow and timely discharge. Externally, the Trust collaborated with the wider healthcare system to provide consistent messaging, encouraging people to attend appointments unless informed otherwise. This communication aims to reduce disruptions and maintain quality care during these challenging times.

Further industrial action by junior doctors is expected on Thursday 13-18 July. The BMA is also currently balloting its consultant members in England for industrial action.

The Royal College of Nursing (RCN) confirmed that the recent ballot for Industrial action did not reach the legal threshold. The RCN reported approximately 140,000 ballot papers needed to be returned in the post to meet the threshold and only 122,000 were received by the closing date of Friday June 23.

Workplace harassment survey launch

A workplace harassment questionnaire has been launched as part of our ongoing commitment to understanding and improving the culture across the organisation and compliments work already undertaken to encourage people to speak up about their experiences of working at the Trust.

A number of steps have already been taken to influence positive behaviour change, including the introduction of our new values 'caring, safe and respectful' and a huge awareness campaign around speaking up. The questionnaire is the next step to recognising where the culture of the Trust is good, where it has improved and where there is more work to do to create an open, inclusive and just culture and environment. It is a component of Our People in the five-year strategy.

It is comprehensive and covers a range of areas that colleagues may have experienced including sexual, racial and religious harassment and bullying based on disability or sexual orientation. Support is in place for those who find completing the questionnaire uncomfortable or distressing because of their experience.

The results will inform our ongoing focus around culture and further impress on colleagues that we are interested in their experiences and actively want them to tell us where there are issues of inappropriate behaviour so that we can act.

Agenda for Change pay award

On 2 May the NHS Staff Council endorsed the pay offer that was made by the government for colleagues employed on Agenda for Change (AfC) terms and conditions of service. Eligible colleagues received payment in their June pay. Full details of the pay deal can be found on the NHS Employers website here, along with details of the new pay scales.

The agreement follows a number of recent ballots by unions, but there are still three trade unions (RCN, Unite and Society of Radiographers) who rejected the offer and could proceed with further industrial action. The NHS Staff Council has provided a joint statement as to how this decision was reached, which can be found here.

This agreement impacts colleagues on Agenda for Change pay scales only, so does not include medical and dental colleagues.

RCN General Secretary and Chief Executive visit

Pat Cullen, the General Secretary and Chief Executive of the Royal Collage of Nurses, visited Blackpool Victoria Hospital in June. The aim of the visit was to connect with nursing colleagues, gain insight into their experiences, and address any concerns they may have.

The visit started with a tour of the hospital's wards across all divisions. Following the ward visits, Pat, accompanied by Jed Walton-Pollard, the Deputy Director of Nursing and Quality, and Maggie Heaton, BTH's RCN representative, dedicated some time specifically for colleagues to drop by on the mezzanine to engage in open conversations.

Sit with Hope

The Good Grief Trust launched a new national initiative on 10 June 2023 at the annual Windsor Flower Show, which Jackie Brunton, the Trust's Lead Nurse for End of Life Bereavement Care, was invited to attend.

The aim of the ‘Sit with Hope’ campaign, is to help improve awareness and signposting to bereavement services. Jackie has been working alongside the Facilities Team to identify existing benches in the Trust that new ‘Sit with Hope" plaques can be added to.

The plaques have a QR code that directs people to the Good Grief webpage and to locally available bereavement support. Plaques will also be added to specific areas to increase awareness of support in the area.

Celebrating 75 years of the NHS

A number of planned key activities will mark the week of the anniversary. Colleagues have also been encouraged to arrange their own ways to mark the anniversary and share their celebrations. Further details can be found on the website here. Appendix 1 of this report highlights the extensive list of activities arranged across the Trust

Marking the King’s Coronation

Colleagues and patients across the Trust celebrated the King’s Coronation which took place at Westminster Abbey on Saturday 6 May.

Thanks to hospital charity Blue Skies, patients were able to enjoy free TV viewing for the three days of the Coronation weekend including the ceremony itself. The restaurants at both Clifton Hospital and Blackpool Victoria Hospital also put on special menus.

Meanwhile, Dr Sharran Grey, Haematology Consultant Clinical Scientist at the Trust, spoke of her memories of receiving an OBE from King Charles and Sonia Khan, lead pharmacist in the Community Frailty Service, won tickets to attend the Coronation procession.

Trust launches new Parent-Infant Relationship Service

A new service is now provided by Blackpool Teaching Hospitals focused on supporting the relationship between parents and infants.

The Parent-Infant Relationship Service (PaIRS) is a specialist multi-disciplinary team and provides a safe space to help parents overcome difficulties such as feeling overwhelmed, dips in confidence or when they struggle with new responsibilities. The team accepts referrals from any services working with care givers when a parent-infant relationship difficulty has been identified and the family would like support.

Walking aid scheme to help patients access vital equipment

The Trust has reinstated its walking aid reuse scheme, allowing people to return walking aids no longer needed to be refurbished and given to other patients. Now residents across Blackpool, Fylde and Wyre who have walking frames, elbow crutches or aluminium walking sticks – issued by the NHS – can return them conveniently.

It is estimated this scheme will not only help future patients get access to equipment they need by will save the Trust as much as £46,00 per year and reduce carbon emissions equal to more than 2,500 car trips from Blackpool to Brighton.

This campaign is once example of the work being carried out in support of the Trust’s Green Plan. The three-year Green Plan sets out how the Trust will work towards a variety of aims and objectives to help the organisation make a real and lasting difference to the environment.

Audiology service cuts waiting times through innovation

The Trust’s Audiology Service has reported how waiting times have been reduced by more than half in the last six months. When the service was disrupted by the COVID pandemic, the Audiology team had to come up with new ways of supporting patients. This included delivering hearing aids to patients so they could start rehabilitation while safe at home, replacing a drop-in repair service with an appointments system and there are plans in place to utilise remote care for modern, digital hearing aids.

Patients have reported they prefer this new way of working, with the added benefit that waiting lists have been cut as a result.

BTH works to support schools through asthma project

As part of the Asthma Friendly School project BTH's School Nurse team is working with health practitioners across Lancashire and South Cumbria. The programme aims to work with partners in healthcare, education and local authorities to support children and young people with asthma attending primary and secondary schools.

Schools are being offered support including asthma management training sessions, emergency kits and management plans and establishing asthma champions through the programme.

Research role created following partnership with local business
A link-up between Blackpool Teaching Hospitals' Research and Development team, Booths Supermarkets and the Cure Leukaemia charity has aided the Trust to fund a research nurse.

Thanks to the agreement, the business will raise a minimum of £100,000 over two years through fundraising activities supporting blood cancer patients across Lancashire and Cumbria. This will ensure that research work spearheaded by the Trust's Consultant Haematologist Dr Paul Cahalin and his team can continue.

'B.Digital' Champions launched

The B.Digital programme officially launched at the Trust with a special event for its champions, which I had the pleasure of attending.

More than 30 B.Digital champions attended the event in the Education Centre at Blackpool Victoria Hospital, to learn about the organisation's digital ambitions, timeline for the Electronical Patient Record rollout and the aim of the programme itself.

Trust Board support for Volunteers Week

The first week of June marks Volunteers Week and an opportunity for the Trust to celebrate the many volunteers who work alongside our colleagues and our partners to make a difference for our patients.

The Trust has more than 265 active volunteers at Blackpool Victoria and Clifton hospitals, each giving at least three hours of their time a week. During the course of the week myself, Executive team members and Non-Executive Directors donned the well-known tangerine t-shirts and spent time seeing and experiencing the work the volunteers carry out.

Some of the roles covered by the Executive team included Outpatients Navigator, Ward Helper at Clifton Hospital, Blue Skies trolley support and volunteer Listener. This demonstrates the invaluable and varied contribution our volunteers make every day.

During my volunteer time I was able to experience the role of chaperone for one of the Trust's Pets as Therapy dogs, Frankie, and met with the Chaplaincy team to understand how important volunteers are to their service. During my 30-year career in the NHS, there has not been a role I have worked in that wasn't supported and touched by volunteers.

For 12 years the Trust's Chief Executives have hosted a special thank you event for our volunteers. This year the event - Picnic in the Park held in Stanley Park - also coincided with marking the 75th year of the NHS, providing an opportunity to reflect on the work that has been carried out by volunteers for so many decades, making a difference to patients and colleagues alike.

We are incredibly grateful to all of our volunteers for their hard work and dedication. They make a real difference to the lives of patients, their families and our colleagues.

Celebrating our nurses and midwives

Every year, the NHS across the country joins in celebrating both the International Day of the Midwife and International Nurses Day. These significant events recognise the invaluable contributions made by midwives and nurses to healthcare and the well-being of individuals and communities.

Over the course of these important days, a chance to celebrate the work of these remarkable people, the Trust shared the stories of colleagues – how they started their careers and why they love what they do.

Among those who shared their stories was Joanne Gregory, Medical Devices Nurse Specialist, who observed how nursing had allowed her to be flexible, able to adapt and passionate. It has been a privilege for Joanne to work closely with patients, particularly when they are at their most vulnerable. She is also thankful that the role has enabled her to develop enthusiasm and curiosity for communication and personal connection – both key skills in healthcare provision.

Blackpool Pride celebrated in style

Colleagues from across the Trust joined the celebrations in Blackpool to Mark Pride 2023. Among those taking part in the procession to show support for our LGBTQ+ colleagues and the wider community was myself and Executive Director of Nursing Bridget Lees.

As well as Pride, the Trust has celebrated a range of awareness days over the last two months, shining a light on the work of a variety of colleagues and services.

These have included:

- Dementia Awareness Week
- International Clinical Trials Day
- Maternal Mental Health Week
- Dying Matters Week
- Clinical Audit Awareness Week
- National Healthcare Estates and Facilities Day
- Armed Forces Week

Blue Skies event raises charity funds

Colleagues at hospital charity Blue Skies organised a successful event which saw more than 300 competitors and hundreds of spectators attend a Dragon Boat race.

In total, 19 teams competed for the title of the fastest team, in an event supported by Trust colleagues as well as members of the local community. The event raised more than £8,000 in the annual event, which will take place on the third Saturday in May every year.

3. 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 3 May 2023. A recording of the meeting is available to watch online here: LSC Integrated Care Board :: 3 May 2023 Board Meeting (icb.nhs.uk)

The Chief Executive's Report submitted by Kevin Lavery as part of the meeting's papers provides a wider update. The report in full is included as *Appendix 1*.

PCB meeting - 21 June 2023

The PCB membership comprises the Chief Executives and Chairs of the five provider Trusts in Lancashire and South Cumbria and meets monthly. It is Chaired by Mike Thomas, also Chair of University Hospitals of Morecambe Bay NHS Trust and the lead Chief Executive is Kevin McGee CEO of Lancashire Teaching Hospitals.

The Board receives updates on a number of standing items and strategic items and a Joint Committee has been established to give the PCB a mechanism via which to make decisions on a number of key programmes of work as agreed with Trust Boards.

Provider Collaborative colleague briefing

A colleague briefing took place on 31 May to update people on work by the local NHS Trusts to improve health and care across Lancashire and South Cumbria.

The event was led by Chief Executives from across the system included BTH CEO Trish Armstrong-Child and provided updates on our collaboration, working together through significant challenges, our clinical strategy, central services collaboration, and our people strategy.

The dates of next briefings are:

- **4 September 2023** (13.00pm –14.00pm)
- **8 December 2023** (11.30am – 12.30pm)
- **5 March 2024** (12.30am – 13.30pm)

NHS chief pharmacist visits Barrow to see impact of work to tackle opioids problem

England's chief pharmaceutical officer, David Webb, visited Barrow to find out how local NHS colleagues are working together to improve medicine safety. The area has previously been under the spotlight for having one of the highest drug death figures in the North West, but over the past five years pharmacy professionals have been working collaboratively in multi-disciplinary teams to help tackle the issue. Partnership working across different organisations has reduced the number of people in the town using opioids.
GPs and practice colleagues explained how they were able to halve the number of opioid prescriptions and improve outcomes for their patients, and the Morecambe Bay Medicines Optimisation Team discussed quality and safety initiatives in primary care.

New AI powered technology to help prevent vulnerable people falling

New artificial intelligence (AI) technology, in the form of a ceiling light, is being piloted in a care home to help prevent residents from falling. The pilot at Hartland House, a residential care home in Milnthorpe, is being funded by NHS Lancashire and South Cumbria Integrated Care Board (ICB) and involves the installation of AI-powered Nobi smart lamps in residents' bedrooms which monitor their behaviour and movement 24/7.
Around a third of people aged 65 and over, and around half of all people aged 80 and over, fall at least once a year.

The Nobi smart lamps have the ability to identify when a fall has occurred, ensuring the person is attended to swiftly. If a resident falls, the lamp detects this immediately and speaks to the resident, asking if they are okay. In the event of no response or a call for help, the intelligent lamp is pre-programmed to send a message to the care team plus an image to show where and how the fall has occurred; ensuring a rapid response and extra information about the fall, helping to prevent a future fall.

New dads can download DadPad for advice and support

Dads-to-be in Lancashire and South Cumbria are set to benefit from the DadPad app - an easy-to-use resource, developed with the NHS to provide support and guidance.
The DadPad app is a useful resource before baby arrives and after baby is born, and is designed to be used as a quick, on-the-go reference tool, allowing new dads to enjoy their babies and feel more confident about fatherhood.

Written by health professionals, DadPad is already up and running in other areas of the UK, and each area has content edited and amended to be bespoke to local needs, including details of nearby support groups and services. The app covers topics such as feeding, holding, changing and cleaning your baby, surviving without sleep and coping with crying and home safety and first aid.

4. Reportable Issues Log

Between 26 April and 25 June 2023, a total of 14 reportable incidents were added to StEIS Seven incidences were in IMPF, one in SAACT, one in Tertiary, one in CSS and four in FICC.

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

No 'Never Events' have been reported.

In addition to the incidents detailed above the Trust has sixty-one complaint cases which are still ongoing. No high-risk complaints were reported.

Regulation 28 Reports

Following an inquest held at Blackpool Town Hall on 6 March – 23 March 2023, the Trust received a Regulation 28 from the Coroner. This is in relation to the death of a lady that occurred in in September 2019.

The Trust and other organisations who were also included in the Regulation 28 notice, have been asked to respond to the report by the 7th of August on a number of issues. This includes, urgent referrals to the PIMHT, access to mental health records, mental health assessments referencing drug/alcohol misuse and delayed assessments of mental health patients due or related to intoxication. The Trust will ensure we meet the timescale for our response, and this will be reviewed at a future Quality Assurance Committee

Trish Armstrong-Child
Chief Executive
27 June 2023

APPENDIX 1

Completed Activity

- **NHS 75 Conversation**
  On behalf of NHS Assembly, the Trust held a special Teams Brief which has had 436 views. A set of questions were used to guide the conversations. Responses and views were collated and shared with the NHS Assembly, who will provide a summary to NHS England on the key learning from the many conversations taking place across the NHS.

- **Children's art competition**
  The competition was open to all children aged up to 14 living in Blackpool, Fylde and Wyre, with children being asked what they love about the NHS to mark the service's 75th birthday. The three winners received family tickets to Merlin Entertainment attractions in Blackpool and their artwork will be displayed at Blackpool Victoria Hospital. All the other entries artwork will be distributed as an NHS75 gift to patients going home from our care of the elderly wards or older people using our community services.

- **Lytham Festival**
  In celebration of the NHS 75 anniversary, the Trust received two tickets for this year's Lytham Festival, 28 June – 2 July. Colleagues were asked to answer the question (via the Trust's closed Facebook group) 'What does the NHS mean to you?' and submit their responses for a chance to win the tickets.

  The winners were selected on Monday 26 June and announced on Teams Brief live and in bulletins. The best responses provided are to be used in the Special Teams Brief to be held on 3 July 2023.

- **First Babies**
  The Trust was able to trace three (two of which are twins) of the six babies first born in Blackpool on the day the NHS was created. The three special 75 year olds were invited for tea and cake with Trish Armstrong-Child.

  The Sunday Mirror picked up the press release from the Trust and are running a feature to be published on the anniversary day.

- **Commemorative planting**
  The E&F team have been reflecting the special anniversary in their planting on our hospital sites. Displays of NHS 75 and blue colour schemes have been created.

- **Celebrating our Volunteers**
  Our volunteers were the focus of NHS75 celebrations during Volunteers' Week. I hosted a picnic in the park event to launch the Trust's volunteer's week activities which included members of the Executive Team buddying up with our volunteers to see and experience the great work they do.

  Also featured during the week was the work of the League of Friends at Clifton Hospital and volunteering led to a job for Jorge White.

- **NHS 75th Toolkit**
  A toolkit is to be issued which incorporates Teams backgrounds, comment cards (memorable person, best day in the NHS, ect) for people to create their own NHS 75 ward boards.

Celebration Week Activity

- **Hospital environments**
  The main entrances of the hospital sites will be dressed to celebrate and welcome in the anniversary week. A set of NHS 75 branded visuals will be displayed in the main entrance of Victoria Hospital, with vinyl graphics on the mezzanine glass panels and digital images on the large screens. A balloon arch is being created for the main entrance of Victoria Hospital.

A display of traditional nursing uniform and instruments/equipment used through the ages will also be on show. Due to limited space in other hospital sites, pop-up banners will be displayed celebrating the anniversary.

- **Raising a cuppa for the NHS**
  Tea party kits have been produced to encourage colleagues to raise a cuppa to toast the NHS. It includes printable materials, including invitations, cake toppers, paper coasters and decorations, including NHS 75 bunting. Anyone organising a tea party will be encouraged to share photos so the activity can be highlighted around the Trust.

- **NHS 75 Special Team Brief**
  Teams Brief on Monday 3 July will be an NHS 75 Special, again providing an opportunity for colleagues from across the Trust to come together at 12noon to raise a cuppa.

  During the event Execs will share their personal favourites of the 75 NHS stories and the NHS 75 Give Aways will be launched. Winners will be announced through the usual communications bulletins and closed Facebook Group.

- **NHS 75 menu**
  A special celebration menu will be available in our restaurants for the week of the anniversary.

  NHS's 75th anniversary service at Westminster Abbey
  One of the key NHS 75 events will be a multi-faith service for NHS colleagues, volunteers and partners at Westminster Abbey, London on Wednesday 5 July from 11am to 12.30pm. It has been confirmed four members of the Maternity Team will represent our organisation at this major event.

- **Lighting up Blue**
  The lighting of Blackpool Tower and the Victoria Hospital clocktower have been confirmed for the day of the anniversary.

- **Walk for Wards**
  On 5 July, Blue Skies is holding a 7.5-mile charity walk between Clifton and BVH with funds going towards the general fund so it can be used where it is needed the most.

- **Bottomless Brew**
  Working with the Catering Team, a 'bottomless brew' event will be held in the restaurant on Thursday 6 July, during the lunch time period. Executive Directors have been invited to spend time talking with colleagues and to raise a cuppa to the NHS.

- **NHS 75 Magazine - 75 stories for 75 days**
  In the build up to 5 July, the Trust has issued engaging stories and photos celebrating the NHS from colleagues' and patients' perspectives. Each story has been shared daily on social media since the launch on 21 April and will continue in the run up to the anniversary. To date, the stories have gathered over a million views on our social media platforms, a testament to their incredible impact and resonance.

  The 75 stories will be collated and formed into a highly attractive magazine to share all the amazing stories in one place. The digital magazine will be published on our website as a flip-book on Friday 7 July and shared widely both.

Continued Activity

- **Charity Dinner**
  Blue Skies charity are holding a NHS75 charity dinner at the Clifton Arms, Lytham on 15 July. All tables have now been sold out.

- **NHS England Activity**
  There are a wide range of ways patients, colleagues and the public can get involved with the NHS's 75th birthday celebrations. The Trust has been sharing these events to amplify the message. These include 30 Days Wild, photography competition in partnership with Fujifilm, NHS Ambassador programme visiting schools to inspire children and young people to consider a career in the NHS, and

NHS England has teamed up with ParkRun to host ParkRun for the NHS on Saturday 8 and Sunday 9 July.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Implementing an Anti-Racist Programme at Blackpool Teaching Hospitals

Meeting:	Board of Directors Meeting
Date:	5 July 23

Authors	Susie Srivastava, Head of Wellbeing, and Inclusion Sharon Adams, Associate Director of OD, Education and Learning					
Exec Sponsor	Louise Ludgrove, Executive Director of People & Culture					
Purpose	Assurance		Discussion	X	Decision	X
Confidential y/n	N					

Summary *(what)*	Racism and discrimination are major drivers of health inequalities. Within BTH, the ethnically and culturally diverse staff are: • Less likely to gain access to development opportunities than white colleagues • Less likely to be recruited to senior roles and • Are slightly more likely to be taken down the formal disciplinary process. Staff survey responses further suggest they are less likely to take part in engagement because of higher levels of mistrust and inaction. The **NHS EDI Improvement Plan** was launched on 8 June 2023. This plan sets out a series of **six**, timebound, high impact actions that providers must implement, measure, and monitor in the short to medium term to address the inherent prejudice and discrimination that exists across the NHS workforce. It is acknowledged that progressing the EDI agenda requires not only a change in systems and processes but also cultures and behaviours, which must be visibly led by executive teams. The Northwest Black, Asian, and Minority Ethnic Assembly are launching a revised approach to the **Anti-Racist Framework.** This framework is organised into three levels of achievement, bronze, silver and gold. The aim of the framework is to support organisations on the journey to becoming 'intentionally and unapologetically' anti-racist. This paper sets out how the Trust will achieve the high impact actions contained within the NHS England EDI Improvement Plan and achieve the bronze level of the Anti-Racist Framework.

Previously considered by	N/A

Implications ***(so what)***	Adopting an anti-racist approach yields numerous organisational benefits including: • Reduced discrimination and bias • Attraction and retention of talent • Increased employee morale and engagement • Promotion of high-quality care • Compliance with legal and ethical standards • Increased inclusivity: leading to enhanced creativity, problem solving and improved decision making

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

EDI implications considered	The Trust regularly reviews its performance by using all available evidence of equality performance data and then analysing shared themes from several sources including: • National Staff Survey (NSS) data, • Workforce Race Equality Standard reporting (WRES), • information and stakeholder feedback from the Equality Delivery System (EDS22) • and external feedback (patient and partner organisations). While there are many potential inclusion objectives for BTH, the Trust is keen to focus its efforts on delivering a limited number of key, high impact actions which will provide the greatest benefit for our people, patients/ service users and workforce.

Proposed Resolution ***(What next)***	It is recommended that the Board of Directors: • Support the commitment to and implememation of the EDI Improvement Plan and Anti-Racist Framework. • Agree to receive a progress update in six months via Workforce Assurance Committee.

Board of Directors meeting

5 July 2023

Implementing an Anti-Racist Programme at Blackpool Teaching Hospitals

1. Introduction

Nationally, it is recognised that racism and discrimination are major drivers behind health inequalities.

There are many inequities in access to and provision of health care which adversely impact on the delivery of culturally competent care to our diverse communities. BTH must be intentional in acknowledging the inequalities that exist across our communities, and committed to addressing the issues that staff, patients, and service users experience.

Executive teams are asked to actively support the inclusion agenda by adopting and implementing the six priorities identified in the NHS Equality, Diversity, and Inclusion Improvement Plan which address the widely known intersectional impacts of discrimination and bias. These are:

- Measurable objectives on EDI for Chairs, Chief Executives and Board members
- Overhaul recruitment processes and embed talent management processes
- Eliminate total pay gaps with respect to race, disability, and gender
- Address health inequalities within their workforce
- Comprehensive induction and onboarding programme for internationally recruited staff
- Eliminate conditions and environment in which bullying, harassment and physical harassment occurs

Amanda Pritchard, Chief Executive of NHS England, has prioritised **four inclusion themes** for immediate focus following the review of a recent Employment Tribunal case within NHS England. These themes align closely to those outlined in the EDI Improvement Plan and Anti-Racist framework and are detailed below:

- Inclusion training for line managers and leaders
- Employee Relation investigations/ panel training
- Increased awareness of grievance and Freedom to Speak Up processes
- Improved Human Resources offerings and training

The Northwest Black, Asian, and Minority Ethnic Assembly have reviewed and refreshed their Anti-Racist Framework accreditation process. The Assembly are three levels of achievement, bronze, silver, and gold. The bronze level is achieved via a self-assessment process, silver and gold status is achieved via an external assessment. The framework contains five anti-racist principles. Organisations need to provide evidence against the following principles to progress through the achievement levels. These principles include:

- Prioritising anti-racism
- Understanding lived experience
- Growing inclusive leaders
- Acting to tackle inequalities
- Reviewing progress regularly

A copy of the letter about the Anti-Racist Framework sent to Chairs and Chief Executives can be found on appendix 1. A copy of the Anti-Racist Framework can be found on appendix 2.

Regionally, North West based providers have made a collective commitment to adopting an Anti-Racist programme.

2. What is an Anti-Racist Approach?

While there is a legislative duty to address this imbalance under the Public Sector Equality Duty, there is also a moral duty to tackle the root causes, not least as racism and discrimination are major drivers behind the health inequalities we still see today.

Anti-racism is a process of actively identifying and opposing racism. The goal of anti-racism is to challenge racism and actively change the policies, behaviours, and beliefs that perpetuate racist ideas and actions. It is about taking steps to eliminate racism at the individual, institutional, and structural levels.

3. Implementation of the Anti-Racist Programme

The anti-racist programme supports organisations to tackle inequalities in outcomes and experience for patients and staff. The tri-partite framework equips staff and line managers with the skills to "**know**", "**show**" and "**do**" (see Figure 1 below.)

Staff and line managers	How will we do this?
(KNOWING) **Can describe an antiracist organisation and race discrimination**	• All line managers and staff trained on recognising race discrimination (vs performance related to competence/attitude/health) • HR/OD teams, investigators and grievance panellists trained on the differing forms racism can take • Cox vs NHSE root cause analysis team know the forms of racism described in the employment tribunal ruling • Boards/"Heads of" know their data (including gaps in decision making committees, Never Events related to racism, disciplinaries/grievances and "heads of" know team aspirations and frustrations) • Book club with critical discussion Shereen Daniels - The Anti-Racist Organization E-Learning Programme (shereen-daniels.com)
(SHOWING) **Demonstrate antiracist behaviours**	Accountability via • FTSU is easy to contact and FTSU shares insights/lessons learned to Staff Networks and Line managers' forums • Organisations view Racism to be a 'never event' and managed in the same way to ensure understanding , learning and development • HR/OD teams respond to race discrimination in a timely manner and provide Board assurances • Boards and "Heads" can describe actions taken to address gaps in decision-making committees, Never events related to racism, support staff aspirations • Antiracist Framework elements related to accountability
(DOING) **Spread antiracist behaviours**	• Implement the Antiracist framework using QI methodology (ie drivers, and implementation methods across a variety of roles and specialisms to diversify thinking, power, and cross system/team collaboration) • Celebrations and fun (food, festivals, dancing)

Figure 1: Anti Racist Programme Framework

To enable the Trust to commence its journey to become 'intentionally and unapologetically' anti-racist the following actions will be implemented:

- A gap analysis against the bronze status criteria within the Anti-Racist Framework will be completed by the end of July 2023. This will be completed in collaboration with colleagues from the Trust's Culturally Diverse Staff Network

- A gap analysis will be undertaken against the high impact actions contained within the NHS equality, diversity, and inclusion improvement plan by September 2023. This will also be completed in collaboration with colleagues from the Culturally Diverse Staff Network

- In partnership with colleagues from the Staff Network, an action plan will be developed containing the priorities needed to achieve bronze status of the Anti-Racist Framework. It is intended to submit the application for bronze status by December 2023

- An update (including the high impact action success metrics) will be developed and presented by colleagues from the Staff Network to the Workforce Assurance Committee in September 2023

4. Conclusion

The Trust remains committed to ensuring it creates an inclusive working environment where our people can thrive, feel that they have a voice that counts and want to recommend the organisation as a great place to work.

The anti-racist programme and EDI Improvement Plan provide the Trust with a framework for improving the working conditions of our BME workforce. It is anticipated that, as the Trust learns more and grows in strength and competency, its approach will evolve and improve.

The approaches contained within this paper are aligned to national and regional EDI priorities

The actions contained within this paper will be driven by the Culturally Diverse Network with support from subject matter experts across the Trust.

Impact will be regularly monitored and measured through an Inclusion Dashboard which will be extracted from the Model Hospital dashboard.

Progress reports will be provided to quarterly to Workforce Assurance Committee via the Operational Workforce Group and bi-annually to the Trust Board

5 Recommendations

It is recommended that the Board of Directors:

5.1 Support the commitment to and implementation of the EDI Improvement Plan and anti-racist programme

5.2 Agree to receive a progress update in six months.

NHS England

Ref RB HH 20230626

Richard Barker
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

richardbarker.nwrd@nhs.net

Chairs and Chief Executives
NHS Trusts and Integrated Care Boards
North West region

By email

26 June 2023

Dear all

Antiracist Framework

Further to our statement sent on 28th March 2023 highlighting the most recent tribunal case of racism and discrimination against a Black nurse, we would like to support the system to address longstanding racial inequalities within the NHS.

In the statement, we called on NHS leaders across the North West to:

- Commit to taking sustained action and demonstrate visible leadership on addressing racism in all its forms – interpersonal, structural, and institutional
- To prioritise addressing race inequalities in health and care both as a system and within their own organisations
- For Integrated Care Boards to demonstrate strong competence in the understanding of causes of racism and the impact this has on people's lives
- Connect with their staff by talking openly, creating an environment of compassion, respect, and safety, and to share experiences and learning from each other.

The recently published NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan supports the NHS Long Term Workforce Plan in the achieving of strategic EDI outcomes of addressing discrimination, increasing the accountability of all leaders, supporting the levelling up agenda, and making progression opportunities equitable.

As an Assembly we are keen to work with NHS leaders from across the North West to achieve these strategic EDI goals by:

- Providing support to the system
- Sharing insights and lived experiences of racism and inequality
- Creating good practice in the realms of EDI and antiracism

- Contributing the collective expertise of the Assembly to EDI strategies and plans

We have developed an Antiracist Framework to support NHS organisations on their journey towards becoming intentionally antiracist. The framework outlines the actions to change racial inequality within your workforce, services, and organisational cultures. The framework will support the improvement of Workforce Race Equality Standard (WRES) data, support Equality Delivery System 2022 reporting, achieve EDI outcomes outlined in the NHS EDI Improvement Plan, and assist with achievement of Model Employer status.

The framework is a step-by-step plan to review the current status of your organisation, assess inequalities, celebrate successes, and encourage continuous improvement. There are 3 levels of achievement to guide organisations from building strong antiracist foundations in their policies and processes to the ultimate goals of diverse representation in leadership, parity in staff experience, and antiracism being business as usual with your organisation. We know several boards have publicly committed to the Antiracist Framework and this is an important signal for staff within these organisations.

The framework is enclosed with this letter for your reference.

We do hope that you join us in creating an equitable NHS for all staff and service users by engaging meaningfully with the Assembly and adopting and implementing the framework.

Yours faithfully

Evelyn Asante-Mensah OBE

Chair
North West, Black Asian and Minority Ethnic Assembly and

Pennine Care Foundation Trust

Richard Barker CBE

Co-Chair
North West, Black Asian and Minority Ethnic Assembly

Regional Director (North West)

NORTH WEST
Black, Asian and Minority
Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

Contents

Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ····· LEARNING ····· GROWTH

Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Empower inclusive leaders through allyship programmes and activities.

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

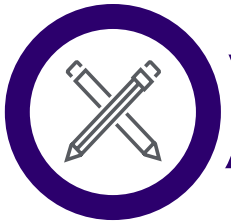
The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.



2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

4. Act to tackle inequalities

"Let my actions speak for themselves" is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation's structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

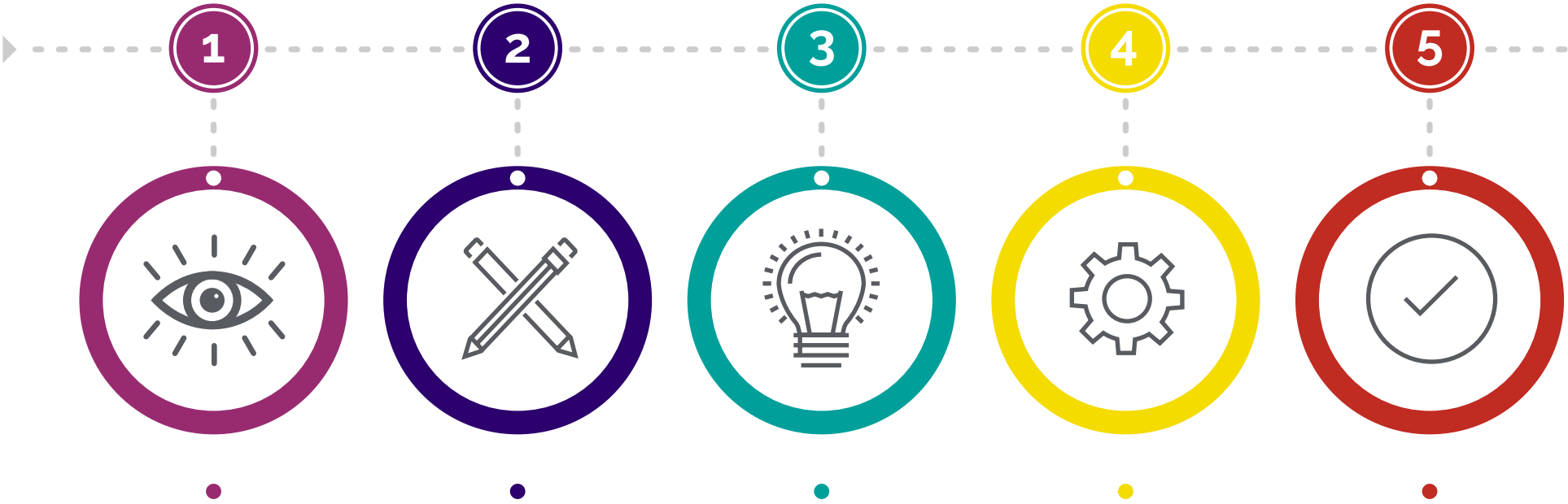
Our voices matter

The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

UNDERSTAND LIVED EXPERIENCE

Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool

The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- [ ] The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- [ ] Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- [ ] An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- [ ] The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- [ ] The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- [ ] Set up a local BAME leadership council within your organisation.
- [ ] Evidence of inclusive leadership education for all executive directors.
- [ ] All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- [ ] An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- [ ] WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- [ ] An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- [ ] An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- [ ] The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- [ ] The organisation can evidence diverse representation within their disciplinary and grievance processes.
- [ ] The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.

Resources

To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Assurance Committee Escalation Report
Meeting:	Board of Directors in Public Meeting
Date:	5th July 2023

Author	Esther Steel, Director of Corporate Governance					
NED Sponsor	Sue McKenna					
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 30th May 2023** No areas were identified for escalation to Board, although some areas with assurance required further action as detailed in the report. **Tuesday 27th June 2023** Two areas were identified for escalation to the Board of Directors, these were in relation to cardiac triage risk, Maternity and Neonatal report and the NHSI Maternity & Safety Support Programme

Previously considered by	N/A

Implications *(so what)*	Actions have been agreed through the Quality Assurance 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)*	The Board of Directors is asked to note the Quality Assurance Committee Escalation Reports and the proposed actions.

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	**Report to:**	Board of Directors
Date of Meeting:	30 May 20232	**Date of next meeting:**	27 June 2023
Chair:	Andy Roach	**Parent Committee:**	Board of Directors

Introduction

Well attended quorate meeting held on MS Teams, good interaction from Committee members with some constructive challenge on the papers presented

Alert

What	So, What	What Next
No areas identified for escalation although some of the areas with assurance also required further action as per the detail below		

Assurance

Patient Story Story describing patient experience with paediatric ED and the Children's ward illustrating the role of all staff in the care of a child with an asthma flare up caused by RSV – the role of the play therapist was highlighted for praise in engaging with a child on bed rest. All staff involved were commended for the care provided for the child and her family.	Committee members welcomed the story and the great compassion and care provided to the child and her family. Committee members agree the importance of learning from stories and further agreed that learning in relation to the benefit of the play therapist could be considered in the care of patients with dementia	Director of Nursing to consider learning from the story
Clinical Governance Committee Chair Report Medication management – highlighted the number of incidents in relation to liquid morphine Pressure ulcer thematic review escalated an increase in the number of category four pressure ulcers	The use of morphine in tablet formed is being considered	Pressure ulcer report to come back to the committee within the fundamentals of care report
Sepsis Escalated to QA Committee as although pathway compliance is still on an upward trajectory there is still work to do to ensure full compliance with all elements of the pathway Sepsis SHMI remains consistently <100 and latest figure is 90	A number of positive actions are in place and the Committee can be assured as evidenced by the mortality metrics that the programme is having an impact. The Trust are leading in a number of areas and are working with the Sepsis Trust on roll out of sepsis leaflets	The next QI "Acutely unwell patient" collaborative will continue to focus on Sepsis and evolve the pathway work. The most recent NHS / ICB case review feedback is still awaited Intensive weekly sepsis data collection and review continues

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Maternity and Neonatal report Detailed report to ensure Board sighted on quality and safety issues. The Trust remain an outlier for neonatal mortality an external review is underway looking at the period April 2021 – March 2023. Neonatal improvement Board will report on a regular basis with effect from June 2023. Freedom to Speak up focus on the unit has identified some themes and actions have been agreed to enhance staff engagement. Work continues to ensure staffing is at birth-rate+ Update provided on CQC actions – while some have slipped this is on track for completion by August	Committee members commended the improvement in the overall quality/content of the report. Committee members discussed the staffing figures and noted the number of vacancies and the actions underway to recruit to posts. The NED maternity lead provided positive feedback following discussions with staff who had been involved in live drills Director of Midwifery confirmed that progress has been made and completion of CQC actions is evidence based with exec check and challenge. Question asked in relation to training compliance – action being taken to look at training plans.	Maternity update to be provided to June Board Future reports to provide details where actions are off track Committee members requested assurance on compliance with training plans
Maternity and Neonatal cycle of reporting Proposed annual reporting cycle to ensure ward to Board reporting for oversight of all aspects of maternity and neonatal care.		The committee approved the schedule and noted that this will be a live cycle that is subject to change if required to meet reporting guidance
Patient Engagement Annual report Report provided on activities within the patient engagement portfolio - 8% increase in FFT response rate thought to be driven by introduction of SMS messages. 93% of patients rated services as good or very good although this is a deterioration from previous years (96% in 2021/22) it is still better than average. Update also provided on other patient engagement initiatives including patient stories, Carer charter and Experts by Experience.	Asked for more on the actions divisions and teams are taking in response to friends and family feedback. Committee members discussed the information from the Friends and Family survey and benchmarking with other trusts	Going forward the focus will be on the so what – what we are doing in response to feedback and incidents and how we use our QI skills and codesign to corelate this work with other aspects of the Trust
Annual Complaint Report Metrics provided within the complaints annual report indicate a 25% increase in the number of formal	Main themes identified are treatment and care issues, communication, and responsiveness to deteriorating patients are the central themes coming through from those formal complaints. In relation to concerns	For future reports consideration to be given to themes and learning from complaints. IPR will be used to track complaints on a monthly basis

complaints and an increase in informal concerns with 444 new complaints received during 2022/23 The number of BTH complaints sent across to the PHSO for further investigation remains low with only four complainant/s contacting the PHSO requesting they review our handling of their complaint, the lowest of any Trust in our ICB.	patients report feeling uninformed about their care, transitions between services and post-discharge responsibilities. 79% of formal complaints received a formal written response within the 25/30-day timeframe which is an improvement of 6% on the previous year	Recognised the importance of early intervention and early contact with families to offer support.
Medicines Management Report provided giving detailed oversight of medicines management Escalated to QA Committee because metrics show an Increase in controlled drug incidents in Q4 – deep dive undertaken to review – significant number are in relation to Morphine and specifically liquid. Positive assurance provided that there has been a reduction in restricted drug incidents	Identified areas are closely monitored by pharmacy with weekly checks – actimorph tablets being used in place of liquid morphine where possible The Controlled Drug Accountable Officer advised that she has a greater level of assurance regarding suspected deviations Electronic prescribing is now across 70% of beds in the organisation and continues to be rolled out - this gives improved visibility and reporting of medicines management/reconciliations.	Thematic reviews introduced where high numbers of incidents are being reported. Action agreed to compare with previous data Next report to include more detail on pharmacy led discharges
Risk Management Committee The Committee continues to mature and detailed reports are now presented by each of the clinical divisions. - detail provided within the report on key risks being managed within the divisions. Risk escalated in relation to clinical triage delays – weekly meeting in place to ensure long term solution is embedded with mitigation in place to reduce the risk.	Committee members noted the robust process now in place, improvements have been made to risk management and there may still be some risks that have not been identified	NEDs confirmed increased assurance regarding risk management
Health and Safety Committee Alert within the report on the risks associated with the use of Entonox – since reporting assurance has been received that this risk is mitigated	Report triangulates with the Risk Committee report	Report noted

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Stroke Improvement report AAA report received from the Stroke Improvement Board - Overall SSNAP data for March is a C and this is reviewed regularly with latest data giving a rating of B SLT which is a national issue remains an issue for us	Key metric is access to bed on a stroke unit, no concerns about mortality. Ability to get to a rating of A is challenging because of resource requirements	Recognised importance of ensuring ring fenced stroke beds Committee noted the continuous improvement and passed on thanks to the team
IPR Cardiac Arrests – QI team have undertaken a piece of work looking at 14 months of arrests in non-critical care areas – review after each arrest has identified learning opportunity regarding reporting – future IPRs will include this data to provide assurance that the care we are giving is the most appropriate.	Committee members reviewed the data presented – recognised the importance of the so what in relation to data and the action being taken to enable the Board and Committees to focus on the metrics	Continued improvement of the report noted with improved narrative The IPR links to a number of quarterly narrative reports received by the Committee including harm free care, medicines management and staffing. The narrative in future reports will be in the AAA format
Duty of Candour/ SIs and inquests There were seven new Serious Incidents (SIs) and no new Never Events reported in April 2023. The Committee were alerted to two addendums provided – one in relation to a backlog of letters and one in relation to a regulation 28 report	Committee members discussed the report, the actions being taken to close reports and compliance with the 60-day SI framework	Committee members recognised the importance of close working with patients and families when investigating and reporting on serious incidents
Quality Improvement Strategy Update Report describes next stage of programmes which build on work undertaken so far	Ward processes will include a focus on fundamentals of care this is linked into earlier discussion on pressure ulcers. The next cohort of the academy will be in partnership with East Lancs to share learning	Update noted
Platinum COAST report	Importance of next steps and actions to share learning and develop further once platinum status is achieved	Recommendation for ward 36 to be granted platinum status approved
Advise		
What	**So, What**	**What Next**
Quality Account Draft Quality Account provided for Committee members review – the objectives are as previously	Committee members endorsed the report and the proposed Quality priorities	For final approval at Board of Directors in July

agreed and next step is to circulate to stakeholders including the ICB for comment.		
Board Assurance Framework Verbal update provided – issues identified, and reports received are aligned to the areas highlighted on the BAF	The Board will be receiving and discussing an update on strategic objectives and will review the risks associated with these objectives	Committee members agreed to move to a formal bi-monthly update on the Board Assurance Framework

Updates also provided on the QI Strategy, the Quality Account objectives and the implementation of PSIRF

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	**Report to:**	Board of Directors
Date of Meeting:	27 June 2023	**Date of next meeting:**	25 July 2023
Chair:	Sue McKenna	**Parent Committee:**	Board of Directors

Introduction

Well attended quorate meeting held on MS Teams, good interaction from Committee members with some constructive challenge on the papers presented

The Committee chair expressed thanks to all attendees with recognition of the progress made – seeing a big difference

Alert

What	So, What	What Next
Maternity and Neonatal report Clinical Negligence Scheme for Trusts (CNST)Year 5 standard has now been published and the initial review has identified a number of safety actions where evidence of embedding actions will be required. Perinatal mortality review tool– external review of 31 cases completed. No safety issues, but did identify a lack of standardised approach with actions to improve communication with families. An update on the CQC action plan was given on request – 59 actions from the report in September 2022, have been progressing but there has been slippage – 13 actions are off track. Assurance was given that work had commenced and we are expecting to be on track by the end of August. **Escalation of concerns from HSIB** one case reported in the reporting period and one ongoing investigation.	Committee members thanked the Director of Midwifery for the continued improvements in the report. Issues with the attendance at the Safety Champion meeting was flagged as a concern. The Director of Midwifery agreed to work on this and to feed back at the next meeting.	Continue to engage with identified Quality Improvement Initiatives with the national team encouraging all staff in Maternity to participate in meetings as required and with the MSSP Programme. Report included within the Board pack

Maternity and Safety Support Programme (MSSP) The Maternity Team continue to work with allocated Maternity Improvement Advisor as part of the Maternity & Safety Support Programme (MSSP). The Diagnostic tool is on track for completion by June 2023 which will inform improvement plan development and exit criteria. Maternity governance 'deep dive' event is planned for June 2023 with expectation that this will review governance structure, processes, roles and responsibilities and the complaints process. MSSP exit criteria progress report has been received - it was disappointing to see that the report indicated little progress in key areas. To help further understanding the Maternity Advisor has been asked to share the criteria that is used to determine the progress status.		
Assurance		
Patient Story Patient story covering experience in a number of areas, attended ED in severe and increasing pain as a result of a twisted bowel. Initial experience in ED was poor, initially discharged without treatment but later readmitted and underwent colorectal surgery and formation of a stoma. Some issues reported in relation to time on the Surgical Assessment Unit but later experiences on ward 14 and with the stoma nurses were very positive. The story has been discussed with all ED staff and a number of actions have been put in place from the lessons learned.	Pain relief will feature within the fundamentals of care programme. Committee members discussed the clinical scenario, the diagnostic process for the presenting condition and the process for discharge from ED after senior review including review of X-rays and test results.	The lessons learned from the story have been picked up and are being discussed through sharing the story with clinical teams. QI work on fundamentals of care to be launched, programme in place to ensure audits of basic elements of care. Ward/Department dashboards will also provide an escalation route for metrics covering fundamentals of care.

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Clinical Governance Committee Chair Report No reports identified for formal escalation – a number of papers included within the QAC pack and picked up through the relevant agenda items Good assurance was noted regarding the arrangements to oversee progression of the Clinical Audit Forward Programme and efforts to strengthen assurance with regards to the implementation of NICE Guidance.	The Committee discussed the triangulation between the staffing report as presented to the Clinical Governance Committee and the staffing risks as discussed within the Risk Management Committee. Committee members asked for clarification on the staffing position and the correlation between the reports – overall there has been an improvement in fill rates however within the FICC division the fill rate for midwives is impacted because of the number of vacancies – plan for recruitment of newly qualified nurses in September address this issue.	The Committee will continue to receive regular updates on the implementation of PSIRF Next Professional judgement report on staffing to September Board will provide assurance
Getting it Right First Time (GIRFT) Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variation. A monthly oversight group ensures shared learning across Trusts in the ICB. A review of litigation included within the report identifies some areas in maternity in lower 5% for maternity	Committee members discussed GIRFT oversight – some specialties really engaged and progressing, the best engaged specialties are breast and urology. Committee discussed variation across specialties and ongoing work required.	Further reports require further assurance on performance outcomes and impact. Focusing on benefits realisation. - Suggestion that future reports have something at specialty level to give better illustration of how GIRFT is used to drive improvements in a specialty. Future report to provide assurance across the programme.
COAST Update provided on progress made by clinical areas against the COAST framework. 7 wards have achieved platinum status, 26 Gold, 15 silver and 6 areas within IMPF remain on bronze – support will be provided for these areas including buddy support from a platinum area. The actions identified in the MIAA internal report on COAST have been addressed Lead nurses from ICB have participated in recent inspections	Discussed measurement of collaborative whole team approach and recognised the plans to include medical engagement to the process to add to the quality of the visit to include medical teams to as part of the ward team. Discussed future changes in COAST 3.0 including support for patients with disabilities	Launch of fundamentals of care and QI programme to support wards to come out of bronze About to launch version 3 in liaison with experts from all areas to ensure expert support for each component. Further platinum standards drafted for review and approval – will be in the next report
Risk Management Committee No risks identified for escalation however the report highlighted a number of risks in relation to staffing which had been picked up during the discussion on the Clinical Governance Chair report	Committee members noted the progress made with the quality of discussion in the Risk Management Committee	Report noted

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Harm Free Care update Detailed update presented on harm free care. Falls – prevalence trending down 4.8 per 1000 occupied bed days with no moderate or above harm in April – keen to ensure learning from incidents – falls steering committee implemented – targeting work on patients who have multiple falls – majority are unwitnessed falls Pressure ulcers – overall increase however majority are deep tissue injuries and only a small amount become pressure ulcers – link identified with long stay in ED – tissue viability providing support and real time education in ED.	The team are introducing new assessment tool to identify patients at risk and linked to falls – intentional rounding will improve care planning. Recognised the risk for end of life patients – working with the end of life team and the palliative care team	Teams will continue to collaborate on improvements through the skin integrity panels and new falls community
Major Trauma Peer Review Action Plan The peer review was undertaken through a visit in Jan 2023 with the report provided late April giving a comparison against national standard and quality indicators. The review team were impressed with engagement from lead and from key departments and the QI work on management of elderly trauma. Previously talked about issues with TARN data – team assured by plans to address data entry issues.	Balance between report and action plan – reassured committee that the concerns raised are relatively minor and do not represent severe concerns Issues include training, radiology reporting, and consistent approach to trauma which sits in a number of areas within the Trust with an action to ensure a single point for all trauma reviews	Progress will be monitored by the Clinical Governance committee and escalated to QAC as needed
IPR Key metrics for harm free care and maternity covered on agenda. Other points to note: • IPC – good for C Diff – alert for E Coli • patient experience FFT for A and E needs improvement • Complaints turnaround time – focus is on quality of responses • SHMI continues to improve - time to death cert and coroner referral – changes to processes to reduce time taken to progress medical examiner scrutiny after the death of a patient	Challenge about the lack of targets for a number of metrics – for accuracy question about stillbirths clarified that there was one neonatal death in April and none in May	Continuing to review complaints process Meetings have been arranged to agree targets and set trajectories for metrics IPR included in Board pack

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Duty of Candour/ SIs and inquests Seven SIs in May and no never events 60 day compliance only 6/13 (46%) - six incidents had extensions approved and one breached	Discussed reporting and measurement of compliance – SI reports are measured for timeliness; Duty of Candour is a measure of provision – not within a timeframe Clear processes are followed for the SI process with action taken directly with the family if concerns not addressed	From next month there will be scrutiny through PIDA on overdue SIs Future report to include a glossary of standards
Quality Account Having previously received the full quality account the Committee received a brief update including the statements from stakeholders.	Quality Account unchanged – statements have been added to the final version	Final report will be published in accordance with the guidance and will be included in the Board papers.
CQC Actions Update Check and challenge sessions held to provide scrutiny of progress with actions to demonstrate assurance – next stage tabletop review of all action plans with feedback to challenge evidence to ensure it fully reflects position. CQC have formally advised that there will not be a formal prosecution in relation to sepsis	CB thanked the team for the work in collating the evidence to defend the CQC submission	Recognition of the impact of the work for the sepsis CB to write formal note of thanks Next report to include summary of number of actions/ actions closed as per MIAA report
Platinum COAST report Cardiac ITU – process followed for panel – recommend award platinum status – all current criteria met	All approved award of platinum status	Four specific stretch targets set to ensure continued improvement
Advise		
What	**So, What**	**What Next**
Committee Workplan	Workplan approved	Add GIRFT to workplan
Improving Fundamentals of Care Programme QI programme to support fundamentals of Care Programme using QI methodology to support improvements	Discussed benefits realisation	To Execs for approval on Tuesday

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	28/06/2023

Author	Jed Walton-Pollard, Deputy Director of Nursing					
Exec Sponsor	Bridget Lees, Executive Director of Nursing, Midwifery, Allied Health Professionals, Quality Chris Barben, Executive Medical Director					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					
Summary *(what)*	**Performance Highlights** **Cardiac Arrests** – The trust saw a decline in cardiac arrests comparing April 21 -22 to April 22-23 1.16 per 1000 v 0.916 per 1000 admissions. **Falls** - Falls remain within normal variation. **Pressure Ulcers (PU)** – PU remain within normal variation **Maternity** - There were no neonatal deaths in May 2023 and no Still Births. **Patient Experience** - Patients continue to rate the care they received positively with an overall rate of 95% stating the care was good or very good. Special attention needs to be given to the Emergency Department which has a 73% of patients stating the care was good or very good which is a 4% decrease on last month **Infection Control** - The Trust is currently on trajectory with all infection control KPI's except for E coli. A local Trust wide trajectory has been agreed for MSSA. **Mortality -** Crude mortality, HSMR and SHMI continue to be satisfactory with an improving trajectory.					

Previously considered by	NA

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	ü
	Our Population	ü
	Our Responsibility	ü

EDI implications considered	EDI implications of quality metrics are considered, and we continue the work to improve EDI reporting on patient records.

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

Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Quality Assurance Committee

May 2023

Caring ▪ Safe ▪ Respectful

Guide to Statistical Process Control

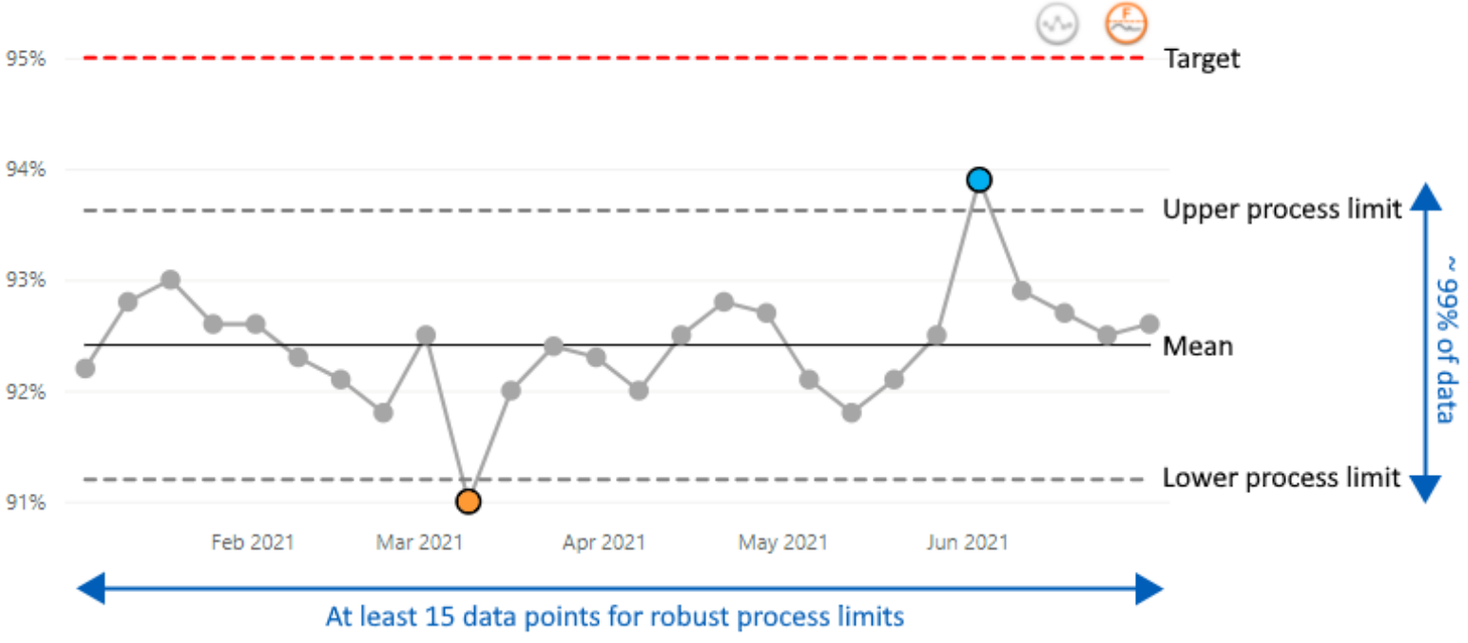
Blackpool Teaching Hospitals NHS Foundation Trust

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	L	
Quality	Harm Free	1	5		11		1	16			
	Patient Experience	3	9	1	1	1		11	1	1	
	Maternity				13	1		10	1		1
	Infection Prevention and Control		5		1		1	4	1		
	Mortality		1	2	3		3	3			

Assurance

Measures the likelyhood of targets being met for this indicator.

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

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

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.

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.

Blackpool Teaching Hospitals
NHS Foundation Trust

Harm Free

Cardiac Arrests
Advise
The resuscitation team at Blackpool Teaching Hospitals recorded 141 Adult cardiac arrests between April 2021 and April 2022 with 96 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. The total number of cardiac arrests in the trust in this time frame equates to 1.3 arrests per 1000 admissions to the trust.
As a comparison the figures between April 2022 and April 2023 are a total of 103 Adult cardiac arrests, with 60 outside those areas previously listed. The total number of cardiac arrests in the trust in this time frame equates to 0.916 arrests per 1000 admissions to the trust.
Assurance
The Trust continues to see a reduction in cardiac arrests rates.
Action
As described in the Trust QI Strategy, our approach to improvement is to use a Breakthrough Series collaborative, which launched in February 2021.
In addition, the Trust will shortly launch a further QI collaborative on the 'Management of the Acutely Unwell Patient' in September 2023.
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Patient Safety Alerts
Advise
There was 1 new patient safety alert received this month which is: NatPSA/2023/006/DHSC - Shortage of Pyridostigmine 60 mg tablets. The due response date for this is 26/05/2023.
Assurance/Actions
Patient safety alerts remain within normal variance.
This has now been completed so has not breached.

Serious Incidents
Advise
In May seven serious incidents (SIs) were reported on Steis, this compares to seven in April and 15 in March. Whilst the Trust would aim to have no SIs reported, seven is in-line with broadly consistent with previous monthly reports , and therefore isn't raising an alert as a concern or spike.
Assurance/Actions
The trust continues to monitor all 72hr Rapid Reviews via the twice weekly panel to ensure correct and earlier identification of SIs, track against the 60-day compliance for completion of reports, and engage with partner organisations.

Falls
Advise
In May 2023, there were a total of 111 incidents reported against the category of falls and this number includes near miss, falls with no harm and unvalidated incidents that are currently under review within divisions and are awaiting categorisation. Validated data shows 47 harms recorded because of a fall, at minimal harm compared to 56 the previous month.
Alert
1 fall was reported that resulted in a moderate to severe and is currently being reviewed following completion of the 72-hour review. Across inpatient areas, 24 wards reported zero falls.
Assurance
Falls remain within normal variance. Whilst there is no national trajectory on falls reduction. The Trust is in the process of setting a local one which will be reported next Month.
Actions
The fall's steering group has reviewed and updated the intentional rounding tool (IR) - this tool ensures that patients individual needs and risks are identified by staff and addressed to mitigate the risk of harm by proactively managing patient needs.

Blackpool Teaching Hospitals
NHS Foundation Trust

Harm Free

Pressure Ulcers
Advise
Acute:
A total of 93 hospital acquired pressure ulcers were reported in May 2023. The breakdown of this is: 41 Category 2's, 1 Category 3 and 0 at Category 4. The acute bed base reported 11 unstageable and 40 Deep Tissue Injuries. Although this is an increase, the
There were also 12 device related pressure ulcers that are not included in the IPR data.
During May, 21 clinical areas from the acute site declared zero hospital attributable skin damage; and of these areas - 7 have reported zero attributable skin damage in the last 6 months.
Assurance
The SPC chart shows the data is within normal variation.
Assurance/Actions
Since the pressure ulcer collaborative ended, the skin integrity committee continues to support the divisional teams to ensure prevention and management of skin and tissue damage remains in focus.

Community:
Advise
A total of 90 non-hospital acquired (community) pressure ulcers were reported in May 2023. The breakdown of this is: 33 Category 2's, 0 category 3's and 1 at Category 4, with 26 Unstageable and 30 Deep Tissue Injuries. There was also 1 device related pressure ulcer that are not within the IPR data.
Assurance
This was a decrease from the previous month and reviewing the SPC chart data is within normal variation.
During May 2023, 1 community teams identified as having acquired zero pressure ulcers.
Actions
The community Skin Surveillance Forum continues to monitor the pressure ulcer prevention journey within the division.

Quality

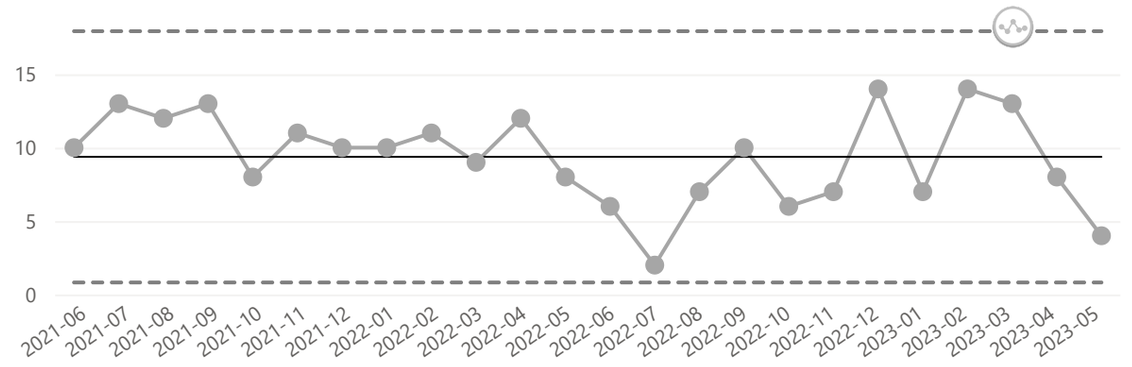
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Cardiac Arrest		4	May 23				8	Apr 23		12.00
IAPT Recovery	50%	58%	May 23		?	50%	58%	Apr 23		
IAPT Wait Times	75%	98%	May 23		P	75%	98%	Apr 23		
Over-seven-day incapacitation of a worker	0	0	May 23		?	0	1	Apr 23	0	1.00
Specified injuries to workers	0	1	May 23		?	0	0	Apr 23	0	1.00
New Community acquired pressure ulcers, trust attributable actual		90	May 23				94	Apr 23		184.00
New Hospital acquired pressure ulcers actual		93	May 23				75	Apr 23		168.00
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days		1.56	May 23				1.21	Apr 23		2.77
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days		0.06	May 23				0.06	Apr 23		0.12
Patient Safety Alerts		1	May 23				0	Apr 23		1.00
Number of SUI/StEIS incidents		7	May 23				7	Apr 23		14.00
Number of never events	0	0	May 23	L	?	0	0	Apr 23	0	0.00
Number of falls		111	May 23				114	Apr 23		225.00

Quality

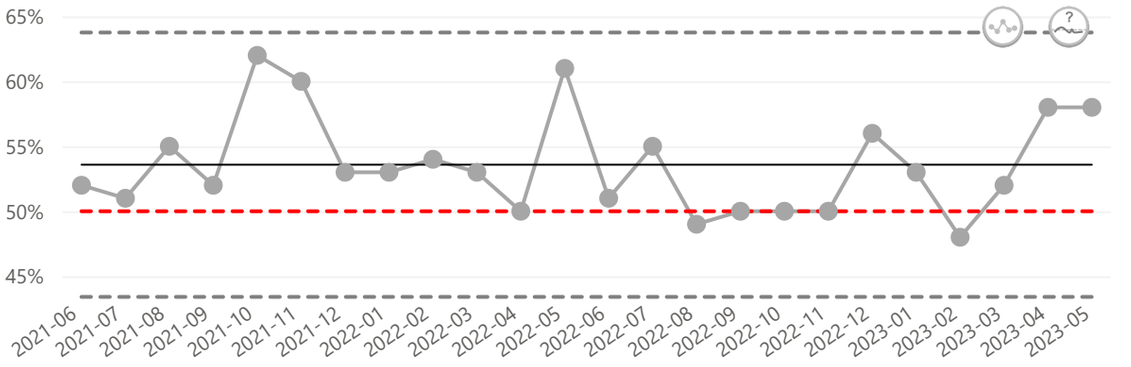
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Patient Falls resulting in harm (number)		48	May 23				56	Apr 23		104.00
Patient Falls - Moderate/Severe/Death - per 1,000 bed days		0.04	May 23				0	Apr 23		0.04
Safe Staffing	90%	94.3%	May 23			90%	92.7%	Apr 23		
30 Day Emergency Readmissions (%)		8.21%	Feb 23				7.64%	Jan 23		

Quality

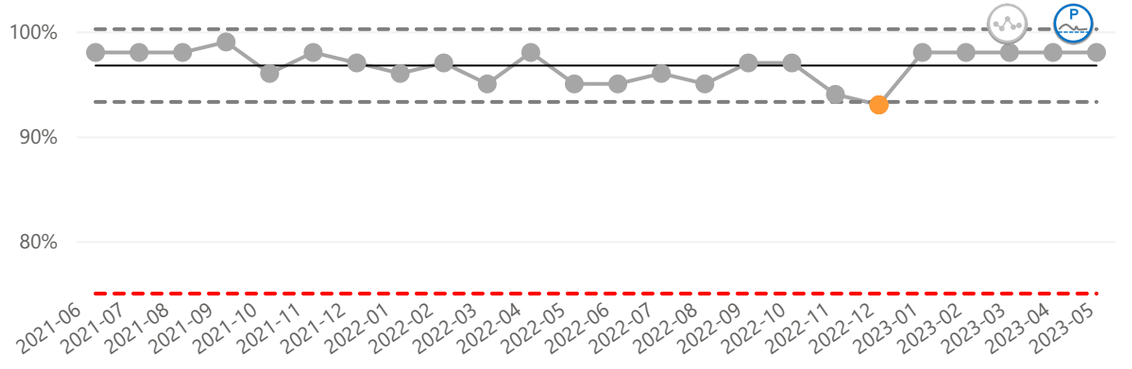
Cardiac Arrest



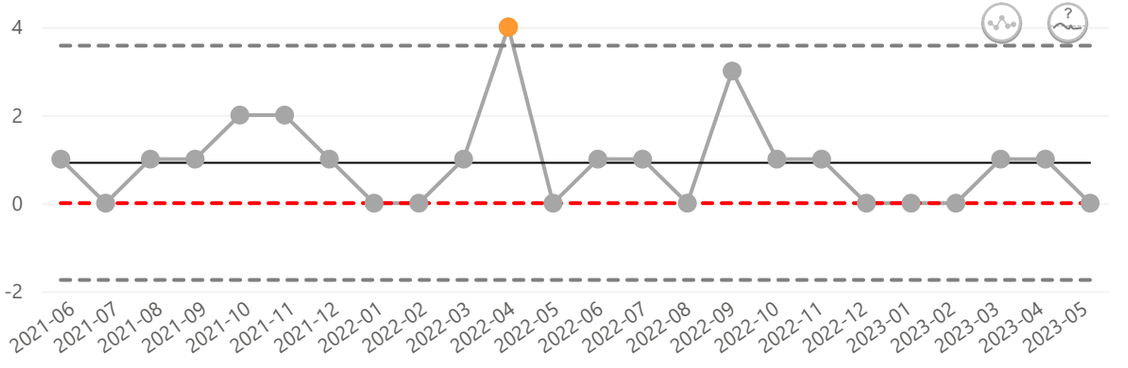
IAPT Recovery



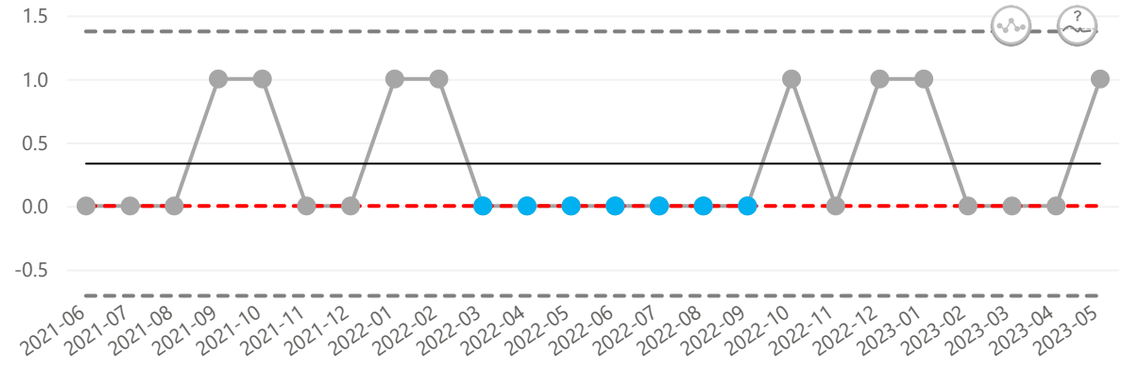
IAPT Wait Times



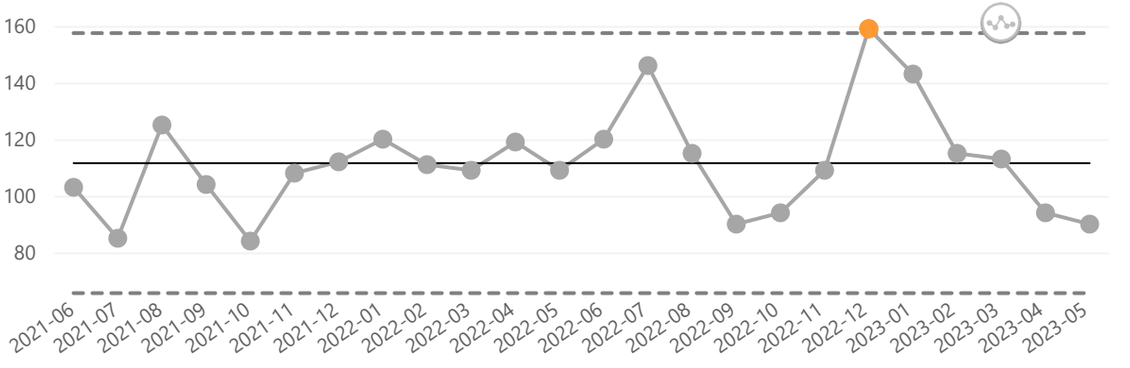
Over-seven-day incapacitation of a worker



Specified injuries to workers

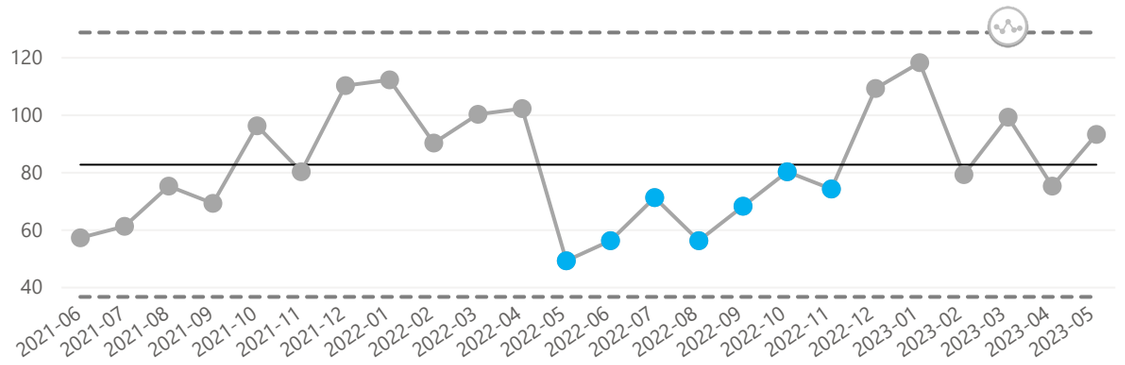


New Community acquired pressure ulcers, trust attributable actual

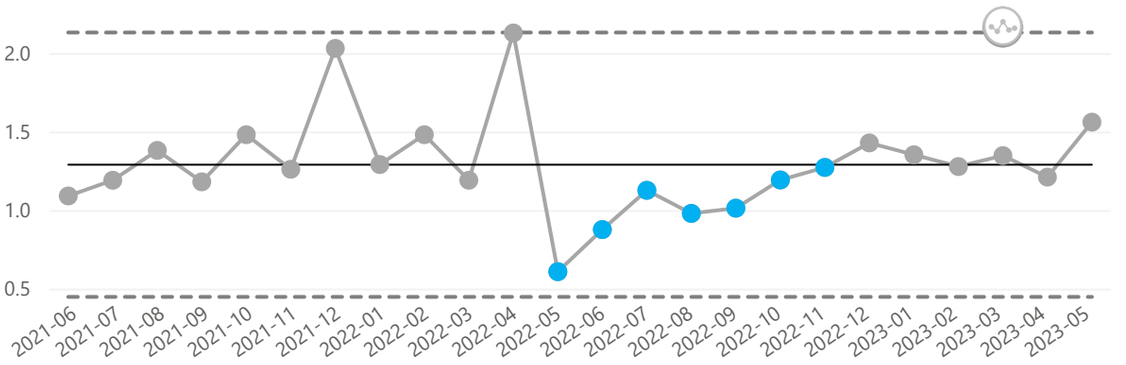


Quality

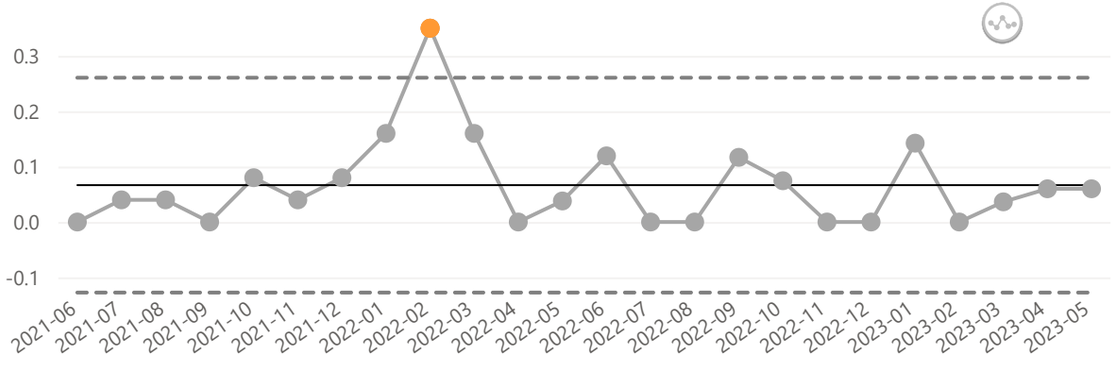
New Hospital acquired pressure ulcers actual



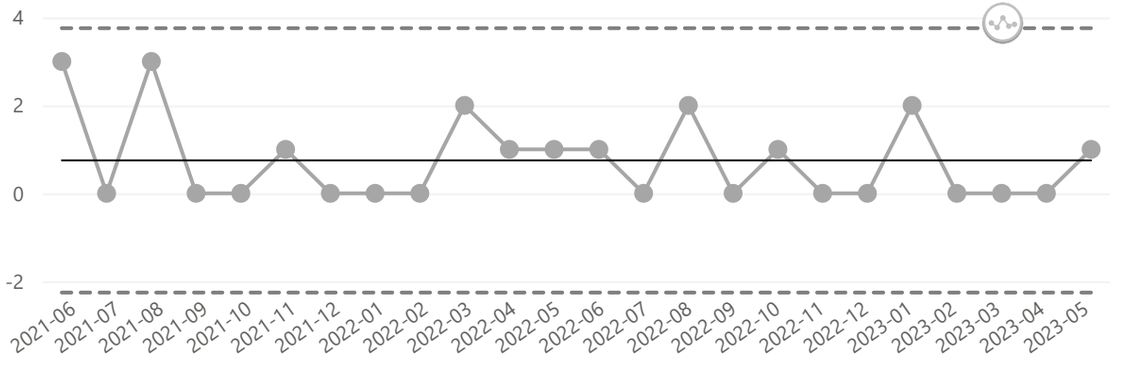
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



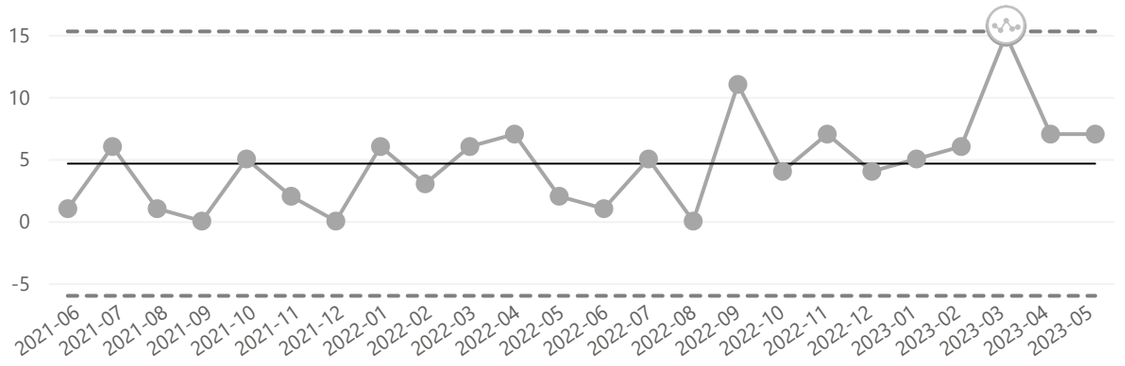
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



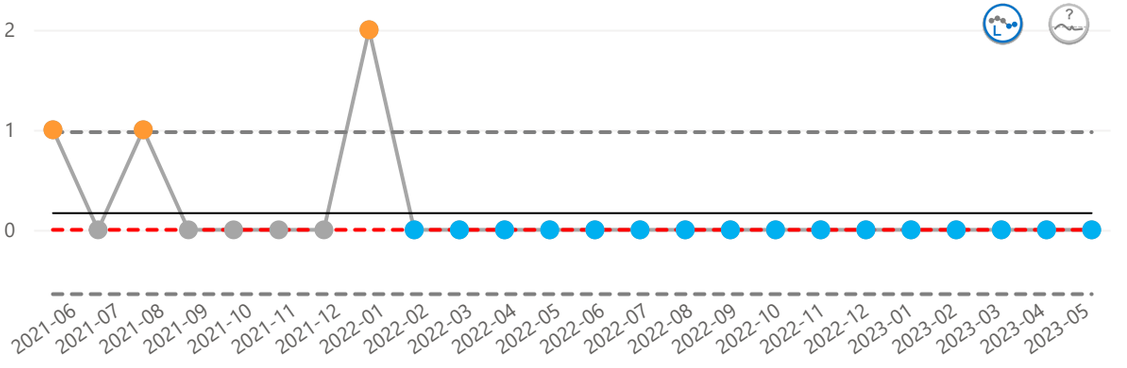
Patient Safety Alerts



Number of SUI/StEIS incidents

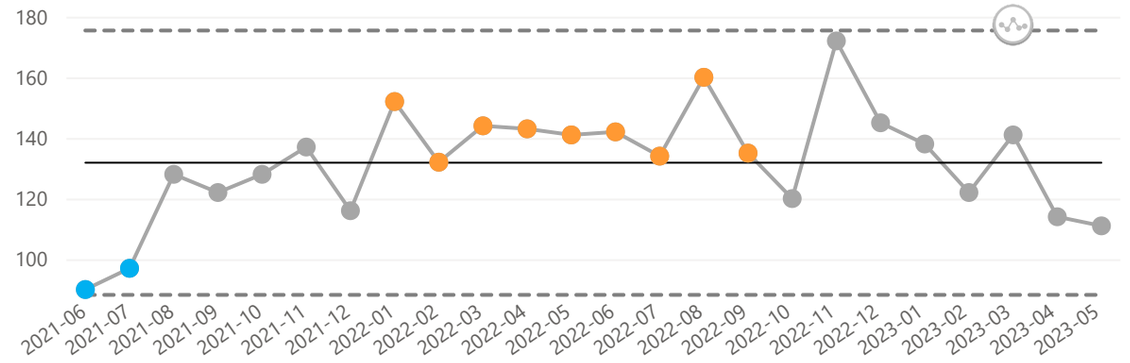


Number of never events

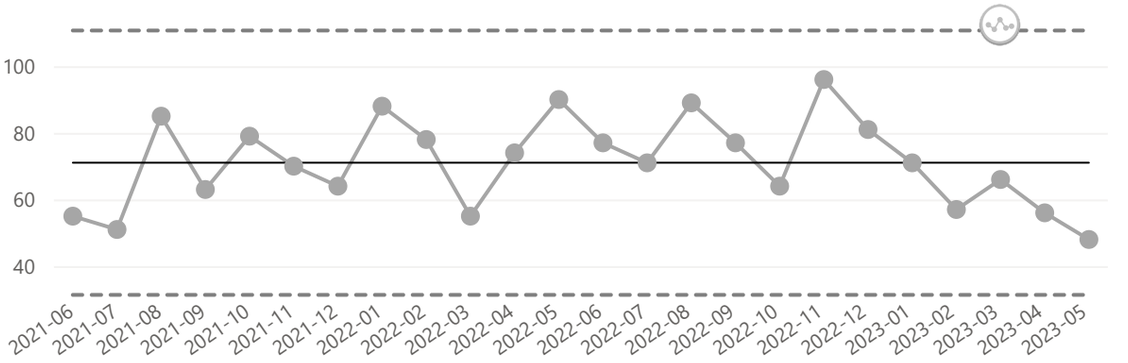


Quality

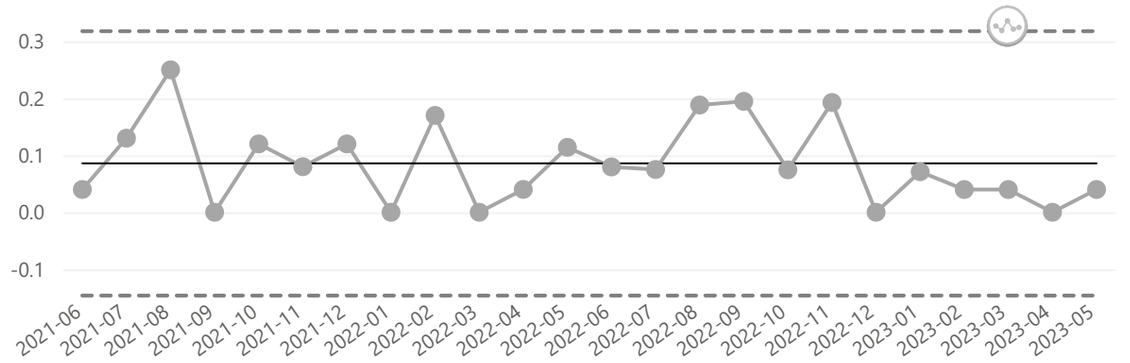
Number of falls



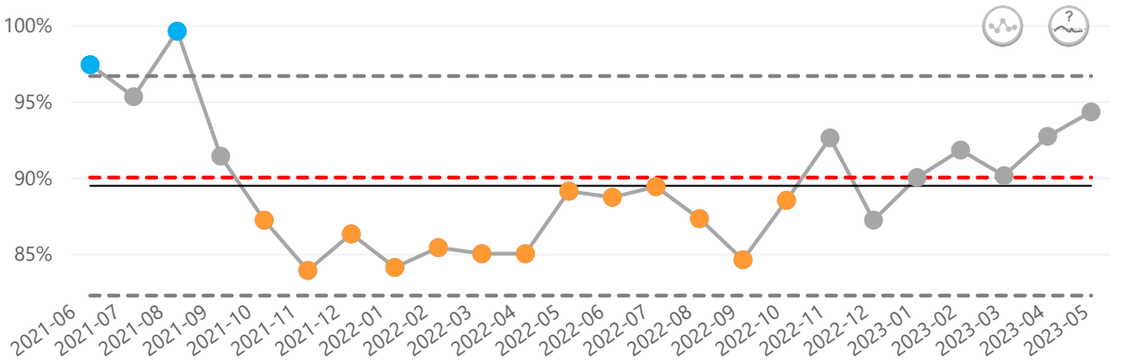
Patient Falls resulting in harm (number)



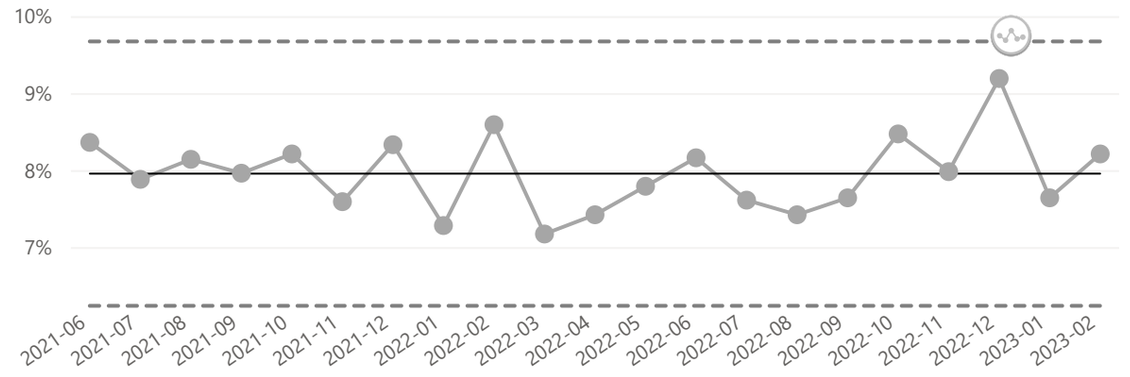
Patient Falls - Moderate/Severe/Death - per 1,000 bed days



Safe Staffing



30 Day Emergency Readmissions (%)



Blackpool Teaching Hospitals
NHS Foundation Trust

Maternity

Cesarean rates
Advise
Cesarean Section rates are monitored for local information only as recommendation from Ockenden.
WHO recommends that 'Robson's classification' be used to gather information only instead of performance metrics. Robson's classification are based on 5 basic obstetric characteristics that are routinely collected in all maternity units (parity, number of fetuses, previous cesarean section, onset of labour, gestational age, and fetal presentation.
Assurance/Action
The Division is currently working through how this information can be collated and included in maternity metrics

Induction Rate
Advise and Assurance
Quarterly audits completed of all inductions of labour and snapshots audits completed monthly. Reduced fetal movements and static growth are main reasons for induction and policy is followed.

Induction of labour - % within 4 hours
Alert– triggering due to two data points below the average
Assurance/actions
Issues regarding robustness of data for transfer to delivery suite within 4 hours.
Work is currently underway to implement an automated reporting system.

Percentage booked by 12 weeks & 6 days
Assurance:-
Performance at 88% expected improvement next month

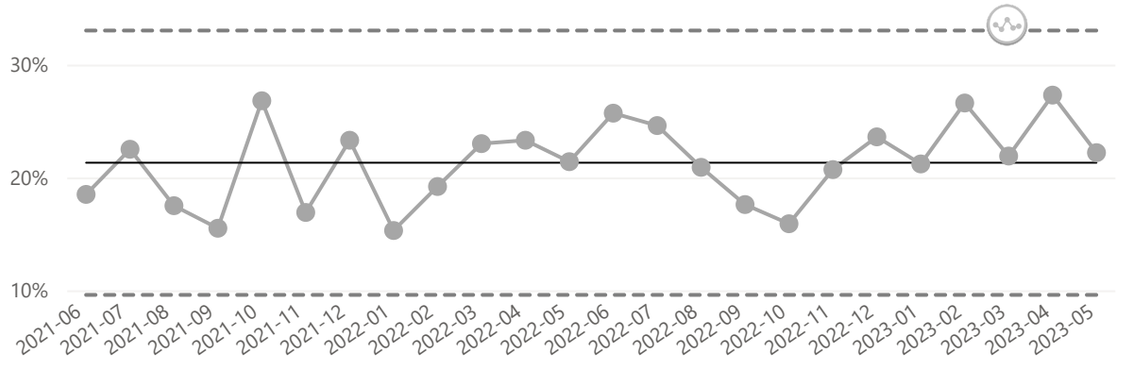
Perineal Repair
(Assisted and Unassisted)
Assurance/Actions
Perinatal pelvic health is a focus for Lancashire and Cumbria LMNS and maternity units in region are working collaboratively. Focus will be on training MDT Team via train the trainer and cascade refresher training on OAS12 by end of November 2023. Recruitment of 0.5wte Specialist Pelvic Health Midwife post supported by LMNS.

Quality

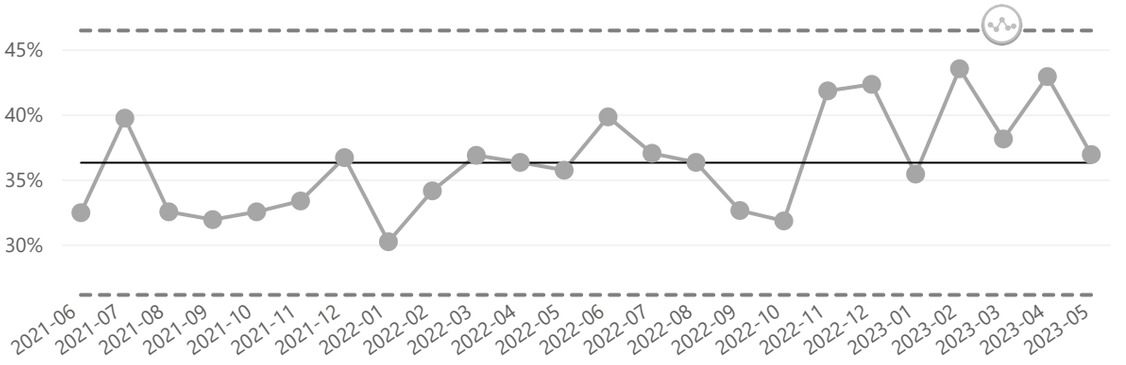
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Emergency C Section		22.2%	May 23				27.3%	Apr 23		
Caesarean Rates		36.9%	May 23				42.9%	Apr 23		
Breastfeeding Initiation		69%	May 23				63.2%	Apr 23		
Neonatal Mortality		0	May 23				0	Apr 23		0.00
Stillbirth		0	May 23				1	Apr 23		1.00
Number of Maternal Deaths		0	May 23				0	Apr 23		0.00
Induction Rate		43.3%	May 23				50%	Apr 23		
Maternity Complaints as % of Deliveries		1%	May 23				1%	Apr 23		
Percentage of Occasions 1:1 Care Provided		97.7%	May 23	H			98%	Apr 23		
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births		2%	May 23				1.8%	Apr 23		
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth		7.9%	May 23	H			4.4%	Apr 23		
Percentage of Women Booked by 12 weeks 6 days		88.0%	May 23				91.3%	Apr 23		
Induction of Labour - % within 4 hours		20%	May 23				7%	Apr 23		

Quality

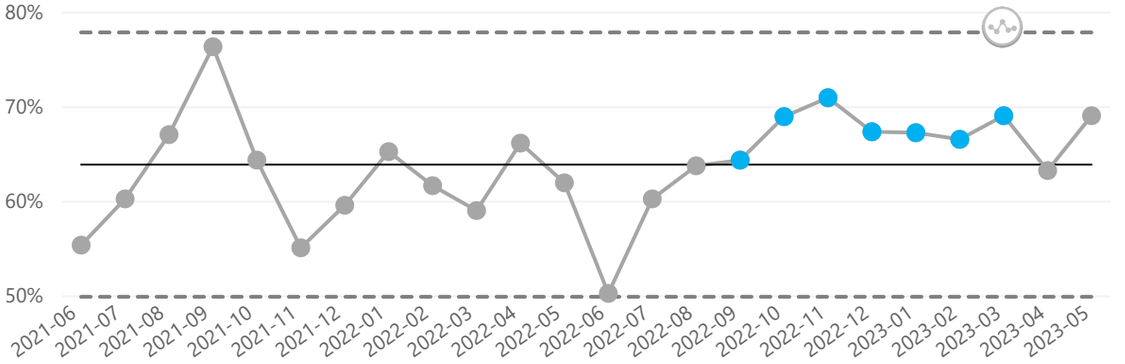
Emergency C Section



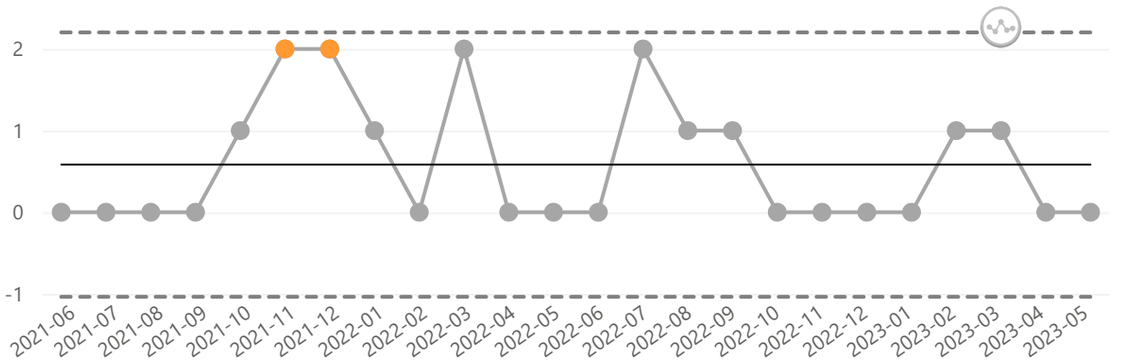
Caesarean Rates



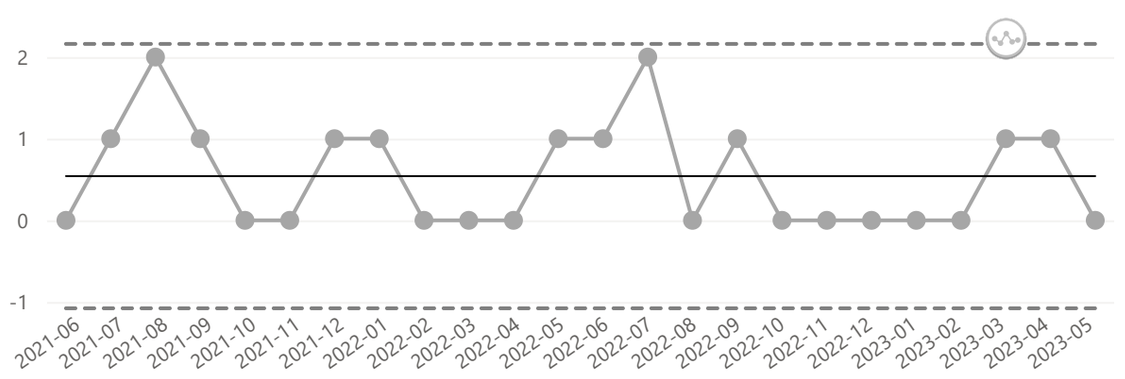
Breastfeeding Initiation



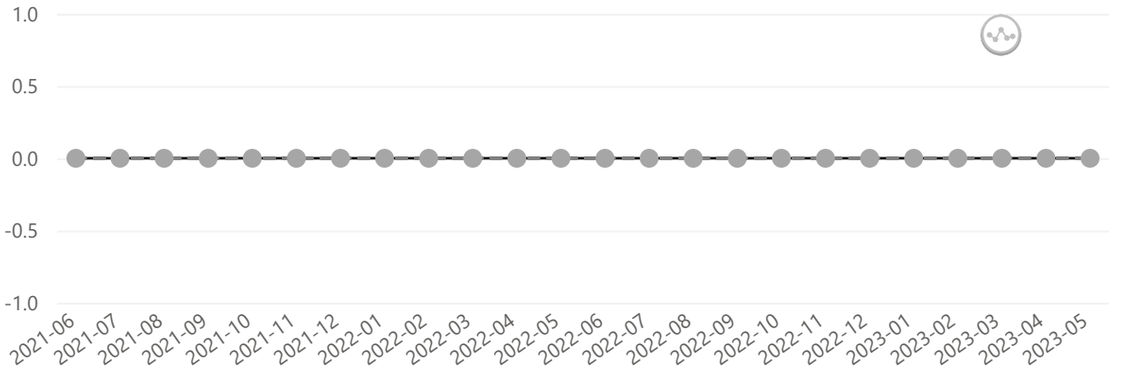
Neonatal Mortality



Stillbirth

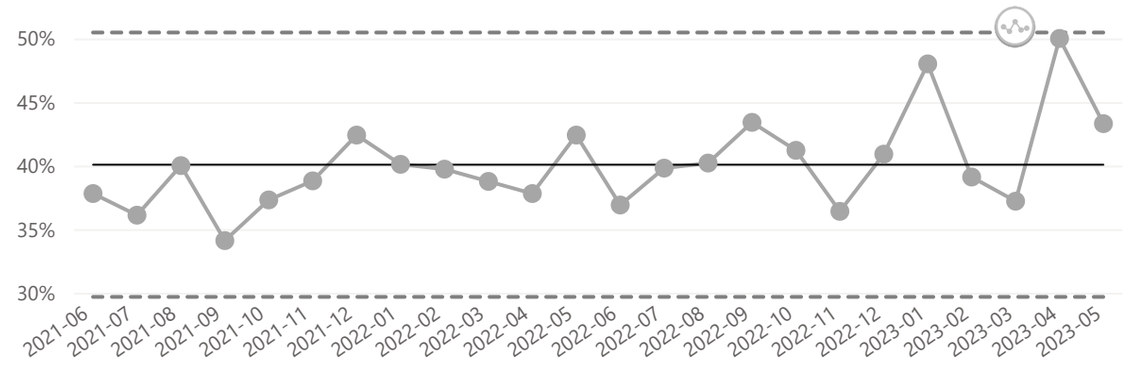


Number of Maternal Deaths

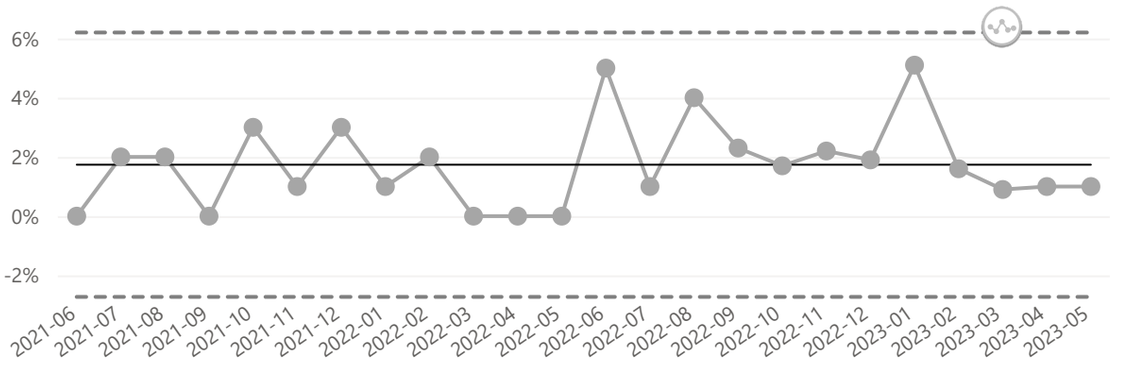


Quality

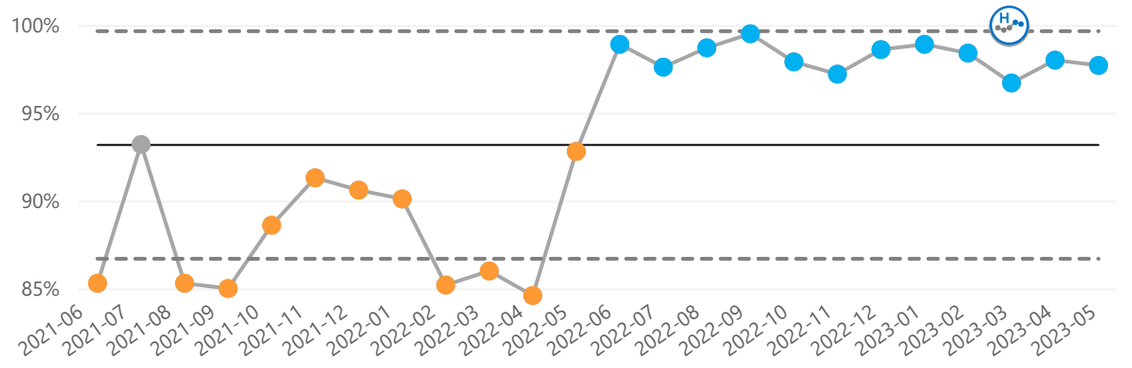
Induction Rate



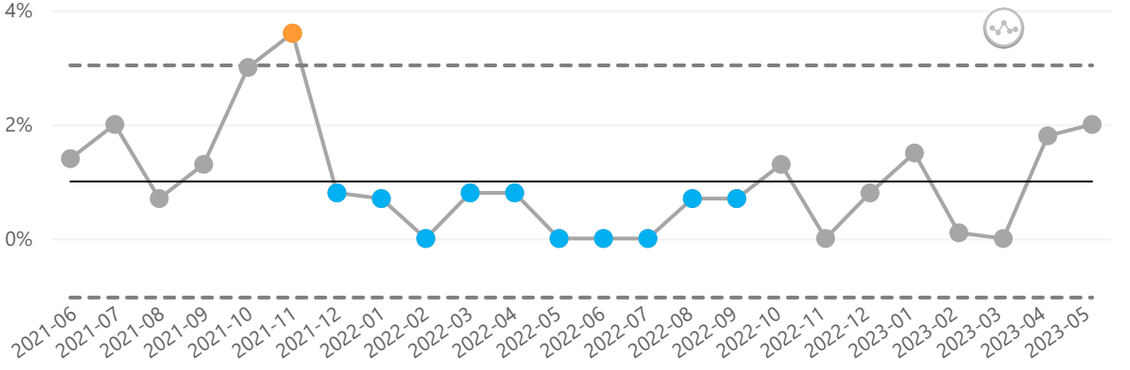
Maternity Complaints as % of Deliveries



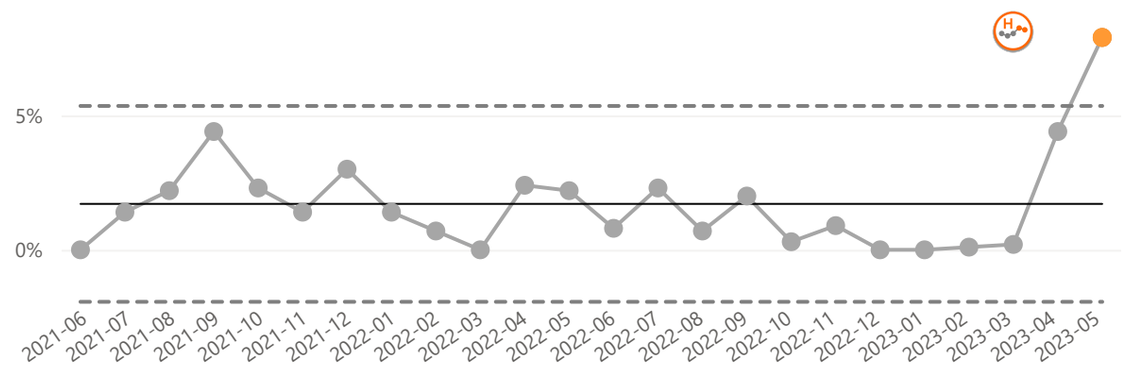
Percentage of Occasions 1:1 Care Provided



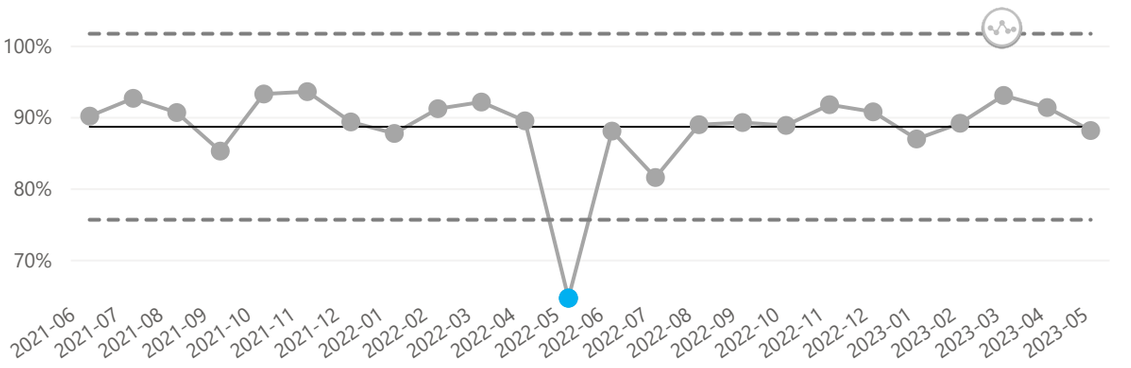
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births



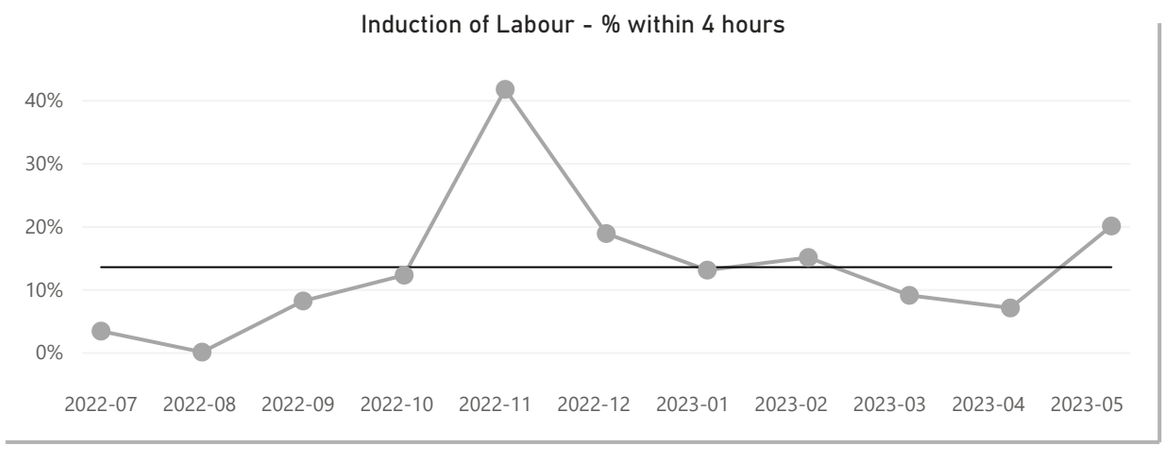
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth



Percentage of Women Booked by 12 weeks 6 days



Quality


Induction of Labour - % within 4 hours
40%
30%
20%
10%
0%
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05

Blackpool Teaching Hospitals
NHS Foundation Trust

Patient Experience

Overall, Friends and Family Test
Advise: There were 5484 FFT surveys completed in May 2023, which is an 11% increase compared to April 2023. SMS is continuing to be rolled out across the Trust, with 43% (2355) of the feedback in May collected via SMS or online.
Alert: 95% of our patients rated their care as good in May which is the same as the previous month, however this remains below the Trust's target of 96%.
Actions: The monthly meetings with services continue to discuss their FFT feedback, where we agree key priorities to improve the patient and carer experience. Patient Engagement continue to share topics on social media every month. One example being promoting staff shout outs and the importance of logging compliments. This is then fed back to the teams, and the shout out winners are awarded with a voucher and certificate to help boost morale. Patient Engagement have created a monthly slide of 'Hotspot Areas' to present to Risk and Freedom to Speak up, this features wards and departments where specific issues are arising, lessons learned and areas of excellence.

Outpatients and Day Case
Advise: There were 2534 FFT surveys completed for outpatients and day case in May, which is a 14% increase compared to April.
Assurance: The overall satisfaction rating was 96%, which is the same as April and keeping in line with the Trust target.
Actions: Patient Engagement are currently participating in COAST assessments, giving us the opportunity to talk with patients on different wards and outpatient departments. This will help widen our understanding of the challenges faced by both patients and staff, acknowledging ideas that we can implement within the team and surrounding areas. Patient Engagement continues to meet with the outpatient clinical matron to identify themes and define an agreed improvement plan. An in-depth monthly report is emailed to the staff from the matron highlighting what is working well and where there is room for improvement. Work is ongoing in cleansing the SMS clinic list for outpatients, with 39% of outpatient feedback this month via SMS, which will inform more targeted actions going forward.

Inpatient
Advise: There were 1190 FFT surveys completed by inpatients across Clifton and BTH sites in May, which is a 17% increase on the previous month.
Assurance: The overall satisfaction rating was 97%, which is a 3% increase compared to April and above the Trust target.
Actions: During Volunteer's Week, our listeners took to their roles whilst working alongside the executive director of nursing to speak to patients about their experience on the ward, giving us real time feedback. This was then promoted to the wards via email highlighting any common themes which were emerging. The Patient Engagement team also attended the Picnic in the Park to celebrate Volunteer's week, this was an opportunity to thank them and recognise all the hard work they do. Patient Engagement have arranged meetings with the clinic leads of the SACCT division to discuss FFT response rates and patient satisfaction for the upcoming months. SMS has been launched within inpatient areas which is supporting the numbers of responses received. However, 81% of feedback returned this month for inpatient areas have been paper surveys.

Emergency Department / Same Day Emergency Care
Advise: There were 248 FFT surveys completed in May, which is a 12% increase compared to April.
Alert: The overall satisfaction rating was 73%, which is a 4% decrease on the previous month and remaining below target.
Actions: The monthly meetings with the ED service leads continue to take place to identify new and emerging themes.

Maternity
Advise: There were 147 FFT surveys completed for maternity in May, which is a 10% increase compared to April.
Alert: The overall satisfaction was 94%, which is a 1% increase on the previous month but remaining below target.
Assurance/Actions: Patient Engagement continue to hold monthly meetings with the maternity team. The team made a conscientious effort to visit the wards and spoke to the maternity matron. A separate meeting has now taken place with the maternity and community matron to discuss the feedback.

Patient Experience

Community
Advise: There were 1274 FFT surveys completed in May within the community, which is a 7% increase compared to April.
Assurance: The overall satisfaction was 96% which is a 1% decrease yet keeping in line with the Trust target.
Actions: The Patient Engagement team are working closely with the sexual health services to promote the importance of alternative translated FFT forms. This will increase the number of surveys from patients who cannot provide feedback in English. This month the Patient Engagement and sexual health team won the Bristol Patient Safety Poster Award for the work we have implemented. This is something we hope to roll out to all services in the future. The Patient Engagement team have arranged meetings with different localities within the sexual health services to discuss the FFT and what we can offer as a department. This month we attended the east locality sexual health staff meeting and are continuing to meet with other sexual health services in the upcoming months.

Paediatrics
Advise: There were 432 FFT surveys completed across paediatrics in May, which is an 8% increase compared to April.
Assurance: The overall satisfaction was 96%, which is a 3% increase on the previous month meeting the Trust target.
Actions: The Patient Engagement team met with the new Children's Engagement lead, giving in depth training on the experience system and talking through the importance of the FFT. Patient Engagement continue to hold meetings with the Children's Engagement leads in both the community and acute settings to discuss how we can improve the FFT feedback.

Mental Health
Advise: There were 91 FFT surveys completed within mental health in May which is a decrease of 88 surveys from the previous month.
Assurance: The overall satisfaction was 98%, which is a 5% increase and above the Trust target.
Actions: Patient Engagement continues to hold meetings with informatics every two weeks to roll out and embed the SMS survey. We have now finalised the frequency with each service, and it has been scripted. We are in the process of conducting a SMS test extract and hope to have this in place over the next quarter. This will drive up the FFT numbers and encourage consistent feedback across all mental health services. Patient Engagement have also reached out to the lead of each mental health service to arrange a meeting to discuss FFT feedback.

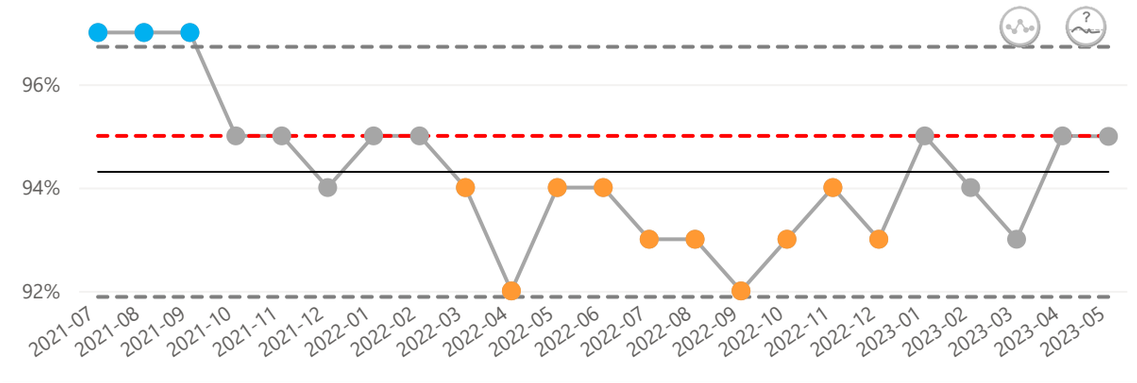
Complaints
Advise: May 2023 saw an achievement of 67% of complaints being responded to completed within our 25/40-day timescale with 14 of 42 still pending. We received 42 new formal complaints, which is an increase from 35 the previous month. There were 14 second responses due to be answered within the agreed 40-day timescale, with 3 of the 14 finalised within this time. The key themes reported remain treatment / care issues, waiting times and a lack of communication. The Patient and Family Relations Team also dealt with 8 informal concerns and 1,407 general enquiries as we continue to resolve concerns at the earliest opportunity.

Mixed Sex Breaches
Alert: We had 12 mixed sex breaches in May. The mixed sex breaches occurred where patients of the opposite sex had to use the same toilet facilities. None of the incidents occurred as a result of sharing the same sleeping accommodation.
Once capacity allowed patients were moved to ensure further breaches did not occur.

Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
FFT Overall - % Rated Good or Very Good	95%	94.9%	May 23		?	95%	95%	Apr 23		
FFT AE - % Rated Good or Very Good	95%	72.5%	May 23		F	95%	77%	Apr 23		
FFT Community - % Rated Good or Very Good	95%	96.3%	May 23		?	95%	97%	Apr 23		
FFT Inpatients - % Rated Good or Very Good	95%	96.5%	May 23	L	?	95%	94%	Apr 23		
FFT Outpatients / Day Case - % Rated Good or Very Good	95%	95.7%	May 23		?	95%	96%	Apr 23		
FFT Maternity - % Rated Good or Very Good	95%	93.8%	May 23		?	95%	93%	Apr 23		
FFT Mental Health - % Rated Good or Very Good	95%	97.8%	May 23		?	95%	93%	Apr 23		
FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED	15%	20.5%	May 23	H	?	15%	18.6%	Apr 23		
Mixed Sex breaches	0	12	May 23	H	?	0	0	Apr 23	0	12.00
Duty of Candour – Stage 1a – Initial Verbal	100%	100%	May 23		P	100%	100%	Apr 23		
Duty of Candour – Stage 1b – Initial Written	100%	100%	May 23		P	100%	100%	Apr 23		
Duty of Candour – Stage 2 – Final DoC	100%	100%	May 23		P	100%	100%	Apr 23		
Complaints Formal (number)		42	May 23				35	Apr 23		77.00
Complaints - % closed within 40 working days	80%	67%	May 23		?	80%	87%	Apr 23		

Quality


FFT Overall - % Rated Good or Very Good
96%
94%
92%
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
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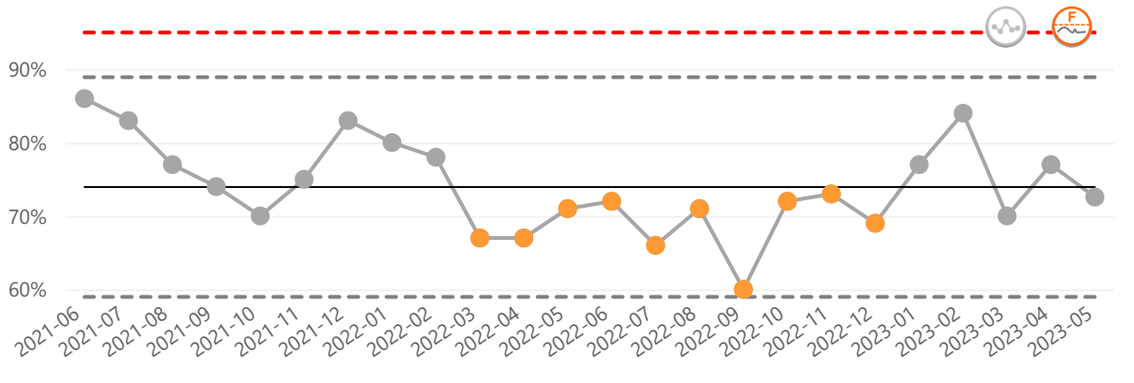
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


FFT AE - % Rated Good or Very Good
90%
80%
70%
60%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
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2023-02
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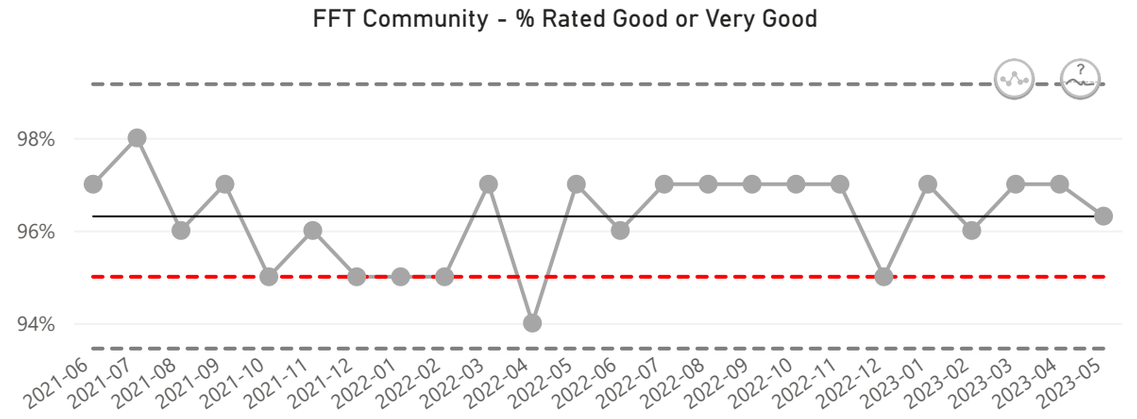
2023-05


FFT Community - % Rated Good or Very Good
98%
96%
94%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
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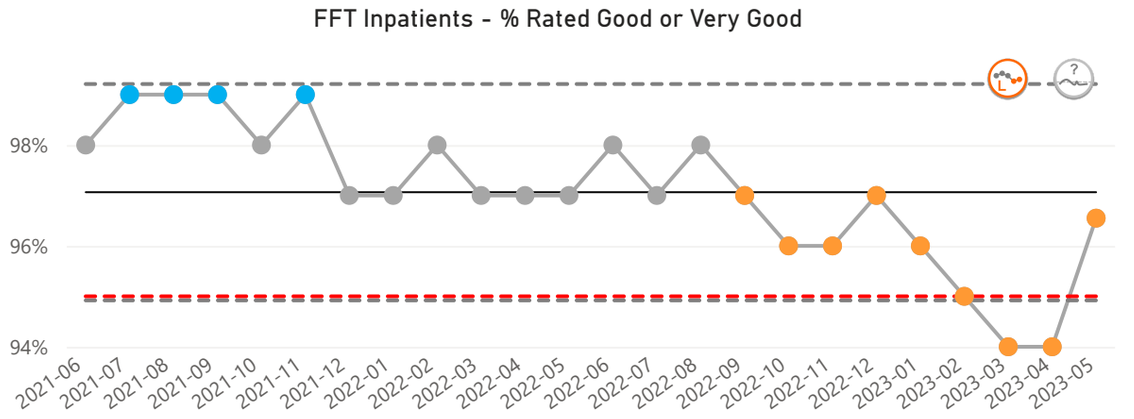
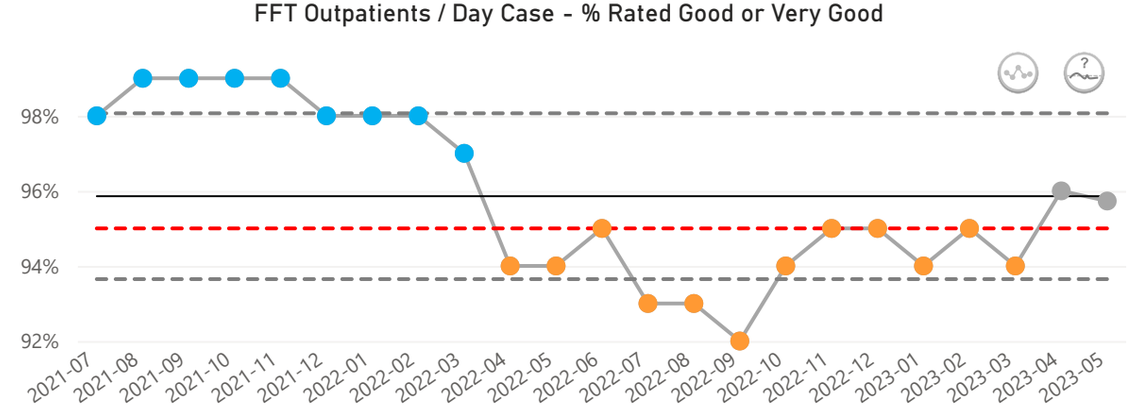
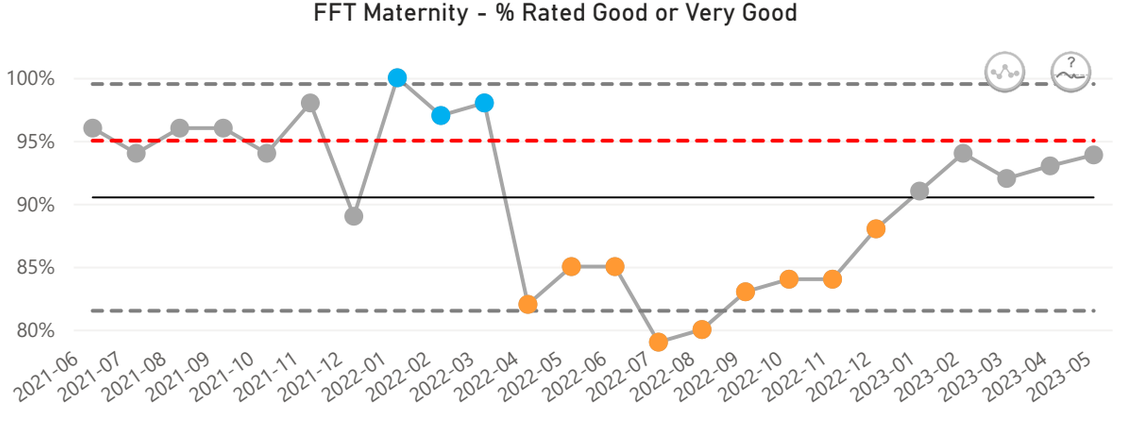
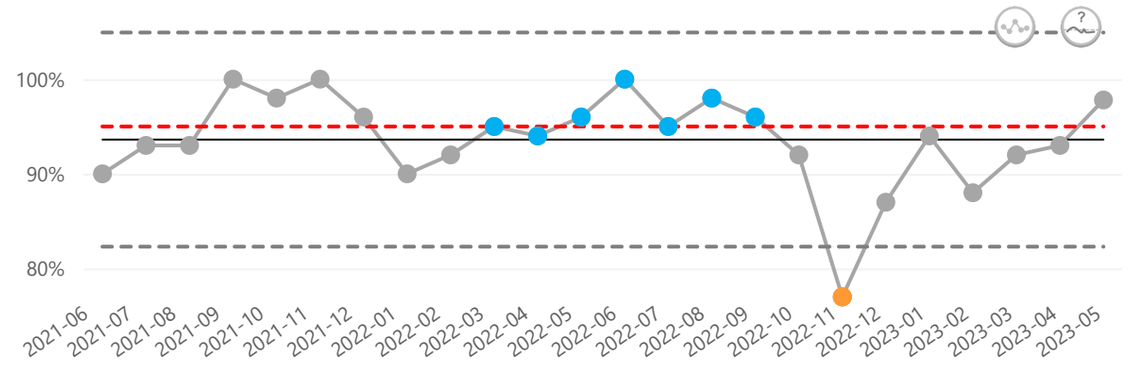
2023-05


FFT Inpatients - % Rated Good or Very Good
98%
96%
94%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


FFT Outpatients / Day Case - % Rated Good or Very Good
98%
96%
94%
92%
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


FFT Maternity - % Rated Good or Very Good
100%
95%
90%
85%
80%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05

Quality


FFT Mental Health - % Rated Good or Very Good
100%
90%
80%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
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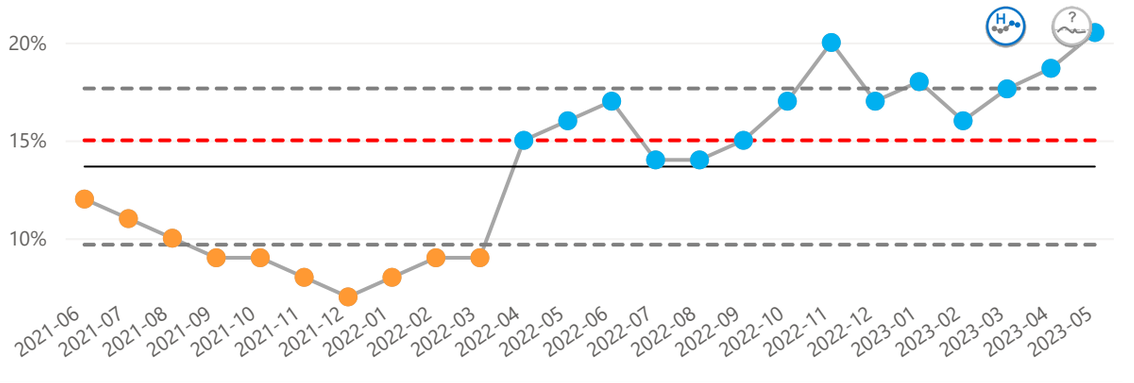
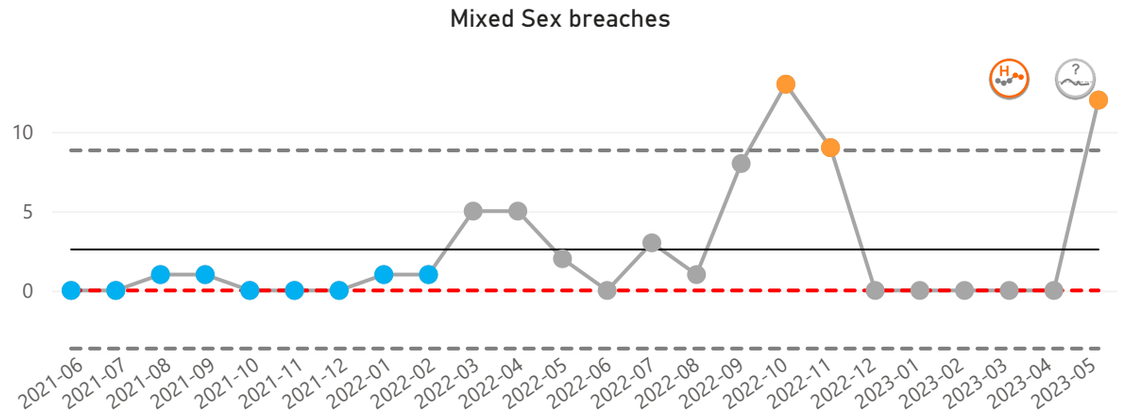
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED
20%
15%
10%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


Mixed Sex breaches
10
5
0
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
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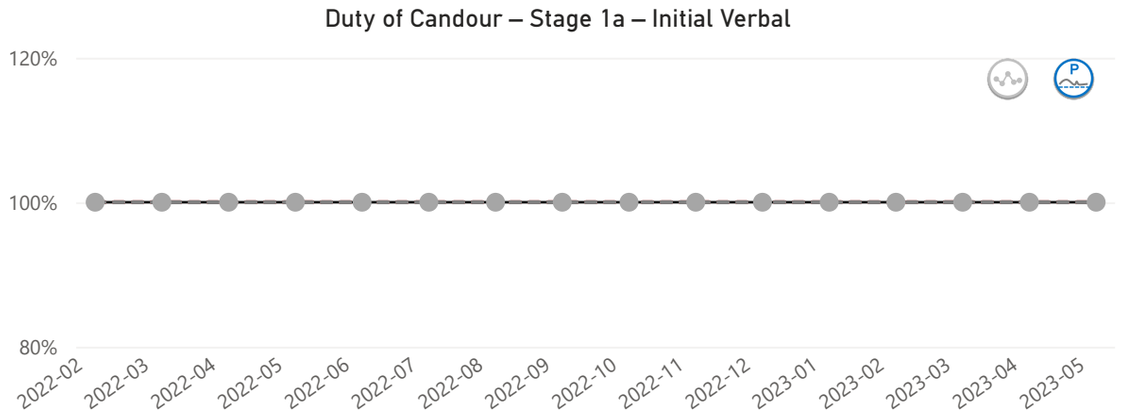
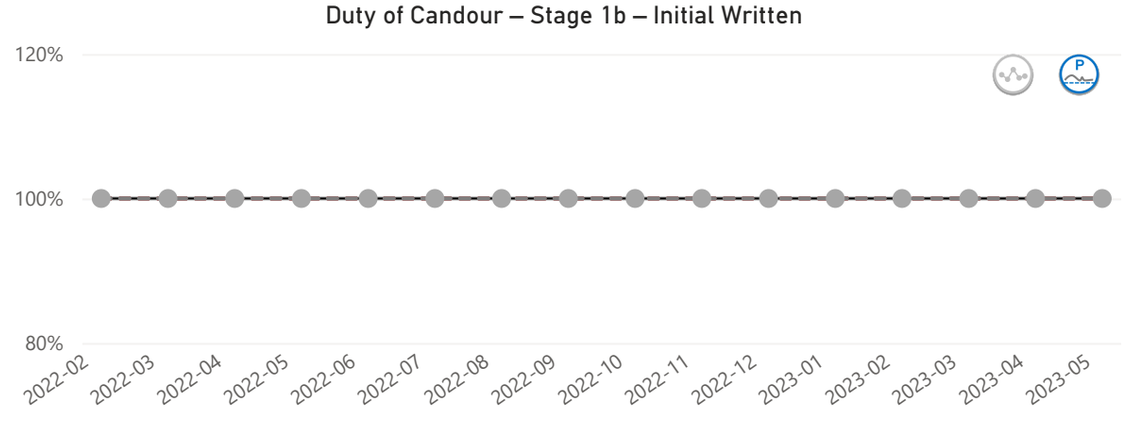
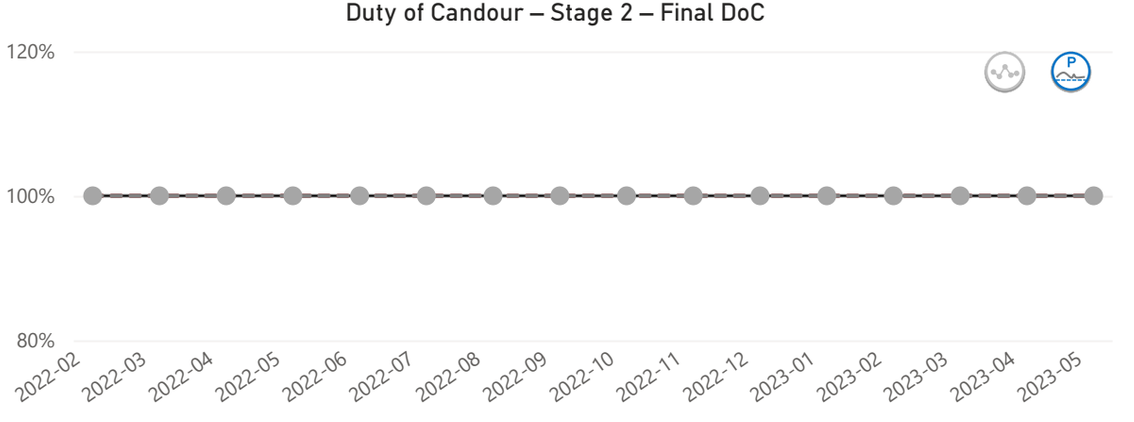
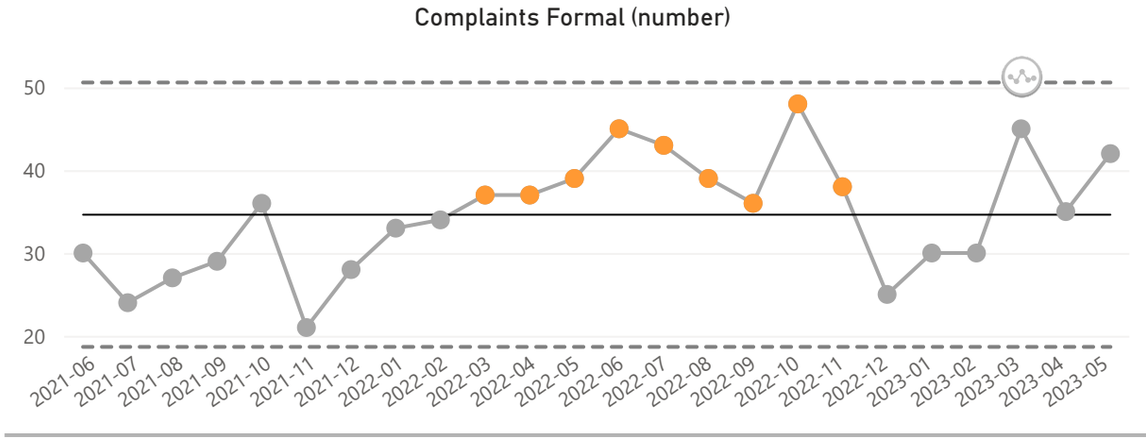
2023-01
2023-02
2023-03
2023-04
2023-05


Duty of Candour – Stage 1a – Initial Verbal
120%
100%
80%
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


Duty of Candour – Stage 1b – Initial Written
120%
100%
80%
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05


Duty of Candour – Stage 2 – Final DoC
120%
100%
80%
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05

Quality


Complaints Formal (number)
50
40
30
20
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
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2023-01
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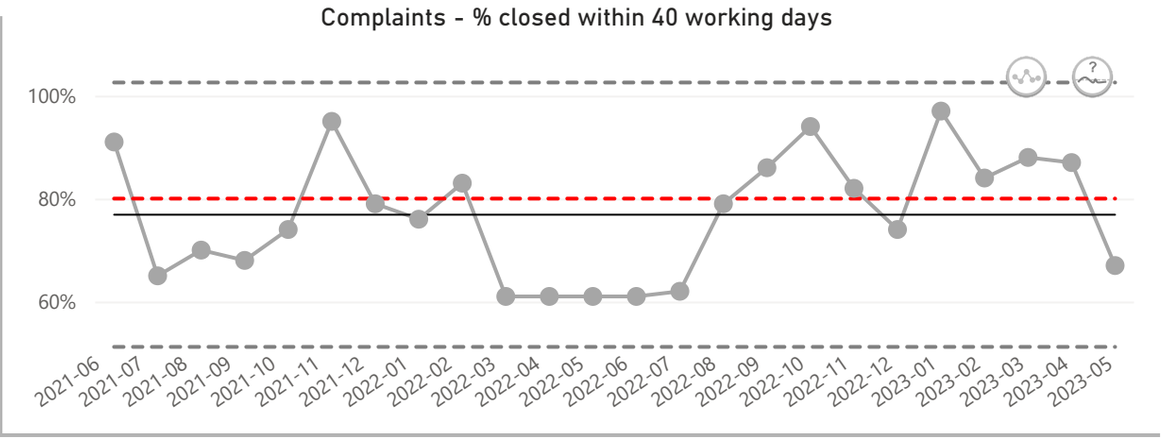
2023-03
2023-04
2023-05


Complaints - % closed within 40 working days
100%
80%
60%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05

Blackpool Teaching Hospitals
NHS Foundation Trust

Infection Prevention and Control

MRSA
Advise - No cases of MRSA bacteraemia were attributed to the trust in April or May 2023. The threshold for MRSA remains at zero.
Assurance - The Trust is meeting the Zero threshold

CDI
Advise - Five cases of CDI were attributed to the trust in May 2023. The new NHS Standard Contract threshold for 2023/24 is 89 cases for the year, or 7.4 cases per month.
Assurance - The trust is currently within plan for this infection.

Pseudomonas aeruginosa
Advise - No cases of Pseudomonas aeruginosa were attributed to the trust in April or May 2023. The new NHS Standard Contract threshold for 2023/24 is 18. Therefore,
Assurance - The trust is currently within plan for this infection.

Klebsiella spp.
Advise - Four cases of Klebsiella spp. were reported in May 2023. The NHS Standard Contract threshold for 2023/24 is 41.
Assurance - The trust is currently within plan for this infection.

E. coli
Advise - Eighteen cases were reported in May 2023 against a new 2023/24 NHS Standard Contract threshold of 86 (7.1 cases per month).
Alert - The trust is currently above plan for this infection.
Further Narrative - Data provided by NHS England shows that 18 of the 24 acute trusts in the northwest breached their threshold for E. coli in 2022/23 and case numbers are rising nationally. This increase is being investigated by the UKHSA. Locally, RCA investigations have determined that urinary tract infections are the most common source and pilot projects, which aim to improve hydration (which can prevent UTIs) are being led by NHS England.

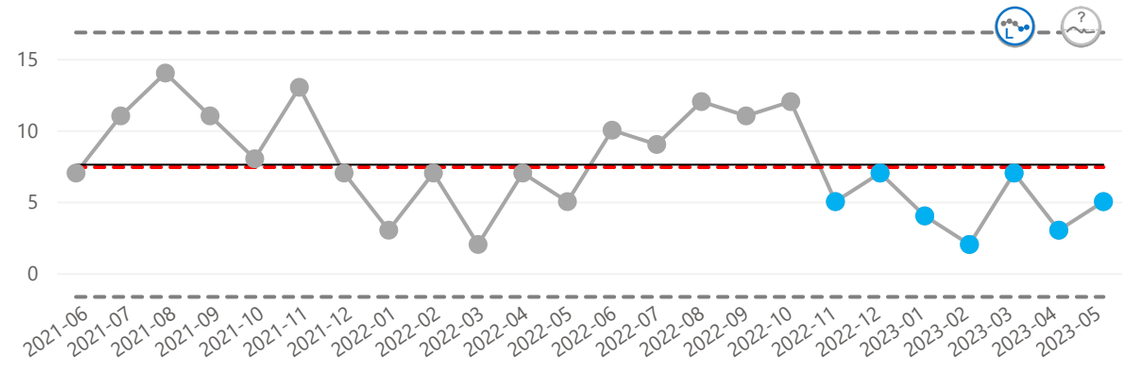
MSSA
Seven cases of MSSA were attributed to the trust in May 2023. A local threshold for MSSA has been agreed with the Director of Infection control of no more than 44 cases which is a 10% reduction on last year.
Alert - The trust is not on track to meet this local trajectory.

Quality

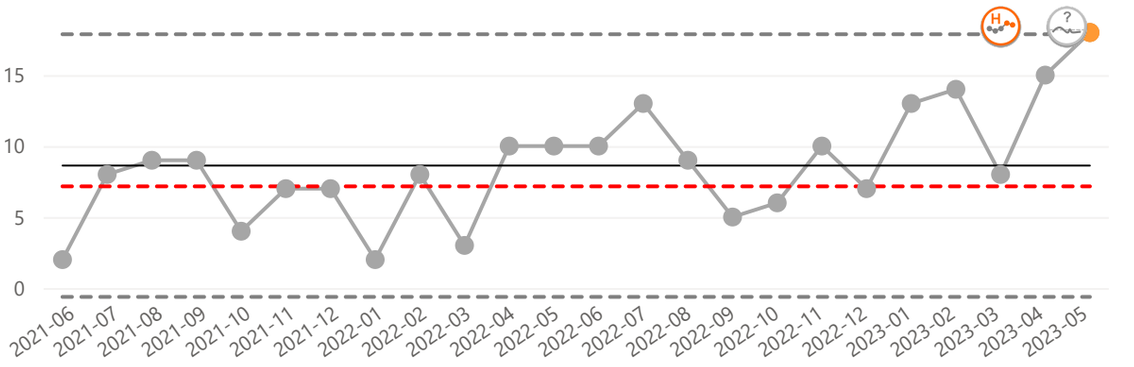
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Clostridioides difficile	7.41	5	May 23	L	?	7.41	3	Apr 23	15	8.00
E. Coli	7.16	18	May 23	H	?	7.16	15	Apr 23	14	33.00
Klebsiella spp.	3.41	4	May 23		?	3.41	2	Apr 23	7	6.00
MRSA Bacteraemia	0	0	May 23		?	0	0	Apr 23	0	0.00
MSSA		7	May 23				4	Apr 23		11.00
P. aeruginosa	1.5	0	May 23		?	1.5	0	Apr 23	3	0.00

Quality

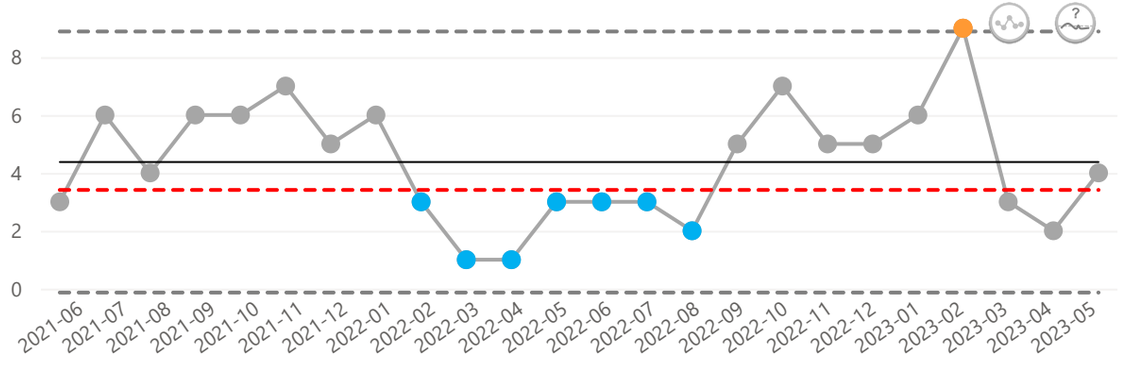
Clostridioides difficile



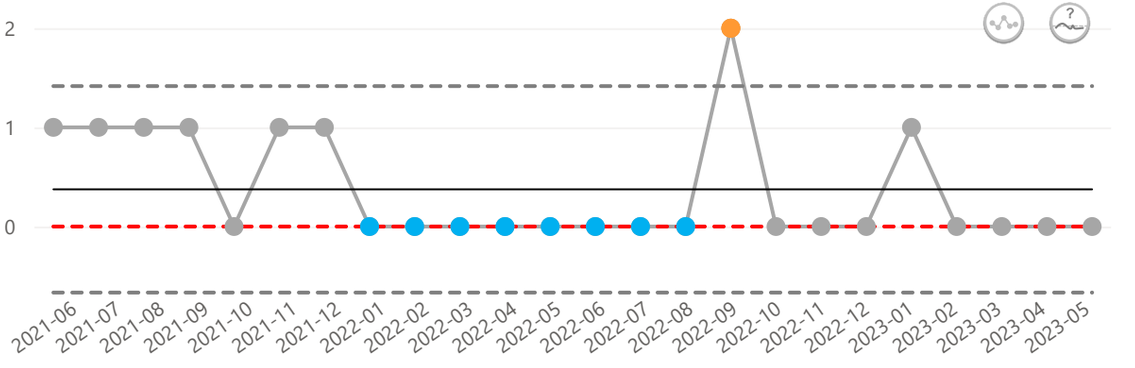
E. Coli



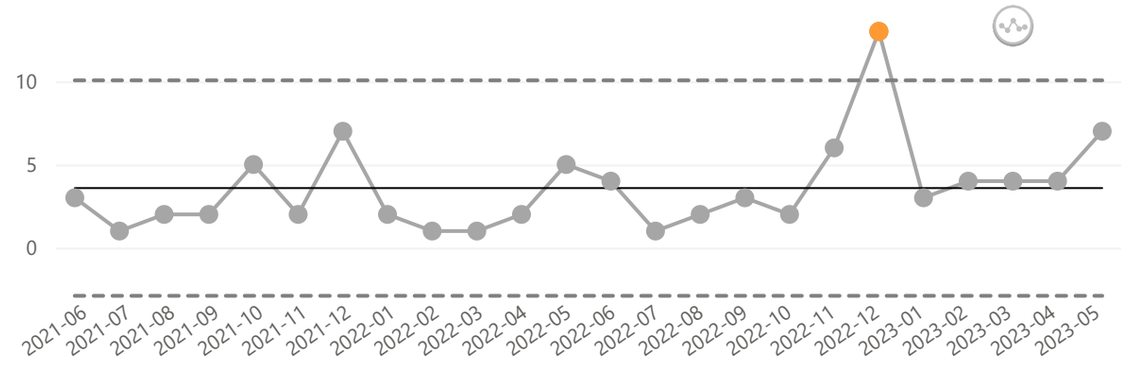
Klebsiella spp.



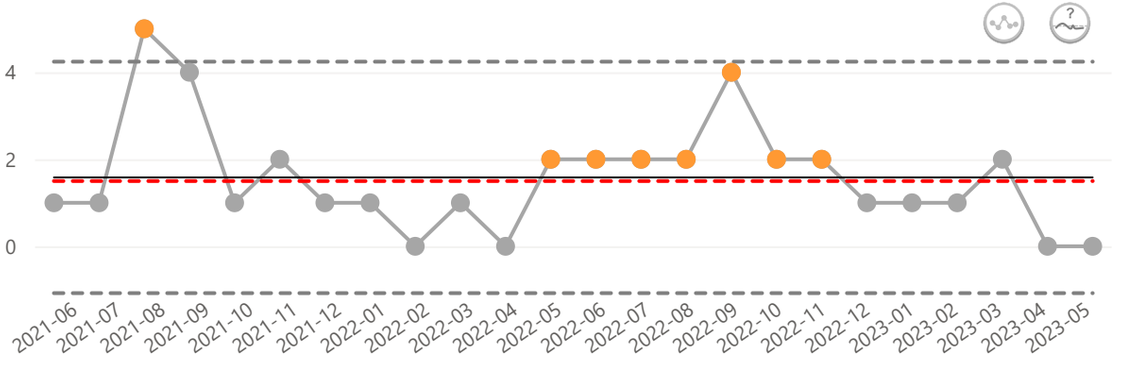
MRSA Bacteraemia



MSSA



P. aeruginosa



Blackpool Teaching Hospitals
NHS Foundation Trust

Mortality

Mortality
Advise/Assurance
• SHMI continues to improve, and is at 102, the lowest level since July 2021

Referral to Coroner
Advise/Assurance
Referral to coroner within 24 hours and percentage of deaths registered within 5 days have both improved slightly this month.

Alert/Action
There is a 2 day turn around to get notes to bereavement, and then a further 2 days for scrutiny to certification or coroners referral.
The medical director has asked that all deaths are discussed on the daily board rounds with an aim to get the notes to the bereavement office earlier.
The medical director has also asked that the Medical Examiners Officer contacts the consultant first rather than the junior doctor, as there are often delays in being able to get hold of the correct junior doctor, and this will allow the consultant to allocate a junior to this task.

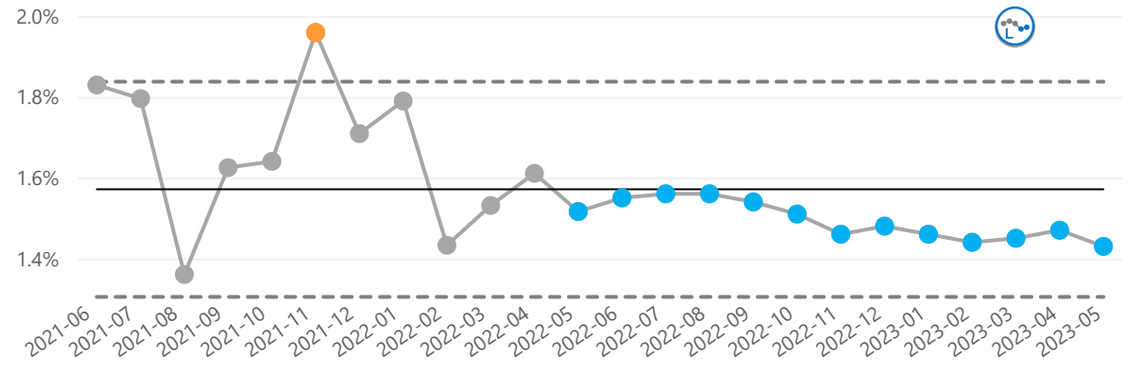
% of Deaths Screened
Advise
Percentage of deaths screened is inconsistent.
Assurance/Action
The Mortality Improvement Group are currently looking at way to improve this.

Quality

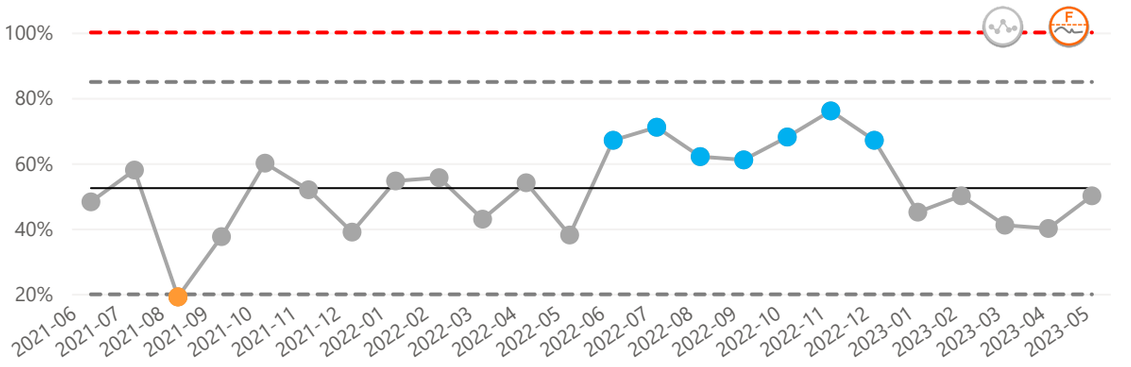
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
CRUDE Mortality Rate (Rolling 12 months)		1.43%	May 23	L			1.47%	Apr 23		
Referral to Coroner Within 24 Hours	100%	50%	May 23		F	100%	40%	Apr 23		
Death Registered within 5 Days	100%	39%	May 23		F	100%	25%	Apr 23		
SHMI – Rolling 12 months		101.66	Jan 23	L			102.52	Dec 22		101.66
HSMR – Rolling 12 months		87.17	Mar 23	L			86.9	Feb 23		87.17
Percentage of Deaths Screened	100%	74.1%	May 23		?	100%	92.2%	Apr 23		

Quality

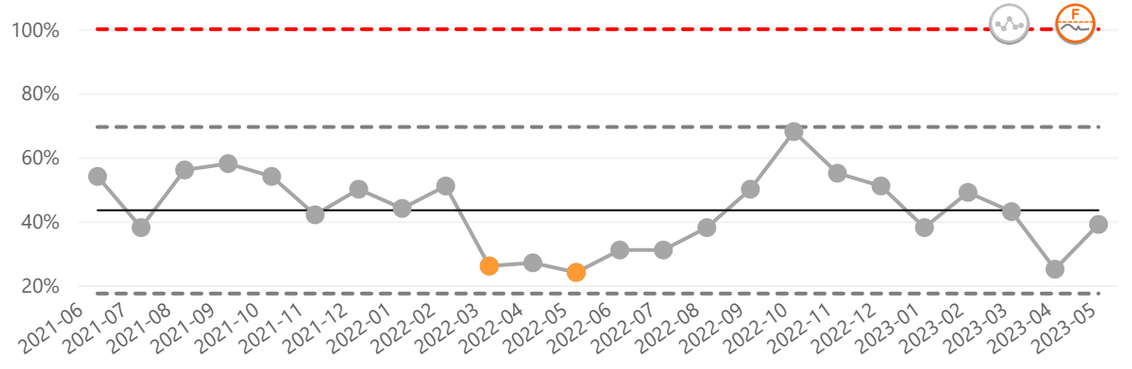
CRUDE Mortality Rate (Rolling 12 months)



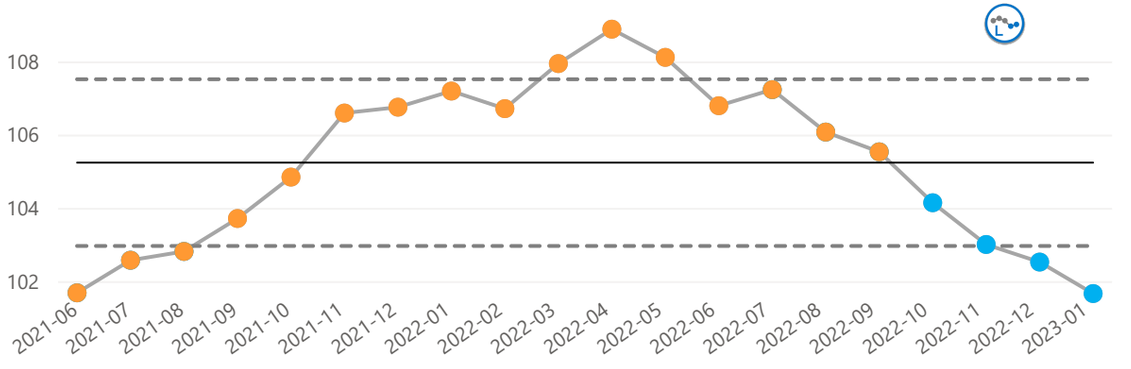
Referral to Coroner Within 24 Hours



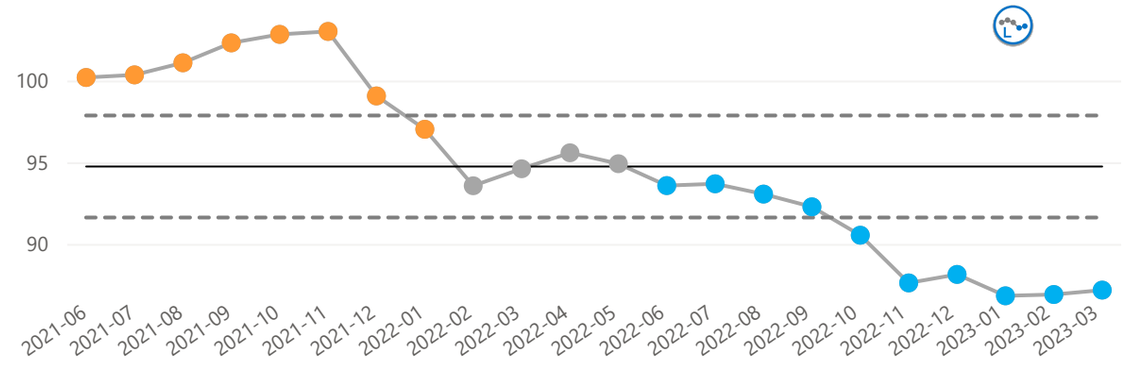
Death Registered within 5 Days



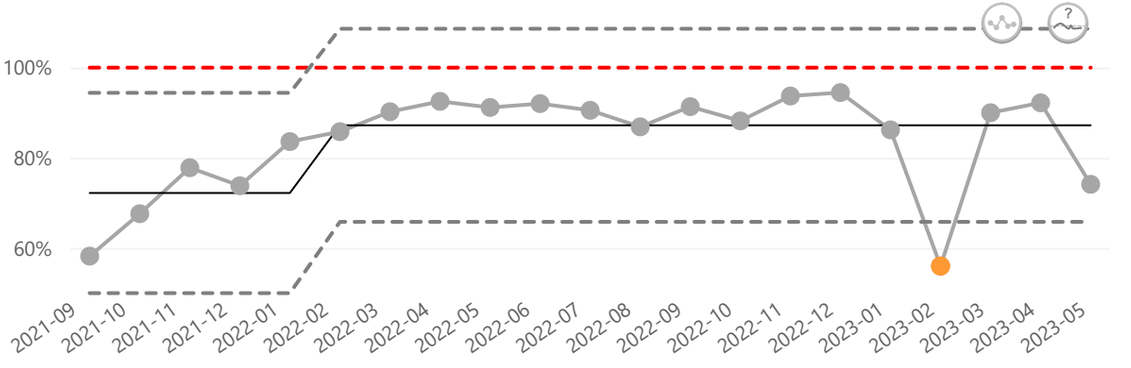
SHMI – Rolling 12 months



HSMR – Rolling 12 months



Percentage of Deaths Screened



Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Account 2022/23 Report

Meeting:	Board of Directors
Date:	5 July 2023

Author	Helena Lee - Quality Governance Manager Louise Cheung – Deputy Director of Quality Governance					
Exec Sponsor	Bridget Lees - Director of Nursing, Midwifery, AHP & Quality					
Purpose	Assurance	x	Discussion		Decision	
Confidential y/n	No					

Summary *(what)*	NHS Foundation Trusts are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts each year. A Quality Account is a published report about the quality of services and improvements offered by an NHS healthcare provider, incorporating patient safety, how effective patient treatments are and patient feedback about care provided. The Quality Account 2022/23 report was submitted to the Trust's Quality Assurance Committee for approval. The Account will be uploaded to the Trust's public internet site and the link submitted to the Secretary of State by 30 June 2023. The final draft Account was also submitted to the Council of Governors in June 2023. The draft Account was shared with the Integrated Care Board (ICB), Healthwatch Lancashire, Blackpool Adult Social Care and Health Scrutiny Committee and the Lancashire County Council Health Scrutiny Committee and response statements were received and included in the final Account.

Previously considered by	This is an annual requirement for the Trust and reports have been submitted to the Clinical Governance Committee and to the Quality Assurance Committee.

Implications *(so what)*	The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by June 30 each year. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

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

Equality, Diversity and Inclusion (EDI) implications considered	In preparing this report, consideration was given to EDI implications. Failure to reflect, report on and share our quality and safety performances, objectives and achievements, ensures no individuals or groups are overlooked or marginalised.
Proposed Resolution ***(What next)***	The Board of Directors are asked to receive the Trust's Quality Account 2022/23 for information and assurance.

QUALITY ACCOUNTS 2022/23

1. About Quality Accounts

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50, and NHS income greater than £130k per annum.

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

2. Information Provided in the Quality Account includes:

- A signed statement from the Trust's Chief Executive, describing the quality of healthcare provided by the organisation.
- Answers to a series of questions all healthcare organisations are required to provide. This includes information on how the healthcare provider measures how well it is doing, continuously improves the services it provides, and how it responds to checks made by regulators like the Care Quality Commission (CQC).
- A statement from the organisation detailing the quality of the services it provides.
- Statements from the provider's main commissioner of services and partner organisations are included at the end of each Quality Account.
- Quality Accounts are no longer required to be externally audited, although providers may choose to do so to verify that they are accurate.

3. Quality Account 2022/23 Governance Process

The Quality Account for 2022/23 was approved through the Quality Assurance Committee (QAC) in May 2023 and then submitted to the ICB for their statement. This is in line with the ask from the ICBs. The statements received from partner organisations were submitted to the June QAC for information, and confirmation provided that no further changes had been made to the Quality Account.

4. Publication of the Trust's Quality Account 2022/23

The final Quality Account 2022/23 will be submitted to the Secretary of State by 30 June 2023 via the following process:

- The Quality Account is uploaded to the Trust's website and a link is forwarded to:
- NHS providers – quality-accounts@nhs.net
- Independent providers – QualityAccounts@dhsc.gov.uk

Recommendations:

The Board of Directors are asked to receive the Trust's Quality Account 2022/23 for information and assurance.

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Quality Account 2022 / 2023

“We are working to improve the lives of people who live, work and volunteer on the Fylde Coast and beyond”

Contents

1 Chief Executive's Statement

Welcome to the Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2022/23.

This report provides an important opportunity for us to look back over the last 12 months and take stock of how we have performed but also to take a look ahead at our priorities for the next year and how we will meet the challenges we face.

There is no denying it's been a difficult year for the NHS nationally and locally, and Blackpool Teaching Hospitals has not been immune to this. We continue to see immense pressures particularly across our urgent and emergency pathways. Despite easing many of our COVID-related restrictions, we are faced with a different set of challenges around financial responsibilities, the health and wellbeing of our teams, reducing our waiting lists and a changing healthcare landscape in Lancashire and South Cumbria.

I'd like to start by thanking every single colleague for their continuing hard work and commitment to providing caring, safe and respectful treatment – this goes for our hospital and community colleagues and our support teams, as well as our partners in the wider community.

I'm so proud of the work being done under such immense pressure. We truly have some tremendous people and I'm never prouder to lead this organisation than when I see how we come together in difficult times to support each other as well as patients and their families.

Last year, following an important period of engagement with colleagues, partners and stakeholders, we were excited to launch our new five-year strategy for 2022-2027 which set out the critical themes and objectives we will achieve. From this, we developed our quality objectives for 2023/24 which continue the important work outline agreed and progressed the previous year.

Quality improvement continues to be a driving force for the Trust and I'm delighted to report that we have made important progress with our three key improvement programmes:

- Establishing our Clinical Quality Academy
- Improving the identification and management of the deteriorating patient
- Reducing fractured neck of femurs (working with local care homes).

In addition, we continue implementing all actions aligned to:

- Better Births, the Ockenden review into maternity services
- The continuity of carer model for maternity services

Our quality priorities for 2023/24 will focus on:

- Building on our sepsis pathways
- Working with system partners to launch a second phase of the 'last 1,000 days' collaborative which aims to provide improved end of life care for everyone
- Working to further build quality improvement capability at all levels of the organisation

In the Trust, there are now around 1,000 people who have participated in collaborative programmes or improvement training and we've built a 12-month programme for clinically led teams known as the Clinical Quality Academy (CQA).

The CQA aspires to create a culture for improvement across the Trust, developing colleagues with skills to improve care while developing advanced improvement science and knowledge. This programme was recognised nationally after being shortlisted for the 'Changing Culture' HSJ Patient Safety Award in October 2022.

Meanwhile, important work has taken place to improve our clinical pathways and in turn the safety of our patients – a prime example is our commitment to the clinical and screening guidelines of the UK Sepsis Trust, including use of the Sepsis Six treatment and testing bundle aimed at delivering resuscitative treatment within the first hour of identifying sepsis.

Finally, I must report on the immense amount of work which has gone on to improve our facilities which include the opening of state-of-the-art Same Day Emergency Care (SDEC) and Critical Care units as part of our ongoing Emergency Village project.

Both these schemes have made an incredible difference to the way we work and ultimately to the care our patients receive. SDEC for instance is removing delays in the emergency care pathway, helping us care for urgent and emergency patients within the same day of arrival as an alternative to hospital admission.

The next phases of the Emergency Village continue at pace and just some of the improvements this will introduce are a dedicated Emergency Department radiology unit, further majors' cubicles, 12 ambulance triage spaces and a new spiritual centre allowing the current Chaplaincy area to be refurbished into ED support accommodation.

To the best of my knowledge, the information in this report gives an accurate account of quality at the Trust and I hope this report will be read with an underlying appreciation of both the work delivered by the team and the commitment of every colleague to continue to make a difference for patients and their families.

I am confident the next 12 months present an opportunity to focus further on progress and the difference we can make for the population we serve and to the way we work and support each other.

Trish Armstrong-Child
Chief Executive Officer

1.1 Our Achievements

2 Priorities for Improvements and Statements of Assurance from the Board

Following the launch of our new strategy in May 2023, the Board agreed five themes and objectives deemed as critical in converting the strategy into action – these are:

- Operational transformation
- Quality and safety
- Finance and investment
- People and culture
- Partnerships and innovation

These are all closely linked and the selection of our quality priorities for 2023/24 will contribute to the achievement of the agreed objectives and the plans agreed with our system partners to continue the improvement journey we are on.

2.1 Rationale for the Selection of Priorities for 2023 / 2024

In our new strategy we agreed an objective to reduce avoidable harm events and improve patient experience and therefore, in terms of the specific priorities for our Quality Account, we have decided to continue our ongoing programmes of work and will continue to work on the Quality Improvement objectives agreed in our last report which are:

- Reduction in pressure ulcers
- Improving the identification and management of the deteriorating patient
- Reducing fractured neck of femurs (in partnership with local care homes)

We will oversee the work on these priorities through our Quality Assurance Committee and will report regularly to our Board of Directors and our Council of Governors on our progress.

In addition to the above objectives, we will also continue with the following programmes:

- implementing all actions aligned to Better Births, the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust and the continuity of carer model for maternity services
- putting quality accreditations in place across all wards and services, with key action plans to address any concerns
- ensuring Getting It Right First Time (GIRFT) plans are in place for all identified specialties and included in regular performance reporting.

2.2 A Review of Quality Improvement Programmes 2022 / 2023

The table below lists the Trust's current quality improvement programmes and their current status. An update for each programme has been provided within individual pages.

Quality Improvement Programme	Status	✓ ⊜ ↓
Clinical Quality Academy	Goal met	✓ ⊜
Improving the Identification and Management of the Deteriorating Patient	Close to goal	⊜
Reducing Fracture Neck of Femurs *(In partnership with local care homes)*	Goal partly met	⊜

The programmes listed above form part of the Trust's current Quality Improvement (QI) strategy (2019-2022). The Trust has now launched a new strategy and these priorities are currently being refreshed in line with the new priorities.

Quality Improvement methods help us to deliver our mission, to deliver safe, effective, sustainable care for everyone, every day. We do this through a targeted portfolio of programmes, which the Trust believed to have a significant impact on unintentional patient harm and mortality. The aims of the initiatives were all strongly linked to the Care Quality Commission (CQC) fundamental standards, and the high-level aims are to:

- Reduce preventable deaths
- Reduce avoidable harm
- Improve the last 1,000 days of life

To achieve our high-level aims, we focussed on three distinct improvement programmes, each with measurable outcomes:

- The "Blackpool Clinical Quality Academy", to build our improvement capability, with ten medically led teams each undertaking a QI project with a focus on reducing avoidable harm.
- "Improving the Identification and Management of the Deteriorating Patient" has focussed on reducing preventable deaths
- "Eliminating Pressure Ulcers" has focussed on reducing avoidable harm
- "Preventing Fracture Neck of Femur (#NOF)" has focussed on improving the last 1000 days of life.

The programmes were delivered using the Institute for Healthcare Improvement's Breakthrough Series Collaborative Framework. This is an evidence-based concept and provides a structure for learning and action that supports real, system-level changes that lead to improvements in care. This includes:

- Recruiting an expert faculty
- Identification and enrolment of participating teams
- Learning sessions and action periods with coaching
- The Model for Improvement, which identifies the four key elements of a successful improvement process
- Measurement and evaluation
- Ongoing support from Executive leaders and summative event

To facilitate this work, the Trust has an established QI Directorate, called the QI Hub, who support improvement from concept to delivery of outcomes.

2.2.1 Clinical Quality Academy (CQA)

What?	Deliver the first Blackpool Clinical Quality Academy
How Much?	By the end of 2022, ten clinically led teams will deliver projects to improve care, whilst developing advanced improvement science, knowledge and skills.

As well as facilitating the large-scale improvement programmes, the Trust aims to increase improvement capability and therefore knowledge in all staff groups and grades to achieve service improvement at every level.

The Trust continues to build on existing initiatives and to create opportunities to accelerate trust-wide learning. A "dosing strategy" was developed to help the Trust ensure colleagues get the support that they require depending on their current QI capability and what they are aiming to achieve, so that everyone is able to contribute to continuous improvement with the right skills and opportunities. Colleagues involved in the Trust-wide collaboratives have been learning the science of improvement and practicing the art of improvement in their jobs. Additionally, all staff are provided with opportunities to attend a range of training programmes.

In the Trust, there are now around 1,000 people who have participated in collaborative programmes or improvement training, and have developed quality improvement key skills, including the quality improvement principles, adapted from the NHS England NHS Improvement Quality, Service Improvement and Redesign (QSIR) programme.

The Trust's efforts to build capability have included a 12-month training programme for clinically led teams, known as the Clinical Quality Academy (CQA). The CQA aspires to maximise potential to move at pace and scale, creating a critical mass of "improvers" and create a culture for improvement across the Trust.

The CQA is designed to deliver an intensive programme of teaching, action learning and coaching in the science of improvement. The programme has been delivered by eminent teachers from around the world, and leaders in the improvement science field. Teaching has been both virtual and where possible, in person.

In 2022, the first ten clinically led teams graduated and by July 2023 a total of twenty teams (104 staff) will have graduated and delivered projects to improve care, whilst developing advanced improvement science, knowledge and skills.

This programme was successfully shortlisted for the "Changing Culture" HSJ Patient Safety Award in October 2022.

Outcome	Ten teams graduated CQA in July 2022, having delivered improvement projects to achieve their safety related aims.
Progress	A further ten teams will graduate the CQA in July 2023

2.2.2 Improving the identification and management of the deteriorating patient

What?	To reduce the number of cardiac arrests (outside of critical care units)
How Much?	Achieve and sustain a mean Trust cardiac arrest rate of 1.0 per 1000 admissions by September 2023

Patient deterioration can be defined as:

"An evolving, predictable, and symptomatic process of worsening physiology towards critical illness"

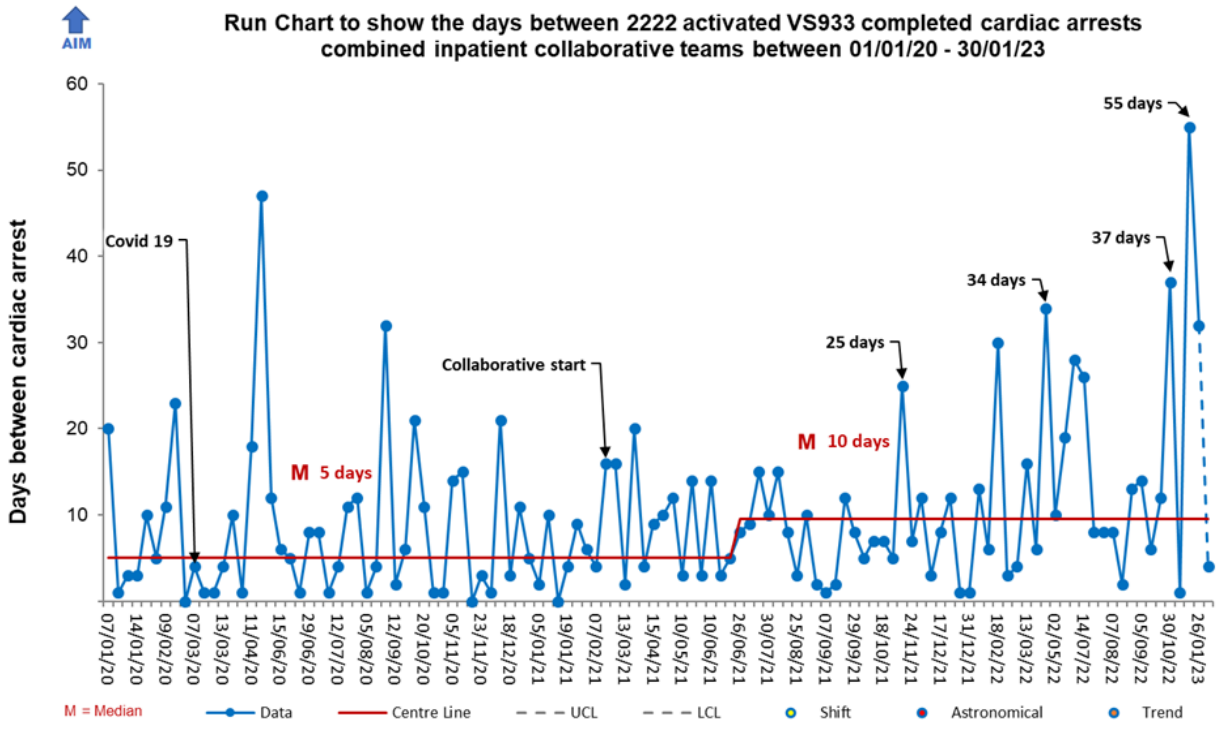
Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely and effective manner. Inadequate clinical monitoring and failure to act on deterioration is associated with preventable deaths and severe patient harm, such as cardiac arrests.

Analyses of nationally collected data have highlighted the need for improving identification and management of deteriorating patients. The Trust launched the "Improving the Identification and Care of the Deteriorating Patient" Collaborative in February 2021. When planning the collaborative, ward data was reviewed, including the capacity and readiness of each team. A change package was developed to guide the teams and a driver diagram was created to focus ideas, shown below.

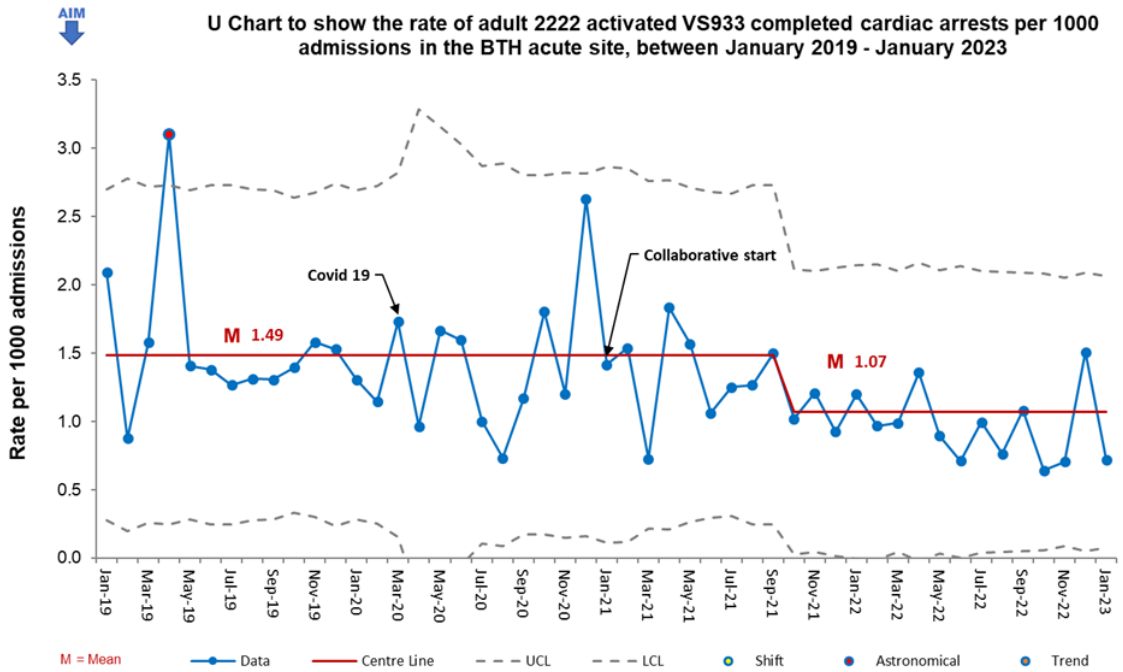
Primary Drivers	Primary Drivers	Secondary Drivers	Change Ideas
In the next twelve months we aim to reduce the number of cardiac arrests outside of critical care areas by 50%	Culture, teamwork & accountability	• Leadership attention • Clearly defined protocols and pathways • Shared learning from effective root cause analysis and mortality reviews • Awareness of human factors and psychological safety • Team development and learning	• MDT mortality reviews, LFD app • RECALL proforma – CCOS reviews • Safety culture awareness
	Assessment & observation	• Identification of patients at risk of deterioration • Standardised processes for observations and escalation planning • Compliance with clinical pathways • Compassionate care of the dying patient in their preferred place of care	• Use of NEWS2 boards, magnets & aids • Testing the use of the term “watcher” • Treatment & escalation plan (TEP) document
	Response	• Increased ward level capability • Immediate response to deterioration • Optimal patient management (step up/step down) • Routine review of step down patients • Availability of support of all queries	• Simulation training • Awareness of barriers to immediate review • Openness to all queries • Escalation document sticker
	Patient flow and communication	• Right patient, right place, right time • Safe, effective and efficient handovers of care and transfers • Increased understanding of systems and interdependencies • Use of SHOP (Sick, Home, Other, Patient model) • Cascade of information and efficient communications • Patient information and engagement	• Ward round checklists & standardisation • Effective safety huddles, handovers & improved communication • Debrief tools • Engagement of patients & families in decision making

Clinical teams were supported to undertake projects which aim to improve the recognition and management of the deteriorating patient, supporting the use of improvement methodology and shared learning, virtual learning sessions, Microsoft Teams shared channels, improvement coaching and virtual drop in collaborative cafés have been utilised.

Change package interventions tested by teams during the collaborative process have led to improvements, e.g. Safety Huddle templates, NEWS2 boards, escalation documentation stickers, Shortness of Breath Boxes, Rapid Evaluation after Cardiac Arrest for Lessons Learned (RECALL) reviews and Treatment Escalation Plan Documentation.



The number of days between 2222 activated cardiac arrests for the inpatient teams involved in the collaborative, a statistically significant shift seen in June 2021, from a median of 5 days to a median of 10 days, continues to be sustained. In January 2023, the combined collaborative inpatient teams achieved 55 days between 2222 activated cardiac arrests.



The monthly cardiac arrest rate per 1000 admissions shows an improvement in the mean rate from 1.49 to 1.07 per 1000 admissions.

Now, the focus of this programme is to sustain the improvements seen and to further reduce incidences where cardiac arrest calls could be avoided. To help sustain improvements, specific change package interventions, that teams have identified as likely to have the biggest impact, are being focussed on. These interventions continue to be tested and are being spread and scaled across the hospital. Teams have access to team specific time between cardiac arrest run charts updated weekly and a monthly drop-in virtual “café’” to access improvement coaching and peer support.

This programme was successfully shortlisted for the “Deteriorating Patients and Rapid Response Initiative of the year” HSJ Patient Safety Award In October 2022.

In line with our aim to reduce preventable deaths, in September 2022, a new collaborative was launched to improve compliance of the sepsis pathway.

Outcome	Aim to achieve 1.0 per 1000 admissions not yet achieved, however statistically significant improvement has been achieved and sustained.
Progress	The monthly cardiac arrest rate per 1000 admissions shows a sustained improvement in the mean rate from 1.49 to 1.07 per 1000 admissions.

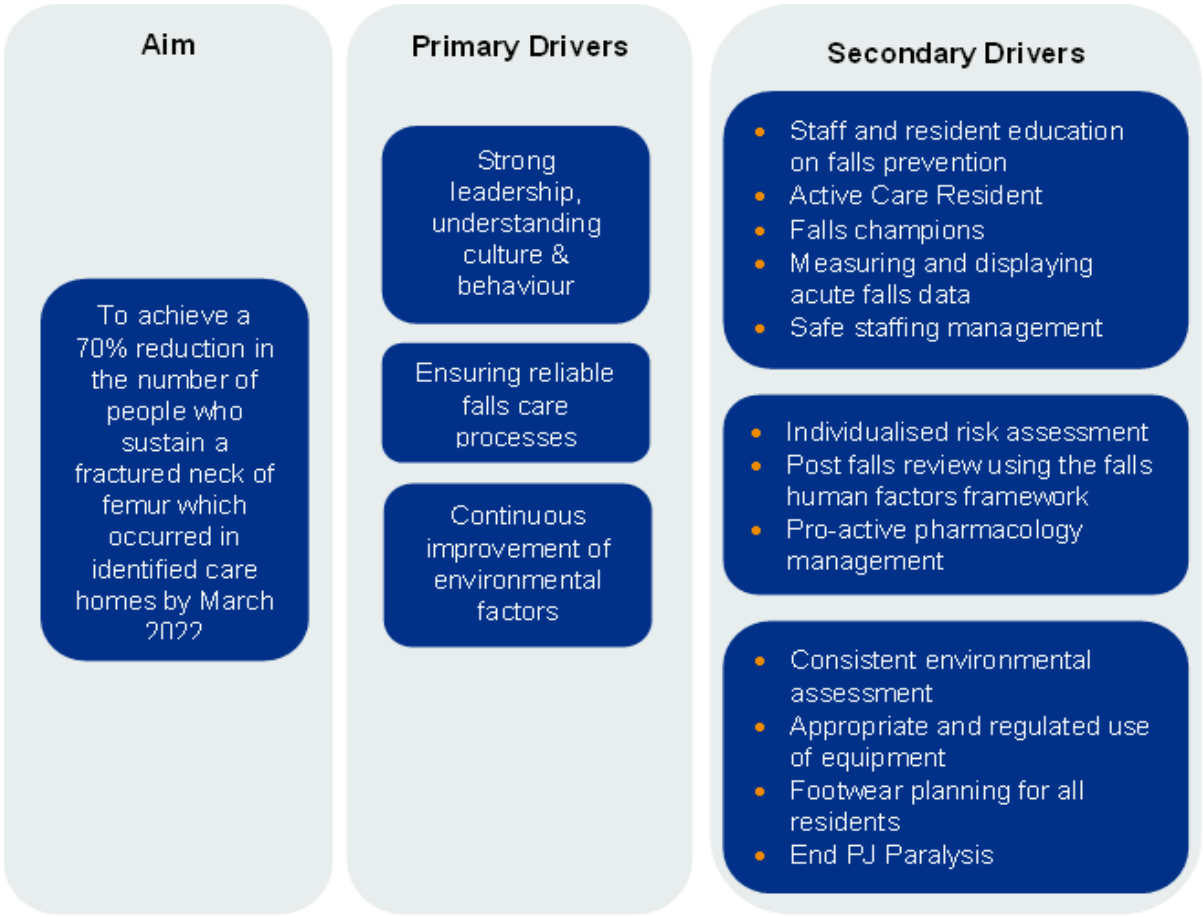
2.2.3 Improving the Last 1000 days of Life: Preventing Fracture Neck of Femur (#NOF)

A fracture neck of femur (#NOF) is defined as a fracture from the head of the femur (fracture of the hip). The “Preventing #NOF” collaborative was launched in September 2021 and is in line with the Trust’s aim to “Improve the last 1,000 days of life” for patients. This refers to how the local population can live as well as possible until they are dying, and how they can then be enabled to die with dignity, ideally in the place of their choosing. This aim is in line with the desire to give the patients and their families back the “gift of time”. The gift of time refers to how people can be supported to spend their precious time as they wish. To achieve this, Fylde Coast system partners came together to improve services, and the Trust has worked with local care homes.

While none of us know when our last 1000 days of life begins, there are certain groups who are more likely to be in this period, for example, older people. There are also certain harms which these groups are more likely to experience. These harms have significant impact on quality of life and health outcomes, but many are preventable, such as fracture #NOF. On average 47 people per month attend Blackpool’s Emergency Department (ED) with a #NOF. The 2010 National Institute for Health and Care Excellence (NICE) guidelines indicated that for those who sustain a #NOF, approximately 10% die within a month and 33% die within three months of sustaining this injury. To help to reduce the number of older people who sustain a #NOF, it is important to look at the main mode of injury, which is a fall. Even if residents do not sustain a #NOF post-fall, they can still be significantly impacted and may lose independence.

Therefore, this programme has focussed on reducing the number of care home residents who have falls, as there is a strong evidence base highlighting that falls can often be prevented.

The following driver diagram highlights the programmes aim in detail.

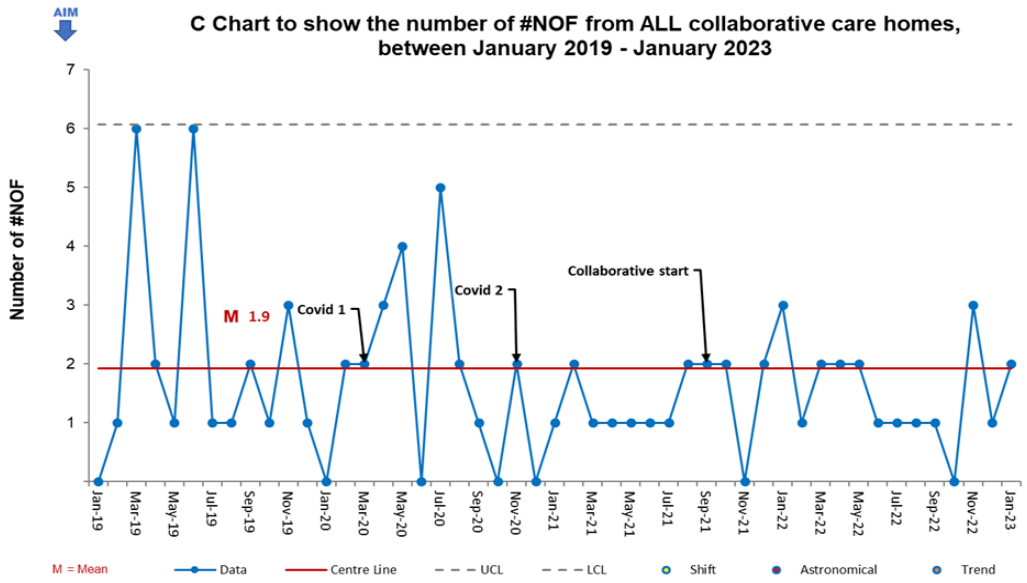


A change package has been created to provide care homes with tools to assist in reducing the number of people whose falls require their admission to hospital. It explains both the technical and, just as importantly, the cultural and behavioural shifts needed to make this improvement programme succeed. It is part of a wider support package that included regular visits to care homes, check-in phone calls and workshops. From the launch of the collaborative in September 2021, care home teams have been supported to undertake projects aligned to the change package which aim to improve the number of falls and #NOF in a care home setting. That included looking at individual resident journeys and preventing admissions to A&E where community support and treatment is available to residents in their own care home.

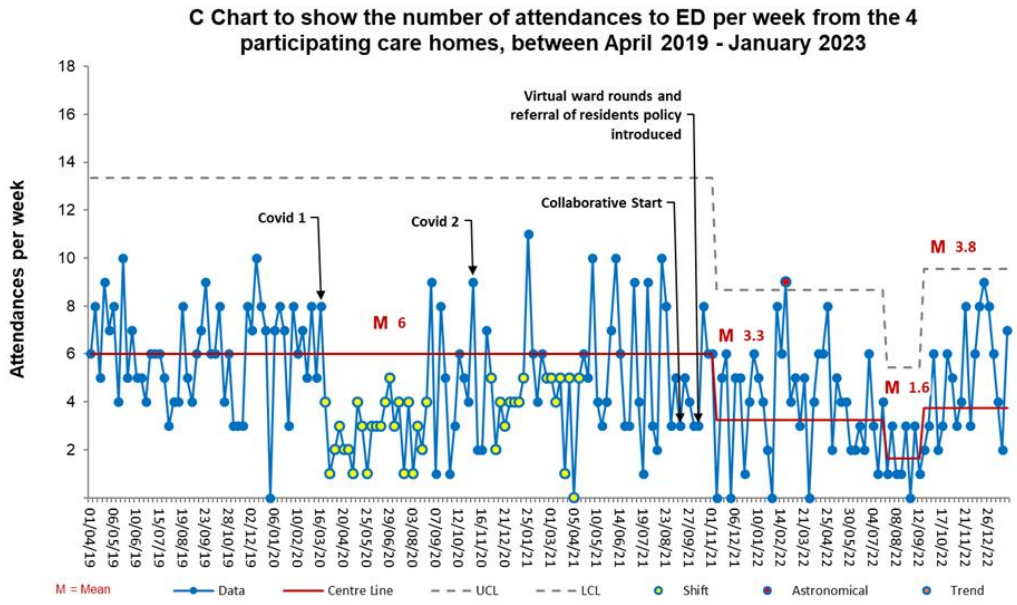
The following change ideas were developed by the teams in a mnemonic to help remember the falls prevention ideas:

- Education – Providing falls prevention to all staff and developing resources such as leaflets, posters and guides for staff, residents and families.
- Safe staffing – Reviewing falls data and looking for patterns to see where more staff may be required.
- Champions - Specially trained colleagues who help to ensure that strategies and interventions are being implemented efficiently and to support teams.

- Active care Resident - Helping staff to provide residents with an individual care timetable depending on their needs, which is similar to intentional rounding in hospitals.
- Proactive medicines management – Actively looking for signs a patient may need a medication review by a trained healthcare professional more urgently than their usual medication reviews.
- Assessments of environment and equipment, and post-falls – using assessment tools to review environments and equipment on a regular basis and for assessing risks for residents, post-fall.
- Displaying data – Using boards to display falls related data and learning from falls prevention with all staff, residents and families.
- End PJ Paralysis – Encouraging residents to get up, dressed in their own clothes and moving, to help reduce functional decline.
- Suitable Footwear – Following guidance on appropriate footwear and ensuring footwear is not too big, poor grip, poor support or lack fastening features.



Although there has been no statistically significant improvement in the number of #NOF, we are no longer seeing the higher numbers experienced prior to the collaborative (reduced variation). Individual care homes have achieved statistically significant improvement.



The number of attendances to the emergency department has reduced from 6 per month to 3.8 per month. Following a review of attendances, 88% of the attending residents were admitted to hospital for treatment.

At the end of September 2022 system leaders met to discuss the findings and results of the Last 1000 days programme and agree on the next steps. It was agreed that learning from the first cohort should be extended to a second cohort which is planned to start in 2023 with care homes, GP's, community nurses and social care teams participating to reduce harms in our local care homes. A new aim will be developed, with focus on reducing Emergency Department (ED) attendances and keeping residents safe in their last 1000 days of life, giving back the gift of time.

The programme was awarded the "Best use of integrated care and partnership working in patient safety" Health Service Journal Award in October 2022.

Outcome	Reduced variation in #NOF. Aim under review and Trust continues to work on this programme.
Progress	As #NOF are relatively rare events, the days between falls have been monitored and statistically significant improvements have been seen in some participating care homes.

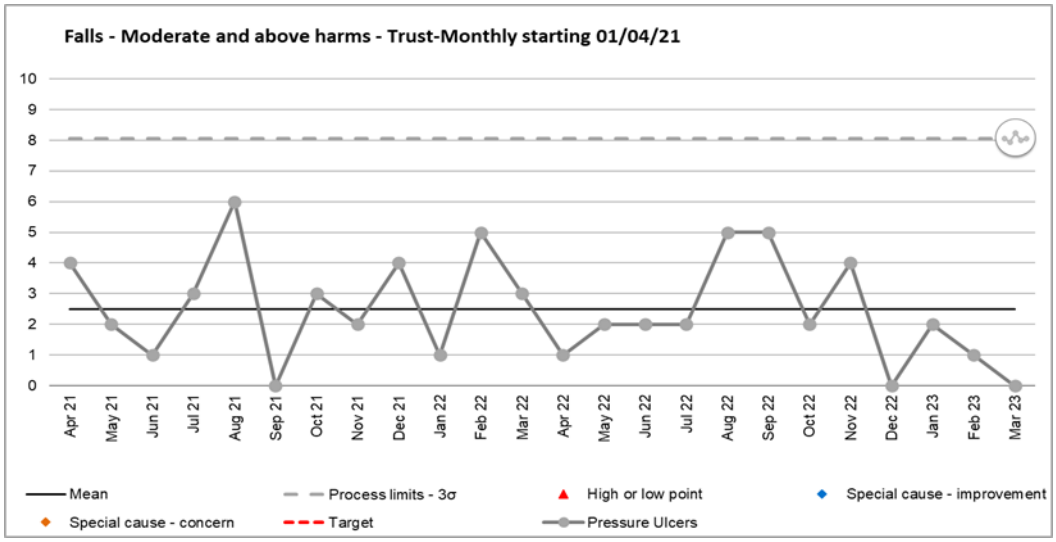
2.2.4 Reducing Patient Falls

What?	Reduce the number of patients experiencing harm as the result of a fall.
How Much?	To achieve a 10% reduction by March 2023.

The use of the 'falling leaf' symbol continues to be used throughout in clinical areas to alert staff of patients who have been identified as being at risk of falls. The process of using visual identification of a risk has been considered and relaunched as part of the new "what matters most to me" at the back of bed boards. The falling leaf symbol will be one of several which will enable staff to easily understand the risk each patient has.

"Leaves are supposed to fall, people are not"

The total number of falls reported in 2022/23 was 874, which is an increase on the year before. There were 25 of these falls which resulted in moderate or serious harm, which is a reduction from the previous year of 29.



A steering group has been convened and following completion of a gap analysis of current practice, will work to develop a change package that can be used by teams to reduce falls in their areas. The group's expert panel is from a wide multi-disciplinary workforce including nurses, allied health professionals, practice development sisters and pharmacy staff. The identification of patients at risk of falls

and the implementation of the appropriate plan of care to reduce the opportunity to fall is an important response in reducing falls. The redesign of the falls risk assessment that now includes lying and standing blood pressure and the supporting falls policy has been concluded and is now in practice.

The risk assessment assists in identifying the level of risk that a patient is at of potentially having a fall. This enables preventative measures to be introduced thus reducing the risk and ensuring a safe environment is maintained.

The trial of a new product to support falls reduction through a non-contact patient monitoring system, which alerts staff to unexpected patient movement is being overseen by the Tissue Viability team. It is anticipated that if successful this will replace the current falls prevention system.

Following consultation and review with clinical teams, the intentional rounding tool has been updated to include a risk assessment and guide for staff to appropriately manage patients in either a red, amber, or green category. In support of falls reduction, this ensures:

- Call bells are within easy reach
- Footwear is appropriate
- Falls monitoring equipment is safely applied
- Patients are given the necessary supervision and support with mobility dependant on need
- Patients / relatives are included in the risk assessment and subsequent care planning

Outcome	Target not met - during 2022/23, the number of patients who had a fall increased by 10.7%. However, there was a decrease in the number of patients who suffered a moderate or above harm of 14%.
Progress	Whilst the overall number of falls increased during 2022/23, the number of falls resulting in a moderate or above harm decreased.

2.2.5 Reduction in Pressure Ulcers – Trust wide - Acute / Community

What?	Reduce the number of patients experiencing a harm as a result of a pressure ulcer
How Much?	• A 50% reduction in category 2 hospital acquired pressure ulcers • A 50% reduction in community acquired pressure ulcers • An 80% reduction in Category 3 and 4 hospital acquired pressure ulcers

Pressure ulcers cause pain and distress to patients, they also increase length of hospital stay and dependence on health care providers. Pressure ulcers are largely avoidable, and the Trust considers hospital acquired category 3 and 4 ulcers to be internal never events due to their severity. The Trust is committed to eradicating category 3 and 4 ulcers and sets challenging targets for a significant reduction of category 2 pressure ulcers and community acquired pressure ulcers.

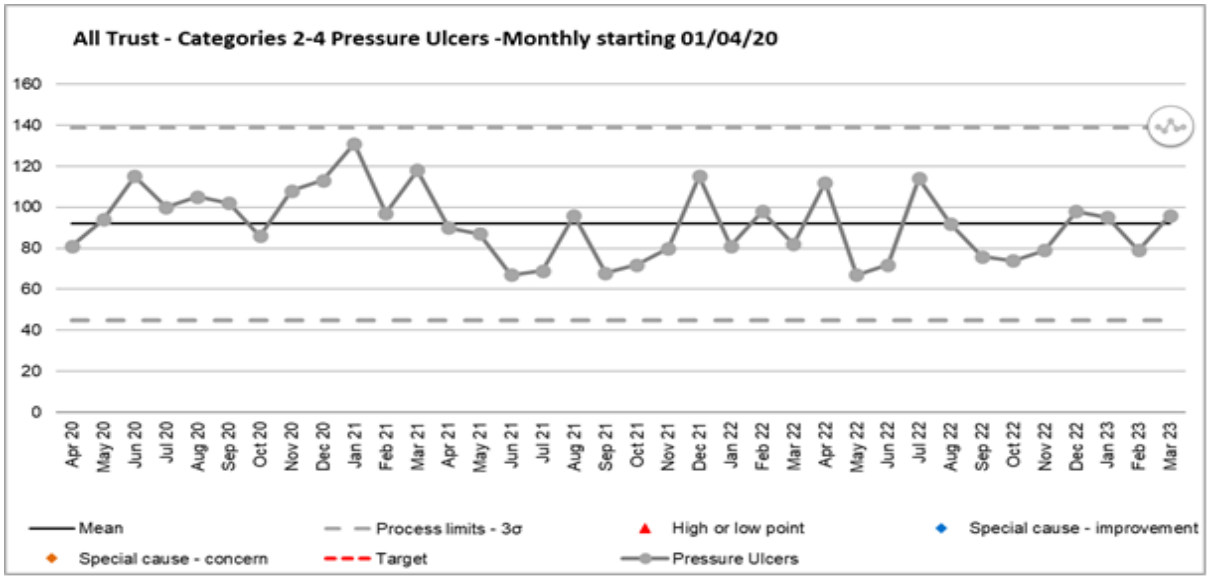
In the 12 months between 2022-2023 the Trust recorded 903 Category 2 pressure ulcers; 43 people sustained Category 3 pressure ulcers, and a reduction from 25 to 11 people sustaining Category 4 pressure ulcers.

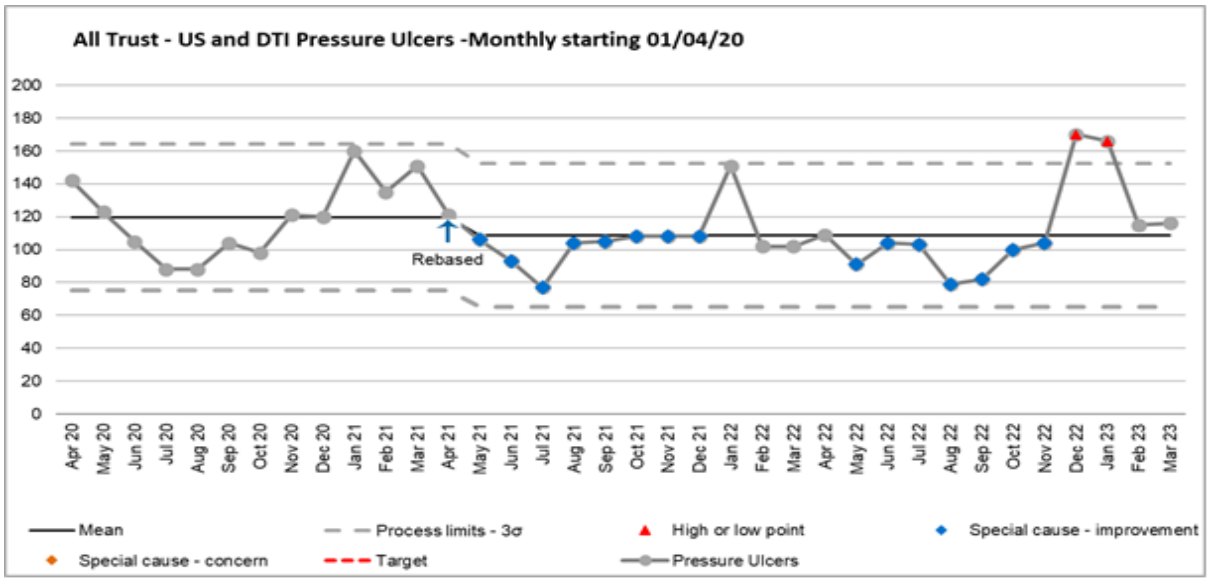
The Tissue Viability service continues to validate reported pressure ulcers face to face within the in-patient services and remotely via wound photography within community services (except for community patients with category 3 and 4 pressure ulcers who are seen face to face). Validation helps to ensure the accuracy of our reported pressure ulcer data, with category 2 pressure ulcers often reported incorrectly; these are corrected by the Tissue Viability Nurse. To support greater accuracy in reported category 2 data, a rolling programme of training on pressure ulcer identification and prevention, along with moisture associated skin damage prevention and management was developed, with monthly sessions available to all staff and good attendance noted.

The Pressure Ulcer Collaborative commenced in July 2020 and concluded in September 2022, and the change package was spread throughout all acute and community teams. To ensure that the lessons learned are sustained and improved upon, the weekly pressure ulcer data review, led by the tissue viability team, that monitors performance continues, and each divisional senior nursing team now attends bi-monthly skin integrity committees, where all acquired skin and tissue damage is reviewed and improvement plans monitored.

The charts below show all Trust pressure ulcers over the previous 12 months, identifying category 2 – 4 in normal variation and two astronomical data points above the line for deep tissue injuries / unstageables (DTI/US). A thematic review of this is underway and will inform further improvements that will be shared across the acute and community settings.

The Tissue Viability team will also support the introduction of Purpose T as the tool for risk assessment and a new intentional rounding document that aligns to this risk assessment approach in the coming 12 months.





Outcome	Target not met
Progress	Across the Trust (acute and community), in 2022, category 2 pressure ulcers decreased by 0.3%, category 3 pressure ulcers increased by 36.4% and category 4 pressure ulcers decreased by 37.5%.

2.2.6 Clinical Pathways

What?	Improve the safety of our patients through delivery of care within defined evidence-based pathways
How Much?	The Trust now participates in Advancing Quality Alliance (AQuA) Audit data collection

The Trust is committed to adherence to the clinical and screening guidelines of the UK Sepsis Trust. This includes use of the 'Sepsis Six' treatment and testing bundle, aimed at delivering resuscitative treatment within the first hour of identifying sepsis with red flag symptoms.

The Trust has updated the sepsis bundle since the last submission and following this there has been an increased adherence to all elements of the bundle from a mean of 24% to a mean of 46%, since its introduction in May 2022. Clinical audit shows that the time to the key task of administration of antibiotics in the first hour following suspicion of sepsis is below the mean of 66 minutes.

To support continuous improvement, the Trust launched the sepsis improvement collaborative in September 2022, supported by an expert faculty that included the sepsis trust and a patient representative, 8 clinical teams took part including the Emergency Department, Haematology, Oncology, Maternity and Clifton Hospital.

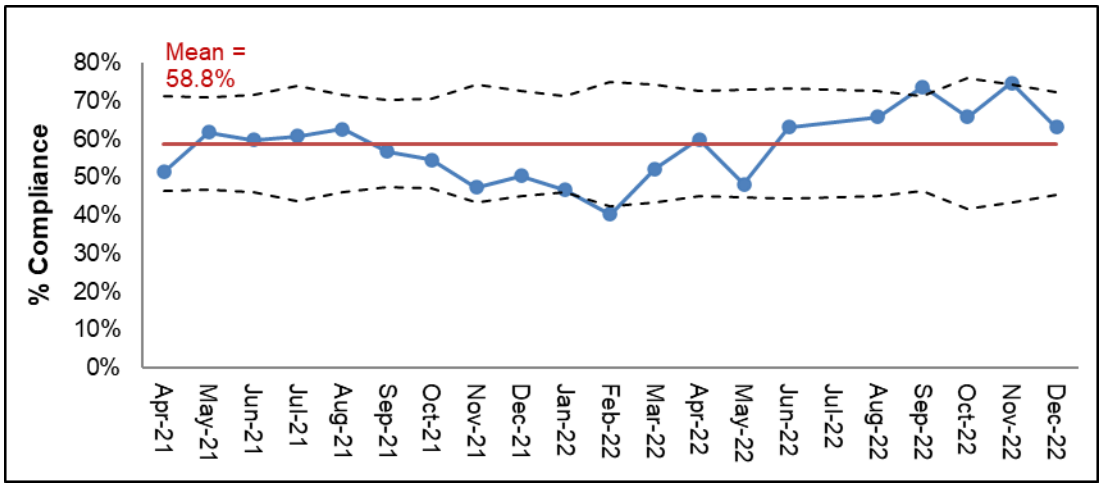
With coaching from our Quality Improvement leads, and a driver diagram framework to improve practice of reliable recognition and assessment, response and escalation, and culture of safety, continuous improvement tools and practice have been developed that will be shared widely across the organisation.

Improvements include the introduction of specialised sepsis trolleys being introduced into the Emergency Department (ED) and the Surgical Assessment Unit (SAU) with the introduction of sepsis 'grab bags' on the wards containing the necessary equipment to assist in initiating the treatment bundle. The maternity team identified improvements that would improve safety in the national badger net system and have successfully influenced this to be updated.

The Trust has an Associate Director of Mortality Governance and Clinical Audit who is providing medical leadership, regarding Sepsis, in conjunction with the Associate Director for Harm Free Care, act as leads for sepsis across the organisation and ensure the delivery of the overall strategy to improve compliance to the sepsis 6. The Trust continues to contribute to the AQUA audit for peer review and has also introduced an internal audit of approximately 40 patients per week to identify good practice and areas of improvement.

Our NEWS2 chart carries prompts to aid recognition of likely sepsis, and these are incorporated into the current training programmes of 'Recognise and Act', 'Forward

to Basics' and Acute Kidney Injury (AKI) / Sepsis sessions which support the practice of nursing staff and Allied Health Professionals (AHPs), junior medical staff, and preceptors, respectively. Our Simulation and Skills team have developed a 'Sepsis in Sim' programme which, when aligned with renewed guidelines will support medical undergraduates with the skills to recognise and treat sepsis in a timely manner. Sepsis continues to be highlighted and explored at a ward level, including at our Clifton site where it is hoped early intervention will reduce the rate of readmission to the acute Hospital site. The Trust has also introduced two corporate practice development nurses who are ensuring availability of robust training packages that can be easily accessed and shared.



Improved monthly compliance to all sepsis indices (>70% November 2022)

Outcome	• AQuA Sepsis NEWS Audit Composite Process Score (CPS) 59.7% (January 2022 to December 2022). • Sepsis Antibiotics administered within an hour 48.6% (January 2022 to December 2022). • Rolling 12 months for Sepsis SHMI maintained below 100 (90 in September 2022 – rolling 12 month figure)

2.2.7 Patient Safety

Lessons Learned

As a large healthcare organisation, which provides both acute and community care services, BTH continues to demonstrate a very positive and proactive culture of patient safety incident reporting and being open with patients, visitors, and staff when things go wrong.

During the financial year 2022/23 - 25,000 patient safety incidents were reported by staff, ranging from harm impacts of near misses, no harm, minor harm, moderate

harm, severe harm, and death. Incidents are also reported and managed which involve staff, visitors, contractors, and other partnership organisations.

Incidents are investigated in accordance with their level of harm and the national serious incident framework; with moderate, severe harm and unexpected death incidents requiring a higher level of investigation using recognised investigation tools. The root cause analysis (RCA) investigation tools help to establish and identify whether there have been gaps or omissions in care or treatment, or process and system errors, whilst also identifying best practice and shared learning. SMART action plans, with definitive timeframes and identified responsible leads are produced for each of these incidents, which are monitored for compliance and effectiveness in reducing harms. However, it is also recognised by the Trust the importance of investigating low harm and near miss incidents, to prevent future more serious harm occurring.

In the event of an unexpected patient death, these incidents are also reviewed through the Trust's mortality and morbidity review process, which in turn help to inform our investigation processes. Details of our internal investigations are also shared with our regulators, Integrated Care Boards (ICBs) and with the coroner, in the event of an inquest.

The Trust ensures that harm investigation findings, conclusions, and learning are shared widely across the organisation. The Trust has in place a 'Safety Focus' newsletter. This newsletter focuses on learning from safety events, including Learning from Excellence, positive patient feedback, clinical incidents, serious incidents and complaints. The Trust's Safety Movement is part of a Safety Culture Programme, which has been developed based on the NHS's Patient Safety Strategy. In addition to this newsletter, shared organisational learning visibility is captured through the creation of videos, simulation exercises, podcasts and through multidisciplinary educational forums and safety huddles.

Video still of a simulation exercise created following a Never Event incident involving an NG (nasogastric) tube.

The Trust also triangulates learning from formal complaints, informal patient concerns, litigation and inquests, as well as from incidents, to capture where improvements and innovative change needs to happen. Some of the ways in which we share learning from incidents, complaints, patient feedback and litigation are through the following processes:

The review of patient harm incidents, their outcomes and trends and themes across all levels of the organisation from the Board reporting Committees, Divisional Governance and

Departmental meetings to departmental and ward level team meetings, handovers, and patient safety huddles.

- A bi-monthly dedicated forum - Learning from Incidents and Risk Committee (LIRC), where divisional quality leads report on and share their learning outcomes and improvement projects following patient safety incidents, risks, complaints, inquests and litigation claims.
- The Trust's Safety Focus newsletter.
- Learning from Serious Incidents (SIs) and Never Events is shared routinely with the QI team to inform the QI Strategy and Improvement Programme.
- Sharing with Clinical Divisions weekly and monthly data reports on incidents, complaints, and litigation, including trends and themes and new initiatives established to improve patient safety.
- The submission of a monthly Incident summary report to the Trust's Quality Assurance Committee, which provides assurance on the management of incidents, SIs, Duty of Candour compliance and shared learning.
- Videos, podcasts, simulation exercises and presentations arranged through multidisciplinary forums, to share thematic reviews and trends and themes from incidents, SIs, and Never Events.

2.2.8 Being Open and Duty of Candour

The Trust promotes and encourages openness, transparency and candour between staff and patients / service users throughout the organisation. This is an integral part of the Trust's safety culture which supports organisational and personal learning.

The intention of the duty of candour legislation is to ensure that health providers are open and transparent with people who use their services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

In March 2022, the Trust updated its Being Open and Duty of Candour Policy to further raise awareness to staff of their obligations to keep patients informed when patient safety incidents occur, to offer apologies and to inform the patient or Next of Kin (NOK) of what we are doing to resolve the issue.

This policy outlines the expectations of the Trust in relation to open and transparent communication with patients, (or where appropriate their families and carers) following a patient safety incident. In particular the policy focuses on providing guidance for Duty of Candour Leads to support the statutory Duty of Candour process.

Adherence to this policy will ensure that staff communication with patients and their families is open and transparent when an incident has occurred and that the organisation meets its statutory Duty of Candour requirements in relation to "notifiable" incidents, as detailed in Regulation 20 of the Health and Social Care Act (Crown, 2014; Public Health England, Updated 5 October 2020).

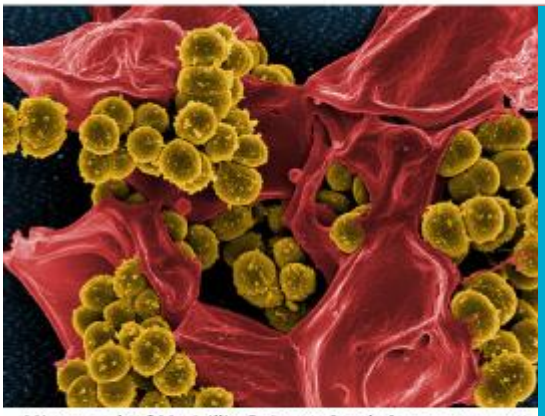
In addition, the Trust makes every effort to keep patients, or their NOK/family informed of the progress of investigations and offers to share the outcome of investigations and our learning, preferably through face-to-face meetings, or if this is not possible, by sharing the investigation report with a covering letter and providing contact details of a Trust representative.

The Trust's compliance against the Duty of Candour Regulation, is monitored by the Incident and Risk Team and reported through the Trust's Quality Assurance Committee. The Trust have demonstrated 100% compliance with all elements of Duty of Candour in between 1st April 2022 and 31st March 2023.

2.2.9 Infection Prevention

2.2.9.1 Reduce cases of Meticillin Resistant Staphylococcus aureus *(MRSA) – Acute*

What?	Reduce cases of Meticillin-Resistant *Staphylococcus aureus* (MRSA) Blood Stream Infections within the Trust
How Much?	Zero cases of MRSA Blood Stream Infections



Micrograph of Meticillin-Reistant *Staphylococcus aureus* (MRSA) and a dead human neurophil (Credit: National Institute of Allergy and Infectious Diseases (NIAID)

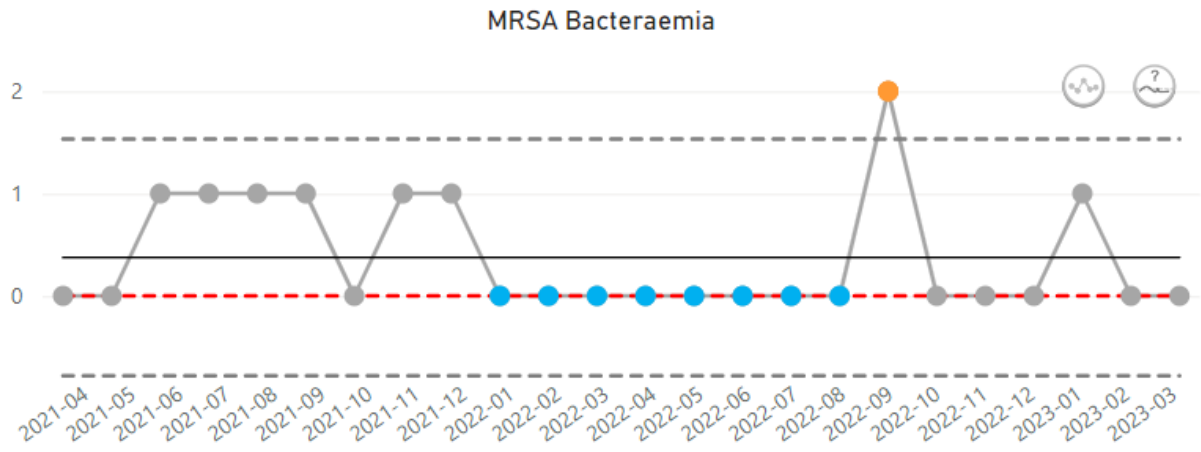
Staphylococcus aureus (*S. aureus*) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure.

If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves (endocarditis), pneumonia and bacteraemia (blood stream infection).

Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed Meticillin-Resistant Staphylococcus aureus (MRSA) and often require different types of antibiotics to treat them.

The NHS Standard Contract 2022/23 includes quality requirements for NHS Trusts and NHS Foundation Trusts to minimise rates of MRSA, Clostridioides difficile and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement.

The graph below shows that three cases of MRSA blood stream infection were attributed to the Trust during 2022/2023.



Two cases were defined as 'Hospital-Onset Healthcare Associated' (HOHA) – where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1).

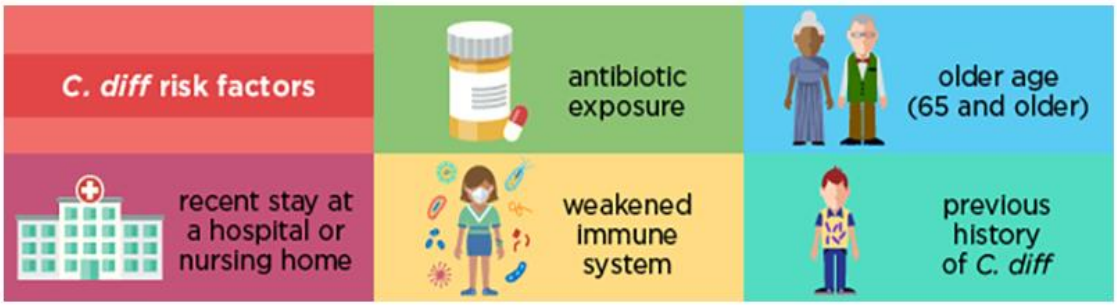
One case was defined as 'Community-Onset Healthcare Associated' (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).

One of the HOHA cases was linked to a lapse in care relating to inappropriate antimicrobial prescribing. There was also a delay in starting topical treatment. An action plan was developed to address these issues and progress was monitored by the Whole Health Infection Prevention Committee.

Outcome	Three cases of MRSA Blood Stream infection
Progress	Target not met

2.2.9.2 Reduce cases of *Clostridioides difficile*

What?	Reduce cases of *Clostridioides difficile* infections (CDI) within the Trust.
How Much?	109 cases of CDI

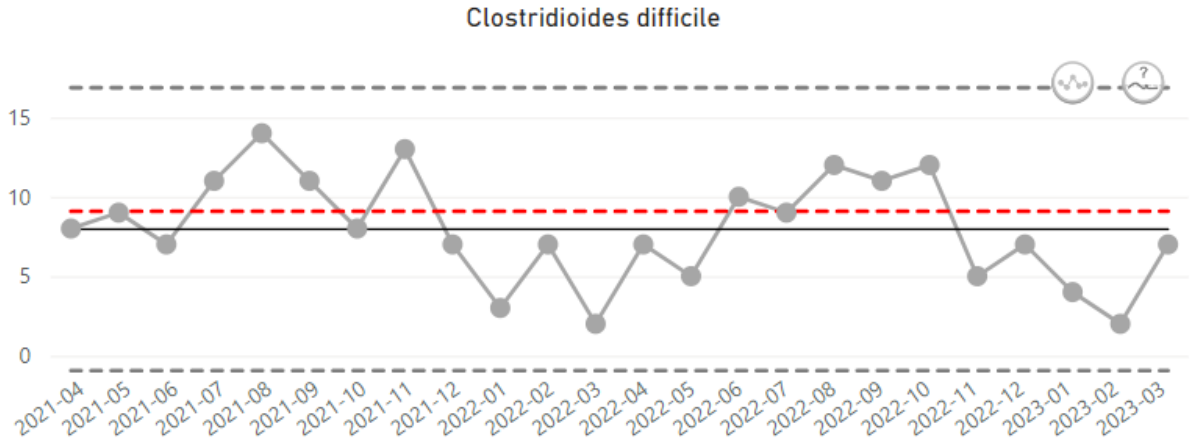


Clostridioides difficile (*C. difficile*) is a bacterium that's found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies).

C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows *C. difficile* to grow to unusually high levels. It also allows the toxin that some strains of *C. difficile* produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea. *C. difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis).

C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients. You can become infected with C. difficile if you ingest the bacterium (through contact with a contaminated environment or person). People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised.

A total of 91 cases were attributed to the Trust in 2022/2023 against an NHS Standard Contract threshold of 109.



62 cases were defined as 'Hospital-Onset Healthcare Associated' (HOHA) – where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1)

29 cases were defined as 'Community-Onset Healthcare Associated' (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).

This equates to a 9.9% reduction compared with 2021/22. Furthermore, 2022/23 data provided by NHS England shows that 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).

Outcome	91 cases of *Clostridioides difficile*
Progress	Target achieved

2.2.9.3 COVID-19

Virtually all national COVID-19 infection prevention guidance was stepped down in April 2022 and instead, NHS trusts were advised to follow the National Infection Prevention and Control manual (NIPCM).

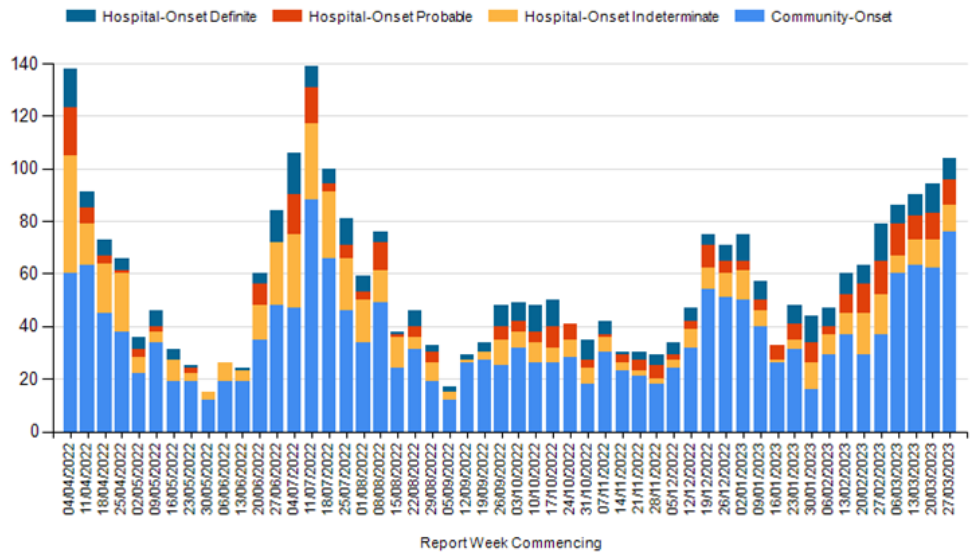
However, the pandemic continued to impact on services at BTH during 2022-23. The ongoing need to test and isolate patients with COVID, even when asymptomatic, had a particular impact on patient flow from admission to discharge.

The situation was made worse by the return of other seasonal respiratory infections such as influenza and Respiratory Syncytial Virus (RSV), as well as increases in other infections such as Norovirus.

Individual trusts were advised to make local decisions about the universal use of facemasks based on local COVID-19 prevalence data. This led to the scaling up and down of facemask use throughout the year.

Updated national SARS-CoV-2 testing guidance was also issued in August 2022 which saw the end to asymptomatic inpatient and staff testing. Further guidance is due to be published in April 2023 that is likely to further reduce testing requirements for patients.

The chart below shows the number of inpatients who have tested positive each week throughout the year and each peak corresponds with increased community prevalence.



The Omicron variant remained dominant throughout 2022/23 and despite multiple peaks of infection during the autumn and winter months, most cases resulted in mild illness. This is credited to a highly vaccinated population and increased access to COVID-19 therapeutics. Indeed, there is evidence to suggest that the likelihood of being admitted to hospital for SARS-CoV-2 is lower than influenza. Hence all asymptomatic patient testing, which impacts on services and patient flow, is due to end in April 2023.

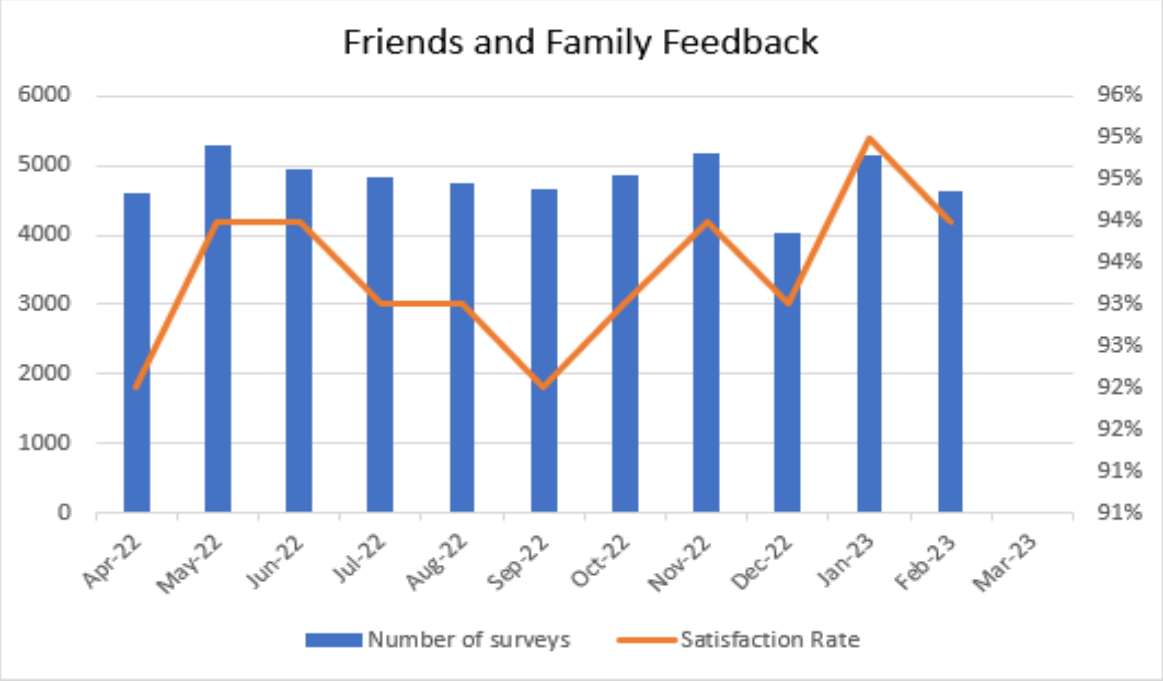
2.2.10 Patient, Family and Carer Experience

2.2.10.1 NHS Friends and Family Test

What?	To improve the Friends and Family Test (FFT) satisfaction rate
How Much?	The organisational objective by 2022 was that 98% of patients would rate our services as good or very good in the NHS Friends and Family Test survey (FFT).

The Patient Engagement Team have been working throughout the year to promote the importance of the NHS Friends and Family Test survey (FFT) survey with Trust staff and increase the number of survey responses from patients and their families. This work has seen the number of responses grow consistently over 4000 per month.

The survey feedback is collected using a variety of methods, such as paper (A5 / A4 / Large Print / Easy Read), SMS or online surveys accessed through QR codes. Paper surveys continue to be the preferred method of giving feedback amongst patients, with 52% of surveys completed by paper in 2022-23.



The Trust employ CIVICA Solutions to manage all patient and family satisfaction data. The 'Experience' system enables our staff to compare their FFT survey data with other patient experience feedback, so they know how their service is performing in the eyes of patients and the public. They use both the positive and negative feedback to influence the care and treatment they provide, detailing any actions they have taken if required.

Outcome	In 2022/23 BTH surveyed 57,209 patients using the FFT survey. 93% of patients rated their care as good from April 2022 – March 2023.
Progress	FFT satisfaction rates have been affected on a national level in 2022-23 by the significant pressures post Covid-19 pandemic and unprecedented demand, especially in emergency and urgent care. Nationally the current satisfaction rate in the Emergency Department is around 83%. There has been an increase of 17,425 surveys when compared to 2021-22. 27,534 of the FFT surveys in 2022-23 were collected via online and SMS text, compared to 8817 in 2021-22. SMS text implementation continues to be rolled out across the Trust. The FFT survey is now available in easy read and the six languages most spoken in Trust services, Urdu, Bengali, Romanian, Polish, Arabic, and Kurdish Sorani. To ensure robust implementation this piece of work was submitted to the Clinical Quality Academy as a quality improvement project.
Actions for 2023/24	• Continue to provide visible evidence in public places throughout the Trust to demonstrate what actions have taken place because of FFT feedback. • Continue the roll out of the SMS texting to cover Mental Health services. • Increase the number of actions recorded on the platform, empowering the staff to respond to these in a thorough manner.

2.2.10.2 Co-production with patients and the public

What?	Ensure the model for co-production is followed by staff across the organisation
How Much?	Trust staff engage groups of people with 'lived experience' at the earliest stages of service design, development and evaluation as they are best placed to advise on what support and services will make a positive difference to their lives.

Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

Acknowledging that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

The Patient Engagement Team has visited pop-up events in the community over the last 12 months, engaging with local communities about the different opportunities available at the Trust for co-production involvement.

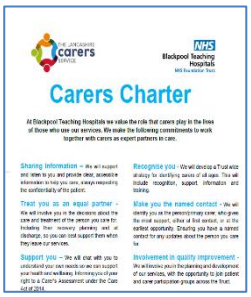
During 2022-23 the Trust has launched its 'Expert by Experience' programme of work. Where Experts by Experience are recruited as partners, they have personal experience of using or caring for someone who uses our health, mental health, or social care services.

Our Experts by Experience provide the critical and unique perspective required to reshape the system, and they bring strengths and networks to support improvement.

One of our Experts has been involved in the Clinical Quality Academy work, around the adoption of cardiology outpatient virtual appointments. The team involved has found their input extremely beneficial, whilst the Expert has really enjoyed the experience and looks forward to attending and contributing to the project.

Other areas of Co-production:

- A carers guideline is under development to support and embed the co-production work highlighted at the Carers Charter consultation workshops.
- Continued work to improve relationships with N-Vision, Healthwatch, Lancashire Carers, SPARKS network, Blackpool Council etc to increase partnership working and engagement in and around local communities.
- The Influence Panel work together with staff advising and supporting on new ideas and projects across the Trust. The Trust's Influence Panel work continues across the Trust with the membership growing this year by 9 new members.
- The implementation of the Future Collaboration Platform across the Expert by Experience and Influence Panel groups to encourage and support joint working, the forum space allows the groups to share thoughts, ideas and generate new ideas for areas of work.
- Hidden disabilities continues to be highlighted, actively used and supported across the Trust. With over 8000 pieces of hidden disabilities promotional materials being handed out.
- #Hellomynameis yellow badges continue to be available for staff to order across the Trust, with over 10,700 ordered and distributed. A recycling scheme has now been implemented for any areas with surplus badges to return for reissuing to new staff members.



Outcome	Achieved
Progress	Workplan for 2022-27 in progress.
Actions for 2022/23	Continuation of objectives and actions held within the 2022-27 Workplan.

2.2.11 Workforce Experience

Percentage of staff not experiencing harassment, bullying or abuse at work from other colleagues (historical comparison):

2018	2019	2020	2021	2022
79%	77%	79%	82%	81%

Percentage of staff believing the Trust offers equal opportunities for career progression (historical comparison):

2018	2019	2020	2021	2022
57%	59%	61%	61%	60%

Please note that the national survey coordination centre has amended scoring for the above question. This has been amended for historical data too.

Summary of Performance

The Trust's response rate reduced slightly in 2022/2023 to 51%. But this response rate is significantly above the average for Acute and Community Trusts of 44%.

National benchmarking of Acute and Acute and Community Trusts placed BTH in the top 20% of Trusts for six of the seven NHS People Promise themes.

The survey highlighted some areas for the Trust to focus on improving, however this is to be expected given the challenges faced by the NHS in the previous couple of years. There are no areas of significant concern to report.

Future Priorities and Targets

Divisional leaders are preparing to host the annual Big Conversation 'listening into action' events. Feedback from colleagues who attend these sessions is used to develop meaningful divisional improvement action plans.

Progress against divisional improvement plans will continued to be regularly reviewed at the quarterly Employee Engagement Sponsor Group which is chaired by the Chief Executive.

2.2.12 Freedom to Speak Up

The Trust has had a Freedom to Speak Up Service (FTSU) in place since 2017. The Trust remains committed to listening and encouraging all our staff to have a voice to speak up.

The table below shows the yearly figures for concerns raised and dealt with during 2022/23, compared with 2021/22:

	2022/23	2021/22
Concerns Raised	289	65

Analysis of our data shows that there is an increase in the number of medical staff speaking up and a reduction in the number of anonymous concerns raised.

In October 2020, a review was carried out at the Trust by the National Guardian's Office (NGO). The NGO exists to help people working across the NHS to speak up about any issues or concerns through the Freedom to Speak Up initiative and team of FTSU Guardians.

The report was published in October 2021, almost a year after the review. Due to the delay in the publication of the report the Trust was able to evidence that progress had already been made against several of the identified recommendations. This included the Trust:

- Making sustained improvement in the quality of safe and effective clinical services;
- Prioritising improvements and investing in Freedom to Speak Up – with a team of Guardians in place;
- Scoring above the national average for the number of concerns raised across all categories, which was improving year on year;
- The NSS results for 2020 demonstrating an improvement in staff feeling supported to speak out - two thirds of people saying they felt safe speaking up.

The Trust made this difference by listening to people including staff, our F2SU Guardian and the NGO and learning from and acting on feedback with real initiatives. This is something we will continue to do to help us progress even further in the future and the NGO report recommendations will form part of that.

The National Guardian's Office conducted a review at the Trust. The Trust were given thirty-seven recommendations to improve its speaking up culture. There were six areas of focus, including:

- Freedom to Speak Up Guardian
- Identifying something might be wrong
- Speaking up
- Examining the facts
- Outcome and feedback
- Reflecting and moving forward

These recommendations were implemented and signed off by NHS England in March 2023.

In October 2022, members of the Board completed the Freedom to Speak Up self-assessment tool. This resulted in the production of an action plan aimed at further improvements to creating a safe, speaking up culture. This process also identified the need for all staff, managers and Board members to complete Speaking Up training. Speaking Up training will become mandatory training for all staff from April 2023.

In May 2022, the Trust disbanded the joint Freedom to Speak Up office it had in place with East Lancashire Hospitals Trust. Blackpool Teaching Hospitals now has its own dedicated Freedom to Speak Up service.

2.2.13 Improving Care for Patients Living with Dementia

Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving patient experience and delivering improvements in clinical outcomes. During 2022/2023 our workforce was recovering from the response to the COVID-19 pandemic. As we started to restore our services back to pre-pandemic levels, reset learning, how we innovate, and consider how we maintain improvement; we also had different ways available to us in how we could do this. This different world is no less important for the people living with dementia who experience the care and treatment we provide. This delivery plan sets out our ambitions to provide the best care without waits, without harm and effectively use the resources available. Key to this is the education of our staff and as one of the key commitments within this delivery plan this will support improvement in conjunction with our Quality Improvement team and be demonstrated through our lived experiences, measured through participation in local and national audits and shown through our COAST (ward accreditation) programme.

Our aim is to be recognised as a paragon of Dementia care and treatment by continuously building upon the progress already made and listening to those experts through experience and key stakeholders. Following the consultation event which took place in June 2021 seven key commitments were identified to take forward. These commitments, the passion our staff give, and the measurable performance indicators are at the centre of this new strategy and fundamental to ensuring that we continue to ‘Remember the Me in Dementia’.

Those 7 commitments are:

- Dementia Friendly Environments
- Person-centred approach to dementia care
- Improve the hospital experience
- Educated and informed workforce
- Living Well at Home
- Partnership working
- End of Life care

Each of the 7 Key commitments has an identified lead to take forward the associated work stream. The progress of each workstream, as well as the monitoring of the key performance indicators, will be presented by each lead at the quarterly Trust Dementia Advisory Board (DAB). The DAB reports on a biannual basis to the Trust’s Quality Assurance Committee.

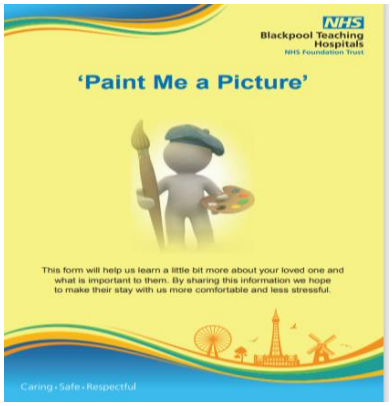
Dementia Champions

Dementia champions meet monthly and are part of clinical and non-clinical teams across the trust. Their role is to promote awareness around supporting people living with dementia as well as being the “go to person” for dementia resources in their area.

We currently have 62 active champions who have received appropriate training and have agreed to the responsibilities of being a champion. The ambition is to increase this number so that all clinical areas have at least one champion.

Butterfly Scheme

The trust subscribes to and is committed to the Butterfly scheme with close links to its founder. It is used to as an alert on tracker and the newly rolled out “what matters to me most” back of the bed boards. This alert acts as a quick reference to inform staff that patients have either a diagnosis of dementia or a mild confusion. Training and awareness of this scheme has been delivered to Champions and ward staff.



Paint me a Picture

This is a person-centred tool that is used widely in the Trust, it gives vital information about the individual needs, wants, and wishes of a person and allowing staff supporting that individual to deliver a more holistic and individualised approach to their care, as well as applying any reasonable adjustments. COAST review the use of this as part of their assessments.

Education

Identified as commitment 4 the education and training of our staff is an important part of our delivery plan. Reported through the Trust’s Quality Assurance Committee this is also monitored through COAST assessments.

Tier One Training

This training is currently available on the Trust's Electronic Staff Record (ESR) to all staff and will be a core training requirement from April 2023. It is provided on a face-to-face basis to all new Healthcare Assistants (HCA's) and as part of the Registered Nurses' Induction days.

Tier Two Training

This package has been revised and is now provided over two days, to ensure it meets the requirements of Health Education England (HEE). Training sessions take place monthly with good attendance and very positive feedback received. This training is available to all staff who have direct contact with people who have dementia.

Feedback from candidates on the course:

All the course was clinically beneficial and relevant and enlightening.

The entire 2 day course has been amazing and very informative.

Learning more about people living with dementia

So much more empathy for patients and their family.

Barbara's story. Very lively and interactive presenter.

Face to face interaction and discussion with other colleagues. Facilitator is amazing.

What will staff take back to clinical areas?

John's Campaign

Blackpool Teaching Hospitals has pledged to John's Campaign, which promotes partnerships in care with families & carers, improving patient experience & quality of care. Development of this is to be included as part of a new Carers policy so that if appropriate, relatives and carers can support and enhance the care that is provided to all patients in Hospital, rather than just those living with dementia.

National Dementia Audit

Participation in this National audit forms an important measure of our performance as an organisation. Phase One was completed in December 2022, with 40 patients identified for the case note audit. Phase Two started on the 6 March 2023, and will identify a further 40 patients in order to complete the audit. Results are expected by quarter three 2023/2024. During the audit patient, carers and staff surveys were sent out, which will form part of the overall outcome report. The process for gaining this feedback will however continue as part of our delivery plan and improvement has already been identified as part of this audit and influenced the content of both the tier 1 and tier 2 training.

Enhanced Care and Enhanced Care Workers

The enhanced care policy was launched in 2021 and this policy aims to improve the quality and patient experience of 1:1 care. It aims to improve the quality of care for patients by ensuring their individual needs are met and improve their experience by building a partnership approach to care delivery. The increased interaction and engagement will have therapeutic advantages and moves away from a culture of providing 1:1 care through a medical model approach to a partnership in care approach, a holistic model. This policy will be reviewed alongside the development of the Carers policy.

COAST Ward Accreditation Assessments

COAST assessments have led to an increased understanding and awareness of a dementia friendly hospital, and areas of good practice and areas for improvement have been identified. The lead nurse for learning disabilities and dementia, now sits on the planning meetings for any new builds or improvements that are carried out in the Trust, to ensure a dementia friendly approach is considered.

2.2.14 Palliative, End of Life and Bereavement Care

The Swan model of care is about providing excellent, individualised end of life and bereavement care for every patient and every family, every time.

It is patient and family focussed and centres on meeting the unique needs of each individual and their loved one.

It has been another busy year for the Hospital Palliative Care, End of Life and Bereavement Care Teams. The teams are led by a Consultant for Palliative Medicine, as Head of Department and a newly established role of Lead Nurse for End of Life & Bereavement Care. There is an Executive and Non-Executive Lead for End of Life Care represented on Trust Board.

The team continues to develop and invest time in quality improvement and improving education and training for our colleagues across the Trust.

There has been year on year a rise in referral numbers, and since the commencement of seven day working, weekends are becoming increasingly busy. There is a plan to undertake a review of 7 day working as part of a team away day in April 2023, to look at plans for the service and future staffing models over the next year. This will align to the Fylde Coast End of Life Strategy 2023-27, currently in development, with a major focus on advance care planning and education.

The team were also awarded the Trust's Pakho Li Special Recognition Quality Improvement award for the Emergency Department's In-Reach project.

97 % patients seen within 24 hrs of referral

Trinity launch virtual ward & Living Well Service

Team win QI Pakho Li award for the Emergency Department in reach project

The final National Audit for Care at End of Life (NACEL), cohort 4, was submitted in October 2022. Overall performance was good with the trust achieving above average scores across most domains, when compared with the rest of the UK.

In particular, the staff survey demonstrated that the majority of staff feel confident when caring for a dying person and well supported by the hospital palliative care team.

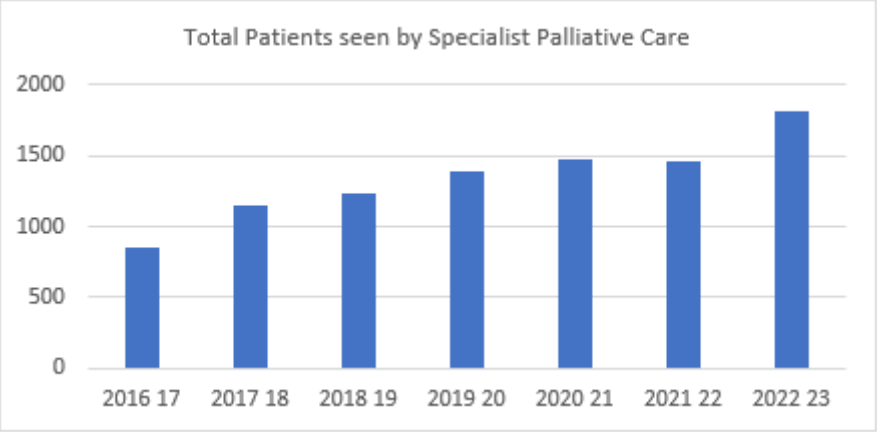
Areas highlighted for improvement included increasing the of use of the individualised plan of care for the dying person & individualised nursing care plans. We will be reviewing our documentation in the light of these findings.

NACEL has now ended and we await updates from the National team with regard to how the national audit programme will look going forward. In the meantime, we will continue to undertake regular audits of our own of documentation across the Trust.

A quality survey reported that relatives also felt well supported, when compared with the national average, although a low number of quality surveys were returned. We have reviewed and relaunched our Trust Bereavement Survey earlier this year. We have seen a 53% reduction in complaints involving bereavement or end of life issues

Palliative Care:

- The number of referrals has risen by over 200 this year.
- Response rate remains high with 97% of patients being seen within 24 hours of referral
- To date the team have undertaken 5768 weekday face to face visits and 1291 weekend face to face visits.
- There were 1773 more face to face contacts and 276 more phone calls made by the team so far this year.
- Palliative Care Emergency in reach continues with 107 patients having been seen in the department and 18 admissions avoided. The Emergency Department in reach project has been highlighted as an area of good practice by NHS England Benchmarking January 2022
- Referrals for non-malignant patients have increased due to close working with frailty and liver disease specialities and accounts for 54% of the case load.



Swan & Bereavement Team

- We welcomed new members to the team including a new Clinical Lead
- The service commenced 7 day working across both acute and community in January 2023
- The number of referrals has risen to a total of 557 in 2022/23, compared to 549 in 2021/22 and 257 in 2020/21.

- The service provided 740 ward visits to support staff, patients and families
- All bereaved loved ones have access to bereavement support – this is offered to all and the service is promoted and offered through ward teams, bereavement office staff and also within our bereavement booklet.
- The team support education and training and have provided training sessions for 476 staff throughout the year
- The team worked alongside Occupational Health and established a monthly drop-in staff bereavement support café
- Established new roles and service with a Swan Bereavement Midwife and Support worker joining the existing Specialist Nurse to enable Maternity Services to have improved access to immediate and ongoing support after loss in pregnancy
- Our Bereavement Midwife was nominated in two categories and winner of Compassion in Care at this year's Celebrating Success Awards

Community End of Life Team

- We have a community end of life team who support teams across the primary care networks including care homes
- The teams provide education and training across the acute Trust and community services and are involved in quality improvement programmes
- Swan End of Life Care Champions

Our Champions meetings were held monthly utilising Microsoft teams which continued to support the teams across acute and community care and care homes and nursing homes. The Champions' feedback has informed development of the education programmes to support and develop them in their role.

Education and Training

The Education Programme has undergone an extensive review, which included training needs analysis across all staff groups, benchmarking against national markers for required competences and analysis of projected numbers of staff required to attend. This is in line with CQC requirements. There is now a defined competency matrix which makes it clear what training and competencies are required in terms of end of life, palliative and bereavement care, according to role.

Education has been delivered across all settings – acute, community and care homes, in both formal and ad-hoc sessions. For the more formal sessions training was delivered to 476 staff members.

Support for staff in care homes has been delivered through the End-of-Life Educator/Facilitator. A bespoke education and support package has been developed and piloted with a group of care homes. Work is now underway to roll this out further and ensure meaningful engagement with care homes across the Fylde Coast

There are several quality improvement projects underway within the End of Life Team.

- Verification of Expected Death – increasing the number of registered nurses able to verify expected deaths in acute and community settings. Aim to reduce the amount of time spent waiting for a person to be verified after death.
- Electronic Communication of Advance Care Planning – looking at developing electronic communication mechanism to allow Cancer CNS' (pilot group) to notify GPs when an advance care planning conversation has taken place in order for an accurate EPaCCS record to be created.
- Electronic Palliative Care Coordination Systems – project focussed on maximising the quantity and quality of EPaCCS records across the Fylde Coast as well as improving accessibility of the information contained within them.

Engaging and supporting our communities

We continue to support national, regional and local campaigns to raise awareness of the support and services available to our Fylde Coast Community, these include a Dying Matters Week in May 2022 and National Grief Week Campaign during December 2022 which coincided with our annual remembrance services - "Tree of Lights"" and Baby Remembrance Service" and we held a Child Memorial Snow Drop Service in February 2023.

2.2.15 Mortuary

The Mortuary at BTH has a main body store which has capacity for 124 deceased patients in both refrigerated and freezer storage. Two additional separate refrigerated units can accommodate 60 deceased patients. The Mortuary also has two rooms available for bereaved families to visit their loved one, a large post-mortem room and separate forensic/infectious post-mortem suite. The Mortuary is licensed with the Human Tissue Authority (HTA) and has United Kingdom Accreditation Service (UKAS) ISO 15189:2012 accreditation with the most recent HTA inspection having taken place in January 2022.

Over the past 12 months, there has been an increase in the number of both hospital and community deaths. Average occupancy has remained higher than previous years, indicating the length of stay for deceased patients has increased. This is likely due to a higher number of deaths within community settings, leading to a decrease in available storage at funeral homes.

The mortuary perform post mortems on behalf of the Blackpool & Fylde and the Lancashire with Blackburn & Darwen Coroners. The past 12 months have seen a slight increase in the number of post mortems performed. The Mortuary also run a successful Care of the Deceased Patient training session. This is open to all staff who care for the deceased patient and/or their relatives, or are involved in the bereavement process and would like to gain further understanding of our Mortuary and Bereavement Services to ensure that high standards of care, dignity and respect are maintained. From April 2022 – March 2023, over 90 members of staff have attended the training. The following is examples of the positive feedback we have received following the training:

Area	Comments
ED	*"I found the training excellent. I feel it is very much needed especially for staff in the ED"*
Chaplaincy	*"I have heard good things about this training which is why I decided to go. I hoped to understand the patient journey from death on the ward to leaving in a hearse. My expectation was achieved and I also learnt about other activities that the Mortuary staff are involved with"*
Ward 5	*"The course exceeded my expectations. I didn't expect the course to be as interesting as it was. I had no idea just how much goes on in the bereavement office and in the whole department"*
ED	*"It was lovely to meet all the staff responsible for ensuring all patients are well cared for following their death and every member of staff I met was lovely and it shows they really care"*
Clifton 2b	*"I now feel very confident regarding any questions I may be asked by next of kin/relatives of a deceased patient. Therefore, able to support if necessary"*

Alongside the Care of the Deceased training, the mortuary also provide training for Forensic Medicine and Anthropology students at UCLan, new starters as part of the End of Life Core training programme and post mortem examination training for ST1s from around the region.

Our mortality statistics for the past five years are as follows:

Deaths	2018-19	2019-20	2020-21	2021-22	2022-23
Number Hospital Deaths	1887	1847	2105	1855	2000
Number Community Deaths	643	642	661	724	730
Total Number Deaths	**2530**	**2489**	**2766**	**2579**	**2730**

Post Mortems (PMs)	2018-19	2019-20	2020-21	2021-22	2022-23
Number Coroner PMs	467	458	245	528	471
Number Hospital PMs	1	2	0	0	1
Number Infectious PMs	81	80	241	61	127

Number Home Office PMs	30	15	14	27	18
Number Independent PMs	9	0	21	0	1
Number of CT PMs	94	93	101	120	110
Total PMs Combined	**682**	**648**	**622**	**616***	**618**

**invasive does not include Computed Tomography Post Mortems*

2.2.16 Medical Examiner System

Blackpool Teaching Hospitals has recently introduced a Medical Examiner system, which has been operational since March 2021. The purpose of the medical examiner system is to scrutinise non-coronial deaths both here at BTH and Clifton Hospital, to improve the quality of death certification, provide a better service for the bereaved and provide an opportunity to raise concerns as well as improving the quality of mortality data and subsequent learning.

During the initial roll-out, there was an expectation that all non-coronial acute deaths were scrutinised by the Medical Examiner (ME), and the system was due to be extended to community deaths from April 2022. The date for mandatory scrutiny for all non-coronial deaths has now been pushed back to April 2023, with a likely extension on this deadline until Summer 2023. Throughout 2022-23 the Trust has employed a number of MEs and Medical Examiner Officers who are working with Lancashire and South Cumbria Integrated Care Board to gradually expand the scrutiny into community settings. Currently the team are reviewing deaths from Trinity Hospice, Highfield and Fernbank surgeries.

The Medical Examiner's service continues to work closely with the Swan Bereavement Nurses, the Coroner's team, and Governance and Mortality teams in order to support the improvement of patient care and provide greater safeguards for the public by identifying matters for clinical governance and improving how we can learn from deaths.

2.2.17 Spiritual and Pastoral Care

The Chaplaincy and Spiritual Care Department consists of seven members of staff: three full time Chaplains, and four part time Chaplains covering a variety of faiths. There are 15 Chaplaincy Volunteers, and an online directory of Local Faith Communities is maintained by the team to ensure all spiritual requests are met.

The Trust Chaplains provide a 24/7 on-call service to help meet specific spiritual and religious needs, often in an end-of-life context. In 2022-23 they had 501 emergency calls to attend the hospital, 282 (56%) of which were out of hours, this is the highest number of urgent call outs we have had in a 12-month period. We have also led on 55 contracted funerals for the hospital.

There is a Chaplaincy Service Level Agreement with Lancashire and South Cumbria Mental Health Trust to meet the spiritual care needs of patients at The Harbour.

There is also a Chaplaincy Service Level Agreement with Trinity Hospice and Brian House, helping to facilitate a continuity of spiritual care for patients, carers, and family members across the Fylde Coast Healthcare community.

The annual bereavement service, Tree of Lights, was held in December 2022. As a team we also helped facilitate the Light up a Life event (Trinity Hospice), Baby Remembrance Service (at the Winter Gardens), Butterfly Service (Brian House remembrance service), and Snowdrop Remembrance Service (at Stanley Park).

The Chaplaincy and Spiritual Care Department continue to deliver an education programme to staff that promotes good spiritual care, religious needs, spiritual assessment, and staff health. Increasingly the training is delivered in collaboration with the other teams we work closely with, such as Swan and Patient Experience.

Plans are underway for the relocation of the Chaplaincy and Spiritual Care Department in 2023. This gives an opportunity to improve the facilities we have available to patients, visitors, staff, and volunteers.

2.2.18 Learning Disability Service

“Getting it Right" For People with a Learning Disability and or Autism Delivery Plan

Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving patient experience and delivering improvements in clinical outcomes. This ambitious delivery plan sets out our how we will drive improvements for patients with a learning disability and or autism and for whom care is often complex and admissions to hospital challenging. The delivery plan also takes up the key actions developed following an index case where concerns were raised. It sets out our ambitions to provide people with a learning disability and or autism safe effective care, for everyone, every day. To achieve this will require strategic planning, commitment, and leadership at all levels within our organisation, co-production with those with the lived experience, self-advocates, and the contribution

of our entire workforce. Improvement will be made in conjunction with our Quality Improvement team and be shown through our COAST programme as well as through the development of the key performance indicators.

The commitment is to be recognised as a paragon in the care and treatment of people with a learning disability and or autism, by a delivery plan that reflects the needs of people with a learning disability and or autism and listening to those experts through consultation and engagement. Following the consultation event which took place in July 2021, seven key actions were identified to take forward to improve further the quality of care and treatment for people with a learning disability and or autism. These key actions along with the commitment of our staff team and the measurable performance indicators are at the centre of this new delivery plan and fundamental to ensuring that we are “Getting it Right” for people with a learning disability and or autism. Those seven key actions are:

1. Person centred care
2. Reasonable Adjustments
3. Workforce
4. Decision making
5. Training
6. Service user engagement
7. Transition

The “Getting it Right” for people with a learning disability and or autism delivery plan will ensure that the foundations of high-quality person-centred care, treatment, operational delivery, and governance are embedded in our commitment to patients with a learning disability and or autism. It has clear and robust indicators that show our progress against the key actions within this. This will be further demonstrated through regular engagement events supported by the Patient Experience and Engagement team and driven by our experts by experience. This will provide the narrative to our journey so that we can continue to demonstrate, influence, and innovate across the Fylde Coast, and amongst our system partners.

Key Quality Improvement (QI) areas:

National Benchmarking Exercise

The Trust participated in round five (2022/2023) of the learning disability improvement standards project. The findings of this exercise have been incorporated in the delivery plan and training programmes.

Community Teams

The Adult Community Learning Disability Team is an integrated team with Blackpool Council which is made up of different professional groups. They are a long established team and strive to promote health equality for people with Learning Disabilities.

The Children and Young Persons Learning Disability Team is a small team that became operational in September, and this is the first time this support has been available in the Trust. The team has strong links with other Children and Young

People (CYP) services such as: CAMHS, Youtherapy, Mental Health in Schools Team and other paediatric services.

Together, both Community Learning Disability Teams offer a robust, evidence-based transition process called “moving forward together” this new way of working promotes integration to ensure the best outcome for those this service supports across their life span and aims to prevent avoidable hospitals admissions and ensuring reasonable adjustments in care is paramount.

Champions

The learning disability champions meet on a monthly basis and are from all areas/departments and the community who are the “go to person” for learning disability and autism resources in their area. They are responsible for updating the Learning Disability folder that all wards and departments have, which provides information on reasonable adjustments, easy read information, and pictorial supports.

DNACPR

There is now an easy read resource pack available on the Trust intranet that gives accessible information on DNACPRs.

John’s Campaign

The Trust signed up to John’s Campaign and this is now embedded within the clinical areas. Although initially set up to support patients with Dementia, this has been utilised to support anyone who would benefit from having family members or carers present during a hospital stay. Within the ‘Oliver McGowan’ training, it is identified that supporting family and carers is seen as a reasonable adjustment and staff are encouraged to promote John’s Campaign when caring for people with learning disabilities.

Training

Currently Learning Disability and Autism awareness training is provided on an ad hoc basis direct to teams. In line with the Government requirement to provide awareness training to all staff, an online programme ‘The Oliver McGowan’ training has been developed by NHS England and Health Education England (HEE) which is being rolled out to all Trusts. This training is currently available on the Trust’s web training platform and has been promoted to all the Learning Disability Champions and Trust staff.

Learning Disability Diamond Standard Training that has been adapted for use within the Trust continues to be carried out on a face-to-face basis. This training captures

learning from deaths, reasonable adjustments, the principles of the Mental Capacity Act (2005), diagnostic overshadowing and stopping over prescribing of medications.

The Heath and Care Act (2022), states it is a requirement that regulated providers ensure their staff receive learning disabilities and autism training which is appropriate to their role. From April 2023 this will become a required part of the trust's core skills training framework.

Learning from Deaths

The Learning Disability Lead has met with the Trust Mortality Lead and reviewed the current process for patients that have died in the Trust with a learning disability. The revised approach utilises Inpatient alerts and system management will now better capture this information. During 2022/23, there were 11 Trust cases for LeDeR review.

Structured judgement reviews (SJR) are being carried out, these feed into the regional LeDeR reviews and information from this will then be shared with clinical areas. This will ensure that lessons learned, and good practice can be fed back in a timelier manner. In addition to this a letter will be sent to clinical areas for feedback on the reviews using a revised structured approach once the review is completed. It is essential that SJR's (which can take up to 2 days to complete) are carried out in a timely manner, so identified learning can be fed back to clinical areas to improve the care that is provided. The Integrated Care Providers (ICP) will be providing recommended timescales for SJR's to be completed. Once this timescale is identified, Trust performance against this will be reported alongside the themes found through the Quality Assurance Committee.

Learning Disabilities Audit

To inform improvement against the "Getting it Right" for people with a learning disability and or autism delivery plan, a live audit of all inpatients took place on the 2 February 2023, this was the first audit carried out and will be repeated on a quarterly basis. This will be reported as part of the Quality Assurance Committee update.

Alert and symbol

A learning disability symbol continues to be promoted within clinical areas. This symbol is used as an alert on tracker and on the back of the bed boards and is used to inform staff that patients have either a learning disability and or autism so consider reasonable adjustments and read the hospital passport. It was important to incorporate the colour blue in this symbol as a reminder of some of the lessons learnt from the index case where a much loved and treasured blue blanket was lost, resulting in great upset and distress.

Enhanced Care

The Enhanced Care policy was launched in 2021 and this policy aims to improve the quality and patient experience of one on one care. It aims to improve the quality of care for patients by ensuring their individual needs are met and improve their experience by building a partnership approach to care delivery. The increase interaction and engagement will have therapeutic advantages and moves away from a culture from providing one on one care through a medical model approach, to a partnership in care approach, a holistic model.

Hospital Passports

Hospital passports are used throughout the hospital, and promotion of these person-centred documents, means clinical areas are using these tools to support individuals. The template can be accessed via the Trust's intranet site as well as the learning disability folder so staff can complete with those individuals who do not come with their own passport. These can now be added to the electronic document management system so that they follow the person during their admission.

2.3 Our Plans for the Future

The Trust's QI Strategy (2019-2022) has been delivered and we are now developing enabling plans for the Trust Strategy for 2022-2027. For all existing programmes, there are ongoing plans to ensure sustainability and spread of improvements. The Trust will continue to focus on current improvements, to help ensure they become part of everyday practice and "business as usual," and is currently developing and launching further improvement programmes, which are under review.

2.4 Our Quality Priorities 2023 / 2024

In 2023/24, we will focus on the following Quality Improvement priorities:

- To further build on our sepsis pathways, we will expand on the theme and commence a breakthrough series collaborative to improve outcomes for "the acutely unwell patient."
- Working with system partners we will launch a second phase of the "Last 1000 Days" breakthrough series collaborative in order to reduce Emergency Department (ED) attendances and keeping residents safe in their last 1000 days of life, giving back the gift of time.
- We will work with our staff to further build quality improvement capability at all levels of the organisation. We will work with staff across multiple areas and from a variety of different roles to deliver our improvement goals.

2.4.1 Statements of Assurance from the Board of Directors

Review of Services

During 2022/23, BTH provided and/or subcontracted over 150 acute and community services including the following:

- Urgent and Emergency Services
- Medical care (including Care of the Older Person)
- Surgery
- Tertiary Cardiac
- Haematology
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients
- Diagnostic Imaging
- Gynaecology
- Community Services
- CAMHS
- Neonatal Care
- Cancer Services
- Dementia Services
- Pain Management

Blackpool Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by BTH for 2022/23.

2.4.2 Participation in Clinical Audits and National Confidential Enquiries

The Trust's participation in National Confidential Enquiries includes the National Confidential enquiry in patient Outcome and Death (NCEPOD) which also includes the Child Health Clinical Outcome Review Programme. They are supported by the Local NCEPOD Reporter (Clinical Audit & Effectiveness Lead) and NCEPOD Ambassador (appointed consultant in November 2022). The National Confidential Enquiries that the Trust was eligible for and subsequently participated in are set out in the table below.

Five Studies were identified to be eligible for Blackpool Teaching Hospitals.

Study Title	Eligible	Participated	Position
Transition	✓	✓	Ongoing
Crohn's disease	✓	✓	Ongoing
Testicular Torsion	✓	✓	Ongoing/
Endometriosis	✓	✓	Ongoing
Juvenile Idiopathic Arthritis	✓	N/A	To start in 2023/ 24 Piloted in March 2023

2.4.3 National Clinical Audits

Participation in both national and local clinical audit is a statutory and contractual requirement for healthcare providers. During 2022/2023, 86 national clinical audits covered relevant Health Services that the Trust provides. The Trust participated in 79 (92%) of national clinical audits in which it was eligible to participate in.

The national clinical audits mandated by NHS Digital and Quality Accounts that the Trust participated in, and for which data collection was completed during 2022/2023, are listed below:

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Surgery, Anaesthetics, Critical Care & Theatres					
1	Case Mix Programme (INCARC)	Yes	Continuous	INCARC	100%
2	National Emergency Laparotomy (NELA)	Yes	Continuous	RCA	100%
3	PQIP	No	Continuous	RCA	N/A
4	BCIR	Yes	Continuous	BCIR	100%
5	National Audit of Breast Cancer in Older People (NABCOP)	Yes	Continuous	RCS	100%
6	Inflammatory Bowel Disease (IBD) programme/ IBD Registry Biological Therapies	No	Continuous	IBD Registry	N/A
7	National Gastro-intestinal Cancer Programme	Yes	Continuous	NHS Digital	100%
9	Elective Surgery: PROMs Programme	Yes	Continuous	NHS Digital	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
10	National Bowel Cancer Audit Programme (NBOCAP)	Yes	Continuous	NHS Digital	100%
11	National Oesophago-Gastric Cancer	Yes	Continuous	NHS Digital	100%
12	National Ophthalmology Database Audit	Yes	Continuous	RCOpth	100%
13	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Continuous	RCA	100%
14	National Hip Fracture Database (NHFD)	Yes	Continuous	RCP	100%
14	National Joint Registry (NJR)	Yes	Continuous	HQIP	100%
15	Fracture Liaison Service Database	No	Intermittent	RCP	N/A
16	Muscle Invasive Bladder Cancer Audit	No	Intermittent	BAUS	N/A
17	National Prostate Cancer Audit	Yes	Continuous	RCS	
Integrated Medicine & Patient Flow					
18	2022 UK Parkinson's Audit	No	Intermittent	UK Parkinson's	N/A
19	Diabetes Audit- Includes National Diabetes	Yes	Continuous	NHS Digital	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
	Inpatient Audit (NADIA)				
20	National Diabetes Core Audit	No	-	NHS Digital	N/A
21	Pain in Children	Yes	Intermittent	RCEM	100%
21	Assessing Cognitive Impairment in Older People/ Care in ED	Yes	Intermittent	RCEM	100%
22	National Asthma and COPD audit program (NACAP)	Yes	Continuous	RCP	100%
23	National Lung Cancer Audit (NLCA)	Yes	Continuous	RCP	100%
24	National Cardiac Arrest Audit	Yes	Continuous	NICOR	100%
25	Society of Acute Medicine Benchmarking Audit	No	Intermittent	SAMBA	N/A
26	National Clinical Audit for Rheumatoid and Early Inflammatory arthritis (NEIAA)	Yes	Continuous	Continuous	100%
27	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Continuous	RCP	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Families & Integrated Community					
28	Child Health Clinical Outcome Review Programme	Yes	Intermittent	NCEPOD	100%
29	National Paediatric Asthma Secondary Care	Yes	Continuous	RCP	100%
30	Maternal, infant and new-born programme (MBRRACE UK)	Yes	Continuous	NCEPOD	100%
31	National Audit of Seizures and Epilepsies in Children and Young People Epilepsy 12	No	Intermittent	RCPCH	N/A
32	National Child Mortality Database	Yes	Continuous	University of Bristol	100%
33	National Paediatric Diabetes Audit	Yes	Continuous	RCPCH	100%
34	National Diabetes in pregnancy audit	Yes	Continuous	NHS Digital	100%
35	National Perinatal Mortality Review Tool	Yes	Continuous	NCEPOD	100%
36	National Maternity and Perinatal Audit	Yes	Continuous	NCEPOD	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
37	National Neonatal Audit Programme	Yes	Continuous	RCPCH	100%
38	Smoking Cessation Audit-Maternity and Mental Health Services	No	Intermittent	NHS Digital	N/A
Tertiary Services					
39	Acute Coronary Syndrome or Acute Myocardial Infraction (MINAP)	Yes	Continuous	NICOR	100%
40	National Audit of Cardiac Rhythm Management	Yes	Continuous	NICOR	100%
41	National Audit Cardiac Surgery (NICOR)	Yes	Continuous	NICOR	100%
42	National heart Failure Audit	Yes	Continuous	NICOR	44.51%
43	National Coronary Interventions (PCI)	Yes	Continuous	RCP	100%
44	National Audit of Cardiac Rehabilitation	Yes	Continuous	University of York	100%
45	Adult Respiratory Support Audit	No	Continuous	RCP	N/A
46	UK Cystic Fibrosis Registry	Yes	Continuous	UK CF Registry	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Clinical Support Services					
47	National End of Life Care (NACEL)	Yes	Continuous	NHS Digital	100%
48	Serious Hazards of Transfusion (SHOT) UK-National Hemovigilance Scheme	Yes	Continuous	SHOT	100%
49	National Acute Kidney Injury Audit	Yes	Continuous	UK Aki Registry	100%
Corporate					
50	LeDeR- Learning from lives and deaths of people with learning disability and autistic people	Yes	Continuous	Continuous	100%
51	National Audit of Dementia	Yes	Continuous	Continuous	
52	National Audit of Inpatient Falls	No	Intermittent	RCP	N/A
53	Trauma Audit and Research Network (TARN)	Yes	Continuous	TARN	86%
54	Medical and Surgical Outcome Review Programme	Yes	Continuous	NCEPOD	100%

National Audit Participation in 2022- 2023

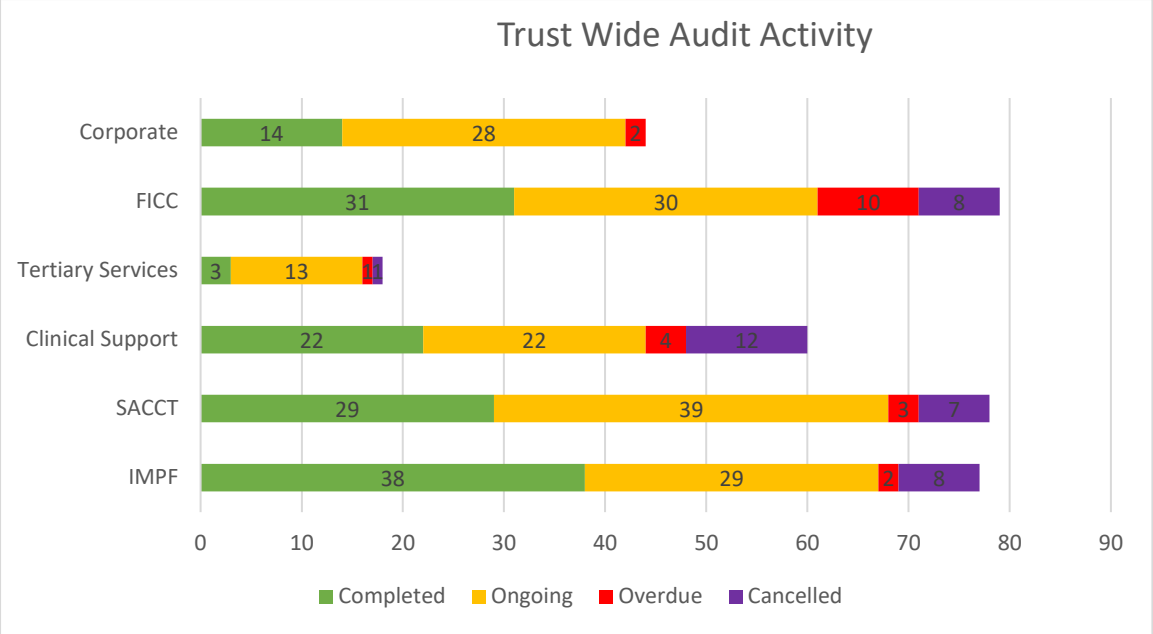
	Title	Participation	Local Ref Number
1	National Audit of Seizure Management (NASH)	Yes	DI2101N
2	BAPEN National Care Audit	Yes	PH2101N
3	CO-GENT: national Audit of Clinical Outcomes in Gentamicin prescribing and monitoring	Yes	HM2201N
4	National Comparative Audit 2022 of blood sample collecting and labelling	Yes	PA2204N
5	National Comparative Audit of Blood Transfusion 2018 major Haemorrhage Audit	Yes	PA1803N
6	National Comparative Audit of Patient Blood Management & NICE 2021 Quality standard 138	Yes	PA2101N
7	National IR(ME)R Audit	Yes	RA2101N
8	CQUIN Activity: Pneumonia & Nutrition Audits	Yes	CG2203
9	NatSSIPS/ LoCSSIPs	Yes	CG1703N
10	Safe Administration of Gentamicin	Yes	CH1910N
11	Antenatal and new born national audit FASP - SO7	Yes	OB2004N
12	Antenatal and new born national audit IDPS S05	Yes	OB2003N
13	National evaluation of accuracy of stillbirth certificates (NESTT) study	Yes	OB1911N
14	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (Saving Babies' Lives Care Bundle Version 2)	Yes	OB2009N
15	Care of Children in Emergency Departments	Yes	AE1906N
16	Fractured Neck of Femur	Yes	AE2004N
17	Infection Prevention & Control	Yes	AE2005N
18	Adult Community Acquired Pneumonia	Yes	GM1814N

	Title	Participation	Local Ref Number
19	Implant Breast Reconstruction Evaluation IMBRA Study	Yes	GS1608N
20	Savi Scout R Radar Localization for non-palpable breast lesions	Yes	GS2108N
21	Post colonoscopy colorectal cancer audit	Yes	GAS2102N
22	Cardiovascular outcomes after major abdominal surgery (CASCADE)	Yes	GS2111N
23	Rectal Cancer management during the COVID 19 Pandemic (Re-cap)	Yes	GS2001N
24	Surgical Site Infection Surveillance Service / Getting it right first time (GIRFT)	Yes	GS1701N
25	TranEXamic Acid in elective colorectal Surgery (TEXAS)	Yes	00012
26	National Potential donor audit	Yes	CC1303N
27	British and Irish Orthoptic Society Vision Screening	Yes	OR2103N
28	Foot and Ankle Thromboembolism Audit	Yes	OR2202N
29	BAUS Renal Colic Audit 20/21	Yes	GS2009N
30	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	GS2108N
31	Percutaneous Nephrolithotomy (PCNL)	Yes	GS1615N
32	RESECT TURBT Surgery	Yes	GS2004N

** Note: - Continuous Data Collection relates to rolling audits with open submissions all year round.*

The reports of four national clinical audits were reviewed by the provider in 2022/2023 and the Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix A).

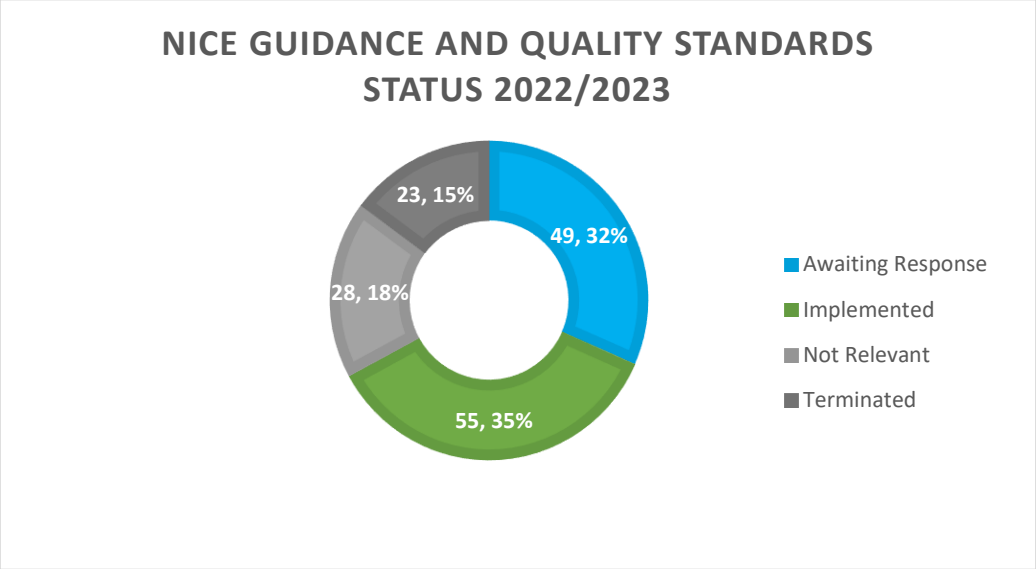
There have been total of 356 audit projects registered since April 2022 to March 2023. 137 (39%) have been completed on time, 161 (45%) are currently still ongoing, 22 (6%) are overdue and 36 (10%) were cancelled and not progressed. The actions of the 76 completed are included in the Appendix B.



2.4.4 NICE Guidance Summary

The Clinical Audit and Effectiveness team continues to maintain the Trust's NICE Guidance database in order to monitor the dissemination and implementation of guidance throughout the Trust where appropriate. The NICE database currently holds a record of all published NICE guidance including clinical guidelines, interventional procedures, cancer service guidance, technology appraisals and public health interventions, medical and diagnostic technology appraisals and highly specialised technologies.

In 2022/2023 there were 154 new NICE guidelines and 1 Quality Standard published.



Exception reporting on NICE Guidance and Quality Standards will be incorporated into Divisional Clinical Effectiveness reports and monitored through the Clinical Audit Group.

2.4.5 Participation in Clinical Research in 2022/2023

Developing new research platforms for clinical translation and integrating these into point-of-care technologies is seen as pivotal in the future NHS strategy. Such research developments enhance staff development but also serves to deliver a more efficient service to the end-user, i.e., the patient. On a number of fronts the Trust has been at the forefront of developing innovative solutions towards levelling up health inequalities.

Within the Clinical Research and Development department, there is now located the NIHR-funded Patient Recruitment Centre (PRC) and in collaboration with the Biomedical Research Centre (BRC) Manchester, the Trust's arm of the BRC. In line with this we have through the 2022-23 period initiated and undertaken 67 clinical trial studies that have recruited a total of 1,878 patients into frontline, primarily, phase 3 clinical trials. This has allowed access for our patients to the very latest in cutting-edge treatments.

The clinical trial work consisted of 20% commercial (with leading global pharmaceutical companies) and 80% non-commercial (academic, including CancerResearchUK-sponsored). In parallel, the emerging BRC initiative which kick-started in December 2022 (with five years funding) will develop research activities in the areas of oncology, genomics, respiratory, cardio-thoracic and cardiovascular, amongst others.

The vision of establishing this set-up is to integrate the early-phase research in-house and employing facilities through BRC Manchester and exploit these towards enhancing our late-phase clinical trial research. In line with this, a number of critical appointments have been made, including a research professor lead, a medical statistician and a number of dedicated research nurses.

Two studies of world-leading interest include the Northwest Cancer Research (NWCR) funded study into a prospective lung cancer screening trial through primary care and a haematology clinical trial (funded by Roche) investigating state-of-the-art blood handling techniques.

The NWCR-funded research led to the recruitment of 2000 study participants (as an NIHR portfolio study) through primary care and in parallel with CT scans and urgent referral of identified patients, has led to the potential research development of a rapid saliva test that could facilitate future, inexpensive, triage of patients. This research, developing a portable sensor-based technology harnessed to computational predictive algorithms, is being prepared for publication in leading peer-reviewed journals. The Roche-funded study recruited more than 200 patients and was deemed a significant commercial success.

Finally, significant linkages with local universities are being fostered in order to grow and develop further research activities.

2.4.6 Information on the Use of the Commissioning for Quality and Innovation (CQUIN)

The CQUIN scheme is designed to provide financial incentives for providers to maintain and improve quality in specific clinical priority areas. However due to the COVID-19 pandemic response, NHS England suspended the CQUIN financial incentive scheme for 2020/21 and 2021/22. To support the NHS to achieve its recovery priorities, CQUIN was reintroduced from 2022/23.

The CQUINs on which the Trust was monitored in 2022/23 focussed on the following quality indicators:

Lancashire & South Cumbria ICB	NHSE Specialised Commissioning
Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery.
Compliance with timed diagnostic pathways for cancer services.	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines.
Treatment of community acquired pneumonia in line with BTS care bundle.	
Anaemia screening and treatment for all patients undergoing major elective surgery.	
Supporting patients to drink, eat and mobilise after surgery.	

The CQUIN indicators monitored by the ICB did not have a financial value attached to them in 2022/23.

The monetary value attached to the Specialised Commissioning CQUINs was £882,000. The Trust received the full value in 2022/23 after agreement was reached that any funding associated with a shortfall in performance would be re-invested in the provider to support local health economy strategic system objectives.

2.4.7 Registration with the Care Quality Commission and Periodic / Special Reviews

BTH is required to register with the Care Quality Commission (CQC).

Statements from the Care Quality Commission

In April 2022, the CQC carried out a follow up unannounced inspection which covered Urgent and Emergency services, Medicine, and Surgery. The surgery inspection focused solely as a follow up to the section 29a warning notice issued in October 2021. The inspection report was published in July 2022. Post inspection the CQC rescinded the section 29a warning notice, however, a section 31 letter was issued in relation to the management of Sepsis and Rapid Tranquilisation. Only medicine was re-rated and this was rated requires improvement overall.

In June 2022, the CQC carried out an unannounced inspection of our Maternity services and published their inspection report in September 2022. The overall rating for our Maternity services was inadequate.

2.4.8 Special Reviews / Investigations

As outlined above, the Trust received a section 29a warning notice in October 2021 which was rescinded in 2022 following CQC's April inspection, however a section 31 letter was issued in relation to Sepsis and Rapid Tranquilisation and conditions placed on the Trust's licence, will still remain.

2.4.9 Information on the Quality of Data

High quality information leads to improved decision making that in turn results in better patient care, wellbeing, and patient safety. Data should always be accurate, up to date and clear.

To respond to our ambitions, over the last year we launched a new Integrated Performance Report (IPR) and rolled this out at the committee level to support both day-to-day operations and executive oversight. We continued to provide the Operational Exception Report weekly to the Executive Team for further oversight and assurance.

In recognition of our system working being in the developmental stages and the release of a new Standard Operating Framework (SOF) in 2020/2021, any updates and improvements to the reporting mechanism have become business as usual, led by the Associate Director of Business Intelligence and the Board updated accordingly.

Data quality policies and procedures are reflected in the Data Security and Protection Toolkit (DSPT) and all evidence is audited via the Information Governance Team and Internal Audit. Data quality reports are developed and submitted through the Information Assurance Group and through to the Board of Directors when required.

The Board of Directors ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency, and economy as well as the quality of its healthcare delivery. The Board regularly reviews the performance of the Trust through its Board Committees who monitor performance against regulatory requirements as well as the Board Assurance Framework.

All data that supports the performance dashboards, Integrated Performance Report, and national returns, are checked and have Executive oversight prior to submission, to ensure that compliance with the reporting standards criteria is met and activity conforms to the standard definitions.

The Trust is provided with external assurance on a selection of the quality data identified within the Quality Accounts which was taken from National Data Submissions, HED, National Patient Survey results, Local Inpatient Survey results and Data Security and Protection Toolkit (DSPT) results. Local internal assurance is also provided via:

- Provision of external assurance on a selection of the quality data identified within the Quality Report
- Analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents, analysis of complaints and claims data and safe nurse staffing
- Quality and safety metrics performance data reporting for scrutiny to the Board on a monthly basis through the Integrated Performance Report, and committees of the Board
- Controlled processes for the provision of external information with control checks throughout the process with formal sign off procedures
- Data reporting validation by internal and external control systems involving Clinical Audit, the Audit Commission, Senior Manager and Executive Director Reviews
- Random check processes on pathways by the Trusts internal performance team
- Monthly formal divisional reviews by way of the Performance, Improvement, Delivery and Assurance (PIDA) meetings, held with Executive Directors to overall monitor financial, operational, governance and quality key performance indicators
- Scrutiny of data provision to commissioners monitored at the Quality and Performance contract meetings
- Peer review processes as part of the National Quality Surveillance Programme
- Data Quality assurance reports through Specialist Commissioner Quality Dashboard quarterly submission and routine meetings

The Trust has a fully controlled process for the provision of external information with control checks throughout the process. Formal sign off processes of key performance indicators are facilitated by the Trust's Performance department.

The assurance on the performance of operational data that impacts on quality of care, such as elective waiting times, is monitored through the process of 'patient tracking list' meetings, where all divisions hold internal meetings and then report up to an Assurance and Escalation meeting weekly. Random audits across the patient pathways at sub-speciality level are carried out throughout the year. Results of these audits are used to generate any improvement plans required.

Good quality data will continue to inform performance against the key quality goals within the Trust's strategy and will influence future developments to enhance achievements against metrics attached to each of the quality goals.

2.4.10 NHS Number and General Medical Practice Code Validity

BTH submitted records during 2022/2023 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data*:

Which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 99.9% for outpatient care
- 99.1**%** for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

**Data from April 2022 – February 2023*

2.4.11 Information Governance Assessment Report 2022-23

Information Governance (IG) relates to the way organisations 'process' or handle information. It covers personal information, for example that relating to patients' / service users and employees, and corporate information, for example financial and accounting records.

The Data Security and Protection Toolkit is an online system, which allows the Trust to undertake a self-assessment by providing evidence and judging whether the organisation is able to meet assertions that demonstrate that the organisation is working towards or meeting the National Data Guardians (NDG) standards.

The purpose of the assessment is to assist the Trust in measuring our compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

2.4.12 Payment by Results (PBR) Clinical Coding Audit

Blackpool Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during this reporting period by the Audit Commission.

2.4.13 Learning from Deaths

In March 2017, the National Quality Board published guidance to introduce a standardised approach to the way NHS Trusts review, report, investigate and learn from deaths. Therefore, NHS Trusts are required to collect and publish information on deaths through a paper and an agenda item to a public board meeting on a quarterly basis as a minimum. Following the published guidance, the Trust reviewed internal processes, embedded a new way of working and updated the *Responding to Deaths Policy (BTH NHSFT CORP/POL/189)*.

During the period April 2022 to March 2023, 1,612 Blackpool Teaching Hospitals' patients died. This comprised of the following number of deaths, which occurred in each quarter of that reporting period:

- 377 in the first quarter
- 365 in the second quarter
- 440 in the third quarter
- 430 in the fourth quarter

The three conditions with the highest number of excess deaths are as follows (from the most recent HED data –12 month rolling SHMI average to September 2022):

- Stroke
- Pneumonia
- Liver disease

Following recommendations from a number of key enquiries a new National Service, the Medical Examiner Service has been rolled-out across England and Wales to provide greater scrutiny of deaths. The system also offers a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. The Trust hosts and line manages the service, but the Medical Examiners (MEs) and Medical Examiner Officers (MEOs) are independent of the Trust and have a separate professional line of accountability to both regional and national teams. There has now been full implementation of the Medical Examiner's Office which has contributed substantially to sustained improvements.

Learning from Deaths App

In May 2021, the Trust launched the Learning from Deaths App (LfD App). The App is a digital tool used for retrospective review of the case records of deceased patients. The purpose is to ensure all phases of care are evaluated in order to

identify actions for implementation and learning points for dissemination as a means of continuous quality improvement.

All deaths require an initial screening, and where the screening triggers the need for a more in-depth analysis of the patient journey, a Structured Judgment Review is then enabled through the application. The input from the LfD App then informs Directorate and Divisional Mortality & Morbidity meetings, and Quality meetings, to enable specialities to put the learning into practice. The information provided then populates the mortality dashboards and supports the on-going monitoring of quality of care.

However, the Trust's current mortality reporting does not meet the Trust Key Performance Indicators or national standards. The compliance rate is inconsistent, with long delays in some cases.

Following the launch of the LfD App, use of the tool has continued to be inconsistent, but has increased in usage.

Actions that were identified and implemented to resolve the challenges for staff to consistently use this tool for improved reporting of learning from deaths, included:

- Trust wide training and awareness of the Learning from Deaths App, including a training video.
- The appointment of an Associate Medical Director for Mortality Governance & Clinical Audit.
- The establishment of a Trust wide Mortality Improvement Group.
- The development of the LeDeR programme, with support from the Swan and Quality teams.
- Revised process for communication with doctors failing to complete relevant paperwork within required timescales.
- Establishment of a Mortality Community Roll Out Task & Finish Group.
- New Medical Examiners' and Medical Examiners' Officer appointments made.
- A revised Learning from Deaths Policy.
- New formal process adopted for complaints from bereaved families to be routed via the PALS team.

Further improvement recommendations have also been identified for implementation, including:

- Implementation of the action plan for review of Community Deaths originally scheduled for April 2022, and has now been postponed until 2023-24.
- Development of a clear Mortality Improvement Strategy.
- Initiating Phase 2 of the Learning from Deaths App is on hold due to the development of an Electronic Patient Record.
- Build further case record review capacity through cascading Structured Judgement Review (SJR) training to enable detailed review completion for outliers as identified through monthly HED data. An electronic tool is now available via NHS England and will be implemented in 2023-24.

- Full implementation of the Medical Examiner's Office and the Learning from Deaths Application are both anticipated to continue to contribute substantially to sustained improvements.
- Engagement with the processes of mortality governance, such as Morbidity and Mortality Meetings at Departmental and Divisional level and completion of SJRs, still shows room for improvement. There will be continued emphasis on these aspects of mortality governance, overseen by the Mortality Governance Committee, with the completion of the SJR learning on the LfD App.
- An electronic Bereavement and Chaplaincy package from Ulysses has been commissioned and this will join up seamlessly with the Trust's Ulysses Risk Management system.

2.4.14 Consolidated Annual Report on rotas for NHS doctors and dentists

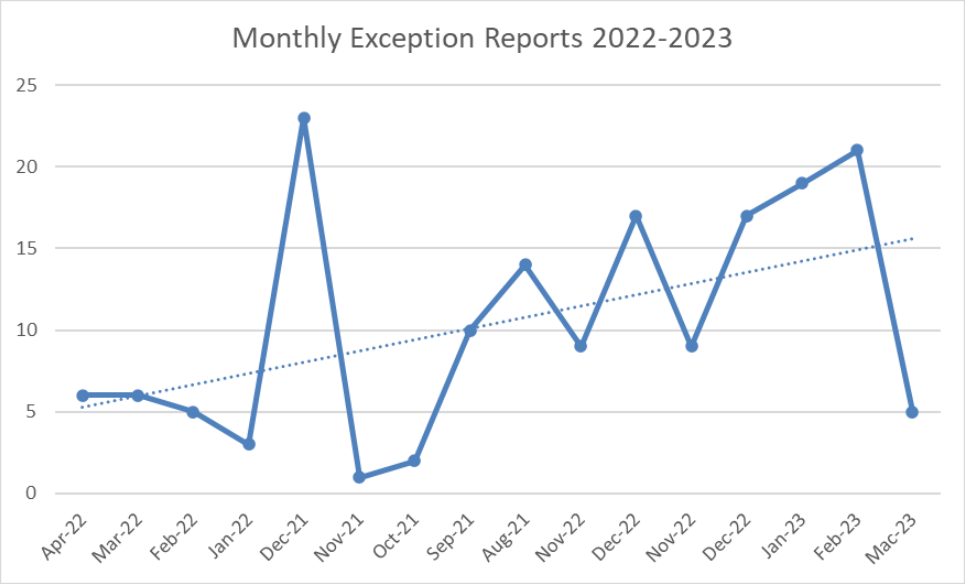
The Trust guardian of safe working hours has oversight of the issues relating to junior doctors in training. A key part of the role is overseeing the exception reporting process of rotas as stipulated in the 2016 junior doctors' contract.

Exception reports mainly relate to additional hours worked. A key factor driving this pattern of exception reporting arises from pre-existing rota gaps.

Efforts have been made in the recruitment drive to plug rota gaps to facilitate safe staffing levels especially out of hours ensuring patient safety.

Key areas of the hospital which have encountered sustained clinical pressure have to prioritise fully staffed rotas, which will create a sustainable workforce and workload.

Exception Reports (ER) 2022-2023	
Total number of exception reports received	116
Number relating to immediate patient safety issues	3
Number relating to hours of working	94
Number relating to pattern of work	8
Number relating to educational opportunities	7
Number relating to service support available to the doctor	7



There have been concerted efforts to improve the working relationship between junior doctors in training and the rota coordinators in the respective departments and areas. This includes:

- Clear annual leave and study leave guidance
- Ensuring timely responses to email or telephone enquiries
- Senior clinical involvement in rota design and decision making
- Integrating self-development time into rota templates

ER outcomes - work schedule reviews

Specialty	Grade	Review meeting notes
General medicine	ST1 *	None
General medicine	ST1 *	None
Trauma & Orthopaedic Surgery	FY1 *	Approved
Cardiology	FY2	Reveiw with HOD

2.4.15 The NHS Outcome Framework Indicators

The NHS Outcomes Framework sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes.

It is important to note that whilst these indicators must be included in the Quality Accounts, the most recent national data available for the reporting period is not always for the most recent financial year and where this is the case, these will be noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Domain	**Preventing people from dying prematurely –**								
Indicator	**SHMI - The value and banding of the summary hospital level mortality indicator (SHMI) (October 2021 to September 2022 107 (within the expected range)**								
National Average	**100**								
Where applicable – Best Performer	**75**								
Where applicable – Worst Performer	**121**								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:						• This is the most up to date data available.			
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:						• Mortality Governance Committee and Mortality Improvement Group in operation. • All deaths in hospital reviewed, Medical Examiner Process and team embedded into Trust process. • Medical Examiner monthly forum with Medical Director. • Lead Medical Examiner reports into Medical Director			
2018/19	113	**2019/20**	109	**2020/21**	107	**2021/22**	107 (Jan-Dec 2021)	**2022/232**	107 (Oct 21–Sep 22

Domain	**Enhancing quality of life for people with long-term conditions**								
Indicator	**% of patient deaths with palliative care coded at either diagnosis or speciality level for February 2022 to March 2023, taken from Latest HED information.**								
National Average	41.2%								
Where applicable – Best Performer	92.5%								
Where applicable – Worst Performer	2.0%								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:						• Data taken from National HED System as governed by standard national definitions.			
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:						• Education of staff regarding documentation of palliative care input			
2018/19	22.80%	**2019/20**	23.16%	**2020/21**	28.05%	**2021/22**	32.12%	**2022/23**	42.8%

Domain	**Helping people to recover from episodes of ill health or following injury**		
Indicator	Patient outcome scores for hip replacement surgery		
National Average	**Adjusted National Average**	Not available	
Where applicable – Best Performer	**Adjusted average health gain – best performer**	Not available	
Where applicable – Worst Performer	**Adjusted average health gain – worst performer**	Not available	

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Patient reported outcome measures (PROMS data taken from NHS Digital as governed by standard national definitions) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following hip replacement surgery.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Promotion continues throughout the Trust, on the importance of completing the questionnaire and enhancing patient awareness. There has been a significant increase in the number of surveys collected by the Patient Engagement Team. • It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • Monthly bulletins are circulated to the Medical Director and Director of Operations, as the Trust leads for PROMs and shared with Theatre teams. • Alternative electronic methods of collecting data have been explored, with the Trust requesting to take part in a provider trial in this area.

2018/19	0.386	**2019/20**	0.396	**2020/2021**	0.424	**2021/2022**	Data not yet available	**2022/2023**	Data not yet available

Domain	**Helping people to recover from episodes of ill health or following injury**		
Indicator	**Patient outcome scores for knee replacement surgery**		
National Average	**Adjusted National Average**	Not available	
Where applicable – Best Performer	**Adjusted average health gain – NHS Trusts best performer**	Not available	
Where applicable – Worst Performer	**Adjusted average health gain – NHS Trusts worst performer**	Not available	

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• Patient reported outcome measures (PROMS) data taken from NHS Digital as governed by standard national definitions) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following knee replacement surgery.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Promotion continues throughout the Trust, on the importance of completing the questionnaire and enhancing patient awareness. It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • Monthly bulletins are circulated to the Medical Director and the Director of Operations, as the Trust leads for PROMs, and shared with the Theatre teams. • Alternative electronic methods of collecting data have been explored, with the Trust requesting to take part in a provider trial in this area. •

2018/19	0.335	**2019/20**	0.308	**2020/2021**	0.315	**2021/2022**	Data not yet available	**2022/2023**	Data not yet available

Domain	**Helping people to recover from episodes of ill health or following injury**								
Indicator	**28-day readmission rate for patients 16 or over**								
National Average	No national benchmarking data available								
Where applicable – Best Performer	No national benchmarking data available								
Where applicable – Worst Performer	No national benchmarking data available								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The number of patients readmitted to hospital within 28 days of being discharged from hospital expressed as a percentage of all discharges in the period (data taken from local source and as governed by NHSI standard national definition).								
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions. • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes. • Monitoring at Trust Board a quality improvement programme for the year. • Monitoring of relevant performance indicators and plans at Commissioning Quality Review Board and contract meetings.								
2018/19	5.24%	**2019/2020**	7.66%	**2020/2021**	9.15%	**2021/2022**	7.14%	**2022/2023**	5.23%

Domain	**Helping people to recover from episodes of ill health or following injury**								
Indicator	**28-day readmission rate for patients 0-15**								
National Average	No national benchmarking data available								
Where applicable – Best Performer	No national benchmarking data available								
Where applicable – Worst Performer	No national benchmarking data available								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The number of patients readmitted to hospital within 28 days of being discharged from hospital expressed as a percentage of all discharges in the period (data taken from local source and as governed by NHSI standard national definition).								
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions. • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes. • Monitoring at Trust Board a quality improvement programme for the year. • Monitoring of relevant performance indicators and plans at Commissioning Quality Review Board and contract meetings.								
2018/19	13.05%	**2019/20**	13.43%	**2020/21**	14.14%	**2021/22**	13.95%	**2022/23**	13.59%

Domain	**Ensuring that people have a positive experience of care**							
Indicator	**Responsiveness to inpatients personal needs: - NHS Outcomes Framework Indicators**							
National Average	Not available							
Where applicable – Best Performer	Not available							
Where applicable – Worst Performer	Not available							
Trust Statement								
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The NHS Outcomes Framework Indicator 4.2 – is scored from a selection of questions within the National Inpatient Survey that focus on the responsiveness to personal needs. The score indicates how NHS Trusts are personalising care to suit their patients' individual needs. • Following the merger of NHS Digital and NHS England on 1st February 2023 the trust is reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed.							
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage / proportion / score / rate / number) and so the quality of its services, by undertaking the following action:	• The Patient Engagement Team shared the Trusts 2021-22 National Inpatient survey results with staff across the Trust, updating at Quality Assurance Committee, Divisional Governance Committees and Ward Manager discussion forums. • A meeting with the Senior Pharmacy Team took place to discuss reoccurring themes around medications on discharge. • The importance of communicating to patients on discharge how to take their medication and reducing staff noise levels at night was the campaign focus last year. • The Patient Engagement Team monitored the Trust's local patient feedback survey data to see if the improvements identified in the national survey, were consistent themes throughout the year. • Trust staff worked collaboratively with our patients and carers to plan and co-design new ideas for service improvement, this took place through our Influence Panel which supported the Emergency Village plans, SDEC and Critical Care. • The Patient Engagement Team also attended local community engagement events across the Fylde Coast.							
2018/19	64.6	**2019/20**	65.7	**2020/21**	72.8	**2021/22**	Data not yet available	**2022/23**	Data not yet available

Domain	**Ensuring that people have a positive experience of care**						
Indicator	**Percentage of <u>patients</u> who would recommend the provider to friends or family needing care. Inpatients**						
National Average	95% - January 2023 – latest figure on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	79% - January 2023 – lowest figure on NHS England website						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	We remain above the national average for our FFT inpatient survey score. The COAST ward accreditation system has ensured that high standards are maintained across both our hospitals. With the COAST inspection team reviewing how ward staff engage with their patient and carer feedback on their visits. The Patient Engagement Team also drop into the wards collecting FFT surveys, whilst our volunteers visit the wards on a weekly basis encouraging patients to fill out the inpatient's listeners survey to provide us with further feedback. Training is also offered to the Ward Managers on the Experience platform, ensuring they action their feedback. SMS text messaging is now being used as a method to support the paper feedback form received across inpatient areas.						
2019/20	96% - figure from March 2020	**2020/21**	98% - figure from March 2021	**2021/22**	97%- figure from March 2022	**2022/23**	96% - figure from March 2023

Domain	**Ensuring that people have a positive experience of care**						
Indicator	**Percentage of <u>patients</u> who would recommend the provider to friends or family needing care. Patients discharged from Maternity Services as per question asked at birth.**						
National Average	92% - January 2023 – latest figures on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	67% - January 2023 – lowest figure on NHS England website						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• We are currently below the national average for our FFT maternity survey score. The Patient Engagement Team is working with the team on Ward D and Delivery Suite providing them with tips and advice on how they can improve their FFT performance which is discussed in our monthly meetings. Adaptions have been made to the environment based on patient feedback with QR code posters now placed in central areas. • Patient experience also submit information to the Divisional Governance meeting where themes and hot spots can be raised and shared across the Division. • The SMS text FFT survey has also been reviewed to ensure women can feedback about the whole of their birth journey.						
2019/20	86%	**2020/21**	85%	**2021/22**	98%	**2022/23**	87% - figure from March 2023

Domain	**Ensuring that people have a positive experience of care**						
Indicator	**Percentage of <u>patients</u> who would recommend the provider to friends or family needing care. Patients discharged from Accident and Emergency.**						
National Average	83% - January 2023 – latest figure on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	43% - January 2023 – lowest figure on NHS England website						
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	We remain below the national average for our FFT Emergency Department score. Urgent and emergency care continues to be seriously impacted by the COVID-19 pandemic recovery with patients reporting delays in receiving timely and accessible care across the country. Our Emergency Department has been under considerable pressure, with often over 100 patients in the department waiting for review or treatment. Patients have reported long waits to access a bed on a ward, or delays in receiving their diagnosis or information about their condition or treatment from our Emergency Department staff.						
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	Escalation areas and new wards have been opened to try and ease patient flow from the Emergency Department. The Patient Engagement Team meet regularly with the Departmental Managers to discuss their feedback and highlight any significant concerns. From these monthly meetings, we have created a 'what to expect whilst waiting in the Emergency Department' poster focusing on feedback received from the survey, highlighting information on processes within the department, what we offer to patients and any other relevant information which has been raised as a common theme during our meetings.						
2019/20	88%	**2020/21**	85%	**2021/22**	67%	**2022/23**	70% figure from March 2023.

Domain	**Ensuring that people have a positive experience of care**
Indicator	**Percentage of staff who would recommend the Trust as a provider of care to their Friends or family. Staff Survey.**
National Average	61.9% (2022/23)
Where applicable – Best Performer	86.4% (2022/23)
Where applicable – Worst Performer	39.2% (2022/23)

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Data extracted from the National Staff Survey management and key findings report for 2022..
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Further exploration of staff sentiment is taking place through divisional Big Conversations, and though engagement with staff networks. Trust wide and local action plans will then be developed to address issues of concern, including that of advocacy. • Significant programmes of work are being led by the staff engagement service and QI hub to improve staff and patient experience. Coast accreditations remain ongoing, while strategic programmes of work contained within the local delivery plan and the Integrated Care Partnership aim to improve patient pathways.

2019/20	63%	**2020/21**	69%	**2021/22**	65.3%	**2022/23**	58.6%

Domain	**Ensuring that people have a positive experience of care**						
Indicator	**The number of Mixed Sex Accommodation Breaches**						
National Average	Average Breach rate in Trusts is 3.2 taken in January 2023						
Where applicable – Best Performer	0 breaches recorded by another NHS Trust in January 2023						
Where applicable – Worst Performer	478 breaches recorded by another NHS Trust in January 2023						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Under the revised DSSA guidance (2019), the Trust records a breach when: ▪ A patient is not stepped down from level 2 or 3 care in Critical Care Units within 4 hours of the clinical decision being made that they are safe to transfer. ▪ Patients have not been moved from an assessment / observation unit within four hours of a decision to admit. We had a higher amount of MSA breaches in 2022/23. The Trust has been escalated to OPEL level 4. There have been extremely high levels of bed occupancy / surge patients making it difficult to step down patients from all our critical care areas due to general beds not being available.						
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	The Trust has completed a number of building projects over the last year, with services moving into the newly opened areas, this has created some single sex ward spaces across the Trust. The Associate Director of Nursing and Head of Patient Experience conduct regular inspections of areas where MSA breaches have occurred or where there are planned building changes, to ensure they meet the DSSA Guidelines.						
2019/20	0	**2020/21**	4	**2021/22**	14	**2022/23**	41

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm –**								
Indicator	**Percentage of admitted patients' risk-assessed for Venous Thromboembolism (VTE)**								
National Average	This has been put on hold due to COVID								
Where applicable – Best Performer	See above								
Where applicable – Worst Performer	See above								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	National Audit not reinstated since Covid pandemic.								
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	Local actions include: • ongoing monitoring and local audit. • VTE Group with a Medical Chair in place.								
2018/19	65%	**2019/20**	72.25%	**2020/21**	The audit was put on hold due to COVID	**2021/22**	Audit not reinstated since Covid	**2022/23**	Audit not reinstated since Covid.

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
Indicator	**Rate of *Clostridioides difficile* (C Diff) per 100,000 bed days of cases reported amongst patients aged 2 or over (2022/2023)**
National Average	2021-2022 = 25.20 (Data for 2022/2023 not yet available)
Where applicable – Best Performer	2021-2022 = 0.96 (Data for 2022/2023 not yet available)
Where applicable – Worst Performer	2021-2022 = 78.60 (Data for 2022/2023 not yet available)

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	NHS England and NHS Improvement set the NHS Standard Contract Thresholds for acute trusts. The threshold was 109 cases and the Trust reported 84 cases. Data regarding the 84 cases reported was extracted from the United Kingdom Health Security Agency (UKHSA) and Healthcare Associated Infection Data Capture System (HCAIDCS) and is governed by standard national definition. Rates per 100,000 overnight bed days and day admissions have been included in this report. This denominator is used to determine the rate for 'Healthcare Associated' infections which includes hospital and community onset cases. This rate does not however take into consideration local risk factors such as deprivation, older NHS Estates which do meet modern IPC standards, or differences in geographical location such as rural versus urban areas. The Trust 2021-2022 rate was 44.08. Data for 2022/23 is not yet available.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage / proportions / score / rate / number) and so the quality of its services, by undertaking the following action:	The clinical divisions continue to undertake a root cause analysis of all cases. The outcome of these investigations determine which actions are required and forms the basis of a divisional action plan. The Infection Prevention team undertake commode cleanliness audits and the results also factor in to the Divisional action plans. Each Division then reports their progress against their CDI action plans at the Whole Health Infection Prevention Committee meeting.

2018/19	Count 60 Rate 25.69	**2019/20**	Count 127 Rate 56.68	**2020-21**	Count 92 Rate 45.56	**2021/22**	Count 101 Rate 44.08	**2022/23**	Count 84 Rate not yet available

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm –**								
Indicator	**The number of and percentage of patient safety incidents within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (April 2022 - March 2023)**								
National Average	**No national averages for this indicator**								
Where applicable – Best Performer	**No national averages for this indicator**								
Where applicable – Worst Performer	**No national averages for this indicator**								
Trust Statement									
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	The Trust continues to promote and exhibit a culture of open and honest reporting. Incident data is recorded through the Trust's Risk Management Incident Reporting system, governed by national standards and definitions for levels of harm and timescales for incident reporting.								
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage / proportion / score / Rate / number) and so the quality of its services, by undertaking the following action:	• Encouraging a culture of voluntary reporting by staff by continuous improvement of Trust risk management systems. • Implementing a monitoring system for the management of timely reporting and management of incidents to capture early learning. • The implementation of easily accessible training for staff on incident reporting and management of incidents and investigations. • Promoting Duty of Candour and supporting staff to ensure initial contact is made with the patient/family within 10 days of the incident being identified. • The continued review and development of the 'Management of Incidents, Incorporating Serious Incidents' Policy and the streamlining of new processes for reporting and managing incidents. • The implementation of further training for staff in undertaking an effective investigation, to ensure quality learning and effective SMART action plans. • Continued engagement with the Quality Improvement Team to ensure that the Quality Improvement Strategy and Programme is informed through learning identified from incident trends and themes.								
2018 / 19	0.009% (12 months data)	**2019 / 20**	0.05% (12 months data)	**2020 / 21**	0.02% (12 months data)	**2021 / 22**	0.02% (12 months Data)	**2022 / 23**	0.03% (12 months data)

Domain: Preventing people from dying prematurely

The standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our predicted number of deaths. The Trust has continued to implement its mortality governance programme concentrating on pathways of care. The latest nationally published SHMI rate for the Trust is 107 for the period October 21 to September 2022, which remains the same as for the previously reported period.

The 12-month rolling SHMI indicator for the Trust remains within the expected range.

Domain: Helping people to recover from episodes of ill health or following injury

Patient reported outcome scores

A patient reported outcome measure (PROM) is a series of questions that patients are asked in order to gauge their views on their own health. Using data gathered in relation to knee replacement and hip replacements, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.

The patient is invited to complete two questionnaires; the data provided then gives the average difference between their first score (pre-surgery) and second score (post-surgery).

Blackpool Teaching Hospitals works closely with Quality Health to continuously look at different ways to increase responses to PROMs, to gain a comprehensive overview of our service in these areas.

Domain: Ensuring that people have a positive experience of care

Responsiveness to Inpatients' personal needs

This indicator provides a measure of quality, based on the CQC's National Inpatient Survey. The score is calculated by averaging the answers to five questions in the inpatient survey. The highest score achievable is 100%.

The patient experience delivery plan provides the structure to increase the feedback we obtain from patients and relatives which we use to influence and evolve service developments.

Domain: The number of and percentage of patient safety incidents within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (April 2022 - March 2023)

Patient safety incidents are reported to NHS England, via the NRLS. The number of patient admissions and attendances for the year 2022/23 was 571,525 and the number of patient safety incidents reported by BTH for the same period was 24,996. This equates to a percentage of 4.37%. The number of severe harm or death incidents reported and closed within this period was seven, which equates to 0.03% of patient safety incidents reported. This low figure of severe harm or death incidents, in comparison with the high number of patient safety incidents reported, indicates that the Trust's safety record remains high. Organisations that report more incidents usually have a better and more effective safety culture and the organisation continues to perform within the top 25% of Trusts nationally.

3 Review of Quality Performance

3.1 An Overview of Quality of Care

The measures in the table below provide performance in 2022/23 against indicators selected by the Board, which reflects the list of priorities that the Board deemed necessary to continue to monitor throughout the year. Previous years priority indicators have remained the same and these continue to be measured as the metrics within the quality strategy. The below are areas that feature in the Trust's strategy for quality improvement, feature within the Trust's Quality Strategy and which the Trust wishes to highlight within the quality accounts.

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
Patient safety Outcomes	Hospital Standardised Mortality Rate (Summary Hospital Mortality Indicator)	89 (Jan–Dec 22)	106 (Aug 21 – July 22)	107 (Dec 20 to Nov 21)	111 (Dec 18 to Nov 19)	115	111
	Stroke Mortality Rate *Data Source HED:*	115 (Oct 21 – Sept 22)	107 (Jan-Dec 2021)	114 (Mar 20 to Feb 21)	107 (Dec 18 to Nov 19)	132	132

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Pressure Ulcer harm reduction	Category 2 0.3% decrease, category 3 36.4% increase, category 4 37.5% decrease	Category 2 21.34% decrease, category 3 70% increase, category 4 19.05% increase	Category 2 4.85% decrease, category 3 20% decrease, category 4 81.82% increase	Category 2 18.7% decrease, category 3 5.2% increase, category 4 75.2% decrease	Stage 2 29.62% increase, stage 3 9.4% increase, stage 4 20.83% increase.	Stage 2 10.96% increase, stage 3 183.33% increase and stage 4 56.25% increase.
	Reduction in harm as a result of a fall	12.5 % decrease	8.84% increase	32.04% increase	59.7% reduction	16.9% reduction	2.47% increase overall
	Opportunities to care within clinical pathways - sepsis	No longer audited. Audit changed to LIVE data collection with collaborative.	94.93% (Apr21-July 21) Audit ceased WEF 1.8.21	95.04% (Apr20-Feb21)	93%	89%	86%
	Opportunities to care within clinical pathways – AKI	No longer audited. AKI live collection commenced in February 2023.	92.25% (Apr 21 – Feb 22)	92.37% (Apr20-Feb21)	91%	84%	79%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Opportunities to care within clinical pathways – pneumonia	No longer audited. Moved to Acute Pathway Group.	Audit ceased WEF 1.4.21	98.70% (Apr20-Feb21)	98%	98%	97%
	Opportunities to care within clinical pathways - Stroke	No longer audited. Moved to Acute Pathway Group	94.14% (Apr21 - Aug 21) Audit ceased WEF 1.9.21	91.33% (Apr20-Feb21)	92%	95%	96%
	Opportunities to care within clinical pathways – Fractured Neck of Femur (#NOF)	No longer audited. Moved to Acute Pathway Group	Not audited from April 2018	Not audited from April 2018	Not audited from April 2018	Not audited from 01.04.2018	75%
	Opportunities to care within clinical pathways – Cardiac Chest Pain	No longer audited.	No longer Audited	No longer audited	No longer audited	97%	98%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Opportunities to care within clinical pathways – Chronic Obstructive Pulmonary Disease (COPD)	95.23% (audited quarterly Apr 22 - Nov 22). Feb 23 data not yet available.	94.64% (audited quarterly Apr21 – Feb22)	96.32% (audited quarterly Apr20 – Feb21)	99.33%	95%	95%
	Opportunities to care within clinical pathways – Abdo Chest Pain	No longer audited	No longer audited	No longer audited	No longer audited	91%	86%
	Opportunities to care within clinical pathways – Heart Failure	No longer audited	71.88% Apr 21 – Jan 22)	67.60% (Apr 20 - Feb21)	68.53%	61%	56%
Patient Experience	Percentage of Adult Inpatient who rate care as excellent / very good / good	2022 data not yet available	(2021 data) 81%	(2020 data) 83%	(2019 data) 81%	(2018 data) 81%	(2017 data) 79%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Percentage of Adult Inpatients who have been treated with Respect & Dignity	2022 data not yet available	(2021 data) 92%	(2020 data) 91%	(2019 data) 89%	(2018 data) 88%	(2017 data) 85%
	Percentage of Adult Inpatients who felt involved in their care and/or treatment	2022 data not yet available	(2021 data) 69%	(2020 data) 70%	(2019 data) 71%	(2018 data) 68%	(2017 data) 67%

3.2 The Risk Assessment Framework

The Trust aims to meet all national targets and priorities and we have provided an overview of the national targets and minimum standards including those set out within the NHSI Single Oversight Framework.

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum two weeks from:	GP Urgent Referral for suspected cancer to First Consultant Appointment	93%	Under achieved: Q1 88.08% Q2 78.9% Achieved Q3 93.9%	Under Achieved: Q1 91.3% Q2 92.4% Q3 79.7% Q4 Not yet available	Achieved: Q1 94.1% Q2 96.9% Q3 97.0% Q4 95.7%	Under Achieved: Q1 81.7% Q2 87.6% Achieved: Q3 93.7% Q4 94.6%	Under Achieved: Q1 84.2% Q2 82.9% Q3 88.8% Q4 84.1%
	GP Urgent Referral for breast symptoms (where cancer not initially suspected) to First Consultant Appointment	93%	Achieved: Q1 93.8% Q2 96.5% Q3 97.98%	Under Achieved: Q1 62.0% Achieved: Q2 96.8% Under Achieved: Q3 75.3% Q4 Not yet available	Under Achieved: Q1 74.0% Achieved: Q2 95.9% Q3 95.8% Under Achieved: Q4 85.1%	Under Achieved: Q1 3.2% Q2 58% Q3 89.6% Q4 98%	Under Achieved: Q1 22.2%, Q2 20.4% Q3 52.2% Q4 – 30.5%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum 28 days:	Faster Diagnosis Standard	75%	Under achieved Q1 71.2% Q2 66.9% Q3 65.9%	Under Achieved Q3 66.2% Q4 68.5%			
Maximum one month (31 days) from:	Decision to Treat to First Treatment	96%	Under achieved: Q1 86.6% Q2 83.4% Q3 88.4%	Achieved: Q1 99.0% Q2 98.5% Q3 96.1% Under Achieved: Q4 92.0%	Achieved: Q1 95.9% Q2 96.9% Q3 97.9% Q4 97.4%	Achieved: Q1 98.1% Q2 97.7% Q3 99% Q4 99%	Achieved: Q1 98.1% Q2 99.8% Q3 98.9% Q4 98.4%
	Decision to Treat to Subsequent Treatment – Drugs	98%	Under achieved Q1 94.4% Q2 66.6% Achieved Q3 100%	Achieved: Q1 100% Q2 100% Q3 100% Under Achieved: Q4 95.0%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 –100%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	Decision to Treat to Subsequent Treatment – Surgery	94%	Under achieved Q1 87.2% Q2 91.3% Achieved Q3 97.3%	Achieved: Q1 94.1% Under Achieved: Q2 92.9% Q3 93.5% Q4 86.7%	Under Achieved: Q1 75.7% Q2 81% Achieved: Q3 100% Under Achieved: Q4 93.5%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%
Maximum two months (62 days) from:	GP Urgent Referral for suspected cancer to First Treatment	85%	Under achieved Q1 66.9% Q2 65.8% Q3 75.7%	Under Achieved: Q1 80.9% Q2 73.5% Q3 67.4% Q4 62.3%	Under Achieved: Q1 71.1% Q2 82.3% Q3 74.8% Q4 72.0%	Change in Allocation Rules. Under Achieved: Q1 76.9% Q2 80.0% Q3 78.9% Q4 78.9%	Achieved: Q1 86.0% Under Achieved: Q2 81.0% Q3 82.7% Q4 79.0%
	A National Screening Service to First Treatment	90%	Under achieved Q1 46.8% Q2 35.2% Q3 56.5%	Under Achieved: Q1 31.3% Q2 25.9% Q3 25.7% Q4 35.2%	Under Achieved: Q1 29.4% Q2 29.6% Q3 73.3% Q4 63.0%	Under Achieved: Q1 73.7% Q2 89.2% Q3 48.8% Q4 38.8%	Under achieved Q1 75.9%: Q2 82.3% Q3 83.6% Q4 – 64.7%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	A Consultant Upgrade to First Treatment	No separate operational standard set	Q1 56.0% Q2 58.4% Q3 67.4%	Q1 89.1% Q2 87.4% Q3 72.0% Q4 76.2%	Q1 83.3% Q2 87.5% Q3 90.0% Q4 87.7%	Q1 89.9% Q2 88.1% Q3 88.9% Q4 92.3%	Q1 91.1% Q2 89.8% Q3 96.6% Q4 91.2%
Maximum 6 weeks for:	Patients waiting for a diagnostic test	99%	Under achieved Q1 72.5% Q2 75.1% Q3 73.8%	Under Achieved: Q1 76.9% Q2 72.6% Q3 82.3% Q4 80.5%	Under achieved: Q1 61.5% Q2 67.0% Q3 75.4% Q4 78.7%	Under achieved: Q1 98.9% Q2 97.0% Q3 95.8% Q4 91.3%	Achieved: Q1 99.58% Q2 99.54% Q3 99.52% Q4 99.05%
Cancelled Operations	Percentage of Operations Cancelled	No separate operational standard set	Q1 1.32% Q2 1.29% Q3 1.11%	Data Collection reinstated from Q3 21/22 Q3 1.26% Q4 0.91%	Not collected due to Pandemic	Under achieved Q1 1.67% Q2 1.42% Q3 1.82% Q4 1.88%	Under achieved Q1 1.67% Q2 1.17% Q3 1.26% Q4 1.55%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	Percentage of Operations not treated within 28 days	No separate operational standard set	Q1 17.71% Q2 18.71% Q3 16.45%	Data Collection reinstated from Q3 21/22 Q3 17.24% Q4 13.6%	Not collected due to Pandemic	Q1 11% Q2 5% Q3 4.3% Q4 4.68%	Q1 3.5% Q2 0% Q3 0% Q4 7.14%
Maximum 18 weeks for:	Patients on an incomplete pathway awaiting consultant-led treatment	92%	Under achieved Q1 68.4% Q2 65.6% Q3 65.9%	Under Achieved: Q1 73.4% Q2 71.5% Q3 71.4% Q4 69.4%	Under Achieved: Q1 52.9% Q2 60.2% Q3 64.7% Q4 67.6%	Under achieved Q1 80.98% Q2 81.56% Q3 81.62% Q4 79.87%	Under achieved Q1 81.04% Q2 79.99% Q3 81.24% Q4 81.06%
Infection Control	Incidence of MRSA		3 cases	Under achieved	Under achieved	Under achieved	0 Achieved
	Incidence of *Clostridioides difficile*	Threshold 109	Achieved 91 cases	Achieved	Under achieved	Under achieved	31 Achieved

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum four hour wait from:	Arrival to Admission, Discharge, or Transfer	95%	Under achieved Q1 80.2% Q2 79.4% Q3 78.9%	Under Achieved: Q1 85.0% Q2 81.1% Q3 79.5% Q4 77.8%	Under Achieved: Q1 92.0% Q2 88.4% Q3 80.2% Q4 80.7%	Under Achieved: Q1 84.57% Q2 86.82% Q3 83.85% Q4 85.79%	Under Achieved: Q1 – 85% Q2 – 83% Q3 – 86% Q4 – 85%
VTE Risk Assessment	Venous thrombo-embolism risk assessment	95%	No Audits undertaken due to COVID	No Audits undertaken due to COVID	No Audits undertaken due to COVID	Under achieved Q1 69.76% Q2 71.72% Q3 74.07% Q4 73.96% Q4 Data collection suspended 17th March due to COVID19	

NB. For all indicator figures where the Trust are providing limited assurance, they are clearly referenced with Ⓐ

The reported indicator performance for A&E has been calculated on the number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge as per the national guidance.

The reported indicator 62-day cancer has been calculated based on the accountable number of first definitive treatments for patients diagnosed with a new primary cancer (the numerator) and the number of accountable breaches (the denominator). The definition of a breach as per Cancer Waiting Time Guidance, is any patient treated more than 62 days after receipt of a GP suspected Cancer referral.

All quality performance targets form part of the quality contract between the Trust and Commissioners. These targets are reported monthly within the Trust integrated performance report which is monitored through the sub committees of the Trust Board and the quality contract targets are discussed at the monthly Quality Contract Review Group. Under performing indicators are captured within relevant work programmes and quality improvement projects which inform future service developments, for example: the proposed development of an emergency village, has been influenced by the A&E Boards programme of work to improve 4- and 12-hour targets.

3.3 Statements from the Integrated Care Board (ICB), Local Healthwatch Organisations and Overview and Scrutiny Committees (OSCs)

3.3.1 Commentary from the Lancashire and South Cumbria Integrated Care Board (ICB)

Lancashire and South Cumbria Integrated Care Board (ICB) thanks Blackpool Teaching Hospitals NHS Foundation Trust (the Trust) for producing this year's Quality Account, reporting on 2022-2023. The ICB acknowledges the achievements made during a very difficult year for the NHS, both nationally and locally, which is still greatly affected by the impact of the Covid 19 pandemic on service demand and provision of health care delivery. The ICB would like to thank all members of the Trust's workforce for their dedication, hard work and resilience in these challenging times.

This comprehensive Quality Account describes the Trust's drive towards a culture of continuous quality improvement. The launch of the new five-year strategy for 2022-2027 clearly sets out the critical themes and objectives the Trust aims to achieve, through significant engagement with colleagues, partners and stakeholders. We look forward to reviewing the impact and outcomes of the strategy in next year's Quality Account.

The ICB is encouraged to see the establishment of the Clinical Quality Academy (CQA) and the way use of data and capability-building is focused on reducing avoidable harm in very tangible and meaningful quality improvement activity. The ICB congratulates the Trust on being recognised nationally for this work. Through analysis of a range of data over the following year, the Trust will be able to evidence which approaches best sustain these improvements.

It is encouraging to see the Trust's ongoing commitment to duty of candour and that it is embedded in the Trust's safety culture. The Trust should be commended for achieving 100% compliance with all elements of duty of candour between 1st April 2022 and31st March 2023.

Another positive example of the Trust being open and transparent, has been the invitation for ICB representatives to join a number of committees/groups, observing internal governance arrangements and the ICB's participation in ward and clinical area COAST assessments. These have provided assurance to the ICB that the trust provides safe, high quality health care and has an effective internal review and governance process in place. The assessments allow wards and clinical areas to demonstrate a wide coverage of standards through key measures on quality; the identification of any issues and improvement opportunities. The Trust has achieved an appropriate and effective balance of providing support and guidance to the wards and clinical areas and promoting a high standard of care. The Quality Account highlights that the Trust will continue to put quality accreditations in place across all wards and services. The ICB will continue to monitor the evidence that the Trust has equally effective processes and escalation in place to support wards and clinical areas when assessment identifies improvements are required.

A vital component of quality improvement is engagement with groups of people with 'lived experience' and the ICB is delighted to see patient/family/carer groups now involved at the earliest stages of service design, development and evaluation. We look forward to seeing the impact of this way of working across the Trust's hospital and community services. Collaboration with other services including Healthwatch, Blackpool Council and Blackpool Carers will allow for a greater understanding of the Trust's local community, its needs and increase engagement with other out of hospital services.

The ICB continues to see an appropriate focus in the response to the Care Quality Commission inspections of urgent and emergency services, medicine and surgery and more recently maternity services. For example, cross-trust improvements in the identification and management of sepsis have been seen and we look forward to working with the Trust to ensure actions taken are having a real and sustained benefit in terms of patient safety.

The Trust is demonstrating more joined-up work around care of the elderly, end of life and in raising awareness of dementia, management of patients with dementia in an acute setting, and identifying those at risk of falls. The ICB credits the Trust on its provision of education to staff on caring for patients with dementia, particularly the implementation across the trust of the person-centred tool "Paint me a picture" which allows for a more personalised, holistic approach to a person's stay in hospital.

A notable reduction in grade 4 pressure ulcers is reported and the rolling programme of training on identification and prevention of pressure ulcers, should sustain this improvement. It is hoped with the training; the introduction of the Purpose T risk assessment tool and a new intentional rounding document, that reductions in category 3 and 2 pressure ulcers will be evident in next year's Quality Account.

The ICB has noted the ongoing work to improve the facilities in the emergency village project and how the Same Day Emergency Care (SDEC) has demonstrated a reduction in delays in the emergency pathway. The ICB is keen to work with the Trust to ensure these faster patient flows are appropriately communicated to the patients and those who support any aftercare in the community.

The ICB recognises the ongoing effort in improving the identification and management of the deteriorating patient. Although the ambitious aim of achieving a cardiac arrest rate of 1 per 1000 admissions had not yet been achieved, there had been sustained improvement in the rate from 1.49 to 1.07 per 1000 admissions. The identification and care of the deteriorating patient collaborative is clearly making an impact on this priority. Triangulation of information with incidents relating to the deteriorating patient will continue to help identify specific areas which need to be prioritised.

It is encouraging to see cases of Clostridioides difficile infections (CDI) reduced to 91 which is below the NHS Contract threshold of 109, and that the Trust are one of 7 out of 24 acute trusts in the northwest to remain within the NHS Standard Contract threshold for CDI. The learning from actions which have had impact will need to be embedded to ensure this improved position is maintained.

The ICB notes the Trust's rationale for the selection of priorities for 2023/24 and the decision to continue its ongoing programme of work on reducing pressure ulcers, improving the identification and management of the deteriorating patient and reducing fractured neck of femurs in partnership with local care homes. The ICB would like to praise the team in their achievement and engagement with the selected care homes. It is encouraging to see a 14% decrease in the number of falls resulting in moderate or serious harm within the acute elements of the Trust, however, there has been an increase in falls overall. The development

of a steering group to reduce falls that includes a wide multi-disciplinary workforce is welcomed by the ICB therefore.

It is pleasing to see that despite another difficult year, patients who chose to take up the opportunity to provide feedback through the Friends and Family survey, have sustained a high level of satisfaction with the care they received and experienced, despite narrowly missing the Trust target of 98% positive feedback. There is also a marginal increase in positive workforce experience and the ICB welcomes the Trust's action in preparing for several listening events in the coming year. It is hoped that the responsiveness to these will boost staff morale and support an increase in the retention of the workforce.

The ICB acknowledges the Trust's participation in clinical audits and national confidential enquiries. It is commendable that during these challenging times in the NHS, only a minimal amount had to be cancelled or not progressed. This demonstrates the trust's commitment to quality improvement.

The ICB is committed to working in collaboration with the Trust in meeting its quality priorities for 2023/24; a necessary foundation on which to ensure patients across Fylde and Wyre and Blackpool receive safe, high quality and harm free care from their local NHS services. This future collaboration also extends to the ICB’s responsibilities in supporting and working with trusts to improve or maintain the System Oversight Framework (SOF) position and providing assurance to NHS England regarding quality of care across the Lancashire and South Cumbria System.

Professor Sarah O’Brien

Chief Nursing Officer

3.3.2 Statement from Healthwatch Lancashire

Healthwatch Lancashire

Response to Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 22-23

Introduction

We are pleased to be able to submit the following considered response to Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts for 2022-23.

Part 1: Including Chief Executive's Statement

A comprehensive statement commenting on activity across the trust including the launch of the five-year strategy. It was pleasing to learn of the achievements of the last year, especially that 93% of patients rated their care as good, and the launch of the 'Expert by Experience' programme.

Part 2: A review of Quality Improvement Programmes 2022/23

2.2.7 Patient Safety

Listed are what the trust intends to take/have taken to improve the quality of patient safety. Worthy of note is the 'Safety Focus' newsletter that is in place to share learning and patient feedback.

2.2.10 Patient, Family and Carer Experience

We would like to highlight the 'Expert by Experience' programme as it is recognised that when people are involved at the earliest stage of design and development, the quality of services improve. We are particularly interested in learning how patients are more involved with co-production as the programme progresses.

2.2.13 Improving Care for Patients Living with Dementia

We are pleased to learn of the seven key commitments the trust is committing to in order to improve the experience of those patients lining with Dementia, and pledging to the

John's Campaign. We look forward to learning more about the improvements made to environments to improve a person's hospital experience.

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement. The Quality Indicators, results and supporting narrative are clear and well laid out.

Summary

Overall, this is a fair and well-balanced document which acknowledges areas for improvement and details comprehensive actions being taken to further improve patient treatment, care and safety.

We welcome these and as a Healthwatch we are committed to supporting the Trust to achieve them.

Jodie Ellams

Manager- Healthwatch Lancashire

3.3.3 Statement from Lancashire County Council Health Scrutiny Committee

The Lancashire County Council Health Scrutiny function welcomed the detail included in the Quality Accounts report on the examples of the challenges faced in 2022-23 and how improvements had been made.

The range of information that the Trust is required to reference in this report was acknowledged, and members noted the challenges in producing a report for both professionals and the public. The Quality Account is well presented and reflects the requirements to benchmark against peers.

The Committee noted that due to the complexity of the information reported, consideration could be given to producing a summary document of the report with the focus on patients and the public as the key audience. However, members welcomed the summary at the start of the report outlining the high level priorities, progress and future plans as well as the clear table of contents, use of graphics and the glossary.

Members noted that there appeared to be little information on access to services and staffing and would like to have seen more detail on these particular areas, the challenges and plans in place. In addition, it was felt that more information on progress since the CQC inspections would have further strengthened the report.

Members welcomed the information provided as part of the NHS Outcome Framework Indicators; however it was noted that a number of these did not include national data which limited the ability to contextualise the information provided.

The table of information provided as part of the 'Risk Assessment Framework' provided a useful overview, however it was felt that additional headline information on actions taken to address those areas identified as 'under achieving' would have strengthened this element of the report.

The Lancashire Health Scrutiny function welcomed the opportunity to comment on the Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts for 2022/23 and would welcome early involvement with the planning process to produce the Trust's 2023/24 Quality Account.

Samantha Parker

Senior Democratic Services Officer

Overview and Scrutiny

Legal and Democratic Services

Lancashire County Council

3.3.4 Statement from Blackpool Council Adult Social Care and Health Scrutiny Committee

The Democratic Governance Senior Adviser has provided the following response:

Thank you for your email. We have just had all our elections here at Blackpool and the Adult Social Care and Health Scrutiny Committee has not yet been reappointed by the Council, which it will do at the Annual Council on Wednesday 24 May 2023.

The Committee will therefore not have the time to contribute to the quality account process this year, however, once the Committee has been established we will send them the quality account for information.

Jodie Stephenson

Democratic Governance Senior Adviser

Democratic Governance

Blackpool Council

3.4 Statement of Directors' Responsibilities in Respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual updated March 2023* and supporting guidance.
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes for the period April 2022 to March 2023.
  - Papers relating to quality reported to the Board over the period April 2022 to March 2023.
  - Feedback from the Integrated Care Board (ICB) dated 15 June 2023
  - Feedback from Healthwatch Lancashire dated 8 June 2023
  - Feedback from Blackpool Council Adult Social Care and Health Scrutiny Committee dated 22 May 2023
  - Feedback from Lancashire County Council Health & Scrutiny Committee dated 2 June 2023
  - The Trust's annual complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, has not yet been completed for 2022/23, however an annual summary of complaints for 2021/22 was submitted to the Quality Accounts Committee in April 2022. Quarterly reports have also been completed for each quarter within 2022/23.
  - The 2021 national patient survey results published in 2022. The 2022 survey results have not yet been published by the CQC; these are expected in August 2023..
  - The national staff survey published in 2022.
  - Care Quality Commission inspection report, published in July 2022.
  - The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
  - The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS England's reporting guidance (which incorporates the Quality Accounts regulations) published at: NHS England » Financial accounting and reporting updates as well as the NHS England's Quality Accounts Requirements 2022/23 available at NHS England » Quality Accounts requirements 2022/23.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board:

Chairman:	Chief Executive:
Steve Fogg	Trish Armstrong-Child
June 2023	June 2023

4 Appendices

Appendix A: Actions taken following issue of National Report

Report	Action Taken
National Smoking Cessation Audit	1) Aim for 85% of patients to have a documented smoking status in the notes by the next BTS smoking cessation audit. 2) Weekly task and finish groups and three- monthly treating tobacco dependency steering group meetings.
National Maternity and Perinatal Audit	Confirmed all elements of saving babies lives 2 being implemented.
Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction- Saving babies' Lives Care Bundle V2	Improved referral system- carry our new triage system and proforma to facilitate better referral for ultrasound at appropriate gestation.
National Paediatric Diabetes Audit	1) Improve data collection in BP, HbA1c levels, eye screening, cholesterol and foot examination- changes to NEXUS 2) Emotional wellbeing support, to fill and input onto NEXUS when completing mental health check- Weekly Youth Therapy Clinics- patients newly diagnosed and following individual assessment are referred to Youth Therapy 3) Regular review of patients with elevated HbA1C- Review of sub-optimum glycaemic control pathway, to include monthly upload to NPDA and clinical review , Virtual clinics, Extra clinic appointment Structured education and use of resources- Development of personal Sick day rule cards. Sick day rules Policy.
BAPEN National Care Audit	MUST training video made. Ward based training.

Appendix B: Examples of actions taken as a result of local audits

Ref Number	Audit Title	Actions taken as a result of local clinical audit
	Integrated Medicine & Patient Flow	
GM2122	Accuracy of admissions diagnosis of UTI in the older people >65	Improvement of clerking documentation in AMU
		Avoidance of unnecessary investigation like Urine dipstick in a catheterized patient
GM2127	Preventing avoidable harm with safe IV fluid therapy	Increase knowledge about safe IV fluid prescription
		Facilitate access of NICE CG174 to prescribers
GM2210	Documentation of DNACPR	To discuss DNACPR early
		Decisions to be completed in patients notes
GM2228	Optimising anticoagulation management in atrial fibrillation amongst patients admitted to AMU	Doctors' education about importance of reviewing anticoagulation- presentation at local AMU teaching
GM2121	Pre-treatment assessment for Dapsone	Emphasise the need for regular blood tests
GM2001	Documenting the Diabetic Foot MDT	Development of comprehensive food booklet
GM2126	Atrial Fibrillation Detection in Stroke Patient	Update staff with Stroke Pathway around the importance of 12 lead ECG and AF detection: Basic ECG interpretation training
AE2102	Documentation of well's score in A&E	Reduce inappropriate requests for d-dimers
AE2007	Prescription of Critical medicines in ED	Reminder to use MAXIMS alert for Critical meds. Reminder on the shop floor and in handover.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
AE2101	An investigation into sepsis pathway	1)Posters: Related to the new sepsis pathway displayed 2)Encourage utilising the sepsis pathway in the department. The Trust have introduced a new pathway.
	Surgery, Anaesthetics, Critical Care & Theatres	
AN2102	Review of documentation of Anaesthetic and recovery room care	1)Reminder for anaesthetic documentation at WH sign out 2)Dermatome map available in every recovery area- to document neuroaxial block height.
GS2203	VTE Prophylaxis in the Urology Department within 48 hours of admission	1) Clerking doctor to have discussion with Senior doctor on Ward Round to ensure Secondary Clerking document is completed fully. Reminder during WR that both VTE and medication chart to be reviewed to ensure TED/Dalteparin appropriately prescribed
OP2202	Biometry Ultrasound audit	1) Integrated data sharing with optometrists on medisight
AN2102	Review of documentation of Anaesthetic and recovery room care	1) Dermatome map available in every recovery area, Stickers available in theatres. Computers and paper already available in theatre to type note. Additional reminder at WHO sign out for documentation to be completed and reversal to be documented- reminder on WHO board
AN2104	Elective Caesarean Sections lists operational standards	1) Rota coordinator for obstetric consultants to make sure that they are aware about any changes. Consultant obs./ anaesthetists for elective sections need to push to have team brief at 8:30

Ref Number	Audit Title	Actions taken as a result of local clinical audit
CC2101	Assessment of appropriate and adequate documentation of chest x-ray findings in Critical Care procedures	1) Train doctors for documenting x-ray findings. Introduce review checklist stamp reinforced with Radiology and Critical Care Department. Add to daily nursing handover announcement Nurses to ensure stamp is complete before starting feed.
GAS2101	Compliance with NICE CG100 Alcohol Disorders and CORP/PROC/487	1) Ongoing training on the assessment and management of patients with alcohol use disorders. Use of link nurses on all wards to promote identification and assessment referrals and effective care.
GS2109	Analysis on the safe use of intra-operative torniquets	Ongoing education and reminders on tourniquet machines. Pre-operative proforma changes to reflect BOAST guidelines
GS2110	Improving long-term follow-up of post treatment thyroid cancer patients	Blood forms available in ENT clinic to request thyroglobulin levels, Clinic letters to follow following template provided in PPT
GS2112	Re-audit of medical documentation of surgical patients	Refresher training and continuous induction sessions to emphasise . Documentation. Provision of stamps to all medical staff involved in documentation. Medchart to be escalated to all areas of the trust.
GS2202	Compliance of Trust VTE guidelines in Acute General Surgical admissions	Posters, emails and presentation sent to ensure that blood results are checked before prescribing VTE prophylaxis and, ensure the primary assessment is completed within 4hrs of admission and that the secondary assessment is done within 24hrs by post-take/on call team to maintain the 100% compliance
GS2205	Quality of Surgical wards documentation against standards	Highlight at induction to the junior doctors the importance of the other tools to be accurately documented.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
GS2207	Compliance of Trust VTE guidelines in Acute General Surgical admissions re-audit	Staff education taken place in ensuring blood results are checked before prescribing, ensuring the primary VTE is done within 4hrs of admission and the secondary assessment is done within 24hrs by post-take/on call team
OP2103	Implementation of NICE Guidelines for treatment of Neovascular AMD with antiVEGFs	Number of slots available increased for same day injections. Virtual clinics to continue
GS2212	Ward round documentation	Ongoing teaching delivered in using a template form
IC2201	Improving eye care in Intensive Care Unit	Outdated prescription chart to be updated. Provide teaching to nursing team and doctors' induction, distribute posters around ICU are on eye care
	Families & Integrated Community Services	
OB2010 -	Management of severe pre-eclampsia	Document if postnatal appointment offered,, staff education - remind junior doctors to ensure documentation of postnatal follow up on discharge letter - email communication .
OB2012	Obesity in pregnancy re-audit	Change from a paper BMI proforma to an electronic form. Clinicians to use Electronic system to document Care Plan. Audit cycle completed new audit to be considered 6 months after implementation of electronic maternity record
OB2102	SBL Element 5 - Premature live births receiving Corticosteroids, Magnesium Sulphate and delivery in appropriate setting	Email sent to community midwives to ensure documentation on Euroking at booking is completed. Regular teaching sessions will occur to keep doctor's and midwives up to date with the IT system at least twice a year. Preterm risk assessment has been added to the new Badger system. LMS proforma to be created.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
OB2105	Emergency Caesarean Section re-audit	Poster produced & in circulation to raise awareness of the importance of documenting time to decision to allow calculation of time interval to delivery.
OB2107	Detection and management of small for gestational age	Escalate the importance to community midwifery staff of measuring CO at booking. SBL v2 educational sessions for community midwives
OB2204	Management of miscarriage	Improved training for MVA use & recurrent miscarriage referral and cytogenetic testing (for eligible cases). VTE risk assessment proforma attached to patient record for all cases.
CH2105	Adherence to local antenatal alert policy	Alert stickers to be placed on maternal notes when Antenatal Alert form completed. Delivery Suite team updated of Antenatal alert Process. Ongoing training of new paediatric staff at induction to the department. Develop process to be able to share documented antenatal alert plan with women prior to delivery of baby.
CO2105	Prescribing and management of dental infection	Clinicians informed of their individual scoring patterns and trends. Use of SOE screen encouraged. Thermometer available for use in each clinic. Staff made aware of FGDP and BNF Guidelines
CO2201	Use of the difficult to engage escalation policy within adult community teams	Ensure staff are aware of CIT training on management of non-compliance available on patient safety training programme. Offer CIT non -compliance training package to individual teams. Distribute guidance to staff on the correct process for using the difficult to engage escalation policy.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
CO2203	Clinical Supervision re-audit	Training dates sent out to all team leaders and line managers, clinical supervision booklet sent out to all team leaders and line managers, clinical improvement team rep met with the BTH Clinical Improvement Lead to establish opportunities for joint working and methods to embed clinical supervision within teams.
CO2206	Dental Radiography Quality Assurance Audit 2021	Refresher training on calibration in grading radiographs, all sites will use the radiograph tabs to enter data for auditing
Clinical Support Services		
RA2106	Compliance with Radiology Bio-Medical Research trials with Trust procedure	100% compliance findings to highlight good practice cascaded
RA2107	Compliance with justification of an exposure of ionising radiation to patients for non-medical imaging reasons as per RAD/GEN/PROC/024	Audit findings cascaded and staff asked to make themselves familiar with the policy and to carry out the guidance when required. Discussion with PACS team to develop filter/ group to ensure images are only reported by those required to do so.
RA2108	Audit of correct checks and documentation of patient's pregnancy status prior to x-ray exposure	Staff asked to make themselves familiar with best practice guidance and ensure compliance. Poster displayed in all clinical areas. LMP check reminder also displayed in clinical areas. Radiographer to be present for WHO checklist HCG blood results recorded on WHO checklist
RA2109	Audit of justification of medical exposure prior to imaging examination	100% compliance achieved staff will routinely follow the pause and check methodology
RA2110	Audit of compliance with QA testing schedule of equipment performance as Per RAD/GEN/PROC/016	The audit demonstrated that there is good compliance performing QA tests as per RAD/GEN/PROC/016 Quality Assurance Programme

Ref Number	Audit Title	Actions taken as a result of local clinical audit
RA2111	Audit of compliance with Trust procedure RAD/GEN/PROC/057 investigating suspected accidental or unintended medical exposures	Audit met target & demonstrated good compliance findings cascaded at radiology audit meeting.
RA2113	Audit of correct patient identification and documentation prior to x-ray exposure	Staff asked to make themselves familiar with best practice guidance and to always comply with this. Review of procedure RAD/GEN/PROC/012
RA2114	Audit of Collimation during x-ray exposure	Staff asked to make themselves familiar with and follow guidance as per "Pause and Check" methodology when recording patient dose.
Tertiary Services		
CAR2105	Improving the adherence to Trust Guidelines for the management of acute kidney injury on post Cardiothoracic	Ongoing education in the AKI Pathway
CAR2106	Audit of compliance with a minimum data set for transthoracic echo study in patients	Trainee education completed. Reminder on echo machine to attach ECG cables. Laminated copy of minimum dataset to echo machine. Remind trainees of need to report onto McKesson

Appendix C: Glossary of Abbreviations and Terms

Table i: Glossary of Abbreviations

Abbreviation	Meaning
SUTS	Sign up to Safety
NICE	National Institute for Health and Care Excellence
CAUTI	Catheter Associated Urinary Tract Infection
NHS	National Health Service
AKI	Acute Kidney Injury
IV	Intravenous
CCG	Clinical Commissioning Group
CDI	*Clostridioides difficile* Infection
PROMS	Patient Reported Outcome Measures
HED	Healthcare Evaluation Data
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
GP	General Practitioners
MRSA	Methicillin Resistant *Staphylococcus aureus*
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Care Excellence
PbR	Payment by Results
SHMI	Summary Hospital Level Mortality Indicator
VTE	Venous Thromboembolism
RCP	Royal College of Physicians
CTG	Cardiotocography
UV-C	Ultra Violet

Abbreviation	Meaning
AMU	Acute Medical Unit
AEC	Ambulatory Emergency Care Unit
NIHR	National Institute of Health Research
#NOF	Fractured Neck of Femur
COPD	Chronic Obstructive Pulmonary Disease
A&E	Accident & Emergency
SSNAP	Sentinel Stroke Audit Programme
RCEM	Royal College of Emergency Medicine
CADS	Complicated Acute Diverticulitis Audit
MINAP	Myocardial Ischaemia National Audit
NICOR	National Institute for Cardiovascular Outcomes Research
ICNARC	Intensive Care National Audit Research Centre
NPDA	National Paediatric Diabetes Audit
NCAA	National Cardiac Arrest Audit
NELA	National Emergency Laparotomy Audit
C-diff	*Clostridioides difficile*
LeDer	Learning Disabilities Mortality Review
HQIP	Healthcare Quality Improvement Partnership
SCR	Serious Case Review
SAR	Safeguarding Adult Review
DHR	Domestic Homicide Review
ACS	Accountable Care System
ICP	Integrated Care Partnership
MoU	Memorandum of Understanding
SUS	Secondary User Service

Abbreviation	Meaning
IG	Information Governance
VOICES	National Bereavement Survey
MSK	Musculoskeletal
MINAP	Myocardial Ischaemia National Audit Project
BAUS	British Association of urology Surgeons
NBOCAP	National Bowel Cancer Audit Programme
CRM	Cardiac Rhythm Management
CMP	Case Mix Programme
ICNARC	Intensive Care National Audit and Research Centre
CHD	Congenital Heart Disease
PCI	Percutaneous Coronary Interventions
NPDA	National Paediatric Diabetes Audit
FFFAP	Falls and Fragility Fractures Audit Programme
HANA	Head and Neck Cancer Audit
IBD	Inflammatory Bowel Disease
TARN	Trauma Audit & Research Network
MBRRACE-UK	Mothers and Babies; Reducing Risks through Audits and Confidential Enquiries
NABCOP	National Audit of Breast Cancer in Older Patients
NAIC	National Audit of Intermediate Care
NBSR	National Bariatric Surgery Registry
NCAA	National Cardiac Arrest Audit
RCP	Royal College of Physicians
NCSARI	National Clinical Audit of Specialist Rehabilitation for patient with Complex needs following Major Surgery
NJR	National Joint Registry

Abbreviation	Meaning
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
RCOphto	National Ophthalmology audit Royal College of Ophthalmologists
PICANet	Paediatric Intensive Care
POMH	Prescribing Observatory for Mental Health
SHOT	Serious Hazards of Transfusion
GIRFT	Getting It Right First Time
BTS	British Thoracic Society
SUS	Secondary User Service
IG	Information Governance
BTH	Blackpool Teaching Hospital
EPaCCS	The Electronic palliative care co-ordination system
COAST NACEL	Collaborative Organisational Accreditation System for Teams National Audit for Care at End of Life

Table ii: Glossary of Terms

Term	Meaning
Aseptic Non Touch Technique	A specific type of technique to protect key sites and key parts of a patient from microorganisms which may be transferred from a healthcare worker or the environment to a patient.
Catheter associated urinary tract infection	An infection which it is believed to have started by a urinary catheter.
Clinical	Relating to the care environment.
Commissioners	Group responsible for most healthcare services available within a specific geographical area
Clostridioides difficile	*Clostridioides difficile* (C.diff) is a bacterium that is present naturally in the gut. Some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C.diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C.diff.
CQUIN	Commissioning for Quality and Improvement. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Emergency readmissions to hospital within 30 days of discharge	Standardised percentage of emergency admissions to any NHS or independent sector hospital undertaking NHS commissioned activity in England occurring within 30 days of the last, previous discharge from hospital after admission.
Friends and Family Test	A test that provides us with a simple, easily understandable way to obtain patient feedback to pinpoint areas for improvement Further information can be located at the following link: NHS England » Friends and Family Test

Term	Meaning
Methicillin Resistant *Staphylococcus aureus*	MRSA stands for Methicillin-Resistant *Staphylococcus aureus*. It is a common skin bacterium that is resistant to some antibiotics. MRSA Bacteraemia is when MRSA is found in the blood, which can lead to septicaemia, the clinical term for a severe illness caused by the bacteria in the blood stream. This is the kind of MRSA infection that has the highest death rate.
Mortality	Mortality relates to death. In health care mortality rates mean death rate.
National Johns Campaign	National campaign to promote the right of families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' Statistics » National Patient and Staff Surveys (england.nhs.uk)
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care.' Location of the latest published data can be accessed from: Results | Working to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and caring for people in a safe environment Available at: NHS Outcomes Framework Indicators, March 2022 release - GOV.UK (www.gov.uk)

Term	Meaning
NICE	National Institute of Excellence. An independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
Organisational Strategic Framework	The organisations process of defining it strategy, or direction, and making decisions on allocating its resources and priorities to achieve the strategy.
Patient Reported Outcome Measures	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery Patient Reported Outcome Measures (PROMs) - NHS Digital Statistics » Patient Reported Outcome Measures (PROMs) (england.nhs.uk)
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: Patient Reported Outcome Measures (PROMs) - NHS Digital Statistics » Patient Reported Outcome Measures (PROMs) (england.nhs.uk)
Quality Strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality
Quality Improvement	A formal approach to the analysis of performance and systematic efforts to improve it resulting in better outcomes for patients, better systems performance and better staff development.
Root Cause Analysis	A method of problem solving that tries to identify the root causes of issues and why they are happening
Safety Thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism)
Sign up to Safety Campaign	This is a national campaign and unified programme for patient safety across the NHS in England

Term	Meaning
Summary Hospital Level Mortality Index	The Summary Hospital-level Mortality Index (SHMI) is a system which compares expected mortality of patients to actual mortality. The Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations. Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the term used for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
Leading Change Adding Value	A National Framework for Nursing, Midwifery and Care Staff
Clostridioides difficile Target	Number of patients identified with positive culture for *Clostridioides difficile*
Rate of *Clostridioides difficile*	Location of the latest published data can be accessed from: clostridioides difficile - Search - GOV.UK (www.gov.uk) The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for *Clostridioides difficile* which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia

Term	Meaning
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; and Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.

Term	Meaning
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultation The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition, or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Waiting times and the 18 weeks referral to treatment (RTT) pledge	The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. Patients have the legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer, or it is clinically appropriate that the patient wait longer.
4-hour A&E waiting times	The maximum four-hour wait in A&E is a key NHS commitment and is a standard contractual requirement for all NHS hospitals. In addition, NHS England has an added contractual requirement covering NHS hospitals that no A&E patient should wait more than 12 hours on a trolley.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Improvement (QI): Update

Meeting:	Board of Directors
Date:	July 2023

Author	Katharine Goldthorpe, Associate Director of Quality Improvement					
Exec Sponsor	Bridget Lees, Director of Nursing, Midwifery, AHP & Quality					
Purpose	Assurance	X	Discussion	X	Decision	
Confidential y/n	N					
Summary *(what)*	A new QI enabling plan is currently under development in line with Trust Strategy. This will include new programmes in line with Trust Strategy: - Acutely Unwell Patient Collaborative - Improving Fundamentals of Care Programme Ongoing programme progress: • **Identification and Management of the Deteriorating Patient – under review.** Sustained 1.07 per 1000 admissions in monthly cardiac arrest rate. Acutely Unwell Patient Collaborative will progress this work further and will incorporate sepsis pathway improvement. • **Safer Improving Ward Processes – complete –** programme will now be support through divisional structures and QI support incorporated into the new Improving Fundamentals of Care programme. • **Improve the Last 1,000 days of life: Reducing Fracture Neck of Femur (#NOF) – ongoing**. Although there has been a recent increase in attendances at the Emergency Department, the 4 care homes have held overall improvement from 6 attendances per week to 3.8. The next phase of this programme is under development. • **Improvement Capability** –1,143 staff have been trained in QI (all levels). The Trust's Clinical Quality Academy will graduate in July with a third cohort in planning phase in partnership with East Lancashire Teaching Hospitals NHS Foundation Trust.					

Previously considered by	N/A

Implications ***(so what)***	Through all programmes and the additional various QI training on offer, QI capability is growing at pace and scale. Programmes are progressing well which means that the Trust are continuously reducing harm and therefore improving patient care.

Link to strategic objectives	Our People – The Trust is supporting all staff, patients, and carers to improve care continuously using QI methodology.	
	Our Place – The Trust continues to work with local system partners in Blackpool, Fylde, and Wyre, for example, local care homes to improve. The Trust also continues to work with its partners in the wider region of Lancashire and Cumbria as part of the Provider Collaborative Board.	
	Our Responsibility – Improvement where it is needed most continues to be prioritised and to help the Trust to get the basics right, as demonstrated by programmes such as the new Improving Fundamentals of Care programme.	

EDI implications considered	The QI Hub are continuously striving to consider equality, diversity and inclusion within all programmes and have previously gained advice about how to do this from the Equality and Diversity Lead and other colleagues passionate about EDI.

Proposed Resolution ***(What next)***	Review and approve.

Quality Improvement Strategy: Update

1. PURPOSE

The purpose of this report is to provide assurance on progress made towards the goals outlined in Blackpool Teaching Hospitals NHS Foundation Trust's (BTH) Quality Improvement (QI) Strategy,[1] since January 2023, when an update was last provided to the Board. A new QI enabling plan is currently under development, in line with the Trust Strategy 2022-2027, a draft will be completed in accordance with the Trust plans for enabling strategies. An initial proposal has been presented and agreed by Executive Directors to include:

- Improving the Fundamentals of Care Programme - starting with the wards, a new values-based programme will work intensively in each area to deliver a package of improvement methods that will help teams "to do the job and improve the job". The QI team will work with each ward (or team) for one month, delivering a series of training and coaching approaches. This programme will allow a 360º view of wards (or teams), alongside COAST and other existing and new initiatives that link to fundamentals of care. Ability to review progress through our intelligence systems (e.g., ward dashboards and IPR) will be built into the programme.
- Breakthrough Series Collaboratives to include – an Acutely Unwell Patient Collaborative and Phase 2 of Last 1000 Days Collaborative.
- Clinical Quality Academy – in partnership with East Lancashire Teaching Hospitals
- Patient Safety Incident Framework (PSIRF) – collaboratives will be developed in line with the findings of the analysis.

Each improvement programme described in the enabling plan will have a fully worked up Project Initiation Document (PID), to be presented to Executive Directors.

2. BACKGROUND

2.1 QI Strategy
All associated data relating to progress is displayed in Appendix 1.

3. IMPROVEMENT PROGRAMME DELIVERY

3.1 Reduce Preventable Deaths - Identification and Management of the Deteriorating Patient

3.1.1 Executive Sponsor: Medical Director

3.1.2 Specific Aim: Achieve and sustain a mean Trust cardiac arrest rate of 1.0 per 1000 admissions by September 2024

3.1.3 Assessment
Charts displaying cardiac arrest data is displayed in Appendix 1. In terms of the days between 2222 activated cardiac arrests in the combined inpatient collaborative teams, the statistically significant shift, continues to be sustained. The current mean rate of cardiac arrest for the Trust is 1.07 per 1000 admissions. A PID to commence a 12 month Acutely Unwell Patient Collaborative from September 2023 was reviewed by Quality Assurance Committee in May 2023. Sepsis pathway has shown some initial improvements, but further work is required through the Acutely Unwell Patient Collaborative.

3.1.4 Upcoming Key Milestones/Events

Key milestone/event	**Date**
Acutely Unwell Patient Collaborative Launch	September 2023 (under development)

3.2 Patient Flow Improvement Programme – Safer Improving Ward Processes

3.2.1 Executive Sponsor: Deputy Chief Executive

3.2.2 Aim - To reduce delays for patients on in-patient wards through standardisation of ward processes.

- 33% of patients to be discharged before 12 noon
- 80% of patients to be discharged by 5pm

3.2.3 Assessment

As part of the Trust's Patient Flow Improvement Programme (PFIP), In-Hospital Patient Flow Workstream, the QI Hub have supported an Improving Ward Processes Collaborative with an aim to achieve discharge earlier in the day to facilitate better flow. Sixteen teams participated in two cohorts of the collaborative.

At the summit, cohort one achieved a statistical improvement that had sustained since November 2022, discharges before 5pm have increased from 41% to 58%. Cohort two achieved a statistical improvement in discharges before 5pm from 54% to 65% and before 12 noon from 12% to 19%. Although the aim was not yet fully met, an evaluation was undertaken and presented to the Expert Faculty. The programme will now move into its next phase, this will include operational support through divisional structures and will be incorporated into the new Improving the Fundamentals of Care programme.

3.2.4 *Upcoming Key Milestones/Events*

Key milestone/event	**Date**
Improving the Fundamentals of Care Programme Launch	July 2023

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

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

3.3.2 Specific Aim: 70% reduction in the number of fracture neck of femur (#NOF) which occur in identified care homes by September 2022 *(aim to be reviewed for phase 2)*

3.3.3 Assessment

In line with the draft QI enabling plan, the second phase of this programme is planned with care homes, GP's, community nurses and social care teams participating to reduce harms for residents of local care homes. A new aim will be developed, with focus on reducing Emergency Department (ED) attendances and keeping residents safe in their last 1000 days of life, giving back the gift of time. Data for the first phase of the programme, presented in Appendix 1 shows that the number of fractured neck of femurs occurring in collaborative care homes remains within normal variation and ED attendances have held overall improvement from 6 per week to 3.8.

3.3.4 Upcoming Key Milestones/Events

Key Milestone/Event	**Date**
PID to be presented to Executive Directors.	August 2023

3.4 Safety Culture Improvement

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

3.4.2 Aim: To improve safety culture, with specific safety aims to be agreed by each team

3.4.3 Assessment

The Trust continues to focus efforts on improving safety culture using the four pillars of the National Patient Safety programme. The first phase of this work has created a digital safety dashboard, showing timely data over time to drive improvements that matter to the staff. This is being tested with three teams in the Trust's Surgical, Anaesthetics, Critical Care and Theatres (SACCT) division (Theatres, Gastro and Ward 14). These teams have had input into the design and delivery of this project. It should be noted that the data comes

from different sources (e.g., data warehouse, risk team, HR etc) and there are some challenges in ensuring the data is timely and automated and issues are being worked through with the relevant teams.

3.4.4 Upcoming Key Milestones/Events

Key milestone/event	Date
Boards installed and fully operational	30th October 2023

3.5 Ambulance Handover

3.5.1 Executive Sponsor: Joint between Director of Operations (Trust SRO) and Chief Executive Officer (PCB SRO)

3.5.2 Aim: To reduce the lost minutes to handover by reducing the average handover time, by 50%, from 47.5 minutes to 23.75 minutes by March 2023 (to be reviewed – ongoing)

3.5.3 Assessment
In December 2022, Trust representatives joined colleagues from across Lancashire and South Cumbria to collaboratively improve timely handover of ambulances at the emergency department (ED). Teams from Blackpool ED and Same Day Emergency Care (SDEC) have progressed a number of key interventions. These include:

- A focus on SDEC utilisation and optimising inclusion criteria
- Standardisation of the Hospital Arrival Screen (HAS) process to improve compliance,
- The escalation of ambulance delays processes and initiatives such as the Trust's Home for Easter campaign.
- The ED is utilising an improvement huddle board 2 hourly during the day and 4 hourly at night to review improvement data and tests of change which include a triage nurse co-ordinator during the day. Two Ambulance Liaison Officers are also now in post covering six days a week (focused on HAS screen usage and ambulance co-ordination).

The daily data (Appendix 1) demonstrates a reduction in the mean average time from NWAS arrival to handover to 25 minutes from January 2023 when the chart was rebased however there are a significant number of astronomical data points in March during periods of OPEL 4 and junior doctors strikes. The team are working to build reliability into their processes, even when there is pressure in the system.

The final collaborative event was held for the 23rd of May where teams from across the region (Lancashire & South Cumbria, Cheshire & Mersey, and Greater Manchester) came together for shared learning, with the Blackpool team winning a prize for their poster display of the work undertaken.

4. IMPROVEMENT CAPABILITY

4.1 Dosing strategy
The QI Hub have continued to deliver improvement training. At time of writing, 1,143 staff (13.7%) have been trained in QI methodology. Once trained, individuals are supported and coached in delivery of improvement projects,

4.2 Clinical Quality Academy
The second cohort of the academy are preparing for their celebration summit taking place on the 11th of July. Teams will present their learning and project posters will be on display. The Trust is delighted to be hosting Kathryn Perera, Director of Improvement Capability Building at NHS England as a guest speaker. Plans for a joint academy with East Lancashire Teaching Hospitals to commence in November 2023 are underway.

At the Bristol Patient Safety conference, the Clinical Quality Academy team led by Dr Tina Dwivedi, Consultant Sexual and Reproductive Health won the "QI in Progress" poster presentation competition for their All-Views Matter project which aims to increase feedback from non-English speaking patients in Sexual Health services. Other Clinical Quality Academy teams also presented posters at the Bristol Patient Safety

conference including Dr Alison Seed's "BEAT HF QiK" project and Dr Daniel Lokko's "Improving Same Day Emergency Care Capacity" project. In June, Dr Seed's team presented to Council of Governors.

4.3 Local Quality Improvement Projects
There has been a total of 203 local quality improvement projects (QIP's) logged by divisions with the QI Hub, with 59 currently active.

4.4 Health Service Journal (HSJ) Patient Safety Awards 2023

Shortlisted QI projects include:

- Preventing hospital acquired pneumonia QI project (Patient Safety Pilot of the Year Award)
- All Views Matter project (Improving Health Outcomes for Minority Ethnic Communities)

Both projects have been delivered by staff who have attended QI training (CQA and QSIR).

5. PROVIDER COLLABORATIVE IMPROVEMENT

The QI Hub continues to support system improvement relating to frail patients with long term respiratory conditions through the Engineering Better Care Programme, which reports through Provider Collaborative Board.

6. CHIEF REGISTRARS

The Trust currently has two Chief Registrars in post.

The Chief Registrar in Medicine/Geriatric Medicine is undertaking a project with the aim: to increase the percentage of patients whose length of stay is less than 48 hours on the Frailty Assessment Area to 100% over a 12-month period. Supporting the work of the IMPF division Frailty Workstream group with a focus on improving the functionality of the Frailty Assessment Area. They are also the Project Lead on a project aimed at improving delirium diagnosis and management, Clinical Lead for the Fylde and Wyre Engineering Better Care team and supporting the development of a higher-level trainee simulation programme for ST4+ Trainee Doctors in General Medicine - work which has fed into a wider piece of work on simulation training for the Northwest Deanery. This work will be presented to the Royal College of Physicians Regional Board.

The Chief Registrar in Paediatrics is leading a project with the aim: To improve patient safety culture within the Paediatrics department as measured by validated patient safety culture tools over a 12-month period. They have commenced a Patient Safety Initiative across the Paediatric and Neonatal wards, using QI methodology to improve the culture of patient safety across services. The first initiative was the establishment of a ward safety huddle, with the aim of bringing together medical, nursing and community staff to communicate risks faced by the ward such as acutely unwell patients, staffing issues, site issues, and more. This is now embedded in daily practice and ongoing evaluation of its impact of staff awareness of risk is continuing. Changes have also been made to simulation training to integrate medical and nursing teams into one training session, the aim to improve human factors awareness and team working. This is now fully established with good staff feedback on neonates and is planned to scale and spread to Paediatrics.

7. RISKS

7.1 None of significance.

8. FINANICAL AND LEGAL IMPLICATIONS

8.1 Financial Implications
There are no financial implications

8.2 Legal Implications
There are no legal implications.

9. RECOMMENDATIONS

The Board are asked to consider the matters raised in this report for assurance.

10. REFERENCES

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

Appendix 1 – Data

Identification and Management of the Deteriorating Patient

Chart 1

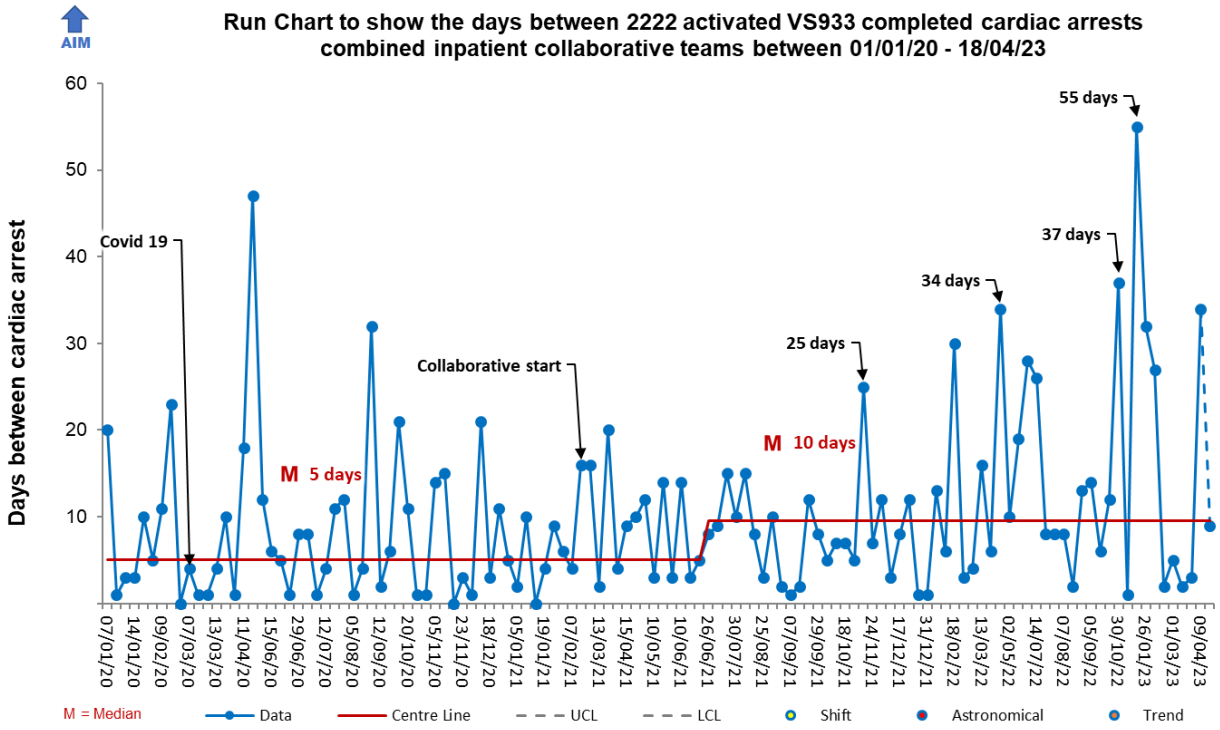


Chart 2

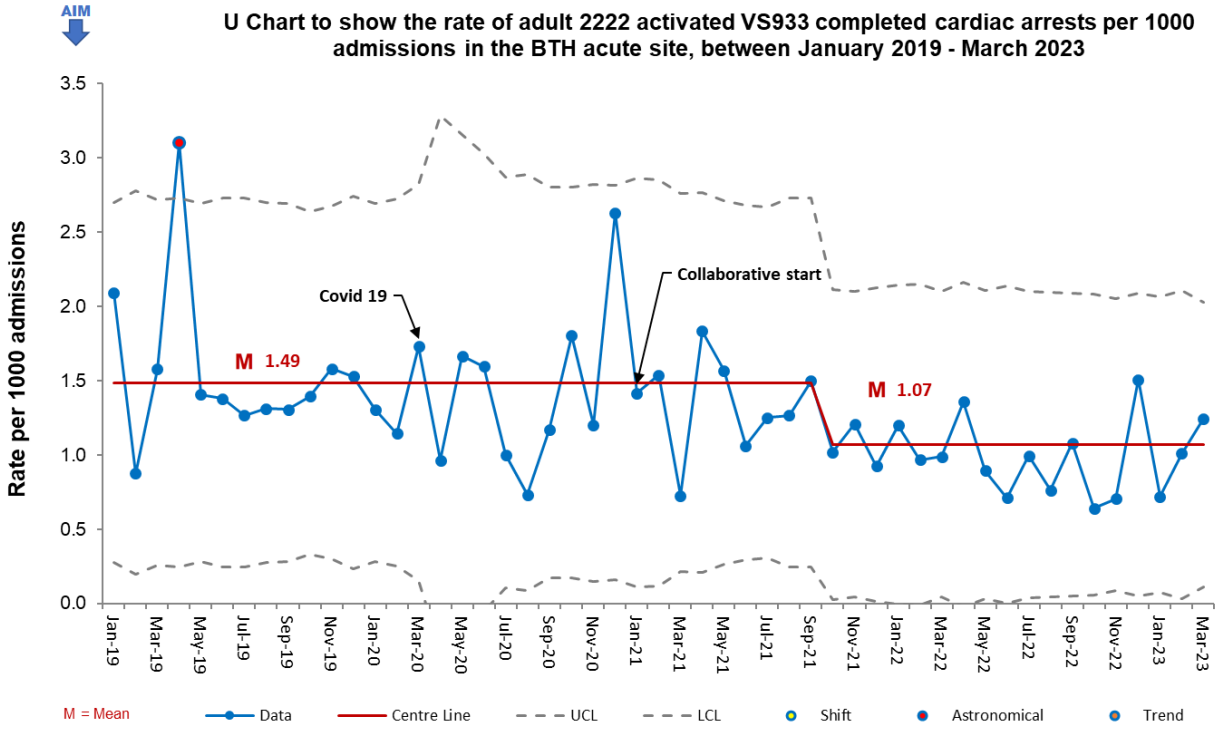


Chart 3

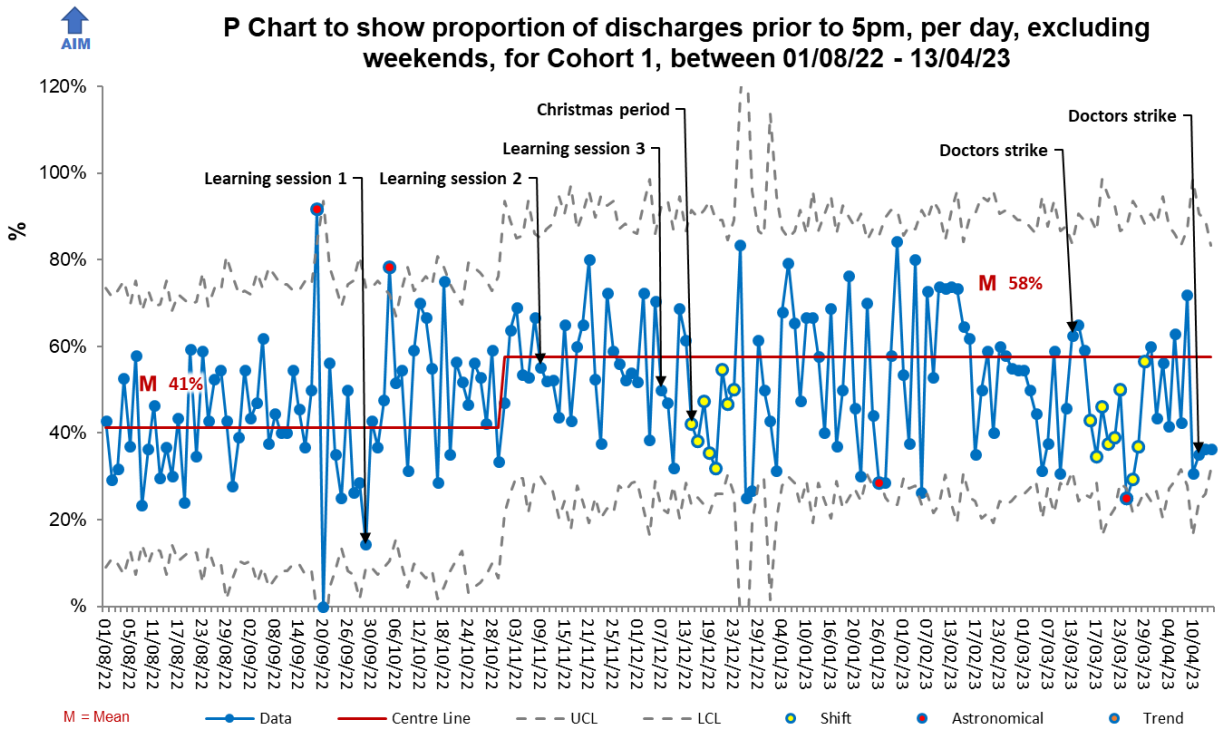
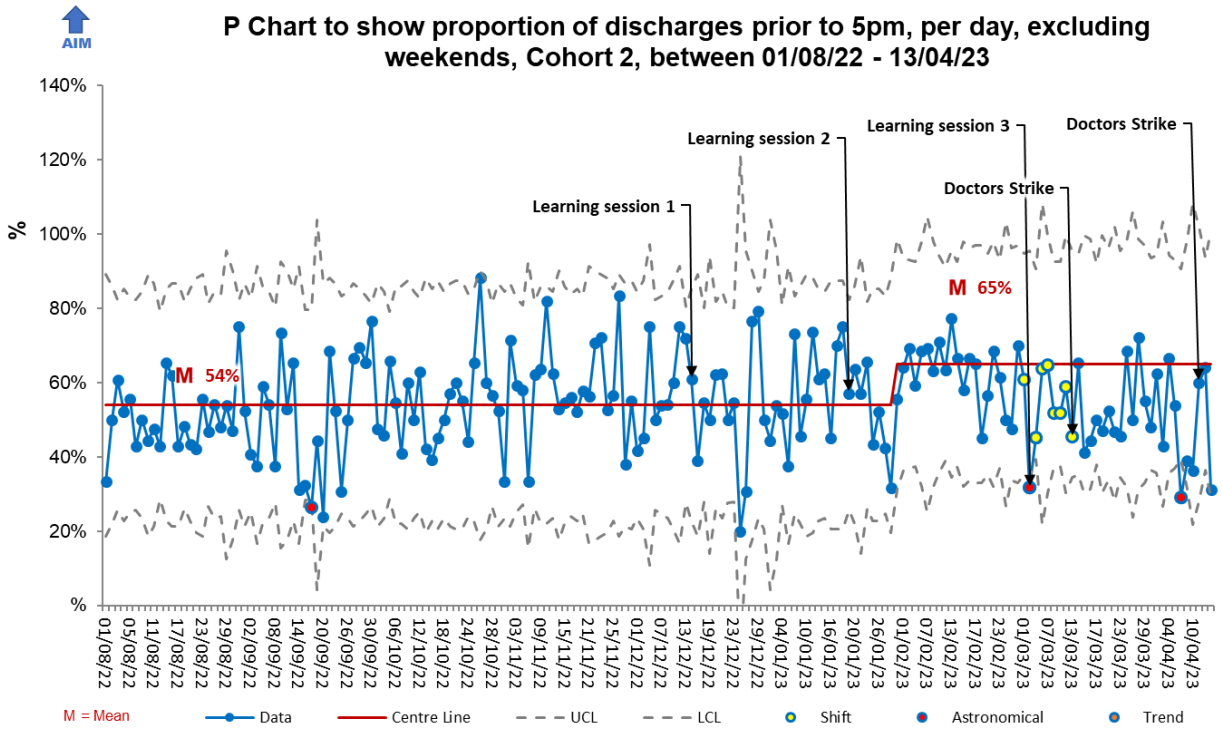


Chart 4



Last 1000 Days – Reducing #NOF

Chart 5

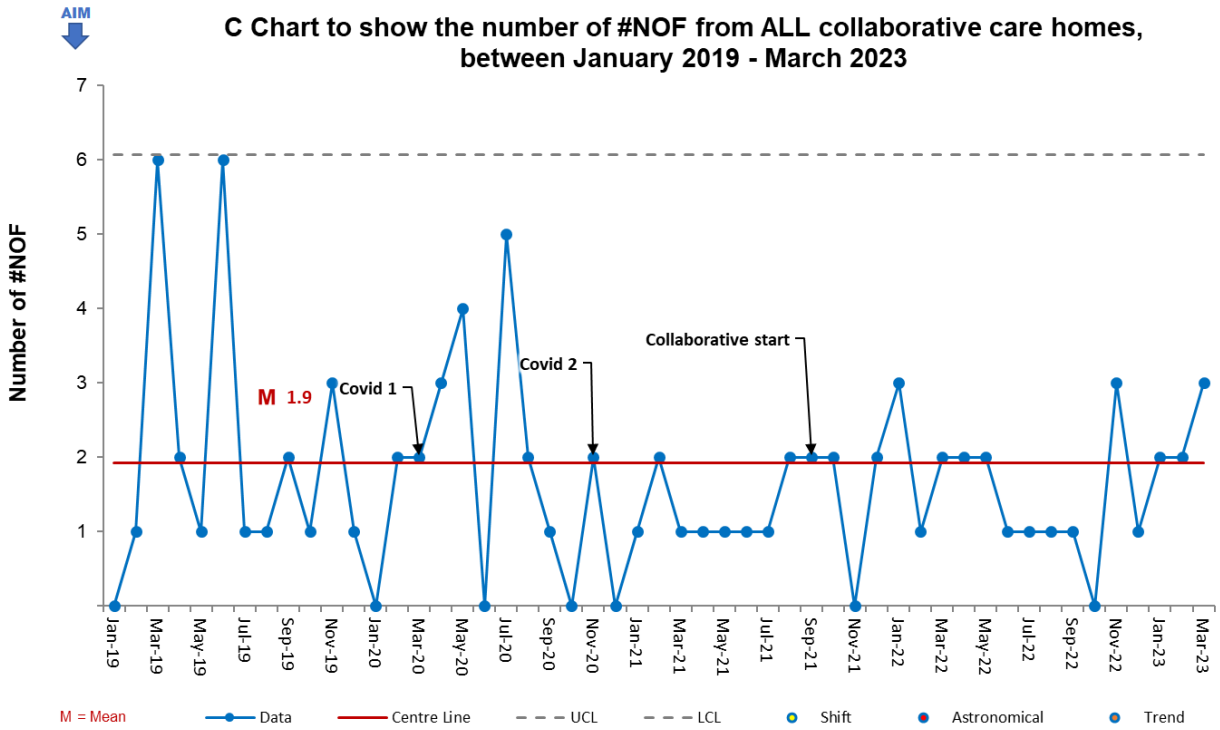
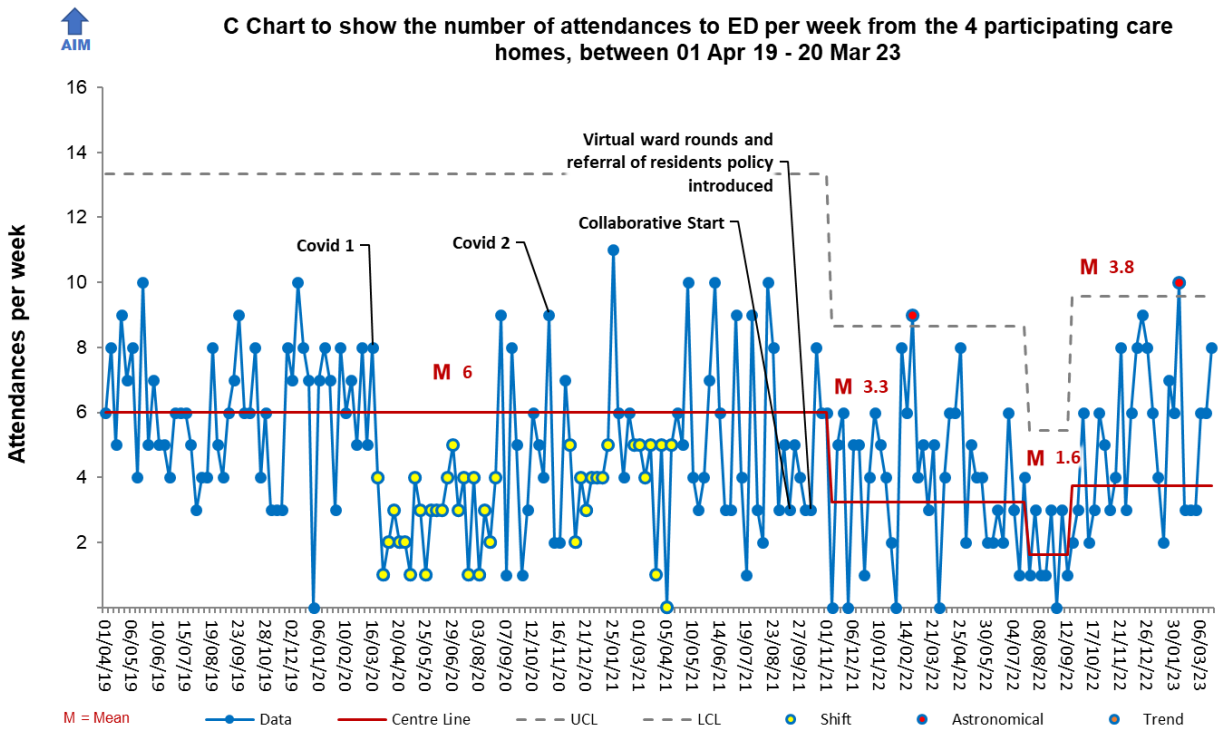
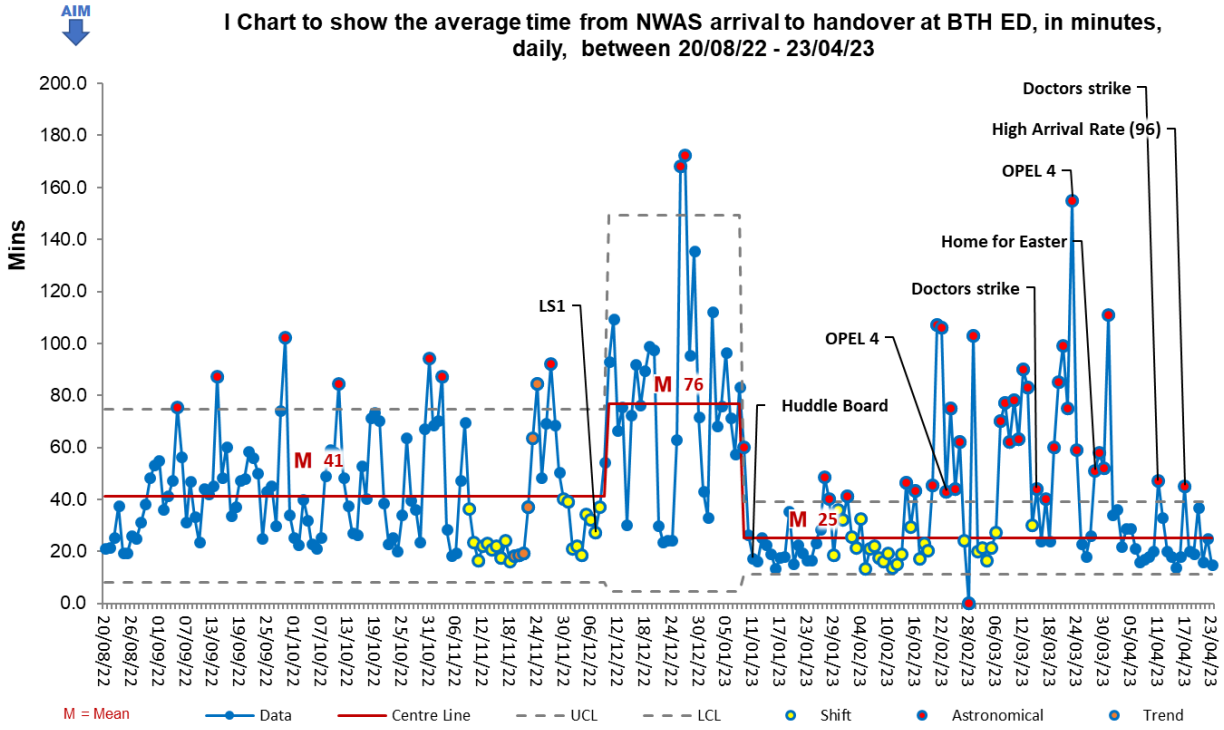


Chart 6



Ambulance Handover

Chart 7



Blackpool Teaching Hospitals NHS Foundation Trust

Title	Maternity and Neonatal Report for June 2023

Meeting:	Board of Directors
Date:	July 5 2023

Author	Lynne Eastham, Director of Midwifery & Neonates					
Exec Sponsor	Mr Chris Barben, Executive Medical Director Bridget Lees, Executive Director of Nursing, Midwifery, Allied Health Professionals, Quality					
Purpose	Assurance	X	Discussion		Decision	X
Confidential y/n	No					

Summary *(what)*	The purpose of this report is to provide an overview of safety and quality programmes of work within Maternity and Neonatal Services and to inform the Board of present or emerging safety concerns or activity. This is to ensure safety with a two-way reflection of 'ward to board' insight. Regular reporting of information to Trust Board on safety and quality in Maternity and Neonatal services is required to comply with: • The Perinatal Quality Surveillance Model • CNST (Clinical Negligence Scheme for Trusts) operated by NHS Resolution • Ockenden (2021) • East Kent (2022) Going forward a monthly Maternity and Neonatal Update Report will be presented at Quality Assurance Committee and reported bi-monthly at Board, supported by other reports, which will provide updates for the reporting period or progress in compliance with national standards such as Clinical Negligence Scheme for Trusts (CNST). These supporting reports will be presented following an Annual Cycle. **Highlights** **Alert** **Clinical Negligence Scheme for Trusts (CNST)** **Year 4:** Maternity Services did not declare full compliance with the 10 Safety Actions demonstrating compliance with 2.

Summary *(what)*

Year 5:

Publication of Year 5 Safety Actions are expected in June 2023. There are a number of Safety Actions that will require evidence of embedding of processes in response to previous years CNST Safety Actions.

Whilst collating evidence in preparation for progressing through Year 5, the Maternity and Neonatal Team have found that evidence is not robust for some actions in previous years. This is not solely to do with Board reporting structures. This may have an impact on progressing through Year 5 compliance. This includes:

Avoiding Term Admissions (CNST Safety Action 3) and Saving Babies Lives (CNST Safety Action 6) where quarterly audits and multidisciplinary reviews have been required. An update on progress and compliance will be presented at the next Quality Assurance Committee.

Advise

Perinatal Mortality Review Tool (PMRT) Process

External support was requested to undertake a 2 year look back of the Trust Perinatal Mortality Review Tool (PMRT) process to identify if the tool was being used to review perinatal deaths to the required standard. This was to provide assurances of the process.
The principles of PMRT reviews are set out in the Maternity Incentive Scheme Standards and National Perinatal Epidemiology Unit Guidance. The focus being that there is a timely, systematic approach for multidisciplinary high-quality perinatal reviews for stillbirth babies and neonatal deaths from 22+0 days gestation until 28 days after birth and that families are included in the review and the report is shared with them.

There were 31 eligible cases reviewed against 8 criteria as follows:

Standard	**% Compliance**
Perinatal deaths eligible to be notified to MBRRACEUK are notified within seven working days.	81%
The surveillance information must be completed within one month of the death.	51%
A review using the Perinatal Mortality Review Tool will have been started within two months of each death.	80%
The PMRT report is published within six months of each death	83%
External representation on the panel.	55%
Parents informed of the review.	100%
Parents views sought.	97%

Evidence within the report regarding future pregnancies.	74%

Findings:

It was identified the PMRT tool is used to complete the questions within the tool and is compliant with the Maternity Incentive Scheme for Trusts, however

- 1 standard out of 8 met full compliance of 100%
- Whilst all families were notified of PMRT there was no process to follow this up families after discharge home.
- Case reviews are also completed and noted to be robust, but the PMRT report should also encompass the details of the case issues and actions

These are not safety issues but there is improvements required to consistently meet a standardised approach to managing investigation of baby deaths and in maintaining contact with bereaved families to ensure their views are included and answers to their questions are provided

Actions Taken

- There were 7 recommendations from the review which include development of an action plan to ensure the process is robust and re audit in 3 months time
- The report has been shared with the Governance team with a plan to develop an action plan in response to the seven recommendations. This will be presented to the Divisional Board and to the Safety Champions Meeting in June 2023.
- Since the review a new process has been introduced that ensures each family have a named contact and in agreement with the family, contact is made by the team at least on alternate weeks.

Escalation of Concerns from HSIB

HSIB have raised concerns in relation to ongoing case, regarding governance of electronic records to enable learning. This includes:

1. Retrospective and amended medical record
2. Ensuring records are attributed to an individual clinician and Staff sharing the same electronic devices do not always log out after use
3. Training relating to information governance and the use of electronic records

Immediate actions have been taken and external support has been requested from the Local Maternity and Neonatal System to undertake a review of the Badgernet Maternity System to further understand scope of issues for both local and wider learning. This is the third escalation of concerns regarding this case.

Occupational Entonox Exposure Testing

The external report was received on the 22 May 2023. The exposure monitoring shows that at the time of the assessment no regulatory workplace exposure limits were exceeded.
Recommendations made:

- Provide supplementary fresh air when Entonox is administered to the patients.
- Provide an Entonox Administration Training program for midwives and doctors and develop standard operating procedure (SOP).
- Suitable administrative controls, such as job rotation, must be adopted to reduce the length of time that midwives are exposed to nitrous oxide.

The recommendations are currently being actioned. The risk assessment has been downgraded but will remain in place until these actions have been completed

Training Compliance – Maternity skills drills

Compliance with Maternity Skills Drills has had month on month downturn over the last 4 months.

A process for allocation of training is in place however, there has been a number of non attendances. Reasons for this have included changes made by line managers and shift leaders at the request of staff, to meet the needs of the Maternity Unit or to accommodate annual leave that was not booked in prior to the training being booked.

Actions Taken:

- There is a trajectory in place to recover training compliance.
- Both Maternity Matrons and Practice Development Midwives meet at least fortnightly to review allocations in line with trajectory and staff allocation
- Each month a sitrep to come to the FICC Divisional Board with compliance for the month to provide ongoing support
- Updates on progress will continue through the Maternity and Neonatal Update report.

Neonatal Update - Improvement Board

The Neonatal Improvement Board, chaired by the Medical Director reports to the Trust Clinical Governance Committee. This has had refresh of terms of reference and agenda with the first meeting taking place in May 2023.

Neonatal Update - External Review

The Neonatal External Independent Review has commenced supported by the Northwest Neonatal Operational Delivery Network (NWNODN) and the Lancashire and South Cumbria (LSC) Local Maternity and Neonatal Service (LMNS). It is expected that the review will take 3 months to complete.

Maternity Safety Support Programme

The Maternity Team continue to work with allocated Maternity Improvement Advisor as part of the Maternity & Safety Support Programme (MSSP). The Diagnostic tool is on track for completion by June 2023 which will inform improvement plan development and exit criteria.
Maternity governance 'deep dive' event is planned for June 2023 with expectation that this will review governance structure, processes, roles and responsibilities and the complaints process.

MSSP exit criteria progress report has been received however was disappointing to see that the report indicated little progress is being made in key areas. To help further understanding the Maternity Advisor has been asked to share the criteria that is used to determine the progress status.

CQC Action Plan

The action plan contains 59 actions with assigned leads and progress is monitored by Divisional forums.
CQC Panels with Executive and ICB representation are in place from May 2023 to test sustainability of CQC actions taken and assess both Trust wide and Divisional processes.

We continue to engage with identified Quality Improvement Initiatives with the national team encouraging all staff in Maternity to participate and with the MSSP Programme.

Externally, we are working in collaboration with the Maternity Voices Partnership to make improvements in the care women and their families experience based on the feedback.
Progress against the Maternity CQC action plan continues, however there has been slippage on a number of actions.
13 areas of improvement
59 actions
46 Actions – Completed
13 actions – Amber/Off track

In view of actions off track, additional support has been sourced to focus on progressing outstanding actions. This support will be in place form June 2023.

Assure

Neonatal Training
SIM Training for both nurses (trained and untrained) and Consultants remains at 100%

Registered Staff	May 2023	April 2023	March 2023	February 2023
% Nursing staff who have attended SIM Training	100%	100%	100%	100%
% of Consultants who have attended SIM Training	100%	100%	100%	80%

	4 yearly Newborn Life Support (NLS) compliance is 73% The Trust aims for 95%. This reflects leavers who had been trained and the number of new starters joining the Trust. All available places have been allocated internally. To manage the risk, the NLS training proforma is utilised for annual basic resuscitation, training principles are used for SIM training and live skills drills and there is always a bleep holder trained in NLS on every shift.
Previously considered by	Quality Assurance Committee received a detailed report covering all the elements above

Implications ***(so what)***	Refer to Advise/Assure section above

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications considered	Yes

Proposed Resolution ***(What next)***	**Recommendation to Board** To note the Alert, Advise and Assure on the front sheet of the report To consider if the information contained in this report requires additional narrative or further clarification **Actions for Maternity and Neonatal Services** To continue to work to address the outstanding actions from the Ockenden report, all with the objective of improving care for women and families sustainably. To benchmark the 'Three Year Delivery Plan for Maternity and Neonatal Services' (NHS England March 2023) and work with local, regional, and national colleagues to determine how we progress the actions needed Work through CNST Year 5 Safety actions To ensure that the experience of women, babies and families who use our services are listened to, understood and responded to with respect, compassion and kindness. Ensuring triangulation of data and from different feedback mechanisms. To receive feedback from the external reviews planned and plan next steps

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Finance & Performance Committee Escalation Report
Meeting:	Board of Directors in Public
Date:	5th July 2023

Author	Esther Steel, Director of Corporate Governance					
NED Sponsor	Robbie Ryan					
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 (F&P) Committees on: - Thursday 25th May 2023 - Thursday 29th June 2023 Both meetings focused on financial and operational challenges with areas for alert identified within both escalation reports. At the meeting on 29 June 2023, the Committee received the first "Service Story" this highlighted benefits of enhanced technology within MRI scanning. The Committee also received a business case to invest to save through investment in substantive ED staffing – this will be presented to the part two Board for approval.

Previously considered by	n/a

Implications *(so what)*	Board members are asked to note

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	None noted

Proposed Resolution *(What next)*	The Board of Directors is asked to note the F&P Committee's Escalation Reports

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:	25 May 2023	**Date of next meeting:**	
Chair:	Robby Ryan	**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.

Discussion on quality of papers with new guidance to be issued to ensure standardised approach to papers

Alert

What	So What	What Next
Data Quality and Elective Waiting List Report Improving picture but remains challenging in some specialities with the waiting list increasing year on year and focus on reducing longest and clinically urgent waits	Work to do on PTL management and providing assurance on waiting list position	Future system working through reconfiguration with a strategic approach to addressing increase in demand which is anticipated to continue.
Integrated Performance Report (IPR) **ED** Challenge noted across a number of areas • Urgent care pressures • SDEC conversion rate • 12-hour DTA breaches • Ambulance delays • Clerking delays and delays in discharge	There is ongoing analysis to understand the discharge profile of the hospital in more detail. Many discharges take place late into the afternoon and evening which can affect flow through the rest of the day. Aim to get right patient in the right place and take pressure off beds	Looking at pathways to manage speciality referrals
RTT Those specialties with over 78-week waiters at April month end were: General Surgery (1), Gastroenterology (5), Cardiology (2), Rheumatology (1), Gynaecology (2) and all were attributable to unavoidable delays such as patient choice, clinical complexity, or medical reasons. Although under	RTT weekly escalation PTL in place – focusing on key speciality areas to maximise theatre productivity Theatre utilisation discussed – stand by list of patients in place and focus on ensuring patients are prepped and ready	Weekly performance meeting to hold to account for cancer delivery over 65-week wait be added to the IPR

delivered against the activity plan endoscopy continues to see a sharp reduction in their waiting list due to insourcing and the modular endoscopy unit.		
Cancer Exception Report 2 week wait performance deteriorated driven by capacity issues in breast – mutual aid being supported by the ICB The 62-day performance remains a challenge but there has been an improvement in March 23. Cancer Backlog. The trust has exceeded the plan for April 23 with an undiagnosed backlog of 132 against a forecasted internal target of 160.	Fortnightly assurance meeting is in place with place with the cancer alliance to support the delivery of the recovery plan. The Cancer alliance are assured that the Trust has plans in place and progress is being made	Improved PTL process being established with the aim of delivering the required progress. FPI need assurance on the high-level plan and the key actions to reduce waiting times
Assurance		
What	**So, What**	**What Next**
Month 1 Finance Report Update provided on month one finance report The Trust performance at the end of April is in line with the plan. The 2023/24 planned deficit of £24.3m is based on delivery of a 5.5% QEP plan of £37.7m, financial recovery measures of £19.5m and additional income of £17.7m. The Trust needs to ensure that measures continue to be taken to deliver the plan for the remainder of the 2023/24 financial year.	Committee members discussed the delivery of QEP seeking clarification about non-recurring QEP with confirmation that the aim is for the QEP target to be delivered recurrently Cash is better than previously anticipated and aim at the moment is to deliver without the need for cash support. Agency expenditure in month 1 – challenge –	Aim by end of June to have clear line of sight on all elements Element of control through ICB Format of report to be updated to provide clear visibility of QEP Going forward there will be quarterly reports from divisions on their QEP plan Ownership accountability and granularity are important - clear monthly reporting on the run rate
Patient Flow Improvement Programme Most areas showing good progress and are ahead of plan – positive picture	Still two areas to address – ambulance delay and 12 hr dta waits Have seen increase in SDEC length of stay reviews – methodology improved for check and challenge of long stay patients	

Committee/Group Chair's Report

Blackpool Teaching Hospitals NHS Foundation Trust

Atlas Client Performance Meeting Escalation Report Issue previously escalated in relation to gas safety remains – mitigations are in place and Atlas have been working with a specialist firm to ensure the work is completed	Asked about progress since last time – Atlas continue to work with specialist firm to ensure the work is done. Fire safety has progressed, concerns about access to face to face training had been escalated Electricity upgrade – members asked for assurance that robust plans in place to maintain supply – Atlas are supporting the preparation and planning of this exercise that is led by the electricity board	Working to ensure that all staff who require face to face training can access this
Digital Committee Escalation Report Interim digital programme director attended to provide update on the digital programme – changing the committee to a B Digital committee to reflect overall programme – the programme will bring an overview of all digital programmes to ensure prioritise the right things and align projects to strategic goals 2 high profile projects – PAS and PAS replacement – good progress being made, working towards 4 November 2023	PAS – risks of new PAS noted and the need to manage expectations and any unintended consequences – need to ensure the Board are appraised of the potential risks/consequences and noted the importance of understanding implications and risks in relation to all IT programmes	Paper on the risks associated with the PAS upgrade to a future meeting to provide assurance that potential risks are mitigated. Future reports also to include updates on LIMS Future paper on PACS and RIS
Terms of Reference Minor changes to terms of reference for accuracy of names – no significant change to the remit of the Committee	Terms of Reference approved	Formal approval sought from the Board of Directors
BAF – verbal update Key risks impacting on the financial objective are achievement of QEP, grip and control, financial governance and cash. Key issues impacting operationally are ED performance, RTT and cancer		BAF to be updated following June Board meeting objective update. BAF to be reviewed bi-monthly going forward

Committee/Group Chair's Report

Blackpool Teaching Hospitals
NHS Foundation Trust

Advise		
What	**So, What**	**What Next**
Compliance with Month 1 Reporting Update provided on compliance against the financial governance timetable	Noted areas of non-compliance with reporting deadlines and set an expectation from the Committee that all future submissions are timely – expectation that an improvement is made.	

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Finance and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	29 June 2023	**Date of next meeting:**	25 July 2023
Chair:	James Wilkie	**Parent Committee:**	Board of Directors

Introduction

Well attended quorate meeting held on MS Teams, good interaction from Committee members with some constructive challenge on the papers presented.

JW chaired in the absence of Robbie Ryan with a focus on time for discussion

Alert

What	So, What	What Next

Assurance

Discussed peer review response and action to close – remain on until Audit Committee		
Integrated Performance Report (IPR) **Operational performance** UEC – The Trust has seen higher than predicted demand for UEC activity including 3 entries into the top 10 highest days of attendances since reporting commenced in 2017 which have resulted in additional pressures with performance. The Trust has been able to withdraw surgical day case from use as an escalation area – corelates to reduction in length of stay – a key initiative in the Patient Flow Improvement Programme. The focus on de-escalation of unfunded capacity continues. RTT – There have been 3 reportable 78-week breaches in May 23 due to capacity issues. There were a further 16 excluded breaches due to unavoidable delays such as patient choice, clinical complexity, or medical reason. Focus being on the challenging services (Gastroenterology, Gynaecology & Cardiology) with all having improvement plans and focused decisions at weekly assurance meeting held	We are on plan with many trajectories set within the Trust plan for Operational Performance. The key focus remains on improving key national performance targets across UEC.	Clinical productivity board established to focus on theatre and outpatient transformation, patient flow and cancer improvement using QI methodology

with Deputy CEO. We have reported 149 fewer patients against plan of 341 waiting above 65 weeks. Cancer – backlog position for 62 day target – when a cancer is suspected pat should have confirmed diagnosis and start to treatment in 62 days – May 135 patients in backlog against target of 151 – currently at 99 patient undiagnosed – best since May 2021		
Finance New format for finance IPR – run rates to be included in future reports, report will also be included in Board paper with cash plan and actuals to give full information. At month two we are on plan	New format welcomed. Review of profiling of QEP – NED seeking assurance on position when QEP target increases – through monitoring seeking assurance that on target for month 3 – DoF anticipate should be on plan to deliver for month 3. Weekly touch points with divisions both individually and together to seek assurance on progress and readiness to deliver against the agreed PID. A number of plans are reliant on recruitment of substantive staff which is acknowledged as a risk. Checked about on plan – contradiction in narrative – bottom line position is on plan – cumulatively got more income and more expenditure – non operating income higher than plan in month 2. Check – are we on plan because of windfall that balances – still have concern about agency spend – still high, seeking assurance that this will turnaround. Recognition of actions need to reduce expenditure – progress made with substantive recruitment in nursing but more of a challenge in medical workforce. Business case on the agenda for approval is part of the plans to move forward with substantive appointments SC – within the QEP governance, in terms of reduction	Comments welcome on the format of the new report Overreliance on agency to support operational pressures – efforts to improve performance and reduce length of stay will also be key Also working with the system on priorities for fragile services to drive down agency. Recognise work going on to reduce agency spend but will it land in time

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Cancer Performance Assurance Report Cancer features with the IPR – discussion about the reporting aligned with the IPR to move from monthly reporting. 28 day faster diagnostic standard – ensures diagnosis for suspected cancer to accelerate initiation of treatment. Met ICB target but fell short of the Trust trajectory, have identified a number of actions for specific tumour groups, specific challenges across Gynae, upper GI and colo-rectal.	Report gives detail on recovery actions for specific pathways and tackling any will be a priority unwarranted variation. Cancer is an evolving practice – the Trust is part of Lancs and S Cumbria cancer alliance whereby good practice is shared in line with NICE guidance. It was noted that, in many tumour groups, haven noted an increase in demand post pandemic which can impact on recovery.	Pathways are being reviewed responding to increase in demand and change in presentation since Covid linked to delayed diagnosis– using best practice examples from other areas.
Elective Recovery Report Operational governance reinforced with introduction of SOAG to give scrutiny and monitoring of patient pathways with an escalation arrangement when a speciality does not meet criteria and needs greater surveillance. Key actions for monitoring by SOAG included in the report. Within validation a patient with 104 week wait was identified – patient was on an incorrect pathway – patient now seen and treated, clinical review undertaken and assured that no clinical impact.	How did the data issue come about – is it an isolated issue or indicative of a wider problem. Can never guarantee due to human error – this was coding issue in the way treatment was recorded The Trust has increased resources in validators, set SOPs in line with Access Policy, enhanced training, and improved surveillance of process.	Suggest sampling of this in the data quality review – never eradicate – agree that potentially a good area for internal audit scrutiny New PAS will help that is planned for deployment towards the end of 23/ 24. MIAA review on RTT data quality will be useful to support assurance.
Atlas Client Performance Meeting Escalation Report Alert about call bells becoming obsolete – to be included in programme Gas house – previously an alert but work in July Fire Safety – new training dates available and being booked Electrical shutdown took place without hitch	How extensive is the call bell issue – they are working at the moment and there is no risk to patients but are no longer supported – extensive work required to replace.	

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

PACS and RIS update Paper to reverse previous decision to end the AGFA contract – plan had previously been to align for procurement but can't be done by April so will enact the one year extension with the possibility of a second one year option after that		
Service Story – Clinical Support Division Nigel Lewis Divisional Director of Ops attended to share a service story Shared background to MRI scans with an explanation of how the process works to produce a diagnostic image. Historically MR scans have been lengthy procedures, BTH service previously reliant on outsourced scans. Investment in new state of the art scanners and AAT – automated acceleration technology enable faster scan with no loss of image quality. AAT implementation reduces appointments slots, increases capacity in MR and improves patient experience. Described the process with illustrations of scans to show the potential time saving with no reduction in image quality – 32% increase in scanning capacity – this has enabled reduction in outsourcing of capacity – 564 extra patients scanned pern month All in all really positive experience, pioneered new technology	Massively impressive story – increased productivity Asked about the bid for money – how much have we invested just over £200k with a significant return on investment. Are there other areas where we could do similar investment Other potential option in imaging using AI machine learning Demonstrates invest to save on mobile vans, reduction in inpatient waiting times and increase in patient experience. Have there been any negative impacts – can the radiologists cope with the increased volume – working to ensure scans can be reported in a timely fashion	
Digital Committee Escalation Report & ToR for New B.Digital Committee Escalation report provided from the B Digital Committee – important to recognise the level of risks being managed Seeking approval for B Digital terms of reference	Alerts and mitigations noted, recognised the good work going on with recruitment of digital champions to support digital transformation programme. Committee members agreed now getting a better understanding of the challenges and the complexity of issues. In relation to PAS training and the need for space – JB advised that a workable solution with interim options	This will be the largest digital transformation programme the Trust has undertaken. Site utilisation is a key element of the future plans for the Trust and is a key element in the STP Report noted

	has been agreed and there has not been any delay to training.	
Lancashire Procurement Cluster Update Update on the procurement strategy- keeping quadruple aims at the heart of everything we do Progress made as a system for market management of agency rate card – on target for April and May £323k of savings made for Blackpool – potential to deliver up to £1.2m of savings in the year	Sustainable change will be through changes of behaviours as a system	Recognised the contribution of the procurement team to the delivery of QEP – procurement provide a consistent and supportive presence.
Strategic Transformation Committee Key Highlights STP portfolio – 13 projects and 62 workstreams for year one delivery with some workstreams already live and well underway achieving deliverables. In terms of progress to date, all blueprints approved and basic infrastructure and governance approved Highlights interdependencies 3 key challenges being managed – capacity to delivery scale of change to embed for sustained change Clinical engagement will be critical Competing demands and interdependencies with system wide plans Four enabling plans signed off by the Board and now working on next ones	Good to start seeing the detail and the range and scale of projects and recognise the challenge of delivery of change in a challenging operating environment. Recognised importance of comms and engagement and alignment with other change programmes including digital. The team are facilitating rapid improvement events	Board strategy session in August will go into programmes in further detail looking at risks and benefits Developing a more formal dashboard to provide updates for each programme on progress being made. Committee members endorsed the programme and offered support when needed. Exciting, innovative and difficult Great thinking about the risks – how are we developing a risk mitigation strategy – importance of alignment of priorities and optimisation of resources – discussed how this is managed – risk register for each programme with an escalation procedure in place

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Sustainable Medical Workforce in ED Business Case The current situation is not sustainable due to an over reliance on temporary workforce provision. Due to the transient nature of the workforce, it has proven difficult to embed QI or service developments. The Trust is not meeting RCEM and GMC standards both from a workforce and performance perspective and this case sets out a plan to address. The case is seeking endorsement of the 3-year strategy and asking the committee to approve implementation of Phase 1. Phase one is looking to reduce reliance on temporary workforce by repurposing the current run rate to deliver the service into budgeted expenditure. Any further advancements beyond Phase one would need a review and full business case. The paper describes the gateway review stages and confirms that any subsequent phase will need to be approved and will be subject to scrutiny.	Discussed the structure of the case, the planned benefits – plan is to increase substantive posts with a transition from agency staff Currently have a situation where additional workforce has been expensive, inefficient, temproaryu – spending the money anyway – business case makes the consultant posts perm and uplifts ACP roles to increase scope in roles – this will increase efficiency and sustainability of the department without additional expenditure. This is year one of a three year plan – will also be discussing with the ICB Not more money – using money in a better way. If we know that we are not doing in a good way – when we get to three year position will this be where we should be Also does QEP need to be considered in this In regards to the three year strategy this would align with best practice, financial due diligence would need to be worked through. How will it improve ED – will it be a high performing department MB – through build back have funded the recurrent spend so this is recycling of budgets -	For final approval at Board of Directors in July Benefit will be a stable substantive workforce who will engage in transformation and improvement programmes and potential future economies using programmes such as scan for safety. Potential return on investment by developing a stable platform. We are trying to address legacy issues and build a team with a future vision to raise standards and look to the longer term strategy. No doubt that this is the right thing to do, clear now that this is not an ask for additional expenditure Committee members approved to recommend approval in Board next week
Advise		
	So, What	**What Next**

Committee/Group Escalation Report

Blackpool Teaching Hospitals
NHS Foundation Trust

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Finance Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	28/06/2023

Author	Mark Brearley, Interim Director of Finance					
Exec Sponsor	Mark Brearley, Interim Director of Finance					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					
Summary *(what)*	**Financial Performance** **The Trust's financial performance for May** is a £7.5m Deficit, in line with plan. **The Trust's financial performance Year to Date** is a £13.8m Deficit, in line with plan. **The Trust's agency spend** year to date at May is £6.7m, which is 9.0% of the total pay bill (the system agency ceiling target is 3.7%). **Capital**: The total programme expenditure year to date at the end of May 2023 is £1.0m. **Cash**: The Trust's cash balance at 31st May 2023 is £31.1m, a decrease of £3.4m in month but £8.7m higher than plan.					

Previously considered by	NA

Implications *(so what)*	We are broadly on plan for the first two months of the financial year.

Link to strategic objectives	Our People	ü
	Our Population	ü
	Our Responsibility	ü

EDI implications considered	Yes

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

Key Financial Headlines: Month 2 – May 2023

Executive Summary

Financial Performance

The Trust's financial performance for May is a £7.5m Deficit, in line with plan.

The Trust's financial performance Year to Date is a £13.8m Deficit, in line with plan.

The Trust's agency spend year to date at May is £6.7m, which is 9.0% of the total pay bill (the system agency ceiling target is 3.7%).

Capital: The total programme expenditure year to date at the end of May 2023 is £1.0m.

Cash: The Trust's cash balance at 31st May 2023 is £31.1m, a decrease of £3.4m in month but £8.7m higher than plan.

The content of the financial information is being developed and any feedback would be welcome. We have already received some requests that we will look to incorporate in future month's reports. We will be including run-rate charts in the report for month 3 and thereafter.

Key Financial Headlines: Month 2 – May 2023

Financial Performance

Reporting Period May 2023

Key Financial Headlines: Month 2 – May 2023

May 2023 I&E

- The Trust's I&E performance year to date at May 2023 is a £13.8m Deficit, in line with plan.

Income and Activity

- For 2023/24 the Trust is operating under an Aligned Payment & Incentive (API) contract with Lancashire & South Cumbria (L&SC) ICB and NHSE Specialised Commissioning. API contracts have two elements:
  1. A variable element that covers elective activity, diagnostics and high-cost drugs & devices.
  2. A fixed element that covers all other aspects of commissioned activity such as emergency care and outpatient follow ups.
- Emergency admissions are 7% ahead of plan with A&E attendances 2% ahead. Increased admissions in general medicine, general surgery and stroke services are driving this over-performance.
- Income generation for the Trust at the 31st May 2023 is £1.0m ahead of plan. Key drivers of this include increased income due to the pay award (£1.4m) and higher than planned use of high-cost drugs & devices (£0.5m), both of which are offset by increased expenditure; partially offset by lower than planned income & expenditure against services funded through FCUs, CDC funding and the virtual ward (£1.0m).
- The Trust is working closely with the ICB to monitor elective recovery performance, but no financial adjustments have been made to date.

Expenditure

- Year to date at 31st May 2023 operating expenditure is £1.4m worse than plan. The key drivers of the variances are mainly:
  - Bank and agency pay costs are higher than budgeted levels to cover vacancies and are partially offset by an underspend on substantive staff (£0.4m);
  - 2023/24 Agenda for Change pay award (£1.4m) which is offset by additional income;
  - Higher than planned costs of high-cost drugs (£0.9m) which is offset by additional income;
  - Lower than planned costs relating to excluded devices, CDC, virtual wards and covid of £1.4m which is offset by reduced income.
- The Trust has implemented the following to strengthen financial controls:
  - TAC Group
  - Vacancy & Spend Control Panel
  - Fortnightly QEP meetings
  - Lower Scheme of Delegation limits

Non-Operating Income & Expenditure

- Year to date at 31st May 2023 non-operating income and expenditure is £0.4m better than plan. The main reason for this is an increase in finance income following the Bank of England raising interest rates to 4.14%.

Key Financial Headlines: Month 2 – May 2023

Performance against agency cap

- The Trust's year to date agency spend is £6.7m, £2.8m higher than the budget.
- There is a system agency ceiling of 3.7%. If this was applied to the Trust, it would equate to £2.7m so the YTD position is £4.0m higher than the indicative agency ceiling.
- The agency spend incurred relates to cover for vacancies, sickness and escalation.
- As part of QEP and Financial Recovery delivery a number of schemes are being developed to reduce the level of agency spend e.g. reduction of nursing agency rates in line with ICB rates.

Cash

- The Trust's cash balance at 31st May 2023 was £31.1m, a decrease of £3.4m from April 2023 but £8.7m higher than plan, predominantly linked to lower than planned capital expenditure and higher levels of trade payables offset by higher levels of receivables.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Plan	32.8	22.4	17.0	11.0	8.7	2.2	2.2	4.9	5.5	7.2	7.6	8.4
Actual	34.5	31.1										
Variance	1.7	8.7										

- The Trust has paid 98% of suppliers by value and 95% by volume against the better payment practice code (BPPC) target of 95%.
- Liquidity continues to be a risk with the Trust forecasting revenue support in Q3 to maintain minimum cash balances.
- The Cash Management Group meet on a fortnightly basis to review cash forecasts, activity KPIs, levels of aged debt, levels of accrued income and details of prepayments to ensure cash balances are maximised.

Capital

- The total capital programme expenditure at the end of May 2023 is £1.0m which is £1.5m behind plan due to the delayed approval of the 23/24 capital plan.
- Spend incurred to May has been incurred against;
  - £0.4m Emergency Village & Critical Care
  - £0.5m ICT licence renewals and project staffing
  - £0.1m Estates development schemes

Finance Ratios

- Operating Deficit: Income percentage year to date at May 2023 is (12.7%) compared to the planned level of (12.5%).
- The year to date agency to total pay ratio is 9.05%, which is 3.6% above the budgeted ratio. NHSE have set a target for systems in 2023/24 to remain within 3.7% of the overall system pay bill.

QEP and Financial Recovery

- Year to date at May the Trust has delivered £2.1m of savings which is £0.5m higher than the QEP and Financial Recovery targets.
- It should be noted that the profile of the targets is weighted towards the period 1st October 2023 to 31st March 2024.

Key Financial Headlines: Month 2 – May 2023

Statement of Comprehensive Income:

Month 2 May 2023

		May-23				Year to Date at May-23			
		Budget £m	Actual £m	Variance £m	Variance %	Budget £m	Actual £m	Variance £m	Variance %
I&E (TOTAL)	NHS Clinical Income	48.3	49.4	1.2	2%	95.9	96.5	0.7	1%
	Non NHS Clinical Income	(0.2)	0.2	0.4	-195%	0.3	0.7	0.4	147%
	Other Operating Income	2.2	2.2	0.0	1%	4.2	4.1	(0.1)	-3%
	Total Operating Income	**50.2**	**51.8**	**1.6**	**3%**	**100.4**	**101.3**	**1.0**	**1%**
	Pay Costs (excluding agency)	(34.5)	(34.5)	0.0	0%	(68.9)	(67.4)	1.5	-2%
	Pay Costs - Agency	(2.2)	(3.2)	(1.1)	49%	(4.0)	(6.7)	(2.8)	70%
	Non Pay	(20.5)	(21.1)	(0.8)	4%	(40.1)	(40.1)	(0.1)	0%
	Total Operating Expenditure	**(57.2)**	**(58.8)**	**(1.8)**	**3%**	**(112.9)**	**(114.2)**	**(1.4)**	**1%**
	Operating Surplus / (Deficit)	**(6.9)**	**(7.0)**	**(0.2)**	**3%**	**(12.6)**	**(12.9)**	**(0.4)**	**3%**
	Non Operating	(0.6)	(0.5)	0.2	-26%	(1.3)	(0.9)	0.4	-29%
	Adj for Depreciation on Donated & Granted Assets	0.0	0.0	(0.0)	-3%	0.1	0.1	(0.0)	-5%
	Adjusted Financial Performance Surplus / (Deficit)	**(7.5)**	**(7.5)**	**(0.0)**	**0%**	**(13.8)**	**(13.8)**	**(0.0)**	**0%**
RATIOS	*Agency : Total Pay*	*5.86%*	*8.51%*	*2.64%*		*5.43%*	*9.05%*	*3.62%*	
	Operating Deficit : Income	*-13.79%*	*-13.53%*	*0.25%*		*-12.54%*	*-12.73%*	*-0.19%*	
	Net Deficit : Total Income	*-15.02%*	*-14.40%*	*0.62%*		*-13.77%*	*-13.58%*	*0.20%*	

Key Financial Headlines: Month 2 – May 2023

Phasing of 23/24 Income & Expenditure Plan across the financial year

In order to deliver a full year planned deficit of £24.3m, the in-month financial plan shows a reduced monthly deficit from Q2 moving to an in month surplus position towards the end of the year.

This is predominantly due to the phasing of the QEP, financial recovery plans and system funding gap. The QEP and Financial Recovery phasing is shown later in the report.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	23/24 Total
In month Surplus / (Deficit)	(6.3)	(7.5)	(6.8)	(3.7)	(3.4)	(2.6)	(0.7)	(0.1)	1.2	(0.7)	3.2	3.3	**(24.3)**
Cumulative Surplus / (Deficit)	(6.3)	(13.8)	(20.6)	(24.3)	(27.7)	(30.3)	(31.0)	(31.2)	(29.9)	(30.7)	(27.5)	(24.3)	**(24.3)**

Key Financial Headlines: Month 2 – May 2023

Statement of Financial Position May 2023

Statement of Financial Position as at 31st May 2023	Audited Position as at 31/03/23 £000	Actual Position as at 30/04/2023 £000	Actual Position as at 30/05/2023 £000	Monthly Movement £000	Forecast Position as at 31/03/24 £000
NON-CURRENT ASSETS					
Intangible Assets	9,845	9,670	9,392	(278)	23,277
Property, Plant and Equipment	303,427	302,157	300,567	(1,590)	308,702
Trade and Other Receivables, non-current	2,230	2,258	2,300	42	2,230
Total Non-Current Assets	**315,502**	**314,085**	**312,259**	**(1,826)**	**334,209**
CURRENT ASSETS					
Inventories	8,793	8,977	8,465	(512)	8,793
Trade and Other Receivables, current	34,150	33,995	37,715	3,720	40,244
Cash and Cash Equivalents	47,820	34,494	31,158	(3,336)	8,445
Total Current Assets	**90,763**	**77,466**	**77,338**	**(128)**	**57,482**
Total Assets	**406,265**	**391,551**	**389,597**	**(1,954)**	**391,691**
CURRENT LIABILITIES					
Trade and Other Payables	(110,220)	(99,868)	(106,984)	(7,116)	(100,259)
Other Liabilities	(9,906)	(12,368)	(11,401)	967	(9,906)
Borrowings, current	(9,214)	(9,158)	(9,219)	(61)	(9,163)
Provisions	(1,540)	(1,534)	(1,509)	25	(1,190)
Total Current Liabilities	**(130,880)**	**(122,928)**	**(129,113)**	**(6,185)**	**(120,518)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**275,385**	**268,623**	**260,484**	**(8,139)**	**271,173**
NON-CURRENT LIABILITIES					
Trade and Other Payables	(1,657)	(1,657)	(1,657)	0	(1,657)
Borrowings, non-current	(71,482)	(71,042)	(70,495)	547	(62,399)
Provisions	(2,919)	(2,920)	(2,920)	0	(2,920)
Total Non Current Liabilities	**(76,058)**	**(75,619)**	**(75,072)**	**547**	**(66,976)**
				0	
TOTAL ASSETS EMPLOYED	**199,327**	**193,004**	**185,412**	**(7,592)**	**204,197**
TAXPAYERS' EQUITY					
Public dividend capital	309,412	309,412	309,412	0	339,049
Revaluation Reserve	20,380	20,381	20,381	0	20,380
Income and Expenditure Reserve	(130,465)	(136,789)	(144,382)	(7,593)	(155,232)
TOTAL TAXPAYERS' EQUITY	**199,327**	**193,004**	**185,411**	**(7,593)**	**204,197**

The Statement of Financial Position at 31st May 2023 is presented opposite and the reasons for the significant movements in month are highlighted below:

Non-Current Assets –

- Property, Plant & Equipment (PPE); movement relates to depreciation & amortisation (see capital note for further information).

Working Capital

- Trade & Other Receivables; £1.0m reduction in invoiced debt, offset by £4.4m increase in prepayments - £1.3m relating to maintenance contracts in Atlas; £0.6m LTH oncology consultant charges and £2.5m property rates.
- Trade & Other Payables; increase largely related to additional pay accruals £5.1m.
- Other Liabilities (deferred income); unwinding of NHSE £1.1m income deferral offset by new deferral of HEE income £0.2m.

Taxpayers Equity

- Income & Expenditure Reserve deficit position decreased by £7.6m in month and £13.9m YTD being the adjusted financial performance.

Key Financial Headlines: Month 2 – May 2023

Statement of Financial Position: Working Capital

Key Performance Indicators - 31 Mar 2023				
Debtor/Creditor Days	**Target**	**May-21**	**May-22**	**May-23**
Debtor Days	30	17	16	25
Creditor Days	30	121	171	185
BPPC (Cumulative)	**Target**	**May-21**	**May-22**	**May-23**
Value	95%	63%	82%	96%
Volume	95%	71%	92%	95%
Aged Debt	**Target**	**May-21**	**May-22**	**May-23**
	£000's	**£000's**	**£000's**	**£000's**
Current less than 30 Days		1,095	2,794	2,836
30 - 60 Days		601	4,550	736
60 - 90 Days		671	923	1,249
Over 90 Days	< 5%	2,188	940	1,258
Total		**4,555**	**9,207**	**6,079**
% Over 90 Days		48%	10%	21%
Liquidity	**Target**	**May-21**	**May-22**	**May-23**
Current ratio	> 1	0.77	0.82	0.60

The Trust's BPPC performance by value and volume are both above the target of 95%.

With ongoing training, performance continues to improve and expect to achieve 95% compliance during 2023-24.

Aged Debt (Sales Ledger)

- In the month the number of outstanding invoices has increased by 63 from 848 to 911 and the value of debt has decreased by £1.0m from £6.7m to £5.7m.
- Debtors aged 0-30 days has increased by £1.2m, debtors aged 31 to 60 days has decreased by £3.1m, debtors aged 61-90 days has increased by £0.9m and there has been no movement in debtors aged over 91 days.

The key over 90 day receivables are set out below:

Debt > 90 Days			
Reason	Current Month	Prior Month	Movement
	£'000s	£'000s	£'000s
Overseas Debt	485	476	10
NHS Debt	434	468	- 34
Non-NHS Debt	145	149	- 4
Intercompany	98	-	98
Salary Overpayment	77	74	3
Private Patients	16	57	- 40
Council Debt	2	2	-
Welsh / Irish / Scottish Debt	-	6	- 6
Total	1,258	1,232	26

Private patients are provided with an advance price and asked for advance payment or proof of insurance cover. Overseas & private patient debt is chased by an internal specialist team.

NHS debt is predominantly due from local providers £0.1m, L&SC ICB £0.2m and £0.1m NHSE. The team continue to chase heads of services at counterparties to resolve disputes and non-payment.

Non-NHS debt 83% or £0.1m is with 3 customers relating to R&D, Pathology testing and rent and the team continue to chase.

Key Financial Headlines: Month 2 – May 2023

QEP and Financial Recovery

The Trust is reporting over delivery against the 5.5% QEP target of £0.5m at the end of May 2023. This is due to additional savings reported by Tertiary, FICC and Clinical Support Divisions.

The financial recovery programme savings are in line with plan.

	Month 2			YTD Month 2		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Recurrent 5.5% QEP	0.50	0.78	0.28	0.63	0.91	0.28
Non-Recurrent 5.5% QEP	0.36	0.49	0.13	0.62	0.81	0.19
Financial Recovery	0.19	0.19	0.00	0.38	0.38	0.00
Total	**1.05**	**1.46**	**0.41**	**1.63**	**2.10**	**0.47**

Phasing of 23/24 QEP & Financial Recovery Measures in the Plan

As indicated in the Summary, the savings plan is weighted to the latter half of the year.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	23/24 Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
QEP	0.4	0.9	2.1	2.7	3.2	3.5	4.0	4.1	4.0	4.2	4.1	4.5	**37.7**
Financial recovery	0.2	0.1	0.3	0.5	0.5	0.5	2.8	2.9	2.9	2.8	2.9	3.0	**19.5**
Total	**0.6**	**1.0**	**2.4**	**3.2**	**3.7**	**4.0**	**6.8**	**7.0**	**6.9**	**7.0**	**7.0**	**7.5**	**57.2**
Cumulative Total	**0.6**	**1.6**	**4.0**	**7.2**	**10.9**	**14.9**	**21.7**	**28.7**	**35.6**	**42.6**	**49.6**	**57.2**	**57.2**

Divisional Targets

Division	Divisional QEP £000	2023/24 Target Trust Specific QEP £000	Financial Recovery £000	Total £000
Clinical Divisions				
Clinical Support	3,070	785	700	4,555
Families & Integrated Community Care	4,010	-250	500	4,260
Integrated Medicine & Patient Flow	4,991	9,775	300	15,066
Surgery, Anaesthetics, Critical Care & Theatres	3,716	3,575	2,500	9,791
Tertiary Services	3,203	856	1,000	5,059
Corporate Divisions				
Chief Executive	130	22	22	174
Chief Operating Officer	184	30	38	252
Clinical Governance	367	58	69	494
Communications	16	2	4	22
Corporate Governance	47	7	5	59
Finance	238	37	36	311
FM & Emergency Planning	631	100	79	810
Medical Director	32	5	8	45
Medical Education	186	29	35	250
People & Culture	430	174	61	665
Planning, Transformation, Strategy & Digital (Other)	76	56	11	143
Planning, Transformation, Strategy & Digital (ICT)	711	68	108	887
Research & Development	114	18	22	154
Trust-Specific	0	0	7,000	7,000
Other Divisions				
Corporate Income	0	0	5,500	5,500
Other Divisions	0	163	1,500	1,663
Grand Total	22,152	15,510	19,498	57,160

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Operations Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	28/06/2023

Author	Steve Christian, Deputy CEO					
Exec Sponsor	Steve Christian, Deputy CEO					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					

Summary *(what)*	**Operational Performance –** see IPR for full details and narrative across a range key performance indicator (KPIs). The below summary is a high-level overview against several constitutional standards lifted from the IPR for Operational Performance. **Urgent & Emergency Care (UEC):** Alert: The Trust has seen higher than predicted demand for UEC activity including 3 entries into the top 10 highest days of attendances since reporting commenced in 2017 which have resulted in additional pressures with performance. Advise: The Trust is using the Patient Flow Improvement Programme to mobilise and monitor the improvement workstreams to address the UEC Performance. The details of the workstreams and their progress is routinely presented to the Finance and Performance Committee. Assure: The Trust has withdrawn from Surgical Day Case Unit as an escalation unit due to Length of Stay improvements. **Referral to Treatment (RTT):** Alert: There have been 3 reportable 78-week breaches in May 23 due to capacity issues. There were a further 16 excluded breaches due to unavoidable delays such as patient choice, clinical complexity, or medical reason. Focus being on the challenging services (Gastroenterology, Gynaecology & Cardiology) with all having improvement plans and focused decisions at weekly assurance meeting. Assure: We have reported 149 fewer patients against plan of 341 waiting above 65 weeks. Advise: The Trust has established a Clinical Productivity Board (chaired by Deputy CEO) to enable improvement in theatre, endoscopy, and outpatient utilization.

Summary *(what)*	**Cancer:** Assure: The trust has exceeded the plan for the Cancer Backlog with an undiagnosed position of 135 in May against a forecasted internal target of 151. This is despite the peak holiday period and reduced working days due to bank holidays. Advise: Breast surgical workforce challenges likely to cause a deterioration in 62-day and 31-day performance. Division working up recovery plan. Alerts: Treatment for Tertiary patients continues to be a challenge mainly impacting Urology & Gynae pathways. The Trust is working with the Cancer alliance to consider system wide improvements.

Previously considered by	Finance & Performance Committee

Implications *(so what)*	We are on plan with many trajectories set within the Trust plan for Operational Performance. However, the Trust is failing to meet national key performance targets across UEC like many NHS Trusts up & down the country. The IPR narrative describes the intentions to drive performance improvement through the established Patient Flow Improvement Programme (PFIP).

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

EDI implications considered	Yes

Proposed Resolution *(What next)*	The Board of Directors are asked to acknowledge and approve the IPR and associated narrative which describes key actions.

Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Finance and Performance Committee

May 2023

Caring ▪ Safe ▪ Respectful

Guide to Statistical Process Control

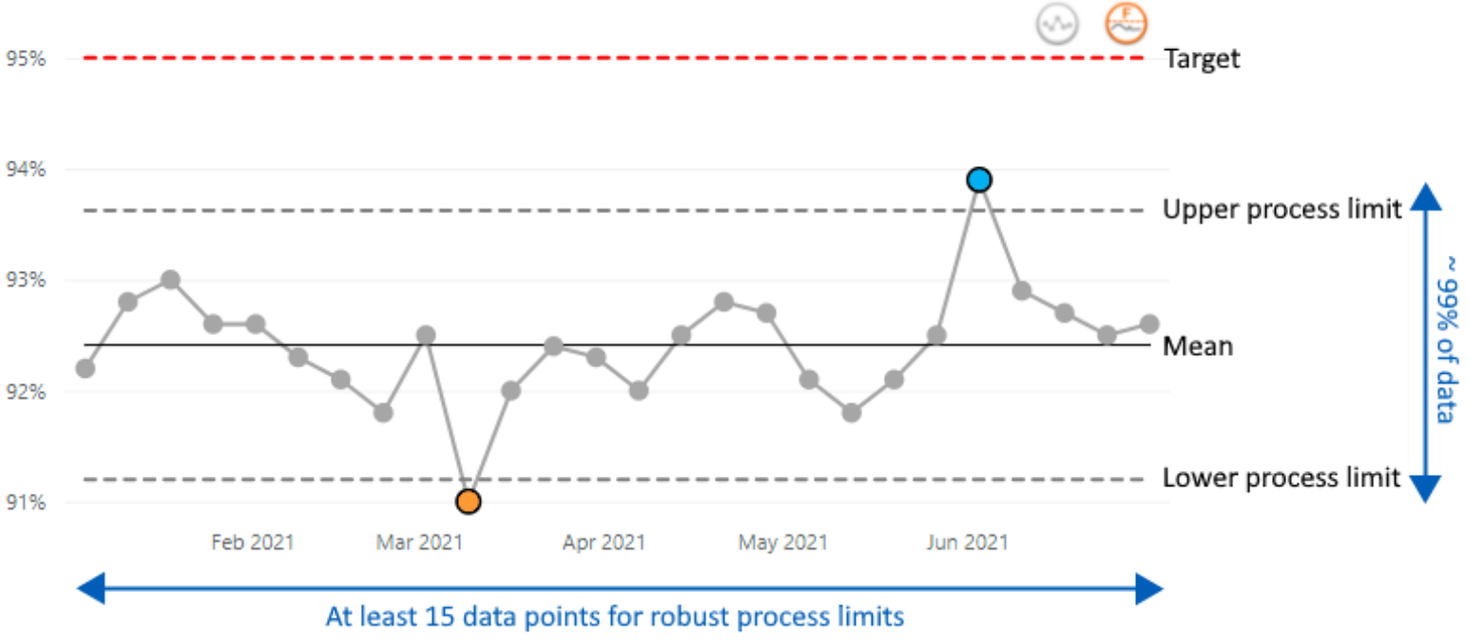
Blackpool Teaching Hospitals NHS Foundation Trust

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	L
Operations	Access		5	8	7	1	2	13	3	1
	Activity		6			1		5		
	Cancer		6	3	2	2	1	8		
	Productivity	1	2	3	5	1	1	8		1

Assurance

Measures the likelyhood of targets being met for this indicator.

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

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

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.

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.

Operations

Blackpool Teaching Hospitals
NHS Foundation Trust

Access

UEC:
Alert
• April 2023 represented a significant improvement for ambulance handovers and turnaround times within the Trust – a reduction from 440 to 92. This improvement was a result of the Home for Easter campaign and focus on all matters related to flow and de-escalation. Improvements were sustained throughout April; however, May 2023 did represent a challenging month with a deterioration on performance with only 84% (i.e., 370 breaches) of ambulances being handed over under an hour.
• Patients awaiting more than 12 hours from a decision to admit is significantly high, with 731 patients breaching the standard in April 2023 (reduction of 330 from the previous month). A change to the DTA processes has been drafted with a small Task and Finish Group identified to operationalise the changes. The view from colleagues within the department is that sometimes, DTAs are pre-emptively assigned to patients as part of speciality referral. The risk with this process is that patients are subsequently admitted when an alternative to admission could be considered.
• At the time of writing, the Trust has seen 3 entries into the top 11 highest days of attendances since reporting commenced in 2017 which have resulted in additional pressures with time in the department and time to be seen by a clinician.
Advise
• There is ongoing analysis to understand the late discharge profile of the hospital in more detail. Further use of the discharge lounge is also required as morning flow is not timely, and there is a reliance on escalation measures such as full capacity protocol.
• 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 (PFIP) presented to the Finance and Performance Committee.
Assure
• A change to the DTA processes has been drafted and will commence in July 2023.
• The IMPF Division is also seeking to reduce reliance on escalation capacity in ED. The Trust is seeking to launch a 'reset' focussed effort to re-establish expectations and withdraw from escalation capacity where possible.

Stroke / TIA:
Alert
• The high-risk patients being treated within 24 hours remains low across the month (47.5%). This issue is primarily a result of no weekend provision being available in the service, due to medical staffing pressures.
• At present, only 66.7% of patients have 90% of their stay on Stroke ward (April data).
Advise
• Recruitment is ongoing for substantive posts.
Assure
• The Division and Patient Flow teams have been actively protecting ring-fenced capacity on Stroke and reducing outliers on the ward to improve Right Patient, Right Place.
• The Divisional Director of Operations has met with the Stroke Team to understand the current service model and review the weekend working provision. In the short-term the Division is seeking to return weekend working into the model in the current funding available.
• The Directorate has also completed a workforce strategy recognising the challenges in recruitment. The Divisional Director of Operations and HR Business Partner are meeting with the team to review the strategy and what alternate models could be delivered.

On the day cancellations:
Alert
• Issues with pre-operative capacity are reducing opportunities to have patient on standby list to fill cancelled slots.
• Reduction of staff additional hours rates is impacting on staff uptake for additional shifts. Expected to be September before staff uptake increases and this will impact on pre-operative capacity.
• Set for surgery not currently implemented - work in progress to engage GPs.
Advise
• Cancellations are reviewed at the end of each week to support lessons learned.
Assure
• Pre-operative screening in Orthopaedics is being offered as a stratified model to increase pre-op'd patients ready for surgery.
• Pilot site for the NHS weigh management programme.

Operations

Access

Diagnostics (Endoscopy):
Alert
• There is a OP backlog in Gastroenterology that as it is cleared and higher volumes seen, will result in increased volume of endoscopies being requested.
• Bowel screening service will require an additional list as per contract and this will impact on the endoscopy waiting list.
• Both will be manageable and are not anticipated to affect the original trajectory of improvement too significantly.
Assure:
• Insourcing arrangements still in place to support Endoscopy Room 5 and Room 6 (Modular).
• Waiting list size reduced from 3500 to 1180 - lowest in ICB.
Advise
• Controlled drug licence for modular unit (Stanley Park) finally approved by Home Office and this will increase type of scopes being offered (i.e. under sedation) from 26 June 2023.

RTT:
Alert
• There have been 3 reportable 78-week breaches in May 23 due to capacity issues. There were a further 16 excluded breaches due to unavoidable delays such as patient choice, clinical complexity, or medical reason. Focus being on the challenging services (Gastroenterology, Gynaecology & Cardiology) with all having improvement plans in development and focused decisions at weekly assurance meeting.
Assure
• We have reported 149 fewer patients against plan of 341 waiting above 65 weeks.
Advise
• Orthodontic service meeting with NHSE to take place in next week due to continued challenges in workforce pressures

Operations

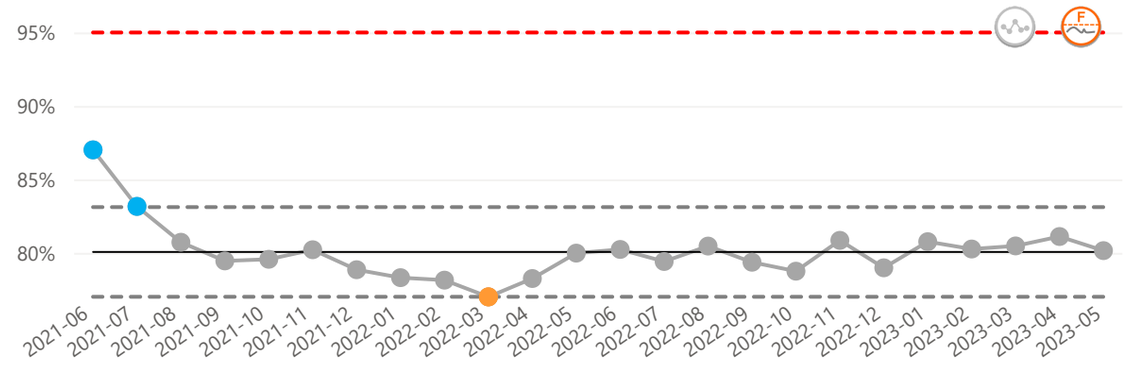
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
4 Hours from arrival to ADT - % within 4 hours	95%	80.1%	May 23		F	95%	81.1%	Apr 23		
A&E Type 1 Performance %	65%	55.5%	May 23		F	65%	57.4%	Apr 23		
Ambulance Handovers - % within 15 minutes	65%	22.9%	May 23		F	65%	34.2%	Apr 23		
Ambulance Handovers - % within 30 minutes	95%	66.7%	May 23		F	95%	83%	Apr 23		
Ambulance Handover 30-60 Mins		483	May 23				321	Apr 23		804
Ambulance Handover Over 60 Mins	0	393	May 23		?	0	92	Apr 23	0	485
Number waiting over 12 hours from DTA		928	May 23	H			731	Apr 23		1659
Number of Patients spending 12+ Hours in ED - Trust		1595	May 23				1339	Apr 23		2934
% of Patients spending 12+ Hours in ED - Trust	2%	7.67%	May 23		F	2%	6.92%	Apr 23		
% of patients waiting less than 6 weeks for a diagnostic test	95%	76.0%	May 23		F	95%	77.0%	Apr 23		
Total RTT Waiting List - Trust		35892	May 23	H			34940	Apr 23		35892
RTT Incomplete Pathways - % within 18 weeks	92%	58.8%	May 23	L	F	92%	59.0%	Apr 23		
RTT Incomplete Pathways - Over 52 Weeks		1164	May 23	H			928	Apr 23		1164

Operations

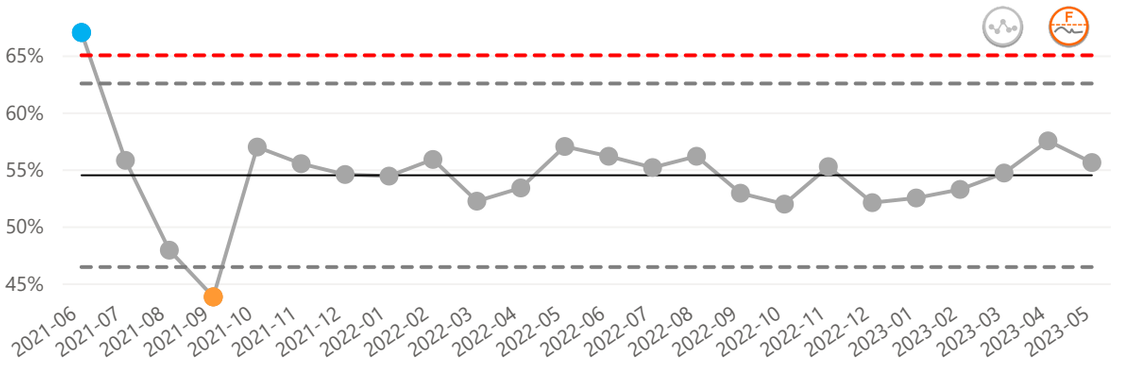
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
RTT Incomplete Pathways - Over 78 Weeks		16	May 23				11	Apr 23		16
RTT Incomplete Pathways - Over 104 Weeks	0	1	May 23			0	1	Apr 23	0	1
Total 52 week waits – completed		269	May 23				229	Apr 23		498
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days	0%	11.9%	May 23			0%	8.45%	Apr 23		
TIA - High Risk Treated within 24Hrs	60%	40.3%	May 23			60%	47.5%	Apr 23		
Stroke - 90% Stay on Stroke Ward	80%	80.6%	May 23			80%	66.7%	Apr 23		
2-Hour UCR	70%	90.9%	Apr 23			70%	88%	Mar 23	70%	90.9%

Operations

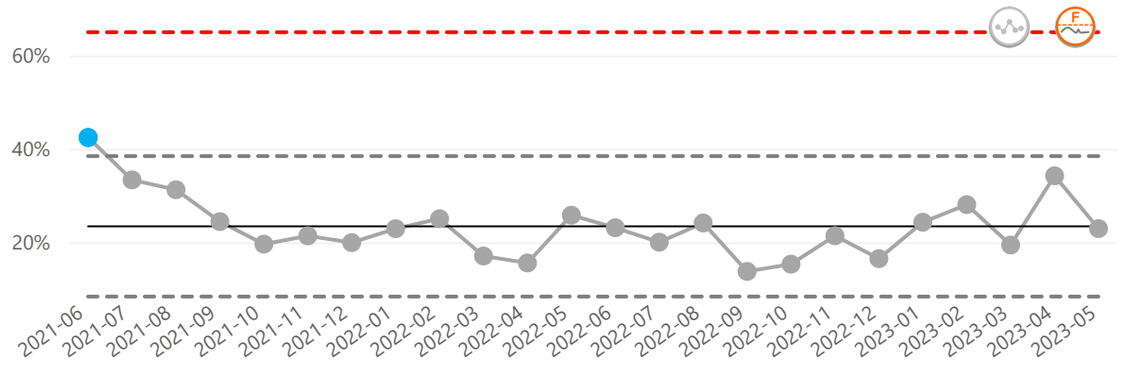
4 Hours from arrival to ADT - % within 4 hours



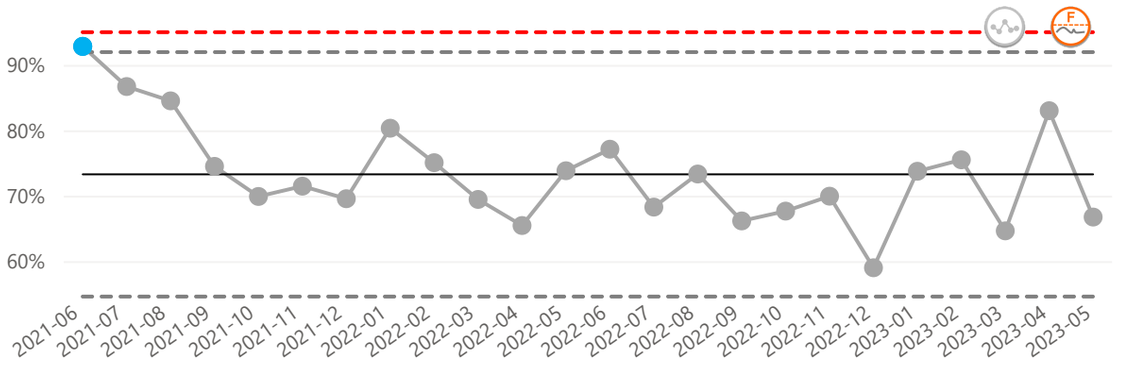
A&E Type 1 Performance %



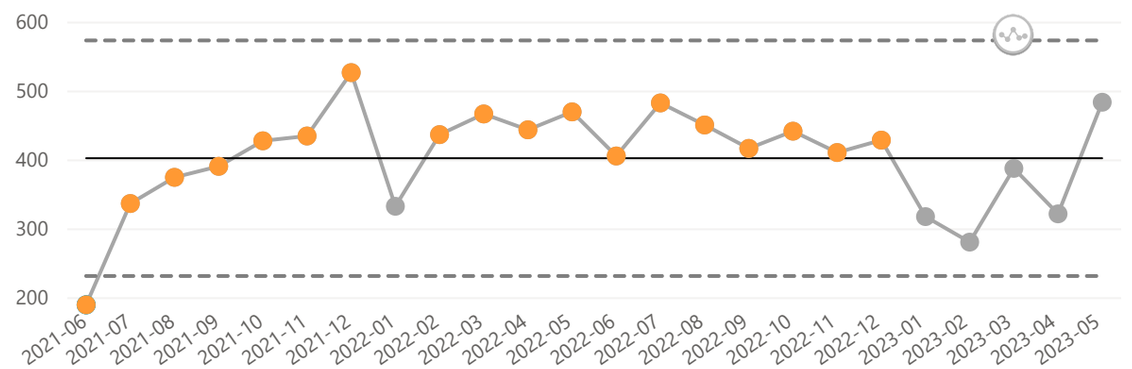
Ambulance Handovers - % within 15 minutes



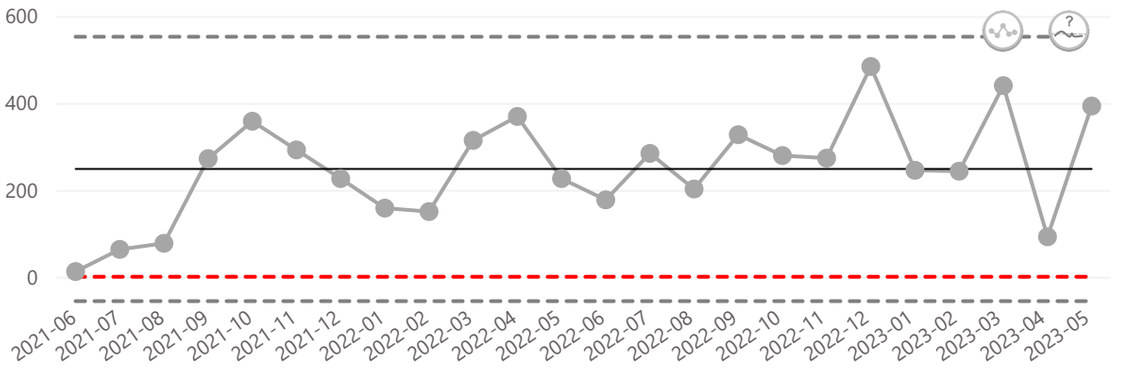
Ambulance Handovers - % within 30 minutes



Ambulance Handover 30-60 Mins

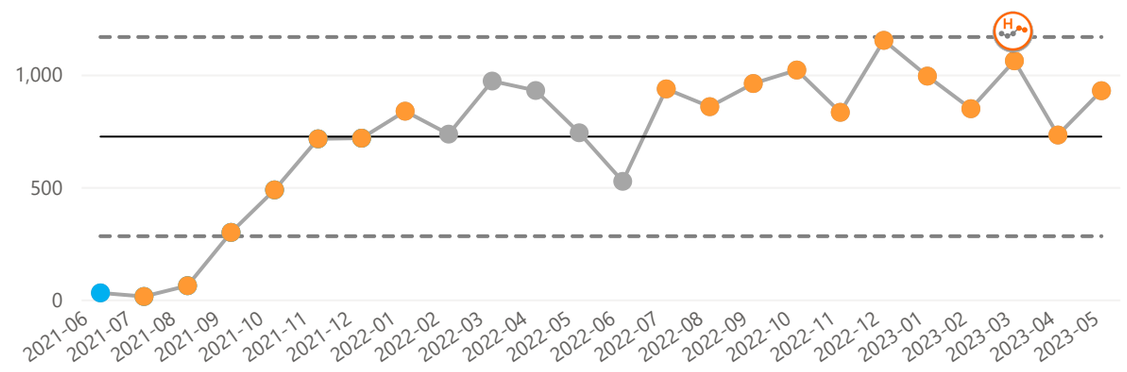


Ambulance Handover Over 60 Mins

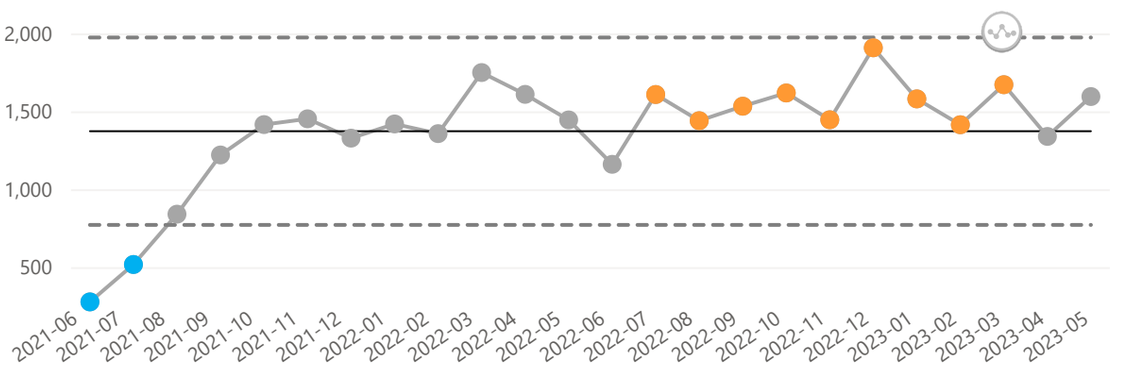


Operations

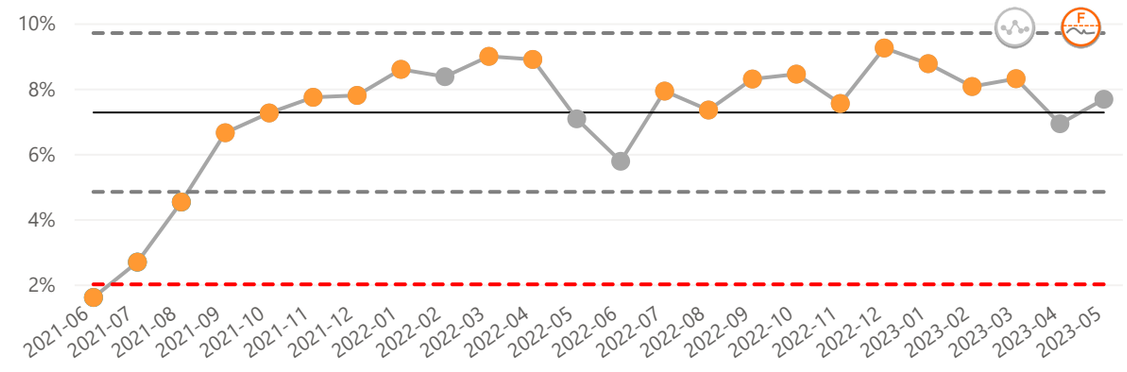
Number waiting over 12 hours from DTA



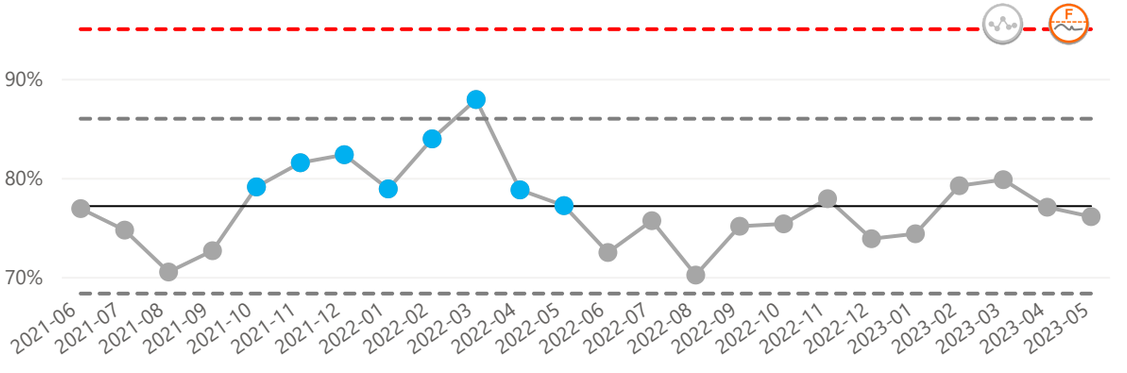
Number of Patients spending 12+ Hours in ED - Trust



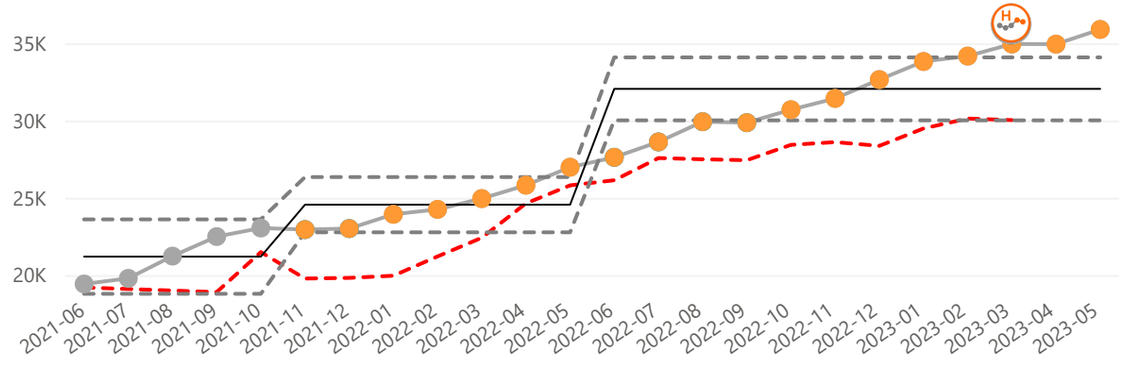
% of Patients spending 12+ Hours in ED - Trust



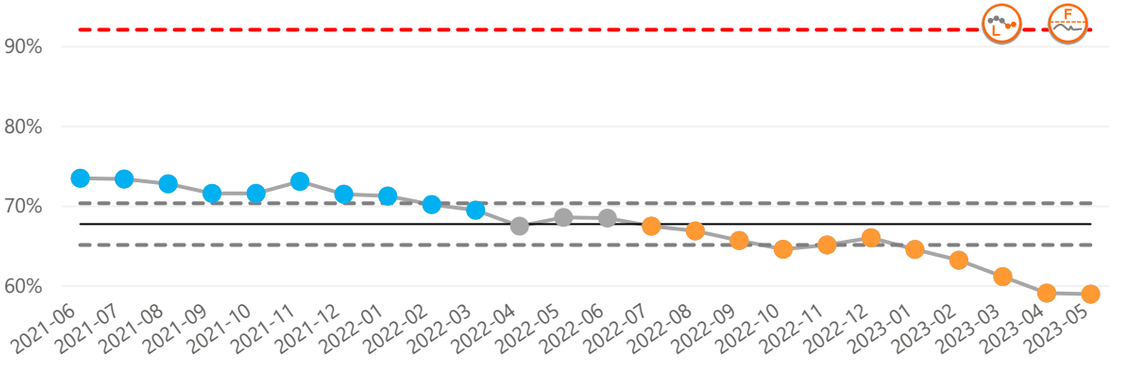
% of patients waiting less than 6 weeks for a diagnostic test



Total RTT Waiting List - Trust

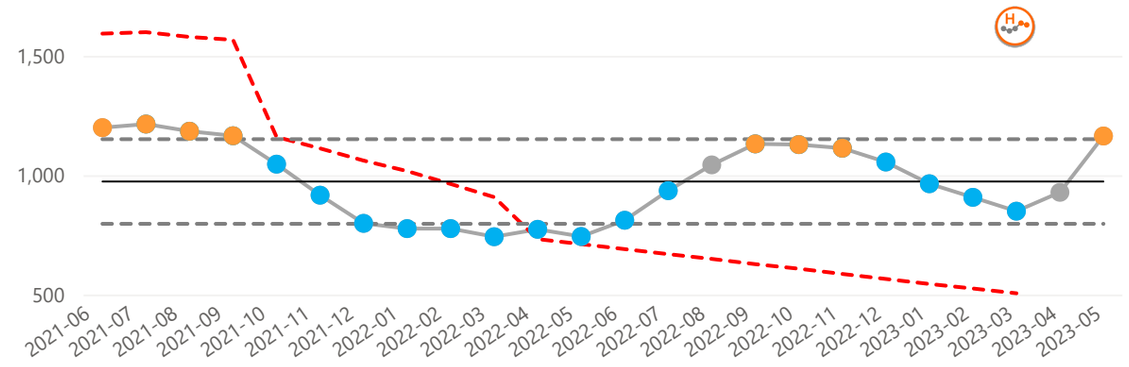


RTT Incomplete Pathways - % within 18 weeks

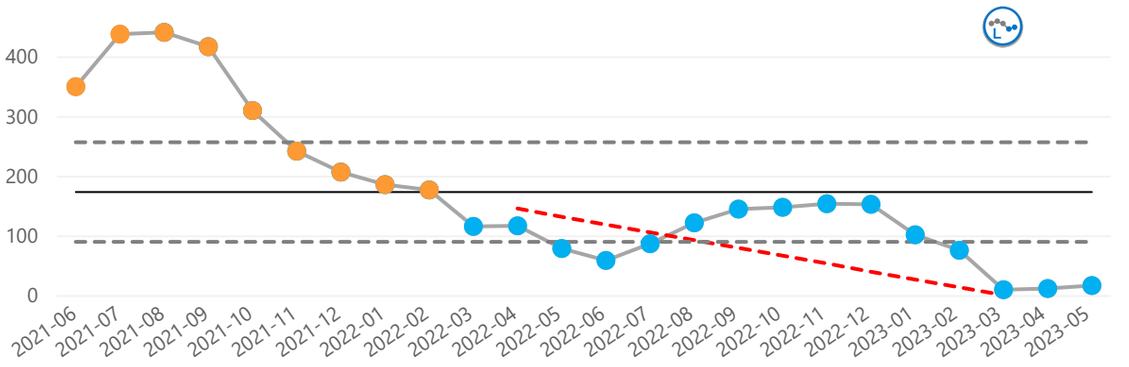


Operations

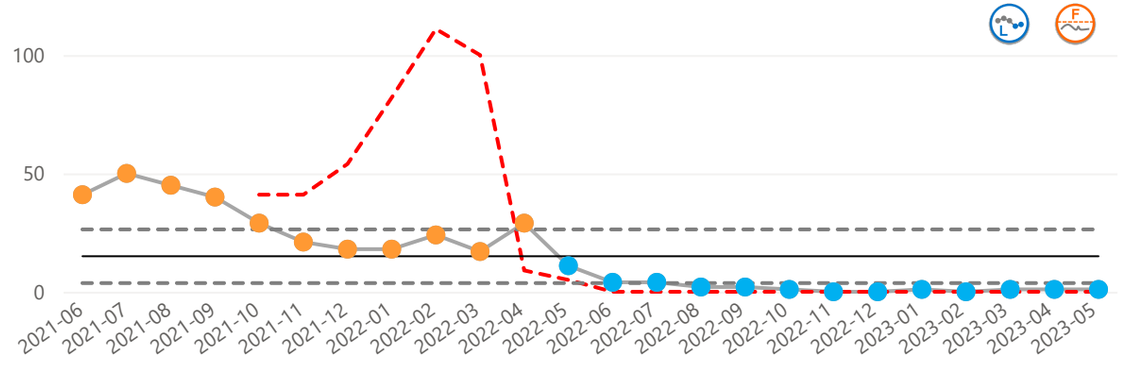
RTT Incomplete Pathways - Over 52 Weeks



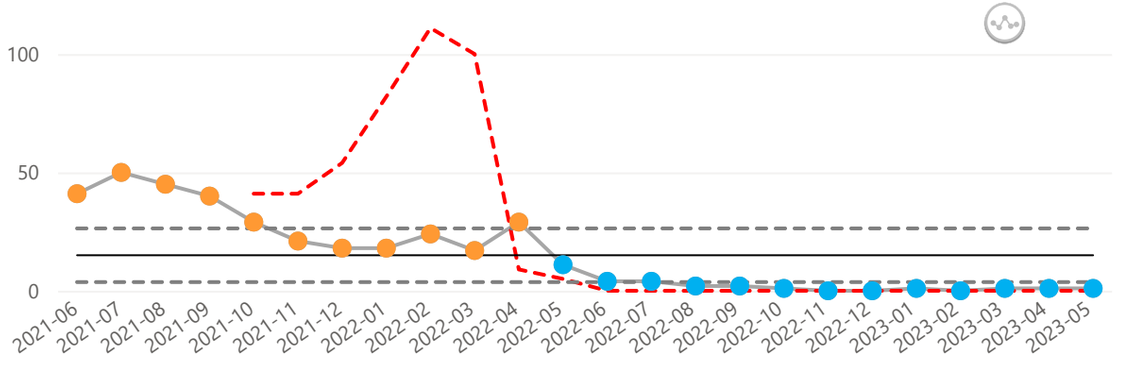
RTT Incomplete Pathways - Over 78 Weeks



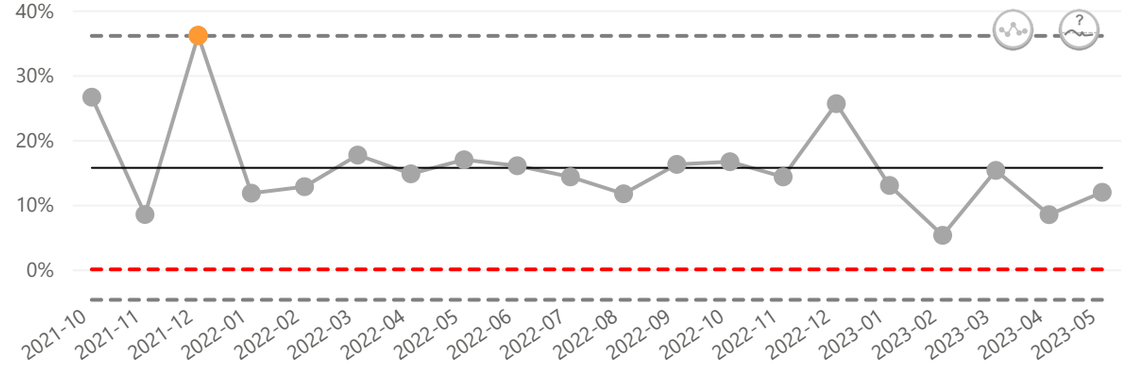
RTT Incomplete Pathways - Over 104 Weeks



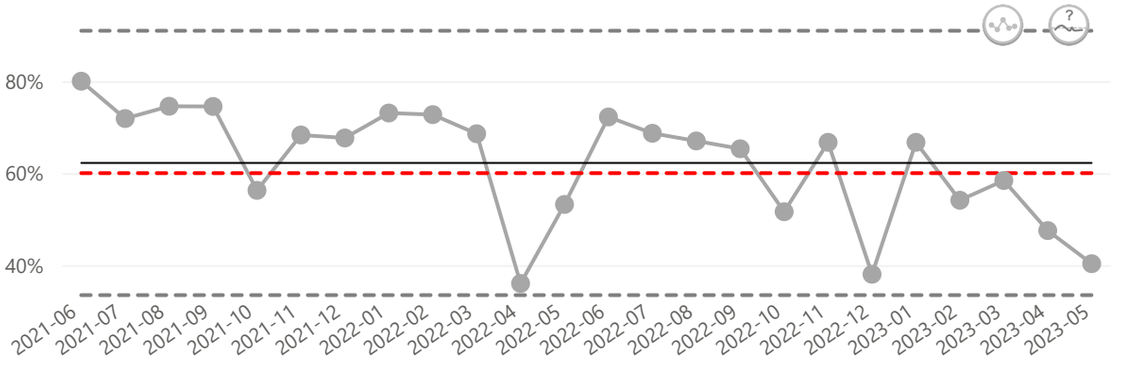
Total 52 week waits – completed



On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days

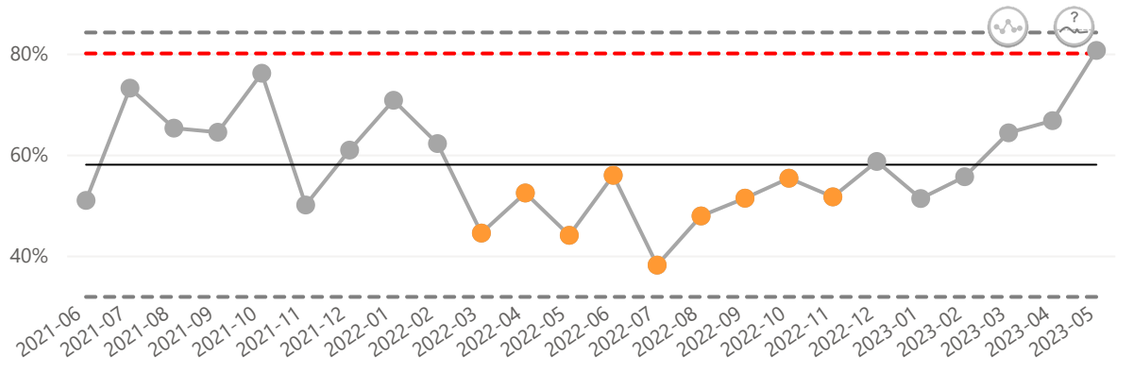


TIA - High Risk Treated within 24Hrs

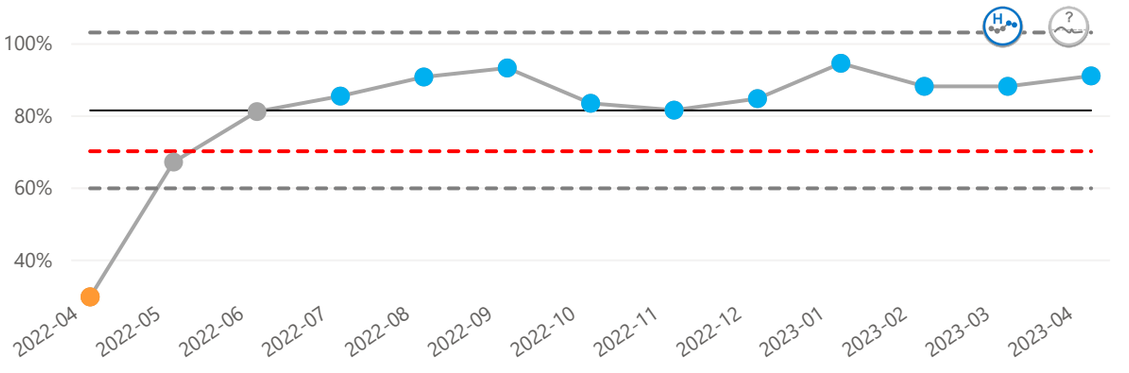


Operations

Stroke - 90% Stay on Stroke Ward



2-Hour UCR



Operations

Blackpool Teaching Hospitals
NHS Foundation Trust

Activity

Assure
- Outpatient Follow Up Appointments below plan for month of May-23.
- Biggest contributors to being below plan:
- Respiratory Physiology | - Gastroenterology | - Gynaecology
- Day Case above plan for month of May-23 and cumulative year to date.
- May-23 Biggest contributors to being above plan:
- Medical Oncology | - Urology | - General Surgery
- YTD Biggest contributors to being above plan:
- Medical Oncology | - Urology | - General Surgery
- Elective Inpatients above plan for year to date.
- Biggest contributors to being above plan:
- General Surgery | - Cardiothoracic Surgery | - Ophthalmology

Advise
- Non-Elective Inpatients above plan for the month of May-23 and cumulative year to date.
- May-23 Biggest contributors to being above plan:
- Rehabilitation | - Geriatric Medicine | - ENT
- YTD Biggest contributors to being above plan:
- Geriatric Medicine | - Rehabilitation | - General Surgery
- Emergency Department Attendances above plan for the month of May-23 and cumulative year to date.

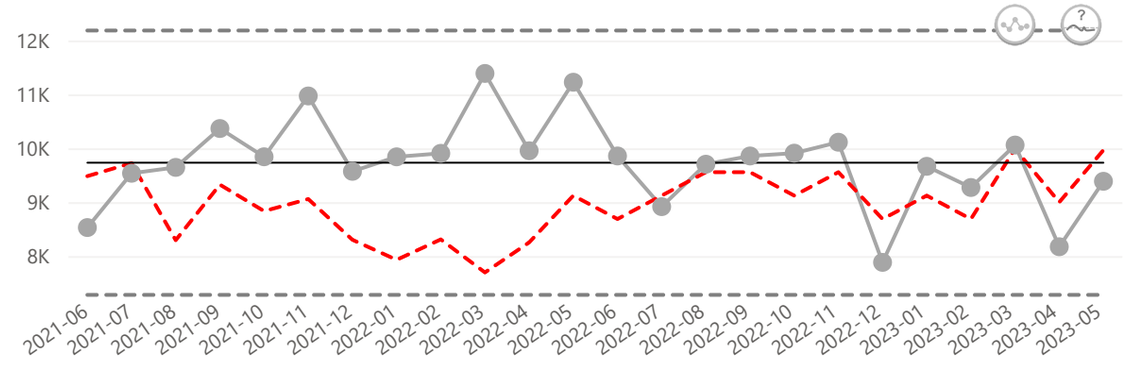
Alert
- Outpatient New Appointments below plan for both the month of May-23 and cumulative year to date.
- May-23 Biggest contributors to being below plan:
- Anaesthetics | - Gynaecology | - General Surgery
- YTD Biggest contributors to being below plan
- Anaesthetics | - Gastroenterology | - Respiratory Physiology
- Outpatient Follow Up Appointments above plan for cumulative year to date.
- Biggest contributors to being above plan:
- Medical Oncology | - Midwifery Led Care | - Cardiothoracic Surgery
- Elective Inpatients below plan for month of May-23.
- Biggest contributors to being below plan:
- Cardiology | - Trauma & Orthopaedics | - Urology

Operations

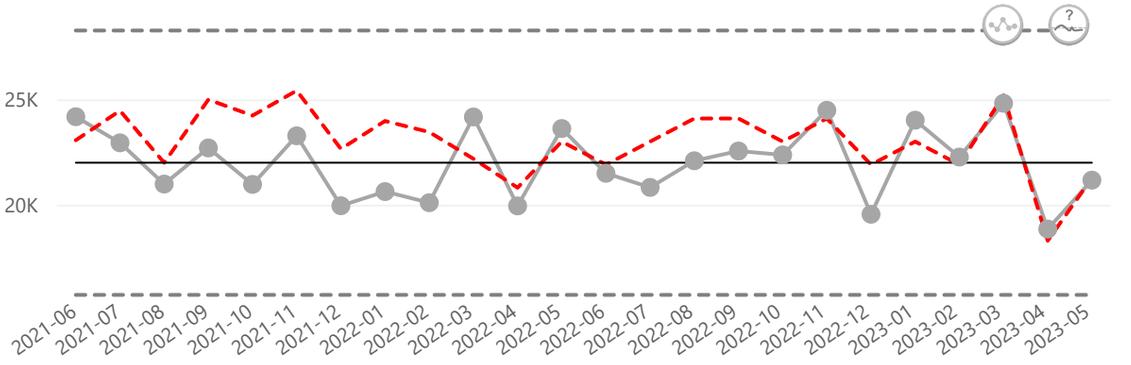
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Outpatient New	9966.42	9387	May 23			8999.55	8173	Apr 23	18966	17560
Outpatient Follow Up	21269.52	21166	May 23			18291.15	18844	Apr 23	39561	40010
Day Case	3967.15	4698	May 23			4324.17	4270	Apr 23	8291	8968
Elective Inpatient	443.21	428	May 23			399.24	437	Apr 23	842	865
Non-Elective Inpatient	4249	4625	May 23	H		4117.44	4337	Apr 23	8366	8962
ED Attendances	6438.19	6757	May 23			6230.57	6192	Apr 23	12669	12949

Operations

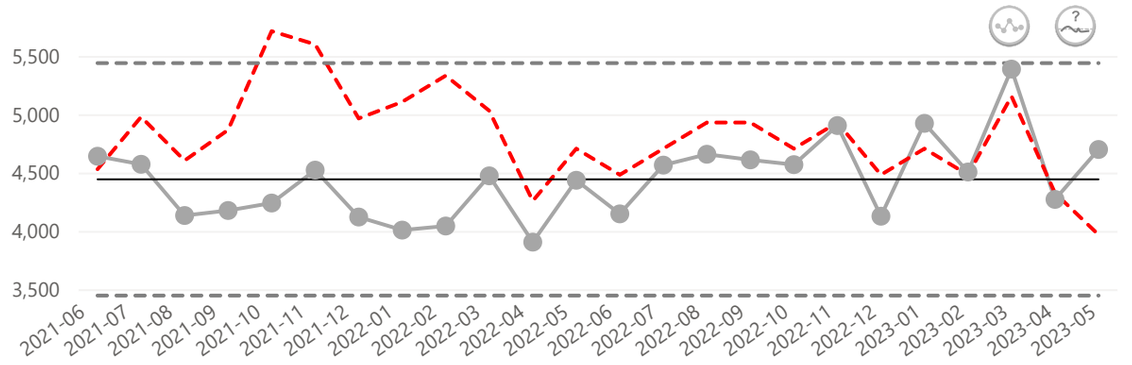
Outpatient New



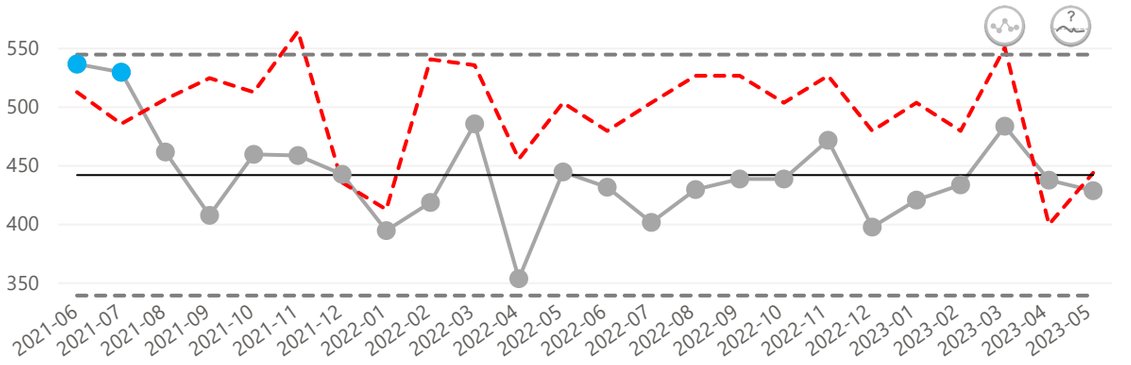
Outpatient Follow Up



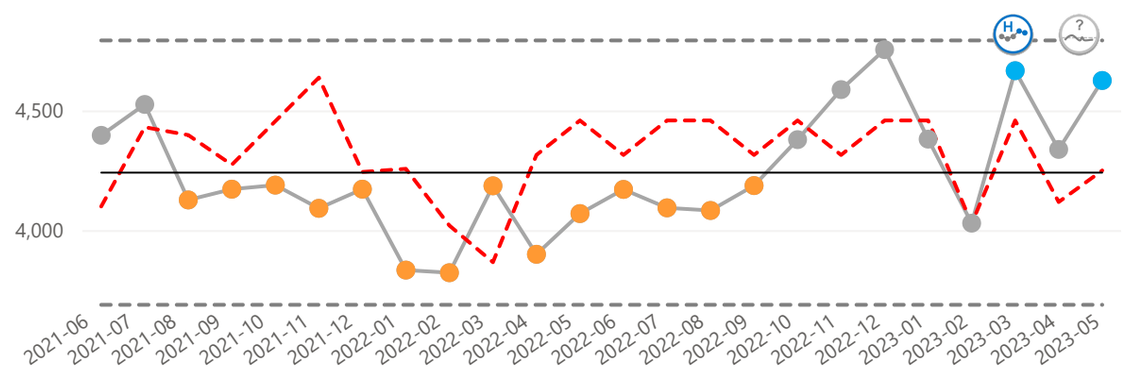
Day Case



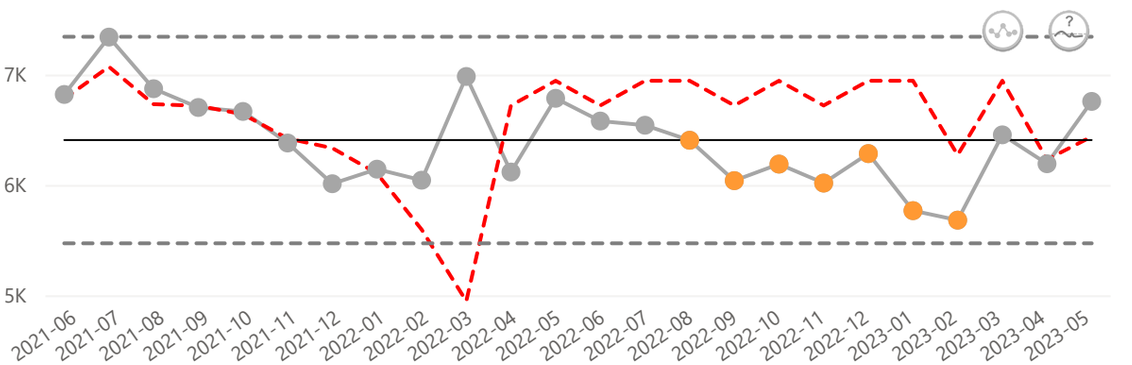
Elective Inpatient



Non-Elective Inpatient



ED Attendances



Blackpool Teaching Hospitals
NHS Foundation Trust

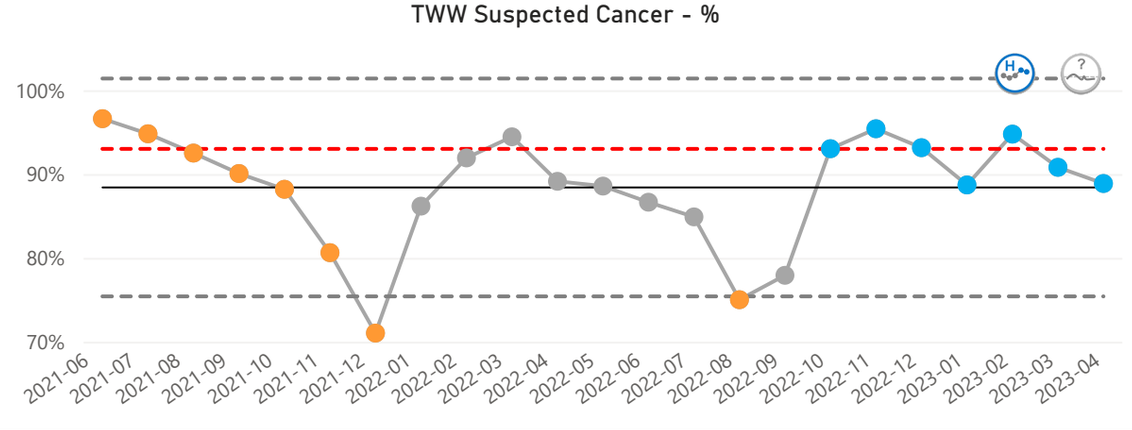
Cancer

Cancer:
Assure
• Undiagnosed cancer backlog reduction has continued and is meeting forecasted target.
• Significant improvements made in the FDS standard ad is forecasted to meet the ICS agreed target but miss the internal target set.
• The trust has exceeded the plan for the Cancer Backlog with an undiagnosed position of 135 in May against a forecasted internal target of 151. This is despite the peak holiday period and reduced working days due to bank holidays. The undiagnosed backlog recovery is currently at 115 as of the 21st June 2023 within the month end forecasted position of 128.
• New governance structure for cancer PTL and performance has been established. The assurance meetings with the cancer alliance have been stepped down to monthly given the continued improvement and control measures in place.
Advise
• Breast surgical workforce challenges likely to cause a deterioration in 62 and 31 day performance. Division working up recovery plan.
• Chemotherapy capacity constraints likely to impact 62 and 31 day performance. This is being felt nationally. Options appraisal paper being developed with input from the cancer alliance given the system wide challenges
Alerts
• Unable to meet the Two Week Wait target with challenges in Gynae, Colorectal, Breast & Upper GI.
• Treatment for Tertiary patients continues to be a challenge mainly impacting Urology & Gynae pathways

Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
TWW Suspected Cancer - %	93%	88.8%	Apr 23	H	?	93%	90.8%	Mar 23		
TWW Breast Symptomatic - %	93%	86.4%	Apr 23		?	93%	81.0%	Mar 23		
28 Days Faster Diagnosis Standard - %	75%	73.6%	Apr 23	H	F	75%	71.6%	Mar 23		
31 Days First Treatment - %	96%	92.2%	Apr 23		?	96%	92.5%	Mar 23		
31 Days Subsequent Treatment - Drugs - %	98%	100%	Apr 23		?	98%	100%	Mar 23		
31 Days Subsequent Treatment - Surgery - %	94%	90.9%	Apr 23		?	94%	100%	Mar 23		
62 Days GP Referred (Classic) - %	85%	69.0%	Apr 23		F	85%	72.1%	Mar 23		
62 Days National Screening - %	90%	37.0%	Apr 23		F	90%	80.9%	Mar 23		
62 Days Consultant Upgrade - %	85%	70%	Apr 23		?	85%	66.0%	Mar 23		
62 Days - GP Referred (Classic) Open Pathways >62 Days		142	May 23	L			140	Apr 23		142
62 Days - GP Referred (Classic) Open Pathways >104 Days		44	May 23				47	Apr 23		44

Operations


TWW Suspected Cancer - %
100%
90%
80%
70%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
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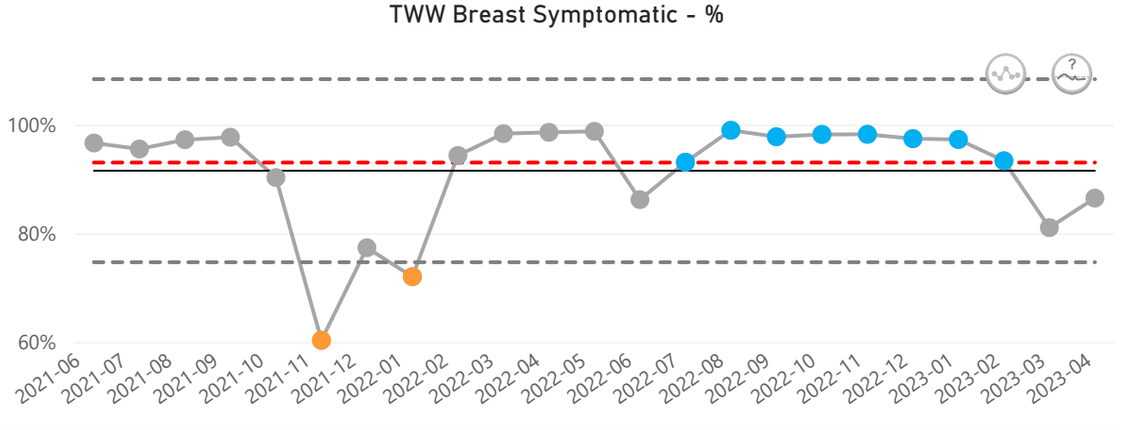
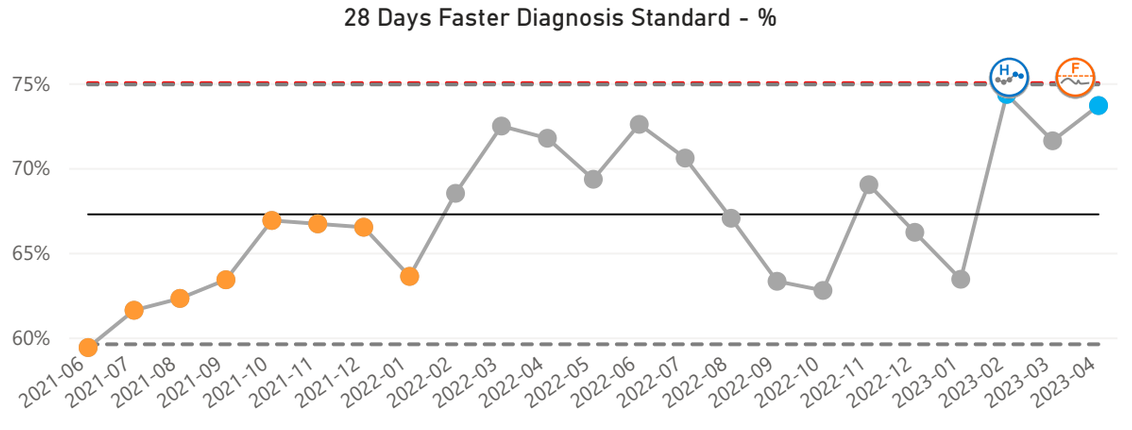
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04


TWW Breast Symptomatic - %
100%
80%
60%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04


28 Days Faster Diagnosis Standard - %
75%
70%
65%
60%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
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2022-11
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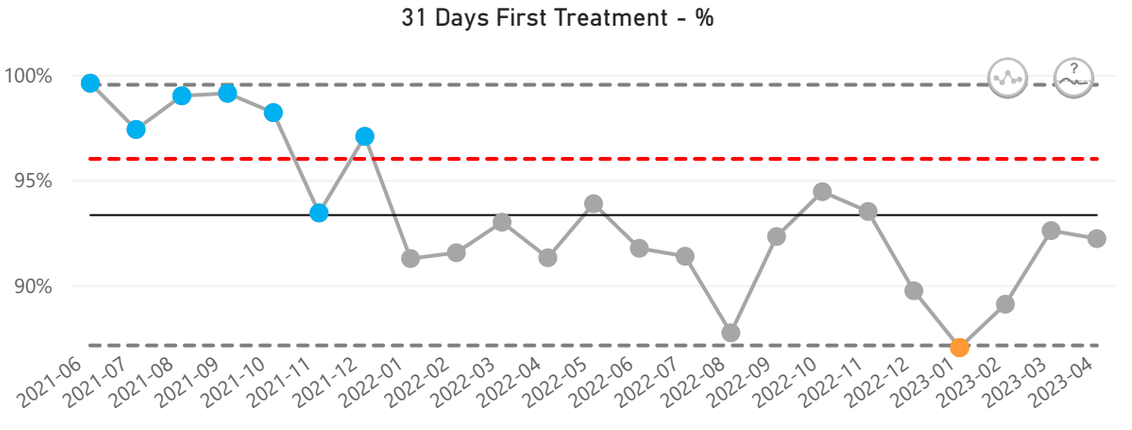
2023-01
2023-02
2023-03
2023-04


31 Days First Treatment - %
100%
95%
90%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
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2022-09
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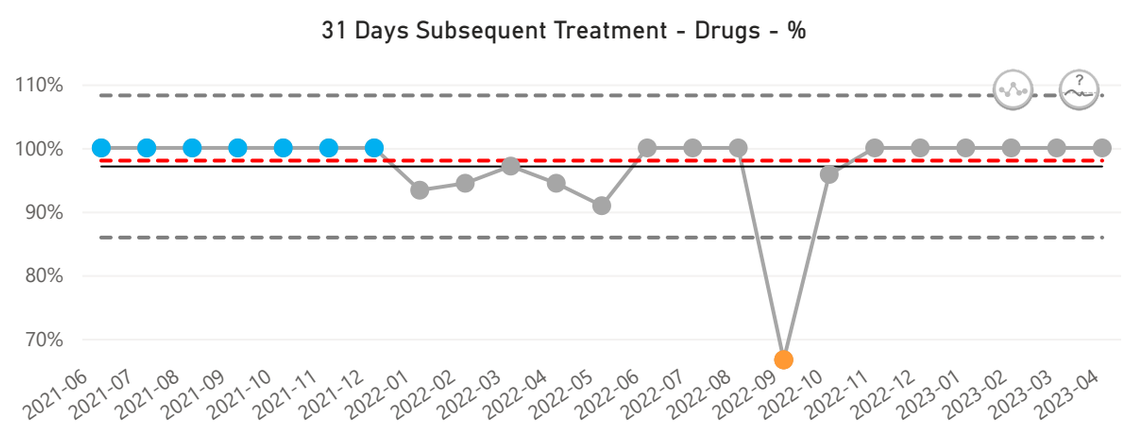
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04


31 Days Subsequent Treatment - Drugs - %
110%
100%
90%
80%
70%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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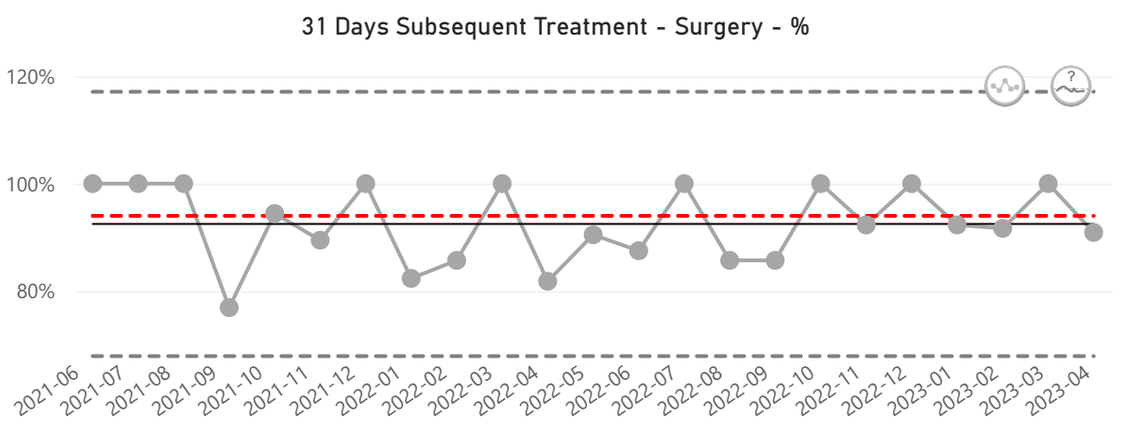
2023-04


31 Days Subsequent Treatment - Surgery - %
120%
100%
80%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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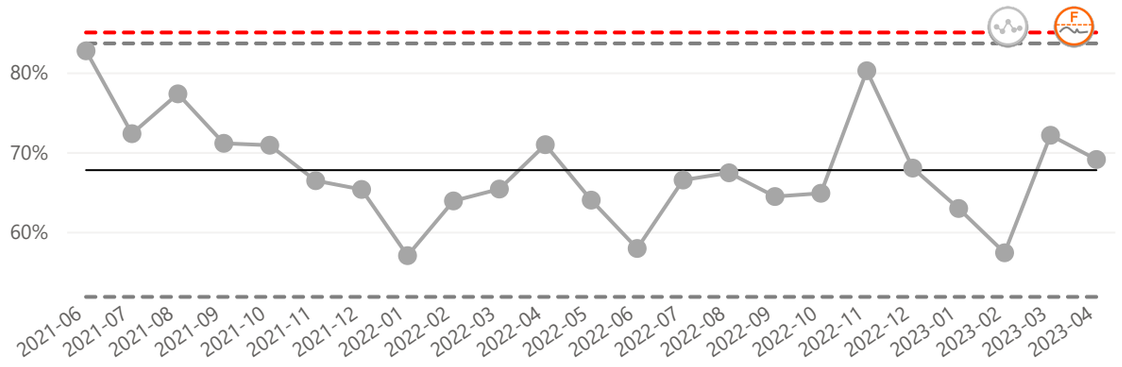
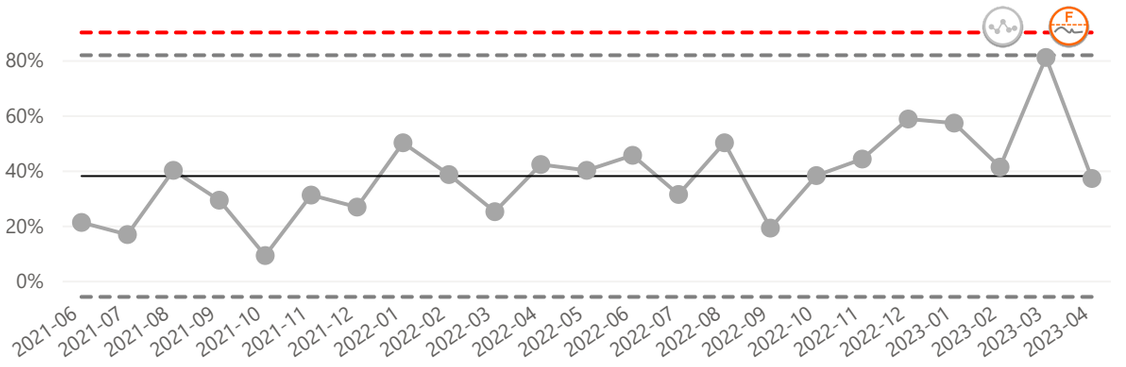
2023-04

Operations

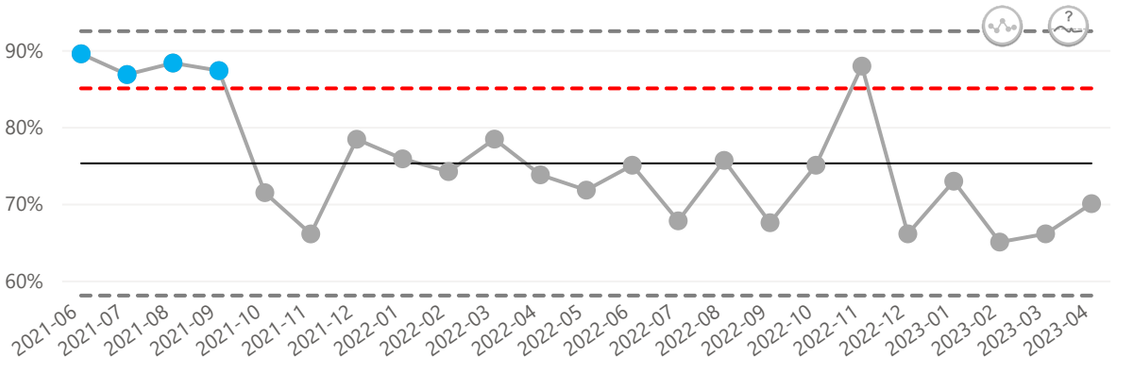
62 Days GP Referred (Classic) - %



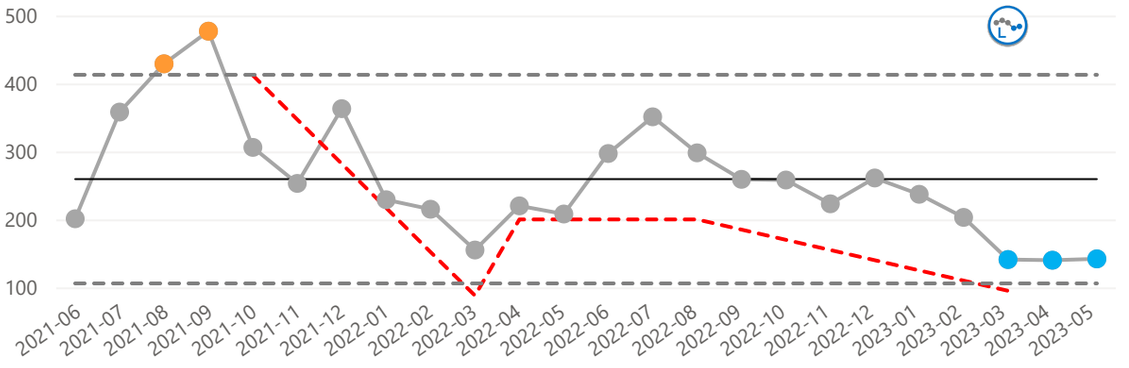
62 Days National Screening - %



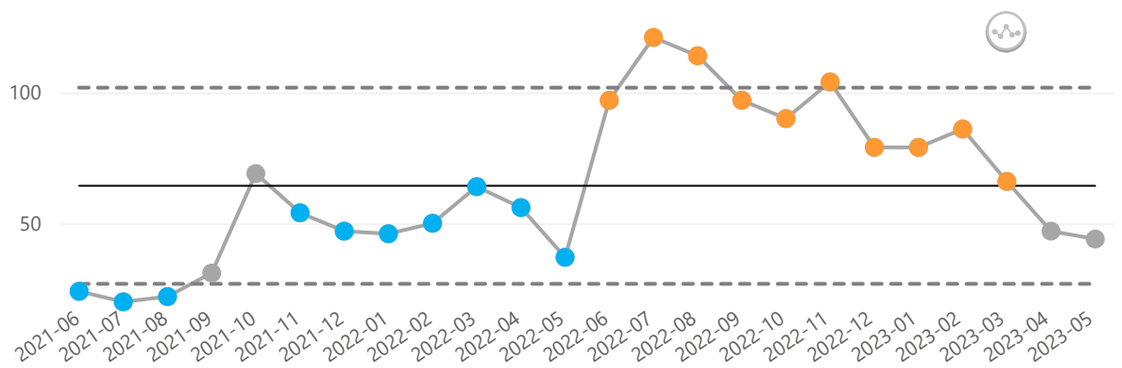
62 Days Consultant Upgrade - %



62 Days - GP Referred (Classic) Open Pathways >62 Days



62 Days - GP Referred (Classic) Open Pathways >104 Days



Blackpool Teaching Hospitals
NHS Foundation Trust

Productivity

Outpatient Slot Utilisation:
Assure
• Vacant slot report is utilised daily to ensure all slots are filled
• 6-4-2 meetings are now established in Ophthalmology, Orthopaedics and ENT
• 7 day and 1 day text reminders fully embedded to ensure patients are fully informed regarding their appointment
Advise
• No standby list available within the current PAS therefore difficult to backfill very last-minute cancellations. The implementation of a new PAS addresses this current issue.
Alert
• The calculation of clinic utilisation is currently a manual process and is therefore open to errors

Patient Initiated Follow Up (PIFU):
Assure
• PIFU is currently live in 5 specialties (Rheumatology, Pain Management, Paediatrics, Ophthalmology, Trauma & Orthopaedics)
• ENT and Urology are currently piloting PIFU
• PIFU is reported through the PIFU Dashboard, and all patients tracked
• Follow up waiting list to be discussed at June's Outpatient Programme Board to identify areas where PIFU would support the reduction in the follow up waiting list
Advise
• NHSE PIFU Sprint Event through July-23 will help inform best practice and any new specialties to explore
• Work commenced with General Surgery, Gastroenterology, Gynaecology regarding identifying suitable PIFU pathways
Alert
• BTH is currently Projecting 3.2% against the 5% target by Mar-24 for patients on an active PIFU Pathway

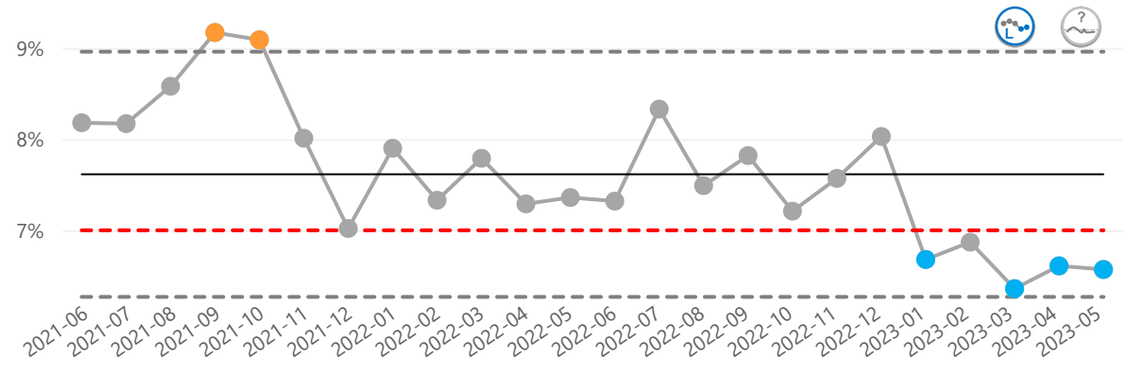
Theatre Utilisation:
Assure
• Theatres process mapping completed with engagement of clinical teams. Positive feedback from theatres staff around being involved in identifying issues and solutions. Output currently being analysed and themed to support improvement programme focus.
• Identification of Ophthalmology as first task and finish group around cancellations on the day which is clinically supported.
• Commenced roll out this month of 1:1 meet with waiting list team and operating surgeon to ensure lists are planned to be fully utilised.
Advise
• List utilisation impacted by Vascular LTH, Podiatric Surgery and Community Dental, Gynaecology therefore links will be made with these services to support optimal utilisation of lists.
• Capped utilisation (SACCT theatres) is 5-7% lower than uncapped and this relates to start /end time. Review of official session start times has been considered in other Trusts and will be explored at BTH.
Alert
• Capacity issues with pre-operative capacity is reducing opportunities to ensure patients are optimised prior to surgery and low number of pre-op ready patients on waiting lists
• Non elective orthopaedics (trauma) increasing demand resulting in cancellation of elective activity and impacting theatre utilisation data.
• CDCU continues to be escalated due to UEC pressures which impacts on flow of elective work.

Operations

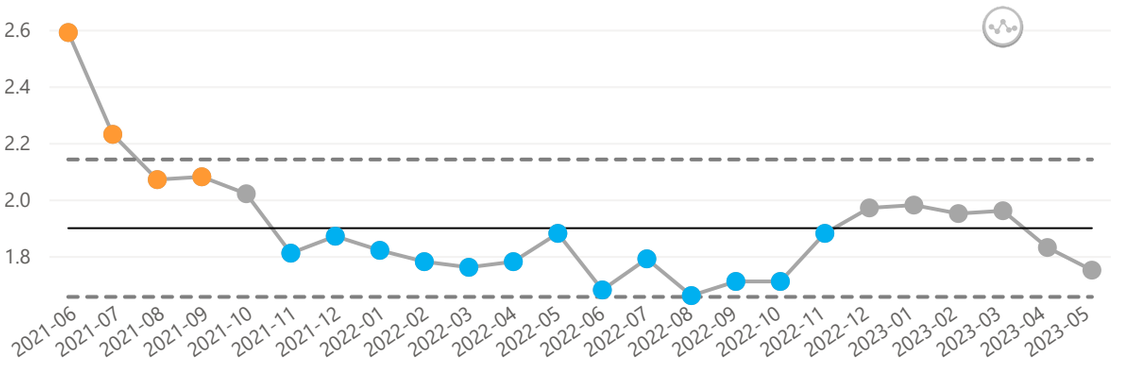
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
DNA rate (OPD) %	7%	6.57%	May 23	L	?	7%	6.61%	Apr 23		
New:Follow Up rate		1.75	May 23				1.83	Apr 23		1.75
OP Slot Utilisation	95%	93.6%	May 23		?	95%	95.0%	Apr 23		
ED Conversion Rate		37.8%	May 23				39.6%	Apr 23		
Bed Occupancy - BTH	85%	93.3%	May 23		F	85%	92.4%	Apr 23		
Stranded Patients (>6 Days LOS)		329	May 23				311	Apr 23		329
Super Stranded Patients (>20 Days LOS)		109	May 23				116	Apr 23		109
Theatre Utilisation, All Specialties, Urgent & Elective	85%	76.0%	May 23		F	85%	73.5%	Apr 23		
Data Quality Maturity Indicator	82.5%	91.3%	Feb 23	H	P	82.5%	91.1%	Jan 23		
Depth of Coding		5.14	Mar 23	L			6.95	Feb 23		5.14
PIFU Open Pathways	5%	0.37%	May 23		F	5%	0.2%	Apr 23		

Operations

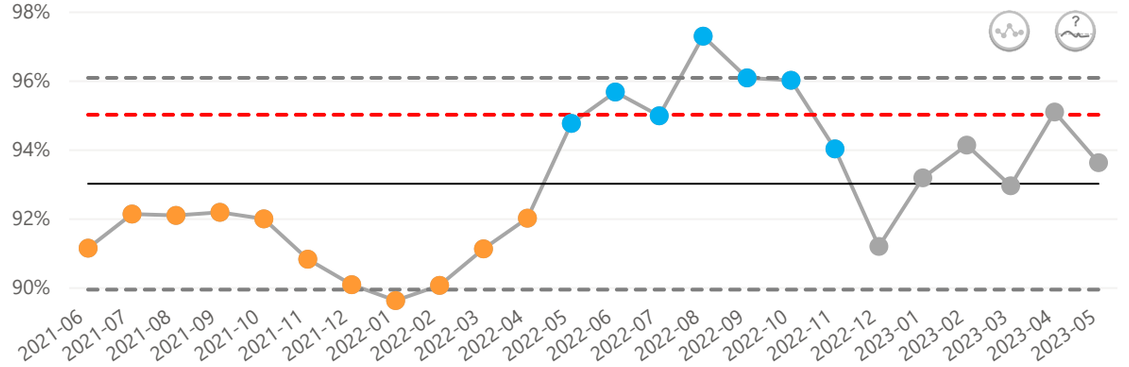
DNA rate (OPD) %



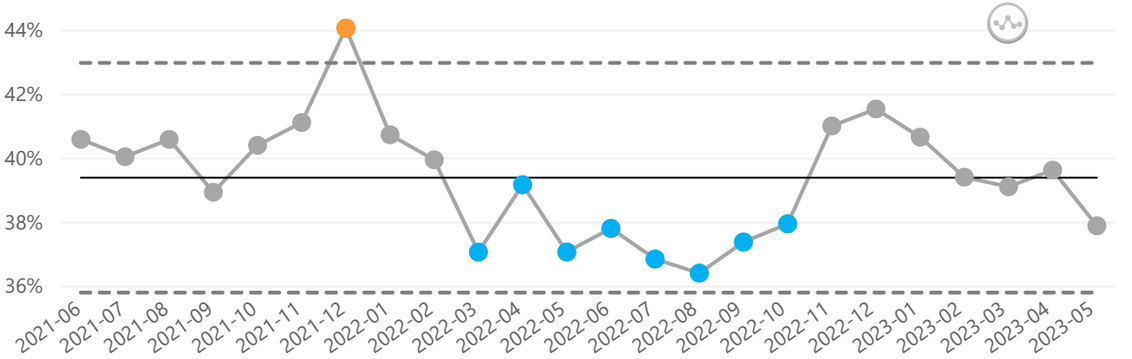
New:Follow Up rate



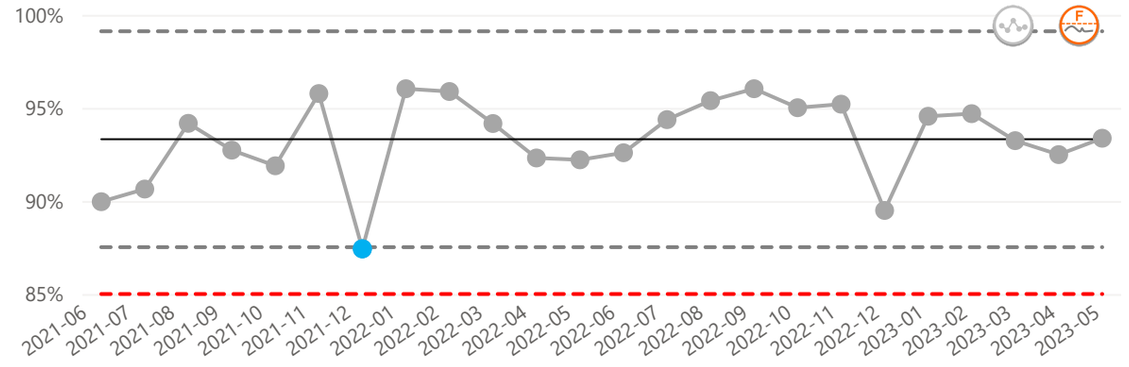
OP Slot Utilisation



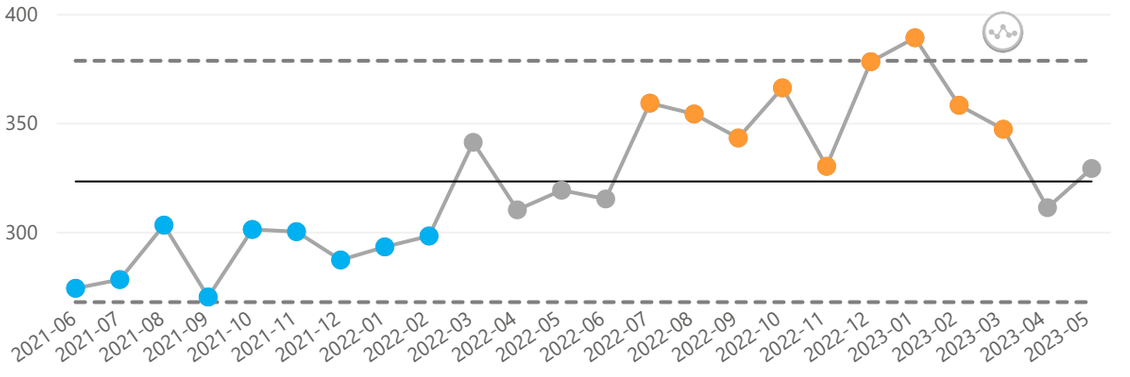
ED Conversion Rate



Bed Occupancy - BTH

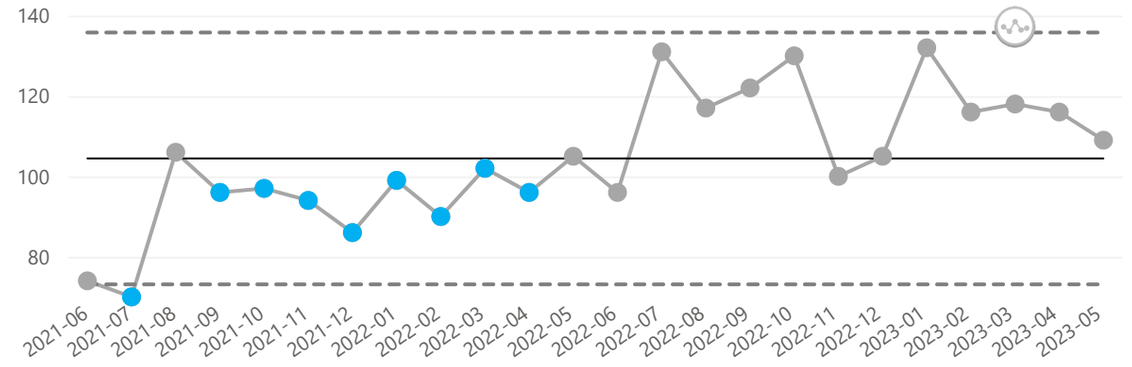


Stranded Patients (>6 Days LOS)

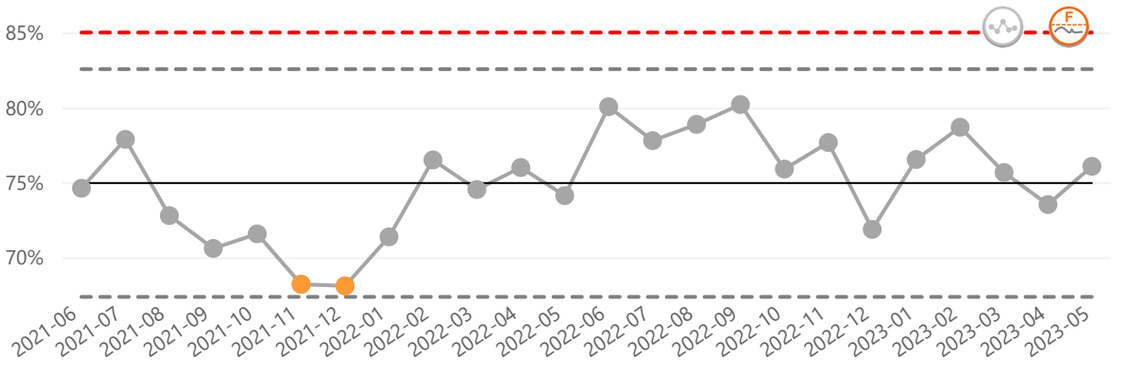


Operations

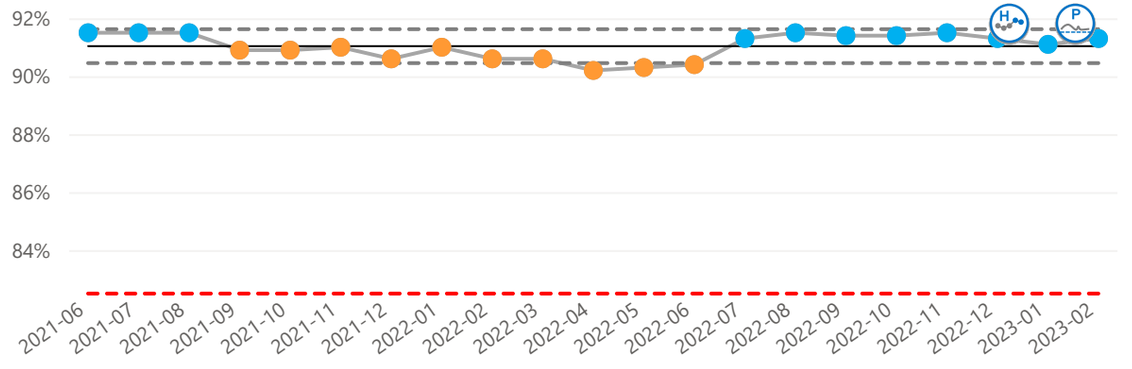
Super Stranded Patients (>20 Days LOS)



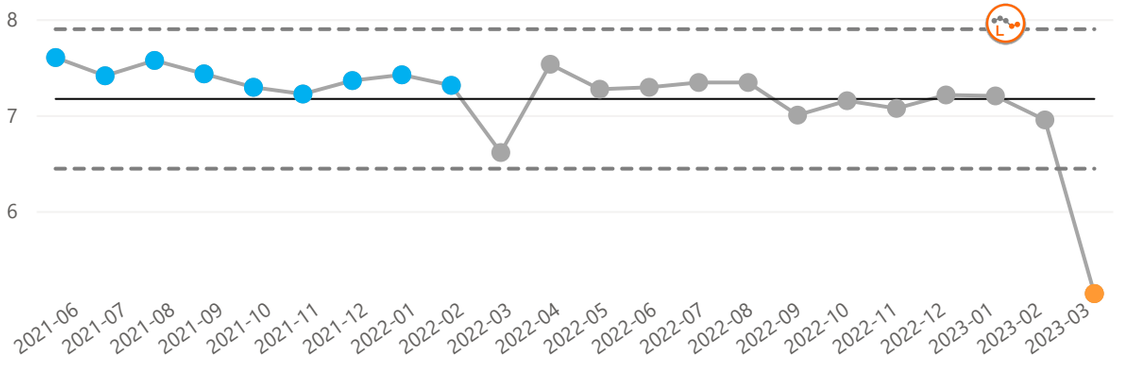
Theatre Utilisation, All Specialties, Urgent & Elective



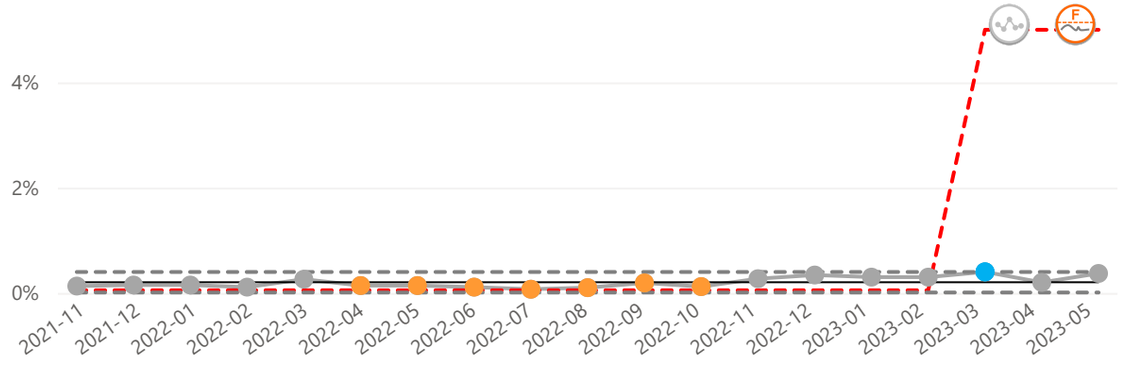
Data Quality Maturity Indicator



Depth of Coding



PIFU Open Pathways



NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Workforce Assurance Committee Escalation Report

Meeting:	Board of Directors in Public
Date:	5th July 2023

Author	Esther Steel, Director of Corporate Governance					
NED Sponsor	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 17th May 2023.

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)*	The Board of Directors is asked to note the Workforce Assurance Committee Escalation Report.

Committee/Group Chair's Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	**Report to:**	Board of Directors
Date of Meeting:	17 May 2023	**Date of next meeting:**	Workshop 21 June 2023
Chair:	C Fitzsimons	**Parent Committee:**	Board of Directors

Introduction		
Quorate meeting in person with some members on Teams -		
Alert		
What	**So, What**	**What Next**
No issues identified for escalation of risk		
Assure		
What	**So, What**	**What Next**
Staff Story A junior doctor attended to provide a story of his experiences at the Trust since August 2021 – he felt welcomed and supported but experienced challenges of busy shifts –he has noticed an improvement in senior support since starting in post. Now appointed as Senior Registrar – pros and cons of not being on the on call rota Key points raised: Implications of remaining on virtual training since – harder to engage since pre Covid - more of an effort for face to face training since Covid Variability in the quality of supervision – impact of locum consultants on supervision quality. Positive feedback on opportunities to speak up and be listened to	Committee members posed a question about recruitment challenge –identified as geography, and challenging work but lots of strong points – the QI approach was important – strong selling point and excellent training. A reflection was provided about different practices in different areas with very positive feedback provided about his time with the IMPF division. Good scope for development of services – potential to develop further People of Blackpool deserve good care – play to the strengths of the Trust and the opportunities to help	How do we use our people to help us recruit and retain Quick win –better time for feedback sessions Big hope – more face to face activities for team building IMPF division catching up with Alex before he leaves Discussed use of staff stories in recruitment – have a cohort of people who share and interact with trainees to promote the Trust. Challenges are geography and reputation – more work to do to sell the organisation. Actions to understand factors impacting on junior doctor placements

Committee/Group Chair's Report

Blackpool Teaching Hospitals NHS Foundation Trust

Workforce IPR Core skills under target but slight increase, on track with the majority of trajectories Appraisals – monitored through PIDA, check challenge and coach in all divisions with localised approach	Discussed the appraisal target – challenge if high enough – target is aligned with others and includes staff who are on mat leave etc. Also recognised the need for high quality appraisal Discussed turnover rates in different staff groups including adaptation nurses and the steps taken to retain staff in the right areas. Detailed discussion on the appropriate metrics to monitor to provide assurance and triangulate with quality and financial metrics	Noted importance of regular conversations with managers and the importance of regular conversations in changing culture. Expect recruitment gap for nurses to be addressed by August – Nurse and AHP staffing report will provide the detail of vacancies and recruitment. Need to understand attrition rates and evaluate actions. IPR will include a high level dashboard to triangulate metrics, medical recruitment metrics to be included.
Culture Improvement Update/Staff Survey Presentation covering the factors that impact on culture, the metrics that might give an insight into culture and an overview of Trust metrics including latest staff survey result metrics on speaking up and responses to speaking up Healthy Teams MDT – targeted approach to focus on key areas to promote best practice and give managers the tools to lead	Noted the increase in people who have been able to speak up – what do we do about it Importance of being excellent not just average – need to be able to differentiate Blackpool – demonstrate that take issues seriously – differentiate. How will we see responses and how will we identify hot spots for focus – pulse surveys to be used as an indicator Discussion points - how do we model the right behaviours – do we all agree the values and behaviours. The Committee also asked the question around consequence – ie what happen to leaders who do not want to change behaviour to meet the requirements of the culture plan WAC will need to understand how the Trust will successfully tackle apathy /disengagement in low scoring areas	Update in future months on how this is progressing – what would excellence look like and how do we drive towards it - Should be an aspiration for excellence not just average Refresh of objectives Next workshop is on engagement Culture dashboard to be developed with the proposed metrics Culture strategy to July Board
Advise		
What	**So, What**	**What Next**
Leadership and management development		Update noted - to be part of the June discussion

Briefing provided on the development of a Triumvirate leadership programme		
Revalidation and appraisal Update provided on previously agreed actions	How do we hold people to account to ensure that performance against job plans is measured Debate about job plans, environment	Committee extended thanks to Report back to next formal meeting

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Workforce Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	5/07/2023

Author	Louise Ludgrove, Executive Director of People & Culture					
Exec Sponsor	Louise Ludgrove, Executive Director of People & Culture					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					
Summary *(what)*	**Workforce Performance** **Core Skills** 91.06% against a target of 95% **Appraisal** 74.49% against a target of 90% **Sickness Absence** 5.56% **(May)** 6.56% (Rolling twelve months)					

Previously considered by	NA

Implications *(so what)*	We have seen improvement in all workforce indicators.

Link to strategic objectives	Our People	ü
	Our Population	ü
	Our Responsibility	ü

EDI implications considered	The Workforce team consider the EDI implications of the metrics

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

Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Workforce Committee

May 2023

Caring ▪ Safe ▪ Respectful

Guide to Statistical Process Control

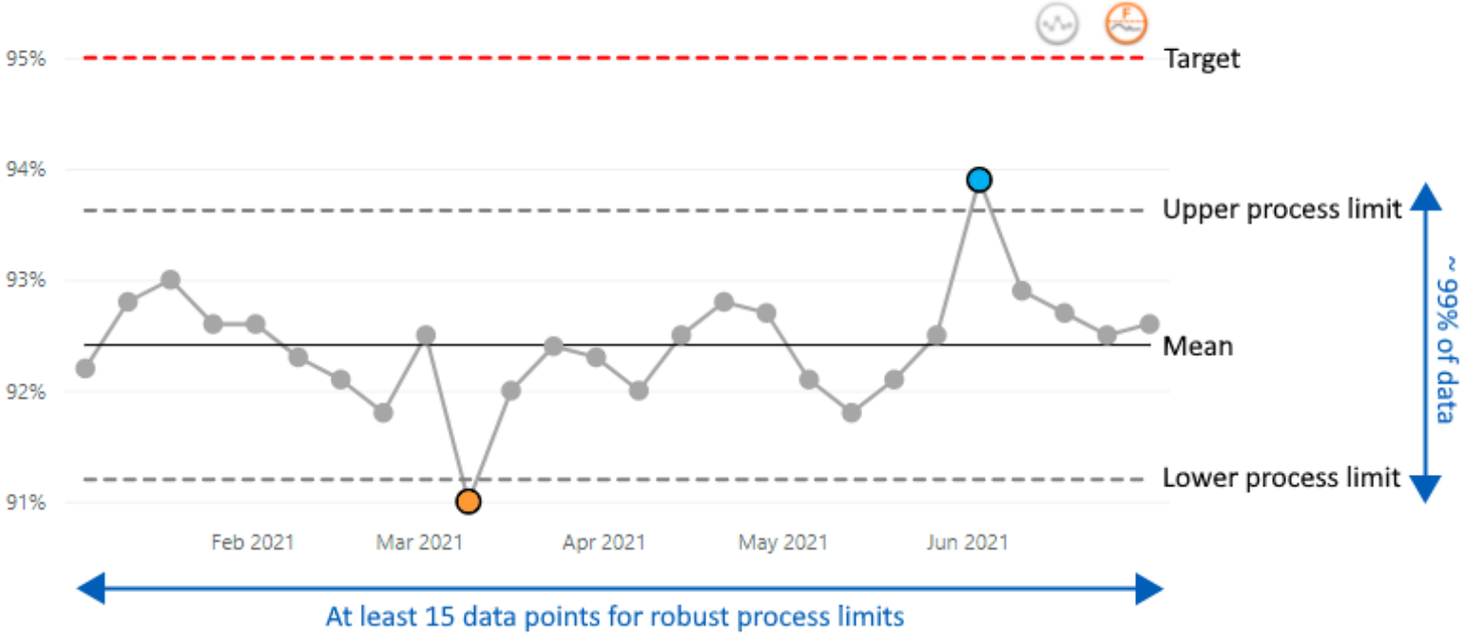
Blackpool Teaching Hospitals NHS Foundation Trust

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		1	2	3	2		1		3
	Sickness, Vacancy and Turnover	4	5	5			3	6	5	

Assurance

Measures the likelyhood of targets being met for this indicator.

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

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

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.

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.

Blackpool Teaching Hospitals
NHS Foundation Trust

Organisational Development

Core Skills
Assure:
• Trust compliance in May 2023 was 91.06%, a slight increase from April 2023 (90.52%). This is against a target of 95%
• Although compliance has increased, there was a mixture of divisions that had increased, whilst others decreased.
• A similar pattern is noted when role specific training is also included
• Compliance with core skills training is monitored monthly at the divisional PIDA meetings and appropriate action plans implemented
• The Trust is in the process of re-aligning its Core Skills programme to the national CSTF. It was highlighted that the Medical Workforce were not aligned with the M&H training refresh recommendations. CSTF prescribes a refresh should take place every 2 years, however at BTH the medical workforce completes every 3 years.

Advise:
• The medical workforce has been informed that they will be required to complete M&H level 2 training every two years instead of every 3 years.
• A M&H L2 e-learning package has been developed and launched in May. This will help to reduce the need for staff to attend a full training session. If there is a M&H champion in their areas, they can have the required competencies 'signed off' through observation or simulated environment.
• If there is not a champion in the area, staff can book onto a reduced 2-hour session.
• There is now a dedicated M&H training rooms; more training can be delivered.
• The distribution of champions is to be looked at and a targeted approach for areas that do not have a champion or those who may need additional resources
• Review of the Trust's approach to role specific training taking place. The next meeting is to discuss requests to add training competencies to ALL staff. If approved these will be escalated to the WAC for agreement.
• An external trainer was sourced to deliver practical face-to-face Conflict Resolution Training. 118 members of staff were trained.
• Face-to-face Conflict Resolution Training is to be discussed at the next CSTF Steering group to attempt to reduce the waiting list (currently 5141 members of staff are allocated the training, with 2758 non-compliant). Discussion to take place as to which staff groups definitely require the training, and then a risk-based approach to be taken for further training requirements.

Alert:
• Medical workforce compliance for M&H level 2 training will reduce when the ESR team make the changes to the system.
• The Trust continues to see lower compliance rates in those subjects that require face to face training. This is due to several reasons including addressing the back log generated by standing down training during the Covid pandemic, room availability and non-attendance of clinical staff at training due to operational pressures

Organisational Development

Non-Medical Appraisals compliance

Assure:

- Non-medical appraisal compliance is currently at 74.49%, with a target of 90%. This is a slight increase from April (73.91%)
- Clinical divisions that have seen an increase in non-medical appraisal compliance levels are: • CSS - 64%-66%, • Tertiary –76%-79%
- Clinical divisions who have had a decrease in compliance or stayed the same are: • FICC - 80%-78%, • IMPF –77%-77%, • SACCT –79%-79%

Advise:

- New streamlined appraisal system will be launched before the end of 16 June 2023
- A comms strategy will be introduced to inform staff of the changes
- Champions will be re-engaged to support disseminating the changes and promoting regular and meaningful conversations between managers and staff.
- Training dates will be advertised.
- There is an appraisal guide on the appraisal system and help on completing each section.
- Documents on the appraisal system will be re-devised to ensure neurodiverse individuals are not challenged by the appraisal system.

Alert:

- There may be a reduction in compliance levels during the transition from the old appraisal system to the new appraisal system

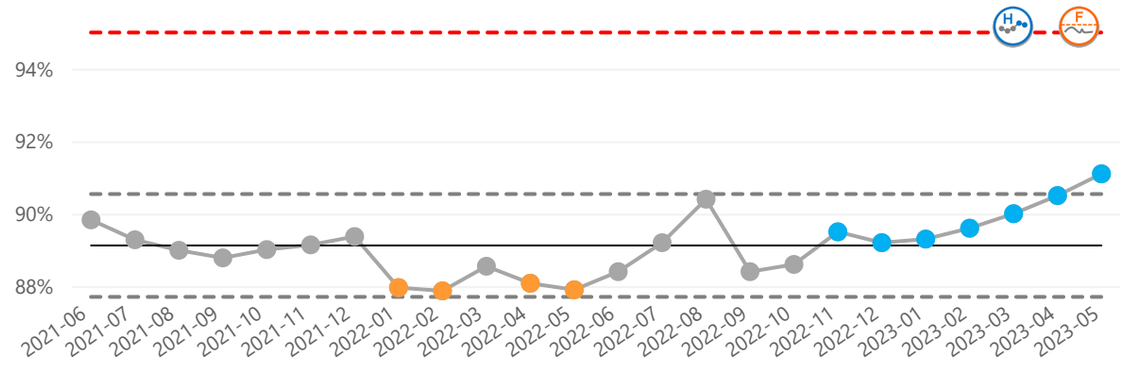
Workforce

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Core Skills Training Compliance %	95%	91.1%	May 23			95%	90.5%	Apr 23		
Data Security & Awareness Training (%)	95%	95.5%	May 23			95%	95.1%	Apr 23	95%	95.5%
Appraisal Completeness %	90%	74.6%	May 23			90%	72.3%	Apr 23		

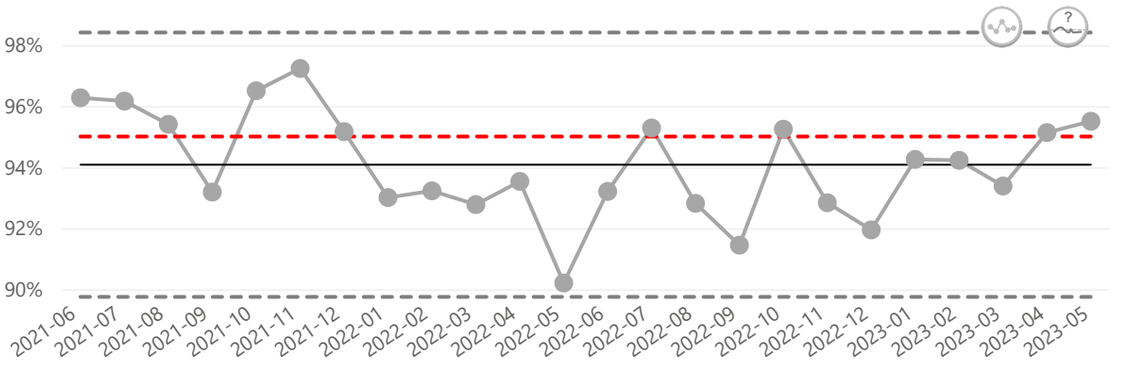
Indicator	2017-04	2018-04	2019-04	2020-04	2021-04	2022-04
Staff Survey - Care of my patients / service users is my organisations top priority	72.40%	72.70%	73.80%	78.70%	77.20%	74.00%
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	66.30%	65.20%	63.20%	69.30%	65.30%	59.00%
Staff Survey - I would recommend my organisation as a place to work	61.10%	62.10%	62.00%	68.10%	64.30%	60.00%

Workforce

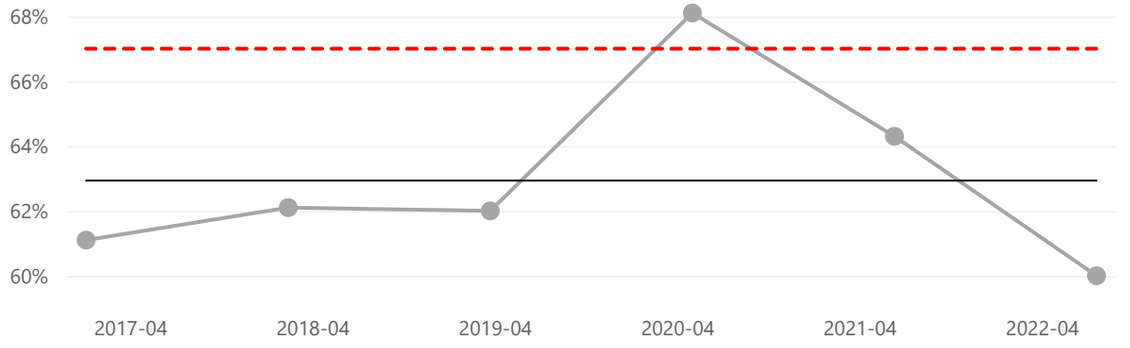
Core Skills Training Compliance %



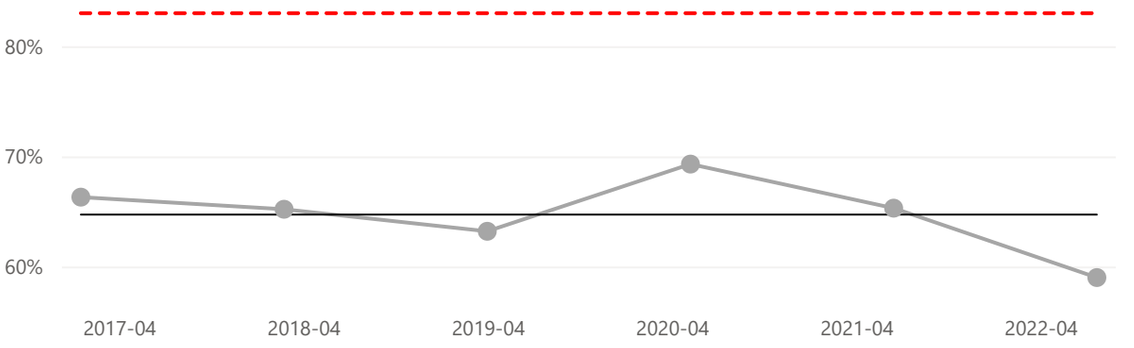
Data Security & Awareness Training (%)



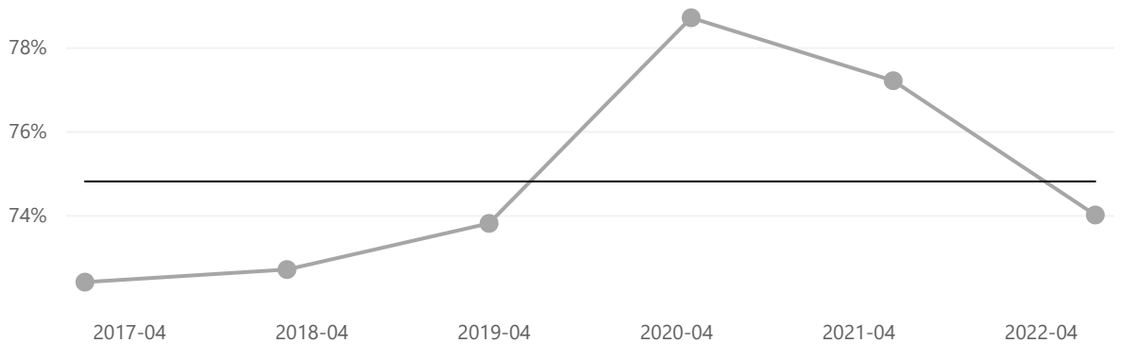
Staff Survey - I would recommend my organisation as a place to work



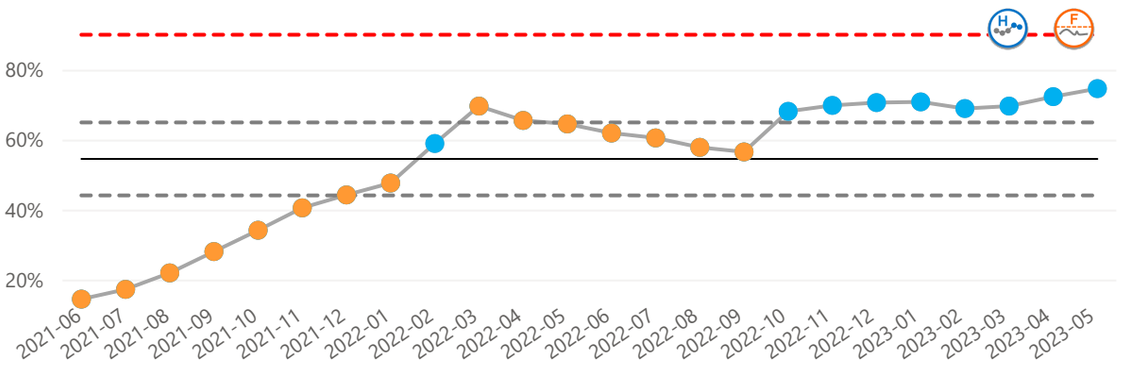
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



Staff Survey - Care of my patients / service users is my organisations top priority



Appraisal Completeness %



Blackpool Teaching Hospitals
NHS Foundation Trust

Sickness, Vacancy and Turnover

Sickness:
We have seen a slight decrease of 0.7% in the sickness absence percentage this month taking the figure to 5.56%. The largest reason for sickness absence in May remains the same as previous months and is related to Anxiety/stress and depression and the second largest reason for sickness absence is injury/fracture. Due to this, both the top reasons for short term and long term absence relates to stress/anxiety with 27.44% relating to short term absences and 36.03% to long term. Other reasons for short term absence include injury and fracture and gastro problems. Long term includes MSK and Injury/fracture.

We have seen a reduction in sickness across the Trust with sickness percentages in divisions and directorates as follows:
CHIEF EXECUTIVE 0.00% | CHIEF OPERATING OFFICER 3.10% | CLINICAL EDUCATION 7.24% | CLINICAL GOVERNANCE 7.61% |
COMMUNICATIONS 23.13% | CORPORATE GOVERNANCE 5.48% | CLINICAL SUPPORT 4.70% | FAMILIES & INTEGRATED COMM CARE 5.31% |
FINANCE, PROCUREMENT & AUDIT 3.79% | FM & EMERGENCY PLANNING 6.43% | INTEGRATED MEDICINE PATIENT FLOW 7.09% | MEDICAL DIRECTOR 0.00% |
PEOPLE & CULTURE 4.78% | PLANNING, TRANSFORMATION, STRATEGY & DIGITAL 2.62% | R & D 3.11% | SURGERY, ANAESTh'S, CC & THEATRES 5.53% |
TERTIARY SERVICES 4.94%

Actions:
• Targeted approach to staff absent with anxiety/stress/depression –deep dive to understand specific reasons for absence under this category. This will provide reassurance that staff are receiving correct support to aid recovery.
• Review of the top 50 sickness absence cases both short term and long term across the Trust
• Continue to review annual leave utilisation across the divisions to ensure adequate rest periods for staff
• Identify hot spot areas for targeting support for managers within these areas who require support to manage complex attendance cases
• Ensure every member of staff has received a health and wellbeing conversation with their manager
• The Fast Track process (EASE) is now in place to manage the Early Access to Support for employees with MSK or mental health conditions
• A review of all long term sickness cases to ensure they are being picked up at the 28 day stage and supported within HR and HR are pro-actively contacted managers at this stage to offer support. On analysis of data this has shown an improvement in sickness and support for staff.
• Targeted approach to divisions where sickness absence percentage is high. Weekly meetings with the managers to help support proactive management of cases
• The Healthy Teams MDT continues to meet weekly to identify teams in need and to facilitate support within these areas

Vacancy Rate:
Alert:
• Our vacancy rate has increased significantly, this is due to substantial establishment increases for both nursing 144.2 wte and Medical and Dental 59.19 wte with a total increase in establishment of 465.83 from the start of the financial year. This has resulted in a vacancy rate for M&D of 18.1%, and Nursing of 9.88%.

Turnover
Assure:
• Turnover continues to be low, with all metrics below the 11% maximum target and turnover for all staff groups at 7.9% (April was at 8.17%).
• Nursing turnover was 6.1% the lowest it has been for over 12 months, although medical increased slightly between April and May to 9.44% this is still much lower than 12 months ago when it was almost 14%.
• There were just 3 medical and dental leavers in May, 2 retired and one has relocated overseas. 14 nursing and midwifery staff left the organisation (12.49 wte) – 9 retired, with 6 of those who will return, 3 Resigned to relocate, and 1 resigned due to work life balance. Regrettably 1 also died.

Time to Hire:
Assure:
• Average time to hire is currently 9.04 weeks, which is a slight improvement from the position in April which was 9.78 weeks against a target of 12 weeks. This continues an improving trend since February 2023.

Workforce

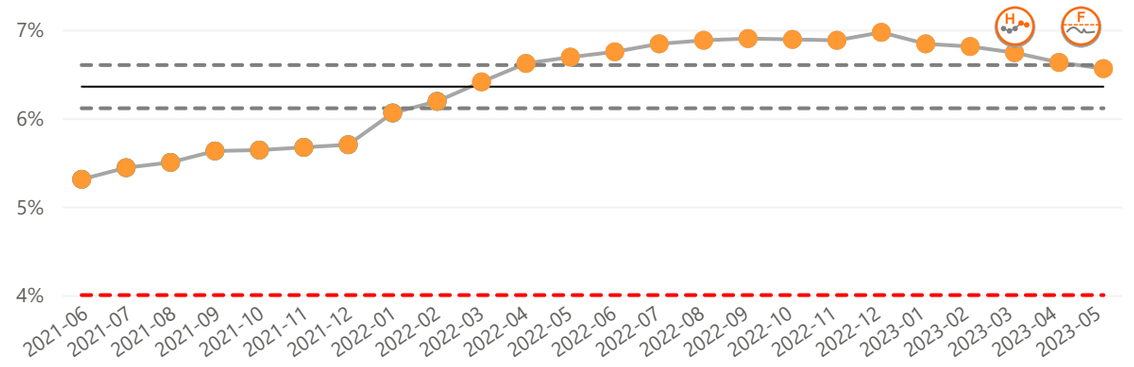
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Sickness % - Rolling 12 Months	4%	6.56%	May 23	H	F	4%	6.63%	Apr 23		
Sickness % - All Staff (In Month)	4%	5.56%	May 23		F	4%	6%	Apr 23		
Sickness % - Medical Staff (In Month)	4%	2.43%	May 23		?	4%	2.02%	Apr 23		
Sickness % - Nursing Staff (In Month)	4%	5.55%	May 23		F	4%	6.74%	Apr 23		
Sickness % - AHP (In Month)	4%	4.2%	May 23		?	4%	4.61%	Apr 23		
Sickness % - Not related to Covid 19 Trust (In Month)	4%	5.23%	May 23		F	4%	5.3%	Apr 23		
Turnover % - All Staff (Rolling 12 months)	11%	7.9%	May 23	L	P	11%	8.17%	Apr 23		
Turnover % - Nursing & Midwifery (Rolling 12 months)	11%	6.1%	May 23	L	P	11%	6.28%	Apr 23		
Turnover % - AHP (Rolling 12 months)	11%	7.46%	May 23	L	P	11%	7.63%	Apr 23		
Vacancy Rate % - All Clinical Staff	4.28%	7.89%	May 23	H	?	4.28%	2.28%	Apr 23		
Vacancy Rate % - Medical Staff (Excluding Deanery Drs)	4.28%	18.1%	May 23	H	F	4.28%	10.5%	Apr 23		
Vacancy Rate % - Nursing & Midwifery Staff	4.28%	9.88%	May 23	H	?	4.28%	4.31%	Apr 23		
Vacancy Rate % - AHP	4.28%	11.5%	May 23	H	?	4.28%	7.01%	Apr 23		

Workforce

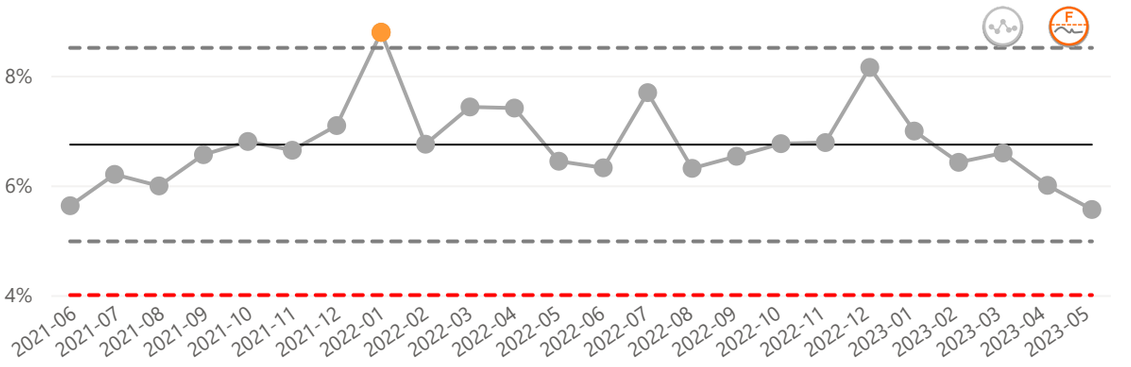
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Time to Recruit (Weeks)	12	9.04	May 23			12	9.78	Apr 23	12	9.04

Workforce

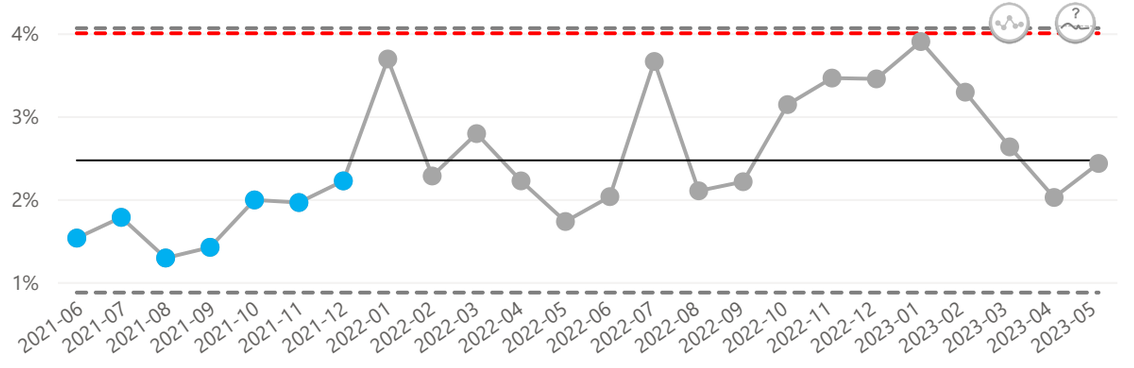
Sickness % - Rolling 12 Months



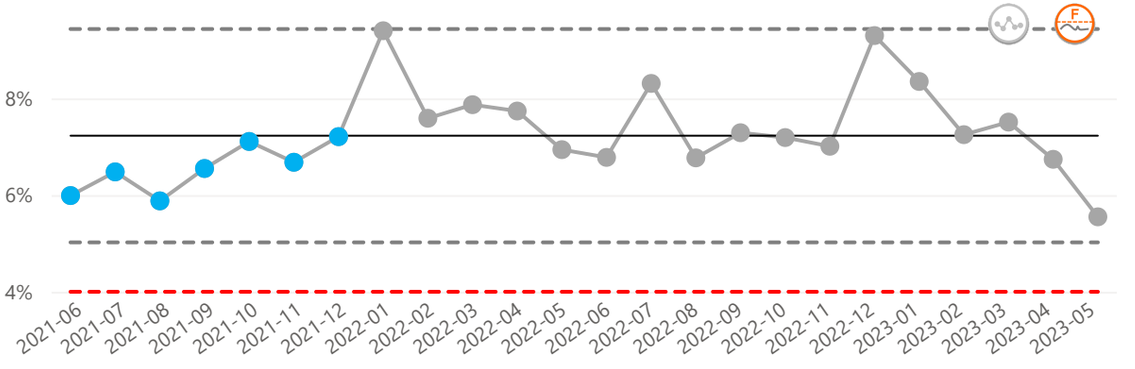
Sickness % - All Staff (In Month)



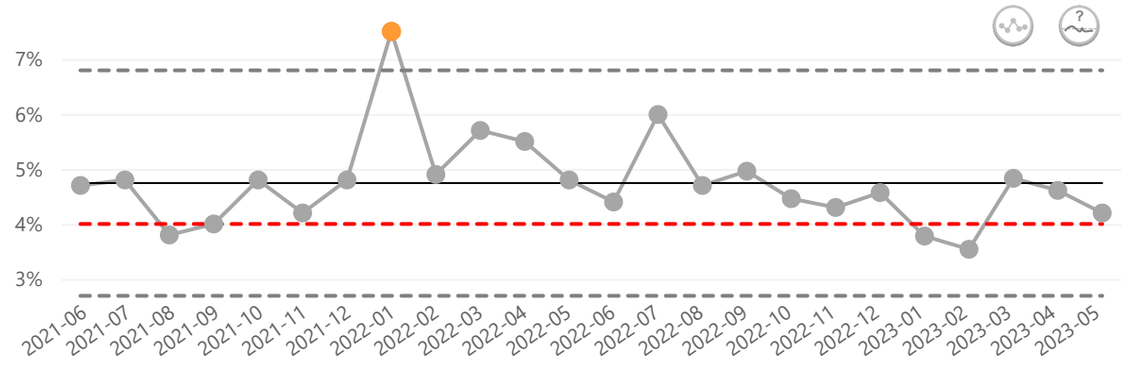
Sickness % - Medical Staff (In Month)



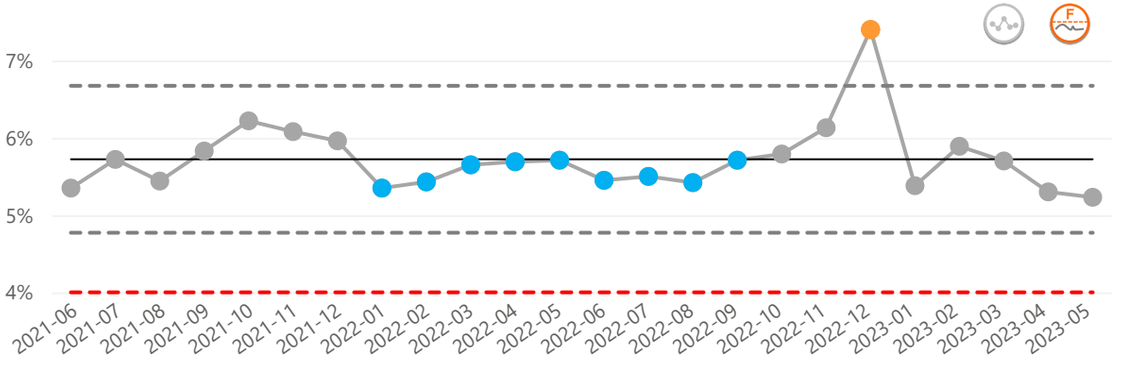
Sickness % - Nursing Staff (In Month)



Sickness % - AHP (In Month)

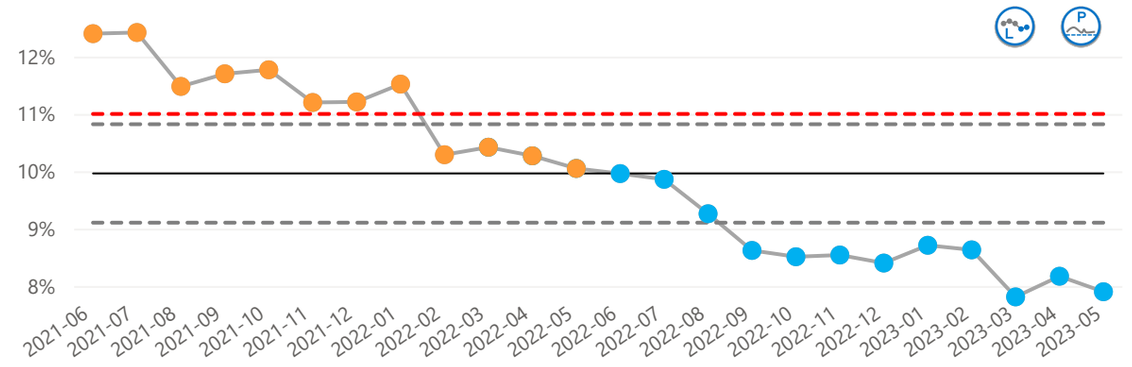


Sickness % - Not related to Covid 19 Trust (In Month)

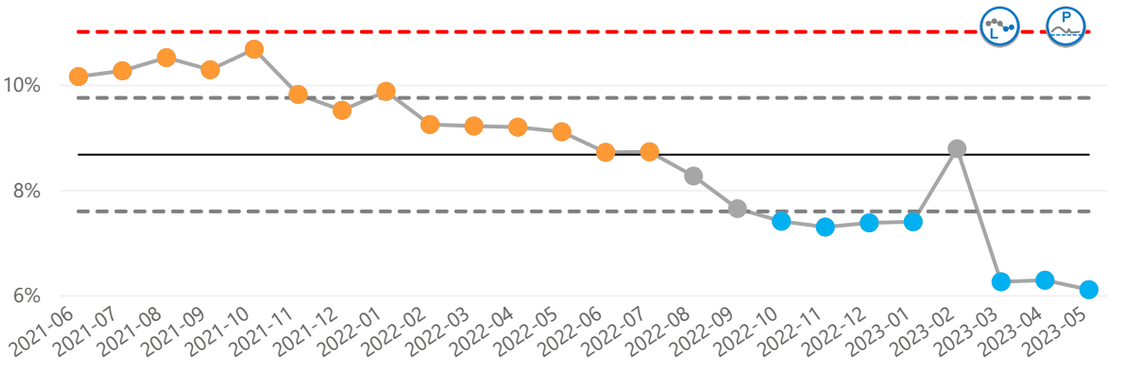


Workforce

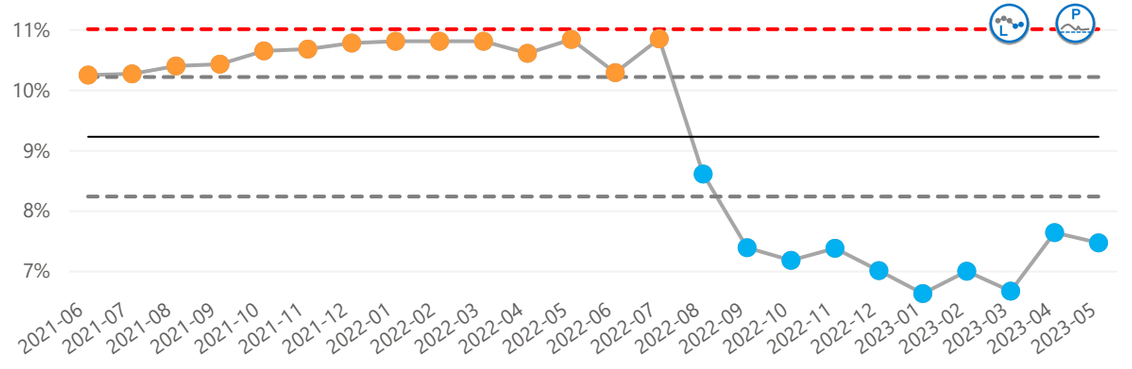
Turnover % - All Staff (Rolling 12 months)



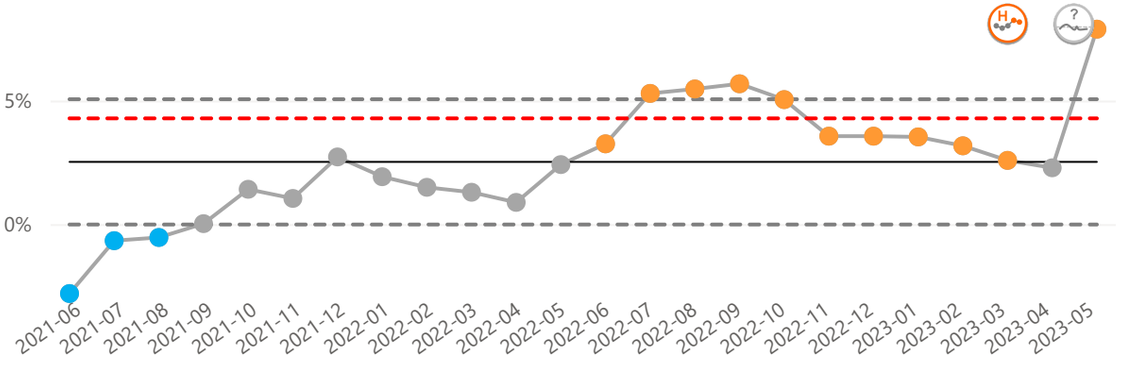
Turnover % - Nursing & Midwifery (Rolling 12 months)



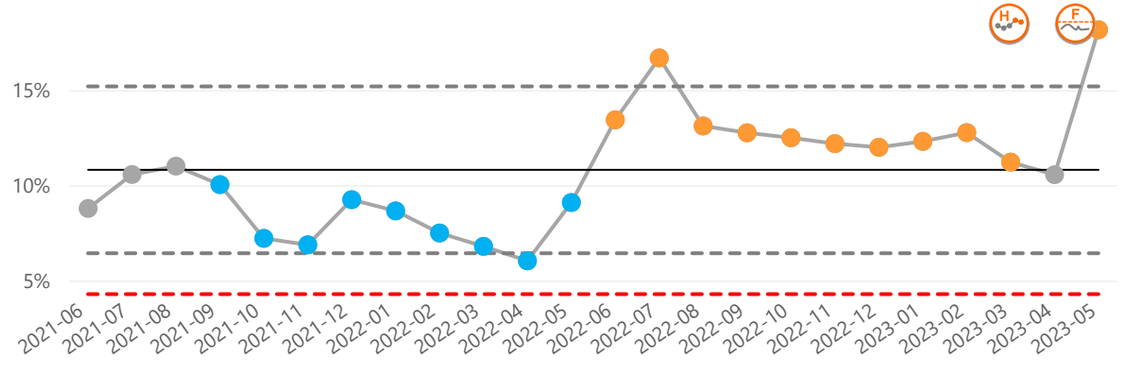
Turnover % - AHP (Rolling 12 months)



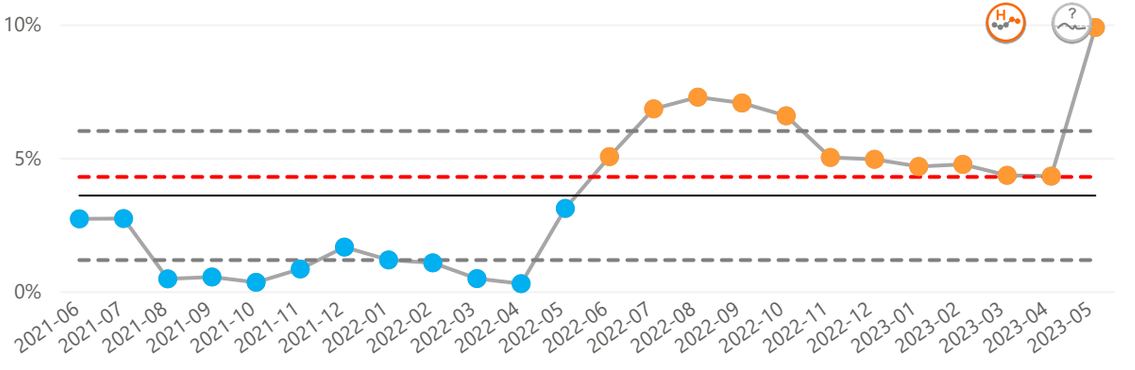
Vacancy Rate % - All Clinical Staff



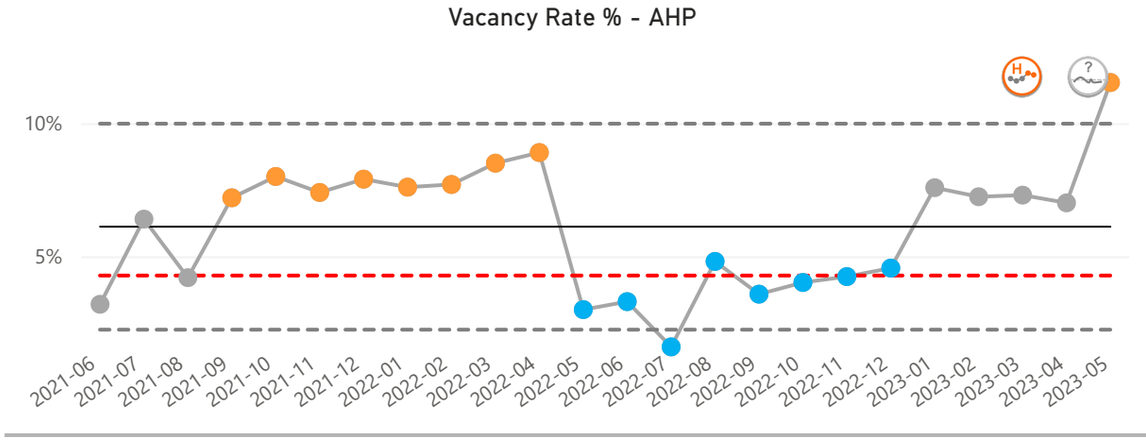
Vacancy Rate % - Medical Staff (Excluding Deanery Drs)



Vacancy Rate % - Nursing & Midwifery Staff



Workforce


Vacancy Rate % - AHP
10%
5%
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
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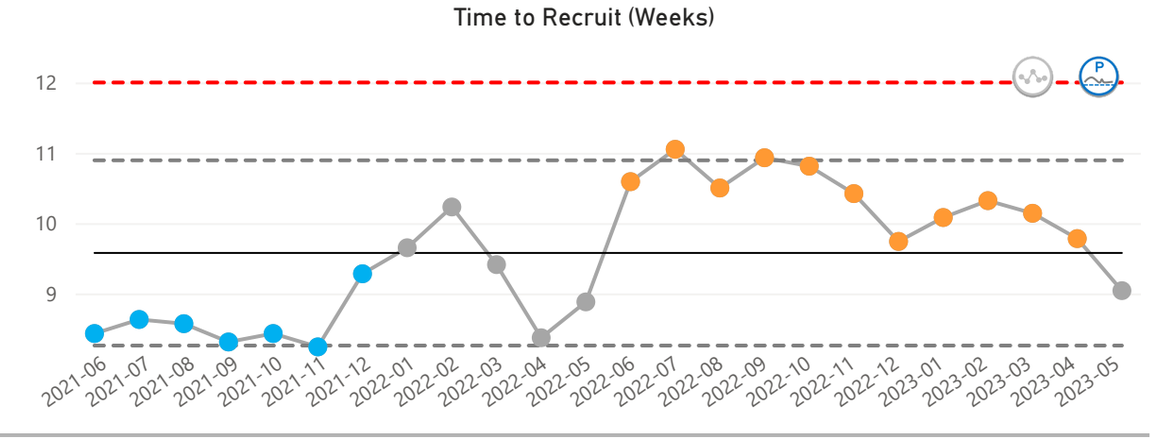
2023-01
2023-02
2023-03
2023-04
2023-05


Time to Recruit (Weeks)
12
11
10
9
2021-06
2021-07
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Audit Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	5th July 2023

Author	Esther Steel, Director of Corporate Governance					
NED Sponsor	Fiona Eccleston					
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 Tuesday 13th June 2023. Two areas were highlighted for escalation to Board of Directors including External Audit Report and Internal Audit Follow-Up Report. There will be a short meeting of the Audit Committee immediately after the July Board meeting to review and approve the Annual accounts and Annual Report

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)*	The Board of Directors is asked to note the Audit Committee Escalation Report.

Committee/Group Escalation Report

Name of Committee/Group:	Audit Committee	**Report to:**	Board of Directors Meeting
Date of Meeting:	13th June 2023	**Date of next meeting:**	15th August 2023
Chair:	Fiona Eccleston	**Parent Committee:**	Board of Directors Meeting

Introduction

Quorate meeting held on MS Teams with attendance from internal and external auditors with good engagement from all Committee members.

Alert

What	So What	What Next
External Audit Update Verbal update on status of the external audit report. Full report to be presented to the Extraordinary Audit Committee meeting on 29.06.23. Delays had been experienced in reconciling transactions and some work remained outstanding. Interim DoF confirmed issues would be worked through and an update provided to Committee at the above meeting. The Annual Report had been shared with Deloitte and a review against their checklist had been undertaken. Awaiting feedback.	Risk rating elevated due to changes in senior finance staff positions and capacity, combined with the reduced forecast deficit. Additional staff allocated to provided independent challenge to the work and conclusion made, possible impact on timescale and delivery. Significant risk had been highlighted in three areas: 1) Management of override control – testing was ongoing 2) Valuation of fixed assets – floor area testing outstanding 3) Accrual balances – work ongoing with BTH Finance Team Two unadjusted items of significance were reported:- 1) Fixed assets and use of vesting certificates. 2) Accrual on AfC pay award for June 2023. The external audit report would highlight the issues raised in relation to: 1) Issues on the purchase ledger interface 2) VfM work weaknesses 3) CQC issues for both 2021/22 and 2022/23, 4) The Trust's financial position	Testing remained ongoing and a possible extension to testing sample on accrual areas, which may impact delivery. Full details on all issue areas to be provided in the Auditor's Opinion longform report. Additional work would have a fee impact, full details once year end work has been completed. The Trust to work alongside Deloitte to work towards meeting the NHSE submission deadlines. Correspondence via email to be provided to the Extraordinary meeting for auditing purposes. Members were asked to send any comments on the Annual Report to the Corporate Governance Team for inclusion in the report.

Internal Audit Follow-Up Report Since the April Audit Committee meeting, twelve recommendations had been implemented in relation to: Sickness Absence Management, Cyber Security Controls, 2 Hour Urgent Community Response (Data Quality), Medical Staff Recruitment and Retention and Payroll/ESR. A total of 57 are to be progressed, 49 of which are not yet due, and 15 of these have a revised date for completion. The remaining ones are being progressed. There remain five old KPMG recommendations outstanding for 2020/21 with an agreed date for completion of end July 2023. Limited assurance had been provided on follow up of IA recommendations.	Proposed for the Trust to have a nominated lead to ensure follow up on IA recommendations. Committee members noted a verbal update on the progress to close old KPMG actions however evidence was still required in order to fully close the actions	The five outstanding KPMG actions to be closed by the end of July 2023. Further discussion to be undertaken to agree the process of follow up. Internal audit protocol has been drafted setting out timescales for ToRs and responses to ToRs.
Assurance		
What	**So What**	**What Next**
Internal Audit Report on CQC Overall moderate level of assurance received with one high-level risk recommendation which related to frequency and depth of updates on the CQC action plan.	Ongoing discussions between Deputy Director of Clinical Governance and MIAA and a timeframe for completion had been agreed. Check and challenge sessions had commenced to provide additional scrutiny from EDs, ICB colleagues and external partners.	Director of Nursing, Midwifery, AHP's & Quality confirmed that the outstanding actions were resolvable and had confidence in the process and actions in place. The audit programme would support the CQC agenda. Evidence and timeline of interventions for the Emergency Department business case would be provided in order to close the associated action from 2021/22.
Head of Internal Audit Opinion HoIA report presented for noting. Moderate level of assurance provided with limited progress on follow ups.	MIAA had provided good summary of reports during the year with relevant ratings.	The AGS to be reported to the Extraordinary Audit Committee meeting on 29th June 2023.

Financial Peer Review Committee was provided with background of the commissioned report.	Completed action plan to be further discussed with the author of the report.	A full update to be provided to Committee in August 2023. To be added to the workplan and remain on the A/C agenda as a standing item until completion. Finance & Performance Committee will monitor progress and receive monthly progress reports to provide oversight.
Annual Report and Accounts The Trust's A/R had been drafted in line with the FT ARM and had been sent for cross-checking against the EA's checklist.		Copy to be provided to the DoCG to ensure alignment and avoid duplication. Members were requested to forward comments to the CGT team.
Governance Self Certification 2023 It was reported that the Trust was compliant with the new Provider Licence.	The required conditions had been complied with and all necessary improvements made to declare full compliance.	Committee approved the declaration and recommended it for approval to Board of Directors in July 2023.
Fit and Proper person Annual Assurance Annual assessment required to be undertaken by the Trust. The DoCG reported that a robust process was in place	It was noted a delay in receiving HR files for new EDs.	Queries to be made to ascertain why there was a delay and lesson learnt to be implemented and added to the internal audit plan for additional level of assurance in line for future CQC well led inspection. Agreed files would be completed and received by end of June 2023.
Register of Interests The DoCG reported a good process in place for all staff. It was noted that the IA audit plan had been reviewed and the IA review for conflict of interests was agreed to be pushed back to 2024/25 and would be replaced with a Fit & Proper Persons review.	A cross check to be undertaken on all declarations, with Companies House, private practice, pharmaceutical sponsorship/hospitality and waivers for conflicts of interest.	The IA audit plan to be amended to reflect that the planned IA review on register of interests be pushed back to 2024/25, and replaced with the IA review for F&PP. Reminders to be sent to consultants to complete declarations. Communications to be sent to all staff to ensure processes are understood. MIAA to provide internal scrutiny on process in 2024/25. Agreed that Ms Senior and DoCG discuss the processes for Atlas staff declarations.
Advise		
What	**So What**	**What Next**

Committee/Group Escalation Report

MIAA Internal Audit Report Members noted that a request had been made to MIAA for two reviews to be pushed back to early Q2 from Q1, agency expenditure and QEP reviews, due to the pressures on Trust's Finance team with year end focus. MIAA provided progress on the details of the concluded 2022/23 plan. The internal Clinical Audit had been deprioritised as a robust audit plan had been set for 2023/24 with robust reporting to the Board of Directors from Clinical Governance Committee.	The Interim DoF advised that progress had been made on both control of agency expenditure and QEP schemes and the audit would be better placed in Q2. Planned reviews ToRs had been circulated for comment with a further two to be circulated.	It was noted that future finance reviews would not be planned for Q1 to allow the Trust's finance team to focus on year end matters. Deputy Director of Clinical Governance to provide the governance reporting processes to committee members.
Board Assurance Framework (BAF) The DoCG provided an overview of the updated BAF format including the ongoing work on the recommendations from a recent IA audit review.	Work was ongoing on modification of the BAF, with links to objectives, impact of not achieving objectives and risks. The BAF would sit alongside the IPR and dashboard to provide additional assurance.	Objectives included agreed BoD objectives and peer review actions. Progress was noted and NEDs present were asked for input. It was agreed that further debate would be required and the BAF would be shared with the Chair for comment and would be the topic of a BoD workshop session.
Data Security and Protection Assessment (DSPT) Report The Deputy CEO (Strategy, Operational Performance, Transformation and Digital) and Chief Information Officer (CIO) provided background on the annual self-assessment audit tool and report. The report highlighted that the Trust had been assessed against 10 National Data Guardian (NDG) standards and achieved a 'substantial Assurance' rating.	B.Digital Programme Board was providing governance oversight on MIAA recommendations, with a bi-monthly report to F&P and updates to Committee. It was noted that a further assessment would be required to be undertaken by Atlas.	CIO to confirm if a second submission would be required for Atlas.

Approach to Effectiveness Review An annual report was required to be presented to BoD on the Committee's, IA, EA and counter fraud effectiveness. The Chair confirmed that a checklist taken from HFMA Audit Committee handbook could be utilised to put a robust process in place and that discussions with the CGT would be undertaken.		Checklist once agreed to be circulated to all members. Deloitte and MIAA were happy to assist with this process. A similar approach to be used for the Counter Fraud effectiveness review.

Title	Governance Self Certification 2023

Meeting:	Board of Directors
Date:	5 July 2023

Author	Esther Steel – Director of Corporate Governance					
Exec Sponsor	Esther Steel – Director of Corporate Governance					
Purpose	Assurance		Discussion		Decision	✓
Confidential y/n	No					

Summary *(what)*	The 2022/23 NHS provider licence condition G6 requires trusts to consider and self-certify for that period whether or not they have: • complied with the NHS provider licence condition • taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)) At their meeting on 13 June, the Audit Committee reviewed a comprehensive report setting out the evidence to approve each of the above – Committee members approved the recommendation to certify compliance with all aspects of the 2013 version of the NHS Provider Licence. On 27 March 2023, NHS England published the new NHS provider licence. The NHS provider licence forms part of the oversight arrangements for NHS providers. It was first introduced in 2013 and has since been held by all foundation trusts, as well as independent sector providers, unless exempt. The new provider licence aims to support effective system working, enhance the oversight of key services provided by the independent sector, address climate change and make a number of necessary technical amendments.

Previously considered by	Approved by the Audit Committee 13 June 2023 Reviewed by the Board and Audit Committee in May/June 2022

Implications *(so what)*	NHSE have previously indicated that they would undertake an audit of a sample of FTs for evidence of self-certification including Board minutes and supporting papers.

	The new provider licence took effect from 1 April 2023, and going forward, there is no requirement for the Trust to publish a self-certification declaration for 2023/24.

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications considered	Good governance underpins the delivery of the Trust's strategy

Proposed Resolution ***(What next)***	Board members are asked to approve the statement of compliance with the licence as recommended by the Audit Committee. A report on compliance with the new provider licence will be presented to the Audit Committee in Q3 2023/24

1. Background – compliance with the provider licence in 2022/23

All NHS Foundation Trusts have previously been required to undertake an annual review of compliance with the NHS Provider Licence (this requirement ends with this report and the adoption of the new licence). The conditions within the Licence are detailed at Annex I

The NHS provider licence was last updated in February 2013) and as a consequence this document contains multiple references to Monitor which should be read in this context.

New guidance issued by NHSI in 2017 and updated in 2019 replaced the requirement to submit a formal declaration with a requirement to self-certify the following Licence Conditions after the financial year-end:

- General Condition G6 - The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution
- Continuity of Services Condition CoS7 - If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service
- Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.
- Governor training - NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles.

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2. General Condition G6

The Licensee should 'take all reasonable precautions against the risk of failure to comply with:

- the conditions of this Licence;
- any requirements imposed on it under the NHS Acts; and
- the requirement to have regard to the NHS Constitution'.

The steps the Trust is expected to take (paragraph 2(a) and 2(b) of the Licence) are:

- the establishment and implementation of processes and systems to identify risk and guard against their occurrence; and
- regular review of whether those processes and systems have been implemented and of their effectiveness.

2.1 Evidence of Compliance

The systems and processes are in place to identify risk and over the course of 2022/23 progress has been made on improving governance arrangements including the establishment of a revised committee structure with a new Risk Management Committee chaired by the CEO and a new Workforce Assurance Committee alongside a refreshed Quality Assurance Committee and Finance and Performance Committee.

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3. Continuity of Services Condition CoS7

Commissioner Requested Services CRS are defined as *"services that will be subject to regulation by NHSI in the course of a licensee's operations, that, in the event of a provider failure, must be identified and kept in operation at that specific locality."*

The current designation of Blackpool Teaching Hospitals NHS Foundation Trust for CRS is a 'default' position (i.e. automatic full designation, across all services). In effect, the current CRS designation is inherited from the position in April 2013, when CRS principles were first established. At that point in time, the FT licence saw all NHS funded services "grandfathered" into CRS status.

The Board are asked to consider confirmation of the following statement:

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

3.1 Evidence of compliance

The Going Concern report provides evidence that the Trust will continue to have the resources required to operate.

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4. Declaration of compliance with conditions of the NHS Provider Licence

This declaration should be made to confirm that the Trust is compliant with required governance arrangements as defined by condition FT4. NHSI provide a template which while not mandated provides a useful format for Board members to note evidence of compliance and the risks and mitigations in relation to each statement

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5 Governor Training

NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles.

5.1 Evidence of compliance

In 2022/23 Governor training was provided as follows:

- Face to face induction for all newly elected governors with the offer extended to other governors as a refresh
- NHS Providers half day training course on membership and public engagement
- Blackpool Governor attendance at the national NHS Provider conference

In addition to this other training and development opportunities including regional NHS Provider meetings and training sessions provided by Mersey Internal Audit are routinely offered to and taken up by significant numbers of Blackpool Governors.

Recommendation

That the Board consider confirmation of the self-certification of compliance against the requirements of General Condition 6 and 7 and FT4, and approval of compliance with Governor training