Board of Directors in Public Meeting (Part 1)
7th September 2023
09.30 – 12.30
Boardroom, Trust HQ.

NHS
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
	7.1	Response to NHS England's Letter - L Letby	Chief Executive	Report ✓	To receive for assurance
Quality					
10.00	8	Quality Assurance Committee Escalation Report	Chair of Quality Assurance Committee	Report ✓	To note for assurance
	9	Quality Integrated Performance Report	Medical Director / Director of Nursing	Report ✓	To note
	10	Maternity and Neonatal Report	Director of Midwifery	Report ✓	To note for assurance
	11	Professional Judgement Update – Nurse Staffing	Director of Nursing	Report ✓	To provide assurance
Finance and Performance					
10.40	12	Finance and Performance Committee Escalation Report	Chair of Finance and Performance Committee	Report ✓	To note for assurance
	13	Finance Integrated Performance Report	Interim Director of Finance	Report ✓	To note
	14	Operational Performance Integrated Performance Report	Deputy Chief Executive	Report ✓	To note
	15	NHS winter planning arrangements	Deputy Chief Executive	Report ✓	To note

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Time		Topic	Lead	Process	Purpose / Expected Outcome
Workforce					
11.20	16	Workforce Assurance Committee Escalation Report	Chair of Workforce Assurance Committee	Report ✓	To note for assurance
	17	Workforce Integrated Performance Report	Director of People and Culture	Report ✓	To note
	18	Freedom to Speak Up (FTSU)	FTSU Guardian	Report ✓	To provide assurance
	19	EDI Improvement Plan	Director of People and Culture	Report ✓	To note
Governance					
12.00	20	Audit Committee Escalation Report	Chair of Audit Committee	Report ✓	To note for assurance
	21	Strategy and Transformation Committee Escalation Report	Chief Executive	Report ✓	To note for assurance
	22	Medical Appraisal and Revalidation Report	Medical Director	Report ✓	To note
Consent agenda for information ***Papers in this section are provided for information and assurance. If you wish to raise a question in relation to one of the reports, please advise in advance of the meeting.***					
	23	Regulatory and Mandatory Lead Roles		Report ✓	To note
	24	New Hospital Programme Update		Report ✓	For information
	25	Fit and Proper Persons Framework		Report ✓	For information
Closing matters					
12.20	26	Any Other Business	Chair	Verbal	To note
		To respond to any questions from members of the public received in writing 24 hours in advance of the meeting			
		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 2nd November 2023 at 9.30am

Meeting	Board of Directors Public Meeting	
Time	09.30 am	
Date	5th July 2023	
Venue	Boardroom (observers on MS Teams)	
Members: -		
Steve Fogg	Trust Chair	Chair
Trish Armstrong-Child	Chief Executive	
Chris Barben	Executive Medical Director	
Janet Barnsley	Executive Director of Integrated Care	
Mark Beaton	Non-Executive Director	
Mark Brearley	Interim Finance Director	
Adrian Carridice-Davids	Non-Executive Director	
Steve Christian	Deputy CEO (Strategy, Operational Performance, Transformation & Digital)	
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	
Andy Roach	Non-Executive Director	
Robby Ryan	Non-Executive Director	
Fergus Singleton	Non-Executive Director	
James Wilkie	Non-Executive Director	
Shelley Wright	Executive Director of Communication (non-voting)	
In attendance: -		
Lynne Eastham	Deputy Director of Nursing	Item 13
Jacinta Gaynor	Corporate Governance Officer	Minutes
Katharine Goldthorpe	Associate Director of Quality Improvement	Item 12
Esther Steel	Executive Director of Corporate Governance	
Observers: -		

Howard Ballard	Public Governor – Wyre Constituency
Margaret Bamforth	Appointed Governor for Blackpool and the Fylde College
Amanda Bamber	Staff Member
Sue Crouch	Public Governor – Wyre Constituency
Tina Daniels	Staff Governor – Non-Clinical Constituency
William Jackson	Public Governor – Wyre Constituency
Maggie Heaton	Union Representative
Stuart Howard	Staff Member
Andrew Marr	Student
Shelagh Parkinson	Local Democracy Report, Gazette
Mark Singleton	Chief Information Officer
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. The Chair acknowledged the NHS 75th birthday and noted the recognition work that had taken place.

2. Declarations of Interest

There were no declarations of interest.

3. Apologies for Absence

Apologies were noted as above.

4. Approval of Previous Minutes

The minutes of the meeting held on 4th May 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.

Matters Arising

There were no matters arising.

6. Chair's Update

The Chair expressed his appreciation to all Trust staff for their hard work during the ongoing challenges. The Chair noted the NHS 75th birthday celebrations and thanked all staff for their continued support of the NHS and delivery of services.

7. Chief Executive Report

The Chief Executive (CEO) drew attention to the events that had taken place and were due to take place to celebrate the NHS's 75th birthday and noted it was good to take time out and reflect on all the good work across the Trust.

The CEO provided a high-level overview of some key activities within the Trust since the previous meeting. These included the below highlights: -

Awards and Recognition

- Simulation and Clinical Skills Re-accreditation.
- NHS Pastoral Care Quality Award for International Recruitment.
- HSJ Patient Safety Awards shortlisted across seven categories.
- Nursing Times Awards 2023 – shortlisted in the Critical Care Nursing category.
- Research Team shortlisted in the Northwest Coast Academic Health Science Awards.
- Bristol Patient Safety Conference winner in the QI in Progress' category.
- The Finance Costing Team won the Healthcare Financial Management Association's (HFMA) Northwest Embracing Technology Award.
- DynaMed Award for Library Service Team.

Trust News

- A new Interim Director of Finance, Mr Brearley had commenced following Mr Patel moving to the ICS.
- Royal College of Nursing General Secretary/Chief Executive visited BTH in June 2023.
- Trust Board supported Volunteers Week during first week of June 2023.
- The Trust celebrated nurses and midwifes on International Nurses Day and International Day of the Midwife.
- Colleagues across the Trust celebrated Blackpool Pride 2023.
- Blue Skies Dragon Boat race raised funds for charity.

System News and Developments

- The Lancashire & South Cumbria (LSC) Integrated Care Board (ICB) met on 3rd May 2023.
- The Provider Collaborative Board met on 21 June 2023 and a staff briefing took place on 31 May 2023.
- NHS Chief Pharmacist visited Barrow to explore improvements made in medicine safety.
- New artificial intelligent powered technology being used to prevent falls in care homes.
- New DadPad resource for new fathers to provide support and guidance.

Reportable Issues Log

- 14 reportable incidents logged between 26 April and 25 June 2023; all being investigated as serious incidents (SI).

- Trust issued with a Regulation 29 letter from the coroner and a response from the Trust is required by 7 August 2023 and oversight would be through the Quality Assurance Committee.

There was a short discussion around serious incidents and Duty of Candour, and it was agreed that a future Board session would be dedicated to providing a more in depth understanding of the processes in place for Serious Incidents and the alignment with the new Patient Safety Incident Framework (PSIRF) in order to provide assurance that the correct processes are in place.

The Executive Joint Director of Communications drew attention to the events taking place across the Trust to celebrate the NHS's 75th birthday and highlighted that there had been a vast amount of interest with the stories shared via social media.

Resolved: The members noted the CEO's report and the update.

Action: Arrange for a future Board session on SIs and Duty of Candour.

8. Anti-Racist Programme

The Executive Director of People and Culture introduced the report and provided some background on the reasons and benefits of the Trust adopting an anti-racist programme. Members acknowledged the hard work of the Trust's Equality, Diversity & Inclusion (EDI) Lead in this area. Members further noted that there would be a specific approach with four main inclusion themes of focus for the framework.

There was a detailed discussion and members highlighted that further discussion would be required in order to ensure meaningful and measurable key performance indicators (KPIs) were agreed upon. Furthermore, it was agreed that this should be driven by the Cultural Diverse Group, who have the knowledge and expertise of different ethnicities and lived experiences.

Resolved: Members noted the update.
Action: To arrange an EDI developmental session between Board members and the Cultural Diverse Group.

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 for May and June 2023 that had been circulated with the papers and detailed the alerts, advice and assurance items.

Members noted two alerts from the meeting on 27 June in relation to:-

- Cardiac Triage Risk, and;
- Maternity & Neonatal Report – NHS England's Maternity & Safety Support Programme.

Resolved: The members noted the reports.

10. Quality Integrated Performance Report

The Executive Director of Nursing, Midwifery, AHPs and Quality referred to 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.

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

- There were no neonatal deaths or stillbirths in May 2023.
- Falls remained with normal variations.
- Patient experience feedback remained good overall with a rate of 95% of patients stating they received good or very good care; however, a specific focus was required across the Emergency Department at only 73%, a reduction of 4% from the previous month.
- The Trust was currently on trajectory with all infection control KPIs, except E.coli.

In response to a member's query regarding E.Coli rates, the Executive Director of Nursing, Midwifery, AHPs and Quality confirmed that the data was being looked at for opportunities to support the Infection Prevention & Control programme.

The Executive Medical Director highlighted the following key points: -

- The Trust had noted a decline in cardiac arrests from 1.16 per 1000 in 2021/22 to 0.916 per 1000 admissions in 2022/23.
- All mortality indicators continue to be satisfactory with an improving trajectory.

In response to queries from members regarding the mortality data, the Executive Medical Director confirmed that the process had been reviewed and changes had been implemented to streamline processes from the bottom up.

There was a discussion in relation to the complaints process and it was agreed that it would be helpful for the Board collectively to gain a better understanding of the governance process. The Chair also requested that an update be provided to a future Council of Governors meeting to provide assurance on the management and governance of the complaints process.

The Chair further requested that an update be provided to the Council of Governors on all the good quality development work being undertaken across the Trust.

Resolved: Members noted the IPR and updates.
Action: To include complaints in the Board session referred to earlier on incidents and PSIRF**.**
Action: The Executive Director of Nursing, Midwifery, AHPs and Quality to link in with Corporate Governance Team to arrange for an overview of quality work at a future Governor Development session, and to include a discussion relating to the complaints governance process.

11. Quality Accounts

The Executive Director of Nursing, Midwifery, AHPs and Quality drew attention to the previously circulated report. Members noted that production of a Quality Account was a requirement for all Foundation Trusts under the Health and Social Care Act 2012, which details the quality of services and improvements offered by the healthcare provider.

Members noted that the Quality Accounts 2022/23 had been presented to the Quality Assurance Committee for approval and would be uploaded onto the Trust's website.

The Executive Director of Nursing, Midwifery, AHPs and Quality thanked all staff involved with the production of the document.

Resolved: Members approved the Quality Accounts 2022/23.

12. Quality Improvement

The Associate Director of Quality Improvement provided members with an update on the quality improvement work across the Trust. Members noted that new QI enabling plans were currently being developed in line with the Trust's Strategy and ongoing programmes continued to make good progress, with QI training offered to staff and outcomes resulting in reduction of harm and improvements in patient care.

The Executive Medical Director commented that he had received feedback from the Mortality Team who due to the QI programme had enabled them to affect change and created a more of a 'can do' attitude.

The Chief Executive thanked the QI team for all their hard work and highlighted that this programme empowered staff to effect change and to see how their improvements made a difference.

The Chair requested that future invitations to QI events be forwarded to all Board members and to Governors.

Resolved: Members noted the report and update provided.
Action: To ensure invitations to all future QI events are sent to all Board members and to Governors.

13. Maternity and Neonatal Report

The Director of Nursing provided an overview of the safety and quality programmes of work within Maternity and Neonatal Services. Members noted that regular reporting on safety and quality was required to comply with:-

- The Perinatal Quality Surveillance Model
- CNST (Clinical Negligence Scheme for Trusts) operated by NHS Resolution
- Ockenden (2021)
- East Kent (2022).

There was one alert highlighted in relation to Clinical Negligence Scheme for Trusts (CNST) whereby full compliance had not been declared for Year 4, and it was noted that during data collection for Year 5 reviewers had found evidence not robust to cover action from previous years, which may impact progressing through Year 5 compliance. Further updates to be provided to Quality Assurance Committee.

There was a short discussion and it was agreed for the need to have good governance processes in place.

Resolved: Members noted the report and update provided.

14. Finance and Performance Assurance Committee Escalation Report

The Finance and Performance Committee Chair drew attention to the Finance and Performance Committee Escalation Reports for May and June 2023 that had been circulated with the papers which detailed the alerts, advice and assurance items.

Resolved: The members noted the reports.

15. Finance Integrated Performance Report

The Interim Finance Director provided a high-level overview of the Finance IPR and highlighted the following areas of note:-

- Financial performance for May - £7.5m deficit in line with plan.
- Financial performance year to date - £13.8m deficit in line with plan.
- Agency spend year to date (May) - £6.7m (9.0% of total pay bill vs system ceiling target of 3.7%).
- Capital Programme Expenditure year to date (May) - £1.0m.
- Cash balance (May) - £31.1m (decrease of £3.4m in month, but £8.7m higher than plan).

Members discussed the continued issues with high agency/bank costs and sought assurance that there were robust control processes in place, the Interim Director of Finance confirmed there were clear controls in place for the use of agency/bank staff. The Chief Executive commented that Executive Directors needed to undertake some work on how to clearly demonstrate the process of system controls in order to appraise Board members.

In response to a member's query in relation to indicating the achieved monthly QEP position versus the trajectory, the Interim Director of Finance agreed to include this data within future financial forecast reports

Resolved: Members noted the IPR and updates provided.
Action: EDs to undertake some work on clearly demonstrating the process of system controls in place for agency/bank spend and to feedback back to F&P Committee and to Board.
Action: To include data on the achieved monthly QEP position versus the trajectory, within future financial forecast reports.

16. Performance Integrated Performance Report

The Deputy Chief Executive/Executive Director of Strategy provided a high-level summary of the Operational Performance IPR circulated with the papers. The following areas were of note:-

- UEC capacity – higher than predicted demand creating additional pressures, with the Patient Flow Improvement programme being mobilised.
- RTT - 3 reportable 78-week breaches in May 2023. A further 16 excluded breaches due to patient choice or medical reasons.
- A Clinical Productivity Board established to enable improvement in 3 main areas of risk; theatre endoscopy and outpatients.

The Chair commented that it was useful to hear of the good work being undertaken, but stated it was hard to get a feel of the overall impact. It was suggested that a future Board session be dedicated to a single topic, such as, cancer pathways, in order to ascertain how this aligns to the Trust's strategy from beginning to end.

Resolved: The members noted the report and the update.
Action: Arrange a developmental session for a future Board session on cancer pathways from beginning to end.

17. Workforce Assurance Committee Escalation Report

The Workforce Assurance Committee Chair provided a brief overview of the Workforce Committee Escalation Report for May 2023 that had been circulated with the papers and provided members with a verbal update on the main areas of focus of the Workforce Assurance Committee workshop in June 2023.

Resolved: The members noted the report and the update.

18. Workforce Integrated Performance Report

The Executive Director of People and Culture provided an overview of the workforce IPR circulated with the papers, with the following areas of note:-

- Core Skills stood at 91.06% vs target of 95%
- Appraisal stood at 74.49% vs target of 90%.
- Sickness absence stood at 5.56% (May), rolling 12-month total of 6.56%.
- Vacancy rates within M&D and N&M were highest.

Members noted that new system-wide approaches were being considered to improve sickness absence, but noted there may be cost implications to seeking external support for staff already on sickness absence. Members had a short discussion on the implications of providing support, and it was noted this would be highlighted by the Chief Executive at future ICB/PCB meetings.

Resolved: The members noted the report.

19. Audit Committee Escalation Report

The Audit Committee Chair outlined the two alerts from the Audit Committee Escalation Report circulated in the papers in relation to:-

- External Audit Update
- Internal Audit Follow-Up Report.

Members noted there may be some delay with signing off the annual accounts and Annual Report, but that these were being worked through and NHS England had been informed.

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

20. Provider Licence Declaration

The Director of Corporate Governance drew attention to the paper circulated within the papers and members noted that the Audit Committee had reviewed a comprehensive report which set out evidence to assure members that the Trust was compliant with condition G6 of the 2022/23 NHS Provider Licence and a Statement of Compliance had been produced for approval.

Members were informed that NHS England had published a new provider licence and a compliance report would be presented to Audit Committee in Q3 2023/24.

The Director of Corporate Governance confirmed that the internal audit follow up process had been discussed at a recent Executive Director meeting and a process had been agreed.

Resolved: Members noted the report and update and approved the Statement of Compliance.

21. Any Other Business

There was no other business.

Date and Time of Next Meeting

Thursday 7th September 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/23/27	Part 1	10	05.07.23	Quality Integrated Performance Report	Include complaints in the Board session referred to in BOD/23/24.	B Lees	07.09.23		That is currently being actioned. A formal report on patient experience will be reported to the next Quality Assurance Committee.	A
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	02.11.23	EDI Board development session to be scheduled - after October culture session	A
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	A
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 offered from September but response needs to be chased	A
BOD/23/24	Part 1	7	05.07.23	Chief Executive's Report	Arrange for a future Board discussion on SIs and Duty of Candour.	B Lees	07.09.23		Agenda item Board of Directors Part two meeting on the 7th September 2023.	Y
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		Atlas Shareholder report on part two agenda	Y
BOD/23/25	Part 1	8	05.07.23	Anti-Racist Programme	Arrange for a EDI development session for the Board of Directors.	E Steel / Corporate Governance Team	05.10.23		To be scheduled.	B
BOD/23/28	Part 1	10	05.07.23	Quality Integrated Performance Report	overview of quality work at a Governor Development session. To include a discussion relating to the complaints governance process.	B Lees / C Barben	04.01.24		This overview on quality work will be undertaken at the Governor conference now in planning for Q4.	B
BOD/23/32	Part 1	16	05.07.23	Performance Integrated Performance Report	Arrange a developmental session for a future Board session on cancer pathways	C Barben / Corporate Governance Team	05.10.23		This item has been added to the BoD forward planner.	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/23/21	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		Discussed at WAC and safe staffing report provided as agenda item to September Board	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	05.10.23	October strategy/development session to be focused on culture	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/23/33	Strategy	5	03.08.23	Strategy Review	Board discussion on car parking	Corporate Governance Team / J Barnsley	05.10.23		All Board members have been invited to the Journeys to work group on the 5th September.	G
BOD/23/26	Part 1	8	05.07.23	Anti-Racist Programme	Add to the WAC and BoD workplans for a six-monthly update to WAC and a bi-annual update to Board.	Corporate Governance Team	10.07.23		These updates have been added to both the WAC and BoD workplans.	G
BOD/23/29	Part 1	12	05.07.23	Quality Improvement	Ensure future invitations to events are sent to all members of the Board of Directors and to Governors.	K Goldthorpe / Corporate Governance Team	27.07.23		Invites will be sent.	G
BOD/23/30	Part 1	15	05.07.23	Finance Integrated Performance Report	Undertake some work on clearly demonstrating the process of system controls in place for agency/bank spend and to feedback back to F&P	Executive Directors	27.07.23		These updates are now included in the IPR going to Finance & Performance Committee on the 27th of July, the F&P committee will	G
BOD/23/31	Part 1	15	05.07.23	Finance Integrated Performance Report	Include data on the achieved monthly QEP position versus the trajectory, within future financial forecast reports.	M Brearley	27.07.23		These updates are now included in the IPR going to Finance & Performance Committee on the 27th of July, the F&P committee will	G
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		Complete - report provided on agency and bank staff levels	G

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

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Chief Executive's Report

Meeting:	Board of Directors
Date:	7 September 2023

Author	Trish Armstrong-Child, Chief Executive					
Exec Sponsor	Trish Armstrong-Child, Chief Executive					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** The attached briefing paper provides some high-level updates on activities within the Trust since the previous meeting of the Board of Directors. These include: • Awards and Recognition • News and Developments • Trust News • Reportable Issues Log • Risk Register and Board Assurance Framework

Implications *(so what)*	**Alert** The report includes a summary of reportable issues **Assure** Several teams within the Trust have received national recognition in recent months – further detail provided within the report

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	We aim to consider EDI implications of all activities

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

1. Awards and Recognition

HSJ Awards 2023

Three BTH teams have been shortlisted in the 2023 HSJ Awards.

Two teams were successful in the Patient Safety Award category. They were “Preventing hospital acquired pneumonia: introducing the COUGH care bundle” submitted by project lead Jessica Murphy and “Reducing pressure ulcer through proactive working” submitted by Faye Burke, Sue Baldwin and Terri-Anne Shaw from the South Neighbourhood team in Blackpool.

The third shortlisted team was in the Provider Collaboration of the Year category: “Hospital based health Independent Domestic Violence Advisors and Independent Sexual Violence Advisors” submitted by Natasha Rowan, Speciality Business Manager Safeguarding.

Each team will now carry out an online presentation about their entry ahead of the awards ceremony in London on 16 November. A record-breaking 1,456 entries were received for this year’s awards with 223 projects and individuals reaching the final shortlist.

Trust team scoops Parliamentary award

The team behind the Lancashire and South Cumbria Reproductive Trauma Service was awarded the Excellence in Mental Health Award in the NHS Parliamentary Awards.

The service was set up in March 2022 by Lancashire and South Cumbria Integrated Care Board (ICB) and is operated by Blackpool Teaching Hospitals. The service delivers an integrated approach to providing innovative, person centred support and therapy to women experiencing moderate to severe or complex mental health difficulties. These difficulties are directly arising from, or related to, maternity experiences following birth trauma, perinatal loss or severe fear of childbirth (tokophobia).

BTH service receives Home Office funding boost

A service provided by the Trust, ensuring victims of sexual violence get the support they need, has received an extra £200,000 Home Office funding.

The funding will help make sure victims of sexual violence who present at hospital and wish to make a disclosure, are offered timely and appropriate trauma-informed support. It will also support colleagues identify possible victims, building on the success of the Independent Violence Advisor programme.

Costing team assembles to celebrate finance award

The Trust’s Finance Costing team met with the other teams in our Integrated Care System to celebrate their recent success in the Healthcare Financial Management Association North West Embracing Technology Award. It goes to 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 team’s collaborative technological approach used to develop an integrated care system patient-level cost benchmarking tool. They are now sharing the tool with divisions to identify opportunities for cost reduction, service change and improvement.

Spotlight shines on Quality Improvement

Teams from across the Trust showcased their improvement projects and stories at a special event held in July.

Representatives from 10 teams joined the second cohort of the Clinical Quality Academy, meeting to celebrate their graduation alongside senior Trust colleagues and a guest speaker, Kathryn Perera, Director of Improvement Capability-Building for NHS England.

Among the improvement projects were:

- Turning Heads – a project to increase the number of women presenting as breech being managed appropriately.
- Smart Choice – to increase the proportion of cardiac outpatient appointments conducted as video consultations.
- Reducing urethral catheter related emergency presentation to the ED and SDEC

2.Trust Update

Industrial action

The Trust continues to manage ongoing industrial action by professional groups and trade unions over a pay dispute with the Government. There have been multiple periods of industrial action since the last report, which proved particularly challenging as they coincided with school summer holidays.

Most recently, British Medical Association (BMA) members including junior doctors (also known as post graduate doctors and clinical fellows) took part in industrial action at NHS organisations across England, including the Trust, from Thursday, 13 July until Tuesday, 18 July and Friday, 11 August to Tuesday, 15 August.

Consultant doctors also took strike action for the first time in nearly 50 years from Thursday 20 July - Saturday 22 July, and August 24-25. They have announced further industrial action for 19 and 20 September.

Careful planning has and will continue to take place to minimise the impact on patients, families, and colleagues.

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 and signposting to appropriate pathways for treatment.

Celebrating our volunteers

BTH volunteer Barry Evans, widely known for his piano playing at both Victoria and Clifton hospitals, celebrated his 80th birthday with a special party organised by colleagues. The event was held at Clifton Hospital where Barry has been a volunteer for 22 years.

Flu vaccination campaign

The Trust has launched a colleague campaign to recruit vaccinators to support with the 2023/24 flu vaccination roll out, expected to begin in late September.

Registered nurses, midwives and nursing associates, operating department practitioners, paramedics, physiotherapists and pharmacists are all invited to complete training at a time and date that suits them.

2. Reportable Issues Log

Between 27 June and 23 August 2023, a total of 13 reportable incidents were added to StEIS

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

In addition to those detailed above the Trust recorded a number of complaints including three low risk, one moderate risk and 86 cases which are still ongoing. No high-risk complaints were reported.

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 5 July 2023. A recording of the meeting is available to watch online here: LSC ICB: 5 July Board Meeting.

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 - 20 July 2023

The overview of the July meeting is at the end of this report.

Provider Collaborative colleague briefing

A colleague briefing is to take place on 4 September to update people on work by the local NHS Trusts to improve health and care across Lancashire and South Cumbria.

The event will be led by Chief Executives from across the system and will provide updates on collaboration, working together through significant challenges, our clinical strategy, central services collaboration, and our people strategy.

The dates of next briefings are:

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

Collaborative UEC strategic redesign day

Organisations involved in urgent and emergency care (UEC) across Lancashire and South Cumbria have met to look at how we can ensure that our services are fit for the future.

Colleagues from provider trusts, ICB, primary care, out of hours providers, NWAS, Lancashire and South Cumbria NHS Foundation Trust (LSCft), social care, community services, Public Health, NHS England and voluntary, community, faith and social enterprise along with patient representatives, discussed what we can start to do now to adapt and develop over the next few years.

The meeting looked at what has worked well in other systems, with help from the emergency care improvement support national team, and what we could focus on locally and across our footprint.

This was just the start of a journey of collaborative design with colleagues and patients across our system, to ensure all services in Lancashire and South Cumbria provide the best experience and outcomes for our communities, starting with how we support people in their

own homes before they even need UEC, and are workplaces where staff want to work, thrive and feel empowered.

ENDS

Trish Armstrong-Child

Chief Executive

Date August 23, 2023

Appendix

Provider Collaboration Board – 20 July 2023

The Provider Collaboration Board (PCB) met on 20 July 2023. As this was a day of Industrial Action by Consultants the meeting was kept brief.

It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

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

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on key programmes of work as agreed with Trust Boards. Updates on central services, clinical services and progress on Elective Recovery were discussed under Joint Committee working items. An item on Developing Provider Led Population Health Management was deferred.

System pressures – acute

The implications and costs of the ongoing Industrial Action was the most pressing issue for the system and needed to be reviewed including the increase in costs of those who were acting up into more senior roles; the income lost as a result of having to stand activity down and the premium costs of reclaiming the lost activity. It was not yet clear how this would be managed at a national level and given that more Industrial Action was planned this is an ongoing issue for the system in terms of both performance and finances. It was agreed that local Trusts should take a joint approach until the national approach was clear.

The PCB acknowledged the ongoing hard work of staff across the system.

System pressures – mental health, autism and learning disabilities

The Care Quality Commission had been at Lancashire and South Cumbria NHS Foundation Trust (LSCFT) for the last two weeks undertaking a review of adult services. Feedback had been positive.

The Trust Medical Director was due to meet the Integrated Care Board (ICB) Medical Director to discuss a strategy for moving from NHS system oversight framework (SOF) segment 3 to SOF 2, looking at the evidence in relation to the encouraging progress made to date.

Financial Update

Month three year-to-date is a deficit of £72.9m versus a plan of £65.3m, with three Trusts currently off plan.

The impact of Industrial Action up to month three is £4.1m - £2.6m of which are additional costs and £1.5 which is lost income.

The recent pay award for 23/24 has created a net pressure for providers, with the year-to-date pressure at £0.9m, and the full year at £3.6m. Further work is underway to ensure consistent impact assessment given the variation.

Central Services Transformation Update

The half-day workshop on 18 July had been a productive session with 40 plus central services leadership colleagues which discussed the mandate from the Joint Committee for the development of the Target Operating Model and was the final planning session for the prioritisation of the D1-D4

services as we move towards a Central Services Delivery Model. A further session would be held in around 4 weeks' time to look at the HR and comms interdependencies to ensure messages are aligned. There are clear functional delivery plans, but as the transformation opportunities are cross functional, we will now spend some time considering this.

There was a very clear discussion with each of the leads that the development of the Operating Model for Central Services will now have an Executive lead from each of the providers who will be part of an Executive Delivery Board chaired by Aaron Cummins as CEO and Senior Responsible Officer (SRO) for the programme. The Professional leads would still be involved in the design and delivery.

Good work has taken place on developing engagement toolkits and other engagement mechanisms and infrastructure were now mobilising. All Providers were asked to dovetail this with activity undertaken by local communications leads to ensure appropriate cascade and usage of these within their own organisations. The PCB SRO for Governance was working with local teams to ensure Trust leadership and assurance processes were aligned with the Central Services programme so there were no surprises when decisions came out of Joint Committee meetings.

The Central Services Interim Managing Director role had gone out for expressions of interest and interviews were due to take place shortly. An appointment should be made by the end of July. The role will then start to fill the operating model leadership team, up to a point where we will want to go out for permanent appointment for that new structure.

It is expected that there would be a financial benefit to the system this financial year as a result of the Central Services work. There would be an intense focus on delivering savings from procurement, bank and agency, and individual Cost Improvement Plan (CIP) performance from management of vacancies in in-scope services. There has been some good early progress at Q1 but there was still much more to do and plenty of risk. There would be further discussion on this over the next month.

The PCB have previously agreed that transactional operational central services will be brought together into one 'umbrella' service hosted by one of our NHS Trusts, known as a 'Host Trust Model'. Organisations are being asked for formal expressions of interest to host this – there will be clear criteria and this should be resolved over the summer period.

Clinical Programme Board Update

The PCB supports the discussions that were held on 19 July around unsustainable services, encouraging their teams to be bold and ambitious in thinking through solutions. Good work has taken place in specialities where alternative models of care are being delivered and will provide support for these in both development and implementation phases. The ICB will be standing up a commissioning group to support the clinical programme in decision making and implementing new care models that are now being agreed, and community transformation groups have been set up to look at working with alternative models, particularly for the winter period and into next year.

Notable updates included; the implementation of a system-wide networked service model for Cardiology; the establishment of the Lancashire and South Cumbria (LSC) vascular network with a single inpatient unit at Royal Preston Hospital (RPH); the development of a networked service model for Urology that meets the national service specifications for cancer surgery but also delivers a more robust service; development of networked services in Musculoskeletal (MSK) Trauma and Orthopaedic (T&O); pathway improvement in Dermatology with the establishment of training and education workstreams; GIRFT implementation in Ophthalmology; and a Business Case that is being developed for Integrated Mental and Physical Health that will implement a new model for early assessment and treatment of mental health issues in Emergency Departments.

Elective Recovery Programme Group Update

This was the second programme update to the PCB since the refresh of the programme was approved in Q4 of 2022/23. It set out key highlights and risks, providing a high-level update of each of the six transformation programmes within the Elective Recovery Portfolio including an overview of the programme's financial benefits.

The update intentionally focused on the Surgical Hub programme given the priority currently being given to this programme. The work to co-create a strategic plan for Surgical Hubs in LSC has now concluded, with this report setting out the strategic priorities and objectives proposed by stakeholders across the system, the scale of the opportunities to be released and immediate next steps. Members of the PCB were asked to support the strategic intentions set out for surgical hubs and provide organisational commitment to working collaboratively in delivering the immediate next steps and actions.

The Lancashire and South Cumbria Elective Recovery Programme continues to perform and benchmark well across a range of key metrics on both a regional and national footprint, with Day case rates at 83.1%, maintaining LSC's position within the top quartile. As at the 4 July, 1,893 patients were waiting over 65 weeks. This is ahead of the end of July trajectory by 583, with the 65-week cohort reducing by 31% in the first three months of 2023/24. The Surgical Hub programme has made excellent progress in creating a LSC strategic plan, setting out an agreed vision and strategic priorities and also forecasting the scale of the opportunity to accelerate elective recovery and repatriate activity, and LSC is pursuing the opportunity to become the first system in the country to implement the nationally developed Patient Treatment List (PTL) tool. This is a key enabler to delivering the collective ambition of managing our waiting lists and capacity 'as one.'

Programme highlights discussed included; referral optimisation, waiting list management, outpatient transformation, theatre transformation, surgical hubs and use of the independent sector.

One strategic risk was brought to the Board this month, stating that the ongoing impact of industrial action is impeding the system's ability to fully eliminate 78-week waits, impacting on productivity and activity, whilst also reducing our operational and clinical leaders' capacity for system-wide transformation programmes.

The Surgical Hubs programme was also discussed in detail, confirming opportunities and challenges on how the Hubs are helping to address the elective backlog. There is significant opportunity to increase activity levels within LSC's surgical hubs through both improving utilisation of current capacity and expanding the hours surgical hubs are staffed and operational in line with Get It Right First Time (GIRFT) expectations. Our existing hubs cover 16 specialities. The total LSC admitted waiting list for these specialities has grown by 7% in the last 12 months, with this growth highest in Trusts with existing surgical hubs. Expanding Surgical Hub capacity would provide the opportunity to repatriate activity currently being undertaken by the independent sector.

Next steps will be to develop the delivery plan and taking forward technical solutions for managing waiting lists across the system.

PCB members stressed the importance of appropriate public and stakeholder engagement and agreed the direction of travel of the programme.

Interim PCB arrangements

It was agreed that Aaron Cummins would take up the role of lead Chief Executive for the Provider Collaborative following Kevin McGee's departure in the autumn and discussions around handover are taking place. Kevin's last meeting would be in September, as the August meeting has been cancelled due to a number of apologies.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	BTH Response to the NHSE Letter re Verdict in the trial of Lucy Letby

Meeting:	Board of Directors Meeting
Date:	28th August 2023

Author	Katy Coope, Deputy 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)*	**Advise** NHS England have written to all NHS Trusts following the outcome of the trial of Lucy Letby. The Department of Health and Social Care have commissioned an independent enquiry into the events at the Countess of Chester to ensure lessons are learnt from this case. In addition, NHS leaders and Boards are asked urgently to ensure key five actions are in place: 1. All staff have easy access to information on how to speak up. 2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme. 3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place. 4. Boards are regularly reporting, reviewing and acting upon available data. 5. This paper will provide the Blackpool Teaching Hospitals (BTH) response to these actions.

Implications *(so what)*	**Alert** The implications of not having these actions in place could assist in a similar case occurring.

	Assure
	In response to the five urgent actions, the Board are provided with assurance that BTH have responses to all of these and where needed, further enhancements are being actioned immediately.

Previously considered by	N/A

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	ED&I implications have been considered as part of the response to the five key actions.

Proposed Resolution ***(What next)***	The Board of Directors are asked to be assured that we have the five key actions in place however we have identified four additional actions that can further enhance the response for the Trust.

NHS England - Letter dated 18 August 2023: Verdict in the trial of Lucy Letby

1. Introduction

NHS England have written to all NHS trusts following the outcome of the trial of Lucy Letby **(Appendix 1).** The Department of Health & Social Care have commissioned an independent enquiry into the events at the Countess of Chester to ensure we learn every possible lesson from this awful case. NHS England have advised they are committed to doing everything possible to prevent anything like this happening again and are taking decisive steps towards strengthening patient safety monitoring.

2. Patient Safety Monitoring

Since 2021 there has been a national roll-out of medical examiners which has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by the coroner which improves data quality making it easier to spot potential problems.

There is also a new Patient Safety Incident Response Framework which will be implemented from Autumn 2023 across the NHS which will represent a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

3. Board Responsibility

In addition, the letter also provides a reminder of the importance of NHS Leaders listening to the concerns of patients, families, and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level. To ensure that everyone working in the health service feels safe to speak up and confident it will be followed by a prompt response, Boards are asked to urgently ensure five key actions are in place.

The below details the response for the Trust in relation to these actions:

1. All staff have easy access to information on how to speak up.	In all letters sent from HR for Employee Relations matters there is a standard paragraph that advises of the availability of the Freedom to Speak Up (FTSU) guardian who can be contacted to provide help and support. There are posters providing details of the FTSU Service in all areas of the Trust including the staff car parking areas, which includes contact details of the FTSU Guardian along with a QR code which directs staff to the Intranet Page. The FTSU Guardian attends the monthly 'tea and toast' Trust induction where she promotes and advises new starters of the FTSU service. The FTSUG also attends the consultant leadership programmes, student nurse, junior doctor induction and does bespoke sessions in areas and teams across the organisation. The HR team actively advise staff to contact the FTSU if they require their support.

	FTSU is advertised via the main banner on the Trust Intranet Sites main page. This link takes staff straight to the dedicated intranet page. FTSU is referred to in all HR training with contact details for the service. FTSUG details are also included in all HR correspondence that are sent out to staff that are going through formal processes. The FTSU Guardian attends the Healthy Teams MDT where concerns are confidentiality discussed and referred to her as required. Staff are regularly signposted to FTSU within the weekly Teams Brief via the Chief Executive and the Executive Director of People & Culture FTSU month is promoted within the Trust every year with the FTSU Guardian and Champions visiting all areas within the Trust. Including a Teams background which all employers are encouraged to use during the month of October. The FTSU training has now been mandated within the Trust for all staff and managers having to complete level 2 and senior managers level 3. As a Trust we now have several FTSU Champions for staff to access across the Divisions and continue with our pro-active recruitment.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	HR & the FTSU Guardian are aware of the National support scheme. To date the FTSU Guardian has not signposted anyone to this specific scheme. The FTSU Guardian supports workers to speak up externally if it would be beneficial to address the matter externally. **Action:** Therefore, we will ensure details of the scheme will be incorporated into all the marketing documentation for FTSU. We will also ensure that all HR staff are fully aware of the scheme and how to signpost and / or make a referral into the scheme. **Action:** The FTSU Guardian will incorporate details of the national support scheme into the advice and support we offer to staff. **Action:** We will include the scheme on our internet page. For reference, this is the link: NHS England » Speaking Up support scheme

	Action: A full detailed communication will be sent to all HR colleagues to ensure everyone is aware of the national scheme
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	The FTSU Guardian embraces cultural requirements and supports the development of removing cultural barriers by: • Attendance at diverse networks. • Continuously developing the FTSU service with regards to a safe speaking up culture, • Communication plans in place. • Policies reviewed and re-written to remove potential barriers, • Diverse champions recruited. • Working with the inclusion lead on removing FTSU barriers The FTSU awareness campaign for this year's FTSU month in October is 'Breaking barriers.' Work is ongoing and in partnership with ED&I leads to develop the Trust response to this. In addition, the FTSUG is currently creating a training programme for managers and leaders on how to respond to concerns.
4. Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.	The FTSU Guardian has a scheduled slot on the Board workplan to attend in person to present her quarterly report – there have been delays due to the absence of the FTSU Guardian and the report to the September 2023 Board will cover a six-month period. Each meeting of the Workforce Assurance Committee starts with a staff story and the Workforce Assurance Committee workshops provide an opportunity for staff who might not normally attend the Board to discuss relevant workforce issues with Board members.
5. Boards are regularly reporting, reviewing and acting upon available data.	As above, the Board received regular reports from the FTSU Guardian, in addition to this the Workforce Assurance Committee acting on behalf of the Board regularly reviews in detail metrics in relation to speaking up and culture including the report from the Wellbeing Guardian, the results of the National Staff Survey. The Board and the Workforce Assurance Committee also review and act on other relevant metrics including sickness absence data, appraisal rates and turnover rates. The Board have supported the commissioning of work led by an external provider to understand the culture of the organisation (Real World HR) and provide appropriate targeted support.

4. Conclusion

Following an independent review of FTSU within BTH by the National Guardians Office in 2020, several actions were identified and following this there was overhaul of the FTSU approach. This included appointing a dedicated resource for the Trust in July 2022. The action plan is now complete and NHSE have verbally advised they are satisfied with all the work we have done and we are awaiting written confirmation.

In addition, NHSE published a **Freedom to Speak Up Policy** for the NHS in June 2022. BTH adopted this national policy, and it was launched within the Trust in July 2022. All trusts now have until January 2024 to adopt this national policy and have it implemented.

Assurance can be provided to the Executives / Board that the Trust has in place the processes and governance identified however further actions to enhance 'Action 2' will be completed immediately**.**

The letter also reminds all NHS organisations of their obligations under the **Fit and Proper Person (FPP)** requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements. This includes that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not).

5. Recommendation

The Board of Directors are asked to note the content of the paper and be assured that the Trust has in place the key actions and that the further work identified will enhance our response further.

Appendix 1

Classification: Official

To: All integrated Care Boards and NHS Trusts
Chairs
Chief Executives
Chief Operating Officers
Medical Directors
Chief Nurses
Heads of Primary Care
Directors of Medical Education

Primary Care Networks
Clinical Directors

Cc NHS England Regions:
Directors
Chief Nurses
Medical Directors
Directors of Primary Care and Community Services
Directors of Commissioning
Workforce Leads
Postgraduate Deans
Heads of School
Regional Workforce, Training and
Education Directors/Regional Heads of Nursing

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.
NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.
This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a

sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.
We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.
Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.
That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.

2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.
Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely




Amanda Pritchard NHS Chief Executive	Sir David Sloman Chief Operating Officer NHS England	Dame Ruth May Chief Nursing Officer England	Professor Sir Stephen Powis National Medical Director NHS England

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Assurance Committee AAA report July and August 2023

Meeting:	Board of Directors
Date:	7 September 2023

Author	Esther Steel – Director of Corporate Governance					
NED Sponsor	Sue McKenna – Chair of QAC Andy Roach – Deputy Chair QAC					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** The Quality Assurance Committee has met twice since the last Board meeting, the attached AAA reports provide a summary of the issues discussed, the assurance received and the issues that are now escalated to the Board of Directors

Implications *(so what)*	**Alert** The issues alerted within the two meetings are: • Results from the Urgent and Emergency Care survey. • The Maternity Staffing report. • A lapse in performance in the prescription and administration of antibiotics to patients on the sepsis pathway. • Results from the National Paediatric Diabetes Audit. • The MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries identifies the Trust as having a neonatal mortality rate that is 5% higher than the average for similar trusts. **Assure** Positive assurance received in relation to a number of areas where good progress has been made including national recognition for the Safeguarding service and assurance on nurse staffing levels – further detail on all these areas included within the following pages.

Previously considered by	The Quality Assurance Committee

Link to strategic objectives	Our People	✓
	Our Place	✓

	Our Responsibility	✓

Equality, Diversity and Inclusion (EDI) implications	The Committee actively consider the EDI implications of the reports received and also consider the impact of the levels of deprivation with the population we serve.

Proposed Resolution ***(What next)***	The Professional Judgement review and the maternity reports are included within the Board pack to be noted by the full Board. Other items discussed in the Committee will be followed up either through the QA Committee or within the Clinical Governance Group as deemed appropriate by the QA Committee.

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:	29th August 2023	**Date of next meeting:**	26th September 2023
Chair:	Sue McKenna	**Parent Committee:**	Board of Directors

Introduction

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

Alert

What	So What	What Next
Urgent and Emergency Care Survey Survey results now published – comparisons with other Trusts are not good and show a deterioration in patient experience since the previous survey. For context the survey took place in October 2022 when building work was underway in the department. The ED team have reviewed the report and developed short- and long-term actions in response	Committee members recognised the impact on patients and staff, many the issues will be addressed with the completion of the Emergency Village development. Committee members considered how service users will be involved in the action plan including the involvement of volunteers	Further survey FFT results Oversight of action plan through Clinical Governance Committee.
Maternity Staffing Report Maternity staffing report presented – full report on the Board agenda.	Committee members discussed Birthrate plus staffing levels, the number of funded and unfunded posts and the actions taken to date including the decision to undertake a further Birthrate plus assessment of establishment levels – anticipate a Birthrate plus review in October.	Report to be presented in full to Board – Board to note that the Trust is not compliant with Birth-rate plus funded establishment. Plans to mitigate for shortfall in staffing described Undertaking a review of staffing levels with Birthrate plus
Sepsis	There are some ongoing estate challenges with the ongoing development of the Emergency Village – also staffing issues in relation to medical staffing.	Business case for ED staffing should improve staffing challenges including a designated sepsis lead within the department.

The Committee requested assurance about the actions being taken to address actions in the sepsis plan. A lot of action has been taken but still struggling with some of the key measures – what additional action is needed. Concerns are antibiotics in and hour and blood cultures – largest volume is in ED and have moved to daily reporting with regular input from the QI team. The main challenge is in relation to the prescription and administration of antibiotics – there is assurance that patients are not coming to harm (average performance is 69 minutes against a target of 60 minutes)	Committee members discussed the challenge, the actions taken so far and the next steps to meet these residual concerns – how can the organisation be assured that everyone is focused on the actions needed to ensure our patients receive the care needed. SHMI for sepsis is below 100	The Committee need to understand how far we are off target and the actions that need to be taken to ensure all patients get the right treatment.
Risk Management Committee (RMC) - Escalation Report AAA report from the Risk Management Committee highlighted key risks within the Trust and the actions being taken – risks escalated: ED pressures and ambulance offloading Orthodontics service recruitment challenge – the Trust are closed to admissions but still have 500 patients on case load and are collaborating with partners to ensure clinical supervision for patients Pathology LIMS – transition to new system deadline extended – risks highlighted in relation to transition FICC escalated risk in relation to paediatric staffing	Committee members noted the escalated divisional risks. In relation to delayed ambulance handovers – Committee members requested more information on the approach and the actions being taken Committee members discussed the ongoing review following the incident in relation to paediatric letters – validating the impact of the incident on patients and families.	Longer term solution needed for orthodontic service Board update on LIMS on part 2 agenda
National Paediatrics Diabetes Audit	Discussed factors impacting on capacity and demand including increased rate of type 1 diabetes	Action plan to be monitored by the divisional board and the Clinical Governance Committee

Blackpool is an outlier for monitoring blood glucose levels in the population of the children with diabetes that we work with	in children and the use of technology for monitoring.	
Patient Safety Implementation Response Framework Transition to PSIRF to begin in November. PSIRF training to be made mandatory for all staff Alert flagged in relation to the timeliness of completing the actions and finalising the development of the model.	Committee members discussed the implications of the framework to be used and t	The Committee endorsed the implementation as outlined in the paper and the selection of the priorities for review Report to be presented to Board for approval of the policy
Advise		
What	**So What**	**What Next**
Clinical Governance Committee (CGC) - Escalation Report Escalation report from Clinical Governance Committee – majority of papers covered on the QAC agenda. Alerts from the Committee in relation to PSIRF and sepsis – covered within the items in this report. The Committee received an AAA report from the CSS division, other divisions will report on a rolling programme	Other divisions will be presenting AAA reports to the Clinical Governance Committee.	Update noted with questions picked up within other agenda items
Medicines Management Continuing to monitor and support wards and departments in relation to controlled drugs incidents – no deviations currently suspected and the Controlled Drug Accountable Officer reports greater assurance regarding the management of controlled drugs		Follow up for clarification on enhanced monitoring areas

Maternity and Neonatal Report Monthly update for July – alert on training compliance with maternity skills drills – target not achieved since January – recovery plan in place. CNST compliance requires all staff to be 90% and above training compliance. CQC action plan – can demonstrate areas of improvement although seven areas remain off track HSIB assured regarding actions taken in response to escalation reports.	Discussed the importance of training, the link between mandatory training and appraisals and the factors in relation to staff not completing training included formally escalating with individuals who have not completed the required training. Assurance that medical staff are 100% compliance on clinical skills drills however recognised the need for compliance with core skills mandatory training. Question asked about increased trend in C Section rates – no longer monitored as a target, recognise the factors that should be monitored to ensure the best possible choice for mums and babies. The Committee discussed proactive FTSU work within the department noting that initial engagement was slower than the team would have liked.	The Committee discussed the actions to be taken to ensure compliance is achieved with all outstanding areas for action. Report back from the department to understand variations and the use of Robson criteria to collate and analyse the data. Consideration to be given to external testing of actions taken in response to previous actions – external partners undertaking a “mock CQC” to evaluate approach including checks on induction times which have improved – approx. 80% of women are taken to delivery within 24 hours
Cardiac Peer Review Action Plan Action plan presented for approval as agreed in the July 2023 QAC meeting	Action plan noted	Continue to monitor through Clinical Governance Committee
Integrated Performance Report Most metrics picked up within individual reports. Committee members noted the improved mortality levels	Committee members discussed the metrics reported on pressure ulcers	Infection Prevention and Control – will be reported within new Fundamentals of Care report.
Inpatient Survey Update provided on responses to the CQC inpatient survey – overall performance is in line with other trusts with the main challenge being performance in the ED	The Committee noted the update on the report provided in July 2023	Follow up by the Committee to be through the quarterly patient experience update

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Assurance		
What	**So What**	**What Next**
Patient Story The patient story illustrated good and timely care in A&E, before onwards pathway to cardiac with a positive outcome.	Very positive story highlighting the importance of taking action in a timely, caring and professional manner.	The Committee noted the story and the importance of timely care.
Learning Disabilities Improvement seen in training levels although remain an outlier and recognise that further work is needed. Report now includes harms experienced by patients with learning disabilities	In terms of training – have we set a trajectory to define which staff and by when – plan agreed for a soft launch before mandating this by the end of 23/24. In terms of inpatient alerts – how - daily update in terms of patients that are on the system, matrons also record patients in their area as a back-up.	Learning disability support plan developed to ensure all learning disability patients have a daily audit of care delivered.
Professional Judgement Update – Nurse Staffing Review undertaken using a recognised acuity tool – gives assurance that most templates are safe, with actions recognised for a couple of specific wards. A monthly update is provided on compliance with templates and the agreed target is achieved and corelates with incidents reported in relation to staffing levels. Safer Nursing Care tool licence now in use for ED and community and used for one round of data. Neonatal template is BAPM compliant. Maternity staffing provided in separate report.	Committee members assured that templates are appropriate	Action proposed to review uplift Monitoring compliance with BAPM template. No financial ask
Quality Impact Assessment Update Overview provided of the QIA process – QIA should be completed for any change including QEP, STP or any other changes.	MIAA undertaking a review of the process. The overall QEP scheme is reviewed in the F&P Committee.	Reviewing future reporting mechanism Post implementation reviews are scheduled but not yet completed – the majority are in relation to QEP.

QIA process is embedded in the PID document but should be used for any change scheme.		
AoB Letby letter The committee noted the national response and focus following the outcome of the trial of a Chester Nurse (LL) and noted that a report would be provided to Board		

Committee/Group Escalation Report

Name of Committee/Group:	Quality Assurance Committee	**Report to:**	Board of Directors
Date of Meeting:	25 July 2023	**Date of next meeting:**	29th August 2023
Chair:	Andrew Roach	**Parent Committee:**	Board of Directors

Introduction

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

Alert

What	So What	What Next
Urgent and Emergency Care Survey A high-level summary was provided at this meeting as the full results from the UEC survey was still embargoed when this report was submitted. The Trust was placed 61 out of 62 for overall positive score.	Since the survey was undertaken in September 2022, a large amount of work had been undertaken to improve the UEC Department, therefore, a broader, more perspective review and action plan would be developed to explain the whole situation.	A full comprehensive report supported by actions to be taken and already undertaken would be provided to the next meeting.
Health and Safety Committee Escalation Report The H&SC was informed of the concern around the low attendance of face-to-face Level 2 Moving & Handling training which potentially increased the risk of injury to staff. At the time of the Committee, 79 Fire Risk Assessments were identified as outstanding and require expediting.	Members drew attention to the 79 outstanding risk assessments and requested that Executive Directors urgently review this to provide assurance that there was no risk to the Trust and that everything was being undertaken to mitigate this risk.	The next report would include a timetable for completion of the outstanding risk assessments and outline any themes.

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Advise		
What	**So What**	**What Next**
Clinical Governance Committee (CGC) - Escalation Report Three alerts were brought to the Committees attention: - Sepsis, Urgent Emergency Care (UEC) Survey Results 2022 and the Audit and Clinical Effectiveness Group Chair's Report	Dip in performance against the Sepsis pathway, however the CGC were assured regarding the actions being taken. Alerted to position on NICE guidance following a look back and review of all guidance and quality standards issued over the last ten years.	The position regarding sepsis would be reviewed again next month. The Clinical Audit and Effectiveness Lead continued to engage with Divisional and Specialty teams to expedite completion of NICE compliance reviews, the Chair of the Clinical Audit and Effectiveness Group would support this. Monthly updates regarding the NICE position will continue to be reported to the CGC on a monthly basis.
Maternity and Neonatal Report Two papers on the agenda as the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) report and the usual monthly report. The Neonatal mortality rate was 1.16 per 1,000 live births. This was more than 5% higher than the average for similar Trusts (Red rating) which triangulated with information the Trust was already aware off and improving.	To ensure oversight of any trends in the last 3 years Trusts were reviewing their PMRT and HSIB investigations to identify any avoidable causes of mortality.	It was noted that the neonatal mortality external review commenced in May 2023 and was expected to be completed by September 2023 and the outcomes of the review would be formally reported to this Committee.
Cardiac Peer Review On 16th November 2022 the Cardiac Intensive Care Unit (CITU) underwent a peer review by the Lancashire and South Cumbria Critical Care Network with the final report being shared on the 25th May 2023.	Members attention was drawn to the action plan and that the dates for delivery were not included.	A more up to date, comprehensive action plan would be presented to the next meeting which would include completion dates and provide members with a level of assurance on the actions being taken following the review.
Risk Management Committee (RMC) - Escalation Report	The report provided updates on both these matters.	Confirmed that these would continually be monitored at the RMC.

There were two alerts noted from the RMC, Pathology LIMS System Installation and the Paediatric Dictated Letters.		
Integrated Performance Report A challenge was flagged in relation to the Friends and Family Test for Maternity as the overall satisfaction was 86%, which was an 8% decrease on the previous month and remaining below the trust target of 95%. In relation to mixed sex breaches in June there were 8 mixed sex breaches.	Members were informed that work was still on going in relation to including trajectories for all data within the IPR.	A full report on patient experience would be presented to the September 2023 Committee. It was noted that the IPR was a working progress and improvement would be seen over the coming months.
Inpatient Survey A high-level summary was provided at this meeting as the full results from the Inpatient survey was still embargoed when this report was submitted.	Members were advised that of the 70 Trusts that were surveyed, Blackpool Teaching Hospitals ranked at number 32 for overall positive scores.	A full comprehensive report supported by actions to be taken would be provided to the next meeting.
Infection Prevention and Control and IPC BAF The Trust breached its 2022/23 NHS Standard Contract threshold for MRSA, E. coli, Klebsiella spp. and P. aeruginosa blood stream infections	Several key actions had been incorporated in Trust Annual Infection Prevention Programme for 2023/24. These actions include targeted HCAI education for Divisional teams as well as training on how to undertake enhanced surveillance, root cause analysis and post infection reviews.	The next report would be presented to the November 2023 meeting.
Mortality and Learning from Deaths SHMI continued to improve, and was at 102, the lowest level since July 2021. It must be noted, that 102 was within the normal range of 90 - 110 for an Acute Trust. The Trust was an outlier for Stroke.	The Stroke Improvement Board was monitoring this and Executive Directors were supporting that group to accelerate key actions to support sustainability.	An update on Stroke would be provided to the next meeting.

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Assurance		
What	**So What**	**What Next**
Safeguarding The Trust had received national accreditation for its services to domestic abuse and for serious violence presentation in ED. National recognition and royal recognition had been received for services to victims of serious violence in the ED department which the Trust provided. National Patient Safety Award for the response to victims of domestic abuse.	Trust was compliant with all KPIs - the only organisation in the northwest region fully compliant.	Members welcomed the significant positive progress on MCA and DOLS and the clear overall, trajectory of improvements around safeguarding.
Cardiac Arrest Report Reported that the Integrated Performance Report (IPR) provided the Committee with the number of arrests that occur in hospital over time (monthly), but sub-data was now included within this report to provide more detail.	It was noted that the Trust Acutely Unwell Patient Collaborative aimed to achieve and sustain a mean Trust cardiac arrest rate of 1.0 per 1,000 admissions, by September 2024. Members were made aware that progress had been made and the Trust was expecting a trajectory of sustained improvement.	Committee requested additional information on the outcomes of cardiac arrest that occur and it was agreed that the Deputy Medical Director would seek this information.
Waiting List Risk Assessments/Harm Reviews and SOP None of the completed harm reviews had incurred moderate or server harm because of delayed treatment, with only 28 (29%) demonstrating low harm.	The process for harm review was being embedded and a weekly Senior Operational Assurance Group (SOAG) that takes place includes harm reviews on that agenda to ensure it was reviewed weekly and managed.	Members noted the grip and control the Trust had on this matter and welcomed the positive progress
Safe Staffing The Deputy Director of Nursing provided clarity on the safe staffing	Following a data cleanse, we have 146 WTE vacancies for Registered Nurse and 106.3 for Clinical Support workers.	A level of assurance was provided that the Trust will be all full complement of nursing by the end of 2023.

	It was noted that the Trust had a robust pipeline of nurses that will be recruited into the Trust. A level of assurance was provided that the	
Board Assurance Framework (BAF) Committee members noted the quality element of the BAF.	Agenda items covered key risks included on the BAF.	No new areas identified for inclusion on the BAF
Patient Story The story featured the Foster Carer of a child who had been neglected and had a number of conditions that had gone untreated resulting in them coming into their care at 5 months old.	The foster carer had come into contact with Dr Kate Goldberg and the team at Blenheim House who played a huge part in getting this child the referrals and treatment they needed	Members welcomed the powerful story and the positive outcomes due to a Multi-disciplinary approach. It was agreed that the staff involved in the care from the patient story would be acknowledged with a thank you from the Committee.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Integrated Performance Report (IPR) – Quality

Meeting:	Board of Directors Meeting
Date:	7th September 2023

Author	William Wood, Associate Director of Business Intelligence					
Exec Sponsor	Bridget Lees, Executive Director of Nursing, Midwifery, AHP and Quality Chris Barben, Executive Medical Director					
Purpose	Assurance	✓	Discussion	✓	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise**
	Falls - Falls overall remain within normal variation. **Pressure Ulcers (PU)** – PU overall remain within normal variation and there had been a reduction from the previous month. **Patient Experience** - 95% of our patients rated their care as good in July which is a 1% increase on the previous month, keeping in line with the Trust's target of 95%. **Infection Prevention** - The Trust is currently on trajectory for MRSA, Klebsiella spp and Pseudomonas aeruginosa.
Implications *(so what)*	**Alert**
	Pressure Ulcers (PU) - 2 Category 3 pressure ulcers have been validated for the acute site in the month of July. 72-hour reviews have been completed to ensure immediate safety actions taken and wider lessons are also identified for sharing across the organisation through inclusion in the pressure ulcer reduction framework. **Emergency Department / Same Day Emergency Care - Friends and Family Test** – The overall satisfaction rating was 71%, which is a 1% decrease on the previous month and remains below our Trust target of 86%. Our ED (Emergency Department) target is currently set at 86% which is thought to be attainable and in line with other trusts. **Infection Control** - The Trust was currently above plan for MSSA, CDI and E Coli for July 2023. **% of Deaths Screened** - There has been a significant reduction in the percentage of deaths screened in the last 2 months. Previously compliance with this was being supported significantly by the Associate Medical Director for Mortality, who has recently been redirected to dealing with another task. Their involvement in this is due to finish in the

	coming weeks, allowing them to then support screening (via the Learning for Deaths app) but also develop a new process to ensure this is completed by the clinical teams. In addition, all deaths (except those referred to the Coroner) are reviewed by the Medical Examiners, senior independent doctors from within the Trust who have not been involved in the patient's care, and look at both the quality of care provided, and assess the accuracy of the proposed cause of death.
	Assure
	Mortality - SHMI continues to improve and as of May 2023 is at 100.3. **Maternity** - There were no neonatal deaths in July 2023 and no Still Births.

Previously considered by	Quality Assurance Committee.

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	✓

Equality, Diversity and Inclusion (EDI) implications	In preparing this report consideration was given to EDI implications – failing to improve our KPIs could worsen inequality and exclusion.

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

Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Quality Assurance Committee

July 2023

Caring ▪ Safe ▪ Respectful

Guide to Statistical Process Control

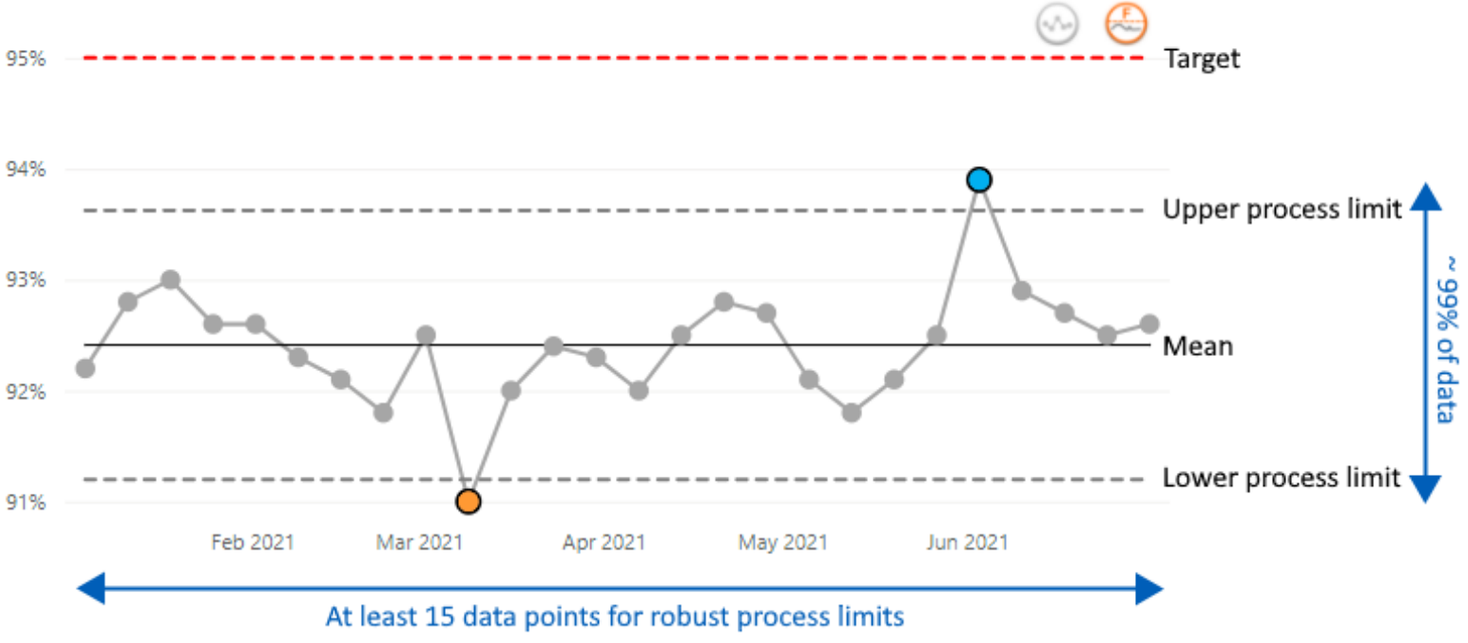
Blackpool Teaching Hospitals NHS Foundation Trust

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			
								
Quality	Harm Free	1	13	2	2	2	2	14	
	Patient Experience	3	10		1	1		13	
	Maternity				13	1		12	
	Infection Prevention and Control		6					6	
	Mortality		1	2	3		3	2	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.

Blackpool Teaching Hospitals
NHS Foundation Trust

Harm Free

Cardiac Arrests
Advise:
The resuscitation team at Blackpool Teaching Hospitals recorded 116 Adult cardiac arrests between June 2021 and June 2022 with 86 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 1.075 arrests per 1000 admissions to the trust.
As a comparison the figures between June 2022 and June 2023 are a total of 95 Adult cardiac arrests, with 68 outside those areas previously listed. The total number of cardiac arrests in the trust in this time frame equates to 0.834 arrests per 1000 admissions to the trust.
It is challenging to examine arrest data against rate of admission, due to the exclusion of ED, ITU/HDU, cardiology catheter labs and CCU from the data, hence why the data per 1000 is only representing the total number of Adult cardiac arrests in the given time frame.
Assurance:
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.

Patient Safety Alerts
There were 2 new patient safety alerts received this month which are:
NatPSA/2023/009/OHID - Potent synthetic opioids implicated in heroin overdoses and deaths. The due response date for this is 04/08/2023.
NatPSA/2023/008/DHSC - Shortage of GLP-1 receptor agonists. The due response date for this is 18/10/2023.

Falls
Advise:
In July, across inpatient areas, 20 wards reported zero falls, and there was a total of 127 incidents reported against the category of falls across the rest - this number includes near miss, falls with no harm and unvalidated incidents that are currently under review within divisions and awaiting categorisation. Validated data shows 65 harms recorded because of a fall and 64 of these validated as minimal harm. Overall, this is below plan.

Alert:
There was one fall with moderate harm, a fractured neck of femur, 72 hours has been completed and actions taken to prevent this from happing in future.

Assure:
The intentional rounding tool (IR) will launch across the organisation in October – using a risk assessment framework this will support staff to work with patients to identify risk and plan mitigation to prevent falls. Following the launch of the Fundamentals of Care – the fall's steering group has increased and includes medical, nursing and AHP staff and spans both the acute and community. This group will focus on sharing best practice standards to prevent falls, improved access to education for prevention and post falls management. Also, a falls prevention framework across the acute and community trust.

Pressure Ulcers
Acute
Advise:
A total of 42 hospital acquired pressure ulcers were reported in July that includes 16 Category 2's – this is below the trajectory of 1.4 per 1000 beds and as an improved position. In addition, the acute reported 6 unstageable and 18 Deep Tissue Injuries, however – this is also decreased on previous months.

Alert:
2 Category 3 pressure ulcers have been validated for the acute site in the month of July. 72-hour reviews have been completed to ensure immediate safety actions taken and wider lessons are also identified for sharing across the organisation through inclusion in the pressure ulcer reduction framework.

Harm Free

Assure:
In month the acute site reported zero Category 4 pressure ulcers. Also of note, during July, 30 clinical areas declared zero health care associated pressure ulcers; and of these areas - 11 have reported zero attributable skin damage in the last 6 months. The skin integrity committee continues to support the divisional teams to ensure prevention and management of skin and tissue damage remains a priority. Whilst the organisation has continued to experience high pressures within the Emergency Department, there has been a renewed focus on joint working between the Tissue Viability team and the senior ED nurses with a daily huddle in the department with good effect and impact on harm.
The project to implement nurse led wound photography has commenced in Clifton Hospital. The Fundamentals of Care Pressure Ulcer Group has commenced with priority one being to support the roll out of purpose T across the organisation through October 2023.

Community
Advise:
A total of 98 non-hospital health care associated (community) pressure ulcers were reported in July, remaining in normal variation though above the stretch target. This includes 35 Category 2's, 17 Unstageable and 39 Deep Tissue Injuries which is an improved position on the previous month of 92.

Alert:
Validation has confirmed 5 category 3's and 2 at Category 4 – 4 of which were attributed to a single patient. Reviews are underway to ensure immediate safety actions taken and wider lessons are also identified for sharing across the organisation through inclusion in the pressure ulcer reduction framework.

Assure:
One community team identified as having acquired zero pressure ulcers. The community validation project is well underway with 5 District Nurse Bases now validating category 2 pressure ulcers. For assurance of this process - audit to monitor the validation is undertaken and managed by the Tissue Viability Team. The community teams are part of the Fundamentals of Care Pressure Ulcer Group and supporting the roll out of purpose T.

Quality

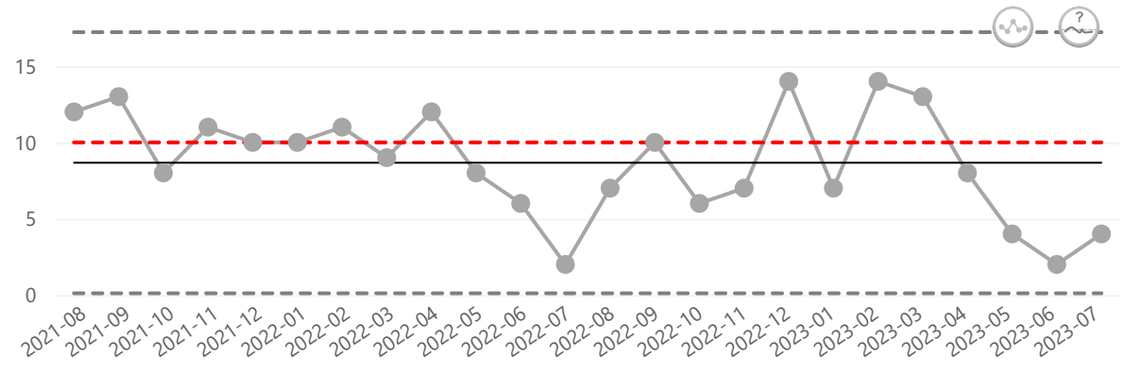
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Cardiac Arrest	10	4	Jul 23			10	2	Jun 23	40	18.00
IAPT Recovery	50%	51%	Jul 23			50%	61%	Jun 23		
IAPT Wait Times	75%	99%	Jul 23	H	P	75%	97%	Jun 23		
Over-seven-day incapacitation of a worker	0	1	Jul 23			0	1	Jun 23	0	3.00
Specified injuries to workers	0	1	Jul 23			0	1	Jun 23	0	3.00
Inpatient Category 2 pressure ulcers per 1000 bed days	1.4	0.6	Jul 23			1.4	0.97	Jun 23	1.4	0.6
Inpatient Category 3/4 pressure ulcers per 1000 bed days	0	0.07	Jul 23			0	0.12	Jun 23	0	0.07
Inpatient DTI/US pressure ulcers per 1000 bed days	0.22	0.9	Jul 23		F	0.22	1.44	Jun 23	0.22	0.9
Community Category 2 pressure ulcers per 1000 bed days	1.4	1.31	Jul 23			1.4	1.48	Jun 23	1.4	1.31
Community Category 3/4 pressure ulcers per 1000 bed days	0	0.26	Jul 23			0	0.19	Jun 23	0	0.26
Community DTI/US pressure ulcers per 1000 bed days	0.22	2.1	Jul 23		F	0.22	3.57	Jun 23	0.22	2.1
Patient Safety Alerts		2	Jul 23				1	Jun 23		4.00
Number of SUI/StEIS incidents		4	Jul 23				10	Jun 23		28.00

Quality

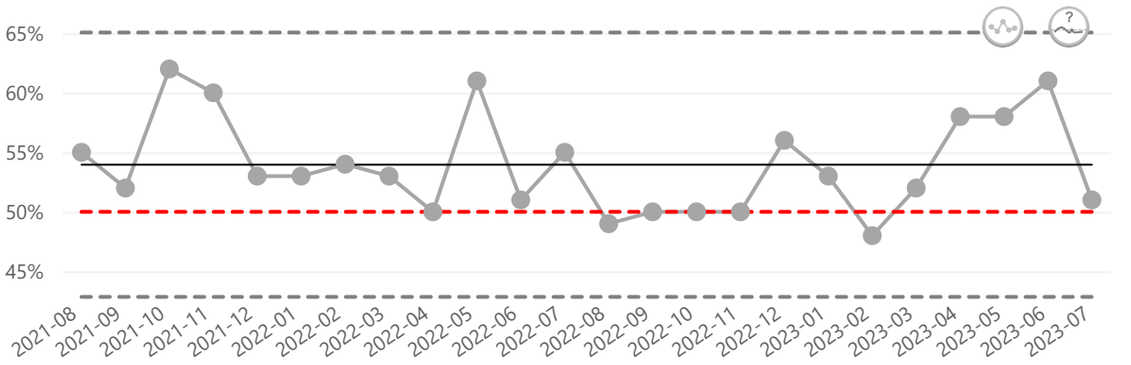
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Number of never events	0	0	Jul 23			0	0	Jun 23	0	0.00
All Inpatient Falls per 1000 bed days	6.42	4.75	Jul 23			6.42	4.93	Jun 23	6.42	4.75
Inpatient Falls with moderate and above harm per 1000 bed days	0.14	0.04	Jul 23			0.14	0	Jun 23	0.14	0.04
Safe Staffing	90%	92%	Jul 23			90%	91.5%	Jun 23		
30 Day Emergency Readmissions (%)	7.12%	7.91%	Apr 23			7.12%	8.49%	Mar 23		

Quality

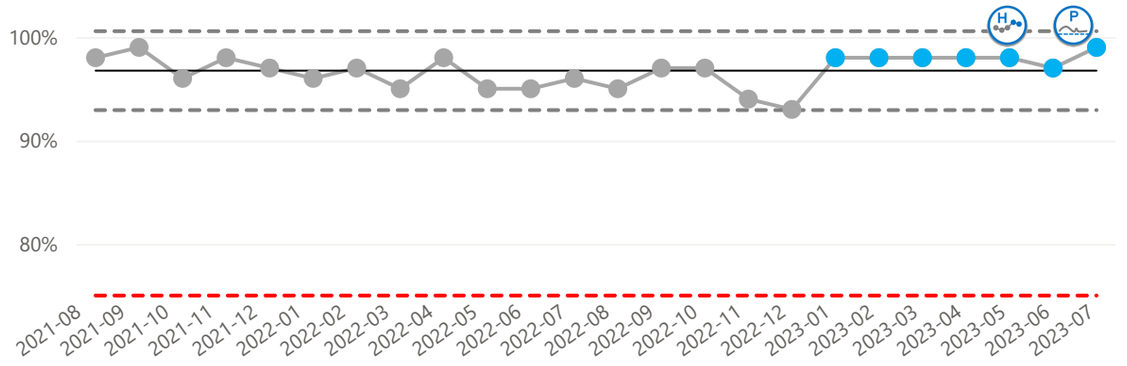
Cardiac Arrest



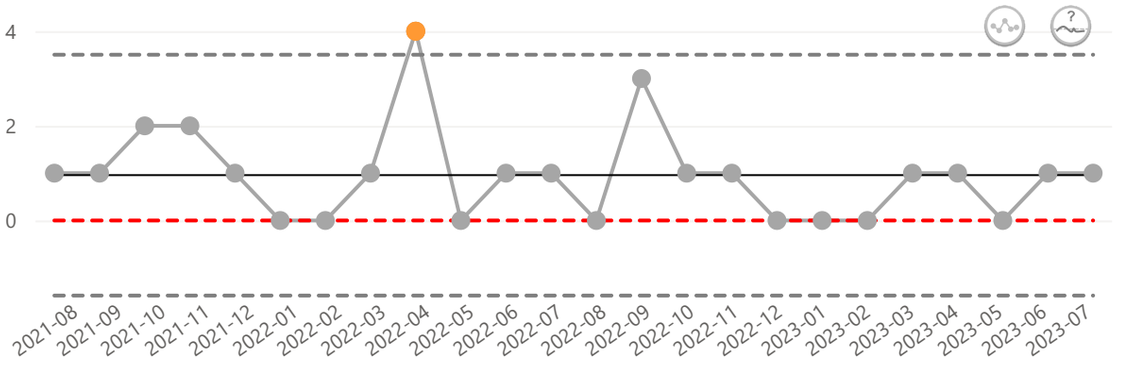
IAPT Recovery



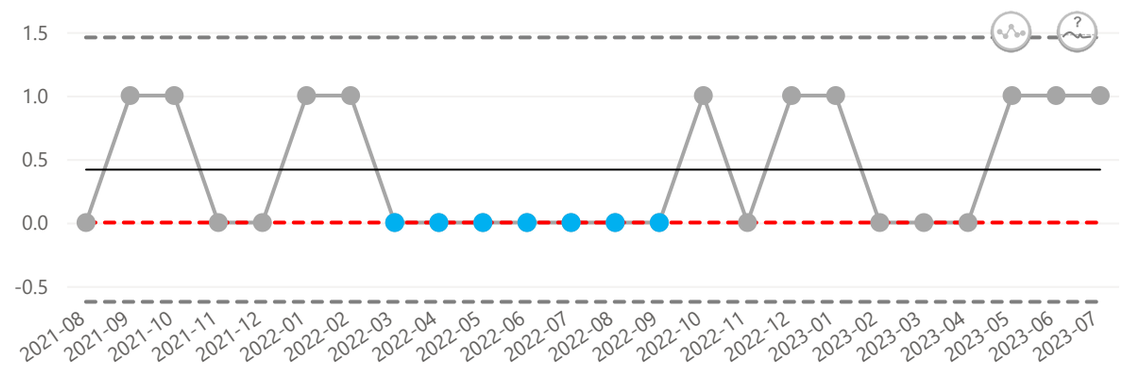
IAPT Wait Times



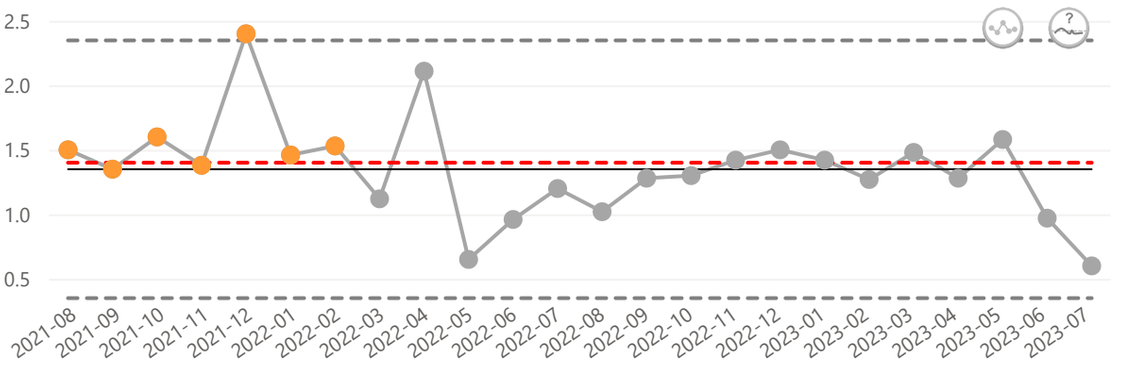
Over-seven-day incapacitation of a worker



Specified injuries to workers

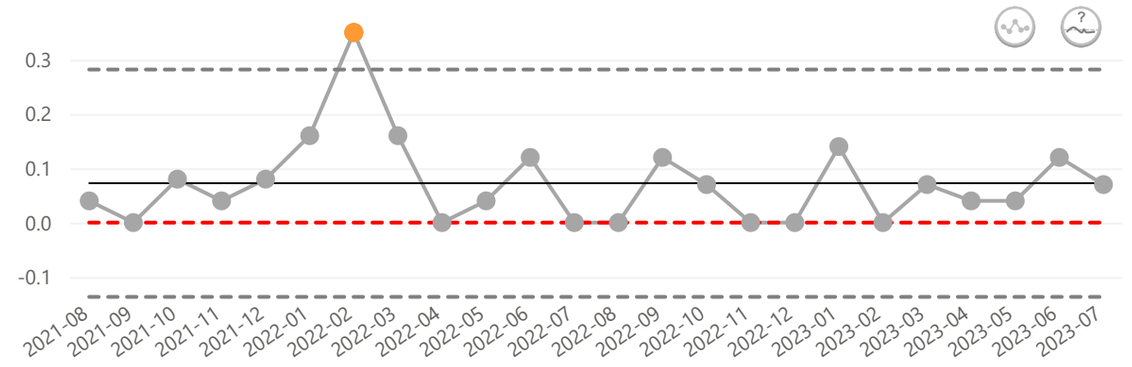


Inpatient Category 2 pressure ulcers per 1000 bed days

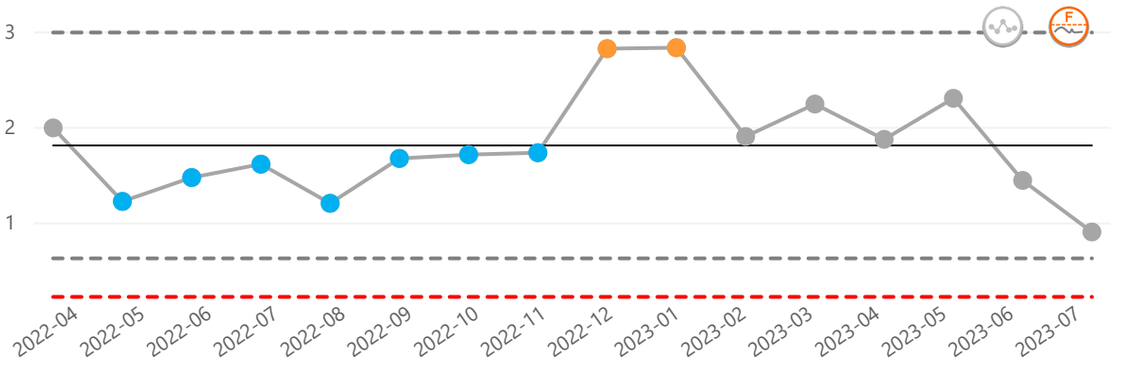


Quality

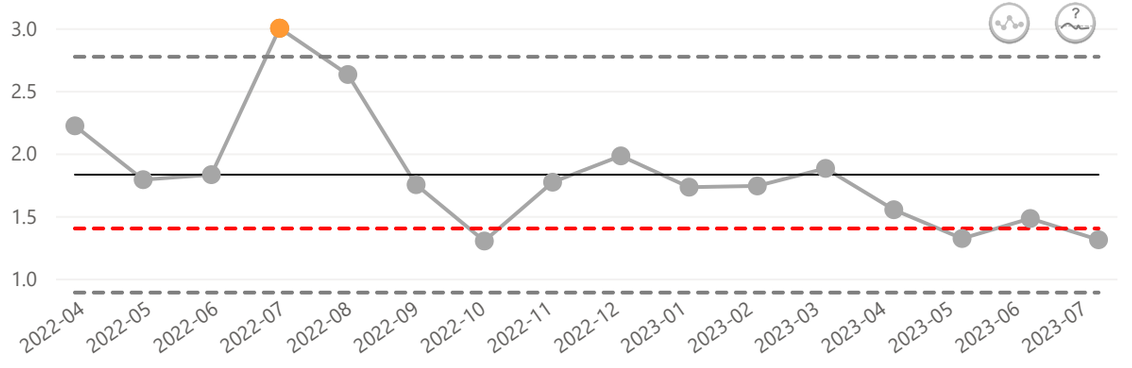
Inpatient Category 3/4 pressure ulcers per 1000 bed days



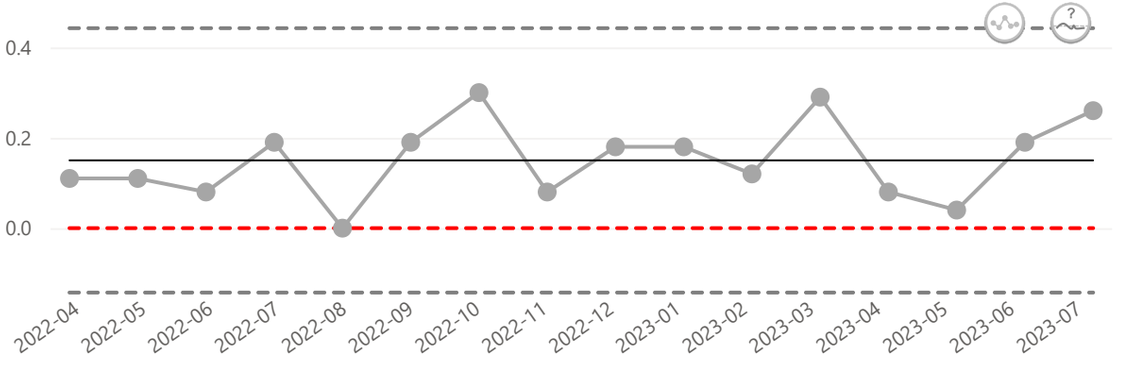
Inpatient DTI/US pressure ulcers per 1000 bed days



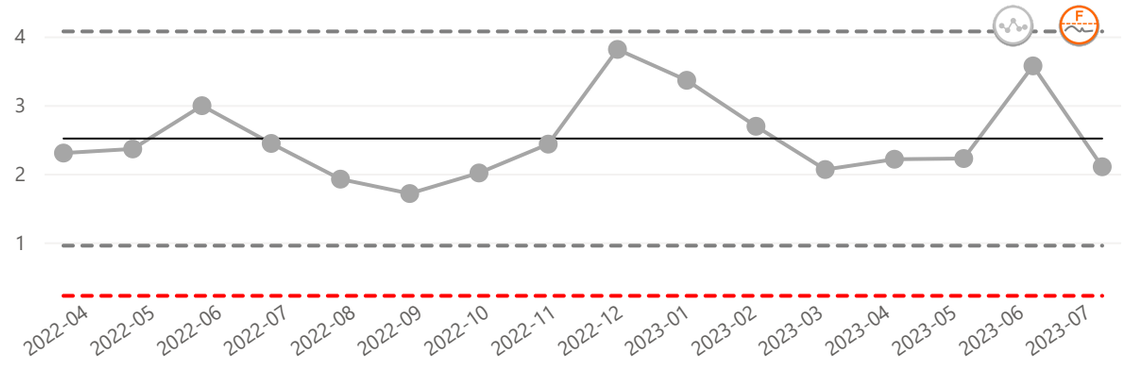
Community Category 2 pressure ulcers per 1000 bed days



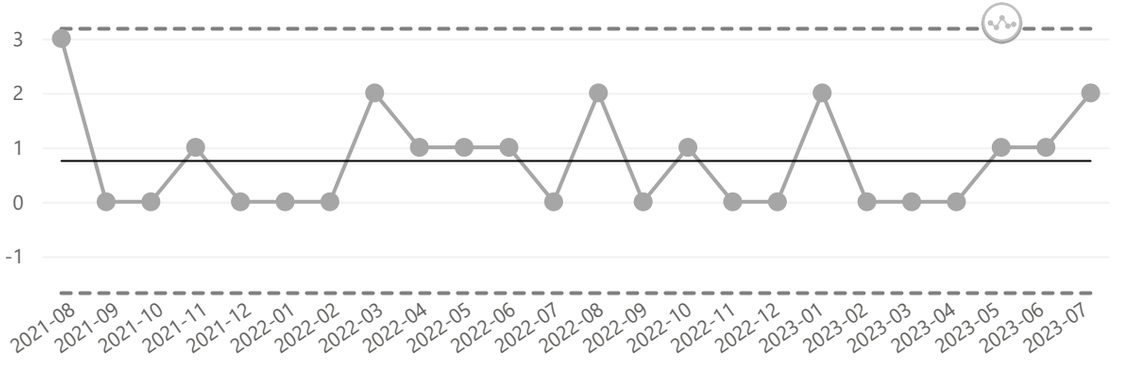
Community Category 3/4 pressure ulcers per 1000 bed days



Community DTI/US pressure ulcers per 1000 bed days

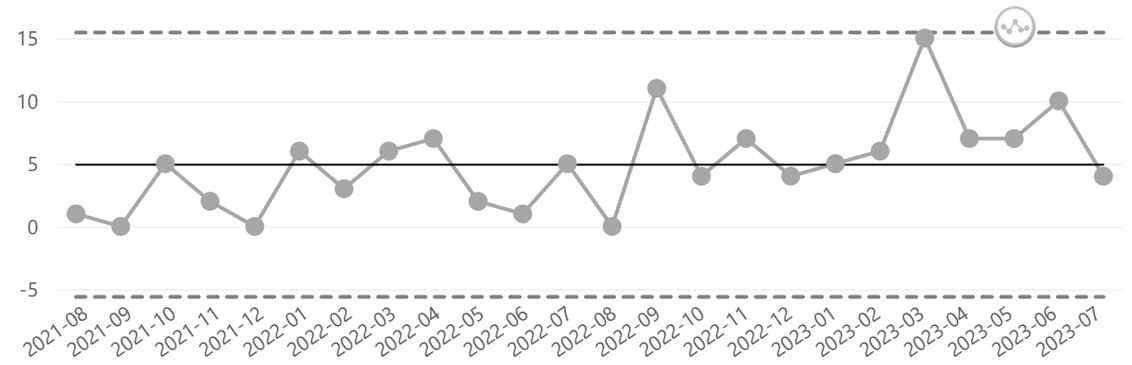


Patient Safety Alerts

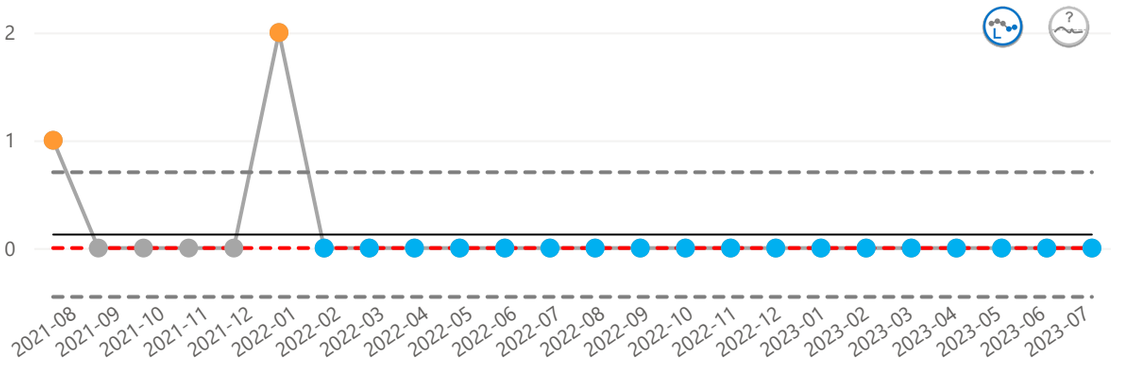


Quality

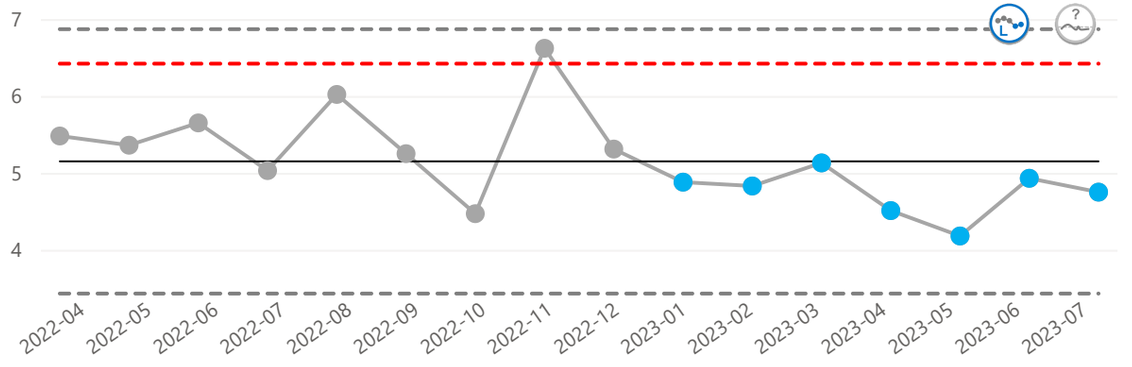
Number of SUI/StEIS incidents



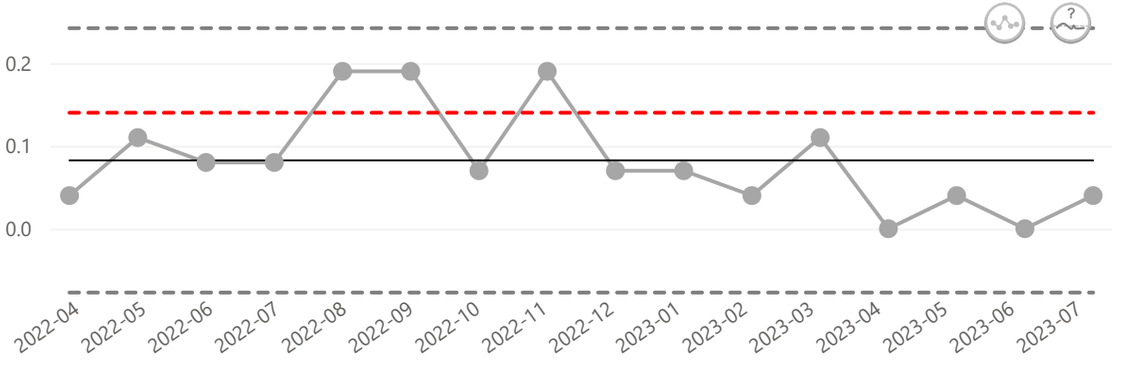
Number of never events



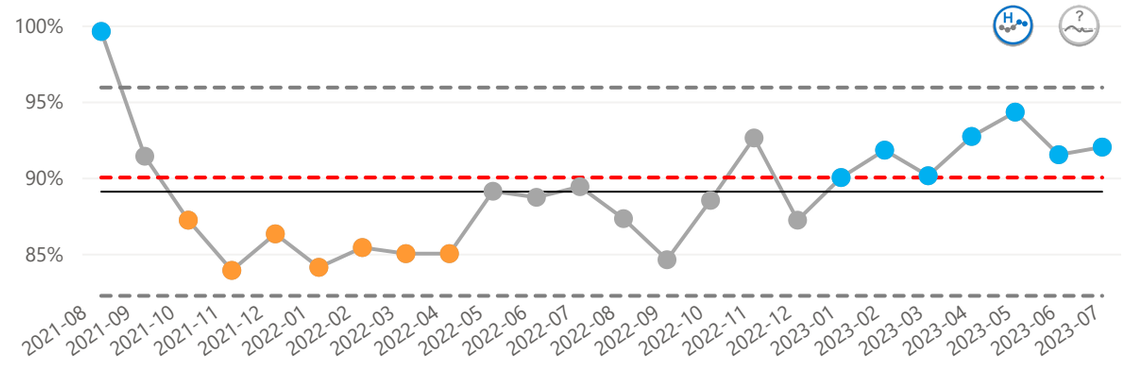
All Inpatient Falls per 1000 bed days



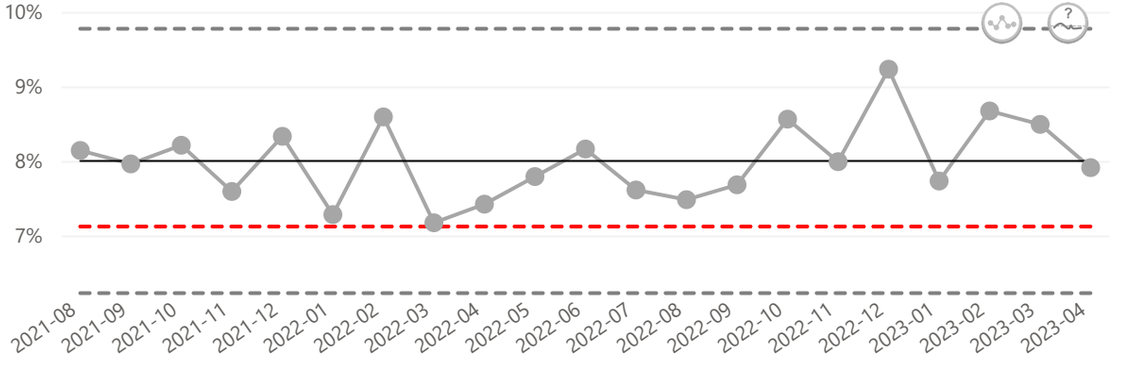
Inpatient Falls with moderate and above harm per 1000 bed days



Safe Staffing



30 Day Emergency Readmissions (%)



Blackpool Teaching Hospitals
NHS Foundation Trust

Maternity

Caesarean section rates - Advise – not triggering this month and has reduced in both emergency and total c/s figures | Caesarean 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, this is because every effort should be made to provide a caesarean section for women in need, rather than striving to achieve a specific rate and because there is no scientifically proven classification system to observe and compare caesarean rates between Maternity Units | Assurance/Action -The division are currently working through how this information will be collated and included in the local maternity metrics. QI deep dive on maternity dashboard and reporting data occurred 11/08/2023 supported by the MSSP. Reporting capability confirmed present through digital system (Badgernet).

Breastfeeding initiation - Alert – has decreased slightly from June from 75.7% to 72.2% | Assurance/ Action- There are strategic and operational infant feeding meetings held regularly, incorporating the wider agencies within Blackpool Fylde and Wyre. The ambition is for all areas to achieve level 2 BFI accreditation by the end of next year. This is a collaborative approach between, Midwifery, health visiting and children services. Infant feeding education has been increased across the area to support improving breastfeeding rates and help sustain work already implemented within this area which resulted in improvements, with further resources planned for the next year.

Neonatal mortality, stillbirth and maternal deaths - Assurance - all areas are reporting 0 for the month of July | Advise-There are 2 open HSIB cases – 1 awaiting the final report. Maternity Services are undertaking a retrospective review of PMRT and HSIB reports and action plans with the multidisciplinary team in August 2023. There is also a plan to review all stillbirth cases for the last 3 years using the 'Saving Babies Lives' processes to benchmark their maternity pathway. This will enable the findings to be matched against the PMRT/HSIB actions to ensure all issues and areas of concern have been picked up. Findings will be reported to Trust Board level and shared with the LMNS and ICB. The neonatal mortality external review commenced in May 2023 and is expected to be completed by September 2023. Findings and next steps will also be reported to Trust Board level and shared with the LMNS, NWODN and ICB.

Induction rate - Assurance - has remained consistent at 47% | Advise- There were 97 inductions in July, 47.3% were recorded to have progressed within 4 hours. Due to annual leave, the induction of labour % within 4 hours audit is not yet ready for this IPR but will be combined with next months. Induction of labour delays is monitored daily through safety huddles, and flow meetings and risk assessments completed by the consultant of the day daily.

Maternity complaints as % of deliveries - Alert – maternity complaints remain within the upper limits at 5% of all deliveries. 1 formal complaint and 2 informal complaints were received in July | Assurance/ action – All complaints reviewed, and families contacted to ensure lessons are learnt and families' experiences are heard. The divisional quadrumvirate are reviewing roles and responsibilities to ensure all complaints are being reviewed and resolved within a timely manner. Head of Midwifery and consultant midwife will review all complaints to address key themes and ensure actions to decrease further complaints, are being implemented and monitored.

Percentage of Occasions 1:1 Care provided - 1:1 care is quality marker for a maternity service and evidence safe care | Assure-The ambition is to achieve 100% consistently and this is the required target for the maternity incentive scheme safety action 5 year 5. The maternity matron for inpatient care will be proactively reviewing and auditing anyone who is documented as not having 1:1 to care. In July there was 0.5 records documented as incomplete resulting as not validated to achieve 1:1 care. When this documenting error is rectified, we will achieve 100% in July | Advise- Birth rate plus acuity tool monitors increase in staffing and acuity and midwifery red flags (A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing). Mitigating actions and redeployment of staff to achieve 1:1 care can be documented through this system. The tool was completed 73.66% in July with 86% achieving safe staffing levels, 10% where 2 or less midwives were needed and 5% where two or more were midwives required. The aim is to increase completion percentage to increase accuracy of safe staffing reporting.

Blackpool Teaching Hospitals
NHS Foundation Trust

Maternity

3rd and 4th degree tears - Alert – There were 7 women who sustained a 3rd degree tear (5 women 3a, 2 women 3c) in the month of July, 0 women sustained a 4th degree tear. Grade 3a tear= Less than 50% of external anal sphincter (EAS) thickness torn. Grade 3b tear= More than 50% of EAS thickness torn. Grade 3c tear= Both EAS and internal anal sphincter (IAS) torn | Assurance/ action – Ongoing training within of OAIs (obstetric Anal Injury) care bundle and followed up by OASI 2. All 3rd and 4th degree tears reviewed to ensure key themes and learning is actioned to work towards decreasing this rate. A new pelvic health midwife job is currently live and will contribute to the train the trainer programme and target of training at least 75% of midwives by November 2023 and also support increasing patient experience and after care, working closely within the ICS perinatal pelvic health team.

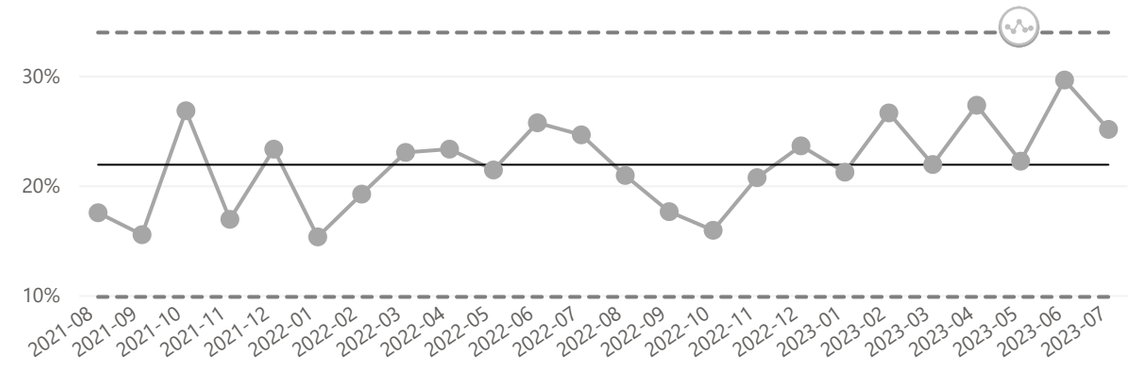
Percentage of Women Booked by 12 weeks and 6 days - Assurance – 91.5% of women were booked before 12 +6/40 | Advise -The new addition of a maternity matron for community and enhanced care services commenced in May. This role will help and support the care women will receive throughout their pregnancy journey and contribute to the early identification of medical and social risk factors to ensure appropriate referral and booking.

Quality

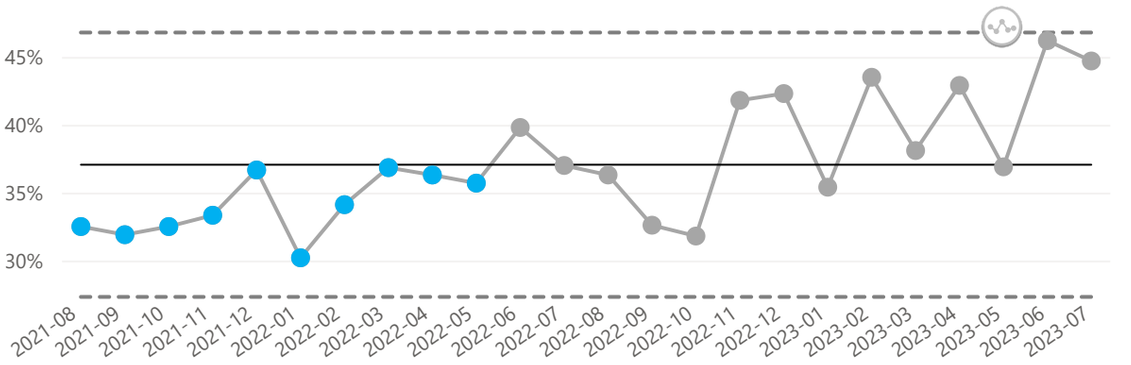
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Emergency C Section		25.1%	Jul 23				29.6%	Jun 23		
Caesarean Rates		44.7%	Jul 23				46.2%	Jun 23		
Breastfeeding Initiation		72.2%	Jul 23				75.7%	Jun 23		
Neonatal Mortality		0	Jul 23				0	Jun 23		0.00
Stillbirth		0	Jul 23				0	Jun 23		1.00
Number of Maternal Deaths		0	Jul 23				0	Jun 23		0.00
Induction Rate		47%	Jul 23				47.7%	Jun 23		
Maternity Complaints as % of Deliveries		5%	Jul 23				0.5%	Jun 23		
Percentage of Occasions 1:1 Care Provided		99.4%	Jul 23	H			98%	Jun 23		
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births		0.9%	Jul 23				0%	Jun 23		
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth		4.7%	Jul 23				0%	Jun 23		
Percentage of Women Booked by 12 weeks 6 days		91.5%	Jul 23				90.6%	Jun 23		
Induction of Labour - % within 4 hours		39.8%	Jul 23				47.3%	Jun 23		

Quality

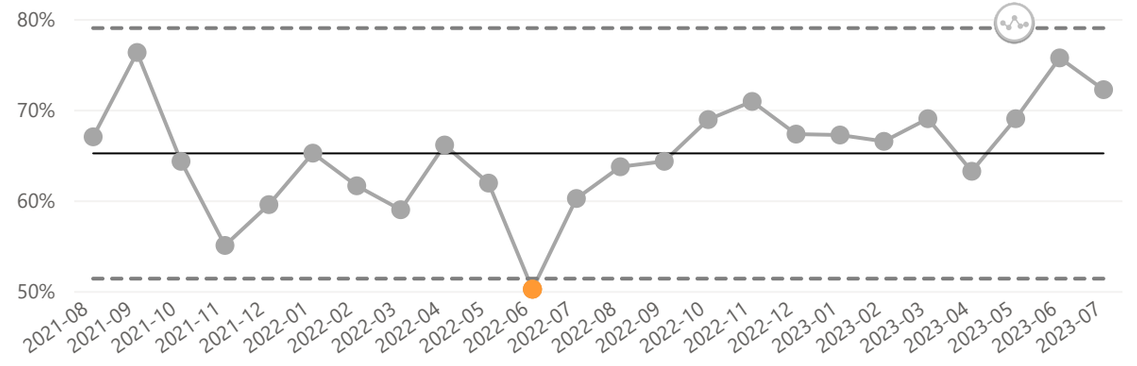
Emergency C Section



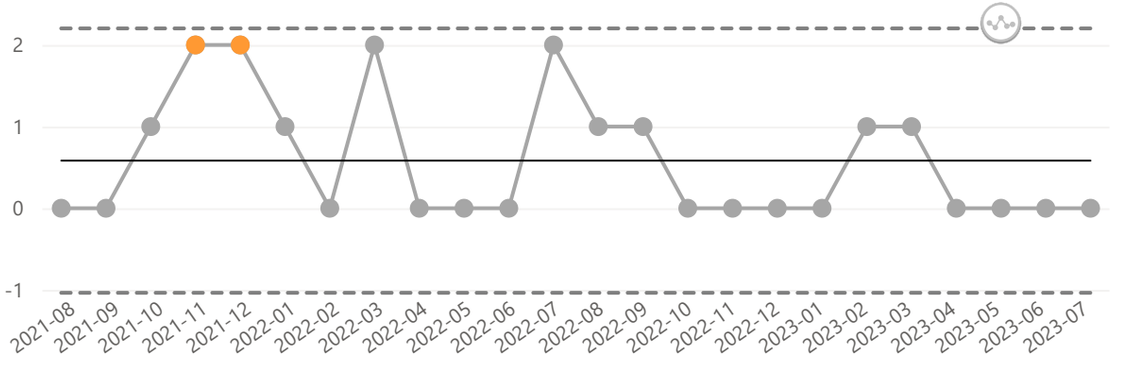
Caesarean Rates



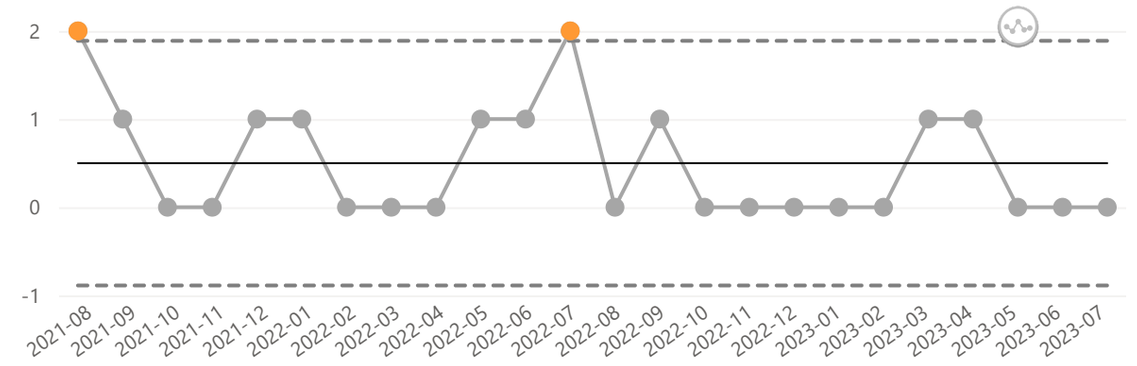
Breastfeeding Initiation



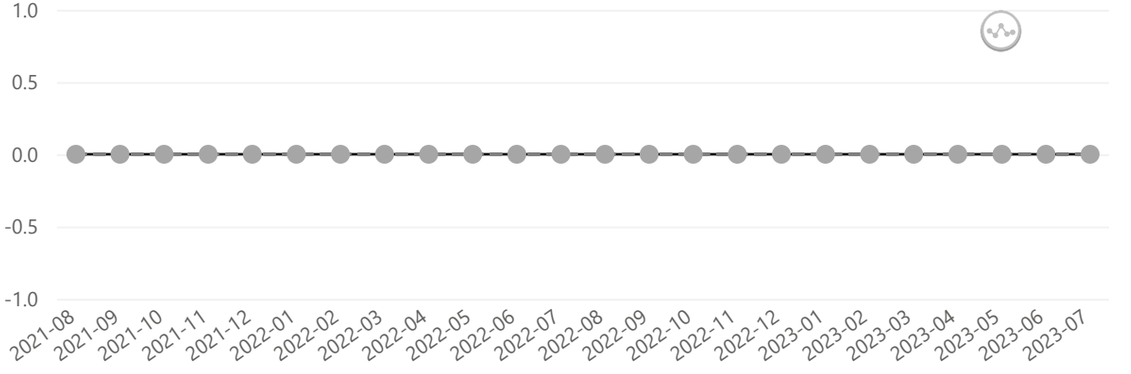
Neonatal Mortality



Stillbirth

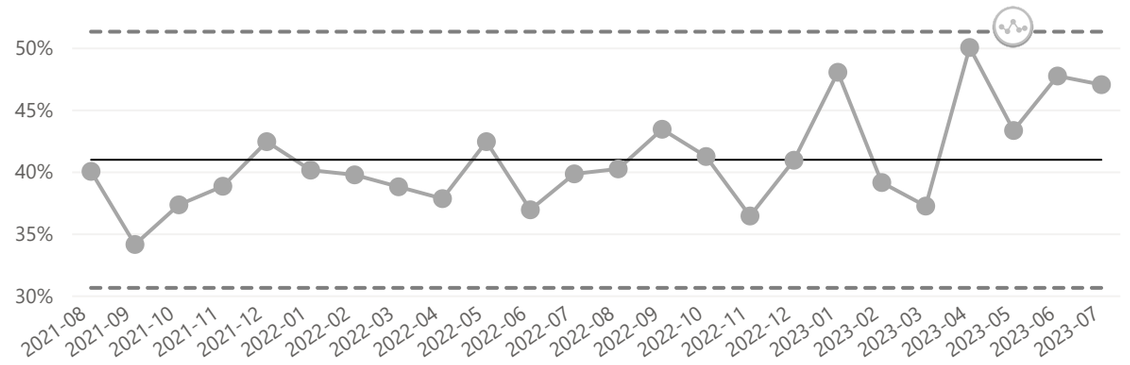


Number of Maternal Deaths

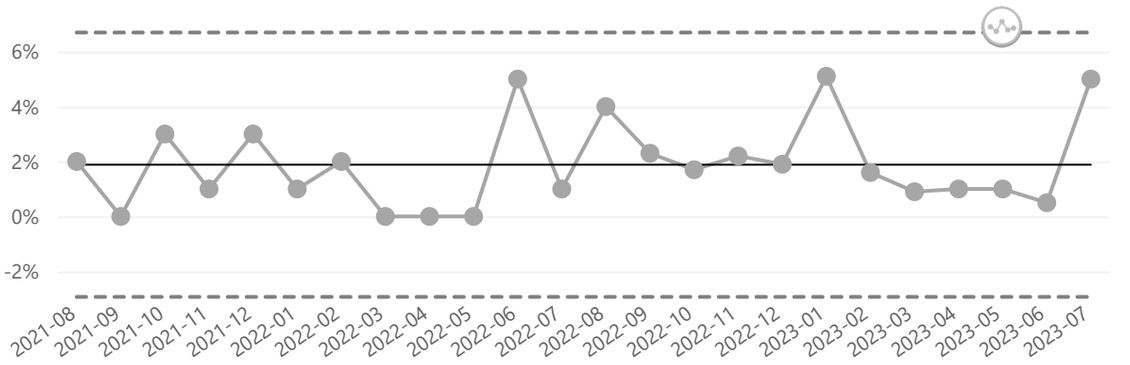


Quality

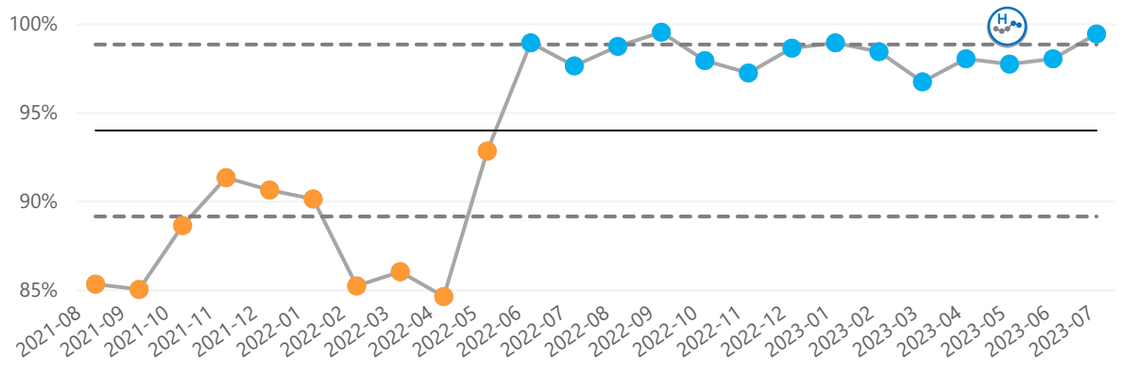
Induction Rate



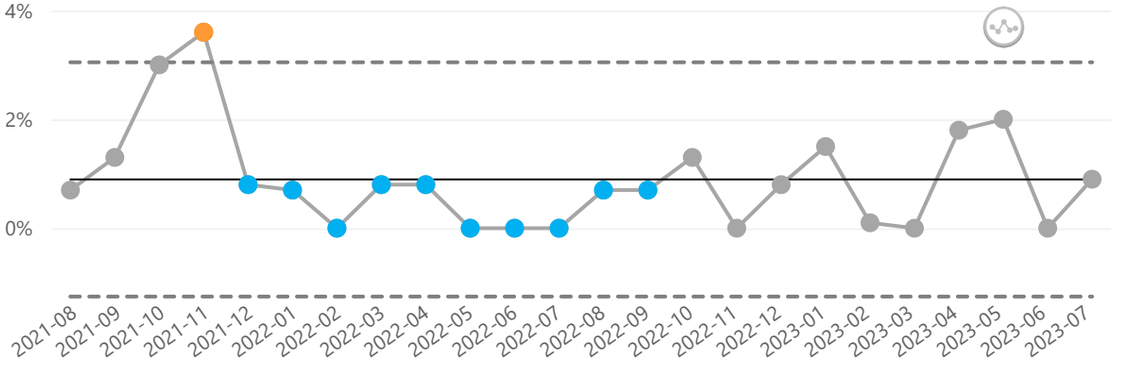
Maternity Complaints as % of Deliveries



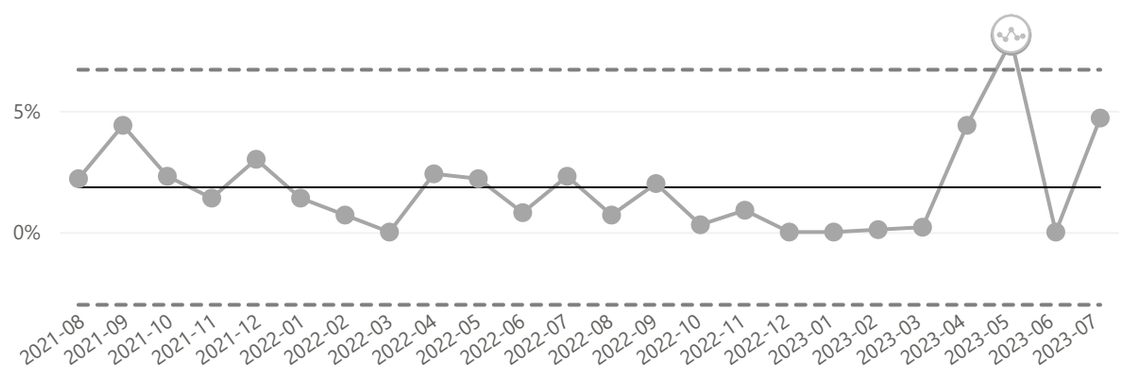
Percentage of Occasions 1:1 Care Provided



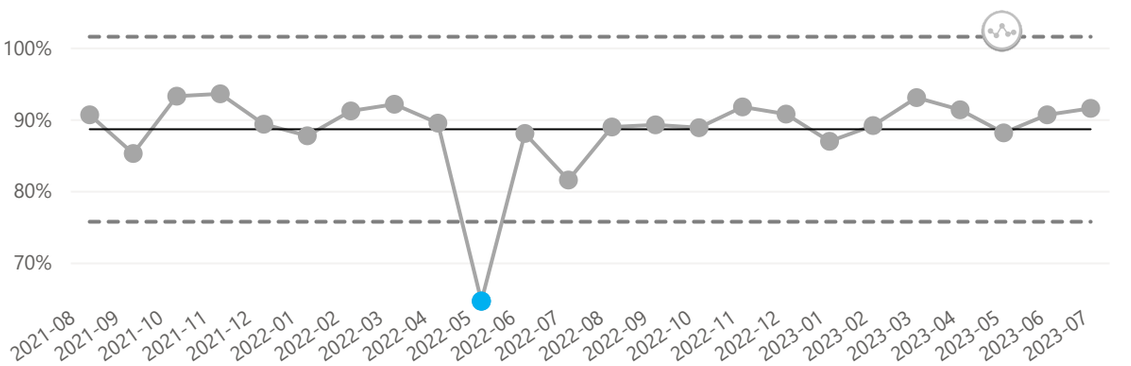
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births



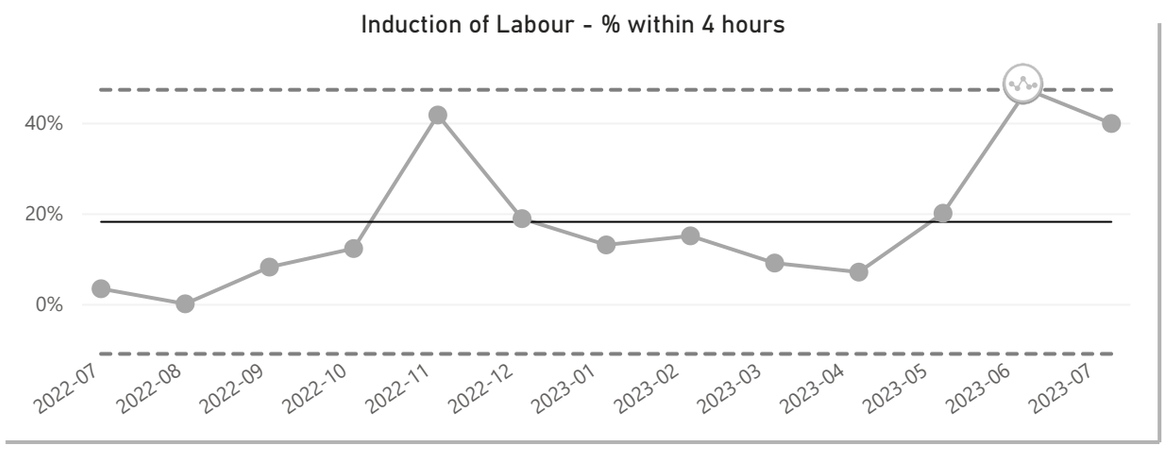
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth



Percentage of Women Booked by 12 weeks 6 days



Quality


Induction of Labour - % within 4 hours
40%
20%
0%
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07

Blackpool Teaching Hospitals
NHS Foundation Trust

Patient Experience

Overall, Friends and Family Test
Advise: There were 5063 FFT (Friends and Family Test) surveys completed in July 2023, which is an overall 3% decrease compared to June 2023. There was a 21% decrease in feedback received via SMS.
This decrease is due to SMS feedback not being available between 6th – 18th July.
Assure: 95% of our patients rated their care as good in July which is a 1% increase on the previous month, keeping in line with the Trust's target of 95%.
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 attended the Patient Carer Experience and Involvement Committee to discuss any actions from the previous meeting and other important topics with other Trust members.
SMS is continuing to be rolled out across the Trust, with 37% (1864) of the feedback in July collected via SMS or online. On July 19th, the provider of SMS feedback advised the trust that they had made a change in protocol resulting in the SMS data we were passing not being able to get through to them between the 6th – 18th July. Patient Engagement have worked alongside informatics to enable the text messages to be re sent to those patients that were missed after repeat security and exclusion checks were made. The Patient Engagement team have now set triggers in SMS response rates which will alert them if this were to happen again.

Outpatients and Day Case
Advise: There were 1999 FFT surveys completed for outpatients and day case in July, which is a 15% decrease compared to June.
Assure: The overall satisfaction rating was 95%, which is the same as last month and in line with the Trust target.
Actions: 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 35% of outpatient feedback this month via SMS, which will inform more targeted actions going forward.

Inpatient
Advise: There were 1188 FFT surveys completed by inpatients across Clifton and BTH (Blackpool Teaching Hospitals) sites in July, which is a 9% increase on the previous month.
Assure: The overall satisfaction rating was 97%, which is a 1% increase compared to June and above the Trust target of 95%.
Actions: SMS has been launched within inpatient areas which is supporting the numbers of responses received. However, 84% of feedback returned this month for inpatient areas have been paper surveys.
Patient Engagement attended the IMPF (Integrated Medicine and Patient Flow) action learning session, this allowed the opportunity for the team to discuss and share the work they do as a department and support collaborative working. We also provided training on the action manager software and how to respond appropriately to patient feedback with meaningful actions.

Emergency Department / Same Day Emergency Care
Advise: There were 306 FFT surveys completed in July, which is a 9% increase compared to June.
Alert: The overall satisfaction rating was 71%, which is a 1% decrease on the previous month and remains below our Trust target of 86%. Our ED (Emergency Department) target is currently set at 86% which is thought to be attainable and in line with other trusts.
Actions: The monthly meetings with the ED service leads continue to take place to identify new and emerging themes. 14 new volunteers have been recruited in ED, who will provide more consistent and continuous presence in the waiting area. Patient Experience contacted the voluntary services manager and spoke with the volunteers to confirm that they can help promote the completion of FFT and signposting to the QR codes. The team have also placed 8 new posters with QR codes and links (A3 & A4) around the department. These have been placed at entrance and exit points, along the corridor, and in the waiting room. There are now 19 QR points across ED, and the ED Paediatric department.
As part of our continued communication with health informatics, we have highlighted to them the importance of reviewing the existing ED SMS script. This will ensure that all exclusions that are currently included are accurate, will give assurance that this is capturing all patients that are visiting the department and ensure that the script is up to date.
Patient Engagement have collaborated with Patient Relations to create a monthly report for ED to present at their Governance meeting. This will show our ongoing work with the department as well as offer them any additional support.

Patient Experience

Maternity
Advise: There were 121 FFT surveys completed for maternity in July, which is a 4% increase compared to June.
Alert: The overall satisfaction was 89%, which is a 3% increase on the previous month but remaining below the trust target of 95%.
Actions: Patient Engagement continue to hold monthly meetings with the maternity team. Following the FFT feedback received, the team have worked with Ward D to create a poster and an information leaflet. The poster has been laminated and placed on the ward and in the bays, whilst the information leaflet is handed to patients on arrival. The poster and leaflet contain key information such as contact numbers, a picture of each staff members uniform, the standard protocol for each stage of pregnancy, and a diagram of the layout of the ward. The leaflet and poster have been further reviewed by Patient Experience, the manager on Ward D and patient feedback which has resulted in further changes being made.
Translated FFT forms have now also been distributed within maternity, which will increase feedback for non-English speaking patients.

Community
Advise: There were 1358 FFT surveys completed in July within the community, which is a 4% increase compared to June.
Assurance: The overall satisfaction was 98% which is a 2% increase compared to last month, and above the Trust target.
Actions: Patient Engagement continues to hold meetings with informatics every two weeks. SMS has now been rolled out within the mental health services, and we are now looking to roll it out within community. This will improve overall responses and give us more specific feedback. The Patient Engagement team are working closely with the sexual health services to promote the importance of alternative translated FFT forms, increasing the number of surveys from patients who cannot provide feedback in English. Our 6 most common available languages have now been translated on the experience system, to allow non-English-speaking patients to feedback on their care online as well as paper format. QR codes and links have been created and distributed to the sexual health teams.

Paediatrics
Advise: There were 420 FFT surveys completed across paediatrics in July, which is a 6% decrease compared to June.
Assurance: The overall satisfaction was 97%, which is a 6% increase on the previous month and above the Trust target of 95%.
Actions: 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. We discuss which services have had no responses and how we can better this for the following month. Updated QR codes and posters have been sent and FFT forms have been ordered to the departments with no responses this month. A Paediatric Patient Experience report is shared with nursing staff in the department to highlight the FFT concerns. On review of the FFT feedback, the team have introduced an information poster. This has been placed next to every bed on the children's ward ensuring vital information is more accessible for parents and children. As well as this, discounted parking is now offered to parents with children who are admitted on the ward.

Mental Health
Advise: There were 91 FFT surveys completed within mental health in July which is a decrease of 10% on the previous month.
Assurance: The overall satisfaction was 98%, which is a 1% decrease on the previous month but above the Trust target.
Actions: Patient Engagement continues to hold meetings with informatics every two weeks. The mental health SMS trial extract has been evaluated and approved, and text messaging has now been rolled out. This will improve the FFT numbers and encourage consistent feedback across all mental health services. This month Patient Experience met with three different services within mental health, CAHMS, Children and Young Persons Learning Disability team and the Mental Health Support Team. In the meetings we provided training on the system to team members, and discussed how SMS has now been rolled out within mental health and the importance of driving up the responses.

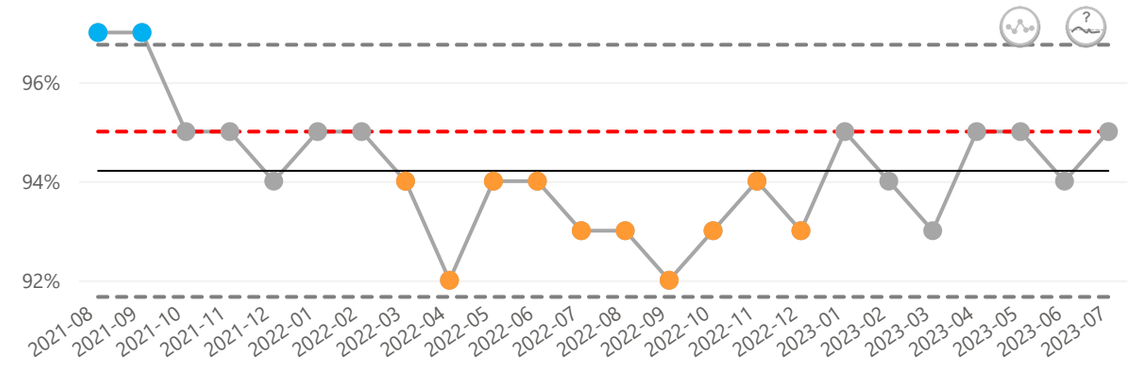
Complaints
Advise: In July 2023, the Patient Relations team managed 2,261 patient and family cases with 4,794 individual contacts. There were 47 new formal complaints registered in July, a 15% increase on the 41 registered in June.
Alert: There were 48 complaints 'Due to be responded to' in July, 34 of which (71%) were completed within our 25/40-day timescales, meaning 14 cases breached the local target. The key themes reported in complaints in July were treatment / care issues, poor or lack of communication, staff attitude, bed management and waiting times. This month the team also registered 27 informal concerns and 2,187 general enquiries.

Mixed Sex Breaches
Alert: In July there were 0 mixed sex breaches.
Action: The Patient Engagement team are scheduling meetings with key stake holders, including patient flow, to review the processes around eliminating mixed sex breaches which will be captured in the updated delivering same sex accommodation policy.

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%	95%	Jul 23		?	95%	94%	Jun 23		
FFT AE - % Rated Good or Very Good	86%	71%	Jul 23		?	86%	72%	Jun 23		
FFT Community - % Rated Good or Very Good	95%	98%	Jul 23		?	95%	96%	Jun 23		
FFT Inpatients - % Rated Good or Very Good	95%	97%	Jul 23		?	95%	96%	Jun 23		
FFT Outpatients / Day Case - % Rated Good or Very Good	95%	95%	Jul 23		?	95%	95%	Jun 23		
FFT Maternity - % Rated Good or Very Good	95%	89%	Jul 23		?	95%	86%	Jun 23		
FFT Mental Health - % Rated Good or Very Good	95%	98%	Jul 23		?	95%	99%	Jun 23		
FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED	15%	18.1%	Jul 23	H	?	15%	18.9%	Jun 23		
Mixed Sex breaches	0	0	Jul 23		?	0	8	Jun 23	0	20.00
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)		47	Jul 23				41	Jun 23		165.00
Complaints - % closed within 40 working days	80%	71%	Jul 23		?	80%	76%	Jun 23		

Quality


FFT Overall - % Rated Good or Very Good
96%
94%
92%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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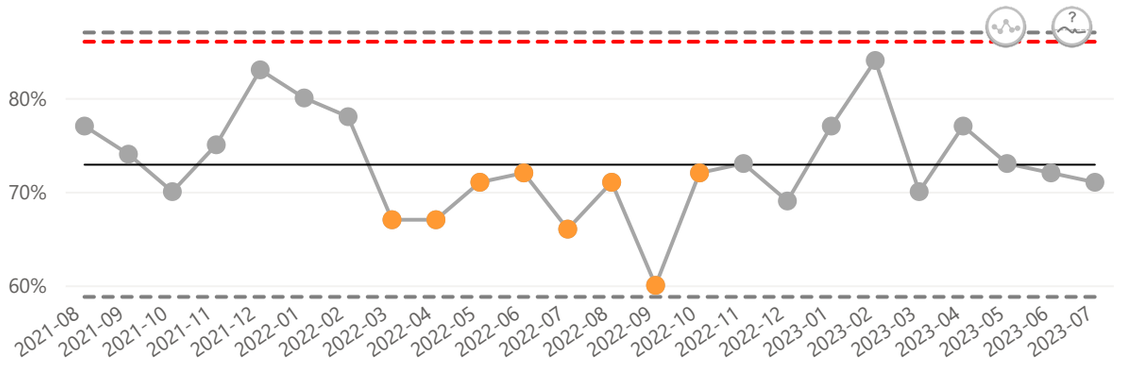
FFT AE - % Rated Good or Very Good
80%
70%
60%
2021-08
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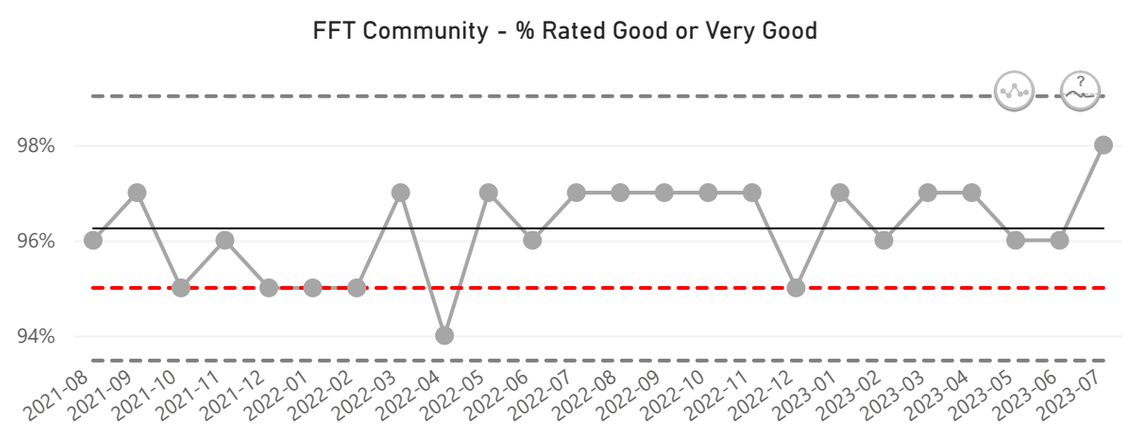
FFT Community - % Rated Good or Very Good
98%
96%
94%
2021-08
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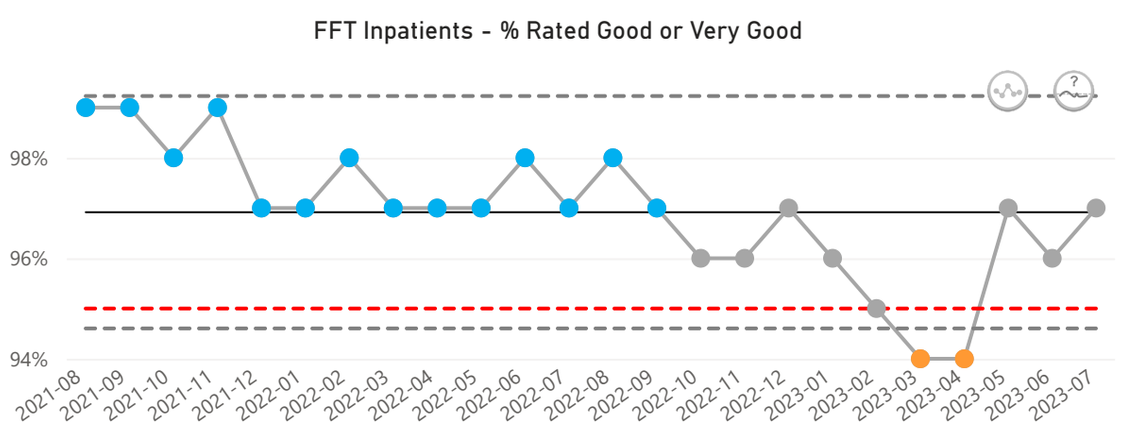
FFT Inpatients - % Rated Good or Very Good
98%
96%
94%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
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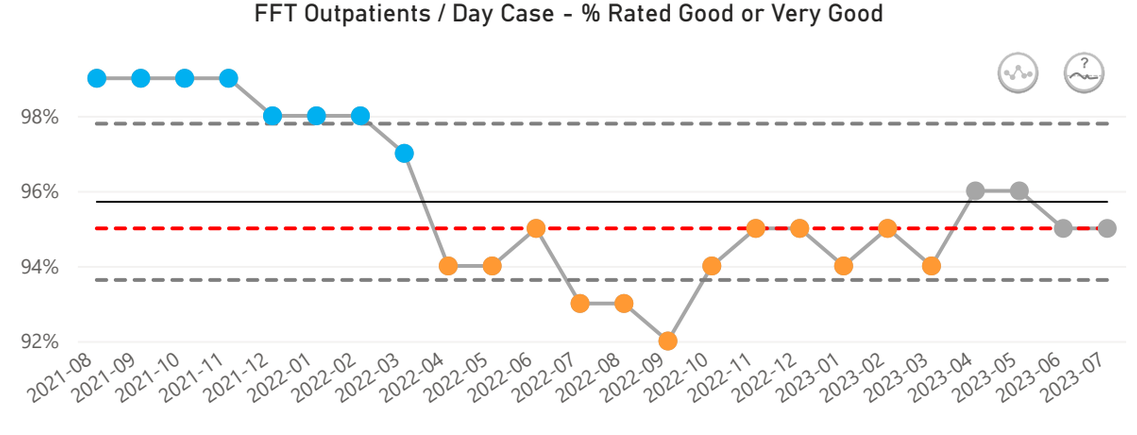
2023-06
2023-07


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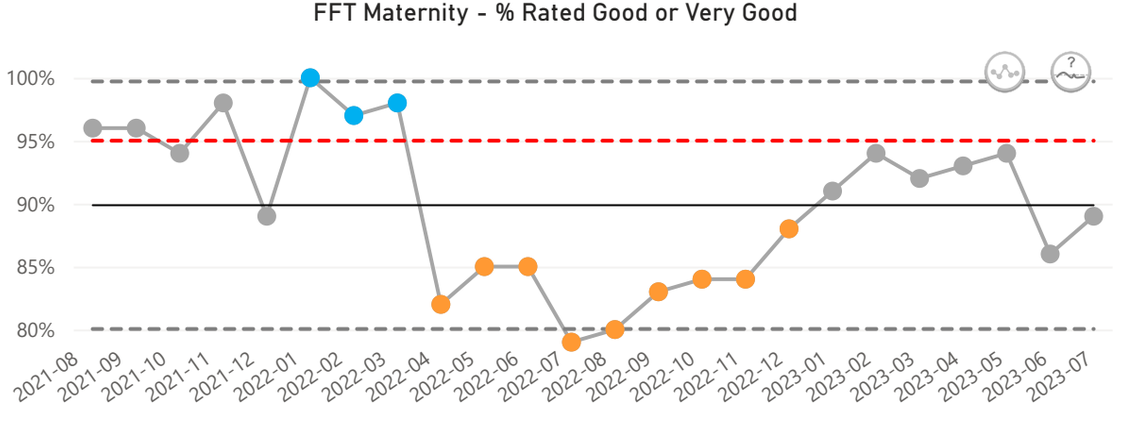
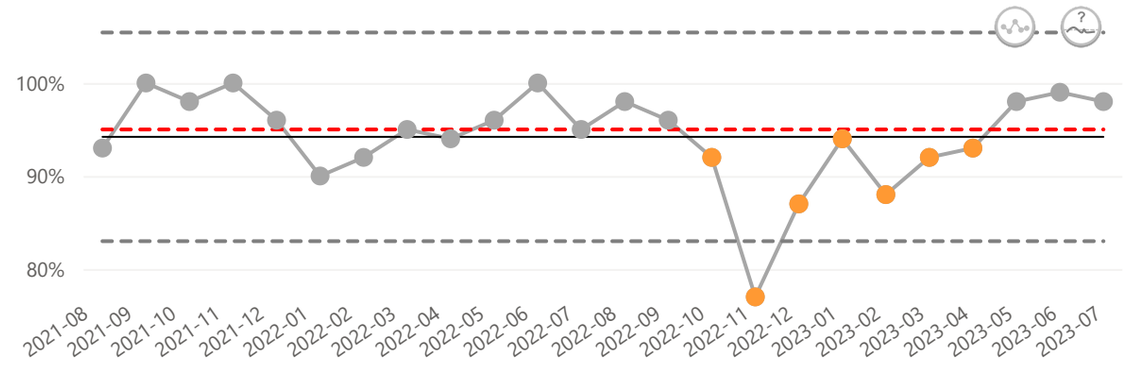
2023-03
2023-04
2023-05
2023-06
2023-07

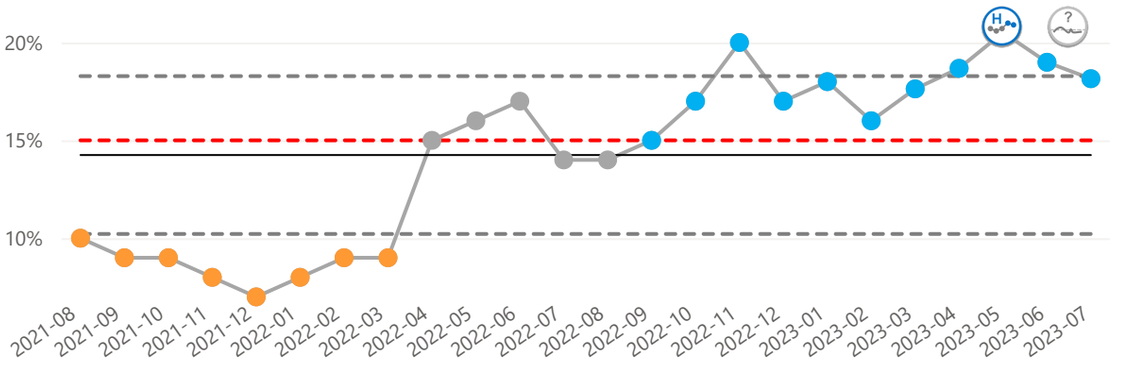

FFT Maternity - % Rated Good or Very Good
100%
95%
90%
85%
80%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07

Quality

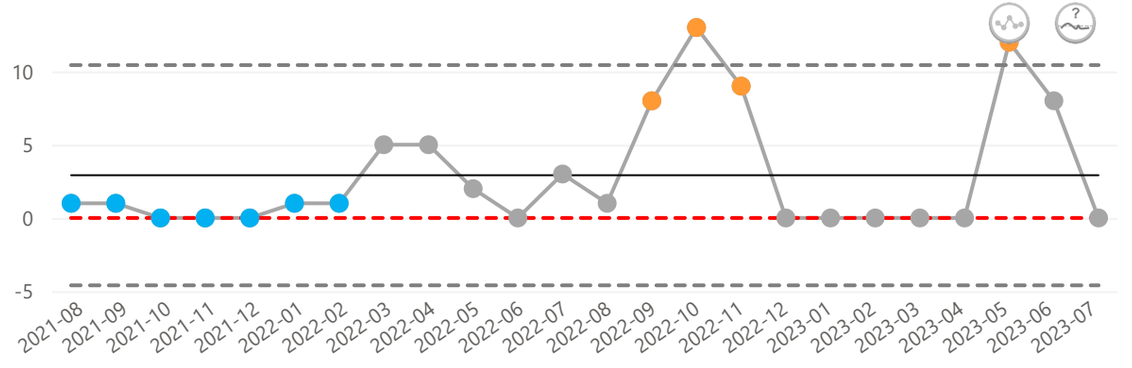
FFT Mental Health - % Rated Good or Very Good



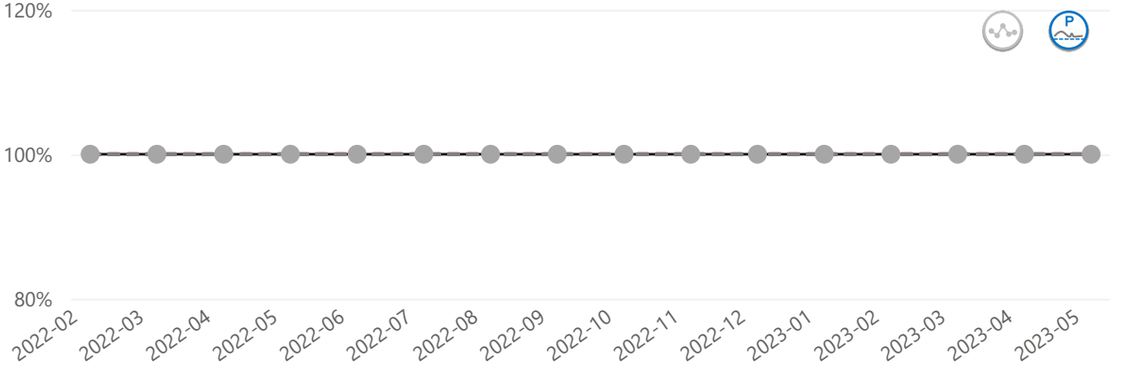
FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED



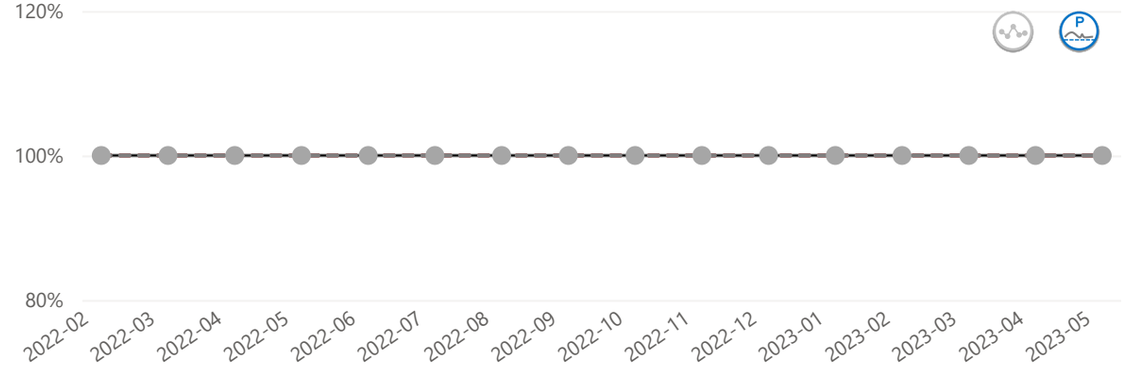
Mixed Sex breaches



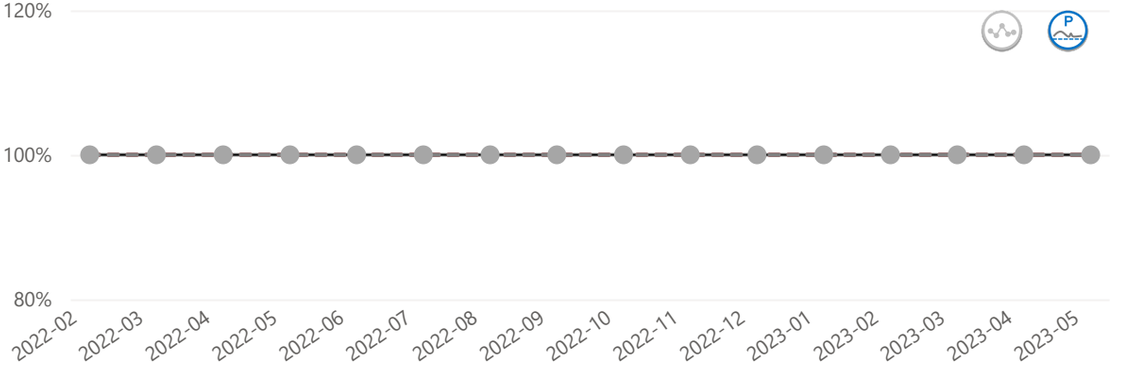
Duty of Candour – Stage 1a – Initial Verbal



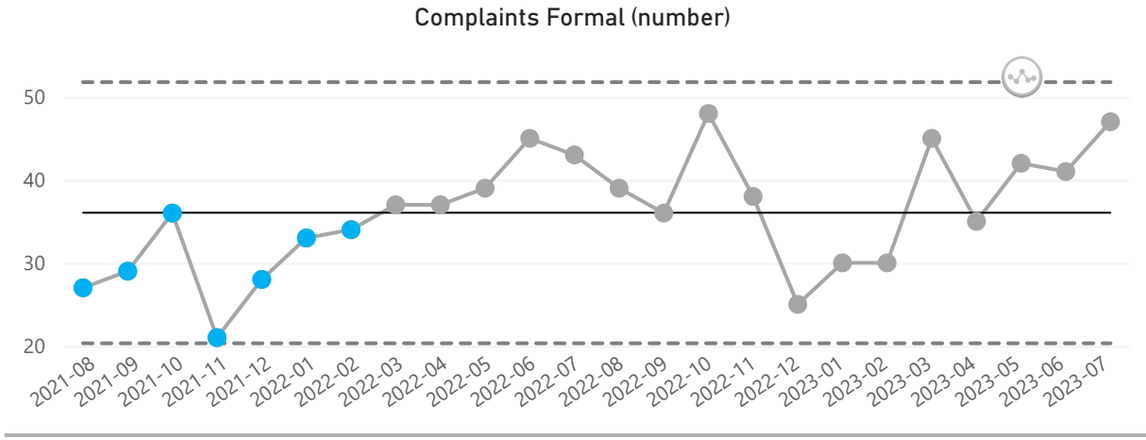
Duty of Candour – Stage 1b – Initial Written



Duty of Candour – Stage 2 – Final DoC



Quality


Complaints Formal (number)
50
40
30
20
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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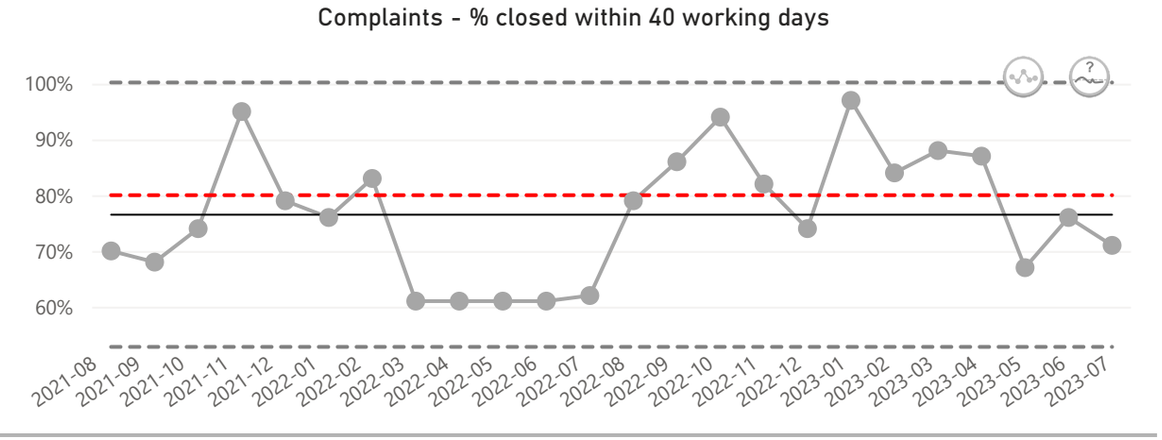
Complaints - % closed within 40 working days
100%
90%
80%
70%
60%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
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2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07

Blackpool Teaching Hospitals
NHS Foundation Trust

Infection Prevention and Control

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

MSSA
Advise - Three cases of MSSA were attributed to the trust in July. A local Trust threshold of no more than 44 cases has been agreed internally.
Alert - The trust is currently above plan for this threshold.
Assurance/Actions – The Trust aims to tackle MSSA blood stream infections as part of the Fundamentals of Care Quality Improvement Programme. Progress with this initiative will be reported quarterly at the Quality Assurance Committee.

CDI
Advise - Eight cases of CDI were attributed to the trust in July bringing the total number of cases to 25. The NHS Standard Contract threshold for 2023/24 is 89 cases for the year, or 7.4 cases per month.
Alert - The Trust is above the monthly plan for this infection for July.
Assurance - The trust is currently within the annual plan for this infection.

E. coli
Advise - Fourteen cases were reported in July against the NHS Standard Contract threshold of 86 (7.1 cases per month).
Alert - The trust is currently above plan for this infection.
Assurance/Actions - Case numbers remain high in England with the Northwest being a particularly high outlying region. Therefore, a regional Hydration and Urinary Tract Infection Improvement group which aims to tackle E. coli and other Gram-negative blood stream infections is being facilitated by NHS England. Locally, the Trust aims to tackle E. coli as part of the Fundamentals of Care Quality Improvement Programme.

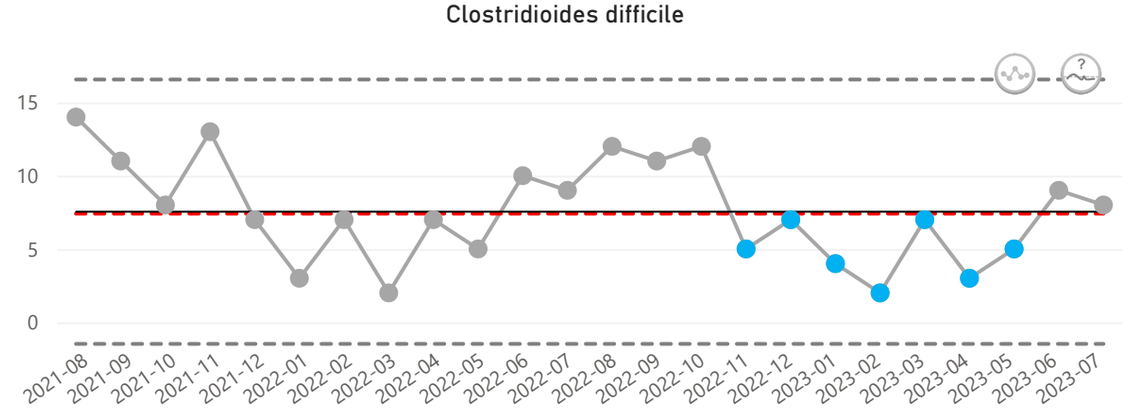
Klebsiella spp.
Advise - Two cases of Klebsiella spp. were reported in July 2023. The NHS Standard Contract threshold for 2023/24 is 41.
Assurance - The trust is currently within plan for this infection.

Pseudomonas aeruginosa
Advise - One case of Pseudomonas aeruginosa was attributed to the trust in July. The new NHS Standard Contract threshold for 2023/24 is 18.
Assurance - The trust is currently within plan for this infection.

Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Clostridioides difficile	7.41	8	Jul 23			7.41	9	Jun 23	30	25.00
E. Coli	7.16	14	Jul 23			7.16	13	Jun 23	29	60.00
Klebsiella spp.	3.41	2	Jul 23			3.41	3	Jun 23	14	11.00
MRSA Bacteraemia	0	0	Jul 23			0	0	Jun 23	0	0.00
MSSA	3.6	3	Jul 23			3.6	6	Jun 23	14	20.00
P. aeruginosa	1.5	1	Jul 23			1.5	5	Jun 23	6	6.00

Quality


Clostridioides difficile
15
10
5
0
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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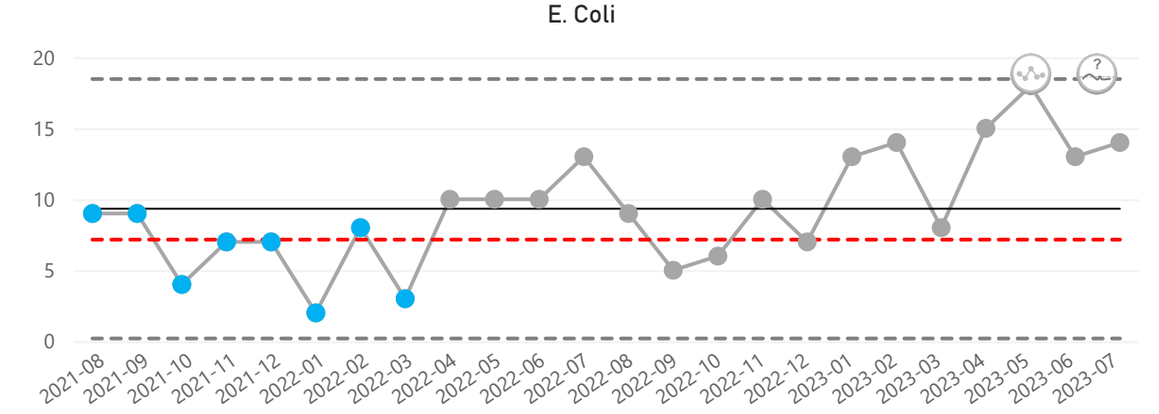
E. Coli
20
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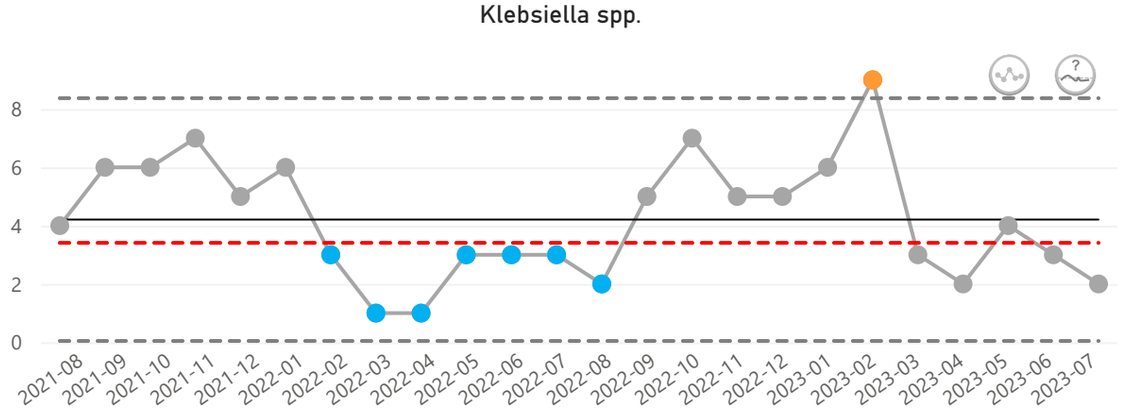
Klebsiella spp.
8
6
4
2
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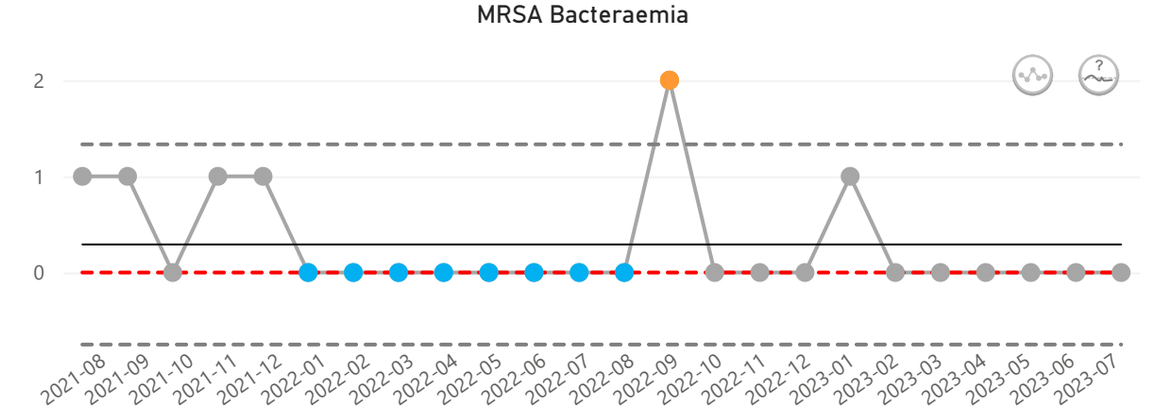
2023-07


MRSA Bacteraemia
2
1
0
2021-08
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2022-03
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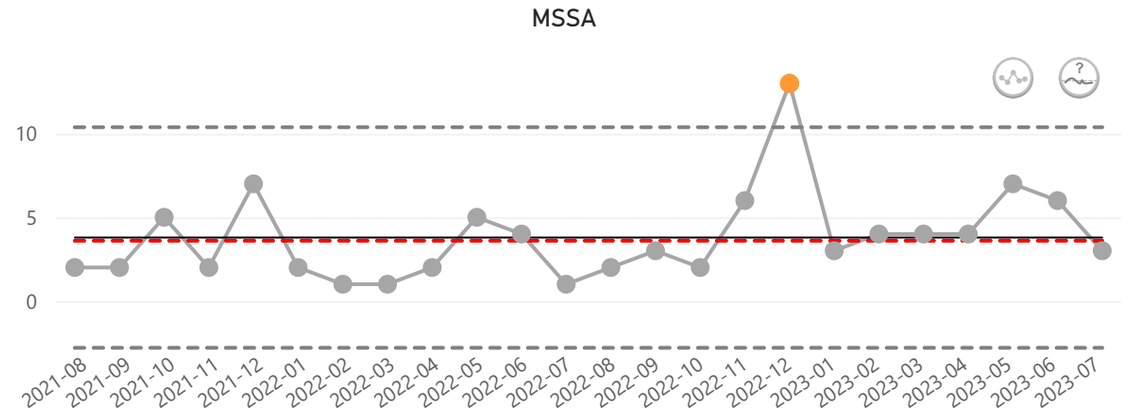
MSSA
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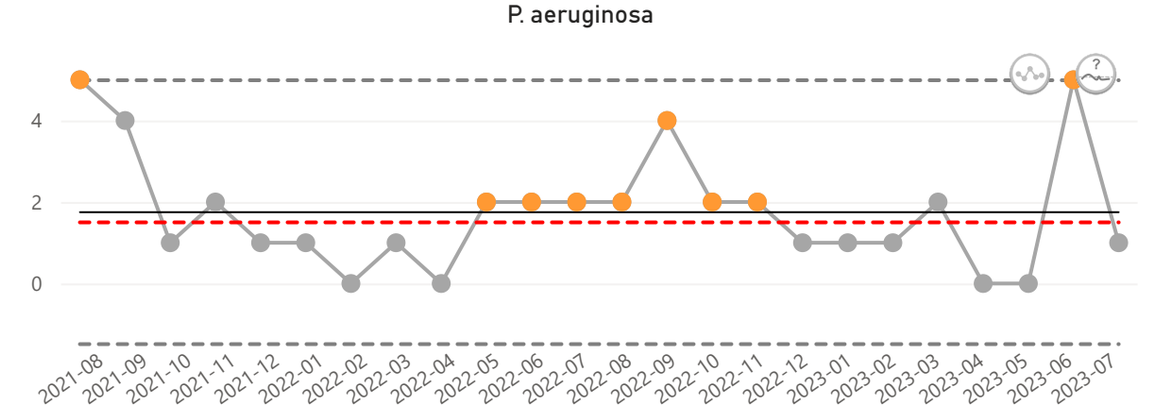
2023-06
2023-07


P. aeruginosa
4
2
0
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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2023-06
2023-07

Blackpool Teaching Hospitals
NHS Foundation Trust

Mortality

Mortality
Advise/Assurance
SHMI continues to improve and as of May 2023 is at 100.3.

Referral to Coroner
Advise/Assurance
Referral to coroner within 24 hours and percentage of deaths registered within 5 days in July was 97%.
The GRO data for July sees Blackpool above than the national average for the first time for registration within 5 days so we are improving.

MCCD completion
Advise/Assurance
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.
Since June, a change in process has seen the Medical Examiners Officer contact the consultant first if there is a delay in the junior doctors attending the ME office. This has improved turnaround times.

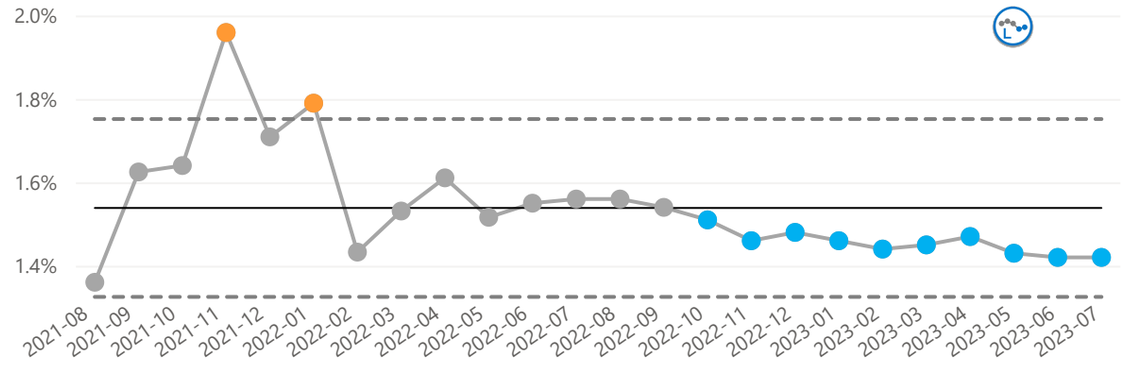
% of Deaths Screened
Advise/Alert
There has been a significant reduction in the percentage of deaths screened in the last 2 months. Previously compliance with this was being supported significantly by the Associate Medical Director for Mortality, who has recently been redirected to dealing with another task. Their involvement in this is due to finish in the coming weeks, allowing them to then support screening (via the Learning for Deaths app) but also develop a new process to ensure this is completed by the clinical teams.
In addition, all deaths (except those referred to the Coroner) are reviewed by the Medical Examiners, senior independent doctors from within the Trust who have not been involved in the patient's care, and look at both the quality of care provided, and assess the accuracy of the proposed cause of death.

Quality

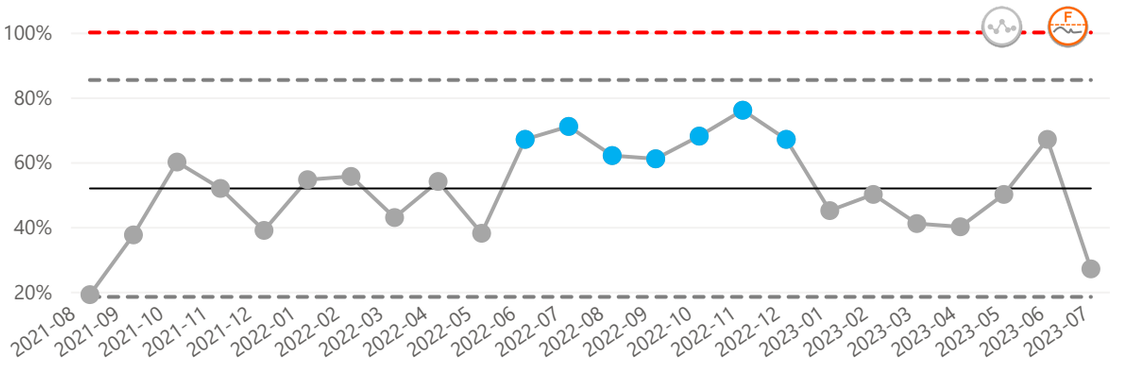
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
CRUDE Mortality Rate (Rolling 12 months)		1.42%	Jul 23				1.42%	Jun 23		
Referral to Coroner Within 24 Hours	100%	27%	Jul 23			100%	67%	Jun 23		
Death Registered within 5 Days	100%	65%	Jul 23			100%	54%	Jun 23		
SHMI – Rolling 12 months		100.3	Mar 23				101	Feb 23		100.3
HSMR – Rolling 12 months		88.83	May 23				88.69	Apr 23		88.83
Percentage of Deaths Screened	100%	28.3%	Jul 23			100%	38.6%	Jun 23		

Quality

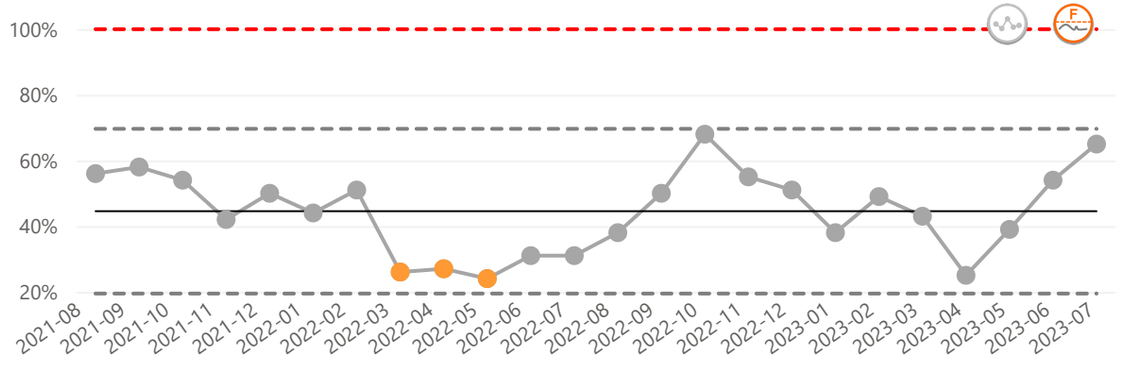
CRUDE Mortality Rate (Rolling 12 months)



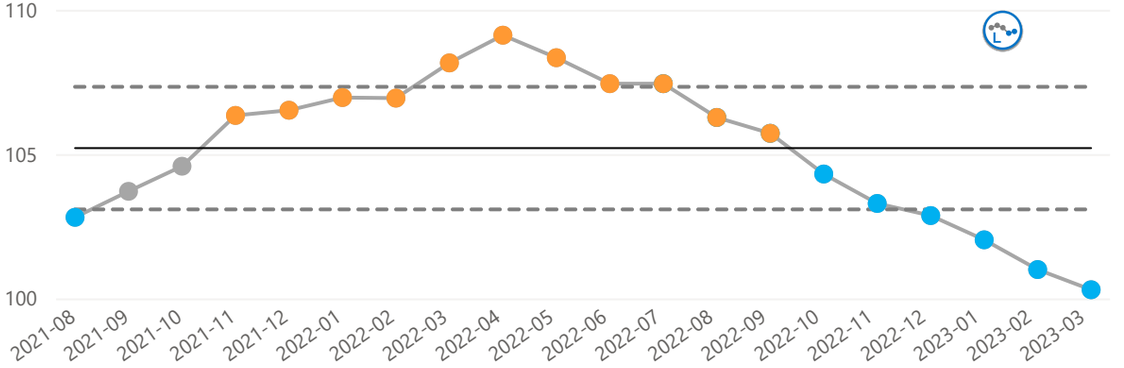
Referral to Coroner Within 24 Hours



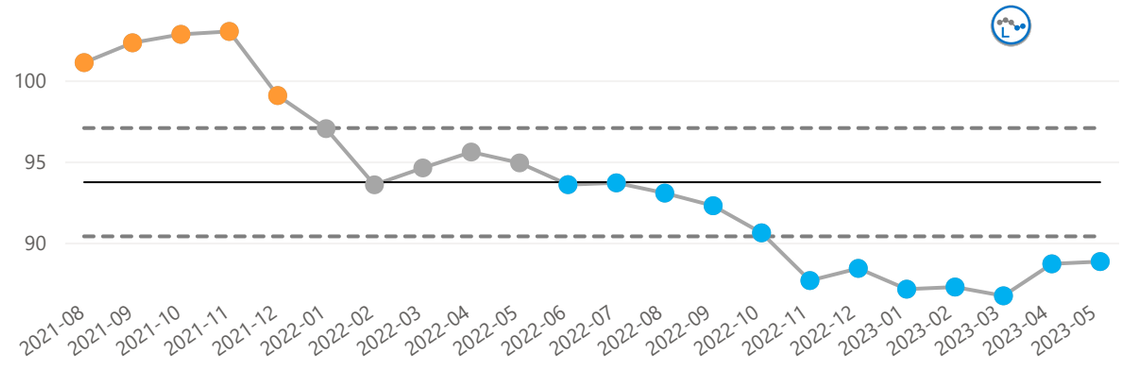
Death Registered within 5 Days



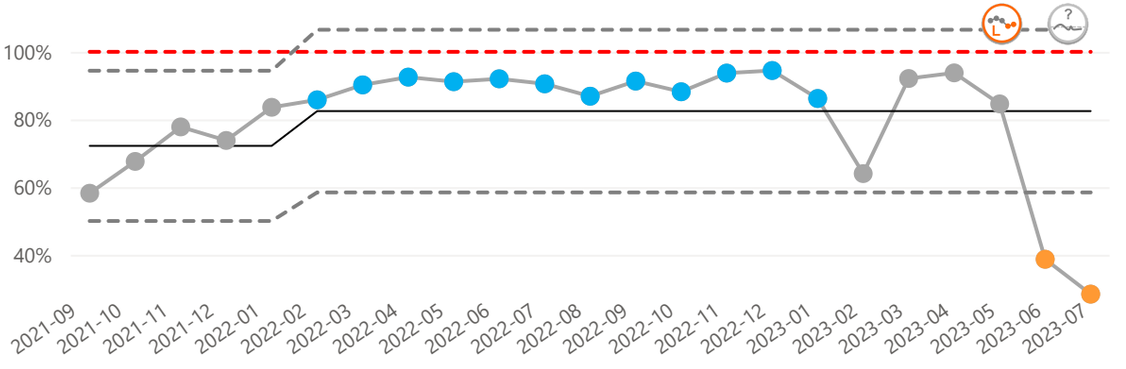
SHMI – Rolling 12 months



HSMR – Rolling 12 months



Percentage of Deaths Screened



Title	Maternity and Neonatal Report (reporting for July 2023)

Meeting:	Board of Directors Meetings
Date:	September 2023

Author	Lynne Eastham, Director of Midwifery & Neonates					
Exec Sponsor	Bridget Lees, Executive Director of Nursing, Midwifery, Allied Health Professionals, Quality Chris Barben, Medical Director					
Purpose	Assurance	X	Discussion		Decision	X
Confidential y/n	No					

Summary *(what)*	**Advise** 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. **Perinatal Deaths and Learning (Section 3.0, page 9)** Perinatal mortality includes stillbirths and neonatal deaths in the first week of life. • In May, June and July 2023, there have been no stillbirths. • In April, May, June and July 2023, there have been no Neonatal deaths.

Recommendations from MBRRACE-UK (section 3.0, page 10)

The MBRRACE-UK report (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) is published annually and includes details of stillbirths and neonatal deaths that occurred in each Trust.

The MBRRACE report (May 2023) was presented at the Trust Quality Committee in July 2023. A rag rating was applied as to where the stillbirth and neonatal death rates fell within the spectrum of the national average mortality rate. The Trust was given an amber rating for stillbirths and a red rating for Neonatal deaths.
To ensure oversight of any trends in the last 3 years Trusts were asked to review their PMRT and HSIB investigations to identify any avoidable causes of mortality.
Maternity Services are undertaking a retrospective review of PMRT and HSIB reports and action plans with the multidisciplinary team in August 2023. There is also a plan to review all stillbirth cases for the last 3 years using the 'Saving Babies Lives' processes to benchmark their maternity pathway. This will enable the findings to be matched against the PMRT/HSIB actions to ensure all issues and areas of concern have been picked up. Findings will be reported to Trust Board level and shared with the LMNS and ICB.

The neonatal mortality external review commenced in May 2023 and is expected to be completed by September 2023. Findings and next steps will also be reported to Trust Board level and shared with the LMNS, NWODN and ICB

Board Level Safety Champions (Section 7.0, page 17)

The Maternity & Neonatal Safety Champions meeting process is still in the early stages and therefore we have reached out to the MSSP advisor to request support and signposting to ensure our maternity safety champions are equipped and enabled to have an effective and responsive system and meetings in place.

The Board level safety champions and service level safety champions undertake at least monthly walkabouts to speak to staff and patients. The next walkabout is taking place later in the month.

OD Support (Section 8, page 20)

Face to face meetings currently being arranged with OD support to progress FTSU action plan.

CQC Action Plan (Section 11.0, page 21)

In the Maternity Neonatal update presented in June 2023 (May information) it was highlighted that whilst progress against the Maternity CQC action plan continues, there had been slippage on a number of actions. Some of the areas RAG rated 'Green' had moved back to 'Amber'.

These actions could be grouped into:

- Mandatory Training and appraisal compliance
- Professional Midwifery Advocacy
- Bereavement Room environment
- Governance – Risk assessments, safety champions meeting

Several mitigations were implemented to support plan for recovery by August 2023. Good progress has been made over the last 2-3 months with improvements.
There remain risks to delivery of the action plan which include:

- Mandatory training and appraisals – whilst there have been improvements in mandatory training and appraisal rates these still require close monitoring and management, as discussed earlier in this report.
- Medicines management – Whilst there is no dedicated maternity pharmacist, the Maternity team are supported by the pharmacy team who undertake weekly audits of the clinical areas. There have been some concerns raised via the audits. This is particular to the Maternity Ward. The Ward Leader and Matron are sighted on these with management plans in place. The Head of Midwifery and Director of Midwifery continue to oversee and support as required.

To 'test out' compliance with the CQC plan we have identified dedicated support to focus on clinical walkabouts and discussion with the clinical teams so that they are sighted on improvements and appraised on progress.

The Local Maternity and Neonatal System have also been asked to provide external support and conduct a peer review. This is expected to take place in the next couple of months.

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.

The current position

Action Plan	June 2023	August 2023
Areas of improvement	13	13
Number of actions	59	59
Completed Actions	46	52
Actions moved to Amber/off track	13	7

Implications
(so what)

Alert

Training Compliance – Maternity skills drills (Section 5.0, page 15)

- The overall target of 90% for mandatory training has not been achieved since January 2023.
- Compliance with Maternity Skills Drills having month on month downturn over the last 4 months since May 2023

A recovery plan was implemented to ensure more a more robust process for planning and training and ensuring attendance. The team are pleased to report that this has been successful with improvements seen in compliance of Maternity Skills drills training and no deterioration in mandatory training, albeit improvements still needing focused attention in in the medical team compliance.

In addition to safety and quality, risks are associated with Maternity Incentive Scheme Year 5 - the training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period. The deadline being:

12 consecutive months should be considered from 1st December 2022 until 1st December 2023.

	Apr-23	May-23	June -23	July-23
Midwives	75.83%	72.13%	70.18%	86.29%
MSWs	58.6%	60.9%	80.56%	83.78%
Obstetric Consultants	62.5%	62.5%	50%	50%
All other Obstetric Doctors	100%	89.47%	75%	75%
Obstetric Anaethesists Consultants	47.05%	47.05%	53%	53%
All other Obstetric Anaethesist Doctors	66.66%	66.66%	84.2%	67%
All staff	69.87%	64.35%	74.28%	78.43%

All the medical team have been allocated dates for training. Discussion commenced regarding the reflection of training requirements in individual appraisals.

Assure

HSIB Quarterly Review Meeting (section 3.0, page 12)
Escalation of Concerns from HSIB

In response to the HSIB Escalation letters received between April and June 2032, in relation to the HSIB Case, MI-021273, the maternity team presented an update of actions completed in response and were able to share learning and safety improvements made.

Neonatal Training (Section 5.0, page 14)

SIM Training for both nurses (trained and untrained) and Consultants remains at 100%

Registered Staff	June 2023	May 2023	April 2023
% Nursing staff who have attended SIM Training	100%	100%	100%
% of Consultants who have attended SIM Training	100%	100%	100%

Toolkit for High Quality Neonatal Service (DH) (2009) recommend a **minimum** of 70% of the registered nursing workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS). The Trust aim is for >95% compliance.
Currently situation is 58%
There is an improvement plan in place and by the end of November 2023 QIS % will be 65% and by the end of the Jan 2024 QIS % will be 70%

The Neonatal Improvement Board (Section 8.0, page 17)

The Neonatal Improvement Board meeting was held in July 2023, at which time the Neonatal team discussed progress for the reporting period of June 2023
Good progress being made across quality, safety and workforce. Avoiding Term Admissions rate remains below the national and regional average.

Neonates remains an outlier in the region for mortality for 2022/2023 and for born babies under 27 weeks gestation. To date for Quarter 1/2 there have been no neonatal deaths. Data is expected to be published in August 2023.

NWNODN Annual Review (section 8, page 20)

The aim of the Annual Review by the Neonatal Operational Delivery Network (NWNODN) is to improve access to consistent high-quality neonatal care which supports improved outcomes for babies and families across the region. Annual visits provide an opportunity for the Neonatal team to engage in person with members of the NWNODN to share local successes and challenges.
The previous visit, in 2022, was undertaken face to face. Whist there was positive feedback and acknowledgement of good practices, recommendations were put in place which included:

- The Neonatal Unit to monitor <27week deliveries (including <28weeks if multiple or any baby <800g) in collaboration with the obstetric team to identify all missed opportunities for transfer

	out and feedback any lessons learnt. These will be identified and reported to NHSE by the NWNODN • Neonatal Lead Consultant job plan to be developed. • Ways of ensuring Paediatricians stay up to date with neonatal skills and changes in practice to be considered. • Workforce challenges • Governance In March 2023, the meeting was completed virtually with the report being received in July 2023. Findings were positive and the neonatal team were noted to be engaging well with the NWNODN and actively responded to actions identified following the Annual review in 2022. Many positive changes were recognised which has included improved data and outcomes and the embedding of quality improvement initiatives into everyday practice. They also noted that the team had identified that mortality and <27week deliveries has been high and the implementation of the Internal Neonatal Improvement Board to proactively address any issues and provide assurance.

Previously considered by	Trust Quality Assurance Committee

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	This report's recommendations, conclusions, and actions are considered to be fair and inclusive to all individuals regardless of their gender, age, race, religion, disability, sexual orientation, or any other protected characteristic.

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

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

Maternity and Neonatal Update Report – August 2023 (reporting for July 2023)

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1.0. Introduction

The purpose of the Maternity and Neonatal Update Report is to provide an overview of safety and quality programmes of work within Maternity and Neonatal Services and to inform the Board of Directors 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 on safety and quality in Maternity and Neonatal services is required to comply with the requirements of:

- The Perinatal Quality Surveillance Model
- CNST (Clinical Negligence Scheme for Trusts) operated by NHS Resolution
- Ockenden (March 2022)
- East Kent 'Reading the Signals' (October 2022)

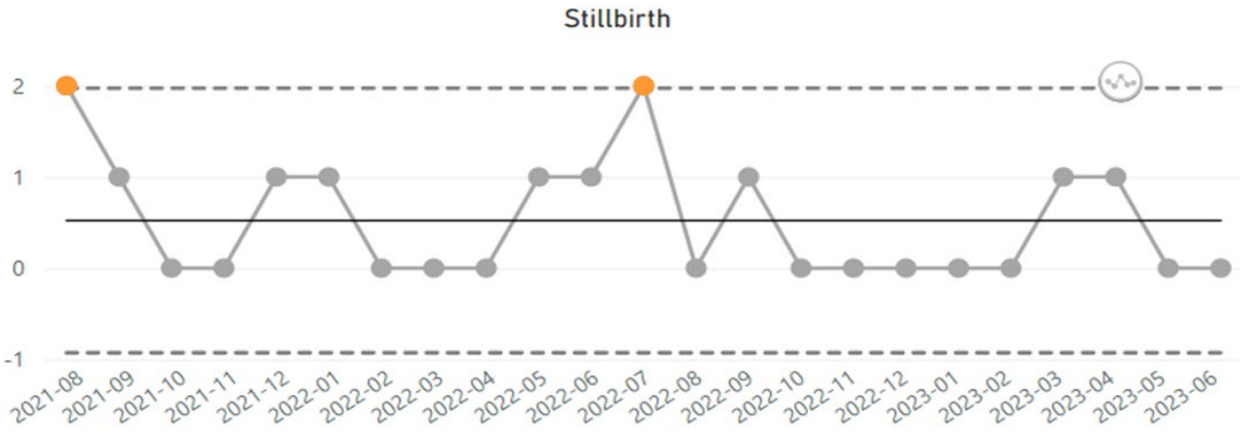
This report will be presented monthly at the Trust Quality and Safety Committee and to Board of Directors in line supported by other update papers, in line with Annual Cycle.

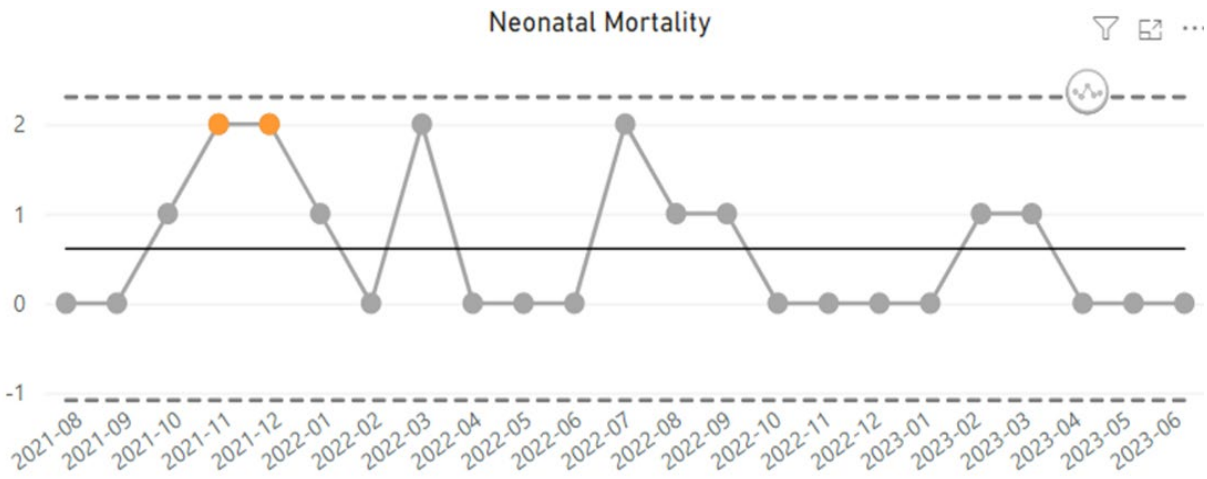
2.0. Perinatal Surveillance Model

The Perinatal Quality Surveillance Model was developed in response to the Ockenden findings. It incorporates 5 principles for increasing oversight of perinatal clinical quality, integrating perinatal clinical quality into ICS structures, and providing clear lines for responsibility and accountability in addressing quality concerns at each level of the system.
Appendix 1 sets out the Minimum data measures dashboard for Trust Board overview recommended by the Perinatal Surveillance Model supported by the narrative in this report.

3.0. Perinatal Deaths and Learning

Perinatal mortality includes stillbirths and neonatal deaths in the first week of life.
In May, June and July 2023, there have been no stillbirths.
For April, May, June and July 2023, there have been no Neonatal deaths.





Recommendations from MBRRACE-UK

The MBRRACE-UK report (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) is published annually and includes details of stillbirths and neonatal deaths that occurred in each Trust.

The MBRRACE report (May 2023) was presented at the Trust Quality Committee in July 2023. A rag rating was applied as to where the stillbirth and neonatal death rates fell within the spectrum of the national average mortality rate. The Trust was given an amber rating for stillbirths and a red rating for Neonatal deaths.
To ensure oversight of any trends in the last 3 years Trusts were asked to review their PMRT and HSIB investigations to identify any avoidable causes of mortality.
Maternity Services are undertaking a retrospective review of PMRT and HSIB reports and action plans with the multidisciplinary team in August 2023. There is also a plan to review all stillbirth cases for the last 3 years using the 'Saving Babies Lives' processes to benchmark their maternity pathway. This will enable the findings to be matched against the PMRT/HSIB actions to ensure all issues and areas of concern have been picked up. Findings will be reported to Trust Board level and shared with the LMNS and ICB.

The neonatal mortality external review commenced in May 2023 and is expected to be completed by September 2023. Findings and next steps will also be reported to Trust Board level and shared with the LMNS, NWODN and ICB.

Perinatal Mortality Review Tool (PMRT) Process

The action plan developed in response to the external review of the PMRT process in March 2023 is progressing with no exceptions to report.

Healthcare Safety Investigation Branch (HSIB)

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018). In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- **Intrapartum stillbirth:** where the baby was thought to be alive at the start of labour but was born with no signs of life.
- **Early neonatal death:** when the baby died within the first week of life (0-6 days) of any cause.
- **Severe brain injury diagnosed in the first seven days of life, when the baby:**
  - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
  - Was therapeutically cooled (active cooling only) or
  - Had decreased central tone and was comatose and had seizures of any kind

The criteria also include:

- **Maternal Deaths**: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

The data included within the maternity investigations update below is from the beginning of April 2019, when the HSIB maternity programme was live across the whole of England until July 2023.

There has been one HSIB case reported in in this reporting period still in progress (MI- 021273):

Cases to date	
Total referrals	25
Referrals / cases rejected	9
Total investigations to date	16
Total investigations completed	14
Current active cases	2

The current ongoing investigations are:

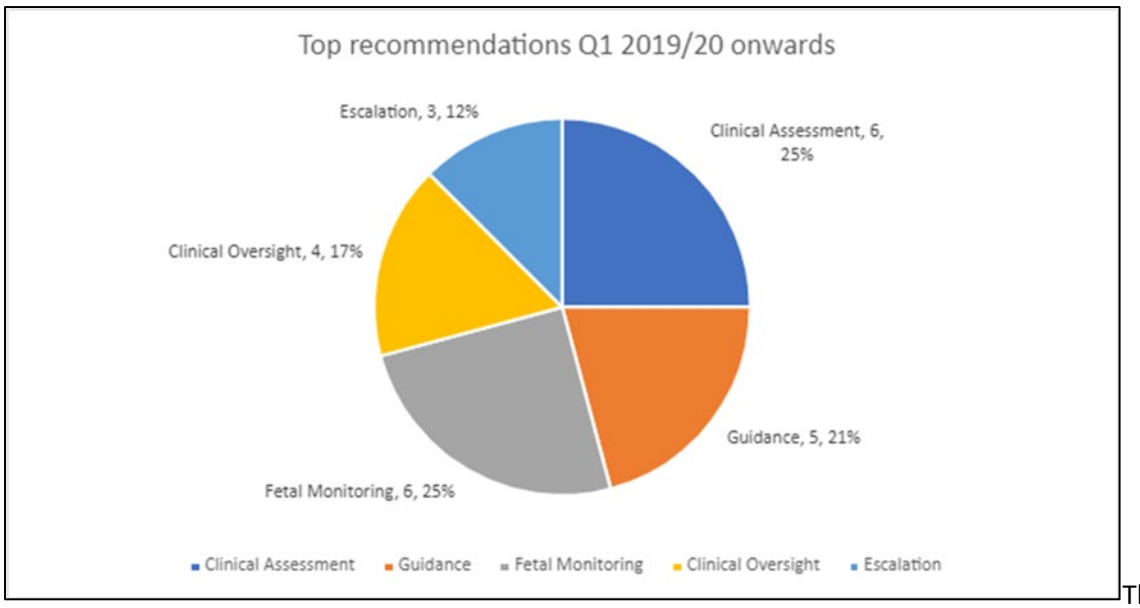
- Baby delivered in January 2023, who was transferred to a tertiary unit for cooling therapy. Care was subsequently withdrawn, and baby died February 2023. Expected date for completion of investigation was mid-July 2023 but waiting for post-mortem examination findings (MI-021273)
- Baby delivered in June 2023, requiring cooling following birth. Family have consented to HSIB investigation and records have been requested. (MI-028403)

HSIB Quarterly Review meeting.

On the 26 July 2023, the HSIB team were on site for the HSIB Quarterly Review meeting. It was well attended by the multidisciplinary team including Trust Executive presence, Safety Champions and leads from the LMNS.

Feedback was presented on Trust findings from HSIB investigations which included the top three recommendations were regarding:

- Fetal monitoring
- Clinical assessment
- Guidance/Guidelines



This was similar to the national picture:

National

- Guidance
- Clinical Assessment
- Fetal Monitoring
- Clinical oversight
- Escalation

Escalation of Concerns from HSIB

In response to the HSIB Escalation letters received between April and June 2032, in relation to the HSIB Case, MI-021273, the maternity team presented an update of actions completed in response and were able to share learning and safety improvements made.

The external review by the LMNS to undertake a review of Badgernet Maternity System is taking place on the 10 August 2023and the outcome and any recommendations made will be shared with the LMNS and other Maternity units in the region and via this report to Trust Clinical Governance Committee and Trust quality Assurance Committee.

4.0. Moderate and above Harm incidents

In July 2023, there were no serious incidents (SI) declared in Maternity or Neonates. Any serious Incidents are also reported to Lancashire & Cumbria Local Maternity & Neonatal System for regional oversight in compliance with Ockenden recommendations.

there were 8 moderate harms reported, 3 of these were downgraded following review:

Moderate Harms and above – July 2023

moderate incidents	3rd / 4th Degree Tear	Communication Failure - Within Team	Falls Prevention (Assisted To Floor)	Operative Birth Complications	Postpartum Haemorrhage >1500mls	Staffing Levels Inappropriate	Transfer Out To Specialist Care Setting
Delivery Suite	1			1	2	1	
Neo Natal Unit (SCBU)							1
Ward D (Maternity)		1	1				
Total	1	1	1	1	2	1	1

Delivery Suite – 3rd degree tear	Moderate	373580 – 3rd degree tear following normal birth Downgraded to minimal harm following review
Communication failure within team	Moderate	373271– Patient underwent caesarean section and was transferred to Maternity Ward via the NNU as did not want to leave baby. Risks of not returning to ward not discussed with patient. Downgraded after review
Patient accident – fall (assisted to floor)	Moderate	373902 – Member of staff supporting patient to toilet when she felt faint. Member of staff had lower back pain as a result Currently under review
Delivery Suite – operative birth complication	Moderate	374010 – Bowel injury at emergency caesarean section. Ongoing investigation
Delivery Suite – PPH >1500mls	Moderate	371981 – PPH >1500mls Downgraded after review
Delivery Suite – PPH >1500mls	Moderate	372239 - PPH at Elective Caesarean Section of 3100mls Ongoing investigation
Delivery Suite - Staffing Levels	Moderate	373688 – Agency Midwife failed to attend for shift leaving suboptimal staffing levels. Currently under review
Neonatal Unit – Transfer our to specialist care setting	Moderate	373059 – baby transferred to tertiary unit for surgical review. Currently under review

Moderate and above incidents require multidisciplinary review as part of a 72 hour review and may require further investigation as an After Incident Review or as a Serious Incident depending on findings.

Regulation 28

Nil to report for this month.

Never Events

Nil to report this month.

5.0. Training Compliance
Neonatal Training

A comprehensive training report is produced by the Practice Development team quarterly. Quarter 1 (for April – June 2023 inc) is discussed via the Divisional Governance forums

Registered Staff	June 2023	May 2023	April 2023	March 2023	February 2023
% of workforce establishment holding a current NMC registration	88%	88%	88%	88%	84%
% of all registered staff providing direct nursing care QIS	58%	58%	58%	58%	63%
% of overall mandatory training compliance	95%	91%	94%	91%	91%
% of annual NLS compliance (excluding those on long term sick, mat leave, and secondment)	100%	100%	100%	100%	100%
% of 4 yearly NLS compliance (excluding those on long term sick, mat leave, and secondment)	73%	73%	73%	73%	70%
% of 4 yearly NLS compliance for Consultants	100%	100%	100%	100%	100%
% of nursing staff (qualified and unqualified) who have attended SIM training	100%	100%	100%	100%	100%
% of consultants who have attended SIM training	100%	100%	100%	100%	80%

- Toolkit for High Quality Neonatal Service (DH) (2009) recommend a **minimum** of 70% (special care) and 80% (high dependency and intensive care) of all the workforce establishment hold a current Nursing and Midwifery Council (NMC) registration. Current situation is 88%

- Toolkit for High Quality Neonatal Service (DH) (2009) recommend a **minimum** of 70% of the registered nursing workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS). The Trust aim is for >95% compliance. Currently situation is 58%
  There is an improvement plan in place and by the end of November 2023 QIS % will be 65% and by the end of the Jan 2024 QIS % will be 70%

- 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.

Maternity Training Compliance

Maternity Skills Drills

Skills drills training in line with CNST requirements are facilitated monthly. In response to

- The overall target of 90% for mandatory training has not been achieved since January 2023.
- Compliance with Maternity Skills Drills having month on month downturn over the last 4 months since May 2023

A recovery plan was implemented to ensure more a more robust process for planning and training and ensuring attendance. The team are pleased to report that this has been successful withy improvements seen in compliance of Maternity Skills drills training and no deterioration in mandatory training, albeit improvements still needing focused attention n in the medical team compliance.

In addition to safety and quality, risks are associated with Maternity Incentive Scheme Year 5 - the training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period. The deadline being:

12 consecutive months should be considered from 1st December 2022 until 1st December 2023.

All the medical team have been allocated dates for training. Discussion commenced regarding the reflection of training requirements in individual appraisals.

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	June -23	July-23
Midwives %	94.11	75.63	85.71	75.83	72.13	70.18	86.29
MSWs %	87.9	56.41	61.54	58.6	60.9	80.5	83.78
Obstetric Consultants %	77.77	78	78	62.5	62.5	50	50
All other Obstetric Doctors %	86	86	86	100	89.47	75	75
Obstetric Anaethesists Consultants %	100	41	47	47.05	47.05	53	53
All other Obstetric Anaethesist Doctors %	90.9	33	67	66.66	66.66	84.2	67
All staff %	92.09	69	77	69.87	64.35	74.28	78.43

- Overall mandatory training compliance for July 2023 is 86.23% The overall target of 90% has not been achieved since January 2023.
- Compliance with Maternity Skills Drills has had month on month downturn over the last 4 months is starting to recover following revised process for monitoring.

The NHS England Core Competency Framework for Training (Version 2) has been released. This is included in the CNST Safety Action 8. There are several changes and stretch targets. The Practice Development Team are completing a gap analysis and plan.

Multidisciplinary live skills drills have been ongoing since May 2023. These have been coordinated by the Practice Development team in Maternity and Neonates and will now include the Neonatal and Maternity Medical, Nursing and Midwifery teams working through different scenarios together.

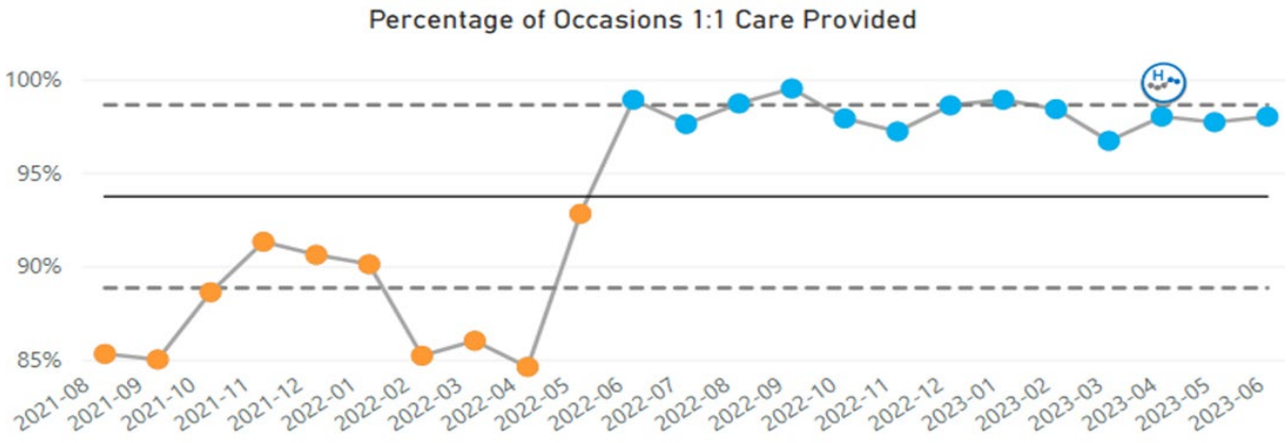
These drills are unplanned and include out of hours and different times and dates to ensure all teams have opportunity to participate.

6.0. Safe Staffing

Percentage for Provision of One to One Care in Labour

One to one care is a measure of safe staffing. This is when a woman is cared for by a Midwife who is looking just after her. Maternity services aim to achieve 100% 1-1 care in labour, and this is monitored via Badgernet and monthly via PIDA. Compliance has had a further slight improved from 97% last month to 98% in July 2023. this demonstrates the commitment to ensuring safe care in labour. The incidents where one to one care cannot be provided is escalated to the Matron and appropriate action is taken.

The team are committed to achieving 100% and a retrospective review of Maternity Records takes when this is not achieved to understand the detail of when this is not being achieved.



Midwifery Staffing

In line with Maternity Incentive Scheme a Maternity Staffing Report has been completed for Quarter 1 (April to June 2023)

In line with best practice, a Birthrate Plus reassessment is being arranged as the last assessment took place in 2021. This is expected to take place towards the end of the summer period and are awaiting confirmation from the assessors.

Obstetric Workforce

The MSSP programme Obstetric Lead is working with the Head of Department to understand roles and responsibilities in line with Ockenden requirements and further updates regarding the Obstetric workforce will be provided in the Maternity & Neonatal Update Report going forward.

Neonatal Workforce

The nursing structure is BAPM compliant, and a review of the Leadership Nursing structure is being finalised to include senior support for the Matron and Governance Lead
Middle Grade permanent cover does not meet BAPM standards and is therefore not compliant with CNST Safety Action 4. A risk assessment is in place and has been reviewed. The position of not being compliant with BAPM is not unusual in the region however the team are trying to understand the position against peers. A business case to request funding is currently progressing within division with oversight by the Neonatal Improvement Board.

7.0. Board Level Safety Champions Meetings

Maternity and Neonatal Safety Champions work at every level of Maternity Services, that is Trust, Regional and National levels. The Maternity Incentive Scheme (CNST) Safety Action Nine requires the Trust to demonstrate that the Safety Champions (obstetrician, midwife, neonatal) are meeting at least bi-monthly with Board level champions to escalate locally identified issues.

The Board Safety Champions are Fergus Singleton, Non-Executive Director, and Bridget Lees, Executive Director of Nursing and Midwifery. The Director of Midwifery and Neonates chairs the meeting.
The meeting process is still in the early stages and therefore we have reached out to the MSSP advisor to request support and signposting to ensure our maternity safety champions are equipped and enabled to have an effective and responsive system and meetings in place.

The Board level safety champions and service level safety champions undertake at least monthly walkabouts to speak to staff and patients. The next walkabout is taking place later in the month.

8.0. Neonatal Update

The Neonatal Improvement Board

The Neonatal Improvement Board meeting was held in July 2023, at which time the Neonatal team discussed progress. The agenda and team presentation provided assurances of continuing improvements. For the reporting period of June 2023:

- There have been no moderate incidents or above, no AIRs or serious incidents. There have been no complaints or claims.
- Nurse staffing / structure, reviewed with HR Business Partner and is progressing.
- Ockenden money received for 1WTE Governance lead and recruitment progressing.
- Achieved **Green** in FI Care reaccreditation (previously Amber)
- Simulation training – alternate weeks – learning from SIs.
- Difficult airway policy & Intubation checklist embedded in simulation.
- Learning from excellence initiative now in place
- Joint obstetric / Neonatal live drills ongoing
- 3 key messages of the week shared at each handover.

- Human factors / leadership & team training for all staff working on the neonatal unit.
- QEP Competition ongoing to be followed by Quality competition
- World Prematurity Day fundraising event
- Stribe APP to be introduced by Wellbeing team.
- wellbeing initiative for parents – Parent drop in re-named “Neo natters”, representation from ‘Dad’s matters’ and Chaplaincy team, Introducing “Mindful Moments”
- Appointed Physiotherapist and Occupational Therapist

Mortality and Babies less than 27 weeks gestation born in wrong place

Neonates remains an outlier in the region for mortality for 2022/2023 and for born babies under 27 weeks gestation. To date for Quarter 1/2 there have been no neonatal deaths. Data is expected to be published in August 2023.

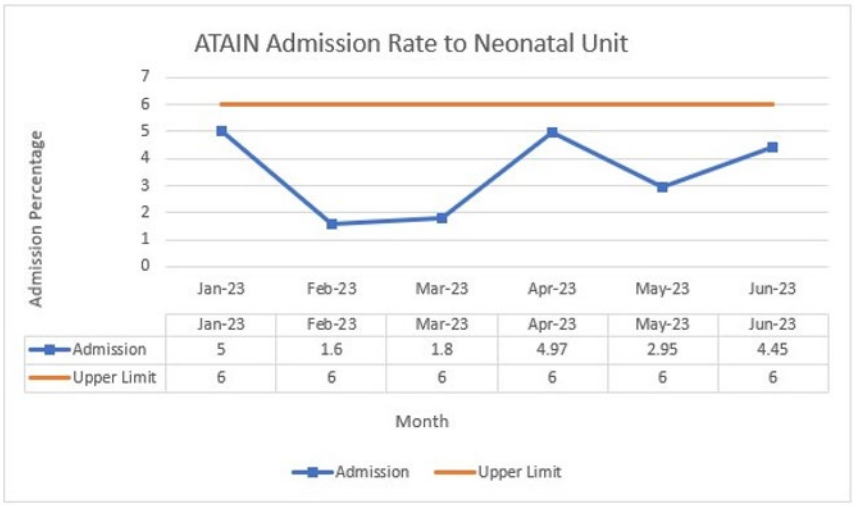
Avoiding Term Admissions (Quarter 1)

The ‘Avoiding Term Admission in Neonatal Units Programme’ (ATAIN)is a national initiative that provides the framework for best practice to reduce term admissions. Learning themes will inform changes to practice so that term admissions can be reduced, resulting in better family experience.

The ATAIN multidisciplinary meetings are held monthly and attended by an Obstetric Consultant, Consultant Paediatrician, Consultant Midwife and Neonatal Matron to ensure the reviews of babies admitted to the neonatal unit have a perinatal collaborative. Any learning is incorporated into an action plan to ensure care pathways are reviewed with aim to reduce mother and baby separation.

In summary the Trust term admission rate is below the national average. This will continue to be monitored to by the ATAIN team to identify any variations in practice and themes.

Avoiding Term Admission into Neonatal Unit (ATAIN)
Term Admissions – Quarter 1



Newborn and Infant Physical Examination (NIPE)

Maternity and Neonatal services perform well on ensuring all babies have a full physical examination within 72 hours of birth. This examination is completed by paediatricians or Midwives with training and competencies.
The table below demonstrates actual performance against what national guidance states is acceptable/achievable

	Acceptable %	Achievable %	Actual
Q1	≥ 95%	≥ 97.5%	98.8%
Q2	≥ 95%	≥ 97.5%	98.8%
Q3	≥ 95%	≥ 97.5%	99.4%
Q4	≥ 95%	≥ 97.5%	98%

External Review

The Neonatal External Independent Review commenced in May 2023, supported by the NWNODN and the Lancashire and South Cumbria Local Maternity and Neonatal Service (LMNS) is ongoing. There have been no immediate concerns raised and the team meets with the Senior Neonatal Team monthly.

NWNODN Annual Review 2023

The aim of the Annual Review by the Neonatal Operational Delivery Network (NWNODN) is to improve access to consistent high-quality neonatal care which supports improved outcomes for babies and families across the region. Annual visits provide an opportunity for the Neonatal team to engage in person with members of the NWNODN to share local successes and challenges.
The previous visit, in 2022, was undertaken face to face. Whist there was positive feedback and acknowledgement of good practices, recommendations were put in place which included:

- The Neonatal Unit to monitor <27week deliveries (including <28weeks if multiple or any baby <800g) in collaboration with the obstetric team to identify all missed opportunities for transfer out and feedback any lessons learnt. These will be identified and reported to NHSE by the NWNODN
- Neonatal Lead Consultant job plan to be developed.
- Ways of ensuring Paediatricians stay up to date with neonatal skills and changes in practice to be considered.
- Workforce challenges
- Governance

In March 2023, the meeting was completed virtually with the report being received in July 2023. Findings were positive and the neonatal team were noted to be engaging well with the NWNODN and actively responded to actions identified following the Annual review in 2022.

They noted many positive changes which has included improved data and outcomes and the embedding of quality improvement initiatives into everyday practice. They also noted that the team had identified that mortality and <27week deliveries has been high and the implementation of the Internal Neonatal Improvement Board to proactively address any issues and provide assurance.

OD Support

Face to face sessions with the Multidisciplinary team are being arranged with support from the OD team. The remit of these sessions will be to progress the action plan developed in response to the FTSU concerns.
Staff have been rostered to attend to ensure that they are all given opportunity to contribute as a team.

Escalation

An escalation report of each Neonatal Improvement Board meeting is presented at the Trust Clinical Governance Committee monthly to update on any issues, progress and concerns.

9.0. Service User Feedback

Maternity Voices Partnership (MVP) Involvement.

The MVP are a working group of women and their families, commissioners, midwives and doctors who work together to review maternity care, provide a voice of women's experiences and contribute to its development. Collaborative work continues including monthly MVP meetings. The MVP chair is a member of the Maternity Safety Champions meeting, is commencing involvement in training compliance and works more widely with the Maternity Team and the LMNS at joint meetings.

10.0. Maternity Safety Support Programme

An allocated Maternity Improvement Advisor continues to attend the Trust 3-4 days per month working closely with the Divisional Senior Leadership Team focusing on three key issues identified from the CQC findings (appendix 3):

- Key issue 1 – Leadership
- Key Issue 2 – Clinical Pathways
- Key Issue 3 – Governance

The Diagnostic report has been drafted along with a plan for the exit criteria. A QI plan to support ongoing improvement will then be developed.

Governance

The MSSP have supported a three day 'deep dive' pf Governance that was well attended by the multidisciplinary team. Feedback of these sessions was completed in July 2023 along with discussion on next steps. An improvement plan is currently being developed by the Divisional Governance team Governance processes remains a challenge however the 'deep dive' will provide an understanding of where processes can be improved or streamlined.

11.0. Care Quality Commission (CQC)

In the Maternity Neonatal update presented in June 2023 (May information) it was highlighted that whilst progress against the Maternity CQC action plan continues, there had been slippage on a number of actions. Whilst there were no 'Red' alerts. Some of the areas RAG rated 'Green' had moved back to 'Amber'.

These actions could be grouped into:

- Mandatory Training and appraisal compliance
- Professional Midwifery Advocacy
- Bereavement Room environment
- Governance – Risk assessments, safety champions meeting

Several mitigations were implemented to support plan for recovery by August 2023. Good progress has been made over the last 2-3 months with the following improvements:

- Safety champions meetings relaunched with new membership and agenda.

- 5 New PMA's qualified this month (total now is 11) with plan for training 5 more in September 2023. The Maternity team are working with LMNS to standardise a PMA strategy across the region.
- Whilst the bereavement room on the Delivery Suite now meets infection control requirements, the Midwifery team are working with SWAN team, SANDS and bereaved parents to upgrade our bereavement room to make it more comfortable and calming environment and have identified monies to do this.
- Governance Deep Dive supported by MSSP/QI took place in June 2023 and the team are now working through improvement plan.
- Identified funding to recruit Risk & Governance Lead for Maternity to coordinate and embed governance. This reflects best practice standard (Ockenden/National Maternity Assessment Tool)
- Drafted Families and Integrated Community Care: Quality Governance, Assurance & Accountability Framework Expected to be ratified August 2023

There remain risks to delivery of the action plan which include:

- Mandatory training and appraisals – whilst there have been improvements in mandatory training and appraisal rates these still require close monitoring and management, as discussed earlier in this report.
- Medicines management – Whilst there is no dedicated maternity pharmacist, the Maternity team are supported by the pharmacy team who undertake weekly audits of the clinical areas. There have been some concerns raised via the audits. This is particular to the Maternity Ward. The Ward Leader and Matron are sighted on these with management plans in place. The Head of Midwifery and Director of Midwifery continue to oversee and support as required.

To 'test out' compliance with the CQC plan we have identified dedicated support to focus on clinical walkabouts and discussion with the clinical teams so that they are sighted on improvements and appraised on progress.

The Local Maternity and Neonatal System have also been asked to provide external support and conduct a peer review. This is expected to take place in the next couple of months.

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.

The current position

Action Plan	June 2023	August 2023
Areas of improvement	13	13
Number of actions	59	59
Completed Actions	46	52
Actions moved to Amber/off track	13	7

Progress is as follows:

	CQC Must Dos	Position	Actions per Must Do/Should Do	
1	The service must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experiences persons, to include resuscitation and safeguarding training. (Regulation 18 (1)).	**Progress:** On track – no issues	**June 2023 - Overall position Green** 17 actions: I action – on track (amber) 16 actions completed.	**August 2023 - Overall position Green** 17 actions: I action – on track (amber) 16 actions completed.
2	The service must ensure that persons employed receive appropriate support, training, professional development, supervisions and appraisals to carry out the duties they are employed to perform. The trust must ensure there is sufficient capacity for clinical supervision to be delivered effectively by utilising the PMA roles or equivalent (regulation 18 (2) (a)).	**Progress:** Changes made to actions previously completed: Mandatory training below compliance – compliance improving remains below 95% Appraisals rates below compliance improving remains below 95% Regular professional midwifery advocate (PMA) process needs auditing to ensure embedding. Audit not yet completed	**June 2023 - Overall position Amber** 5 actions: 1 action completed. 4 actions off track	**August 2023 - Overall position Amber** 5 actions: 2 actions completed. 3 actions off track
3	The service must ensure that they suitably assess and communicate the risks to the health and safety of service users receiving care and treatment and do all that is reasonably practicable to mitigate any such risk. (Regulation 12 (1) and (2) (a) and (b))	**Progress:** On track – no issues	**June 2023- Overall position Green** 8 actions completed	**August 2023-Overall position Green** 8 actions completed
4	The service must ensure that the premises used by the service are safe for their intended purpose and used in a safe way (Regulation 12 (2) (d))	**Progress:** The bereavement room environment does not facilitate best experience for family – work ongoing with support of SWAN team and monies identified for upgrade	**June 2023 - Overall position Amber** 1 action off track (amber) 1 action completed.	**August 2023 - Overall position Green** 2 actions completed
5	The service must ensure that the equipment used by the service for providing care and treatment is safe for use (Regulation (12) (e))	**Progress:** On track – no issues	**June 2023 - Overall position Green** 2 actions completed	**August 2023 - Overall position Green** 2 actions completed

6	The service must ensure there is proper and safe management of medicines to include the storage of medicines and safe disposal of medicines no longer than required (Regulation 12 (2) (g))	**Progress:** There is no designated pharmacist for Maternity. However, there is support from the Paediatric pharmacist and pharmacy team. Risk assessment completed and plan to meet with Chief Pharmacist to discuss anything further needed (date for meeting June 2023) Business case developed in draft expected to be presented to Execs in August 2023	**June 2023 - Overall position Amber** 1 action off track – (amber) 5 actions completed.	**August 2023 - Overall position Amber** 1 action off track – (amber) 5 actions completed
7	The service must ensure that they assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. This must include ensuring appropriate cleaning schedules and cleaning is undertaken (Regulation 12 (2) (h))	**Progress:** On track – no issues	**June 2023 - Overall position Green** 2 actions completed.	**August 2023 – Overall position Green** 2 actions completed
8	The service must ensure the care and treatment of service users must be appropriate, meet women and babies breast feeding and ensuring available access to expressed milk (Regulation 9 (1))	**Progress:** On track – no issues	**June 2023 - Overall position Green** 4 actions completed.	**August 2023 - Overall position Green** 4 actions completed.
9	The service must ensure that they assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity (Regulation 17 (2) (a)	**Progress:** The previously named Perinatal Surveillance Group has been renamed as the 'Maternity & Neonatal Safety Champions Group.' with refreshed Maternity Safety Champions agenda and Terms of Reference. This is to ensure the remit of the meetings meets the requirements of CNST (Safety Action 9) and Ockenden	**June 2023 - Overall position Amber** 1 action – off track (amber) 3 actions completed.	**August Overall position Green** 4 actions completed.
10	The service must ensure that they assess, monitor and mitigate the risks related to the health, safety, and welfare of service users, and others who may be at risk which arise from the carry-on of the regulated activity (Regulation 17 (2) (b))	**Progress:**. Support from Corporate Risk Team to undertake risk clinics External review being completed in June 2023 via MSSP Programme Monthly attendance at Trust Risk Committee	**June 2023 - Overall position Amber** 3 actions off track – (amber)	**August 2023 - Overall position Green** 3 actions completed.

		Risk register currently under review to ensure all risks assessments in date Currently 33 risks with 6 overdue		
	CQC Should Dos	**Position**	**Actions**	
11	The Trust should ensure that women are fully informed about the reason for remaining in hospital ahead of an induction.	**Progress:** On track – no issues	**June 2023 - Overall position Green** 4 actions completed.	**August 2023 - Overall position Green** 4 actions completed.
12	The Trust should consider utilising the trained professional midwifery advocates to support in professional development and supervisions.	**Progress:** Off track – relates to Professional Midwifery Advocates (Must Do No 2)	**Overall position – Amber** 1 action off track (amber)	**Overall position – Amber** 1 action off track (amber)
13	The Trust should consider involving all staff in baby abduction drills as per the providers policy.	**Progress:** Work ongoing with multidisciplinary team Structured meetings in place with action log. Policy for abduction in draft Skills drill still to be facilitated.	**June 2023 - Overall position Amber** 1 action off track (amber)	**August 2023 - Overall position Amber** 1 action off track (amber)

12.0. CNST Maternity Incentive Scheme

Year 5 Update:

A benchmark against the CNST Year 5 Safety actions published in June 2023, is in progress and will be available for the next report. There are a number of Safety Actions that will require evidence of previous embedding of processes and other requirements in response to previous years CNST Safety Actions.

13.0. Maternity Vision and Strategy

The Maternity Framework is set out in four key documents:

- Ockenden (2020 & 2021)
- East Kent 'Reading the Signals' (2022)
- The National Assessment Tool
- Three Year Delivery Plan for Maternity and Neonatal Services (NHS England March 2023)

Many of the recommendation are similar and the overall aim is to have all these recommendations in one overarching improvement plan. Work is ongoing.

Three Year Delivery Plan for Maternity and Neonatal Services (NHS England March 2023)

This plan sets out how the NHS will make Maternity and Neonatal care safer, more personalised, and more equitable for women, babies, and families over the next three years.
This plan sets out what is needed to be in place and the responsibilities for each part of the NHS, which includes Trust Boards, LMNS, ICB and with NHS England providing national leadership, concentrating on four high level themes.

A template including 62 actions for the Trust element of the plan has been developed by Lancashire and Cumbria LMNS to support benchmarking. Arrangements are being made to commence this.

14.0. Maternity Dashboard (Refer to Appendix 2)

Please see Appendix 2 exceptions are monitored through the FICC Divisional Meeting, and Trust Performance Improvement Delivery and Assurance meeting (PIDA) attended by the Executive Team each month.

15.0. Recommendation to Board

To note the review of actions plans developed in response to national guidance to gain an understanding of Trust position.

To ensure continued visibility and presence at maternity and neonatal staff engagements events, with the Board Level Maternity and Neonatal Safety Champions.

To consider if the information contained in this report requires additional narrative or further clarification.

16.0. 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

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 step

(Appendix 1) Perinatal Surveillance Model

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
	Requires Improvement					

Maternity Safety Support Programme	Select Y /N	Yes – Commenced October 2022

2023/2024	2023											
	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
1.Findings of review of all perinatal deaths using the real time data monitoring tool				Section 1	Section 1	Section 1	Section 1					
2. Findings of review of all cases eligible for referral to HSIB				1 case ongoing	1 case ongoing	1 case ongoing	2 cases ongoing					
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken				8 Moderate Incidents 5 progressed to Air. No themes	4 moderate currently being reviewed	6 moderate Includes 3 downgraded	8 moderate incidents 3 downgraded					
2b. Overall Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training												
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively				TBC	TBC	TBC	TBC					
3.Service User Voice Feedback				Leaflets production Birth Afterthoughts	Leaflets production Birth Afterthoughts	Support with IOL audit	Attending Safety Champs meeting					
4.Staff feedback from frontline champion and walk-abouts				Monthly Walkabouts completed	Monthly Walkabouts completed	Monthly Walkabouts	Monthly Walkabouts completed					

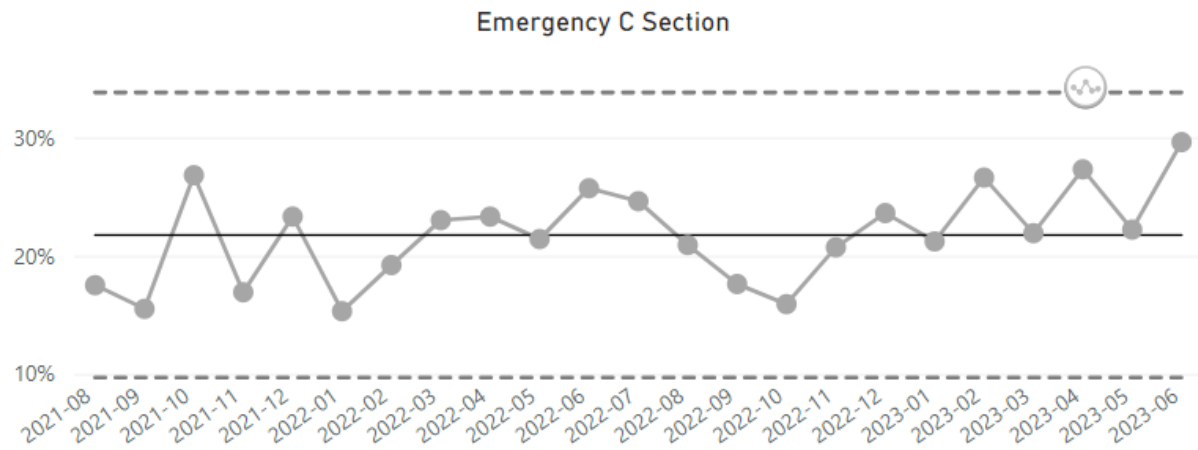
						completed						
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust				HSIB Escalation letter x 2	HSIB Escalation letter x 1 (3)	Nil	Nil					
6.Coroner Reg 28 made directly to Trust				None	None	None	None					
7.Progress in achievement of CNST 10				Compliant – 2 Safety Actions	Compliant 2 Safety Actions	Under Review	Under review					

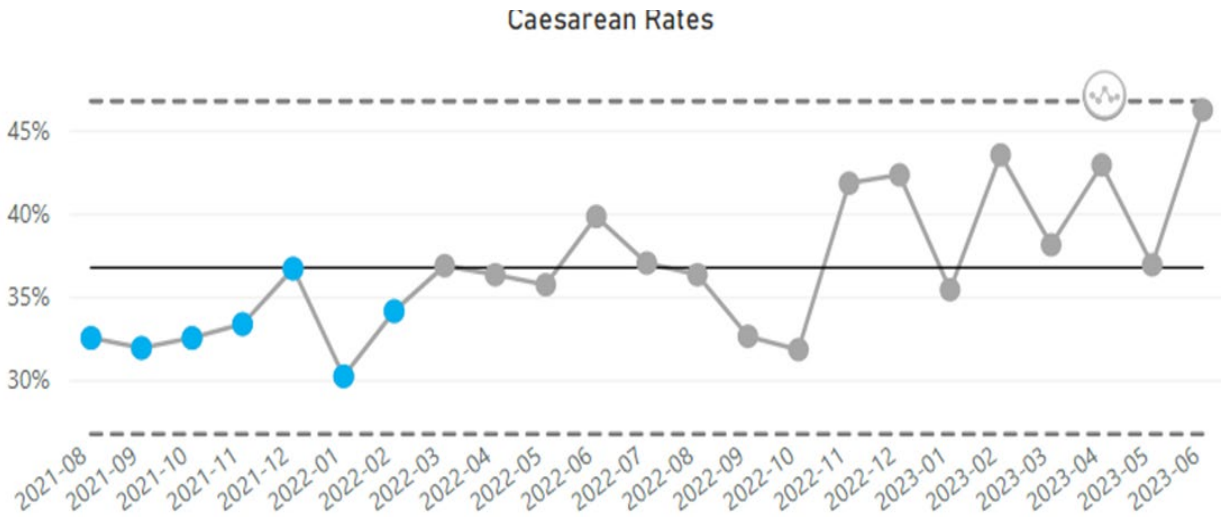
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually

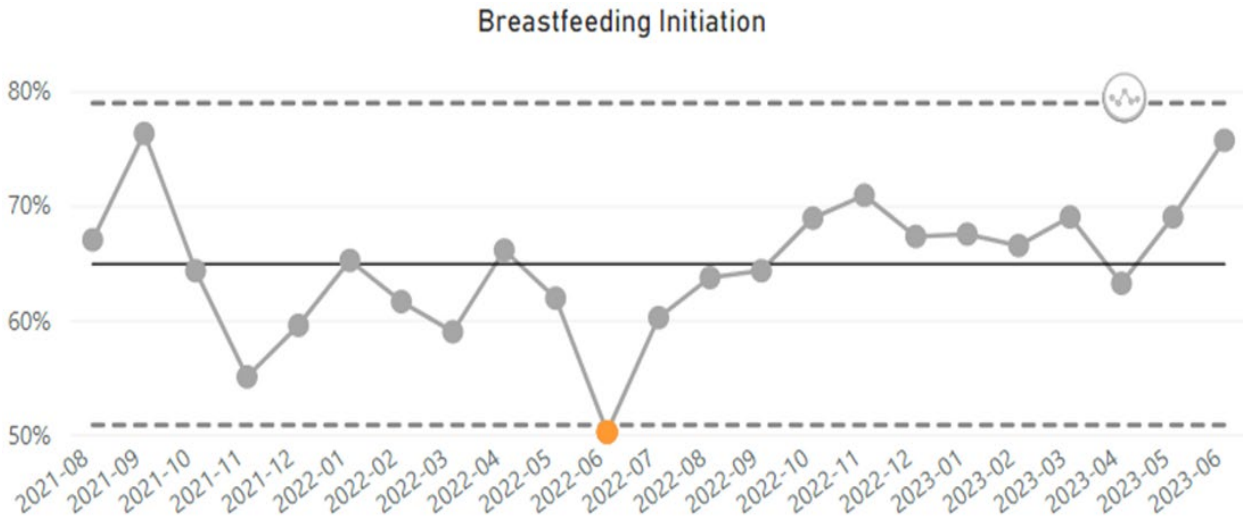
(Appendix 2) Maternity Dashboard

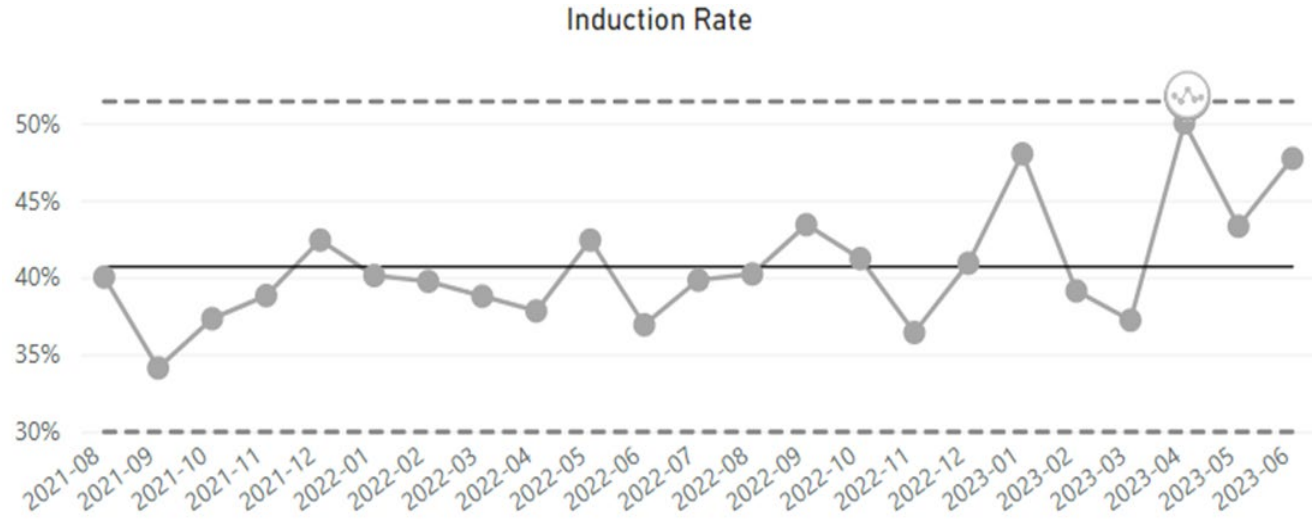
Families and Integrated Community Care

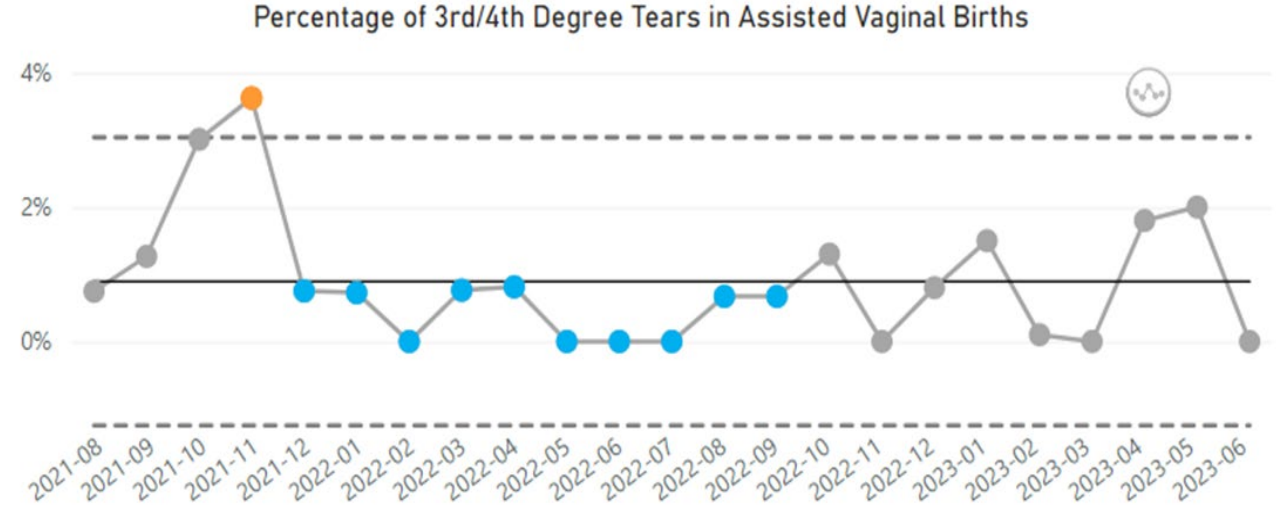
August 2023 (June 2023 data)



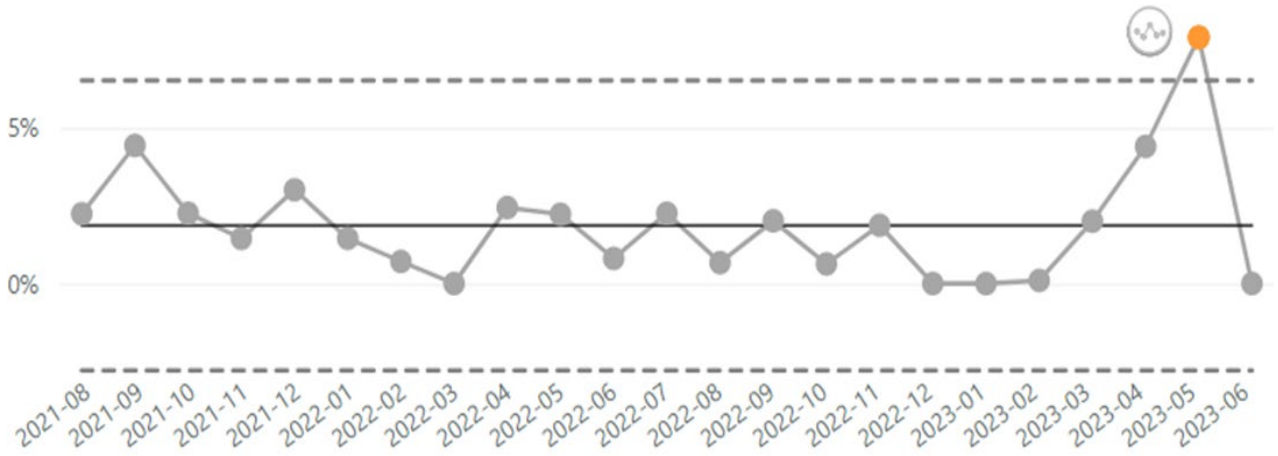



Breastfeeding Initiation
80%
70%
60%
50%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06

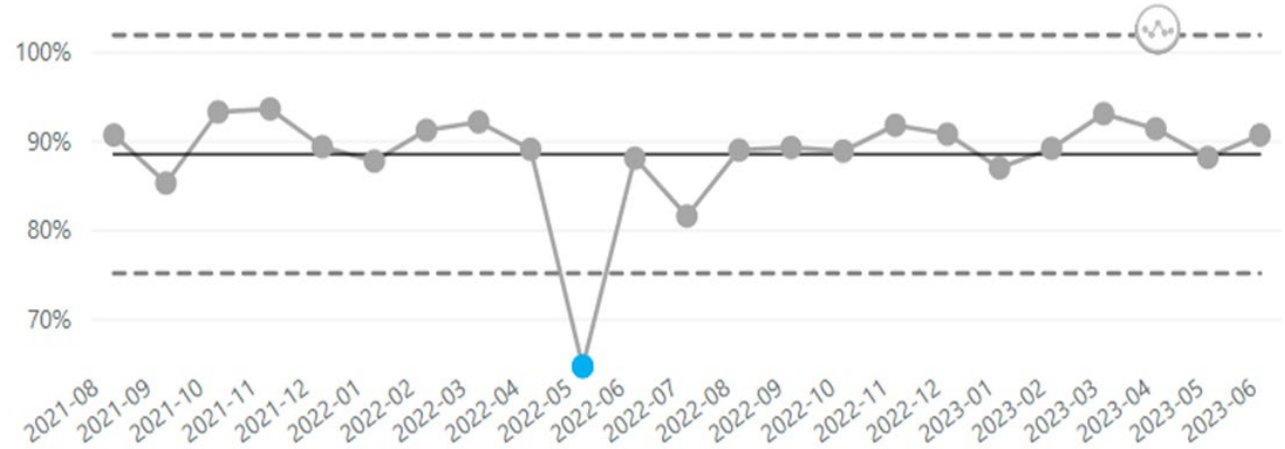

Induction Rate
50%
45%
40%
35%
30%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06


Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births
4%
2%
0%
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
2023-06

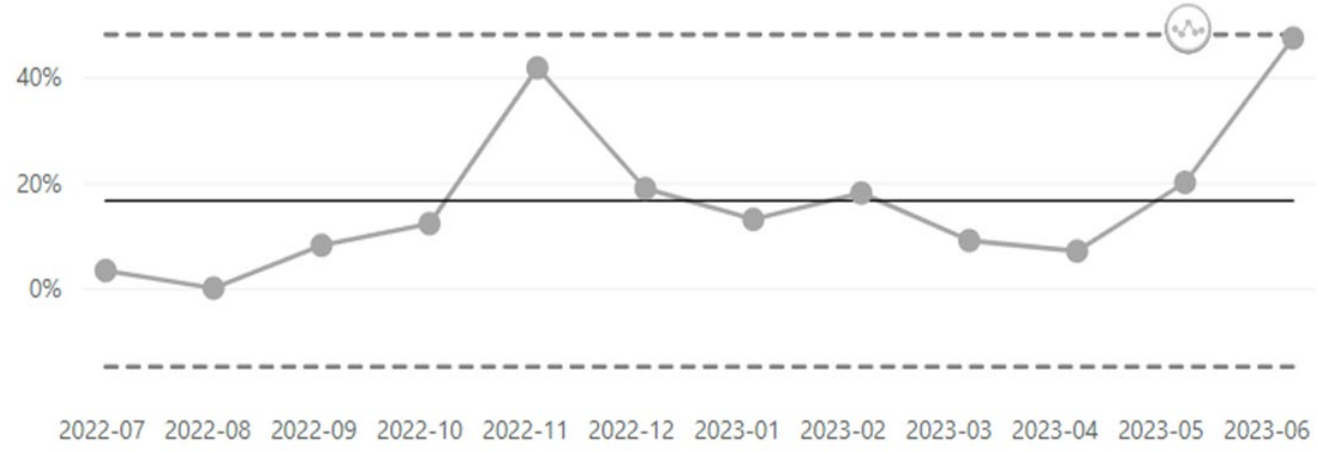
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth

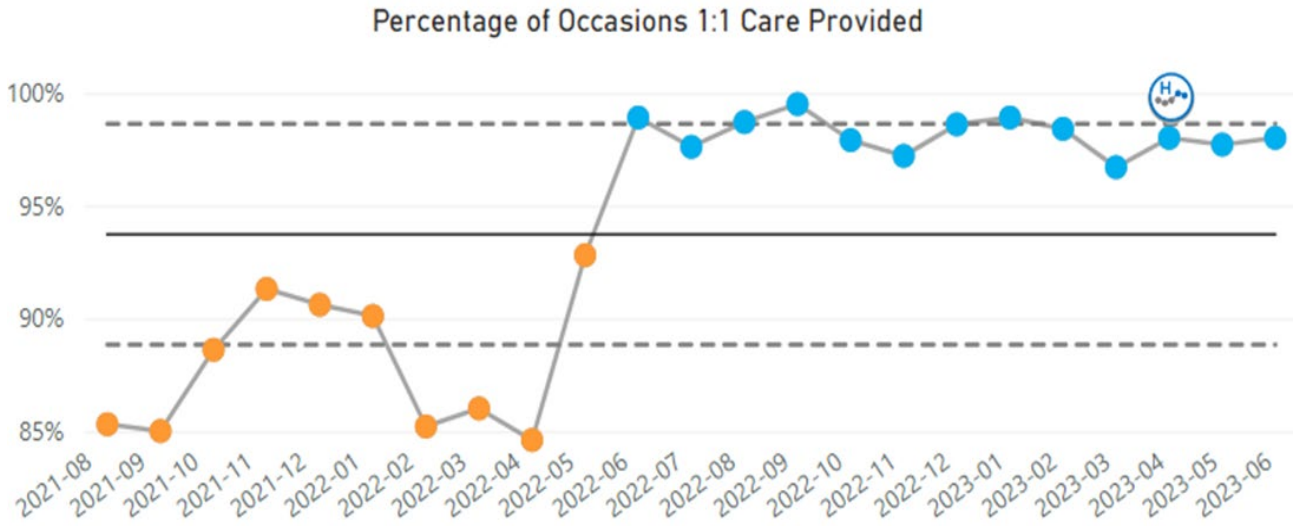


Percentage of Women Booked by 12 weeks 6 days



Induction of Labour - % within 4 hours




Percentage of Occasions 1:1 Care Provided
100%
95%
90%
85%
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
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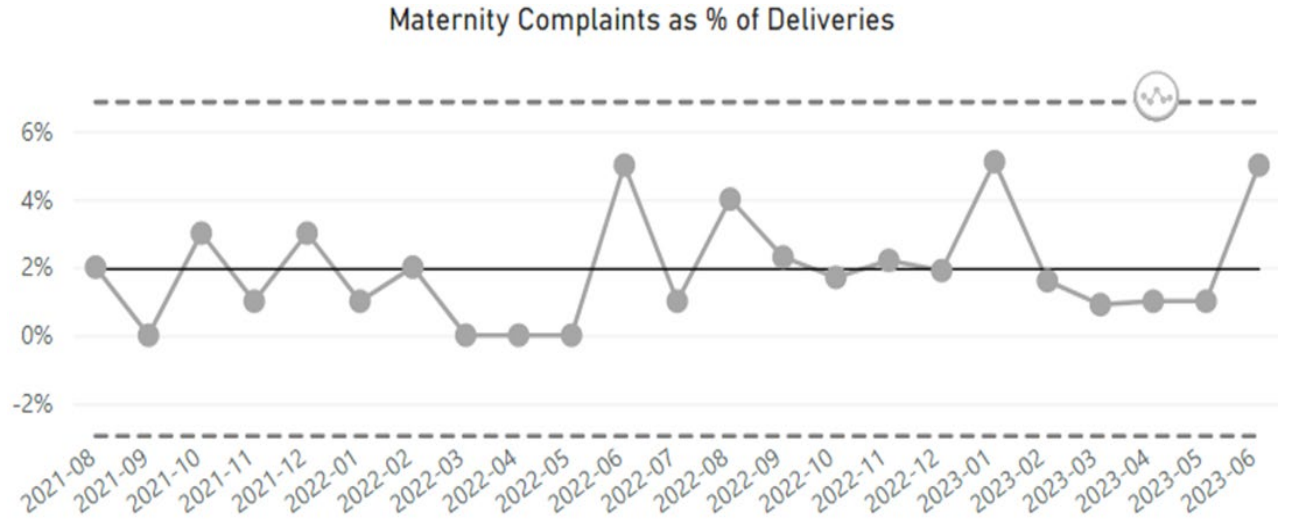
2023-02
2023-03
2023-04
2023-05
2023-06


Maternity Complaints as % of Deliveries
6%
4%
2%
0%
-2%
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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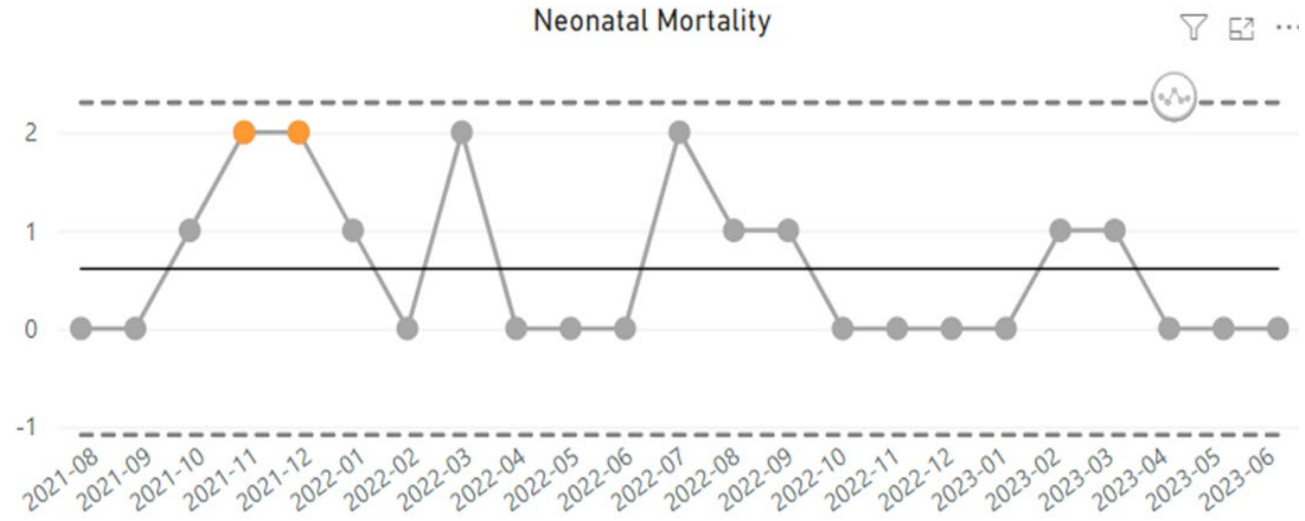
2023-02
2023-03
2023-04
2023-05
2023-06


Neonatal Mortality
2
1
0
-1
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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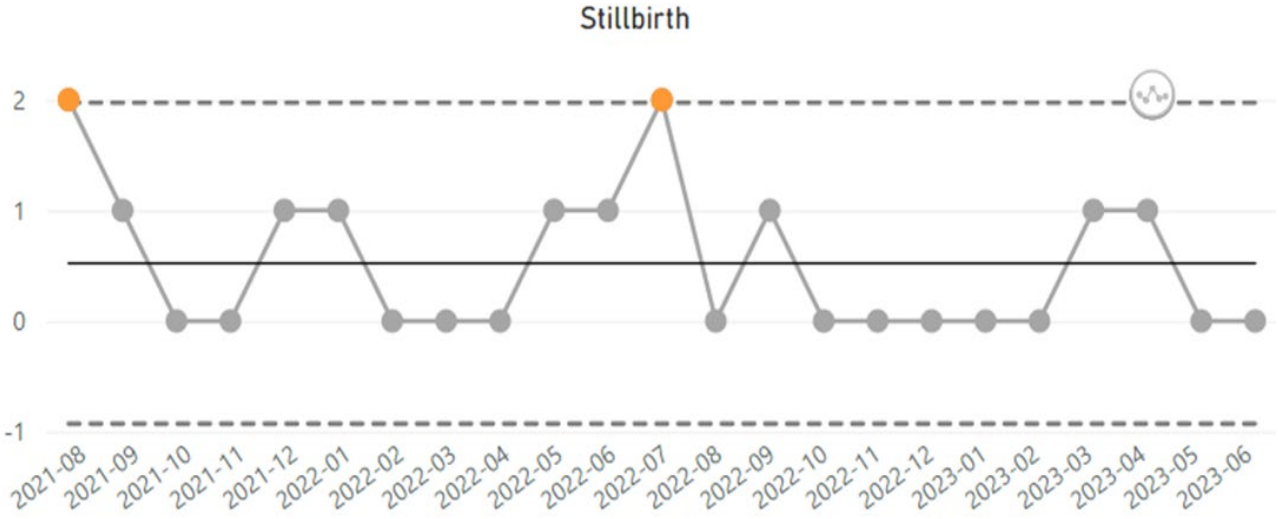
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06


Stillbirth
2
1
0
-1
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
2023-06

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quarterly Maternity Staffing Report - For period April 2023 to June 2023

Meeting:	Board of Directors Meeting
Date:	September 2023

Author	Lynne Eastham, Director of Midwifery & Neonates					
Exec Sponsor	Bridget Lees, Executive Director of Nursing, Midwifery, Allied Health Professionals, Quality					
Purpose	Assurance	X	Discussion		Decision	X
Confidential y/n	No					

Summary *(what)*	**Advise**
	An effective monitoring of safe midwifery staffing levels using a nationally accredited Maternity workforce tool (Birthrate Plus) is required. This is in response to national inquiries into Maternity safety such as Morecambe Bay, Ockenden and East Kent and the recently published 'Three Year Delivery Plan for Maternity and Neonatal Services' (NHS England March 2023). The Maternity Incentive Scheme (CNST) also requires that Maternity Services should demonstrate an increase in staffing levels where recommended and have mitigation to cover shortfalls. Continuity of Carer implementation remains a priority on the national and regional Maternity agenda and safe staffing levels are required as one of the 'building blocks' of implementation. A Birthrate Plus assessment was carried out in 2021. This assessment recommended a birth to midwife ratio of 22.7 births to 1.0wte Midwife across the service and identified a gap of 17wte Midwives. As part of the Continuity of Carer implementation plan an additional 3wte Midwives were identified to ensure 100% compliance. (Total of 20wte Midwives) Funding has been secured in response to a business case and external funding (Ockenden), however there remains a shortfall of 5.75wte Midwives from the Birthrate Plus recommendations made.

Implications *(so what)*	**Alert**
	Maternity is not compliant with the Birthrate Plus recommendations.

It is a requirement of the NHS Resolutions Maternity Incentive Scheme (CNST) Safety Action 5, that:

a) **There is a systematic, evidence-based process to calculate midwifery staffing establishment is completed**.

This is the Birthrate Plus assessment. The previous assessment was completed in October 2021 and a reassessment is currently being arranged.

b) **The Trust Board evidence the midwifery staffing budget reflects establishment as calculated in a) above**.

We are not compliant with the Birthrate plus recommendations with a shortfall in the midwifery establishment of 5.75wte Midwives.

c) **In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of the funded establishment being compliant with outcomes of Birthrate+ or equivalent calculations.**

We are not compliant with the Birthrate plus recommendations with a shortfall in the midwifery establishment of 5.75wte Midwives.

d) **Where Trusts are not compliant with a funded establishment based on Birthrate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.**

The plan is attached as Appendix 3. The Board are asked to approve and include agreement in the Trust Board minutes.

e) **The plan to address the findings from the full audit or table-top exercise of Birthrate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.**

The Board are asked to agree that the plan and findings of the Birthrate Plus reassessment are shared with the LMNS and MSSP

Assure

Planned versus actual midwifery staffing levels mitigation/escalation for managing a shortfall in staffing levels.
Safe staffing levels are monitored daily with processes in place to mitigate risks and escalate concerns both Trust and Region wide.
To monitor safe staffing metrics are used which include 'red flag' indicators, one to one care in labour and the supernumerary status of the delivery suite shift coordinator.

Recruitment
In response to the ongoing historic midwifery vacancies a proactive approach has been required to increase recruitment which has included:

	• Recruiting 3.0wte international midwives who are being supported through their training competencies and development, with a plan to permanently recruit them following successful completion of clinical examinations. • Recruiting 2.0wte experienced midwives returning to practice • Supporting 10.37wte of our student midwives by offering them permanent positions on qualifying in September 2023. To support them in the transition additional support has been provided by the practice facilitator and maternity team to commence their preceptorship package early. This means that by September 2023, the vacancy rates will have reduced to approximately 4.0wte, which is the best it has been for several years.

Previously considered by	Trust Quality Assurance Committee

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	Yes

Proposed Resolution ***(What next)***	The Board of Executives are asked to note the contents of this report and note that it is a requirement of the NHS Resolutions Maternity Incentive Scheme (CNST) Safety Action 5, that the Board of Executives: • formally record in the Board minutes that the Trust is not compliant with the funded establishment based on Birthrate Plus calculations. • Formally record the agreed action plan (Appendix 3), including timescale for achieving the appropriate uplift in funded establishment – (this will be dependent on the Birthrate Plus reassessment). • The plan (Appendix 3) must include mitigation to cover any shortfalls in staffing levels. • that, where deficits in staffing levels have been identified this must be shared with the local commissioners.

Blackpool Teaching Hospitals NHS Foundation Trust

QUARTERLY MATERNITY STAFFING REPORT

For period April 2023 to June 2023

1. Introduction

The aim of this report is to provide assurance to the Board of Directors that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels. Previously midwifery staffing data has been included in the nurse staffing paper, however, it is a requirement of the NHS Resolutions Maternity Incentive Scheme (CNST) Safety Action 5, that a separate paper is provided. and the following standards are used as outlined in the table below:

Table 1: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above
c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d)	All women in active labour receive one-to-one midwifery care.
e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period

2. Background

There is an expectation nationally and regionally that Maternity Services is compliant with the recommendations of a nationally accredited Maternity workforce tool (Birthrate Plus) and as such Trusts are benchmarked on compliance as a measure of safety. This is in response to national inquiries into Maternity safety such as Morecambe Bay, Ockenden and East Kent and the recently published 'Three Year Delivery Plan for Maternity and Neonatal Services' (NHS England March 2023).
The Maternity Incentive Scheme also requires that Maternity Services should demonstrate an increase in staffing levels where recommended and any mitigation to cover shortfalls.
Continuity of Carer implementation remains a priority on the national and regional Maternity agenda and safe staffing levels are required as one of the 'building blocks' of implementation.

2.1 Birthrate Plus Workforce Planning

Birthrate Plus (BR+) workforce planning, and the real time staffing acuity tools use validated methodology to support the delivery of safer maternity care as required by the Maternity Incentive Scheme. They are the only midwifery specific national tools that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services.

In 2021, a BR+ assessment was completed, based on 3 month's case mix data from December 2020 to February 2021. The report received in October 2021 provides a clear breakdown of how the required maternity establishment has been calculated. (see appendix 1)

This assessment recommended a birth to midwife ratio of 22.7 births to 1.0wte Midwife across the service and identified a gap of 17wte Midwives. As part of the Continuity of Carer implementation plan an additional 3wte Midwives were identified to ensure 100% compliance.

In March 2022, the Trust received funding from NHSEI for 6.5wte Midwives in response to Ockenden recommendations. A business case was submitted to fund the remaining shortfall of 13.5wte midwives.

In view of the vacancy level at the time, the outcome of the business case was that whilst funding was not agreed, recruitment could continue above funded establishment if the workforce was available. This led to an increase in the staffing establishment, however, whilst midwifery numbers have been slowly growing, the service has historically continued to carry vacancy.

In April 2023, a revised business case was submitted to request funding for 5.75wte midwives (50% of funding of the initial business case) in view of a reducing birth rate and a further formal BR+ assessment being arranged. This was supported.

3. Current Position

In May 2023, a 'tabletop exercise' was completed using the maternity dashboard and a three month sample of births from February 2023 to April 2023, which indicated that the case mix remained unchanged.

The table below shows the current workforce position for clinical midwives:

	Substantive staff in post (FTE)	Funded establishment (FTE)	Vacancy gap (FTE)
Registered Midwives	**94.43**	**110.97**	**16.54**
Band 5	9.74	10.00	0.26
Band 6	57.61	75.23	17.62
Band 7	22.65	21.31	-1.34
Band 8+	4.43	4.43	0.00

The service has historically carried high vacancy rates which can be impacted by maternity leaves and sickness absence rates.

3.2 Planned versus actual midwifery staffing levels mitigation/escalation for managing a shortfall in staffing levels.

Each month a 'Check, Coach, Challenge' meeting is held with the Director of Midwifery and Neonates, maternity leaders, HR Business Partner and the Rostering team to review fill rates, percentages of sickness absence, annual leaves, vacancy, starters and leavers with oversight by the Director of Midwifery, at which time any issues can be discussed and mitigations put in place.

At least twice weekly staffing meetings are in place to focus on a two week forward look ahead which provides a further opportunity to identify 'hot spot' areas and action appropriate solutions to maintain safe staffing levels.

Each morning a staffing huddle is facilitated, led by a senior member of the team, at which time staffing levels, acuity and activity are reviewed and the birth rate acuity tool discussed, and appropriate actions taken.

There is a dedicated 1043 maternity bleep holder who oversees operational management with the multi-disciplinary team to ensure that when there is staff sickness, staff vacancies or an increase in demand within maternity, midwifery and support staff are moved to areas that require additional support, ensuring that women in labour have 1:1 midwifery care. Out of hours a Band 7 midwife supporting the Delivery Suite Coordinator will carry the 1043 bleep and will work in partnership with the Divisional Manager on-call.

Each day there is a regional 'Gold Command' call overseen by the Local Maternity and Neonatal system to review staffing levels and capacity of each unit in the region where mutual aid can be facilitated if required or a divert supported.

Maternity is represented at the twice daily Trust staffing meetings and at the Trust patient flow meetings where any issues can be escalated.

The service also benefits from a recruitment and retention midwife supported by regional funding. This post has recently been extended as a commitment to continuing to support midwives in practice.

3.3 Recruitment

In response to the ongoing historic midwifery vacancies a proactive approach has been required to increase recruitment which has included:

- Recruiting 3.0wte international midwives who are being supported through their training competencies and development, with a plan to permanently recruit them following successful completion of clinical examinations.
- Recruiting 2.0wte experienced midwives returning to practice
- Supporting 10.37wte of our student midwives by offering them permanent positions on qualifying in September 2023. To support them in the transition additional support has been provided by the practice facilitator and maternity team to commence their preceptorship package early.

This means that by September 2023, the vacancy rates will have reduced to approximately 4.0wte, which is the best it has been for several years.

4. Specialist Midwives

Maternity complies with the BR+ recommendations that 8-11% of the total establishment of specialist midwives and those in management positions are not included in the clinical numbers. The specialist midwives in post reflect the needs of our local population.

There are 15.70wte specialist midwives.

Fetal Monitoring Midwife		Governance midwife
Bereavement Midwife Laura Walsh		Perinatal Mental Health Midwife

Practice Development Midwives		Complex Medical Midwife
Recruitment and Retention		Complex Social Care Midwife
Antenatal & Newborn Screening Lead		PEF Midwife
Public Health Midwife		Digital Midwife

5. Birth Rate Plus Live Acuity Tool

For this report, acuity refers to intrapartum activity (the number of women being cared for on the delivery suite) and is measured using the BR+ acuity tool. BR+ defines acuity as "the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency".

Positive (green) acuity scores mean that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite at that time. Negative (amber and red) acuity scores mean that there may not be an adequate number of midwives to provide safe care to all women on the delivery suite at the time. In addition, the tool collects data such as red flags which are defined as a "warning sign that something may be wrong with midwifery staffing".

The table below shows the midwife to birth ratio, number of red flags followed by the percentage of shifts identified by the acuity tool as red, amber or green acuity.

Month	Births	1:1 care	Birth ratio	Red flags	Birth rate plus completion %	Green – acuity	Amber – acuity (up to 2 midwives short)	Red - acuity (over two midwives short)
April	200	98%	1:28.6	17% 24 – shift leader not supernumerary but not providing 1:1 care 1 - shift leader not supernumerary providing 1:1 care	74.73%	51%	43%	7.1%
May	202	98.51%	1:27.5	17% 24 – shift leader not supernumerary but not providing 1:1 care 1 - shift leader not supernumerary providing 1:1 care	74.01%	68%	20%	12%
June	201	98%	1:27.45	15% 16 - – shift leader not supernumerary but not providing 1:1 care 2 - shift leader not supernumerary providing 1:1 care 1 – delay in pain relief 1 – delay in admission for induction and starting induction.	72.78%	65%	28%	7%

5.1 Red Flags

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the matron for maternity is notified who will then determine whether midwifery staffing is the cause and the action that is needed. Appendix 2 describes the red flag events.

5.2 Supernumerary Delivery Suite Co-ordinator

Availability of a supernumerary delivery suite co-ordinator is recommended as best practice to oversee safety on the delivery suite. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the delivery suite.
When the Delivery Suite Coordinator do not have supernumerary status, escalation to the Matron takes place to implement mitigating actions.

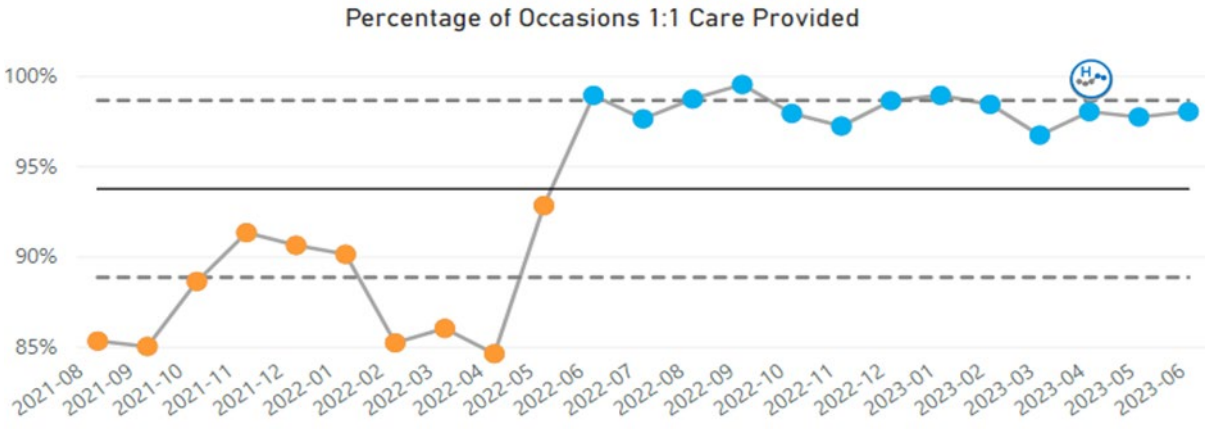
The table below shows the number of red flags and the number of times the delivery suite coordinator has not been supernumerary.

Red Flags	April	May	June
Shift coordinator not supernumerary but not providing 1:1 care	24	24	16
Shift coordinator not supernumerary and providing 1:1 care	1	1	2
Delay in administering pain relief			1
Delay in admission for induction and starting induction.			1

5.3 One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. This is when a woman is cared for by a midwife who is looking just after her. Maternity services aim to achieve 100% 1-1 care in labour, and this is monitored via Badgernet and monthly via PIDA. One to one care increases safety and contributes to reducing both the length of labour and the number of operative deliveries and improves patient experience. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the delivery suite co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.



6. Recommendations

The Board of Executives are asked to note the contents of this report and note that it is a requirement of the NHS Resolutions Maternity Incentive Scheme (CNST) Safety Action 5, that the Board of Executives:

- formally record in the Board minutes that the Trust is not compliant with the funded establishment based on Birthrate Plus calculations.
- Formally record the agreed action plan (Appendix 3), including timescale for achieving the appropriate uplift in funded establishment – (this will be dependent on the Birthrate Plus reassessment).
- The plan (Appendix 3) must include mitigation to cover any shortfalls in staffing levels.
- that, where deficits in staffing levels have been identified this must be shared with the local commissioners.

Appendix 1

Birthrate Plus Report – October 2021 (attached as separate document)

Appendix 2

Maternity red flag events,

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Delivery Suite coordinator unable to maintain supernumerary status – providing 1 to 1 care in labour.
- Delivery Suite coordinator unable to maintain supernumerary status – NOT providing 1 to 1 care in labour.

Appendix 3 – Action Plan for Birthrate Plus 2023/2024.

Issue	Specific Action Required to Achieve Standard	Lead	Timescale	Evidence	Progress
Monitor the midwifery establishment in line with Birthrate Plus	Re-fresh of Birthrate Plus	DOM	October 2023 – on track	Evidence collated by BR+ analysis.	Finances identified awaiting confirmation of date from BR Team
	To submit staffing paper with recommendations from Birthrate Plus on completion	DOM	December 2023 – on track	Agenda/minutes of Board meeting	Awaiting assessment
	Review area staffing levels each shift using the BR+ acuity tool to ensure appropriate staffing levels in line with Birthrate Plus Present monthly safe staffing audit to Divisional Board to include red flags, supernumerary shift coordinator birth ratio and one to one care in labour.	HOM	Complete	BR+ acuity tool data	Monthly safe staffing report to be commenced from September reporting for July 2023 onwards
	To present monthly safe staffing report PIDA and include in Maternity Board reporting through to Board.	DOM	September 2023 – on track	BR+ acuity tool data	Monthly safe staffing report to be commenced from September reporting for July 2023 onwards
	To annually review the recruitment and retention plan.	HOM	Rolling programme Complete	Up to date plan in place	In place

birthrateplus® | Safe Staffing for Maternity Services

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

Final Report

October 2021

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Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have more than 8000 births. In addition, it caters for the various models of providing care, such as traditional, community based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.**

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there ae women who birth in a particular hospital but from out of area so are 'exported' to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows. Should more local women choose to birth at the local hospital in the future adjustments will need to be made to workforce to provide the ante natal and intrapartum care.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal bookings.

Discussion of Results

1. The results are based on three months casemix data obtained for the months of December 2020 - February 2021.

2. An allowance of 23% uplift has been calculated and 12.5% community travel are included in the staffing figures.

3. Annual Activity is based on the FY 2020/2021 and total births of 2574, allocated as below:
    - 2531Delivery Suite births
    - 43 births at home.

4. The Birthrate Plus® staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

5. Time is included for Band 7 Coordinators, Ward and Department Managers and Team Leaders to cover the day to day management and coordination in all areas.

6. The Delivery Suite casemix (Table 1) indicates that 64.2% of women are in the 2 higher categories IV and V which slightly higher than the average for England of 58% based on 55 maternity units from a wide range of size and location. The casemix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines. Appendix 1 provides a description of the 5 categories.

Blackpool Victoria Hospital	Cat I	Cat II	Cat III	Cat IV	Cat V
% Delivery Suite Case Mix 20/21	4.7%	9.3%	21.8%	30%	34.2%
	35.8%			64.2%	

Blackpool Casemix Table 1

7. There will be a correlation between the casemix, and maternity stats recorded on the dashboard especially in relation to Induction rates, delivery method, post-delivery problems, obstetric and medical conditions.

8. Annually, 448 antenatal cases are seen on delivery suite as the women require one to one care and are often warded for ongoing observation and monitoring.

9. Inductions of labour (prostin/propess) are based on the annual number of doses (1367) administered so will be less women. The staffing is allocated to the Delivery Suite for this activity.

10. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. The annual activity indicates 785 admission episodes to the ward excluding inductions and elective sections.

11. The 'extra care babies' of 520 are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is covered in the casemix as more hours are allocated to women in the higher categories IV and V.

12. Staffing is included for 95 babies to have their NIPE carried out by a midwife. NIPE for home births is routinely included.

13. The staffing for the Triage is based on adopting the BSOTS model which provides 24hrs, 7 days a week service. A total of 8069 Triage annual episodes and 2775 Day assessments are seen.

14. Outpatient Clinic services are based on services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service.

15. The community annual total of 3087 includes 276 women who birth in neighbouring units and receive antenatal and/or postnatal care only from Blackpool midwives (community imports). The antenatal and birth episodes are provided by neighbouring units.

16. There are 20 women who birth in Blackpool and as from 'out of area' receive their community care from their home Trust (community exports).

17. The annual total of women receiving community care is 3130, whilst the bookings are 3387 with the addition of 257 attrition cases.

18. The total clinical wte will contain the contribution from Band 3 MSWs in hospital and community postnatal services.

19. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team.

Birthrate Plus® Staffing: Core staffing & includes 10% Continuity of Carer

Blackpool Teaching Hospitals NHS Foundation Trust • Total Deliveries 2574 • Total Community Cases 3130 • Total Bookings 3387 (includes 257 attrition cases)	
Clinical WTE required	
Delivery Suite: • Births (2531) • A/N cases (448) • Non-viable pregnancies (19) • Induction of Labour Activity (137)	35.45wte
Triage (8070)	8.27wte
Maternity Ward D • A/N Admissions (785) • Inductions of labour (1230) • Postnatal women (2531) • NIPE (95) • Extra Care Babies (520) • Postnatal readmissions (44)	34.30wte *Includes MSWs*
Outpatients Services • Midwife Clinics • Obstetric Clinics • Maternity Day Unit (2775)	2.78wte 1.31wte
Community Services: • Home births (43) • Community AN & PN care (3087) • Attrition (257) • Obstetric Outreach clinics • Additional safeguarding	31.30wte *Includes MSWs*
Total Clinical WTE	**113.41wte**

Breakdown of Birthrate Plus Recommended Staffing

Blackpool Victoria Hospital/Community

Table 2

Clinical Specialist Midwives

20. The % of clinical time provided by specialist midwives included in the workforce calculations is a local decision although there is a commonly applied rationale within the methodology and generally accepted by Heads of Midwifery.

Non-Clinical Midwifery Roles

21. The total clinical establishment as produced from Birthrate Plus® is 123.61wte and this excludes the non-clinical midwifery roles needed to provide maternity services, as summarised below.
    - Director of Midwifery, Head of Midwifery, & Matrons/managers with additional hours for team leaders to participate in strategic planning & wider Trust business
    - Consultant Midwives (50% nonclinical)
    - Additional time for specialist midwives to undertake audits, training of staff, etc.
    - Safeguarding Coordinator
    - Teenage Pregnancy
    - Perinatal Mental Health
    - Clinical Practice Facilitators
    - Practice Development
    - Supervision –PMA role
    - Risk and Governance
    - Bereavement midwife

    The above roles require 10.21wte applying 9% based on the clinical total wte.

    Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles. The % can be set locally, although the RCM Staffing Guidance support 9-11% and Birthrate Plus is NICE endorsed hence being generally applied in maternity services.

Summary of Results

22. The Birthrate Plus clinical, non-clinical and management recommendation is 123.61wte staff which is based on the current activity and delivery of 10% Continuity of Carer.

23. The clinical requirement is 113.41wte which can be adjusted for 90/10 skill mix so that some of the postnatal care is provided by suitably qualified support staff band 3s in hospital and community. Clinical requirement is 102.07wte RMs and 11.34wte MSWs.

24. Comparing the Birthrate Plus recommended 123.61wte to Blackpool Teaching Hospitals NHSFT current funded establishment of 112.23wte, indicates that there is a shortfall of 11.38wte based on the current activity.

Using ratios of births/cases to midwife wte for projecting staffing establishments

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will consider an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (9%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase

in community staffing so the ratio of 102 cases to 1 wte is the correct ratio to apply. To use the 1:22.7ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Example: A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 31.3 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results

The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Ratios:

- Home births — 34.6 births to 1 wte
- Delivery Suite births (all hospital care) — 31.3 births to 1 wte
- Ante &/or Postnatal Community care — 102.7 cases to 1 wte
- Overall ratio for **all** births — 22.7 births to 1 wte

Note: The overall ratio for Blackpool of 22.7 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte, but they are not directly comparable for the above local factors. The latter ratios are based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Professional Judgement Update – Nurse Staffing

Meeting:	Trust Board of Directors
Date:	7th September 2023

Author	Jed Walton-Pollard (Deputy Director of Nursing)					
Exec Sponsor	Bridget Lees (Director of Nursing, Midwifery, AHP and Quality)					
Purpose	Assurance	✓	Discussion	✓	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise**
	This paper will provide the Board of Directors (BOD) with the bi-annual Professional Judgement Review which incorporates a formal evaluation of the Trust's ward/unit/department(s) staffing templates using a triangulated approach. This includes an analysis of 20 days census data utilising the safer nursing care tool (SNCT) (Shelford Model) during June 23, a review of the last quarter (April – June 23) nurse sensitive indicators and the professional judgement of the senior nursing team. Whilst there are some recommendations in the IMPF division for an increase in two ward establishments (Ward 12 & AMU), the associated costs can be met from within the division by pulling resources from other establishments (Ward 11 & SSU). The triangulated approach supports this action, and it is recommended this will be reviewed in six months' time. The are no requests for extra resource within the Tertiary Divisions. Utilising the triangulated approach, the staffing templates are appropriate. However, there are some National Standards in Haematology that the Trust is currently not meeting (see narrative). There is one ward within the SACCT division that is currently requesting extra resource. Using the triangulated approach this is supported by the census (early shift) and professional judgement of the senior team. Whilst the ward is not an outlier regarding any associated harms, the team were unable to use this data as the ward was already staffing to the proposed level as a cost pressure. The division can use resource from another area (see narrative) which is supported using the triangulation approach. It is recommended this is reviewed in six months' time utilising 2 sets of SNCT data.

	There are no requests for extra resource in the Family and Community care division currently. The community directorate has completed the first round of data collection using the newly launched community SNCT however, it is not recommended any decision is made as two sets of data are required along with the triangulated approach. It is worth noting the community teams do not have any uplift within their establishments. The overall % compliance against the current staffing templates from April to June 23 (Q1) is 91.8% against a national trajectory of 85% and a Trust wide Trajectory of 90%. The committee can be assured this is monitored monthly at the Quality Assurance Committee. The Board of Directors also have sight of monthly nurse staffing data in the Integrated Performance Report (IPR). Sickness rates amongst nursing staff for both Registered and Unregistered was 6.8% in Q1. This is higher than the Trust target of 4.0%.

Implications ***(so what)***	**Alert**	
	No alerts.	
	Assure	
	In September 2021 the BOD approved a 4.6-million-pound investment into the ward-based nurse staffing templates. This did not include the Emergency Department (ED) or the Maternity Unit (MU). However, during March 22 the BOD approved an uplift in MU staffing to improve compliance with Birth Rate + and in May 22 approved an uplift in the ED Staffing to ensure compliance with RCN workforce standards. A further evaluation of these templates was carried out in March 2023 and presented to the Quality Assurance Committee (QAC) as per national guidance against the in-patient templates. This paper will provide the six-monthly update as per national guidance. The BOD can be assured that the 'Triangulated Approach' as defined in Developing Workforce Safeguards (2018) NHS Improvement Guidance has been adhered to. The Professional Judgement review concluded most of the templates are safe with a few minor cost neutral adjustments required.	

Previously considered by	Clinical Governance Committee and Quality Assurance Committee

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

Equality, Diversity and Inclusion (EDI) implications	Yes.

Proposed Resolution ***(What next)***	The BOD is asked to consider the professional judgement and agree the recommendations and further actions. The BOD is asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans

Introduction

In September 2021, the Board of Directors (BOD) approved a 4.6-million-pound investment into the ward-based nurse staffing templates. This did not include the Emergency Department or Maternity Unit. However, during the last twelve months the board of directors has approved further investments into both these units to make them compliant with RCN Workforce Standards (2020) and improve compliance with Birth Rate + (2022) respectively (see narrative). The Trust has also for the first time utilised the Safer Nursing Care Tool within the Community (June 23) and Emergency Department (April 23) settings.

In line with national guidance which recommends a professional judgement is carried out every six months. An evaluation exercise was carried out in June 2023 against the recommendations of the 2021 Professional Judgement review. This paper will provide the six-monthly update as per national guidance.

The professional judgement was carried out in the Month of June 2023 using the nationally recognised acuity tool (Safer Nursing Care Tool (SNCT) Shelford model) as the trust has a licence to use this tool. A correlation was also made with the relevant nurse sensitive indicators (see appendix one) along with the professional judgement of the Deputy Directors of Nursing, Divisional Directors of Nursing, Assistant Directors of Nursing, Matrons, and Ward Managers. Although there is no financial ask within this paper, assurance can be given that the divisional finance teams have been heavily involved providing accurate and up to date information on Establishments and advice/guidance has been sought from Human Resource colleagues on any proposed relocation of recourses.

Professional Judgement June 23

General Points

- As a result of this review, most of the current in-patient templates were professionally judged as safe. There are some cost neutral minor recommendations around re-allocation of resources with a review in 'six months' time.

- The compliance against the templates (Actual v Planned) is monitored monthly in the Clinical Governance and Quality Assurance committees. Assurance can be provided the Trust does have a Standard Operational Policy (SOP) for the day-to-day management of nurse staffing which is described in detail in the monthly safe staffing reports which are monitored at Quality Assurance Committee. There is an acknowledgment (see below) the Trust has and continues to improve on the Fill Rates for Registered Nurse and Support staff with an overall average fill rate for Q1 of 91%. This is against a national trajectory of 85% and a local trajectory of 90% (see below).

Q1

	Day Average Fill Rate %		Night Average Fill Rate %		Day %	Night %	Overall %
Hospital Site	**Registered nurses/ midwives (%)**	**Unregistered staff (%)**	**Registered nurses/ midwives (%)**	**Unregistered staff (%)**	**Average fill rate - combined**	**Average fill rate - combined**	**Total average fill rate – combined**
Victoria	90.2%	85.5%	95.3%	92.1%	88.2%	94.1%	90.4%
Clifton	103.6%	102.4%	97.8%	112.3%	103.6%	106.3%	104.5%
Trust Overall	91.3%	88.1%	95.5%	94.6%	89.9%	95.1%	91.8%

- There is a minimal nurse patient ratio of 1-8 with an additional shift co-ordinator during day light hours on most acute in-patient wards. Some exceptions remain where the ward has less than 10 beds and therefore, a co-ordinator is professionally judged as unnecessary.

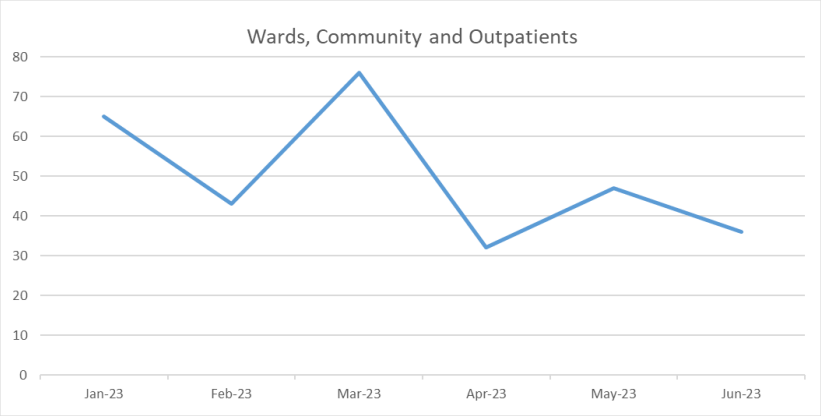
- It has been confirmed by the Safe Staffing Fellows at NHS England/Improvement (NHSE/I) that the SNCT census will potentially show some establishments as 'overstaffed' when comparing the census outcome to the establishment on smaller wards. The is exacerbated if acuity/activity is low. The Victoria site has several smaller (8-12 bedded) wards which need a minimum of 3 staff per shift for clinical safety reasons. Once exception to this is the Lancashire Suite which has six beds and has 2 RNs at night. This is mitigated as it is adjoining to the CCU.

- The finance team have confirmed there is an uplift of 24% across all in-patient establishments in the Tertiary & SACCT Division and 23.9% for RN's and 26.6% for Support Workers within the IMPF division. Assurance can be given that the SNCT tool has been modified to accommodate these uplifts which is an embedded facility within the software.

- All Ward Managers have supernumerary status as per the Francis (2013) recommendations. However, at times of pressure do work clinically within the numbers. Some of the larger wards (39, 11, Critical Care (General), Critical Care (Cardiac), Acute Stroke and Rehab Unit (ASRU), Emergency Department) have two ward managers.

Nurse Staffing related Incidents.

Along with fill rates, incidents related to nurse staffing are monitored by the Deputy Director of Nursing and have shown a decrease as fill rates have improved. There have been no known staffing related incidents which have caused harm in Q1 (April 23 – June 23).



Registered Nurse and Clinical Support Worker Sickness (April to June 23)

The Sickness/Absence rates for Q1 (April 23 – June 23) are displayed in the table below. Although there has been an improvement since the last Q4, sickness is still over the Trust trajectory of 4%.

Average	Number of staff	Occurrences	Covid Sickness %	Non Covid Sickness %	Total %
Support	1949	560	0.50%	6.97%	7.47%
N&M	2582	584	0.47%	5.67%	6.14%

Nursing Vacancies, Recruitment and Attrition

The Trust currently has 146.56 WTE RN and 106.34 support worker vacancies. With the current recruitment of Internationally Educated Nurses, U.K Educated nurses and the Trust's Nurse Degree Apprentice/Registered Nursing Associates due to Qualify in Sept 23. Taking attrition into account of 8-12 RNs per month, the Trust should be fully recruited by the end of the Calendar year.

Divisional Points to note.

Integrated Medicine and Patient Flow Division

- The Acute Stroke and Rehabilitation unit (ASRU) has 39 inpatient beds and an establishment which facilitates 8 Registered Nurses (RN) + an Assistant Practitioner + 8 Clinical Support Workers (CSW) during the day shift. During the night shift there are 8 RN's along with 6 CSW's. The above figures do not include a bleep holder who is at minimal band six level to respond to new patients who require Thrombolysis. Whist the budgeted establishment does show a deficit of – 9.23 WTE when compared to the SCNT date. Due to the ongoing stroke investigation, there has been an agreement to increase the number of staff on shift (see numbers above) which is none recurrently funded. When this is taken into consideration the SNCT census data shows the current establishment to be safe (see appendix one). It is worth noting the current Stoke Unit (ASRU) staffing levels do not meet the criteria for a Hyper Acute Stroke Unit however, funding will be available over the next 2 Years from the Integrated Care Board (ICB) to enable the stoke unit to meet this criterion. The unit has not yet formally been designated this status currently.

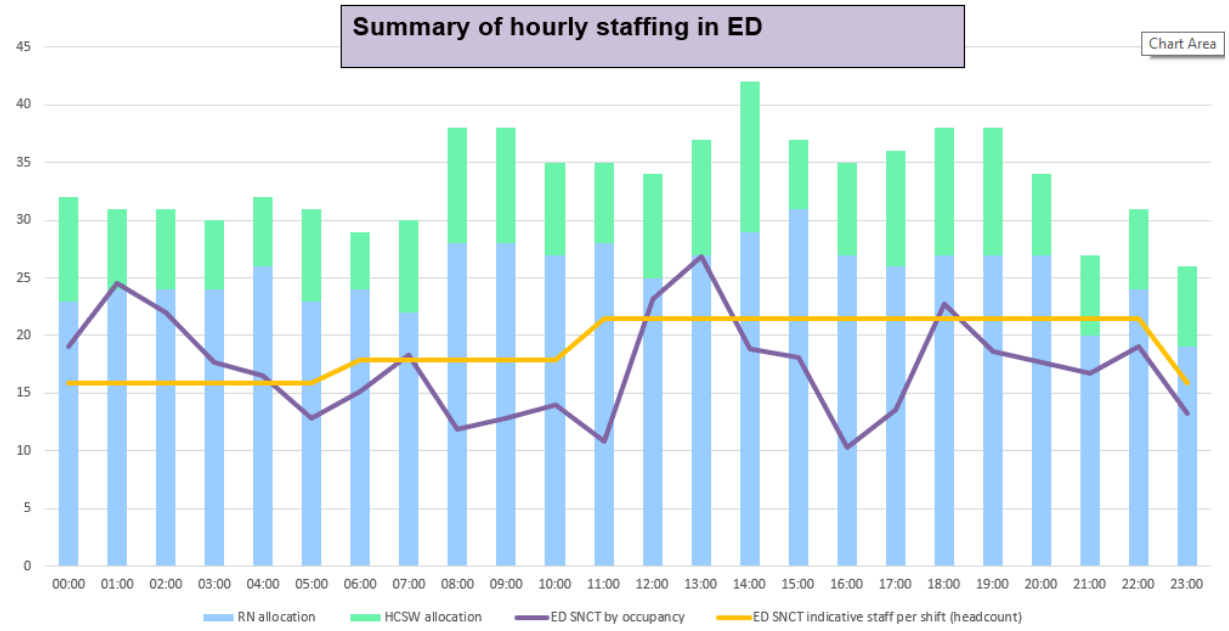
- Since the introduction of the Same Day Emergency Care Unit, the acuity and dependency on the Acute Medical Unit (AMU) has increased. The AMU is 36 bedded and has a template of 8 RN's and 5 CSW's 24/7. Following a review of the geographical layout of the unit, along with a review of the SNCT data with the Deputy Director of Nursing, Divisional Director of Nursing, Assistant Director of Nursing, Matron and Ward Manager it is proposed there is an uplift of 1 RN during the early and late shift. This should be for a trial of six months so that the safe care data can be reviewed again in six months as the current census data shows the unit is safely staffed. It is proposed in the first instance this should be financed from the Short Stay Unit (SSU) which the SNCT census data is showing as over resourced. If the committee approves this, the Divisional finance team have agreed to move funds on a nonrecurrent basis to support the proposal. The proposed new temporary establishments can be seen in Appendix one.

- Ward Twelve's template is showing as not meeting the requirements identified in the census data on the late shift. This is also supported using the triangulated approach. Therefore, it is proposed funding of 1.4 WTE of a band 2 will be moved from ward 11 which the SNCT census data is showing as over resourced. This will provide an extra support worker on the late shift on ward twelve. This will be reviewed in six months' time. If the committee approves this, the Divisional finance team have agreed to move funds on a nonrecurrent basis to support this. The proposed new temporary establishments can be seen in Appendix one.

- The current staffing requirements for the Emergency Department is complex and fluid. In May 2022 the Board of Directors agreed a 1.2-million-pound investment to meet the requirements of the Royal College of Nursing Workforce standards. This does not include 2 RNs for corridor care, a nurse for the waiting room B Facility and 2 RNs for Escalation Cabin 24 hours per day. However, nonrecurrent funding is now available to meet these needs which are currently staffed with bank

and agency. Significant capital work is being carried out within the ED which will need interim staffing arrangements before the work is completed in December 23, which include the department taking over the ward one footprint. In addition, the Trust has purchased the Safer Nursing Care Tool licence specifically for Emergency Care and staff have been fully trained to use this. The unit has reviewed its template using the safer nursing care tool (see summary below) however, it has been agreed that this will need to be repeated before any reliable analysis can be made alongside current templates. The tool shows the current establishment, which has been set using RCN Workforce Standards is over resourced however, on further discussion with the NHSE/I safer staffing Fellow, it has become apparent that the tool does not consider patients who have been in the department greater than 12 hours. At present, most patients who require admission spend greater than 12 hours within the department due to pressures around flow. Therefore, it is not recommended any decision is made on the ED SNCT data.

Summary of ED Safer Nursing Care Tool (Staffing v Occupancy)



Emergency Department Fill Rates Q1

Date Range	Day Reg Fill Rate	Night Reg Fill Rate	Day Unreg Fill Rate	Night Unreg Fill Rate
27/03/23 - 23/04/23	90.2%	85.5%	95.3%	92.1%
24/04/23 - 21/05/23	103.6%	102.4%	97.8%	112.3%
22/05/23 - 18/06/23	91.3%	88.1%	95.5%	94.6%
19/06/23 - 18/07/23	91.3%	88.1%	95.5%	94.6%

Tertiary Division

- The are no requests for extra resource within the Tertiary Divisions currently. Utilising the triangulated approach, the staffing templates are appropriate.

- Using the Safer Nursing Care tool, the Coronary Care Unit is showing as over resourced. However, the staff have not made the 'telemetry nurse' supernumerary on the unit which has affected the outcome. The telemetry nurse's role is to constantly observe and interpret the cardiac monitors for the ward-based patients and therefore, needs to be supernumerary. It is also recognised there may be a training need when scoring the acuity of each patient. This will be rectified before the next professional judgement. The staffing template for the coronary care unit is 4 RN's + 1 SW on days and 3 RN's + 1 SW on nights. The unit is 10 bedded and there is a telemetry RN in addition to the above 24 hours a day. Using the triangulated approach, it has been agreed that the Coronary Care Unit's establishment is appropriate.

- The SNCT census data is showing the Haematology unit's establishment is safe and there are no concerns when utilising the triangulated approach compared to other units. However, there has been an increase in chemotherapy administration of 60% over the last 12 months. Therefore, the unit is not meeting always meeting the 1-2 RN patient ratio recommended by Joint Agency Commercial Imagery Evaluation standards (JACIE).

- The Cardiac Intensive Care Unit (CITU) has an establishment which is staffed to provide compliance with Guidelines for the Provision of Intensive Care Services (GPICS). The unit has provided assurance this is monitored monthly see below: -

Month	Compliance %
April	89%
May	97%
June	86.67%

SACCT Division

- The professional judgement of the senior divisional leadership team within the SACCT division requested, as part of the review on ward 15a an extra support worker for 12 hours during the Early and Late shift. The division have implemented this as a cost pressure around 18 months ago due to an increase in falls with harm. This is supported by the census on the late shift only but overall, the template is adequate. Using the triangulate approach, it is difficult to assess the harms as the staffing is already in place and it would be impossible to say if harms would increase if the support worker was removed. Ward 15a is a 16 bedded a multi-speciality surgical ward with a high daily turnover of patients along with a high number of side rooms. The staffing template is 3 RN's and 2 CSW's during the daytime. The division are currently looking at ways to fund this cost neutrally from other recourses.

- The General Critical Care Unit (CITU) has an establishment which is staffed to provide compliance with Guidelines for the Provision of Intensive Care Services (GPICS). Unfortunately, the unit does not monitor this monthly and could not provide data as the CITU can. The unit is in the process of setting up a system so that the Trust can review compliance monthly. In addition, this will be monitored in all future professional judgments.

FICC Division

Community Staffing

The Trust acquired the Community SNCT licence from NHS England in January 2023 and in February 2023 began the training of all staff who would be required to input into the tool. This was a divisionally led roll out over 18 weeks and aimed to provide a structured achievable plan which met the needs of the service and teams. So far 329 staff have been trained on the use of the tool and passed an inter-reliability test. Training has now been transferred to the clinical improvement team to ensure the division is able to sustain training and utilisation of the tool in the future. Each team has undertaken a trial census period to embed the learning and week commencing the 10th of July all teams completed a census for which the results are below. The teams which have taken part within the community are in the table below: -

Blackpool	Fylde	Wyre
Central west	Lytham	Fleetwood
Central	Garstang	Poulton
South	Great Eccleston	Far North
North	Kirkham	Thornton + treatment room

Current staffing

The staffing establishment for the community nursing teams are in the table below. It is accepted that some of these teams work as part of a neighbourhood care team and therefore, care has been taken to extract the community nursing team from the wider establishments.

Team	Current agreed establishments							
	WTE	WTE	WTE	WTE	Total Reg	WTE Non reg	WTE	Team total WTE budgeted
	Band 7	Band 6	Band 5	Band 4		Band 4	Band 3	
Central west	1	4.2	9.65	1	15.85	0	1.8	17.65
Central	1	4.1	14.5	4	24.2	1	5	30.2
South	1	6.2	11.21	4	22.41	0	5.6	28.01
North	1	4	9.03	2	15.03	0	4.61	19.64
Lytham	1	7	17.51	3.2	29.71	0	4.53	33.24
Garstang	1	1	8.08	1	11.08	0	1.69	12.77
Great Eccleston	1	1.53	7.7	0	10.3	0	1.77	12.07
Kirkham	1	1	8	0	10	0	1	11
Fleetwood	1	3	12.22	1	17.22	1	1.75	18.97
Poulton	1	2.25	7	0	10.25	0	1	11.25
Far North	1	2.8	7.4	1	12.2	1.8	2.39	16.39
Thornton	1	2	7.7	0	10.7	0	1	11.7
Thornton TR	0	0	1.47	0	1.47	0	0.672	2.14

Results

Overall, the nursing establishments compare well with the community SNCT tool when an uplift is not taken into consideration, with an overall positive variance of 1.2 WTE RNs and 0.82 WTE Support Staff (see table below). However, if an uplift of 22% is taken into consideration the community nursing team would need to increase the RN establishment by 37.25 WTE and support staff by 5.29 WTE.

It has been confirmed by the NHSE/I Safe Staffing fellow that nationally uplifts within community settings are rare and a comparison with the Integrated Care Board demonstrates a similar picture. The SNCT recommends at least two sets of data collection before any increase/decrease in establishments are acted upon. Therefore, no further action on establishment is recommended currently.

Approximate costs for the increase

Team:		Variance without HR
Registered including band 4	WTE	+1.2
Health care assistants	WTE	+0.84

Neonatal Nurse Staffing

The neonatal unit meets the service specification for neonatal nursing standards.
The National Nurse Workforce Tool (NNWT) for direct Patient/Cot side Care and the Northwest Neonatal Operational Delivery Network (NWODN) Quality Nursing Roles Calculator (QNRC) - For Quality Roles has been completed and submitted to the NWNODN in 2022.
Following the National Neonatal critical care review (NCCR) The Trust received funding for 5.0 WTE nurses to enable compliance with British Association of Perinatal Medicine (BAPM) standards for nurse staffing. This was based on activity and acuity in the previous 3 years. The staff have commenced in post therefore, assurance can be given the unit staffing template is compliant with BAPM standards). Unfortunately, the unit does not monitor this monthly and could not provide data. It is recommended that the unit collates and monitors BABM compliance monthly in the Divisional Governance Meeting so that assurance can be provided to the Trust Board at the six-monthly professional judgements going forward.

Maternity Staffing

In March 22 the BOD approved the business case of £648K to comply with the Birth-rate Plus (BR+) workforce assessment and the full implementation of Continuity of Carer (CoC) as recommended by Ockenden (2022). Funding into the maternity budget was not agreed, with a plan that recruitment could continue above funded establishment if the workforce was available. Further to this, the Trust received funding from NHSEI for 6.5wte Midwives in response to Ockenden recommendations and in April 2023 a revised business case was agreed to fund a further 5.75wte Midwives. This has left a shortfall of 5.75wte Midwives from the recommendations of the BR+ assessment.

The unit has recruited 10.37wte Midwives due to Qualify in September 23 which will significantly reduce the vacancy rate to approximately 4.0 WTE. The Birth-rate Plus exercise is carried out by an external team every two years and is due later in this calendar year and will identify if current staffing establishment now meets BR+ recommendations or if there remains a shortfall.

Birth Rate plus (BR+) is a framework for workforce planning, the principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG).

Finance

There are no financial requests as part of this professional judgement review. However, the BOD can be assured the Divisional Finance Directors have been involved and supportive in the review providing accurate data on establishments and uplifts.

Conclusion

The BOD is asked to consider the professional judgement and agree the recommendations and further actions.

The BOD is asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.

Appendix 1

IMPF Professional Judgement Review June 2023

Ward	Beds	Current Staffing Numbers per shift	WTE Current Establishment + 23.9 % uplift for RN's and 26.6% uplift for HCA excluding HK/WM/WC	SNCT Data June 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	COAST Status
						In the last 3 Months				
ASRU	39	Early: 8 + 8 Late: 8 + 6 Night: 8 + 6	63.67 Budgeted 83.13 Working to	72.9	See narrative re ICB funding	7	4	10	0	Bronze
12	28	Early: 5 + 5 Late: 5 + 3 Night: 3 + 4	44.98	47.7	Increase to 46.38. Taking 1.4 from ward 11	8	6	21	0	Bronze
2	18	Early: 3 + 3 Late: 3 + 2 Night: 2 + 2	25.41	25.2	No Change	5	2	6	3	Silver
6	15	Early: 3 + 3 Late: 3 + 2 Night: 2 + 2	25.41	25.9	No Change	5	8	4	0	Platinum
FAA	10	Early: 3 + 2 Late: 3 + 2 Night: 2 + 2	22.00	13.8	No Change	3	0	1	0	Gold
23	25	Early: 4 + 6 Late: 4 + 3 Night: 3 + 3	38.9	39.7	No Change	8	10	15	2	Silver
24	25	Early: 4 + 6 Late: 4 + 3 Night: 3 + 3	38.9	38.3	No Change	10	9	13	2	Silver
25	25	Early: 4 + 6 Late: 4 + 3 Night: 3 + 3	38.9	36.9	No Change	12	10	5	1	Silver
26	24	Early: 4 + 6 Late: 4 + 3 Night: 3 + 3	39.9	35.9	No Change	17	6	15	0	Gold

Clifton W1	24	Early: 3 + AP + 5 Late: 3 + 3 Night: 2 + 3	39.84	41.1	No Change	9	8	8	0	Bronze
Clifton W2	24	Early: 3 + AP + 5 Late: 3 + 3 Night: 2 + 3	39.84	40.6	No Change	8	8	7	0	Silver
Clifton W2b	17	Early: 3 + 3 Late: 2 + 3 Night: 2 + 2	29.26	27.3	No Change	8	1	5	1	Gold
Clifton W3	24	Early: 3 + AP + 5 Late: 3 + 3 Night: 2 + 3	39.84	41.0	No Change	11	5	9	1	Silver
Clifton W4	24	Early: 3 + AP + 5 Late: 3 + 3 Night: 2 + 3	39.84	40.7	No Change	8	7	5	1	Bronze

Ward	**Beds**	**Current**		**WTE Current Establishment excluding HK/WM/WC**	**SNCT Data June 23**	**Proposed Establishment**	**Falls**	**Pressure Ulcers**	**Complaints**	**Med Errors**	**COAST Status**
							In the last 3 Months				
ED		**Early:** 23+15 **Late:** 24+16 **Night:** 21+14	**Mid Shift:** 2+0 **Long day:** 1+0 **Twilight:** 1+2	166.15 recurrent + 41.32 nonrecurrent	**96.6** **NA**	See separate BC	26	74	15	83	Bronze
ED PAEDs		**Early:** 2 + 2 **Late:** 2 + 2 **Night:** 2 + 2		NA (Included above)	NA	NA					Gold
SSU	20	**Early:** 4 + 5 Proposed (4+4) **Late:** 4 + 5 Proposed (4+4) **Night:** 3 + 3 Proposed (3+2)		41.88	25.4	36.5	5	0	0	15	Gold
AMU	36	**Early:** 8 + 5 Proposed (9+5) **Late:** 8 + 5 Proposed (9+5) **Night:** 8 + 5		68.22	54.3	70.62	23	30	0	48	Gold

Ward	Beds	Current	WTE Current Establishment + IMPF uplift excluding HK/WM/WC	SNCT Data June 23	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	COAST Status
						In the last 3 Months				
1	10	Early: 2 + 2 Late: 2 + 2 Night: 2 + 1	18.68	16.2	No Change	7	3	0	11	Gold
C1	14	Early: 3 + 3 Late: 2 + 3 Night: 2 + 3	27.80	18.4	No Change	4	5	0	32	Gold
C2	17	Early: 3 + 4 Late: 3 + 3 Night: 3 + 3	32.96	23.8	No Change	8	1	0	15	Gold
3	9	Early: 2 + 2 Late: 2 + 2 Night: 2 + 1	18.68	12.6	No Change	3	4	0	4	Gold
4	24	Early: 4 + 6 Late: 4 + 5 Night: 3 + 5	46.88	37.9	No Change	12	10	1	11	Gold
8	8	Early: 2 + 2 Late: 2 + 1 Night: 2 + 1	17.20	13.1	No Change	1	6	0	10	Gold
11	31	Early: 6 + 7 Late: 5 + 7 (6) Night: 4 + 5	62.35	46.1	Reduced to 60.95 allowing 1.4 to move to ward 12.	14	8	0	21	Gold
5	19	Early: 5 + 5 Late: 3 + 3 (inc 1 B6) Night: 3 + 2	35.46	29.8	No Change	8	5	0	8	Gold
7	15	Early: 3 + 3 Late: 3 + 2 Night: 2 + 2	26.85	22.9	No Change	9	7	0	8	Bronze
10	19	Early: 6 + 5 Late: 4 + 3 Night: 4 + 2	40.94	35.8	No Change	10	2	2	4	Silver
MECU	8	Early: 3 + 2 Late: 3 + 2 Night: 3 + 2	26.34	14.2	No Change	3	5	0	13	Gold

SACCT Professional Judgement Review June 2023

Ward	Beds	Current	WTE Current Establishment + 24% uplift excluding HK/WM/WC	SNCT Data June 23	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	COAST Status
						In the last 3 Months				
14	20 (8 High Care)	Early: 5 + 3 (7 days) Late: 5 + 3 (7 days) Night: 4 + 3	41.26	29.2	No Change	2	4	2	14 2	Silver
15b	12	Early: 3 + 2 (m-f) Late: 2 + 2 Night: 2 + 1	18.59	15.7	No Change	2	0	0	2	Platinum
15a	16	Early: 3 + 2 Late: 3 + 2 Night: 2 + 2	24.29	22	No Change	3	0	2	4	Gold
18/SAU	15 (23)	Early: 3 + 3 (5+4) Late: 3 + 4 (5+4) Night: 3 + 2 (4+3) Twilight	44.13	26.1	No Change	2	1	1	10	Platinum
16	12	Early: 3 + 2 (3+3) Late: 2 + 2 (2+3) Night: 2 + 2 (2+2)	20.79	17.2	No Change	2	1 x Cat2	0	7	Silver
34	27	Early: 5 + 7 Late: 5 + 4 Night: 3 + 4	56	42.8	No Change	3	2 x Cat 2	1	7	Silver
35	27	Early: 5 + 7 Late: 5 + 4 Night: 3 + 4	52.53	38.7	No Change	3	5 x Cat 2	2	10	Silver

Tertiary Division Professional Judgement Review June 23

Ward	Beds	Current	WTE Current Establishment +24% uplift excluding HK/WM/WC	SNCT Data June 23	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	COAST Status
						In the last 3 Months				
37 Cardiology	33	Early: 6 + 6 Late: 5 + 4 Night: 3 + 3	47.27	42.5	No Change	12	1	1	11	Silver
38 Cardiothoracic	28	Early: 7 + 2 Late: 6 + 2 Night: 3 + 2	40.30	38	No Change	14	1	1	5	Gold
39 Cardiology/ Cardiothoracic	25	Early: 6 + 1 Late: 5 + 1 Night: 3 + 2	37.21	36.5	No Change	7	0	1	12	Platinum
CCU Cardiology	10	Early: 4 + 1 + 1 Late: 4 + 1 + 1 Night: 3 + 1 + 1	32.29	11.9	No Change	7	0	0	1	Platinum
Haem	21	Early: 6 + 2 Late: 6 + 2 Night: 4 + 1	37.22	29.9	No Change	1	0	1	11	Gold
Lancashire Suite Cardiology/ Cardiothoracic	6	Early: 2 + 1 Late: 2 + 0 Night: 2 + 0	10.64	7.8	No Change	4	0	0	2	Platinum

Paediatric Ward Professional Judgment June 2023

Ward	Beds	Current	WTE Current Establishment +23% uplift excluding HK/WM/WC	SNCT Data June 23	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	COAST Status
						In the last 3 Months				
Paediatric Ward	21 inc 3 (HDU)	Early: 5 + 1 Late: 5 + 1 Night: 5 + 1	46.71	14.3		0	0	2	14	Gold

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Blackpool Teaching Hospitals NHS Foundation Trust

Title	Finance & Performance Committee Escalation Report

Meeting:	Board of Directors in Public
Date:	7 September 2023

Author	Esther Steel, Director of Corporate Governance					
Exec Sponsor	Robbie Ryan, Non-Executive Director (Committee Chair)					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** To update the Board on the alerts, assurance and advise content, discussed at the Finance & Performance (F&P) Committees on: - Thursday 27 July 2023 - Thursday 31 August 2023 Both meetings focused on financial and operational challenges with areas for alert identified within both escalation reports.

Implications *(so what)*	**Alert** Operational pressures exacerbated by industrial action remain a challenge and are covered within the escalation report from both meetings. Finance – while we remain on plan the significance of the challenge is a concern and action will be recommended to discuss the potential need for revenue support **Assure** Although there are some significant issues within the escalation report the Committee members are assured that appropriate actions are being taken with continue improvement in the governance and oversight of the areas that support this committee.

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	No EDI issues noted.

Proposed Resolution ***(What next)***	The Board of Directors is asked to note the F&P Committee's Escalation Reports

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Finance and Performance	**Report to:**	Board of Directors
Date of Meeting:	31 August 2023	**Date of next meeting:**	28 September 2023
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.

Level of information and quality of papers continues to improve

Alert

What	So What	What Next
Finance Integrated Performance Report (IPR) Assurance with regard to actions taken and progress made to date but alerted within this report because of the challenge of meeting the full year plan. On plan year to date for the planned deficit and starting to see progress in controlling expenditure and seeing a gradual reduction in both medical and nursing agency expenditure although expenditure and agency costs are still running higher than budget Recurrent QEP down but offset by non recurrent, recurrent schemes behind plan are either staff recruitment or additional elective income schemes. Still over-achieving on QEP and Financial Recovery Actions. Additional mitigations are being considered to assist with keeping to plan. Including a potential incentive scheme to reward over achievement.	Committee members noted the progress made however all acknowledged that things will get tougher and there is an underlying overspend which should be escalated – focus from Committee members on the likely outturn at the end of the year. The Committee members noted good commitment from teams on QEP plans with continued action needed to maintain performance against forecast. Caveat that a number of QEP schemes are predicated on substantive recruitment to posts to release agency and locum costs. Committee members recognised the improvements in process and the actions taken in response to the peer review but recognised the high risk.	Despite all the good work and all the improvements there remain significant challenges some outside the control of officers of the Trust giving limited assurance that the budget will be achieved this year As a Board we should consider if we are doing everything we can to deliver the financial performance – the Director of Finance was clear that the Trust managers and staff are doing everything they can to deliver or facilitate the best position we can. The Committee will continue to closely monitor performance and recognise the attitude and effort applied to a significant challenge.
Cash Requirement forecasting and the potential for central support.	Committee members discussed the pros and cons of accessing additional cash, the cost of seeking additional public dividend capital and the scrutiny that would be	The Committee noted the cash position and forecast and considered the actions that would be needed before submitting an application for provider revenue support.

Cash position is challenged, a decision is required as to whether to recommend to Board with regard to accessing cash support.	required to provide this revenue. The potential need for cash support was identified during the planning process. Other actions to mitigate cash position discussed including handling of aged debtors and payment against the Better Payment Practice Code The additional revenue would be a drawdown facility to draw down cash as needed	Cash will only be drawn down as required – the report will be discussed on the part two Board agenda to seek Board approval for the advance process to draw down up to £10m of cash if needed. The Committee supported the paper and recommended the paper for consideration by the Board
Outpatient Transformation Programme Outpatient Improvement Board attended by all Divisions – regular quarterly reports will be provided to the FAP Committee. Starting to see progress on Patient Initiated Follow ups but this is an area where we are behind other Trusts in the ICB. Poor uptake of video consultations – optimistic that launch of new platform will improve take up. The Trust has received a letter from NHS England asking for increased activity to reduce follow ups – currently working to a 10% reduction target (national target is 25%)	Assurance provided on progress made with clinical optimisation and the use of Chatbot to undertake validation of patients on the waiting list. The Committee discussed the offer of virtual clinics and the need to offer choice to patients who may not be technically enabled.	Will continue to report back to FAP and to Execs
Integrated Performance Report (IPR) UEC pressures have persisted through Summer and can be attributed to a rise in the number of long stay patients (21+ day) on base wards particularly for patients of 65 years of age or older. This leads to challenges in bed availability and high occupancy which then results in crowding in the Emergency Department (ED) impacting the ability to treat patients in a timely manner. A key component in the rising of the cohort of patients with length of stay (LOS) 21+ days is reflected in patients that are ready for discharge from hospital but have care needs. The current	Committee members discussed the different seasonal challenges – out of area attendance in the summer months increases resulting in additional challenges in repatriation of patients who have ongoing care needs to support hospital discharge. The backlog of patients with undiagnosed cancer on our 62-day PTL has reduced steadily in recent months. Our current backlog is 70, down from 73 the previous week – and meeting trajectory set out in the operational plan.	Update on Clinical Productivity Board to next meeting. Update on RTT to next meeting.

position is that circa 13% of total occupied bed base that don't meet criteria to reside. Virtual Ward usage remains low across adult specialties. Further work is required to increase uptake and reduce the volumes of patients requiring admission into acute beds. Industrial action is starting to impact on RTT activity and reduction of long waits – as action continues and is more sustained the impact increases – this is monitored for both financial and performance impact		
B.Digital Committee Escalation Report Committee members noted the alerts in the report specifically the delay to PAS and challenges with LIMS. The B.Digital Committee have taken a decision to delay November implementation of PAS and are now working on a revised plan – new date not yet available and will need to avoid winter pressures	Committee members noted that delays have been outside the control of the digital team and mitigating actions were now being taken to negotiate a new deployment plan and to discuss the delay with the supplier.	LIMS will be covered in a briefing to the part two Board.
Assurance		
What	**So, What**	**What Next**
Service Story The Divisional Director of Operations provided an overview of the services provided by the division, the challenges experienced in terms of managing demand and flow and the opportunities for transformation and the development of new models of care.	Committee members discussed the challenges facing the division including medical recruitment and the actions taken to attract potential candidates to fill vacancies within services. The Workforce strategy for the division sets out an aim to work differently using a blended workforce and new models of care	The Committee recognised the leadership provided within the division and the challenges and opportunities facing the team and individuals in the team. Now driving accountability across the division to deliver. 100% of recurrent QEP schemes have been identified and are being tracked.
Atlas Client Performance Meeting Escalation Report Positive report provided on oversight of the work with the Trust's subsidiary – no issues of concern	Committee members noted the positive feedback	Atlas performance to continue to be monitored

escalated, and good progress made on previously escalated areas		
Board Assurance Framework The Committee noted that the papers received covered risks on the BAF –		consideration will be given to how the cash position is reflected on the BAF
Information Governance/SIRO The Committee received a report in line with the Data Security Protection Toolkit to highlight risks in relation to digital and cyber		Committee members noted the report submitted for information – a Cyber Risk Group is in place for operational monitoring, and this overseen by the Digital Risk Group
Advise		
What	**So, What**	**What Next**
Acute Frailty Unit and Discharge Unit Development Business Case Business case presented for £1.35m recurrent investment which will enable a reduction in non-recurrent investment in years one and two and an overall saving on an invest to save basis. The investment will deliver new substantive posts for a blended workforce and will ultimately save circa £1m. An investment of £2.4m for Frailty had been included in the 2023/24 plan and spending currently is in excess of the proposed business case.	The development of a Frailty Service has been a long-standing strategic ambition for Blackpool in terms of the services that can be delivered to the current and future population. The Trust is an outlier in terms of the numbers of elderly patients in the bed base – a frailty unit can improve conversion rates and occupancy levels. By delivering on the frailty business case, the Trust will achieve a QEP and service improvement through alternatives to admissions. Affordability was discussed - Committee members noted that this is good practice and requested assurance on the funding – Committee members were assured that the case	The Committee supported the ask to establish an Acute Frailty Unit. The case is affordable based on having been specifically included in the budget. If the case cannot evidence delivery a revised model must be considered to safeguard the organisation from ongoing premium staffing costs. Committee members believe were told that the case will lead to efficiencies in the future. Case to be presented for Board approval in line with the Scheme of Delegation

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:	27 July 2023	**Date of next meeting:**	Thursday 31 August 2023
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.

Improvement in the quality of papers noted and reflections were invited on the approach to challenges which were felt to be appropriate in providing assurance on the areas within the remit of the Committee with constructive and objective challenge and support and clarity on key actions to move forwards.

Alert

What	So What	What Next
Urgent and Emergency Care/Ambulance handover June 2023 represented an improvement from the previous reporting period compared to the previous month. Challenges remain because of volumes of NWAS arrivals in short periods of time and the overall volume of attendances (+600 from previous period). Patients waiting more than 12 hours from a decision remains significantly high, with 821 patients breaching the standard in June 2023 (decrease of 107 from the previous month). A change to the DTA processes has been produced and will be piloted from 31st July 2023.	The Committee noted that while some progress has been made there is still work to do to reduce ambulance turnaround time – latest update outlined a 3.5% improvement in ambulance turnaround when comparing June 23 against June 22, for the same period the Trust delivered a 13% reduction in the number of patients experiencing corridor care.	PFIP continues to oversee and drive the improvements regarding all elements of flow. As part of the reset of the programme, the workstreams have been given specific areas to focus on during the coming months with detailed KPIs associated with each project/milestone.

Assurance

What	So, What	What Next
Service Story (Families and Integrated Care) DDO for the FICC Division attended to share a service story. Following the SEND inspection in 2021 a number of findings needed to be addressed with a written statement of action including a need to make	In March 2020 there were 250 children waiting for up to 18 months; now 43 patients are waiting an average of 7 weeks. Good engagement with families on the pathway redesign and recognition of the complexity of the pathway with waits within waits and a need for watchful waiting as part	Parent representative to be involved in panels and patient carer forum. Collaborating with schools to improve the experience for families. Continue to implement actions in the SEND improvement plan.

improvements on therapy waiting times and specifically waiting times for diagnosis of autism. Waiting list initiative implemented to address increased demand for services, work undertaken in partnership with the commissioner to address long backlog including resource to support families along the pathway.	of the diagnostic pathway – importance of feedback from families recognised. Further actions identified to improve understanding and communication will be included in a continued improvement journey. Quarterly monitoring ongoing for the system and the service will be reinspected formally within the next year. Discussed impact of funding/budgets and confirmed that the divisional plan is on track and does not constrain the development.	More to do within place in terms of transformation and meeting the holistic needs of families.
Performance Integrated Performance Report (IPR) IPR reviewed with detail on RTT, and cancer covered within separate update reports	Stroke performance remains challenged, still reliant on temporary medical support with some actions in place to address immediate workforce challenges including increased autonomy for nurse practitioners. Latest monthly SSNAP has improved to grade B	The Division and Patient Flow team will continue to actively protect ring-fenced capacity on Stroke and reduce outliers on the ward to improve Right Patient, Right Place principle. The Directorate has also completed a workforce strategy recognising the challenges in recruitment. The proposed model is due to be discussed/agreed in August.
Elective Recovery and Data Quality Report No patients waiting over 104 weeks, The Trust has reported 116 fewer patients against plan of 308 waiting above 65 weeks. This figure also represents a 43% reduction in comparison to June 22. Good work in diagnostic services to support improvement. There are 267 above plan for patients against plan of 984 waiting above 52 weeks.	Discussed actions being taken to address backlog and challenges, detailed plans for focused work in most challenges specialities. Industrial action impact – around 300 – 350 appointments cancelled for junior doctor IA and approx. 600 for consultant IA – all cancellations are risk stratified. The Trust will not be impacted by the Radiographer strike. Short-term mitigating actions discussed alongside longer-term transformative actions to embed sustainable and affordable approach	SOAG monitor waiting list, weekly, for each service with targeted improvement plan for each area of concern. The biggest contributors to 65-week waiters by volume are Cardiology, Gastroenterology and Gynaecology. Service improvement plans also monitored at monthly PIDA meetings with Clinical Divisions. Enhanced surveillance on improvement and ongoing improvement work for long term sustainability
Cancer Improvement Plan Update The current backlog figure is at 81 (5.50%). This represents a significant improvement. The Trust is	Noted that while the wait is still higher than standard improvement has been made and the engagement of clinical teams has contributed to improvement.	62-day Screening has seen further deterioration in May primarily due to Breast Surgical workforce challenges we are assured we will see an improvement as the first consultant commences in post this

exceeding our year-end target and worth noting progress in 2023: March 2023 – backlog figure 161 (11.3%) & 7th worst in national rankings June 2023 – backlog figure 81 (5.50%) & 92nd worst in national rankings	The assurance meetings with the cancer alliance have been stepped down to monthly given the continued improvement and robust control measures in place.	month and the remaining post being interviewed also this month. Tumour group action plans in place monitored at service level through the Cancer performance group with forecasted delivery and review of system wide and national performance. Monthly Cancer Board re-established as a clinically led forum to address clinical pathways
Atlas Client Performance Meeting Escalation Report Escalation of issue with call bells Previously reported issue with the gas house inspection now addressed.	Escalation report noted	
Integrated Performance Report (IPR) Finance At 30 June 2023, the Trust has reported a deficit of £20.6m which is in line with plan however costs and agency costs are running higher than planned. Cash is better than plan forecast shows pinch points in September and October – working with partners to avoid the need to apply for a capital injection within would be repayable by PDC. Now have granularity of ownership with signed accountability agreements in place	Discussed delivery of QEP – aiming to have identified full year target by end of Q3 – better performance than previously but still work to do. Pay expenditure for agency medical staff is ahead of plan but offset by underspend on substantive staff. Discussed delivery of stretch target and recognised role of the system in elements of the plan. Governance and stewardship supports robust discussions for delivery of budgets.	Weekly scrutiny of all agency assignments to build an exit plan for temporary workforce. Forecasting in place from month one with monthly reporting and service review against plan. Divisional governance – training for divisions so that everyone knows how to manage with divisional autonomy and accountability. Closure of escalation areas is supporting marginal gains and a shift in mindset with increased optimism about ownership of financial challenge
2023-24 Capital Plan Because of the level of schemes approved in previous years have funded new developments from maintenance monies. This year potential shortfall of 1.67m – the plan proposed management of the shortfall through slippage on internally and externally funded schemes	Discussed programme and potential slippage seeking assurance that the programme would be managed	Reviewing plans and spending in the 3 key areas with intervention if needed in Q3. The Committee APPROVED the 2023/24 Capital plan

Committee/Group Chair's Report

Blackpool Teaching Hospitals NHS Foundation Trust

Finance Peer Review Action Plan Substantial progress has been made to implement actions identified in the external peer review.	**Report noted**	Plan to agree capital and revenue budgets for 2024/25 before the year starts
Board Assurance Framework The Committee reviewed the updated BAF and agreed that key risks were covered within the agenda		
Advise		
What	**So, What**	**What Next**
AOB		

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Title	Finance IPR at 31st July 2023

Meeting:	Board of Directors
Date:	7th September 2023

Author	Paul Cunday, Associate Director of Finance – Operational Finance					
Exec Sponsor	Mark Brearley, Interim Director of Finance					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	Y					

Summary *(what)*	**Advise** The purpose of the report is to provide the Board of Directors with an update on the Trust's financial performance at 31st July 2023 (Month 4). **The Trust's financial performance for July** is a £3.7m Deficit, in line with plan, but contains off-setting variances, as per previous months. **The Trust's financial performance Year to Date** is a £24.3m Deficit, in line with plan. **The Trust's agency spend year to date at July** is £14.6m, which is 9.9% 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 July 2023 is £3.9m. **Cash:** The Trust's cash balance at 31st July 2023 is £13.4m, a decrease of £10.7m in month and £2.4m higher than plan.

Implications *(so what)*	**Alert** The Trust performance at the end of July 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 additional income of £17.7m in the Plan refers to the System Stretch. Delivery of this resource to the Trust by System Working remains the highest risk in the delivery of the Plan.

	The collective efforts of all staff will be required to secure delivery of the financial plan for 2023/24.
	Assure
	At July 2023 the forecast is a £24.3m deficit which is in line with the planned deficit. The assumptions made are as follows: • The system stretch target £17.7m is delivered; • The Trust Specific QEP and Financial Recovery targets are delivered or mitigated; • Winter related activity is either system funded or managed within internal resources; • Divisional operational pressures and risks will be managed or mitigated. Additional mitigations currently being assessed to assist with keeping the Trust on Plan are: • Further Pay controls – vacancy control and flexible pay; • Additional non-pay expenditure controls; • Opportunities to improve PbR income levels through additional work for Commissioners; • Scan4Safety Stock tracing and control system Business Case and implementation – both recurrent and non-recurrent savings; • Incentive scheme for Divisions and Directorates to over-achieve budget and QEP performance.

Previously considered by	Finance and Performance Committee on 31st August 2023

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

Equality, Diversity and Inclusion (EDI) implications	Not applicable to this report.

Proposed Resolution ***(What next)***	The Board of Directors is asked to note the content of the report.

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Financial Performance

Reporting Period - July 2023

Blackpool Teaching Hospitals
NHS Foundation Trust

July 2023 I&E

- The Trust's bottom-line I&E performance year to date at July 2023 is a £24.3m 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 8% ahead of plan with A&E attendances 5% ahead. Increased admissions in general medicine, general surgery and gynaecology are driving this over-performance.

- Income generation for the Trust at the 31st July 2023 is £0.8m ahead of plan. Key drivers of this include higher than planned use of high-cost drugs & devices (£1.8m) which is offset by increased expenditure; partially offset by lower than planned income & expenditure against services funded through FCUs (£1.1m).

- The Trust is working closely with the ICB to monitor elective recovery performance, but no financial adjustments have been made to date.

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Expenditure

- Year to date at 31st July 2023 operating expenditure is £1.0m 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 (£1.4m);
  - 2023/24 Agenda for Change pay award pressure (£0.2m);
  - Higher than planned costs of high-cost drugs and devices (£1.8m) which is offset by additional income;
  - A number of non pay underspends that are assisting the position;
  - Lower than planned costs relating to commissioner funded services outside of the main contracts £1.1m.
- The Trust has implemented the following to strengthen financial controls:
  - Temporary Agency Control Group
  - Vacancy & Spend Control Panel
  - Fortnightly QEP meetings
  - Lower Scheme of Delegation limits
  - A weekly agency medical staff deployment scrutiny meeting is in the process of being established.

Non-Operating Income & Expenditure

- Year to date at 31st July 2023 non-operating income and expenditure is £0.3m better than plan. The main reasons for this are an increase in finance income of £1.0m following the Bank of England raising interest rates to 5.14% offset by an adjustment for donated assets income of (£0.5m).

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Performance against agency cap

- There is a system agency ceiling of 3.7%. If this was applied to the Trust, it would equate to £5.5m so the YTD position is £9.2m 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.
- A weekly scrutiny meeting is in the process of being established. In the table below both medical and nursing agency expenditure is showing a run rate reduction.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Normalised Medical Agency Expenditure	1.8	1.8	2.2	2.5	2.5	2.5	2.2	2.6	2.4	2.1	2.8	3.0	2.6	2.3	2.2	2.1
Normalised Nursing Agency Expenditure	0.8	0.9	0.8	1.1	1.2	1.2	1.4	1.5	1.5	1.0	1.5	1.9	1.5	1.2	1.3	1.0

Cash

- The Trust's cash balance at 31st July 2023 was £13.4m, a decrease of £10.7m from June 2023 but £2.4m higher than plan. The reduction in cash balance is mainly driven by the increased operating deficit, decrease in trade and other receivables, increase in inventories, increase in trade and other payables, capital expenditure, lease payments and decrease in provisions. This is offset by depreciation, increase in deferred income and PDC received relating to capital projects.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
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	24.1	13.4								
Variance	1.7	8.7	7.1	2.4								

- In month the Trust has paid 96% of suppliers by value and 98% by volume against the better payment practice code (BPPC) target of 95%.

Blackpool Teaching Hospitals NHS Foundation Trust

Cash continued

- Liquidity continues to be a risk with the Trust annual plan suggesting revenue support in Q3 to maintain minimum cash balances. This is being kept under close scrutiny.
- 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 July 2023 is £3.9m which is £3.6m behind plan due to the delayed approval of the 23/24 capital plan.
- Spend incurred to July has been incurred against;
  - £1.4m Emergency Village & Critical Care
  - £1.0m ICT licence renewals and project staffing
  - £1.3m Estates development schemes
  - £0.2m Charity Donated assets

Finance Ratios

- Operating Deficit: Income percentage year to date at July 2023 is (10.8%) which is line with the planned level.
- The year to date agency to total pay ratio is 9.9%, which is 5.2% 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 July the Trust has delivered £7.7m of savings which is £0.4m 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.

Finance

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Month 4 July 2023

Statement of Comprehensive Income

		July 23				Year to Date at July 23			
		Budget £m	Actual £m	Variance £m	Variance %	Budget £m	Actual £m	Variance £m	Variance %
I&E (TOTAL)	NHS Clinical Income	49.7	48.9	(0.7)	-1%	196.2	195.4	(0.9)	0%
	Non NHS Clinical Income	0.2	0.5	0.3	137%	0.6	1.7	1.1	177%
	Other Operating Income	2.5	3.0	0.5	20%	9.1	9.7	0.6	6%
	Total Operating Income	**52.3**	**52.4**	**0.0**	**0%**	**206.0**	**206.7**	**0.8**	**0%**
	Pay Costs (excluding agency)	(33.5)	(31.7)	1.8	-5%	(139.8)	(133.8)	6.0	-4%
	Pay Costs - Agency	(1.5)	(3.9)	(2.4)	164%	(6.8)	(14.6)	(7.9)	116%
	Non Pay	(20.4)	(19.5)	1.0	-5%	(81.3)	(80.5)	0.8	-1%
	Total Operating Expenditure	**(55.4)**	**(55.1)**	**0.3**	**-1%**	**(227.9)**	**(229.0)**	**(1.0)**	**0%**
	Operating Surplus / (Deficit)	**(3.1)**	**(2.7)**	**0.4**	**-12%**	**(22.0)**	**(22.2)**	**(0.3)**	**1%**
	Non Operating	(0.6)	(0.5)	0.2	-26%	(2.5)	(1.6)	0.9	-35%
	Adj for Depreciation on Donated & Granted Assets	0.0	(0.5)	(0.5)	-1786%	0.1	(0.4)	(0.6)	-484%
	Adjusted Financial Performance Surplus / (Deficit)	**(3.7)**	**(3.7)**	**0.0**	**-1%**	**(24.3)**	**(24.3)**	**0.0**	**0%**
RATIOS	*Agency : Total Pay*	*4.23%*	*10.97%*	*6.74%*		*4.63%*	*9.87%*	*5.24%*	
	Operating Deficit : Income	*-5.88%*	*-5.17%*	*0.71%*		*-10.66%*	*-10.76%*	*-0.09%*	
	Net Deficit : Total Income	*-7.06%*	*-7.01%*	*0.05%*		*-11.77%*	*-11.76%*	*0.02%*	

Blackpool Teaching Hospitals NHS Foundation Trust

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)**

Statement of Financial Position July 2023

Finance

Statement of Financial Position as at 30th June 2023	Audited Position as at 31/03/23 £000	Actual Position as at 30/06/2023 £000	Actual Position as at 31/07/2023 £000	Monthly Movement £000	Forecast Position as at 31/03/24 £000
NON-CURRENT ASSETS					
Intangible Assets	9,845	9,070	8,966	(104)	23,277
Property, Plant and Equipment	303,427	300,870	299,701	(1,169)	308,702
Trade and Other Receivables, non-current	2,230	2,333	2,293	(40)	2,230
Total Non-Current Assets	**315,502**	**312,273**	**310,960**	**(1,313)**	**334,209**
CURRENT ASSETS					
Inventories	8,793	8,707	9,622	915	8,793
Trade and Other Receivables, current	34,150	24,914	27,233	2,319	40,244
Cash and Cash Equivalents	47,821	24,096	13,353	(10,743)	8,445
Total Current Assets	**90,764**	**57,717**	**50,208**	**(7,509)**	**57,482**
Total Assets	**406,266**	**369,990**	**361,168**	**(8,822)**	**391,691**
CURRENT LIABILITIES					
Trade and Other Payables	(110,220)	(94,134)	(86,352)	7,782	(100,259)
Other Liabilities	(9,906)	(12,395)	(14,593)	(2,198)	(9,906)
Borrowings, current	(9,214)	(8,833)	(8,893)	(60)	(9,163)
Provisions	(1,540)	(1,457)	(1,035)	422	(1,190)
Total Current Liabilities	**(130,880)**	**(116,819)**	**(110,873)**	**5,946**	**(120,518)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**275,386**	**253,171**	**250,295**	**(2,876)**	**271,173**
NON-CURRENT LIABILITIES					
Trade and Other Payables	(1,657)	(1,657)	(1,657)	0	(1,657)
Borrowings, non-current	(71,482)	(69,944)	(69,412)	532	(62,399)
Provisions	(2,920)	(2,920)	(2,920)	0	(2,920)
Total Non Current Liabilities	**(76,059)**	**(74,521)**	**(73,989)**	**532**	**(66,976)**
TOTAL ASSETS EMPLOYED	**199,327**	**178,650**	**176,306**	**(2,344)**	**204,197**
TAXPAYERS' EQUITY					
Public dividend capital	309,412	309,412	310,235	823	339,049
Revaluation Reserve	20,380	20,231	20,231	0	20,380
Income and Expenditure Reserve	(130,465)	(150,993)	(154,160)	(3,167)	(155,232)
TOTAL TAXPAYERS' EQUITY	**199,327**	**178,650**	**176,306**	**(2,344)**	**204,197**

NHS Blackpool Teaching Hospitals NHS Foundation Trust

The Statement of Financial Position at 31st July 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 and in-year additions (see capital note for further information).

Working Capital

- Increase in inventories following counts undertaken within the Tertiary division.
- Trade & Other Receivables; £1.4m increase in invoiced debt, £2.1m increase in VAT, offset by £1.2m reduction in accrued income.
- Trade & Other Payables; £0.9m increase in non capital payables, offset by £0.9m reduction capital payables, £0.6m reduction in receipts in advance; £3.3m reduction in social security costs and £3.7m reduction in other taxes payable due to higher costs paid in month 3 relating to the pay award.
- Increase in other liabilities as a result of education & training income from NHSE relating to future periods

Taxpayers Equity

- Income & Expenditure Reserve movement of £3.2m in month and £23.9m YTD being the adjusted financial performance.

Finance

Statement of Financial Position: Working Capital

Key Performance Indicators - 31 July 2023				
Debtor/Creditor Days	**Target**	**Jul-21**	**Jul-22**	**Jul-23**
Debtor Days	30	21	17	18
Creditor Days	30	130	178	149
BPPC (Cumulative)	**Target**	**Jul-21**	**Jul-22**	**Jul-23**
Value	95%	74%	91%	96%
Volume	95%	83%	91%	97%
Aged Debt	**Target**	**Jul-21**	**Jul-22**	**Jul-23**
	£000's	**£000's**	**£000's**	**£000's**
Current less than 30 Days		1,833	1,748	3,359
30 - 60 Days		1,583	1,366	4,678
60 - 90 Days		221	195	1,556
Over 90 Days	< 5%	1,564	1,176	1,358
Total		**5,201**	**4,485**	**10,951**
% Over 90 Days		30%	26%	12%
Liquidity	**Target**	**Jul-21**	**Jul-22**	**Jul-23**
Current ratio	> 1	0.84	0.73	0.45

The Trust's BPPC performance by value and volume are both above the target of 95%.

With ongoing management, we expect to maintain 95% compliance during 2023-24.

Aged Debt (Sales Ledger)

- In the month the number of outstanding invoices has decreased by 2 from 934 to 932 and the value of debt has increased by £1.4m from £9.5m to £10.9m. This Is mainly driven by outstanding debt with Lancashire and South Cumbria ICS £3m, Lancashire County Council £1.8m and a disputed invoice with Lancashire Teaching Hospitals for £350k which has been escalated for follow up action.
- Debtors aged 0-30 days has decreased by £2.6m, debtors aged 31 to 60 days has increased by £3.0m, debtors aged 61-90 days has increased by £0.9m, debtors aged over 90 days has decreased by £2.2K

The key over 90 day receivables are set out below:

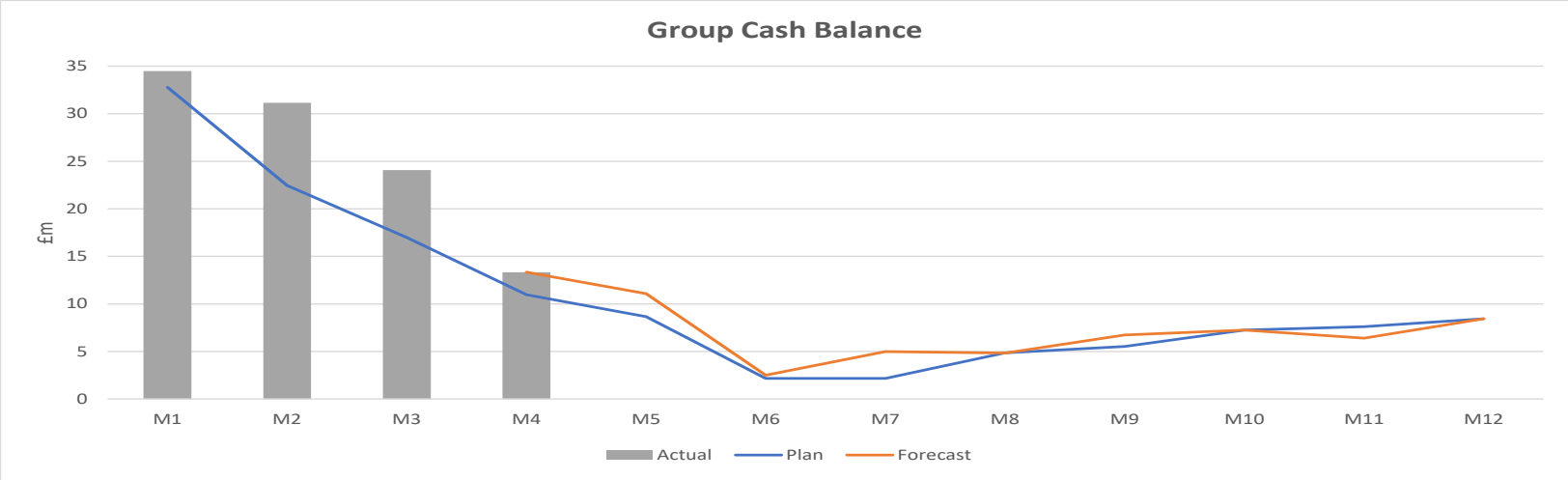
Debt > 90 Days - 31st July 2023			
Reason	Current Mont	Prior Month	Movement
	£'000s	£'000s	£'000s
NHS Debt	713	762	- 49
Non-NHS Debt	201	167	34
Salary Overpayment	87	85	2
Private & Overseas Patients	355	340	15
Council Debt	- 0	- 0	-
Welsh / Irish / Scottish Debt	3	6	- 3
Total	1,358	1,360	- 2

Statement of Financial Position: Working Capital continued

- 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 £0.6m and L&SC ICB £0.1m. The team continue to chase heads of services at counterparties to resolve disputes and non-payment.
- Non-NHS debt mainly relates to relates R&D, Occupational Health and rent and the team continue to chase.

Finance

Cashflow Forecast



- The cash balance to the end of July 2023 of £13.4m is a decrease of £10.7m from £24.1m in June, and £2.4m ahead of planned levels. This decrease is mainly driven by the operating deficit, decreased receivables, increased payables, and capital expenditure. This is offset by increased deferred income, depreciation and PDC capital funding received.
- The 2023/24 Cash Plan assumes Provider Revenue Support PDC in September of £1.1m and October of £2.5m to maintain the required minimum cash balance level. In the intervening period since the plan was submitted, the cash position in the first six months has improved marginally meaning that support has not been required in Q2.
- Delivery of the cash position will be predicated on the Trust achieving its financial position and planning assumptions including both the QEP & financial recovery targets.
- Whilst the group position maintains a positive balance close monitoring will be required to ensure both Trust & Atlas maintain adequate cash balances.

Blackpool Teaching Hospitals
NHS Foundation Trust

QEP and Financial Recovery

The Trust is reporting over delivery against the 5.5% QEP target of £0.3m at the end of July 2023. This is due to an over-delivery reported by Tertiary and Corporate Divisions.

The financial recovery programme savings are £0.1m ahead of plan. Delivery is supported by UEC funding received.

	Month 4			YTD Month 4		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Recurrent 5.5% QEP	2.22	1.21	(1.01)	4.61	2.93	(1.68)
Non Recurrent 5.5% QEP	0.49	1.35	0.86	1.48	3.43	1.95
Financial Recovery	0.50	0.33	(0.17)	1.19	1.29	0.10
Total	**3.21**	**2.89**	**(0.32)**	**7.28**	**7.65**	**0.38**

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**

Finance

QEP and Financial Recovery continued

Blackpool Teaching Hospitals NHS Foundation Trust

Division	Targets: Divisional QEP £000	Targets: Trsut Specific QEP £000	Targets: Financial Recovery £000	Targets: Total £000	Divisionally Generated Savings (YTD Delivery): Target £000	Recurrent £000	Non-Recurrent £000	Total £000	Variance £000
Clinical Divisions									
Clinical Support	3,070	785	700	4,555	496	420	19	439	-57
Families & Integrated Community Care	4,010	-250	500	4,260	492	126	391	516	24
Integrated Medicine & Patient Flow	4,991	9,775	300	15,066	806	186	64	250	-556
Surgery, Anaesthetics, Critical Care & Theatres	3,716	3,575	2,500	9,791	600	309	108	417	-183
Tertiary Services	3,203	856	1,000	5,059	517	352	298	650	133
Corporate Divisions									
Chief Executive	130	22	22	174	25	51	0	51	26
Chief Operating Officer	184	30	38	252	34	34	0	34	0
Clinical Governance	367	58	69	494	69	82	49	132	63
Communications	16	2	4	22	3	3	0	3	0
Corporate Governance	47	7	5	59	9	18	0	18	9
Finance	238	37	36	311	44	275	0	275	231
FM & Emergency Planning	631	100	79	810	118	99	19	118	0
Medical Director	32	5	8	45	6	6	0	6	0
Medical Education	186	29	35	250	35	35	0	35	0
People & Culture	430	174	61	665	97	71	0	71	-26
Planning, Transformation, Strategy & Digital (Other)	75	12	11	98	14	26	0	26	12
Planning, Transformation, Strategy & Digital (ICT)	711	112	108	931	133	84	46	130	-3
Research & Development	114	18	22	154	21	11	10	21	0
Trust Specific	0	0	7,000	7,000	0	0	0	0	0
Other Divisions									
Other Divisions	0	163	7,000	7,163	2,562	743	2,425	3,168	606
Grand Total	22,151	15,510	19,499	57,160	6,081	2,931	3,429	6,360	279

Blackpool Teaching Hospitals
NHS Foundation Trust

Forecast

	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	M6 £m	M7 £m	M8 £m	M9 £m	M10 £m	M11 £m	M12 £m	2023/24 Total £m
Plan 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)**
Actual / Forecast 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)**
Variance to Plan	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

At July 2023 the forecast is a £24.3m deficit which is in line with the planned deficit. The assumptions made are as follows:

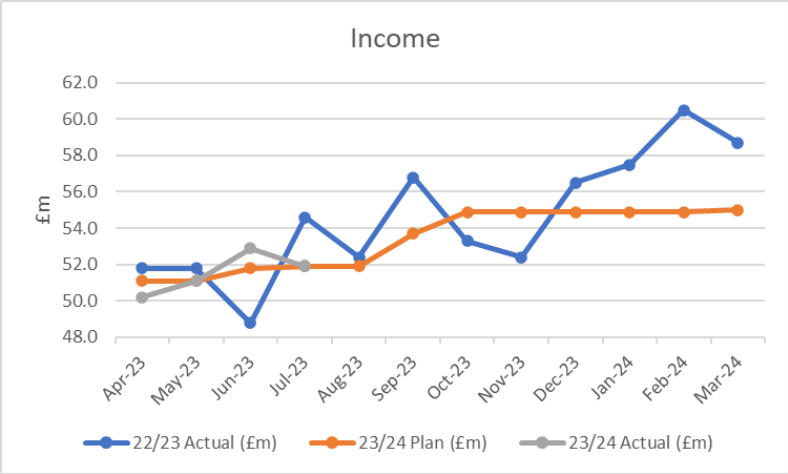
- The system stretch target £17.7m is delivered;
- The Trust Specific QEP and Financial Recovery targets are delivered or mitigated;
- Winter related activity is either system funded or managed within internal resources;
- Divisional operational pressures and risks will be managed or mitigated.

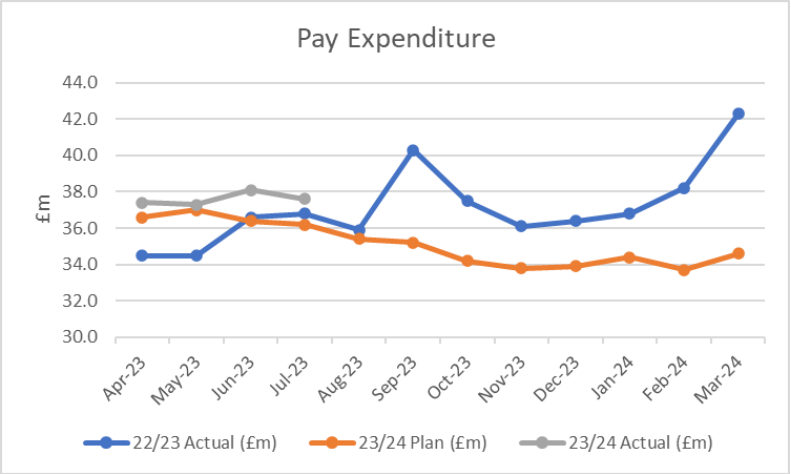
Additional mitigations currently being assessed to assist with keeping the Trust on Plan are:

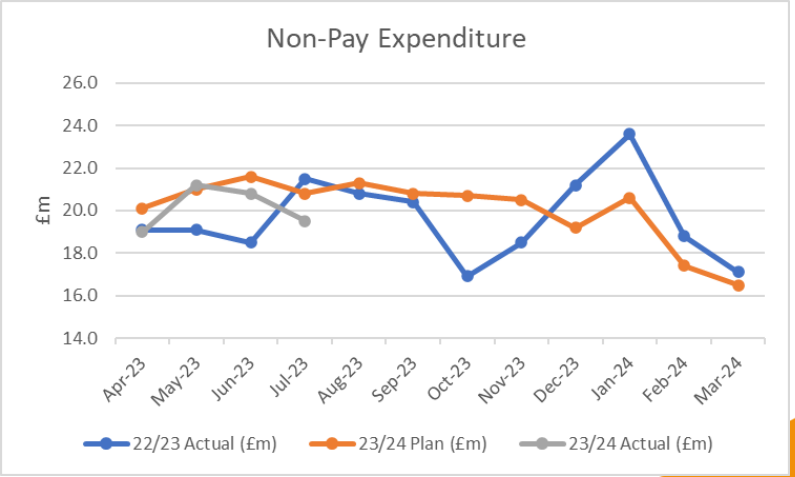
- Further Pay controls – vacancy control and flexible pay;
- Additional non-pay expenditure controls;
- Opportunities to improve PbR income levels through additional work for Commissioners;
- Scan4Safety Stock tracing and control system Business Case and implementation – both recurrent and non-recurrent savings;
- Incentive scheme for Divisions and Directorates to over-achieve budget and QEP performance.

Blackpool Teaching Hospitals
NHS Foundation Trust

Run Rate







For comparison purposes, the 22/23 actuals in the run rate graphs have been normalised to remove 22/23 non recurrent income and expenditure and uplifted to 23/24 prices.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Integrated Performance Report (IPR) – Operational Performance

Meeting:	Board of Directors Meeting
Date:	25/08/2023

Author	Steve Christian, Deputy Chief Executive Officer Chrisella Morgan, Director of Operations & Performance William Wood, Associate Director of Business Intelligence					
Exec Sponsor	Steve Christian, Deputy Chief Executive Officer					
Purpose	Assurance	✓	Discussion	✓	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** The IPR covers all national and reginal KPIs that the Trust must report in line with the Operational Plan 23/24 for all acute NHS Trusts. The IPR narrative describes the current position and intended priorities for KPIs that are not meeting the required targets and / or trajectories. The Trust has continued to exceed our in-year plan in reducing the cancer backlog for undiagnosed patients. The Trust continues to work towards eliminating waits over 65 weeks. Improvement plans in place to address challenging specialities - significant national pressures experienced in two of three specialities. The Trust is making progress in the achievement of the Cancer 28-day Faster Diagnostic Standard (FDS). For July the Trust recorded its highest performance in year. Significant challenges persist across UEC pathways. There has been a notable rise in higher acuity of self-presenting patients and a rise in the number of long stay patients (21+ day) on base wards. These factors have resulted in crowding in the Emergency Department (ED) resulting in a decreased ability to treat patients in a timely manner.
Implications *(so what)*	**Alert** 4-hour performance: 215 less patients experiencing corridor care in July 23 in comparison to July 22, representing a 32% improvement. Ambulance handover: > 60 minutes: Since March 2023, the metric is showing signs of recovering its position. However, at time of writing the Trust is seeing August prove to be significantly challenged period for patient flow with the Trust triggering the highest level of escalation (external OPEL L4). Across August the Deputy CEO has been chairing

	Place based Tactical meetings with partners to address system-wide factors. RTT 65 week waits: The Trust has reported 45 fewer patients against plan of 280 waiting above 65 weeks. This figure also represents a 33% reduction in comparison to July 22. The biggest contributors to 65-week waiters by volume are Cardiology, Gastroenterology and Gynaecology. Service action plans in place with forecasts monitored at PIDA / SOAG. Whilst plans and enhanced oversight is in place it is anticipated for August that delivery of the 65 week wait trajectory won't be achieved.
	Assure
	Cancer 62-day backlog: The current backlog figure is at 74 (4.82%). Work is ongoing to address the themes identified in those Tumor sites with the largest backlog. Most challenged services are Colorectal and Gynaecology. Tumor site level improvement plans being developed with forecasts monitored at CIG. The Trust is exceeding our year-end target and worth noting progress in 2023: • March 2023 – backlog figure 161 (11.3%) & 7th worst in national rankings • July 2023 – backlog figure 74 (4.82%) & 92nd worst in national rankings.

Previously considered by	Executive Team Meetings, Clinical Division PIDAs, Senior Operational Assurance Group (SOAG), Finance & Performance Committee

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

Equality, Diversity and Inclusion (EDI) implications	Not applicable

Proposed Resolution ***(What next)***	Deliver against the key actions and priorities as set out in the IPR narrative.

Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Finance and Performance Committee

July 2023

Caring ▪ Safe ▪ Respectful

Guide to Statistical Process Control

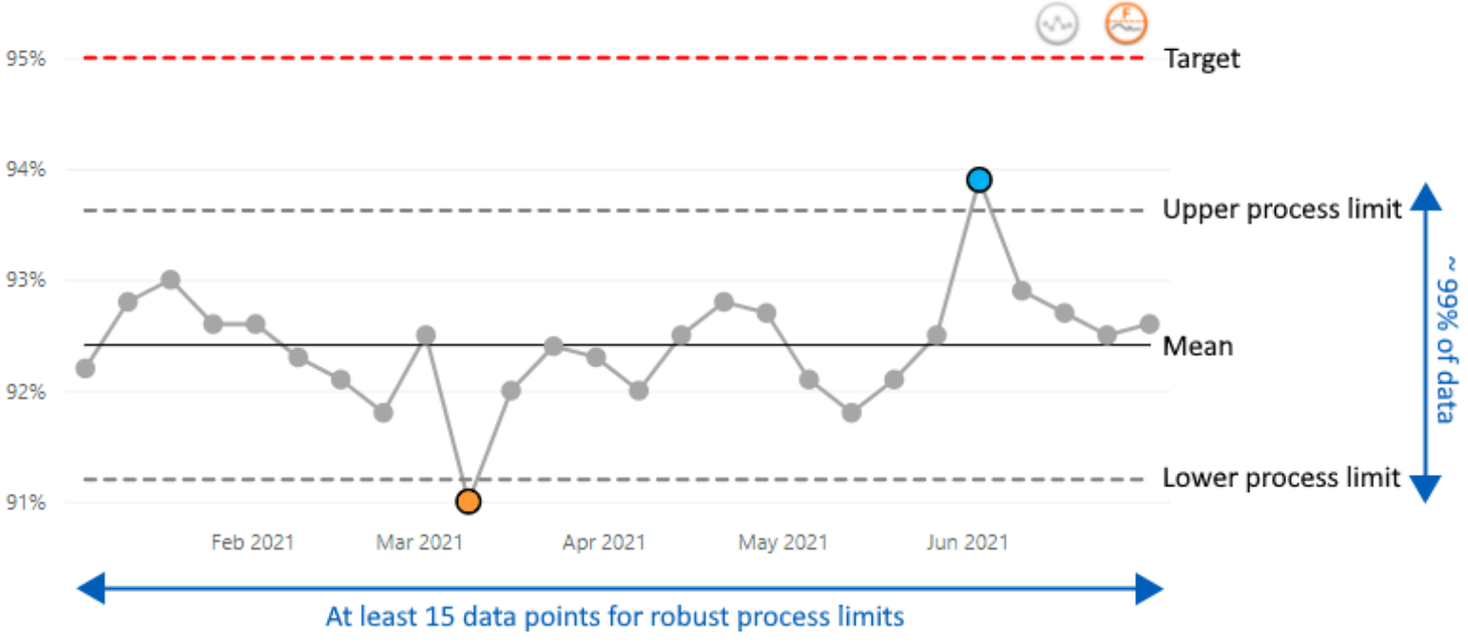
Blackpool Teaching Hospitals NHS Foundation Trust

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	2	2
	Activity		6					6		
	Cancer		7	2	2	2	2	5		2
	Productivity	1	2	3	5	2	1	7		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.

Blackpool Teaching Hospitals
NHS Foundation Trust

Access

Urgent & Emergency Care (UEC) - number of patients waiting over 12 hours from decision to admit (DTA) and ambulance handover
Advise:
- The recent pressure has been down to a combination of factors and has not arisen due to an increase in demand (in terms of volume). There has been a notable rise in higher acuity of self presenting patients and a rise in the number of long stay patients (21+ day) on base wards. These factors have resulted in crowding in the Emergency Department (ED) resulting in a decreased ability to treat patients in a timely manner.
- Final phase of a 2 year ED refurbishment has commenced. The capital development will move the department from 22 adult majors' cubicles to 32, in line with GIRFT requirements. The ED refurbishment is due for completion by mid December 2023. Whilst the final phase of the A&E refurbishment doesn't reduce the current physical adult majors' capacity (22) the configuration of the dept. has changed.
- The Trust has a historical over reliance on temporary workforce arrangements, specially across Urgent Care and General Internal Medicine (GIM) specialties. This is down to long standing vacancies. Therefore, the Trust is "currently" reliant on transient provision to support medical rotas .
- The trust has experienced some short notice cancellations of temporary resources. Whilst key roles have been covered due to displacing Supporting Professional Activities (SPA) time, there has been lost capacity which has added to the operational pressures.
Assure:
- Exceptional Long length of stay reviews to include heads of department and Allied Health Professional (AHP) leads for all patients over 21 day with clear actions undertaken to facilitate discharge
- Clifton Hospital capacity & utilisation of beds to be reviewed to ensure all beds are maximised and escalated where appropriate.
- Full review of current conversion rate and improvement plan developed to reduce demand on beds where appropriate.
- Understanding and review of system wide Directory of Services and alternate to transfer pathways that are available.
- Trust wide Winter planning underway.
Alert:
- Virtual Ward usage remains low across adult specialties. Further work is required to increase uptake and reduce the volumes of patients requiring admission into acute beds.
- A key component in the rising of the cohort of patients with length of stay (LOS) 21+ days is reflected in patients that are under the care of the Transfer of Care Hub. These are patients ready for discharge from hospital but require ongoing care through pathways 1 - 3. The current position is circa 13% of total occupied bed base that don't meet criteria to reside.

RTT
Advise:
- 78 week wait breaches were 11 in July.
- Specialties with the largest 18-week backlogs are Gastro, Cardiology, ENT and Gynaecology.
- Gastroenterology insourcing commences in September 2023 to address backlog.
- ENT insourcing proposal has been endorsed by the Trust Executive team in August and awaits ICB approval.
- Cardiology- has increased WLIs with 200 additional patient appts provided in July and August with continued clinical triage of all new referrals, as a test for change has commenced.
- Gynaecology- Briefing paper and Action Plan in relation to Gynaecology RTT is being prepared. This will be presented to Executives at the September PIDA meeting.
Assure:
- No 104-week breaches reported in July.
Alert:
- 65 week wait – largest volume in Gynaecology, Gastroenterology and Cardiology - this position has and is increasing, driven by Gastroenterology in the main – the planned insourcing commencing in September for outpatients will support improvement with this.
- 52 week wait – largest volume in gastroenterology with cardiology then gynaecology next – To note- industrial action has directly impacted and reduced activity for pathways earlier in the week bands. This poses a risk via increase tip overs for 52 weeks and then 65 weeks – This will be reviewed and modelled by the Trusts BI team.

Access

Stroke - Transient Ischaemic Attack (TIA)
Advise:
- There is currently no weekend provision for TIA clinics as a result of the staffing challenges.
Assure:
- IMPF to work with new Stroke consultants to drive Nurse Led TIA clinics forwards.
- Substantive recruitment for Stroke posts to be key focus.
- Reviewing opportunities for additional weekend locum shifts to support performance recovery.
Alert:
- Recent changes to the medical team for Stroke (locums) have occurred. The team are being supported and welcomed to IMPF, recognising the operational challenges the service faces.

Stroke - 90% Stay on the Stroke Ward
Advise:
- LOS continues to be a key pressure for the organisation with an approximate 13% of its bed base housing patients who no longer meet the criteria to reside. The pressure across all beds adds an additional challenge to ring-fence Stroke capacity.
Assure:
- Improvements have been made through timelier escalation and active management from the Division's Manager of the Day rota.
- Ongoing work with the medical team for Stroke continues with a focus on timely discharges and optimising patients for discharge, to keep flow across the Stroke Unit.
Alert:
- Recent changes to the medical team for Stroke (locums) have occurred. The team are being supported and welcomed to IMPF, recognising the operational challenges the service faces.

Endoscopy
Advise:
- There continues to be a focus on ensuring booking of 2 week rule (2WR) in chronological order and as highest priority.
- Additional focus on diagnostic (DM01) position – gastroscopy, colonoscopy, sigmoidoscopy to improve this position.
- Booking processes changed to meet different challenges of new waiting list size: Introduced force booking principles, whereby patients are sent their appointment slot, with ownership taken by the patient.
- Head of Department (HoD) reviews outstanding referrals as 'consultant to do' and has validated some for the Non-Medical Endoscopists (NMEs) to complete.
- All fast-track referrals are being allocated to Remedy insourcing, ensuring a greater scope of patients to book and fill their lists.
Assure:
- Recovery of waiting list backlog has continued through to August- Recovery ahead of schedule – circa 34 lower than projection.
- 2WR standard for endoscopy is now being delivered.
Alert:
- Utilisation target achievement is inconsistent. This relates to suitability of patients on remaining waiting list for insourcing/ outsourcing non-medical endoscopists to provide versus the number that require specialist intervention. This means some lists are not filled.

Operations

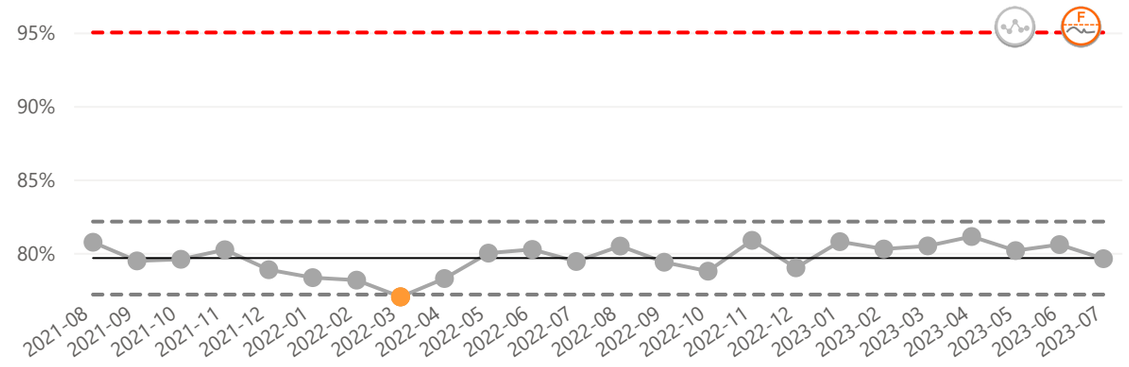
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
4 Hours from arrival to ADT - % within 4 hours	95%	79.6%	Jul 23		F	95%	80.5%	Jun 23		
A&E Type 1 Performance %	65%	53.9%	Jul 23		F	65%	56.0%	Jun 23		
Ambulance Handovers - % within 15 minutes	65%	24.2%	Jul 23		F	65%	28.3%	Jun 23		
Ambulance Handovers - % within 30 minutes	95%	75.8%	Jul 23		F	95%	78.4%	Jun 23		
Ambulance Handover 30-60 Mins		466	Jul 23				373	Jun 23		1643
Ambulance Handover Over 60 Mins	0	164	Jul 23		?	0	171	Jun 23	0	820
Number waiting over 12 hours from DTA		859	Jul 23				821	Jun 23		3339
Number of Patients spending 12+ Hours in ED - Trust		1565	Jul 23				1479	Jun 23		5978
% of Patients spending 12+ Hours in ED - Trust	2%	7.64%	Jul 23		F	2%	7.25%	Jun 23		
% of patients waiting less than 6 weeks for a diagnostic test	95%	77.9%	Jul 23		F	95%	80.3%	Jun 23		
Total RTT Waiting List - Trust		37153	Jul 23	H			36636	Jun 23		37153
RTT Incomplete Pathways - % within 18 weeks	92%	56.1%	Jul 23	L	F	92%	55.4%	Jun 23		
RTT Incomplete Pathways - Over 52 Weeks		1449	Jul 23	H			1218	Jun 23		1449

Operations

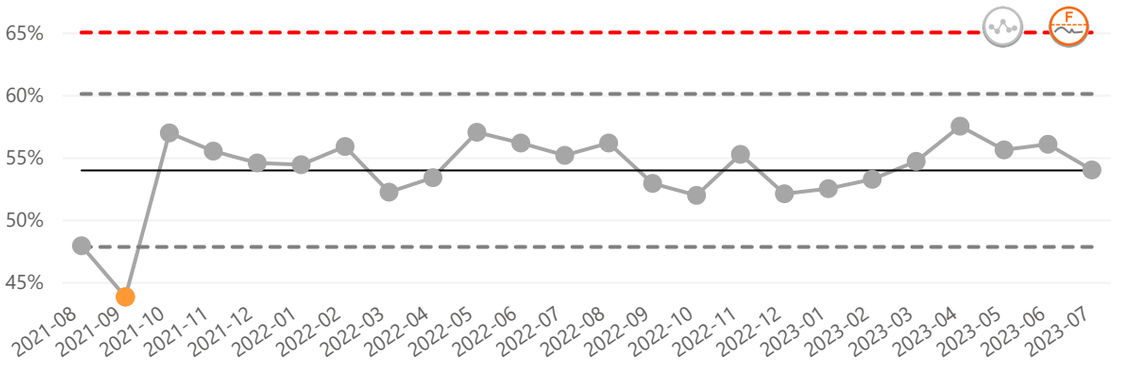
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
RTT Incomplete Pathways - Over 78 Weeks		11	Jul 23				15	Jun 23		11
RTT Incomplete Pathways - Over 104 Weeks	0	0	Jul 23			0	0	Jun 23	0	0
Total 52 week waits – completed		278	Jul 23				299	Jun 23		1075
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days	0%	22.0%	Jul 23			0%	17.8%	Jun 23		
TIA - High Risk Treated within 24Hrs	60%	32.2%	Jul 23			60%	32.6%	Jun 23		
Stroke - 90% Stay on Stroke Ward	80%	81.8%	Jul 23			80%	51.9%	Jun 23		
2-Hour UCR	70%	86.2%	Jun 23			70%	91.3%	May 23	70%	86.2%

Operations

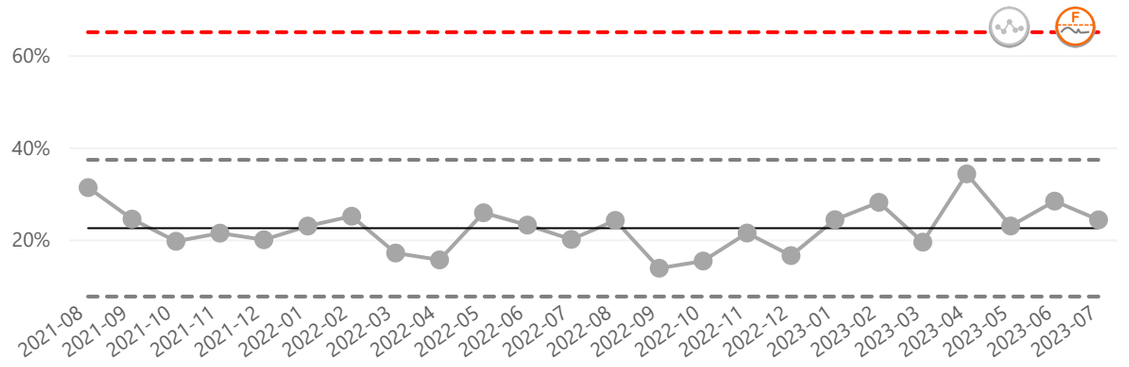
4 Hours from arrival to ADT - % within 4 hours



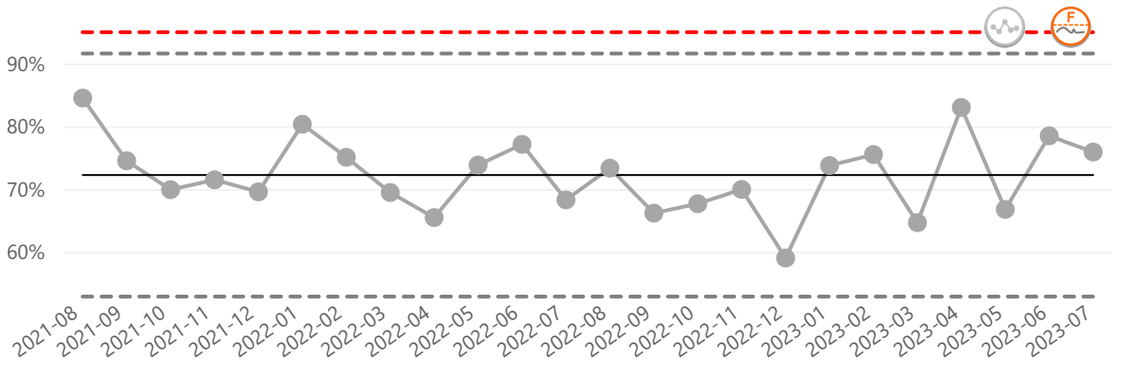
A&E Type 1 Performance %



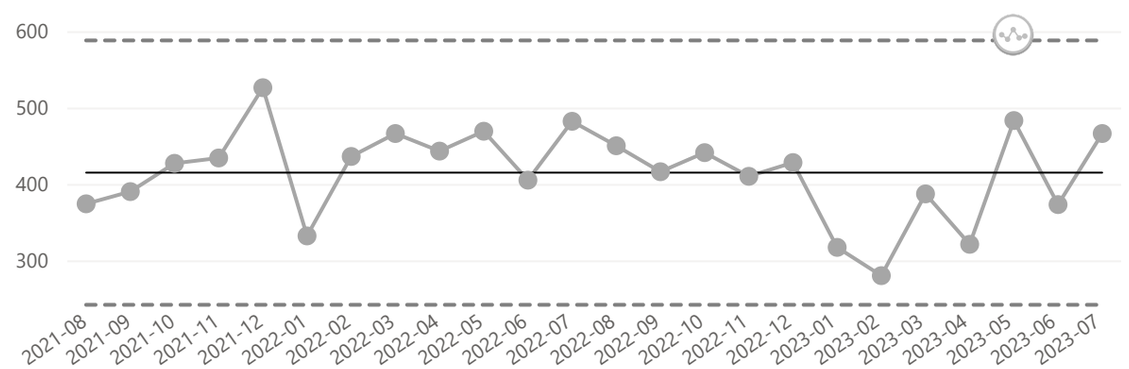
Ambulance Handovers - % within 15 minutes



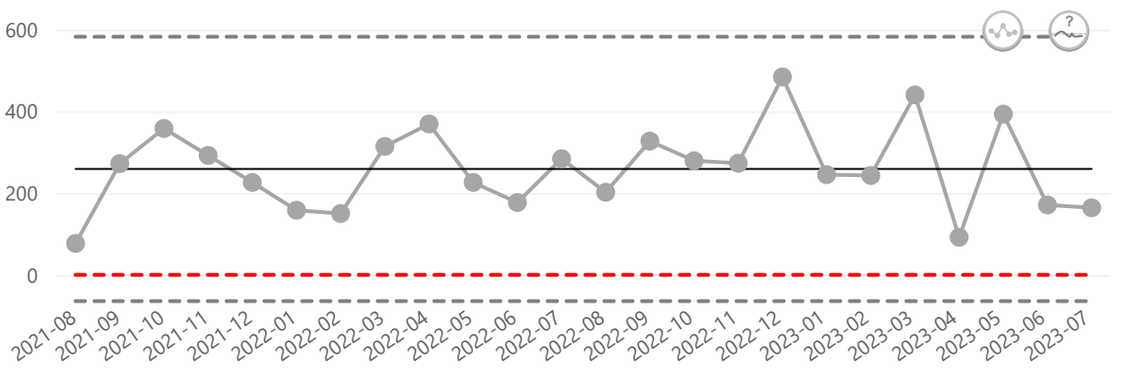
Ambulance Handovers - % within 30 minutes



Ambulance Handover 30-60 Mins

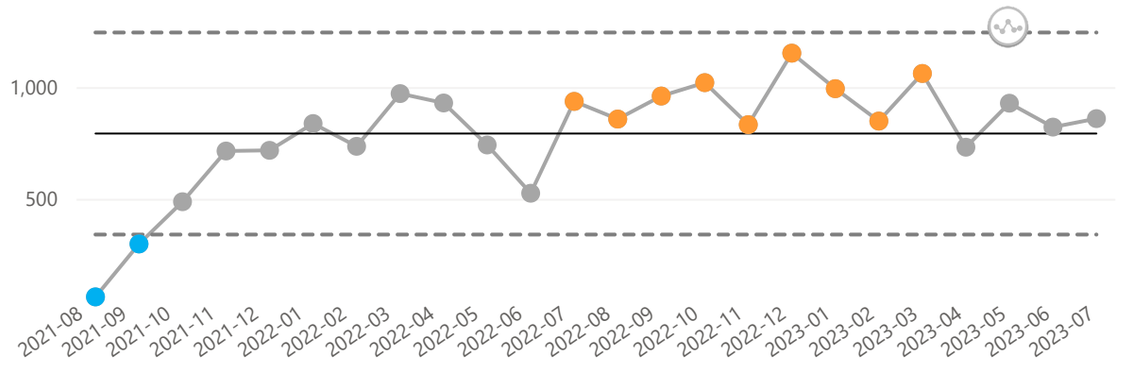


Ambulance Handover Over 60 Mins

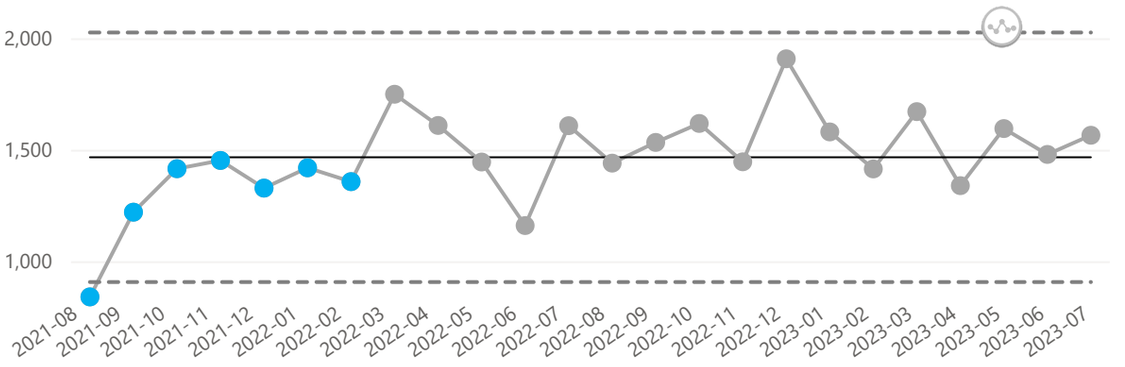


Operations

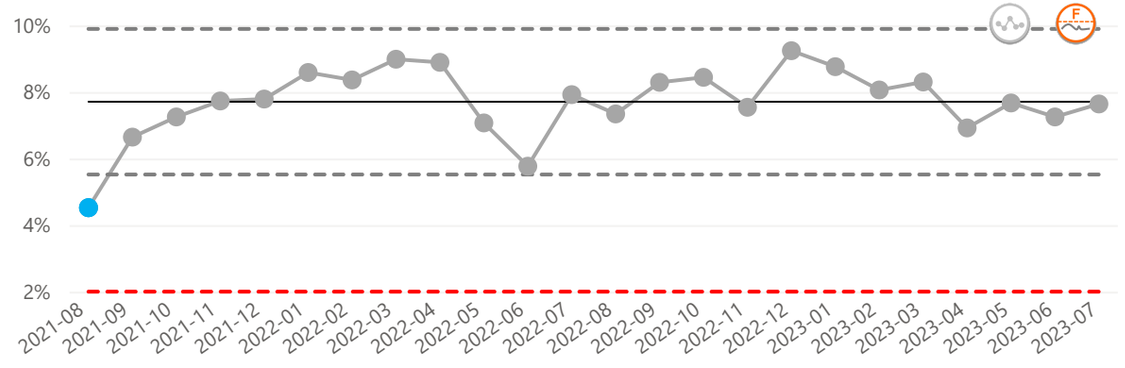
Number waiting over 12 hours from DTA



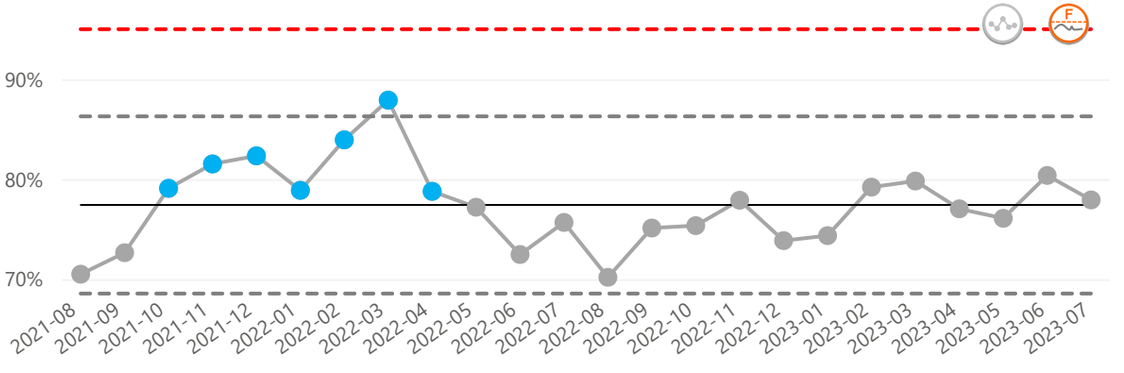
Number of Patients spending 12+ Hours in ED - Trust



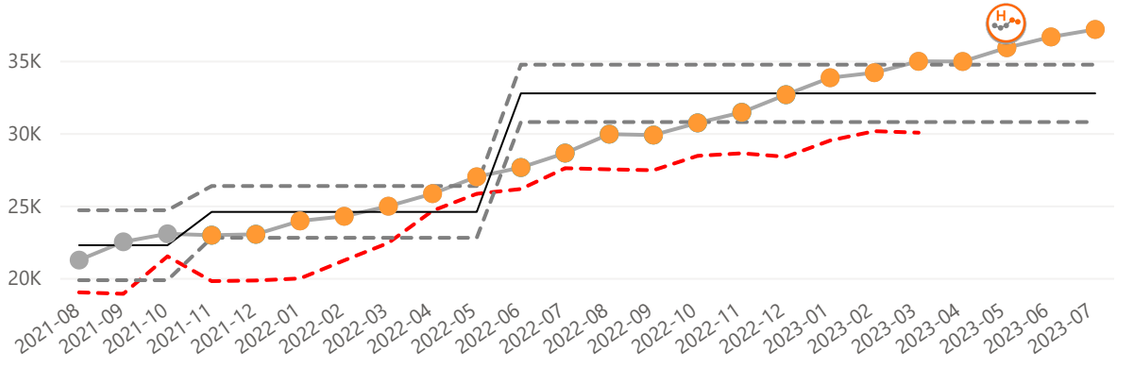
% of Patients spending 12+ Hours in ED - Trust



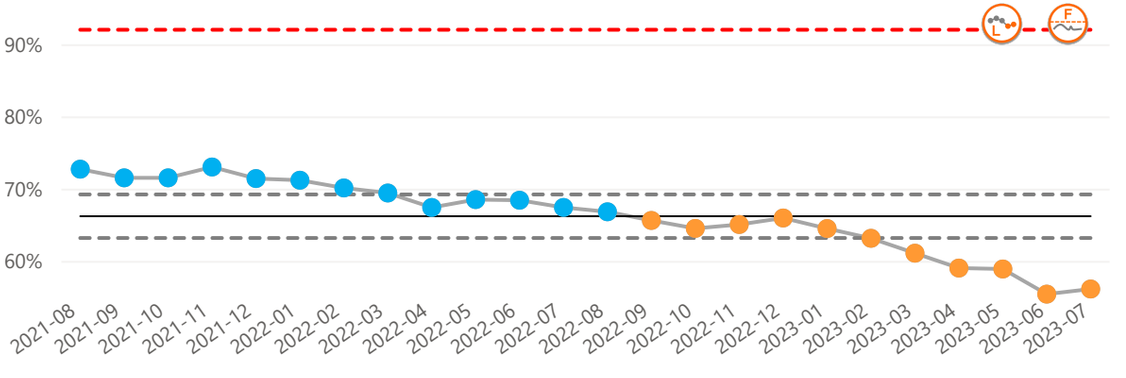
% of patients waiting less than 6 weeks for a diagnostic test



Total RTT Waiting List - Trust

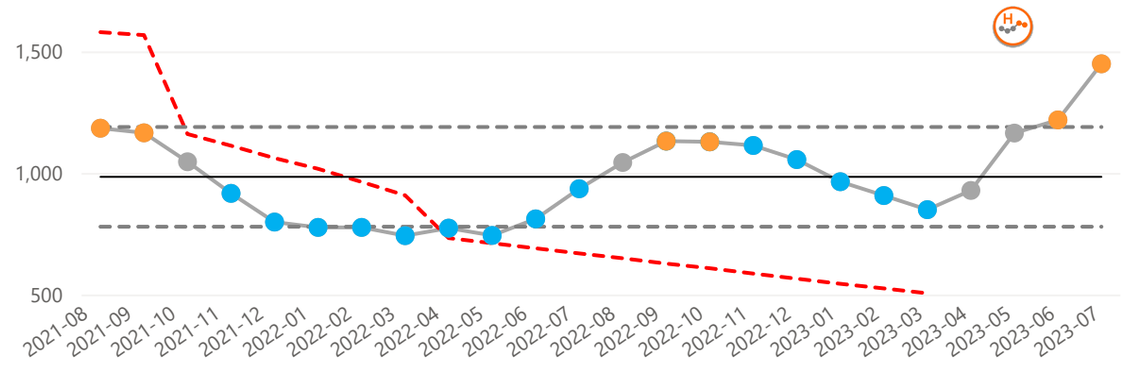


RTT Incomplete Pathways - % within 18 weeks

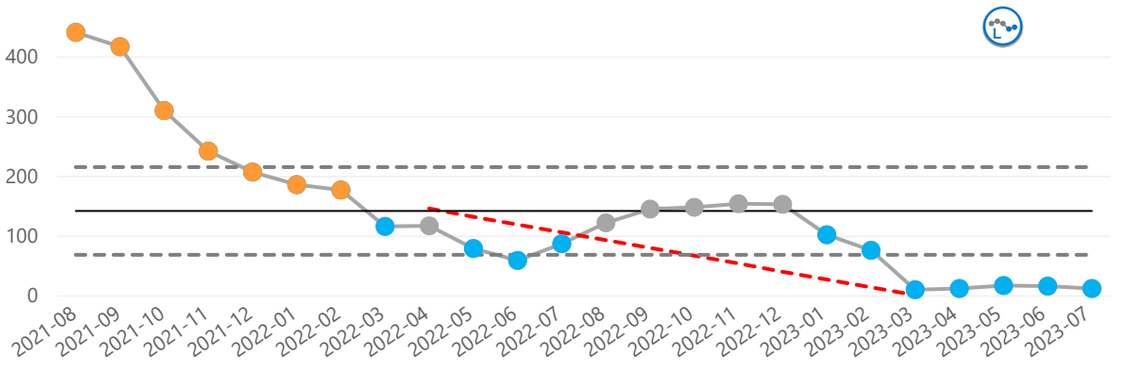


Operations

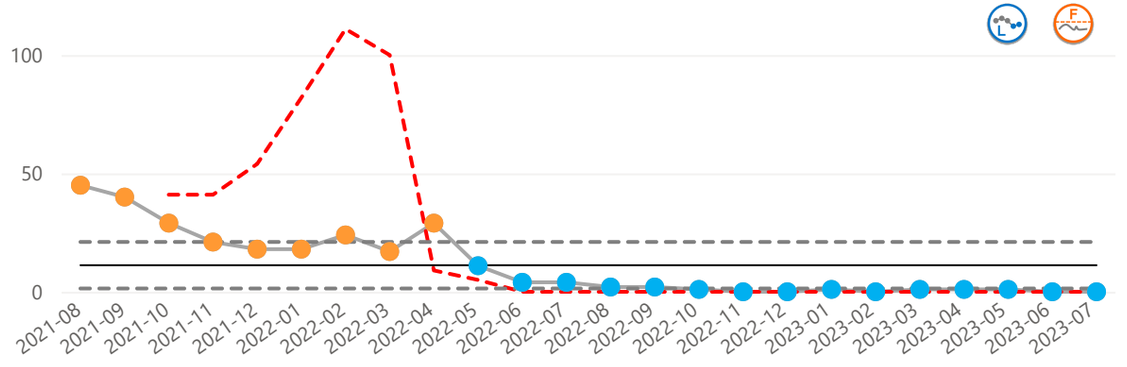
RTT Incomplete Pathways - Over 52 Weeks



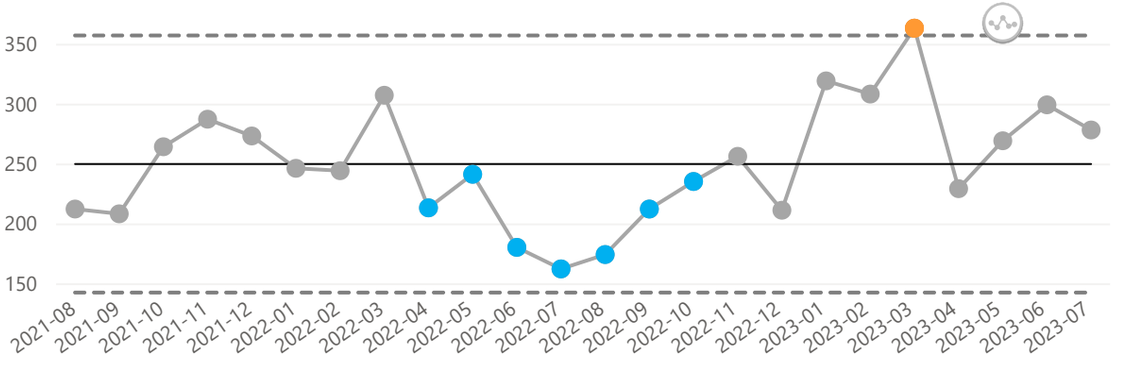
RTT Incomplete Pathways - Over 78 Weeks



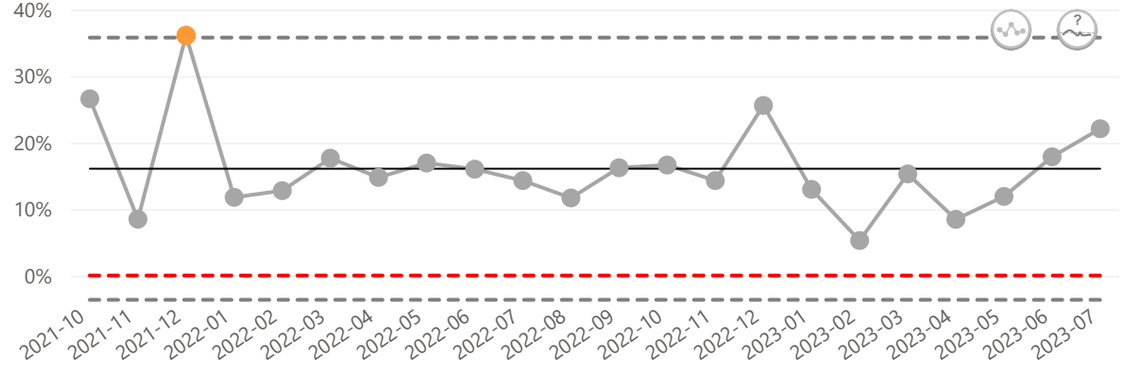
RTT Incomplete Pathways - Over 104 Weeks



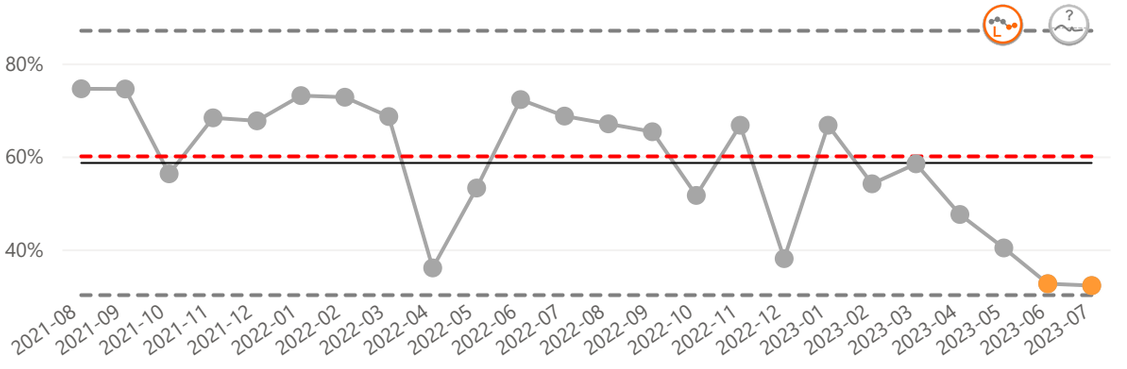
Total 52 week waits – completed



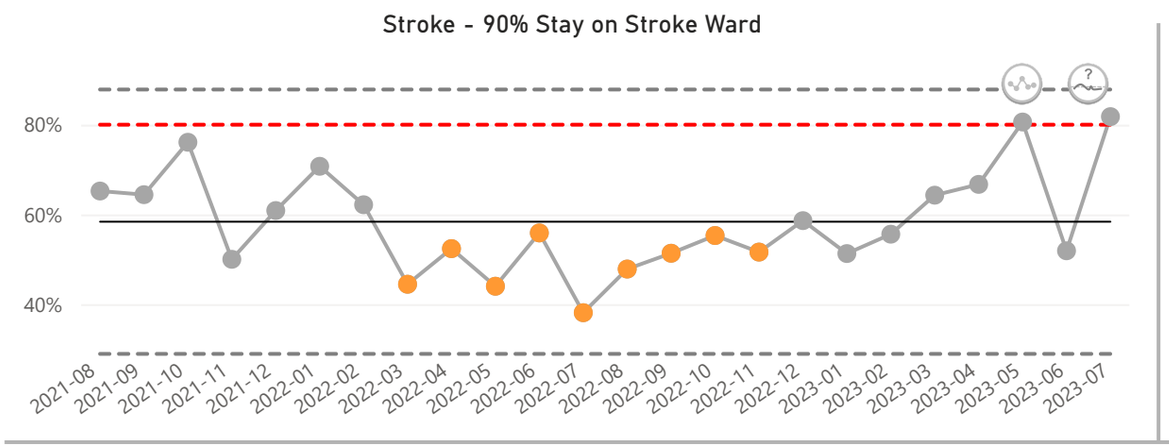
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days

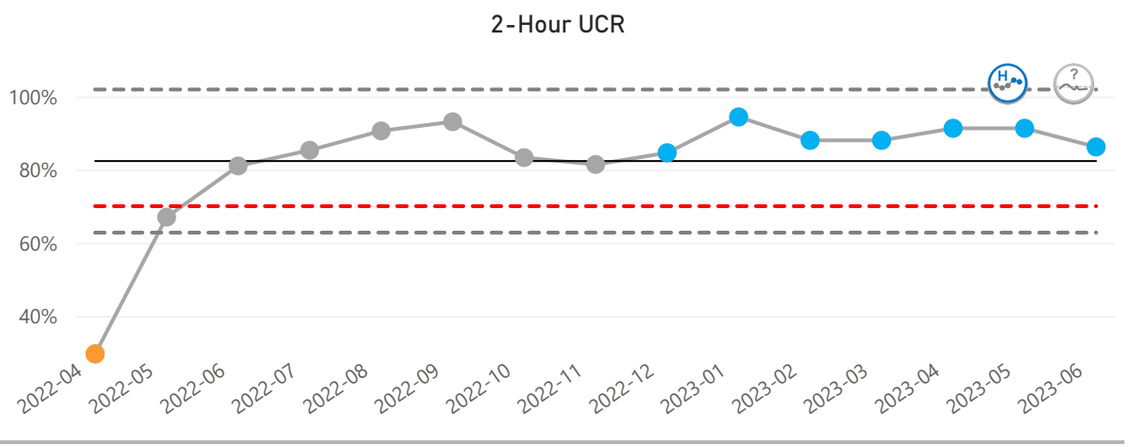


TIA - High Risk Treated within 24Hrs



Operations


Stroke - 90% Stay on Stroke Ward
80%
60%
40%
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
2023-06
2023-07


2-Hour UCR
100%
80%
60%
40%
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
2023-06

Operations

Activity

Assure
- Outpatient Follow Up Appointments below plan for month of Jul-23 and cumulative year to date.
- Jul-23 Biggest contributors to being below plan:
- Gastroenterology | - Gynaecology | - General Surgery
- YTD Biggest contributors to being below plan:
- Gastroenterology | - Gynaecology | - General Surgery

- Elective Inpatients above plan for month of Jul-23 and cumulative year to date.
- Jul-23 Biggest contributors to being above plan:
- Clinical Haematology | - Medical Oncology | - Ophthalmology
- YTD Biggest contributors to being above plan:
- Clinical Haematology | - Ophthalmology | - Colorectal Surgery

Advise
- Non-Elective Inpatients above plan for the month of Jul-23 and cumulative year to date.
- Jul-23 Biggest contributors to being above plan:
- Paediatrics | - Geriatric Medicine | - Rehabilitation
- YTD Biggest contributors to being above plan:
- Paediatrics | - Geriatric Medicine | - Rehabilitation

- Emergency Department Attendances above plan for the month of Jul-23 and cumulative year to date.

Alert
- Outpatient New Appointments below plan for both the month of Jul-23 and cumulative year to date.
- Jul-23 Biggest contributors to being below plan:
- Anaesthetics | - Gastroenterology | - Gynaecology
- YTD Biggest contributors to being below plan:
- Anaesthetics | - Gynaecology | - General Surgery

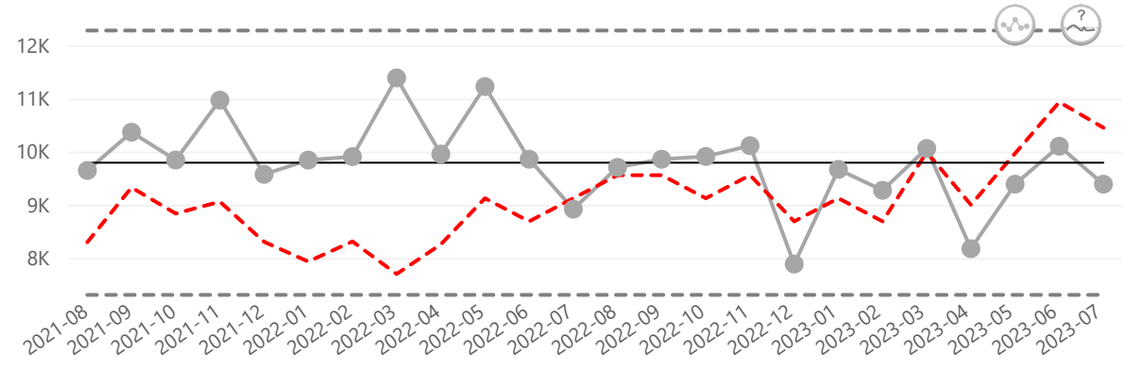
- Day Case below plan for month of Jul-23 and cumulative year to date.
- Jul-23 Biggest contributors to being below plan:
- Gastroenterology | - Clinical Haematology | - Oral Surgery
- YTD Biggest contributors to being below plan:
- Gastroenterology | - Clinical Haematology | - Dermatology

Operations

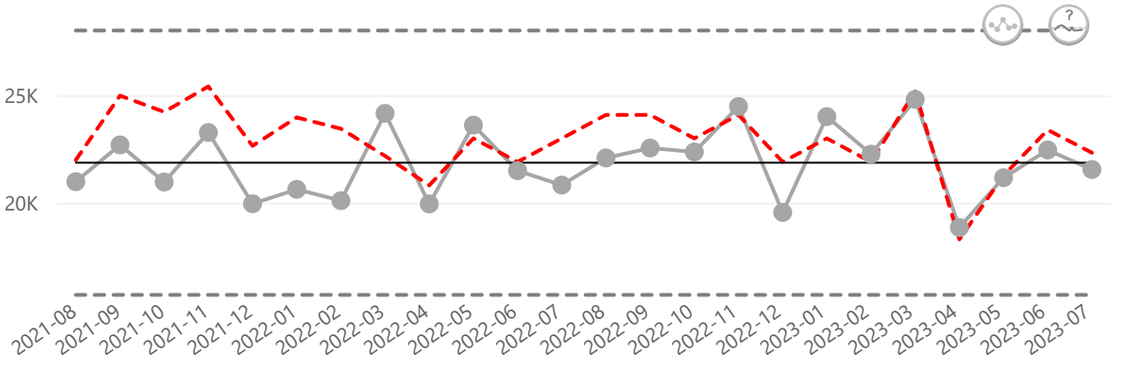
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Outpatient New	10449.85	9387	Jul 23			10933.29	10102	Jun 23	40349	37049
Outpatient Follow Up	22330.63	21547	Jul 23			23391.75	22458	Jun 23	85283	84015
Day Case	4164.94	3789	Jul 23			4362.73	3958	Jun 23	16819	16715
Elective Inpatient	465.2	476	Jul 23			487.18	460	Jun 23	1795	1801
Non-Elective Inpatient	4249	4502	Jul 23			4117.44	4652	Jun 23	16733	18116
ED Attendances	6438.19	6848	Jul 23			6230.57	6713	Jun 23	25338	26510

Operations

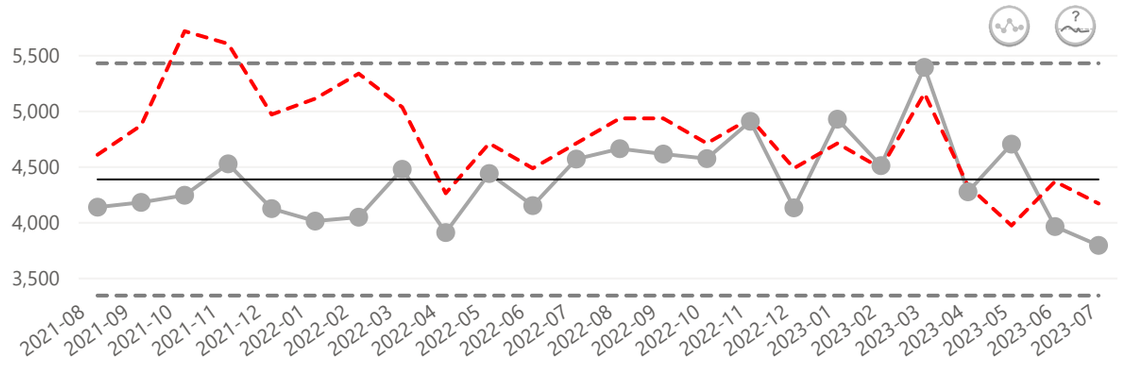
Outpatient New



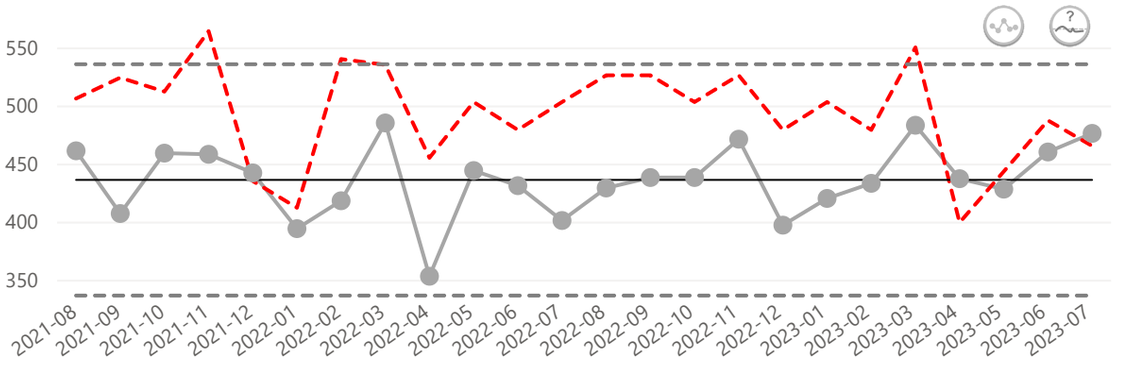
Outpatient Follow Up



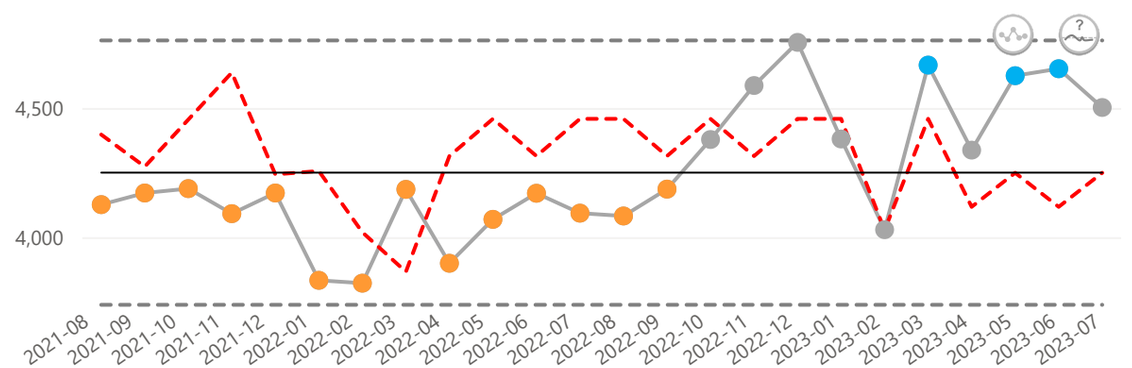
Day Case



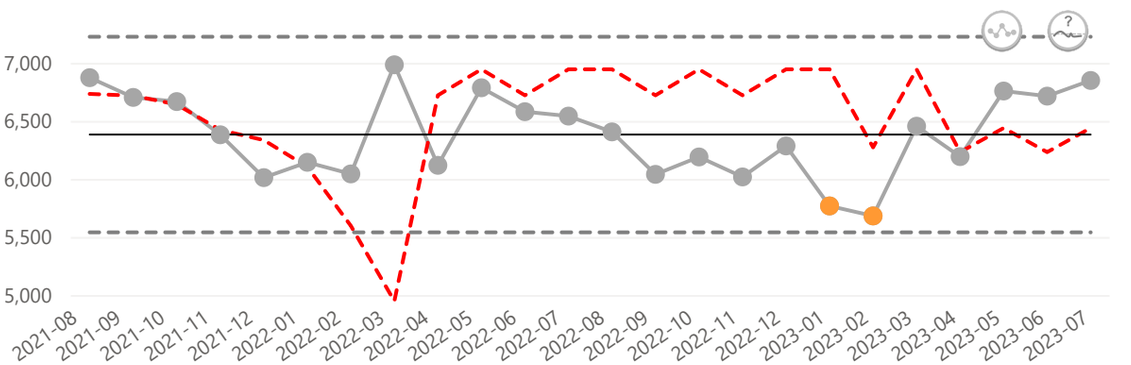
Elective Inpatient



Non-Elective Inpatient



ED Attendances



Blackpool Teaching Hospitals
NHS Foundation Trust

Cancer

Cancer
Advise:
- Increase in Breast surgical workforce - One WTE Consultant returned from retirement. Two WTE Consultants appointed. One of the two appointed consultants commenced employment in August 2023, the second consultant appointment is due to join mid/end October. The increase in surgical capacity will significantly increase capacity to review, investigate and treat Cancer Waiting Times (CWT) patients. Reduction in chemotherapy treatment delays - Wait time for chemotherapy reduced from 5 weeks to 2.5 weeks for new patients. Chemotherapy scheduler recruited. This will help free up more clinical time and ensure scheduling of patients is optimised. The reduction in delays for chemotherapy is likely to improve 31-day and 62-day compliance.
- Lung two week wait (2WW) performance - BTH has the best Lung 2ww performance in the LSC Cancer Alliance region. BTH Achieved 98.67% 2WW compliance for May 2022 – April 2023, only 4 out of 300 patients were seen beyond 14 days. Lung 2WW performance for July 2023 is currently 95.4%.

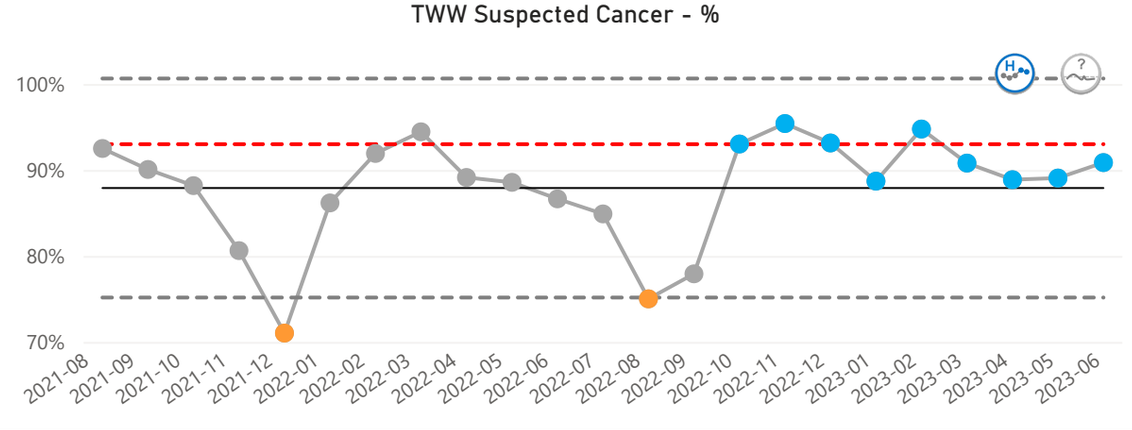
Assure:
- Improved 28-day Faster Diagnosis Standard (FDS) performance - July 2023 performance currently stands at 78.7%. We are on course to achieve FDS compliance for the first time this calendar year. Preliminary figures indicate BTH is on course to achieve FDS compliance in August 2023.
- Reduction in the Backlog of undiagnosed Cancer - The backlog of patients with undiagnosed cancer on our PTL has reduced steadily in recent months. Our current backlog is 70, down from 73 the previous week. Currently, we are ranked 92nd on the National report and already exceeding our end of year target by 34.4%.
- Introduction of Weekly Cancer Services Team meetings - Members of Cancer Services' team will convene weekly to review performance, collaborate, and plan for the weeks ahead. This meeting will also be used to provide feedback, deliver training and teaching sessions designed to upskill the team and address deficiencies within the team.

Alert:
2WW Compliance - 2WW performance for July 2023 is currently 89.6%. Target is 93%. 176 Patients breached their respective 2WW target in July. 107 out 176 breaches were coded as patient choice. 57 breaches were due to capacity. 52 of 57 patients who breached due to a lack of capacity are Upper GI (UGI) patients. Non-compliance at tumour site level for UGI, Lower GI (LGI), Haematology, Gynaecology, Urology and skin.

Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
TWW Suspected Cancer - %	93%	90.8%	Jun 23	H	?	93%	89.0%	May 23		
TWW Breast Symptomatic - %	93%	98.8%	Jun 23		?	93%	92.4%	May 23		
28 Days Faster Diagnosis Standard - %	75%	69.0%	Jun 23		?	75%	72.8%	May 23		
31 Days First Treatment - %	96%	84.2%	Jun 23	L	?	96%	83.5%	May 23		
31 Days Subsequent Treatment - Drugs - %	98%	100%	Jun 23	H	?	98%	100%	May 23		
31 Days Subsequent Treatment - Surgery - %	94%	94.1%	Jun 23		?	94%	86.6%	May 23		
62 Days GP Referred (Classic) - %	85%	49.7%	Jun 23		F	85%	53.1%	May 23		
62 Days National Screening - %	90%	2.38%	Jun 23		F	90%	8.7%	May 23		
62 Days Consultant Upgrade - %	85%	71.9%	Jun 23	L	?	85%	62.2%	May 23		
62 Days - GP Referred (Classic) Open Pathways >62 Days		74	Jul 23	L			100	Jun 23		74
62 Days - GP Referred (Classic) Open Pathways >104 Days		18	Jul 23	L			25	Jun 23		18

Operations


TWW Suspected Cancer - %
100%
90%
80%
70%
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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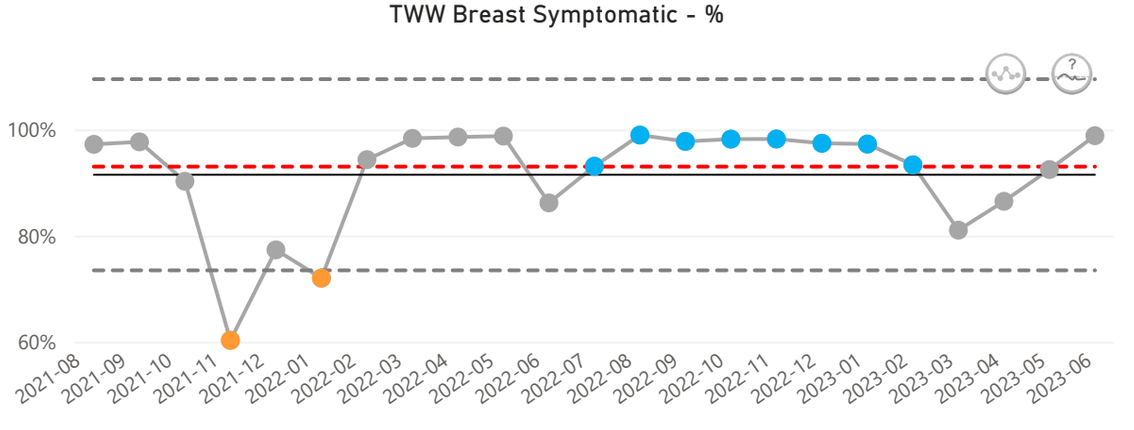
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06


TWW Breast Symptomatic - %
100%
80%
60%
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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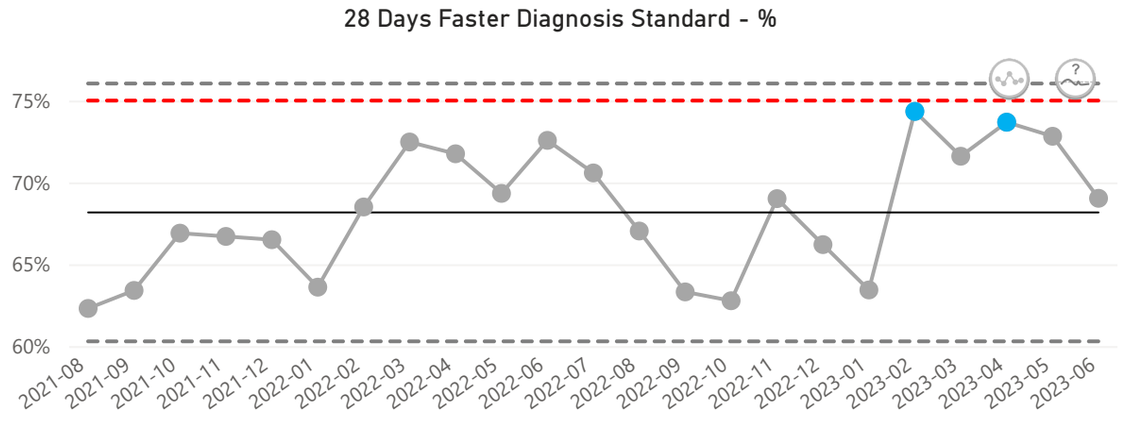
2023-02
2023-03
2023-04
2023-05
2023-06


28 Days Faster Diagnosis Standard - %
75%
70%
65%
60%
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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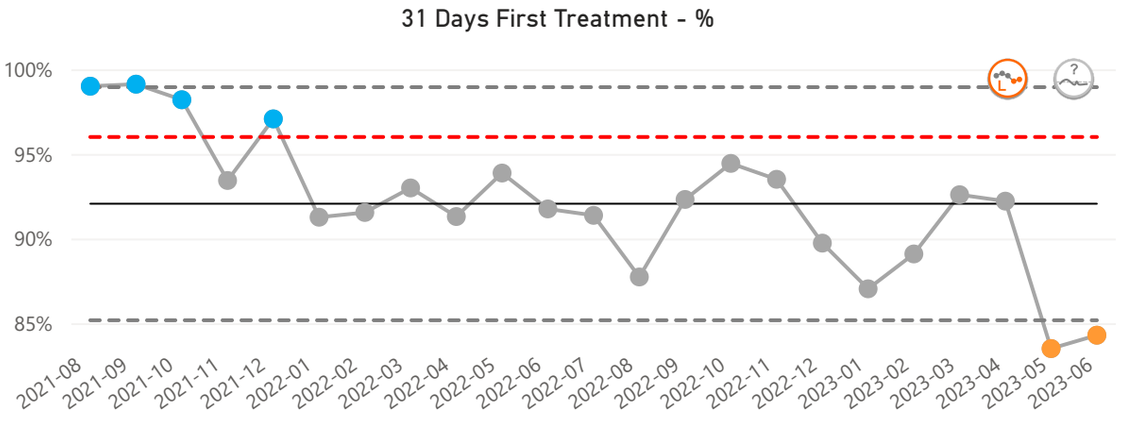
2023-02
2023-03
2023-04
2023-05
2023-06


31 Days First Treatment - %
100%
95%
90%
85%
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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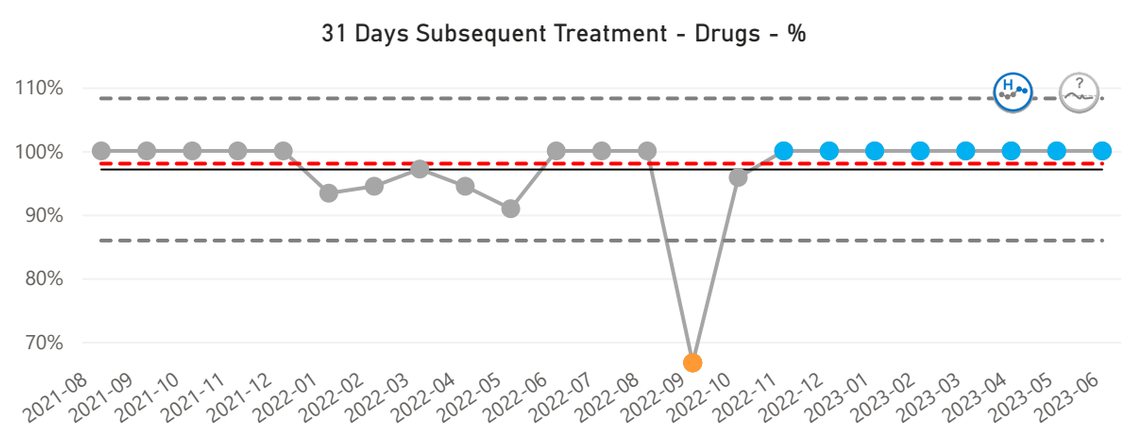
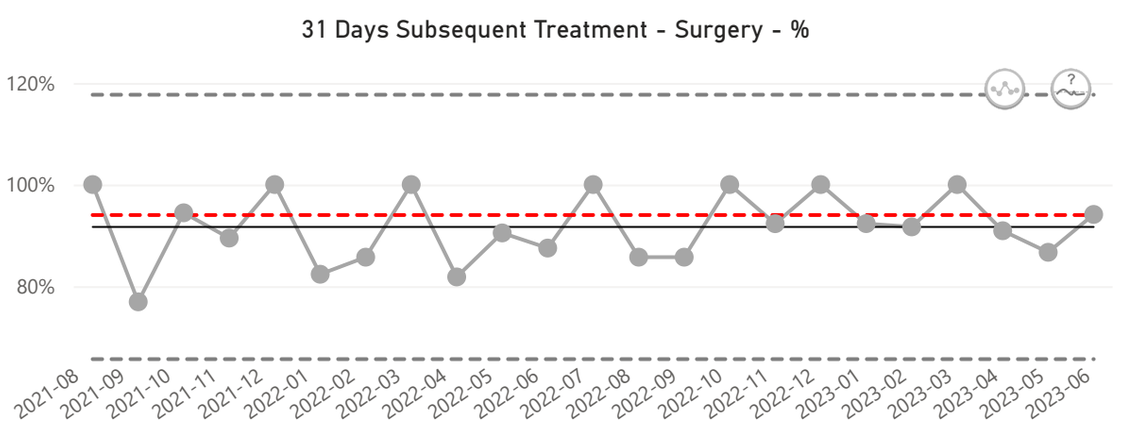
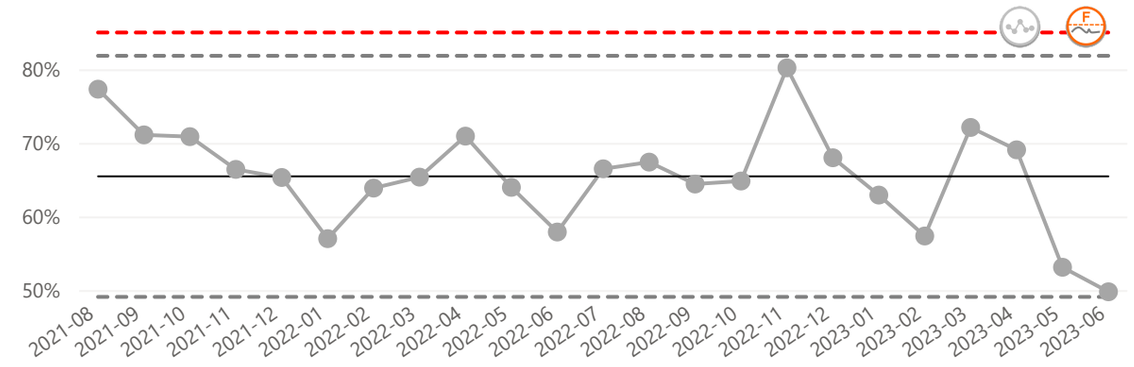
2023-02
2023-03
2023-04
2023-05
2023-06


31 Days Subsequent Treatment - Drugs - %
110%
100%
90%
80%
70%
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
2023-06

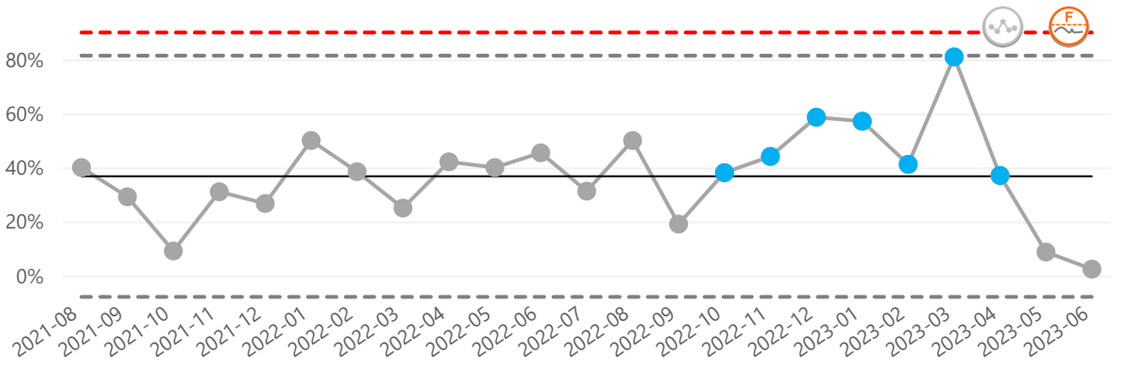

31 Days Subsequent Treatment - Surgery - %
120%
100%
80%
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06

Operations

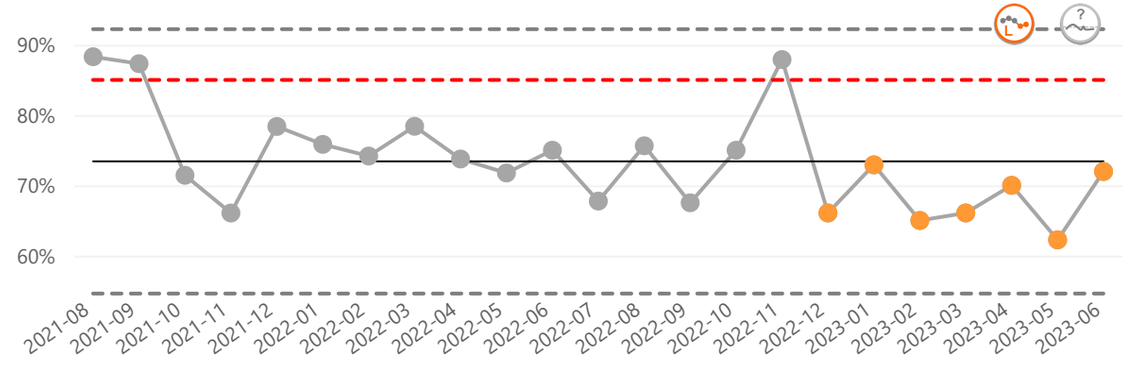
62 Days GP Referred (Classic) - %



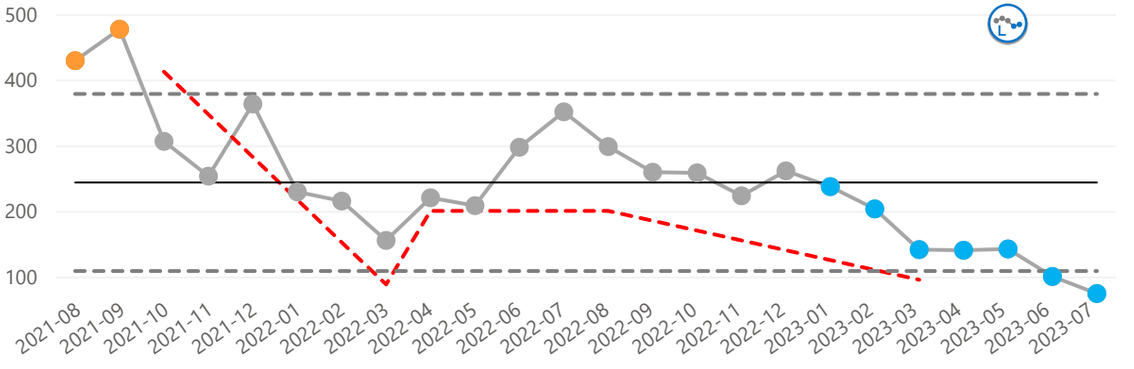
62 Days National Screening - %



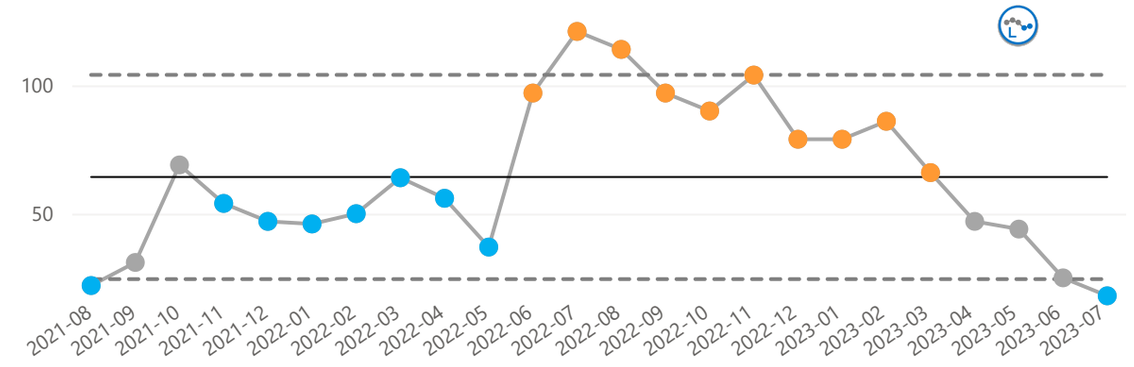
62 Days Consultant Upgrade - %



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

Theatres
Advise:
- Due to case complexity and lengthy procedure durations, it is not possible to backfill vacant time in Theatre with smaller cases to maximise every minute of each list.
Assure:
- Continued focus on efficiency improvements with a reduction in average late start duration (↓20 mins) and average underrun (↓ 65 mins)
- Division continues to improve its use of Discharge Lounge (as shown below) and bring the average time of discharge forward to support flow and mitigate turnaround delays. 14% of discharges before 12pm in June compared to 8% in the previous month.
- 7 workstreams have commenced in August as part of the Enabling Clinical Productivity programme which will positively impact on utilisation and ensure robust improvement initiatives are embedded quickly and deeply.
Alert:
- Decrease in utilisation expected in July and August attributed to the continued Trust pressures. This translates Divisionally into turnaround delays whilst identifying and/or facilitating bed capacity to proceed with afternoon cases, often then leading to on the day (OTD) cancellation and significant underrun which cannot otherwise be utilised.

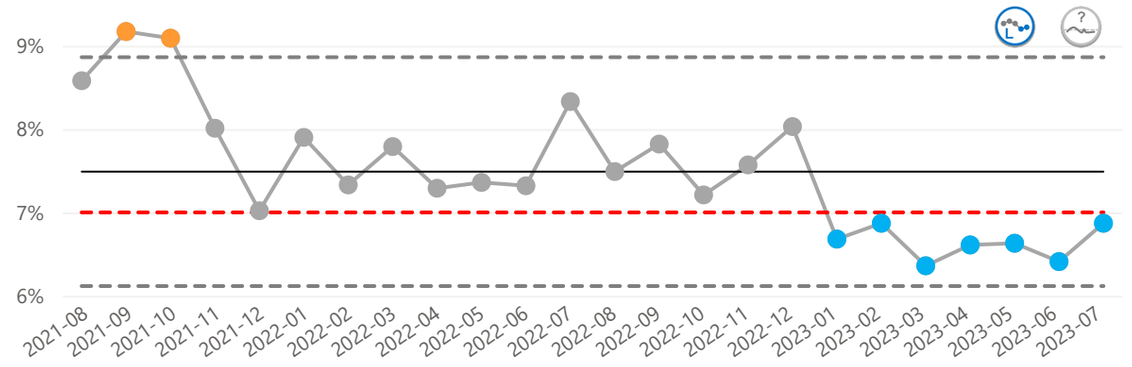
Stranded patient:
Assure:
- The Trusts discharge processes have been identified as a national exemplar.
- The Home First capacity (pathway one) continues to operate 7 days per week.
- Clifton has seen a reduction in LoS improving flow for patients requiring rehabilitation in an acute setting (pathway 2).
Advise:
- Good partnership working arrangements in place across the system with a number of MADE events planned to support expediting discharge delays.
Alert:
- The Not Meeting Criteria to Reside numbers (i.e. those patients ready for discharge not needing a hospital bed) remains above plan due to delays for Local Authority provision.

Operations

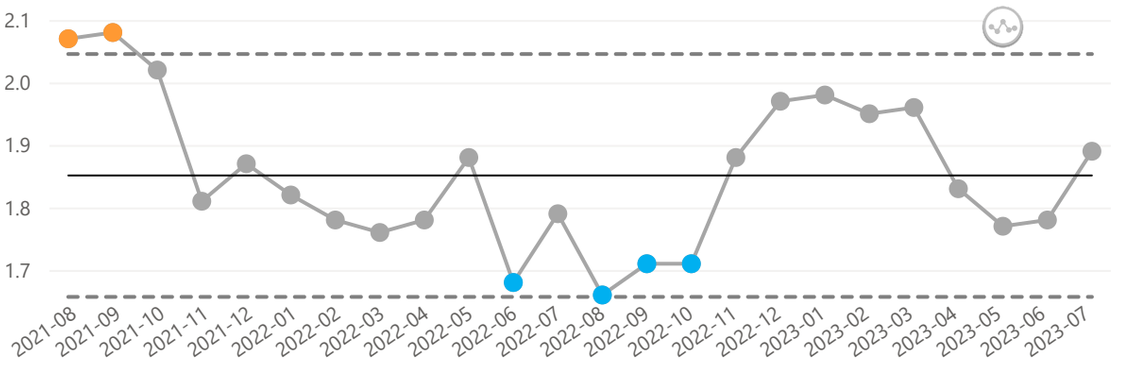
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
DNA rate (OPD) %	7%	6.87%	Jul 23	L	?	7%	6.41%	Jun 23		
New:Follow Up rate		1.89	Jul 23				1.78	Jun 23		1.89
OP Slot Utilisation	95%	93.8%	Jul 23		?	95%	95.5%	Jun 23		
ED Conversion Rate		36.7%	Jul 23				38.0%	Jun 23		
Bed Occupancy - BTH	85%	92.8%	Jul 23		F	85%	93.6%	Jun 23		
Stranded Patients (>6 Days LOS)		331	Jul 23				329	Jun 23		331
Super Stranded Patients (>20 Days LOS)		124	Jul 23				104	Jun 23		124
Theatre Utilisation, All Specialties, Urgent & Elective	85%	80.6%	Jul 23	H	F	85%	80.5%	Jun 23		
Data Quality Maturity Indicator	82.5%	92.5%	Apr 23	H	P	82.5%	91.4%	Mar 23		
Depth of Coding		4.69	May 23	L			6.89	Apr 23		4.69
PIFU Open Pathways	5%	0.4%	Jul 23		F	5%	0.42%	Jun 23		

Operations

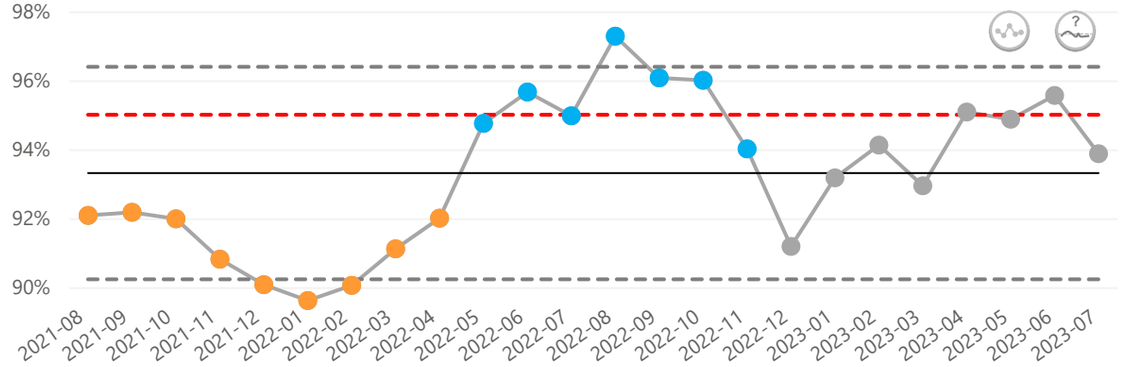
DNA rate (OPD) %



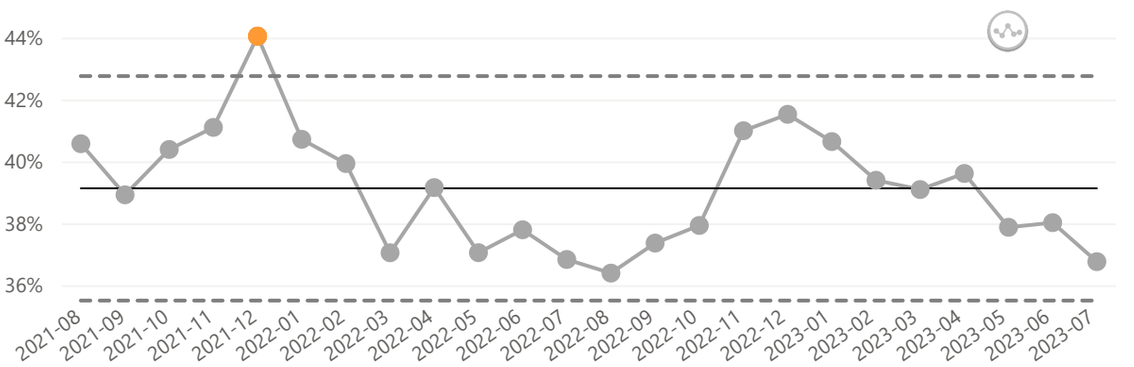
New:Follow Up rate



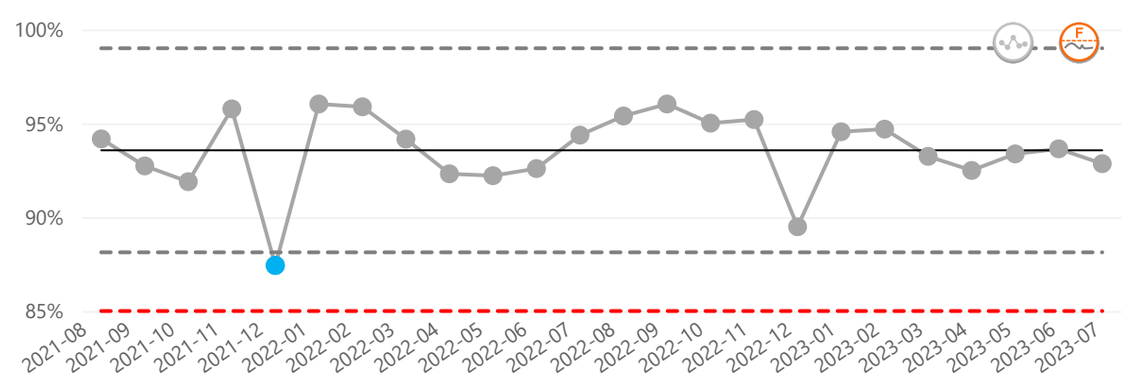
OP Slot Utilisation



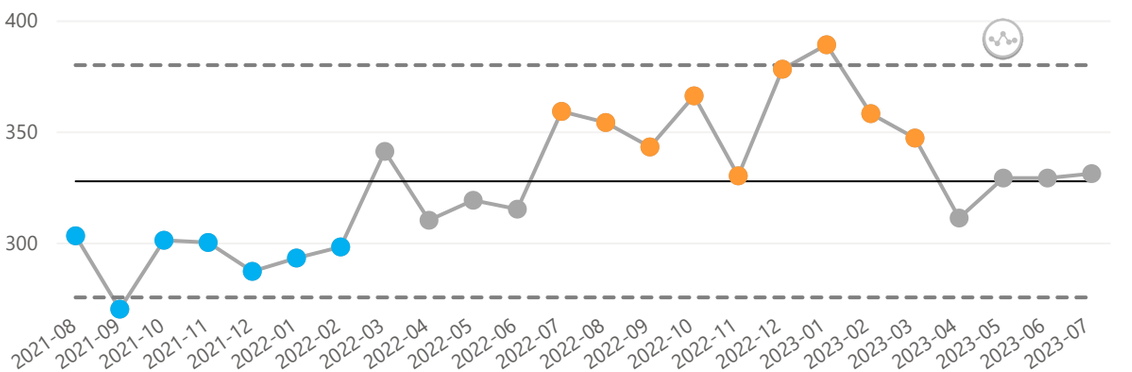
ED Conversion Rate



Bed Occupancy - BTH

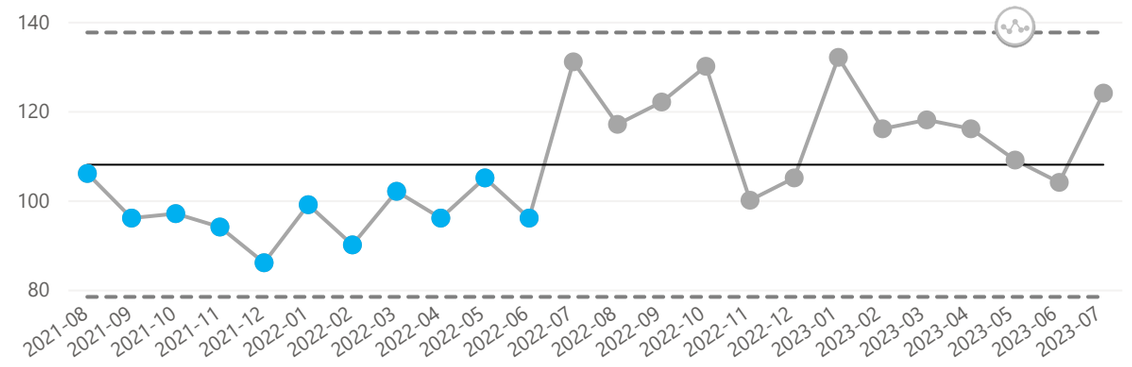


Stranded Patients (>6 Days LOS)

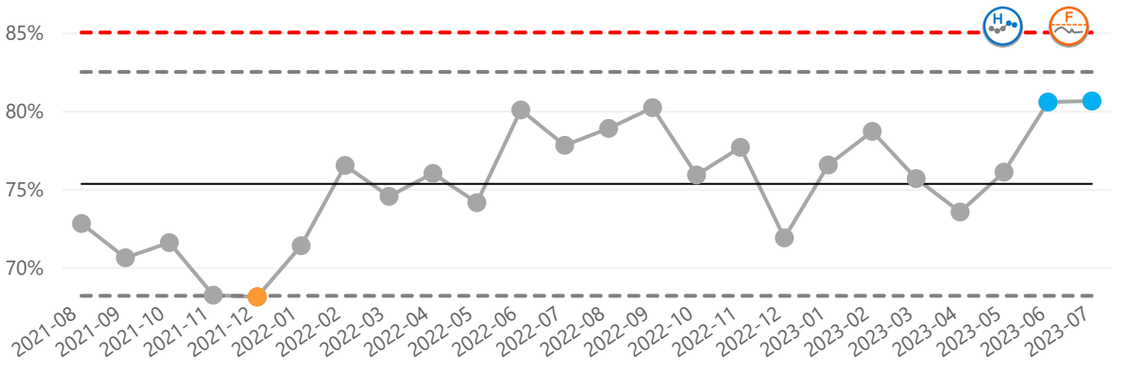


Operations

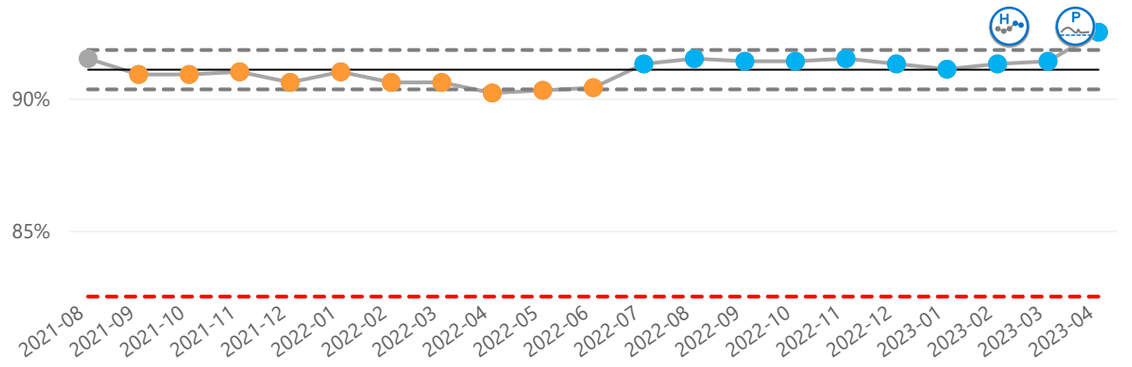
Super Stranded Patients (>20 Days LOS)



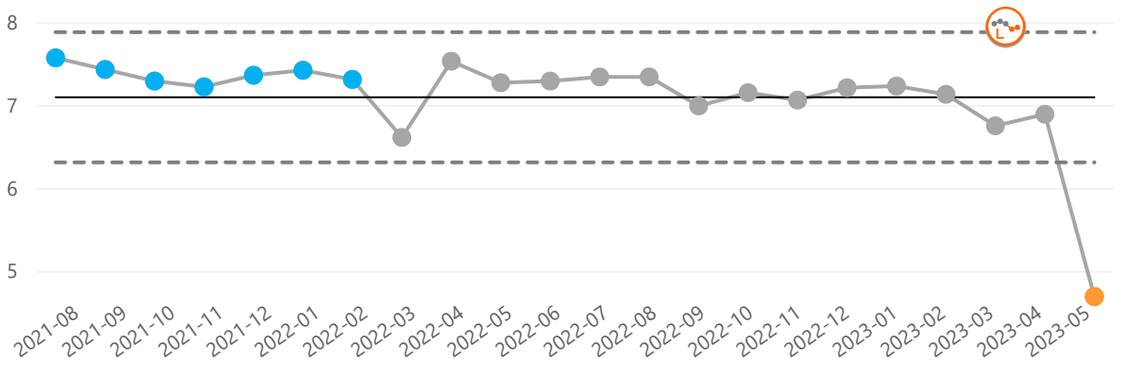
Theatre Utilisation, All Specialties, Urgent & Elective



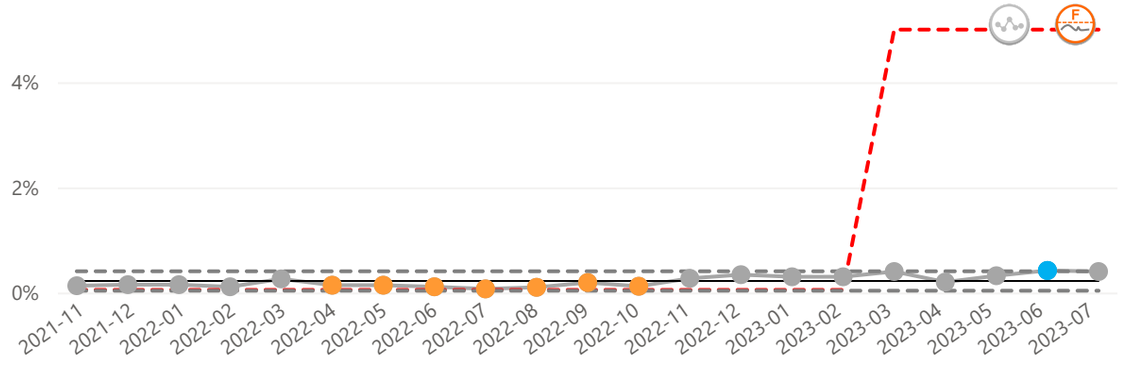
Data Quality Maturity Indicator



Depth of Coding



PIFU Open Pathways



Blackpool Teaching Hospitals NHS Foundation Trust

Title	Winter Planning Arrangements

Meeting:	Public Board of Directors Meeting
Date:	07/09/2023

Author	Steve Christian Deputy CEO					
Exec Sponsor	Steve Christian Deputy CEO					
Purpose	Assurance		Discussion	X	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** This short slide deck sets out the national approach to 2023/24 winter planning, and the key steps that must be taken together across all parts of the health and care system to meet the challenges ahead. The two national ambitions for UEC recovery are that: • 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25. • Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25. The slide deck provides insight of winter planning arrangements at system and Trust level. The Trust working in partnership with Place and ICB partners will be firming up winter plans over September. The identification of schemes and prioritisation has been undertaken across August, and the next step is to firm up (and progress) delivery plans over September.

Implications *(so what)*	**Alert** The plans are reliant upon actions we take need to take that extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector. The ICB has established system governance to oversee delivery of the system-wide winter plan and the Trust is dependent on all parts of the system delivering the key priorities set out in the NHSE national planning guidance. **Assure** Trust Winter Planning Task & Finish group established reporting into the Place UEC Delivery Board.

Previously considered by	Executive Directors Team Meeting

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

Equality, Diversity and Inclusion (EDI) implications	Not applicable

Proposed Resolution ***(What next)***	• Trust Board to receive / sign-off the final Trust (and Place) winter plan in October Public Board meeting. • The relevant Committees of the Trust Board will receive an update on progress in advance of October Public Board

Winter Planning Arrangements

August 2023

Overview

Blackpool Teaching Hospitals
NHS Foundation Trust

Delivering operational resilience across the NHS this winter guidance was issued on 27th July 2023.

- The letter set out our national approach to 2023/24 winter planning, and the key steps we must take together, across all parts of the system, to meet the challenges ahead.

- The two national ambitions for UEC recovery are:

    - **76% of patients** being admitted, transferred, or discharged **within four hours** by March 2024, with further improvement in 2024/25.
    - **Ambulance response times** for Category 2 incidents to **30 minutes on average** over 2023/24, with further improvement in 2024/25.

Winter Incentive

Blackpool Teaching Hospitals
NHS Foundation Trust

While good progress has been made towards achieving our overall ambitions, NHSE want to encourage providers to achieve even better performance over the second half of the year.

- NHSE will therefore be launching an **incentive scheme** for those providers with a **Type 1 A&E department** to overachieve on their planned performance in return for receiving a share of a **£150 million capital fund** in 2024/25.

- NHSE are asking providers to meet two thresholds to secure a share of this money:
  - ✓ Achieving an average of **80% A&E 4-hour performance** over Q4 of 2023/24.
  - ✓ Completing at least **90% of ambulance handovers within 30 minutes** during Q3 and Q4 of 2023/24.

System Leadership

Blackpool Teaching Hospitals
NHS Foundation Trust

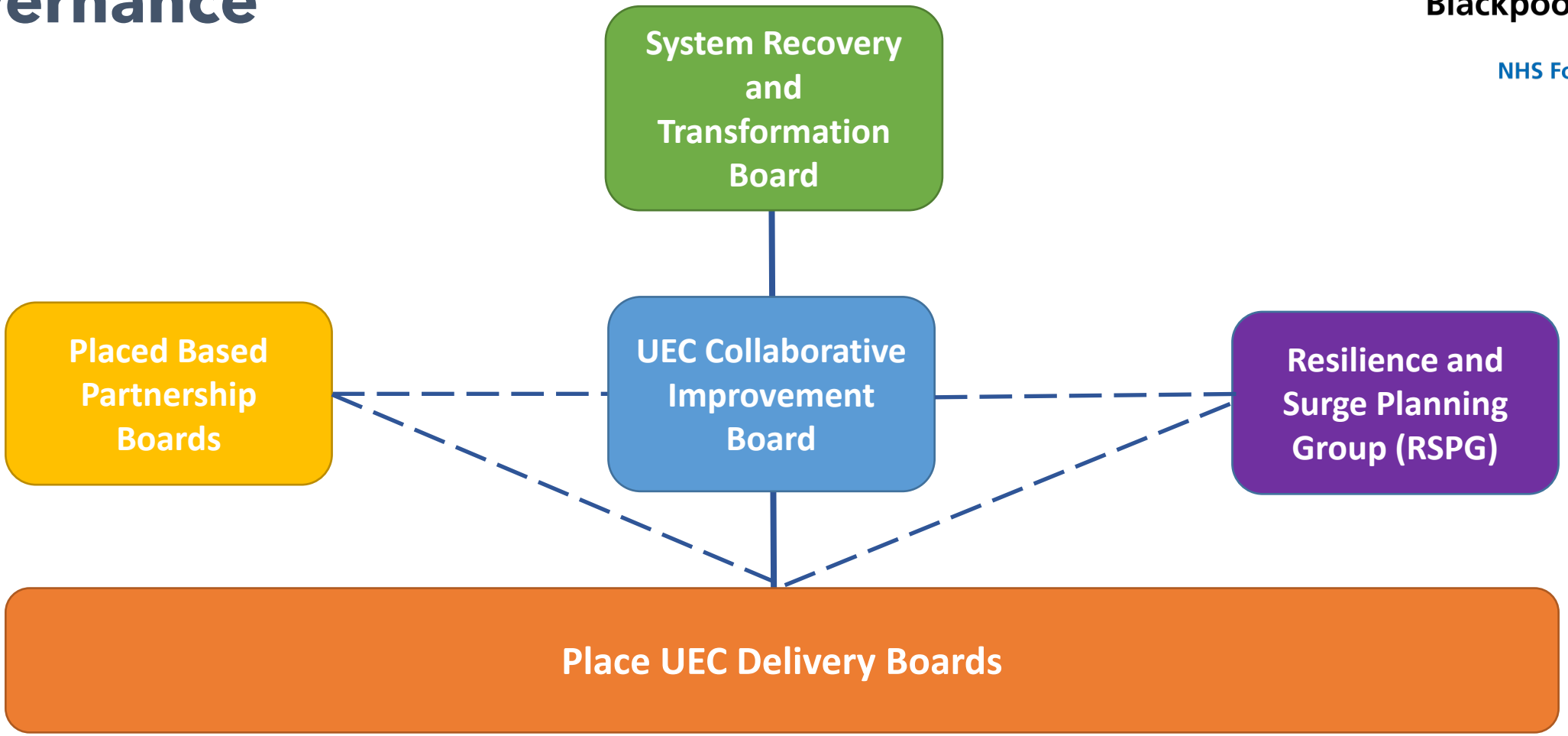
- NHSE are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients.

- ICBs will play a vital role in system leadership as the actions we need to take extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

- ICB are coordinating planning against NHSE **four areas of focus** for systems to help prepare for winter:
  - Continue to deliver on the UEC Recovery Plan by **ensuring system wide high-impact interventions are in place**
  - Completing **operational and surge planning** to prepare for different winter scenarios
  - ICBs should ensure **effective system working** across all parts of the system
  - **Supporting our workforce** to deliver over winter

Governance

Blackpool Teaching Hospitals
NHS Foundation Trust



Ten High Impact Interventions

In hospital (acute Trusts lead the delivery of high-impact interventions)

1. Same day emergency care
2. Acute Frailty services
3. Acute hospital flow – ward processes
4. Community bed productivity and flow
5. Care Transfer Hubs

Out of Hospital (ICB lead the delivery of high-impact interventions)

1. Intermediate care demand and capacity
2. Virtual wards
3. Urgent community response
4. Single point of access (SPOA)
5. Acute respiratory infection hubs

Trust Position

Blackpool Teaching Hospitals NHS Foundation Trust

- A Trust Winter Planning Task & Finish group was established reporting into the **Place UEC Delivery Board**

- This Task & Finish Group is chaired by the **Director of Operations & Performance** and is reviewing **capacity & demand** to agree and implement the **key priority schemes**. These schemes are broken down into three specific categories:

  1. **Service improvement** (medium risk, no funding necessary)
  2. **Planned service development** (medium risk, funding confirmed)
  3. **Escalation arrangements to rapidly boost capacity** (high risk, funding not in place)

- The operational and financial planning assumes **non-implementation of category 3 schemes.** This assumption is highly reliant on **Out of Hospital high impact interventions being delivered** as a critical interdependency of any Trust winter plan. For example, the planning assumes that only **5% of patients** who no longer meet **criteria to reside** will occupy a hospital bed at any given period over Winter (currently ranges between 7% and 13%).

High level overview of ‘In Hospital High Impact Interventions’

Acute Trusts lead the delivery of high-impact interventions 1- 5

Blackpool Teaching Hospitals
NHS Foundation Trust

HIA 1 - Same Day Emergency Care (SDEC)

Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.

Assessment:

The current operating model for BTH is that SDEC runs from 8am to 12am, 7 days per week. The current model sees on average, 350 patients per week with a 17% conversion rate. The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to be admitted to an inpatient ward. The winter plan assumes pathways into SDEC would be supported by the Rapid Response team to ensure that patients who could be managed in community are streamed away from the acute hospital setting. Also all SDEC GP Referrals will be triaged for Virtual Ward/Rapid Response in the first instance.

HIA 2 - Frailty

Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.

Assessment:

The current Acute Frailty model within BTH is limited due to the footprint and staffing for the area. It is essential that frail older people receive care by a team of professionals competent to assess and manage their individual needs. Early diagnosis and treatment will minimise time in an acute hospital while maintaining functional status or giving the best chance of restoration of function. Early identification of patients with frailty syndromes at the time of proposed admission is essential so that assessment is not delayed. Best practice is to deploy acute frailty teams at the front of the hospital pathway to identify patients with frailty. The current model shows that 13% of frail patients have a LOS greater than 21 days (bottom quartile performance when comparing to peers). The BTH winter plan assumes delivery of an enhanced Acute Frailty Unit which will deliver early comprehensive geriatric assessment with an intention to minimise length of stay in an acute setting.

HIA 3 - Inpatient flow and length of stay (acute):
Reducing variation in inpatient care and length of stay bringing forward discharge processes for pathway 0 patients.

Assessment:
The Trust needs to move at pace the improvement work stream that is focused on standardising ward processes to minimise variation between individual clinicians and between clinical teams. The Trust has commenced implementation of the SAFER patient flow bundle which includes introducing a daily, early morning board rounds enabling teams to rapidly assess the progress of every patient in every bed and address any delays and obstacles to treatment or discharge. The Trust has *exemplar wards* delivering the SAFER approach but its not standard practice. The ambition is to roll out SAFER across all inpatient ward areas, with an aim to improve morning discharges. This will allow new patients to be admitted early enough to be properly assessed and for their treatment plan to be commenced. The aim should be for at least 30% of the day's discharges to have left their wards by midday. This requires teams to priorities activities associated with discharge.

HIA 4 - Community flow

Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.

Assessment:

An MDT admission avoidance team will work through the winter period to support the emergency department and help to keep patients safely managed in community. Utilising the current workforce from the TOCH (Both Local Authorities), IAT, and Community Teams (RAPID Response, virtual wards), the MDT will design and implement agreed pathways to reduce admissions to the acute site. The winter period will also see the introduction of a Community Adults Manager of the Day (CAMoD) role to oversee the implementation of a Community Services escalation action card which will include virtual review of patients within the ED by the Community IV Therapy team, in addition to virtual or in person in-reach to ED from the Rapid Response team to support the optimised utilisation of established community pathways.

As part of the BTH Winter Plan, there will be a planned increase in system wide MADE events across the site with additional LOS reviews locally to support. In addition, 'perfect week' approaches in the run up to Christmas will be planned with the aim of reducing occupancy ahead of January.

HIA 5 - Care Transfer Hubs

Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.

Assessment:

BTH have a fully functioning Transfer of Care Hub that employs over 70 Health Staff plus full team contingents from both our Local Authority Social Services that are co-located. Within this we include a fully inclusive MDT approach to Triage and pathway determination for all (adult) patients referred for consideration for pathway 1, 2 and 3. We have on-site service staff from both British Red Cross and Age UK that provide practical support to enable discharges.

Most of the Trusts Pathway 1 discharges are facilitated via 'Homesfirst Service' and this is managed via ToCH and has direct access with both Social Services resources in terms of commissioned care. The timescales for this pathway have improved since the service start-up and we are regularly within 24-hour turnaround.

Pathway 2 rehabilitation is jointly provided at the Trusts Rehab unit (Clifton) but also direct access is available to the Council run intermediate care facilities in both localities. Pathway 2 'Discharge to assess' is an ICB and local authority led service.

ED Refurbishment Update

Blackpool Teaching Hospitals NHS Foundation Trust

- Final phase of a 2 year ED refurbishment has commenced. The capital development will move the department from 22 adult majors' cubicles to 32, in line with GIRFT requirements.
- The ED refurbishment is due for completion by mid December 2023.
- Whilst the final phase of the A&E refurbishment doesn't reduce the current physical adult majors' capacity (22) the configuration of the dept. has changed.

Next Steps and Timescales

- Winter Planning Task & Finish Group continue progress of Trust Winter plan for formal approval at Trust Board of Directors in October 2023. At this time the Trust Board of Directors will gain oversight on ICB / Place planning.

- The Trust to present Winter Plan at Place UEC Delivery Board in October. The Trust expects to have sight on Place / Partner arrangements to support system-wide

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Workforce Assurance Committee Escalation Report

Meeting:	Board of Directors in Public
Date:	7 September 2023

Author	Esther Steel, Director of Corporate Governance					
Exec Sponsor	Carl Fitzsimons, Non-Executive Director (Committee Chair)					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** To update the Board on alerts, assurance and advise content, discussed at the Workforce Assurance Committees on 19 July 2023.

Implications *(so what)*	**Alert** There was one item for escalation to the Board of Directors as an alert:- • Bank and Agency Tracker report - no reduction in agency spend in Q1 2023/24 and over budget. **Assure** There were two items highlighted for assurance purposes:- • Health and Wellbeing Report • Guardian of Safe Working Report

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	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 Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	**Report to:**	Board of Directors Meeting
Date of Meeting:	19th July 2023	**Date of next meeting:**	16.08.23 Workshop
Chair:	Carl Fitzsimons	**Parent Committee:**	

Introduction

Quorate meeting in person with one member on Teams.

Alert

What	So What	What Next
Bank and Agency Tracker New report received giving detailed breakdown of month by month bank and agency expenditure from April 2019 In the first quarter of 2023/24 there has not been a reduction in the agency spend and this is currently over budget.	Committee members discussed the optimal way to utilise the data in the report and requested that the monthly budget against the monthly actual spend be included in the report for the next meeting	A similar report has been requested on staffing numbers, showing the required establishment against the predicted numbers and the actual numbers.

Assurance

What	So What	What Next
Health and Wellbeing Report Update provided on the progress and impact of the Health and Wellbeing action plan	The members were pleased to see the programs are having an impact and tackled issues staff members face that are often overlooked.	Further definition of the targets were requested in the next report.
Guardian of Safe Working Report The GoSW reported there have been vast improvements in the identified hot spots and the recruitment drive for middle grade has made a large difference alongside education and better hand-over processes, although there is always room for further improvements.	Committee members agreed that improving the culture, training and processes is as essential as recruitment to retain staff members to ensure a healthy and safe establishment for staff members and patients.	The GoSW advised that after five years he will be advancing to the role of Associate Director for Wellbeing and Development within the Trust and a new GoSW will be appointed.

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Advise		
What	**So What**	**What Next**
Staff Story Robert Joseph Yusay, a Theatre Practitioner in cardiac theatres and the Cultural Diversity Network Lead attended the meeting to share his insights of Cultural Diversity within the Trust. He described mixed experiences with good support from his immediate team but he had experienced a verbal racist attack on his first day walking in the town centre	• There can be a divide between local and international staff due to cultural differences and unintentional offence can occur. • There were ten other members of the team from the Philippines, and they continue to support each other. • The International programme has improved since 2021 and is now performing more reviews and immersion into departments is more controlled.	Workshops with international staff members to be arranged to explore how to improve international staff members' experiences in the Trust and within the community.
Workforce Integrated Performance Report (IPR) Key workforce metrics presented for discussion and assurance with the following points noted: • There is no longer access to the Resilience Hub for anxiety, stress and depression. This has been escalated to the ICB and has been highlighted as part of the collaborative approach and work is ongoing for an interim solution. • There is a disparity between trusts occupational health services and some of the trusts are seeing the corporate collaborative as levelling down. • The reason turnover has decreased, and vacancy rates have increased is multi-faceted due to the Build-Back process, review of establishments, approval of business cases, and the review of the Quality, Efficiency and Productivity Programme (QEP).	The members discussed the adaptation turnover rate and concurred that it is a complex issue to report, because adaptation staff can have a very positive experience at the Trust, but need to leave the Trust to complete their training and may return once qualified. However, there is value in monitoring it and the committee having oversight.	Work is ongoing refining the metrics for the future. The Deputy Director of People and Culture and the Executive Director of Nursing, midwifery, AHPs and Quality will bring an Adaptation Turnover Report to a future committee.
Workforce Planning The Deputy Director of People and Culture encapsulated the key points from the June 2023 NHS Long-Term Work Plan and advised there will be funding until 2028.	The NHS Long-Term Work Plan will be refreshed every two years and it is a high-level plan that the Trust has begun working through to develop at the local level and it will be incorporated into the Trust's Workforce Planning Framework	It was felt that the Trust has a lot of cultural work to do in recognising skill sets as opposed to roles, and the Trust does need to drive forward with the concept.

The focus of the plan is integrated care systems and increasing education, training, apprenticeships, opportunities, alternative routes, and retention to increase the supply of qualified staff members to meet the demand and growth in population.		
Multi-professional Educational Governance Committee Escalation Report (MEG) Four alerts included in the report: Due to the national expansion of Undergraduate medical placements a request to take 25% more students was made from Liverpool HEI. Lancaster has also approached the trust to increase numbers. Concerns were raised that Apprentices now need to go through the vacancy panel. Work experience placements being organised outside of the work experience team. Difficult in recruiting qualified Librarians for the service. Currently, three vacancies in the team which is impacting service delivery.		Work is ongoing to resolve these issues and a report will continue to come to the Workforce Assurance Committee.
Other agenda items		
Medical Appraisal and Revalidation Report – was noted and members were assured that the Trust remains compliant with the Responsible Officer Regulations. Future Workshop Plans – Members were asked to review and comment back to the Corporate Governance Team. Board Assurance Framework – Members were asked to review and comment back to the Deputy Director of People and Culture.		

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Workforce Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	7/09/2023

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)*	**Advise** Workforce Performance Core Skills 91.7% against a target of 95% Appraisal 81% against a target of 90% Sickness Absence 5.78% (June) 6.53% (rolling 12 months)

Implications *(so what)*	**Alert** Slight increase in Sickness Absence **Assure** We have seen improvement in Core Skills and Appraisal workforce indicators as well as maintaining under 6% for the month of June

Previously considered by	N/A

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	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

July 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			4	6	4	

Assurance

Measures the likelyhood of targets being met for this indicator.

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

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 July 2023 was 91.7%, a slight increase from June 2023 (91.5%). This is against a target of 95%
• Two out of five clinical divisions have increased compliance with the biggest improvement the Tertiary Division.
• When role specific training is included, compliance decreases to 91.54. Since the start of the financial year, compliance for role specific and CSTF training has increased by 3.5%
• It is encouraging to see that when role specific training is added compliance of all 5 clinical divisions has increased
• Compliance with core skills training is monitored monthly at the divisional PIDA meetings and appropriate action plans implemented
• The Trust has realigned its Core Skills programme to the national CSTF. This means that the medical workforce are now required to complete M&H refresher training every 2 years instead of every 3 years. This information will be reported in August's IPR

Advise

• Attendance at M&H L2 practical training has been lower than expected and this is possibly to how the training is communicanted. A review of the communication plan is being undertaken to help increase training uptake
• A new member of staff has been recruited to the Health & Safety Team, who will, as part of their role deliver practical Conflict Resolution training.
• The medical workforce have 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
• 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 was discussed at the last CSTF Steering group in an attempt to reduce the waiting list (currently 5141 members of staff are allocated the training, with 2758 non-compliant). The Head of Quality Governance agreed to review the risks around removing training from certain roles and will feedback at the next meeting in July.

Alert

• Medical workforce compliance for M&H level 2 training will reduce when the ESR team make the changes to the system. This will be included in August 2023 compliance reports.
• 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

Non-Medical Appraisals compliance

Assure

• Non-medical appraisal compliance is currently at 81%, with a target of 90%. This is a positive increase from June 2023 (74.5%)
• All clinical divisions have seen an increase in non-medical appraisal compliance levels:
• CSS - 68%-73% | Tertiary - 81% - 90% | FICC - 79% - 87% | SACCT –81%-88.17% | IMPF –75%-82%
• Positive feedback has been received with regards to the new system.
• I've got to say I've worked with many appraisal systems and the new one is much improved, great work to those involved, not only the ease of the system, but the messaging and language on there. Well done. (Team's brief chat – 7th August)
• Just gone onto the appraisals and wow, I'm blown away, you have done a great job. Other people in the service have said how much better it is (Email to OD)

Advise

• New streamlined appraisal system was launched on 19 June 2023
• There is an appraisal guide on the appraisal system and help on completing each section.
• Initial feedback from staff about the new system is really positive
• Requests to attend the training is increasing, and additional appraisal training dates are being arranged.
• Documents on the appraisal system are being re-designed with support from our neurodivergent colleagues to ensure that the appraisal system is inclusive and meets the needs of all members of the workforce

Alert

• There may be a reduction in compliance levels during the transition from the old appraisal system to the new appraisal system
• There are a small number of appraisal system 'technical glitches', which are being resolved. The fixes are due to be completed before the end of August

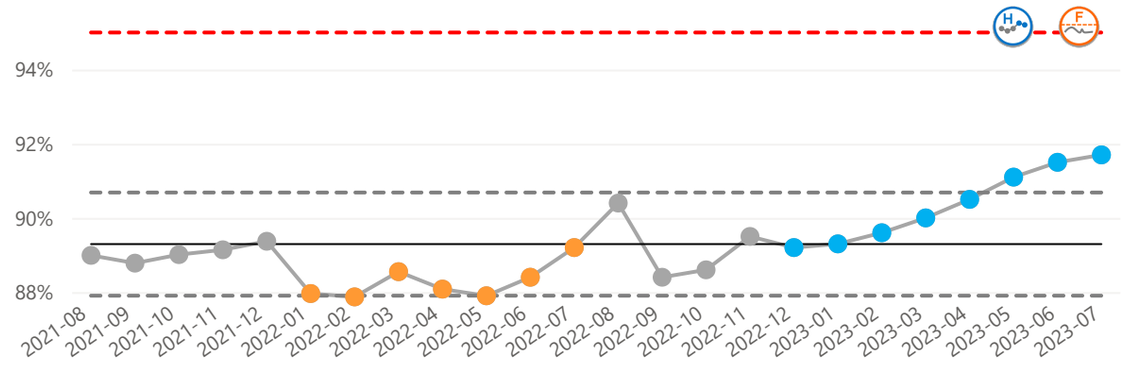
Workforce

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Core Skills Training Compliance %	95%	91.7%	Jul 23			95%	91.5%	Jun 23		
Data Security & Awareness Training (%)	95%	93.2%	Jul 23			95%	94.5%	Jun 23	95%	93.2%
Appraisal Completeness %	90%	71%	Jul 23			90%	75.5%	Jun 23		

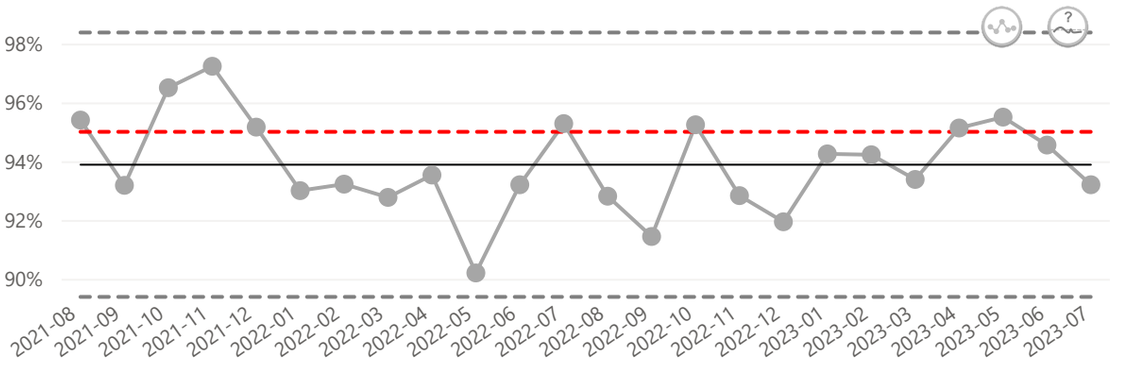
Indicator	2017-04	2018-04	2019-04	2020-04	2021-04	2022-04
Staff Survey - Care of my patients / service users is my organisations top priority	72.40%	72.70%	73.80%	78.70%	77.20%	74.00%
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	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

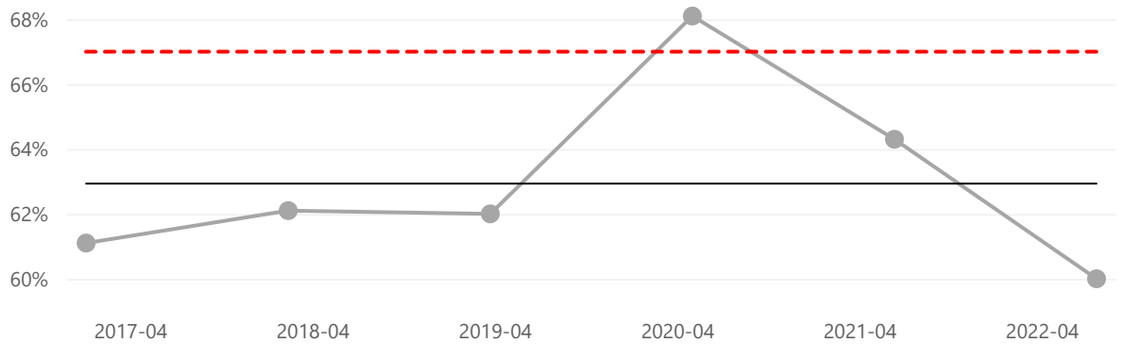
Core Skills Training Compliance %



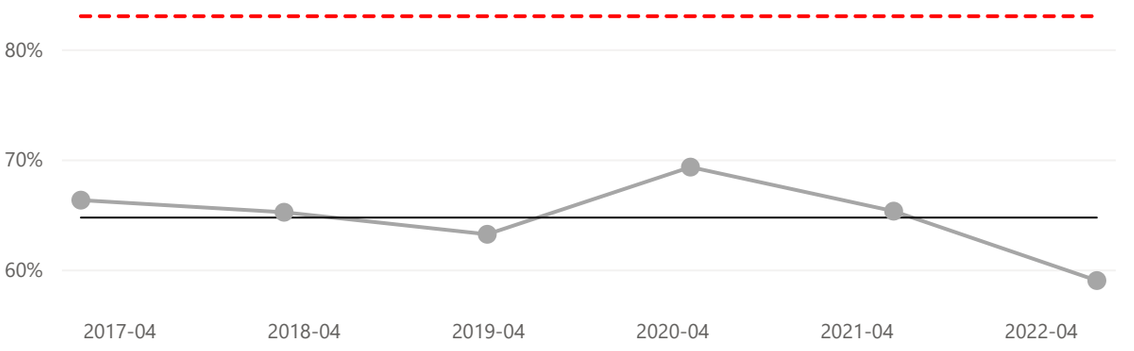
Data Security & Awareness Training (%)



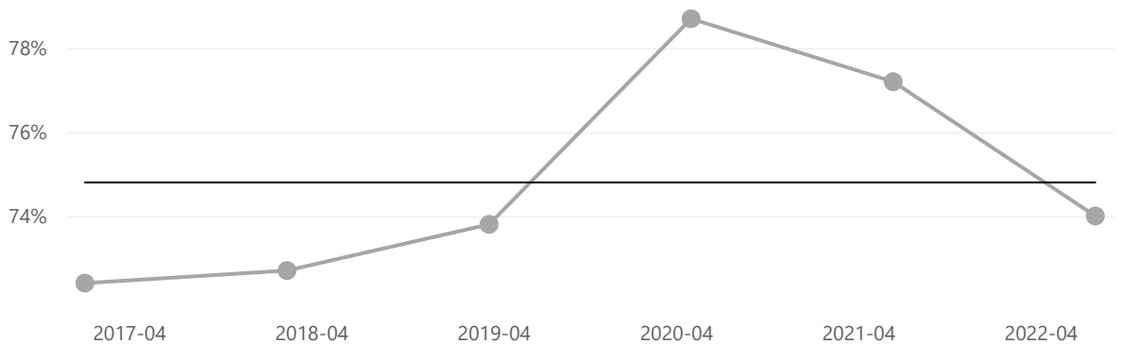
Staff Survey - I would recommend my organisation as a place to work



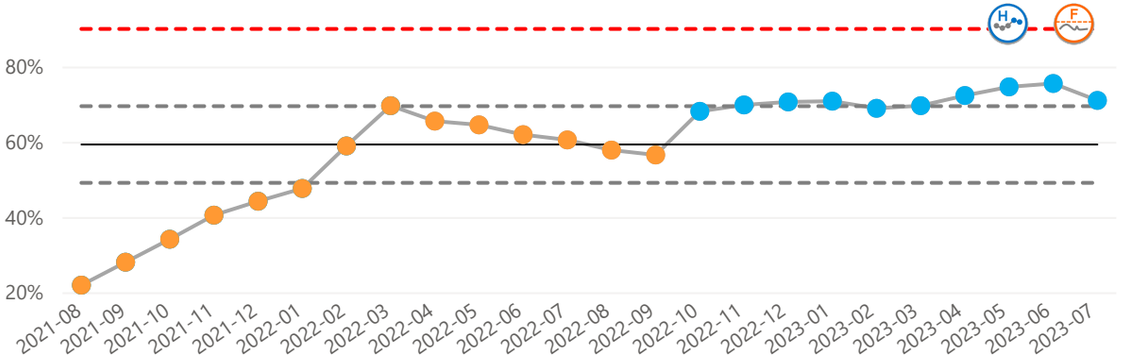
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



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

Vacancy Rate:
Assure: Vacancy rates are not being driven by a lack of recruitment, but by increasing in establishment. Turnover still indicates a strong position for all staff groups
Advise:
• Current vacancy rate for all clinical staff is 8.85% against a target of 4.28%
• Medical vacancy rate has improved between June and July by 2.2% and is now at 16%
• We are working closely with our International Recruitment Partner on sourcing suitable vacancies with 7 appointments so far
• MRR Focus in September will be on recruitment activity and agency spend
• Our Agency Partner retinue are continuing to move placements to Direct Engagement to achieve VAT saving, with currently 88% of medical staff on DE
• Nursing vacancy rate has improved marginally between June and July and is now 9.53%
Alert:
• Current recruitment trajectories for Nursing show the gap closing by October 2023
• Current recruitment trajectories for Medical and Dental continue to show a shortfall until the year end

Turnover
Assure: Turnover rates should continue at their current levels which remains significantly below the 11% target
Advise:
• Medical and Dental Turnover is 8.11%
• There were 5 leavers in July although none were Consultants. 4 Voluntary Resignations – with 3 of those promotions, and 1 relocation. 1 Senior Dental Officer took early retirement.
• Nursing turnover is 5.6%
• There were 13 leavers in July (11.22 wte). 10 of those were retirements, with 5 returning.
Alert: Discussion in September within MRR will focus on Recruitment and Agency spend, but we also need to discuss promotions for our non-consultants

Time to Hire:
Assure: Average time to hire is currently 10.12 weeks against a target of 12 - There has been a slight increase from the previous month but this is due to the preparations and activities for Foundation doctors changeover
Advise: Our time to hire can be impacted by overseas recruitment and this is a core pipeline for medical and dental and nursing
Alert: Time to hire may continue to be impacted by vacancies within the Recruitment Team, and the administration of the Trust and now the ICS Vacancy Panel

Workforce

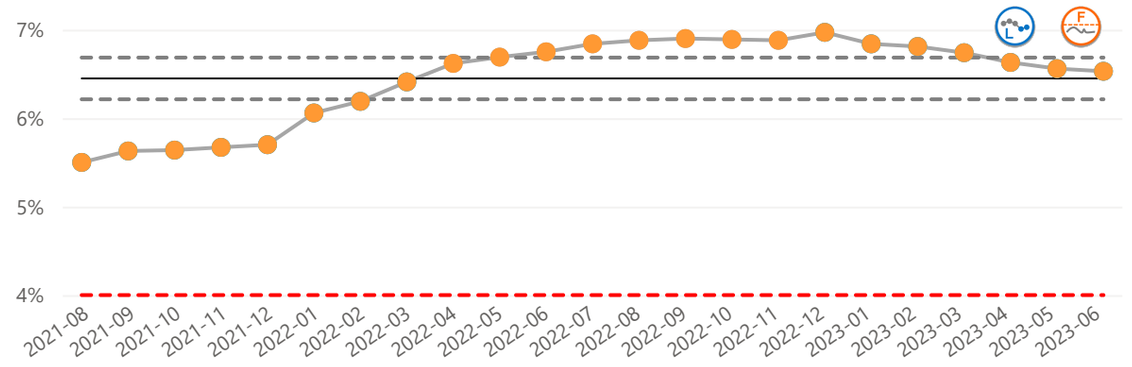
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Sickness % - Rolling 12 Months	4%	6.53%	Jun 23	L	F	4%	6.56%	May 23		
Sickness % - All Staff (In Month)	4%	5.78%	Jun 23		F	4%	5.56%	May 23		
Sickness % - Medical Staff (In Month)	4%	2.72%	Jun 23		?	4%	2.43%	May 23		
Sickness % - Nursing Staff (In Month)	4%	6.18%	Jun 23		F	4%	5.55%	May 23		
Sickness % - AHP (In Month)	4%	4.71%	Jun 23		?	4%	4.2%	May 23		
Sickness % - Not related to Covid 19 Trust (In Month)	4%	5.67%	Jun 23		F	4%	5.23%	May 23		
Turnover % - All Staff (Rolling 12 months)	11%	7.34%	Jul 23	L	P	11%	7.68%	Jun 23		
Turnover % - Nursing & Midwifery (Rolling 12 months)	11%	5.6%	Jul 23	L	P	11%	5.93%	Jun 23		
Turnover % - AHP (Rolling 12 months)	11%	6.58%	Jul 23	L	P	11%	7.59%	Jun 23		
Vacancy Rate % - All Clinical Staff	4.28%	8.85%	Jul 23	H	?	4.28%	8.14%	Jun 23		
Vacancy Rate % - Medical Staff (Excluding Deanery Drs)	4.28%	16.0%	Jul 23	H	F	4.28%	18.2%	Jun 23		
Vacancy Rate % - Nursing & Midwifery Staff	4.28%	9.53%	Jul 23	H	?	4.28%	10.1%	Jun 23		
Vacancy Rate % - AHP	4.28%	15.1%	Jul 23	H	?	4.28%	10.7%	Jun 23		

Workforce

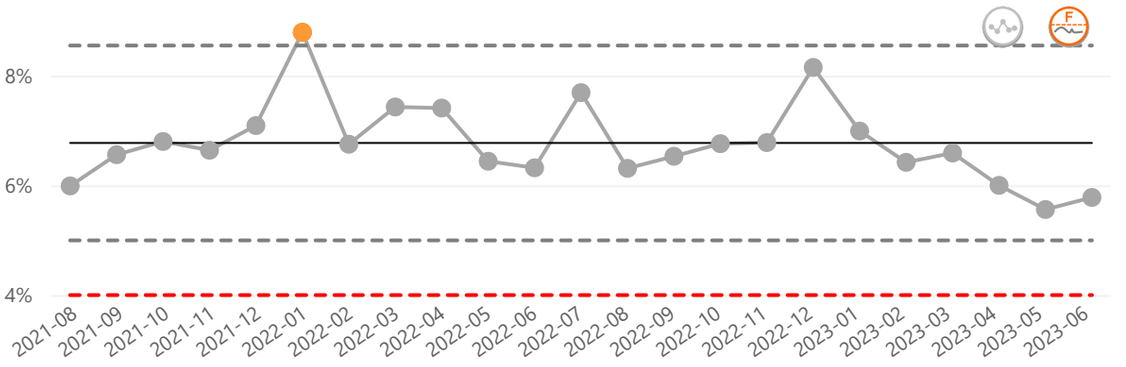
	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Time to Recruit (Weeks)	12	10.12	Jul 23			12	9.63	Jun 23	12	10.12

Workforce

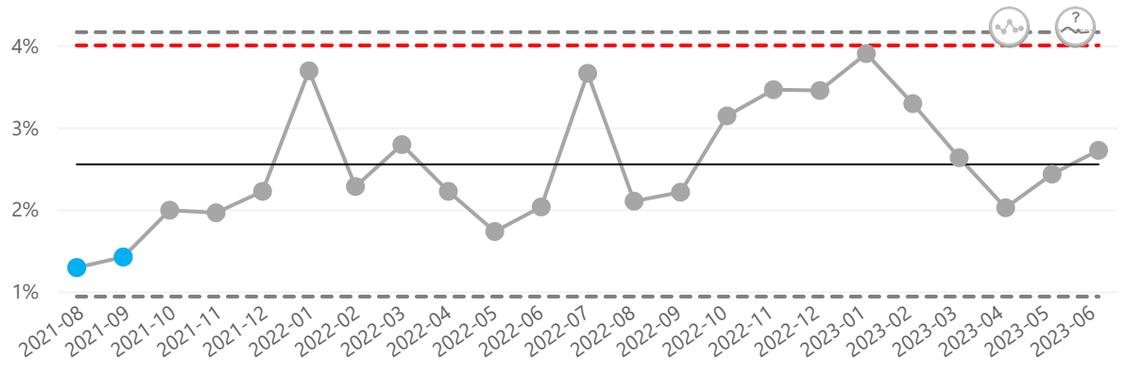
Sickness % - Rolling 12 Months



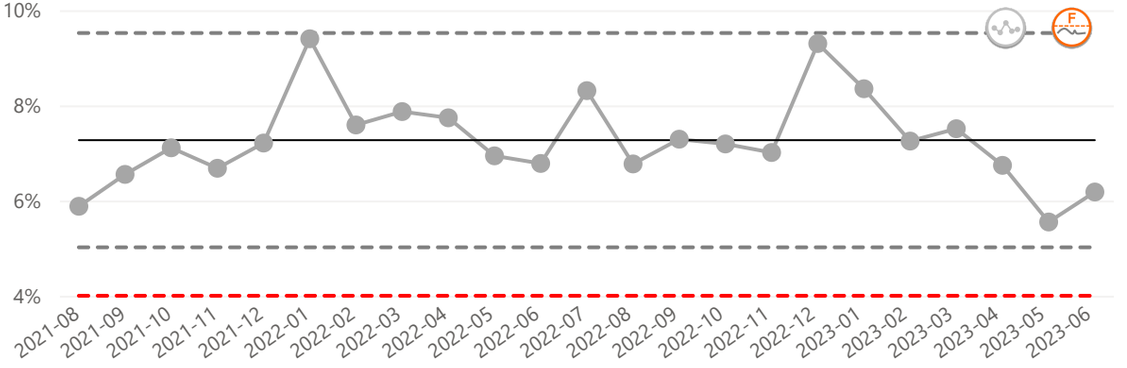
Sickness % - All Staff (In Month)



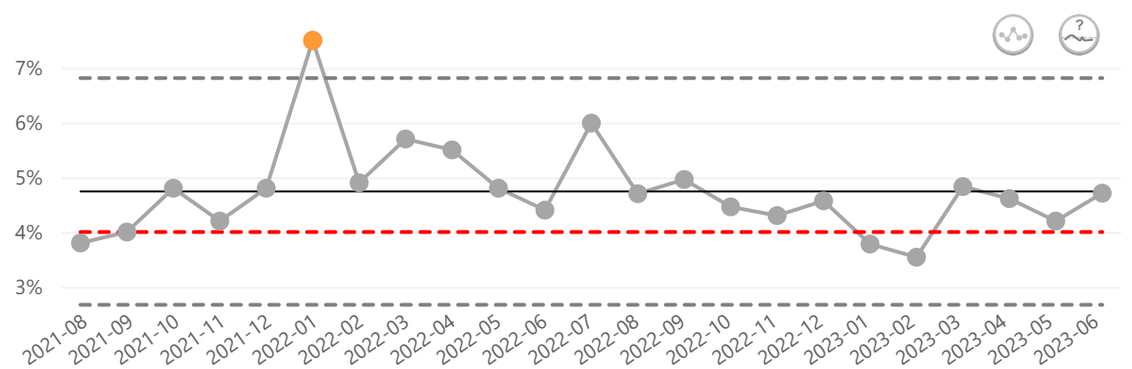
Sickness % - Medical Staff (In Month)



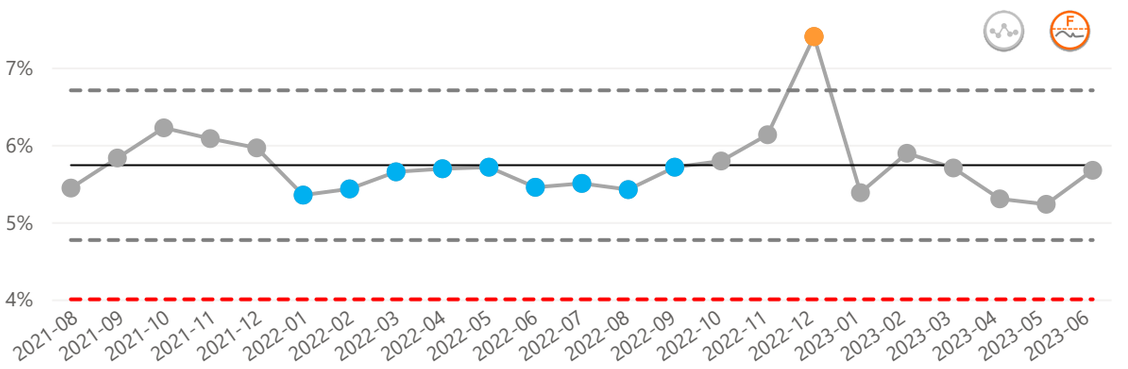
Sickness % - Nursing Staff (In Month)



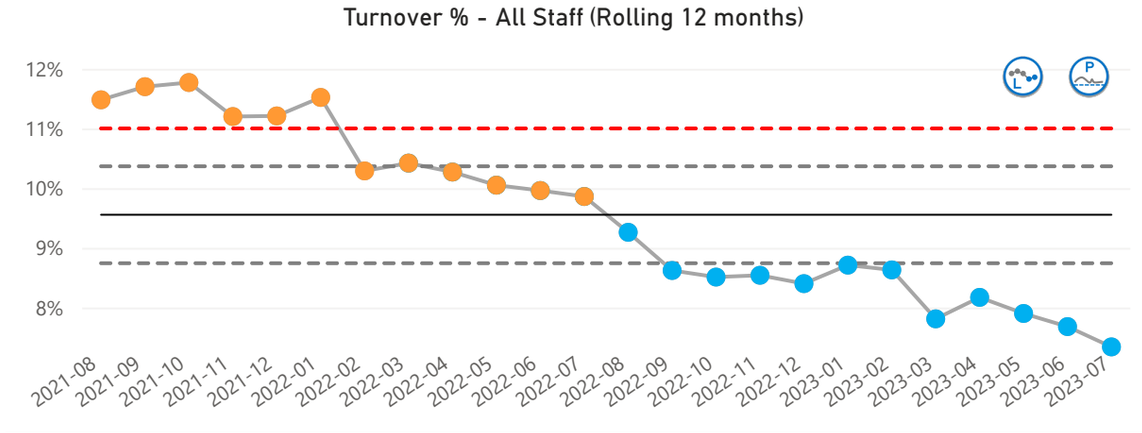
Sickness % - AHP (In Month)

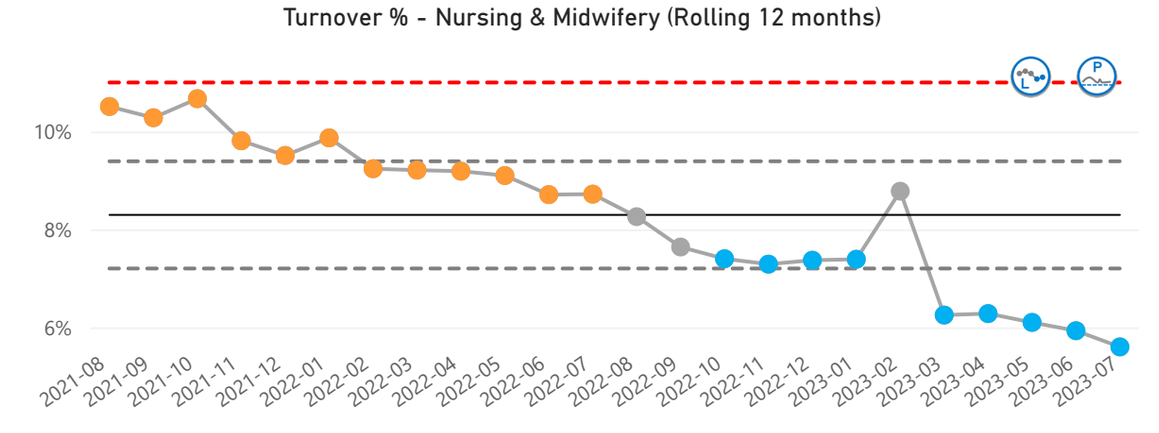


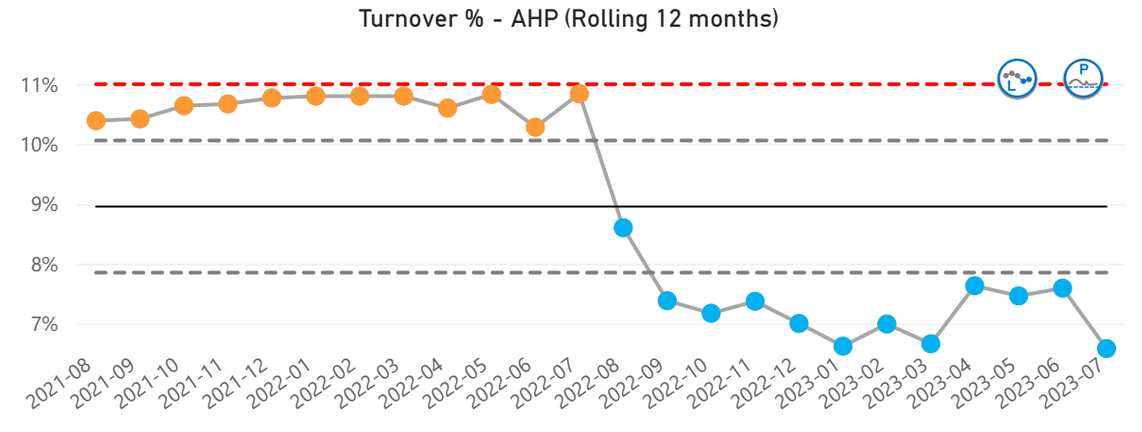
Sickness % - Not related to Covid 19 Trust (In Month)

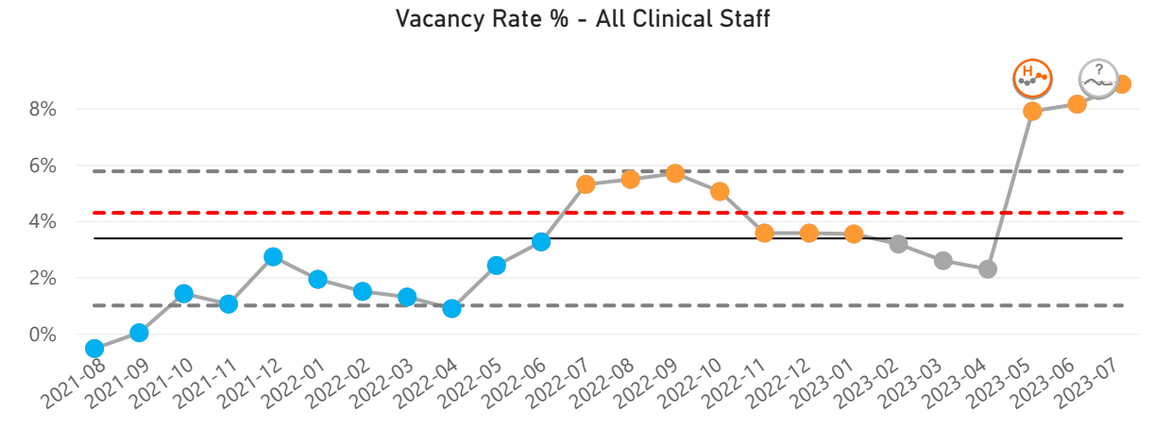


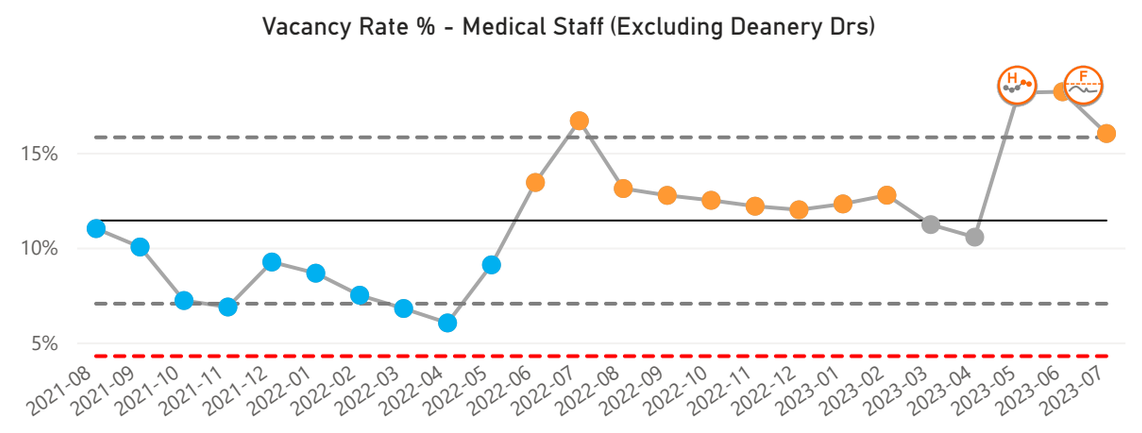
Workforce

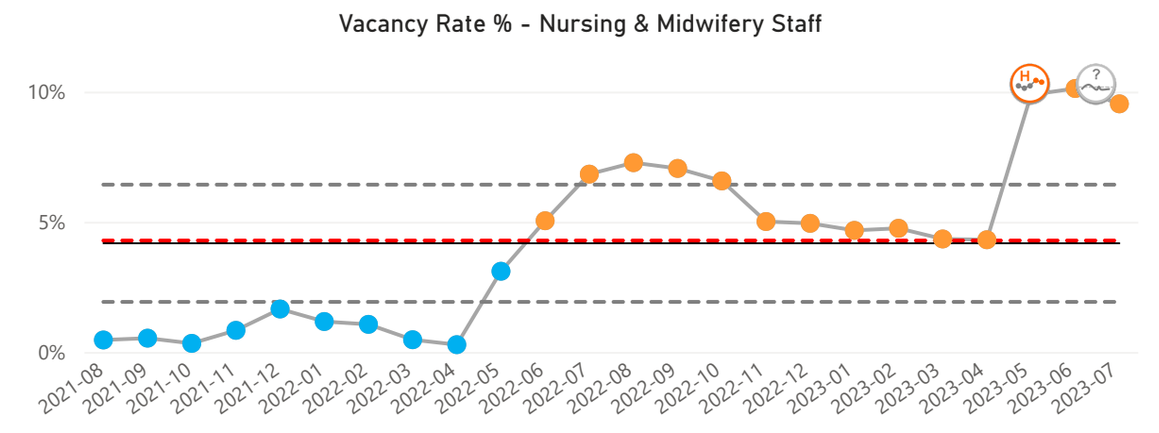

Turnover % - All Staff (Rolling 12 months)
12%
11%
10%
9%
8%
2021-08 2021-09 2021-10 2021-11 2021-12 2022-01 2022-02 2022-03 2022-04 2022-05 2022-06 2022-07 2022-08 2022-09 2022-10 2022-11 2022-12 2023-01 2023-02 2023-03 2023-04 2023-05 2023-06 2023-07


Turnover % - Nursing & Midwifery (Rolling 12 months)
10%
8%
6%
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 2023-06 2023-07

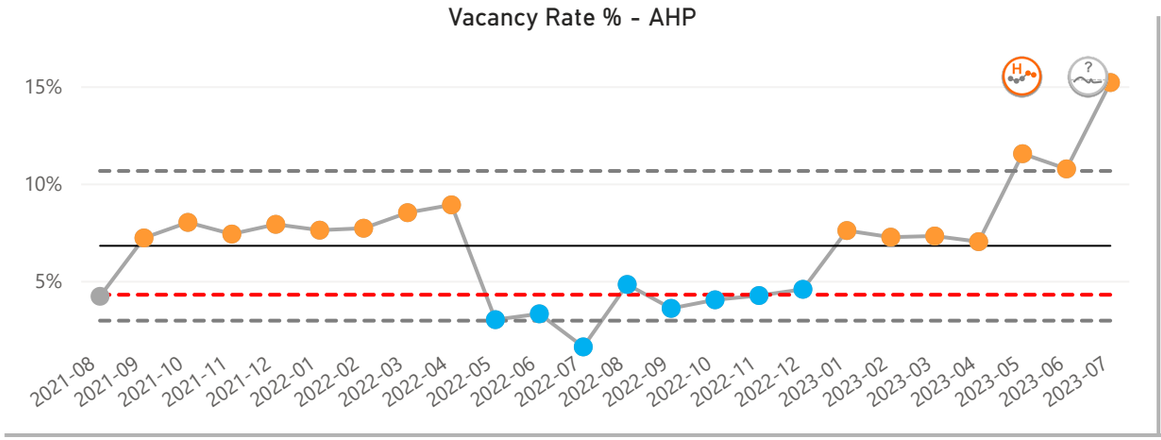

Turnover % - AHP (Rolling 12 months)
11%
10%
9%
8%
7%
2021-08 2021-09 2021-10 2021-11 2021-12 2022-01 2022-02 2022-03 2022-04 2022-05 2022-06 2022-07 2022-08 2022-09 2022-10 2022-11 2022-12 2023-01 2023-02 2023-03 2023-04 2023-05 2023-06 2023-07


Vacancy Rate % - All Clinical Staff
8%
6%
4%
2%
0%
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 2023-06 2023-07


Vacancy Rate % - Medical Staff (Excluding Deanery Drs)
15%
10%
5%
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 2023-06 2023-07


Vacancy Rate % - Nursing & Midwifery Staff
10%
5%
0%
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 2023-06 2023-07

Workforce


Vacancy Rate % - AHP
15%
10%
5%
2021-08
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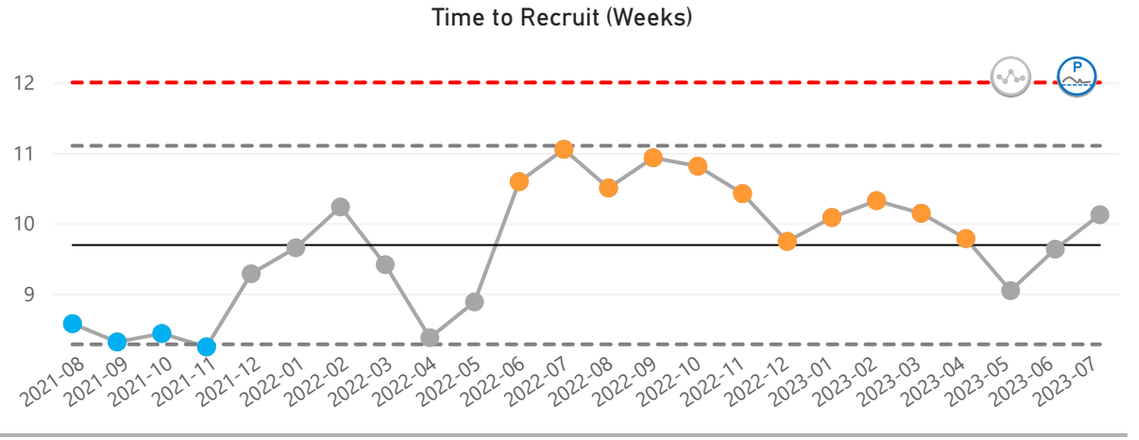
Time to Recruit (Weeks)
12
11
10
9
2021-08
2021-09
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
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2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Freedom to Speak Up Report

Meeting:	Board of Directors
Date:	7th September 2023

Author	Lauren Staveley – Freedom to Speak Up Guardian					
Exec Sponsor	Louise Ludgrove					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** Blackpool Teaching Hospital (BTH) wants anyone within the workplace to be able to speak up and be listened to if they have concern if they have concern. It is important as it will help us to keep improving our services for patients and the working environment for our staff. This report has been developed to advise and assure the Board of Directors regarding the progress made and further work undertaken around the Freedom to Speak Up agenda between **January 2023 to March 2023** (Q4) as well as **April 2023 to June 2023** (Q1). The report contains information on the numbers of staff reporting concerns, emerging themes, actions taken. It also includes an update on the latest news from the National Guardian Office and progress of the FTSU service. A GAP analysis has also been included from the NGO recommendations to the ambulance service.
Implications *(so what)*	**Alert** Having a safe, open, honest, and transparent speak up culture, will encourage staff to speak up without fear of detriment. By addressing concerns raised, it will have an impact on staff feeling able to speak up and in turn provide assurance to the organisation on the services being delivered. **Assure** The Board of Directors are asked to note the: content of the report and receive assurance that when concerns are raised that appropriate action is being taken in a timely manner by the Freedom to speak Up Guardian.

Previously considered by	

Link to strategic objectives	Our People: Embedding a safe, open, honest and transparent speak up culture	
	Our Place: Provide psychological safety for staff to speak up	
	Our Responsibility: To address all concerns raised and identify lessons learnt	

Equality, Diversity and Inclusion (EDI) implications	It is noted that staff from diverse backgrounds face barriers to speaking up. Work is ongoing to identify and remove barriers.

Proposed Resolution ***(What next)***	To continue to raise awareness of FTSU, identify barriers and embed a safe speaking up culture where concerns are listening too and acted upon.

Board of Directors Meeting –

Freedom to Speak Up Report for Q4 22/23 and Q1 23/24

1. Background

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

2. Progress to date

This report has been developed to advise and assure the Board of Directors of progress made and further work undertaken around the Freedom to Speak Up agenda between **January 2023 to March 2023** (Q4) as well as **April 2023 to June 2023** (Q1). The report contains information on the numbers of staff reporting concerns, emerging themes, actions taken and priorities moving forward.

During both quarters the Freedom to Speak up Guardian has been focusing on raising awareness and ensuring when concerns are raised action is being taken. Below is a summary of the key activities that have progressed during each quarter:

Quarter 4 (January 2023 to March 2023) Key Activities

- The development of a new role, the Freedom to Speak Up Advisor, to support the Guardian in the management of the day-to-day caseload;
- A planned and targeted approach of raising awareness of FTSU through attendance at divisional meetings;
- Through Trust governance, approval of the FTSU National Office training for all staff and leaders (level 1 & 2) to be part of mandatory training from the 1st April 2023;
- The FTSU Guardian meeting monthly with monthly with HR colleagues to strengthen partnership working to ensure consistency and alignment.
- The BTH's response to the National Guardian Office's action plan signed off by NHSE;

Quarter 1 (April 2023 to June 2023) Key Activities

- The FTSU advisor was appointed and commenced in role on June 1st 2023.
- The FTSU level1/2/3 training became mandatory and went live on 1st April 2023 and was communicated through local channels to ensure awareness. As of July 2023, 79% of workers have completed this training.
- A FTSU review took place in the Neonatal unit, Clinical Coding and the Hospital Safety Team. This is a targeted approach to spend focused and dedicated time with identified teams to inform a report with findings and recommendations.
- A Standard Operating Procedure was developed and agreed by the Executive Team to ensure that following a FTSU Review, roles and responsibilities are understood and follow up action is taken.
- The BTH Freedom to Speak Up Guardian has been asked NHSE to support new and struggling Trusts in the Midlands to develop and embed the FTSU approach. In addition, The BTH Guardian has been asked to take on the role of mentor for other FTSU Guardians.

The workplan for **Quarter 2 (July 2023 – September 2023)** has been developed and the activities included in this are detailed below:

- Monitor uptake of the FTSU mandatory training and ensure this is promoted through local channels.
- Attendance at Equality, Diversity & Inclusion Network meetings to strengthen relationships with those who may be facing barriers.
- Recruit and train further Champions from across the organisation
- Develop and socialise the communications plan for FTSU month.
- Develop a training programme for managers and leaders on responding to concerns.
- The FTSU Guardian will be leading the Trust's Mediation Service from September 2023 with the aim to ensure impartiality and remove current perceived barriers
- Undertake further FTSU Reviews in targeted and agreed areas.

4. Blackpool Teaching Hospitals Raising Concerns Data

The FTSUG has continued to support staff that raised concerns. This section of the report highlights the numbers of concerns raised between **January 2023 – March 2023** (Q4) and between **April 2023 to June 2023 (Q1)**. It also provides a summary of the themes of concerns raised by the staff.

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

Quarter 4 (January 2023 – March 2023) Concerns Overview

For the period of January 2023 – March 2023 (Q4) a total number of 83 concerns were raised via the Freedom to Speak Up Guardian. This was a another increase from last year.

2022/2023	Q1	Q2	Q3	Q4
Total number of concerns raised	62	56	87	83
Number of those raised anonymously	1	8	11	5
Cases with elements of patient safety/quality	22	18	44	25
Cases related to behaviours including bullying & harassment	51	23	26	47
Cases where people indicate that they are suffering detriment as a result of speaking up	1	0	0	0

Theme	Count
Potential bullying and harassment	46
Work Related Issues	58
Patient Care/Safety	25
Racism	3
HR Issues	4
Sexual Harassment	6

Staff Group	Count
AHP	8
Medical & Dental	11
Nurses & Midwives	27
Admin & Clerical	24
Additional Clinical Services	7
Estates & Ancillary	1
Anonymous	5
External	0

Quarter 1 (April 2023 to June 2023) Concerns Overview

For the period of April 2023 – June 2023 (Q1) a total number of 82 concerns were raised via the Freedom to Speak Up Guardian, this is another increase in comparison to last year's Q1 of 32%.

2023/2024	Q1	Q2	Q3	Q4
Total number of concerns raised	82			
Number of those raised anonymously	2			
Cases with elements of patient safety/quality	14			
Cases related to behaviours including bullying & harassment	46			
Cases where people indicate that they are suffering detriment as a result of speaking up	1			

Theme	Count
Potential bullying and harassment	46
Work Related Issues	47
Patient Care/Safety	14
AFC Banding	3
Annual Leave	2
Racism	2
Temporary Staffing Issues (bench)	2
HR Issues	4
Fraud	1
Sexual Harassment	3
Lack of Training	4

Staff Group	Count
AHP	5
Medical & Dental	3
Nurses & Midwives	29
Admin & Clerical	25
Additional Clinical Services	10
Estates & Ancillary	7
Anonymous	3
External	1

5. Data Overview Summary

The highest number of concern's were linked to work related issues, we have actively supported colleagues in finding resolutions and solutions to their work issues. This has involved (but not limited to):

- The FTSUG attends Healthy Teams MDT weekly to work collaboratively to address concerns that are raised in terms of what intervention is best for each individual team, whether that be TED tool, team engagement sessions, trauma/psychological support etc.

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

- Staff are also encouraged to raise concerns to management if feel able to do so.

- The FTSU Guardian works closely with the Senior HR Team, Occupational Health and Wellbeing team and is working with our Union colleagues to address some of the concerns raised.

All of these interventions provide a more collective approach to ensuring that staff are supported and that there are systems and policy in place to assist staff.

6. National Update

This year's FTSU month theme has been launched ahead of October and is titled; **'Breaking FTSU Barriers'.** A communications plan is currently underway and the FTSUG will link in with diverse networks, FTSU champions and the ED&I lead.

In addition, the National Guardian has responded to NHSE's publication of the Fit and Proper person test framework for board members and stated: '' "It recognises the negative consequences of defensive leaders who victimise people who speak up, and ensures processes so that this behaviour can be held to account. Victimising people who speak up has a serious impact on patient safety, and creates an environment of silence and fear.''

7. Conclusion

A total of eighty-three concerns were raised during Q4 2023 and eighty-two concerns raised in Q1 2023. The trend around types of concern has remained consistent with the 'potential of bullying and harassment' and 'work related issues' being the most common reason for staff speaking up. All concerns raised are escalated to the relevant level of management and actions are put in place to address these concerns which are audited to ensure concerns are being taken listened and responded to.

Work has been ongoing to improve the visibility of the service and to encourage staff to speak up and speak out.

8. Recommendations

The Board of Directors are asked to:

8.1 Note the content of the report and receive assurance that when concerns are raised that appropriate action is being taken in a timely manner from the FTSUG.

8.2 To ensure the service us understood the board are asked to encourage and promote to staff the need to complete mandatory training and support colleagues to attend management training where appropriate.

NGO CASE REVIEW FOR THE AMBULANCE SERVICE: PUBLISHED MARCH 2023.

BTH GAP ANALYSIS COMPLETED AUGUST 2023 by Lauren Staveley (FTSU Guardian)

Review Findings and Comments	BTH Gap Analysis
1. Review broader culture matters in NHS Ambulance Trusts NGO recommends an independent cultural review to consider the following: • Management and leadership behaviours and focus on worker wellbeing • Effectiveness of governance/leadership structure given the complex geographical footprint of ambulance trusts • Models of leadership • Defensiveness and 'Just' culture • Fair and open values-based recruitment • Operational and workforce pressure • Bullying & Harassment • Discrimination • Working with other organisations to share good practice • Action plan to be developed	**The trust is compliant with this finding although work is ongoing** • Healthy Teams MDT established with identified work streams including Action Planning for teams in difficulty • Workplace harassment survey launched in June 2023 • Real world HR working across the organisation • FTSU reviews being undertaken across the organisation to help with psychology safety in speaking up and assurance concerns are being listened too
2. Making 'Speaking Up' business as usual • Mandate training on speaking up - in line with guidance from the National Guardian's Office - for all their workers, including volunteers, bank and agency staff, as well as senior leaders and board members. • Ambulance trust leadership (including managers, senior leaders and board members) to fully engage with Freedom to Speak Up, evidenced by board members undertaking development sessions, delivered by the National Guardian's Office, with a view to role model effective speaking up, including purposefully providing and seeking feedback in the carrying out of their leadership roles. • Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and Freedom to Speak Up guardians across ambulance trusts through regular communications. Trust leadership teams should identify the professional groups/areas within the trust that need support in implementing Freedom to Speak up by diagnosing root causes and	**The Trust has mandated FTSU training since April 2023** • Trust has mandated speaking up training in line with NGO guidance. • Board development sessions are held and self-assessment tool was completed in October 2022 • FTSU Guardian and Comms have regular meetings and an active comms plan • FTSU Guardian identifies 'hot spots' and shares information with HR/OD so they can support and provide interventions • Work ongoing as to how to annually evaluate effectiveness of speaking up arrangements • FTSU Guardian attends regional and national meetings for networking and to share good practice/access latest recommendations etc • FTSUG undertakes FTSU reviews, proactively and reactively • FTSUG attend consultant leadership programmes • FTSUG meets with NHSEI monthly

putting in place a support mechanism for managers and workers to feel psychologically safe when speaking up and reduce detriment. • Ambulance Trust Boards to annually evaluate the effectiveness of speaking up arrangements; including effectiveness of facilitating all workers, including those from groups facing barriers to speaking up, being able to speak up about all types of issues and action being taken in response to speaking up. Trust boards will report on this evaluation publicly in their annual reports. • Working with the Care Quality Commission, NHS England and others to promote the impact of effective speaking up culture and arrangements. • Working with partners, including NHS England, NHS Providers, NHS Employers, and the Association of Ambulance Chief Executives, to facilitate networking and the sharing of good practice, innovation, policy and research in the field of speaking up among non-executive directors, including those on the boards of ambulance trusts	
3. Effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts This recommendation requires the Care Quality Commission and NHS England to: • Ensure workers' voices are effectively captured and reflected in regulators' decisions when reviewing their frameworks and treated with parity to those of patients' voice. • Implement mandatory and regular training on speaking up - in line with guidance from the National Guardian's Office - for all workers (including senior leaders) involved in the regulation, inspection, and improvement support of ambulance trusts. • Make assessment of the speaking up culture and arrangements a cornerstone of their regulatory and oversight frameworks, recognising that the safety of patients and the public - as well as the sustainability of the health service - depends on workers' ability to speak up and for regulators to listen and follow up when they do.	**This recommendation is for CQC and NHS England**

• The Care Quality Commission to continue to improve their inspection methodology around the rigorous assessment of speak up culture and psychological safety. • Communication and partnership working among national bodies to share information about speaking up culture and arrangements. The National Guardian's Office commits to the following: • Support training for NHS England and the Care Quality Commission workers on speaking up. • Leading the collaboration with partners including the Department of Health and Social Care, the Care Quality Commission and NHS England. • Working with NHS England and the Care Quality Commission to strengthen their approach to addressing detriment.	
4. **Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers** This recommendation requires **all ambulance trusts** to: • Meaningfully invest in the Freedom to Speak Up Guardian role. In discussion with their Freedom to Speak Up Guardian(s), leaders should identify the time and resources needed to meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions and board plans for implementing Freedom to Speak Up roles should be clear on resource implications and set realistic timescales. • The National Guardian's Office suggests that as a minimum, the equivalent to three full-time workers is needed to carry out the reactive and proactive parts of the Freedom to Speak Up Guardian role in ambulance trusts. This is because of the characteristics of ambulance trusts, including their complex geographical footprint, and broader cultural and operational issues. The National Guardian's Office and NHS England will support, review and challenge the rationale arrived at by	**The Trust is compliant with this recommendation** • Reviewed time and resource for FTSU Guardian role – additional support recruited to the service in June 2023 (band 5 FTSU advisor) **For reference- NWAS has 7,100 employee's and BTH have 8,500** • Guardian was appointed through open and fair recruitment process in June 2022 • 43 FTSU champions have successfully been recruit over last 12 months and FTSU Network is established and running • FTSU Guardian has regular access to psychological supervision, also used regional peer support network

ambulance trusts about how much time is allocated to the role. • The recruitment process used for the appointment of Freedom to Speak Up guardians must be fair, open and transparent and comply with current good practice in recruitment and equality, diversity, inclusion and belonging principles. This will help ensure that people appointed have the confidence of, and are representative of, the workers they support. • Create (if not already in place), maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up. Consideration to the organisation's size, geographical footprint and the nature of their work should be given to ensure support for workers, especially those facing barriers to speaking up. • Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s). This support should reflect the challenges of the role and ensure the need for confidentiality. There should also be periodic check-ins with Freedom to Speak Up Guardian(s) about the effectiveness of this support. The National Guardian's Office commits to the following: • Support ambulance trusts and NHS England in determining the amount of time and resources needed. • Review the feedback we received about the support the National Guardian's Office provides Freedom to Speak Up guardians, including review of the universal job description for Freedom to Speak Up guardians. • Publicising guidance to assist in the calculation time and resources needed to carry out the role.	

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Delivering the EDI Improvement Plan

Meeting:	Board of Directors in Public
Date:	7th September 2023

Author	Susie Srivastava, Head of Wellbeing and Inclusion					
Exec Sponsor	Louise Ludgrove, Executive Director of People and Culture					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** NHS England published the Equality, Diversity and Inclusion (EDI) Improvement Plan in June 2023. The plan sets out six timebound, high impact actions that providers must action to address prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. This report provides an overview of the plan, together with the Trust's planned approach to implementation and what action we have taken to date.

Implications *(so what)*	**Alert** Failure to develop a culture of inclusivity and belonging will adversely impact on workforce engagement, satisfaction, wellbeing and retention. This may impact on the quality of patient and service user care. In turn, the Trust's ambition to become an employer of choice may be compromised, leading to increased turnover, lower morale, and amplified bank and agency expenditure, further impacting the Trust's financial position. Furthermore, the Trust may not meet its duties under the Public Sector Equality Duty, or the terms of the Workforce Race and Disability Equality standards, which are stipulated in the NHS standard contract. **Assure** The development of a robust and timebound plan that enables the delivery of these key, high impact actions will support the Trust's ambition to foster a happy, healthy workforce. This approach will ensure colleagues feel included and engaged, supported to perform at their peak, reach their full potential and deliver and/or contribute to safe patient care.

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	In order to deliver both impact and progress on a set of multifaceted and interconnected indicators about the experiences of our workforce, it is imperative that efforts and resources are directed to the areas which will have the biggest return for our workforce. Delivery of the six high impact actions will be a vital factor in embedding transformational and sustainable change, and in improving patient outcomes and experiences.

Proposed Resolution ***(What next)***	The Board of Directors is asked to: • Approve the proposal to report progress of the plan's implementation at annual intervals to the Board of Directors • Receive ongoing progress updates through the Workforce Assurance Committee. • Note the requirements for NHS Executive Directors set out in the EDI Improvement Plan.

1. Introduction

1.1 National workforce data demonstrates that there is “more to do” before the NHS can say that inclusive workplace environments are commonplace.

1.2 Recent Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WRES), Gender Pay Gap and NHS Staff Survey data consistently highlights that underrepresented groups are more frequently subject to discrimination, bullying and harassment. This national picture is mirrored here at Blackpool Teaching Hospitals.

1.3 NHS England has therefore published the first equality, diversity and inclusion (EDI) improvement plan, setting targets for Trusts that will support them to:

- Provide better support to international staff.
- Improve diversity in senior leadership positions.
- Eliminate bullying.

1.4 The plan, published in June 2023, comes as the health service workforce is more diverse now than at any point in its 75-year history, and highlights that a diverse workforce, in an inclusive environment would “likely improve staff engagement, lower turnover and enhance innovation”. All of these factors are correlated with improved patient outcomes. The Long-Term Workforce Plan identifies “Supporting inclusion and belonging for all and creating a great experience for staff” as one of the key outcomes-based functions that must be delivered by NHS leaders and organisations.

2. The Benefits

2.1 The aim of this plan is to enhance the sense of belonging for all NHS staff to improve their experience It is widely accepted that organisational efficiency correlates positively with staff and patient experience:

- Staff who are bullied are less likely and less willing to raise concerns and admit mistakes.
- Increased leadership diversity correlates with better financial performance.
- In hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection control, Care Quality Commission (CQC) ratings and financial performance.
- High work pressure, staff perceptions of unequal treatment, and discrimination against staff all correlate adversely with patient satisfaction.
- A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover.
- Fair treatment of every individual in the workforce helps reduce movement of substantive staff into bank and agency roles in order to avoid discrimination at work.
- A diverse workforce that is representative of the communities it serves is critical to addressing the population health inequalities in those communities.
- Organisations with more diverse leadership teams are likely to outperform their less diverse peers.
- Psychologically safe work environments, where people feel they are treated with dignity and respect, achieve more effective, safer patient care.

3. The High Impact Actions

3.1 The plan highlights six timebound high impact actions (HIAs) to address the key factors that are widely recognised to adversely impact on the experience on staff with protected characteristics. A number of workstreams are aligned to each HIA, as may be seen below. Progress will be tracked through the Inclusion Steering Group, with updates provided by stakeholders at the System Transformation Project meetings.

High Impact Action	Requirement	Action Owner	Date	Activity	Success Measure
1. Measurable objectives on EDI for Chairs Chief Executives and Board members.	Every Board and Executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.	Board Lead	Mar-24	Robust EDI objectives incorporated into Board and Executive colleagues' appraisals	EDI KPIs agreed and met
	Board members should demonstrate how organisational data and lived experience have been used to improve culture.	Board Lead	Mar-25	Teams that are hotspots of poor culture are identified through a series of metrics from which the Healthy Teams Collaborative develops a bespoke measurable action plan. Progress is reported to the Workforce Assurance Committee. Staff and patient experience stories are shared at Board and Workforce Committee to highlight good practice and identify areas for improvement.	The Healthy Teams Dashboard will evidence an improvement in teams with low levels of engagement. Number of staff and patient stories heard over a 12-month period.
	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework.	Board Lead	Mar-24	WRES, WDES, Gender Pay Gap data and action plans are presented annually to Board with priority actions identified and progress reported bi-annually.	Year on year improvement in WRES, WDES and GPG metrics.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Create and implement a talent management plan to improve the diversity of executive and senior leadership teams and evidence progress of implementation . Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.	Associate Director of Workforce	Implement process by June 2024, evidence progress by June 2025	Development of talent management programme and implementation plan for senior leadership positions	Increased diversity in executive and senior leadership teams. Increased social mobility across ICS System footprint (2025).

	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes.	Assistant Director of Workforce	Oct-24	Review local pathways to recruitment, strengthening relationships with local community and third sector organisations. Increase in engagement with local colleges and schools.	Increase in staff employed who live in postcodes FY1-FY4 Increased work experience placements Increase in graduate management trainees
3. Develop and implement an improvement plan to eliminate pay gaps	Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce.	Head of Medical Workforce/ Head of Human Resources	Mar-24	Develop an implementation plan for the Mend the Gap recommendations.	Improved Gender Pay Gap reporting for medical and senior non-medical workforce.
	Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards.	Head of Employment Services	Sex and race by 2024, disability by 2025, and other protected characteristics by 2026.	Undertake a deep dive into pay gaps by sex and race. Implement a programme of work to ascertain the reasons for this gap.	Increase of at least 10 % of staff self-declaring on ESR to ensure data is representative. Increase in number of staff with a protected characteristic participating in leadership development programmes. (Initially, the focus will be on sex and race.) Decrease in pay gaps for staff with declared protected characteristics.
	Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns.	Head of HR	Mar-24	Continue to raise awareness of flexible working opportunities among all staff groups.	Increase in % of flexible working applications and % approved.
4. Develop and implement an improvement plan to address health inequalities within the workforce	Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as the national NHS health and wellbeing framework.	Head of Wellbeing and Inclusion	Oct-23	Continue to offer line manager training on wellbeing conversations. Promote the value of wellbeing conversations in leadership training content and resources	Increase in appraisal compliance to 95% Trust wide.
	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health	Assistant Director of Medical and Clinical Education	Apr-25	Continue to run effective programmes with partners including Princes Trust, DWP, Project Search and local Colleges. Development of schools' programme	Establishment of a talent pipeline Proven conversion rate between engagement with widening participation

	Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare.			Continue and expand T-level adult nursing provision. Implement a Therapies T-Level pathway. Support the new digital T-Level industry placement.	programmes and progression into paid employment.
5. Implement a comprehensive induction, onboarding and development programme for internationally recruited staff	Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options.	Assistant Director of Workforce	Mar-24	Review international recruits' welcome booklet in partnership with our international nurse community to amend and update as appropriate.	Increased satisfaction levels in national staff survey data. Increased retention levels.
	Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback.	Associate Director of Workforce	Mar-24	Survey international colleagues on their experience of onboarding to co-create a revised onboarding programme, informed by staff voice. Introduce pastoral lead for international recruits.	Increased satisfaction levels in national staff survey data. Positive cohort feedback. Increased retention levels.
	Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety.	Associate Director of Workforce	Mar-24	Include content on supporting international staff in the Trust's "Managers' Guide to Recognition, Wellbeing and engagement." Co-create cultural awareness training with international colleagues for managers to attends	Increased satisfaction and engagement levels in national staff survey. Decreased staff turnover on wards. Increased Trust retention levels.
	Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and	Associate Director of Workforce	Mar-24	Collaborate with the Deputy Director of Nursing to develop a support programme for international nurses to establish what support international nurses need to develop in order to fulfil potential and access opportunities for career progression.	Improvement in WRES metrics: • Likelihood of accessing non mandatory training or CPD compared to white staff. • Belief that the Trust offers equal opportunities for career progression. • Likelihood of bullying harassment or abuse from staff in

	opportunities for career progression.				the past 12 months. • Likelihood of bullying harassment or abuse from patients, relatives or the public in the past 12 months.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set and plans implemented to improve staff experience year-on-year.	Head of Wellbeing and Inclusion	Mar-24	Review data by protected characteristic. Identify trends and set reduction targets. Ensure that efforts to address the root cause are underpinned by the cultural transformation and values and behaviours programmes of work.	Reduction in instances of stress related sickness absence. Reduction in bullying and harassment cases. Reduction in ER cases.
	Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.	Head of Wellbeing and Inclusion	Mar-24	Review disciplinary and employee relations data by protected characteristic. Identify trends and set reduction targets. Review disciplinary and employee relations data to ensure that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics.	Reduction in staff with protected characteristics entering the disciplinary process. Assurance of consistency of approach.
	Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.	Head of Human Resources	Jun-24		
	Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff.	Staff Guardian	Mar-24	Continue to raise awareness of the Staff Guardian role through: -A comprehensive communications campaign. -By increasing the number of Champions and including ensuring that all staff networks have at least one member trained as a Freedom to Speak Up Champion. Review case work by protected characteristic, where possible.	Increase in case work of staff guardian. Reduction in instances of stress related sickness absence Reduction in bullying and harassment cases Reduction in ER cases

	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination, or violence.	Head of Occupational Health	Mar-24	Ensure that all staff that report they are a victim of bullying, harassment, discrimination or violence are offered timely access to appropriate psychological support through occupational health.	Increase in % of staff accessing EAP for reasons of bullying, harassment, discrimination or violence. % of ER cases related to bullying and harassment. Number of onward referrals made to Occupational Health
	Have mechanisms to ensure staff who raise concerns are protected by their organisation.	Staff Guardian	Immediate	Review mechanisms in place to protect staff that raise concerns.	Reports of staff experiencing detriment from speaking up are zero.

4. Next Steps

4.1 Progress towards meeting the standards will be monitored monthly. The EDI Improvement Plan, together with the Anti-Racist Framework, informs the Equality and Inclusion workstream within the Trust's Culture Improvement Project. Progress will be reported to the Strategic Transformation Committee.

4.2 Reliable, consistent and timely data is crucial to ensuring effective progress. There are significant differences in the range and quality of data held for the protected characteristics, so a local EDI dashboard will be developed that enables accurate and timely reporting of both progress and impact.

4.3 A communications plan will be crafted together in partnerships with staff networks to convey the rationale for this work and what is expected of individuals and teams. To support this activity, The voluntary, Inclusion Ambassador role will be relaunched, with activity aligned to the EDI Improvement plan.

5. Conclusions

5.1 The key change management principle guiding this work is that EDI is everyone's business. Our leaders set the tone and culture, but we all have a role to play**.**

5.2 It is recognised that progressing the EDI agenda requires not only a change in systems and processes, but also cultures and behaviours. The EDI Improvement Plan challenges providers to hold a mirror up to pre-existing policies and practices in order to make real and lasting positive change.

5.3 NHS England guidance stipulates that NHS leaders**,** specifically chairs and chief executives, must lead by example and demonstrate that they are committed to creating an EDI environment for their workforce. Board members should collectively and individually decide what support and development they require to confidently lead this complex and challenging agenda.

5.4 Managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and financial performance as well as turnover and absenteeism.

5.5 At Blackpool Teaching Hospitals, delivery of the high impact actions has been embedded into a timebound plan, which will be monitored at the Inclusion Steering Group and reported to the Strategic Transformation Committee.

5.6 It is vital that these actions are not considered in isolation, rather as part of the wider belonging agenda that is an integral part of the people promise.

6. Recommendations

6.1 The Board of Directors is asked to:

- Approve the proposal to report progress of the plan's implementation at annual intervals to the Board of Directors
- Receive ongoing progress updates through the Workforce Assurance Committee
- Note the requirements for NHS Executive Directors set out in the EDI Improvement Plan.

End of Report.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Audit Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	7 September 2023

Author	Esther Steel, Director of Corporate Governance					
Exec Sponsor	Fiona Eccleston, Non-Executive Director (Committee Chair)					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** To update the Board on the alerts, assurance and advise content, discussed at the Audit Committee on Tuesday 15th August 2023. The Committee also convened a short additional meeting on July 13 for final approval of the 2022/23 accounts and report.

Implications *(so what)*	**Alert** There were no items highlighted for escalation to Board of Directors as an alert. **Assure** The items noted for assurance are detailed in the escalation report – good progress has been made on closing old internal audit actions

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	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:	15th August 2023	**Date of next meeting:**	11 October 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. Continued improvement in the quality of papers noted.

Alert		
What	**So What**	**What Next**
No items identified for escalation as an alert		

Assurance		
What	**So What**	**What Next**
Internal Audit Progress Report Update provided on progress to implement actions in response to recommendations. All outstanding KPMG action now addressed. No reports phased for Q1 with 7 in progress for Q2 and planning underway for Q3.	Discussed change to data quality phasing and agreed that for 2023/24 the data quality review should focus on Cancer waiting time data	Audit Committee approved change to plan, MIAA to commence background work to prepare for audit of Cancer data quality.
Internal Audit Follow-up Report Follow up report provided on implementation of actions – all outstanding KPMG actions now addressed or superseded.	Work to close actions recognised, updates provided on outstanding actions. Discussed the process for agreeing changes to dates to understand expectations for delivery – changes to high priority actions will need to be approved by Audit Committee	Updates on Blue Skies audit and Business case review to be provided at the October Committee. Work to close down old actions to continue with the Committee seeking to continue improvement on addressing actions within the agreed timeframe
Data Security and Protection Toolkit Report Overall substantial assurance provided		Report noted
Counter Fraud Executive Summary July 2023	Trust wide counter fraud risk assessment scheduled for Q3.	Update noted

Comprehensive update provided on Counter Fraud work – consideration being given to mandating the Counter Fraud training in the review of core training	Committee members discussed input of counter fraud with regard to policies	
Counter Fraud Functional Standards Report Every year NHS CFA is required to provide assurance to Cabinet Office of how the NHS is identifying and mitigating the risk of fraud, bribery and corruption. NHS funded services are required to provide an annual submission of performance against the Functional Standards.	The Trust annual self assessment of Counter Fraud provision is an overall green rating with an improvement made since 2022/23	The Committee noted the report
Counter Fraud Briefing notes: • NHS Counter Fraud Authority Strategy 23-26 & Business Plan 23-24 • Briefing Note on Failure to Prevent a Fraud Offence • Briefing Note on Fraud Prevention Values	Summary provided highlighting key elements in the national counter fraud strategy and business plan New offence of failing to prevent fraud to be introduced making it the responsibility of organisations to ensure reasonable procedures are in place to prevent fraud Additional guidance to be applied locally to ensure a consistent approach when recording fraud losses, prevented losses and recoveries	Provided for information
Local Protective Exercise Report on Artificial Intelligence Fraud Risk Proactive report is to provide the Audit Committee with the outcome of a Local Proactive Exercise (LPE) on the dangers and subsequent fraud risks relating to Artificial Intelligence. The Local Counter Fraud Specialist (LCFS) reviewed articles available online to identify where AI could potentially exacerbate fraud risks.	Committee members discussed the use of AI technology. As with any new and emerging technology, criminals will seek opportunities to use these new tools to bypass current controls and to develop new criminal methodologies.	Report and actions to mitigate the risk noted – follow up reports will be presented to the Audit Committee
Workforce BAF review Committee members reviewed the workforce element of the Board Assurance Framework noting the index of papers received by the Workforce Assurance Committee (WAC) providing assurance on the effectiveness of controls		Update noted

Medical Job Planning/Medical Staffing Recruitment and Retention Review Assignment Report 22/23 Medical Director attended to provide a follow up on actions taken in response to previous internal audit report. Reconciliation of payments to job plan is now addressed in Job Panel Consistency panels, payroll is represented on the panel, and the dashboard provides comparative data from ESR. All discrepancies are challenged and the 'rounding' of payments versus exact payments is currently being reviewed by HR colleagues, to establish the financial implications and recommend a way forward.	Progress made to ensure all job plans are signed off with a dispute process developed for those that are in dispute or not signed off – dispute process includes appeal and CEO final sign off. Committee members discussed the dispute process including the potential factors that might lead to dispute noting that job plans include clinical time, admin time, non-core activities. Committee members noted the impact/risk in progressing this alongside recognised challenges of recruitment and retention.	The next round of prospective job planning (April 2024) will commence in October 2023.
Financial Peer Review Action Plan Update Update provided on actions taken in response to financial management peer review – 29 of the 32 actions due for completion in June have been completed and there are plans in place to address the three outstanding actions	Both the peer review and hfma check list represent best practice in the NHS – Committee members discussed potential follow up once all actions implemented and embedded with a full year cycle to ensure full impact.	The Committee noted the update and agreed to follow up with an internal audit review of progress
Losses and Special Payments Q1 No losses reported in the reporting period 11 special payments made in the period – a reduction on previous years		Review being undertaken to look at losses of personal possessions of patients
Waivers Report on the volume and values of orders placed that were not subject to the formal receipt of quotations or competitive tenders.	ICB scrutiny will impact on the value and volume of waivers from July 2023.	Future reports will include daily rates for locum contracts
Audit Committee Effectiveness Review Verbal update on Committee effectiveness – time frame for feedback for elements of the review still underway	Overall feedback positive, all members provide scrutiny in an environment that is felt to be conducive for debate bringing about improvements in internal controls.	The feedback will be reported to Board and Governors within the Audit Committee Annual Report Further work recommended in completing actions and learning and considering setting objectives for the Committee
Blue Skies Governance Review Update provided on actions taken in response to Blue Skies audit – good progress made with all but two actions completed		MIAA to confirm closure of actions

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Advise		
What	**So What**	**What Next**
External Audit Progress Report Verbal update – final procedures on accounts completed and accounts submitted – final element is the issue of the long form written audit report and vfm commentary – deadline end of this month.	Completing de-brief to review this year's process. Currently working on the accounts for Blue Skies and Atlas – progressing well with no issues and no concerns about meeting the agreed timetable	Update noted – formal report to be provided by the end of the month
Trust Responses to ISA 260 Issues Committee members received updated action plans on a number of control weaknesses highlighted in the Deloitte ISA 260 report; vesting certificates, capital items in revenue expenditure, system interface issues, accruals justifications, and accounting for leases. Committee also received a plan on accounting for income in 23/24 given the changes in NHS funding regarding Aligned Payment Incentive (API) rules.	Improvements as defined by Management in these areas are required to improve quality and timeliness of reporting. The Trust needs to ensure that signed contracts are in place covering payment arrangements with commissioners.	Management's approach was supported in all cases. Two policies will be written by management, reviewed by Deloitte and approved by Audit Committee (Vesting Certificates and Accruals) Further work is needed to understand the controls in relation to signing leases – update to Audit Committee in October
Appointment of External Auditors (members only) Committee members along with the lead governor discussed the arrangements for the renewal of the audit contract		Proposal for a contract extension to be discussed with the Council of Governors

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Strategy and Transformation Committee Escalation Report

Meeting:	Board of Directors
Date:	7 September 2023

Author	Esther Steel – Director of Corporate Governance					
Exec Sponsor	Trish Armstrong Child - CEO					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** The Strategy and Transformation Committee is established as a management committee to provide oversight to the Strategy and transformation Programme

Implications *(so what)*	**Alert** Highest risks are the need for transformational investment and staff engagement linked to availability and operational pressures. **Assure** Updates provided on the plans and supporting arrangements

Previously considered by	N/A

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	The Committee will play a role in ensuring the EDI implications of our STP programme are considered

Proposed Resolution *(What next)*	The Board are asked to note

Committee Escalation Report

Name of Committee/Group:	Strategy & Transformation Committee	**Report to:**	Board of Directors
Date of Meeting:	27 July 2023	**Date of next meeting:**	7 September 2023
Chair:	Trish Armstrong-Child	**Parent Committee:**	Board of Directors Meeting

Introduction

Quorate meeting held on MS Teams, good engagement and discussion with a key focus on progress with transformational plans.

More time scheduled outside the meeting to think about the links between the programmes including sustainability, health impact assessment, health equity audit

Alert

What	So What	What Next
Highest risks are the need for transformational investment and staff engagement linked to availability and operational pressures.	Engagement from all staff is vital for the success of the transformation programme	Commitment to continue with planned meetings adjusting membership flexibly to allow clinical service delivery.

Assurance

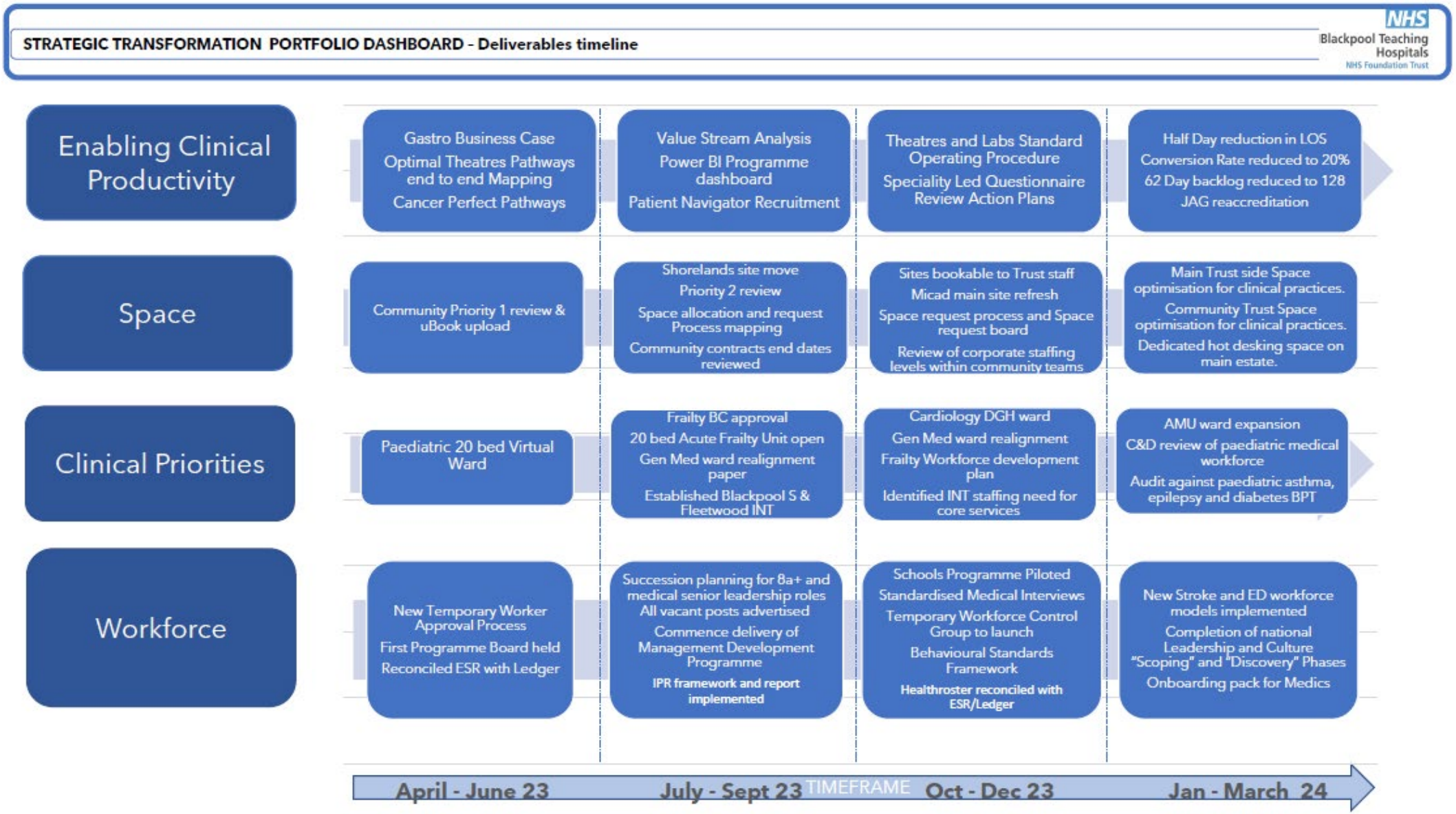
What	So What	What Next
Portfolio Dashboard Review (STP) Programme highlight report provided for each programme in the STP - Four programmes, 14 projects and 66 workstreams for delivery in year one. Deliverables timetable appended to this report.	Progress made in all areas, PIDs in development for all areas, risks identified for each programme. Detailed updates provided for each programme.	Updates to be provided as a standing agenda item
STP Comms Plan Overview of the communications plan to support delivery of STP and engage with staff and the general	Discussed future opportunities for communication of STP	Continue to promote through all available challenges
Programme Highlight Reports: Overview provided of each of the 4 programmes in the STP namely:	Each overview provided a programme highlight report outlining progress since the last report including key achievements, metrics to measure programme success, progress against putting the required	Progress noted, regular updates to continue

• Workforce • Clinical Productivity • Clinical Priorities • Space	governance in place and comms and engagement.	
Enabling Plans: QI The enabling plan outlined the key areas that QI can support the organisation in achieving its strategy. The enabling plan has been shared and amended following feedback gained from multidisciplinary colleagues and patient representatives, it will replace the Trusts previous 2019-2022 QI Strategy	Discussed links with culture and values and importance of embedding through everything we do	Reporting for enabling plans to be reviewed to track progress on delivery – the Strategy Delivery Group will report up to the STC
Enabling Plans: R&D Detailed enabling plan based on Department of Health plans for research and development – focus on the importance of embedding research in the trust. Potential for future investment highlighted within the report	Discussion focused on enabling, embedding and growing to bring R&D front and centre in the organisation – going forward wards and departments will need to demonstrate engagement in research and development to achieve platinum status	Road map needed to move along on ambitions. Future Board session with a focus on R & D
Enabling Plans: Innovation The NHS Long Term Plan (2019) highlights the importance of innovation in the NHS and commits to developing the infrastructure required for innovations to thrive. Our Trust 5-year strategy asserts that we will use innovation and research to deliver new efficient models of care to widen access, enhance health promotion and improve our environmental impact. The Innovation enabling plan set out the actions to be taken by the Trust to provide opportunities to improve our services and the care we deliver	Discussed interdependencies with R&D, QI, health inequalities and other enabling plans –agreed that innovation is the thread through all other plans – recognised the progress made with more work to do to establish an innovation network, develop the necessary links, and avoid duplication.	Further work on the development of the Innovation enabling plan and the links with other enabling plans. Need for more consultation with staff - everyone should feel like an innovator.

Committee Escalation Report

Enabling Plans: Clinical Strategy Update provided on the planned approach to developing a Clinical Strategy, which will sit as an enabling Plan under the Trust Strategy. Development will include discussion with Governors, clinical divisions and with place-based partners	Importance of linking in with the PCB clinical strategy discussed, this will be pivotal in terms of the development of our clinical strategy – affordability and system wide reconfiguration. Recognised the importance of planned and co-ordinated clinical engagement. Recognised the complexity but also the benefits of engagement with clinical teams to drive and own this key piece of work	Working group to meet on 1st August to work towards the launch of the Clinical Strategy Further discussion to agree the timeline for the strategy with alignment to PCB service reconfiguration.
Advise		
What	**So What**	**What Next**
Any Other Business - ToR Agreed to review to include comms in the membership		ToR to be approved at next meeting
Other agenda items		
None		

Blackpool Teaching Hospitals NHS Foundation Trust



NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Medical Appraisal and Revalidation Report

Meeting:	Board of Directors Meeting
Date:	1st September 2023

Author	Nicola Di Vito, Medical Professional Standards Manager					
Exec Sponsor	Chris Barben, Medical Director					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	N					

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

Implications *(so what)*	**Alert**
	No alerts.
	Assure
	• To support quality improvement at the Trust • To provide the necessary assurance to the higher-level Responsible Officer • Acts as evidence of CQC inspections

Previously considered by	Workforce Assurance Committee

Link to strategic objectives	Our People Happy and Healthy Workforce – ensuring wellbeing, resilience, and respect through Medical Appraisal Learning Culture – Encouraging learning and building leadership through Development	
	Our Place Prevention and Health Promotion – Ensuring doctors are Fit to Practice and embedding equity into our delivery plans. Integrated Care – Service Improvements and improvement of access/timeliness of care	
	Our Responsibility Getting the Basics Right – Achieving quality standards and working collaboratively	

	New Ways of Working – Transformation and innovation and enhancing active participation in research	

Equality, Diversity and Inclusion (EDI) implications	All doctors employed by the Trust, who have a prescribed link are included

Proposed Resolution ***(What next)***	To confirm that Blackpool Teaching Hospitals is complaint with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)

NHS England North West

Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

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Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

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

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

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

c) act as evidence for CQC inspections.

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

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Blackpool Teaching Hospitals NHS Foundation Trust**
What type of services does your organisation provide?	Acute Trust

	Name	**Contact Information**
Responsible Officer	Mr Chris Barben	01253 953722 c.barben@nhs.net
Medical Director	As above	As above
Medical Appraisal Lead (AMD)	Dr Ben Holden	01253 956850 benedict.holden@nhs.net
Appraisal and Revalidation Manager	Nicola Di Vito	01253 957256 nicola.di-vito@nhs.net
Dir. of Professional Standards (DoPS)	Steve Wiggans	01253 958250 dr.wiggans@nhs.net
Administration Team (Contact for the Trust)	Revalidation Team	01253 951060 bfwh.revalidation.team@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: Trinity Hospice and Palliative Care Services **Please describe arrangements for Responsible Officer to report to the Board:** **Blackpool Teaching Hospitals provide RO services to Trinity Hospice as they don't employ enough doctors to form their own Designated Body.**

Date of last RO report to the Board: Trinity Board on 3rd August 2022 **Action for next year: To continue the provision of services to Trinity Hospice, including revalidation of doctors and provision of Board Report for Trinity Board assurance**

Section 2a: Appraisal Data

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

Total number of doctors with a prescribed connection as at 31 March 2023?	428
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	412
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	2
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	14
Total number of appraisers as at 31 March 2023?	79

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

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

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**57**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	45
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	12
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	**2**
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	**14**

How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**24**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	**2**

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
Appraisal and Revalidation for Medical Staff	22nd November 2022	21st November 2025

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**
Handling Concerns Procedure for Medical and Dental Staff	22nd November 2022	21st November 2025
Disciplinary Policy	8th September 2020	Due for review
Remediation and Rehabilitation of Practitioners Performance Procedure	4th October 2021	Due for review

Other relevant policies	**Implementation date**	**Review date**

How do you socialise your policies?
All Policies are available Trust Wider on OneHR intranet page

Section 4: General Information

The board / executive management team can confirm that:

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

Yes
Action for next year (1 April 2023 – 31 March 2024). No Action Required

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

Yes
If No, please provide more detail: No Action Required

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? **The Trust use MYL2P software system to manage medical appraisal and revalidation. In addition, a separate database is kept ensuring all prescribed links are supported.**
If no, what are your plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? **The last full review took place in 2017 and an annual peer review discussion is in place. A full Peer Review process is currently ongoing and due to be completed in September/October 2023. Six Trusts are reviewing each other's processes - Blackpool Teaching Hospitals NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Airedale NHS Foundation Trust and Lancashire & South Cumbria NHS Foundation Trust.**

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

All short-term locum/placement doctors are put into the medical appraisal and revalidation processes. **Including provision of an annual appraisal and a multi-source feedback exercise if requested by doctor.**

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

1. The Trust has established a robust pathway with Spire Hospital regarding practicing privileges and data flow **2. A Team Leader role has been added to the Medical Appraisal and Revalidation Team to provide extra support and leadership to the administration team** **3. The identification of themes and performance/development issues are being supported by Practitioner Support Group**

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

1. A new Associate Medical Director for Medical Revalidation and Appraisal recruited (following retirement of previous AMD) **2. Appraiser's to be remunerated for their role** **3. Trust Recognised Appraisers to undergo a selection process** **4. A gap analysis to be completed for Medical Appraisal and Revalidation against Good Medical Practice**

5. Review of the Trust Quality Assurance Programme

6. Review and change the Clinical Governance Programme

5.5 How do you train your appraisers?

Appraiser Training is provided by the Associate A&R Medical Director/Revalidation Team and the Organisational Development Team in house at the Trust

5.6 How do you Quality Assure your appraisers?

This process is under review, however, currently the Associate A&R Medical Director reviews the first three appraisals for new appraisers. In addition, each appraisal summary is reviewed by the AMD prior to Revalidation submission.

5.7 How are your Quality Assurance findings reported to the board?

This has not been completed to date, but is under review

5.8 What was the most common reason for deferral of revalidation?

The most common reason is non-completion of appraisal documentation or multi-source feedback.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The Trust escalation process of Local Process (pre-appraisal) and Formal process (post-appraisal) is used – with a total of 6 reminders.

Non-completion of appraisal is escalated within formal processes, including; reports provided to the RO and DoPS.

The Head of Department and Divisional Director are informed of any issues within the formal processes to support engagement.

The AMD/DoPS make contact with the individual outside of any formal processes and are kept informed of progress.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Practitioner Support Group (PSG) – is a mechanism by which the Trust supports Divisions/individuals and identifies themes and trends. This group deals with informal issues and has HR, DoPS, Medical Education, AMD Wellbeing and Medical Staffing support. It is an advisory and signposting committee.

Multi-Disciplinary Approach – in difficult cases a cross team approach is taken with direct discussion with the Line Manager of the individual, HR, DoPS, Medical Staffing and Division Director (this list is no exhaustive). An agreed plan of action is then formed and managed.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Data for PSG is shared at Medical Workforce Committee, chaired by DoPS and feeds into the Board

Data is kept within the following data sets - BAME, Sex, Trust or Agency, formal or informal.

A monthly Employee Relations report is provided to the Executive Team

6.3 How do you ensure that any concerns are managed with compassion?

The Trust has an Associate Medical Director for Wellbeing and he sits on PSG to enable support for colleagues who are have informal concerns.

The Trust offer buddy/peer support to doctors who are undergoing any formal process, whether GMC, Trust or police matter.

6.4 How do you Quality Assure your system for responding to concerns?

An annual review of process is being implemented

6.5 How if this Quality Assurance information reported to the board?

Not at the present time

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

The Trust provide and complete MPITs as required. **If an event happens for a doctor who is a prescribed link to a different responsible officer (such as a locum agency doctor/Doctor in Training), the DoPS/AMD will make contact with the relevant RO if any issues occur during placement at the Trust.**

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Trust has a Handling Concerns policy to support the Maintaining High Professional Standards framework. **Outside agencies are contacted for support, such as PPA and ELA** **All doctors have the right to be accompanied to any meetings whether formal or informal**

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

The Trust are now: **1. Remunerating Trust Appraisers** **2. Established a reporting process with Spire Hospital** **3. Practitioner Support Group has been implemented to support the Trust's management of informal issues**

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

The Trust will participate in: **1. Peer Review (full review)** **2. Review the Trust Clinical Governance processes** **3. Incorporate good practice from the Peer Review** **4. Review an electronic solution to capture feedback for agency locum doctors**

Section 7: Employment Checks

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

NHS Check standards are completed **MPIT process if completed for all UK based doctors that are employed at the Trust**

Do you collate EDI data around recruitment and /or concerns information?

Yes/No (delete as applicable)
If yes, how do you use this information?'

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

Section 9: Statement of Compliance:
The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ……..…….

Name: …….

Role: ……..

Date: ……..

Medical Appraisal and Revalidation (A&R)

Action Tracking Document

NHS Blackpool Teaching Hospitals NHS Foundation Trust

Ref No	Item	Action to be Taken	Person respon	Date to be Completed	Change of Date	Progress	RAG Status
5	Peer Review of A&R	To participate in Peer Review activity for callibration and good practice	Steve Wiggans Nicola Di Vito	Ongoing		BTH have participated in annual Peer Review since 2017, one full peer review took place in 2017 where by organisations evaluate each others practice. Annual review meetings have taken place discussing any current issues and best practice annually. Full peer review to take place in May 2023 by UHMB, LTH, BTH, ELHT, Airdale, Lancs Care ***02.05.23*** - ELHT visited the Trust on Friday 28.04.23 to review BTH processes and BTH will visit ELHT in May 2023 ***13.06.23*** - BTH Visited ELHT to review processes and BTH are awaiting the final report from ELHT	***Amber***
6	Agency Locum Doctors	To understand practice issues	Steve Wiggans Nicola Di Vito	Ongoing		An electronic solution is being reviewed to enable insight into any practice issues whilst delivering DCC at Blackpool ***03.05.23*** - This remains in review stage	***Amber***
7	Clinical Governace Data	Compliants, Claims and Incidents are required for annual appraisal and revalidation purposses	Steve Wiggans Nicola Di Vito	Ongoing		This is a statutory requirement for Medical A&R. There have been issues with the collection of this data due to lack of information being provided from Clinical Governace Teams which is causing a risk. Steve Wiggans and Nicola Di Vito are due to meet with Louise Chueng on 22nd February to review the process and improve data provision. ***03.05.23*** - Awaiting a response from L Cheung following the meeting in February, S Wiggans to discuss the matterwith L Cheung w/c 02.05.23 ***29.08.23 -*** The Team are awaiting access	***Amber***
15	Administration	The A&R team to move away from a spreadsheet based process and use MYL2P to manage Doctors	Nicola Di Vito Tracey Nolan	31.07.23		MYL2P has been embedded into the Trust, the administration team will move to removing the spread sheet that has managed processes since 2013. ***21.08.23*** - This has been reviewed	***Green***
16	Scope of Work (SOW)	Review a system of managing full SOW (including other NHS organisations)	Steve Wiggans Ben Holden Nicola Di Vito	31.12.23		A process to ensure full SOW is included within an annual appraisal, for example, clarity around practice completed in another Trust to be provided for annual appraisal.	***Amber***
17	Medical Governace	Review against Good Medical Practice	Steve Wiggans Ben Holden Nicola Di Vito	31.12.23		A gap analysis to be completed against Good Medical Practice	***Amber***
18	Recognised Trust Appraiser Role	Requirements of a Medical Appraiser role to be met and monitored	Steve Wiggans Nicola Di Vito Tracey Nolan	31.03.23		Following ratfication of the Apprisal and Revalidation Policy - appraisers are required to complete a set number of appraisals.	***Green***

Closed Actions

Ref No	Item	Action to be Taken	Person respon	Date to be Completed	Change of Date	Progress	RAG Status
1	Responsible Officer Training	CB to attend Training	Chris Barben	14.09.22		Course Attended	***Green***
2	Resources of the Revalidation Team	NDV to manage and recruit to vacant posts	Nicola Di Vito	31.03.23		A team leader has commenced in post and one administrator has been been sourced with a second currently undergoing pre-employment checks	***Green***
3	Accurate record of Prescribed Links	Ensuring accurate records of Prescribed Links is kept	Nicola Di Vito	N/A		A series of data bases are kept by the team to ensure: 1. An accurate list of Prescribed links (those the Trust are responsible to Revalidate) 2. Clinical Governacre data collection is managed 3. Multi Source Feedback is gained timely	***Green***
4	Policy	To ratify an updated A&R policy	Nicola Di Vito	01.04.22		The policy was updated and ratified at JLNC on 22nd November 2022	***Green***
8	Number of Trust Appraisers/Remuneration for the role of Trust Appraiser	Ensure there are enough appraiers for the Trust's number of prescribed links and the role of Trust Recognised Appraiser is now within Job Plans	Nicola Di Vito	31.03.23		1. Regular Trust Training is in place for the role of Trust Recognised Appraiser and supported by Prof Gulati (Associate MD for A&R) 2. Trust policy now reflects remuneration for the role of Trust Recognised Appriaser 3. There are currently sufficent appraisers for the needs of the Trust but this remains under review	***Green***
9	Appraiser Education	Regular Appraiser Update Sessions	Prof Gulati			Local Network Meetings are held several times a year and it is a requirement for all Recognised Appraisers to attend at least one per annum	***Green***
10	Quality Assurance process	Quality of Appraisals to be reviewed	Nicola Di Vito Ravi Gulati	31.05.23		The EXCELLENCE tool is used to ensure the quality of Appraisal summaries, however, the person undertaking this role has left the Trust and a replacement is commencing in April. Therefore, there is a slight delay in continuing this process ***03.05.23*** - New person has commenced in post and this process will be reviewed and managed	***Green***
11	Local/HR Concerns	Gathering of data Practitioner Support Group	Nicola Di Vito Steve Wiggans			Data is gathered for annual appraisal and GMC revalidation PSG is in place and supporting informal concerns within a multi disciplinary team and reviewing themes	***Green***
12	Private Practice	Link with Spire	Steve Wiggans Nicola Di Vito			There is now an established reporing line between BTH and Spire	***Green***
13	Associate Medical Director for A&R	Recruitment	Steve Wiggans	30.06.23		Prof Gulati has resigned from the post and is due to leave on 31st March 2022, recruitment process are in place ***03.05.23*** - The post has been advertised and interviews are proposed in June 2023	***Green***
14	Higher Level Responsible Officer Visit	NHS England Visit to Blackpool	Chris Barben Steve Wiggans Prof Gulati Nicola Di Vito			An NHS Engand took place on 9th February 2023 The visit went very well and no concerns were raised	***Green***

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Regulatory and Mandatory Lead Roles

Meeting:	Board of Directors in Public
Date:	7 September 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)*	**Advise** There are a number of posts set out in legislation that a foundation trust is required to have. Additionally, there are a number of posts that are required by regulators or which have been recommended as a result of inquiries, investigations or as best practice.

Implications *(so what)*	**Alert** No risks or financial implications associated with this report **Assure** The content of this report covers legal requirements for foundation trusts and serves to provide assurance that all statutory requirements have been satisfied.

Previously considered by	n/a

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

Equality, Diversity and Inclusion (EDI) implications	Leads for EDI, wellbeing and safeguarding are included within this list

Proposed Resolution *(What next)*	Board members are asked to prior to publication on the Trust website

Post	Description	Required by	Post holder
Chair	There must be a Chair of the organisation who Chairs both the Board of Directors and the Council of Governors	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Steve Fogg - Chair
Accounting/Accountable Officer	There must be a Chief Executive of the organisation who must be designated as the Accounting/Accountable Officer	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Trish Armstrong Child - Chief Executive Officer
Director of Finance	There must be a finance director on the board	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Mark Brearley - Interim Director of Finance
Registered medical practitioner or dentist as a director	One of the executive directors must be a registered medical practitioner or dentist	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Chris Barben - Executive Medical Director
Registered nurse or registered midwife as a director	One of the executive directors must be a registered nurse or midwife	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Bridget Lees - Executive Director of Nursing, Midwifery, AHPs and Quality
Senior Independent Director	To provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary. Should be available to governors if they have concerns that contact through the normal channels has failed to resolve or for which such contact is inappropriate.	Provision A.4.1 NHS Foundation Trust Code of Governance	James Wilkie - SID and Vice Chair
Company Secretary	The secretary of the foundation trust or any other person appointed to perform the duties of secretary	Foundation Trust Constitution	Esther Steel - Director of Corporate Governance
Responsible Officer for Revalidation	A medical practitioner, at the time of appointment and for the preceding 5 years, who must remain a medical practitioner during the course of their appointment. Duties set out in the regulations	The Medical Profession (Responsible Officers) Regulations 2010	Chris Barben – Executive Medical Director
Nominated individual for CQC regulated activities	Responsible for supervising the management of the carrying on of CQC regulated activities.	Regulation 6, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Bridget Lees - Executive Director of Nursing, Midwifery, AHPs and Quality
Director of Infection Prevention and Control	An individual with overall responsibility for infection prevention and control and accountable	Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and	Bridget Lees - Executive Director of Nursing,

Post	Description	Required by	Post holder
	to the registered provider in NHS provider organisations.	control of healthcare associated infections and related guidance	Midwifery, AHPs and Quality
End of Life Care – Executive Director	• National Care of the Dying Audit Round 4 2014 • Neuberger Review. More Care: Less Pathway. 2013 • LACDP. One Chance to get it Right. 2014 National Hospitals End of Life Care Audit 2015 • CQC Inspection Framework: NHS Acute Hospitals 2016	• Take responsibility for and champion End of Life Care at Board level. • Ensure End of Life Care within the Trust, and provided by the Trust, is appropriately monitored. • Demonstrate strong leadership and role model for all Trust staff regarding End of Life Care. • Assess the impact of all existing and new policies on End of Life Care and make recommendations for change. • Recognise the impact of the perception of poor end of life care on bereaved families and provides Board assurance that complaints and incidents are dealt with in a way that reduces this impact.	Chris Barben – Executive Medical Director
End of Life Care – Non Executive Director	• National Care of the Dying Audit Round 4 2014 • Neuberger Review. More Care: Less Pathway. 2013 • LACDP. One Chance to get it Right. 2014 National Hospitals End of Life Care Audit 2015 • CQC Inspection Framework: NHS Acute Hospitals 2016	• To have specific responsibility of care of the dying, focusing on the dying patient, their relatives and carers and reviewing how End of Life Care is provided. • Support , and where necessary challenge, the Executive Director for End of Life Care • Act as a patient, family and public voice & ensure that the patient, family and public perspective is considered in all End of Life Care related discussions and Board level scrutiny. • Provide scrutiny to the monitoring of End of Life Care, oversight for End of Life complaints, and the handling of the bereaved within the Trust.	Andy Roach – Non Executive Director

Post	Description	Required by	Post holder
Learning from Deaths Champion	To ensure that processes are robust, focus on learning and can withstand external scrutiny, that quality improvement becomes and remains the purpose of the exercise and that the information published is a fair and accurate reflection of achievements and challenges	National guidance on learning from deaths (National Quality Board, March 2017)	Chris Barben – Executive Medical Director
Health inequalities lead	Named executive board member responsible for tackling inequalities	Bullet C4(4), letter from Simon Stevens and Amanda Pritchard dated 31 July 2020 ("Phase 3 letter")	Chris Barben – Executive Medical Director
Equality and Diversity	Equality Act 2010 - Public Sector Duty The Workforce Race Equality Standard	To act as a Board champion to set an example and demonstrate that the Board is committed to promoting equality. To challenge and promote the E&D agenda in the Trust. Act as a voice at Board meetings for the E&D agenda.	The People Plan 2020 states that it is the explicit responsibility of the CEO to lead on equality, diversity and inclusion. Adrian Carradice – Davids NED Champion
Guardian of Safe Working Hours	To oversee work schedule review process and to address concerns relating to hours worked and access to training opportunities	2016 terms and conditions of service for doctors and dentists in training	tbc
Freedom to Speak Up Guardian	A person appointed by the organisation's Chief Executive to act in a genuinely independent capacity	Freedom to Speak Up Review, Feb 2015	Lauren Staveley – Freedom to Speak up Champion
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Louise Ludgrove - Director of People and Culture
NED Lead for Freedom to Speak Up	A nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board	Freedom to Speak Up Review 2015	Robbie Ryan - Non Executive Director
Senior Information Risk Owner	Executive director or member of the senior management board with overall responsibility for an organisation's information risk policy, accountable and responsible for information risk across the organisation.	David Nicholson letter dated 20 May 2008 (Gateway reference 9912)/Data Security and Protection Toolkit	Steve Christian - Deputy CEO, Executive Director of Strategy and Operations

Post	Description	Required by	Post holder
Caldicott Guardian	A senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly	Health Service Circular HSC 1999/012	Chris Barben - Executive Medical Director
Data Protection Officer	To inform and advise on legal obligations, on the carrying out of data protection impact assessments, to act as the point of contact for the ICO and to monitor compliance with personal data policies.	Section 69 Data Protection Act 2018; General Data Protection Regulation	Hayley Atkinson
Designated Individual for the Human Tissue Act	Duty to secure that suitable people and suitable practices are used in the course of carrying out the licensed activity and that the conditions of the licence are complied with.	Human Tissue Act 2004	Dr Sameer Shaktawat
Responsible Person - Blood and tissue	To ensure the correct processing of blood or blood components, including storage and distribution and providing information as required	the person who has been designated pursuant to regulation 6 as the responsible person for that blood establishment Blood Safety and Quality Regulations 2005	Imtiaz Ali – Transfusion Practitioner
Medical Physics Expert (Nuclear medicine)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Elizabeth Millington NM Modality Manager Emma Birch Consultant Clinical Scientist / RPA. Christies (CMPE)
Radiation Protection Advisor (Ionising Radiation and Lasers)	To secure compliance with the regulations in respect of work carried out in areas made subject to local rules.	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Joseph Bastin Principal Clinical Scientist Christies (CMPE)
MRI responsible person	A person with day-to-day responsibility for safety in the MRI centre	MHRA guidance	Neil Woodhouse MRI Modality Manager
MRI Safety Expert ?			Michael Hutton Consultant Clinical Scientist Christies (CMPE)
Board level lead for maternity services	National Maternity Review: Better Births (2016)	Routinely monitor information about quality, including safety, and take necessary action. Promote a culture of learning and continuous improvement to maximise quality and outcomes from their services.	Bridget Lees - Executive Director of Nursing, Midwifery, AHPs and Quality

Post	Description	Required by	Post holder
NED maternity board safety champion	Oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions	Safer Maternity Care 2016, and Ockenden Review 2020	Fergus Singleton NED
Accountable officer for controlled drugs	A fit, proper and suitably experienced person who satisfies the requirements as to seniority, reporting arrangements and activities	Section 8 The Controlled Drugs (Supervision of Management and Use) Regulations 2013	Rebecca Bond
Medication error lead	A board-level director to have the responsibility to oversee medication error incident reporting and learning	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Rebecca Bond
Medication Safety Officer	A person notified to the Central Alerting System to support local medication error reporting and learning and to act as the main contact for NHS England and MHRA.	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Rebecca Bond
Board lead for Learning Disability	This includes having a clearly designated executive-level lead for restrictive intervention reduction and an overarching restrictive intervention reduction policy.	The learning disability improvement standards for NHS trusts (2018)	Bridget Lees - Executive Director of Nursing, Midwifery, AHPs and Quality
Executive lead for safeguarding	A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements	Section 11, Children Act 2004 and Working Together to Safeguard Children 2015 (mandatory guidance)	Bridget Lees - Executive Director of Nursing, Midwifery, AHPs and Quality
Named doctor for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Dr J Hopewell and Dr K Goldberg
Designated doctor for child death	To take a lead in coordinating responses and health input into child death review processes across the locality.	Child Death Review: Statutory and Operational Guidance (England), October 2018	N/A - as we a provider organisation
Named Doctor for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions.	The Care Act 2014	We don't have one – depending on the speciality we go to the appropriate clinical lead
Named Doctor for Looked After Children	To advocate and ensure that looked after children's issues are reflected in policies and service delivery across the organisation.	The Care Act 2014	Named roles incorporate Looked After, also incorrect legislation

Post	Description	Required by	Post holder
Named nurse for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults at risk. This should be explicitly defined in job descriptions	The Care Act 2014	Maxine Stansfield and Paul Corry as Named Professional for Adults
Named nurse for safeguarding children	To support all activities necessary to ensure the organisation meets its responsibilities to safeguard/protect children and young people. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Melissa Gregan and Lisa Parry
Named midwife for safeguarding	To support other professionals in their agencies to recognise the safeguarding needs of pregnant women and the unborn/newborn child. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Schelley Lowe and Lisa Elliot
Named nurse for looked after children	A registered nurse with additional knowledge, skills and experience that has a particular role with looked after children and is the lead professional for these children	Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015)	Named roles incorporate Looked After
Accountable executive for security	Sec of State Direction to NHS Bodies on Security Management Measures 2004	To be the accountable person for security at an Executive Level within the NHS Trust.	Janet Barnsley – Executive Director of Integrated Care
Security Management NED Champion	There is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates.	Directions to NHS Bodies on Security Management Measures 2004	Fiona Ecclestone NED
Authorisation of Authorised Officers in relation to Section 120 of the Criminal Justice and Immigration Act 2008	Section 120 of the Criminal Justice and Immigration Act 2008 If an authorised officer reasonably suspects that a person is committing or has committed an offence …, the authorised officer may (a)remove the person from the NHS premises concerned, or (b)authorise an appropriate NHS staff member to do s	The procedure for the authorising of authorised officers is not laid out in the act, but it is recommended that authorisation of officers is made in writing by a person at board level in the NHS body They should have assurance as part of this process that the authorised officers and appropriate NHS staff are suitably trained and competent to carry out their roles.	Janet Barnsley – Executive Director of Integrated Care

Post	Description	Required by	Post holder
Accountable Emergency Officer	Board-level director responsible for EPRR with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements and to provide assurance to the Board.	Section 252A National Health Service Act 2006	Janet Barnsley – Executive Director of Integrated Care
Accredited Security Management Specialist	Focal point for the local delivery of professional security management work carried out to a high standard within a national framework	Direction to NHS bodies on Security Management Measures 2004	Paul Matthews
Accredited Local Counter-Fraud Specialist	To manage fraud, bribery and corruption risks across the organisation and ensure the Trust is compliant with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.	NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013) 2021	John Marsden Local Counter Fraud Specialist
UK Visa and Immigration Authorising Officer	Senior and competent person responsible for the actions of staff and representatives who use the Sponsorship Management System	UK Visas and Immigration	Katy Coope – Deputy Director of People and Culture
Doctors disciplinary NED champion/independent member	There is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case.	Maintaining High Professional Standards in the Modern NHS (2003) and the associated Directions on Disciplinary Procedures (2005)	James Wilkie – Vice Chair Other NEDs to deputise as required
Wellbeing Guardian	To look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and safety lies with Chief Executives or other accountable officers.	NHS People Plan	Andy Roach Non-Executive Director
Board-level lead for Net Zero	Board-level lead	Delivering a Greener NHS, 2021	Steve Christian - Deputy CEO, Executive Director of Strategy and Operations

Blackpool Teaching Hospitals NHS Foundation Trust

Title	New Hospitals Programme Quarter 1 Board Report

Meeting:	Board of Directors
Date:	7 September 2023

Author	Rebecca Malin, Programme Director Jerry Hawker, Programme SRO					
Exec Sponsor	Janet Barnsley, Executive Director of Integrated Care					
Purpose	Assurance	X	Discussion		Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 1 period: April to June 2023. This quarterly report is presented to the following Boards: • University Hospitals of Morecambe Bay NHS Foundation Trust • Lancashire Teaching Hospitals NHS Foundation Trust • East Lancashire Hospitals NHS Trust • Blackpool Teaching Hospitals NHS Foundation Trust • Provider Collaborative

Implications *(so what)*	**Alert** N/A **Assure** The report includes the progress against plan for April to June 2023, in particular providing an update on the outcome of the Government funding announcement, further work on potential new site locations and preparations for future public consultation.

Previously considered by	None

Link to strategic objectives	Our People	
	Our Place	X
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	None

Proposed Resolution ***(What next)***	It is recommended the Board: • Note the progress undertaken in Quarter 1. • Note the activities planned for the next period.

NEW HOSPITALS PROGRAMME Q1 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 1 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP).

2 Background

2.1 University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) are working with local NHS partners to progress the case for investment in new hospital facilities.

2.2 The L&SC NHP is part of cohort 4 of the Government's national New Hospital Programme (NHP).

2.3 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the current ageing hospital buildings. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.4 On 25 May 2023 the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer.

2.5 Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital.

2.6 Being able to build new hospitals on new sites will be truly transformational, giving us the freedom to design our services and facilities around the needs of our patients, future-proofing services for the next generation. This once-in-a-generation opportunity will be a huge contribution to our recovery as a health and care system after Covid-19, bringing new

facilities and much needed investment into our area for the benefit of patients and colleagues. The L&SC NHP gives us a real opportunity to achieve our ambitions for being an exemplar health and care system by transforming the way we work across our hospitals in Lancashire and South Cumbria, enabling us to improve quality, safety and patient experience for our whole population and have a positive impact for our NHS colleagues, who undertake incredible work to support our communities every day.

2.7 The existing Royal Lancaster Infirmary and Royal Preston Hospital sites will remain in place and deliver services to our population until new hospital facilities are opened. What this means for future hospital services needs to be worked through. The local NHS will continue to keep communities involved and provide further updates as more information becomes available.

3 National New Hospital Programme

3.1 **Programme business case** – following review of the national programme business case by the Major Projects Review Group in Q3 and Q4, the local NHS welcomes the subsequent government announcement on 25 May 2023, confirming national funding for the next phase of the national New Hospital Programme, which paves the way for new hospital facilities in Lancashire and South Cumbria.

3.2 This means that L&SC NHP can progress with the business cases for two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. The L&SC NHP will continue to work with partners across Lancashire and South Cumbria along with NHS England to determine the requirement and focus of any future public consultation.

3.3 **Enabling works –** Whilst a construction start date for two new hospitals is now delayed until 2030, the national NHP is committed and keen to support the L&SC NHP to progress, ensuring readiness for 2030 (or earlier should there be any change). In line with this, the L&SC NHP welcomed the opportunity to bid for enabling / early works funding. This will be focused on work that enables two new hospitals, including further work on potential new sites.

3.4 **National guidance** – as part of cohort 4 of the national NHP, L&SC NHP will be a full adopter of national NHP guidance on Hospital 2.0, an integrated systems approach built on best practice standards and delivery solutions, enabling best-value procurement and Modern Methods of Construction (MMC). The aim of this is to drive an accelerated programme,

creating transformative environments that will benefit patients and the public as a whole. A critical part of this system will be the ability to create prototypes to enable quick learning, collaboration and validation of hospital design including new greener and safer ways of building.

3.5 During Quarter 1, the L&SC NHP team have attended a number of workshops focused on the development of national ambitions around Hospital 2.0. Sessions to date have covered topics such as the approach to building design considering the needs of patients and staff; cost and benefits; delivery plans and phasing; commercial strategy; roles and responsibilities; out of hospital / community care considerations; clinical services; and addressing environmental targets. This forms part of six months of engagement sessions to maximise the opportunity for collaboration and co-creation of Hospital 2.0 between local schemes and the national NHP.

4 Progress against plan (for the period April to June 2023)

4.1 **Potential new sites** – work is underway to assess the viability of potential locations for new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital. Following an initial land search, the NHS in Lancashire and South Cumbria has been working in partnership with town, city and county councils to assess the deliverability of a number of potential sites, including environmental, planning and highways considerations, capacity for utilities and high-level design. Travel and transport analysis will also form a key element of consideration of viable sites. The programme team will continue to consider and assess any sites put forward against the existing criteria. There is still a lot of work to be completed in this area and further information will be shared in due course. New builds on new sites would be within around a 10-mile radius of the current Royal Lancaster Infirmary and Royal Preston Hospital sites respectively.

4.2 A Strategic Infrastructure Group has been established with representatives from Lancaster City Council, Preston City Council, Chorley Council, South Ribble Borough Council, Lancashire County Council, L&SC NHP and the ICB to focus on a strategic approach to potential new sites and the existing hospital sites.

4.3 **Public consultation planning** – L&SC NHP is working with NHS England and the national NHP team regarding the approach to future public consultation and will continue to work with local Health Overview and Scrutiny Committees, who are instrumental in determining the requirement to consult and the approach to be taken.

5 Public, patient and workforce communications and engagement

5.1 **Funding announcement** – Following the Government announcement of national funding on 25 May 2023, communications have been shared with key internal and external stakeholders, colleagues, partner organisations, local and national media, and local people. This included issuing updates to Boards, Governors and Foundation Trust Members, with internal communications shared with colleagues across Lancashire and South Cumbria Trusts and NHS Lancashire and South Cumbria Integrated Care Board (ICB). A media release on the funding announcement was issued, with a number of interviews held, resulting in widespread coverage across local media. Social media news alerts and email updates have been shared through L&SC NHP channels and shared by partners. The frequently asked questions continue to be updated on the L&SC NHP website on a regular basis, with ongoing enquiry handling.

5.2 The Health Minister Lord Markham and the national New Hospital Programme is embarking on a series of roadshow events throughout the summer including Lancashire and South Cumbria. This event is an opportunity to learn more about the national New Hospital Programme and discuss proposals for the Lancashire and South Cumbria schemes with Health Minister and members of the national New Hospital Programme team. The L&SC NHP is very much looking forward to hosting this event and taking this opportunity to further involve and engage a range of local stakeholders and colleagues.

5.3 **Stakeholder management** – Updates regarding the funding announcement have been issued to MPs; Local Authority leaders, Chief Executive Officers, Health Overview and Scrutiny Committees, and Health and Wellbeing Boards; and wider partners, with the repeat of an offer to meet with the L&SC NHP team to discuss programme progress further.

5.4 In response, meetings have been held to discuss the next phase of the L&SC NHP and the announcement of two new hospitals on new sites to replace Royal Lancaster Infirmary and Royal Preston Hospital, with investment in Furness General Hospital, with Simon Fell MP (Barrow and Furness), Mark Menzies MP (Fylde) and David Morris MP (Morecambe and Lunesdale) during June 2023.

5.5 Members of the Programme team updated the Lancashire Health and Adult Services Scrutiny Committee on 12 July 23 and attendance at Westmorland and Furness Health and Adults Scrutiny Committee and Cumberland Health Overview and Scrutiny Committee is in the process of being arranged.

5.6 **Your Hospitals, Your Say** – the report which brings together all the valuable input from the engagement work undertaken to date was published in September 2022. A British Sign Language (BSL) version of the Your Hospitals, Your Say report has been produced, with support from Lancashire Teaching Hospitals NHS Foundation Trust's Blended Learning team. The BSL video is now available on the Your Hospitals, Your Say section of the NHP website, along with an Easy Read version and accessible website content.

6 Next period – Q2 2023/24

6.1 The Programme will continue to work on assessing the viability of potential locations for new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital and preparations for future public consultation. The Programme team will commence discussions with the national NHP regarding the timing of business case products and work with ICB colleagues to develop an agile governance model.

7 Conclusion

7.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 1 of 2023/24.

8 Recommendations

8.1 The Board is requested to:

- Note the progress undertaken in Quarter 1.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
July 2023

Jerry Hawker
Programme Senior Responsible Officer

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Fit and Proper Persons Framework

Meeting:	Board of Directors
Date:	07 September 2023

Author	E Steel – Director of Corporate Governance					
Exec Sponsor	E Steel - Director of Corporate Governance					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** Update provided on the implementation of the new Fit and Proper person Framework for all NHS Board members

Implications *(so what)*	**Alert** Compliance with the framework is mandatory and will be tested by the CQC **Assure** MIAA have commenced testing for a pro active review of our policy and compliance with the policy

Previously considered by	N/A

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	All appointments to the Board are made in accordance with our EDI policy

Proposed Resolution	Board members are asked to note the processes in place and specifically the need to comply with requests in relation to testing compliance including the completion of an annual self-attestation.

Fit and Proper Persons Statement

1) Introduction

The Fit and Proper Persons Requirement (FPPR) is a statutory requirement for all care providers registered with the Care Quality Commission (CQC).

The FPPR regulations first introduced in November 2014 in response to the Francis report, apply to NHS board directors and equivalents who are responsible and accountable for delivering care, including associate directors and any other individuals who are members of the board, irrespective of their voting rights or tenure - this applies to interim positions as well as permanent appointments.

As part of the recruitment process for Board members checks are conducted including but not limited to:

- Checks on an individual's
    - Qualifications
    - Competence and ability,
    - relevant experience
    - Good character
- Consideration to the physical and mental health in line with the role and good occupational health practice
- To ensure, as far as possible the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful of not) in the course of carrying on a regulated service; this includes any allegations of such.

Through appraisal each year, individual Board members will be continually monitored to ensure that they meet the requirements to hold office. If they do not, action will be taken by the Trust Chair after appropriate consultation with the Remuneration or Nomination Committee.

The Director of Corporate Governance maintains the evidence required to support compliance with the 'Fit and Proper Person Test'.

It is ultimately the responsibility of the Chair to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.

As part of the CQC inspection for the Well-Led Review in 2021, evidence was requested to support our Fit and Proper Person declaration. This information is checked annually, and it can be confirmed that all Board members are still compliant against these external checks, and all have a valid Disclosure and Barring Service (DBS) check in place.

2) Changes to legislation

In August 2023, in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review), NHS England published an updated Fit and Proper Person Test (FPPT) Framework for board members, NHS England Fit and Proper Person Test Framework for board members.

The revised framework introduces new and more comprehensive requirements around board appointments, annual reviews, and provision of references, which have widespread implications from a HR, legal and governance perspective.

An updated FPPT annual checklist will be introduced in October 2023 this has been brought in line with the NHSE FPPT framework and will include areas for the Trust to consider as follows:

- Training and development
- References
- Last appraisal and date
- Disciplinary findings
- Grievance
- Whistleblowing
- Behaviour
- Type of DBS disclosed/received
- Date of medical clearance
- Date of professional register check
- Insolvency check
- Disqualified directors register check
- Disqualification from being a Charity Trustee check
- Employment tribunal judgement check
- Social Media check
- Self-attestation form signed
- Sign-off by Chair/CEO

3) Next Steps

a) The Trust's Fit and Proper Persons Policy (CORP/PROC/672) to be brought in line with the NHSE's FPPT framework for board members.

b) MIAA have recently commenced their testing as part of a scheduled pro-active review of our compliance with the previous guidance – the scope has been considered to ensure this is reflective of the latest guidance.

c) The Board will receive an annual update on overall compliance with the framework and a Chair's declaration attesting to the Fit and Proper status of all Board members.