Board of Directors in Public Meeting (Part 1)
2nd November 2023
09.30 – 12.30
Boardroom, Trust HQ.

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Time		Topic	Lead	Process	Purpose / Expected Outcome
9.30	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
Quality					
9.50	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 *Louise Peacock (Maternity and Neonatal Independent Senior Advocate) to join for this item*	Director of Midwifery	Report ✓	To note for assurance
	11	Learning from Deaths / Mortality	Medical Director	Report ✓	To note
Finance and Performance					
10.30	12	Finance and Performance Committee Escalation Report	Chair of Finance and Performance Committee	Report ✓	To note for assurance
	13	Petty Cash Reimbursement	Deputy Director of Finance	Report ✓	To approve
	14	National Cost Collection 2023 Submission Process	Director of Finance	Report ✓	To approve

Time		Topic	Lead	Process	Purpose / Expected Outcome
	15	Finance Integrated Performance Report	Interim Director of Finance	Report ✓	To note
	16	Operational Performance Integrated Performance Report	Deputy Chief Executive	Report ✓	To note
Workforce					
11.00	17	Workforce Assurance Committee Escalation Report	Chair of Workforce Assurance Committee	Report ✓	To note for assurance
	18	Workforce Integrated Performance Report	Director of People and Culture	Report ✓	To note
	19	Freedom to Speak Up (FTSU)	FTSU Guardian	Report ✓	To provide assurance
	20	Equality and Diversity Report (including WRES & WDES & Gender Pay Gap)	Director of People and Culture	Report ✓	To note
Collaboration					
11.30	21	Place Based Partnership Plan Update	Director of Adult Services, Blackpool Council	Presentation ✓	To note
	22	Winter Plan	Deputy Chief Executive	Report ✓	To note
Governance					
12.10	23	Audit Committee Escalation Report	Chair of Audit Committee	Report ✓	To note for assurance
	24	Audit Committee Annual Report	Chair of Audit Committee	Report ✓	To note for assurance
	25	Strategy and Transformation Committee Escalation Report	Chief Executive ✓	Report ✓	To note for assurance
	26	Chair and CEO Roles and Responsibilities	Director of Corporate Governance	Report ✓	To approve

Time		*Topic*	*Lead*	*Process*	*Purpose / Expected Outcome*
	27	Emergency Preparedness Resilience and Response (EPRR)	Director of Integrated Care	Report ✓	To note for assurance
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.***					
	28	Clinical Strategy Guiding Principle and Themes	Deputy Director of Strategy and Transformation	Report ✓	For information
	29	New Hospital Programme Update	Deputy Chief Executive	Report ✓	For Information
Closing matters					
12.20	29	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 11th January 2024 at 9.30am

Meeting	Board of Directors Public Meeting	
Time	09.30 am	
Date	7th September 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 Brearley	Interim Finance Director	
Adrian Carridice-Davids	Non-Executive Director	
Steve Christian	Deputy CEO (Strategy, Operational Performance, Transformation & Digital)	
Fiona Eccleston	Non-Executive Director	
Bridget Lees	Executive Director of Nursing, Midwifery, Allied Health Professionals (AHPs) and Quality.	
Louise Ludgrove	Executive Director of People and Culture	
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	Items 10 & 11
Jacinta Gaynor	Corporate Governance Officer	Minutes
Lauren Kavanagh	Corporate Governance Officer	
Lauren Staveley	Freedom to Speak Up Guardian	Item 18
Esther Steel	Executive Director of Corporate Governance	
Observers: -		
Howard Ballard	Public Governor – Wyre Constituency	

William Jackson	Public Governor – Wyre Constituency
Maggie Heaton	Union Representative
Hayley Howson	Staff member
Dr Ranjit More	Staff Governor, Medical & Dental
Beverly Nesbit	Staff member
Shelagh Parkinson	Local Democracy Report, Gazette
Nigel Patterson	Public Governor, Blackpool
Mark Singleton	Chief Information Officer

Apologies:-

Mark Beaton	Non-Executive Director
Sue McKenna	Non-Executive Director

1. Welcome and Introduction

The Chair welcomed members to the meeting.

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 5th July 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 provided a verbal update on the below actions and confirmed those completed and that the remaining actions had a future completion date.

BOD/23/08 – A formal invite has been sent and will be chased.
BOD/23/16 – Ongoing work being undertaken on the IPR to reflect the requirements.
BOD/23/24 – An EDI Board development session to be arranged once the Culture Plan has been presented to the Board of Directors.
BOD/23/27 – A formal report would be presented to the next Quality Assurance Committee.

Matters Arising

There were no matters arising.

6. Chair's Update

The Chair acknowledged that it was a full agenda. The Chair referred to item 7.1 on the agenda and stated that it was important to work through the response, but noted this would be subject to a full inquiry.

7. Chief Executive Report

The Chief Executive (CEO) provided a summary of the key activities within the Trust since the previous meeting. These included the below highlights: -

Awards and Recognition

- HSJ Awards 2023 – three teams had been shortlisted.
- Excellence in Mental Health Award in the NHS Parliamentary Awards – The Lancashire and South Cumbria Reproductive Trauma Service won the award.
- A Trust team who support victims of sexual violence received Home Office funding of £200k.
- Healthcare Financial Management Association North West Embracing Technology Award – The Trust's Costing Team were successful alongside colleagues in the Integrated Care System (ICS).
- Clinical Quality Academy – Teams across the Trust showcased their improvement projects in July.

Trust Update

- The Trust continues to manage the ongoing industrial action.
- Volunteer, Barry Evans celebrated his 80th birthday with colleagues.
- The flu vaccination campaign due to be launched at end of September commenced a campaign to recruit vaccinators.

Reportable Issues Log

- 13 reportable incidents logged between 27 June and 23 August 2023; all being investigated as serious incidents (SI). None were identified as 'never events'.
- The Trust received three low risk and one moderate risk complaints and have 86 ongoing cases.

System News and Developments

- The Lancashire & South Cumbria (LSC) Integrated Care Board (ICB) met on 5th July 2023.
- The Provider Collaborative Board met on 20 July 2023 and a staff briefing took place on 4th September 2023.
- An Urgent and Emergency Care (UEC) strategic redesign event took place in collaboration with colleagues from the ICB, primary care, external stakeholders and Lancashire and South Cumbria NHS FT (LSCft).

Resolved: Members noted the CEO's report and the update.

7.1 Response to NHS England's Letter – L Letby

The Chief Executive provided an overview of the Trust's response to a letter sent to all NHS organisations by NHS England (NHSE) following the outcome of the Lucy Letby trial. Members noted that an independent enquiry had been commissioned into the events at the Countess of Chester Hospital NHS FT.

Members noted that the letter had requested five key actions were put in place by all NHS leaders, and the CEO confirmed that these had been responded to as highlighted within the report.

The CEO assured members that all staff had a variety of avenues in which to raise issues and that it was the duty of the Trust to fully investigate any issues raised.

There was a discussion on how members gained assurance from a governance perspective on how Board members develop with a specific emphasis on the Freedom to Speak Up matrix and how this could be supported by Board members. The Chair stated that the upcoming Board development session would provide an opportunity to undertake an effective governance review.

Resolved: Members noted the report and update.

8. Quality Assurance Committee Escalation Report

Andy Roach (Non-Executive Director member of the Quality Assurance Committee) drew the member's attention to the Quality Assurance Committee Escalation Reports for July and August 2023 that had been circulated with the papers and detailed the alerts, advice and assurance items.

Members noted the alerts from both meetings related to:-

- The UEC survey results.
- The Maternity Staffing Report.
- The lapse in performance in the prescription and administration of antibiotics to patients on the sepsis pathway.
- The National Paediatric Diabetes Audit results.
- The MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) which identified the Trust as having a neonatal mortality rate 5% higher than the average for similar trusts.
- The 79 outstanding fire risk assessments to be expedited.

Resolved: Members noted the reports.

9. Quality Integrated Performance Report

The Medical Director and 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 Medical Director highlighted the following key points: -

- The Trust was currently above target for MSSA, CDI and E-Coli infections for July 2023.
- The Summary Hospital-level Mortality Indicator (SHMI) scored had improved as of May 2023 at 100.3.
- There had been a significant reduction in the percentage of deaths screened within the last two months.

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

- There had been no neonatal deaths or stillbirths in July 2023.
- Falls across the Trust continued to be within normal parameters.
- Patient experience feedback remained at a rate of 95% of patients stating they received good or very good care.
- Work was ongoing within UEC with a specific focus on addressing the overall satisfaction rating of 71%.
  A total of 48 complaints were received in July 2023, 14 of which breached the local response target.

The Chief Executive referred to the decrease in feedback from the Friends and Family Test and stated that it was important to have consistent feedback in order to gain assurance that the Trust was performing well. The Chief Executive also drew attention to the complaints review and stated that the quality of responses should remain a priority along with the 40-day deadline.

In response to a query from the Chair relating to the mortality review processes, the Medical Director confirmed that the Trust had its own internal reporting framework and an external independent process undertaken by the Medical Examiner who was independent from the medical team.

In response to a query from a Non-Executive Director as to whether sepsis data should be included within the IPR, the Executive Director of Nursing, Midwifery, AHPs and Quality confirmed that it would be embedded within the IPR.

Resolved: Members noted the IPR and updates.

10. Maternity and Neonatal Report

The Director of Midwifery 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).

The Director of Midwifery highlighted the following alerts in relation to training and compliance and maternity staffing:-

- The Trust's Maternity services were not currently compliant with the Birthrate Plus recommendations and a shortfall of 5.75wte midwifes.
- The overall compliance target of 90% for mandatory training had not been reached since January 2023.
- Maternity skills drills compliance had decreased over the past four months.

Members discussed the concerns related to the shortfall of 5.75wte midwives and acknowledged the action plan which set out the plans to ensure the Birthrate Plus recommended rates would be achieved within the 2023/24 financial year.

Members were reassured that the implemented recovery plan for training and compliance had produced an improvement in compliance and noted that medical teams had been allocated dates for training.

Resolved: Members noted the reports and updates provided.

11. Professional Judgement Update – Nurse Staffing

The Chief Nurse provided a high-level summary of the report previously circulated with the papers, which provided the six-monthly review of staffing templates for nurse staffing. The following key points were highlighted:-

- A review was undertaken in June 2023 covering the last quarter (April to June 2023).
- The overall percentage compliance vs the current staffing templates is 91.8% against the national trajectory of 85% and Trust wide trajectory of 90%.
- Sickness rates were at 6.8% against a Trust target of 4%.
- Staffing levels are monitored through the Quality Assurance Committee.
- The Professional Judgement review concluded most templates were safe with some minor cost neutral adjustments.

Members noted that the Trust had been proactive in reducing the gap in vacancies in midwifery and by end of September 2023 there would be 4 wte vacancies. Members were assured that escalation plans were in place with daily monitoring to ensure safe in accordance with regulations.

In response to a query from a Non-Executive Director seeking clarification on funding, the Director of Midwifery confirmed that the original Birth rate business case funding had not been added into the maternity budget, but Birth rate and CNST require the funding to be evidenced within the maternity budget, the business case was resubmitted in April 2023 for half the funding into the budget, but the 5.75 shortfall remained.

In response to a query from a Non-Executive Director on the possible impact of non-compliance with Birth rate targets, the Director of Midwifery confirmed that the Trust would be able to evidence the rationale of actions taken and mitigations put in place, the monitoring of safe staffing levels and partaking in Birth rate plus assessments the Trust would not be criticised.

A short discussion took place on the attrition rate of midwifes and members noted that the Trust was not actually losing staff, but staff were choosing a work life balance and reducing their working hours. The Director of Midwifery confirmed the Trust had increased student numbers from local universities and were progressing maternity support workers to become midwifes.

Resolved: Members noted the report and update provided.

12. Finance and Performance Assurance Committee Escalation Report

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

The following alerts were highlighted:-

- Operational pressures continue to be challenging due to industrial action.
- Limited assurance was provided that the Trust would achieve plan for the year, and there was the potential need for revenue support.

Members of the Committee were assured that appropriate actions were being taken to address the significant issue areas.

Resolved: The members noted the reports.

13. Finance Integrated Performance Report

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

- Financial performance for May - £3.7m deficit in line with plan.
- Financial performance year to date - £24.3m deficit in line with plan.
- Agency spend year to date (May) - £14.6m (9.9% of total pay bill vs system ceiling target of 3.7%).
- Capital Programme Expenditure year to date (May) - £3.9m.
- Cash balance (July) - £13.4m (decrease of £10.7m in month, but £2.4m higher than plan).

Members noted of the ongoing collaborative working with the ICB to identify additional mitigations, and the Chief Executive stated that it was imperative to ensure there was no double counting with regards QEP and system savings. Members noted that deliver of the budget was heavily reliant on QEP savings and reducing agency spend.

In response to a query from a Non-Executive Director relating to recurrent and non-recurrent QEP targets and whether there would be any impact in not hitting the targets, the Director of Finance confirmed the only impact would be an increased rate for the following financial year.

There was a discussion on the possible impact and the action needed to be put in place to negate such issues, and it was noted that a review would be undertaken October 2023. The Chair suggested that part of the next Board Strategy session be used for further discussion by the Board of Directors.

Resolved: Members noted the IPR and updates provided.
Action: Undertake a further discussion at the next Board Strategy session.

14. Operational Performance Integrated Performance Report

The Deputy Chief Executive provided a high-level summary of the Operational Performance IPR circulated with the papers. The following alerts were highligted:-

- The Accident & Emergency Care (A&E) 4-hr performance target – 215 less patients experienced corridor care in July 2023 indicating a 32% improvement in the same time last year.
- Ambulance handover timing had shown improvement since March 2023, but due to the Trust being in Opel 4 during August 2023 this has been a challenging time.
- RTT – 45 fewer patients against a plan of 280 were waiting above 65-weeks, a reduction of 33% compared to July 2022. The main issues were in cardiology, gastroenterology and gynaecology, although mitigations are in place it is not anticipated to hit trajectory in August 2023.

Members were assured that discussions were ongoing with Place based partners to resolve patient flow and length of stay issues. The Chair informed members that Karen Smith, Director of Place had given a presentation to the recent Council of Governors meeting and stated it would be useful to invite her to attend a Board session. Members requested further information on the partnership work being undertaken to improve hospital flow and reduce patient attendance at A&E.

In response to a query from the Chair in relation to the transfer of cancer care interventions, the Deputy Chief Executive confirmed that responsibility lies with the organisation who accepts the transfer with oversight from the Cancer Alliance. The Medical Director assured members that handovers and discussion for care took place within multi-disciplinary team meetings.

Resolved: Members noted the report and updates.
Action: Invite Karen Smith to attend a future Board session.
Action: Provide a further update on the partnership work being undertaken to improve hospital flow and reduce patient attendance at A&E.

15. NHS Winter Planning Arrangements

The Deputy Chief Executive provided a brief overview of the national approach to winter planning for 2023/24, the key measures required to be put in place and the two national ambitions for A&E recovery, being:

- 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 Deputy Chief Executive referred to the previously circulated presentation and confirmed that work was ongoing across the Trust and ICB to complete winter plans by the end of September provided. Members acknowledged that winter plans relied upon collaborative working across all health and social care organisations and system governance had been established to provide oversight or delivery.

The Chief Executive commented that as a Board of Directors it was important to have assurance that robust plans were in place. Members noted that as leaders it was necessary to consider preventative and holistic measures as well.

Resolved: Members noted the presentation and update.

16. Workforce Assurance Committee Escalation Report

The Workforce Assurance Committee Chair provided a brief overview of the Workforce Committee Escalation Report for July 2023 that had been circulated with the papers, with the following alert highlighted:-

- Bank and agency tracker report identified no reduction in agency spend in quarter 1 and was over budget.

Resolved: Members noted the report and the update.

17. 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 91.7% vs target of 95%
- Appraisal stood at 81% vs target of 90%.
- Sickness absence stood at 5.78% (May), rolling 12-month total of 6.53%.
- Vacancy rates for all clinical staff stood at 8.85% against a target of 4.28%.
- Medical vacancy rate had improved by 2.2% stood at 16%.

Resolved: The members noted the report.

18. Freedom to Speak Up (FTSU)

The FTSU Guardian provided a high-level summary of the report, which was to advise and assure the Board of Directors on the progress of, and further work undertaken in connection with the Freedom to Speak Up agenda in quarter 4 of 2022/23 and quarter 1 of 2023/23. The report detailed; the number of concerns raised during the time periods identified, any emerging themes, the actions taken to address the concerns raised and news from the National Guardian's Office (NGO) and included a gap analysis on the NGO recommendations to the ambulance service. The following were areas of note:-

- A new FTSU advisor had been recruited.
- FTSU mandatory training compliance stood at 80%.
- FTSU Awareness month during October 2023 with a variety of engagement events planned to take place.
- 83 cases had been raised in Q4 2022/23 and 82 concerns had been raised in Q1-2023/24, with full details in the report.

There was a short discussion on the positive change in the FTSU culture across the Trust, but it was noted there was a lot more work to be done, including a training programme for staff and support for managers.

Members acknowledged and thanked the FTSU Guardian for all her hard work.

Resolved: Members noted the report and update.

19. Equality, Diversity & Inclusion (EDI) Improvement Plan

The Executive Director of People and Culture provided a summary of the NHS England's (NHSE) EDI Improvement plan published in June 2023, which set out six high impact and time bound actions that all Trusts are required to action. The report identified the Trust's planned approach to implement the plan, actions that had already been undertaken and those actions that still and undertaken.

In response to a query from a Non-Executive Director relating to embedding this into the IPR as a measure of success for the organisation, the Executive Director of People & Culture confirmed that these targets would be monitored at Workforce Assurance Committee

Members acknowledged the report and agreed this was a critical piece of work that required a focus and further discussion from the Board of Directors and it was agreed that examples of best practice should be sought from other organisations who have implemented the plan well and to invite a speaker to attend a Board development session.

Resolved: Members noted the report and update.
Action: Seek out examples of best practice from other organisations that have implemented this well and invite a speaker to attend a BoD development session.

20. Audit Committee Escalation Report

The Audit Committee Chair drew attention to the Audit Committee Escalation Report that had been circulated with the papers which detailed the alerts, advice and assurance items.

The following twos areas were highlighted for assurance purposes:-

- Internal Audit Follow-Up Report – all outstanding KPMG actions had now been addressed or superseded.
- Committee Effectiveness review had been undertaken with positive feedback received

Resolved: Members noted the report and update.

21. Strategy & Transformation Committee Escalation Report

The Chief Executive drew attention to the Strategy & Transformation Committee Escalation Report for July 2023 that had been circulated with the papers which detailed the alerts, advice and assurance items.

Members noted that the highest risks were noted as the need for transformational investment and the lack of staff engagement due to operational pressures.

In response to a query from a Non-Executive Director in relation to local aims feeding into efficiency programmes, the Deputy Chief Executive confirmed that the main strategic

transformation portfolio was focussed on QEP and the development of efficient models of care.

Resolved: Members noted the report and update.

22. Medical Appraisal and Revalidation Report

The Medical Director gave an overview of the report which provided assurance that the Trust was compliant with the Medical Profession (Responsible Officers) Regulations 2010 and provided an update on the progress of the medical revalidation and appraisal process for the Trust.

Members noted the Workforce Assurance Committee monitored and had oversight of medical appraisal performance. The Medical Director informed members that a discussion had taken place at the Committee in relation to regulation processes. Members noted that the Trust had participated in an annual peer review and were awaiting the full report from East Lancashire Hospitals NHS Trust.

The Director of Corporate Governance confirmed that agenda item 23 provided a list of the regulatory and mandatory lead roles that foundation trusts are required to have as set by legislation and provided the compliance with the Responsible Officer Regulations referred to previously.

Resolved: Members noted the progress report and were assured that the Trust was compliant with the Medical Profession (Responsible Officers) Regulations 2010.

23. Regulatory and Mandatory Lead Roles

The Director of Corporate Governance referred to the above discussion and confirmed that the report provided assurance that all legal and statutory requirements were covered. Members noted that this information would be recorded for all existing and any new directors and any changes would be reviewed and updated accordingly. Members were informed that MIAA were undertaking a review of the processes in place to ensure that the Trust is fully compliant with the requirements of the Fit and Proper Persons regulations.

Resolved: Members approved the report**.**

24. New Hospital Programme Update

Members noted the previously circulated report.

Resolved: Members noted the report and update.

25. Fit and Proper Persons Framework

Members noted the previously circulated report.

Resolved: Members noted the report.

26. Any Other Business

General Medical Council

The Medical Director informed members that he wanted to congratulate the Education Team as due to a recent assessment they had been removed from enhanced monitoring

Date and Time of Next Meeting

Thursday 2nd November 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/23/16	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		Cross reference with action BOD/23/34	A
BOD/23/34	Part 1	14	07.09.23	Operational Performance Integrated Performance Report	Invite Karen Smith to a Board session dedicated to winter planning and Place Based partnerships.	Corporate Governance Team/ S Christian	02.11.23		Karen Smith attending the 02.11.23 Board.	Y
BOD/23/35	Part 1	14	07.09.23	Operational Performance Integrated Performance Report	Provide further update on the partnerships work being undertake to improve hospital flow and reduce patient attendance at A&E.	S Christian	02.11.23		To be included in the Op Perf IPR update	Y
BOD/23/36	Part 1	19	07.09.23	EDI Improvement Plan	Seek out best practice and other organisations that have implemented this well. Invite a speaker to attend a BoD development session.	L Ludgrove	01.02.24		propose link the 3 EDI Board development actions to one item and ensure we schedule a Board Development session on EDI before the end of the financial year	B
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		propose link the 3 EDI Board development actions to one item and ensure we schedule a Board Development session on EDI before the end of the financial year	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/23/24	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	propose link the 3 EDI Board development actions to one item and ensure we schedule a Board Development session on EDI before the end of the financial year	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		QI session delivered to Governors at Governor Quality Workshop on 10.10.23	G
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	G

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

Caring · Safe · Respectful

Agenda Item

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Chief Executive's Report

Meeting:	Board of Directors	Purpose	Assurance	✓
Date:	02 November 2023		Discussion	
Author	Trish Armstrong-Child, Chief Executive		Decision	
Exec Sponsor			Confidential y/n	N

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

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

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

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

1. Awards and Recognition

Dr Nicola Cable named best Doctor

Dr Nicola Cable, Head of Paediatrics at Blackpool's Blenheim House Child Development Centre, has been named Best Doctor in the popular national Who Cares Wins awards.

During the awards night, hosted by Davina McCall, the audience heard about the care Dr Cable provided to baby Evie and her Mum Kelly. After Kerry Coles gave birth, her little girl stopped breathing and doctors pronounced her brain dead.

Evie was put on a life support machine so her devastated parents Kerry and Jack could say goodbye. But thanks to the heroic efforts of Dr Nicola Cable, Evie is now a thriving three-year-old.

Dr Cable was nominated by Evie and her mum Kerry and her colleague, specialist nurse practitioner Angela Richardson.

Thanks to Dr Cable's determination to help Evie fulfil her potential and three years of hard work, she has finally been discharged from her care, and is a happy and healthy little girl.

Trust scoops major awards for patient safety

Blackpool Teaching Hospitals has been recognised for its work to improve patient care, winning top categories at the recent HSJ Patient Safety Awards.

The Trust won the award for Improving Care for Children and Young People Initiative of the Year, for its ED Navigator Service. This service works to provide support for young people who attend hospital with violence-related injuries and was described by the award organisers as "remarkable work which supported outcomes for children, young people and families."

A joint project between Blackpool Teaching Hospitals and Lancashire Constabulary brought success, winning the Best Use of Integrated Care and Partnership Working award. Operation Provide is a multi-agency programme which supports victims of domestic abuse across Blackpool, the Fylde Coast and North Lancashire. Organisers said that judges found the entry 'original and impactful.'

Finally, the Trust was highly commended in the category of Patient Safety Pilot Project of the Year for its work to reduce Hospital Acquired Pneumonia (HAP), which is associated with issues including increased mortality and length of stay in hospital.

A congratulatory letter from Richard Barker, CBE, Regional Director of NHS England North West, was issued to Chairs and Chief Executives and is included as *Appendix 1*.

TAVI team celebrates benchmarking success

Our Transcatheter Aortic Valve Implantation (TAVI) team has celebrated being recognised as a centre of excellence when they successfully completed the Edwards Benchmark Programme on transcatheter valve care pathway.

In order to be accredited, centres enrol in the programme, learn from experts, work as a team to identify areas of improvements and share experience with others. It sets standardised practices to achieve minimalistic TAVI with a focus on conscious sedation, recovery outside the intensive care unit, and a goal of next-day discharge.

MUST project shortlisted for FabQI Award

Congratulations to Cristian Jesus Figueredo Martinez, a trainee ACP working in care of the older person.

Cristian's Quality Improvement project has been shortlisted for a FabQI individual award. It focuses on improving the patient's quality of life by using the Malnutrition Universal Screening Tool (MUST score "Must be done"). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

The Academy of Fabulous Stuff is a social movement for sharing health and social care ideas, projects and service improvements. The award winners will be decided by a public vote and further information will be shared in our communications.

Blackpool healthcare professional recognised with Charity Award

Rosanne Norman, health play specialist at the Trust has been named as the country's runner up Mentor of the Year at Starlight's Health Play Awards. Starlight, the UK's leading charity for children's play in hospitals and hospices, holds the annual Health Play Awards to recognise inspirational healthcare professionals who work to ensure every child experiences the power of play. Play can reduce fear, pain and trauma, so they advocate for this during a child's treatment and recovery from illness.

Having been a health play specialist for over 18 years, Rosanne has a wealth of experience using play to relieve children's anxiety, help them understand their diagnosis and even reduce their pain. As well as this, Rosanne now also inspires future health play specialists as a mentor.

Jackie completes Leadership Scholarship from the Florence Nightingale Foundation

Congratulations to Jackie Brunton, Lead Nurse End of Life and Bereavement Care who recently graduated at a ceremony in London having completed a Florence Nightingale Foundation (FNF) Leadership Development Scholarship

FNF Leadership Scholarships are created to enable scholars to explore and discover their own leadership style and develop the essential skills to be a courageous leader.

The award was presented to Jackie by Chief Nurse for Wales Sue Tranka and Prof Greta Westwood, who is CEO of Florence Nightingale Foundation. Jackie also had the opportunity to meet Ruth May who is the Chief Nursing Officer for England.

Executive Director of Nursing Award

Bridget Lees, Executive Director of Nursing was recently presented with the Carvel Award. This award is for nurses who go above and beyond to support nurses and health care assistants and Bridget was nominated by senior members of the leadership team who recognised the positive impact and contribution she has made since joining the Trust.

2. Trust Update

Trust appoints Executive Director of People and Culture

Following a robust recruitment process Katy Coope, who is the current Deputy Director of People and Culture at the Trust, was appointed as the new Executive Director of People and Culture.

Katy will be bringing a wealth of experience and expertise gained from her previous career to the post, as well as the knowledge she already has from her time in Blackpool to date.

The Trust's current Executive Director of People and Culture, Louise Ludgrove, will remain with the team until the end of March 2024 with a significant focus on supporting the Trust to implement our culture plan.

Trial of Catherine Hudson and Charlotte Wilmot

The Trust has been working with Lancashire Constabulary across a number of investigations.

This has culminated on 5 October with a verdict being returned following a trial at Preston Crown Court involving two former colleagues, a registered nurse and an assistant practitioner, who faced a number of serious allegations.

Catherine Hudson was convicted on three counts of ill-treating patients and one charge of the theft of drugs. Charlotte Wilmot was convicted of one count of encouraging the ill treatment of a patient. They were both convicted of conspiracy to ill-treat a patient.

From the evidence presented during the trial it was clear that inappropriate and unacceptable conduct and practices were taking place at the time. Tris Armstrong-Child, Chief Executive of the Trust, issued an apology to patients, families and colleagues who were impacted by that behaviour and to stakeholders as active partners in supporting our communities.

The Trust has made significant improvements across a range of issues – but particularly in the areas of staffing, managing medicine and creating a more respectful culture.

Sentencing will take place at Preston Crown Court in December.

Industrial action

The Trust continues to manage ongoing industrial action by professional groups and trade unions over a pay dispute with the Government.

The most recent periods of industrial action took place during September and October. These proved particularly challenging due to Junior Doctors and Consultants combining their strike action on four days, with 'Christmas Day' levels of cover on those days being provided from both groups.

Careful planning has and will continue to take place to minimise the impact on patients, families, and colleagues. However, it must be highlighted that this is having a significant impact on all aspects of operational delivery.

Urgent Care

Since the last Trust Board the organisation has continued to experience significant and continued pressures around urgent care demand. Our senior team continue to have oversight and to ensure plans are in place to maintain patient safety.

Building work that continues in our Emergency Department to enable the last phase of our new refurbishment is having a significant impact on the Trust's ability to achieve ambulance handover times. We continue to work with colleagues at NWAS to improve this.

Flu vaccination campaign

Following the effective flu vaccination campaign recruiting vaccinators to support with the 2023/24 flu vaccination roll out, a successful vax-athon event was held.

The Trusts first ever Vax-athon event which aimed to vaccinate as many colleagues as possible over a 12-hour period with the flu vaccine, started at 9.30am with colleagues queuing to get their jab.

By the close of the event the Occupational Health team together with peer vaccinators had successfully set a new BTH personal best for most people vaccinated in one day – vaccinating 376 colleagues. Our current vaccination rate is 28%.

Staff survey launch

Each autumn everyone who works in the NHS in England is invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements.

The aggregated survey results are official statistics, providing a rich source of data that is used by a wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

In 2021 the questions were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be. This year, the survey was extended to Bank workers and General Practice colleagues following successful pilots.

The survey closes on 24 November and results will be shared with organisations in spring 2024. Our current response rate is 41.1%.

Trust's Behavioural Framework

Earlier this year, the Trust undertook an engagement exercise with the workforce to review the Trust values. Colleagues decided that new values were needed to reflect the changes in the organisation. These new Trust values were confirmed as Caring, Safe and Respectful. These are currently being rolled out across the organisation.

In addition to the values, a behavioural framework which will underpin the values is in development. The behavioural framework will be co-produced with colleagues and patients and will describe what good and poor behaviours look and sound like.

The behavioural framework will provide a simple tool which defines the effective behaviours to be reflected in daily working practices. The behaviours, based on the Trust's core values, will be developed for the whole organisation, and therefore provide a common language and benchmark to be used when talking about behavioural performance.

In this context the framework will clearly set out the organisation's expectations in terms of how all colleagues go about their work. The framework will also include examples of ineffective behaviours and actions not expected to be reflected in daily working practices.

The framework will be used as a reference point as part of everyday work activity, and they will describe the behaviours required by all employees.

A comprehensive engagement plan is being followed to ensure the behavioural framework is co-produced with patients and members of our workforce, with the final version of the framework being presented to the Board in November 2023.

'Sit with Hope' benches unveiled

The Trust's Sit with Hope benches were unveiled, providing a place for contemplation as well as signposting bereaved people via a QR code on a plaque to sources of grief support.

The Trust's Lead Nurse for end-of-life bereavement care, Jackie Brunton, attended the Good Grief Trust's launch of their national campaign earlier this year at the Windsor Flower Show where she met HRH The Duchess of Edinburgh.

Those who visit a bench will be able to access advice and resources to guide them through bereavement via a QR code and signpost them to a choice of bereavement support organisations. It will also provide an opportunity to reflect and talk to someone.

Trust support is provided for colleagues by the Swan and End of Life team, the Chaplaincy and the Well team.

Trust consultant to lead research project to understand the impact of surgery on patients

Consultant Cardiac Surgeon Cristiano Spadaccio is embarking on a year-long research project looking at patient outcomes following cardiac surgery.

The project, funded by a grant awarded by the Manchester Biomedical Research Centre, will capture data on the "real life" impact of surgery for patients.

A dedicated clinical research unit within the Cardiothoracic department at Blackpool Victoria Hospital will be established to assess patient-reported outcomes (PROs) in cardiac surgery interventions using special questionnaires looking at both generic and disease-specific issues.

The overarching aim is to integrate Patient Reported Outcomes (PROs) assessment into the standard clinical pathway for cardiac surgery patients, promoting overall well-being and enhancing cardiovascular health outcomes.

If successful within the one-year funding period, the proposed framework could be introduced into the standard pathways of cardiac patients, with potential extension to longer-term follow-up. Additionally, the results may inform the development of new patient-facing digital applications that allow patients to directly report PROs, enabling telemonitoring, or remote monitoring, of their cardiovascular health.

Cultural diversity network welcomes new cohort of nurses

Robert Joseph M. Yusay and the cultural diversity network recently welcomed a new cohort of nurses from the Philippines. Arriving safely here in Blackpool they received an induction and warm welcome from the network.

First service held in the new Spiritual Care Centre

A milestone was reached in the progress of the new Spiritual Care Centre at Blackpool Victoria Hospital which recently held its first service led by the Trust's Imam, Ashfaq Patel.

The Centre has undergone a major transformation including the careful relocation of stained-glass windows from the previous facility and is part of the wider Emergency Village development.

The improved facilities include the provision of a quiet room and ablution facilities.

Deputy Chief Nursing Officer, NHS England & NHS Improvement Visit

The Trust was pleased to host Duncan Burton on 3 October 2023. Duncan took the opportunity to go on some walkabouts with the senior nursing team and we showcased the work we have done around our Quality Improvement projects. Duncan was very impressed and complimentary about the focus on quality and our approach to continuous improvement.

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 13 September 2023. A recording of the meeting is available to watch online here: LSC ICB: 13 September 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 2.*

PCB meeting - 20 July 2023

The PCB membership comprises the Chief Executives and Chairs of the five provider Trusts in Lancashire and South Cumbria and meets monthly. It is Chaired by Mike Thomas, Chair of University Hospitals of Morecambe Bay NHS Trust. Aaron Cummins, CEO of University Hospitals of Morecambe Bay NHS Trust took over as lead Chief Executive, following Kevin McGee's appointment as Director General of the Gibraltar Health Authority.

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

The overview of the September meeting is at the end of this report as *Appendix 3*.

Provider Collaborative colleague briefing

A colleague briefing took place on 4 September updating attendees of the work being carried out by the local NHS Trusts to improve health and care across Lancashire and South Cumbria.

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

The dates of next briefings are:

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

Ambitious strategy to tackle smoking in Lancashire and South Cumbria announced

The Tobacco Free Lancashire and South Cumbria Strategy 2023-28 is an ambitious five-year plan to address smoking rates and meet the NHS Long Term Plan target of less than five per cent smoking rates across the country by 2030.

The plans were endorsed at a recent ICB board meeting and work will now begin on bringing together local authorities, the wider NHS, service providers and communities to help achieve its goals.

The Government recently announced proposed legislation that will make it an offence for anyone born on or after 1 January 2009 to be sold tobacco products – effectively raising the smoking age by one year each year until it applies to the whole population – and while the Tobacco Free Lancashire and South Cumbria Strategy was agreed before those targets were announced, it will complement those proposals.

4. **Reportable Issues Log**

Between 24 August and 22 October 2023, a total of 21 StEIS reportable incidents were reported during this period. Three related to treatment/procedure; six to patient accidents; three to delay in diagnosis; three failure to recognise; three to maternity; one medication error and two pressure ulcers.

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

In addition to those detailed above the Trust recorded a number of complaints including three low risk, one moderate risk and 78 cases which are still ongoing. No high-risk complaints were reported.

Trish Armstrong-Child
Chief Executive
Date: 23 October 2023

Appendix 3

Provider Collaboration Board – September 2023

- The Provider Collaboration Board (PCB) met on 21 September 2023. As this was a day of Industrial Action by Junior Doctors, following the previous day's joint industrial action with 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 finance, central services, clinical services and pathology were discussed under Joint Committee working items.

System Pressures – Acute

- The content of the report was noted.
- Lancashire and South Cumbria performance on cancer, elective and emergency care has generally been positive, with Urgent and Emergency Care (UEC) 4 hour waiting time performance well above the regional and national average. However, ambulance handover pressures are starting to rise, and None Medically Fit to Reside numbers and Lengths of Stay are beginning to grow so the system needs to focus on this and continue to support one another.
- Elective and cancer care are increasingly being impacted by strike action and it was important for the system to be clear on what the financial impact has been. As we go into the winter period there would be a national focus on eliminating 78 and 65 week waiters and reducing the overall size of waiting lists.
- Providers were seeing a dramatic increase in patients attending Emergency Departments (ED), so the work of the Recovery and Transformation Board and Place Based leaders on the out-of-hospital provision was going to be vital. In Blackpool, in particular, the ambulance attendances were exceptionally high and the cancellation of outpatient appointments due to strike action was exacerbating this, as people unable to access these appointments would default to accessing UEC.

- The Integrated Care Board (ICB) suggested that the four Place Based leaders attend one of the regular Trust CEO meetings, and there was a three weekly Local Authority CEO meeting that it would be useful for some PCB colleagues to attend to explore if any further action could be taken in mitigation of the pressures described.
- The PCB expressed their appreciation for ongoing hard work of staff across the system in managing services during the prolonged period of Industrial Action.

System pressures – mental health, autism and learning disabilities

- Lancashire and South Cumbria Foundation Trust (LSCFT) had written to all Place leaders about the high levels of patients (30% of the bed base) who met the criteria for discharge but for whom no out-of-hospital arrangements had been secured. A further meeting about housing had taken place with the Place Based lead for Central Lancashire. There was a reluctance to commission out with current local authority commissioned provision, however there were vacancies within the current provision, the reasons for which needed to be explored. A meeting with all the Place leaders was in the diary and the dialogue would continue.
- The ICB felt that there were some opportunities with large housing associations that needed further exploration and they would be happy to facilitate some meetings.
- A number of Learning Disability placements had failed in the community recently, so these patients had been admitted into the Mental health bed base. This has an adverse impact on the ability to service Mental Health as two beds had been taken down as a result. A number of PICUs had or were about to close, and whilst additional area placements had been sourced in mitigation, these come at a cost and have very conservative admission criteria.
- It had previously been discussed that the autism wait for children was over two-years with around 2,000 children on the list. There had been very positive discussion at ICB, and this was now out to tender for fourth and third sector organisations to come and provide the autism assessment part of the pathway. The intention is to have had all these children assessed by the end of March 2024.

Financial Update

- At month five in-year the system had spent £60m more than projected. Non-delivery of savings was the biggest challenge, and in addition recurrent savings are increasingly slipping and being offset by non-recurrent mitigation. Work was needed across the system to deliver Cost Improvement Plans and stretch targets so we can demonstrate a reduction in run rates and give our regulators confidence that we will deliver the pace of change needed to get things back on track.
- The above would include difficult decisions, so consistent use of data and agreement between all providers on where the gains lie would be key to the success of the programme.

Central Services Transformation Update

- The process for confirming the host Trust had been agreed at PCB Board and had now been concluded. Following the scoring process, East Lancashire Hospital Trust (ELHT) had been successful - the decision was ratified by the PCB Board.
- The bids received had been strong and feedback had been given to Chairs and CEOs. A letter confirming the outcome would be sent to Boards, senior leaders and staff-side representatives across the Integrated Care System (ICS) following the PCB meeting with local communications to follow up by disseminating more widely. The next step would be to establish the hosting arrangement and updates would be brought to Board as things progress.
- The focus would now be on the key programmes for this year including the Bank and Agency Collaborative Project Blue and would then seek to establish the One LSC Leadership team under the structures agreed at PCB Board and would work with ELHT to set up the Executive team and the client facing delivery programmes.
- The key piece of work post December will be the transformation agenda. Within each of the service portfolios, we need to determine how we are going to release Year two and Year three costs and release the efficiencies required.
- There have been number of workshops with each of the professional groups and following feedback there is a view from the central services team that digital and estates and facilities are probably in a position to transition more quickly into the one LSC model. CEOs had asked for some more detail from the Central Services team and the professional groups about what this means in practice, what the risks might be in terms of doing things more quickly and the discussion will be taken into the Central Services Board.
- A bid for funding from the national vanguard programme had been unsuccessful – unfortunately we were viewed as too far ahead to need the support. £30,000 had been received which will help with some project support and Organisational Development and further discussions would take place with the national team about the possibilities of us becoming a really high performing programme with additional resources.
- The programme is on track to achieve £13 million of the £16 million stretch target for Central Services. The majority of this is in procurement and bank and agency.

- The programme is looking to escalate the bank and agency and the medical agency ahead of winter – currently the savings are projected in quarter four moving this forward as it will have an impact in the latter part of the year.
- Some of our teams are involved in national work for functional services which is causing some debate in the workshops and the need for additional discussion and engagement. The challenge is now to agree what good should look like whilst maintaining pace and the agreed timescales.
- The ICB were encouraged by progress but expressed the view there were opportunities to accelerate bank and agency.
- PCB Board recognised the work that had gone on and all the complexities involved and passed on their thanks to all involved.

Clinical Programme Board Update

- The Case for Change had been finalised for the top four priority areas for reconfiguration with input from the regional team and business cases would now be developed.
- Directors of Strategy were pulling together the outcomes on individual Trust positions on fragile services and this would be completed by the end of September. Next steps would be discussed at a time out session in October involving colleagues across the Trusts and the ICB.
- At the first time out session on 4 August there had been agreement on the need to maximise the opportunities provided by the New Hospitals Programme (NHP), particularly those based around the new

hospital within Central Lancashire. Work now needed to take place with the NHP team to determine the detail of the business case.

- In the short to medium term, decisions were needed on how to address the structural deficit. An independent, objective and data driven view was going to be important to help develop a clinical reconfiguration plan with clear milestones that all organisations could sign up to in the run up to the NHP coming to fruition. This would be discussed at the next time out in October and at the Recovery and Transformation Board. Lancashire Teaching Hospitals were undertaking a piece of work to establish how Chorley and South Ribble Hospital could continue to be best utilised to free up the Royal Preston site to see what we could get there now as there was the need to maximise the capacity that exists currently.
- There is an issue around the resourcing for the clinical programme as there are a number of people working on project management for whom the funding ceases at the end of October. A collective view is now needed on how to resource this programme to achieve the required outputs.

Transformation and Recovery Board Update

- The first meeting had now taken place and was felt to have been very productive.

Pathology Network Update

- A new LIMS system was being deployed at BTH which was proving challenging in terms of design, training and roll out, so the project was being extended by six months. This has financial implications, so financial assistance was being sought from the NHSE digital team.
- The Digital Pathology Programme had just begun, views of staff were being sought in relation to the workforce strategy, and an exercise had taken place within the network and agreement reached to go out to procurement for all equipment across all four acute provider trusts.
- Significant funding was now back on the table for the development of a model for pathology that included a central facility alongside some locally retained services, and it had been agreed that a business case would be developed. There are challenges as the available funding did not take inflation into account, and an element of the building would need to be developed by 2025.
- The full business case would need to be submitted to the Department of Health and Social Care by the end of the financial year.
- Work was taking place on the terms of reference with appropriate engagement with Trust Boards with a view to allow the decision on the full business case to be made by the Joint Committee of the PCB.
- Directors of Finance had asked for assurance that the process and inputs in relation to the business case be discussed with them in advance and that they remained fully sighted on the development of this before it came back to the Joint Committee. This would be discussed further at the Pathology Board, which would also be seeking assurance that all appropriate stakeholders had been involved in discussions and were fully sighted.
- A Pathology Colleague briefing was taking place on 22 September to ensure that staff had the opportunity hear about the latest developments within the service and have the opportunity to ask questions.

Reflections from and tributes to Kevin McGee

- As this was Kevin McGee's last meeting in his capacity as lead Chief Executive for the Provider Collaborative, he was invited to share his reflections.
- He thanked colleagues for their support and noted how much he had enjoyed his NHS career which for all its challenges had been a great privilege. He felt very optimistic about the future of LSC and was confident that the work taking place on Quality Improvement and Engineering Better Care would make a huge difference to the success of the system. He spoke about the importance of ensuring that LSC competed with other systems to attract good jobs, research and development, education and training, and maintain as many tertiary services as possible, as this would help build social infrastructure and social cohesion and was optimistic that the current LSC leadership would work together to ensure that this happens. He ended by wishing all colleagues the very best for the future.
- All those present reflected on their personal experiences of working with Kevin and wished him well in his new role as Director General of the Gibraltar Health Authority.

NHS England

Ref:20231004_RBLS

All NW Chairs & CEOs

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

richardbarker.nwrd@nhs.net

By email

04 October 2023

Dear Chair / CEO

I am pleased to note the achievements of NHS organisations across the North West recognised at this year's Health Service Journal (HSJ) Patient Safety Awards.

The sheer volume of initiatives delivered and actively improving the lives of our patients in the region reflects the passion and commitment I see from NHS staff across the region every day.

It is absolutely a point of pride to see the hard work and dedication of colleagues across the region and I wanted to take the time to offer my own personal congratulations to every member of staff who won awards this year. Their outstanding contributions put patients at the heart of everything we do and are a testament and tribute to every member of NHS staff who has worked so hard to meet the challenges of the last few years.

I have included the complete list of every winner and hope you will join me in congratulating each one for their outstanding achievement.

Kind regards,

Richard Barker CBE
Regional Director (North West)

The HSJ Patient Safety Awards helps drive improvements in culture and quality across the NHS and recognises teams and individuals who strive to deliver excellent patient care. The organisations who won awards are;

Best Use of Integrated Care and Partnership Working in Patient Safety Award
WINNER:
Blackpool Teaching Hospitals NHS Foundation Trust - Operation Provide - Reaching Out to Victims of Domestic Abuse

Harnessing a Human Factors Approach to Improve Patient Safety Award
WINNER:
Liverpool University Hospitals NHS Foundation Trust - Ambitious New Hospital Transfer Simulation Testing Project

Improving Care for Children and Young People Initiative of the Year
WINNER:
Blackpool Teaching Hospitals NHS Foundation Trust - ED Navigator Service

Improving Medicines Safety Award
WINNER:
Midlands and Lancashire Commissioning Support Unit and Lancashire and South Cumbria Integrated Care Board - Inhaler prescribing errors - do they matter?

Maternity and Midwifery Initiative of the Year
WINNER:
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust - Daisy Team - Complex Midwifery Care

Mental Health Safety Improvement Award
WINNER:
Lancashire and South Cumbria NHS Foundation Trust - Advocacy for Autistic People in Mental Health Inpatient Settings

Safety Improvement through Technology Award
WINNER:
NHS Cheshire and Merseyside Integrated Care Board- Remote monitoring enabled heart failure virtual ward

Virtual or Remote Care Initiative of the Year
WINNER:
The Clatterbridge Cancer Centre NHS Foundation Trust - The collaborative design and evaluation of a virtual tour of a Radiotherapy department to provide patients with key information prior to visiting the hospital.

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	13 September 2023
Title of paper	Chief executives' board report
Presented by	Kevin Lavery, chief executive officer, Integrated Care Board
Author	Hannah Brooks, communications and engagement manager and executive team lead contributors
Agenda item	5
Confidential	No

Executive summary

Ahead of the ICB's annual general meeting, and in light of NHS England's annual assessment of our performance, this report celebrates the success of the organisation, acknowledges the hard work of colleagues working across the system, and highlights the need to review our progress.

In order to provide a sustainable long-term health and care system, we need to reset and fundamentally change our approach, and transform our way of working to promote a community-centric approach, with more prevention and better use of our health and care partners.

Difficult decisions will need to be made, backed up by the evidence that shows that the quality and safety of our services will not be compromised.

Recommendations

The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
SO2	To equalise opportunities and clinical outcomes across the area	**x**
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	**x**
SO4	Meet financial targets and deliver improved productivity	**x**
SO5	Meet national and locally determined performance standards and targets	**x**
SO6	To develop and implement ambitious, deliverable strategies	**x**

Implications	Yes	No	N/A	Comments
Associated risks			x	

Are associated risks detailed on the ICB Risk Register?			x	
Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
n/a	n/a	n/a

Conflicts of interest associated with this report
n/a

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Kevin Lavery, chief executive officer

Integrated Care Board – 13 September 2023

Chief executives' board report

1. Introduction

"Progress is impossible without change, and those who cannot change their minds cannot change anything."

1.1 As we approach our annual general meeting and consider the feedback from NHS England's annual assessment of the ICB 2022-23, we are faced with an opportunity to reflect on the great work and progress that has been made since the establishment of the ICB.

1.2 It is clear that colleagues across the system are working hard to improve the quality of our care provision and outcomes for people in Lancashire and South Cumbria. There is much to be proud of, but this is also a good time to review our progress. There is more that we need to focus on across our health and care system and fundamentally change the way we do things around here to ensure that our health and care system is affordable in the future.

1.3 There are several items on the agenda for today's board meeting that lend themselves to the forward view that we must take, for both the short and medium term. This includes the New Hospitals Programme, the system recovery and transformation plan and the Working in Partnership with People and Communities strategy 2023-2026.

2. NHS England's annual assessment of the ICB

2.1 In late July, we received a letter from NHS England with the annual assessment of our performance in 2022-23. The letter acknowledged that it was a year of transition and there will be many challenges ahead. We received positive feedback around our governance arrangements, for example our board's inclusion of partner members from the wider health and social care system and professional leadership from a medical and nursing perspective.

2.2 The feedback was split into the four fundamental purposes of an ICS.

Improving population health and healthcare

Performance in areas such as 104-week waits, 78-week waits and plans to eliminate 65-week waits by March 2024 were praised. Urgent and emergency care was noted as more challenged, though it was highlighted that performance exceeds the national average.

Our Quality Committee was also observed as delivering its functions in a way that secures continuous improvement in the quality of services.

Our working with people and communities strategy, along with the establishment of our Public Involvement and Engagement Advisory Committee, was highlighted as ensuring the voice of local people and resident is actively embedded and valued in decision making.

Tackling unequal outcomes, access and experience

It was recognised that we include prevention and improving population health as a cross-cutting priority and that we are focused in driving down inequalities in access, outcomes and experience for people in Core20plus communities.

Enhancing productivity and value for money

We were recognised for remaining within our cash limit and within our capital resource limit, as well as maintaining within our running cost allowance.

Unsurprisingly, it was acknowledged that the year ahead is already proving challenging from a financial aspect, with the need for all system partners to work together. We were also encouraged to begin developing our medium-term financial plans to achieve our system clinical ambitions in a sustainable manner.

Helping the NHS support broader social and economic development

The ICB's work with providers and place-based partners to embed anchor approaches and share good practice was recognised. The Lancashire and South Cumbria ICB Green Plan was also referenced as outlining how the ICB will support NHS England and the UK government to fulfil the emission goals.

2.3 The main recommendation for us as an ICB was the need to focus on driving continued improvement in access to services, both physical and mental health, and in both primary and secondary care – alongside a relentless focus on productivity and value for money.

2.4 Table 1 (see next page) sets out how we are performing as an ICB against the national targets, national average and north west average.

2.5 Performance on most key metrics is generally a little above average or good. Cancer has been a problem area for us, but is now fast improving.

2.6 This is a testament to the hard work of staff working across the Lancashire and South Cumbria health and care system over the last year; we are making real progress and it is being recognised regionally and nationally, so I would like to thank all colleagues for their efforts.

Table 1: ICB performance

Performance metric	Target	Lancashire and South Cumbria ICB	North west average	National average	Comments
Winter and UEC					
Not meeting medical criteria to reside		8.57%	15.61%	14.13%	Jun-23
A&E 4 Hour Standard (76% Recovery Target)	76.00%	77.49%	73.00%	73.99%	Jul-23
Average ambulance response time: Category 2	00:18:00	00:25:22	00:25:22	00:31:50	NWAS Aggregate
Virtual ward occupancy	80%	45.30%	45.92%	64.10%	28/07/23 Snapshot
Virtual ward Capacity per 100k		26.0	20.19	18.9	28/07/23 Snapshot
Cancer					
2 week wait referrals (93% Standard)	93%	89.36%	84.47%	80.52%	Jun-23
31 Day First Treatment (96% Standard)	96%	88.07%	91.31%	91.35%	Jun-23
62 Day referral to treatment (85% Standard)	85%	52.31%	59.44%	59.24%	Jun-23
% meeting faster diagnosis standard	75%	76.14%	70.25%	71.35%	Jun-23
Elective recovery					
65-week wait (% waiting 65+ weeks)	0% (by Mar-24)	0.93%	1.76%	1.29%	Jun-23
Day case rate [BADS Procedures]		82.50%	77.90%	80.40%	Feb-Apr23
Capped theatre utilisation	85%	77.60%	75.00%	76.40%	Rolling 3 months to 30/07/23
Discharge to patient initiated follow-up		3.31%	2.27%	2.57%	Jun-23
Mental health					
Under 18s supported through NHS funded mental health with at least one contact	24,118 contacts in 1 year	26,120 (+8.3% above trajectory)	GM: +1.1% above trajectory C&M: -19.2% below trajectory		May-23
Dementia diagnosis	66.7%	68.8%	GM: 71.5% C&M: 65.8%		July-23
SMI health checks		58%	GM: 63% C&M: 52%		% against LTP
Primary care					
GP patient survey: positive experience		75%	73%	71%	2023 survey
GP patient survey: ease of getting through to GP practice by phone		54%	51%	50%	2023 survey

3. New Hospitals Programme

3.1 Since my last report, we have taken a big step forward for Lancashire and South Cumbria, now that we have funding envelopes for the two new builds.

3.2 The key next stage is to complete land acquisition. We are in the process of submitting a business case to enable us to drawdown capital funds so that we are able to acquire land, which will enable works to starter at the earliest opportunity. This will put Lancashire and South Cumbria in a very strong position to progress the project and, if the opportunity arises in due course to accelerate it, then land ownership would be vital.

3.3 Today's agenda includes a report on the latest position of the New Hospitals Programme, with more detail about the timelines and key milestones. As the programme progresses there will be a number of key decisions for us to take as a board and we will continue to receive updates as the programme develops.

3.4 In August, our New Hospitals Programme team facilitated a ministerial visit from Lord Markham, Parliamentary under-secretary of state for health and social care, and other members of NHS England and the Department of Health and Social Care as part of a roadshow taking place across the country.

3.5 The aim of the event was to update stakeholders on the national programme and what this means for Lancashire and South Cumbria. The day also gave us an opportunity to update national colleagues on the work happening in Lancashire and South Cumbria and to share the experiences of what it is currently like to work and be treated in our current facilities, as well as talk about the programme and any issues or barriers to our progress.

3.6 An afternoon stakeholder session included an invitation to non-executive directors of the ICB and trusts, and I know that many of you attended the session. I would like to extend my thanks to everyone involved in helping the day to run smoothly.

3.7 The New Hospitals Programme timeframe marks out the progress we need to make in those 12 years. By then, we need to have transformed our delivery model to fit the growing needs of the population; so that the demand for services does not overwhelm the system.

4. The need to reset

4.1 What we need in the period between now and when we begin the design of the new hospitals, is to reset our system and reinvent to promote a

community-centric approach, with more prevention and better use of our health and care partners. If we do not change our delivery model, in 12 years we would have an unaffordable challenge.

4.2 We currently deliver a £4 billion budget via a hospital-centric delivery platform, with 60% of our money spent on hospitals. We have some key drivers of this, such as people over 85 with multiple long-term conditions, a generally ageing population with greater health need, increased demand and longer waits for treatment as a result of long COVID, population growth, poverty and the cost-of-living crisis.

4.3 This is why we need to press the reset button now. We need to look at a major expansion over the next few years of hospital at home care (virtual wards). In fact, we need to start thinking about a virtual hospital, with a single platform, and single provider rather than four separate operations.

4.4 We also need a significant expansion of intermediate care, with a dynamic model so that people do not end up institutionalised in care. This needs to be a system that aids early discharge, using care to get people back into the community as soon as possible, or to get them appropriate support to avoid admission in the first place.

4.5 The emphasis will need to be on population health, risk-based primary care and the very frail elderly. People over 85 with multiple long-term conditions are a critical driver of our whole health and care system and that population is due to increase significantly in the next 12 years.

4.6 If we do not change our delivery model, we will not be able to provide the care that will be needed by our population in 2035. Approaches like the Jean Bishop Integrated Care Centre in Hull and East Riding, which I mentioned in my last board report, are the kinds of examples of integration that we quickly need to explore and find ways to implement in Lancashire and South Cumbria, at pace and at scale.

5. The need for tough decisions

5.1 Although the way we are configured is the reason behind our challenged financial situation, we do need to change our approach to health and care because without change, outcomes and care for our residents and communities will only get worse.

5.2 In June, we received negative publicity due to the ICB not providing inflationary uplift for hospices. These are the sorts of choices we are going to need to make as a board. We recognise the important role that hospices play

in our health and care system and essentially the most important thing for us to do is work with the hospices to support the work they do for people in Lancashire and South Cumbria. Our conversation with the hospice leaders has been more around our long-term model and how we can provide more certainty and clarity, focusing on a outcomes-based specification with more flexibility for delivery.

5.3 We know that the scale of cuts is significant; for the ICB alone we are being asked to cut our running cost allowance by 30% by 2025/26.

5.4 As Irish playwright, George Bernard Shaw, said: “Progress is impossible without change, and those who cannot change their minds cannot change anything.”

5.5 All the decisions we make will be backed up by the evidence that shows that the quality and safety of our services will not be compromised, and that certain communities will not be unfairly disadvantaged by those decisions. We are committed to engaging, involving and consulting our residents and communities.

5.6 In July we revised our strategy for working in partnership with people and communities which builds upon engagement with public and partners throughout the past year, with support from the Public Involvement and Engagement Advisory Committee. We have processes in place to involve and engage, and our Working in Partnership with People and Communities strategy will support with keeping the public, patients, carers, staff and partners informed and involved in service change and transformation, including how we reach and involve those who are affected most by health inequalities.

5.7 The fact remains, we cannot continue the way we are. We must make difficult choices and we will have to stand by those choices when challenged. This does not mean that we will never review our decisions, but we must continue to make these choices in the best interests of our residents and communities and, in doing so, be aware of the need to manage media interest or political pressure. That is the only way we will be ready for our new hospitals in 2035.

6. Finance and recovery

6.1 At the end of July, we had a catch-up meeting with NHS England’s chief operating officer for the NHS, Sir David Sloman, urgent and emergency care director, Sarah-Jane Marsh, deputy CEO and director of finance, Julian Kelly, and regional director, Richard Barker.

6.2 We received strong support for the recovery approach that we have adopted, with a focus on clinical and non-clinical transformation and a three-to-four year timeframe. It is recognised that there is a significant amount of change and a high degree of risk in some aspects of the programme.

6.3 The budget remains very challenging for the ICB and for the wider system. What I can say, is that I have been really pleased with the quality of the cost improvement programmes (CIPs) and our quality innovation, productivity and prevention (QIPP). We have got better plans in all places that are being robustly monitored and assured, and I am assured that we are doing all the right things. It is such a big ask, that there remains a lot of risk.

6.4 I have been really impressed with senior middle managers, in our hospitals, mental health trust and in our ICB, rising to the challenge in the most difficult circumstances.

7. Specialised Services Commissioning

7.1 Further to the update in my last report, delegation of a large portion of specialised services commissioning from NHSE to ICBs continues with the completion of the LSC ICB Pre-Delegation Assessment Framework in August. The Finance and Performance Committee approved the framework for submission to the regional NHSE team, on behalf of the ICB board at their meeting on 29 August. This submission will now be moderated by the regional team and then considered by the NHS England board in December 2023.

7.2 This delegation will enable ICBs to join up the specialist elements of pathways with the prevention activity and primary, community and secondary care services they are responsible for.

7.3 Staff who commission the services being delegated from April 2024, or support related activity, will come together throughout England, in commissioning hubs, with LSC ICB as the host organisation for the north west hub. Given the different timeframes for delegating services and to ensure there is a stable support for delegation, the hub teams will continue to be employed by NHSE during 2024/25, whilst supporting the services delegated to ICBs as well as those retained by NHS England. This will allow us to achieve a smooth transition for NHS staff and for the people who rely on these services. All other delegation preparations and hub arrangements continue to ensure we as an ICB and host of the north west hub are ‘ready to receive’ delegated services from 1 April 2024.

8. Ensuring our staff have freedom to speak up

8.1 For many people working across the NHS, the trial of Lucy Letby highlighted a shocking and awful series of events, and our thoughts are with the families at this difficult time.

8.2 A letter from Amanda Pritchard, Sir David Sloman, Dame Ruth May and Professor Sir Stephen Powis, following the verdict in the trial of Lucy Letby, included a number of actions being focused on nationally to prevent anything like this from happening again. In particular:

- The national roll-out of medical examiners provides additional safeguards by ensuring independent scrutiny of deaths not investigated by a coroner;
- The new Patient Safety Incident Response Framework will be implemented this autumn and will provide a sharper focus on data and understanding how incidents happen, engaging with families and taking effective steps to improve and deliver safer care;
- The importance of Freedom to Speak up; which you will note is an item on today's agenda;
- The strengthened Fit and Proper Person Test Framework, an assessment to ensure no individual is appointed as a board director unless they satisfy the requirements, which includes that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not).

8.3 As the statutory inquiry is carried out, we will begin to understand what went wrong and consider how we can learn our own lessons from this tragedy. We will also use this opportunity to look at our arrangements for how we engage, to ensure that all colleagues have freedom to speak up.

8.4 This is important for us as an organisation, not just in the wake of recent events; we have been developing this process over several months and want to continue to build an inclusive and compassionate culture. We want staff to feel safe and comfortable to raise any concerns that they have.

8.5 As the inquiry develops, I am sure we will revisit some of this and give careful consideration to how we can make improvements in our own health and care system.

9. Recommendations

9.1 The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Kevin Lavery

5 September 2023

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Quality Assurance Committee Escalation Report September and October 2023

Meeting:	Board of Directors
Date:	2 November 2023

Author	Esther Steel – Director of Corporate Governance					
NED Sponsor	Sue McKenna – Chair of 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** In October the Committee received a patient story highlighting problems in a complex Cancer pathway. Other issues alerted within the two meetings are: Escalation of challenges from the Risk Management Committee including: cancer standards in gynaecology, the impact of industrial action and challenges in relation to capacity in orthodontics, cardiology and ophthalmology Preparation for PSIRF was identified as a concern in September but the report to the October meeting provided assurance that progress had been made **Assure** Positive assurance received in relation to a number of areas where good progress has been made – 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 maternity report is 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

Name of Committee/Group:	Quality Assurance Committee	**Report to:**	Trust Board
Date of Meeting:	26 September 2023	**Date of next meeting:**	October 2023
Chair:	Sue McKenna	**Parent Committee:**	Board of Director

Introduction

Quorate meeting on MS Teams – apologies from A Roach and C Barben with Deputy in attendance

Alert

What	So What	What Next
Escalation Report: Clinical Governance Committee Three areas escalated and all covered within the agenda – sepsis remains an alert – assurance that improvement has been made in the mean performance. Alert on training in preparation for PSIRF with a note that some actions have been taken. Alert on Clinical Audit participation	Items covered within the QA Committee agenda. Committee members considered the progress made with scrutiny on the actions needed to embed and sustain improvement with a trajectory for achievement	Sepsis will remain an alert until sustained improvement seen. Task and finish group for sepsis established some challenges currently are in relation to ongoing operational challenges in ED – trajectory for improvement developed for review at the next meeting with clinical teams clear on the factors leading to deterioration
Escalation Report: Risk Management Committee Escalation of challenges to performance regarding cancer standards in gynaecology – improvement plan requested for oversight through PIDA. The Risk Management Committee discussed the risk relating to delays in clerking patients aiming to understand what could be achieved with redesign of pathways and processes. Previously identified high risks in cardiology are starting to reduce, further discussion outside the risk meeting to address a risk in relation to Haematology.	The CEO in her capacity as Chair of the Risk Management Committee described the actions being taken within the Risk Management Committee through divisions to mitigate for high risks describing the process for operational management, mitigation, and assurance. The Committee reviews divisional overview of high risks alongside corporate risk registers in accordance with a cycle of business – conversations are maturing but recognition that more to do to see full risk register including low scored risks.	Committee members noted the improved oversight through the Committee. Request from Committee members to receive the gynaecology improvement plan as an appendix to the next escalation report. New cancer pathways report to be provided for information

National and system impact of expertise in orthodontics escalated with explanation of plans in place to manage.		
Sepsis Deterioration in the position – links to operational challenges in ED – daily feedback being provided on data. ICB reviewing with some initial positive feedback	Committee members recognised the challenge and discussed the deterioration in performance – operational challenges as an unintended consequence of building work. Sepsis six is being done but timeliness has been an issue relating to human factors.	Sepsis collaborative continuing focus on time critical interventions Data will be presented in the IPR, training and audits will continue with scrutiny of very sepsis patient. Clinical team to escalate any practical solutions that could help support the continued focused work.
Assurance		
What	**So What**	**What Next**
Patient Story Patient story of a 94-year-old patient who suffered a fall at home resulting in a fractured hip, this was treated with surgery and a period of rehabilitation in Clifton prior to discharge home with support from the community therapy team including mobility aids a falls alarm and adaptations to the home.	The Committee noted the story and the support provided to Pamela by inpatient and community teams with support focused on the individual to help the patient regain her independence. MDT approach to positive story noted – Key learning being not to underestimate the potential in patients and not to generalise so that patients are treated as individuals with aims set to optimise progress for everyone.	Story noted.
Escalation Report: Health and Safety Committee Escalation of outstanding fire risk assessments but no issues arising from this risk is now reducing with progress made on the actions needed. Continuing to refine divisional reporting and developing the committee	Noted the progress made in embedding robust health and safety reporting and the progress made to develop the committee and associated work	Internal Audit review of Group Health and Safety arrangements
National Cancer Survey Overall positive report with highest overall rating in Lancs and S Cumbria and an improvement on previous results	Work to support feedback from patients has been picked up in the fundamentals of care programme.	Report noted – Committee commended the actions taken to continue to provide the high level of care to patients.

Committee/Group Escalation Report

Name of Committee/Group:	Quality Assurance Committee	**Report to:**	Board of Directors
Date of Meeting:	24 October 2023	**Date of next meeting:**	28 November 2023
Chair:	Sue McKenna	**Parent Committee:**	Board of Directors

Introduction

Meeting held in person in the Boardroom Trust HQ. Apologies from C Barben and S Christian with deputies in attendance.

Alert

What	So What	What Next
Patient Story Committee members discussed the story they had viewed prior to the meeting – the story was in relation to the diagnosis, treatment and ongoing care provided for a patient with complex multi-organ cancer. The story highlighted some significant issues in relation to communication and diagnosis and the importance of collaborating across pathways while also recognising some positive aspects of nursing care. https://youtu.be/3rVBnxh59Z0	Committee members reflected on the story and the benefits of learning from patient experiences and seeing the world through the eyes of our patients with ongoing actions in place to ensure improvement in patient pathways to improve flow across organisations. Several of the Exec Directors had been involved in elements of the pathway which crossed multiple organisations and specialities with a gap in terms of patient advocacy.	Formal letter of thanks from the Committee Chair to recognise the value of the shared story and the significance of the challenges and issues this patient faced. Committee members also recognised the impact on the patient's family and the need to ensure families receive appropriate support. Committee to receive an update on the actions taken in response to the learning – this will be included within the SI report and shared in a future meeting. The Cancer Board has been relaunched as a clinically driven pathway meeting.
Patient Safety and Impact due to strikes. Verbal update provided – in the run up to the strike and during the strike, daily meetings were in place to minimise the impact – the biggest impact will be on the elective pathway because of cancellations. Anecdotally there is no increase in incidents on the acute pathway, but the true impact of ongoing action is felt across the Trust.	Committee members discussed the impact of cancellations on patients on elective pathways and the wider consequences of ongoing industrial action. The cumulative impact of continued industrial action will exacerbate the impact and may well have an adverse long-term impact on patients who have cancelled outpatient appointments. SBAR for industrial action included within the Risk Management Committee report.	The Clinical Governance team will undertake a more detailed review of incidents during the period. Harm review paper to the November QAC meeting. Improvements to process and clarity on the action to take for patient safety have been made on the back of a previous near miss incident. Where appropriate impact of industrial action to be highlighted in relevant reports.

Committee/Group Escalation Report

Escalation Report: Risk Management Committee Ambulance delays continue to be a significant risk. Cancer standards in gynaecology - In relation to cancer standards the CEO confirmed that nationally, most services are seeing an increase in demand. Stroke/TIA service – challenges on access to TIA clinics and percentage of patient stay on the Stroke ward Actions to improve the stroke pathway with ring fenced beds and workforce redesign described. Cardiology capacity and demand and delays in triage – the division now have a process in place with monthly meetings to review capacity and demand modelling. Capacity within ophthalmology escalated – redesign of the model needed to provide the most effective care to patients – project plan agreed.	Committee members discussed the escalated risks and the actions planned/taken. SBAR on medical clerking noted for understanding of an issue that has been on the risk register since 2018. Committee members recognised the improvement made by the Risk Management Committee and discussed potential future reporting from divisions to the Quality Assurance Committee. Committee members reflected on the financial impact of increased demand for services including the demand on supporting services that go across multiple pathways. The ICB system transformation and recovery Board has now been established to provide system oversight of the balance of quality and finance.	Report on Ambulance delays to the next meeting SBAR on Ophthalmology capacity and demand to be presented to the next QAC meeting. Divisional reports to be scheduled on the workplan from Q4 with recognition that this will be a developmental process.
Assure		
What	**So What**	**What Next**
Mortality and Learning from Deaths Overall rolling SHMI has continued to reduce with corresponding reductions for most condition groups. Progress made with pathway compliance for pneumonia – now focused on COPD pathway. All deaths (other than coroner) are screened by the Medical Examiner service.	Guidance on coding has been produced for clinicians to improve clarity. Discussion focused on fluid balance compliance and improvement. Committee members discussed the alignment of the multiple programmes and the monitoring of the key measurables.	QI programme continues to focus on key elements of pathways including fluid balance in patients with AKI or sepsis. The Fundamentals of Care Programme includes fluid balance as a key element. Focused educational session on SHMI planned by QI

End of Life/Palliative Care The Fylde Coast strategic group for end of life are continuing to meet in line with the ICB Dying well framework. Challenge escalated in relation to the recruitment of medical staff which is managed through cross cover. Seven-day service provided across the Trust with the Swan model embedded and a sustained reduction in complaints in relation to end of life care.	Committee members assured about approach taken and improvements made. The Team has good links with the different faiths in the area and will continue to work to ensure recognition of patient choice in the individualised planning of care.	Ongoing QI programme covering the care of the acutely unwell patient. Specialist palliative care team were Nursing Times finalists this year.
CQC Actions Update Update provided on action taken and enhanced monitoring of the action plans including external oversight and forward look to ensure future improvement focus.	The Committee discussed the validation process and recognised the need to reflect back to the previous reports to ensure full coverage of all actions. The ICB Associate Director of Quality Assurance provided positive feedback on the review and validation process and the improvements demonstrated.	Update to be provided to the CQC with an invite to undertake walk rounds to demonstrate the improved position. Updates to be provided in December. Trust wide actions to have a similar review process.
Clinical Audit Programme Update provided on the delivery of the Clinical Audit Programme with increased attendance at the Audit and Clinical Effectiveness (ACE) Group to provide grip and challenge.	Detail provided on actions taken through the leadership of the ACE group with recognition of increased engagement and compliance. Committee members welcomed the report and the improved engagement and visibility of Clinical Audit.	PIDA process to add to the process as an escalation route for areas of concern.
Patient Safety Incident Response Framework (PSIRF) Update Progress update provided in readiness for the 1 November launch of PSIRF.	Good progress has been made with regard to training.	Formal reporting of training compliance to be provided

Committee/Group Escalation Report

Advise		
Maternity and Neonatal Report The Committee received the monthly report with an alert flagged in relation to training. Data on hypoxic brain injury now included in the report	Induction within four hours has reduced (an increase in delays to induction) – activity and acuity were high in August and September across the network – all cases are risk assessed with emotional support provided when indication is delayed. Committee members discussed the potential impact of national and regional changes in induction if the increased rate of induction is maintained.	Report included in full on the Board agenda. Ongoing analysis of capacity and demand using Birth Rate plus model. Attendance at Safety Champion meetings has improved, and actions will continue to embed perinatal safety culture. The national team are attending the next meeting to provide assurance with regard to the process. The maternity voice partnership continues with an active partnership.
Clinical Record Keeping Update provided on clinical record keeping audit	The Committee discussed the use of the data recognising the challenge of a small data set and the importance of note keeping underpinning clinical decisions and enable continuity of care between clinicians.	Consideration to be given to future audit methodology and reporting to ensure a focus on the areas that will bring the biggest benefits
IPR Update provided on key metrics in the IPR including trajectories to reduce falls and falls with harm		Full IPR included in the Board pack.
Escalation Report: Clinical Governance Committee - Meeting was stood down due to the Annual Members meeting overrunning. The Committee also received the BAF noting the links with other papers and discussions through the agenda. The Major Trauma Peer Review Plan, Rapid Tranquilisation, Sepsis, Safe Staffing and Cardiac Adult Critical Care Peer Review Action Plan reports were received for information.		

Committee/Group Escalation Report

Maternity and Neonatal Report **Alert** on training compliance with skills drills with description of actions being taken to ensure safety for staff and patients and compliance with CNST requirements by December. Anecdotally starting to see some improvements. FTSUI work within the team has supported the development of an action plan which will be monitored through the Neonatal Improvement Board. Check and challenge underway for previous CQC recommendations. **Assurance** In response to HSIB escalation letters have had external assurance from the LMNS with no concerns identified in terms of the use of Badgernet	The NED lead for maternity services noted the improved reporting and progress made. Progress made to reduce vacancies with plans to reassess staffing requirements for birth rate plus. Committee members asked for assurance that action was being taken to ensure training undertaken as required by all clinical staff. Discussed the assurance on Badgernet and the audit trail to ensure that any changes made to clinical records are tracked.	Request that future reports include information on baby harms.
Stroke Improvement Report Update provided on the Stroke improvement progress plan through the lens of the SSNAP score. Current performance is a B with progress made to address a number of areas – priority areas for future improvement are stroke unit admission and provision of Speech and Language Therapy which is a national issue. **Alert** within the report regarding increase in time to stroke unit admission. Provision of 7-day thrombectomy service will be in place through Lancashire Teaching Hospitals.	Committee members discussed the progress made within the unit including improved morale and recent success in recruitment. Committee members requested further information on the factors contributing to the increase in admission time to the stroke unit. Sustainability of improvement is needed – stroke pathway is being reviewed to ensure optimum process for rapid access to the unit. Committee members also discussed the impact of wider changes and the oversight of the impact of commissioning through the network board.	Next report to include more detail on stroke improvement plan including review of pathways and protection of ring-fenced beds.
EPRR Assurance Return Overview of submission against the EPRR annual return – submission of substantial compliance (97%) has been reviewed by the ICB head of EPRR		Submission noted and approved for submission

Serious Incident Report/Duty of Candour First iteration of new format quarterly report to provide an overview of SI performance and themes identified. The Trust was named in a recent Reg 28 report – the Trust will respond in accordance with the coroner's letter.	Committee members welcomed the report finding the additional detail helpful in supporting understanding. Discussion focused on the impact of human factors and the benefits of learning. Committee noted that number of breaches to timely responses had been reduced with an overall reduction in the time to complete reviews.	Routine monitoring of all SI actions to be undertaken with actions grouped in themes. Reporting will continue to include learning from all SIs and should continue to ensure all opportunities are taken to learn from incidents with the importance of understanding and learning from the impact an incident has had on a family.
Health Inequalities The Trust's Consultant in Public Health attended to present a scheduled update on health inequalities	Committee members welcomed the report and noted links with the earlier discussion about the development of the clinical strategy and the reporting links to the QA Committee to ensure we continue to challenge ourselves to drive improvements through the right lens to engage with and serve all members of the population.	Report noted. The Health Inequalities and Anchor Steering Group will have oversight of the plan and will report on progress through regular reports to the Strategy and Transformation Committee.
Major Trauma Peer Review Action Plan Update provided on actions to address findings in the major trauma peer review		Report noted – further update after review through the Clinical Governance Committee
Patient Experience Update Q1 patient experience report provided with a focus on the improvement actions in response to the inpatient and ED survey. Focus in Q2 will be improvement in complaint response times with oversight of response through weekly meetings to review all complaints	Work has started on the review of the complaints process. Committee members discussed the role of service users in driving improvements ensuring that the voice of our community is heard. Anecdotally it is felt that quality of responses is improving. Committee members discussed measures of patient experience, specifically within ED to assess if changes in the department have led to an improved experience	Report noted. Future reports to include more detail on timely responses to complaints
Clinical Strategy Update provided on the initial steps towards the development of a clinical strategy for the Trust working in close collaboration with service users and stakeholders	Committee members discussed the proposed timeline for the system approach to the development of the strategy noting the ambition, the support offered, and the work already done. Discussed the timing of the development and the engagement with place-based work to ensure actions taken to support fragile services alongside clinical	Engagement and updates to continue in the development of the new Clinical Strategy – over the next six months the threads making up the overall strategy will continue to develop. Updates will be provided for assurance that progress is being made with further discussion within the Board when needed and alignment to the New Hospital Programme and regular

	reconfiguration of the system and place-based work to ensure the right services are provided in the right place for the local population.	reports to the Board from the Strategy and Transformation Committee.
PSIRF PSIFR plan and policy formally approved by the Board, now with the ICB for final approval in readiness for go live across the NHS on 1 November 2023		The introduction of PSIRF will support increased engagement with families. Plans in place to support mandated formal training
Overview of Clinical Audit Reporting Report provided further to a request from the Audit Committee to map the mechanisms that provide assurance to the Quality Assurance Committee and Audit Committee.		Report noted
IPR Update provided on key metrics in the IPR including trajectories to reduce falls and falls with harm		Action previously agreed to include detail on C Sections and inductions within the Director of Midwifery report – Committee members noted that this is for understanding not to drive change or set a target. Quarterly mortality report to next meeting to address questions raised.
The Committee also received the BAF noting the links with other papers and discussions through the agenda. The Rapid tranquilisation report and the Safe Staffing report were received for information.		

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Integrated Performance Report (IPR) – Quality

Meeting:	Board of Directors
Date:	2nd November 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 remain within normal variation overall. **Pressure Ulcers (PU)** – PU remain within normal variation and below the Trust trajectory of 1.4 per 1000 bed days. **Infection Prevention** - The Trust is currently on trajectory for MRSA, Klebsiella Spp and Pseudomonas aeruginosa.

Implications *(so what)*	**Alert** **Pressure Ulcers (PU)** - 1 Category 3 pressure ulcers has been validated for the acute site in the month of August 23. 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. **Patient Experience** - 92% of our patients rated their care as good in September which is 3% below the previous month, and below the Trust's target of 95%. **Mixed Sex Breaches** – There were 3 mixed sex breaches in Sept 2023. **Falls –** there was one inpatient fall which resulted in a # Neck of Femur in a patient at Clifton Hospital **Emergency Department / Same Day Emergency Care - Friends and Family Test** – Although there has been a 26% increase in the overall response rate for the ED. The overall satisfaction rating was 71%, which is a 10% 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 CDI and E Coli for Sept 2023. **% of Deaths Screened** - There has been a significant reduction in the percentage of deaths screened in the last 3 months. A more detailed explanation of this is in the narrative. **Maternity** - There was one still birth in August 2023
	Assure
	Mortality - SHMI continues to improve and as of April 2023 is at 102.2. **Maternity -** There were no neonatal deaths in September 2023 **MRSA –** there were no cases in September. The threshold is zero and the Trust remains at zero.

Previously considered by	NA

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.

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NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Quality Assurance Committee

September 2023

Homepage | Definitions | Executive Summary | Harm Free 1a | Harm Free 1b | Harm Free 2 | Harm Free 3 | Harm Free 4 | Harm Free 5 | Harm Free 6

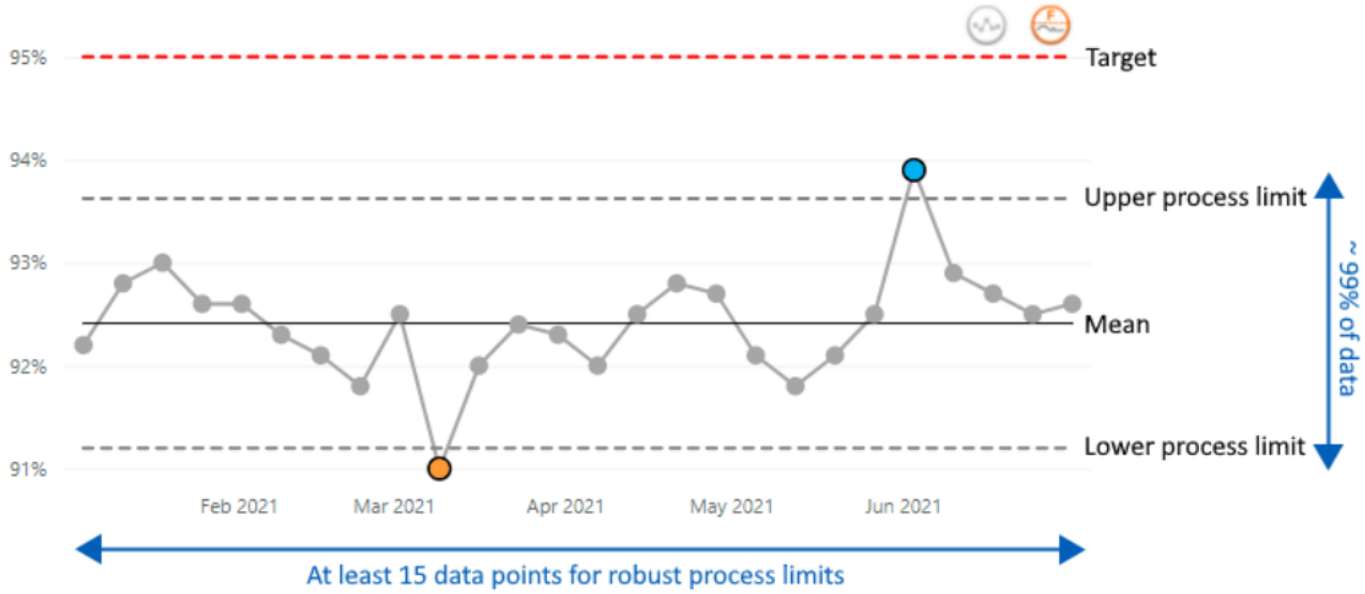
Guide to Statistical Process Control

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

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

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

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



Executive Summary

		Assurance				Variation				
		P	?	F		H	L		H	L
Quality	Harm Free	1	13	2	2	2	1	15		
	Patient Experience	3	10		1	1		12		1
	Maternity				13	2		10	1	
	Infection Prevention and Control		6				1	5		
	Mortality			3	3		3	1		2

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.

Harm Free

Cardiac Arrests
Advise:
The resuscitation team at Blackpool Teaching Hospitals recorded 109 Adult cardiac arrests between Sept 2021 and Sept 2022 with 89 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 1.01 arrests per 1000 admissions to the trust
As a comparison the figures between Sept 2022 and Sept 2023 are a total of 81 Adult cardiac arrests, with 54 outside those areas previously listed. The total number of cardiac arrests in the trust in this time frame equates to 0.77 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:
The Trust continues to see a reduction in cardiac arrests rates.
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/2023/012/DHSC - Shortage of verteporfin 15mg powder for solution for injection. The due response date for this is 20/10/2023.
NatPSA/2023/011/DHSC - Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and g ... The due response date for this is 11/10/2023.
There are 2 ongoing alerts which are:
NatPSA/2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from ... The due response date for this is 01/04/2024.
NatPSA/2023/007/MHRA - Potential risk of underdosing with calcium gluconate in severe hyperkalaemia. The due response date for this is 01/12/2023.

Pressure Ulcers
Acute
Advise:
A total of 64 hospital acquired pressure ulcers were reported in September that includes 27 Category 2's – this is below the trajectory of 1.4 per 1000 beds and as an improved position. In addition, the acute reported 11 unstageable and 23 Deep Tissue Injuries, – this is a decrease on previous months.
Assure:
In September the acute site reported zero Category 3 and 4 pressure ulcers. Also of note, during September, 26 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. Also of note is the emergency department who have reduced attributable skin damage from 101 from January – June 23 to 10 from June – September 23.
Action:
Prevention of attributable skin and tissue damage remains the highest priority with the skin integrity committee supporting the divisional teams. Within the Emergency Department, the joint working between the Tissue Viability team and the senior ED nurses with a Tissue Viability Team presence daily in the department continues with good affect.
The Fundamentals of Care Pressure Ulcer Steering Group continues with priority one being to support the roll out of purpose T across the organisation through October 2023.

Blackpool Teaching Hospitals NHS Foundation Trust

Quality

Harm Free

Community

Advise:

A total of 120 non-hospital health care associated (community) pressure ulcers were reported in September, remaining in normal variation though above the stretch target. This includes 40 Category 2's, 29 Unstageable and 44 Deep Tissue Injuries which is a slight increase on the previous month of 112.

Alert:

Validation has confirmed 5 category 3's and 2 at Category 4 – all of which were attributed to individual patients. Reviews are underway to identify any lapses in care and lessons are also identified for sharing across the organisation.

Assure:

The community validation project is well underway with 5 District Nurse Bases now validating category 2 pressure ulcers. For assurance of this process - audits 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.

Falls

Alert:

There was one inpatient fall that resulted in a fracture NoF in Clifton ward 1 – an investigation is underway to identify any lapses in care. Immediate action was taken by the Clifton team for any patient who suffers an inpatient fall to undergo an MDT review thereafter and a new system for identification of patients at risk of falls is also on trial.

Advise:

Also in September, there were a total of 117 incidents reported against the category of falls and this number includes near miss, falls with no harm and unvalidated incidents that are currently under review within divisions and are awaiting categorisation. Validated data shows 59 harms recorded because of a fall, 57 at minimal harm and 2 at moderate harm, one as noted above and a small skin tear on ward 23. This total number is reduced from 82 the previous month.

Assure:

This remains within normal variation. Across inpatient areas, 27 wards reported zero falls. The falls trajectory has been set as 1.4 per thousand bed days for falls with moderate or above harm.

Actions:

The Fundamentals of Care fall's steering group has updated the intentional rounding tool (IR) - relating to falls - this will ensure patients items are within reach, footwear is appropriate, patient discussions are taking place regularly regarding needs such as the bathroom and falls safety. Evidence supports a 50% reduction in falls through the robust use of IR. This is being launched through October. The group have also updated the admission and assessment documentation to include a falls safety bundle – this will be launched into practice at the same time as IR.

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Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Cardiac Arrest	10	7	Sep 23			10	6	Aug 23	60	31.00
NHS Talking Therapies - Recovery	50%	55%	Sep 23			50%	54%	Aug 23		
NHS Talking Therapies - Wait Times	75%	100%	Sep 23	H	P	75%	100%	Aug 23		
Over-seven-day incapacitation of a worker	0	0	Sep 23			0	1	Aug 23	0	4.00
Specified injuries to workers	0	0	Sep 23			0	0	Aug 23	0	3.00
Inpatient Category 2 pressure ulcers per 1000 bed days	1.4	1.15	Sep 23			1.4	0.97	Aug 23	1.4	1.15
Inpatient Category 3/4 pressure ulcers per 1000 bed days	0	0	Sep 23			0	0.04	Aug 23	0	0
Inpatient DTI/US pressure ulcers per 1000 bed days	0.22	1.3	Sep 23		F	0.22	1.9	Aug 23	0.22	1.3
Community Category 2 pressure ulcers per 1000 bed days	1.4	1.53	Sep 23			1.4	1.34	Aug 23	1.4	1.53
Community Category 3/4 pressure ulcers per 1000 bed days	0	0.27	Sep 23			0	0.22	Aug 23	0	0.27
Community DTI/US pressure ulcers per 1000 bed days	0.22	2.79	Sep 23		F	0.22	2.61	Aug 23	0.22	2.79
Patient Safety Alerts		2	Sep 23				1	Aug 23		7.00
Number of SUI/StEIS incidents		11	Sep 23				10	Aug 23		49.00

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Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Number of never events	0	0	Sep 23			0	0	Aug 23	0	0.00
All Inpatient Falls per 1000 bed days	6.42	4.47	Sep 23			6.42	5.44	Aug 23	6.42	4.47
Inpatient Falls with moderate and above harm per 1000 bed days	0.14	0.08	Sep 23			0.14	0.07	Aug 23	0.14	0.08
Safe Staffing	90%	91%	Sep 23			90%	90%	Aug 23		
30 Day Emergency Readmissions (%)	7.12%	8.47%	Jun 23			7.12%	8.49%	May 23		

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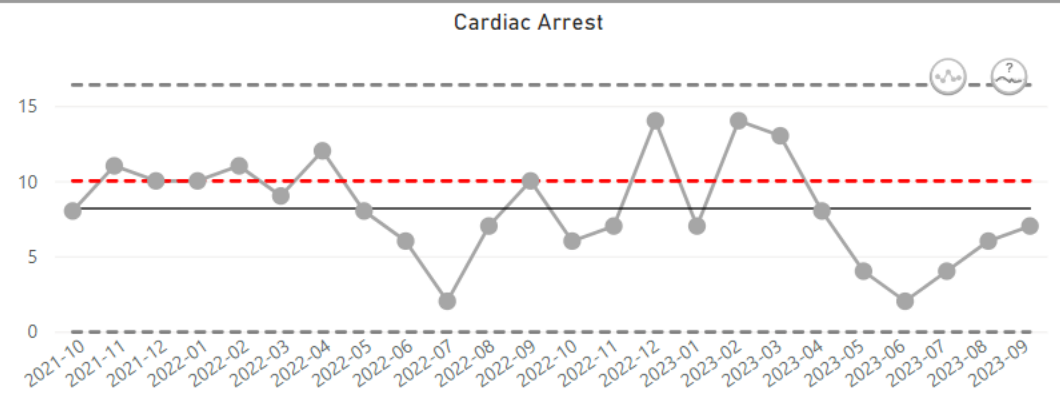

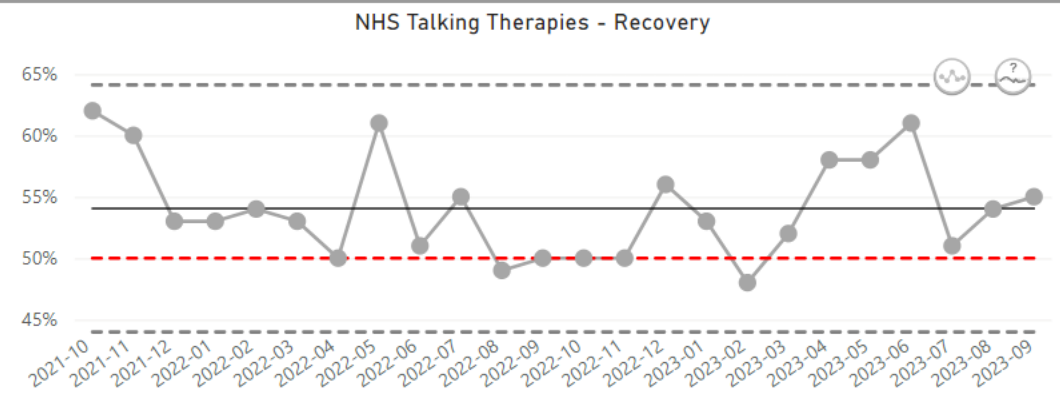

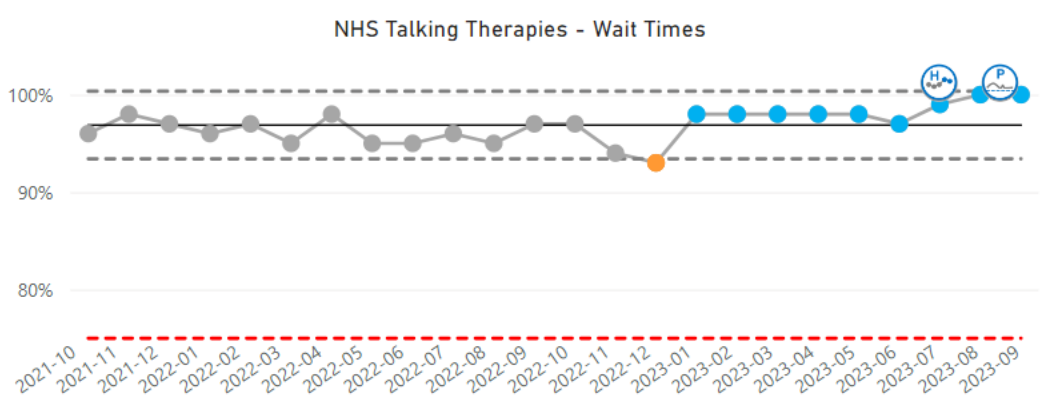

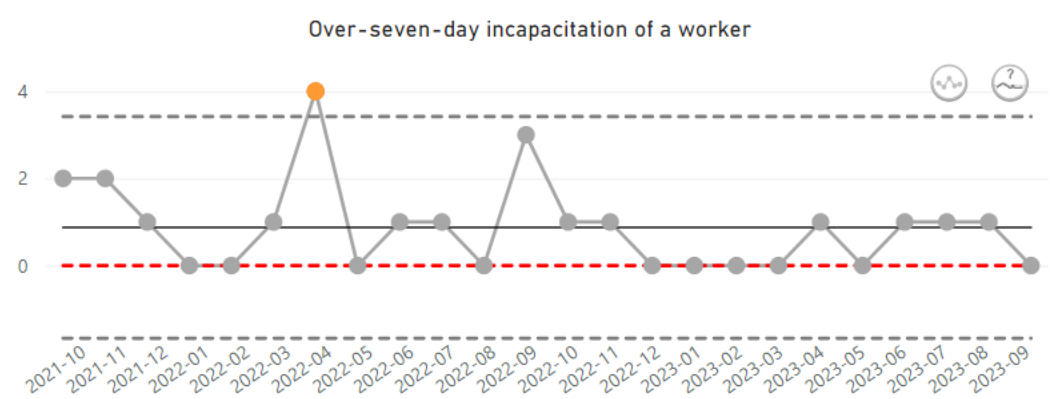

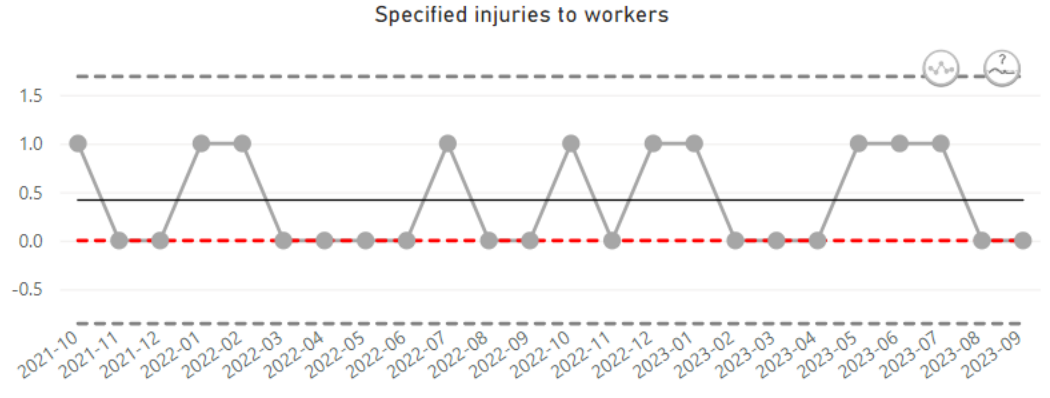

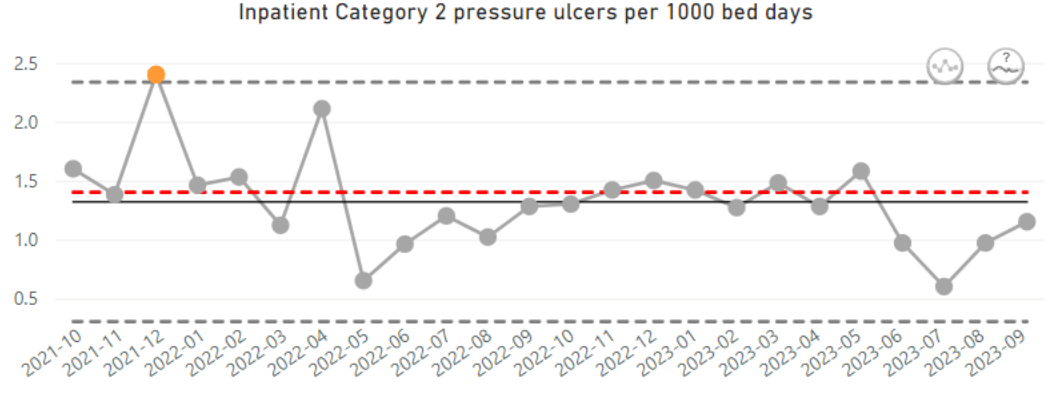

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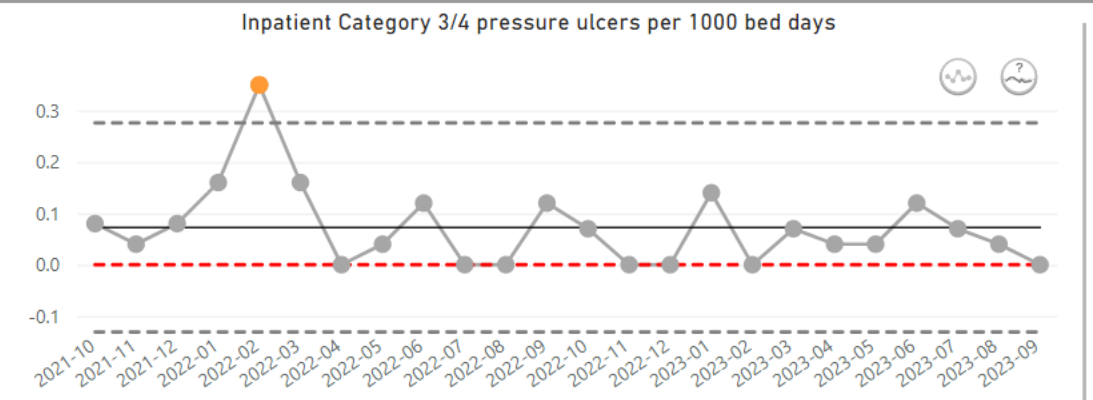

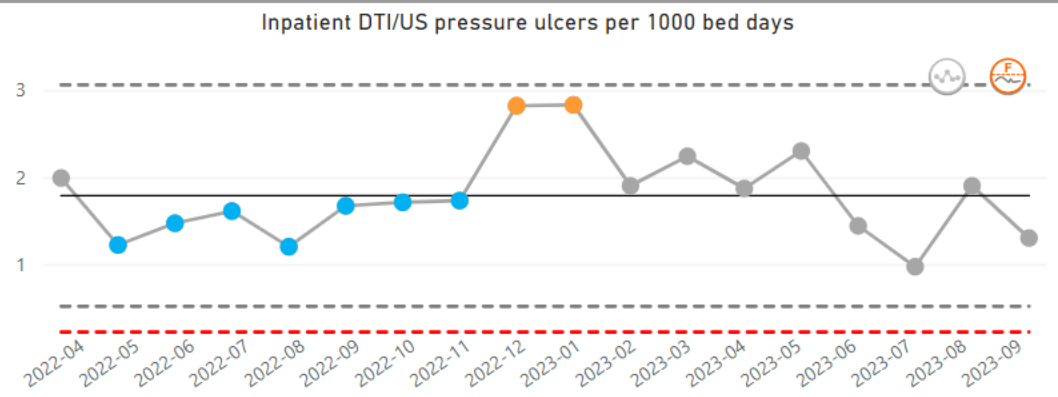

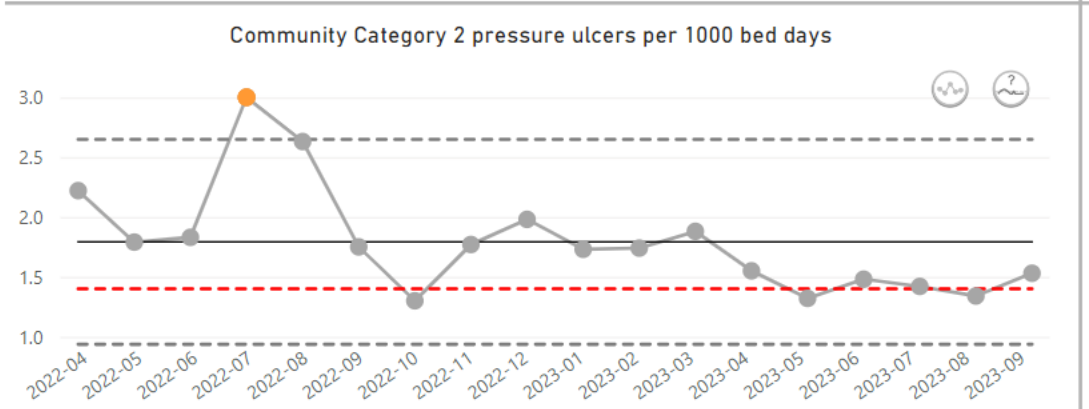

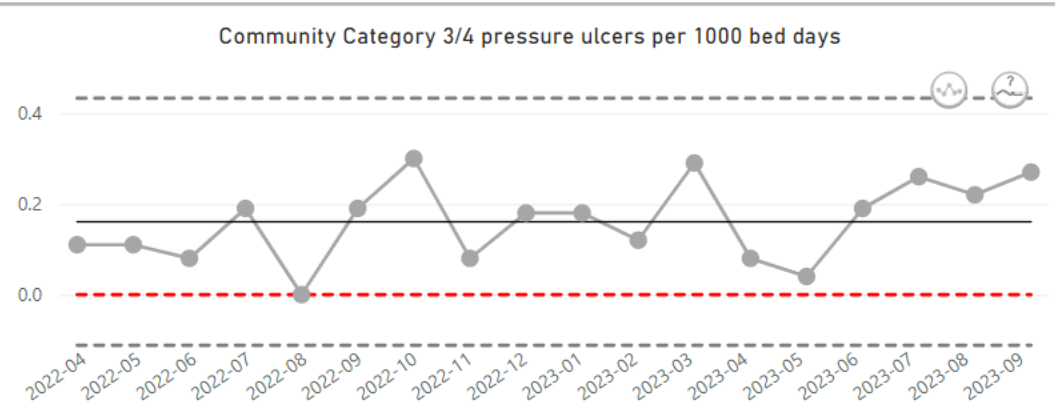

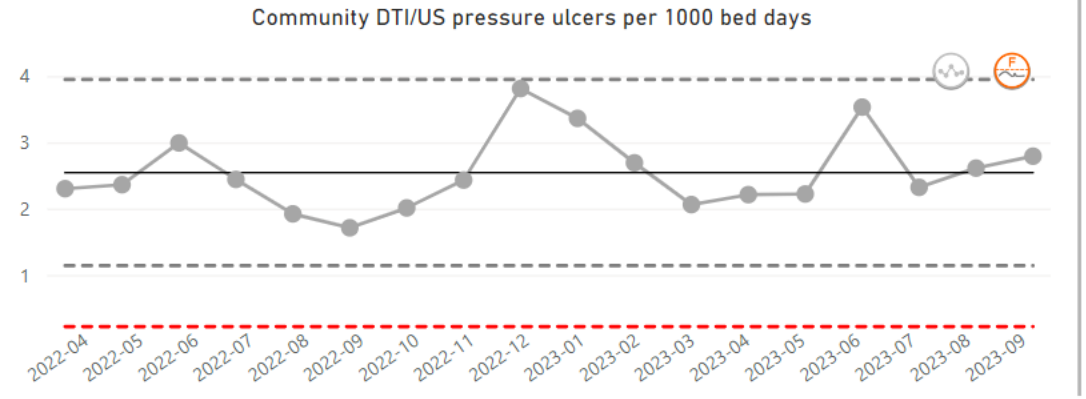

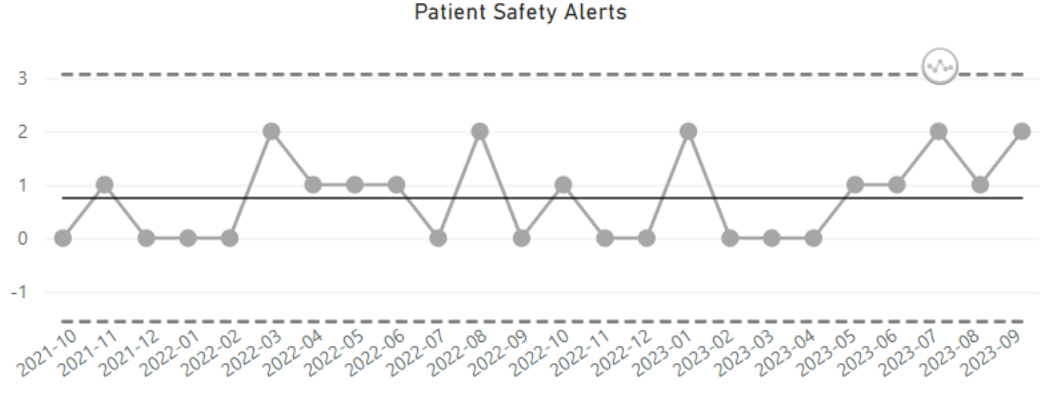

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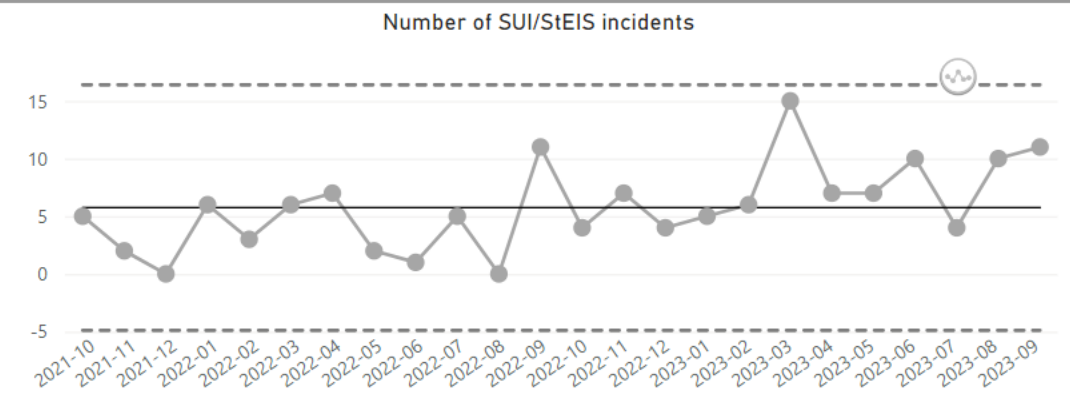

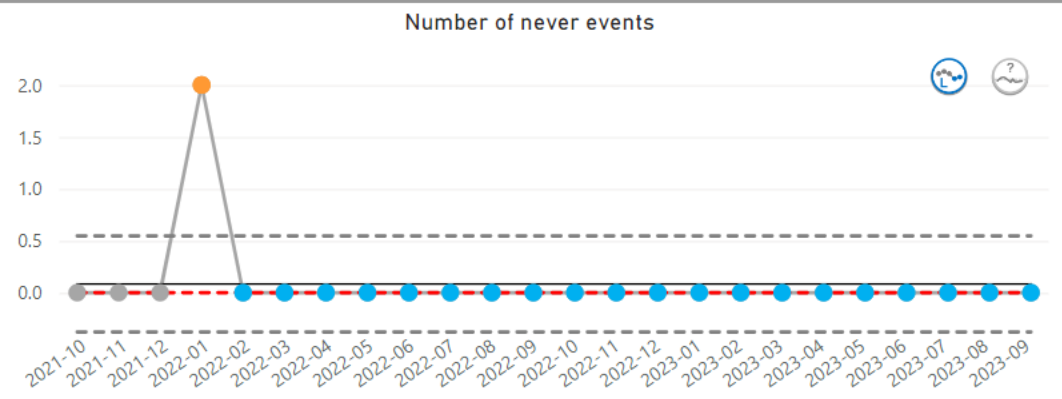

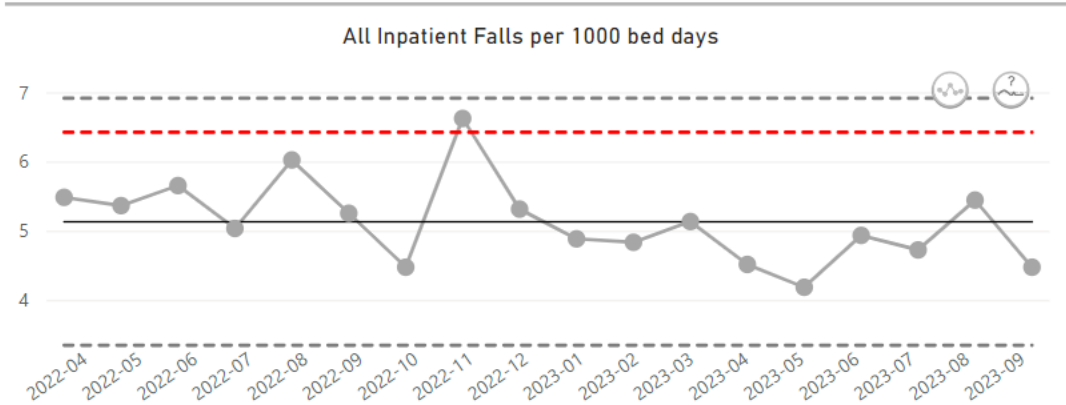

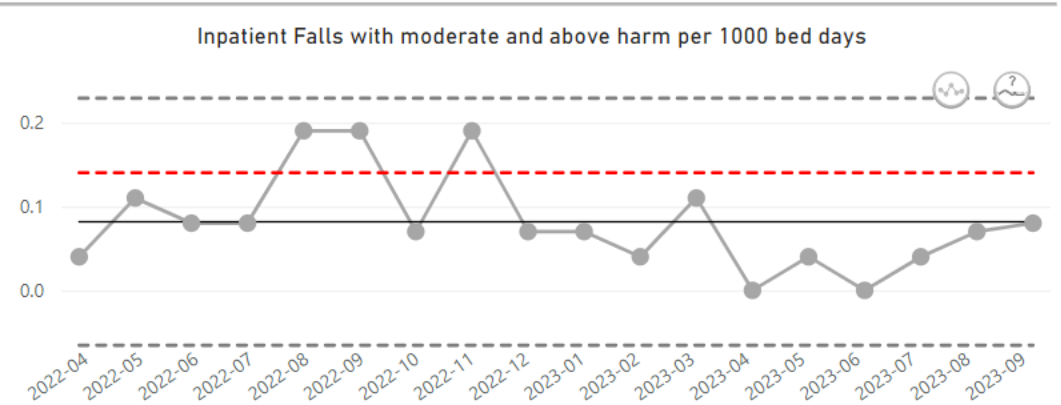

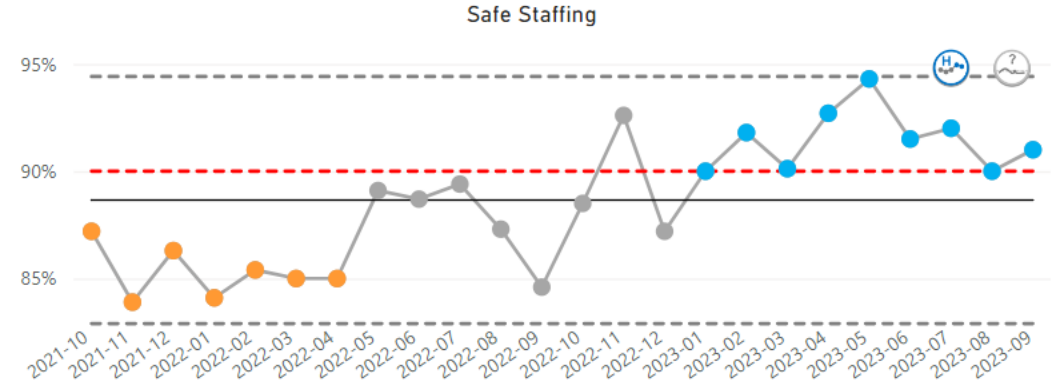

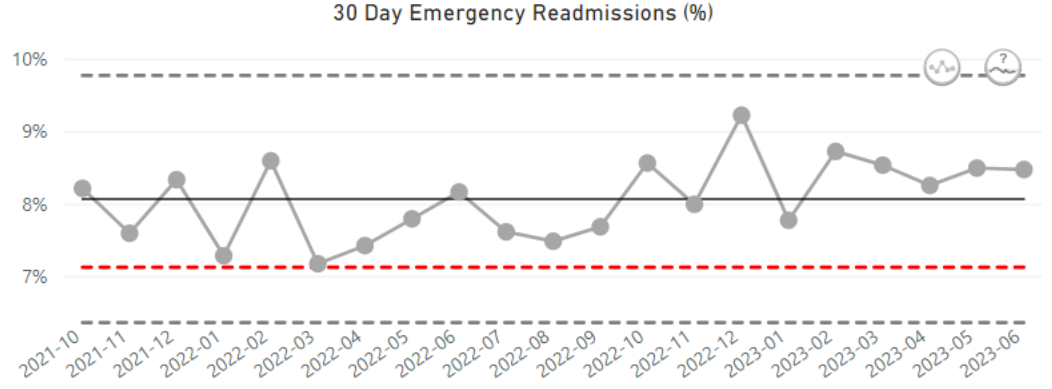

Maternity

Caesarean section rates
Advise –Increase in Caesarean Section this month. 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 as present through digital system (Badgernet). Additional support from national AQUA team to process map data collection and reporting on the 31st of October. Division to commence review of caesarean sections and impact on rates from IOL

Breastfeeding initiation
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 which will and now awaiting impact on improving breastfeeding rates. There has been a vast amount of work contributed already within this area with improvements and further resources planned for the next year.

Neonatal mortality, stillbirth and maternal deaths
Alert – There were no stillbirths in September
Assurance/ action - Neonatal mortality is 0 and maternal deaths is 0 for September 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 which is progressing with support from MSSP 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.. The neonatal mortality external review commenced in May 2023 has been completed and draft report circulated for factual accuracy Findings and next steps will also be reported to Trust Board level and shared with the LMNS, NWODN and ICB.

Maternity complaints as % of deliveries
Assurance/ action – All complaints from the last three months were reviewed by the Head of Maternity and discrepancies found between the reported data in this report. Complaints for August is reporting as 1.1% which is an increase from last month. The division is reviewing roles and responsibilities in the governance team to ensure oversight and timely responses.

Percentage of Occasions 1:1 Care provided.
Assure/ action - 1:1 care is quality marker for a maternity service and evidence safe care. The ambition is achieved 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.
September is reporting 98.6% - review of the women not receiving 1-1 care in labour is under review and will be reported on via the monthly maternity Neonatal report

Maternity

Induction rate – 43.8%
Assurance/ action - Induction of labour delays is monitored daily through safety huddles, and flow meetings and risk assessments completed by the consultant of the day daily.
Audit for IOL delays has demonstrated improvements with 40% of women transferred to delivery suite within 4 hours. Inductions are monitored via the daily safety huddle
5 inductions were transferred out to other units in the region due to periods of increased acuity/activity
There were 75 inductions in September 2023. Induction of labour activity is monitored via the daily safety huddle and flow meetings. All women are risk assessed each day by Consultant
5 inductions were transferred out to other units in the region

Transfer to delivery suite performance:

- Under 4 hours – 40%
- 4-12 hours – 9.33%
- 12-24 hours – 6.67%
- 24-36 hours – 8%
- 36-48 hours – 18.67%
- Over 48 hours – 17.33%

3rd and 4th degree tears
Alert –cases will be reviewed as an AIR to ensure harm and lessons learned are formulated. The SI process will be followed if deemed appropriate.
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 post has been successfully recruited to and will contribute to the train the trainer programme and target of training at least 75% of midwives by November 2023. Also 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/ action – 90% of women were booked before 12 +6/40. The service continues to have good compliance.

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Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Emergency C Section		29.5%	Sep 23				24.6%	Aug 23		
Caesarean Rates		46.7%	Sep 23				42.1%	Aug 23		
Breastfeeding Initiation		64.8%	Sep 23				70.9%	Aug 23		
Neonatal Mortality		0	Sep 23				0	Aug 23		0.00
Stillbirth		0	Sep 23				1	Aug 23		2.00
Number of Maternal Deaths		0	Sep 23				0	Aug 23		0.00
Induction Rate		43.8%	Sep 23				53%	Aug 23		
Maternity Complaints as % of Deliveries		1.1%	Sep 23				1.1%	Aug 23		
Percentage of Occasions 1:1 Care Provided		98.6%	Sep 23				99.4%	Aug 23		
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births		1.8%	Sep 23				0.9%	Aug 23		
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth		8.9%	Sep 23				1.9%	Aug 23		
Percentage of Women Booked by 12 weeks 6 days		89.8%	Sep 23				91.9%	Aug 23		
Induction of Labour - % within 4 hours		40%	Sep 23				29.5%	Aug 23		

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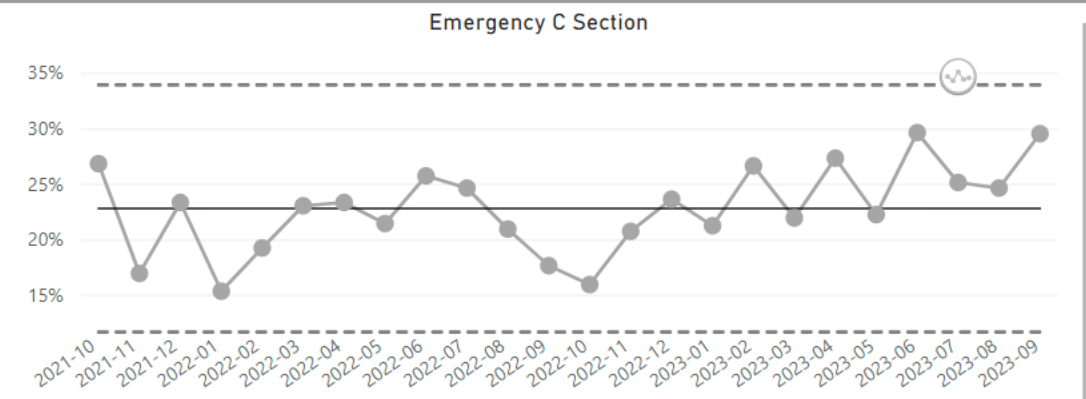
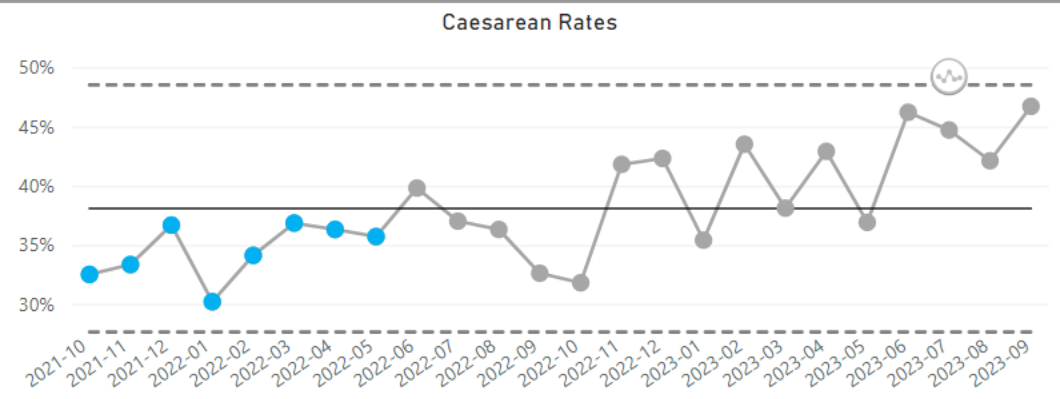
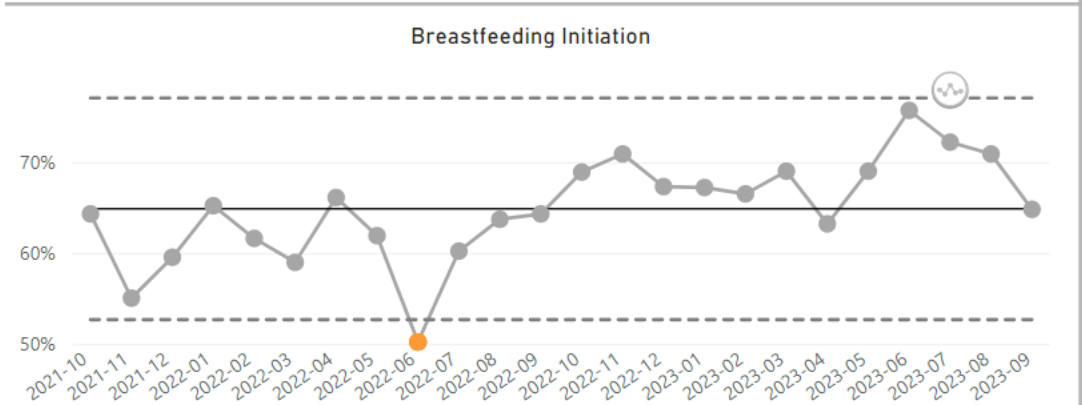
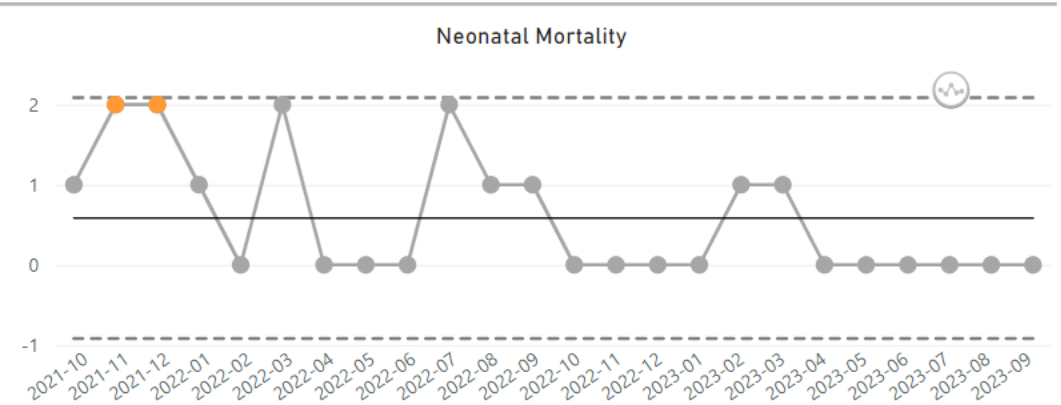
Sign Out

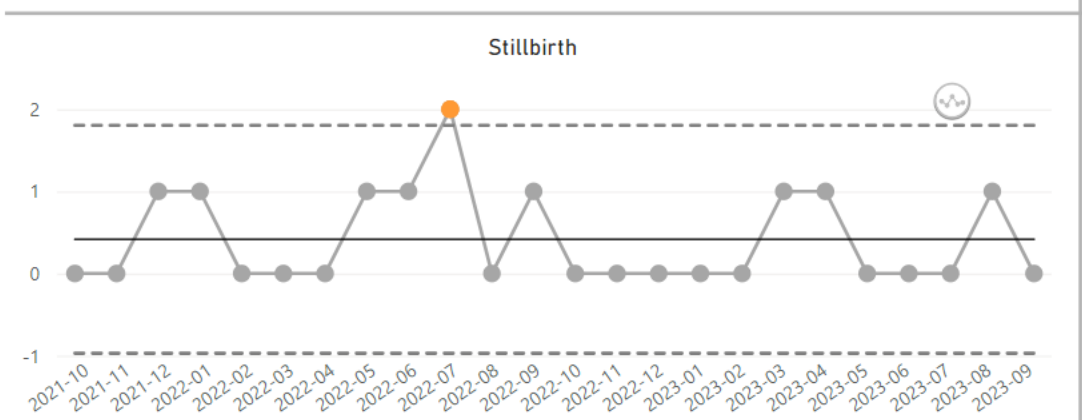
Quality

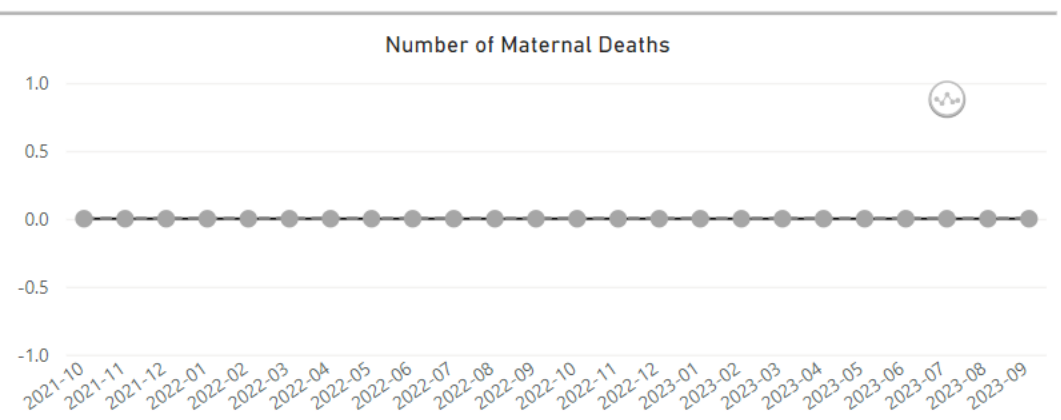












Harm Free 5 | Harm Free 6 | Maternity 1a | Maternity 1b | Maternity 2 | **Maternity 3** | Maternity 4 | Maternity 5 | Patient Experience 1a | Patient Exper

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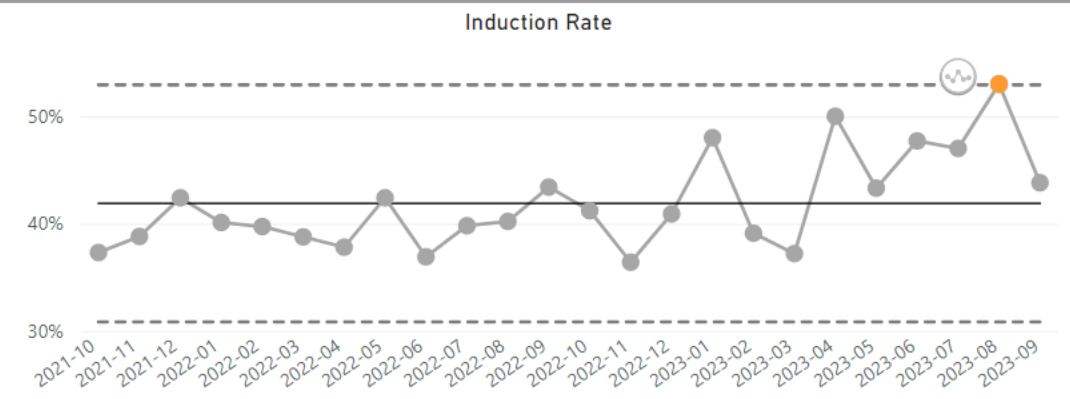
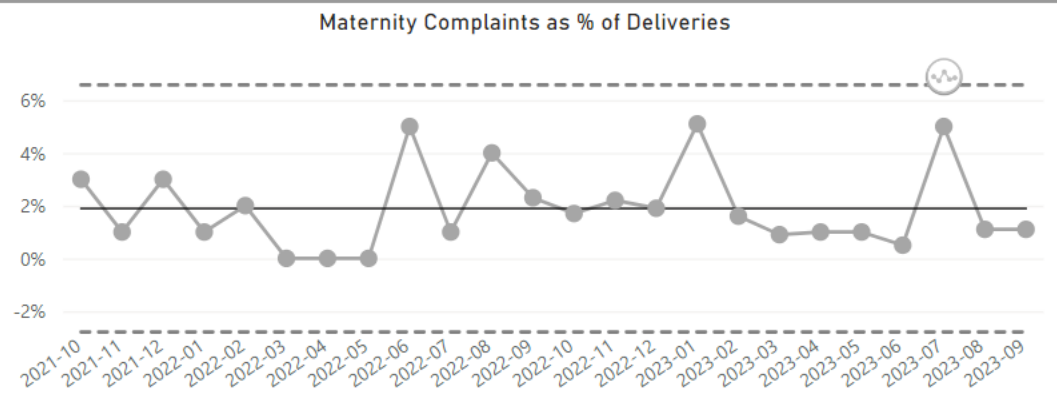
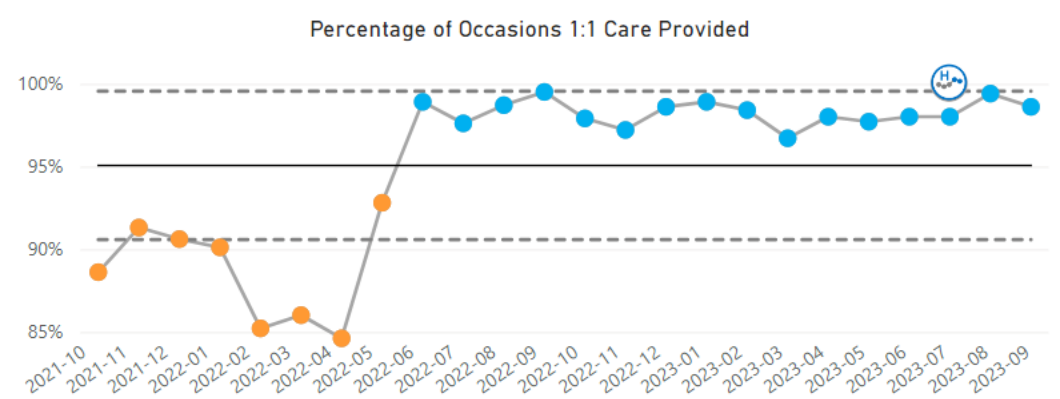
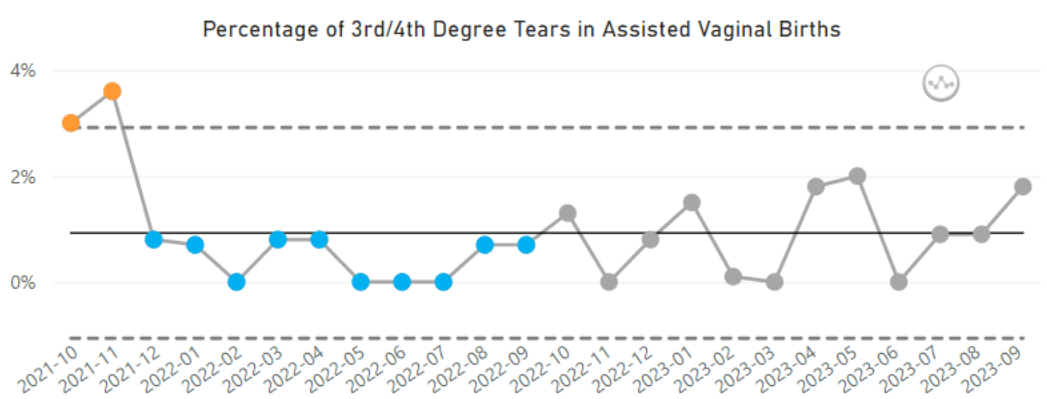
Sign Out

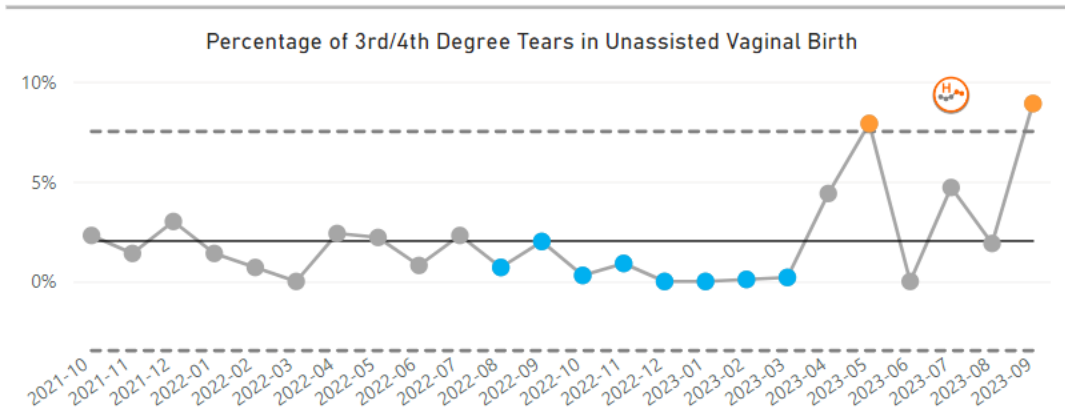
Quality

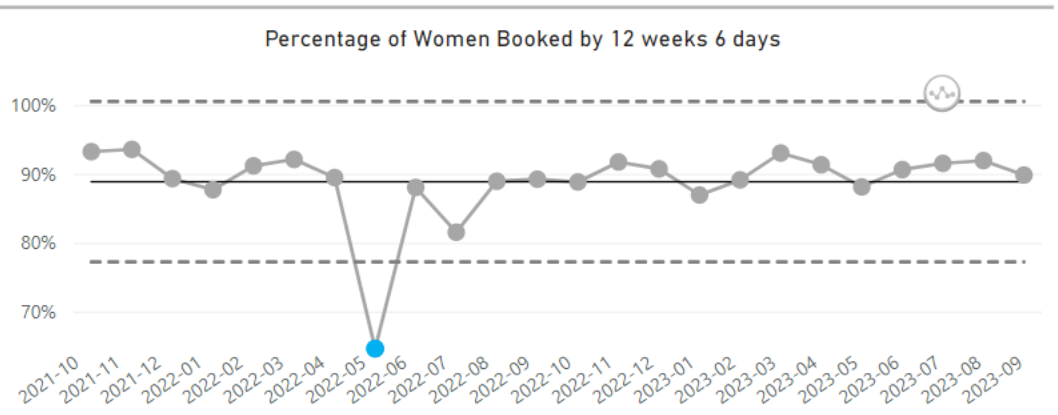












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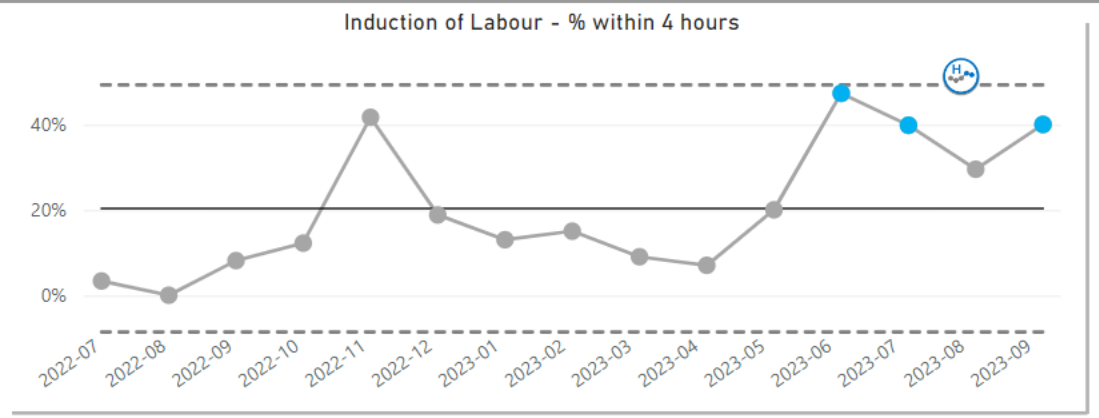

Quality

Patient Experience

Overall, Friends and Family Test

Advise: There were 6297 FFT (Friends and Family Test) surveys completed in September 2023, which is a 20% increase compared to August 2023. SMS is continuing to be rolled out across the Trust, with community services being next to roll out. 56% (3517) of the feedback in September was collected via SMS or online which is a 10% increase on last month.

Alert: 92% of our patients rated their care as good in September, which is a 3% decrease on the previous month, and below the Trust's target of 95%. The reduced patient satisfaction rating is in part due to the decreased patient satisfaction in the ED (Emergency Department), Maternity and Paediatrics. Waiting times and staff attitude have attributed to this decrease along with staff's responsiveness to patient's need for pain relief which is mirrored in the UEC (Urgent Emergency Care) and National Inpatient surveys and this is being picked up in the divisional action plan.

Assure: Patient Engagement met to discuss the relaunch of the 'sleeping helps healing' campaign across the Trust. The campaign gives advice to patients to get a good night's sleep and provides guidance for staff to consider when patients are trying to sleep. The campaign is now included on the Patient Engagement rolling calendar of social media campaigns for promotion. The updated sleeping helps healing posters have been posted on various social media platforms and emailed to all ward managers to put on display around the wards. The campaign has been shared by the Comms team via the Teams Brief, and the campaign has been included in newsletter and bulletins.

Outpatients and Day Case

Advise: There were 2544 FFT surveys completed for outpatients and day case in September, which is an 16% increase compared to August.

Alert: The overall satisfaction rating was 94%, which is a 1% decrease compared to last month and below the Trust target.

Assure: Patient Engagement continues to meet with the outpatient clinical matron to identify themes and define an agreed improvement plan. On the back of the FFT feedback a bi-monthly focus group has been arranged, the consultants and matrons have been invited to address and discuss how we can reduce waiting times and any other reoccurring themes.

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. There is also a huddle meeting held in outpatients every Friday morning to discuss further feedback and emphasise their positive work which the Patient Engagement team have been invited to attend. The outpatient SMS clinic list has now been cleansed, which will inform more targeted actions going forward, 60% of outpatient feedback this month was via SMS.

Inpatient

Advise: There were 1006 FFT surveys completed by inpatients across Clifton and BTH sites in September, which is a 13% increase on the previous month.

Assure: The overall satisfaction rating was 95%, which is a 1% decrease compared to August however is in line with the Trust target of 95%.

Actions: SMS has been launched within inpatient areas which is supporting the numbers of responses received. However, 77% of feedback returned this month for inpatient areas have been paper surveys.

Patient Engagement met with the Divisional and Departmental leads for SACCT (Surgery, Anaesthetics, Critical Care & Theatres), IMPF (Integrated Medicine and Patient Flow) and Tertiary to present the National Inpatient survey results 2022. During the meeting we discussed the Trusts most improved and declined scores in comparison to the 2021 survey, where we are doing well and where we need to work on as a Trust and divisionally, what the Patient Engagement team can do to support, and what actions they are going to implement on the back of the results. The meetings were very well received, and Patient Engagement attended the SACCT divisional nursing meeting to discuss the results further with the wider team. Patient Engagement have also been invited to the IMPF ward managers action learning set session to present the results to the division and support them with creating targeted actions going forward.

Emergency Department

Advise: There were 585 FFT surveys completed in September, which is a 26% increase compared to August.

Alert: The overall satisfaction rating was 71%, which is a 10% decrease on the previous month, remaining 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.

Assure: The Emergency Department have created a 'Friends and Family Feedback' display in the waiting room, which includes a summary of what the FFT is, both positive and negative comments and actions that the department has / is undertaking on the back of the feedback. A 'what to expect from your ED journey' display has also been created in the waiting room. When discussing the FFT feedback at this month's meeting it was identified that some patients felt confused by the variety of uniforms and was not sure who to ask for assistance when needed. Due to this, ED are going to incorporate a picture of each uniform and a description of their job role onto the displays in the waiting room. Concerns relating to waiting time for pain relief have been addressed by a new system is being introduced called 'MPR' which will provide a break down by area so you can see which patients in which area need what medication, giving accountability of coordinators to sense check what is outstanding. This is working well within the department and hopefully will have a positive reflection on the FFT feedback in the upcoming months.

The theme of staff attitude has been identified and the team are currently holding meetings within the department with all band 6's and 7's, as well as on a 1:1 basis to discuss the attitude of staff encouraging roll modelling and promoting immediate challenge to poor staff attitude.

Patient Engagement have visited ED and placed a QR code in each of the patient cubicles, which will hopefully encourage patients to feedback on their care online. We have also discussed the feasibility of ED including a summary of what the FFT is, and where to access the forms over the tannoy whilst patients are waiting to be seen, which again will promote the importance of patient feedback and improve the response rate.

Patient Experience

Maternity
Advise: There were 120 FFT surveys completed for maternity in September, which is a 3% increase compared to August.
Alert: The overall satisfaction was 86%, which is a 1% increase on the previous month however remaining below the trust target of 95%.
Assure: During September we received the national maternity survey results for 2023. The report provided us with a breakdown of the questions, how many patients participated, and a RAG rating of where we are doing well and where we could do better. This is broken down into four sections: antenatal care, your labour and the birth of your baby, care on the ward after birth and care after birth. We are currently waiting for our historical data to compare with the previous year's national maternity survey. Patient Engagement plan to meet with the divisional leads to discuss the survey results.
The survey was conducted by Picker on behalf of the Trust and two staff members from the maternity services have been invited to attend the upcoming Picker workshop in Leeds. This will give them the opportunity to participate in discussions and group activities promoting collaborative thinking, whilst networking with other Trusts and learning from other colleagues.
Community
Advise: There were 1556 FFT surveys completed in September within the community, which is a 6% increase compared to August.
Assurance: The overall satisfaction was 96% which is a 2% decrease compared to last month but above the Trust target of 95%.
Actions: Patient Engagement continues to hold meetings with informatics every two weeks to discuss the implementation of the community SMS roll out. Our strategic plan is to complete the SMS roll out of the community services of each division one at a time, so it is more manageable for each team involved. We aim to have all FICC (Family & Integrated Community Care) services implemented by the end of the quarter as it has the largest about of community services and will then focus on the other divisions. 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. The Patient Engagement team are working with key individuals whose first language is not English to further improve the translation of these surveys and how they are promoted. We continue to have monthly meetings to discuss the roll out of the translated forms to the different services and plan to send the paper forms for further translating once we have received the amendments.
Paediatrics
Advise: There were 257 FFT surveys completed across paediatrics in September, which is an 38% decrease compared to August.
Alert: The overall satisfaction was 91%, which is a 6% decrease compared to last month and below the Trust target of 95%.
Assurance: 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 engage staff to promote the use of the forms and have ordered additional FFT forms for the departments with no responses this month. We have updated QR codes and posters and have sent them to the services.
A paediatric Patient Experience report is shared with nursing staff in children's outpatients, CAU and the children's ward to highlight the FFT concerns. On review of the FFT feedback, the Paediatric team and neonatal unit have introduced neo-natters. This is a parent drop-in session, where drinks and cakes are offered, allowing patients to talk about their experiences. This gives staff members the chance to address situations directly, work closely with the families and explore implementation where appropriate.
Mental Health
Advise: There were 38 FFT surveys completed within mental health in September which is a decrease of 42 compared to August
Alert: The overall satisfaction was 89%, which is a 9% decrease on the previous month and below the Trust target.
Assure: The mental health SMS trial extract has been evaluated and approved, and text messaging was rolled out in July. The purpose of this was to improve the FFT numbers and encourage consistent feedback across all mental health services. On looking at the feedback, there has been no SMS responses for September. The Patient Engagement team have reached out to the mental health services to discuss this. We have met with informatics and confirmed that the extract is working as it should be, however due to the nature of the services and patients being seen on a regular basis, the SMS frequency is less often. This may be why the participation rate is lower than expected and we will continue to monitor the uptake.
Complaints
Advise: In September 2023 patient and relative contact fell 8% to 4,235 contacts. There were 52 new formal complaints registered in the month, a 16% increase on the 45 registered in August.
Alert: There were 44 complaints 'Due to be responded to' in September. In month, a focus on improving the quality of responses has taken place and continues. In some cases, responses have been delayed so that the right response could be achieved. In month this has seen a deterioration in our overall response rate to 30% being responded to within the 25/40-day timeframe. Further reviews of the complaint process are also planned.
The key themes reported in complaints throughout September remain treatment / care issues, waiting time, poor or lack of communication and poor staff attitude. This month the team also registered 20 informal concerns and 2,381 general enquiries in line with the reduction in overall contact numbers.
Mixed Sex Breaches
Alert: In September there were 3 mixed sex breaches due to delayed Critical Care step downs.
Action: The Patient Engagement team have met with patient flow, and the ICB (Integrated Care Board) to review the processes around eliminating mixed sex breaches which will be captured in the updated delivering same sex accommodation policy. Patient Flow and Patient Engagement are doing a scoping exercise of all ward areas to highlight the areas of concern to support decision making on placing patients on wards during times of escalation.

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Sign Out

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%	92%	Sep 23		?	95%	95%	Aug 23		
FFT AE - % Rated Good or Very Good	86%	71%	Sep 23		?	86%	81%	Aug 23		
FFT Community - % Rated Good or Very Good	95%	96%	Sep 23		?	95%	98%	Aug 23		
FFT Inpatients - % Rated Good or Very Good	95%	95%	Sep 23		?	95%	96%	Aug 23		
FFT Outpatients / Day Case - % Rated Good or Very Good	95%	94%	Sep 23		?	95%	95%	Aug 23		
FFT Maternity - % Rated Good or Very Good	95%	86%	Sep 23		?	95%	85%	Aug 23		
FFT Mental Health - % Rated Good or Very Good	95%	89%	Sep 23		?	95%	98%	Aug 23		
FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED	15%	23.8%	Sep 23	H	?	15%	20.8%	Aug 23		
Mixed Sex breaches	0	3	Sep 23		?	0	0	Aug 23	0	23.00
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)		52	Sep 23				45	Aug 23		262.00
Complaints - % closed within 25/40 working days	80%	30%	Sep 23	L	?	80%	65%	Aug 23		

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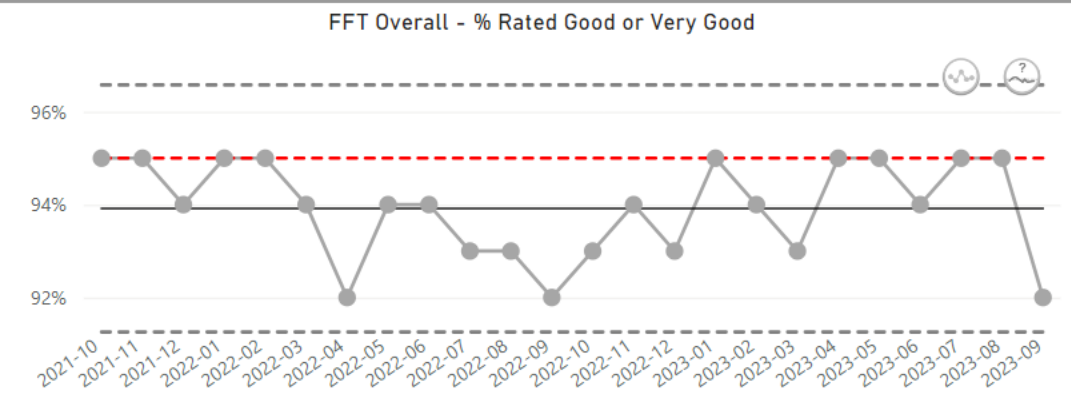

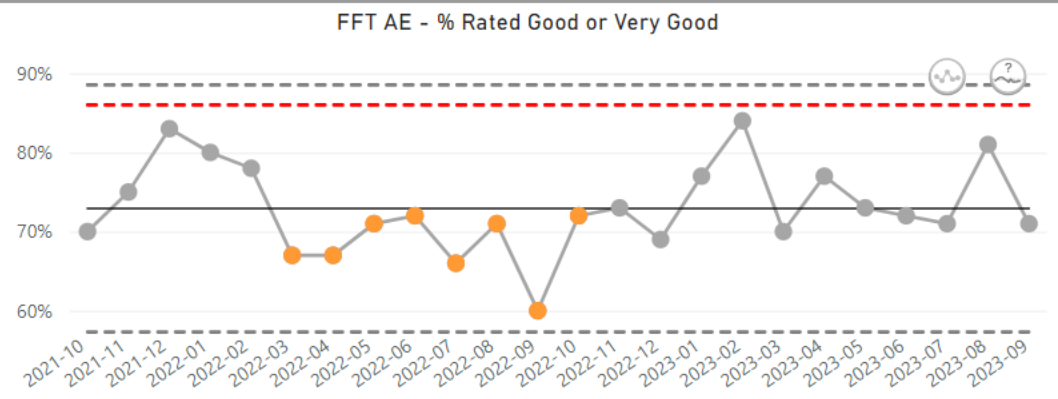

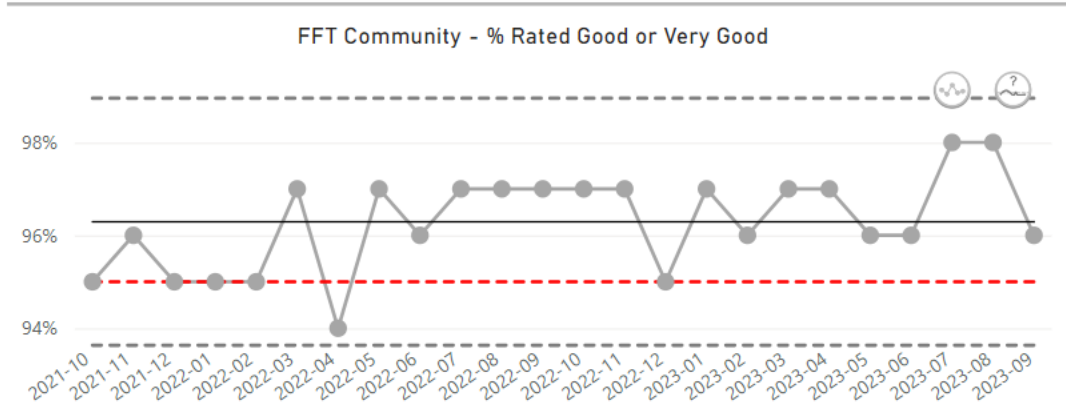

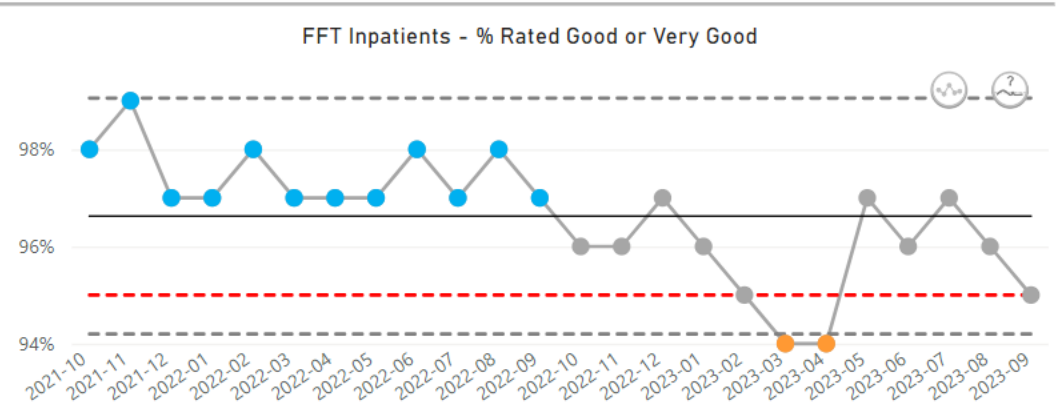

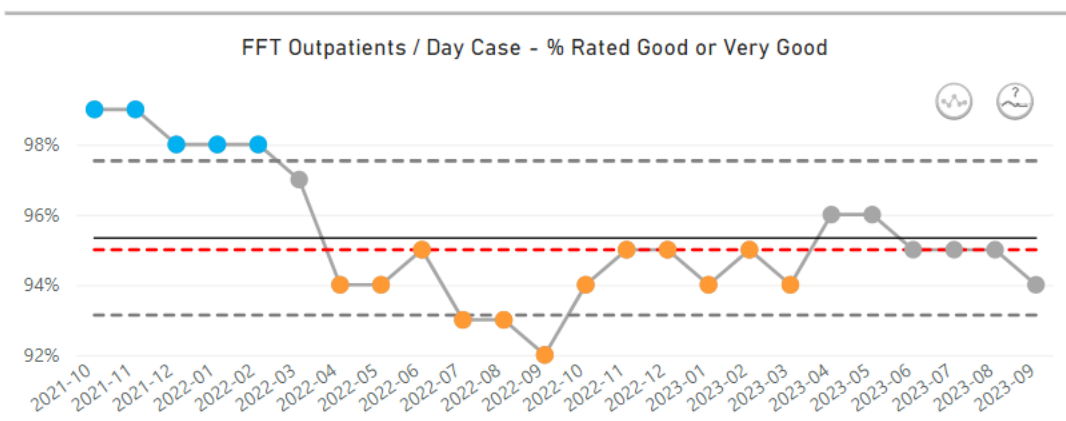

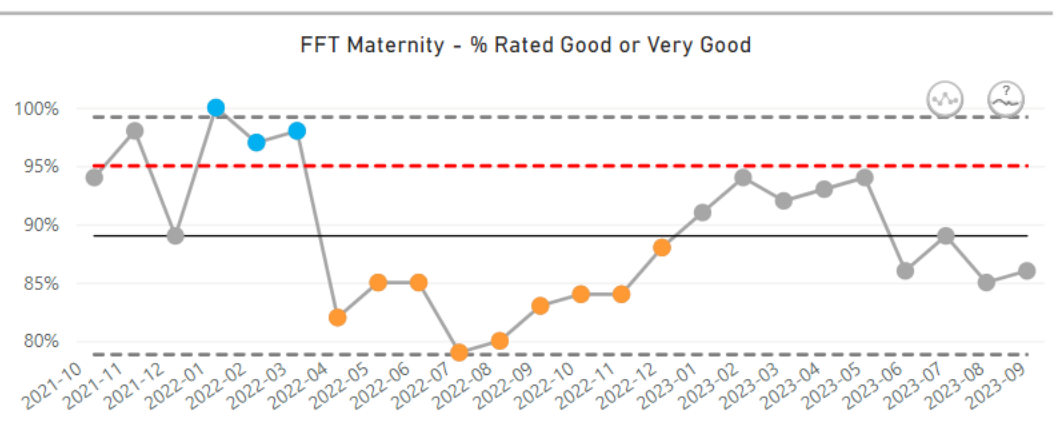

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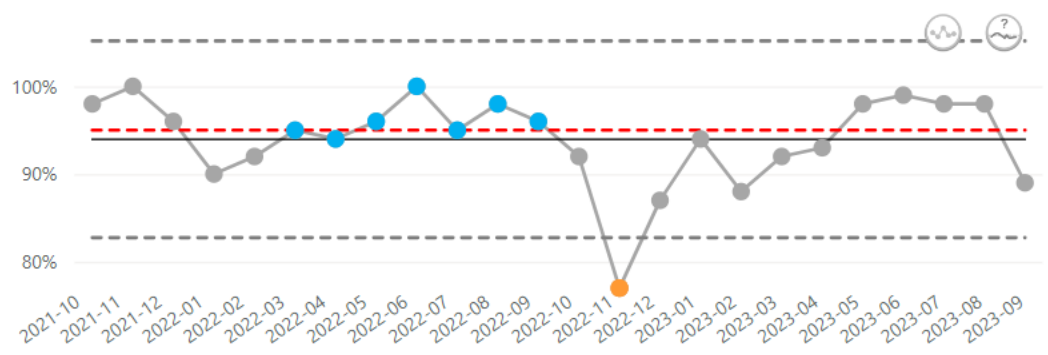
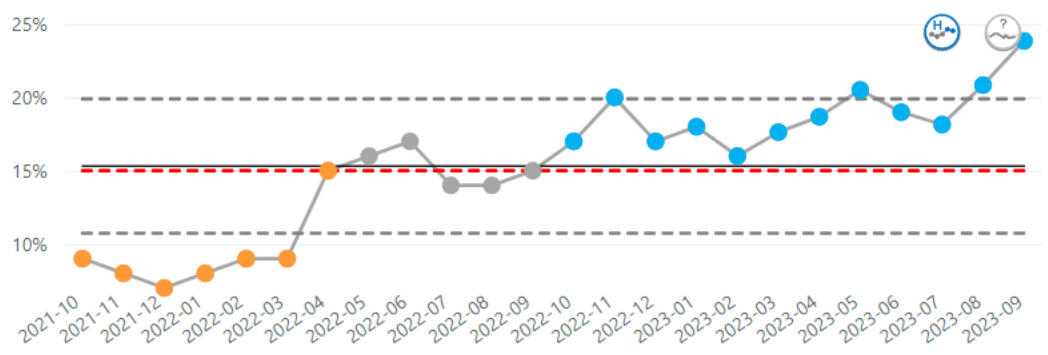
Quality

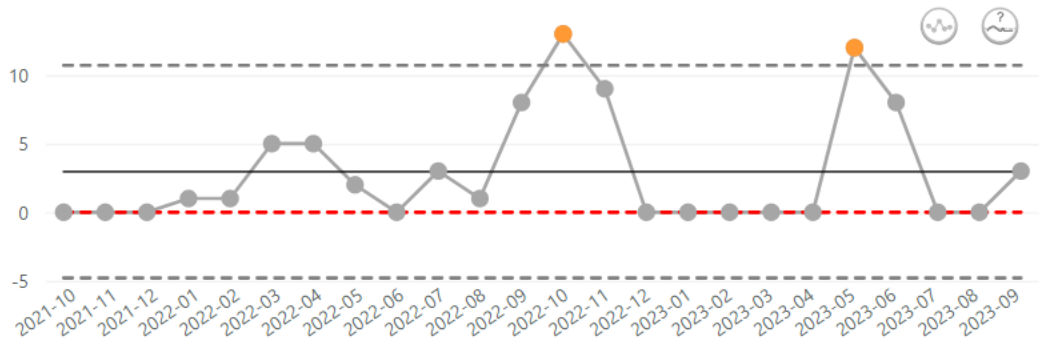
FFT Mental Health - % Rated Good or Very Good



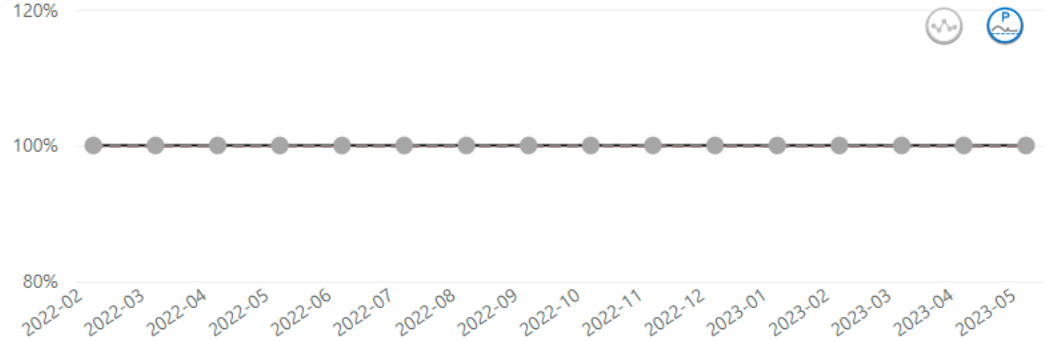
FFT Patients Response Rate - For inpatient, day case, maternity - birth, and ED



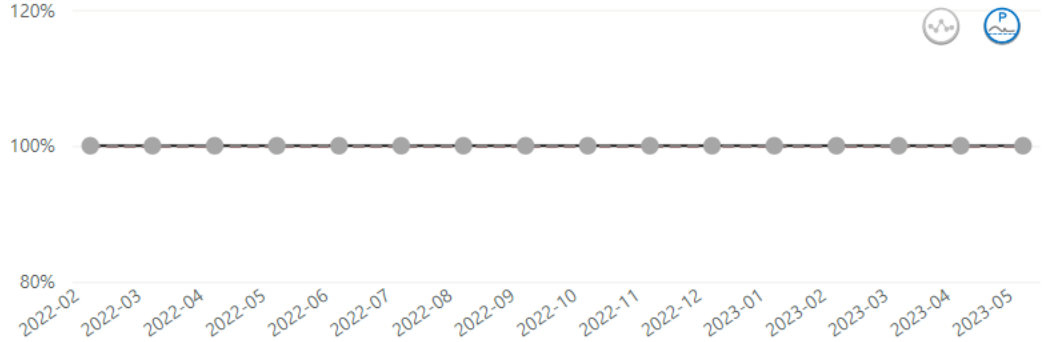
Mixed Sex breaches



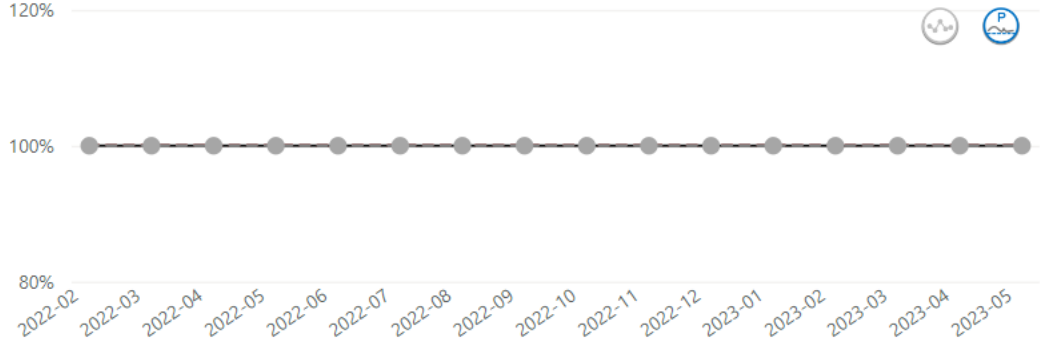
Duty of Candour – Stage 1a – Initial Verbal



Duty of Candour – Stage 1b – Initial Written



Duty of Candour – Stage 2 – Final DoC



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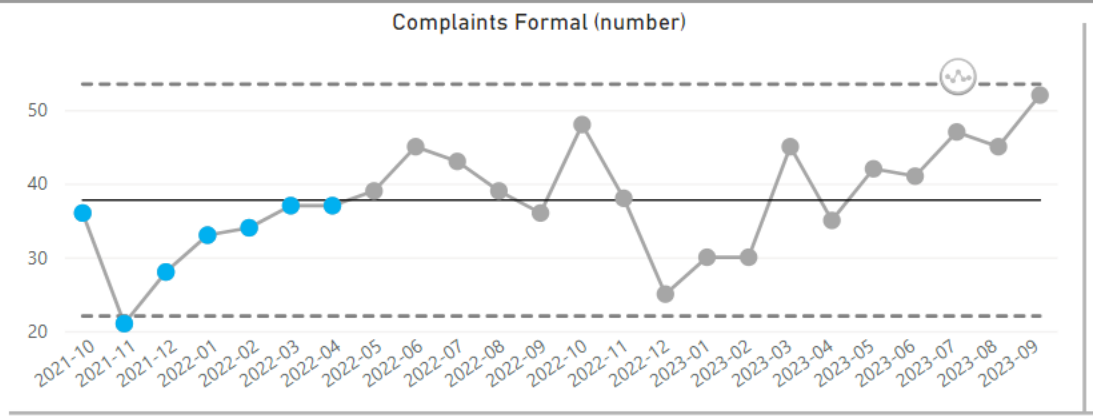

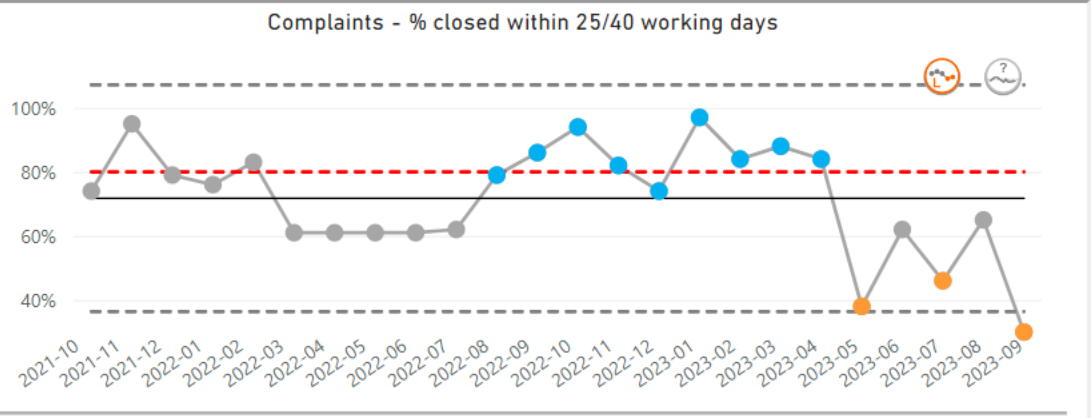

Infection Prevention and Control

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

MSSA
Advise - 3 cases of MSSA were attributed to the Trust in September. 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 - 10 cases of CDI were attributed to the Trust in September bringing the total number of cases to 43. 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 September.
Assurance – However, the Trust is currently within the annual plan for this infection.

E. coli
Advise - 16 cases were reported in September 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. The Trust aims to tackle E. coli as part of the Fundamentals of Care Quality Improvement Programme. The first project focuses on improving and promoting good patient hand hygiene practices. This will be monitored via the COAST FOC audits.

Klebsiella spp.
Advise - 2 cases of Klebsiella spp. were reported in September 2023. The NHS Standard Contract threshold for 2023/24 is 41.
Assurance - The Trust is currently within plan for this infection.

Pseudomonas aeruginosa
Advise - 0 case of Pseudomonas aeruginosa was attributed to the Trust in September. The new NHS Standard Contract threshold for 2023/24 is 18.
Assurance - The Trust is currently within plan for this infection.

NEXUS

Commitee

- Performance
- Quality
- Workforce

Division

- IMPF
- SACCT
- Tertiary
- FICC
- CSS

Sign Out

Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Clostridioides difficile	7.41	10	Sep 23			7.41	8	Aug 23	44	43.00
E. Coli	7.16	16	Sep 23			7.16	13	Aug 23	43	89.00
Klebsiella spp.	3.41	2	Sep 23			3.41	3	Aug 23	20	16.00
MRSA Bacteraemia	0	0	Sep 23			0	0	Aug 23	0	0.00
MSSA	3.6	3	Sep 23			3.6	3	Aug 23	22	26.00
P. aeruginosa	1.5	0	Sep 23			1.5	1	Aug 23	9	7.00

NEXUS

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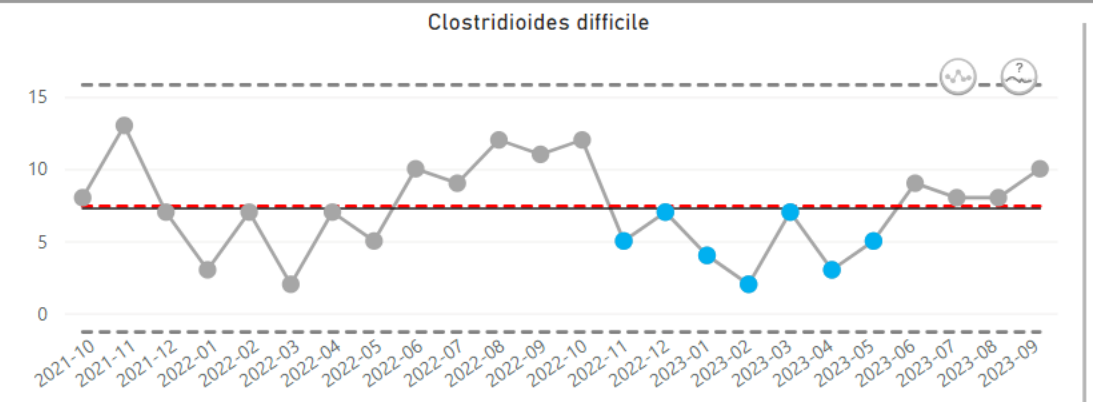
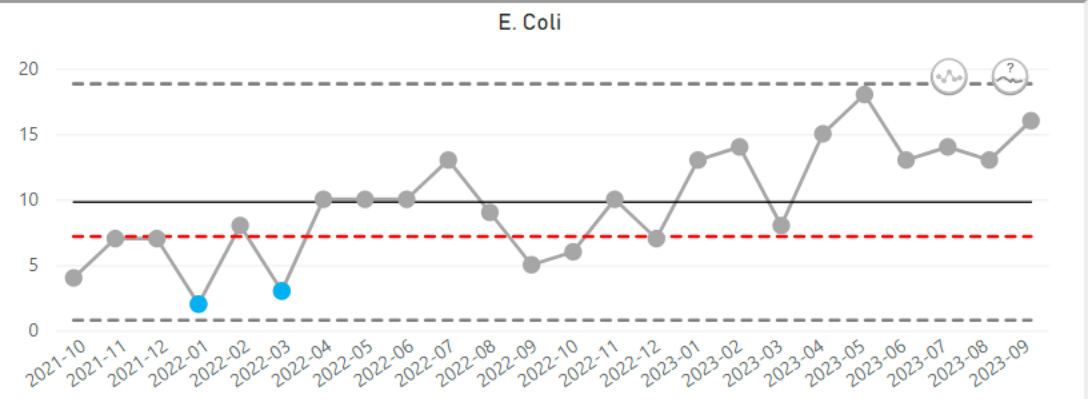
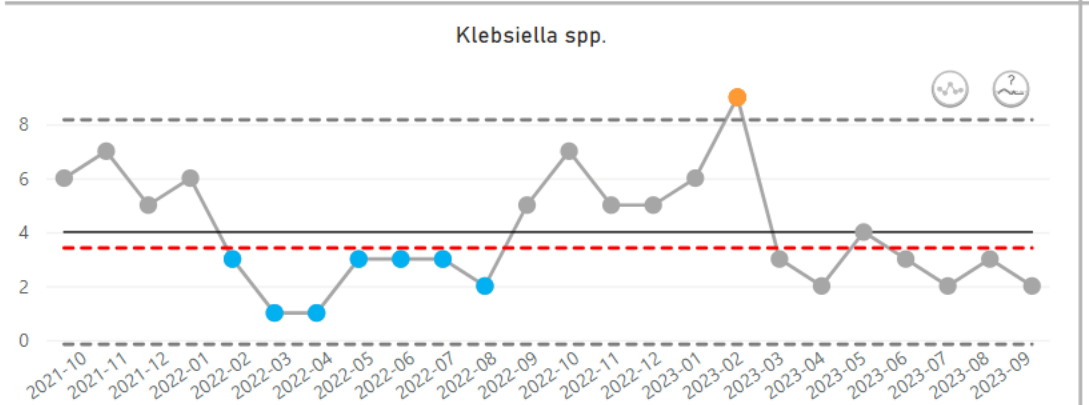
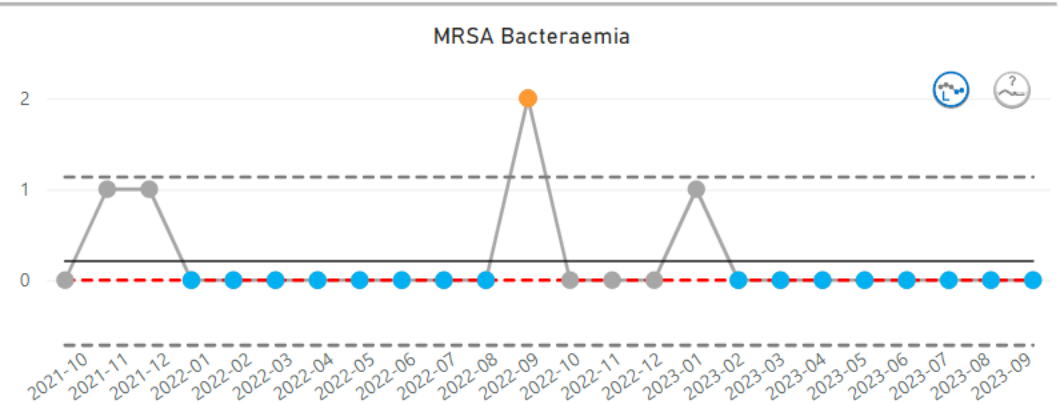
Sign Out

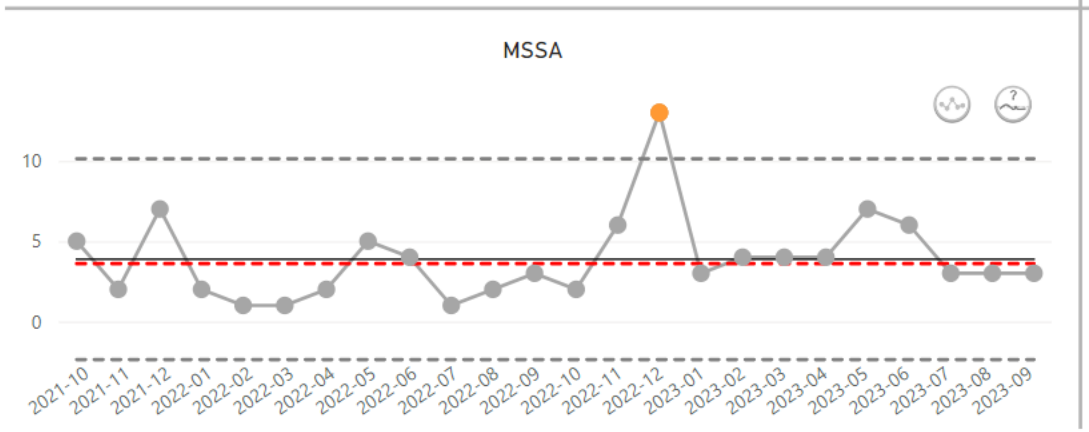
Quality

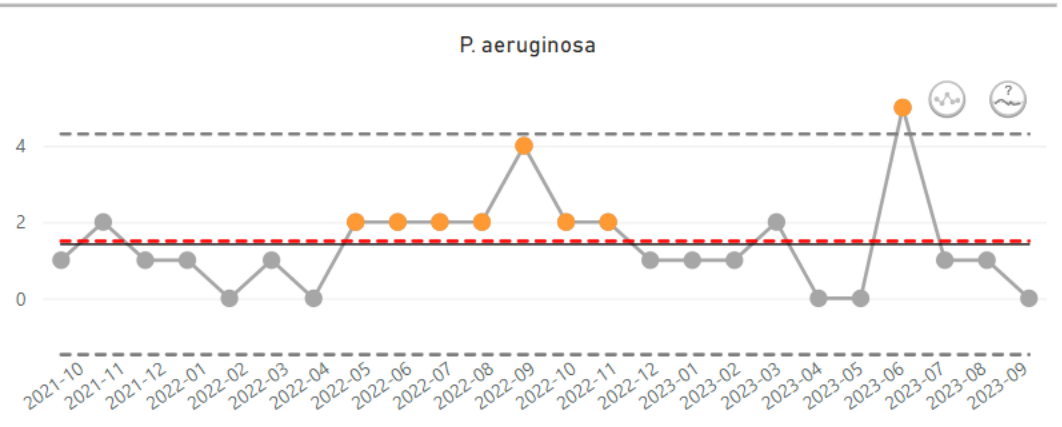












Patient Experience 2 | Patient Experience 3 | Patient Experience 4 | Patient Experience 5 | IPC 1a | IPC 2 | **IPC 3** | Mortality 1a | Mortality 2 | Mortality 3

Mortality

Mortality
Advise/Assurance
SHMI continues to perform well and as of April 2023 is at 102.2.
HSMR continues to remain good at 88.93 (July 23)

Referral to Coroner
Advise/Alert
Referral to coroner within 24 hours has seen a decline over the last few months (currently at 25%). A plan to improve this is with the medical director.

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 although now plateaued.

% of Deaths Screened
Advise/Alert
All non-coronial deaths are screened by the independent Medical examiners . The low percentage of specialty screened deaths is artificially low due to only those undertaken via the LFD app being counted . We are working to develop the App further to make it easier to use and will gain assurance for the true higher levels of screening via the Divisional mortality reports presented at Mortality Governance committee ".

NEXUS

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Sign Out

Quality

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
CRUDE Mortality Rate (Rolling 12 months)		1.39%	Sep 23				1.4%	Aug 23		
Referral to Coroner Within 24 Hours	100%	25%	Sep 23			100%	26%	Aug 23		
Death Registered within 5 Days	100%	58%	Sep 23			100%	58%	Aug 23		
SHMI – Rolling 12 months		102.02	Apr 23				100.77	Mar 23		102.02
HSMR – Rolling 12 months		88.93	Jul 23				87.66	Jun 23		88.93
Percentage of Deaths Screened	100%	15.0%	Sep 23			100%	15.3%	Aug 23		

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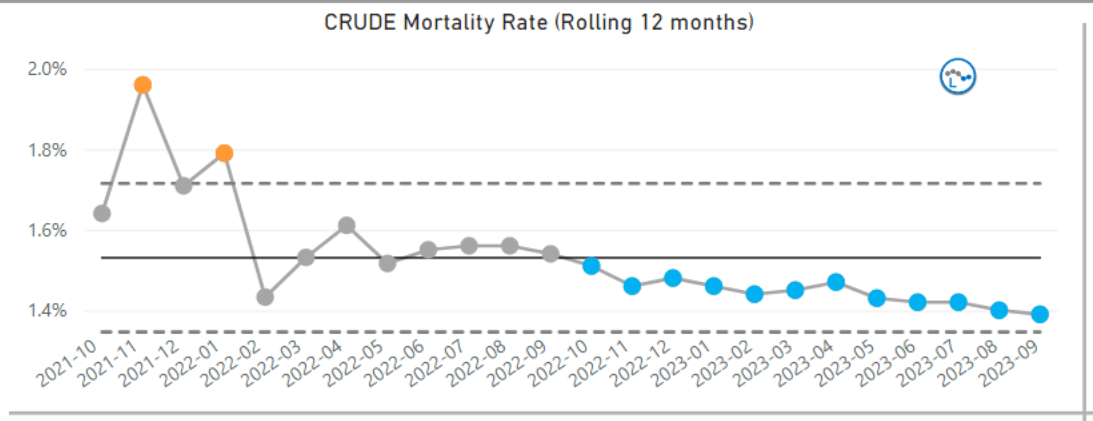
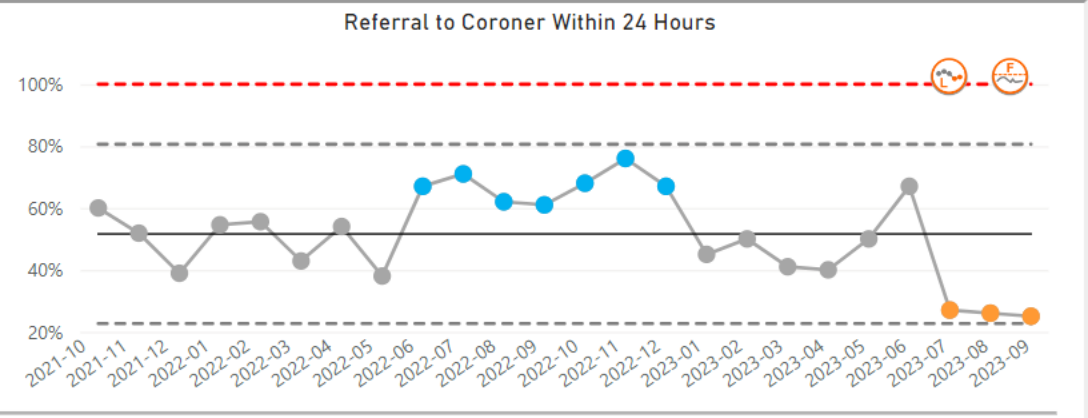
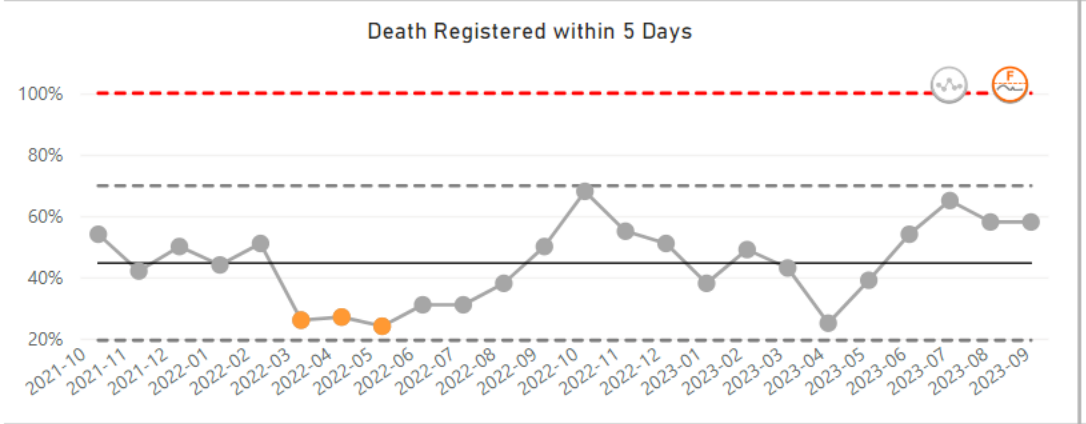
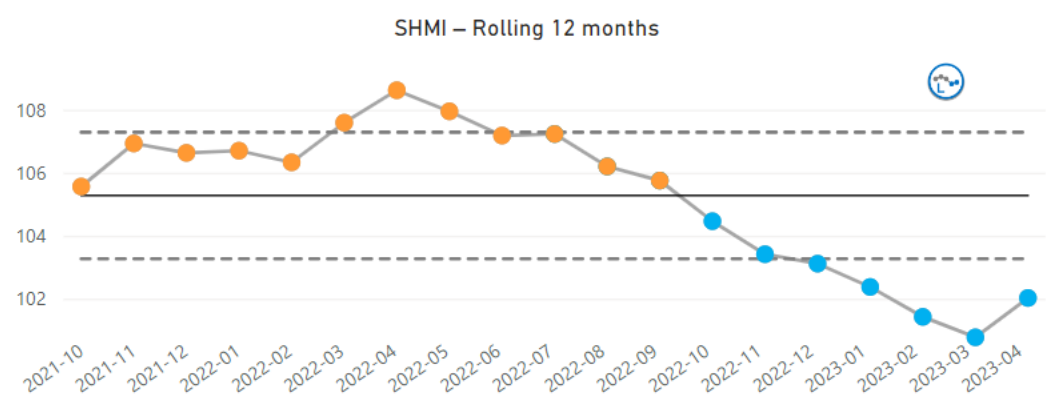
Sign Out

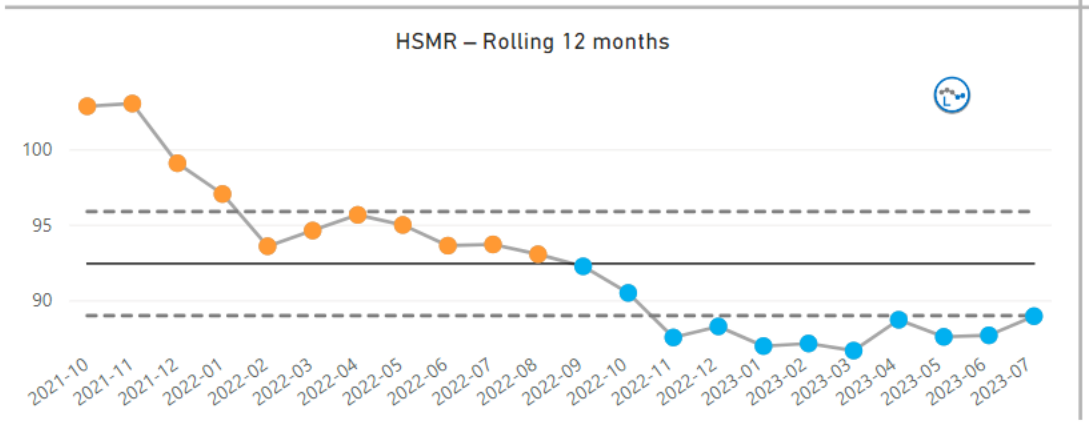
Quality

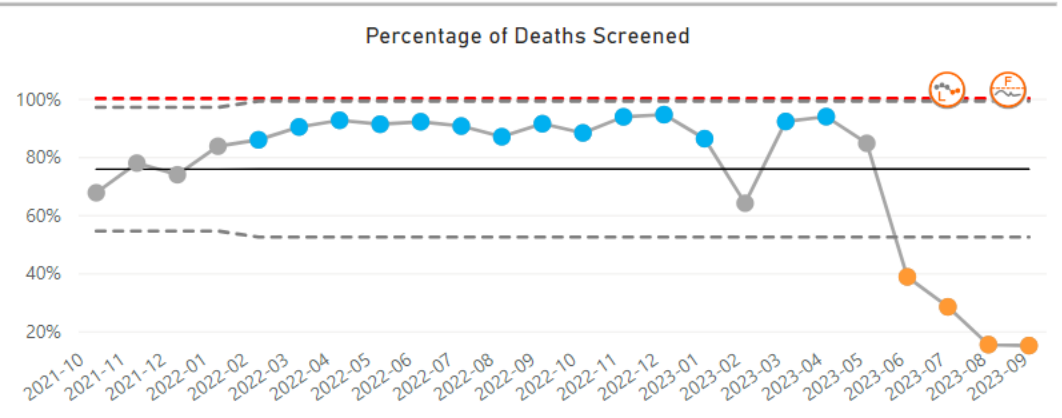












Patient Experience 2 | Patient Experience 3 | Patient Experience 4 | Patient Experience 5 | IPC 1a | IPC 2 | IPC 3 | Mortality 1a | Mortality 2 | Mortality 3

Title	Maternity and Neonatal Report (reporting for September 2023)

Meeting:	Board of Directors in Public
Date:	2 November 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. **HSIB transfer to Maternity and Newborn Safety Investigation Programme (MNSI) (Section 3.0, page 11)**

On 28th September 2023, the Trust was notified that from 1st October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme will be hosted by the Care Quality Commission (CQC) instead of Healthcare Safety Investigation Branch (HSIB). There will be no change to operations or workforce and there will be no interruption to ongoing investigations. The transition is expected to support ongoing high quality family focused investigations, but as a larger organisation will have access to more resources including improved capacity and access to data and statistics and the opportunity to contribute best practice learning through national reporting.

Neonatal Hypoxic – ischaemic Encephalopathy (HIE) (section 4, page 14)

Neonatal Hypoxic – ischaemic Encephalopathy (HIE) is a type of brain damage caused by a lack of oxygen to the brain before or shortly after birth.
Lowering the baby's body temperature soon after birth and for approximately 3 days afterwards can cause a slowing down of the processes that cause brain damage. It is usually carried out on babies born from 36 weeks gestation onwards using a special mattress or a head cap. This is called 'therapeutic cooling'.

The team are currently working through processes to be able to provide a metric which can be included in this report going forward. Until this is completed this will be reported on via a table.

There are 3 grades of HEI:
Mild – most babies recover quickly and will be monitored to check stability and progress.

Moderate to Severe – risk of long term damage to the brain or death in severe cases

Month	Numbers of babies having cooling therapy	Confirmed cases of HIE
July 2023	None	None
August 2023	1 – Emergency C/Section due to fetal distress, Apgars 5@1, 7@5, 10@10 Commenced sepsis pathway transferred to tertiary unit	Confirmed as Grade 1 HEI (mild) by MRI Scan
September 2023	1 – low risk pregnancy with one episode of reduced movements day of elective C/Section Normal CTG. Apgars 2@1, 3@5, 3@10-transferred to tertiary unit	Confirmed as Grade 2 (moderate) HEI by MRI Scan

PMRT (quarter 2 report) attached as Appendix 2
There was 1 case which met the criteria for reporting on the PMRT/MBRRACE system, in the period.
In this case the care up to the delivery was graded as a D, meaning the panel felt there had been issues with care identified that were likely to have made a difference to the outcome for the baby.
3 cases required joint representation with other Trusts to complete as antenatal care had been delivered at Blackpool Victoria Hospital, but the patients transferred out and babies died at other Trusts. There were no issues identified in the antenatal care provided to these patients however, in one case the panel identified that although there was appropriate transfer of care, there was a communication error regarding the transfer resulting in the patient contacting the receiving Trust herself. This did not have had any impact on the outcome. Finalised reports for these cases are awaiting receipt.

External Review (Section 8, page 19)

The neonatal mortality external review commenced in May 2023 completed in September 2023. The draft report has been received for factual accuracy checking. Once the final report has been received next steps will be to complete an action plan in response to recommendations made and to share the report via the Trust Governance Forums to Board. Oversight of the action plan will be via the Neonatal Improvement Board and key highlights shared via the Escalation Report.

OD Support/FTSU (Section 8, page 19)

Face to face sessions with the Multidisciplinary team commenced in August 2023, led by the Director of Midwifery & Neonates and the Divisional Director of Operations with support from the OD team. The remit of these sessions was 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.

A total of 41 out of 47 nurses attended the sessions. The remaining 6 members of staff were either long term sick or on maternity leave. The staff were open and honest and engaged with the sessions well and the view was that the action plan had captured all concerns.

The next steps are to have:

- Monthly action plan meetings with Neonatal Leads, Director of Midwifery and Neonates, HRBP and Head of Occupational Health
- Director of Midwifery and Neonates to attend monthly Neonatal Unit meetings to feedback on progress.
- For Divisional Senior Leadership Team to attend Consultant Meetings to improve engagement and feedback FTSU review findings
- To meet with the neonatal team each quarter to update and discuss progress.

The action plan will be monitored via the Neonatal Improvement Board

Care Quality Commission (Section 11, page 20)

The evidence fodders for each of the CQC actions has been reviewed by the Corporate Governance Team.
The current position being as described in the table below, with 'Red' and 'Amber' requiring additional evidence.

	Red	Amber	Green
Validated position – governance review	7	17	35

The team are currently collating the evidence as required to upload into the folders.

Representation from the Integrated Care Board (ICB) attended on site at the end of September 2023 to review the action plan and visit clinical areas and meet the teams. Further to this a 'mock' CQC inspection is currently being arranged.

Induction of labour – transfers within 4 hours

Audit for IOL delays has demonstrated improvements with 40% of women transferred to delivery suite within 4 hours.

1 induction of labour was transferred out within the LMNS, and 1 was received from RLI as mutual aid.

	August						
w/c	31/07/2023	07/08/2023	14/08/2023	21/08/2023	28/08/2023	Total	%
Under 4 hours	8	5	5	6	2	26	
4 - 12 hours	2	3	8	4	1	18	
12-24 hours	3	4	5	8	3	23	
24-36 hours	4	0	1	4	4	13	
36-48 hours	4	0	0	0	1	5	
48+ hours	2	0	0	0	1	3	
Total	23	12	19	22	12	88	
Transfer out	1						

Alert

Implications
(so what)

Training Compliance –

Neonatal Training (Section 5.0, page 15)

SIM Training for Consultants has dropped to 78% - This involves 2 consultant paediatricians who are overdue for training. This has been escalated to the Head of Department and Clinical Lead with a view to a plan for recovery.

Registered Staff	Sept 2023	August 2023	July 2023	June 2023	May 2023	April 2023
% Nursing staff who have attended SIM Training	100%	100%	100%	100%	100%	100%
% of Consultants who have attended SIM Training	78%	100%	100%	100%	100%	100%

Maternity skills drills (Section 5.0, page 16)

- The overall target of 90% for mandatory training has not been achieved since January 2023.

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	Jul -23	Aug - 23	Sept - 23	October 23
Midwives	75.83%	72.13%	70.18%	86.29%	86.3%	91.8%	98.40%
MSWs	58.6%	60.9%	80.56%	83.78%	83.8%	86.49%	92.11%
Obstetric Consultants	62.5%	62.5%	50%	50%	50%	44.44%	66%
All other Obstetric Doctors	100%	89.47%	75%	75%	94.7%	94.4%	94.73%

Obstetric Anaethesist Consultants	47.05%	47.05%	53%	53%	53%	82.3%	TBC
All other Obstetric Anaethesist Doctors	66.66%	66.66%	84.2%	67%	67%	70%	TBC
All staff	69.87%	64.35%	74.28%	78.43%	72.46%	86.85%	TBC

Current compliance for consultants obstetricians is 66%. Which is an increase of 21% in month. Three consultants currently out of date have dates arranged for November 2023 session. The risk remains that if all three consultants do not attend the requirement of 90% compliance will not be achieved.

CNST Maternity Incentive Scheme (Section 12, page 22)

Year 3

Following the CQC visit to Maternity in June 2022, and the subsequent report on September 2022, NHS Resolution (NHSR) wrote to the Trust on the 11 October 2022, requesting assurances on the CNST submission for Year 3. This request falls under the condition of the scheme as part of the scrutiny and assurance process.

A high-level summary was provided to NHS Resolution and in November 2022, in response to their request, all evidence was submitted to enable them to complete an internal clinical review.

In September 2023, the NHSR team contracted the Trust to advise that there were some gaps in the evidence for safety actions 5, 8 and 9 with opportunity to provide additional evidence.

Further evidence has been submitted however there remains a risk that Safety Actions 8 and 9 will not be compliant.

Assure

Maternity Safety Support Programme (Section 10, page 20)

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 first draft of the framework for the sustainability/exit plan is currently being worked through with the Maternity team and the MSSP advisor, with an expectation that a draft plan will be in place early November 2023.

Previously considered by	Clinical Governance 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 – October 2023 (reporting for September 2023)

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

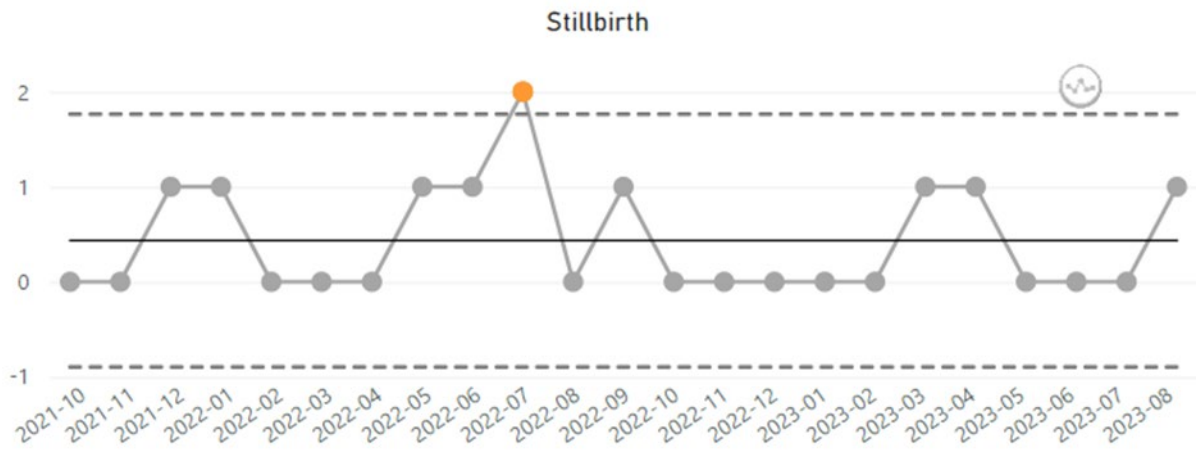
The Perinatal Quality Surveillance Model was developed in response to the Ockenden findings. It incorporates 5 principles for increasing oversight of perinatal clinical quality, integrating perinatal clinical quality into ICS structures, and providing clear lines for responsibility and accountability 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.

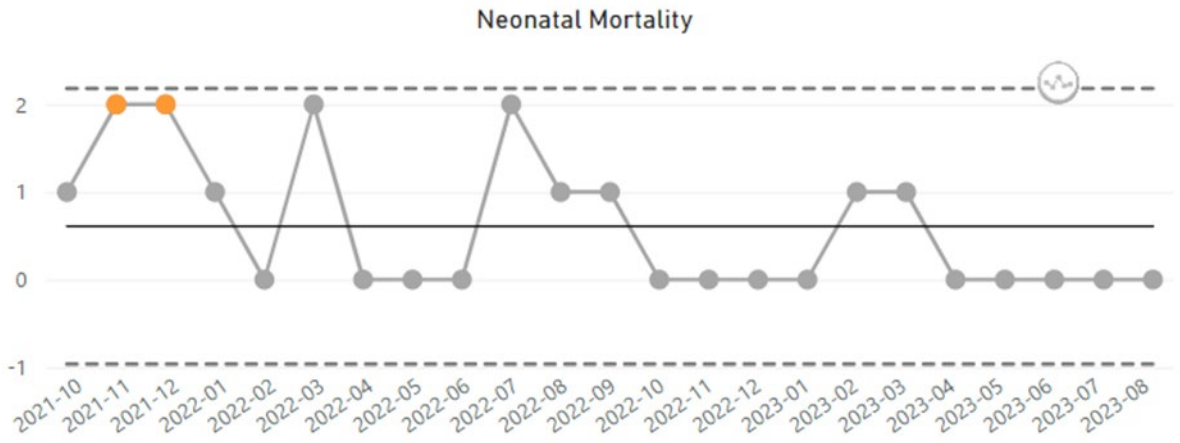
3.0. Perinatal Deaths and Learning

Perinatal mortality includes stillbirths and neonatal deaths in the first week of life.

From April to September 2023, there have been no Neonatal deaths.

In September 2023, there were no stillbirths.





Perinatal Mortality Review Tool (PMRT) Process

The Perinatal Mortality Review Tool (PMRT) was released in January 2018. The purpose of the tool was to establish a national systematic approach for high-quality perinatal reviews for stillbirth babies and neonatal deaths. The fundamental aim being to support objective, robust and standardised review to provide answers for bereaved parents and their families about why their baby died.

All perinatal mortality deaths eligible are notified to MBRRACE-UK within seven working days. The National Perinatal Mortality Tool (PMRT) is used to review eligible deaths. The criteria for eligible deaths are:

- All late miscarriages/fetal loss (22 to 23+6 weeks)
- All stillbirths (From 24 weeks)
- Neonatal Deaths (Up to 28 days after birth)
- Where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (Including at home) when they die.

The review takes place by the multi-disciplinary team including external representation. Parents are informed that the review is taking place and are invited to ask any questions which can be included in the review. Contact is maintained with the parents by the Bereavement Midwife or/and Governance Midwife.

CNST Safety Action 1 states that the Trust Board receive a quarterly PMRT report including details of deaths reviewed and consequent action. For period July 2023 to September 2023 the PMRT report is attached as **Appendix 2.** For this reporting period:

There was 1 case which met the criteria for reporting on the PMRT/MBRRACE system, in the period. In this case the care up to the delivery was graded as a D, meaning the panel felt there had been issues with care identified that were likely to have made a difference to the outcome for the baby.

3 cases required joint representation with other Trusts to complete as antenatal care had been delivered at Blackpool Victoria Hospital, but the patients transferred out and babies died at other Trusts. There were no issues identified in the antenatal care provided to these patients however, in one case the panel identified that although there was appropriate transfer of care, there was a communication error regarding the transfer resulting in the patient contacting the receiving Trust herself. This did not have had any impact on the outcome. Finalised reports for these cases are awaiting receipt.

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 September 2023.

Cases to date	
Total referrals	26
Referrals / cases rejected	10
Total investigations to date	16
Total investigations completed	14
Current active cases	2

The current ongoing investigations are:

- (MI-021273) 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-028403) Baby delivered in June 2023, requiring cooling following birth. Family have consented to HSIB investigation and records have been requested.

HSIB transfer to Maternity and Newborn Safety Investigation Programme (MNSI)

On 28th September 2023, the Trust was notified that from 1st October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme will be hosted by the Care Quality Commission (CQC) instead of Healthcare Safety Investigation Branch (HSIB). There will be no change to

operations or workforce and there will be no interruption to ongoing investigations. The transition is expected to support ongoing high quality family focused investigations, but as a larger organisation will have access to more resources including improved capacity and access to data and statistics and the opportunity to contribute best practice learning through national reporting.

4.0. Moderate and above Harm incidents

In September 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 7 moderate harms reported, 2 of these was downgraded following review :

Moderate Harms and above – September 2023

There were 9 moderate harms and above in September 2023. Of these 4 were downgraded

Department	3rd / 4th Degree Tear	Children - SG	Female Genital Mutilation(FGM)	Low Cord PH <7.0 5 ART Or <7.1 VEN	Maternity - Delay In Care	PPH >1500mls	Term Baby Admitted To Neonatal Unit	Grand Total
Delivery Suite			1	1	1	2		5
Maternity Theatre	1					1		2
Neo Natal Unit (SCBU)							1	1
Ward D (Maternity)		1						1
Grand Total	1	1	1	1	1	3	1	9

Delivery Suite – Safeguarding	Moderate	377563 – Female genital mutilation Type 1 FGM of patient. Patient discussed in antenatal clinic she would prefer for her baby to have FGM as this was the cultural practice in Nigeria. Patient informed this is illegal. Already under CSC and CSN teams Downgraded to minimal harm
Delivery Suite	Moderate	378067 Delay in care Patient proceeded to caesarean section for brow presentation Whilst prepping for theatre emergency in another room.

		Downgraded following review.
Delivery Suite	Moderate	379042 PPH >1500mls PPH due to suboptimal tone following caesarean section. Consultant present Managed appropriately Downgraded
Delivery Suite – Low cord Ph	Severe Harm	377321 – Baby delivered by elective caesarean section. No known risk factors other than reduced fetal movements on day of procedure. Baby delivered in poor condition and transferred to tertiary centre for cooling. Currently under investigation
Delivery Suite -	Moderate	377481 PPH > 1500mls Emergency caesarean section with estimated blood loss of 2000mls. Returned to theatre post operatively for ongoing bleeding and proceeded to hysterectomy. Transferred to ITU following surgery. Rapid review completed progressing to serious incident review
Maternity Theatre	Moderate	377889 PPH > 1500mls PPH following caesarean section under general anaesthetic. Currently under investigation
Maternity Theatre	Moderate	377890 3rd/4th degree tear repaired in theatre. Downgraded following review
D Ward (Maternity)	Moderate	378279 Safeguarding Children Baby on child protection plan Local Authority requested mum and baby to remain in hospital to prevent separation prior to going to foster care – incident reported as maternity unit busy and unable to accommodate. Downgraded after review
Neonatal Unit	Moderate	378382 Term baby admission Baby delivered by emergency caesarean section for fetal distress required some resuscitation at birth. Abnormal movements noted. 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.

Neonatal Hypoxic – ischaemic Encephalopathy (HIE)

Neonatal Hypoxic – ischaemic Encephalopathy (HIE) is a type of brain damage caused by a lack of oxygen to the brain before or shortly after birth.
Lowering the baby's body temperature soon after birth and for approximately 3 days afterwards can cause a slowing down of the processes that cause brain damage. It is usually carried out on babies born from 36 weeks gestation onwards using a special mattress or a head cap. This is called 'therapeutic cooling'.

The team are currently working through processes to be able to provide a metric which can be included in this report going forward. Until this is completed this will be reported on via a table.

There are 3 grades of HEI:

Mild – most babies recover quickly and will be monitored to check stability and progress.

Moderate to Severe – risk of long term damage to the brain or death in severe cases

Month	Numbers of babies having cooling therapy	Confirmed cases of HIE
July 2023	None	None
August 2023	1 – Emergency C/Section due to fetal distress, Apgars 5@1, 7@5, 10@10 Commenced sepsis pathway transferred to tertiary unit	Confirmed as Grade 1 HEI (mild) by MRI Scan
September 2023	1 – low risk pregnancy with one episode of reduced movements day of elective C/Section Normal CTG. Apgars 2@1, 3@5, 3@10-transferred to tertiary unit	Confirmed as Grade 2 (moderate) HEI by MRI Scan

Regulation 28

Nil to report for this month.

Never Events

Nil to report this month.

5.0. Training Compliance
Neonatal Training

SIM Training for Consultants has dropped to 78% - This involves 2 consultant paediatricians who are overdue for training. This has been escalated to the Head of Department and Clinical Lead with a view to a plan for recovery.

Registered Staff	Sept 2023	August 2023	July 2023	June 2023	May 2023	April 2023
% of workforce establishment holding a current NMC registration	86%	88%	88%	88%	88%	88%
% of all registered staff providing direct nursing care QIS	72%**	58%	58%	58%	58%	58%
% of overall mandatory training compliance	95%***	95%	95%	95%	91%	94%
% of annual NLS compliance (excluding those on long term sick, mat leave, and secondment)	100%	100%	100%	100%	100%	100%
% of 4 yearly NLS compliance (excluding those on long term sick, mat leave, and secondment)	79%****	73%	73%	73%	73%	73%
% of 4 yearly NLS compliance for Consultants	100%	100%	100%	100%	100%	100%
% of nursing staff (qualified and unqualified) who have attended SIM training	100%	100%	100%	100%	100%	100%
% of consultants who have attended SIM training	78%	100%	100%	100%	100%	100%

- 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

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 the 1st December 2023. Currently all staff are booked on training, and should they attend, we will achieve >90% compliance.

	Apr-23	May-23	June -23	Jul -23	Aug - 23	Sept - 23	Oct - 23
Midwives	75.83%	72.13%	70.18%	86.29%	86.3%	91.8%	98.40%
MSWs	58.6%	60.9%	80.56%	83.78%	83.8%	86.49%	92.11%
Obstetric Consultants	62.5%	62.5%	50%	50%	50%	44.44%	66%
All other Obstetric Doctors	100%	89.47%	75%	75%	94.7%	94.4%	94.73%
Obstetric Anaethesist Consultants	47.05%	47.05%	53%	53%	53%	82.3%	
All other Obstetric Anaethesist Doctors	66.66%	66.66%	84.2%	67%	67%	70%	
All staff	69.87%	64.35%	74.28%	78.43%	72.46%	86.85%	

Two Consultants were unable to attend the last course at the beginning of October 2023, one due to sickness absence and one was supporting the unit due to the strikes.

Current compliance for consultants obstetricians is 66%. Which is an increase of 21% in month. Three consultants currently out of date have dates arranged for November 2023 session. The risk remains that if all three consultants do not attend the requirement of 90% compliance will not be achieved.

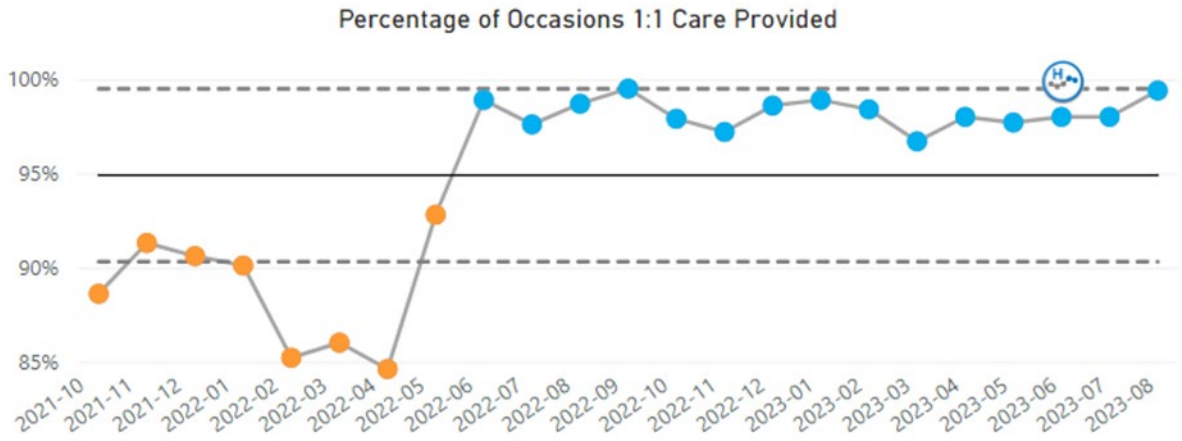
6.0. Safe Staffing

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 ambition is to achieve 100% 1-1 care in labour, and this is the required target for maternity incentive scheme safety action 5 (CNST). This is monitored via Badgernet and monthly via PIDA.
Incidents where one to one care cannot be provided is escalated to the Matron who reviews these cases.

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 2023, with 86% achieving safe staffing levels. The aim is to increase completion percentage to increase accuracy of safe staffing reporting.



Midwifery Staffing

In September 2023, cohort of newly qualified Midwives commenced in post. This team are currently on induction and have a preceptorship package and support plan in place.

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

To ensure the Safety Champions are fulfilling the role requirements, the Maternity advisor from the MSSP programme is supporting the team by facilitating a workshop. This is currently being arranged.

8.0. Neonatal Update

The Neonatal Improvement Board

The Neonatal Improvement Board meeting was held in August 2023, at which time the Neonatal team discussed progress. The agenda and team presentation provided assurances of continuing improvements.

Nurse staffing / structure, reviewed with HR Business Partner and is progressing with interviews on 25 September 2023

- Ockenden money received for 1WTE Governance lead and recruitment progressing.
- Achieved **Green** in FI Care reaccreditation (previously Amber)

Babies less than 27 weeks gestation born in wrong place

Neonates remains an outlier in the region for 2022/2023 and for Quarter 1 of 2023/24 and for babies under 27 weeks gestation in the wrong place.

		2022/23 Q1	2022/23 Q2	2022/23 Q3	2023/24 Q4
<27 WEEKS IN LNU (<28 multi deliveries 2223 Q1 onwards incl <800g)	**Lancashire and South Cumbria**	**4**	**0**	**2**	**1**
	LSC_Other	**1**	**0**	**0**	**0**
	Furness General	**0**	**0**	**0**	**0**
	Royal Lancaster Infirmary	**1**	**0**	**0**	**0**
	Victoria Blackpool	**2**	**0**	**2**	**1**

Neonatal Mortality

Neonates was an outlier for neonatal mortality for 2022/23. For 2023/24 Quarter 1 this has improved.

MORTALITY GESTATION 24-27 WEEKS	**NWNODN**	**12.5%**	**13.6%**	**18.7%**	**11.5%**
	Lancashire and South Cumbria	**26.3%**	**0.0%**	**10.5%**	**16.7%**
	Burnley	**22.2%**	**0.0%**	**0.0%**	**14.3%**
	Furness General	-	-	-	-
	Royal Lancaster Infirmary	**50.0%**	-	**0.0%**	-
	Royal Preston	**0.0%**	**0.0%**	**14.3%**	**25.0%**
	Victoria Blackpool	**66.7%**	-	**50.0%**	**0.0%**
MORTALITY GESTATION 28-31 WEEKS	**NWNODN**	**2.0%**	**5.4%**	**3.7%**	**2.1%**
	Lancashire and South Cumbria	**5.7%**	**8.0%**	**3.8%**	**3.0%**
	Burnley	6.7%	15.4%	10.0%	8.3%
	Furness General	-	-	-	0.0%
	Royal Lancaster Infirmary	0.0%	0.0%	0.0%	0.0%
	Royal Preston	0.0%	0.0%	0.0%	0.0%
	Victoria Blackpool	16.7%	0.0%	0.0%	0.0%
	NWNODN	**5.4%**	**8.0%**	**9.0%**	**4.7%**

MORTALITY GESTATION 24-31 WEEKS	**Lancashire and South Cumbria**	**13.0%**	**5.7%**	**6.7%**	**6.7%**
	Burnley	**12.5%**	**11.1%**	**5.3%**	**10.5%**
	Furness General	-	-	-	**0.0%**
	Royal Lancaster Infirmary	**12.5%**	**0.0%**	**0.0%**	**0.0%**
	Royal Preston	**0.0%**	**0.0%**	**6.7%**	**7.7%**
	Victoria Blackpool	**33.3%**	**0.0%**	**12.5%**	**0.0%**

Avoiding Term Admissions

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 continue to be 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.

External Review

The neonatal mortality external review commenced in May 2023 completed in September 2023. The draft report has been received for factual accuracy checking. Once the final report has been received next steps will be to complete an action plan in response to recommendations made and to share the report via the Trust Governance Forums to Board. Oversight of the action plan will be via the Neonatal Improvement Board and key highlights shared via the Escalation Report.

OD Support/FTSU

Face to face sessions with the Multidisciplinary team commenced in August 2023, led by the Director of Midwifery & Neonates and the Divisional Director of Operations with support from the OD team. The remit of these sessions was 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.
A total of 48 staff attended the three sessions:

- 41 out of 47 nurses attended the sessions. (The remaining 6 members of staff were either long term sick or on maternity leave)
- 3 Paediatric Consultants and 2 Middle Grades
- 1 Housekeeper
- 1 Ward clerk

The staff were open and honest and engaged with the sessions well and the view was that the action plan had captured all concerns.
The next steps are to have:

- Monthly action plan meetings with Neonatal Leads, Director of Midwifery and Neonates, HRBP and Head of Occupational Health
- Director of Midwifery and Neonates to attend monthly Neonatal Unit meetings to feedback on progress.
- For Divisional Senior Leadership Team to attend Consultant Meetings to improve engagement and feedback FTSU review findings
- To meet with the neonatal team each quarter to update and discuss progress.

The action plan will be monitored via the Neonatal Improvement Board

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 first draft of the framework for the sustainability/exit plan is currently being worked through with the Maternity team and the MSSP advisor, with an expectation that a draft plan will be in place early November 2023.

11.0. Care Quality Commission (CQC)

The current position

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

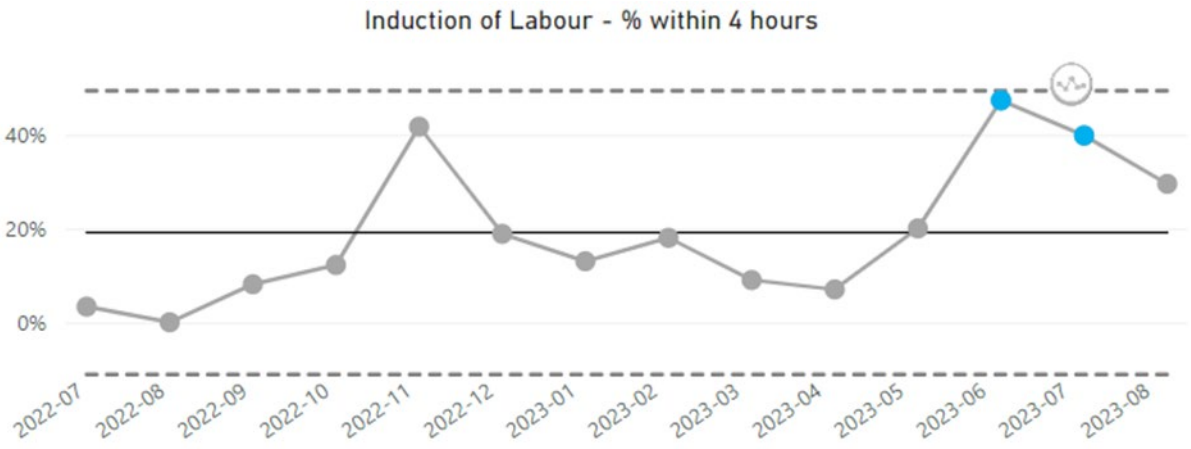
The evidence fodders for each of the CQC actions has been reviewed by the Corporate Governance Team.
The current position being as described in the table below, with 'Red' and 'Amber' requiring additional evidence.

	Red	Amber	Green
Validated position – governance review	7	17	35

Leads for the collating the evidence have been identified prior to quality checking and upload into the folders.

Representation from the Integrated Care Board (ICB) attended on site at the end of September 2023 to review the action plan and visit clinical areas and meet the teams. Further to this a 'mock' CQC inspection is currently being arranged.

Induction of Labour



Induction of labour delays is monitored daily through safety huddles, and flow meetings and risk assessments completed by the consultant of the day daily.
Audit for IOL delays has demonstrated improvements with 40% of women transferred to delivery suite within 4 hours.
1 induction of labour was transferred out within the LMNS, and 1 was received from RLI as mutual aid.

	August						
w/c	31/07/2023	07/08/2023	14/08/2023	21/08/2023	28/08/2023	Total	%
Under 4 hours	8	5	5	6	2	26	29.55
4 - 12 hours	2	3	8	4	1	18	20.45
12-24 hours	3	4	5	8	3	23	26.14
24-36 hours	4	0	1	4	4	13	14.77
36-48 hours	4	0	0	0	1	5	5.68
48+ hours	2	0	0	0	1	3	3.41
Total	23	12	19	22	12	88	
Transfer out	1						

12.0. CNST Maternity Incentive Scheme

Year 3

Following the CQC visit to Maternity in June 2022, and the subsequent report on September 2022, NHS Resolution (NHSR) wrote to the Trust on the 11 October 2022, requesting assurances on the CNST submission for Year 3. This request falls under the condition of the scheme as part of the scrutiny and assurance process.

A high-level summary was provided to NHS Resolution and in November 2022, in response to their request, all evidence was submitted to enable them to complete an internal clinical review.

In September 2023, the NHSR team contracted the Trust to advise that there were some gaps in the evidence for safety actions 5, 8 and 9 with opportunity to provide additional evidence.

Further evidence has been submitted however there remains a risk that Safety Actions 8 and 9 will not be compliant.

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 3)

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	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	2 cases 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	7 moderate incidents 2 downgraded	9 moderate incidents 4 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	TBC	TBC			
3.Service User Voice Feedback				Leaflets production Birth Afterthoughts	Leaflets production Birth Afterthoughts	Support with IOL audit	Attending Safety Champs meeting	Attending Safety Champs meeting	Attending Safety Champs meeting			
4.Staff feedback from frontline champion and walk-abouts				Monthly Walkabouts completed	Monthly Walkabouts completed	Monthly Walkabouts completed	Monthly Walkabouts completed	Monthly Walkabouts completed	Monthly Walkabouts completed			
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made				HSIB Escalation letter x 2	HSIB Escalation letter x 1 (3)	Nil	Nil	Nil	NHSR			

directly with Trust												
6.Coroner Reg 28 made directly to Trust				None	None	None	None	None	None			
7.Progress in achievement of CNST 10				Compliant – 2 Safety Actions	Compliant 2 Safety Actions	Under Review	Under review	Progressing	Progressing			

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

Quarterly PMRT Report for Trust Board
July 2023- September 2023

Author of Report	Angela McKee – Clinical Governance Midwife
Executive Director Sponsor:	Bridget Lees – Executive Director of Nursing & Midwifery
Date of Report:	October 2023

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

The report includes extracted report from the Perinatal Mortality Reporting Tool for information and oversight for Quarter 2 2023/2024

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

Recommendations:

The Committee is asked to take note of the report and actions taken.

There were 4 cases discussed at our monthly PMRT review during this three-month period. Of these cases 3 required joint representation with other trusts to complete as antenatal care had been delivered at Blackpool Victoria Hospital and had been transferred out for care and delivery and the baby had died at another trust.

Sensitivity Level:

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

PMRT/MBRRACE cases closed between 01/07/2023-30/09/2023.

The trust reports all cases which meet the criteria for PMRT/MBRRACE within the 7-day reporting window and aims to complete and close the review within 4 months or reporting. The division generates a quarterly report of cases closed and actions taken for these cases.

PMRT Criteria:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.

- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g.

- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g.

- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere, (Including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:
- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

MBRRACE Criteria

- Late fetal losses – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred

- Stillbirths – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred

- Early neonatal deaths – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth

- Late neonatal deaths – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth

- All maternal death up to 365 days of delivery.

For period July 2023 to September 2023(inclusive):

There was 1 case which met the criteria for reporting on the PMRT/MBRRACE system, in the period 01/07/2023-30/09/2023.

There were 4 cases discussed at our monthly PMRT review during this three-month period. Of these cases 3 required joint representation with other Trusts to complete as antenatal care had been delivered at Blackpool Victoria Hospital and had been transferred out for care and delivery, and the babies had died at another Trust. There were no issues identified in the antenatal care provided to these patients however, in one case the panel identified that although there was appropriate transfer of care, there was a communication error regarding the transfer resulting in the patient contacting the receiving Trust herself. This did not have had any impact on the outcome. Finalised reports for these cases are awaiting receipt.

The 4th case that reported in this period was also reviewed with external representation as good practice recommended in the external PMRT review in March 2023.

In this case the care up to the delivery was graded as a D, meaning the panel felt there had been issues with care identified that were likely to have made a difference to the outcome for the baby.

The review panel felt that it would have been appropriate to have admitted the patient to the ward for observation and CTG monitoring whilst planning for delivery at the earliest opportunity by elective caesarean section, following steroids therapy. This was due to the abnormal ultrasound findings and the patient's history of reduced fetal movements. The review panel felt that this was the most appropriate method for delivery as aiming for delivery by induction of labour would have potentially compromised the baby. The review panel also felt that the management plan should have been discussed with the consultant on call, there was no documentation on the electronic reporting system to support that this had happened. The PMRT review panel felt that whilst they could not state with certainty that the outcome would have been any different, they did feel that by admitting the patient and monitoring the fetal heart with regular CTG's any issues might have been identified and delivery may have been indicated earlier.

Please see action chart below for issues identified and requiring actions from the cases discussed during the time-period 01/07/2023-30/09/2023.

Issues raised which were identified as relevant to the deaths	**Numbers of deaths**	**Reason relevant to outcome**	**Actions taken**
Inappropriate management plan for induction at 27 weeks	1	Could have potentially compromised the baby and should have been discussed with the consultant on call.	Referred to the head of department for case-based discussion to take place with the obstetric trainee involved.

Failure to discuss management plan with the consultant on call	1	Could have potentially compromised the baby and should have been discussed with the consultant on call.	Referred to the head of department for case-based discussion to take place with the obstetric trainee involved.

Further updates

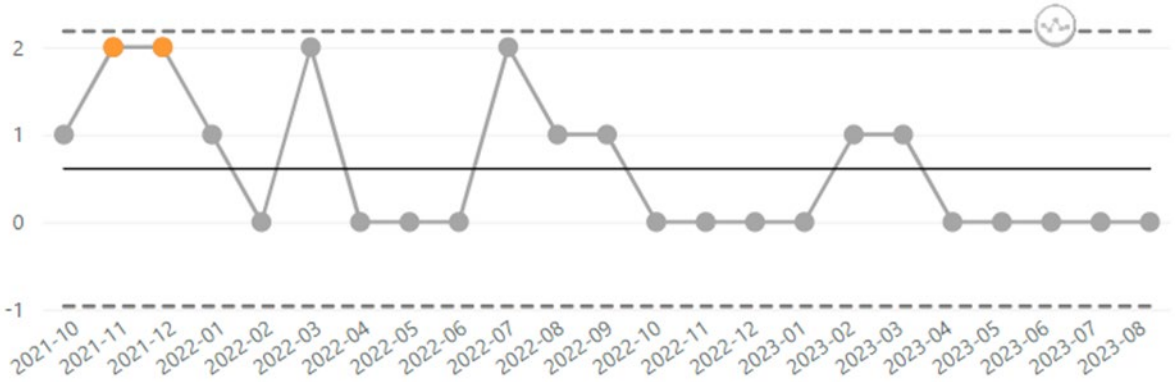
The Governance team have recently worked with the LMNS network, (Local Maternity and Neonatal System), to agree a shared care duty of candour letter for PMRT cases where care is delivered by more than one trust, to ensure parents are involved with the process and have the choice who they wish to take the lead as their primary contact making the process less confusing at such a traumatic time.

(Appendix 3) Maternity Dashboard

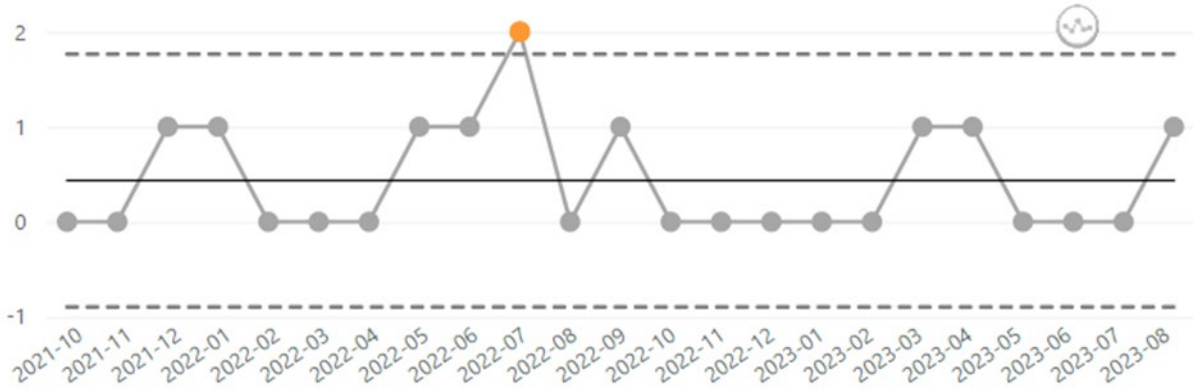
Families and Integrated Community Care

October 2023 (August 2023 data)

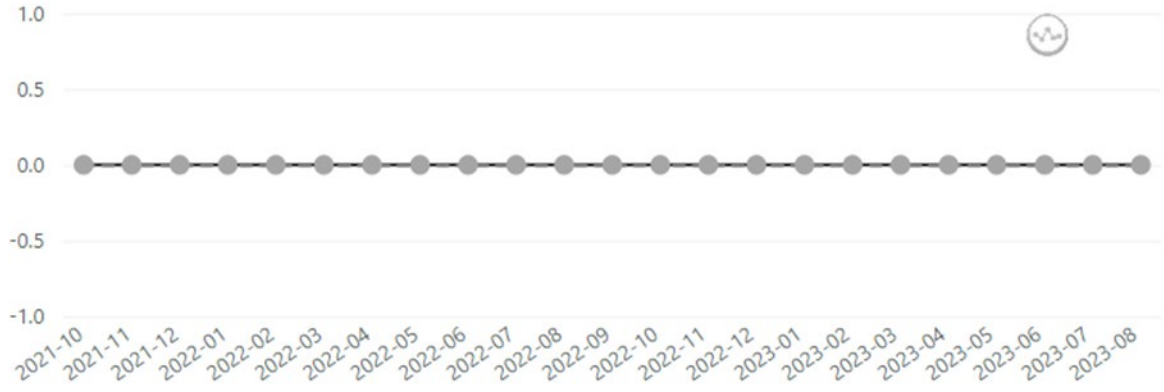
Neonatal Mortality

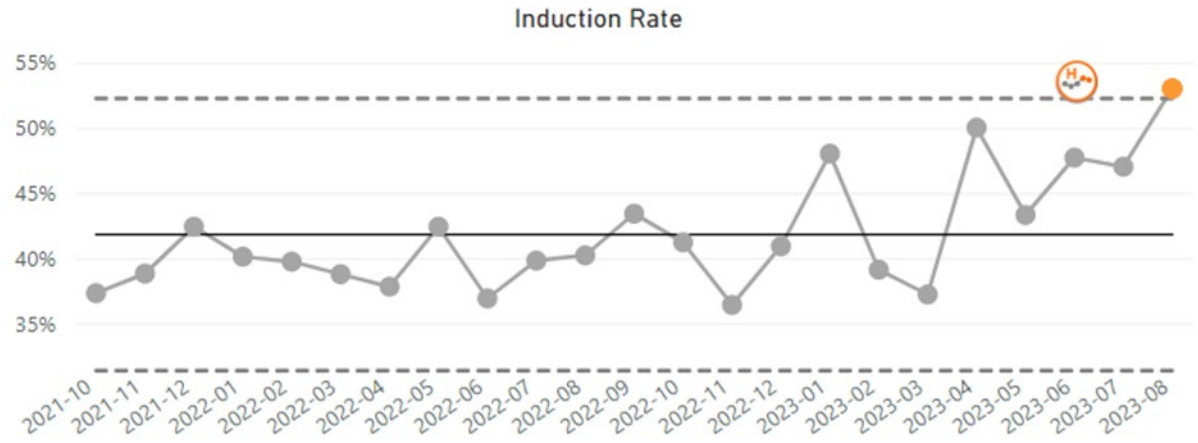


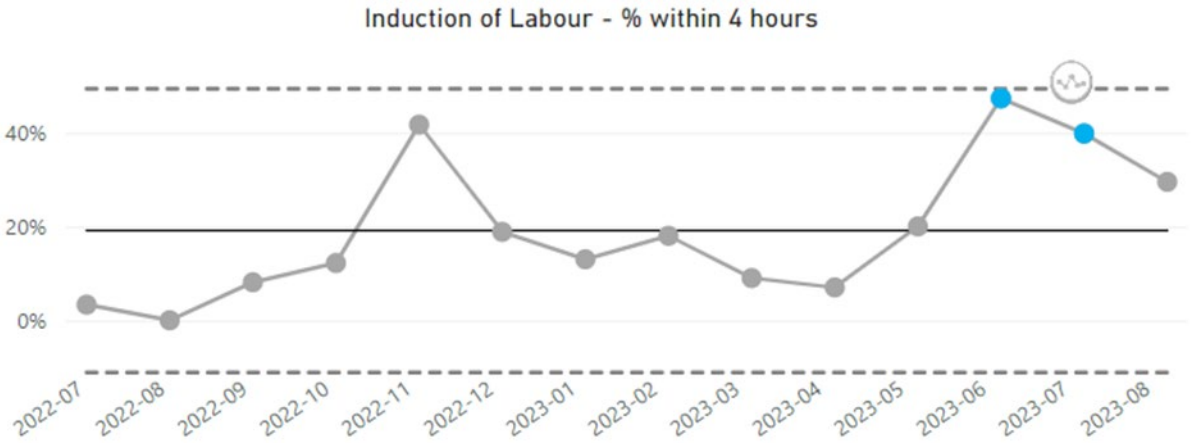
Stillbirth

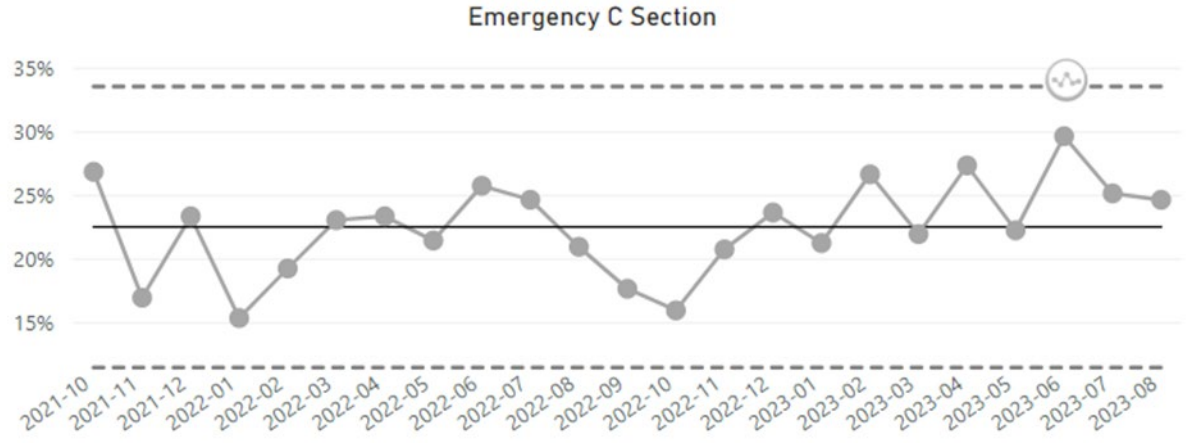


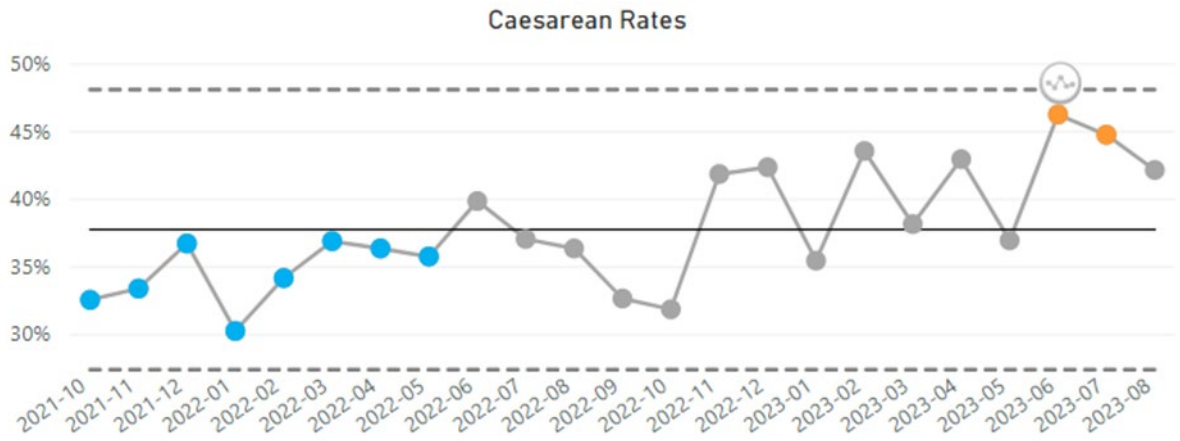
Number of Maternal Deaths

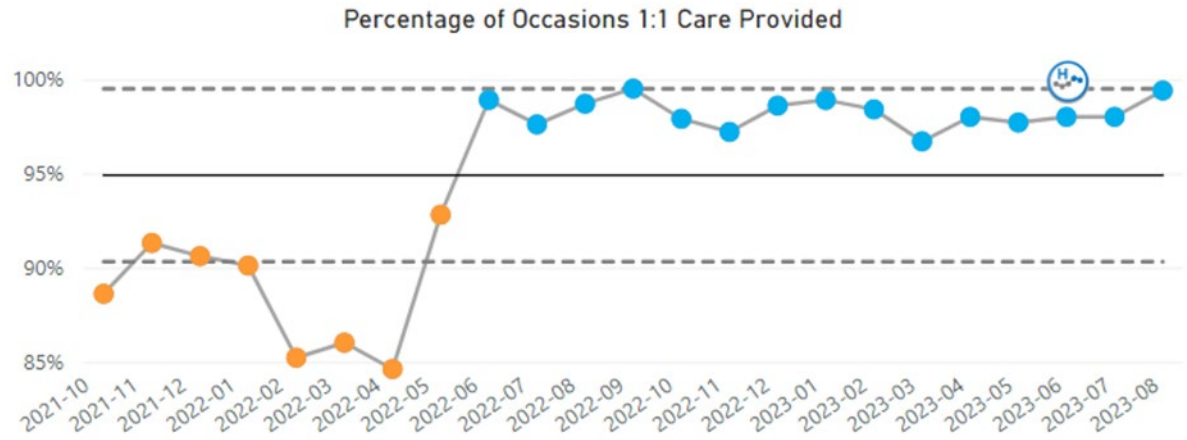


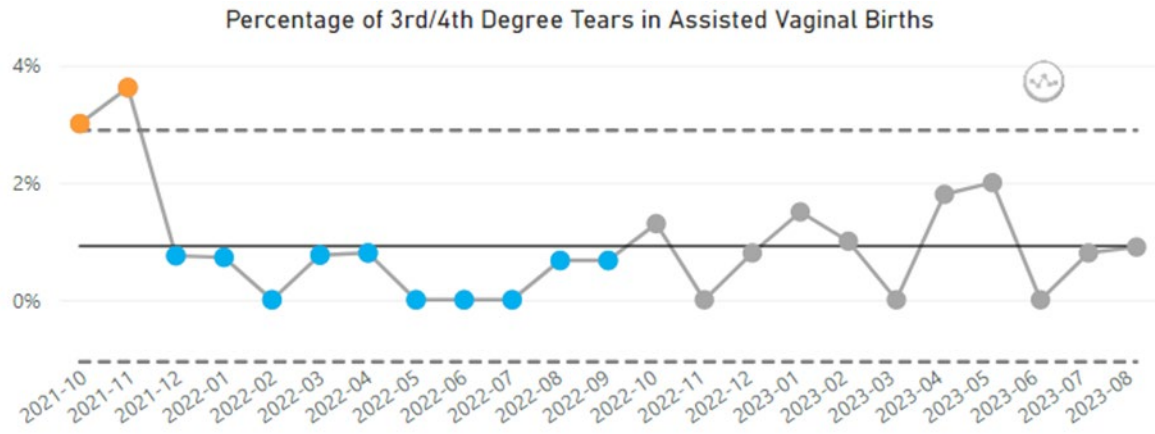

Induction Rate
55%
50%
45%
40%
35%
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07
2023-08

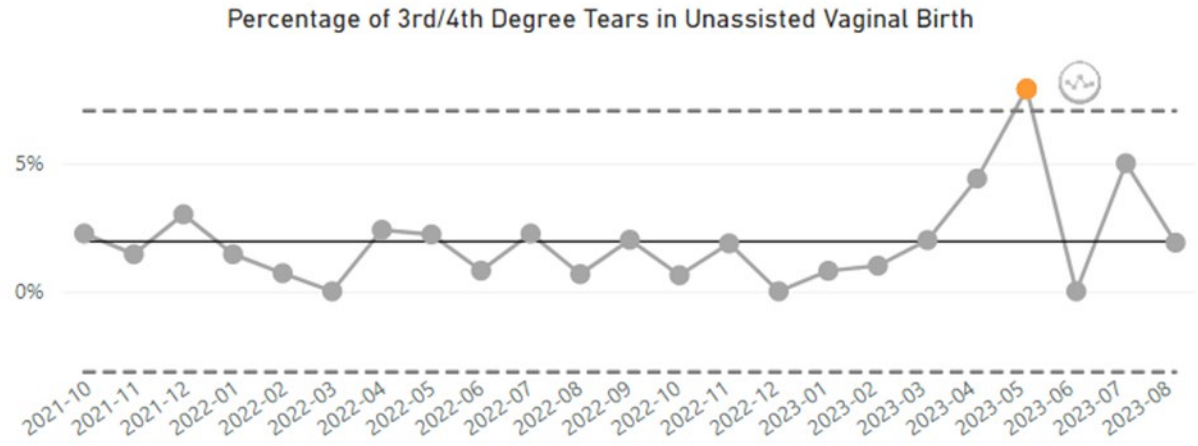

Induction of Labour - % within 4 hours
40%
20%
0%
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07
2023-08

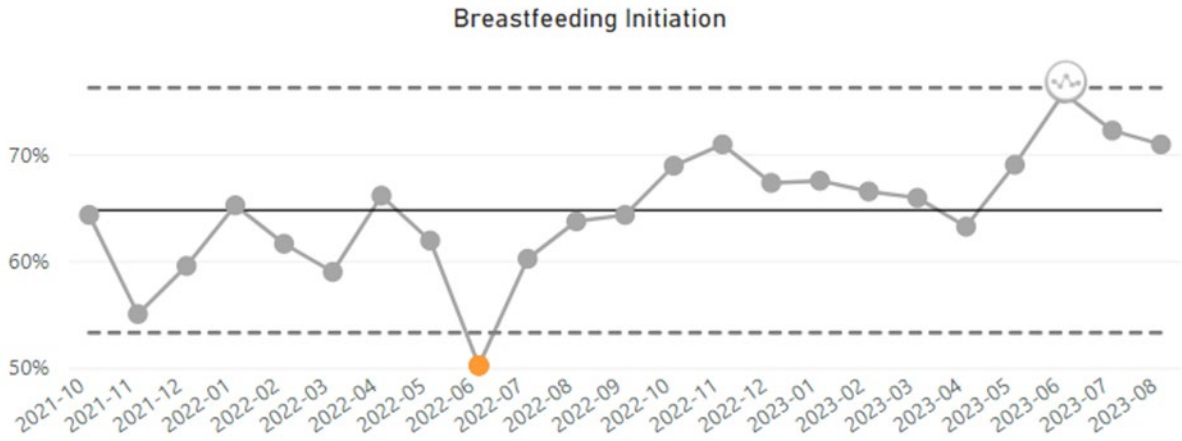

Emergency C Section
35%
30%
25%
20%
15%
2021-10
2021-11
2021-12
2022-01
2022-02
2022-03
2022-04
2022-05
2022-06
2022-07
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
2023-03
2023-04
2023-05
2023-06
2023-07
2023-08


Caesarean Rates
50%
45%
40%
35%
30%
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
2023-08


Percentage of Occasions 1:1 Care Provided
100%
95%
90%
85%
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
2023-08


Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births
4%
2%
0%
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
2023-08


Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Birth
5%
0%
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
2023-08


Breastfeeding Initiation
70%
60%
50%
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
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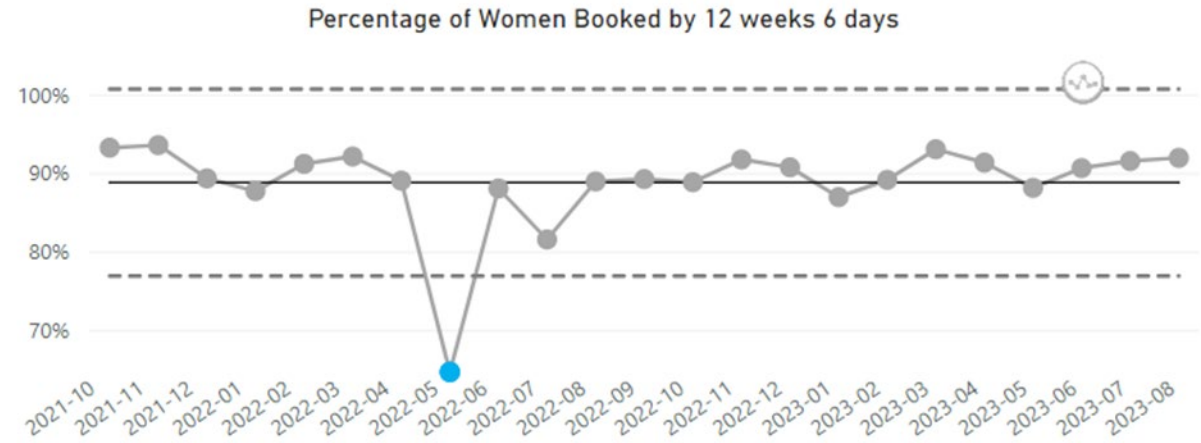
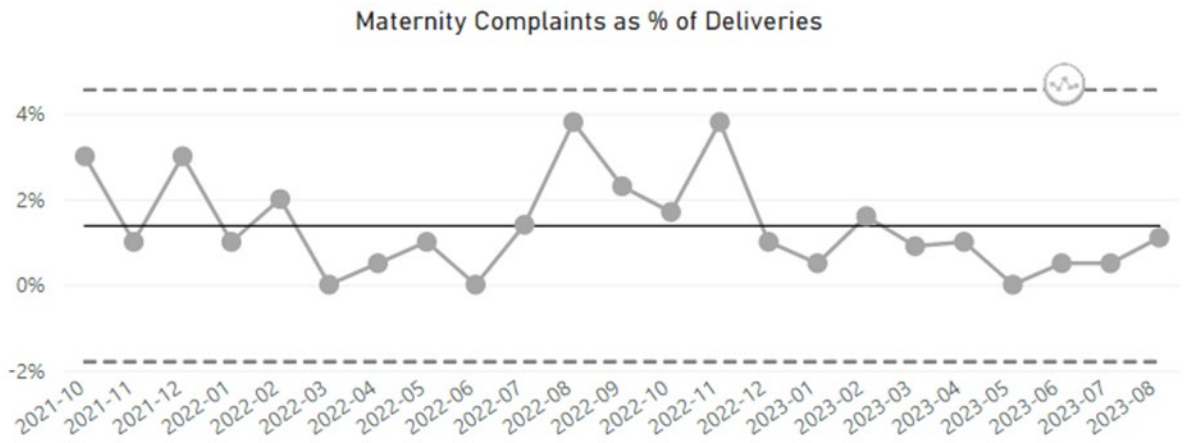
2023-04
2023-05
2023-06
2023-07
2023-08


Percentage of Women Booked by 12 weeks 6 days
100%
90%
80%
70%
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
2023-08


Maternity Complaints as % of Deliveries
4%
2%
0%
-2%
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
2023-08

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Maternity and Neonatal Independent Senior Advocate

Meeting:	Board of Directors Meeting
Date:	2nd November 2023

Author	Louise Peacock, Maternity and Neonatal Independent Senior Advocate					
Exec Sponsor						
Purpose	Assurance		Discussion	x	Decision	X
Confidential y/n	Yes					

Summary *(what)*	**Advise** The board need to be aware of the role of the Maternity and Neonatal Independent Senior Advocate (MNISA) and the fact there is a requirement to provide feedback to the board on individual events and trends alongside recommendations to improve service user experience and patient safety.

Implications *(so what)*	**Alert** The board need to be aware of the impact of the activity to date and actions that have occurred because of feedback received from families who have experienced adverse outcomes to enable them to consider whether further actions are required to increase patient safety and reduce compounded harm for families. **Assure**

Previously considered by	

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

Equality, Diversity and Inclusion (EDI) implications	

Proposed Resolution ***(What next)***	To review feedback provided, have an awareness of work undertaken and consider whether any additional steps are required. To consider approval of the proposed frequency of reporting to board.

Maternity & Neonatal Independent Senior Advocate

Louise Peacock
Louise.peacock9@nhs.net

NHS
Lancashire and South Cumbria
Integrated Care Board

Maternity & Neonatal
Independent Senior Advocate
Louise Peacock
Louise.peacock9@nhs.net

OCKENDEN, KIRKUP & WIDER MANDATE

- The ISA Role has is a partial fulfilment of **Ockenden IEA2** *"Maternity services must ensure that women and their families are listened to with their voices heard."* : *"Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. "*

- The first finding shared from Dr Kirkup's report into care at East Kent was *: "We have found a clear pattern… those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor."*

- The NHS Three Year Delivery Plan for Maternity **Theme 1**: *"Listening to and working with women and families with compassion … Listening and responding to all women and families is an essential part of safe and high-quality care."* inextricably links listening to women and families and the safe delivery of care.

THE PILOT

- Lancashire and South Cumbria are one of 6 fully recruited ICB's. There are 23 ICB's in England who were successful in securing funding for the ISA Role during its pilot phase.
- NHS England Pilot before a 24/25 roll out with MNISAs in every Trust, England wide.
- National training programme in two cohorts

PILOT AIMS

- Assess the impact of the service in supporting women and families feeling listened to, heard and their concerns being acted on.
- Understand the likely MNISA workload, based on referrals and understand working relationships between MNISAs and other patient safety or advocacy roles.

NHS
Lancashire and South Cumbria
Integrated Care Board

Maternity & Neonatal Independent Senior Advocate

Louise Peacock
Louise.peacock9@nhs.net

THE MNISA ROLE

- Provides independent **advocacy** for women, birthing people and their families where they feel their voice is not being heard by their care team, service or Trust.
- Offers **navigational support** and **system advocacy** to families, navigating maternity and neonatal healthcare, in particular, to families where there are concerns about maternity or neonatal care and/or where there has been an **adverse outcome**.
- With the support of the ICB, **reports to both the Trust and the LMNS boards**, providing **robust feedback** on both individual events and trends.
- Supports quality and safety workstreams **making recommendations for actions and improvements** in response to serious incidents or harm in relation to service user experience and patient safety.

NEXT STEPS

- Understand current pathways and support for women and birthing people of all demographics.
- National development of communications and operational guidance.
- Co-produce referral and acceptance criteria and systemwide communications including direct service user communications in line with national guidance and SOP.
- Consider addition of details for the MNISA service to DoC letters and Complaints acknowledgement to ensure families are aware of the service as an additional offer if they feel unheard.

WHAT YOU CAN DO

- Notice families struggling to have their voices heard and system barriers preventing full participation, particularly where there has been any adverse outcome for either mother or baby and consider referral. Trust processes should be utilised first, the MNISA role should be considered as a last port of call
- Consider how your role can contribute to referrals and the ongoing pursuit of listening and hearing women and birthing people at every stage of their perinatal journey.

Maternity & Neonatal Independent Senior Advocate (NHSE Pilot Phase) - BTH Board - November 2023

Board Date: 02/11/2023	**Report Date: 13/10/2023**
Reporting Period: July to October 2023	

Theme:	RAG status	SBAR:
Communication		SB: Families whose babies had died highlighted issues relating to: -Lack of open and transparent conversations about options and investigations 'I feel isolated because nobody is telling me what is happening (are there going to be any meetings/investigations?)' 'I don't know what is happening' 'BadgerNet meant I was in the dark, I wish I could just have paper records again' -Insensitive and impersonal letters from governance teams which don't 'use my baby's name' 'say sorry' 'poor timing made me feel like they didn't care' -Broken promises 'I will come back and keep a close eye on you' but they never did -'you need to be seen to help yourself', 'I felt blamed for my baby's condition because my pregnancy wasn't planned' A: Many of these issues related to cross-organisational communication between BTH and tertiary neonatal provider, clear recommendations for cross-organisational working offered by ICB (see slide 6) Information on BadgerNet not always available to woman R:Meeting arranged between both providers and new process agreed including proposal of joint letter between the organisations which clearly details key contact (see example in slide 7). Maternity governance team made aware of Learn Together work relating to engaging with families, recommendation made to utilise these resources when working with families during investigation processes (see slide 8). Update required as to whether these or another tool are now in use. Electronic patient record system issues highlighted at LMNS board and each provider looking into whether this is a training issue 'i.e. lack of box ticking to reveal information' To review BadgerNet training and shared lesson to maternity team around awareness of tick box to publish to BadgerNotes

Theme:	RAG status	SBAR:
Information Sharing between organisations		SB:-Families raised concerns regarding information sharing between organisations which directly impacted upon their care including: -When transfer occurs antenatally or after birth, to enable effective care 'clinical plans were not shared between teams, I had to update one team with a copy of the care plan myself' 'I went home without my baby and felt forgotten about' -To avoid trauma for families 'I have to keep repeating what happened over and over to different people' 'I feel isolated because nobody is telling me what is happening and I don't know who to ask (are there going to be any meetings/investigations?)' A: Many of these issues related to cross-organisational communication between BTH and tertiary neonatal provider R:Meeting arranged between both providers and new process agreed including proposal of joint letter between the organisations which clearly details key contact (see example in slide 7) Agreement from both organisations to ensure improved communication to avoid families feeling isolated. Agreement from all maternity providers within the LMNS to form a task and finish group to look at formulation of a SOP for cross-organisational investigations, this is to be arranged

Cross Organisational Incident Operating Principles

NHS
Lancashire and South Cumbria

1. We will all commit to 1 patient 1 learning response rather than silo working for cross organisational incidents. We will agree collaboratively through an MDT approach how to allocate defined roles and responsibilities across all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation
2. We will ensure patient, family and staff involvement as part of cross trust delivery of PSIRF, ensuring co-design of a jointly owned safety culture within a well functioning safety system
3. We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required. We will be flexible and adapt our communication methods to ensure that everyone in included and has access and will encourage sharing of information and ideas, promoting kind provocation
4. We will create a safe space where we can have open and honest discussions and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring
5. We will provide a safe environment for all to be open/transparent to share learning from events.
6. Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff and colleagues
7. We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected
8. We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress
9. We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm
10. We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale

Dear

We are very sorry to hear of the loss of your baby, we would like to convey our sincere apologies. We understand that this must be an incredibly difficult and challenging time for you and your family. In any instance where a baby dies, we undertake a review of the care provided. It is important to understand as much as we can about what happened and why your baby died. We would like to assure you that we are in the process of undertaking a review of the care provided to yourself during your pregnancy. To complete the review, in the coming weeks we will hold a meeting known as a PMRT (perinatal mortality review tool) meeting. As your care was shared with XXXXX Hospital, the XXXXX team will also be involved in the review process. At the meeting we will review yours and your baby's care and we will look at the medical records, tests, and results, including postmortem results if you have consented to one. We will answer any questions you may have and address any concerns. During the review process we may need to talk to staff involved in your care and we will look at guidance and policies to ensure the care you received was appropriate. The review may tell us if we need to change the way we do things or that good and appropriate care was given to your family.

Your views are important, and it would be helpful if you could share your feelings and thoughts about your care, or any questions you have with us before we carry out the review. To support you in doing this, you will be allocated a key contact of your choice. XXXX bereavement midwife will provide you with her contact details and will talk to you in further detail about the PMRT review process and discuss the options with you. The bereavement midwife from XXXXXX Hospital, XXXX, will be in contact with you following your discharge home.

Your key contact will be: Telephone number: Email address:

It may take at least sixteen weeks to gather all the information required for the PMRT review meeting. The reason for this delay is that often we are waiting for the results of some specialist tests. We understand that this is a long time to wait, however, we require all of the detailed information to ensure that a thorough review is performed. If you would like to meet with a consultant before the review takes place, please let XXXX know and XXXX will organise this for you. Once the PMRT review report is completed, XXXX will contact you and ask how you would like the findings of the report feeding back to you. If you would like, we can arrange a family meeting with XXXX and a consultant to discuss the report findings with you. We can also send you the PMRT review report by post or email if you prefer.

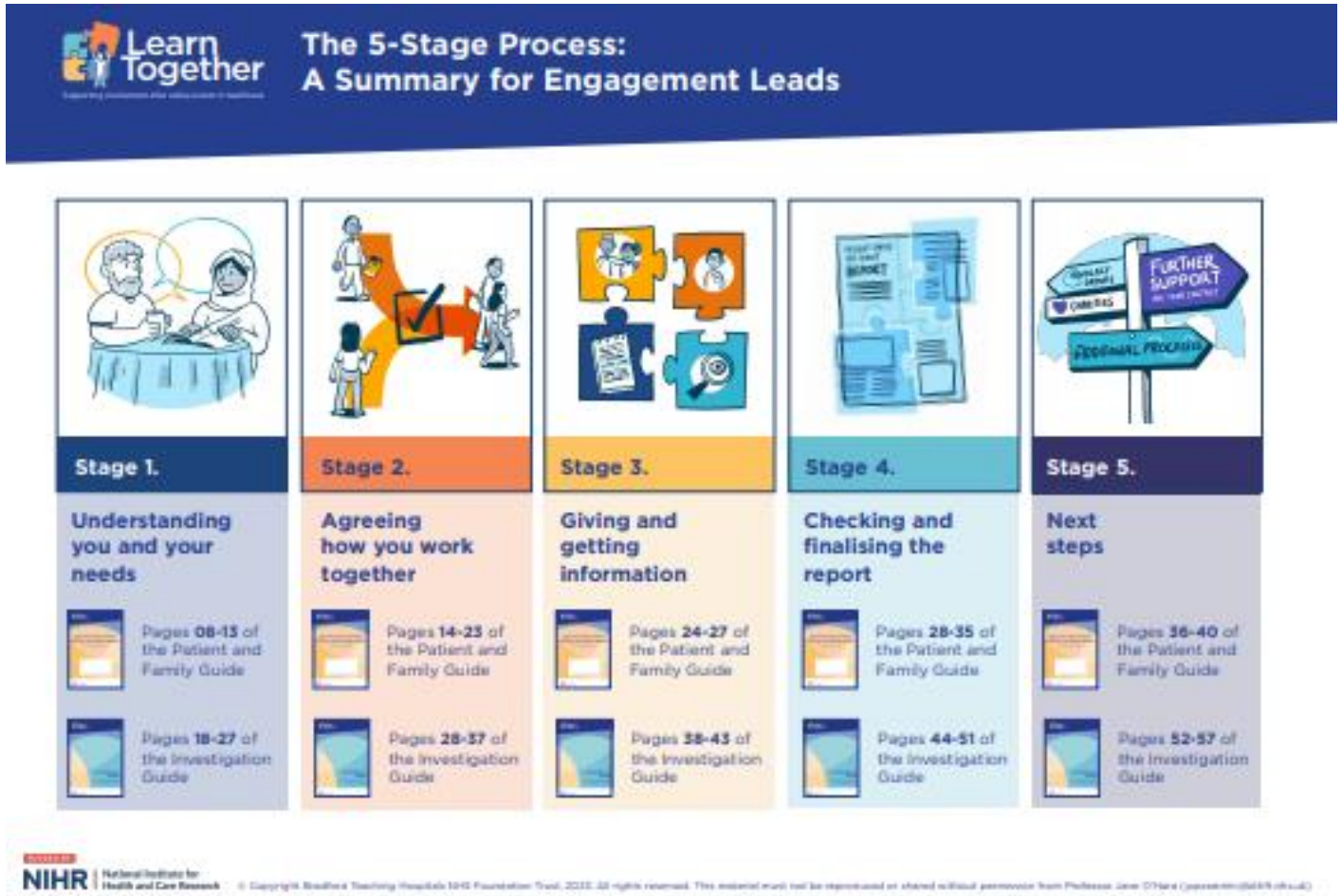
Following the PMRT review of yours and your baby's care, a second CDOP (child death overview panel) review will be undertaken. Government legislation requires that the death of every child and young person should be reviewed by a CDOP panel. The CDOP panel includes doctors, other health specialities, children's services and public health. The CDOP panel are presented with anonymised information about your baby and how they died. The review aims to try and identify any factors which may improve the health and wellbeing of children and families in the future. The information gathered is presented with the greatest respect and in the strictest confidence. The review is about learning and improving services for children and families.

If you have any questions about this information, please ask XXXX or a member of staff before you leave hospital.

Yours sincerely

Learn Together Resources

[Downloads for Engagement Leads – learn-together.org.uk]



Summary of activity in last reporting period:

Worked closely with a small number of families, current pause in taking new referrals due to awaiting communications toolkit and case management system which is being developed by NHS England.

Issues above highlighted to relevant provider organisations and support offered to review processes, BTH alongside tertiary provider for neonatal services have now formulated a 'joint letter' to give to families following a neonatal death when care has been between the two organisations, this highlights who the key contact will be for the family and is based upon the families choice.

Summary of activities planned for next reporting period:

Continue to support families that I have engaged with.

Work with provider trusts across the LMNS to discuss the co-produce a SOP to act as a guide for family-centred engagement following an adverse outcome when care crosses organisations.

Offer of support to trusts to review family engagement processes following an adverse outcome.

Key Risks / Issues: Risk of traumatising families and compounding harm because of issues highlighted, continued engagement from organisations to strengthen processes when care crosses organisations.	**Support needed from the Board:** Continued engagement, to be aware that they are a point of escalation for risks which remain unresolved.

Proposed schedule of MNISA reporting to board- to be agreed by the board

Stakeholder : Blackpool Teaching Hospitals			
Meeting	**Frequency**	**Report**	**Submission required by**
Trust Board	Bimonthly	High level issues and individual trust themes	Two weeks and two days prior to scheduled meeting.

NB Where there are any significant issues which arise in between board meetings which need resolving
These will be discussed with the Maternity and Neonatal Quadrumvirate and if appropriate resolution requires further escalation, this will occur via the maternity and neonatal safety champions.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Mortality / Learning from Deaths

Meeting:	Board
Date:	2 November 2023

Author	Nigel Laycock & Jayne Thomas					
Exec Sponsor	Chris Barben					
Purpose	Assurance	x	Discussion	x	Decision	
Confidential y/n						

Summary *(what)*

Advise

- This report covers the period of Q1, 2023-24.
- SHMI continues to improve, and is at 100.3, and is within the normal range of 90-110 for an Acute trust.
- The conditions with the highest number of deaths are as follows: (SHMI value recorded, annual to March 2023, where applicable)

Deaths	Observed	Expected	SHMI
Septicaemia	324	351	92
Pneumonia	230	247	93
Acute Cerebrovascular disease	88	86	103
Acute Myocardial Infarction	88	101	87
COPD	84	78	108

- The conditions with the highest number of excess deaths are as follows

Deaths	Observed	Expected	SHMI
Fluid & electrolyte disorders	37	21.98	168.33
Other inflammatory condition of skin	18	8.88	202.77
Other connective tissue disease	22	13.4	164.18
Peripheral & visceral atherosclerosis	19	12.4	153.26
Superficial injury; contusion	12	5.89	203.81

	• A new Lead MEO has been appointed and commenced in post in May 2023. • The Medical Examiner's office moved from the Clinical Services Division into the Corporate Division on August 1st, 2023. • There are currently 3 LEDER reviews in progress, one has been referred to the coroner.

Implications ***(so what)***	**Alert**	
	The highest 3 areas with Excess Mortality from SHMI are Fluid and electrolyte disorders, other inflammatory conditions, and other connective tissue disease. This is currently showing a SHMI of 170. In the last 12 months there have been 15 excess deaths. This is to be reviewed by the Mortality Governance Committee.	
	Assure	
	Work is ongoing through the AQuA pathway groups to improve areas with high SHMI scores The Pathways programme activity is continuing to make improvements which is contributing to the reduction in the SHMI score.	

Previously considered by	Quality Assurance Committee 24.10.2023

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

Equality, Diversity and Inclusion (EDI) implications	N/A

Proposed Resolution ***(What next)***	The BI team are building a comprehensive Mortality Dashboard which will be reviewed at the Mortality Governance Committee. Once approved, this will also provide additional information to the Trust Mortality IPR.

1.0 Summary Hospital-level Mortality Indicator (SHMI)

Summary Hospital Mortality Indicators (SHMI) is the most widely used index and is the measure used by the NHSi mortality team. Data sources include Healthcare Evaluation data (HED-12 month rolling average, 2 months in arrears) and nationally validated clinical indicators (12 months rolling average after rebasing, 5 months in arrears).

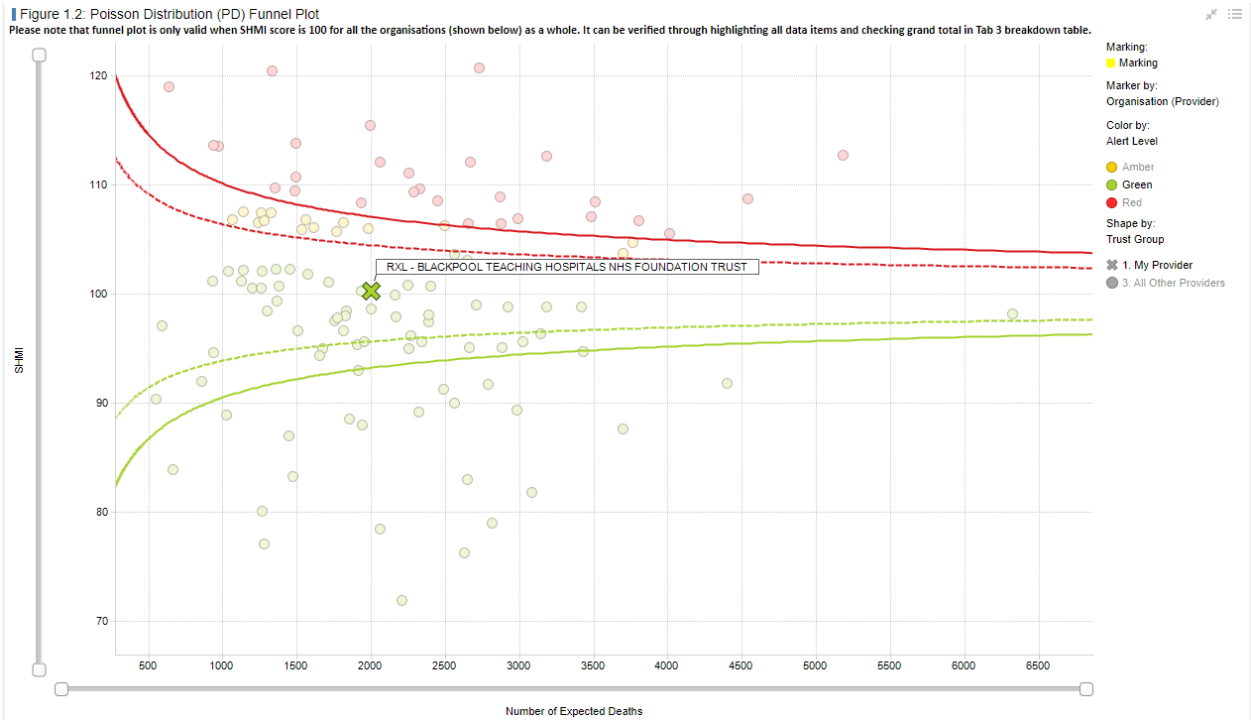


Figure .1. Poisson Distribution Funnel Plot

The latest nationally validated trust-wide SHMI (12-month rolling average to January 2023) is **100.3**, which is down from 102 in January and well within the 95% confidence limits. This is 9 points lower than the previous high of 109, in April 2022.

SHMI (Trust)	112	101	91	85	116	112	103	105	115	118	117	108	117	95	105	94	107	102	103	90	109	101	103	103	105
SHMI 12 Month Rolling (Trust)	106	105	104	101	102	102	103	103	104	105	107	107	107	107	108	109	108	107	107	106	106	104	103	103	102

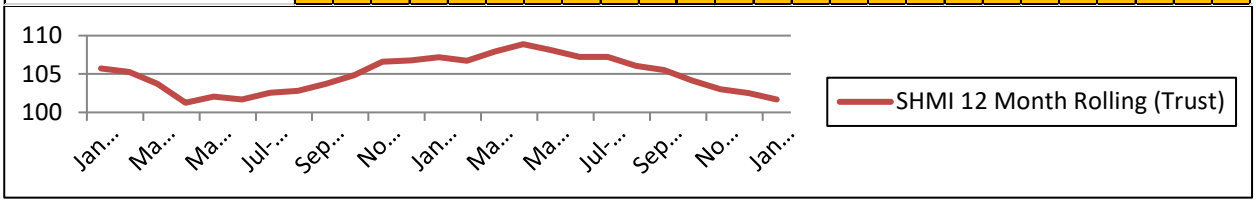


Figure.2. SHMI 12-month rolling average (BTH)

We must be cautious of this result, as the reason for the reduction is SHMI is not immediately clear but could be as a result of increased SDEC activity which may have had a subsequent, positive effect on SHMI.

However, this is a complex system, and the overall effects will undoubtedly be multifactorial in origin… for example other trusts may (and have) performed worse which then impacts on others, plus the calculation metric will have changed over time.

Also note this is also based on legacy data, so there could be further changes afoot we are yet to see due to the time lag. In addition, we could be coding better whilst others are coding worse (be that quality and/or quantity as some Trusts out there are not meeting the SUS submission deadlines so activity is going uncoded so not included in the SHMI calculation).

We must be mindful of the SDEC effect though, as there is the drive to move this from APC coding to ECDS which will remove this activity from the SHMI calculation in the near future.

Going forward this will be discussed at the ECDS user group, and any response will be fed back to the group.

2.0 BTH condition specific SHMI

Figure 2.2: Number of Excess Deaths

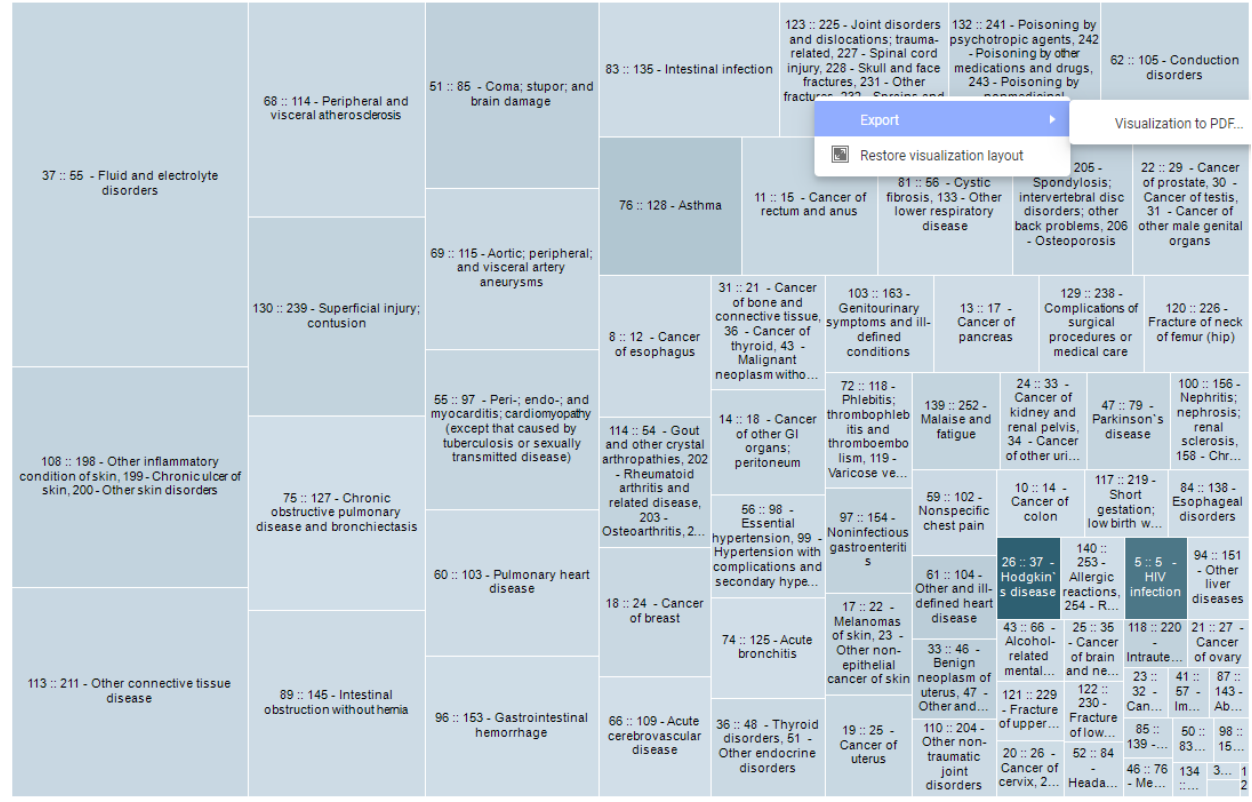


Figure.3. Condition Specific heatmap

Comments:

- The highest 3 areas with Excess Mortality from SHMI are Fluid and electrolyte disorders, other inflammatory conditions, and other connective tissue disease.
- Connective Tissue coding does not relate to Rheumatological conditions specifically

3.0 HED and CUSUM alerts

Healthcare Evaluation Data (HED) are based at the University of Birmingham and produce alerts to trusts from Mortality data.

Below are detailed the relevant alerts for BTH.

The areas of significance are in line with the areas highlighted in the heat map.

My Alerts 1 2

Indicator Name	Period	Value	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 37 :: 55 - Fluid and electrolyte disorders	May 2022 - April 2023	170.22	
Mortality Cumulative Summary Aggregated (HSMR) - 127 - Chronic obstructive pulmonary disease and bronchiectasis	May 2023	3.39	
Mortality Cumulative Summary Aggregated (HSMR) - 199 - Chronic ulcer of skin	March 2023	3.23	

Figure.4. HED & CUSUM Alerts

The highest number of excess deaths is from Fluid and Electrolyte disorders. This is currently showing a SHMI of 170. In the last 12 months there have been 15 excess deaths. This is to be reviewed by the Mortality Governance Committee.

4.0 Mortality case reviewing:

4.1 MCCD

The data shown below covers the period of Q1, 2023-24, which is the latest complete dataset.

Medical Examiner		APRIL 2023	MAY 2023	JUNE 2023	JULY 2023
	Target				
Total Number of Hospital Deaths		188	130	133	143
Total Number of Community Deaths		67	68	57	47
Average TAT for Verification of death (hours:mins)	1 hour	4hr:53mins	49 mins	61 mins	63 mins
Average TAT for completion of MCCD from date of death (days)	2 working days	4	4	3	2.5
Number of MCCDs not completed within 3 calendar days of death (exc. RTC cases)		77	53	34	35
% of MCCDs not completed within 3 calendar days of death	0%	51%	50%	32%	30%
Number of Deaths scrutinised by ME (acute)		173	110	118	124
% of Death Scrutinised by ME (Acute)		97%	89%	86%	98%
Number of Deaths Scrutinised by ME (community)		34	43	28	18
Average TAT for Community Scrutiny (from date of death (days))		1.2	4	1	1

Figure .5. MCCD performance

Advise: The percentage of deaths screened varies month on month and varies dependant in the number of deaths referred to the coroner. E.g., If 100 sets of notes arrive in the ME office and it's obvious that 10 need referral to HMC then those notes aren't screened and therefore results in a 90% screening.

Average verification times are within target of < 1 hour. This is largely as a result of deaths within critical care and ED since their verification is within minutes.
Number of deaths not completed within 3 calendar days of death has significantly reduced.
Number of deaths sent to registrars under 4 days has significantly increased.
Number of deaths sent to registrars over 7 days has significantly reduced.
Number of Deaths registered within 5 days in Blackpool continues to improve and is now above the national average
GRO data is a mixture of acute and all community deaths. No matter how well the Trust perform, the overall results will be determined by community deaths. There are delays in community registrations that adversely affect the figures for Blackpool.

Alert: Currently no cause for alarm and nothing requires escalation.

Assure: GRO data suggests we are not achieving 90% registration within 5 days but this data includes community data. MCCD's are sent to the registrar within 5 days but this is not the same as actually registering a death.

Action: Continue to educate all doctors and ward staff regarding the process. Continue to improve our figures quarter on quarter.

4.2 Referral to Coroner Mick Brack/Deborah Marshall

Indicator	Target	Apr-23	May-23	Jun-23
No. Coroners Referrals in month (Part A or PM)		15	16	21
Average TAT for RTC from date of death (Days)	1 working day	3	2	1
Overall % cases RTC within 1 day	100%	40%	50%	67%

Figure .6. Referral to Coroner

Advise: Overall cases referred to Coroners within 1 day has significantly increased.

Alert: Currently no cause for alarm and nothing requires escalation.

Assure: Communication between ME Office and Coroner's office continuing to improve since Coroners Officers returned to BTH site.

Action: Coroner to attend monthly Medical Examiners forum to improve communication and engagement.

5.0 Learning From Death App – 3 month rolling review, May-July 2023

Specialty	May-2023 No. of Inpt Deaths	May-2023 No. in Progress	Jun-2023 No. of Inpt Deaths	Jun-2023 No. in Progress	Jul-2023 No. of Inpt Deaths	Jul-2023 No. in Progress	May-2023	Jun-2023	Jul-2023	Score 1 - Definitely preventable	Score 2 - Strong evidence preventable	Score 3 - 50:50 preventable	Score 4 - Possible evidence preventable	Score 5 - Slight evidence preventable	Score 6 - Definitely not preventable	Score 7 - Unable to grade
Accident and Emergency	24	24	22	22	21	0	100%	100%	0%							
Cardiology	4	4	2	0	6	0	100%	0%	0%							
Cardiothoracic Surgery	4	4	1	1	3	3	100%	100%	100%							
Care of the Older Person	23	17	24	0	18	1	74%	0%	6%							
Critical Care	14	14	18	18	13	7	100%	100%	54%	1			1		1	1
Endocrinology & Diabetic Medicine	4	4	4	3	1	1	100%	75%	100%							
ENT	0	0	0	0	1	0	-	-	0%							
Gastroenterology	4	4	3	0	5	0	100%	0%	0%							
General / Breast / Colorectal Surgery	3	1	2	0	4	0	33%	0%	0%							
General Medicine	18	17	24	17	31	18	94%	71%	58%			2		2	2	
Haematology	3	3	0	0	0	0	100%	-	-							
Infectious Diseases	2	1	3	0	1	0	50%	0%	0%							
Obstetrics & Gynecology	0	0	1	0	0	0	-	0%	-							
Rehabilitation & Intermediate Care	2	1	7	0	0	0	50%	0%	-							
Respiratory & Thoracic Medicine	19	18	18	12	28	10	95%	67%	36%						4	
Stroke Medicine	5	3	3	0	2	0	60%	0%	0%							
Trauma & Orthopaedics	2	0	2	0	2	0	0%	0%	0%							
Unknown	8	4	2	1	5	0	50%	50%	0%							
Urology	3	2	1	0	0	0	67%	0%	-							
Total	**142**	**121**	**137**	**74**	**141**	**40**				**1**		**2**	**1**	**2**	**7**	**1**
Total % cases reviewed		**85%**		**54%**		**28%**										

Figure .7. Learning from Deaths App 3 month rolling view

Alert Screening scrutiny of death preventability was 85% in May, dropping significantly to 54% in June and 28% in July, down from 93% in April. Julys figures may be explained by reviews still in progress.

Advise There is a significant delay in the recording of case scrutiny on the LfD App. Divisional Directors are aware of this issue

Assure LfD data continues to be reviewed at Mortality Governance Committee

Action Delays in screening will be raised at the Mortality Governance Committee in September.

5.1 Critical Care 3 month rolling review, May-July 2023

A rolling review of all specialities can be extracted from the data, this reports shows the Critical Care data for this period.

Status	May-2023	Jun-2023	Jul-2023
Awaiting screening	**0**	**0**	**6**
Screening in progress	0	0	0
Referred to coroner	0	2	0
Review complete (Coroners case agreed)	**1**	**1**	**0**
Awaiting SJR	**1**	**3**	**1**
SJR in progress	1	0	0
Awaiting learning points (no SJR)	1	0	0
Awaiting learning points	**0**	**0**	**0**
Learning points in progress	**0**	**0**	**0**
Awaiting mortality lead review	0	2	0
Review complete	**0**	**0**	**0**
Review complete (M&M discussion)	**0**	**0**	**0**
Review complete (no SJR)	**9**	**9**	**6**
Closed (Governance Incident triggered SJR Required)	0	0	0
Governance Incident requires SJR	0	0	0
Awaiting SJR summary quadrant	1	0	0
SJR summary quadrant in progress	0	1	0
Total Deaths in Month	**14**	**18**	**13**

Figure 8. Critical Care 3 month rolling review

5.1 Structured Judgement Reviews Q1, 2023-24

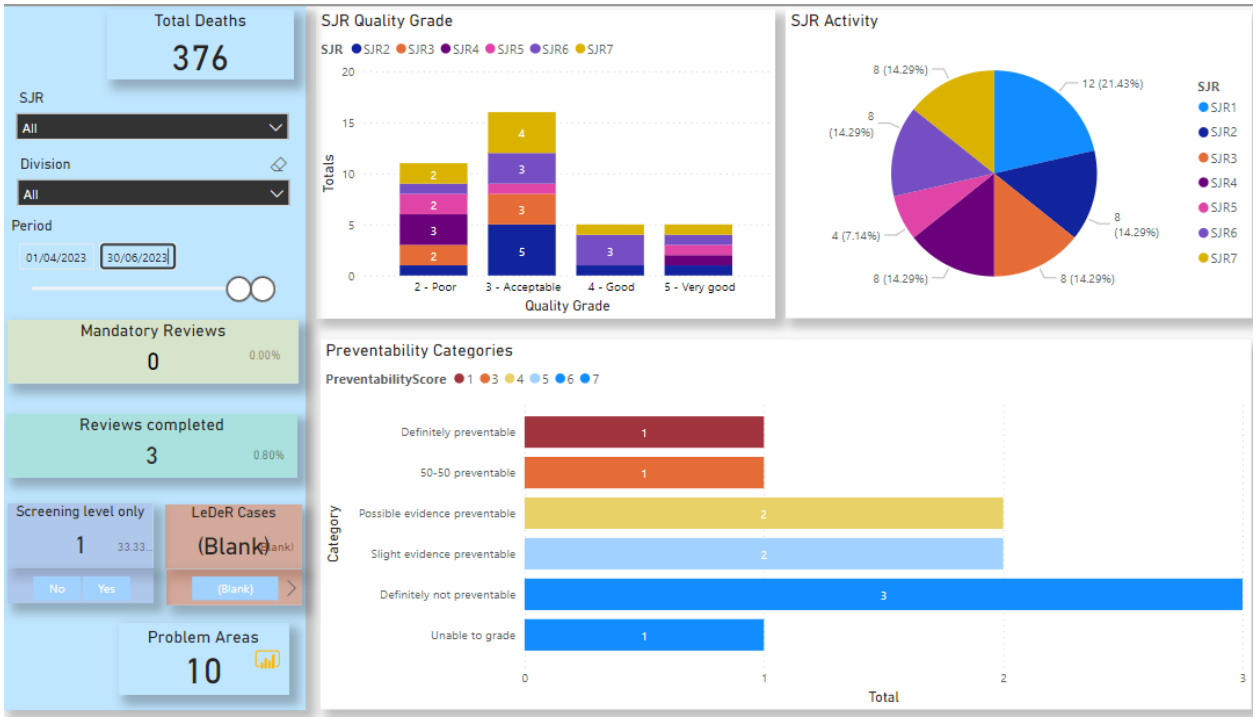


Figure .9. SJR Q1 data

Alert: 1 death was reviewed and scored as being preventable.
3 deaths show evidence of being possibly preventable.

Advise: Some discrepancies in data due to delay in recording information.

Assure: SJR data continues to be reviewed at Mortality Governance Committee

Action: Continue to review at MGC

6.0 IPR Mortality Dashboard

Business Intelligence is currently aligning our Mortality dashboard to a standardised NHSE format. The latest version is under development and is available to relevant parties on nexus. This will be reviewed at the next Mortality Governance Committee meeting, and if approved will be used going forward at the IPR and other relevant forums.

7.0 Learning Disability Deaths

1) Three LeDeR reviews have been identified from April 2023 to August 2023, one of these has been referred to the coroner due to issues that happened with the care the patient received in the community from an external provider and the other 2 are awaiting external review from the LeDer reviewers.
2) Work is ongoing to create a flow chart for LeDeR, looking at agreed timelines and agreed levels of responsibility and a sign of process
3) The Learning Disability alert report, that identifies all inpatients that have an alert is now sent to all the Matrons, to help them easily identify LD patients.
4) Learning Disabilities training is hoped to be made mandatory within the next 3 months.
5) Work is on-going to identify learning disability champions in every clinical area, additional training dates have been put on to support this. The full day development course planned for October has 20 people booked on
6) Hospital passports are being added to the EDMS system, 30 have been added to date.
7) A Learning Disability support plan has been developed to help clinical staff provide a more structured approach to care. The themes on the support plan have been developed from incidents and lessons learned from LeDeR.
8) Learning Disability pathways have been developed for emergency admission, planned admissions and discharges, these are currently being incorporated into the policy that is under review.
9) From April 2023 to August 2023 18 face-to-face Learning Disabilities training sessions have been carried out, training 121 staff.

8.0 Condition specific SHMI trends

8.1 Monthly Pathway SHMI

The chart below gives the monthly SHMI by each specific month

Month	Pneumonia	Sepsis	AKI	COPD	Heart Faliure
2022_03	88.6	87.8	29.7	122.9	159.2
2022_04	80.7	100.0	113.6	60.0	95.1
2022_05	73.6	78.2	88.8	153.4	85.9
2022_06	79.5	95.6	103.0	135.8	63.2
2022_07	134.8	83.8	163.6	108.5	66.5
2022_08	104.6	72.7	29.0	73.4	37.3
2022_09	102.5	113.7	107.4	109.5	39.9
2022_10	89.1	87.7	75.7	87.4	193.1
2022_11	82.2	104.3	0.0	67.7	83.4
2022_12	73.5	90.2	21.2	171.3	75.9
2023_01	106.4	94.9	120.2	85.0	102.0
2023_02	112.4	64.2	93.6	78.7	51.1
2023_03	90.1	107.5	76.1	112.3	124.3

Figure 10. Monthly SHMI specific

8.2 12-month cumulative SHMI

The chart below gives the SHMI for the previous cumulative 12-months

Month	Pneumonia	Sepsis	AKI	COPD	Heart Faliure
2022_03	117.7	85.1	93.7	97.9	118.9
2022_04	117.6	88.6	90.2	94.5	117.1
2022_05	110.9	86.4	93.3	108.4	104.6
2022_06	108.3	86.8	91.0	111.5	100.9
2022_07	108.7	85.9	103.9	108.4	98.9
2022_08	106.4	84.2	101.5	104.0	93.9
2022_09	105.3	88.7	101.1	106.1	91.1
2022_10	102.4	89.1	101.5	108.0	94.3
2022_11	99.6	89.6	90.8	100.4	91.8
2022_12	96.4	91.5	79.0	112.9	91.4
2023_01	94.7	91.7	85.2	111.8	91.3
2023_02	93.0	90.6	82.6	108.2	91.5
2023_03	92.9	92.3	85.6	107.7	89.8

Figure 11. 12 month SHMI cumulative

Advise: Sepsis SHMI continues to improve

Alert: COPD SHMI is continuing to improve but is still above acceptable levels

Assure: Pneumonia, Heart Failure and AKI SHMI are all within an acceptable range

Action: Continue to monitor

8.3 Monthly Mortality Sepsis Audit

Deaths are reviewed daily by the Medical Examiners and the Associate Medical Director for Mortality Governance & Clinical Audit.

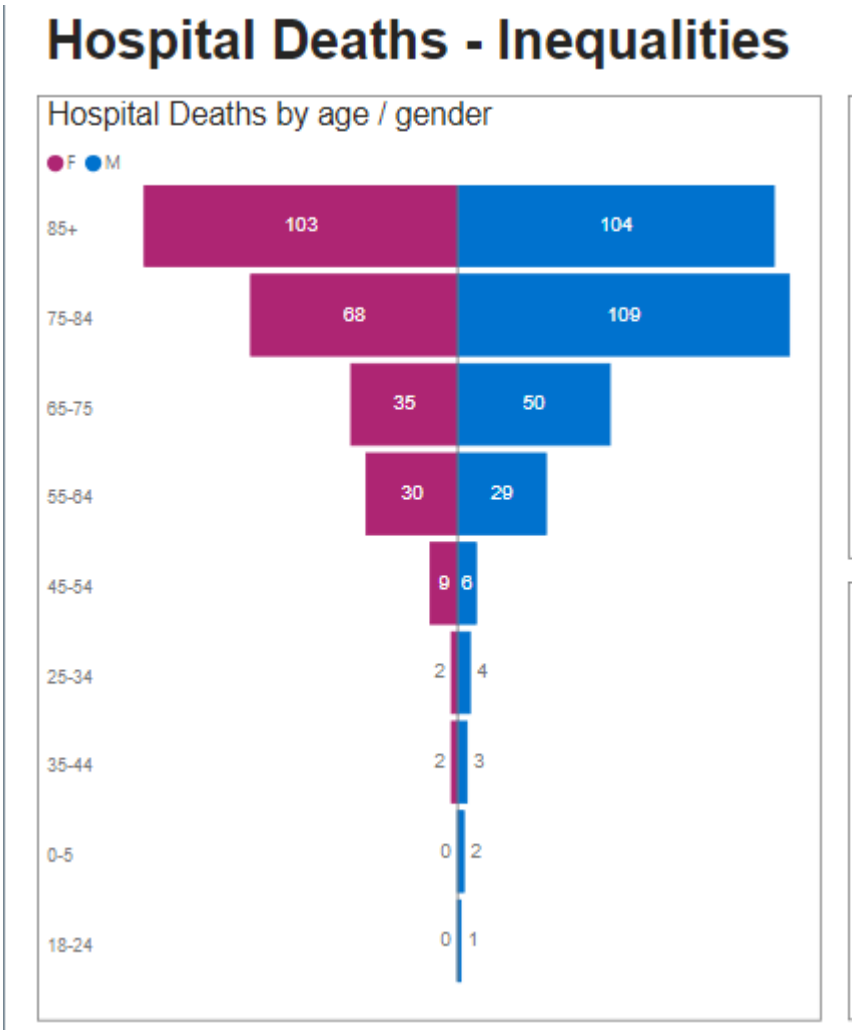
Where Sepsis had been diagnosed in ED and recorded on the Death certificate, compliance against Sepsis pathway was undertaken for all these patients.

Patients with Sepsis usually had significant co-morbidities. End of life and palliative care were often part of the management decisions.

- Mortality cases continue to steadily improve with now 46% compliant for every Sepsis measure (ACS)

- Blood cultures taken, even in End-of-Life situations, is important to optimise treatments.
- Compliance with all patient measures for Mortality patients (CPS) is 92%.
- Therefore, for the sickest patients who are presenting to BTH with Sepsis, we are 92% compliant to pathway – the nearest so far to our 100% trajectory aim
- The challenge is to improve all figures towards this trajectory.

8.4 Hospital Deaths Inequalities Q1, 2023-24



In most of the age groups the ratio of male death is higher than that of females, in particular the 65-74 and 75-84 groups.

9.0 Pathway dashboards

9.1 Documented below is the summary dashboard produced from AQUA

	DLD	HAP	Hip and Knee	Pneumonia	SepsisNEWS
Patient with measures (YTD)	52	72	18	70	54
ACS (Patients who received all their measures)	12%	14%	94%	26%	35%
CPS Denominator (e.g. # of measures)	187	427	102	257	283
CPS Target	60.0%	65.0%	95.0%	80.0%	75.0%
CPS Year to Date (2023)	**39.6%**	**73.8%**	**99.0%**	**69.3%**	**78.1%**
Difference between YTD score and target	-20.4%	8.8%	4.0%	-10.7%	3.1%

Figure .13. AQuA Pathways dashboard

Measures of compliance for each clinical pathway are given by two separate indicators ACS (Appropriate Care Score) and CPS (Composite Process Score). The definition of each of these is given below.

- ACS is defined as the percentage of eligible patients for whom all individual measures of care for a pathway were passed.
- CPS is defined as the percentage of total possible measure/interventions for all eligible patients within the clinical pathway that passed the defined criteria.

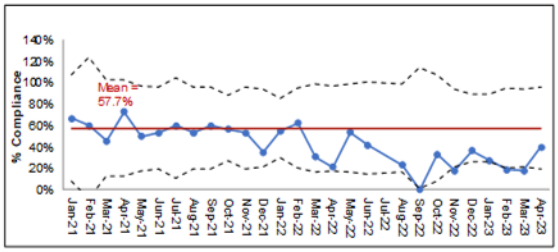
9.2 BTH Pathway Dashboards

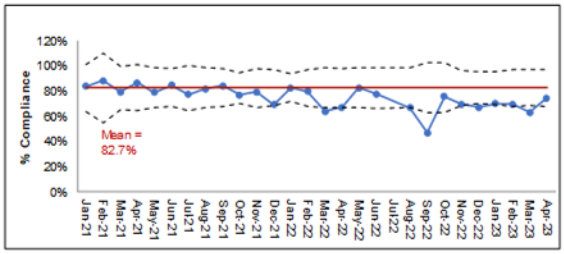
Illustrated below are the BTH produced pathway dashboards encompassing all pathways, using AQUA data, where available, or data from our internal pathway (heart failure/COPD). This covers the period January 2021-April 2023.

All - ACS

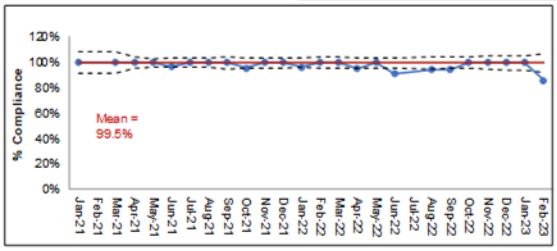
Components of Pathway Completed - Trust (CPS)

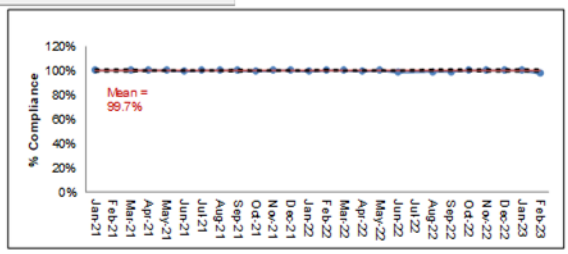
Community Acquired Pneumonia



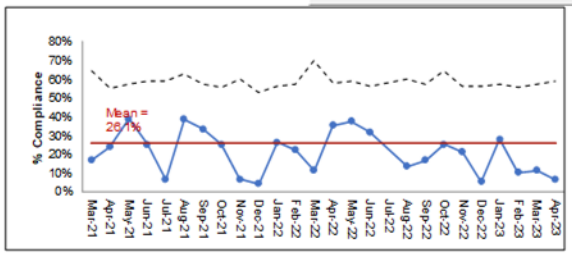


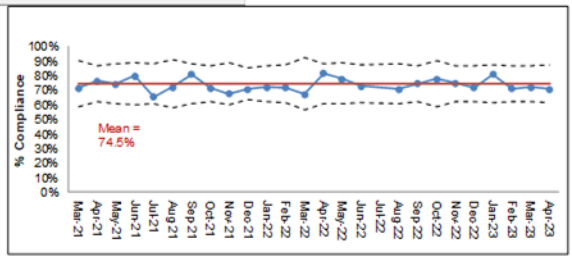
Hip & Knee



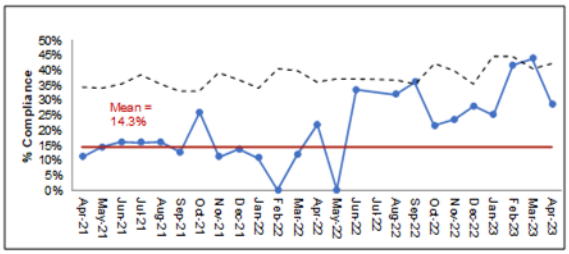


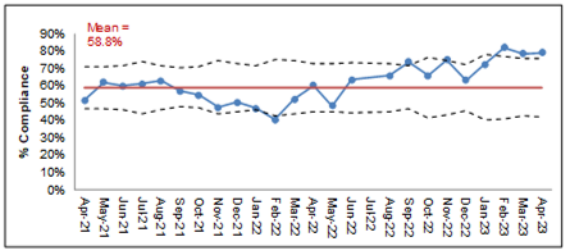
Hospital Acquired Pneumonia



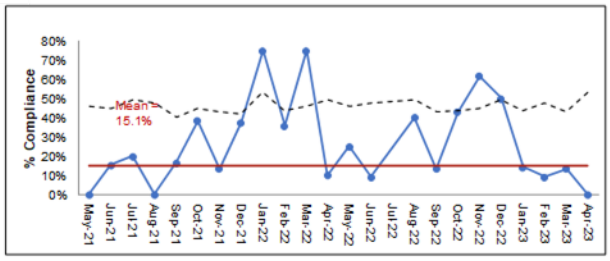


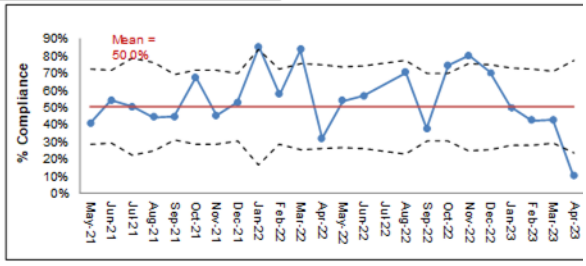
Sepsis NEWS



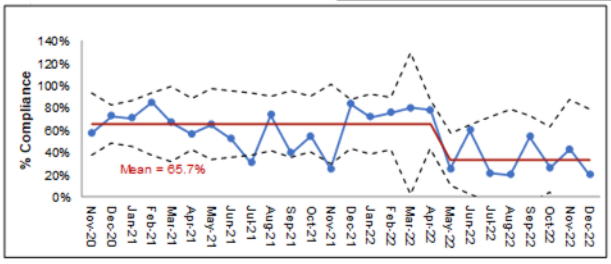


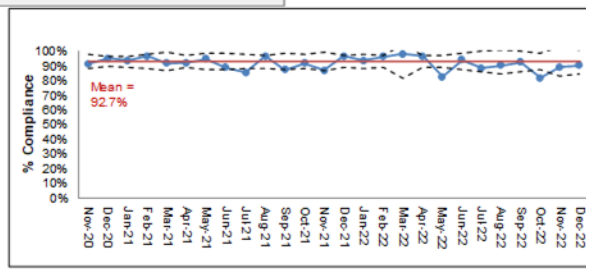
Decompensated Liver Disease



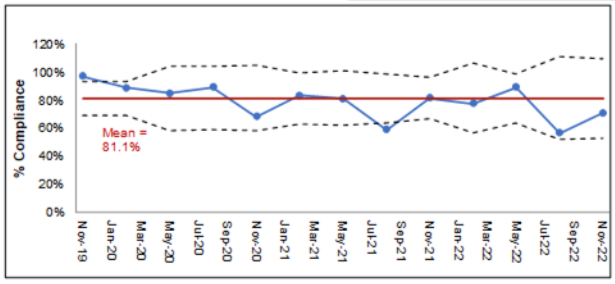


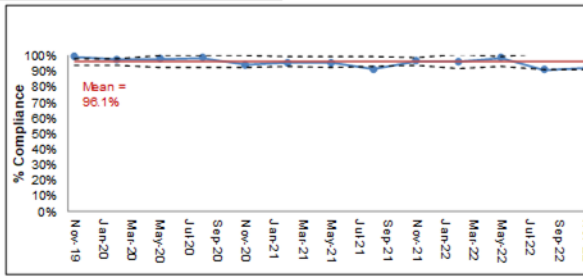
AKI (non AQUA)



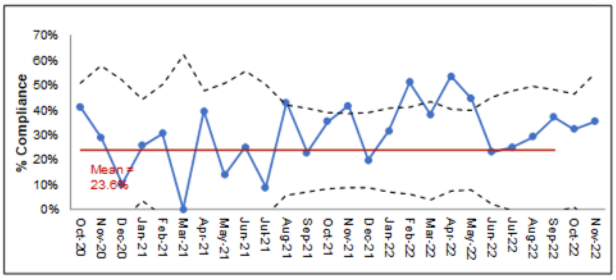


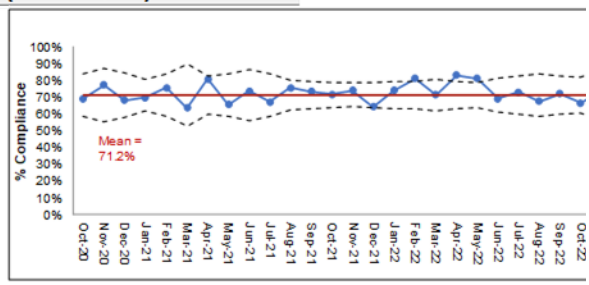
COPD (non AQUA)





Heart Failure (non AQUA)





Blackpool Teaching Hospitals NHS Foundation Trust

Title	Finance & Performance Committee Escalation Report

Meeting:	Board of Directors in Public
Date:	2 November 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 28 September 2023 - Thursday 26 October 2023 Both meetings focused on financial and operational challenges with areas for alert identified within both escalation reports.
Implications *(so what)*	**Alert** The meeting on 26 October received and discussed the winter plan with a focus on the actions needed and the funding envelope available – this will be covered in more detail on the Board agenda. 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 – a detailed discussion is scheduled for the part two board meeting **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

	Our People	x

Link to strategic objectives	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:	Thursday 28th September 2023	**Date of next meeting:**	26 October 2023
Chair:	Robert 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.

Alert

What	So What	What Next
Integrated Performance Report (Finance) Finance is on plan year to date and while QEP is on target it is down on recurrent, and this is offset by nonrecurrent – also important to note that the profile of QEP is weighted towards Q3 and Q4 The medical and nursing agency spend reduced from March to August but has been impacted by annual leave in August with a net overspend on pay. Cash position £7.8m above plan in August The Trust has received a letter from NHSI commending performance against the Better Payment Practice Code.	The Committee discussed the previous request for cash support which was submitted for Board approval earlier in the month. The Director of Finance provided an update on cash support requested for November (£0.8m) and December (£6.4m) QEP plans in IMPF and SAACT have been slower than anticipated and has been impacted by the industrial action. A number of schemes are being developed to reduce the level of agency spend but it is important to note that the Trust has highest % pay spend on Agency in the Northwest – while there are no known direct consequences this remains a concern and patient care and safety remains the priority	Focus on QEP will continue in the second half of the year – working on contingencies to improve position, seeking additional mitigating actions to achieve the planned QEP. Important for the Board to understand the story – fundamental review to be provided to the next Board meeting. Workforce planning remains an action in relation to reducing agency spend the long-term plan is to create a blended sustainable model with partners – in parallel to this other long-term arrangements will be reviewed. The Board will receive a finance update

Assurance

What	So What	What Next
Service Story (Tertiary) The tertiary division presented a service story describing the work of the National Eye Service – a service that provides cosmetic artificial eyes. The story provided the background to the provision of ocular prostheses. The manufacturing of artificial eyes takes place in Bispham with services provided on	The Committee discussed the threats to the service with potential competition from Leeds and Moorfields eye service in London. New methods of manufacturing and new commissioning arrangements could also impact on how the service is delivered in future and this will need to be considered.	The service is looking at scanning and 3 D printing capabilities

a hub and spoke model across the country providing approx. 3,500 eyes per year to approximately 6,000 patients. Typical patient pathway described from initial mould to supply of a bespoke prosthesis and ongoing annual review. The service is ISO 9001 accredited with 93.4% of patients rating the service as excellent (the other 6.6% rate the service as good)	EMIS and electronic patient record now in use and digital technology has been used to improve colour accuracy.	
Atlas Client Performance Meeting Escalation Report RAAC previously discussed in Board earlier in the month, staff have now moved out of the old laundry building and work to remove RAAC from the phase 4 workspace will start. Fire safety – Atlas completed the majority of fire training with a plan for outstanding areas	Report noted	Further surveys to be undertaken to ensure all areas are clear from RAAC
Strategy Review / Strategic Transformation Portfolio Report provided highlight of programmes of work to implement the strategy with the introduction of strategic measures to monitor performance. The plan will be supported by a communications plan and a cohesive road map for delivery. Good progress made with published plans and engagement with clinical strategy has commenced	Report includes summary financial benefits of STP with £5.4m of QEP attributed to STP programmes. Risks to the programme are in relation to competing priorities, site pressures and engagement and vacancies in the team.	Upcoming enabling plans - Estates, finance and people Clinical strategy to be approved by the Board. Reviewing scale and scope and opportunity of programmes

Advise		
What	**So, What**	**What Next**
Integrated Performance Report (Operations) Operational IPR received – ambulance handovers remain a challenge with deterioration in August. Sustained rise in demand for type one UEC activity has impacted on function of ED.	Committee members discussed the challenges that impact on ED performance including activity increase and high numbers of patients attending with mental health needs noting that patients who present as “walk in” might also have urgent and complex needs. In the final year of capital development for ED – remain on track to deliver in December 2023 – capacity has	Subject to ICB endorsement the gastro business case will be presented for approval to the October Board meeting. Working with Primary Care to improve access to UEC – work to be accelerated prior to winter. The Winter plan which will be shared with the Board in November will provide measures for monitoring – as a

Significant reduction in patients waiting more than 62 day for cancer treatment. Nationally 15th best out of 120 trusts. Previously discussed faster diagnostic performance – will achieve compliance and meet the target for 28 days standard. The SOAG forum is providing robust oversight of actions and milestones to improve RTT performance in collaboration with the ICB to ensure a sustainable solution. Backlog will need to be addressed before we start to see improvement.	been reduced during the development – and while the department is functional and safe this has compromised performance delivery. The development will increase physical capacity in the department.	minimum the aim should be to deliver an improvement on last year's performance. The IPR will be updated to incorporate the 65 week and 72-week RTT.
Lancashire Procurement Cluster (LPC) update Update provided on the Lancs and S Cumbria procurement strategy describing enhanced controls and training – savings already being delivered through the strategy.	Committee members discussed the challenge of implementing the increased controls and the management of the change process. Engagement of the LPC in QEP schemes was described as excellent with no problems with the operation of the system/process	The key task in the coming months will be the roll out of training to support the new controls. The Committee noted the benefits of the improved controls. Seeking to use the network to collaborate regionally and nationally to improve buying power.
Scheme of Delegation Proposal to review levels for petty cash repayments (reducing approval level from £50 to £25 to improve control) – this was submitted through the bright ideas to encourage use of appropriate procurement route	While impact might not be significant every opportunity to review controls should be taken to reenforce the need to maintain controls.	The Committee supported and recommended for approval by the Board
Scan4Safety Business Case Business case for the use of a recommended solution that will give efficiency and cost savings and safety benefits – implementation in other areas provides assurance regarding savings. The case has been reviewed in accordance with the business case process. Costs will be recovered from the recurrent benefits.	Committee members fully supported the case and recommended for Board approval.	To be presented for full Board approval

Committee/Group Escalation Report

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Finance and Performance Committee	**Report to:**	Trust Board
Date of Meeting:	26 October 2023	**Date of next meeting:**	02 November 2023
Chair:	Robby Ryan	**Parent Committee:**	Trust Board

Introduction

Quorate meeting held on MS Teams. Good engagement in discussion with a focus on key operational and financial challenges – the Committee received a detailed update on winter planning which will also be shared at the Board meeting

Alert

What	So What	What Next
Winter Plan Presentation on winter planning including financial implications of the additional schemes and funding agreed. Risks in relation to delivery of the winter plan include maximising use of virtual wards, minimising the impact of industrial action and fully implementing the agreed schemes. Additional schemes working up in readiness for any future release of additional funding with prioritisation as agreed with the ICB.	Committee members discussed the management of expectations in relation to future potential schemes. Three high impact priority schemes have been approved and funded by ICB at a cost of £4.5m – committee members considered the implications of not receiving any additional funding for the plans. • Frailty • Intermediate Care • Home first With regard to bed modelling, the Committee discussed the shortfall of beds and the need to work and think differently noting the complexity and balance and the risks in relation to shortfall of capacity.	Winter plan is included as an agenda item on the November Board.

Assurance

What	So What	What Next
Elective Recovery and Data Quality Report Update provided on the Trust's post pandemic elective recovery- Referral to Treatment and Diagnostics position for September 2023, against agreed	An update on the position relating to 52-week, 65-week, 78-week and 104- week risks: • 0x 104-week breaches	Accept that further actions are needed to ensure accessibility to those who are most in need. Committee members noted the report and asked for assurance that consideration was being given for EDI and

trajectories set by the NHS priorities and operational planning guidance for 2023/24. Above plan and working on improvement actions including theatre capacity and additional support – recovery impacted by industrial action.	• 18 x reportable 78-week breaches in September 23 due to capacity issues (with 7 more for other reasons). • 264 more patients than plan of 217 waiting above 65 weeks. • 782 more patients than plan of 1061 waiting above 52 weeks. The biggest contributors to this position by volume are Gastroenterology, Cardiology and Gynaecology.	deprivation to ensure that those most in need are prioritised appropriately
Cancer Improvement Plan Update Exception report provided to update on cancer performance. Detail provided within the full IPR included within the Board pack.	Committee members discussed theatre capacity and utilisation metrics and actions to increase utilisation and efficiency.	External support to be provided to support streamlined approach to pathways to reduce waiting times.
Atlas Client Performance Escalation AAA report provided from the Atlas Client meeting – no areas escalated for risk and confirmation received that the Trust is on track with work to remove RAAC.		Report noted
Finance IPR Financial performance for September is a £2.5m Deficit, £0.1m better than plan, but contains off-setting variances, as per previous months. Financial performance Year to Date is a £30.3m Deficit, £0.1m better than plan. Agency spend year to date at September is £20.9m, which is 9.4% of the total pay bill (the system agency ceiling target is 3.7%). Capital: The total programme expenditure year to date is £7.0m. Cash: The Trust's cash balance at 30th September 2023 is £7.0m, a decrease of £9.5m in month but £4.8m higher than plan.	As anticipated financial challenge will increase in H2. Committee members discussed the financial impact of industrial action – returns are provided to NHSE no provision made to compensate for increased costs and lost work which is in the region of £3m. Noting the ask for funding for business-critical equipment, committee members discussed the capital planning process noting that bids are prioritised in the planning process. Committee members discussed the progress in actions to manage the use of agency staff and the additional costs incurred when rota gaps are filled by staff paid a premium rate or when additional capacity is created that is staffed by agency and/or bank staff.	Report noted – finance IPR included in the Board pack and fundamental finance review scheduled for the private Board session on 2 November 2023 Change to the Capital programme approved to use slippage to fund an ultrasound and an ECG machine for business-critical reasons – this will be funded from contingency and is within budget.

Committee/Group Escalation Report

Financial Peer Review Action Plan internal audit have been asked to review response – The audit work is underway; the report will go to December Audit Report with an update on the delivery of the action plan		Update to December F&P with assurance from the MIAA review of actions.
Advise		
Operational IPR UEC four-hour performance improving but remains challenged, ambulance performance remains challenge – working collaboratively with NWAS to address issues in relation to front end flow. Good progress on cancer pathways although for some conditions remain challenged. The position related to diagnostic targets as per the NHSE 2023/24 Operational plan) shows over-delivery against the plan for ECHO, MRI and CT in September. No 104-week breaches for RTT but above plan for 65 weeks.	The Director of Operations and Performance described key actions taken across the organisation to improve on access targets in all areas. Discussed the challenges in relation to peaks in ambulance arrivals and the actions taken to model and plan for these peaks in demand. Access to TIA/stroke raised as an issue in the Risk Management report to the QAC. The Trust has a higher-than-average ED conversion rate – action requested to understand this rate and plan to reduce.	Capital development on track for delivery in December 2023 – will result in 12% increase in capacity. Full detail in the IPR included within the Board pack. Ensure triangulation of information on stroke/TIA linking to information discussed at the Quality Assurance Committee. 65-week target graph to be included within the next IPR.
B.Digital Committee Escalation Update Alert from the B Digital Committee in relation to the go live plans for the pathology LIMS project. Assurance provided that ICT service desk attained level 3 accreditation for being customer led	The Committee discussed the role of the Data Protection Officer and the reporting line	New data protection officer appointed, annual data protection report to be provided to a future Board. Cyber security training scheduled for the Board. Digital section of the BAF populated for review at the next Committee
Outpatient Programme Board Escalation Report Escalation report provided from the Outpatient Programme Board	Report noted for information	request for a more detailed report to the next meeting
Reports also received on high value contracts and an extension to the scope of the Atlas Service contract		

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Scheme of Delegation, Petty Cash Reimbursement

Meeting:	Board of Directors
Date:	2nd November 2023

Author	Steve Barrow, Deputy Director of Finance					
Exec Sponsor	Mark Brearley, Executive Director of Finance					
Purpose	Assurance		Discussion	✓	Decision	✓
Confidential y/n						

Summary *(what)*	**Advise** The challenging financial position means that the Trust needs to look at every opportunity to tighten financial grip and control to improve its financial performance. The petty cash reimbursement process is designed to recompense individuals for small value sundry items and incidental expenses that are urgently required to avoid delays and disruption in service delivery. The purpose of this paper is to seek support to reduce the value of petty cash reimbursements requiring Executive Director of Finance approval from £50 to £25. The current £50 limit forms part of the Scheme of Delegation and formal Board approval is required to amend any part of the Scheme of Delegation.

Implications *(so what)*	**Alert** Under the current Scheme of Delegation reimbursements under £50 require budget holder approval with any reimbursement over £50 requiring Executive Director of Finance approval. In all cases the incurrence of any costs should be approved in advance and not sought retrospectively. **Assure** The proposal will tighten the financial grip and control.

Previously considered by	Supported by Finance and Performance Committee on 28th September 2023.

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	None

Proposed Resolution ***(What next)***	The Trust Board is requested to support the reduction in the value of petty cash reimbursements requiring Executive Director of Finance approval from £50 to £25.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	National Cost Collection 2023 Submission Process

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

Author	Loie McNeill, Senior Finance Manager – Costing & Service Improvement					
Exec Sponsor	Mark Brearley, Executive Director of Finance					
Purpose	Assurance	✓	Discussion		Decision	✓
Confidential y/n	Y					

Summary *(what)*	**Advise** This report provides an update on the 2023 National Cost Collection submission.

Implications *(so what)*	**Alert** It is a mandatory requirement for Trusts to submit patient level costing data to NHS Improvement on an annual basis. **Assure**

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	N/A

Proposed Resolution ***(What next)***	The Board is asked to: • Approve the process that supports submission of the National Cost Collection. • Delegate sign off of the 2023 National Cost Collection to the Trust's Finance and Performance Committee.

Introduction

1. The Board is asked to review the costing plan and supporting information provided to ensure that it meets the expected requirements noted in the Approved Costing Guidance (see paragraph 3 below).

2. The data collected is the source data used for GIRFT and the Model Health System. Therefore, the board assurance process has been updated to reflect the importance of cost submissions across the NHS and raise the profile of costing across the organisation, especially at a senior level.

Background

3. The 2023 Approved Costing Guidance[1] requires an increased level of board assurance. This is the first of two reports on the process for producing the National Cost Collection required under the NHS Provider Licence. The second report will update the Finance and Performance Committee on the progress, issues which will be addressed before the final submission and any areas where the trust is still working to implement the costing standards required under patient-level costing.

Plan for Submission

4. The Board is asked to approve the following:
   - The high level plan (Appendix 1) is sufficient to meet the requirements to produce the costing submission by the deadline date of the 12th January 2024. This includes:
     - senior review and sign off to ensure the return has been prepared in accordance with the Approved Costing Guidance;
     - processes to validate the activity and costing data with services; and,
     - the information gap analysis and costing standards gap analysis are both completed and any issues addressed as part of the planning process.

   - The costing team is sufficiently resourced to produce and validate the submissions within the planned timeline.

[1] Approved Costing Guidance includes the costing principles, healthcare costing standards for England and a range of tools to support the costing process.

5. The above steps and processes have been included in the overall work plan to ensure they are addressed in the submission.

6. To date, all data feeds have been received and processed into the costing model, and patient matching and overhead processes have been run. We are therefore on track to deliver against the proposed submission plan.

Cost Assessment Tool Score

7. Each year the Trust submits a Cost Assessment Tool to NHS England. The tool assesses the organisation against the following areas:
    - Information requirements
    - Cost categories
    - Cost allocation
    - Data matching
    - Reconciliation
    - Governance and usage

8. The Costing Team have made significant progress during the implementation of the Costing Transformation Programme, as can be seen in the results from the previous four years. (Appendix 2 contains full scoring information).

Financial Year	**Cost Assessment Tool – Overall Score**
2018/19	86%
2019/20	90%
2020/21	99%*
2021/22	97%

*Governance and Usage Category was removed by NHS England during 2020/21

9. 'Governance and usage' remains the area where the most improvement could be made. The Costing team continue to work to improve this area through organisation wide engagement sessions and development of reporting information, however executive level support and the adoption of costing as a key source of information for decision making are required to improve the score further.

Recommendation

10. The Costing team are requesting that the Board approves the process in place as sufficient to complete the mandated costing submission for 2022/2023.

11. The Board delegates approval of the costing submission to the Finance and Performance Committee.

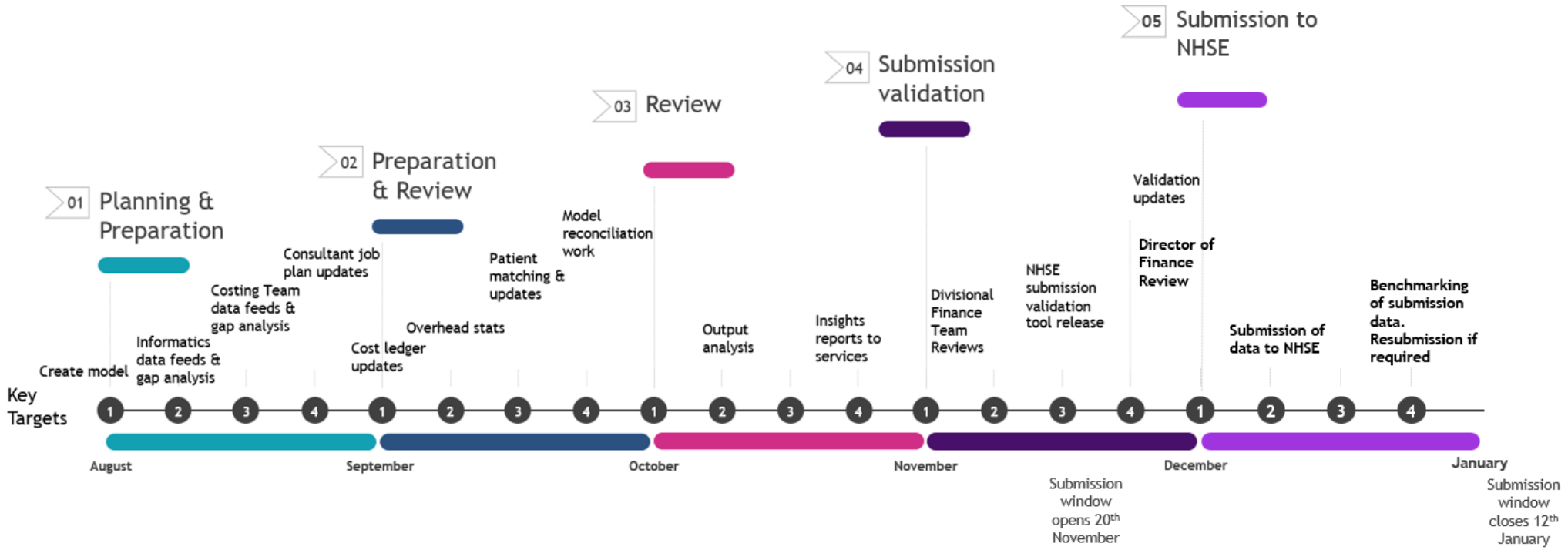
Attachments:

Appendix 1: High level costing plan
Appendix 2: Cost Assessment Tool Scores 2018/19 – 2021/22

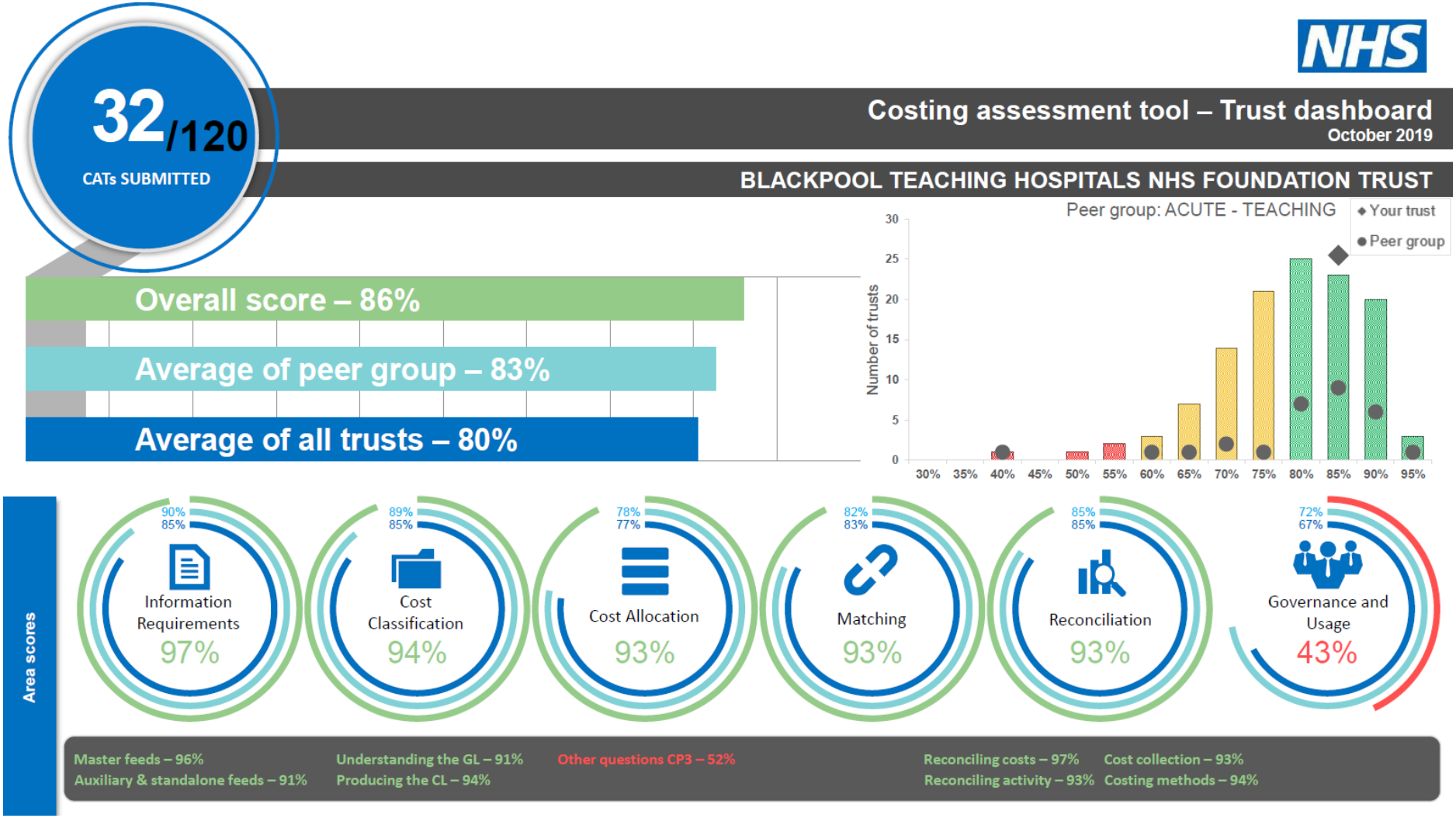
Appendix 1 – High Level Costing Plan

National Cost Collection Submission 2023

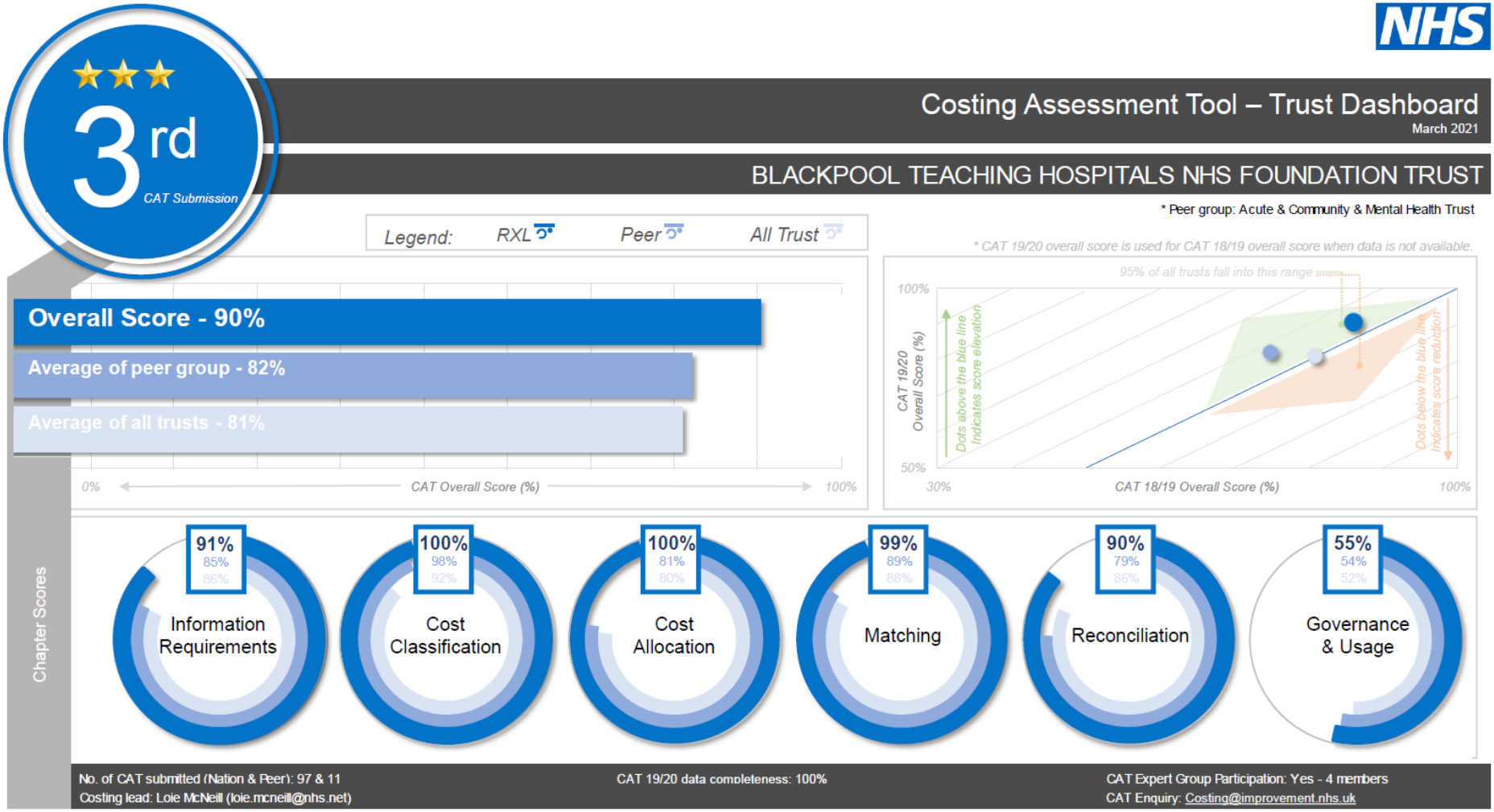
High Level Milestones and Targets



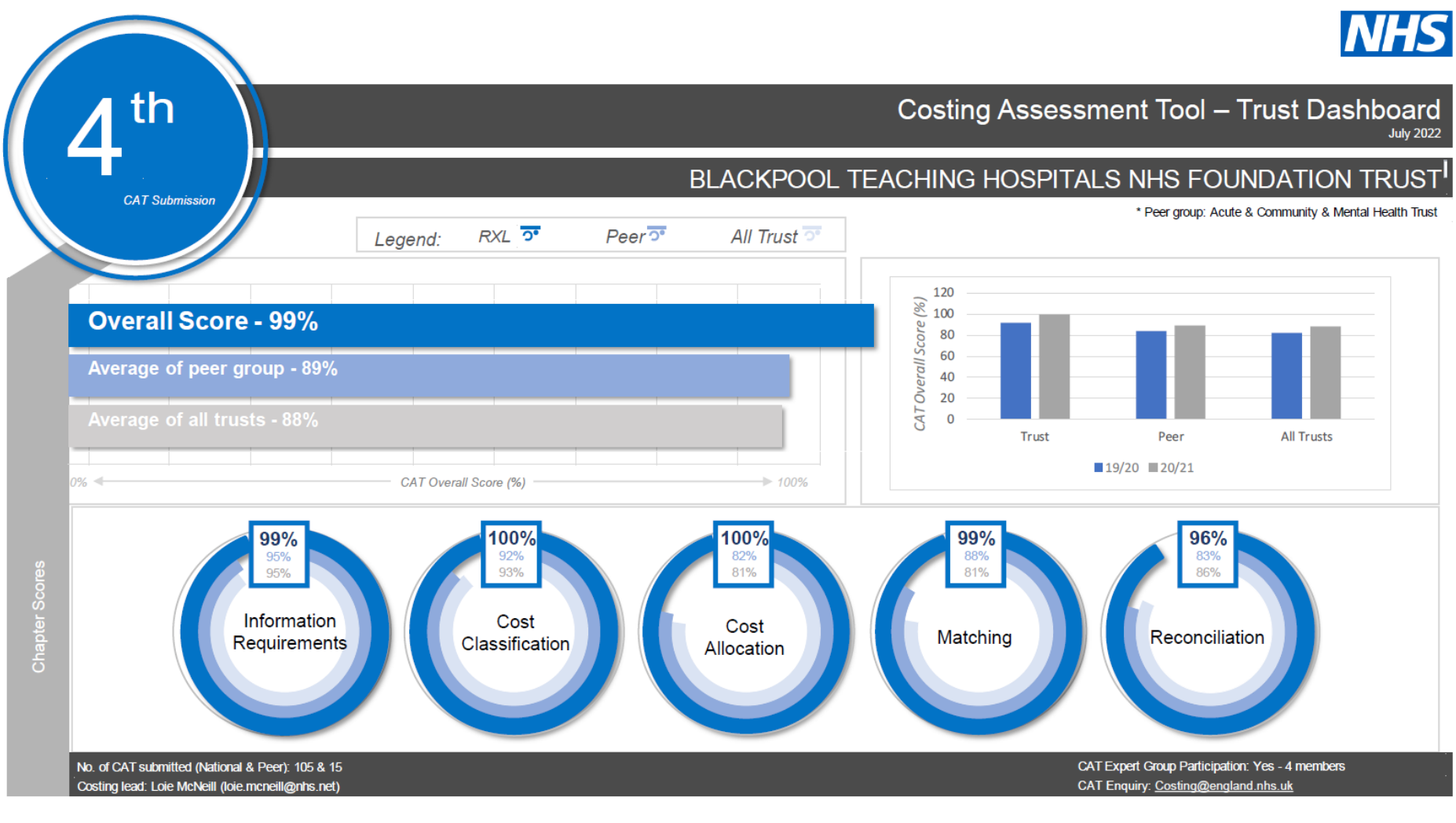
Appendix 2 – 2018/2019 CAT score



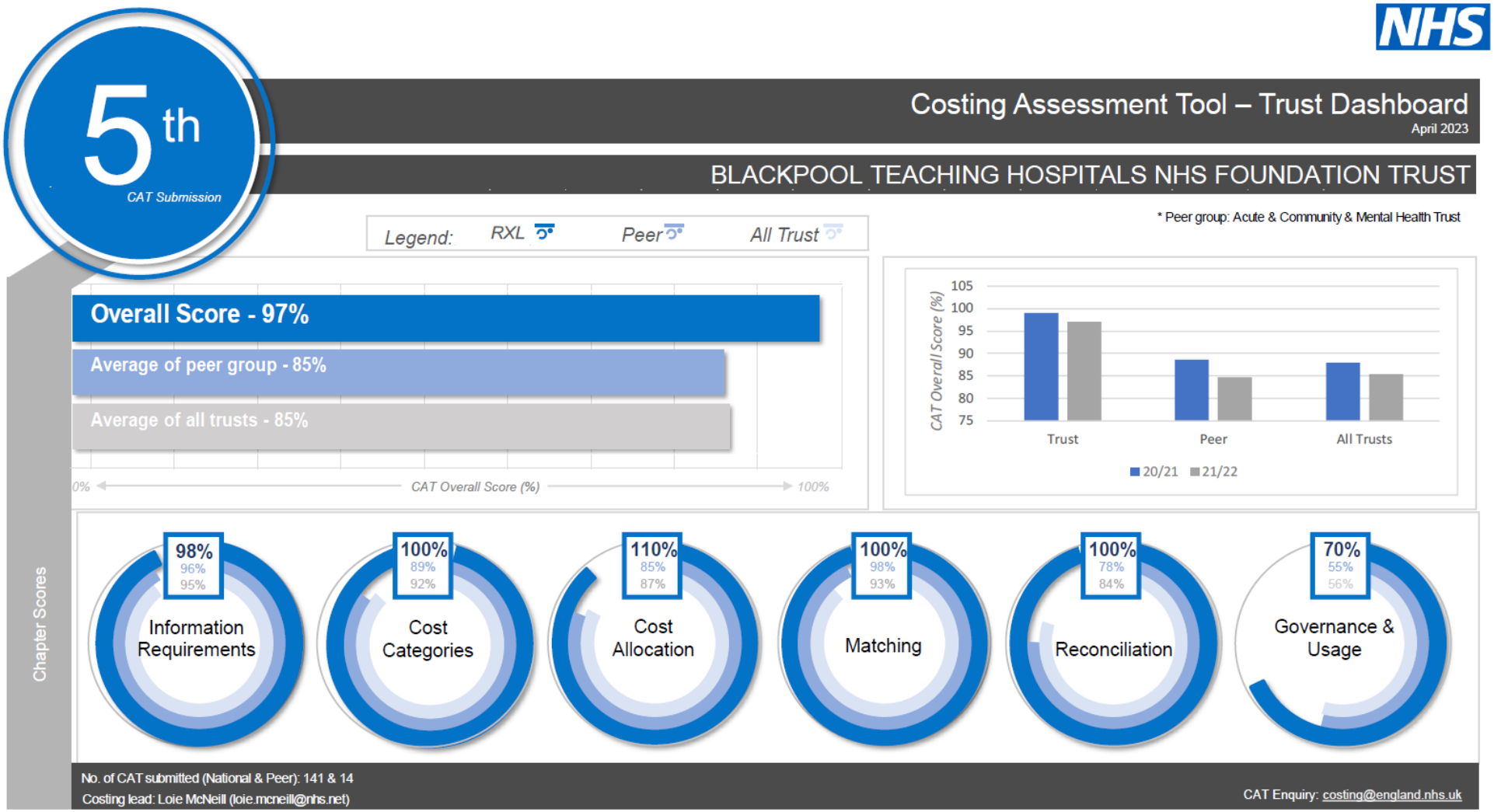
2019/2020 CAT score



2020/2021 CAT score



2021/2022 CAT score



NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Finance IPR for the six months to 30th September 2023

Meeting:	Finance and Performance Committee
Date:	26th October 2023

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

Summary *(what)*	**Advise**
	The purpose of the report is to provide the Finance and Performance Committee with an update on the Trust's financial performance for the six months to 30th September 2023. **The Trust's financial performance for September** is a £2.5m Deficit, £0.1m better than plan, but contains off-setting variances, as per previous months. **The Trust's financial performance Year to Date** is a £30.3m Deficit, £0.1m better than plan. **The Trust's agency spend year to date at September i**s £20.9m, which is 9.4% of the total pay bill (the system agency ceiling target is 3.7%). **Capital**: The total programme expenditure year to date is £7.0m. **Cash:** The Trust's cash balance at 30th September 2023 is £7.0m, a decrease of £9.5m in month but £4.8m higher than plan.

Implications *(so what)*	**Alert**
	The Trust performance at the end of September is £0.1m better than 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.

	Liquidity continues to be a risk with the Trust annual plan and revenue support has been requested in Q3 to maintain minimum cash balances. The collective efforts of all staff will be required to secure delivery of the financial plan for 2023/24.
	Assure
	At September 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	Not applicable

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 Finance and Performance Committee is asked to: a) approve the proposed changes to the capital programme; b) note the contents of the report; c) brief the Board of Directors on the key financial issues.

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Financial Performance

Reporting Period – September 2023

Blackpool Teaching Hospitals
NHS Foundation Trust

September 2023 I&E

- The Trust's bottom-line I&E performance year to date at 30th September 2023 is a £30.3m Deficit, which is £0.1m better than plan.
- In delivering the monthly plan, the Trust has covered the July to September proportion of the System Financial Stretch (£17m), which has been phased equally from July to March 2024.

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 9% 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 30th September 2023 is (£1.7m) behind plan. Key drivers of this include non-delivery of the System Gap funding (£1.9m) and lower than planned income & expenditure against services funded through FCUs (£1.8m).
- These are partially offset by increased education & training and R&D funding (£0.9m), income relating to donated assets (£0.6m) and higher than planned safeguarding income (£0.4m).
- The Trust is working closely with the ICB to monitor elective recovery performance, but no financial adjustments have been made to date.

Blackpool Teaching Hospitals
NHS Foundation Trust

Expenditure

- Year to date at 30th September 2023 operating expenditure is £1.2m better than plan. The key drivers of the variances are predominantly:
  - Bank and agency pay costs are higher than budgeted levels to cover vacancies and are partially offset by an underspend on substantive staff (£1.9m);
  - 2023/24 Agenda for Change pay award pressure (£0.3m);
  - Drugs pressure - in tariff drugs and overperformance on excluded drugs on block contracts (£0.9m);
  - Lower than planned costs relating to commissioner funded services outside of the main contracts £1.8m;
  - A number of non-pay underspends that are contributing to the position.
- 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.

Non-Operating Income & Expenditure

- Year to date at 30th September 2023 non-operating income and expenditure is £0.6m better than plan. The main reasons for this are an increase in finance income of £1.2m following the Bank of England raising interest rates to 5.14% offset by an adjustment for donated assets income of (£0.5m).

Blackpool Teaching Hospitals
NHS Foundation Trust

Performance against agency cap

- There is a system agency ceiling of 3.7%. If this was applied to the Trust, it would equate to £8.3m so the YTD position is £12.6m 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 place to monitor the active assignments. In the table below medical and nursing agency expenditure is showing a run rate reduction.

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

Cash

- The Trust's cash balance at 30th September 2023 was £7.0m, a decrease of £9.5m from August 2023 and £4.8m higher than plan. The downward trend in the cash balance is mainly driven by the increased operating deficit, decreased trade and other payables, decreased deferred income, increased capital expenditure, loan repayments, increased interest payments, increased lease capital and interest payments, and PDC repayment. This is offset by depreciation, decreased receivables, decreased inventories, increased interest receipts, and increased PDC received due to phasing of 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	13.3	16.5	7.0						
Variance	1.7	8.7	7.1	2.3	7.8	4.8						

- In month the Trust has paid 96% of suppliers by value and 96% 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 and revenue support will be required 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, cash 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 September 2023 is £7.0m which is £5.8m behind plan due to the delayed approval of the 23/24 capital plan.
- The Capital Strategy Group has supported a request to fund an Ultrasound and ECG machine for business critical reasons. The total value of these machines is £257k which will be funded from the contingency fund and slippage.
- The F&P Committee is requested to approve the proposed change to the capital programme.
- A further £574k has been awarded to the Trust in October 2023 in relation to the RAAC Removal programme. In addition, the Trust has rephased £6.86m of the EPR frontline digitalisation programme to 24/25. This reduces the Trust capital programme for 23/24 to £36.1m.
- Spend incurred to September is against:
  - £2.6m Emergency Village & Critical Care;
  - £1.3m ICT licence renewals and project staffing;
  - £2.9m Estates development schemes;
  - £0.2m Charity Donated assets.

Blackpool Teaching Hospitals
NHS Foundation Trust

Finance Ratios

- Operating Deficit: Income percentage year to date at September 2023 is (8.7%) which is 0.2% worse than planned levels.
- The year to date agency to total pay ratio is 9.4%, which is 5.5% 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 September the Trust has delivered £15.6m of savings which is £0.7m 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

Blackpool Teaching Hospitals NHS Foundation Trust

Month 6 September 2023

Statement of Comprehensive Income

		September 23				Year to Date at September 23			
		Budget £m	Actual £m	Variance £m	Variance %	Budget £m	Actual £m	Variance £m	Variance %
I&E (TOTAL)	NHS Clinical Income	52.2	50.0	(2.2)	-4%	299.4	296.5	(2.9)	-1%
	Non NHS Clinical Income	2.1	0.4	(1.7)	-82%	2.9	2.4	(0.4)	-15%
	Other Operating Income	2.3	2.3	0.1	4%	12.8	14.5	1.7	13%
	Total Operating Income	**56.6**	**52.7**	**(3.9)**	**-7%**	**315.1**	**313.4**	**(1.7)**	**-1%**
	Pay Costs (excluding agency)	(37.3)	(34.3)	3.0	-8%	(210.4)	(202.1)	8.3	-4%
	Pay Costs - Agency	(0.7)	(3.0)	(2.3)	321%	(8.4)	(20.9)	(12.5)	149%
	Non Pay	(20.6)	(17.5)	3.1	-15%	(123.1)	(117.7)	5.4	-4%
	Total Operating Expenditure	**(58.6)**	**(54.8)**	**3.8**	**-7%**	**(341.9)**	**(340.7)**	**1.2**	**0%**
	Operating Surplus / (Deficit)	**(2.0)**	**(2.1)**	**(0.0)**	**2%**	**(26.8)**	**(27.3)**	**(0.4)**	**2%**
	Non Operating	(0.6)	(0.5)	0.1	-22%	(3.8)	(2.6)	1.2	-30%
	Adj for Depreciation on Donated & Granted Assets	0.0	0.0	(0.0)	-3%	0.2	(0.4)	(0.6)	-324%
	Adjusted Financial Performance Surplus / (Deficit)	**(2.6)**	**(2.5)**	**0.1**	**-4%**	**(30.4)**	**(30.3)**	**0.1**	**0%**
RATIOS	*Agency : Total Pay*	*1.87%*	*8.02%*	*6.15%*		*3.84%*	*9.38%*	*5.54%*	
	Operating Deficit : Income	*-3.57%*	*-3.91%*	*-0.34%*		*-8.51%*	*-8.70%*	*-0.19%*	
	Net Deficit : Total Income	*-4.66%*	*-4.81%*	*-0.15%*		*-9.66%*	*-9.67%*	*0.00%*	

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 September 2023

Blackpool Teaching Hospitals NHS Foundation Trust

Finance

Statement of Financial Position as at 30th September 2023	Audited Position as at 31/03/23 £000	Actual Position as at 31/08/2023 £000	Actual Position as at 30/09/2023 £000	Monthly Movement £000	Forecast Position as at 31/03/24 £000
NON-CURRENT ASSETS					
Intangible Assets	9,845	8,714	8,474	(240)	23,277
Property, Plant and Equipment	303,427	299,882	299,111	(771)	308,702
Trade and Other Receivables, non-current	2,230	2,329	2,312	(17)	2,230
Total Non-Current Assets	**315,502**	**310,925**	**309,897**	**(1,028)**	**334,209**
CURRENT ASSETS					
Inventories	8,793	10,098	9,662	(436)	8,793
Trade and Other Receivables, current	34,150	21,529	20,011	(1,518)	40,244
Cash and Cash Equivalents	47,821	16,524	7,055	(9,469)	8,445
Total Current Assets	**90,764**	**48,151**	**36,728**	**(11,423)**	**57,482**
Total Assets	**406,266**	**359,076**	**346,625**	**(12,451)**	**391,691**
CURRENT LIABILITIES					
Trade and Other Payables	(110,220)	(88,337)	(79,441)	8,896	(100,259)
Other Liabilities	(9,906)	(13,902)	(13,675)	227	(9,906)
Borrowings, current	(9,214)	(8,954)	(8,212)	742	(9,163)
Provisions	(1,540)	(1,028)	(1,043)	(15)	(1,190)
Total Current Liabilities	**(130,880)**	**(112,221)**	**(102,371)**	**9,850**	**(120,518)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**275,386**	**246,855**	**244,254**	**(2,601)**	**271,173**
NON-CURRENT LIABILITIES					
Trade and Other Payables	(1,657)	(1,657)	(1,657)	0	(1,657)
Borrowings, non-current	(71,482)	(68,896)	(67,912)	984	(62,399)
Provisions	(2,920)	(2,920)	(2,920)	0	(2,920)
Total Non Current Liabilities	**(76,059)**	**(73,473)**	**(72,489)**	**984**	**(66,976)**
TOTAL ASSETS EMPLOYED	**199,327**	**173,382**	**171,765**	**(1,617)**	**204,197**
TAXPAYERS' EQUITY					
Public dividend capital	309,412	310,775	311,721	946	339,049
Revaluation Reserve	20,380	20,232	20,232	0	20,380
Income and Expenditure Reserve	(130,465)	(157,625)	(160,188)	(2,563)	(155,232)
TOTAL TAXPAYERS' EQUITY	**199,327**	**173,382**	**171,765**	**(1,617)**	**204,197**

The Statement of Financial Position at 30th September 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

- Inventories; £0.4m reduction due to additional 6 month stock count undertaken.
- Trade & Other Receivables; £1.7m increase in invoiced debt, £0.2m increase in VAT, offset by £1.3m reduction in accrued income, £1.4m reduction in prepayments, and £0.7m reduction in PDC receivable due to 2022/23 year-end outstanding debtor being settled as part of the PDC payment made in month 6.
- Trade & Other Payables; £0.8m decreased invoiced payments, £6.3m decrease in accruals, £2.7m PDC dividend paid and £0.1m reduction in receipts in advance. This is offset by £1.1m increase in social security and other taxes costs.
- Other Liabilities; £0.2m reduction in deferred income.

Taxpayers Equity

- Income & Expenditure Reserve movement of £2.6m in month and £29.7m YTD being the adjusted financial performance.

Finance

Statement of Financial Position: Working Capital

Blackpool Teaching Hospitals NHS Foundation Trust

Key Performance Indicators - 30 September 2023				
Debtor/Creditor Days	**Target**	**Sep-21**	**Sep-22**	**Sep-23**
Debtor Days	30	18	19	14
Creditor Days	30	121	172	141
BPPC (Cumulative)	**Target**	**Sep-21**	**Sep-22**	**Sep-23**
Value	95%	78%	93%	96%
Volume	95%	85%	92%	96%
Aged Debt	**Target**	**Sep-21**	**Sep-22**	**Sep-23**
	£000's	**£000's**	**£000's**	**£000's**
Current less than 30 Days		2,708	2,968	3,824
30 - 60 Days		1,139	545	1,885
60 - 90 Days		124	456	1,357
Over 90 Days	< 5%	2,326	1,605	2,940
Total		**6,297**	**5,574**	**10,006**
% Over 90 Days		37%	29%	29%
Liquidity	**Target**	**Sep-21**	**Sep-22**	**Sep-23**
Current ratio	> 1	0.78	0.67	0.36

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 increased by 28 from 859 to 887 and the value of debt has increased by £1.4m from £8.6m to £10.0m.

- Debtors aged 0-30 days has increased by £0.5m, debtors aged 31 to 60 days has increased by £0.1m, debtors aged 61-90 days has decreased by £0.1m. Debtors aged over 90 days has increased by £0.9m mainly due to amounts outstanding with the Lancashire and South Cumbria ICB, £2.2m has however now been paid in October relating to existing aged debt over 90 days.

The key over 90 day receivables are set out below:

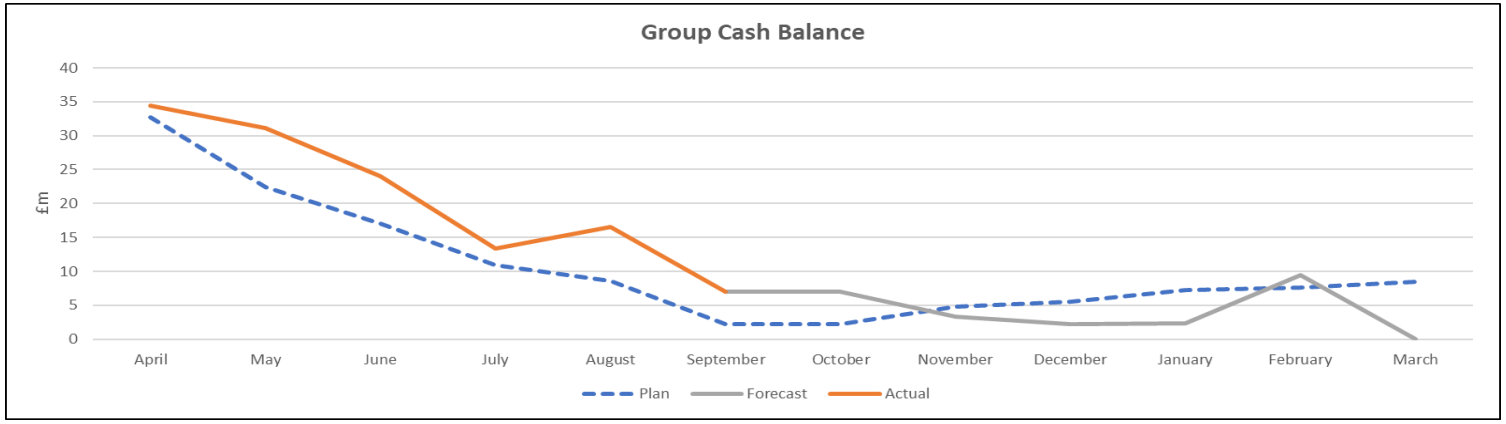
Debt > 90 Days - 30th September 2023			
Reason	Current Mont	Prior Month	Movement
	£'000s	£'000s	£'000s
NHS Debt	2,173	1,395	778
Non-NHS Debt	300	192	108
Salary Overpayment	78	85	- 7
Private & Overseas Patients	374	372	2
Council Debt	-	0	- 0
Welsh / Irish / Scottish Debt	15	22	- 7
Total	2,940	2,066	874

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 £1.5m. 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 September 2023 of £7.0m is a decrease of £9.5m from £16.5m in August, and £4.8m ahead of planned levels. The downward trend in the cash balance is mainly driven by the increased operating deficit, decreased trade and other payables, decreased deferred income, increased capital expenditure, loan repayments, increased interest payments, increased lease capital and interest payments, and PDC repayment. This is offset by depreciation, decreased receivables, decreased inventories, increased interest receipts, and increased PDC received due to phasing of capital projects.
- 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.
- Liquidity continues to be a risk with the Trust annual plan and revenue support will be required in Q3 to maintain minimum cash balances. This is being kept under close scrutiny.
- The Trust achieving its financial position and planning assumptions including both the QEP & financial recovery targets is critical to minimising the level of revenue support which will be required in 2023/24.
- Close monitoring will also be required to ensure both Trust & Atlas maintain adequate cash balances.
- The Trust made an application in September for cash support in Q3, £0.8m in November 2023 and £6.4m in December.

Blackpool Teaching Hospitals
NHS Foundation Trust

QEP and Financial Recovery

The Trust is reporting delivery in line with plan against the 5.5% QEP target at the end of September 2023. This is due to an over-delivery in Clinical Support, Tertiary and Corporate divisions offset by under-delivery in IMPF, SACCT and FICC divisions.

The financial recovery programme is £0.7m ahead of plan due to savings delivering earlier than planned.

	Month 6			YTD Month 6		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Recurrent 5.5% QEP	3.0	1.9	(1.1)	10.3	6.8	(3.5)
Non-Recurrent 5.5% QEP	0.5	1.5	1.0	2.4	5.9	3.5
Financial Recovery	0.5	0.1	(0.3)	2.2	2.9	0.7
Total	**4.0**	**3.5**	**(0.4)**	**14.9**	**15.6**	**0.7**

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**

QEP and Financial Recovery continued

Blackpool Teaching Hospitals NHS Foundation Trust

Division	Targets: Divisional QEP £000	Targets: Trust 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	1,039	888	302	1,190	152
Families & Integrated Community Care	4,010	-250	500	4,260	1,031	471	510	981	-50
Integrated Medicine & Patient Flow	4,991	9,775	300	15,066	1,689	280	65	346	-1,343
Surgery, Anaesthetics, Critical Care & Theatres	3,716	3,575	2,500	9,791	1,257	634	247	881	-376
Tertiary Services	3,203	856	1,000	5,059	1,083	911	315	1,227	143
Corporate Divisions									
Chief Executive	130	22	22	174	52	76	0	76	24
Chief Operating Officer	184	30	38	252	72	72	0	72	0
Clinical Governance	367	58	69	494	144	43	53	96	-48
Communications	16	2	4	22	6	0	13	13	6
Corporate Governance	47	7	5	59	18	27	0	27	9
Finance	238	37	36	311	93	275	0	275	182
FM & Emergency Planning	631	100	79	810	247	214	33	247	0
Medical Director	32	5	8	45	13	13	0	13	0
Medical Education	186	29	35	250	73	73	0	73	0
People & Culture	430	174	61	665	204	165	39	204	-0
Planning, Transformation, Strategy & Digital (Other)	75	12	11	98	30	43	0	43	14
Planning, Transformation, Strategy & Digital (ICT)	711	112	108	931	279	201	73	274	-5
Research & Development	114	18	22	154	45	15	30	45	0
Trust Specific	0	0	7,000	7,000	0	0	0	0	0
Other Divisions									
Other Divisions	0	163	7,000	7,163	5,368	2,426	4,227	6,653	1,284
Grand Total	22,151	15,510	19,498	57,160	12,742	6,828	5,907	12,735	-7

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

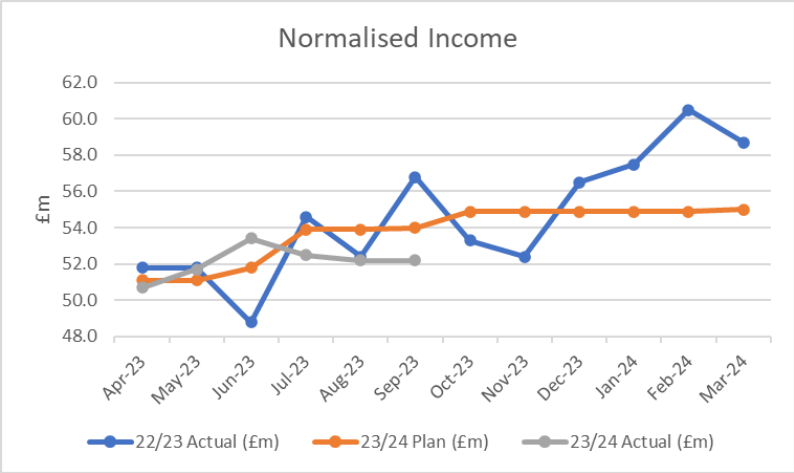
- The system stretch target £17.7m is delivered;
- The Trust Specific QEP and Financial Recovery targets are delivered or mitigated;
- Winter related activity is either system funded or managed within internal resources;
- Divisional operational pressures and risks will be managed or mitigated.

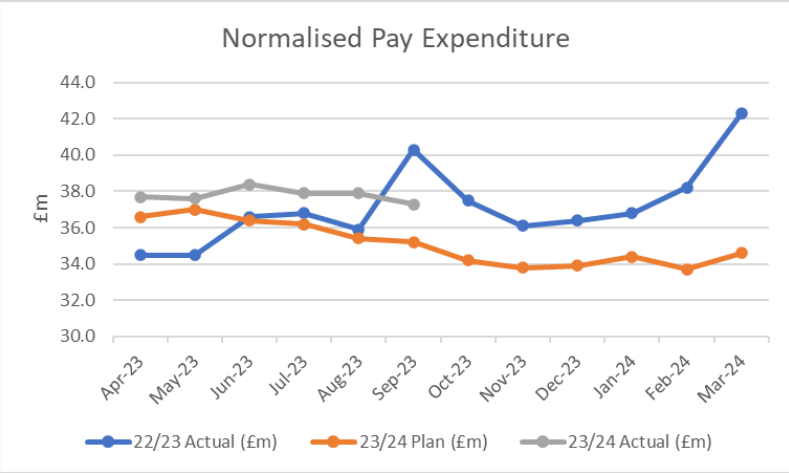
Additional mitigations currently being assessed to assist with keeping the Trust on Plan are:

- 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.

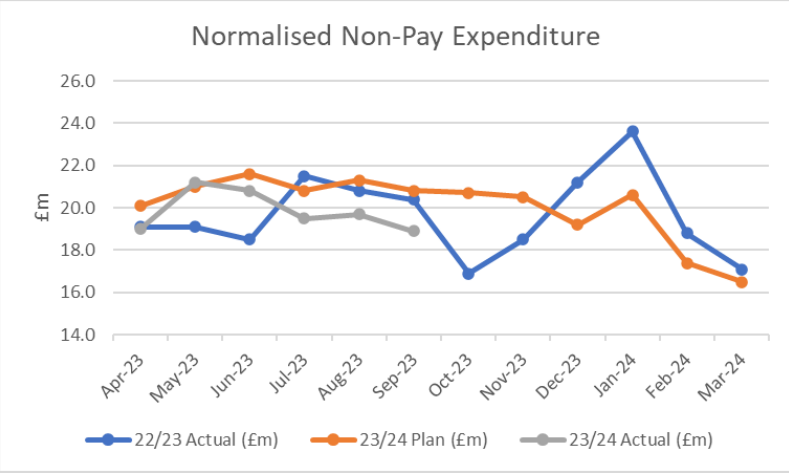
Finance

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	Operational Performance IPR

Meeting:	Finance & Performance Committee
Date:	26/10/2023

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 against the statutory requirements. The narrative outlines the challenges and provides assurance on the intended priority actions against the KPIs that are not meeting the required targets and / or trajectories. • UEC: 4 hour performance: Despite challenges in flow, corridor care continues to be lower than the preceding 39 week period. • UEC: Ambulances handover performance continues to be compromised due to challenges in patient flow. Deputy CEO has been chairing Place based Tactical meetings with partners to address system-wide factors such as Long LoS patients. • Cancer: Breast 31-day performance is on an upward trend. Current unvalidated Breast 31-day performance for Sept 2023 is 95.4% • Cancer: TWW - Current unvalidated 2WW performance for September 2023 is 92.1%. All 2WW breaches will be validated prior to month end submission. • RTT: Zero 104 breaches
Implications *(so what)*	**Alert** • UEC: Ambulance handover: > 60 minutes: performance continues to be very challenging – cohorting of pts by NWAS was in place on a number of days over the month, to enable release of crews. • Cancer: Due system wide under performance for 31-day performance, BTHT 31-day performance in now under scrutiny. All

	Trusts in the ICB including BTHT are required to submit weekly data on surgical patients with a decision to treat (DTT). • RTT: 65 weeks - 264 more patients than plan of 217. 52 weeks 782 more patients than plan of 1061.
	Assure
	• UEC: Perfect week that tested a number of key changes in urgent care delivery was completed and successful. • Cancer: July 2023 FDS performance was 73.7%. Finalised August 2023 FDS performance is 74.8% This exceeded internal and ICB forecast.62 Day Backlog - is 60 (4.2%) of the PTL. • RTT: The position related to DMO1 for 7 modalities (as per the NHSE 2023/24 Operational plan) shows over-delivery against the plan for ECHO, MRI and CT in September.

Previously considered by	Executive Team Meetings, Clinical Division PIDAs and Senior Operational Assurance Group (SOAG)

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

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

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

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NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Finance and Performance Committee

September 2023

Caring · Safe · Respectful

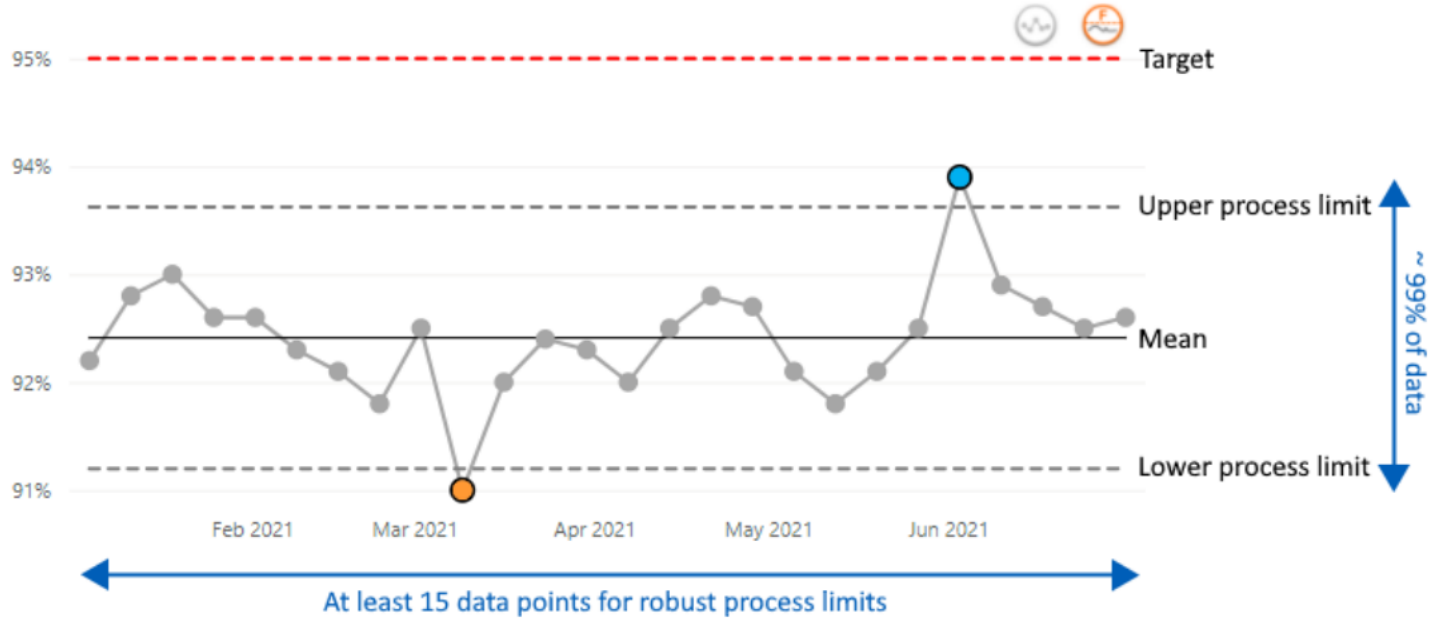
Guide to Statistical Process Control

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

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

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

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



Executive Summary

		Assurance				Variation				
		P	?	F		H	L		H	L
Operations	Access		6	7	7	1	2	14	2	1
	Activity		6			1		5		
	Cancer		7	2	2	2	2	6		1
	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.

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Access

UEC
Advise
• 4 hour performance: Despite challenges in flow, corridor care continues to be lower than the preceding 39 week period.
• Ambulances handover performance continues to be compromised due to challenges in patient flow. Deputy CEO has been chairing Place based Tactical meetings with partners to address system-wide factors such as Long LoS patients.
• Ambulance activity remains stable but acuity has seen a rise alongside increase in demand from non-ambulance arrivals, also with high acuity.
• Capital development still on track to delivery in December 23

Alert
• Ambulance handover: > 60 minutes: performance continues to be very challenging – cohorting of pts by NWAS was in place on a number of days over the month, to enable release of crews.
• Extended delays for Mental Health beds in the department due to the regional demand for speciality beds.
Assure
• Perfect week that tested a number of key changes in urgent care delivery was completed and successful. Key changes that remain in place are
o DTA process change – pts will be reviewed by senior clinician before full DTA confirmed – 44 pts avoided admission in the week
o Rapid assessment by community nursing teams to take place on attendance for admission avoidance. Increase use of virtual wards
o Routine daily medical cover in ED into the evening – reduction in clerking times in ED
o Power Hour - To give support and direction to the senior staff in Urgent and Emergency Care (UEC) when the ED comes under increased pressure due to high influxes of patients, poor flow or challenging staffing numbers

RTT
Advise
• Zero 104 breaches
• 18 x reportable 78-week breaches in September 23 due to capacity issues (with 7 more for choice other reasons).
• Cardiology improvement plan in place with service leads meeting with the Executive triumvirate fortnightly which is demonstrating improvement in opts backlog and P2 activity. Detailed monitoring will continue.
Alert
• 65 weeks - 264 more patients than plan of 217.
• 52 weeks 782 more patients than plan of 1061.
• The biggest contributors to this position by volume are Gastroenterology, Cardiology and Gynaecology
• Improvement plans in place and monitored weekly in SOAG.
• Increase in ENT referrals by 33% compared to pre pandemic baseline. 136% increase in fast track two week wait referrals from 2022-23, which reduces routine slot availability.

Assure
• The position related to DMO1 for 7 modalities (as per the NHSE 2023/24 Operational plan) shows over-delivery against the plan for ECHO, MRI and CT in September.
• There was under delivery in DMO1 for the three modalities relating to GI Endoscopy, attributed to booking challenges provided by the insourcing company and the reduction in lists to reduce risk of under-utilisation. However, this has been addressed and resolved
• Current ENT Consultants continue to provide additional WLI sessions x 4 per month, seeing 96 patients per month. In addition, an insourcing solution for New and Follow up patients has been approved by the Executive team and is currently being mobilised and will commence in November 2023.

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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%	78.1%	Sep 23		F	95%	78.6%	Aug 23		
A&E Type 1 Performance %	65%	51.2%	Sep 23		F	65%	52.3%	Aug 23		
Ambulance Handovers - % within 15 minutes	65%	17.0%	Sep 23		F	65%	14.9%	Aug 23		
Ambulance Handovers - % within 30 minutes	95%	65.9%	Sep 23		F	95%	57.9%	Aug 23		
Ambulance Handover 30-60 Mins		486	Sep 23				535	Aug 23		2664
Ambulance Handover Over 60 Mins	0	359	Sep 23		?	0	489	Aug 23	0	1668
Number waiting over 12 hours from DTA		828	Sep 23				905	Aug 23		5072
Number of Patients spending 12+ Hours in ED - Trust		1724	Sep 23				1675	Aug 23		9377
% of Patients spending 12+ Hours in ED - Trust	2%	8.71%	Sep 23		F	2%	8.38%	Aug 23		
% of patients waiting less than 6 weeks for a diagnostic test	95%	84.5%	Sep 23		F	95%	73.9%	Aug 23		
Total RTT Waiting List - Trust		38234	Sep 23	H			37833	Aug 23		38234
RTT Incomplete Pathways - % within 18 weeks	92%	54.0%	Sep 23	L	F	92%	54.3%	Aug 23		
RTT Incomplete Pathways - Over 52 Weeks		1843	Sep 23	H			1657	Aug 23		1843

Sign Out

Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
RTT Incomplete Pathways - Over 78 Weeks		25	Sep 23				15	Aug 23		25
RTT Incomplete Pathways - Over 104 Weeks	0	0	Sep 23			0	0	Aug 23	0	0
Total 52 week waits – completed		314	Sep 23				262	Aug 23		1651
On the Day Cancelled Operations for Non-Clinical Reasons - % not admitted within 28 days	0%	10.1%	Sep 23			0%	31.2%	Aug 23		
TIA - High Risk Treated within 24Hrs	60%	41.9%	Sep 23			60%	2.2%	Aug 23		
Stroke - 90% Stay on Stroke Ward	80%	66.7%	Sep 23			80%	48.3%	Aug 23		
2-Hour UCR	70%	88.4%	Aug 23			70%	88%	Jul 23	70%	88.4%

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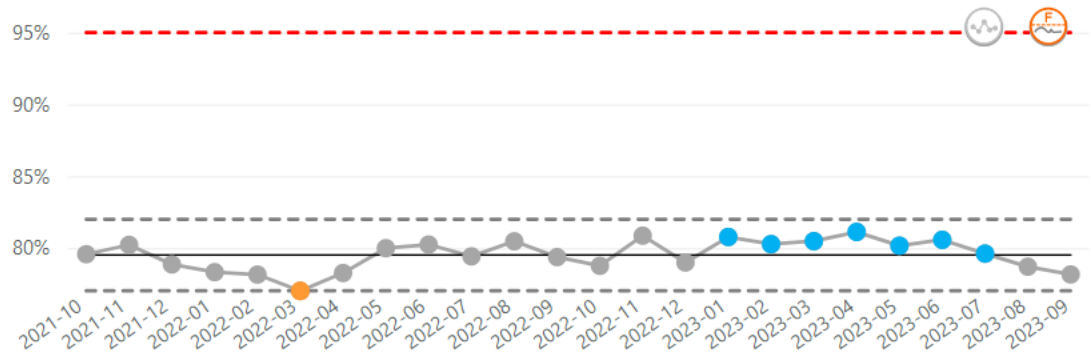
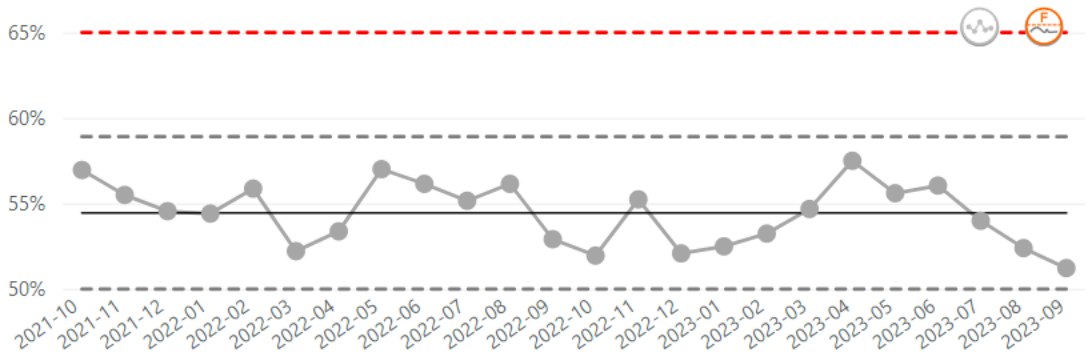
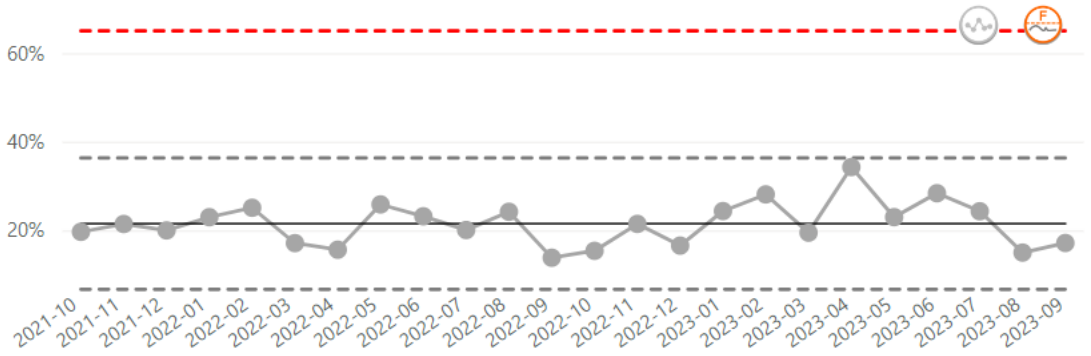
4 Hours from arrival to ADT - % within 4 hours



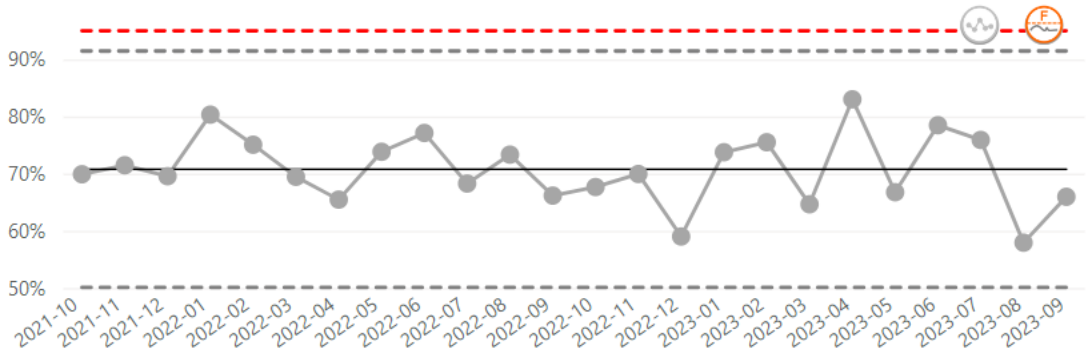
A&E Type 1 Performance %



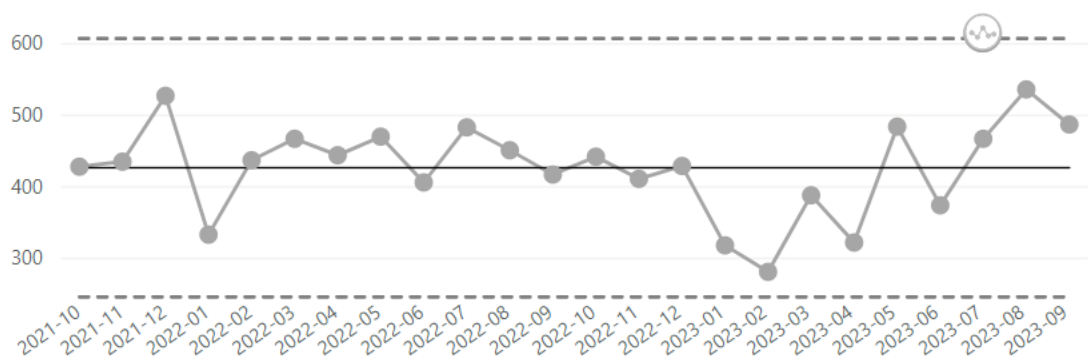
Ambulance Handovers - % within 15 minutes



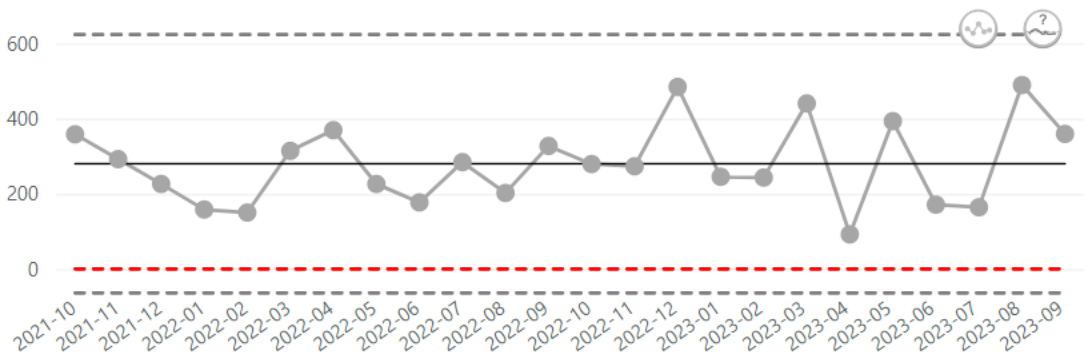
Ambulance Handovers - % within 30 minutes



Ambulance Handover 30-60 Mins



Ambulance Handover Over 60 Mins



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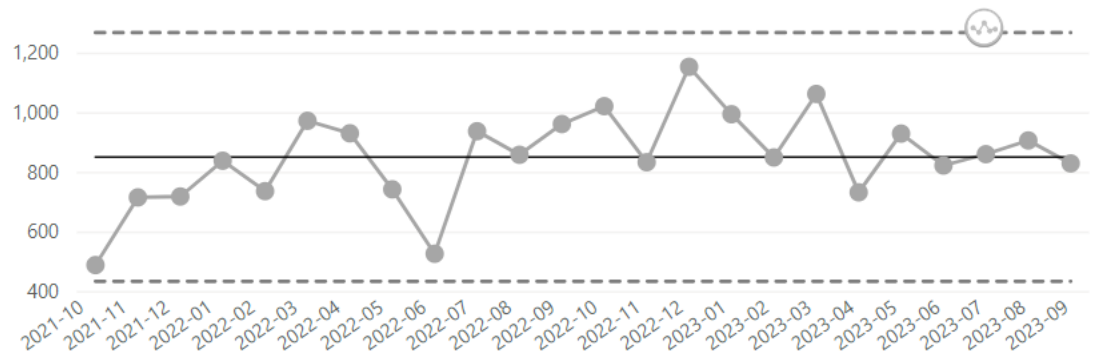
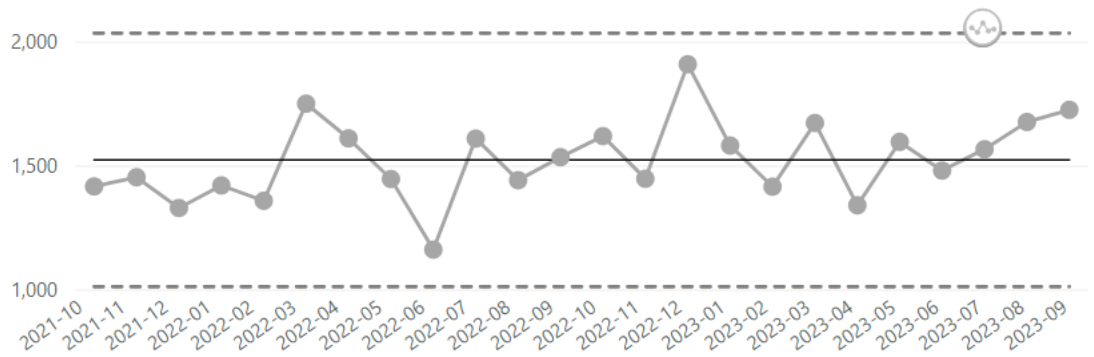
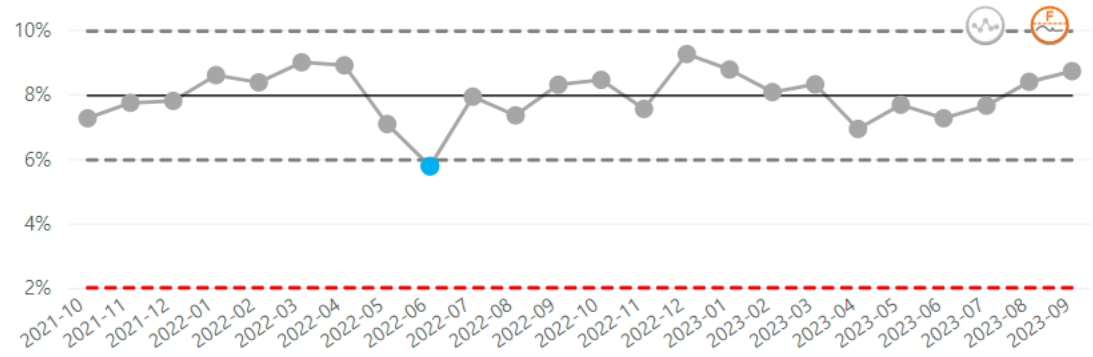
Number waiting over 12 hours from DTA



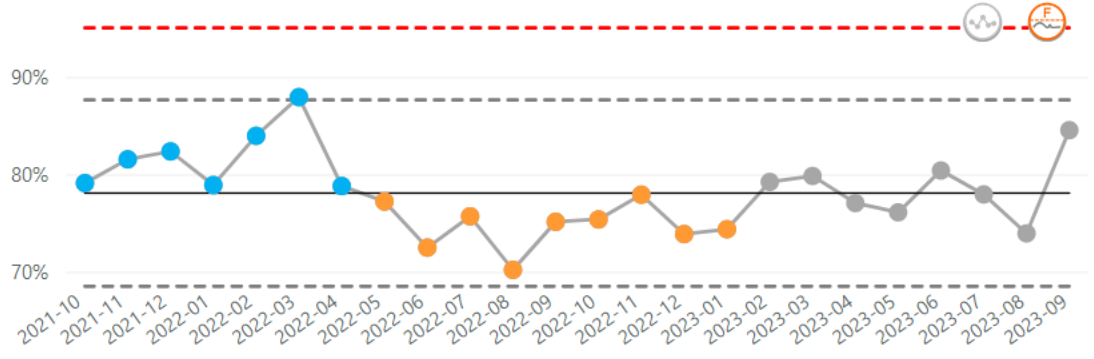
Number of Patients spending 12+ Hours in ED - Trust



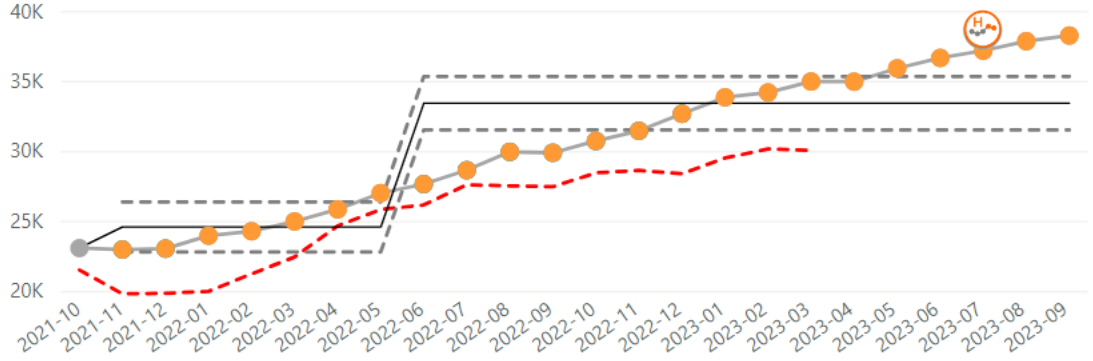
% of Patients spending 12+ Hours in ED - Trust



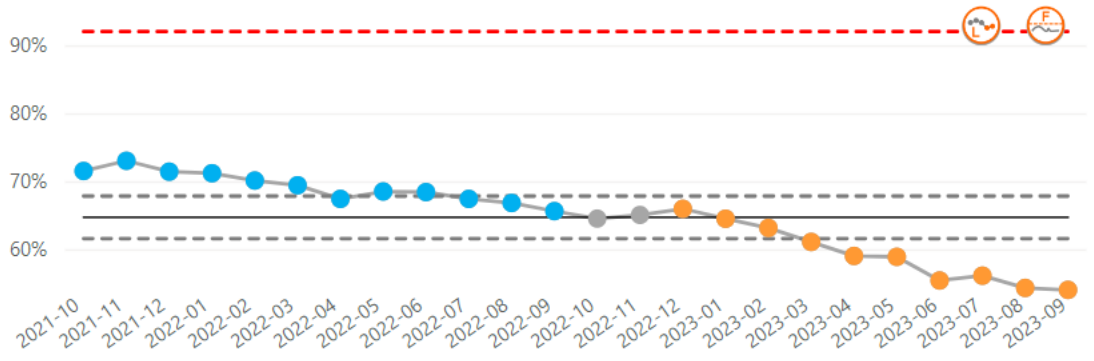
% of patients waiting less than 6 weeks for a diagnostic test



Total RTT Waiting List - Trust



RTT Incomplete Pathways - % within 18 weeks



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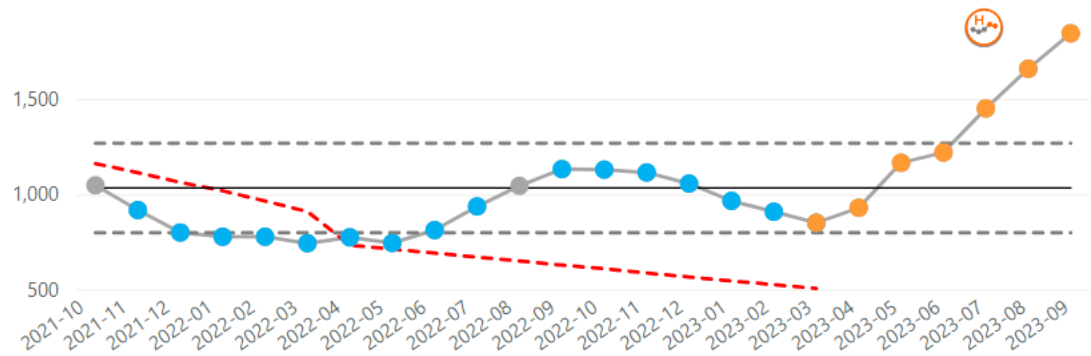
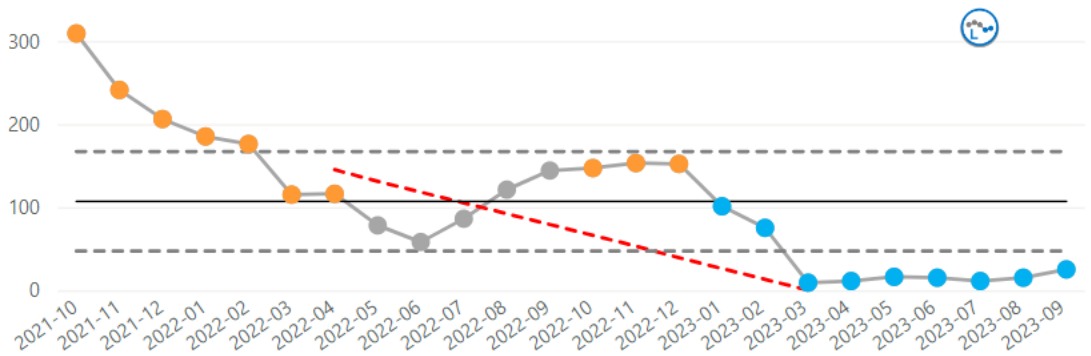
Operations

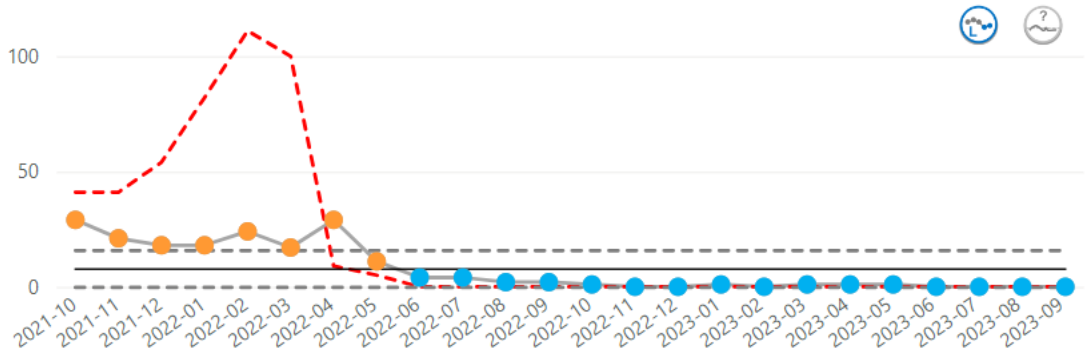
RTT Incomplete Pathways - Over 52 Weeks



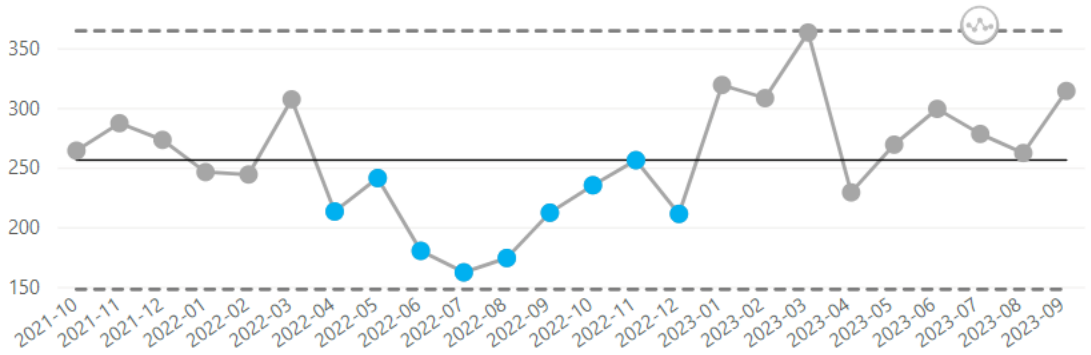
RTT Incomplete Pathways - Over 78 Weeks



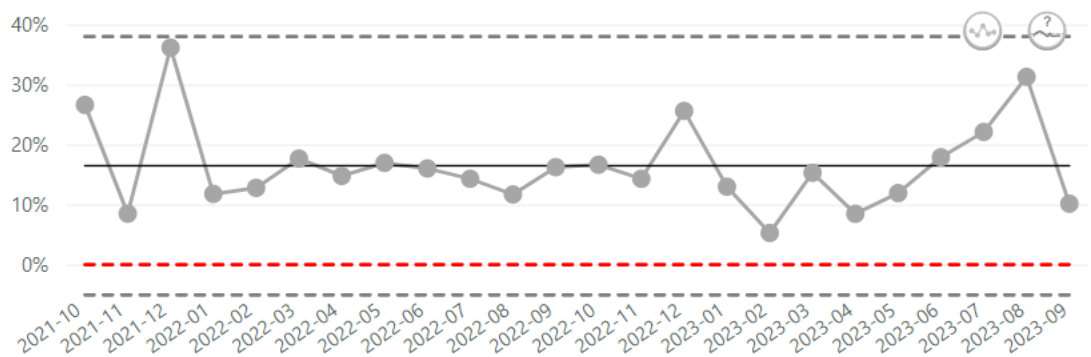
RTT Incomplete Pathways - Over 104 Weeks



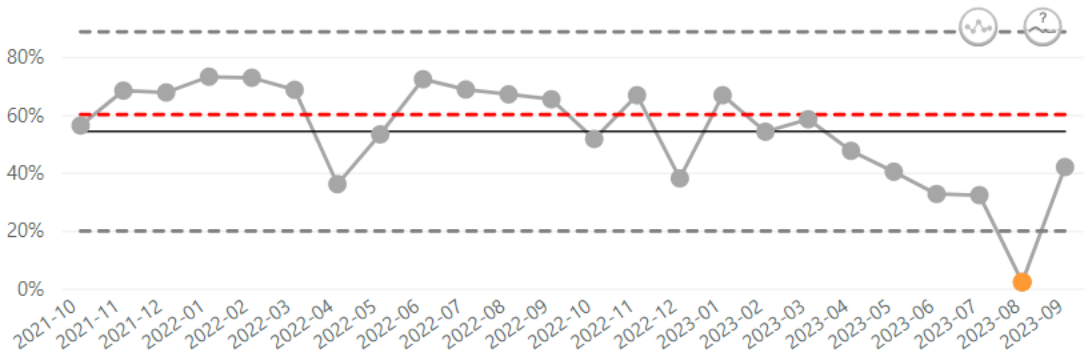
Total 52 week waits – completed



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



TIA - High Risk Treated within 24Hrs



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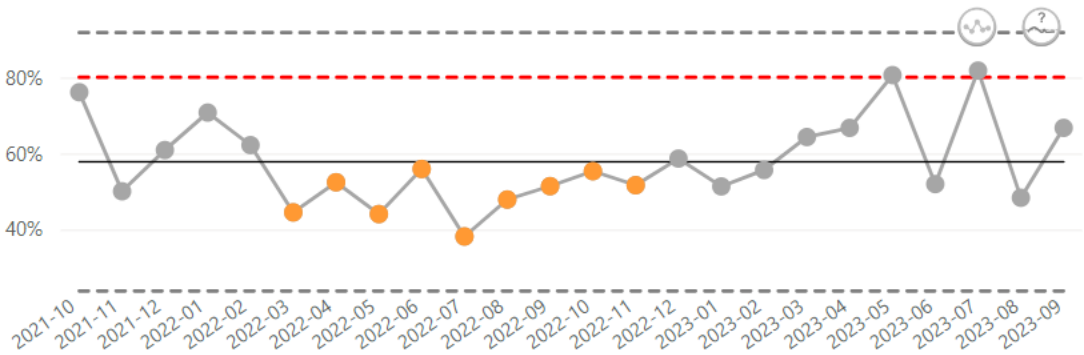
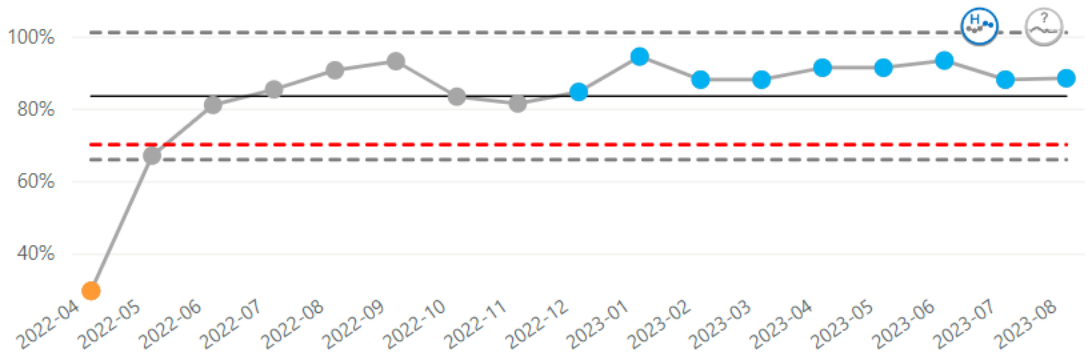
Operations

Stroke - 90% Stay on Stroke Ward



2-Hour UCR



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Activity

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

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

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

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

- Day Cases are below plan for month of Aug-23 and cumulative year to date.
- Aug-23 Biggest contributors to being below plan:
- Gastroenterology | - Ophthalmology | - Cardiology
- YTD Biggest contributors to being below plan:
- Gastroenterology | - Clinical Haematology | - Cardiology

- Elective Inpatients are below plan for month of Aug-23 and cumulative year to date.
- Aug-23 Biggest contributors to being below plan:
- Cardiology | - Trauma & Orthopaedics | - Urology
- YTD Biggest contributors to being below plan:
- Cardiology | - Trauma & Orthopaedics | - Urology

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Homepage | Definitions | Executive Summary | Access 1a | Access 1b | Access 2 | Access 3 | Access 4 | Access 5 | Access 6 | Access 7 | Activity 1a | Activity 2 | Activity 3 | Cancer 1a | Cancer 2 | Cancer 3 | Cancer 4 | Prod

Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Outpatient New	10933.29	9582	Aug 23			10449.85	9387	Jul 23	51282	46631
Outpatient Follow Up	23391.75	21309	Aug 23			22330.63	21547	Jul 23	108675	105324
Day Case	4362.73	3866	Aug 23			4164.94	3789	Jul 23	21182	20581
Elective Inpatient	487.18	481	Aug 23			465.2	476	Jul 23	2282	2282
Non-Elective Inpatient	4249	4644	Aug 23	H		4249	4502	Jul 23	20982	22760
ED Attendances	6438.19	6704	Aug 23			6438.19	6848	Jul 23	31776	33214

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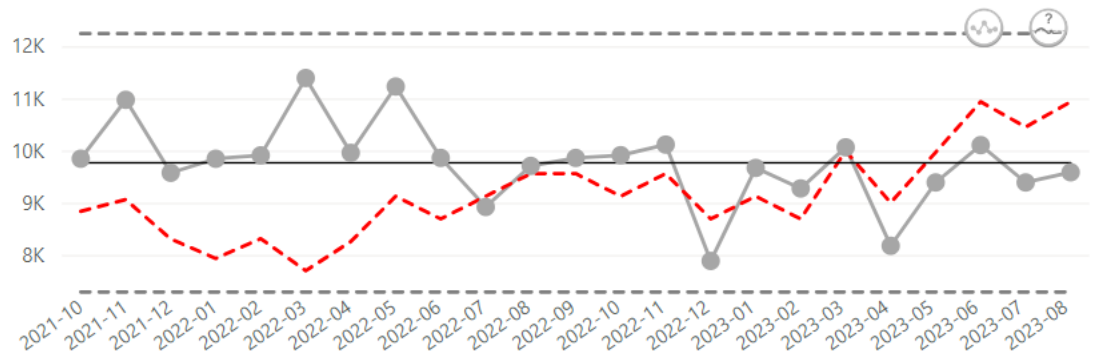
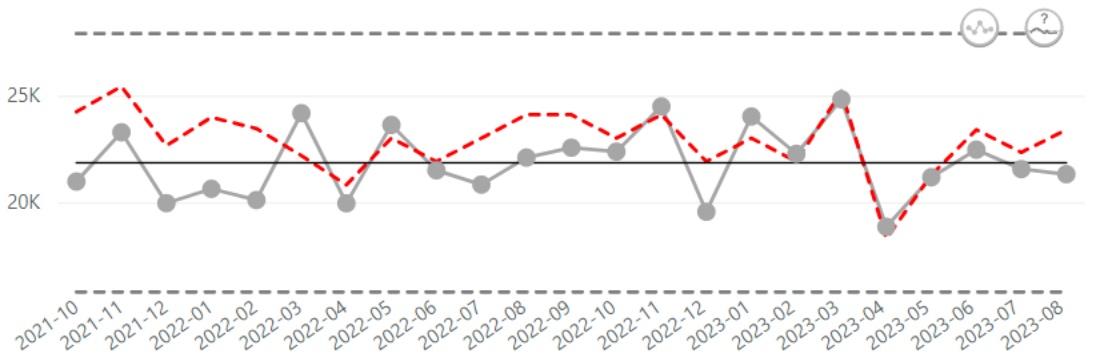
Operations

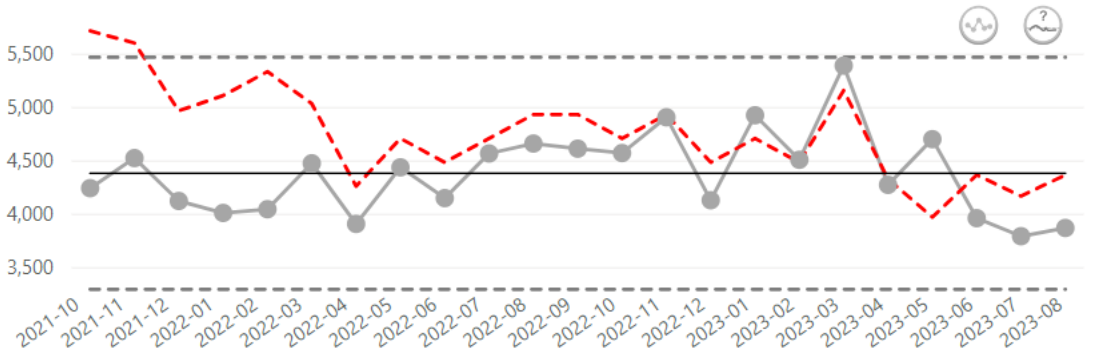
Outpatient New



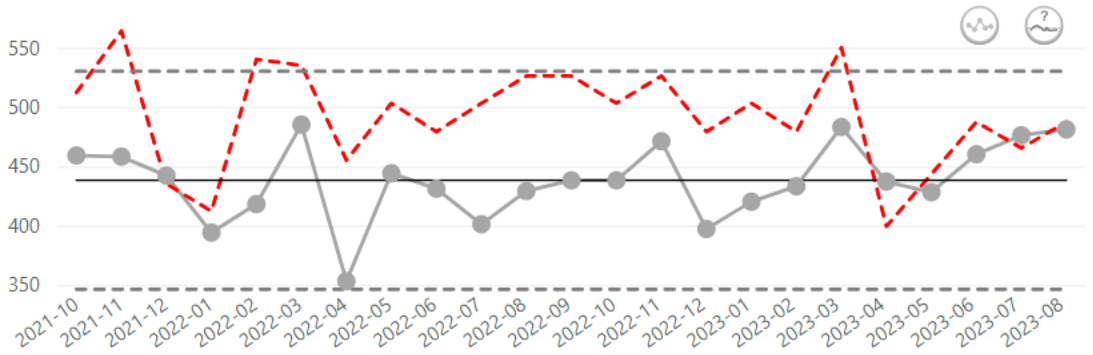
Outpatient Follow Up



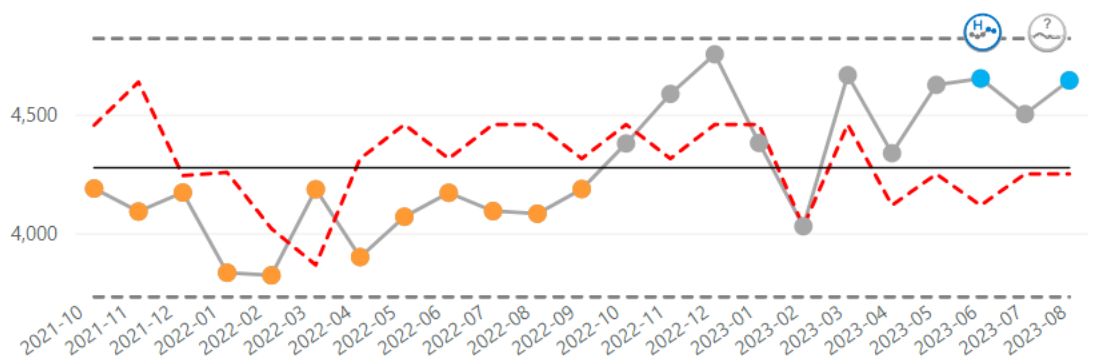
Day Case



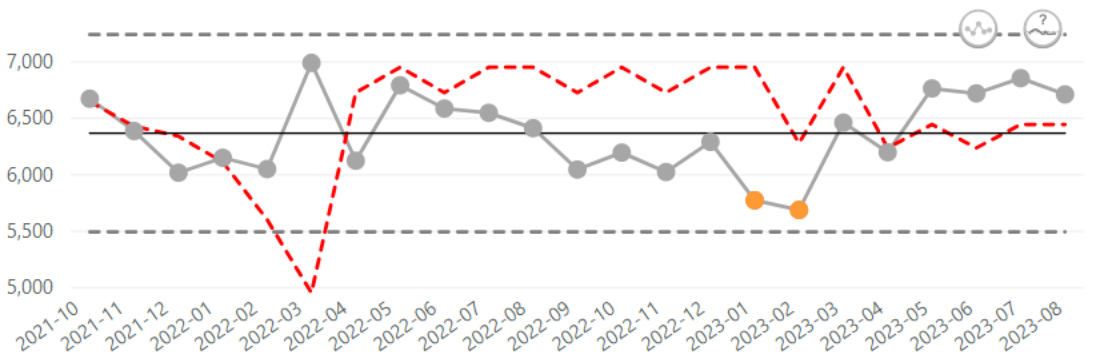
Elective Inpatient



Non-Elective Inpatient



ED Attendances



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Operations

Cancer

Advise:
• Breast 31-day performance is on an upward trend. Current unvalidated Breast 31-day performance for Sept 2023 is 95.4%
• TWW - Current unvalidated 2WW performance for September 2023 is 92.1%. All 2WW breaches will be validated prior to month end submission.
• Challenged tumour sites are Gynae, Haem and UGI.
• Funding for additional Sentinel lymph node machine confirmed. The breast team currently provide sentinel lymph node procedures to breast cancer patients. At present there is only one sentinel lymph node machine within the theatre base setting at BTH.
• The second machine has doubled capacity to perform SLN biopsy.
• Endoscopy Performance - Average wait time for 2WW endoscopy is currently 0.7 weeks. This is a decrease from an average wait of 0.9 wk last week. 2ww breached waiting list decreased to 26 from 33 the previous week.

Assure:
• July 2023 FDS performance was 73.7%. Finalised August 2023 FDS performance is 74.8% This exceeded internal and ICB forecast.62 Day Backlog - is 60 (4.2%) of the PTL.
• Currently, exceeding our target by 53.1%. BTH rank 11th out 120, Reduction in our backlog has led to an improved 28-day FDS performance. Reduction in our backlog has led to an improved 28-day FDS performance.
• Gynae one stop PMB clinic was reinstated at BTHT.
• A new colorectal ACP joined the service in Sept 2023 delivering Rapid Diagnostic Clinics (RDC) which accommodates 8 patients per clinic twice weekly.
• This additional Capacity increased LGI RDC capacity by 40% from 40 to 56 per week.

Alert:
• Due system wide under performance for 31-day performance, BTHT 31-day performance in now under scrutiny. All Trusts in the ICB including BTHT are required to submit weekly data on surgical patients with a decision to treat (DTT).
• NHS England (NHSE) and ICB executives are now engaged in regular contact to review and monitor 31-day performance across the ICB.
• 62-day Breast Screening compliance is challenged. Workforce challenges earlier this year has impacted Breast Screening performance. However, workforce challenges within the breast team are fully resolved.
• Thoracic Surgical delays - Wait time for Thoracic TCI is 4 weeks. This delay has been attributed to drop in the level of anaesthetic cover in the division. This has now been addressed and improvement trajectory under development

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Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
TWW Suspected Cancer - %	93%	88.1%	Aug 23	H	?	93%	89.6%	Jul 23		
TWW Breast Symptomatic - %	93%	93.2%	Aug 23		?	93%	93.4%	Jul 23		
28 Days Faster Diagnosis Standard - %	75%	74.8%	Aug 23		?	75%	72.9%	Jul 23		
31 Days First Treatment - %	96%	88.2%	Aug 23		?	96%	80.6%	Jul 23		
31 Days Subsequent Treatment - Drugs - %	98%	100%	Aug 23	H	?	98%	100%	Jul 23		
31 Days Subsequent Treatment - Surgery - %	94%	0%	Aug 23	L	?	94%	72.7%	Jul 23		
62 Days GP Referred (Classic) - %	85%	70.5%	Aug 23		F	85%	63.9%	Jul 23		
62 Days National Screening - %	90%	14.2%	Aug 23		F	90%	0%	Jul 23		
62 Days Consultant Upgrade - %	85%	68.5%	Aug 23		?	85%	55.8%	Jul 23		
62 Days - GP Referred (Classic) Open Pathways >62 Days		78	Sep 23	L			69	Aug 23		78
62 Days - GP Referred (Classic) Open Pathways >104 Days		17	Sep 23	L			14	Aug 23		17

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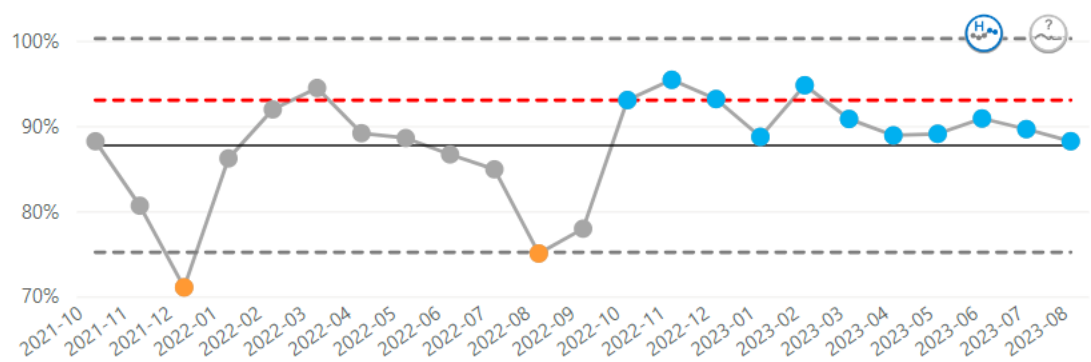
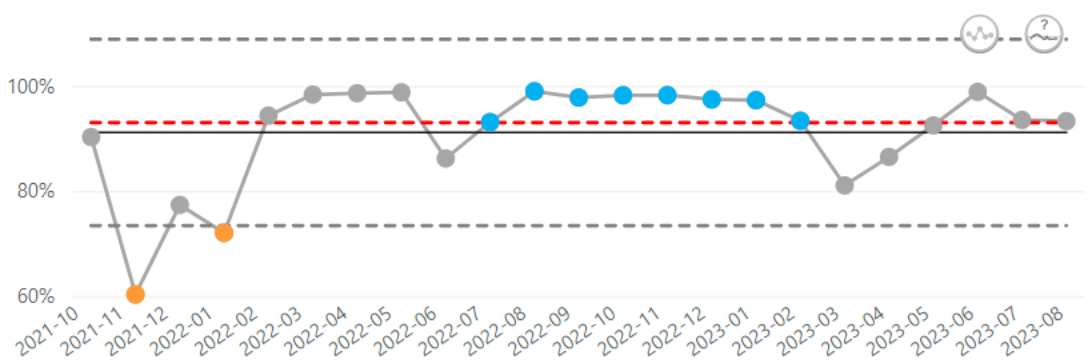
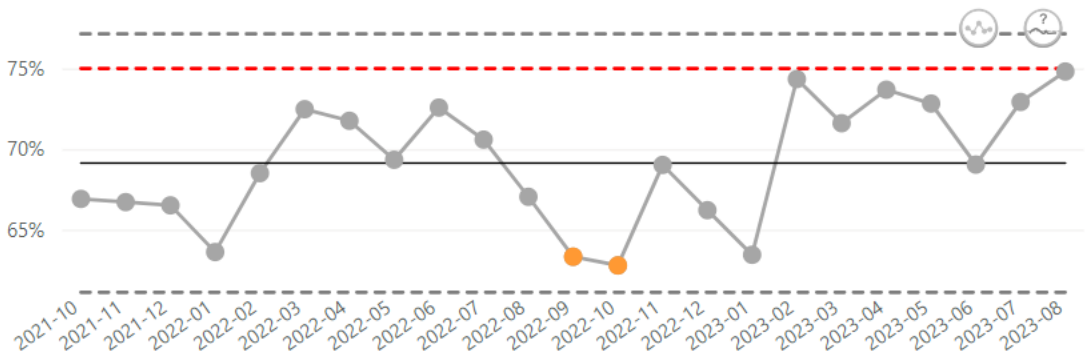
TWW Suspected Cancer - %



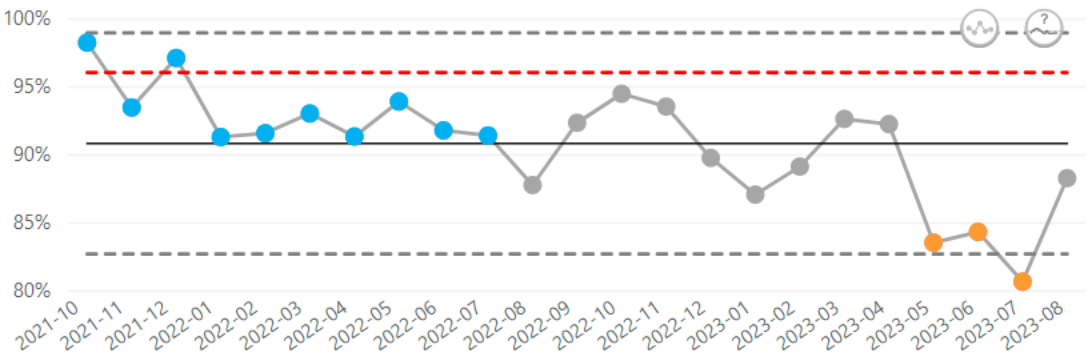
TWW Breast Symptomatic - %



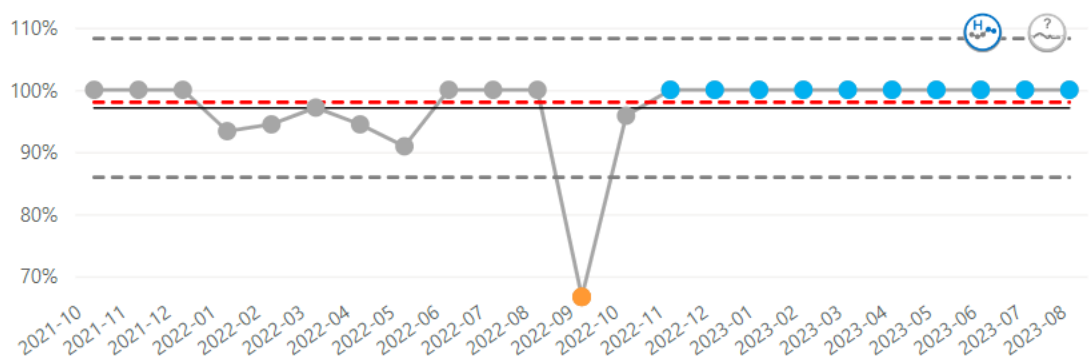
28 Days Faster Diagnosis Standard - %



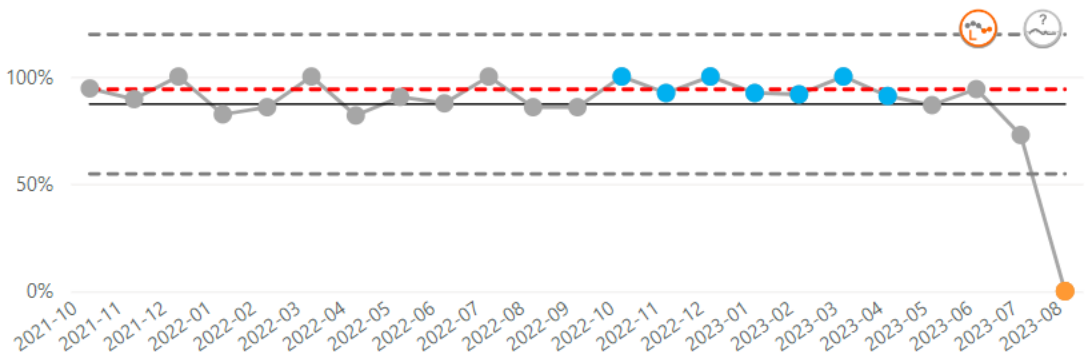
31 Days First Treatment - %



31 Days Subsequent Treatment - Drugs - %



31 Days Subsequent Treatment - Surgery - %



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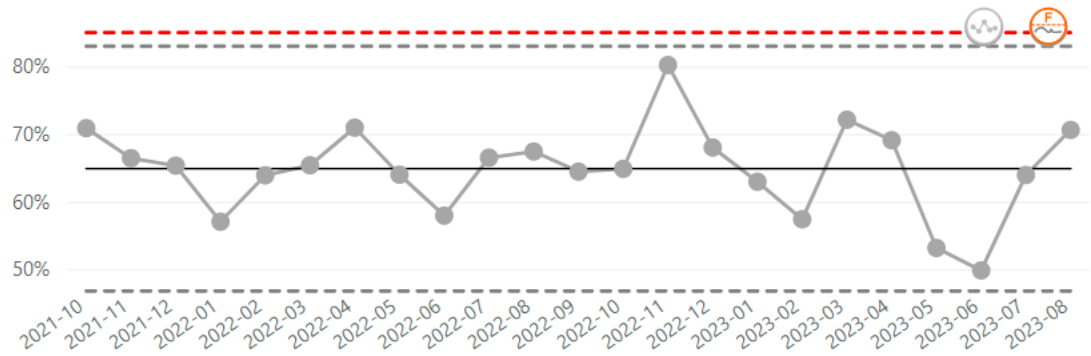
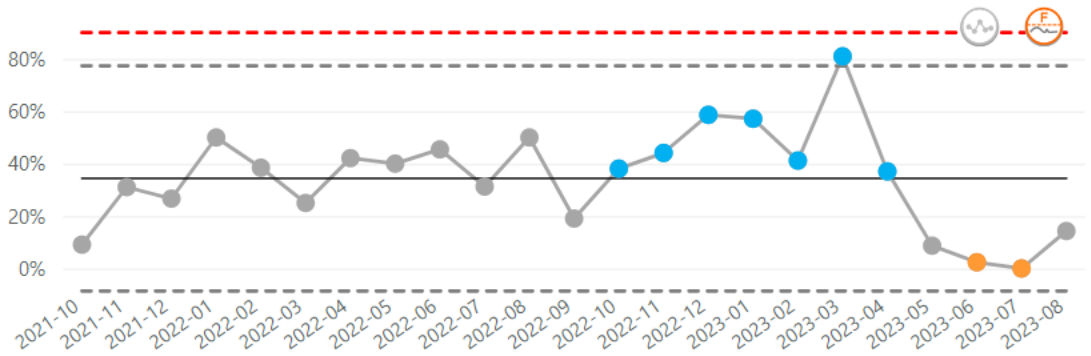
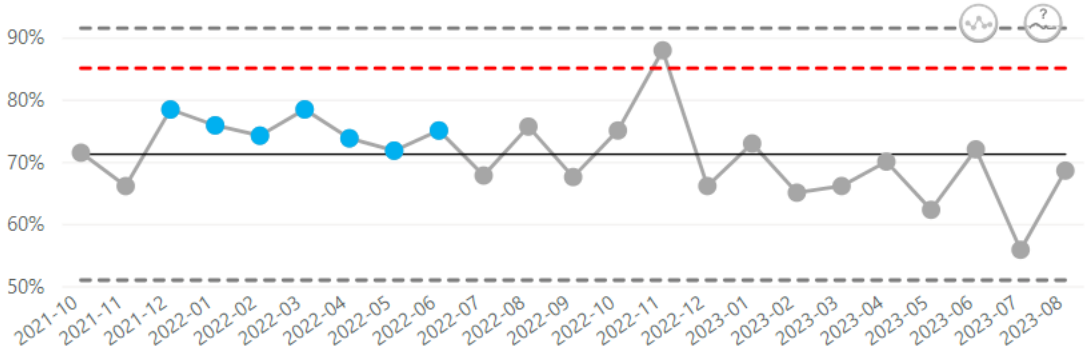
62 Days GP Referred (Classic) - %



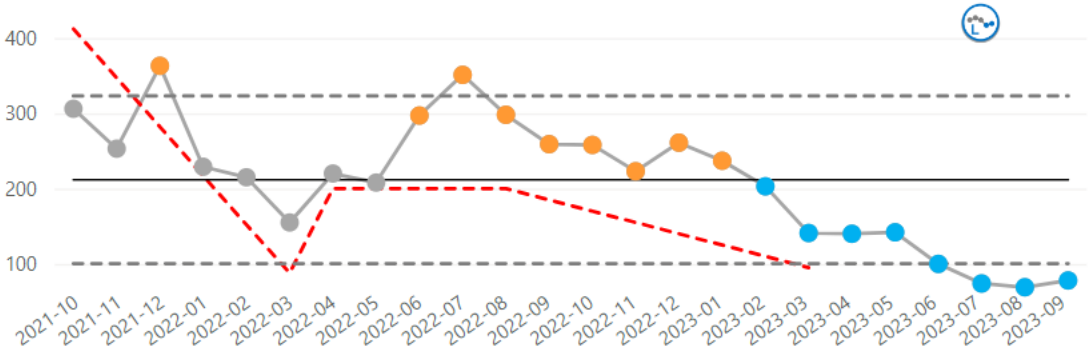
62 Days National Screening - %



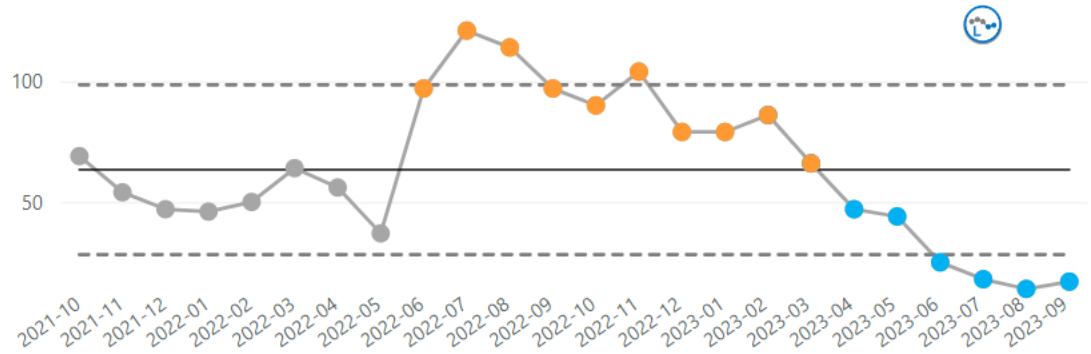
62 Days Consultant Upgrade - %



62 Days - GP Referred (Classic) Open Pathways >62 Days



62 Days - GP Referred (Classic) Open Pathways >104 Days



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Productivity

Alert:
The following KPIs are triggering a negative variation or assurance icon:
- Bed Occupancy - BTH - triggering due to consistent non-achievement of the target.
- Theatre Utilisation, All Specialities, Urgent & Elective - triggering due to consistent non-achievement of the target.
- PIFU Open Pathways - triggering due to consistent non-achievement of the target.

Assure:
The following KPIs are triggering a positive variation or assurance icon:
- DNA Rate (OPD) % - consecutive points below the average and within the target.
- Data Quality Maturity Index (DQMI) - consistent achievement of the target and recent points above the upper control limit.

Advise:
The following KPIs are demonstrating normal variation:
- New: FoI Rate
- OP Slot Utilisation
- ED Conversion Rate
- Stranded Patients (>6 Days LOS)
- Super Stranded Patients (>20 Days LOS)

Sign Out
Homepage | Definitions | Executive Summary | Access 1a | Access 1b | Access 2 | Access 3 | Access 4 | Access 5 | Access 6 | Access 7 | Activity 1a | Activity 2 | Activity 3 | Cancer 1a | Cancer 2 | Cancer 3 | Cancer 4 | Prod

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Operations

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
DNA rate (OPD) %	7%	6.81%	Sep 23	L	?	7%	6.36%	Aug 23		
New:Follow Up rate		1.9458	Sep 23				1.7754	Aug 23		1.9458
OP Slot Utilisation	95%	92.6%	Sep 23		?	95%	94.6%	Aug 23		
ED Conversion Rate		38.9%	Sep 23				38.8%	Aug 23		
Bed Occupancy - BTH	85%	95.2%	Sep 23		F	85%	92.3%	Aug 23		
Stranded Patients (>6 Days LOS)		357	Sep 23				339	Aug 23		357
Super Stranded Patients (>20 Days LOS)		123	Sep 23				116	Aug 23		123
Theatre Utilisation, All Specialties, Urgent & Elective	85%	83.3%	Sep 23	H	F	85%	80.6%	Aug 23		
Data Quality Maturity Indicator	82.5%	92.4%	Jun 23	H	P	82.5%	92.4%	May 23		
Depth of Coding		4.68	Jul 23	L			7.05	Jun 23		4.68
PIFU Open Pathways	5%	1.3%	Sep 23		F	5%	1.4%	Aug 23		

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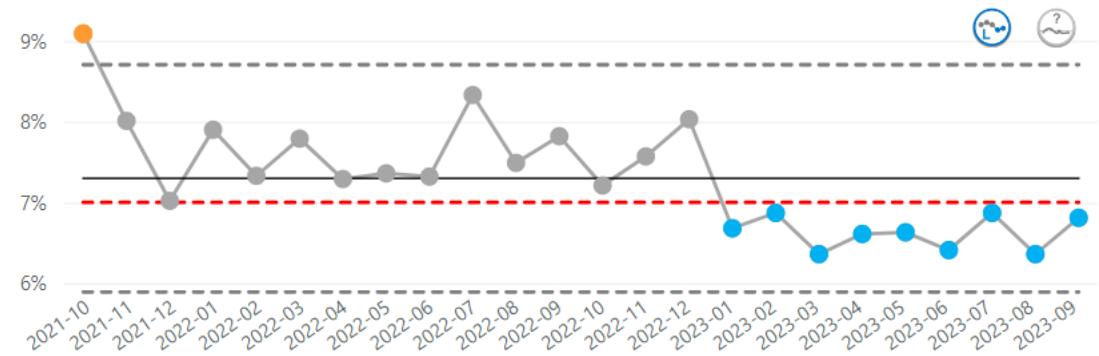
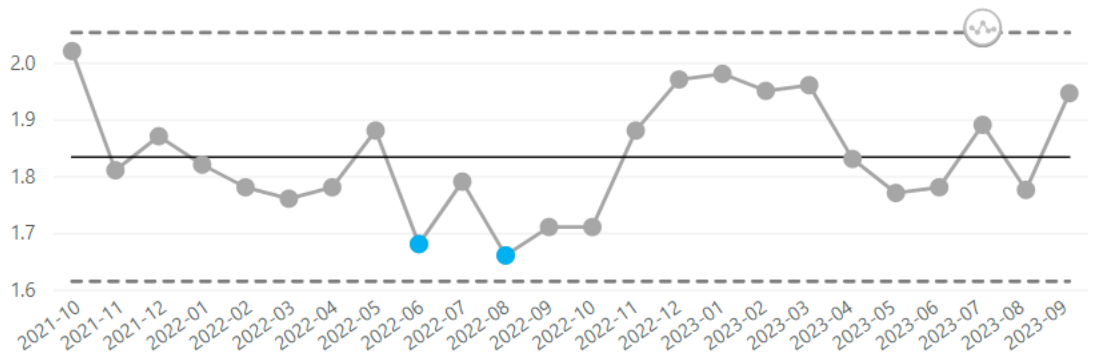
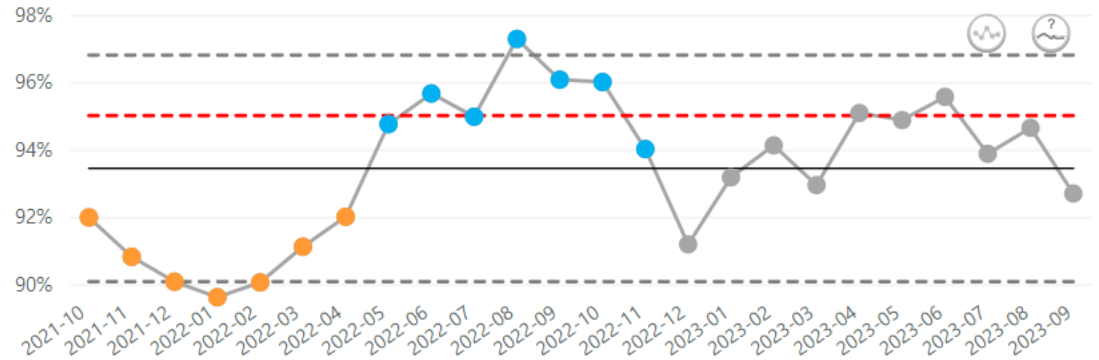
DNA rate (OPD) %



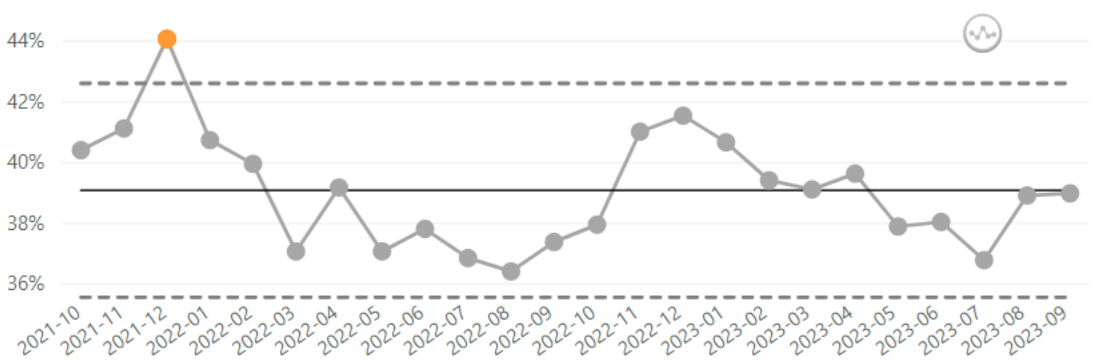
New:Follow Up rate



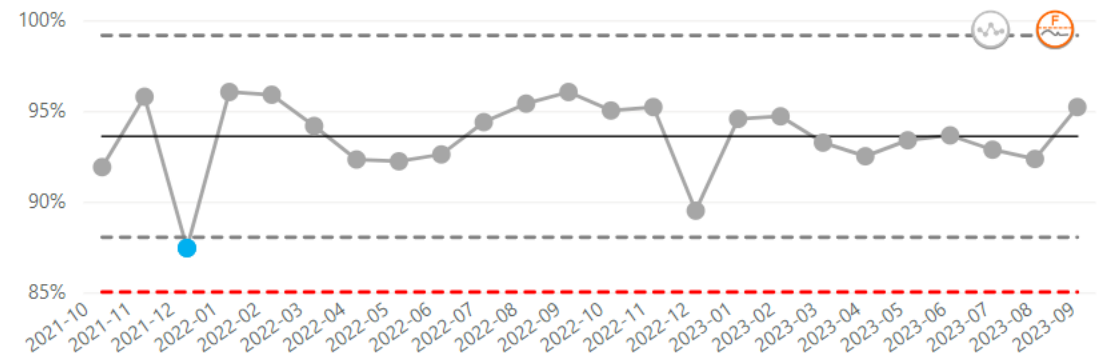
OP Slot Utilisation



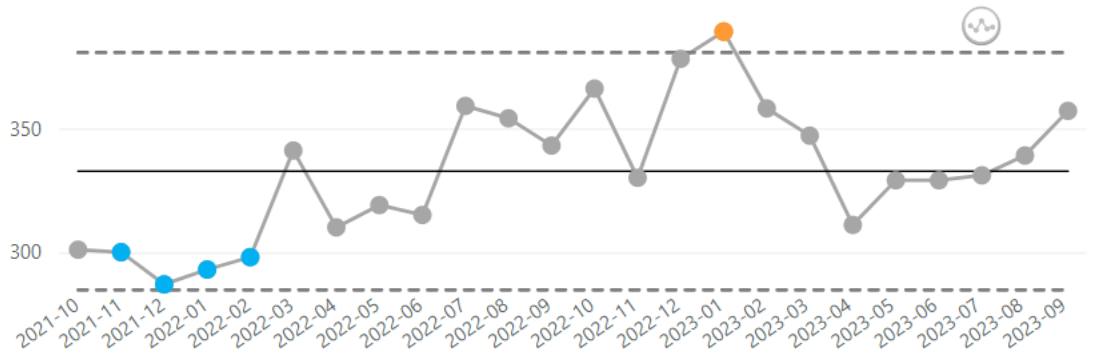
ED Conversion Rate



Bed Occupancy - BTH



Stranded Patients (>6 Days LOS)



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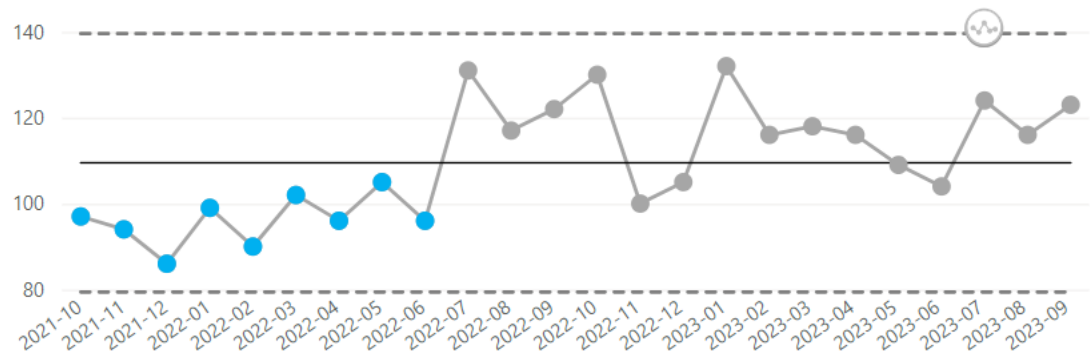
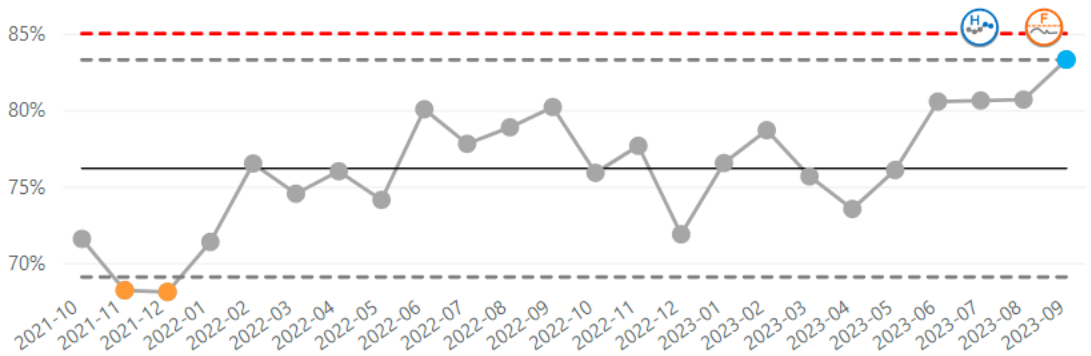
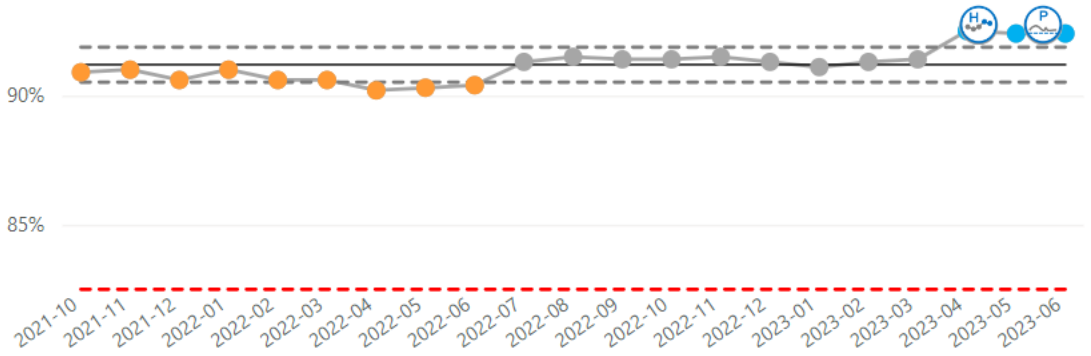
Super Stranded Patients (>20 Days LOS)



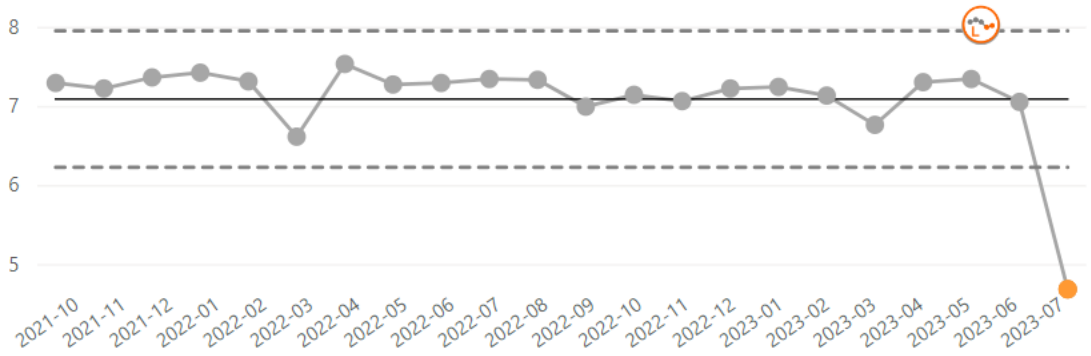
Theatre Utilisation, All Specialties, Urgent & Elective



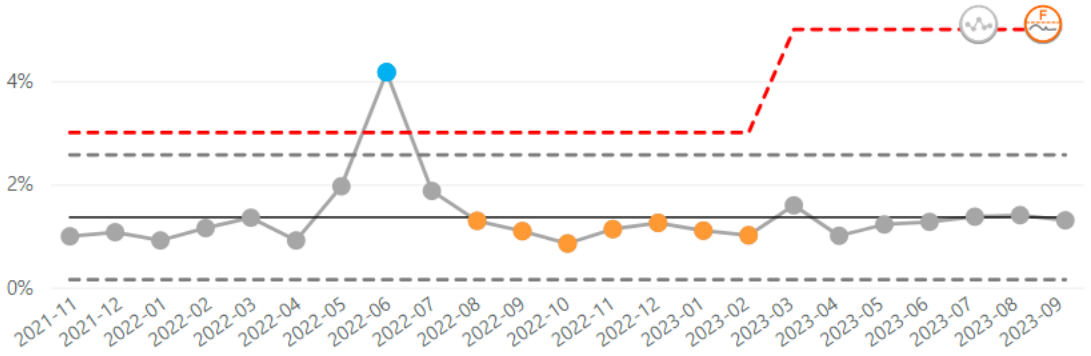
Data Quality Maturity Indicator



Depth of Coding



PIFU Open Pathways



Sign Out

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Workforce Assurance Committee Escalation Report

Meeting:	Board of Directors in Public
Date:	2 November 2023

Author	Esther Steel, Director of Corporate Governance					
Exec Sponsor	Fergus Singleton, Non-Executive Director (Committee Chair) (20.09.23) Adrian Carridice-Davids, Non-Executive Director (Committee Chair) (18.10.23					
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 Committee on 20 September 2023 and at the workshop session on 18 October 2023.

Implications *(so what)*	**Alert** At the September meeting, the Committee heard a staff story highlighting some of the challenges experienced by members of staff with disabilities and long term conditions – this was followed up by a very positive workshop session attended by the Chairs of each of our staff networks and this is an area where we are making real progress **Assure** There were a number of items during both meetings that were provided assurance purposes – Board members are asked to note that the Trust is no longer part of GMC enhanced monitoring having addressed all previous recommendations

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 Reports.

Committee Escalation Report

Name of Committee/Group:	Workforce Assurance Committee	**Report to:**	Board of Directors Meeting
Date of Meeting:	20th September 2023	**Date of next meeting:**	2nd November 2023
Chair:	Fergus Singleton	**Parent Committee:**	Board of Directors

Introduction

Quorate meeting held in the Boardroom with two members joining on MS Teams

Alert

What	So What	What Next
Staff Story A member of the Disabled and Long-Term Conditions (DLTC)Network attended to share her story of working with the Trust prior to, during and after her diagnosis with MS. While there was some very positive feedback in terms of support from the DLTC network there were areas that were of concern including in relation to reasonable adjustments to enable her to continue working safely and maximising her potential	Committee members thanked the staff member for sharing her story and recognised the value of the DLTC network and the work of the network chair	The October workshop for the Committee will provide an opportunity for Committee members to meet with members of all staff networks to discuss the challenges and opportunities for support. The Exec Director of Integrated Care agreed to respond to specific issues raised

Assurance

What	So What	What Next
Health Education England Update Report The Committee were advised that the Trust is no longer part of GMC enhanced monitoring, significant progress has been made and NHSE/GMC have commended the Trust for the work and improvements that have taken place	The Committee also reviewed and approved the NHS England placement provider self-assessment for 2023	The Committee recognised the achievement and commended the work of the teams involved.

Committee Escalation Report

Workforce Operational Group Escalation Report No issues identified for escalation, updates provided on the work of the Core Skills training group and the work of the Healthier Teams MDT. OWG members had queried how any risks associated with moving training from roles would be managed. The Operational Group also received an update on the work of the Healthier Teams MDT	Colleagues were assured that the changed training requirements will not require additional time.	A new Team engagement and development tool is being launched in September 2023
Medical Staffing Recruitment and Retention Review An update was provided on the actions agreed following the MIAA review of systems and controls in place for the recruitment and retention of medical staff – all recommendations in the report have now been addressed	Progress to address the actions noted	
Medical Job Planning The Medical Director provided a briefing on the allocation of activity in relation to the 2003 Consultant contract – this was in response to a request for assurance about the management of consultant contracts and specifically the normal allocation of Supporting Professional Activity (SPA)	All senior doctor job plans are monitored, the panels provide assurance that the time allocation for non-clinical contact is consistent and in keeping with the policy	Committee members noted the report and were assured that the Trust is not an outlier in terms of the allocation of consultant activity
Freedom to Speak UP/NGO The Freedom to Speak up Guardian attended to share her report	The number of reports raised under FTSU has continued to increase and in addition the FTSU Guardian has been involved in targeted work within identified areas of the Trust. As at July 2023, 79% of staff had completed level one FTSU training	Report previously shared with the Board of Directors Regular reporting to Board will continue

Committee Escalation Report

BTH people Plan Draft People Plan received for comment ahead of presentation for Board approval		Plan scheduled for consideration and approval by the Board in November
Multi-professional Educational Governance Committee Report The Committee escalated a continued concern with regard to capacity for facilities and rooms for training.	Committee members noted the report – the concerns about facilities had previously been noted and are captured on the Risk Register A number of papers received by the MPEG Committee provided assurance about the quality of training provided and the experience of learners in the Trust	The Education team continue to monitor learner feedback to ensure students have a positive experience. Retention and return rates are monitored
Advise		
What	**So What**	**What Next**
Equality Improvement Plan - WDES & WRES and Gender Pay Report provided on compliance with the Workforce Race Equality Standard and the Workforce Disability Equality Standard with a separate report on the Gender Pay gap.	Committee members noted that there is a risk that employees from a BME background and those reporting a disability or long-term health condition are treated less favourably than those colleagues who are white, or not declaring a disability or long-term health condition.	An EDI action plan and dashboard is being developed – this will be presented to the Board in November 2023 Committee members also noted the data within the Gender pay gap report noting the difficulty of comparative data but agreeing with the need to ensure female employees are not treated less favourably than male employees
Staff Benefits Committee Update provided on the work of the Staff Benefit Committee	Update noted, change to the Terms of Reference approved	The Director of People and Culture will be the nominated Exec lead for the Staff Benefits Committee
Bank and Agency Tracker Committee members reviewed the data provided in the bank and agency tracker report	Committee members noted that utilisation of bank and agency staff remained above trajectory although had reduced in some areas	Further discussion at the Finance and Performance Committee
Other agenda items Reports were also received for information on Incorporating Quality Improvement (QI) to support Medical Recruitment and International Nursing Overview		

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Workforce Integrated Performance Report (IPR)

Meeting:	Board of Directors Meeting
Date:	2/11/2023

Author	Katy Coope, Executive Director of People & Culture					
Exec Sponsor	Katy Coope, Executive Director of People & Culture					
Purpose	Assurance	Y	Discussion	Y	Decision	N
Confidential y/n	N					

Summary *(what)*	**Advise** Workforce Performance Core Skills 91.2% against a target of 95% Appraisal 83.8% against a target of 90% Sickness Absence 6.64. % (Sept) 6.44% (rolling 12 months)

Implications *(so what)*	**Alert** Slight increase in Sickness Absence **Assure** We have seen the Core Skills and Appraisal workforce indicators maintained.

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

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NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Workforce Committee

September 2023

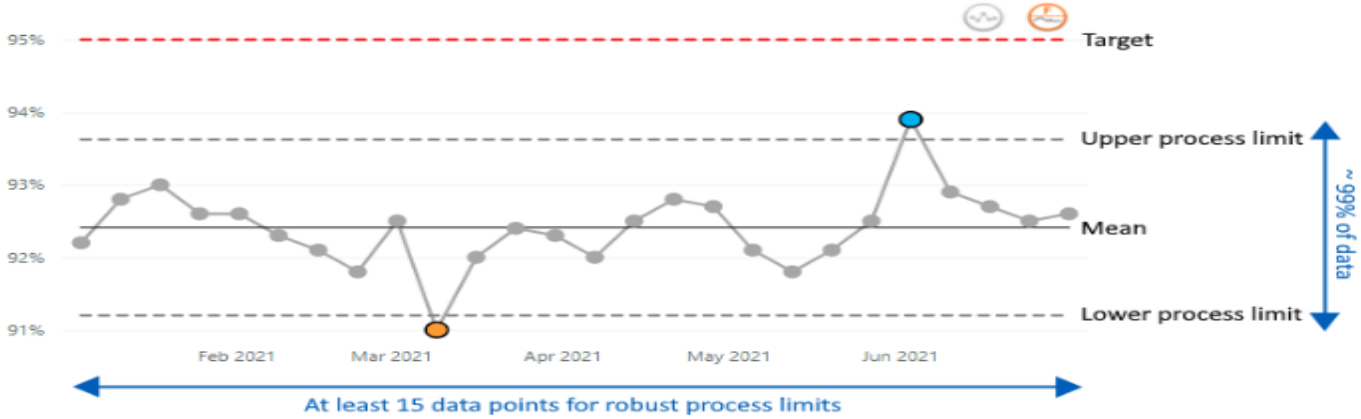
Guide to Statistical Process Control

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

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

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

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



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Executive Summary

		Assurance				Variation				
		P	?	F		H	L		H	
Workforce	Organisational Development		1	2	3	2		1		3
	Sickness, Vacancy and Turnover	5	7	2			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.
- P — Indicates that this indicator is consistently **passing** the target.
- F — Indicates that this indicator is consistently **falling** short of the target.

Variation

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

- Indicates that there is no significant variation recently for this indicator.
- L / H — Indicates that there is **positive** variation recently for this indicator.
- L / H — Indicates that there is **negative** variation recently for this indicator.
- Special cause variation where **UP** is neither improvement nor concern.
- Special cause variation where **DOWN** is neither improvement nor concern.
- Special cause or common cause cannot be given as there an insufficient number of points. Assurance cannot be giv as a target has not been provided.

Organisational Development

Core Skills
Assure
- Trust compliance in September 2023 was 90.92, a marginal decrease from 91.35%, in August 2023. This is against a target of 95%.
- 3 out of 5 clinical divisions increased compliance in September 2023. CSS decreased by just 0.2%, and IMPF by 0.5%
- IMPF, the only clinical division to decrease compliance in August 2023, has this month increased, marginally 90.62%-90.63%.
- When role specific training is included, compliance decreases by just 0.15% from 91.35% - 91.20%
- Since the start of the financial year, compliance for CSTF and role specific training has increased by 3.19%
- Compliance with core skills training is monitored monthly at the divisional PIDA meetings and appropriate action plans implemented.
- The Trust has submitted realignment to the CSTF.

Advise
- A new member of staff has been appointed to the Health and Safety Team. Part of their role, once trained, will be to deliver practical conflict resolution training.
- There are currently 5371 members of staff that are allocated the practical conflict resolution training (dealing with violence and aggression). The training tends to be allocated to patient-facing staff. The Core Skills and Role Specific Steering Group have discussed with the H&S Team whether it is deemed necessary for all those currently allocated, or whether the more high-risk areas should be targeted, and other areas either via a risk assessment or when requested. A decision has not yet been agreed.
- There is a paper going to Execs in the next couple of weeks to raise their awareness of the additional training that all staff need to complete. It will advise Execs that all staff need to complete the following training:
- Dementia training (tiers 1 and 2)
- Learning Disability & Autism (including reference to the Oliver McGowan training)
- PSIRF
- NHS Patient Safety Syllabus levels 1 and 2 training
- Counter Fraud Awareness

Alert
- The M&H Trainer has reported that Trainee Drs have been told that they are required to undertake the L2 practical training at BTH. This is being investigated.
- If the additional training for all staff to complete is approved, this will result in staff being required to complete an additional 5-6 hours training, dependent upon role.
- There has been pushback from across the ICS from staff with regards to the amount of training that is required. A shared spreadsheet is to be devised to populate what each Trust has mandated.

Non-Medical Appraisals compliance

Assure
- Non-medical appraisal compliance remains at 83%, with a target of 90%.
- Four out of five clinical divisions have seen an increase in non-medical appraisal compliance levels, with SACCT achieving the 90% target, and Tertiary exceeding the target.
- CSS – 72% - 74%
- IMPF – 83% - 84%
- SACCT – 87% - 90%
- Tertiary – 94% - 96%
- FICC – 91% - 88%

Advise
- Feedback from staff about the new system continues to be positive.
- It has been advised that any technical issues with the appraisal system should be logged via ICT support.
- 44 members of staff have been trained over 4 sessions. A further 4 additional dates have been advertised.

NEXUS

Commitee

- Performance
- Quality
- Workforce

Division

- IMPF
- SACCT
- Tertiary
- FICC
- CSS

Sign Out

Workforce

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Core Skills Training Compliance %	95%	91.2%	Sep 23	H	F	95%	91.4%	Aug 23		
Data Security & Awareness Training (%)	95%	92.8%	Sep 23		?	95%	93.0%	Aug 23	95%	92.8%
Appraisal Completeness %	90%	83.8%	Sep 23	H	F	90%	84.2%	Aug 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%

NEXUS

Commitee

- Performance
- Quality
- Workforce

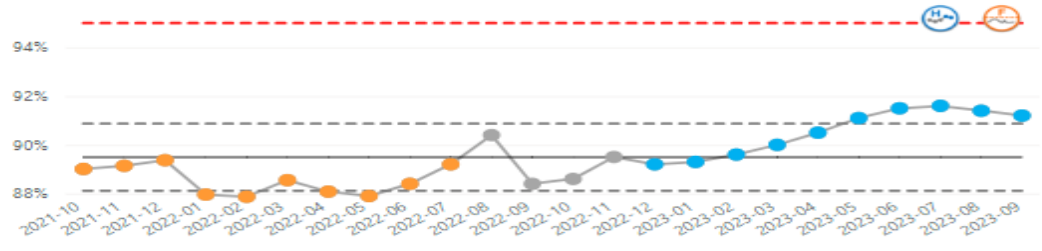
Division

- IMPF
- SACCT
- Tertiary
- FICC
- CSS

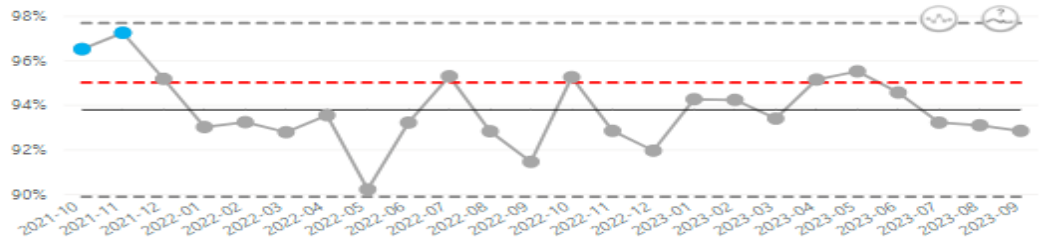
Sign Out

Workforce

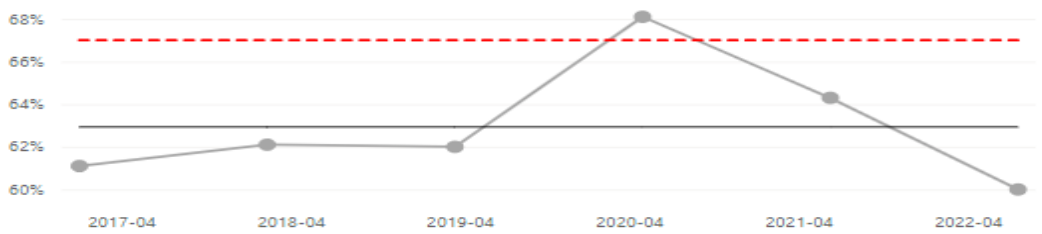
Core Skills Training Compliance %



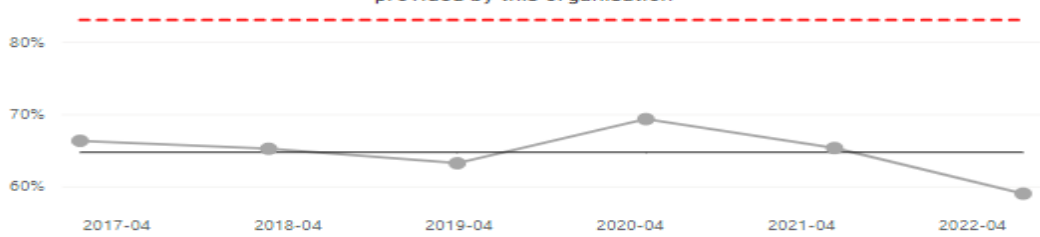
Data Security & Awareness Training (%)



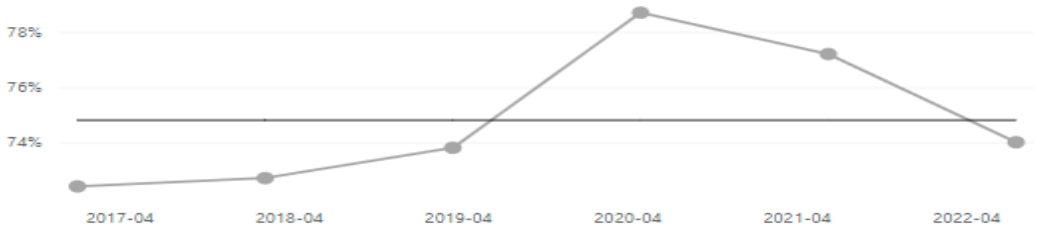
Staff Survey - I would recommend my organisation as a place to work



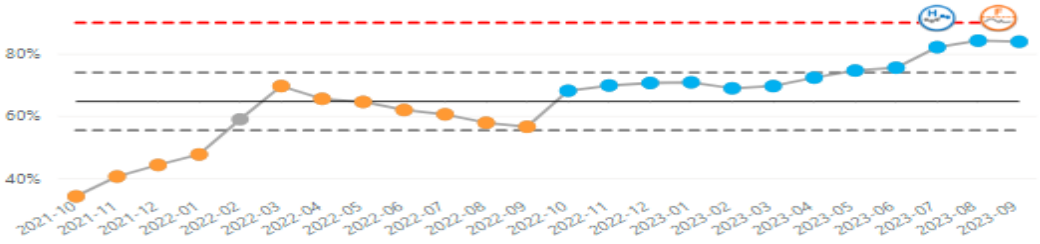
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



Staff Survey - Care of my patients / service users is my organisations top priority



Appraisal Completeness %



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 and we have over 230 more staff in the Trust than in the same month in 2022.

Advise:
• Current vacancy rate for all staff is 8.21% which is a slight improvement on the position in August which was 8.32%
• The target is 4.50%
• The nursing trajectory shows the Trust closing the gap in December 2023

Alert:
• We remain above the vacancy rate and this is likely to continue due to the increased establishments which the Trust is now trying to bridge. Recruitment of medical and nursing staff, which is where the establishment increases has been, takes longer and can generally be more challenging than other groups
• There are still over 140 medical vacancies gaps in the Trust, however there are 9 new starters in November, and 48 in the next 5 months- although there will also still be leavers that must be factored in.
• It is unlikely that full establishment will be reached in 2024 however we anticipated reducing our vacancy gap by at least 50% by the middle of the year when compared with the position in month

Turnover

Assure:
• Turnover rates should continue at their current levels which remains significantly below the 11% target

Advise:
• Turnover overall in September was 7.81% and 7.9% in August
• 20 new nursing/midwifery staff joined in September and 11 medical staff
• 9 Nursing and midwifery staff left in September, although 5 of those are retire and return; one end of fixed term contract and 3 resigned to relocate
• 3 Medical and dental staff left, including one Consultant

Alert:
• Discussion in November within MRR will focus on Agency spend reduction and recruitment of permanent solutions

Time to Hire:

Assure:
• Average time to hire is currently 9.91 weeks which is significantly below the 12 weeks target and is anticipated to continue below target

Advise:
• This is an improved position from the position in August, which was 10.04 weeks

• Our time to hire can be impacted by overseas recruitment and this is a core pipeline for medical and dental and nursing, although the nursing pipeline will cease in its current form in January 2024

Alert:
There are vacancies and sickness within the recruitment team which may impact on time to hire, however we have diverted resource, where possible, from other teams particularly to help focus on Medical Recruitment within IMPF.

NEXUS

Commitee

- Performance
- Quality
- Workforce

Division

- IMPF
- SACCT
- Tertiary
- FICC
- CSS

Sign Out

Workforce

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Sickness % - Rolling 12 Months	6%	6.44%	Sep 23		F	6%	6.42%	Aug 23		
Sickness % - All Staff (In Month)	6%	6.64%	Sep 23	L	?	6%	6.48%	Aug 23		
Sickness % - Medical Staff (In Month)	6%	1.72%	Sep 23		P	6%	1.78%	Aug 23		
Sickness % - Nursing Staff (In Month)	6%	7.09%	Sep 23		?	6%	6.9%	Aug 23		
Sickness % - AHP (In Month)	6%	5.9%	Sep 23		?	6%	5.01%	Aug 23		
Sickness % - Not related to Covid 19 Trust (In Month)	6%	6.6%	Sep 23		?	6%	6.4%	Aug 23		
Turnover % - All Staff (Rolling 12 months)	11%	7.81%	Sep 23	L	P	11%	7.86%	Aug 23		
Turnover % - Nursing & Midwifery (Rolling 12 months)	11%	5.31%	Sep 23	L	P	11%	5.48%	Aug 23		
Turnover % - AHP (Rolling 12 months)	11%	6.39%	Sep 23	L	P	11%	6.65%	Aug 23		
Vacancy Rate % - All Clinical Staff	4.28%	9.01%	Sep 23	H	?	4.28%	9.5%	Aug 23		
Vacancy Rate % - Medical Staff (Excluding Deanery Drs)	4.28%	20.5%	Sep 23	H	F	4.28%	19.9%	Aug 23		
Vacancy Rate % - Nursing & Midwifery Staff	4.28%	8.68%	Sep 23	H	?	4.28%	9.51%	Aug 23		
Vacancy Rate % - AHP	4.28%	11.9%	Sep 23	H	?	4.28%	13.1%	Aug 23		

NEXUS

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Sign Out

Workforce

	Latest					Previous			Year to Date	
Indicator	Plan	Actual	Period	Variation	Assurance	Plan	Actual	Period	Plan	Actual
Time to Recruit (Weeks)	12	9.9	Sep 23			12	10.04	Aug 23	12	9.9

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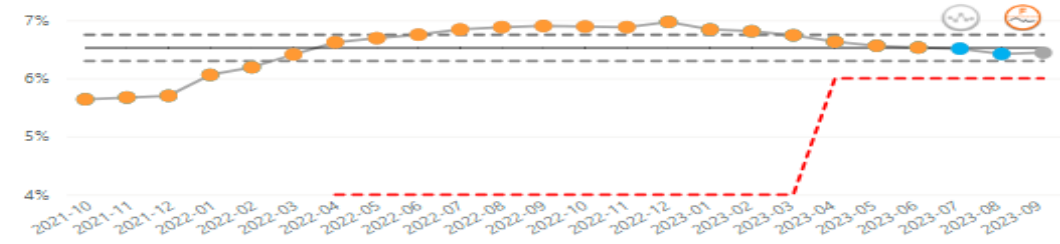
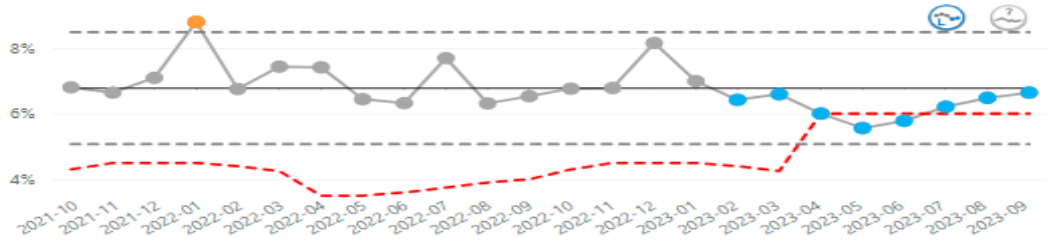
Workforce

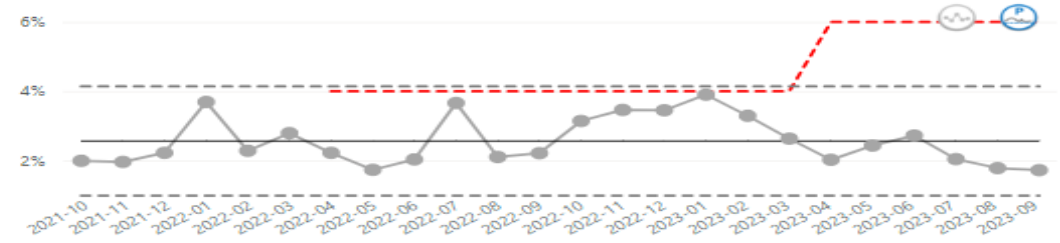
Sickness % - Rolling 12 Months



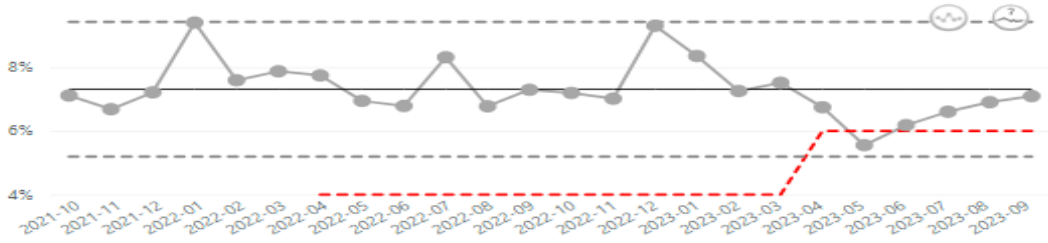
Sickness % - All Staff (In Month)



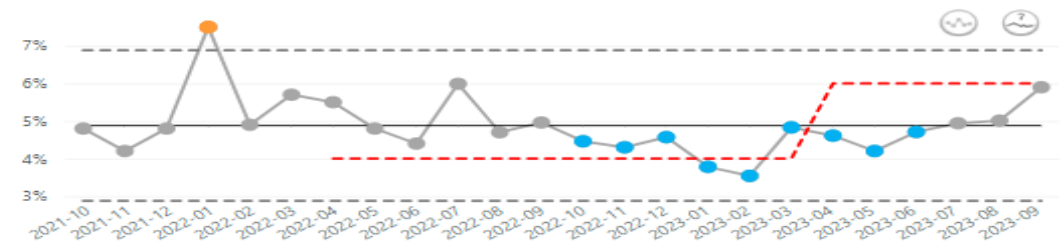
Sickness % - Medical Staff (In Month)



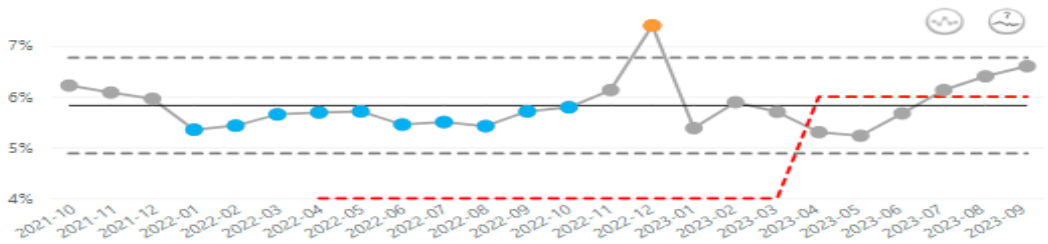
Sickness % - Nursing Staff (In Month)



Sickness % - AHP (In Month)



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



NEXUS

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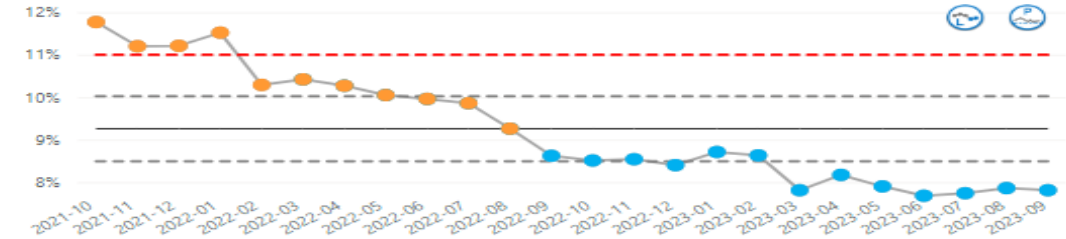
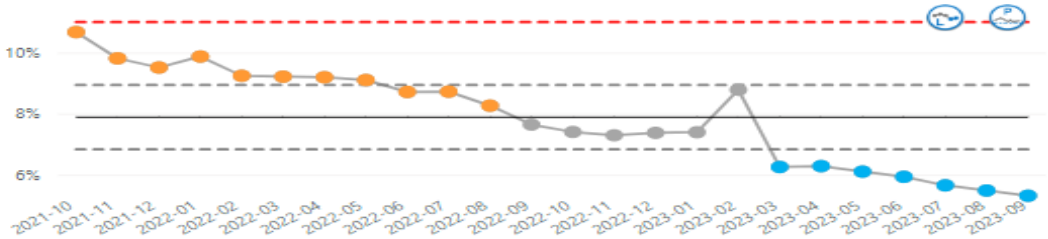
Workforce

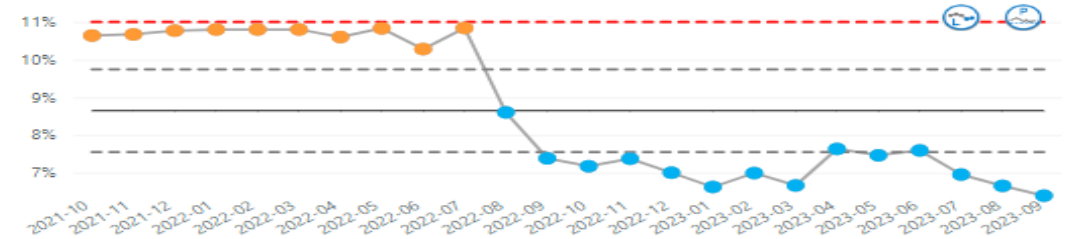
Turnover % - All Staff (Rolling 12 months)



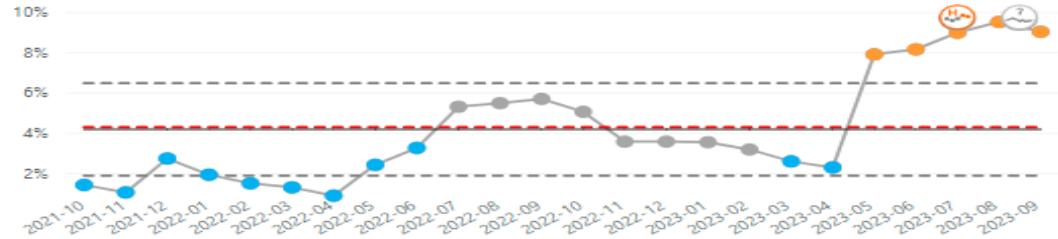
Turnover % - Nursing & Midwifery (Rolling 12 months)



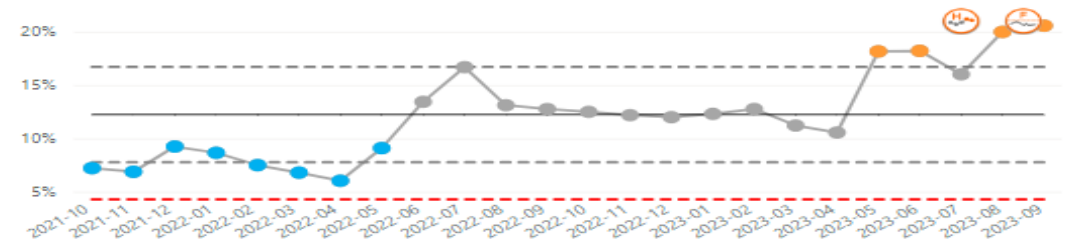
Turnover % - AHP (Rolling 12 months)



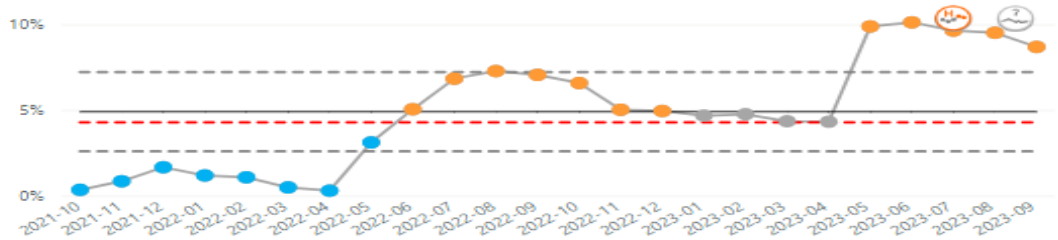
Vacancy Rate % - All Clinical Staff



Vacancy Rate % - Medical Staff (Excluding Deanery Drs)



Vacancy Rate % - Nursing & Midwifery Staff



NEXUS

Commitee

- Performance
- Quality
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Division

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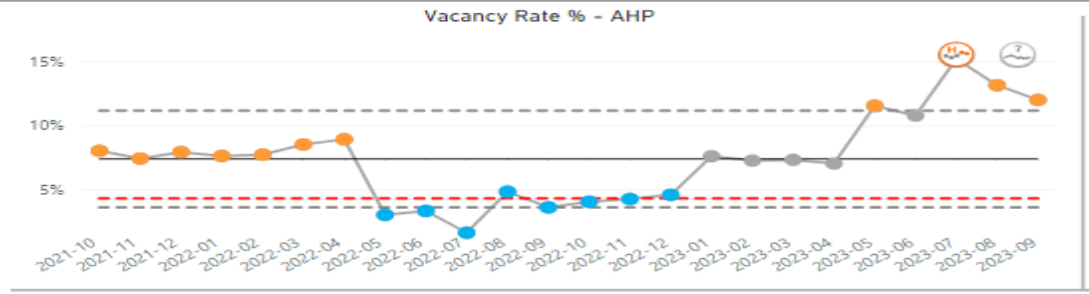
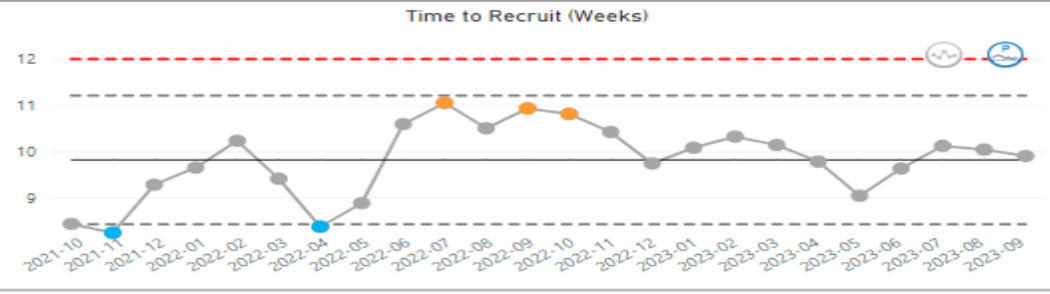
Sign Out

Workforce





Blackpool Teaching Hospitals NHS Foundation Trust

Title	Freedom to Speak Up Report

Meeting:	Board of Directors
Date:	2nd November 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 **July 2023 and September 2023 (Q2).** 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. An action plan has been included as part of the breaking barriers survey from the FTSU team.

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 Q2 2023/2024

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 **July 2023 and September 2023 (Q2)**. The report contains information on the numbers of staff reporting concerns, emerging themes, actions taken and priorities moving forward.

The workplan for **Quarter 3** 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.
- Recruit and train further Champions from across the organisation
- FTSU month throughout October
- Develop a training programme for managers and leaders on responding to concerns.
- Build communications around the trusts mediation service and working across the ICS for more efficient mediation to take place
- Undertake further FTSU Reviews in targeted and agreed areas.
- Attend fundamentals of care sessions
-

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 **July 2023 and September 2023 (Q2)**. 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 2 Concerns Overview

For the period of Quarter 2 a total number of 62 concerns were raised via the Freedom to Speak Up Guardian. This was another increase from last year.

There are currently **43** open cases for 2023/24

Theme	Count
Potential bullying and harassment	33
Work Related Issues	34
Patient Care/Safety	5
Conduct	1
HR Issues	2
Discrimination	2
Lack of training	1

Staff Group	Count
AHP	4
Medical & Dental	3
Nurses & Midwives	15
Admin & Clerical	22
Additional Clinical Services	10
Estates & Ancillary	2
Anonymous	7
External	2

Year on year overview

2021/2022	Q1	Q2	Q3	Q4	Total
Total number of concerns raised	17	14	16	19	66
Number of those raised anonymously	10	1	1	3	
Cases with elements of patient safety/quality	0	4	2	3	
Cases related to behaviours including bullying & harassment	13	8	5	9	
Cases where people indicate that they are suffering detriment as a result of speaking up	0	0	1	1	

2022/2023	Q1	Q2	Q3	Q4	Total
Total number of concerns raised	62	56	87	83	288
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	

2023/2024	Q1	Q2	Q3	Q4	Total
Total number of concerns raised	82	62			
Number of those raised anonymously	1	7			
Cases with elements of patient safety/quality	22	5			
Cases related to behaviours including bullying & harassment	51	33			
Cases where people indicate that they are suffering detriment as a result of speaking up	1	0			

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'.**

FTUG sent out a trust wide survey for colleagues to anonymously fill out and state what they felt the barriers were in them speaking up. See attached document

The responses have been grouped into themes and the FTSUG has created an action plan on how we can remove these barriers for our staff.

7. Conclusion

A total of sixty two concerns were raised during Q2 2023/2024. 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.

Breaking FTSU Barriers Action Plan

Theme/Barrier	Action	Activities	Action Lead	Timescale	Success Metric
Lack of confidence in management	Responding to speaking up programme for managers Upskilling managers	Monthly training for managers on responding to concerns Link to leadership programme and behavioural framework	Lauren Staveley (FTSUG)	Ongoing	Less workers coming through the FTSU service and more concerns being raised and resolved with managers
Fear of repercussion	Develop clear guidance on detriment	Link with NHSE, NGO and regional network	Lauren Staveley (FTSUG) and Katy Coope (exec sponsor for FTSU)	Ongoing	More workers speaking up Less formal complaints around detriment
Negative responses from managers, made to feel like a trouble maker, detriment on career progression	Upskilling managers Zero tolerance	Monthly training for managers on responding to concerns. Link to leadership programme and behavioural framework	Lauren Staveley (FTSUG)	Ongoing	Staff survey Trust wide surveys
No actions when speaking up	Development of feedback communication tool kit Development of lessons learnt tool kit. Share worker stories and lessons learnt via comms, teams brief, board and WAC	Link to responding to concerns programme. Share lessons learnt to managers for real life scenarios	Lauren Staveley (FTSUG)	Ongoing	Staff survey Fewer cases the FTSU service Fewer cases raised to FTSU because tried to escalate via other routes first and no action
Agency, bank, student, community worker	Engaging more with other workers, FTSU to develop other communication channels to capture other workers Recruit more champions from different worker groups	Link with universities, temporary staffing, and retinue	Lauren Staveley (FTSUG)	Ongoing	More workers from these areas speaking up
Lower banded workers feeling dismissed by senior staff	Reassurance from trust board	Comms Teams brief	Trust Board	Ongoing	Lower banded staff speaking up
Breach of confidentiality	Upskill workers amongst the trust on confidentiality and ensure they are aware of the consequences of breaches	IG training compliance Clear guidance from speaking up perspective	Lauren Staveley and Katy Coope	Ongoing	Less detriments raised to FTSU/HR IG around breaches More workers speaking up
Managers not approachable	Emphasising other routes for worker to speak up	Continue to raise awareness of all routes for workers to speak up	Lauren Staveley	Ongoing	Less workers coming through the FTSU service and more concerns being raised and resolved with managers
'Normalised behaviours'	Behavioural framework Ongoing culture piece around respectfully challenging	Launch the Behavioural Framework and embed in Policy, Appraisal and Recruitment Develop the Behavioural Framework to provide a framework for Managers in relation to expectations and standards	Sharon Adams, Louise Ludgrove and Katy Coope	Ongoing	Less bullying and harassment concerns raised to FTSU/HR/Managers
Managers are friends with a lot of colleagues	Empowering confidence to workers to speak up or re-escalate if not satisified	Develop the Behavioural Framework to provide a framework for Managers in relation to expectations and standards	Sharon Adams, Louise Ludgrove and Katy Coope	Ongoing	Less workers coming through the FTSU service and more concerns being raised and resolved with managers
Fear amongst nursing colleagues, perception of don't speak up culture	FTSUG to meet monthly with DDON's to triangulate data	FTSUG to work with the RCN Staff Side representative to understand and develop interventions to support speaking up	Lauren Staveley and DDON's	Ongoing	More pro-active approaches happening to 'nip it in the bud' Early warning signs and action planning
Managers being too busy and no time	Responding to speaking up programme for managers Upskilling managers	Monthly training for managers on responding to concerns Link to leadership programme and behavioural framework	Lauren Staveley (FTSUG)	Ongoing	Less workers coming through the FTSU service and more concerns being raised and resolved with managers

Breaking FTSU Barriers Action Plan

Not being believed	Escalating to a safe route and being thanked. Do not need evidence to raise a concern – emphasise this message	Link to responding to concerns programme. Share lessons learnt for real life scenarios	Lauren Staveley (FTSUG)	Ongoing	Staff survey Trust wide surveys

Title	**Improving workforce inclusion through the delivery of a unified Inclusion Action Plan.**

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

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

Summary *(what)*	**Advise** Developing a diverse, inclusive, and supportive culture is a key priority for Blackpool Teaching Hospitals. It is the right thing to do for patient care, our people, and the local population we serve. Plans are already in place to improve the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) Gender Pay Gap (GPG), and to tackle Health Inequalities. Further plans must be developed to deliver actions in the EDI Improvement Plan, Anti-Racist Framework, and NHS Sexual Safety Charter. This paper provides the Board of Directors with assurance that the Trust's responsibilities will be met through the introduction of a unified inclusion plan that will simplify programmes of work, remove duplication, and increase impact through a more focused approach.

Implications *(so what)*	**Alert** There is a risk that employees with protected characteristics, particularly from a BME background and those reporting a disability or long-term health condition are treated less favourably than those colleagues who are white, or do not have a disability or long-term health condition. Less favourable treatment is known to have a negative impact on wellbeing, belonging and engagement, which may in turn adversely affect

	sickness and retention and engagement levels, thereby indirectly impacting on patient outcomes.
	Assure
	The development of a unified inclusion action plan will provide more effective and efficient delivery of the programmes of work within the inclusion portfolio. This plan forms part of the Trust's Culture Improvement Programme. Delivery will be monitored through the Workforce Programme Board, which in turn reports to the System Transformation Committee (STC).

Previously considered by	The following standalone papers have already been approved by the Executive Team: • Delivering the EDI Improvement Plan: Executive Board (Sept. 2023) • Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES): Workforce Assurance Committee (Sept. 2023) • Gender Pay Gap: Workforce Assurance Committee (Sept. 2023) • Anti Racist Framework: Executive Board (July 2023) • Health Inequalities Action Plan: Executive Board (March 2023) Actions from these papers have been integrated into the unified inclusion plan.

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

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

Proposed Resolution ***(What next)***	It is recommended that the Board of Directors: • Support the commitment to and implememation of the unified inclusion plan. • Agree to receive a progress update in six months via Workforce Assurance Committee.

1. Introduction

1.1 A recent audit of the WRES, WDES and GPG action plans identified considerable overlap in the objectives outlined in each plan produced.

1.2 The development of additional action plans for the EDI Improvement Plan, Anti-Racist Framework, NHS Sexual Safety Charter, and Model Employer programmes of work would result in five different inclusion delivery plans. This could prove confusing both to communicate to the workforce and to deliver on.

1.3 It was therefore identified that the development of a unified inclusion plan would remove this duplication; enabling focus on delivering fewer key, high impact programmes of work that will effectively improve workforce inclusion measures more rapidly.

2. Background

2.1 All providers are required to analyse workforce data and implement annual action plans as follows:

Measure	Requirement	Standard	Trust Governance	Annual Reporting Dates
Workforce Race Equality Standards (WRES)	Annual data submission and action plan	NHS standard contract	Workforce Assurance committee	Data: 31st May 2024 Action Plan: 31st October 2024
Workforce Disability Equality Standards (WDES)	Annual data submission and action plan	NHS standard contract	Workforce Assurance committee	Data: 31st May 2024 Action Plan: 31st October 2024
Gender Pay Gap (GPG)	Annual data submission	Legal requirement for all employers	Workforce Assurance committee	Data: 30th March 2024

2.2 The Trust must also make progress towards the actions outlined in the following cultural programmes of work:

Measure	Requirement	Standard	Trust Governance
EDI Inclusion Plan	Framework detailing six timebound High Impact Actions.	Provider Requirement from NHS England	Workforce Assurance Committee & Strategic Transformation Programme Board
Anti-Racist Framework	The Trust is working towards bronze accreditation	NW BAME Assembly	Workforce Assurance Committee & Strategic Transformation Programme Board
NHS Sexual Safety Charter	Ten standards that must be in place by July 2024.	Requirement from NHS England	Workforce Assurance Committee & Strategic Transformation Programme Board

2.3 The Secretary of State for Health and Social Care has recently directed that inclusion is everyone's responsibility, and activity should be addressed through normal management processes, rather than external providers or dedicated roles. The approach outlined in the unified inclusion plan aligns to this expectation by working with subject matter experts to integrate inclusion activity into existing practice.

2.4 An ICS wide inclusion steering group has recently been established. Scoping is underway to identify what activity might be delivered collectively, in line with the Secretary of State's

direction. As this workstream develops, the unified inclusion plan will be reviewed and updated.

4. Proposed Actions

4.1 A timebound unified inclusion plan has been developed, integrating actions from the following standards:

- Anti-Racist Framework
- EDI Inclusion Plan
- Gender Pay Gap
- Model Employer targets
- NHS Sexual Safety Charter Standards
- Workforce Race Equality Standards
- Workforce Disability Equality Standards

4.2 Regular reporting for individual programmes of work will continue in line with Trust governance processes via the Workforce Assurance Committee programme, with identified risks added to the Board Assurance Framework (also monitored at Workforce Assurance Committee).

4.3 Progress towards meeting the unified inclusion plan will be monitored monthly through the Workforce Programme Board, which in turn reports to the System Transformation Committee (STC).

4.4 The Trust's will concurrently publish its vision for inclusion. This will set out the key strategic priorities that underpin the unified inclusion plan, ensuing the workforce is clear on what is being done to improve inclusion and belonging at Blackpool Teaching Hospitals.

4.5 It is acknowledged that the unified inclusion plan is a dynamic document, which will be updated as additional key priorities are identified.

5. Delivering the Plan

5.1 Priority programmes of work have been identified for delivery by March 2024 as follows:

- Achievement of Bronze level accreditation for the Anti-Racist Framework.
- Review of recruitment practices to guarantee an inclusive and accessible experience for candidates throughout the hiring process.
- Development of a methodology by which "Model Employer" trajectories will be (representative levels of leadership for Black and Minority staff at Bands 8a and above)
- Improved menopause support available to staff.
- Refreshed onboarding and induction programme for international staff.
- Relaunch of staff networks to increase workforce awareness and attendance levels.
- Launch of Zero Tolerance campaign (aligned to racism and sexual safety).

6. Conclusion

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

Analysis of existing workforce data has highlighted areas for development, while the recently published anti-racist framework and EDI Improvement Plan provide the Trust with a framework for taking action to improve the sense of belonging among our workforce.

Work is underway to develop a Trust Strategic Inclusion Plan. Once drafted, this will be socialised through a series of staff engagement events, and with Staff side colleagues and staff networks. The finalised plan will be presented to Executive Colleagues in December, with a launch planned for January 2024.

Given the limited resources to deliver these important programmes of work, it will be vital to maximise productivity and impact when delivering the actions identified. The unified inclusion plan will help to meet this aim.

Actions contained within the unified inclusion plan have been mapped to the key inclusion standards the Trust must meet. Delivery will be led by subject matter experts and delivered in partnership with staff networks. Advocacy will be sought from staff side colleagues. It is anticipated that, as the Trust learns more and grows in strength and competency, the plan will evolve and improve.

The approaches contained within this paper are aligned to national and regional EDI priorities. Impact will be regularly monitored and measured through an Inclusion Dashboard. Progress will be reported through the STP Culture and Leadership Improvement Workstream, to the Workforce Programme Board.

7. Recommendations

7.1 The Board is asked to:

- Agree to the development and implememation of the unified inclusion plan.
- Agree to receive a biannual progress report via the Workforce Programme Board.

Unified Inclusion Action Plan: 2023-25

HIA	Action/ Deliverable	Drivers/ Strategic Link	Key Success Indicators	Activities	Action Lead	Timescale	Progress	Success Metric
1	Measurable objectives on EDI for Chairs, Chief Executives and Board members.	EDI Imp Plan, Anti-Racist Framework, EDS22 Dom 3	a) Every Board and Executive Team member has a SMART EDI target in their appraisal. b) Board members can demonstrate how org data and lived experience has been used to improve culture. c) Boards have reviewed EDI data, identified areas for concern and prioritised actions. Actions are recorded on BAF. d) Exec EDI Sponsor has performance goals relating to anti-racism.	• Board members' Appraisals to be recorded on the non-medical appraisal system. • Bi-annual reporting on WRES/ WDES/ GPG. • Existing EDI data and actions reviewed and prioritised.	Board Led	All March 24 except b) b) March 25	• Appraisal system updated. • Exec HR Director JD now includes EDI accountability. • Staff stories presented at every WAC. • Regular review of organisational needs resulted in development of unified inclusion plan. Key actions will be integrated into the BAF. • Biannual reporting on WRES/ WDES/ GPG data and action plans in Trust governance framework.	• All Board members have a SMART EDI Target set during their Appraisal. • Deployment of unified inclusion plan.
2	Overhaul recruitment processes and embed talent management processes - that include setting aspirational targets to increase representation in recruitment, retention and progression, with a separate plan to increase leadership diversity.	NSS/ EDI Imp Plan, Anti-Racist Framework, WRES/ WDES/ NETS	a) Develop and Implement the Trust's Model Employer Strategy. b) Build on NHS England inclusive recruitment toolkit to develop Fair and Inclusive recruitment practices from development of job description to appointment. c) Use the Model Employer strategy to create leadership talent and career progression plan, working towards representational parity - initial focus on race and disability. d) Set and publish aspirational targets for recruitment, experience and development for minoritised black, mixed and disabled staff. e) Ensure succession plans are in place for all organisational and divisional senior leadership roles. f) All recruitment panels at Band 8a and above to have a female and Minority staff panel member. g) Job relevant equalities interview question/ competencies at Band 8a and above. h) ensure Black, Asian and Minority Ethnic talent is intentionally included across talent programmes and model employer targets. I) Create talent development and pipeline plan for BME Directors or associate non-executive director programme (year 2/3). j) Partner with the NW BAME Assembly to create a membership programme for BME talent (year 2/3.) k) Undertake a skills audit to identify gaps for Black and mixed staff at bands 7 upwards (yr. 2/3).	• Map workforce by band and ethnicity to identify where inequality is evident. • Set Model Employer targets to improve the recruitment, experience & development of minoritised black, disabled and ethnic staff. • Create leadership talent and career progression plans for Black and Mixed staff at bands 7 and above. • Train at least 15 EDR representatives to sit on interview panels. • Develop a "Managers' Guide to Inclusive Interview Practice" that includes advice on inclusive interview questions. • Work with divisions and corporate functions to develop effective succession plans • Monitor attendance of talent programmes by ethnicity and representation. • Complete a skills audit for black and mixed staff at band 7 and above.	Associate Director of Workforce Head of Wellbeing & Inclusion Head of Organisational Development	All by March 24, except I), j), k), by March 25	• A talent and career progression programme and implementation plan is scheduled for development. • Mapping exercise of diversity by band has been completed, and increased diversity targets for bands 8a and above have been drafted (Model Employer targets).	• Parity in access to career progression, training and development opportunities. • Year on year improvement in career progression for minoritised Black, Disabled and ethnic staff leading to parity over the life of the plan. • Year on year improvement in representation of senior leadership (8C and above) over the life of the plan. • Increased diversity in shortlisted candidates (to be developed in 2024/5). • Improved combined indicator score metric on quality of training (NETS).

Unified Inclusion Action Plan: 2023-25

3	Eliminate total pay gaps with respect to race, disability and gender.	EDI Imp Plan/ Pay Gap Reporting	a) Mend the Gap recommendations for medical staff implemented. b) Sustain improvement in gender, race and disability pay gap. c) Extend ethnicity pay gap analysis to include intersectional data by ethnicity, sex, gender, disability and sexual orientation. d) Launch a women's staff network. e) Review Clinical Excellence Award (CEA) distribution among the medical workforce to ensure women are not disadvantaged. f) Promote flexible working to the wider workforces, ensuring that men are equally able to benefit as women.	• Complete gap analysis of Trust practices against Mend the Gap recommendations, incl CEA awards. • Complete annual Gender Pay Gap report for 2022/3, including additional, intersectional data.	Associate Director of Workforce Head of Wellbeing & Inclusion Head of Medical Staffing	Mend the Gap by March 24 sex and race by March 24, disability by March 25, other protected characteristics by March 26	• Mend the Gap analysis underway by Medical Staffing Team. • Gender Pay Gap Report for 22/3 under development for consideration by November Workforce Assurance Committee. • Chair identified for Women's Network. Launch of Network planned Jan '24. • Flexible working requests now centrally triaged and reported monthly to WAC. • Analysis of CEA data underway by medical staffing team.	• Year on year reductions in the gender, race and disability pay gaps. • Successfully established women's network. • Centrally triage flexible working requests and monitor acceptance rates. • Gender Pay Gap data indicates equal CEA payment ratio between men and women.
4	Address Health Inequalities within the workforce - improve workforce health and wellbeing.	EDS22 Dom2 / NSS, NETS	a) Line managers and supervisors routinely have regular and effective wellbeing conversations with their teams. b) Workforce support is available for staff to manage conditions such as obesity, diabetes, asthma, COPD and mental health (aligned to public health priorities.) Uptake and impact monitored. c) Menopause support readily available in the workplace with uptake monitored and % of women over 50 in work tracked. d) The 10 standards outlined in the Sexual Safety Charter are implemented	• Extend the Wellbeing Conversation training availability to all managers, ensuring it is embedded in divisional processes as "business as usual." • Align workforce support to local health inequalities, monitoring uptake by intervention. • Produce a menopause support package for staff, with resources designed in partnership with menopause cafe members.	Associate Director of Workforce Head of Wellbeing & Inclusion Head of Occupational Health	All actions in progress by Oct 23	• Wellbeing conversation training programme extended as part of the Winter Well campaign. • Wellbeing programmes of work aligned to Trust Health inequalities plan and monitored by uptake, with monthly report provided to senior team. • Menopause support package launched including menopause cafe, monthly drop-in sessions, and managers' training. • Trust is working towards menopause friendly accreditation (date tbc). • The Trust has pledged its commitment and signed up to deliver the NHS Sexual Safety Charter.	• Increase in positive response to NSS question: " the organisation takes positive action on staff health and wellbeing." • Improved National Education and Training Survey (NETS). .Combined Indicator Score metric on quality of training. • Increase in number of women over 50 in work. • Trust awarded Menopause Friendly accreditation. • Sexual Safety Charter standards met.
5	Comprehensive induction, onboarding and development programme for internationally recruited staff	EDI Imp Plan, NSS, WRES	a) Reviewed and updated onboarding and induction provision for internationally recruited staff. b) Launch of cultural awareness package for use with line managers and teams welcoming international staff. c) Internationally recruited staff access development opportunities at the same level as non-international staff.	• Develop a working group to review current onboarding and induction provision for internationally staff, with a view to updating content. • Consult with the international workforce to better understand what cultural awareness would be beneficial for colleagues to know and identify any extra cultural awareness that may be helpful when caring for patients. • Monitor CPD/ development courses to ensure uptake by international staff is representative of the wider workforce.	Assistant Director of Human Resources Senior Resourcing Manager Head of Wellbeing & Inclusion	All actions by March 24	• CPD and development courses monitored by update to ensure representation.	• Improved sense of belonging for internationally recruited staff (NSS.) • Reduction in bullying and harassment of international staff from team/ line manager. • Equity in international staff accessing development opportunities. • 100% of managers and teams with international staff have engage with the cultural awareness content.
6	Eliminate the conditions and environment in which bullying, discrimination, harassment and	EDI Imp Plan, EQ Act update, Anti-Racist Framework, EDS22 Dom 2, WRES, WDES	a) Improvement in staff survey results on bullying/ harassment from line managers/ teams. b) Improvement in staff survey results	• Co-design and deliver a zero-tolerance campaign in partnership with staff networks. • with Occupational Health and the Staff Guardian to	Head of Wellbeing & Inclusion Associate Director of Human	All actions by March 2024	• Examples of zero tolerance campaigns collated from their Trusts for review. • Agreed launch date with comms of Feb 2024 to align	• Improvement in staff survey results on bullying/ harassment from line managers/ teams.

	physical harassment occurs		in discrimination from line managers/ teams . c) Improved engagement scores on recommending the organisation to work and receive treatment. d) Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source. Uptake monitored. e) Deployment of a zero tolerance to abuse campaign. f) Development of a processes to address instances of harassment, bullying or abuse within Trust disciplinary policy. g) Deploy Staff Guardian to incidents involving discrimination.	ensure that staff suffering from stress, bullying, abuse, harassment and physical abuse are made aware of support available and how to access it . Monitor uptake. • Partner with Human Resources colleagues to review processes to address instances of harassment, bullying or abuse within Trust disciplinary policy. • Monitor instances (anonymised) of incidents of discrimination reported to the Staff Guardian.	Resources Staff Guardian		with Equalities week. Occupational Health colleagues are currently reviewing how support information is made available to staff. • Staff Guardian prepares quarterly reporting, disaggregated by theme. • Relaunch of Staff Networks to support staff and inform Trust policy and practice	• Improvement in staff survey results on discrimination form line managers/ teams. • Improved Bullying and Harassment score metric (NETS). • 5 active, sustainable staff networks – each with an Executive Sponsor.
7	Improve representation and develop an accessible working environment and culture, enabling Blackpool Teaching Hospitals NHS Foundation Trust to become an employer of choice where all people can flourish.	Anti-Racist Framework, WRES. WDES, NSS	a) Equality Education programme for the Board to improve population health outcomes and tackle inequalities in access, experience and outcomes. b) 75% of Executive Directors have been part of a racial equality reverse mentoring programme. c) Stay interviews with Black and mixed staff band 8a+ introduced to discuss the reasons for staying. Collated and anonymised data to be shared with the People and Culture team and used to inform retention strategy. d) All senior leaders to attend intersectionality and anti-racism training. e) Update HR Attendance Policy to incorporate Reasonable Adjustments and Disability Leave. f) Review pool of managers trained to undertake investigations and take action to ensure representative of wider workforce.	• Scope, develop and deliver an Equality Education Programme for the Board. • Instigate a racial equality reverse mentoring programme for the Board. • Develop a stay interview programme for Black and mixed staff at Band 8a and above and feed back findings to HR SMT for discussion and action. • Develop intersectionality and anti-racism training, agree leaders who are in scope, together with delivery method. • Review feedback and refine training following initial cohort. • Convene a task and finish group to review and draft the new Attendance Policy to socialise with staff networks and staff side colleagues.	Director of Public Health Associate Director of Workforce Head of Wellbeing & Inclusion Head of Occupational Health Senior Manager for Resourcing. Divisional Triumvirates.	By March 25	• None to report.	• 100% of Board has attended equality Education training. • Minimum of 50% of Executive Directors have participated in Equality Reverse Mentoring Programme. • At least 75% of Black and Ethnic Minority staff at Band 8a or above have completed a stay interview. • Minimum 50% of managers has attended intersectionality and anti-racism training. • Profile of managers trained to undertake investigation training is representative of the wider workforce.

8	Ensure timely reporting and monitoring of workforce equality data	PSED, WRES, WDES, GPG, Anti-Racist Framework	a) A detailed breakdown by ethnicity of workforce will be presented to Workforce Assurance Committee and Staff Networks bi-annually, with the involvement of our culturally Diverse Staff Network. b) Trust Chair and non-Execs will be updated quarterly on progress towards the Bronze anti-racist award, disaggregated by granular ethnicity and sex to highlight disparity between groups. c) Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data. d) Bring together black, Asian and Minority Ethnic staff to review EDI progress and build any learning into the following year's plans. e) Senior Leaders convene 6 monthly listening into action sessions to hear the experiences of Black and Mixed staff first hand and commit to actions to address concerns. f)Increase staff declaration rates on ESR by 10%.	• Bi-annual reporting on workforce ethnicity to Workforce Assurance Committee and Staff Networks. • Quarterly updates provided to Chair and non-Execs on progress towards meeting the Bronze standards of the anti-racist framework. • Establishment of A WRES action group to monitor progress. • Biannual Big Conversations for Black and Minority Ethnic colleagues with commitment to addressing concerns with "You Said We did" updates. • Development of campaign to improve awareness of significance ESR declaration.	Associate Director of Workforce Head of Wellbeing & Inclusion	By March 24	• Quarterly Progress reports provided on Anti-Racist Framework journey	• Workforce ethnicity profile by band presented to Workforce Assurance Committee and Staff Networks bi-annually, highlighting retention and promotion percentages compared to the wider workforce. • Quarterly reports to board on progress made towards meeting the Bronze anti-racist award. • Biannual progress updates presented to the culturally diverse network for insight and input. • Creation of a cross-departmental WRES actions working group reporting back to Board biannually. • Senior Leaders convene 6 monthly listening into action sessions. • Increased declaration rates on ESR by 10% each year.

Key: Drivers/ Strategic Links:

Anti Racist Framework		Supporting all North West NHS organisations to become anti-racist by encouraging the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action.
EDI Improvement Plan		Sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.
GPG	Gender Pay Gap	The percentage difference between men and women's median hourly earnings, across all jobs. Employers must work to eradicate the gender pay gap and then eradicate any identified race and disability pay gaps.
Model Employer Plan		The NHS Long Term Plan requires Trusts to set targets for BME representation at bands 8a and above, which must be realised by 2028.
NSS	National Staff Survey	Offers a snapshot in time of how people experience their working lives, with an emphasis on wellbeing and engagement.
PSED	Public Sector Equality Duty	Requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when conducting their activities.
NHS Sexual Safety Charter		Aims to help eradicate sexual misconduct within the health care system. The charter commits the Trust to a zero-tolerance approach to inappropriate and harmful sexual behaviours in the workplace.
WDES	Workforce Disability Equality Standard	A set of ten specific measures which enables the Trust to compare the workplace and career experiences of disabled and non-disabled staff annually. Action plans must be formulated to improve areas of poor experience.
WRES	Workforce Race Equality Standard	The WRES requires NHS trusts and CCGs to self-assess performance against nine indicators of workplace experience and opportunity annually. Action plans must be formulated to improve areas of poor experience.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Blackpool Place update

Meeting:	Board of Directors Meeting in Public
Date:	02 November 2023

Author	Karen Smith, Director of Health and Care Integration, Blackpool					
Exec Sponsor						
Purpose	Assurance		Discussion	✓	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise**
	To ensure the Committee and Board of Directors are fully sighted on progression and next steps within Blackpool Place.

Implications *(so what)*	**Alert**
	Assure
	To ensure the appropriate items are discussed at the appropriate time.

Previously considered by	N/A

Link to strategic objectives	Our People	
	Our Place	✓
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	An underlying theme of Place-based partnerships is to improve people's health and wellbeing and reduce health inequalities that exist in Blackpool. It is not anticipated that this early work would adversely impact on key protected equality groups. Equality Impact Assessments will be undertaken as required.

Proposed Resolution ***(What next)***	The Place-based partnership is on a journey and this update is purely for information. Updates will continue to be provided as required.

Blackpool Place - update

November 2023

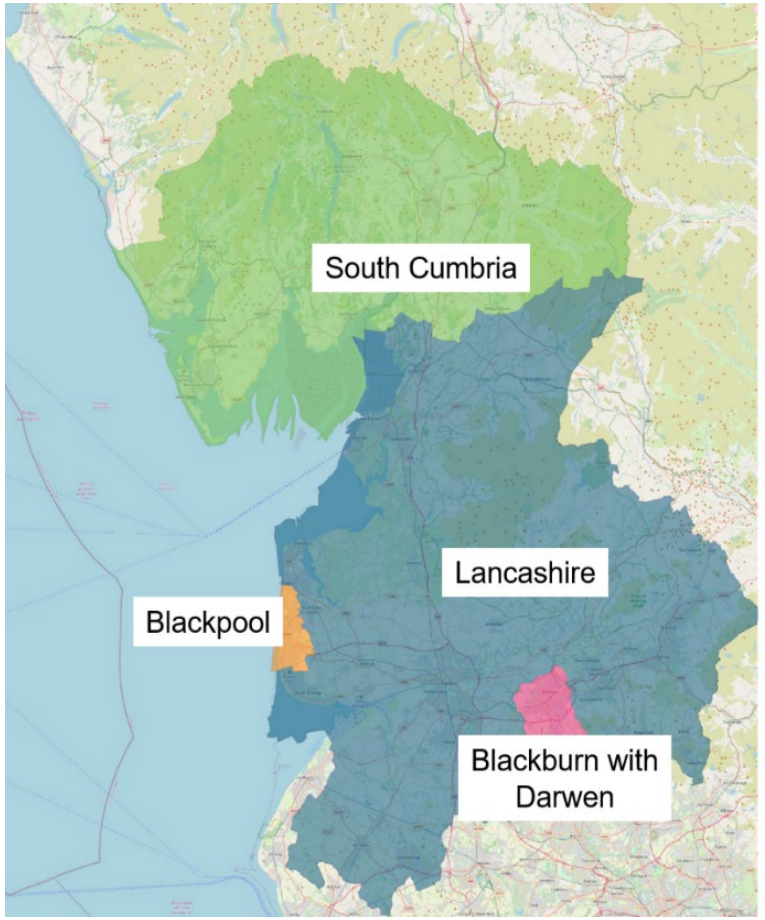
Karen Smith,
Director of Adult Social Services, Blackpool
&
Director of Health & Care Integration,
Lancashire & South Cumbria Integrated
Care Board (ICB)

Place-based partnership
Blackpool

Place-based partnerships

Enabling deeper integration with health and social care in Lancashire and South Cumbria

- In July 2022, the ICB realigned its place boundaries with the upper-tier and unitary local authorities within the footprint.
- This was to mirror adult social care arrangements to enable deeper integration.
- Blackpool is one of our four places.
- Due to its size, within Lancashire there are three delivery units east, central and west and north/coast.
- Karen Smith is the director of health and care integration for Blackpool at the ICB alongside Blackpool Council role. Steve Fogg is the Chair of the Blackpool Place-based partnership
- The ICB structure also allows for joint working with other places where it's beneficial and necessary to 'do things once'.



The ask of L&SC Places - making great headway …

Co-production and research programme – building on further

Listening to our communities

- Listen to the voice of communities to understand their diverse health & care needs, concerns, aspirations & 'what good looks e' from their perspective
- n from the lived experience of our ents and our workforce & ensure a oduction approach to design, ning & transformation

Collaborative leadership

- Create a collaborative leadership culture, bringing partners together and building strong working relationships, respecting & valuing unique abilities & contributions, holding each other to account for delivery of agreed outcomes

Blackpool is building on solid foundations

Monitoring our progress

- Monitor performance & quality, with a clear focus on outcomes, inequalities & resident perience of health & care services ctive in making use of data & ce from all partners to ensure we re we are making a difference & to llaborative decision- making

Key deliverable for 2023/24

Collaborative planning

- Create a shared vision, shared ambitions/objectives & joint delivery plans, aligned to the needs of the communities, the required delivery targets/standards & the Integrated Care Strategy
- Enact the principle of subsidiarity, decisions taken as close to local co as possible

Shared vision / ambition and priorities agreed

Developing our workforce

- Ensure an integrated workforce plan for community-based service delivery across the place
- Support the development of our workforce as move to a population health & care based e, with increased emphasis on wellbeing ention

A key element of our community transformation

Prevention, population health and wellbeing

- Ensure a population health & care based culture, with increased emphasis on wellbeing & prevention.
- Use a population health & care management approach to address current needs & inequalities, predict future challenges a design anticipatory support

Even further alignment with Pop Health programme

Collective use of resources

- Maximise opportunities for collective use of resources through aligning & pooling of budgets to support integrated delivery & maximise the use of community assets
- Proactively manage place resources within an agreed financial envelope, moving resources into wellbeing and prevention

Discussions underway re opportunities

Integrated delivery & transformation

- Integrate, with redesign & change where needed, community-based health creation & service delivery across sectors, organisations & professions, improving quality & outcomes, & maximising the use of resources (physical & financial)

Community services transformation commenced

Our ambition as Place partners: to improve healthy life expectancy for the people of Blackpool

Healthy Life Expectancy for both men and women in the country is the lowest of all local authorities in England (Source: ONS, Healthy Life Expectancy)

- Our priorities have been discussed with partners and have been shaped by considering the following:
  - Blackpool Council Plan priorities and key programmes
  - Blackpool Health and Wellbeing Strategy
  - Prevention and Health Inequalities strategy 2020-25
  - Health Equity Commission recommendations
  - LSC Integrated Care Partnership Priorities
  - The Lancashire 2050 Plan
  - Previous work and engagement relating to Fylde Coast Partnership priorities

- The Blackpool PBP draft priorities have been split into three areas:
  1. **Starting well** – First 1000 days, starting at conception, with a specific focus on parental breakdown
  2. **Staying well** – Respiratory across all ages with a specific focus on housing and smoking.
  3. **Education, employment and training** – Clarifying aspirations, opportunities and ambitions around our workforce; skills matching with the needs of our economy and a co-ordinated place offer with regards to school leavers

- **Transformation Programme** – Community services local transformation (already commenced)

Blackpool place priorities

1. Starting Well	2. Living Well	3. Living Well	4. Living Well	5. Ageing Well
Starting Well	First 1,000 days – specific focus on avoidable parental breakdown. Starts at conception	Employment Education & Training	Workforce – aspiration and ambition‘	Staying Well	Respiratory (all age) – specific focus on housing and smoking. Mild to moderate.
	School readiness		“Milk round” – a co-ordinated place offer for Blackpool school leavers		Mental Health and Wellbeing (all age)
			Skills match with economy’s need		
			Workforce opportunities		

Blackpool place priorities and alignment with ICP strategy priorities

Implementing other local initiatives e.g. Spring into Spring & Active into Autumn

Community Services	Community health and care system – local transformation programme

What are the responsibilities of our place-based partnerships In LSC?

Listening to our communities

- Listen to the voice of communities to understand their diverse health & care needs, concerns, aspirations & 'what good looks like' from their perspective
- Learn from the lived experience of our reside and our workforce & ensure a co-production approach to design, planning & transformation

Collaborative leadership

- Create a collaborative leadership culture, bringing partners together and building strong working relationships, respecting & valuing unique abilities & contributions, holding each other to account for delivery of agreed outcomes

Monitoring our progress

- Monitor performance & quality, with a clear focus on outcomes, inequalities & resident experience of health & care services
- Be proactive in making use of data & intelligence from all partners to ensure we know where we are making a difference & to support collaborative decision- making

Collaborative planning

- Create a shared vision, shared ambitions/objectives & joint delivery plans, aligned to the needs of the communities, the required delivery targets/standards & the Integrated Care Strategy
- Enact the principle of subsidiarity, with decisions taken as close to local communities as possible

Developing our workforce

- Ensure an integrated workforce plan for community-based service delivery across the place
- Support the development of our workforce as we move to a population health & care based culture, with increased emphasis on wellbeing & prevention

Prevention, population health and wellbeing

- Ensure a population health & care based culture, with increased emphasis on wellbeing & prevention.
- Use a population health & care management approach to address current needs & inequalities, predict future challenges and design anticipatory support

Collective use of resources

- Maximise opportunities for collective use of resources through aligning & pooling of budgets to support integrated delivery & maximise the use of community assets
- Proactively manage place resources within an agreed financial envelope, moving resources into wellbeing and prevention

Integrated delivery & transformation

- Integrate, with redesign & change where needed, community-based health creation & service delivery across sectors, organisations & professions, improving quality & outcomes, & maximising the use of resources (physical & financial)

Listening to our community …

Healthwatch Blackpool and Revoelution recently undertook deep dive community activities in the five Blackpool Priority Wards -

Our priority wards are:

- Bloomfield
- Claremont
- Talbot
- Tyldesley
- Park

Over 700 doors were knocked on.

Over 400 people shared their experiences. Discussions took place in peoples' own homes and/or in community-based focus groups.

14 themes were identified from the experiences that people shared, from –

- access to health and care,
- to the cost-of-living crisis,
- to the challenges of social isolation …

The voice of our community is helping to shape our next steps

What's next for Blackpool Place development?

Three Big Questions…

1) What will be planned and delivered in Place – what responsibilities will L&SC Places have in the new system?
2) What resources and delegations will Place receive to enable them to deliver on these responsibilities?
3) How will this clarity enable places to link up the functions of the ICB at a local level? (From Population Health to Primary Care to Urgent and Emergency Care, Adult Health and Care etc)

The answer to all of these questions is being considered as part of the Place Integration Deal…

The L&SC Place Integration Deal

Working with the three other L&SC places and as approved at L&SC ICB Board in July 2023;

- The Lancashire and South Cumbria integration place deal will set out the way in which places will operate within NHS Lancashire and South Cumbria Integrated Care Board arrangements.

- It will describe:
  - The expectations of places - what we agree should be planned and delivered in places
  - The resources that places will receive from the ICB to deliver these expectations – delegations, people and funding allocations
  - The ways of working that will enable the primacy of place and the principle of subsidiarity to be enacted successfully – how places will interact with the ICB directorates and how decision-making will happen between partners in each place

- Underpinning our plan is the assumption that planning and delivery will happen at place unless required as one of these three subsidiarity tests:
  - Working at scale is necessary to achieve a critical mass to get the best outcomes.
  - Where variation in outcomes is unacceptably high and working together will help to reduce variation and share best practice.
  - Where working at scale offers opportunities to solve complex, intractable problems.

What does this mean for Blackpool ?

- **Delegations from the NHS could enable us to integrate services more effectively and faster, reduce duplication, and make services more joined up for our residents -**
- We can use our ‘health and care integration deal’ to get the right delegations which enable us to achieve our vision for residents and communities – bringing decision-making closer to our communities
- This would enable us to integrate this NHS provision with other services in both the planning and delivery of them (such as Blackpool Council services and VCFSE services, for example). We will want to think about the opportunities this creates for us within Blackpool.
- To start this conversation, we have been considering and working through potential delegations from the ICB to Place and from a practical point of view: how this can be undertaken and via what mechanisms.
- This will all be undertaken in a staged way and will be a 2-3 year journey.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	BTH Seasonal Demand Plan – Winter 2023/24

Meeting:	Board Meeting
Date:	02.11.2023

Author	Rachel Crane, Deputy Director of Strategy and Transformation Kelly Jackson, Associate Director of Planning and Delivery					
Exec Sponsor						
Purpose	Assurance	X	Discussion	X	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise**
	The winter period is a nationally recognised pressure point across the NHS. The Blackpool Teaching Hospitals (BTH) Trust wide Winter Plan sets out the organisation's arrangements for the 2023-24 winter period for adult services. The plan sits as part of the wider Lancashire and South Cumbria System and Place Based plans. The purpose of the plan is therefore to ensure internal processes, systems and capacity can meet demand and maintain/optimise patient safety and experience. The BTH plan focusses on: • Providing safe, high quality, efficient services. • Creating the capacity to meet demand, occupancy levels and maintain flow. • Establishing clear pathways for the management of COVID-19, Influenza, and non-respiratory illness patients. As demonstrated in the Trust's Escalation Policy. http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-SOP-055.docx • Enabling timely patient access and experience, delivery of national/GM urgent care standards • Mitigating the impact of winter pressures on the elective recovery programme • Allocating additional resources throughout the duration of winter to meet demand. • Supporting staff through an intense period of pressure. • Admission avoidance schemes and ambulatory care pathways.

Implications ***(so what)***	**Alert**
	• **65** Schemes have been developed for this year's BTH winter plan.
	• **36** schemes will require **additional funding**, these have undergone further analysis and have, for the purpose of the ICB, been broken down into:
	• **Priority 1** schemes totalling **£2.3m** (significant risk if not implemented).
	• **Priority 2** schemes totalling **£2.4m** (less risk if not implemented).
	If the Trust does not receive any additional funding, 36 of our Winter Plan schemes will not be viable for implementation.
	Assure
	• **3** Schemes have already been approved and funded by ICB to sum of **£4.2m**
	  ○ Homes first
	  ○ Intermediate Care
	  ○ Frailty Model
	• In total **29** schemes are considered **cost neutral** and are therefore recommended for implementation.
	• This Winter Plan has been developed in collaboration with our System, and internally across the entire Trust.
	• There is a Trust wide Winter Task and Finish Group which meets fortnightly to continue developing the schemes, tracking progress, and identifying immediate actions require to support our winter operations.
	• Local arrangements are in the process of being implemented within each Division to monitor progress with winter scheme implementation.

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	

Proposed Resolution ***(What next)***	The Board is asked to review and consider the contents of the winter plan. To acknowledge submission and funding conformation actiosn taken to provide assurance on effective planning for 23/24 winter period

Blackpool Teaching Hospitals
NHS Foundation Trust

Blackpool Teaching Hospitals Seasonal Demand Plan

Winter 2023

Author(s)	Rachel Crane, Deputy Director of Strategy & Transformation Kelly Jackson, Associate Director of Planning and Delivery
Date	24th October 2023
Version	Version 1

Seasonal Demand Plan at Blackpool Teaching Hospitals

Winter 2023-24

Executive Summary

The winter period is a nationally recognised pressure point across the NHS. It is not an emergency or considered an unusual event but is recognised as a period of increased pressure during the months of December to April in adults, and early Spring in Paediatrics. During this time, hospitals experience increased clinical acuity of patients, intensified demand in services and resources, and a rise in the number of admissions. In addition, the winter period often brings with it untoward events such as outbreaks of Respiratory infections, widespread infectious diseases including Norovirus, and there is the risk of the onset of the unusual, such as pandemic flu.

The Blackpool Teaching Hospitals (BTH) Trust wide Winter Plan sets out the organisation's arrangements for the 2023-24 winter period for adult services. The plan sits as part of the wider Lancashire and South Cumbria System and Place Based plans.

Each winter, our BTH sites experience increased pressure in patient flow. This year however, the trust has already seen an unprecedented rise in activity with the declaration of Opel 4, which historically happens in the height of winter, having already taken place at intervals all year. It is therefore crucial that BHT make detailed plans and arrangements to better equip itself with the anticipated surge on the horizon.

The purpose of the plan is therefore to ensure internal processes, systems and capacity can meet demand and maintain/optimise patient safety and experience. The BTH plan focusses on:

- Providing safe, high quality, efficient services.
- Creating the capacity to meet demand, occupancy levels and maintain flow.
- Establishing clear pathways for the management of COVID-19, Influenza, and non-respiratory illness patients. As demonstrated in the Trust's Escalation Policy. http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-SOP-055.docx
- Enabling timely patient access and experience, delivery of national/GM urgent care standards
- Mitigating the impact of winter pressures on the elective recovery programme
- Allocating additional resources throughout the duration of winter to meet demand.
- Supporting staff through an intense period of pressure.
- Admission avoidance schemes and ambulatory care pathways.

The winter plan also reflects on previous winter experiences in and across BTH to consider the lessons learnt and to adapt its approach where necessary.

Purpose

This document outlines the BTH Seasonal Demand Plan for Winter 2023-24, highlighting key initiatives that are to be implemented to mitigate the pressures of winter for each Division.

Alongside the Trusts escalation policy, it will serve as a reference guide to other key policies and standard operating procedures (SOP) that should prove useful in managing demand, capacity, and flow during the winter months. For instance, the 'Ward SOP' will offer clear narrative about how each ward conducts and owns their ward and board rounds. The ambition is this clarity will offer better understanding of standards set forward and board rounds as well as supporting and implementing escalation triggers. The SOPs will standardise processes all Divisions will need to adhere to, to help manage more effectively through winter.

This Winter Plan will be an iterative document and is intended to be kept 'live' so it continues to capture and reflect any national or regional guidance changes and continues to be reflective of BTH's approach in managing winter.

NHSE and LSC Winter Context

The delivering operational resilience across the NHS 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.

Regarding UEC recovery, we have been working towards the two national ambitions for which 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.

While good progress has been made towards achieving these ambitions, NHSE want to encourage providers to achieve an even better performance over the second half of the year, including winter. NHSE announced that they 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.

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.

The ICB are coordinating planning against the NHSE four areas of focus to support systems to 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.

The 'in hospital' High Impact interventions are:

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

Through a collaborative team approach and a prioritisation process against key aspects of the above criteria, 65 Schemes have been developed for this year's BTH winter plan. In total 29 schemes are considered cost neutral and are therefore recommended for implementation.

36 schemes will require additional funding, these have undergone further analysis and have, for the purpose of the ICB, been broken down into:

- Priority 1 schemes totalling £2.3m (significant risk if not implemented)
- Priority 2 schemes totalling £2.4m (less risk if not implemented).

The total cost of these schemes comes to approx. £3.7m. (Information on these schemes can be found in Appendix 1).

Assumptions and Demand

Each year, it is important that the learning and insights from the previous winter are captured and applied to the upcoming Winter plan. The Covid 19 pandemic and continuing outbreaks, alongside last year's influenza, adds a complexity to reviewing previous years data, (see appendix 2 for comparative years data) however it is still a useful exercise to better our understanding of previous performance and challenges, and to reflect on what established measures provided their intended relief.

As a starting point for the annual plan and subsequent winter plan, activity levels in ED and admissions for 2022-23 were reviewed. Associated improvement schemes, together with growth were then added into the forecast and plan for 2023-24.

BTH's operational and financial planning assumes the Trust has the right level of capacity to meet anticipated demand over winter. This is highly reliant on 'Out of Hospital' high impact interventions being delivered as a critical interdependency of any Trust winter plan. For example, the annual operational plan assumes that only 5% of patients who no longer meet

criteria to reside will occupy a hospital bed at any given period over winter, when we know that this currently ranges between 7% and 13%.

Specifically challenging elements of this difference in plan, versus experienced activity, are:

- 2,335 more Medical Admissions than plan (2,935 more than previous year)

This translates into:

- a 4% increase in bed day demand
- The equivalent of 25 additional medical beds being required per day between Dec 23 – April 24
- 5% more A&E attendances than planned for in 2023-24

Increased use of SDEC has supported delivery of activity levels, however non-SDEC admissions have still risen, and patient length of stay has increased.

Bed modelling 23/24

There are several assumptions that underpin the 2023-24 Winter Plan and subsequent bed modelling, these are:

- The modelling is based on the UEC sitrep data.
- It excludes Clifton beds from core bed stock.
- Infectious Disease Outbreak beyond the scope of the IPC scheme are not modelled.
- It excludes improvements to Virtual ward utilisation.

Utilises the last few years data from the Trusts Urgent and Emergency Care Sitrep we can predict how many admissions and discharges we expect to see and therefore what the resulting occupancy is likely to be.

The modelling reveals a stark picture for the winter months with a shortfall against the core bed stock.

The table below reports the position against 100% (assuming every bed is used), 95% utilisation (based on Sep-23 data) and then 92% as recommended in the Planning and Operational Planning Guidance for 23/24.

Month	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24
Demand	772	793	803	820	827	809
Core Bed Capacity	764	764	764	764	764	764
Bed Occupancy	101.0%	103.8%	105.1%	107.3%	108.2%	105.9%
Surplus/ Shortfall (@100%)	-8	-29	-39	-56	-63	-45
Surplus/ Shortfall (@95%)	-49	-71	-81	-99	-107	-88
Surplus/ Shortfall (@92%)	-75	-98	-109	-127	-135	-115

At 92% occupancy the position varies from a shortfall of 75 beds per night to 135.

Several schemes have been approved and developed to support improved flow through the high-pressure months:

- Intermediate care (Ward 4)
- Homes First
- Acute Frailty Unit

These schemes have been assessed to quantify their impact on the position, whether that be through increased bed capacity, reduced admissions, or increased discharges.

The following have also been analysed for their impact:

- SDEC GP Triage – admission avoidance
- Escalating into ward 1, adolescents and discharge lounge
- Full escalation into CDCU and DSU

The result of these schemes is a reduced bed shortfall, however, at 92% utilisation we can still expect to be short of 23 and 83 beds across winter period.

In addition to the Winter plan schemes there are still opportunities to be gained by expanding our Virtual ward capacity, Admission avodance scheme and Biweekly MADE events.

Over the last 5 months virtual ward utilisation has been at 25.5%, averaging just 17 spaces occupied from a potential of 68. Working closely with specialities if we are able to double this to just 50%, or 34 of a potential 68 occupied, this could see a big impact on our bed shortfall, reducing it from 5 to 65 bed shortfall.

Overall, of the 65 identified winter schemes there is a cohort that are defined as admission avoidance schemes, these include:

• DTA Model in ED • Increased therapy support on acute wards • 24/7 SDEC provision • Digital radiography/same day CT & MRI scanning • Implementation of criteria led discharge	• Rapid Assessment by community liaison team at front door • Additional Middle grade Dr in ED/SDEC • 7 day trauma operating model • GP referral triage in SDEC	• 6 day working in cardiology • Increased IV therapy capacity • Provision of fracture clinic on public holidays • Cardiac ANP support at weekends • Increase virtual ward capacity for palliative pts

These schemes have an average daily impact of 32 released beds days and leaving us with a potential bed deficit of 32 beds if implemented. There is however, a cost implication.

The MADE events earlier in the year averaged a 4.5% increase in discharges the week after the event. There is a commitment to hold these alternate weeks throughout winter. Averaging out the impact to 2.25% per week, this has an average daily impact of 3.51 released beds bringing the final shortfall to 29 beds.

Governance

To manage and track the implementation and adherence to the Trust Winter Plan, a Planning Task & Finish group has been 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.

Review and analysis of the planned schemes will help evaluate their effectiveness in managing flow and supporting during times of pressure. This information will help to inform future planning for winter by identifying the most successful and impactful schemes. Each Scheme has identified set of benefits and the task and finish group are working on the performance metric to track the improvements made deliver these. Responsibility for the implementation and delivery of the specific schemes will sit with the divisional triumvirate.

It is anticipated the data required for most of these metrics will be captured through business-as-usual reporting and will be used to inform formal and live evaluations of the 2023/24 BVH winter plan.

Risks

Whilst the winter plan itself has an identified risk log which the task and finish group will monitor and oversee, during periods of heightened pressure and demand, additional risks and incidents may occur. It is important that these risks are captured and are actively monitored through the appropriate committees and structures. As per the BVH's governance approach, all identified risks should be managed through the Trust Risk governance system and processes, if necessary, they can be reviewed and discussed in detail at the relevant committee.

Current plan risks

Risks	Mitigation
No funding for additional winter capacity. This may impact upon delivery of the 23/24 financial plan	• Vacancy control panel grip and control • Tight governance and progress reporting of winter progress • Clear communication of predicted cost pressures if no funding available • A 'Ready to implement' list of winter schemes, if winter funding becomes available
Emergency Village project is delayed, this will potentially impact on key schemes (e.g., Ward 1)	• Diligent Project management and adherence to plan
CQC compliance for continued and prolonged use of Adolescent space for escalation	• To develop a plan for adolescent provision medium term
Potential Impact on elective recovery plan and QEP delivery	• Limit escalation to CDCU and DSU to 8 beds each and only during external Opel 4. • Develop escalation procedure • IPC ward development • Ward 1 and 'bedding down' in discharge lounge to be an exception
No location identified to cohort ambulances should demand significantly outstrip capacity	• Review use of additional space e.g., Atrium • Cohorting space will be available once the capital development is completed, however if this is delayed this will have a significant impact in ambulance flow
Timescales to progress core recruitment at pace.	• Specific project established to manage, monitor and expedite IMPF recruitment • Weekly task and finish group
Escalation areas utilised going into winter pressures	• Implementing the actions from Clinical Productivity PFIP • Frailty bed base expanded before winter surge
Lack of system level community bed capacity to support step up/step down and hospital avoidance	• System conversations to understand and react to capacity commissioned to support winter bed capacity

Vision & Values

BTH strives to be a leading organisation delivering exceptional care to the patients of Blackpool, Fylde and beyond. The pressures placed on the system and hospital staff during the winter months is challenging and can result in fatigued and demotivated teams. It is therefore helpful to identify a vision that encompasses the BTH Winter Plan, providing clear directions for all to work towards.

The vision of this plan is therefore to deliver a quality patient experience during unprecedented times with a focus on discharge and flow. In the face of increasing demand, limited resources, and variable capacity, focussing on getting patients out of hospital is vital.

In achievement of the above vision, it is important to acknowledge the values and behaviours that are essential to its delivery. The BTH Winter Plan acknowledges these values and has been developed with our strategic priorities at the forefront of our approach, examples of how are illustrated below:

Our People

- Support the health and wellbeing of our people, the trust has developed a WinterWell scheme to assist staff during this time.

- Utilising our workforce well to be able to deliver the plans, working closely with the operational teams to seek their ideas for improvements.
- Communicating effectively to help prepare our people and provide support.
- Working collaboratively across the Trust, within the community and the System (system wide winter narrative)

Our Population

- Ensuring alternative pathways in community services are optimised ahead of any referral to hospital-based services.
- Extend hospital front-door that sees ambulatory pathways materially reduce admission rates from SDEC and ED, better utilising virtual wards more effective use of acute capacity.
- Making sure that people are only in hospital when they need to be and ensuring discharges are planned well with our partners, 'MADE events and Golden days'.

Our Responsibility

- Utilising technological solutions to enable staff to record and communicate with partner organisations effectively.
- Getting some of the basics right in terms of winter preparedness and responsible use of finance in times of budgetary restraint

Wellbeing and Engagement – "Our People"

Staff wellbeing and morale are fundamental to delivering the resilience plan, especially following the unprecedented pressures, and working arrangements that have been experienced in September and October of this year. To deliver exceptional patient care in challenging and demanding circumstances, staff effort and contribution must be recognised, and realistic and manageable expectations must be in place for all staff.

The Staff Wellbeing and Engagement team have been working on the #WinterWell campaign, providing staff with information that can help and support them to keep well this winter, as an example there are several virtual self-care sessions scheduled for all staff to join, starting from October throughout the winter months, these sessions are aimed at improving the mental health of our staff by providing guidance on own self-care.

The WinterWell information provides details for all staff on the specialist support available including:

- Mental Health Support
- Suicide Prevention
- RUOK? Campaign
- Accessing Flu and Covid Vaccines
- Helping your Money go Further.
- Keeping Warm this Winter

Conclusion

BVH continues to experience unprecedented demand for emergency services, and it is likely that winter pressures will bring a heightened demand and volume of activity into the organisation. It is important that as a Trust we are adequately prepared to cope with the increased pressure we will experience and that adequate resources are allocated to support our staff in doing so.

Staffing and staff morale are imperative to the plan and will dictate its success. It is important that during the busy winter period, staff are cared for and are validated and praised for their extraordinary efforts in extraordinary circumstances.

Finally, patient care is at the core of the BVH Winter Plan. Patients who use our services need to be cared for in a safe and caring environment and the initiatives and resources outlined in this document have been devised to help support this.

Appendix 1
Priority 1 – Schemes Requiring Funding

Scheme	Benefits	Cost
Increase adult community nursing capacity to reduce occurrences of EMS 4 escalation and deferral of non-urgent visits	• EMS level 3 or better 80% of the time • <2000 patients to have non-essential care deferred • 100% of appropriate referrals will be accepted into NCTs	c£446k
Escalation in DSU and CDCU during Opel 4 **(+16 beds)**	• Reduces WL to assisting 65 week waits target. • Deliver cancer targets and elective activity programme/ QEP. • Reduction in bed days lost due to outliers • Reduction in delayed CITU discharges • Reduction in OTD cancellations	c£279k
Escalation into Adolescent Ward **(+ 7 beds)**	• Increased flow across site • Decongestion of ED	c£75k
Escalation into Atrium (if required for ambulance cohorting)	• Ambulance cohort area providing 6 trollies	c£450k
Increased therapy support across acute wards	• Increased rehabilitation capacity & additional support on Critical care, to enable step downs	£142k
Transfer Team - support with time-critical moves across the acute site	• Timelier moves to available beds • Reduction in 60 Minute NWAS breaches • Increased flow across site.	£40k
Cardiology 6 day working	• Reduction in cancellations due to bed availability (76% of cancellations due to this during Winter 2022)	£27k
Additional Urology Middle grade cover on ED / SDEC	• Reduced wait to first assessment/ clerk in • Avoids post 5pm backlog of patients • Reduce admissions by facilitating Treat & Return • Reduces SDEC pause risk	£65k
Additional Surgical Middle grade cover on ED / SDEC	• Reduced wait to first Ax/ clerk in • Avoids post 5pm backlog • Reduce admissions by facilitating Treat & Return • Reduces SDEC pause risk	£41k

Scheme	Benefits	Cost
Community Liaison team in-reach to ED	• 100% of priority 3 patients assessed each day • 10% of priority 3 patients transferred out of an acute setting to receive their care within a community setting	**£38k**
Increase Community workforce capacity to increase administering of IV outside of the acute setting to step down from acute bed base (**4 chairs** at South Shore Health Centre)	• An additional 600 minutes per chair (4 chairs), per day (*delivery of antibiotics equates to 120 minutes) • Total of 268,800 minutes available throughout Dec-March	**£68k**
External radiology reporting of complex cases for quicker ED turnaround	• IP & ED/SDEC examinations reported within 1 hour of examination.	**£200k** through outsource
24/7 SDEC **(potential 100 additional attendances per week in winter)**	• Decongestion of ED • Increase number of patients on Same Day pathways. • Escalation capacity	**£400**
'PRIORITY 1' SCHEMES REQUIRING FUNDING = 13		**£2271,000**

Priority 2 Schemes – Require funding.

Scheme	Benefit	Cost
Trauma 7 day operating	• Trauma backlog minimised • Increase in ambulatory patients that can be managed at home and operated in within guideline. • Reduce LoS for patients due to rapid turnaround of surgery.	£134k
Trauma BH operating (additional list in BH week to mitigate loss on BHs)	• Trauma backlog minimised • Increase in ambulatory patients that can be managed at home and operated in within guideline. • Reduce LoS for patients due to rapid turnaround of surgery. • Positive impact over BH periods	£32k
Extended Cardiac Theatre and Lab days	• Minimise OTD cancellations • Improve theatre utilisation • Support delivery of activity plan	£43k
Locum End of Life Consultant	• Ensure timely referral, reduced LOS and discharge. Admission avoidance	£70k
Dedicated CAMHS Mental Health Resource for Paediatric Ward	• Support/liaison/advice and therapeutic intervention for CYP.	£40k
Agency ST1 level Dr for increased number of medical outliers on surgical wards	• Prompt actioning of diagnostic requests and processes - reduced delays adding to LoS	£48k
Maintain fracture clinic provision on / around the 4 public holidays	• Reduces risk of admission enabling ambulatory provision over key pressure periods	£23k
Cardiac transport for non-critical transfers to and from Preston	• Reduce preop length of stay • Treat & Returns • Reduce late starts • Ensure timely arrival of SDA • Facilitate swaps and repats	£50k

Scheme	Benefit	Cost
Cardiac Inpatient co-ordination	• Reduced preop length of stay • Reduction in bed days • Improved time to surgery • Increased standby patient pool • Reduced OTD cancellations	£58k
Telemetry on CDCU to mitigate issues with lack of recovery space	• Improved flow via earlier availability of ward beds • Reduced OTD cancellation • Reduction in Telemetry-related incidents	£6k
Evening Therapy Parachute team	• Average of 8 patients contacted per evening shift. • -67% of patients assessed were new referrals. • -94% response to referral within 24 hours. • -42% of patients were discharged from therapy caseload once seen, supporting timely discharges	£0 (1.5 wte B6 8 weeks at overtime rates = less QEP delivered)
Digital Radiography	• Referrals received scanned same day. Supports early discharge and admission avoidance	£121k
Same day CT scan capacity	• CT Referrals scanned the same day. Supports discharge and admission avoidance	£135k
Same day MRI capacity	• MRI Referrals scanned the same day. Supports discharge and admission avoidance.	£135k
Extended Virology opening hours to provide rapid respiratory pathogen testing	• Improves patient pathway and response times for suspected respiratory infections	£12k
Front Door Streaming Medic	• Decongestion of ED	£68k

Scheme	• Benefit	Cost if known
Clifton Criteria Review	• Increased acute bed base for patients	£18k
Targeted Elective weekend theatre capacity	• Supported delivery of improved Cancer, P2 and 65-week position. • Avoids excessive pre-op LOS for NEL patients	£138k
Additional Orthogeriatrician	• Support delivery of BPT # NoF pathway. • Reduces LoS through early intervention	£102k
Cytosorb to reduce Cardiac Length of stay	• Reduced preop length of stay • Reduced ward and CITU length of stay reduction (3 days) • Fewer blood product transfusions • Reduction in postoperative sepsis • Reduced bleeding complication rates • Reduce perioperative and postoperative morbidity • Reduced post-op opiate requirements	£82k
Increased Cardiac preadmission capacity	• Increased number of theatre/lab vacancies backfilled with standby patients • Improved scheduling processes • Reduced OTD cancellations	£36k
Additional Cardiac ANP weekend cover	• Improved flow • Increased weekend discharges • Reduced length of stay • Reduced OTD cancellations • Improved Theatre utilisation	£25k
Increase Telemetry on Cardiac wards	• Ensures patient safety isn't compromised	£7k
'PRIORITY 2' SCHEMES REQUIRING FUNDING = 23		**£1383,000**

Schemes requiring no funding.

Scheme	Benefits
Discharge Lounge Escalation overnight	• Surge capacity • Decongestion of ED
SDEC triage of GP referrals	• Increase number of patients on Same Day pathways • Increased usage of the Virtual Ward / 2 hour UCR • Fewer DTA from SDEC
Ward 1 Recommissioned using medical outlier team 2	• Reduction in Opel 4 instances • Decongestion of ED • 10 bed surge capacity
Non-Obstetric Ultrasound (NOUS) on weekends	• Improved TAT for NOUS for SDEC and Inpatients • Increase in number of NOUS on a weekend • Improved utilisation of NOUS on a weekend from winter 22
Increase Palliative Virtual ward capacity	• Increase beds from 16 to 20 • 80% utilisation rate • Reduction in admissions for palliative pathway
Admission Avoidance Team in Emergency Department	• Reduction in Social admissions • Reduction in length of stay in our ED for those requiring social or therapy interventions • Increased Referral to virtual wards • Increased direct admissions to Clifton, ARC , Thornton House
Home First – Maintenance and Clifton Outreach	• Maintenance of 2 days for POC / Home first pathway 1 discharge at the time of being deemed medically optimised for discharge • Maintenance of LOS in the Acute bed / Clifton hospital bed base • Maintain under 10% NMC2R • Increase in pathway 1 discharges and reduction in pathway 2&3 proportion
TOCH – Blackpool Care Home Finding Service	• Maintenance of LOS in the Acute bed / Clifton hospital bed base • Maintain under 10% NMC2R

Scheme	Benefits
Ring-fenced Day Surgery Unit	• Delivers activity to reduce WL to ensure no 65 week waits after 31 March 2024. • Deliver cancer targets and elective activity programme/ QEP.
Ring-fencing and capping escalation in Cardiology	• Reduction in bed days lost due to outliers (83 per month over Winter) • Reduction in delayed CITU discharges • Reduction in discharges directly from CITU • Reduction in OTD cancellations • Support delivery of activity plan • Improved Theatre utilisation
Expansion of Acute Frailty Unit to 24 beds	• Increase % Emergency admissions with a LOS of 0-1 days • Increase No. Patients referred to Frailty Virtual Ward per month from community • Achievement of 10-30% frailty identification CQUIN • Reduction in escalation by 6 beds through reduced LOS
Winter Safety Dashboard	• Reduced patient harms • Improved patient experience • Reduction in complaints
Wellbeing Calendar	• Improved staff wellbeing and morale • Reduction in sickness/absence against winter 22
ED community In Reach	• Reduction in admissions to the acute site. • Increased 2 hour UCR • Increased uptake of Virtual ward pathways
MHUAC Escalation Criteria	• Improved usage of MHUAC • Decongestion in ED
Default displacement task lists	• Appropriate and effective use of medical resources • Effective discharge planning

Scheme	Benefits
IMPF Control Room	• Improved coordination of Divisional response
Bi-weekly MADE Events – Local Monthly MADE Events – System	• 4% increase in discharges following MADE events • Reduced NCTR % following MADE events
IPC Ward	• Reduced IPC outbreaks and loss of beds due to IPC
IMPF Winter Plan Table Top Exercises	• Improved staff wellbeing
Development of a recruitment video to attract candidates to difficult to fill vacancies in adult community ahead of winter	• Substantive fill rate to increase
Improved IT provision for agile workers in community	• Reduce wasted time when staff cannot connect to EMIS • Increase the number of visits that can be completed • Improve staff experience • Improve patient safety as notes can be completed contemporaneously
Implementation of self care template on EMIS and promotion of patient self care	• Reduce unnecessary clinical activity • Support and empower patients
Shared access to digital systems which include Community EMIS, ED Maxims and Nexus patient record	• Enable Rapid Response/Community IV Therapy staff to virtually review patients in ED • Strengthen discharge pathways into community which are initiated by TOCH
Introduction of EMS action cards and a standardised approach to management of EMS 4 pressures	• Matrix reporting on activity deferred by NCT • Improved management of EMS escalation within teams
Enhancing the ways in which community teams (i.e. Rapid and Community IV Therapy) appear on the Directory of Services (DoS system)	• Increased utilisation of established community pathways • Statistically significant increase in direct referrals by NWAS to Rapid Response (either by crews on scene or via CAS)

Scheme	Benefits
Pilot with selected GP practices to encourage use of Rapid Response team as an alternative to SDEC	• Increase 2 hour UCR referrals from selected GPs by 20% • Reduction in ED / SDEC GP referrals
Criteria-led discharge in Cardiac	• Increased discharges before 12pm • Less OTD cancellations • Reduced length of stay
Clinical Skills/Competency Refresh to enable redeployment at EMS 4 or OPEL 4	• EMS level 3 or better 80% of the time

Appendix 2
Demand data comparisons between 2020 - 2022

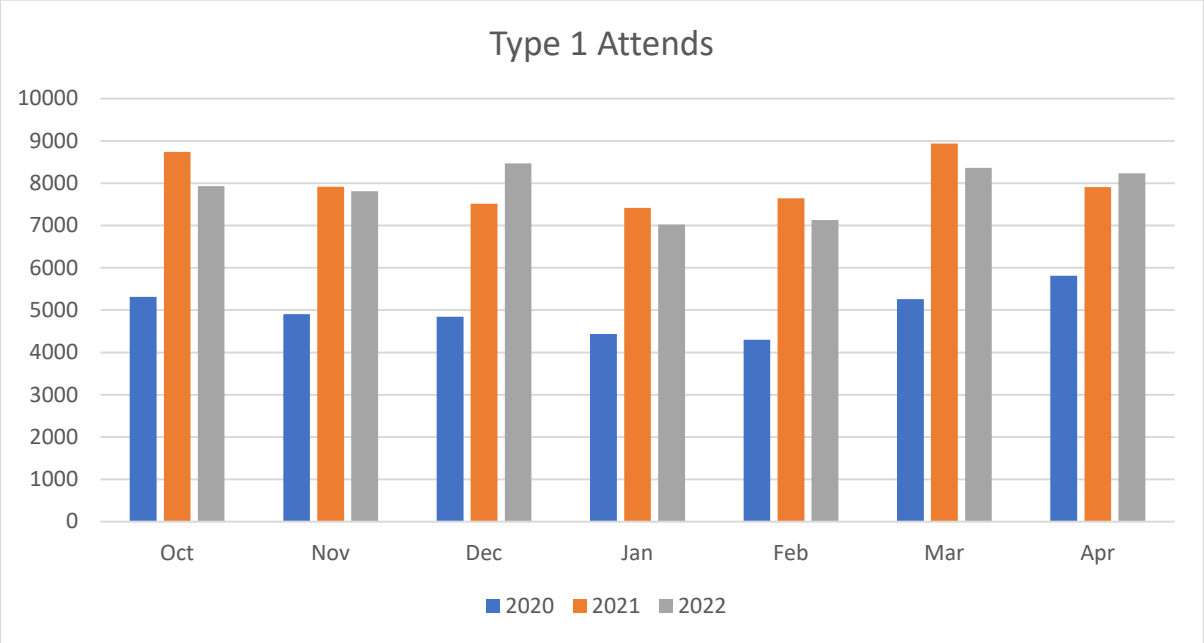


Figure 1: Type 1 ED Attendances 2020 - 2022

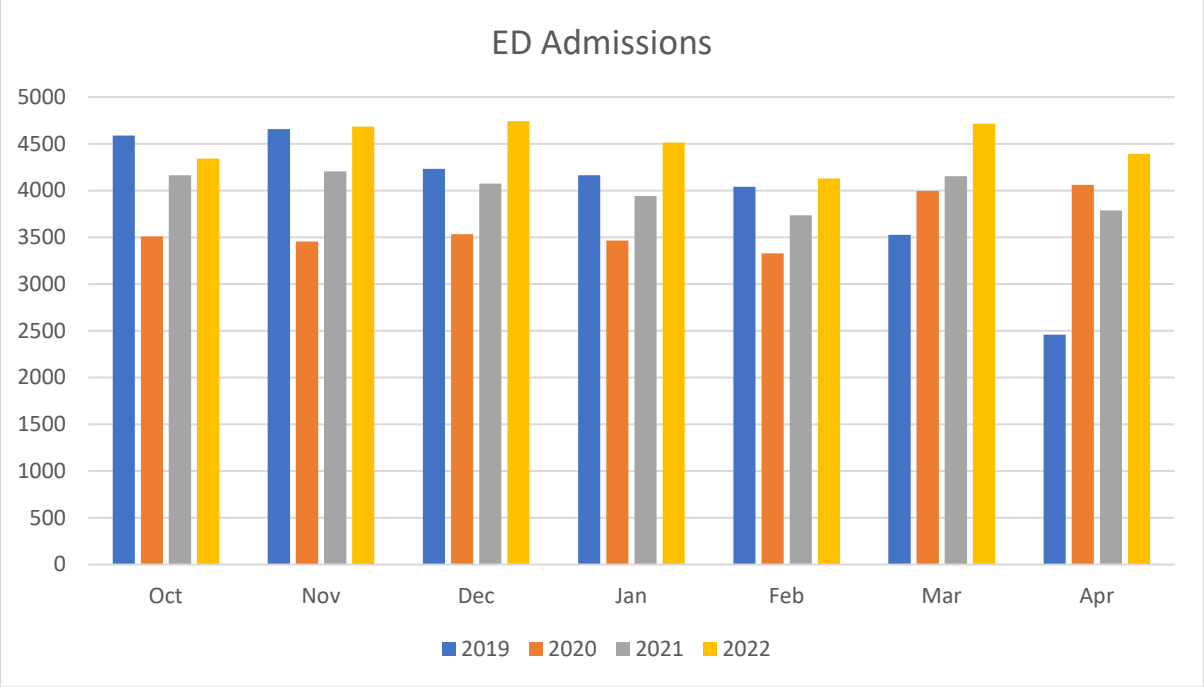
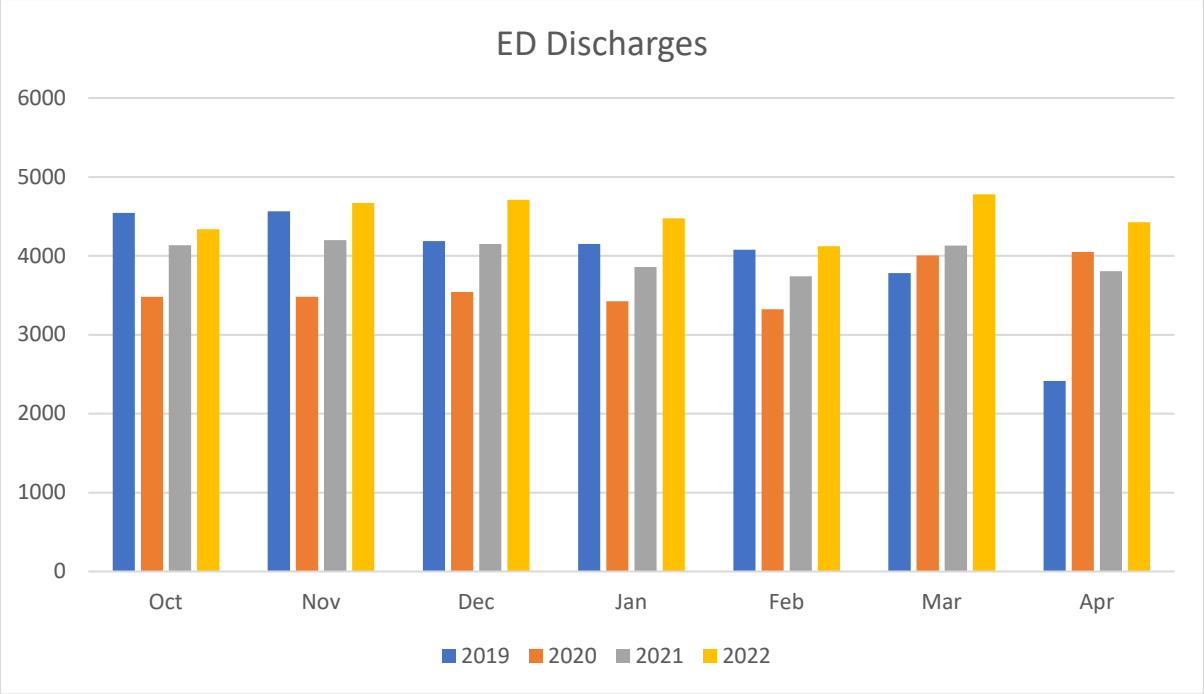


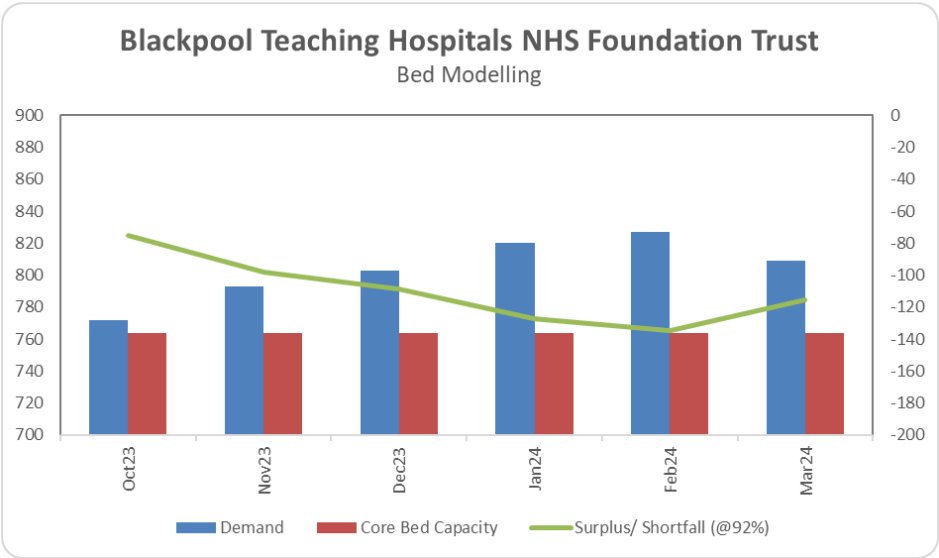
Figure 2: Emergency Admissions 2019 - 2022



Appendix 3
Bed Modelling for 2023 Winter Planning

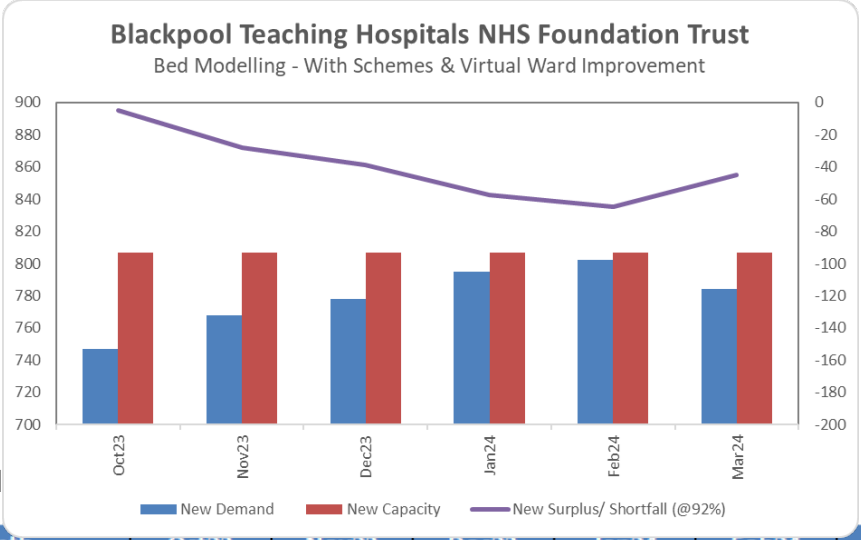
This modelling utilises the data from the Trusts Urgent and Emergency Care Sitrep from the last few years to predict how many admissions and discharges we expect to see and therefore what the resulting occupancy is likely to be:

Month	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24
Demand	772	793	803	820	827	809
Core Bed Capacity	764	764	764	764	764	764
Bed Occupancy	101.0%	103.8%	105.1%	107.3%	108.2%	105.9%
Surplus/ Shortfall (@100%)	-8	-29	-39	-56	-63	-45
Surplus/ Shortfall (@95%)	-49	-71	-81	-99	-107	-88
Surplus/ Shortfall (@92%)	-75	-98	-109	-127	-135	-115



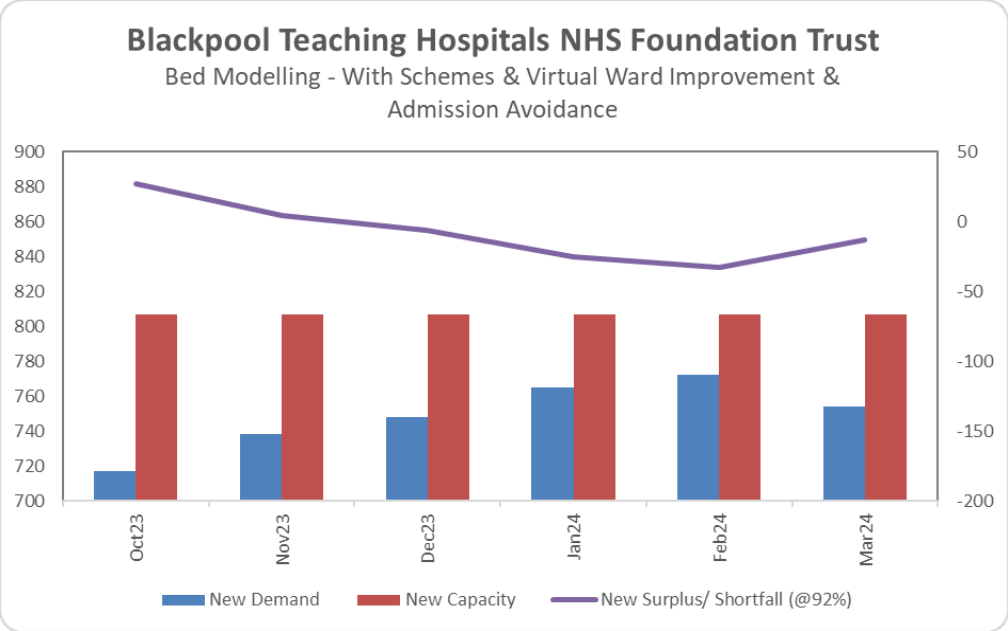
Bed modelling including virtual ward opportunity, assuming utilisation is at 50%:

Month	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24
New Demand	747	768	778	795	802	784
New Bed Capacity	807	807	807	807	807	807
Bed Occupancy	92.6%	95.2%	96.4%	98.5%	99.4%	97.1%
Surplus/ Shortfall (@100%)	60	39	29	12	5	23
Surplus/ Shortfall (@95%)	21	-1	-12	-30	-37	-18
Surplus/ Shortfall (@92%)	-5	-28	-39	-57	-65	-45



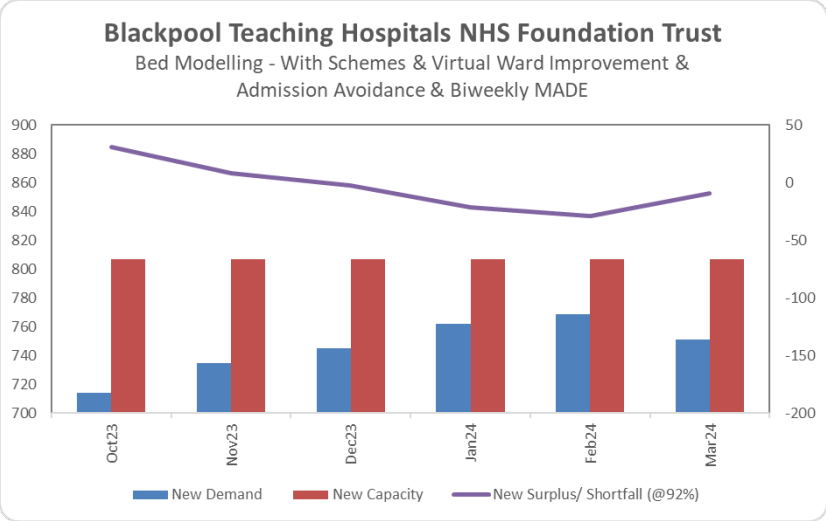
Bed model

onth	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24
New Demand	717	738	748	765	772	754
New Bed Capacity	807	807	807	807	807	807
Bed Occupancy	*88.9%*	*91.5%*	*92.7%*	*94.8%*	*95.7%*	*93.5%*
Surplus/ Shortfall (@100%)	90	69	59	42	35	53
Surplus/ Shortfall (@95%)	52	30	19	1	-6	13
Surplus/ Shortfall (@92%)	27	5	-6	-25	-32	-13



Bed modelling including MADE events:

onth	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24
New Demand	714	735	745	762	769	751
New Bed Capacity	807	807	807	807	807	807
Bed Occupancy	*88.4%*	*91.1%*	*92.3%*	*94.4%*	*95.3%*	*93.0%*
Surplus/ Shortfall (@100%)	93	72	62	45	38	56
Surplus/ Shortfall (@95%)	56	34	23	5	-2	17
Surplus/ Shortfall (@92%)	31	8	-3	-21	-29	-9


Blackpool Teaching Hospitals NHS Foundation Trust
Bed Modelling - With Schemes & Virtual Ward Improvement & Admission Avoidance & Biweekly MADE
900
880
860
840
820
800
780
760
740
720
700
50
0
-50
-100
-150
-200
Oct23
Nov23
Dec23
Jan24
Feb24
Mar24
New Demand
New Capacity
New Surplus/ Shortfall (@92%)

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Audit Committee Escalation Report

Meeting:	Board of Directors in Public Meeting
Date:	2 November 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 11 October 2023.

Implications *(so what)*	**Alert** There were two items highlighted for escalation to Board of Directors as an alert:- • External Audit Update (Annual Auditor's Report) including VfM – this highlighted two previously identified weaknesses • Fit and Proper Persons Review – this identified areas for improvement in the documentation supporting fit and proper person declaration but did not identify any concerns with regard to the fit and proper status of our Board members. **Assure** The items noted for assurance are detailed in the escalation report.

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

Blackpool Teaching Hospitals NHS Foundation Trust

Name of Committee/Group:	Audit Committee	**Report to:**	Trust Board
Date of Meeting:	11 October 2023	**Date of next meeting:**	13 December 2023
Chair:	Fiona Poxon	**Parent Committee:**	Trust Board

Introduction

Quorate meeting held face to face. Good engagement in discussion with a focus on demonstrating the progress made in developing relationships and ways of working across the Board to achieve collective goals.

Alert

What	So What	What Next
External Audit Update (Annual Auditor's Report) incl. VfM Report detailing audit approach and findings including vfm. Two significant weaknesses identified for 2022/23 – these are the same as the weaknesses identified in 2021/22 and are: • Weakness in governance arrangements in how our Trust ensures it is meeting regulatory requirements • Weakness in our Trust's arrangements to ensure financial sustainability	Committee discussed the weaknesses identified in the report, external auditors confirmed that they are satisfied that actions are in place and will be followed up in their next report. Management responses and action plans included in the report, NEDs feel well sighted on the plans. The report is a public report includes unmodified opinion on the accounts – significant weaknesses previously discussed.	Management response to all recommendations to be included in a report to Audit Committee Report noted
Fit and Proper Persons review Report undertaken to ensure FFP requirements are met – requirements changed during the report – review is against old guidance. Issues raised in relation to weaknesses in checks – two high risk recommendations in relation to pre-employment checks and annual checks.	Committee members noted that the report had been requested as this was recognised as an area of potential concern and while there were not concerns with regard to any individual on the Board there were some gaps in the filed evidence to support this	Report back to the next Audit Committee to confirm that evidence on file that all current directors meet the fit and proper person test

Assurance

What	So What	What Next
Internal Audit Progress Report	The follow up report includes all recommendations. Committee members discussed responses to audits	Report noted

Update provided on latest audits and progress on current – two reports finalised and two in draft awaiting final response and accuracy check. Scoping meetings have taken place for audits planned for Q3 and Q4	and agreed that shorter timescales should be agreed for actions that are high risk	
Blue Skies Internal controls The report provides substantial assurance in relation to the completion of actions identified in the previous review	Discussed future frequency of reviews in relation to the Charity – given the substantial assurance seen as low risk at this stage	Director of Corporate Governance and the Chair of the Charitable Funds Committee to develop a plan for charity trustee training.
Internal Audit Follow-up Report All outstanding KPMG actions now closed – report updated to include changes to dates.	Committee members discussed the progress and due date for action in relation to risk management to seek assurance on progress made and to ensure that appropriate date agreed for closure of the actions.	Report noted
Counter Fraud Progress Report Routine Counter Fraud report presented Counter Fraud training is now included in the mandated core training.		Report noted
Effectiveness Review of the 2023/24 Clinical Audit Plan/Programme The report described the reporting arrangements for clinical audit through the Audit and Clinical Effectiveness Group (ACE) to give detailed overview of the clinical audit programme The ACE group is chaired by the Deputy Medical Director – reporting line through CGC to QAC – The QA Committee felt that more than an AAA report needed so have now asked for a quarterly report on Clinical Audit to the Clinical Governance Committee.	Committee discussed their role in relation to Clinical Audit to ensure assured that progress is made recognise that the oversight of the overall programme is through QAC	Progress report on clinical audit plan – 6 monthly to the Audit Committee. Workplan to be updated to reflect 6 monthly update on clinical audit. Governance and oversight of Clinical Audit is improving
BAF and Committee Review (Quality) Deep dive in the quality area of the BAF	Committee members discussed the programme of BAF reviews considering the rationale behind the review and the role of the Audit Committee in relation to the oversight of the BAF	Further consideration to be given to the Committee's role in reviewing the BAF and Board Committees

Committee/Group Escalation Report

Financial Peer Review Action Plan Update Verbal update provided on progress with actions in response to the finance peer review – scope of MIAA review of response now confirmed with the aim to conclude and report to the December meeting along with the full tracker and progress against the actions.	The financial peer review suggests that the Audit Committee should consider increasing the frequency of audits of basic controls – Committee members discussed the items in the 2022/23 year plan	MIAA will undertake an annual review of key controls and in addition this year included QEP and budgetary management – will consider what to include in next year's plan
Whistleblowing Arrangements Review The Audit Committee role is to ensure arrangements are in place for proportionate review to ensure staff can speak up and raise concerns. Paper provided details of whistleblowing cases and adherence to time scales and insight into work to continue to publicise FTSU.	Committee members asked how the Trust ensures appropriate process to raise concerns that are in accordance with the public disclosure act. Described mechanism for reporting and investigating. An ask about the differentiation between FTSU and the whistleblowing noting that there is one policy covering all speaking up and the reporting requirements for formal PIDA whistleblowing cases and contingent liability	Annual report on cases under the public interest disclosure The Board receive quarterly updates from FTSU.
Audit Committee Annual Report The committee received the draft Annual Report detailing the work of the Committee in the financial year 2022/23	Committee members endorsed the report and supported the proposal to provide this earlier in the reporting calendar to align with year end reporting.	Report to be presented to the Board in November and to Governors in December Update the report for committee attendance
Advise		
2-hr Community Response Data Quality Review Associate Director of BI attended to provide update on issues and actions in relation to the 2 hour UCR target – actions taken include development of a new SOP to ensure robust process for data quality. Described wider actions for data quality and the use of Data Quality Maturity Index to gain assurance on data quality – DQMI is above national average for all data other than IAPTS – this was in relation to an error that is now fixed.	Work is underway to understand the data quality checks in place for other data sets to target specific data asset owner training. New Head of Information Governance appointed with expertise to strengthen arrangements	Systematic review planned to validate data sources and give clarity of assurance with a register of data sources. MIAA to support further review of data quality. Review again April 2023 .
The Committee also received routine reports on waivers and losses and special payments and an update on response to IFRS 16 – these were reviewed and noted.		

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Audit Committee Annual Report

Meeting:	Board of Directors in Public
Date:	2 November 2023

Author	Fiona Eccleston					
Exec Sponsor	N/A					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	n					

Summary *(what)*	**Advise**
	The purpose of this report is to advise the Audit Committee of the work undertaken to discharge its responsibilities and meet its terms of reference for period 01.04 2022 to 31.03.2023.

Implications *(so what)*	**Alert**
	This report was due to be presented to the Board of Directors after the financial year end. The timeline had not been met for 2023 but this will be rectified in future.
	Assure
	The contents of this report demonstrate the progress made in developing relationships and ways of working across the Board to achieve our collective goals.

Previously considered by	Audit Committee - Wednesday 11 October 2023

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

Equality, Diversity and Inclusion (EDI) implications	The Committee should ensure the EDI implications of all reports have been considered.

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

Blackpool Teaching Hospitals NHS Foundation Trust

Audit Committee Annual Report 2022/23

1. Introduction

This report details the work undertaken by the Audit Committee in order to discharge its responsibilities and meet its terms of reference for the period 1st April 2022 to 31st March 2023.

This annual report was due to have been presented to the Board promptly after the financial year end but before it considered the organisation's annual report and statutory declarations. This timeline has not been met for 2023/23 but this will be rectified in future.

The committee comprises of four Non-Executive Directors, of which two are required for quoracy. The committee held 5 quorate meetings during the year, details of meeting attendance is in Appendix 1.

2. Work of the committee

The Audit Committee is responsible, on behalf of the Board of Directors, for independently reviewing the robustness of the Trust's governance, risk management and internal control frameworks, using evidence-based assurance. The following work was carried out during the year, in pursuit of this aim.

Governance

- Reviewed and contributed to the development of the Board Assurance Framework
- Considered the Trust's declaration that it is compliant with the general and certain specific conditions of its operating licence including reviewing compliance with the NHS Code of Governance
- Reviewed the Annual Governance Statement
- Declarations of Interest
- Register of Sealings
- Produced a report to the Board of Directors after each Committee meeting providing assurance on the work that has been undertaken and highlighting any areas that the Board should be aware of in an Alert, Assure and Advise format

Internal Audit

- Provided input into and approved the risk-based Internal Audit Plan from the Trust's internal auditors Mersey Internal Audit Agency (MIAA)
- Reviewed and scrutinised all completed internal audit reports; a full list of reviews completed, their associated assurance ratings and recommendations is in Appendix 2
- Monitored the implementation of recommendations made by the internal auditors
- Discussed and reflected on the Head of Internal Audit Opinion, which gave a moderate level of assurance over the Trust's risk management, control and governance processes

- Received assurance from MIAA that the firm complied fully with professional best practice, internal audit standards including the Public Sector Internal Audit Standards, and legal requirements

External Audit

- Received and approved the External Audit Plan from the Trust's external auditors Deloitte
- Received regular progress reports and technical updates
- Received and reviewed the ISA 260 report
- Discussed and reflected on the external auditor's Value for Money assessment

Financial Reporting

- Considered reports on losses, write-offs, special payments, and tender waivers
- Confirmed agreement with the going concern basis of preparation of the accounts and the accounting policies produced by management
- Considered technical issues and areas of judgement associated with producing the Annual Accounts
- Monitored the preparation of the Annual Report and Accounts
- Reviewed the Letter of Representation for approval by the Board
- Recommended approval of the Annual Report and Accounts to the Board following completion of the external audit

Counter Fraud

- Approved the annual work plan presented by the Local Counter Fraud Specialist
- Reviewed regular progress reports and details of investigations carried out during the year
- Received and discussed the Counter Fraud Annual Report

3. Key Matters Arising

Speed of Implementation of Internal Audit Recommendations

The Committee has raised concerns with Management about the time it can take for recommendations made by Internal Audit to be acted on and satisfactorily resolved. As at April 2023, there were a number of recommendations raised in 2020/21 yet to be addressed; 2 high risk, 3 medium risk and 2 low risk.

The Committee requested focused attention on addressing these outstanding recommendations, some of which were reported as having been previously addressed or superseded, but evidence had not been supplied to the Internal Auditors. Through concerted effort, all 2020/21 recommendations were reported as fully addressed or superseded by MIAA in August 2023. The focus subsequently moved to addressing recommendations from 2021/22, of which at that date there were 6 medium risk outstanding.

Delay with signing the Annual Report and Accounts

The deadline for submission of the 2022/23 Annual Report and Accounts was 30th June 2023 however the Trust made the submission on 27th July 2023 which was 3 weeks late with the report and accounts laid before Parliament on 6th September 2023. The Committee was kept up to date with the reasons for and length of the expected delays by both the Interim Director of Finance and

the External Auditor, and there are plans in place to address the causal factors in advance of the next reporting period.

4. Effectiveness of the Committee

In August 2023 the Committee undertook an assessment of its effectiveness, in line with guidance from the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook. This involved:

- Each Committee member individually completing a skills and experience self-assessment
- The Committee Chair and Director of Corporate Governance completing the HFMA Committee Processes Self-Assessment
- Committee members and regular Committee attendees completing the HFMA Committee Effectiveness questionnaire

The Committee reviewed the results of the above and noted that the mix of skills and experience between Committee members was appropriate and that feedback on Committee meetings was positive. The consensus view was that the meetings were well chaired, members and attendees were able to share views, openly debate and challenge assurances in a constructive way. There were a number of areas highlighted in the review where the Committee could improve:

Finding: Recommendations and requests for action from auditors or the Audit Committee are sometimes not delivered on time, accountability can sometimes appear low.

Potential Impact: The value of the work of the Committee and auditors is not fully realised, and improvement to the system of governance is delayed, exposing the Trust to a higher level of risk.

Actions Taken: Committee to ensure realistic timeframes are set for follow up action, taking into account operational and other pressures facing the Trust. Review of outstanding Internal Audit actions is now a standing agenda item at Executive Director meetings. The Trust has appointed a designated point of contact to liaise with Internal Auditors to ensure follow up on actions is robust and timely. Audit Committee to discuss delays and issues experienced directly with the relevant member of the Executive to fully understand challenges faced and agree the way forward.

Finding: The Committee has a robust and wide-ranging workplan in place which reflects the risks and issues facing the Trust at the time it is set. However, the Committee does not set annual objectives and does not have a process to review whether the workplan remains appropriate throughout the year.

Potential Impact: The work of the Committee could become out of date and fail to address key emerging risks.

Actions Taken: Committee workplan has been adjusted to include objective setting at the start of each year and a review of the work plan at each half year point.

5. Acknowledgements and Final Comments

The work conducted means the Committee has been assured that the Trust's system of risk management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks. The committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the comprehensiveness of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decisions and declarations. There are no outstanding areas of significant duplication or omission in the Trust's systems of governance that have come to the committee's attention.

An aim of this Audit Committee is to deliver robust yet fair challenge to ensure that the Trust's system of governance continues to improve, at all times taking into account the not insignificant multifaceted challenges faced. The contents of this report demonstrate the progress made in developing relationships and ways of working across the Board to achieve our collective goals.

I would like to take this opportunity to thank the members of the Committee for their support and input to the work of the Committee and also to thank all those who attend the Committee along with the Corporate Governance team who provide us with administrative support.

Fiona Poxon

Audit Committee Chair

October 2023

Appendix 1: Committee Meeting Dates and Attendance

Members	Number of Meetings
Fiona Eccleston (from 01.05.22)	5/5
Mark Cullinan (until 30.06.22)	2/2
Sue McKenna	2/2
Mark Beaton	3/3
Fergus Singleton (from 01.07.22)	3/3
Carl Fitzsimons (from 01.07.22)	1/1
Robert Ryan(from 01.07.22)	2/2
James Wilkie	2/2
Attendees	
Executive Director of Corporate Governance	5/5
Executive Director of Finance	5/5
Internal Audit	5/5
External Audit	5/5
Counter Fraud	3/4
Deputy Director of Finance	4/5

NB – there were several changes of membership during the course of the year – attendance for each member and attendee is shown as the number attended from the number eligible to attend

Appendix 2: Summary of Internal Audit Reports

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
1	Assurance Framework (inc Survey)	N/A	14 recommendations raised (not RAG rated)				14*
2	HFMA Financial Sustainability Checklist	N/A	4 recommendations raised (not RAG rated)				4*
3	Divisional Risk Management Review	Moderate	0	1	6	3	10
4	Data Protection & Security Toolkit Phase 1	N/A	Feedback provided to support the submission on 30th June 2023				0
5	2 Hr Community response – Data Quality	Moderate	0	1	2	1	4
6	Mental Capacity Act: Consent & Restraint	Substantial	0	0	2	1	3
7	General Ledger & Treasury Management	Moderate	0	0	5	0	5
8	ESR / Payroll	Moderate	0	1	4	2	7
9	Recruitment & Retention of Medical Staff	Moderate	0	1	4	0	5
10	Consultant Job Plans	Limited	0	2	3	1	6
11	Mobile Working & Devices	Substantial	0	0	3	1	4
12	Corporate Risk Register Management and the Escalation of Risks from Divisions (21/22)	Moderate	0	1	4	0	5
13	Cyber Controls (21/22)	Substantial	0	0	3	4	7
14	DSPT – Assessment summary report Phase 2 for 21/22	Substantial	Key areas to support the submission provided separately				-
15	Collaborative Organisational Accreditation System for Teams (COAST) (21/22)	Moderate	0	1	1	2	4
16	Freedom to Speak Up	N/A	-	-	-	-	-
		TOTAL	**0**	**8**	**37**	**15**	**60 plus 18*** (not RAG rated)

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Strategy and Transformation Committee Escalation Report

Meeting:	Board of Directors
Date:	2 November 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** While progress has been made in all areas a key theme through all reports was the resource required for transformation and the balance of competing with operational pressures – this is also reflected in the BAF **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 the Committee's Escalation report. The Board are also asked to approve the updated Terms of Reference – the updates reflect changes in roles and in the membership of the Committee

Committee/Group Escalation Report

Name of Committee/Group:	Strategy & Transformation Committee	**Report to:**	Board of Directors
Date of Meeting:	28 September 2023	**Date of next meeting:**	23 November 2023
Chair:	Trish Armstrong-Child	**Parent Committee:**	Board of Directors Meeting

Introduction

Meeting held on MS Teams, positive engagement and discussion with a key focus on progress with transformational plans. Recognition for the work undertaken to drive transformation. The Board workplan will be updated to ensure the Board are fully engaged and fully sighted on all aspects within the Committee's portfolio.

Although the Committee were reassured that progress is being made in all areas, given that programmes are all in their infancy the updates at this stage have been provided for advice rather than assurance

Alert

What	So, What	What Next
While progress has been made in all areas a key theme through all reports was the resource required for transformation and the balance of competing with operational pressures – this is also reflected in the BAF	Committee members noted the potential impact and the need to balance complex, competing demands	Programme leads discussed opportunities for investment including through grant funding, work with commissioners and invest to save business cases

Advise

What	So, What	What Next
Board Assurance Framework The BAF reflects the actions we are doing to reduce urgent care demand. Key issues that might impact on the achievement of the strategy noted as competing priorities and system maturity.	Progress made on engagement with Fylde and Wyre place with increased momentum and further sessions planned to focus on population health.	The BAF will be updated to include additional actions with place partners
Strategy & Transformation Committee – Highlight Report Overview report on progress against the agreed objectives against the SOF 3 exit criteria agreed with the System Improvement Board.	Work has commenced to evaluate the financial improvement benefits associated with the programme. This piece of evaluation identified £5.4m of the QEP plan can be assisted in its delivery via the STP. Working to analyse financial impact of year one delivery.	A Trust wide comms strategy is now in the roll-out stage and the work continues to develop more bespoke, focused comms plans relating to each programme. Key actions currently in progress: • Stakeholder engagement and communications

Strategic Delivery Group now established to support the operational implementation of the strategy and supporting plans. Update on each element of the strategy provided within this escalation report.		• Accountability framework – Exec leads / SROs to report to STC bimonthly. • Validation of benefits across all project work • Estates plan, people plan, and finance plan being prepared for approval. • Develop Clinical strategy for board sign off
Clinical Strategy – Timeline & Engagement Plan Update provided on the development of the Trust's new Clinical Strategy – this will identify a set of clinical themes and principles to guide development of services from 2024 – 2031. Several workshops have now taken place and engagement with internal and external stakeholders continues	The strategy will sit alongside the overall strategy in the local and regional context recognising the local population health issues and the role of a modern District General Hospital in a wider system.	It is expected that through a series of engagement events and workshops, the Clinical Strategy will be ready for board approval in March 2024 and will be launched in April 2024. Further discussion with place-based partners
Green Plan Annual Review Update provided on progress with the Green Plan approved in 2022. The first year of Green Plan implementation has been one of building relationships and laying the foundations for future years. Several groups have been established with a focus on driving reductions in carbon emissions – this includes clinical teams, facilities and estates working alongside Atlas	Progress made although some way to go to meet target – Green Plan Steering Group is operating well with good engagement. Discussed the potential funding for de-carbonisation plan and potential opportunities to apply for grant funding. All committed to supporting the green agenda including learning from other public and private sector organisations.	Next steps are to secure further engagement across the Trust to continue to deliver positive progress. This will include a continued focus on modal shift and hybrid working to reduce emissions from staff journeys; and working with Atlas to develop plans and seek funding to decarbonise the estate. Consideration to be given to an invest to save business plan with detailed costings including de-carbonisation plan. Review will be provided in full to the Board of Directors.
Health Inequalities Plan The Health Inequalities plan approved by the Board is now ready for launch, partners including governor are engaged in the plan and the Anchor Framework which are now aligned under one steering group.	Work to embed Equality and Health Inequalities Risk and Impact Assessments in the STP is likely to extend the EDI considerations for the Trust to consider wider groups including those facing socioeconomic deprivation, challenges due to geographical location. Committee members discussed the delivery of the Health Inequalities Action plan	The first meeting of the Health Inequalities and Anchor Steering Group will take place in quarter 3.
Digital Enabling Plan	Some challenges in relation to projects that are reliant on others -LIMS and PAS risk previously escalated to Board.	Focus efforts to deliver PAS and LIMS projects to their new timescales and plans. Progress internal improvement schemes around the B.Digital

Update provided on the Trust's digital enabling plan – new digital transformation programme will oversee the delivery of priority digital schemes for the Trust	Discussed the implementation of PAS and the support that will be needed to deliver operationally.	Promote the B.Digital Champions programme and encourage participation. Continue to balance digital enabling schemes with QEP targets.
QI Enabling Plan Update provided on progress against the priority goals in the QI enabling plan. In summary the priority goals are: • Building capacity and capability • Reducing avoidable harm • Reducing preventable deaths • Improving the last 1000 days of life • Progress towards the agreed goals is on track	Noted the impact of operational pressures and the importance of ensuring engagement in QI opportunities	Clinical Quality Academy to launch in November
STP Portfolio Dashboard Dashboard report provided on the 15 projects and 77 workstreams setting out the deliverables for Q2 and Q3 and the year one target benefits. Scope of the programme continues to expand and does have resource implications. Financial benefits of STP are being evaluated	Committee members discussed the capacity and timing to deliver the STP alongside operational delivery recognising the task in workstream to engage with those who are driving the process of delivery. As outlined in the BAF and on the highlight report the biggest challenge is engagement in a context of operational pressures.	Programme leads to escalate any challenges to delivery
Clinical Priorities Frailty business case now approved, looking to appoint specialist clinicians. Risks escalated in relation to ward realignment – good engagement from clinical schemes but moves are complex with multiple interdependencies.	Discussed the engagement with staff and the complexities of managing the "jigsaw" of ward moves to ensure support for staff who are impacted by ward moves	
Clinical Productivity Meetings underway, project leads are engaged – national mandate on the NHS Patient Initiated Digital Mutual Aid System (PIDMAS) aims at offering all patients the ability to opt to a move to an alternative		Will continue to monitor concerns in relation to PIDMAS

provider if they have been waiting for over 40 weeks – this presents a challenge and risks in terms of capacity constraints.		
Space The space programme is reviewing all clinical and corporate services to ensure space is optimised for clinical use.		Renegotiation of lease has resulted in significant savings.
Workforce Programme on track – progress made in admin and corporate workstream		Agreed to review the scope of the programme
Assure		

Committee/Group Escalation Report

Appendix A

Terms of Reference – Strategy and Transformation Committee

1 Constitution

The Strategy and Transformation Committee (STC) is a performance oversight and operational committee of the Board of Directors and to enable the Executive Director of Strategy and Transformation to execute their function to oversee the transformational activities, including STP and Enabling Plans required to deliver the Trust strategy and regulatory improvements.

2. Main Authorities/Limitations

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of third parties with relevant experience and expertise if it considers this necessary.

3. Reporting Arrangements

The Committee will be accountable to the Board of Directors. The minutes of Committee meetings shall be formally recorded and approved by the subsequent meeting. The Chair of the Committee shall through the Chair's report to draw the attention of the Board to any issues that require disclosure to the full Board or require executive action.

Executive Directors will use the Strategy and Transformation Committee to provide assurance into existing assurance structures where there is alignment with the assurance requirements of those committees.

The Board of Directors will receive a quarterly assurance report from the Strategy and Transformation Committee on progress, risks, mitigations, and actions against the strategic priorities.

The annual work plan of the Committee may be reviewed by the Audit Committee at any given time.

4. Purpose

The STC has been established to oversee:

- Development and oversight of the transformational programmes of work that have been prioritised within the STP to deliver the Trust strategy, and transformations linked to regulatory improvements.

- Agree and oversee the Trust annual work plan to deliver the Trust transformations.
- Connect to, influence, and understand the impact of the wider Healthier Lancashire and South Cumbria ICS and Place and Provider Collaborative Board transformational programmes.
- Make necessary transformation decisions and receive decision requests and escalations from Programme Boards.

The STC has the following sub-groups led by the following Deputy Directors:

- Workforce Programme Group – Deputy Director of People and Culture.
- Operational Programme Group – Director of Operations and Performance.
- Clinical Programme Group – Deputy Medical Director.
- Space Programme Group – Deputy Director of Facilities.

The STC will draw upon other external governance structures, including:

- Place Based Partnership Board.
- Provider Collaborative Co-ordinating Group.
- Integrated Care Board.

5. Main Duties and Responsibilities

The STC will:

- Deliver any activity within its terms of reference and produce an annual work programme to discharge its responsibilities.
- Assess and apply external direction to the oversight and delivery of all transformation programmes within the remit of the STP.
- Agree and transfer transformation programmes to business as usual where projects have become established and sustained.
- Monitor progress and impact of the transformation programmes on capital and revenue.
- Ensure all the work of the group is led by the highest possible standards relating to:
    - Evidence and Benchmarking
    - Diversity and Inclusion, incorporating social value
    - Probity and transparency
    - Public involvement and engagement.
- Oversee the implementation of transformation programme KPIs, project briefs and change logs, key outcomes, and high-level plans for all subgroups across the following key areas:
    - System level
    - Place Based Partnership
    - Provider Collaborative level.
- Receive updates on progress, risks, mitigations, and actions against the Trust's 12-month objectives and regulatory actions including projects that impact on the Trust Place, Provider Collaborative or System Level.
- Receive assurance on the delivery of the Transformation Programme, ensuring the appropriate allocation of resource.

- Ensure financial forecasts and plans are in place for each Objective supporting an integrated approach to programme delivery.
- Ensure that any risks associated with transformation are managed via the Risk Register and in accordance with the Risk Management Policy.
- Approve and prioritise initiatives/activities through the appropriate governance forums, ensuring they make best use of resources and capability in line with overall organisational strategy Change control – review / assurance.
- Resolve any competing priorities or other areas of disagreement that may arise from time to time and escalate issues as appropriate.
- Use the experiences, skills, and knowledge of the membership to support the organisation and champion best practice around Transformation.
- To ensure all Trust Service Transformation programmes are co-produced and take a planned approach to change management and benefits realisation – working with the PMO and People Participation Team.
- To ensure all Trust Service Transformation programmes are embedded within Operational and Support Services.

6. Lead Executive

The lead executive for the STC will be the Deputy CEO (Strategy, Operational Performance, Transformation & Digital) ~~Director of Strategy and Transformation / Deputy Chief Executive Officer.~~

7. Membership

The STC will consist of the following members:

- Chief Executive (Chair)
- Deputy CEO (Strategy, Operational Performance, Transformation & Digital)
- Executive Medical Director
- Executive Director of People and Culture
- Executive Director of Nursing, AHPs, Midwives and Quality
- Executive Director of Integrated Care
- ~~Chief Operating Officer~~
- Executive Director of Finance
- Director of Corporate Governance
- Director of Operations and Performance
- Deputy Director of Strategy and Transformation
- Deputy Director of Finance
- Deputy Directors of Nursing
- Deputy Medical Directors
- Deputy Director of People and Culture
- Head of Communications
- ~~Deputy Chief Operating Officer~~

Additional members may be co-opted onto the STC at the discretion of the Committee or its Chair. Representatives may be asked to attend the meeting for ad-hoc requirements.

8. Chair

The Committee will be chaired by the Chief Executive, in their absence the meeting will be chaired by one of the other Executive Directors.

9. Quorum

A quorum shall consist of four members, two Executive Directors and two additional members. Where a quorum cannot be established the STC will continue to meet but will be unable to approve any recommendations.

10. Decisions

Decisions by the Committee must accord with the requirements of the Standing Orders and the Scheme of Delegation – General Principles and be reported to the next available Board of Directors meeting via the Chair report.

11. Attendance

It is highly important that members attend on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. executive members are expected to nominate a deputy to attend in their absence.

If a Committee member or regular attendee is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. The Chair of the Committee will also be required to bring to the attention of the Chair of the Trust if they feel that lack of attendance has not enabled adequate discussion or decision making.

12. Frequency of Meetings

Meetings will be scheduled bi-monthly.

Additional meetings may be called at the discretion of the Chair if appropriate.

13. Agenda and Papers

An agenda for each meeting, together with relevant papers, will be forwarded to Committee members no later than 5 working days before the meeting.

Standard Agenda Items

The Committee will approve an annual workplan to ensure appropriate oversight of all areas deemed to be within its remit. The following items will be received bi-monthly:

- Minutes and actions from the previous meeting
- Board Assurance Framework (BAF)

14. Organisation

The Committee will be supported by the Corporate Governance team whose duties in this respect will include:

- Agreement of the agenda with Chair and collation of papers.
- Taking the minutes and keeping an action log of matters arising and issues to be carried forwards.

Minutes of the meeting will be approved by the Committee members.

15. Conduct of Meetings

The Chair of the Committee will be supported by the Director of Corporate Governance who will ensure that the appropriate processes are followed:

- Minutes and action log are accurate, comprehensive, and timely;
- The agenda and supporting papers are sent out to Committee members five working days prior to the meeting, unless authorised by the Chair for exceptional circumstances;
- Authors of papers presented must use the required template;
- Presenters of papers can expect all Committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues;
- Committee members and those in regular attendance should actively participate in discussions pertaining to the agenda, ensuring that solutions and action plans have multidisciplinary perspectives and consideration of Trust-wide impact.

16. Monitoring Effectiveness

The STC will undertake an annual review of its performance against its annual work plan, to evaluate the achievement of its duties this will inform the production of a board transformation review by the Board of Directors each year.

17. Review of Terms of Reference

These Terms of Reference will be reviewed at least annually. Changes to these Terms of Reference must be approved by the Board of Directors.

Blackpool Teaching Hospitals NHS Foundation Trust

Title	Roles and Responsibilities 2023

Meeting:	Board of Directors
Date:	2 November 2023

Author	Esther Steel Director of Corporate Governance					
Exec Sponsor						
Purpose	Assurance		Discussion	✓	Decision	
Confidential y/n	No					

Summary *(what)*	**Advise** The NHS Code of Governance sets a requirement for a written document clearly setting out the responsibilities of the chair, chief executive, senior independent director if applicable, board and committees this should be agreed by the board of directors and publicly available.

Implications *(so what)*	**Alert** The current version of this report was produced in 2015 **Assure** While the current version has not been updated since 2015 it covered the requirements of the Code and therefore our declaration of compliance was correct

Previously considered by	Discussed within the private Board meeting and reviewed by Board members in advance of this meeting

Link to strategic objectives	Our People	
	Our Place	
	Our Responsibility	

Equality, Diversity and Inclusion (EDI) implications	The Board are aware of the EDI requirements and committed to actions agreed in the Anti-Racist framework, WRES and WDES

Proposed Resolution *(What next)*	Board members are asked to approve for publication.

Purpose of this paper

One of the requirements of both the 2014 version of the Code and the new version is the need to have a clear document setting out the roles of the Chair, the Chief Executive, the Senior Independent Director and the Board and its Committees – this should be approved by the Board and should be publicly available.

A new Corporate Governance manual is being developed that will include the above and all other relevant aspects of the code; this report focuses on the development of a revised declaration of the responsibilities of the Chair and CEO this includes but is not limited to covering the following principles in the Code – it is recommended that this is produced in a format that is accessible and understandable for our staff, our patients and our governors.

A full copy of the code was provided to Board members in advance of the meeting – this is available online here – NHS England » Code of governance for NHS provider trusts

Proposed Declaration

The document below sets out a proposed declaration as required by the code, this has been based on the NHS Providers Foundations of Good Governance model declaration.

Statement of Responsibilities

One of the principles within the *Code of Governance for NHS Provider Trusts 2023* ("the NHS Code") is that responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. The NHS Code notes that, as part of this, no individual should have unfettered powers of decision.

The Code recommends that the responsibilities of the Chair, the Chief Executive, the Senior Independent Director, the Board and its Committees should be set out in writing, agreed by the Board of Directors and made publicly available (B.2.13). These responsibilities are set out in the following statement.

Responsibilities of the Board of Directors and its Committees

The Board of Directors is responsible for setting the overall strategic direction of the foundation trust. The business of the foundation trust is managed by the Board of Directors and all the powers of the foundation trust are exercisable by the Board of Directors on its behalf. The matters that the Board has reserved to itself and those which have been delegated to individual directors or committees are clearly documented within a Scheme of Delegation. The Board operates in accordance with Standing Orders and the organisation operates in accordance with financial rules agreed by the Board in Standing Financial Instructions.

NHS boards play a key role in shaping the strategy, vision and purpose, hold the organisation to account for the delivery of strategy and ensure value for money. The board is also responsible for assuring that risks to a trust and the public are managed and mitigated effectively.

The board of directors is made up of executive directors and non-executive directors.

The executive directors are employees of the Trust they are led by the chief executive and are responsible for the day to day management of the foundation trust. Foundation trust boards must include the following executive directors: a finance director, a director who is a registered doctor, a director who is a registered nurse or a registered midwife.

The non-executive directors are not employees. They bring an independent perspective to the board meeting and have a particular duty to challenge decisions and proposals made by executive directors.

All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance B.2.16)

Board Committees

The Board has established a number of committees in order to have oversight and to seek assurance in specified areas. Each of these committees has clear terms of reference which set out the scope of the committee's responsibilities and any delegated powers given to it by the Board.

The Committee Chair reports back to the Board after each meeting, providing assurance and escalating risks as appropriate.

The Committees established by the Board are:

Remuneration Committee

The Remuneration Committee is responsible for identifying and appointing candidates to fill all Executive Director positions on the Board (both permanent and interim) and for determining their remuneration and other conditions of service. When appointing the Chief Executive, the committee is the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act): 'It is for the Non-Executives to appoint or remove the Chief Executive'.

When appointing the other Executive Directors, the Committee is the committee described in Schedule 7, 17(4) of the Act: 'It is for a committee of the Chairman, CEO and other NEDs to appoint or remove the Executive Directors'

Audit Committee

The purpose of the Committee is to maintain oversight of and provide assurance to the Board with regard to:

- the integrity of the Trust's financial statements and reporting of financial performance;
- the relevance and robustness of governance structures; and
- the effectiveness of the Trust's systems of risk management and internal control

Quality Assurance Committee

The Quality Assurance Committee is the primary mechanism by which the Board gains assurance on the quality of care and treatment in all services provided by the Trust

Finance and Performance Committee

The Finance and Performance Committee is responsible for providing information and making recommendations to the Board of Directors on financial and operational performance and for providing assurance that these are being managed safely.

Workforce Assurance Committee

The Workforce Assurance Committee is responsible for seeking assurance on behalf of the Board that the Trust implements best practice in workforce culture, HR, learning and development and leadership and help to identify priorities and risks on a continuing basis.

The Committee will ensure that equality and inclusion and due consideration to the Human Rights Act are regarded in all aspects of the committee's work.

Charitable Funds Committee

The Board has a Charitable Funds Committee to support its role as Corporate Trustee of the Blue Skies Charity – the Charity is an entity in its own right, the Board as a body corporate is the sole trustee.

Responsibilities of the Chair and Chief Executive

The respective responsibilities of the Chair and Chief Executive are set out in the table below:

(source: NHS Providers and DAC Beachcroft Foundations of Good Governance – A compendium of Good Practice 3rd Edition)

Chair	Chief Executive
Reports to the Board of Directors.	Reports to the Chair and to the Board of Directors.
Other than the Chief Executive, no executive reports to the Chair.	All members of the management structure report, either directly or indirectly, to the Chief Executive.
Ensures effective operation of the Board of Directors and Council of Governors.	Runs the foundation trust's operation and day-to-day business.
Ensures that the Board of Directors as a whole play a full part in the development and determination of the foundation trust's strategy and overall objectives.	Responsible for proposing and developing the foundation trust's strategy and overall objectives.
The guardian of the Board of Directors' decision-making processes.	Implements the decisions of the Board of Directors and its committees.
Leads the Board of Directors and the Council of Governors.	Ensures the provision of information and support to the Board of Directors and Council of Governors.
Ensures the Board of Directors and Council of Governors work together effectively.	Facilitates and supports effective joint working between the Board of Directors and Council of Governors.
Oversees the operation of the Board of Directors and sets its agenda.	Provides input to the board of director's agenda on behalf of the executive team.
Ensures the agendas of the Board of Directors and Council of Governors take full account of the important issues facing the foundation trust.	Ensures the Chair is aware of the important issues facing the foundation trust and proposes agenda items accordingly.
Ensures the Board of Directors and Council of Governors receive accurate, timely and clear information.	Ensures the provision of reports to the Board of Directors which contain accurate, timely and clear information.
Ensures compliance with the Board of Directors' approved procedures.	Ensures the compliance of the executive team with the Board of Directors' approved procedures.
Arranges informal meetings of the directors to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues.	Ensures that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the foundation trust.
Proposes a schedule of matters reserved to the Board of Directors; proposes terms of reference for each Board of Directors committee and proposes other board policies and procedures.	Provides input as appropriate on changes to the schedule of matters reserved to the Board of Directors and committee terms of reference.
Facilitates the effective contribution and the provisions of effective challenge by all members of the Board of Directors.	Supports the Chair in facilitating effective contributions by executive directors including effective challenge.
Ensures that constructive relations exist between elected and appointed members of the council of governors.	Supports the chair in ensuring constructive relations between elected and appointed members of the council of governors.

Chair	Chief Executive
Ensures constructive and productive relations between the board of directors and the council of governors.	Supports the chair in ensuring constructive relations between the board of directors and the council of governors.
Ensures that the non-executive directors are able to lead in being accountable to the council of governors for the board of directors.	Ensures the presence and support of executives to the non-executive directors in order to facilitate the accountability relationship.
Leads the council of governors in holding the non-executive directors to account, ensuring the accountability process works effectively.	Supports the chair in delivering an effective accountability process.
Chairs the remuneration committee and initiates change succession planning measures at board level to ensure appropriate change. Ensures the appointment of effective and suitable members and chairs for board of directors committees.	Provides information and advice on succession planning to the chair, the remuneration committee and to other members of the board of directors, particularly in respect of executive directors.
Proposes the membership and the chairs of board of directors committees.	If so appointed by the board of directors, serve on any committee.
Ensures effective communication on the part of the trust with patients, members, clients, staff and other stakeholders.	Lead the communication programme with members and stakeholders.
Lead the provision of a properly constructed induction programme for new directors.	Contribute to induction programmes for new directors and ensure that appropriate management time is made available for the process.
Lead in updating the skills and knowledge and in meeting the development needs of individual directors and of the board of directors as a whole.	Ensure that the development needs of the executive directors and other senior management staff are identified and met.
Ensure that members of the council of governors have the skills, knowledge and familiarity with the foundation trust to fulfil their role.	Ensure the provision of appropriate development, training and information for the council of governors.
Ensure that the performance of the board of directors and council of governors as a whole, their committees, and individual members of both are periodically assessed. This will include an externally led assessment at least once in every three years.	Ensure that performance reviews are carried out at least once a year for each of the executive directors. Provide input to the wider board of directors' and council of governors' evaluation process.
Promote the highest standards of integrity, probity and corporate governance throughout the Trust and particularly at board of director level.	Conduct the affairs of the foundation trust in compliance with the highest standards of integrity, probity and corporate governance. Promote continuing compliance across the organisation.
Ensure a good flow of information each way between the board of directors, board committees, the council of governors, senior management and non-executive directors.	Provide effective information and communication systems.

Responsibilities of the Senior Independent Director

The Senior Independent Director is appointed by the Board of Directors, in consultation with the Council of Governors. The role of the Senior Independent Director is to:

- act as a sounding board for the Chair and to serve as an intermediary for the other directors when necessary;
- lead the performance evaluation of the Chair, within a framework agreed by the Council of Governors, taking into account the views of directors and governors;
- lead meetings of the non-executive directors without the Chair present at least annually to appraise the Chair's performance and on such other occasions as are deemed appropriate;
- report the outcomes of the Chair's appraisal to the Council of Governors;
- be available to governors if they have concerns that contact through the normal channels of Chair, Chief Executive, Chief Finance Officer or Company Secretary has failed to resolve or where such contact is inappropriate; and
- attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of their views, issues and concerns.

Responsibilities of the Executive Directors

NHS Executive Directors have a vital role in the overall functioning of the healthcare system, with the specific focus and responsibilities varying depending on their position and the specific department or service they lead their responsibilities typically include:.

- Strategic Leadership - developing and implementing the Trust's strategic vision and goals.
- Operational Oversight of the day-to-day operations of their service, ensuring that it runs efficiently and effectively.
- Financial Management with responsibility for managing budgets, allocating resources, and ensuring financial sustainability.
- Ensuring high-quality patient care and safety is a primary concern, including managing clinical services and improving patient outcomes.
- Managing staff, including hiring, training, and performance evaluations
- Stakeholder engagement and strategic partnerships including government bodies, local authorities, patient groups, and healthcare professionals.
- Regulatory compliance and public accountability- ensuring that the department or service complies with all relevant healthcare regulations and standards.
- Promoting innovation, improvement and best practice in healthcare delivery and management.
- Crisis Management – the management response to unexpected events that can affect healthcare services, such as public health emergencies.

Responsibilities of the Non-Executive Directors

The Non Executives of the Trust are appointed by the Council of Governors and work alongside other non-executive and executive directors as an equal member of the board. They share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services for patients.

Non Executives use their skills and personal experience to bring independent judgement and an external perspective to provide constructive challenge and strategic guidance.

Non-executive directors have a key role in appointing and removing executive directors. They should scrutinise and hold to account the performance of the executive directors against agreed performance objectives.

Responsibilities of the Council of Governors

The Council of Governors is comprised of governors who have either been elected from amongst the various constituencies within the foundation trust's membership or appointed by one of our partner organisations. The Council of Governors has two general duties:

1. To hold the non-executive directors to account, individually and collectively, for the performance of the Board of Directors; and
2. To represent the interests of the foundation trust's members as a whole and the interests of the public.

Additionally, the Council of Governors also has a number of specific responsibilities as set out below:

- To appoint and, where necessary, remove the Chair and the other non-executive directors;
- To approve the appointment of a Chief Executive by the non-executive directors;
- To decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors;
- To appoint or remove the external auditor;
- To appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the foundation trust's affairs;
- To be presented with the annual accounts, any report of the external auditor and the annual report;
- To approve significant transactions as defined within the constitution;
- To approve an application by the foundation trust to enter into a merger, acquisition, separation or dissolution;
- To decide whether the foundation trust's non-NHS work would significantly interfere with the fulfilment of its principal purpose (which is the provision of goods and services for the purposes of the health service in England) or the performance of its other functions;
- To approve amendments to the constitution;
- To provide their views to the Board of Directors when the Board is preparing the foundation trust's forward plan;
- To prepare, and from time-to-time review, the membership strategy and the policy for the composition of the Council of Governors, and
- Where appropriate, to act collectively and through individual governors to communicate with members about developments in the foundation trust and the work of the Council of Governors.

This statement was approved by the Board of Directors at its meeting on xxxx.

Steve Fogg
Chair

Trish Armstrong-Child
CEO

For and on behalf of the Board of Directors

Appendix – lead roles document

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

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

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
Director of Infection Prevention and Control	An individual with overall responsibility for infection prevention and control and accountable to the registered provider in NHS provider organisations.	Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance	Bridget Lees - Executive Director of Nursing, 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.	Andy Roach – Non Executive Director

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
		• 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.	
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

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Katy Coope - 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
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)

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
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
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

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
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	depending on the speciality - appropriate clinical lead
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

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
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 Poxon 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
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

Appendix – Regulatory and Mandatory lead roles (approved by Board September 7 2023)

Post	Description	Required by	Post holder
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 –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

Title	EPRR Annual Assurance 2023

Meeting:	Board of Directors in Public
Date:	2 November 2023

Author	Neil Williams, Emergency Planning Manager and Steve Faulkner, Emergency Planning Officer					
Exec Sponsor	Janet Barnsley, Executive Director of Integrated Care and Accountable Emergency Officer for EPRR					
Purpose	Assurance	✓	Discussion		Decision	
Confidential y/n	N					

Summary *(what)*	**Advise** The report provides an overview of this year's Emergency Preparedness Planning and Response (EPPR) Annual Assurance return required as part of the NHS EPRR Framework in line with the NHS EPRR Core Standards. This year the full range of questions apply; 62 across 10 domains. A further 10 questions have been asked in relation to the deep dive exercise which is associated with training. The deep dive does not contribute towards the Trust's overall compliance rating. This year's process requires evidence to be submitted to support the assessment of all core standards including deep dive. This is an additional requirement to previous years. The Trust will be submitting a compliance level of 'Substantial' meeting 97% of the criteria.
Implications *(so what)*	**Alert** It should be noted that 2 metrics are marked as partially compliant from the main assurance criteria and 1 metric is marked as partially compliant from the deep dive exercise. A workplan is in place to make these items fully compliant ahead of the next assurance return exercise. The workplan is illustrated in table 3 of appendix 1. **Assure** The EPRR Manager, EPRR Officer and Executive Director of Integrated Care/Accountable Emergency Officer have recently completed this year's EPRR Assurance submission on behalf of the Trust. The detail and results can be found below. The purpose of this report is to make the Quality Assurance Committee and Trust Board aware of the EPRR assurance process and compliance along with supporting information.

	The report provides the following: • Timeline for the assurance process • Breakdown of scoring criteria • Statement of compliance • Action Plan In summary, • The Trust continues to be '**substantially**' compliant against the Core Standards. • An action plan is required to ensure any areas of non or partial compliance are addressed. This is included in the report. The full EPRR response is attached as appendix 1. For this year's assurance exercise the deep dive is in relation to EPRR training. During last year's assurance exercise the Trust was substantially compliant with 4 of the 62 core standards meeting partial compliance. 3 out of the 4 have been addressed which were in relation to decontamination training and the final standard of partial compliance is in relation to evacuation and shelter. The Trust guidance document for mass evacuation and shelter will be ratified ahead of this year's submission (*consultation for the policy closes 20th September*) which will then close down this outstanding action. A pre-submission meeting with the ICB's Head of EPRR, BTH Emergency Planning Manager and Emergency Planning Officer took place on 08th September to discuss this year's submission including evidence and the ICB representative agreed with our self-assessment of substantial compliance based upon the evidence to be submitted which was displayed during the meeting.

Previously considered by	Updates to: • Quality Assurance Committee – 24.10.23 • Emergency Planning Steering Committee – 06.09.2023 • Clinical Governance Committee – 14.09.2023

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

Equality, Diversity and Inclusion (EDI) implications	Yes, across all assurance domains, the requirement for local planning arrangements need to take account of patients, staff and visitors.

Proposed Resolution ***(What next)***	To note the report and findings and the timeline for approval in order to be submitted to NHSE via the ICB by the timelines noted in the report. To support any short-term actions to enable further compliance ahead of the Assurance Return being finalised.

Appendix 1

Summary:

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
62	xx	2	62
Acute providers: **62**			

There are no areas of non-compliance with regard to the core standards however there are 2 areas of partial compliance out of a total of 62. These can be found in table 3 along with an action plan to bring them in to the fully compliant category. The action plan progress will be reviewed and monitored via the Emergency Planning Steering Committee.

Overall compliance with the standards is confirmed as **'Substantial'**. This report will be formally submitted to the Integrated Care Board. This would normally follow Trust Board approval however due to a conflict in timelines the internal governance and submission runs in parallel. It will then be discussed at the Local Health Resilience Partnership (LHRP) meeting prior to submission to NHSE/I.

This report highlights the current Trust position and recommendations of further actions to be taken to improve the compliance with the standards.

A deep dive exercise has been conducted in relation to training arrangements however the scores of the deep dive do NOT contribute towards the Trust's scores and compliance rating above.

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2023

The timetable for this year's EPRR process is highlighted below. Internally the submission is required to go through our own governance process and this schedule is below in table 1.

Table 1
The timetable of the internal governance process, where this report will be presented, is identified below:

- 06th September – BTH Emergency Planning Steering Committee
- 08th September – Pre-submission meeting with ICB
- 14th September – Clinical Governance Committee
- 26th September – Quality Assurance Committee
- 30th September– Submission to Integrated Care Board
- 02nd November – BTH Formal Board

Breakdown of Scoring

Table 2 below illustrates the breakdown of scoring for each of the assurance criteria. Table 3 towards the end of this report is an action plan of how the Trust aims to become fully compliant in each of the partially met criteria areas.

This year's Deep Dive topic is training. The deep dive questions are not part of the core standards and therefore the scoring does not count towards the Trust's overall compliance rating. There were 10 questions in relation to the deep dive, 9 areas are fully compliant with 1 being partially compliant. An action plan to address the partially compliant element is in table 3.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	10	0	0	1
Hazmat/CBRN	12	12	0	0	7
Total	**62**	**60**	**2**	**0**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	9	1	0	0
Total	**10**	**9**	**1**	**0**	**0**

Table 2

[Lancashire] Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023

STATEMENT OF COMPLIANCE

Blackpool Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS EPRR Core standards self-assessment tool.

Where areas require further action, Blackpool Teaching Hospitals NHSFT will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Janet Barnsley
Signed by the organisation's Accountable Emergency Officer

25/09/2023
Date signed

02/11/2023	02/11/2023	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Table 3 – Emergency Preparedness, Resilience and Response (EPRR) Core Standards Action

Action Plan				Overall Assessment	Substantially Compliant					
Ref	**Domain**	**Standard name**	**Standard Detail**	**Supporting Information**	**Organisational Evidence**	**Self assessment RAG**	**Action to be taken**	**Lead**	**Timescale**	**Comments**
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Emma looking to introduce the ELHT policy at BTH Covered briefly in section 7 of the EPRR Communications Policy	Partially Compliant	Develop a standalone protected individuals/VIP policy aligned to ELHT arrangements.	Emma Cooke - Trust Comms Team	Dec-23	
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Training records are in place. Seeking to improve by using ESR or other tool to develop a personal CPD portfolio. Current method is manual and held by the EPRR team. SMOC and DOC certificates of attendance and training recorded ocentrally on EPRR training records. CPD template developed – not yet in use.	Partially Compliant	Work with Workforce Development to identify if ESR can be used as a platform for EPRR CPD and portfolio.	Workforce Development & EPRR	Mar-24	Role out the manual CPD template until an automated version can be developed.
DD2	**EPRR Training**	**Minimum Occupational Standards**	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Certificate examples of attendance of tactical and strategic staff attendance on Principle of Health Commander courses. TNA aligned to NOS - Screenshot of Mod 1 - Intro to EPRR course. Mod 3 - Tactical PHC course. Mod 4 - Strategic PHC Course	Partially Compliant	Working with Workforce Development there is further work to do to develop individual CPD portfolios. Consider use of ESR.	Workforce Development and EPRR	Jun-24	We can demonstrate that we collect training data and hold centrally training attendance, however we will work with Workforce Development to identify the best method of individual portfolios. We have developed a manual template for individuals but we would like to explore the electronic option/s. TNA and course prospectus aligned to NOS.

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Title	Clinical Strategy Development

Meeting:	Board of Directors Meeting
Date:	02/11/23

Author	Jenny Gilpin Head of Planning					
Exec Sponsor	Chris Barben Executive Medical Director					
Purpose	Assurance		Discussion	✓	Decision	
Confidential y/n	N					

Summary *(what)*	**Advise**
	The attached Presentation provides the committee with a summary on the development of the Trust's clinical strategy. Once complete the strategy will provide a framework for all our clinical services, providing guiding principles by which focussed actions can be driven and future developments and potential investments can be determined. Our clinical strategy will identify a limited set of priority clinical themes and a set of principles to guide development of services over a 7-year period from 2024 to 2031. The BTH clinical strategy will sit alongside and support the Trust 5-year corporate strategy. Work on the strategy started in August 2023, several workshops have taken place to date with key senior leaders, patients and governors who have taken the time to consider the guiding principles against the National and Local strategic context and our Population health data. The presentation outlines the national, regional and local context in which we are developing a clinical strategy. It then outlines draft 'Guiding principles' and 'Priority clinical Themes' on which we wish to engage the organisation by the end of October 2023.

Implications *(so what)*	**Alert**
	There are no issues or risks for alert currently.
	Assure
	It is expected that through a series of engagement events and workshops, the Clinical Strategy will be ready for board approval in March 2024 and will be launched in April 2024.

Previously considered by	N/A

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

Equality, Diversity and Inclusion (EDI) implications	The development of the Clinical Strategy will be collaborative, the approach and actions of the Clinical strategy working party are intended to be inclusive and are therefore considered 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)***	Attendees of the forum are asked to review the presentation content and then submit individual feedback on the Guiding Principles and Clinical Themes using a Microsoft Forms Link https://forms.office.com/e/VnfuBeJ5MJ answering: 1. Do you agree with the Guiding Principles? 2. Do you agree with the Clinical Themes? 3. Do you agree with the Golden Threads?

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Clinical Strategy 2024-2031 Development

Sense Check

Aims of the sense check

Blackpool Teaching Hospitals NHS Foundation Trust

1. To reach an understanding of, and enthusiasm for, the need, process and everyone's role in developing a clinical strategy
2. To sense check the principles that will guide all future service developments
3. To sense check the priority clinical themes that will form the core of the clinical strategy

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Understanding Clinical Strategy

Why do we need a clinical strategy?

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

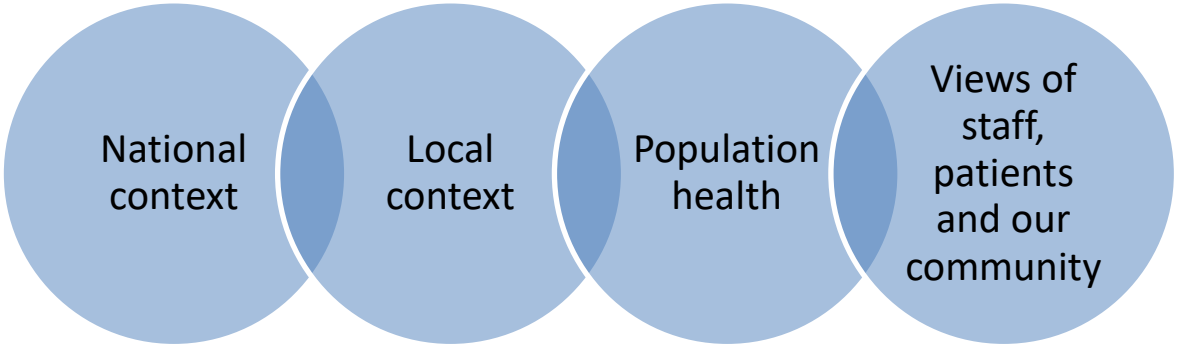
- To provide guiding principles for developments of all services
- To drive focussed action in key clinical areas
- To provide the future direction for site development
- To guide limited investments, in the context of finite resources and budgetary restraint

Our clinical strategy will identify a limited set of priority clinical themes and provide a set of principles to guide development of all services

What is a clinical strategy?

Blackpool Teaching Hospitals NHS Foundation Trust

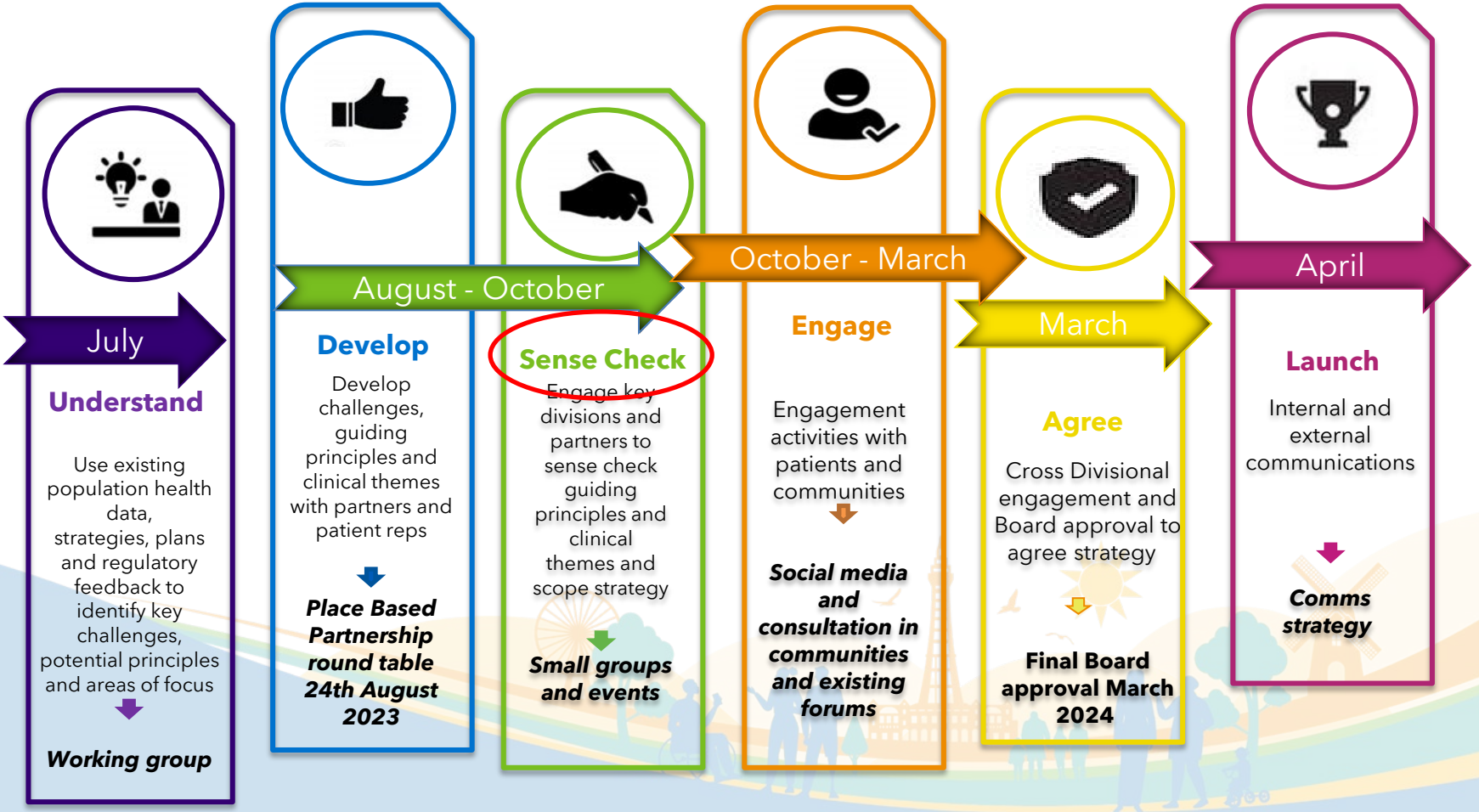
Outlines what our priority services will look like and how we will develop them over the next 7 years, taking account of:



A clinical strategy sits alongside and supports the Trust 5-year strategy.

How will we develop the clinical strategy?

Blackpool Teaching Hospitals NHS Foundation Trust



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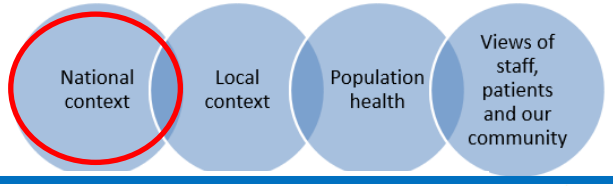
Context setting

National context



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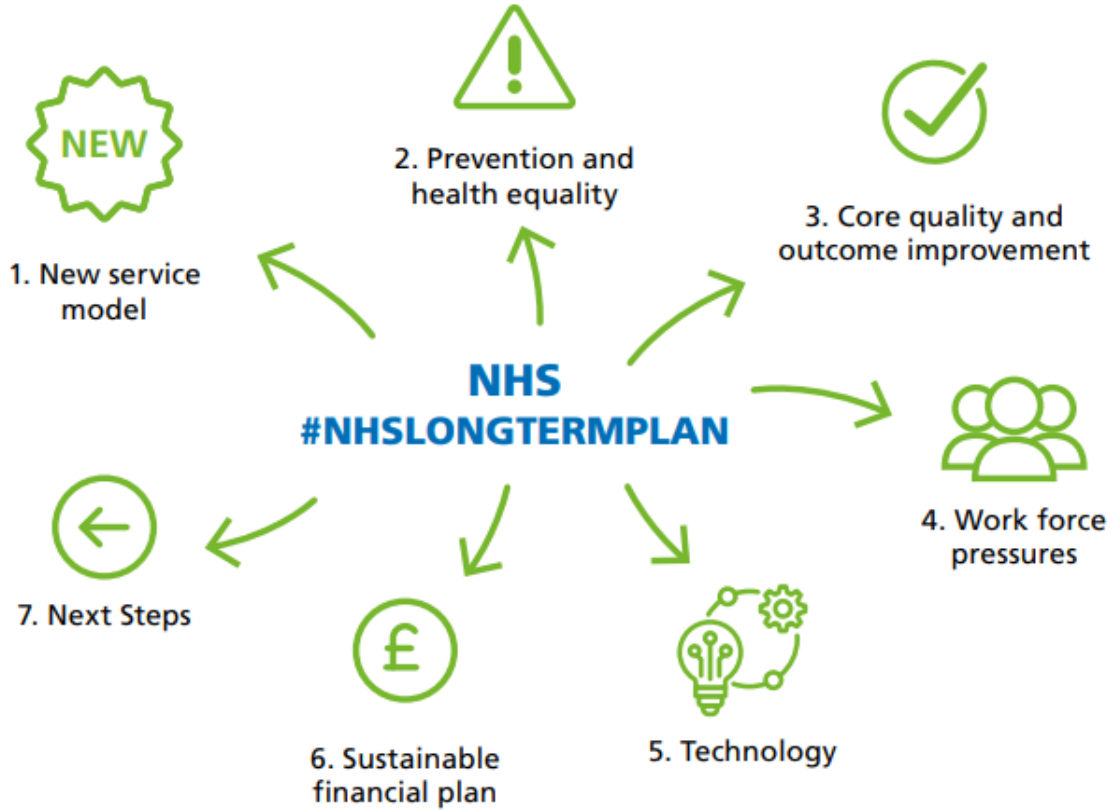
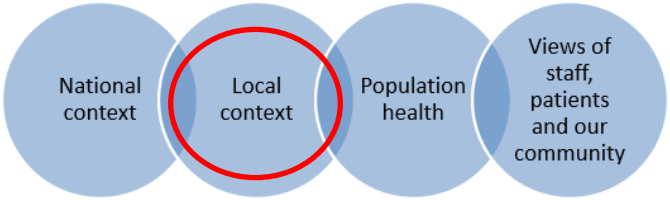


Local context



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Lancashire and South Cumbria

NHS and wider partners

Lancashire and South Cumbria Integrated Care Partnership (ICP)

A group of organisations and representatives that work together to improve the care, health and wellbeing of the population.

Integrated working within the NHS family

Lancashire and South Cumbria Integrated Care Board (ICB)

Established on 1 July 2022, the ICB is responsible for planning and buying health services in the region.

Provider collaborative

Health trusts working more closely together to jointly improve care and productivity for patients.

System

Four place-based partnerships

Our Blackburn with Darwen, Blackpool and Lancashire places cover the entire geography of their respective local authorities - Blackburn with Darwen Borough Council, Blackpool Council, Lancashire County Council and the twelve district councils.

Our South Cumbria place covers the geography of the newly created Westmorland and Furness Council, without the Eden District, some parts of the Borough of Copeland which sit within the newly created Cumberland Council, and some parts of the District of Craven which sit within the newly created North Yorkshire Council.

This means that we need to work with some local authorities and providers of health and care services that are outside of our borders.

Place

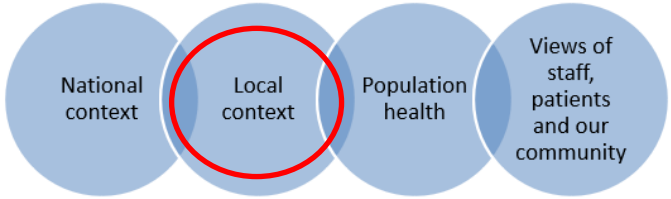
42 neighbourhoods

Neighbourhoods are where communities come together to shape and join up health and care services, but also to address the wider things that have an impact on their health. The exact size and shape of neighbourhoods is agreed locally within places. This is because each neighbourhood is different – they are based around footprints that make sense to communities, often related to specific towns or villages, or centred around resources available within a community.

Integrated working in these areas includes district councils, community groups and organisations, primary care services and wider health and care teams which will come together to form neighbourhood teams.

Neighbourhood

ICS Integrated Care Strategy



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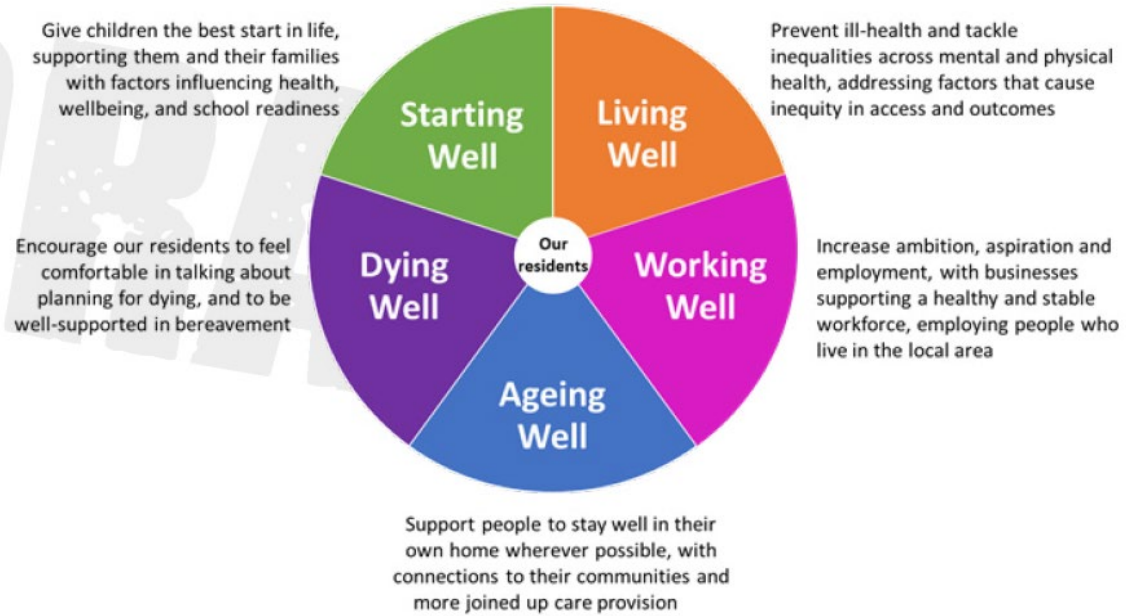
Priorities:

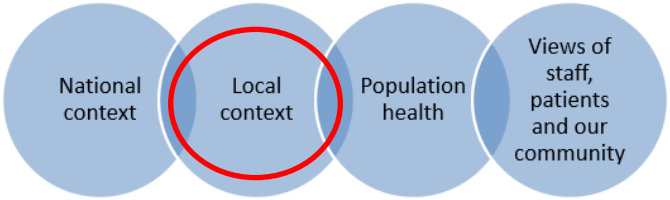
We have used a life course approach to describe our priorities:



Underpinning themes:

- One workforce across health and care
- Supporting unpaid carers
- Digital resources and use of information
- Our buildings
- Our commitment to sustainability

ICB NHS Joint Forward Plan for 2023 onwards



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STRENGTHEN OUR FOUNDATIONS

1. **Improve our long-term financial sustainability** and value for money through transformation with providers.

IMPROVE PREVENTION

2. **Prevent ill-health and reduce inequalities** by collaborating with partners.

IMPROVE AND TRANSFORM CARE PROVISION

3. **Integrate and strengthen primary and community care** at place with partners and providers.

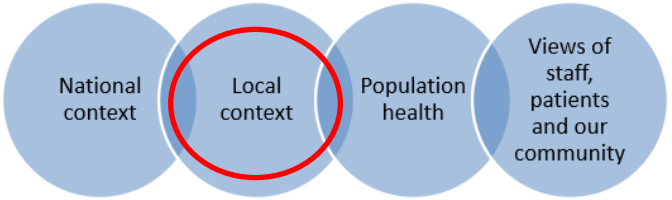
4. **Improve quality and outcomes** through standardisation and networking with providers.

WORLD CLASS CARE

5. **Deliver world-class care** for priority disease areas, conditions, population groups and communities.

Priority disease areas and conditions – cancer, mental health, maternity, cardiovascular disease, respiratory, priority population groups – children and young people, learning disabilities.

Provider Collaborative Clinical Strategy



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Vision

"Together we aim to ensure clinically and financially sustainable services that improve health outcomes, reduce health inequalities and offer a great place to work"

Overarching considerations

- Working together across the Provider Collaborative
- All clinical services following national standards and best practice
- Addressing health inequalities

Key themes

- Network delivery of services:
  - Services delivered in all hospitals with common clinical standards
  - Services delivered as a network
  - Specialised services delivered at one hospital site
- Delivery of care:
  - Close to home and increased use of digital technologies
  - Reconfiguration of centres of excellence for specialised services
- Mental health and autism
  - Joined up, holistic care for mental and physical health

5-year (corporate) strategy

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Our mission Why are we here?	To deliver safe, effective, sustainable care for everyone, everyday.			
Our vision What do we want to achieve?	We will improve the lives of people who live, work and volunteer on the Fylde Coast and beyond.			
Our aims How will we achieve this?	 **Our people** We will widen access to job opportunities, becoming the employer of choice within our community, with an empowered, diverse and engaged workforce	 **Our population** We will work with our population to co-produce high quality services, with a key focus on preventative care and reducing health inequalities	 **Our responsibility** We will work with partners to deliver high quality, financially sustainable services and reduce our environmental impact	
Our priorities What is important to us?	• Grow our own • Happy and healthy workforce • Learning culture	• Integrated care • Health inequalities • Prevention and health promotion	• Get the basics right • New ways of working • Investing in our community (Anchor)	

5-year strategy

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Summary of our priorities

Our people

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

Grow our own

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

Happy and healthy workforce

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

Learning culture

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

Our population

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

Health inequalities

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

Integrated care

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

Prevention and health promotion

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

Our responsibility

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

Get the basics right

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

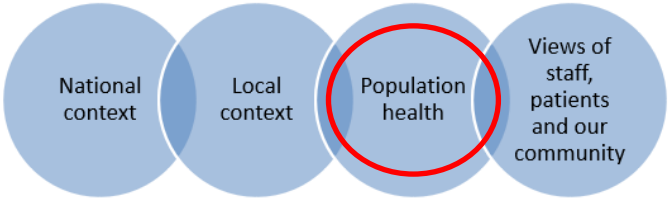
New ways of working

Use transformation, digital, innovation and research to deliver new efficient models of care to widen access, enhance health promotion and improve our environmental impact.

Investing in our community

Work collaboratively with our partners and communities to positively impact beyond health care.

Population Health



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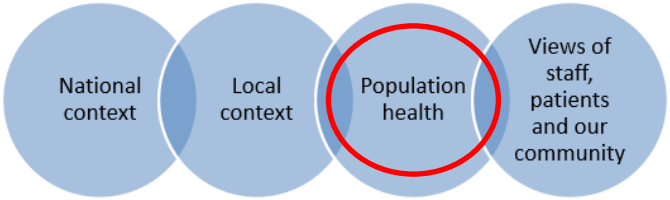
The Fylde coast population:

- Is significantly older population than the national average
- Is significantly more deprived population than the national average
- Combination of coastal and rural geographies
- Has poor health indicators: low life expectancy and high morbidity and mortality from a range of health conditions including respiratory, liver disease and CVD.
- 11% of the population has three or more long term conditions and 13% have complex health conditions
- Has high rates of lifestyle factors associated with poor health including obesity, alcohol consumption and substance misuse, smoking (including in pregnancy), poor diets and physical inactivity
- Has poor infant and child health indicators

Population Health: implications



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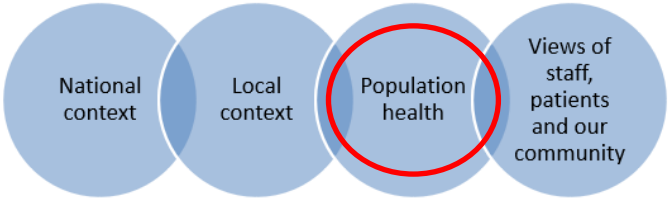
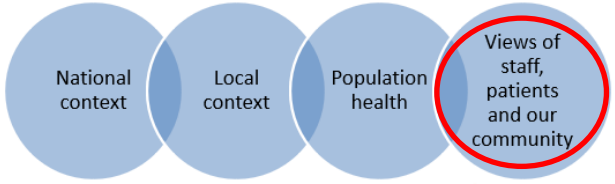
- Ageing population:
  - increased demands for health and social care.
  - Dementia, frailty, hearing and sight impairments are more prevalent.
  - More likely to rely on public transport and experience social isolation.
  - Informal carers face challenges to their mental and physical health.
- Socio-economic and geographic challenges:
  - Deprived areas are more likely to have poorer health and experience challenges with health promoting behaviours and accessing services.
  - Rural communities – social isolation, barriers to accessing health and social care due to longer travel distances, poor public transport links and digital exclusion
  - Health impacts of rural or poor-quality housing and fuel poverty

Population Health: implications



- Children and families:
  - Children and young people living in deprived households are likely to have poor health outcomes throughout their lives.
  - Women's poor health and wellbeing before and during pregnancy is associated with poor health outcomes for infants.
- New ways of working:
  - Increasing numbers of population with multiple LTCs requires new ways of working.
  - Much ill health is preventable and requires proactive care that focuses on prevention and overall population health.
  - Importance of designing services that meet the needs of the population and of providing care that is personalised.

Views of staff patients and our community



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Extensive engagement through the development of the Trust's five-year strategy:

- Staff engagement identified 550 change ideas
- Online survey of residents
- Engagement with Patient Experience Panel
- Engagement of education partners, schools and VCFSE groups to understand what is important to children and young people
- Didn't engage robustly outside of the organisation

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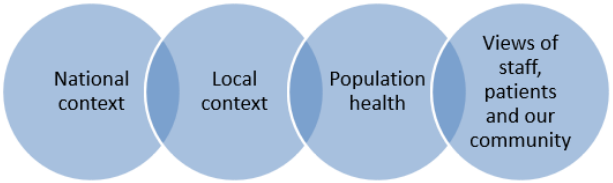
Key challenges

Key challenges



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- We are serving an **ageing population with increasing comorbidities** that require joined up and coordinated care across the health and social care system

- We need to **improve the quality of our services, in the context of varied expectations across generations**. Access to and experience of care varies depending on where people live.

- There are **significant differences in healthy life expectancy and quality of life** across different areas within the Fylde Coast. Recent data suggests this gap is widening and the cost-of-living crisis is expected to widen these further

- We have an **excess of morbidity and mortality that is preventable and premature**.

- **Cultural legacy of siloed working and lack of staff empowerment to drive change,** created through historic commissioning, organisational structures and professional norms

- Attracting, training, supporting and retaining the right **workforce is one of our biggest challenges** and a key challenge across the NHS and our partners

- **Not all our services are configured in the right way** to deliver high quality sustainable and accessible care. And the cost of delivering these services means we are **spending more than we receive**

- Historical **lack of capital, digital and workforce investment** has resulted in our assets becoming a hindrance rather than a benefit and restricted our opportunity for development

- **Advances in digital technology, innovation and AI** are currently missed opportunities to radically transform how we deliver our services

- **System reform in the absence of a clear vision** and **financial deficits** across all partners present a driver for change

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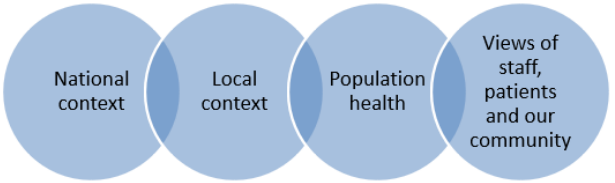
Guiding principles

Guiding principles



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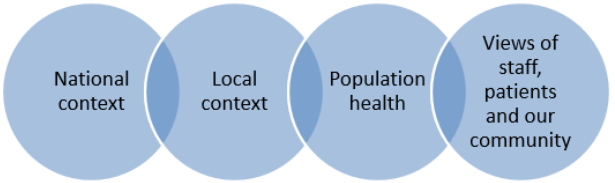
A shared set of principles that will apply to all service developments over the seven-year life of the clinical strategy.

Principles that we will apply to our services to help define both *what* we do and *how* we will do it.

Guiding principles



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Developments of all services between 2024 and 2031 should:

1. Provide a more **agile, coordinated, and integrated** model of care to meet the needs of local people of all ages and **empowers staff** with the delegated authority to deliver change
2. **Collaborate and codesign** with patients, communities, clinicians, and partners
3. Focus on **experience and outcomes** of our services as indicators of quality
4. **Embrace, enable, and empower** people through **technology, research,** and **digital solutions** to support service delivery, service access and self-care
5. Improve our ability to **attract, retain, train**, and support our clinical workforce for the future, with a focus on recruitment that is **local and inclusive**
6. Deliver greater financial **stability**, better **value** to the community and reduced **environmental impact**.
7. Use data and population health approaches across pathways to **tackle inequalities**, by delivering **p**roactive, **p**reventive, and **p**ersonalised care
8. Deliver services **locally where possible, centrally where necessary**

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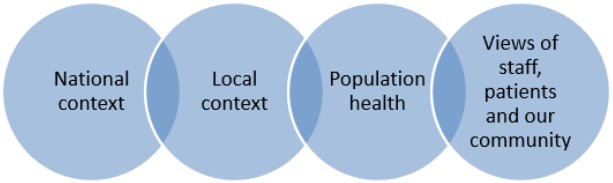
Priority clinical themes

Clinical themes



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Our areas of focus to describe where we want to be in seven years and how we will get there

Figure 6: Life course approach to priorities of the LSC Integrated Care Strategy

Clinical themes

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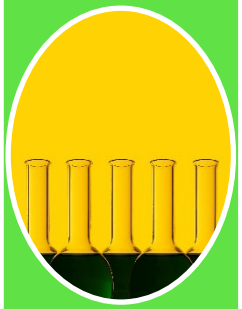
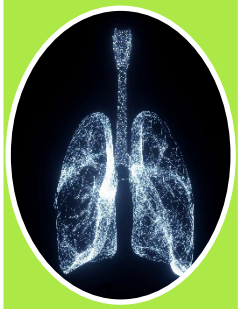
Women's health, maternity & neonates

Children and young people

Long term conditions



Cancer



Respiratory

Frailty

Tertiary

Golden threads: 1. mental health, 2. children and young people, 3. adults

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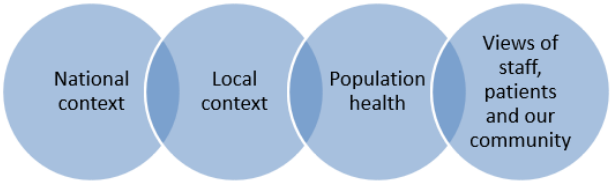
Feedback

Does this make sense?



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We welcome feedback on the proposed guiding principles, clinical themes and golden threads.

This can be through discussion here. Individual responses can be provided here: https://forms.office.com/e/VnfuBeJ5MJ

1. Do you agree with the Guiding Principles?
2. Do you agree with the Clinical Themes?
3. Do you agree with the Golden Threads?

Title	New Hospitals Programme Quarter 2 Board Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	2 November 2023		Discussion	
Author	Rebecca Malin, Programme Director Jerry Hawker, Programme SRO		Decision	
Exec Sponsor	Janet Barnsley, Executive Director of Integrated Care		Confidential y/n	N

Summary ***(what)***	The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 2 period: July to September 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)***	The report includes the progress against plan for July to September 2023, in particular providing an update on the enabling work business cases, further work on potential new site locations and the emerging new governance model.

Link to Strategic objectives		

Proposed Resolution ***(What next)***	It is recommended the Board: • Note the progress undertaken in Quarter 2. • Note the activities planned for the next period.

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 2 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. 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.

3 National New Hospital Programme

3.1 **Enabling works business case** – the Trusts were delighted to have been successful in obtaining funding to commence due diligence on the potential new sites e.g. technical ground surveys and supporting professional expertise. These works will continue for some time and will bring a greater level of certainty as to the deliverability of these sites ahead of public consultations.

3.2 **National guidance** – as part of cohort 4 of the national New Hospital Programme, L&SC NHP will be a full adopter of national guidance e.g. 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.

3.3 During Quarter 2, the L&SC NHP team have supported the national New Hospital Programme team with several data exercises including Hospital 2.0 assessment, costing approach and model and articulating benefits. These have been undertaken to support the national programme team in understanding the L&SC schemes in a greater level of detail and also to ensure a consistent approach across all new hospital schemes.. The L&SC NHP team have welcomed their continued involvement in a number of workshops focused on the development of national ambitions around Hospital 2.0.

4 Progress against plan (for the period July to September 2023)

4.1 **Potential new sites** –the L&SC NHP team has commenced significant preparatory work to appoint advisors to determine the viability of potential new sites for the new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital. In parallel, the Programme team will also continue to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – L&SC NHP is working with NHS England and the national New Hospital Programme team regarding the approach to future public consultations 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. The Strategic Oversight Group (SOG) has reviewed the milestones and dependencies to deliver the public consultations and the Decision-Making Business Cases (DMBC).

4.3 **Governance** – the enabling works (due diligence on the potential new sites) have shifted the programme into a delivery mode and the governance is now evolving to deliver these outcomes. It is anticipated new arrangements will be implemented during Q3 following presentation and discussion of the proposed terms of reference with the Trust's Board of Directors. The SOG has also reviewed and approved a revised risk management strategy and register focusing on the delivery of the programme objectives.

5 Public, patient and workforce communications and engagement

5.1 A summer series of national New Hospital Programme roadshow events visited Preston on 16 August 2023, as Government representatives arrived to discuss the next steps for building two new hospitals in the region. The roadshow event held at Royal Preston Hospital was an opportunity for Health Minister Lord Markham CBE to hear first-hand from staff and patients of University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust, as well as local NHS leaders, members of parliament and local councils, health and social care colleagues. Lord Markham saw first-hand the challenges of working in and being cared for in some of the current buildings. Conversations also explored what the rebuilds of Royal Lancaster Infirmary and Royal Preston Hospital could mean for those who access these facilities, including improving the working lives of staff and enabling patients to access outstanding care in new state-of-the-art hospital facilities, as well as the benefits of investing in improvements to Furness General Hospital. 94 people attended across the various sessions during the day.

5.2 Interaction with L&SC NHP digital communication channels continues to grow, with focus on driving traffic to the New Hospitals Programme website and providing information via Facebook and Twitter, with a new LinkedIn channel launched in August 2023. Social media toolkits continue to be shared with Lancashire and South Cumbria NHS Communications teams on a regular basis, with ongoing sharing of NHP content through partner channels.

5.3 The following new website content was published in Quarter 2:

- Where to build two new hospitals? (6 July 2023)
- Lancashire and South Cumbria NHS welcomes national New Hospital Programme roadshow (16 August 2023)
- Join the National New Hospital Programme patient involvement event (13 September 2023)
- The New Hospital Programme roadshow – what happened? (14 September 2023)
- Kevin McGee on the New Hospitals Programme (28 September 2023)

5.4 **Stakeholder management** – All Lancashire and South Cumbria and neighbouring MPs, Council Leaders and Chief Executives, and Health Overview and Scrutiny Committee Chairs and Members were invited to attend a roundtable discussion led by Lord Markham CBE as part of the national NHP roadshow on 16.08.23. The MP for South Ribble attended, along with Council representatives from across Lancashire and South Cumbria (with Leaders and CEOs or their deputies from Blackburn with Darwen Council, Chorley Council and South Ribble Council, Lancashire County Council, Preston City Council and Westmorland and Furness Council and Health Overview and Scrutiny Committee Members from Burnley, Chorley, Lancaster, Lancashire South East, Lancashire, Preston, South Ribble, Ribble Valley and Westmorland and Furness Council.

5.5 Members of the Programme team updated the Lancashire Health and Adult Services Scrutiny Committee on 12 July 23 and an update on the L&SC NHP was provided to Westmorland and Furness Health and Adults Scrutiny Committee on 15 September 2023 by the UHMBT Executive Lead.

6 Next period – Q3 2023/24

6.1 **Enabling works business case** - the Programme will focus on the delivering the technical assessments required for the due diligence on potential new sites. In parallel, the NHP team will progress a detailed business case regarding the potential new sites.

6.2 **Governance model** - the team will commence the implementation of the new model, delegated authorities and embed a revised decision-making matrix.

6.3 **Consultation approach** – the team will scope the tasks and resource required for future public consultations and pre-consultation engagement. This includes the overarching approach to consultation, a communications and engagement strategy and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies.

7 Conclusion

7.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 2 of 2023/24.

8 Recommendations

8.1 The Board is requested to:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Rebecca Malin

Programme Director

October 2023