Board of Directors - Part 1

Thu 25 November 2021, 09:00 - 12:30

Zoom

Agenda

09:00 - 09:00
0 min

1. Welcome and Introductions

Chair

Verbal update.

09:00 - 09:00
0 min

2. Patient Story - research

Chief Nurse

Verbal update.

09:00 - 09:00
0 min

3. Apologies for Absence

DCG

3. Board of Directors Agenda 25.11.21 - Part 1.pdf (2 pages)

09:00 - 09:00
0 min

4. Declarations of Interest

Chair

Verbal update.

09:00 - 09:00
0 min

5. Minutes of meeting held on 30th September 2021

Chair

5. Board of Directors Minutes Part 1 - 30.09.21.pdf (17 pages)

09:00 - 09:00
0 min

6. Action Log

Chair

6. Board action log for 25.11.21 meeting.pdf (2 pages)

09:00 - 09:00
0 min

7. Matters Arising

Chair

Verbal update.

09:00 - 09:00
0 min

8. Chair's Update

Chair

Verbal update.

09:00 - 09:00
0 min

9. Chief Executive's Report

CEO

- 9. CEO Report.pdf (4 pages)

09:00 - 09:00
0 min

10. Winter Planning Update

COO

Presentation being shared at meeting.

09:00 - 09:00
0 min

11. Quality Assurance Committee Chair Report

QAC Chair

- 11.a. Quality Assurance Committee cover sheet.pdf (1 pages)
- 11.b. Quality Assurance Committee Chair Report October.pdf (5 pages)
- 11.c. Quality Assurance Committee Chair Report November.pdf (4 pages)

09:00 - 09:00
0 min

12. Nursing, Midwifery and AMP Staffing Report

Chief Nurse

Appendix to follow.

- 12. Nursing, Midwifery and AHP Staffing Report.pdf (24 pages)

09:00 - 09:00
0 min

13. Sustainability Development Management Plan (Green Plan)

DoF

- 13.a. Sustainability Development Management Plan (Green Plan) cover.pdf (2 pages)
- 13.b. Sustainability Development Management Plan (Green Plan) presentation.pdf (26 pages)

09:00 - 09:00
0 min

14. Staff Story

DoP

Verbal update.

09:00 - 09:00
0 min

15. People Committee Chair Report

PC Chair

- 15.a. People Committee cover.pdf (2 pages)
- 15.b. People Committee Chair Report October.pdf (3 pages)
- 15.c. People Committee Chair Report November.pdf (4 pages)

09:00 - 09:00
0 min

16. 2021-22 Emergency Preparedness, Resilience and Response (EPRR) Assurance - Statement of Compliance

J Tunn

16. 2021-22 Emergency Preparedness Resilience and Response (EPRR).pdf (4 pages)

09:00 - 09:00
0 min

17. Board Assurance Framework

DCG

17.a. Board Assurance Framework.pdf (31 pages)
17.b. Board Assurance Framework.pdf (18 pages)

09:00 - 09:00
0 min

18. Finance and Investment Committee Chair Report

DoF

18.a. Finance and Investment Committee Chair Report cover.pdf (1 pages)
18.b. Finance and Investment Committee Chair Report.pdf (3 pages)

09:00 - 09:00
0 min

19. Audit Committee Chair Report

DoF

19.a. Audit Committee Chair Report cover.pdf (1 pages)
19.b. Audit Committee Chair Report.pdf (4 pages)

09:00 - 09:00
0 min

20. Trust Transformation Board Chair Report

TTB Chair

20.a. Trust Transformation Board Chair Report cover.pdf (1 pages)
20.b. Trust Transformation Board Chair Report.pdf (6 pages)

09:00 - 09:00
0 min

21. Integrated Performance Report

COO

21.a. Integrated Performance Report cover.pdf (1 pages)
21.b. Integrated Performance Report.pdf (51 pages)

09:00 - 09:00
0 min

22. Safeguarding Adult, Children and Looked After Children Annual Report 2020/21

Chief Nurse

22.a. Safeguarding Adult, Children and Looked After Children Annual Report 2020-21 cover.pdf (2 pages)
22.b. Safeguarding Adult, Children and Looked after Children Annual Report 2020-21.pdf (70 pages)

09:00 - 09:00
0 min

23. Any Other Business

Chair

Verbal update.

09:00 - 09:00
0 min

24.

BOARD OF DIRECTORS MEETING

Date: 25th November 2021
Time: 09.00-13.00
Venue: Zoom

NHS Bolton NHS Foundation Trust

AGENDA - PART 1

TIME	SUBJECT	LEAD	PROCESS	EXPECTED OUTCOME
09.00	1. Welcome and Introductions	Chair	Verbal	To note
09.05	2. Patient Story – research	Chief Nurse	Verbal	To note
09.20	3. Apologies for Absence	DCG	Verbal	Apologies noted
	4. Declarations of Interest	Chair	Verbal	To note declarations of interest in relation to items on the agenda
09.25	5. Minutes of meeting held on 30th September 2021	Chair	Minutes	To approve the previous minutes
	6. Action Log	Chair	Action log	To note progress on agreed actions
	7. Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
	8. Chair's update	Chair	Verbal	To receive a report on current issues
Safety Quality and Effectiveness				
09.30	9. Chief Executive's Report	CEO	Report	To receive and note
09.40	10. Winter Planning update *(presentation being shared at meeting)*	COO	Presentation	To note
10.00	11. Quality Assurance Committee Chair Reports	QAC Chair	Report	To provide assurance on work delegated to the sub-committee
10:10	12. Nursing, Midwifery and AHP Staffing Report	Chief Nurse	Report	To receive for assurance
10.30	13. Sustainability Development Management Plan (Green Plan)	DoF	Report	To approve

10.45	**BREAK**				
11:00	14.	Staff Story	DoP	Verbal	To note
11:15	15.	People Committee Chair Report	PC Chair	Report	To receive assurance from the People Committee
Governance					
11.25	16.	2021-22 Emergency Preparedness, Resilience and Response (EPRR) Assurance – Statement of Compliance	J Tunn	Report	To receive for assurance
11.35	17.	Board Assurance Framework	DCG	Report	To receive for assurance
11.50	18.	Finance and Investment Committee Chair Report	DoF	Report	To receive for assurance
12:00	19.	Audit Committee Chair Report	DoF	Report	To receive for assurance
12:05	20.	Trust Transformation Board Chair Reports	TTB Chair	Report	To receive for assurance
12:10	21.	Integrated Performance Report	COO	Report	To receive and note
12.20	22.	Safeguarding Adult, Children and Looked After Children Annual Report 2020/21	Chief Nurse	Report	To receive for information
12:25	23.	Any Other Business	Chair	Verbal	To note
Questions from Members of the Public					
		To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting			
Resolution to Exclude the Press and Public					
12.30	24.	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 of next meeting: 27th January 2022

Meeting:	**Board of Directors (Part 1)**
Date:	**Thursday 30th September 2021**
Time:	**09:00-13:15**
Venue:	**Via Zoom**

NHS Bolton NHS Foundation Trust

PRESENT:

Donna Hall	Chair	DH
Fiona Noden	Chief Executive	FN
Andy Ennis	Chief Operating Officer	AE
Francis Andrews	Medical Director	FA
Sharon Martin	Director of Strategy and Transformation	SM
James Mawrey	Director of People	JM
Annette Walker	Director of Finance	AW
Malcolm Brown	Non-Executive Director	MB
Rebecca Ganz	Non-Executive Director	RG
Martin North	Non-Executive Director	MN
Alan Stuttard	Non-Executive Director	AS
Andrew Thornton	Non-Executive Director	AT
Jackie Njoroge	Non-Executive Director	JN
Bilkis Ismail	Non-Executive Director	BI

IN ATTENDANCE:

Esther Steel	Director of Corporate Governance	ES
Claire Lovick	PA to Director of Corporate Governance and Chair (minute taking)	CL
Angela Hansen	Deputy Chief Nurse (attended on behalf of the Chief Nurse)	AH
Tracey Garde	FTSU Guardian (attended to present FTSU Annual Report)	TG
Tracey Joynson	Patient Experience Manager (attended to present patient story)	TJ
Lisa Gammack	Deputy Director of OD (attended to present BAME Network and WRES / WDES)	LG
Adam Ilyas	Physiotherapist (attended to present BAME Network and WRES / WDES)	AI
Minimol Santhosh	Ward Manager, Acute Adult Care (attended to present BAME Network)	MS
Sally McIvor	ICP Independent Chair (attended to present ICP Business Plan)	AM
Rachel Tanner	Managing Director, DASS (attended to present ICP Business Plan and ICP Social Care Transformation Plan)	US
	There were also nine observers who attended this meeting	

APOLOGIES:

Karen Meadowcroft	Chief Nurse	KM

1. Welcome

The Chair welcomed everyone to this meeting.

2. Patient Story – Home First / Integrated Care

This patient story relates to an 81-year-old man (G). His wife (M) has kindly chosen to share this story. Highlights to note:

- A video was shown giving details of this patient story.
- G suffers from lower body Parkinson's disease and dementia.
- M has been caring for G, but his condition had worsened and G has had three falls.
- G was taken to A&E at Bolton Hospital where blood tests etc were carried out.
- It was decided the best outcome would be to accommodate G for respite care and he was taken to Wilfred Green. This move went smoothly.
- Due to Covid, G was in isolation for two weeks and M was unable to visit him during that time. M did have daily communication with the staff looking after G.
- Following the two-week isolation, M visited G in a pod outside the care home. She thought this was a good system as it ensured no one was spreading Covid 19 to residents during visits.
- During the visit M was not happy with G's state of mind – he was very woeful. He didn't appear to know where he was and he was crying a lot.
- G cried every time M visited him – he is not someone who usually cries. It was therefore decided it may be best for his mental health if G returned home and was back in a familiar setting.
- A package of care was agreed for G's return home after four weeks in Wilfred Green. There would be two carers in a morning to get him up and washed, and 2 carers in the evening to put him to bed.
- Unfortunately, due to Covid the care package did not happen as planned. G did receive carers initially, but they were arriving too early in the morning and evening so M cancelled them and is still awaiting appropriate care support.
- M has received a lot of support from people but cannot see a way forward until the carers are in place.
- G is still waiting for a level access shower to be fitted at their home and it could be up to six months before this is done.
- M has looked at getting private carers but there appears to be a shortage of care available at the moment.

It was explained that carers do visit some patients early as they have a lot of patients to visit each day. M understands this, but feels that the care offered does need to be more realistic to G's needs.

M confirmed a carer visits twice a week, so she has time to go out for shopping etc, would be a great help. It was suggested volunteers may be able to help M with this.

The Board acknowledged there is a national shortage of social carers and this is something being looked at nationally. Small improvements have been seen this last few weeks.

This patient story highlights that we need to listen more carefully to each patient's individual needs on discharge. A bespoke care package of a carer twice a week at a chosen time, rather than carers each day at the wrong times, would have been more appropriate in this instance.

ACTION: ES will pass Bilkis Ismail's mobile number to Tracey Joynson so she can arrange for Bilkis and M to speak and talk through care package options.	ES/TJ/BI FT/21/48

Resolved: The Board of Directors thanked M for sharing this patient story.

3. Declarations of Interest

There were no Declarations of Interest to report.

4. Minutes of last meeting

The minutes of the meetings on 29th July 2021 were approved as an accurate record of the meetings.

5. Action log

The action sheet was updated to reflect actions taken since the previous meeting.

6. Matters arising

There were no matters arising to report.

7. Chair's Update

The Chair provided the following update:

- Staff are working extremely hard. The hospital and community are currently under pressure and there are a lot of viruses and infections around at the moment, as well as Covid.
- Covid Booster vaccinations are now being rolled out.
- Unfortunately there is still resistance from some people to have the Covid vaccination.
- The Chair is involved in the appointment of a new Chair for the Greater Manchester Integrated Care Partnership.
- Rebecca Ganz was thanked for her support in the new COO recruitment process. Further detail on this will be provided in the Chief Executive's Report (item 8 in these minutes).

Resolved: The Board of Directors thanked the Chair for this update.

8. Chief Executive Report

This paper was taken as read. Main points to note:

- The Associate Medical Director and team visited wards during Know Your Patient week to ensure staff are using the right wording when inputting patient information into EPR. This is a significant learning exercise across the Trust.

- The CQC monitoring assessment took place on the 17th September. The Trust has not received feedback yet but the meeting appeared to go well. The Chief Executive, Chief Nurse, Medical Director and Director of Quality Governance were all in attendance at this meeting.

- The Trust has appointed Rae Wheatcroft as the new Chief Operating Officer, commencing on the 1st January 2022 (Andy Ennis leaves the role on 31st December 2021). Thanks was acknowledged to all the Board and Paul Henshaw for their work in this process, and congratulations was offered to Rae.

- The WRES and WDES dates will be issued today. This will be covered in detail by the Director of People and Lisa Gammack on today's agenda (item 15 in these minutes).

- The Trust submitted our plans on the 9th September for a new estate. Sir Richard Leese visited our estate recently and is supportive of these plans.

- Rachel Tanner is joining our Board meeting today and will be presenting on ICP at the Board of Directors Part 2 meeting this afternoon.

The Board welcomed the new format of this report which has received good feedback. Thanks was expressed to Rachel Carter for all her work on this.

ACTION: ES will bring a full BAF update to the next Board of Directors meeting on 25th November.	ES FT/21/50

Resolved: The Board of Directors thanked the Chief Executive for this update.

9. Integrated Performance Report

The Performance slides were shared at this meeting. Main points to note:

- Quality and safety (presented by the Deputy Chief Nurse):
  - Falls are amber on the report as there was a slight increase in falls in August 2021. We are within the YTD target of 5.1%.
  - Falls with harm have reduced by 50% this month (there has been two compared to four last month).
  - Lots of work is taking place to reduce the number of falls. The team look at post fall safety to ensure lessons are learnt for the future.
  - Pressure damage is amber on the report. A reduction has been seen in August, but unfortunately there has been an increase in category 2 pressure ulcers.
  - Each pressure ulcer is documented and reviewed by a specialist team so improvements can be made going forward.
  - A trial is taking place this month around pressure ulcers. If successful, this will be rolled out and is specific on the patient and risk factors.
  - The new patient information leaflet will include a QI code so families can view videos to help with the prevention of pressure ulcers.

- Clinical correspondence is red on this report. Unfortunately, we are not currently within the target of 79%. Improvements are being seen in variable degrees across the system.
- There is a challenge around shortage of staff and work is being done with HR to fill vacancies.
- Patient experience for family and friends is green on the report. Data collected in August shows patients feel they are treated well and cared for by staff. We have, however, received some complaints around waiting times.
- Complaints are listed amber on the report. The Trust is continuing to achieve three working day response times 87.5% of the time, and are responding to all complaints within 30 days 95% of the time.
- Our complaints process has recently been reviewed in an internal audit. Once this is finalised it will be shared with Board.

- Mortality and Infection Prevention (presented by the Medical Director):
  - Mortality is green on the report.
  - The Trust is within the national target for mortality.
  - For the last three months, the Trust has been within the SHMI target.
  - The Associate Medical Director and BI Team have been visiting wards during Know Your Patient Week to spread awareness on the importance of recording accurate patient data on EPR.

ACTION: An update will be provided, via the Mortality report, at the next Board meeting around review of mortality cases (red and amber).	FA FT/21/51

Board members asked what lessons have been learnt from getting the SHMI down in mortality. The main learning point is around data quality and the Associate Medicate Director and her team are working with teams across the Trust to improve data entry.

A question was raised around when the Trust expects clinical correspondence to be where it needs to be. The Trust are confident this can be done and the Medical Director will look at this in detail and provide a report to the Quality Assurance Committee.

ACTION: FA to provide an update on clinical correspondence to the Quality Assurance Committee.	FA FT/21/52
ACTION: JM will see what can be done to forecast around secretarial sick leave, as currently it is causing delays in getting correspondence out to patients.	JM FT/21/53

- The Infection Prevention feedback target was previously 38%, and the Trust set a new target of 58%. We are currently at 68% against the 58% target. The team are hopeful this can be pulled back. Work is taking place but this is an ongoing process.
- In the past bed pressures have halted the deep clean programme, but there is now an emphasis on this.
- The Trust is not seeing person to person contamination.
- We are confident we will meet performance targets on Pseudomonas and Klebsiella.
- It is 396 days since our last Pseudomonas infection which is the longest gap so far.

- There have been no targets set for MRSA and MSSA – the aim is we should not have any.
- It is 447 days since the last MRSA infection – the previous record was 370 days.
- Blood culture contamination rate is slightly above average. Work is being done in A&E to see if there is more we can do to improve this.
- The IPC have provided three further recommendations around Covid. Rick Catlin has been working with the Divisions, DDOs and DNDs to ensure these recommendations are put in place.

Board members requested a report on up to date sepsis figures. It was confirmed that the Trust's sepsis rate is within range and a detailed sepsis update will be provided at the Quality Assurance Committee.

ACTION: Update on sepsis to be provided to the Quality Assurance Committee.	FA FT/21/55

- Performance (presented by the Chief Operating Officer):
  - Urgent care is red on the report. The large volume of attendances has led to delayed ambulance handovers, long waiting times and delayed discharge.
  - The ED team are working extremely hard to deal with current pressures.
  - There are pressures in ED nationally – this is not just a Bolton issue.
  - Elective recovery is amber on the report. Bolton is doing well and elective activity is ahead of plan.
  - Cancer is on track for this quarter and the Trust has been providing support to our mutual partners to help them get through their cancer patient waiting lists.
  - Cancer 52 week waits are reducing.
  - There has been an increase of lady's presenting for breast screening since Sarah Harding's sad death from breast cancer.
  - Staffing pressures are a risk.

Concern was raised around waiting times in A&E. It was clarified that whilst many patients are now waiting over four hours to be seen, a process is in place to review patients to ensure those needing urgent care are seen as a priority.

There are instances where there are 12 hour waits in A&E. Every patient who has waited 12 hours in A&E is reviewed to see if they have suffered due to the long waiting time.

ACTION: Emergency Department to do a study on the impact of A&E waiting times and report to the Quality Assurance Committee.	AE FT/21/54

There was a query raised as to whether or not GPs can refer patients directly to consultants where appropriate. It was clarified this can be done.

ACTION: AE will liaise with the CCG so GPs can be updated on pathways (i.e. they can send a patient to be scanned/tested by a consultant without going via A&E).	AE FT/21/57
ACTION: Bilkis will update AE and FA on GP's experience of referring patients for scans / tests to hospital.	BI FT/21/56

- Workforce (presented by the Director of People):
  - Staff at the Trust are brilliant. They are working extremely hard and have been doing so for some time now, however they are exhausted. This was evident on the Go Engage Survey.
  - The Go Engage Survey will be circulated again shortly.
  - The Trust is doing all it can to recruit staff. The DND teams and Paul Henshaw are working extremely hard in this area.
  - In September the Trust recruited its largest cohort for nurses and midwives which is something we are very proud of.
  - A recruitment day is taking place tomorrow (1st October).
  - Staff sickness is unfortunately still high.
  - Agency spend is red on the report. This is linked to urgent care pressures and elective recovery. This has been shared at People Committee, Finance and Investment Committee and Board of Directors. Agency spend is currently very high but is absolutely necessary.
  - The Trust is working on ways to reduce agency spend in future. One incentive is to encourage staff to work on bank rather than via an agency.

Board members asked when agency spend is likely to reduce. It was highlighted we are in extraordinary times and there are many pressures on the system which affect the amount of agency staff required. Updates in this area will continue to be provided to Board via the People Committee and Finance and Investment Committee.

- Finance (presented by the Director of Finance):
  - Revenue is red on the report. YTD deficit is £1m and this is off track from where we expected to be.
  - The forecast position in the first half of this year (H1) was £2.4m deficit.
  - The Trust expects to receive additional funding of £2.4m, although there is a potential risk this money may not be received.
  - Cost Improvement is being relaunched next week. Finance have some ideas with the potential to drive better cost improvement.
  - Agency spend is significant: £1.3m in the last month.
  - Capital and Cash is green on the report.
  - Bids have been submitted for capital spend but we don't yet know if we have been successful.
  - Better Payment Practice (BPPC) is behind where we would like to be at 87.5% YTD instead of 95.8% as targeted.
  - Risks are amber on the report. This is due to ongoing pressures from Covid, elective recover and winter planning, and a lack of clarity on H2 financials.
  - The North West is expected to have one of the most challenging H2 financials nationally. Once the Trust receives guidance on H2 plans can be developed around this.

A question was raised around what impact the 3% pay increase is having on financials. It doesn't come out of H1 figures, but potential spend in H2 will rise by approximately £8m.

Resolved: The Board of Directors noted this update.

10. Winter Planning Update

The Chief Operating Officer presented slides on the current position in Urgent Care. Main points to note:

- The Covid pandemic is over, however we have now entered the endemic stage of Covid. This is expect to last for approximately five years.
- The level of Covid in the system over the next five years is expected to fluctuate.
- Attendances in A&E are on the increase. There were many more patients this August than in the previous August, and in September that figure raised further.
- Young and working age people are visiting A&E much later in the day / evening and work is being done to see how best we can staff the department for this shift in culture.
- In Greater Manchester many beds are taken up by patients with no reason to reside, but who are unable to be discharged. This is putting a lot of extra pressure on the system.
- We are starting to do well with our recovery position. We are seeing a reduction in our waiting lists.
- Pressures are being caused by a number of reasons:
  - Patient choice (patients are choosing to wait in Bolton's A&E to be seen that day rather than waiting until the next day to see their GP).
  - A two year waiting list for patients requiring treatment. We have 82 patients who have currently been waiting longer than two years and this needs to be addressed.
  - Theatre staffing issues.

  A clinical review is underway to address these pressures.
- The Trust's cancer position is strong and we are performing very well in this area. We are slightly off achieving target for this quarter.
- The breast team are working extremely hard to keep on top of the number of patients who require checks / surgery. The Sarah Harding case has highlighted the importance for breast checks and we have seen an increase in ladies presenting for check-ups.
- The Trust is well positioned nationally around cancer treatment and we are helping others to keep on track also, to assist with ensuring patient safety.
- Diagnostics are performing well with the exception of endoscopy, and the team are looking at what can be done to improve in this area.
- It looks likely that we will be successful in our Community Diagnostic Hub bid and this will be a big benefit to Bolton.
- No criteria to reside is a critical challenge. The Urgent Care Board and IPC Board are looking at this to see if there is something different we can do to improve this area.
- There are five work streams in our Autumn / Winter Plan:

- ED Front Door (next week the Trust is targeting to move 60 patients from A&E to other areas, with a view to increasing this to 100 patients in future).
- Estates and IPC (working on rooms).
- Community and discharges (outside of workforce, the next biggest challenge we need to look at is finding a solution around discharge).
- Workforce (staff shortages are becoming a risk and a huge amount of work is taking place around recruitment).
- Communications and engagement (a campaign starts next week).

There was a question raised around how often care agencies review their framework. Rachel Tanner confirmed the framework is opened up periodically for agencies who have met with the CQC. It was opened recently and we have over 70 providers, including two new providers.

ACTION: RT will speak with BT with details on the Care Agency Framework.	RT/BI FT/21/58

There was a detailed discussion around the number of patients in hospital with no criteria to reside, workforce pressures, winter planning and finances and it was agreed an update on these areas will be provided at the next Board meeting.

ACTION: AE/JM/AW will bring an update on workforce, winter planning and finance to Board on 25th November.	AE/JM/AW FT/21/59

Resolved: The Board of Directors noted this update and the current pressures the Trust is facing.

11. Quality Assurance Committee Update

The Chair of the Quality Assurance Committee (QAC) provided the following update:

- Congratulations was given to the Medical Director and Associate Medical Director for all their work on quality improvement and mortality.
- Congratulations was also given to the Chief Operating Officer for the ED Planning project.
- QAC have held two meetings since the last Board meeting took place.
- QAC meeting on 18th August:
  - The Chief Nurse provided an update at this meeting (this update will alternative between the Chief Nurse and Medical Director).
  - There is an audit taking place to see if there is a safety issue when a second theatre is not available. Nothing has come to light so far to suggest there is a safety issue.
  - An update was provided on organ donors and there was recognition that more work needs to take place to promote this and hopefully encourage more patients and families to become donors. There is a particular shortage of donors in the BAME community.
  - QI falls are better than targeted, but the number of falls with harm has increased and will be highlighted at Risk Management Committee.

- Pressure ulcers have increased but this is mainly due to the masks being used for oxygen re Covid treatment. The respiratory team are piloting a new mask and it is hoped that will reduce the number of facial pressure ulcers.
- A pressure ulcer policy is being put in place which will be rolled out across the Trust.
- Concern around the attitude of a number of staff was discussed and the Deputy Director of People has taken the action to see if we can include something in our mandatory training modules to improve staff attitudes.
- The Annual Health and Safety Report showed an increased number of incidents, and it was highlighted this is because we are getting better at reporting them and not because they are on the rise.
- Fire escapes are in progress and a further update will be provided once they are complete.

- QAC meeting on 15th September:
  - Etiquette at QAC meetings has deteriorated and the QAC Chair will address this at the start of the next meeting.
  - A Divisional Governance Report was received from Diagnostics and Support Services. The report has changed recently for all divisions and we are getting a balance between detail and assurance.
  - BOSCA is being reintroduced under a slightly different format in more areas.
  - The Trust has been invited to be one of five Trusts to be an earlier adopter of Tommy's App. This is a national initiative to reduce still births. The app currently has restrictions in language and availability, but for patients unable to use the app we will continue providing care in our usual way.
  - The Safeguarding Chair Report highlighted there will be an SI Report in the near future around a missing young person. This invited a discussion around BFT's links with young people's mental health requirements.

Nosocomial infections are increasing in the SI Reports coming through. It was highlighted there are increased nosocomial infections in the BAME community and deprived areas.

ACTION: Angela Hansen, Richard Catlin and BI will have a conversation around nosocomial infections.	AH/RC/BI FT/21/60

The Chief Operating Officer confirmed that work on the D3 fire escape should be complete by mid-October. The engineers have assessed the other two fire escapes and it is safe for these to be deferred until next year, so the Trust can get through the winter without losing those wards.

Resolved: The Board of Directors noted the report.

12. Integrated Care Partnership Business Plan 2021/22

Sally McIvor and Rachel Tanner presented the Integrated Care Partnership (ICP) Business Plan slides (see appendix 1). Main points to note:

- The ICP involves all partners coming together and delivering a system of care in Bolton. This involves the police, housing, social care, council, GPs, primary and secondary care.

- This collective business plan has been put in place over the last six months.
- BFT is host for the ICP – this is a significant role.
- A lot of work has taken place and there is a lot of work to do so we can deliver what needs to happen as a system to support the people of Bolton.
- Neighbourhoods remain at the heart of the community.
- The 2030 Vision is a role in the economy as well as health and care.
- During the first year of the pandemic there has been some outstanding work across partnerships and this is something we can now build on.
- Priorities:
  - Urgent care in the community.
  - Neighbourhoods remain at the heart of the community.
  - Relationship with communities and VCSE.
- Sub-priorities:
  - Care homes.
  - No wrong front door.
- There are four VCSEs in our partnerships.
- Bolton has nine different neighbourhoods.
- This is an opportunity for us all to think differently about what can be done to help people in our communities, working across the whole system to understand our neighbourhoods.
- Work can be done to target inequalities in neighbourhoods.
- The neighbourhood model blueprint has been designed. The pace of how this is implemented could depend on neighbourhood priorities.
- The ICP has a strong place in the future locality structure.
- Training will be provided to staff in all areas over time to really embed what the ICP are aiming to achieve. This will be assisted by Boo Coaching.
- There are big plans for digital around Bolton as we need to build our digital experience for staff.

The question was raised as to whether or not children's services are included in the ICP. Although not currently in the ICP local children's services will be attending meetings to ensure they are part of the discussion around this.

ACTION: RT will bring an ICP Business Plan update to the Board of Directors meeting in 2022.	RT FT/21/61

The Board acknowledged the ICP are fortunate to have Rachel Tanner and Sally McIvor leading on this.

Resolved: The Board of Directors endorsed the ICP Business Plan 2021/22 and agreed to receiving quarterly ICP updates.

13. ICP Social Care Transformation Plan

Rachel Tanner provided an update on the ICP Social Care Transformation Plan. Main points to note:

- This is a summary paper which sets out demands and health inequalities, and considers access to housing and jobs.
- This is not just about care, it is also about enabling people to have good and active lives, and helping people to unlock issues they are facing.
- Demand for social care is increasing, particularly for people with complex needs.
- There is likely to be additional money provided for social care, but the detail around this has yet to be confirmed.
- There will be additional duties and responsibilities on social care around financial assessment – there is a lot of planning to do.
- The ICP will support social care – we need to embrace new technology and support carers.
- Savings will be required in adult care this year and this will be a big challenge.

Resolved: The Board of Directors thanked Rachel Tanner for this update.

14. Staff Story – BAME Network

Minimol Santosh Ward Manager B4 provided the following staff story on the BAME Network. Lisa Gammack and Adam Ilkyas attended to support.

Minimol trained and qualified as a nurse in India, working for five years in ICU before moving to the UK in 2003 and joining the Trust as a Staff Nurse in April 2017.

Minimol spoke of her positive and negative experiences at the Trust. Before joining the Trust, she had been pre warned about racist attitudes to BAME staff at Bolton hospital, and unfortunately, Minimol has at times experienced this. Staff have shouted at her and said they do not understand what she is saying. Minimal's English is fluent, and although she speaks with a different accent, she has never faced issues with her patients or their families, they understand her very clearly.

Minimol spoke of the support she had received from colleagues including Anthony and Natasha and the opportunities she has been able to take up including further study and the BAME forum.

Minimol was not successful in her first application for a ward manager post – the post was offered to a male nurse with significantly less experience but a month later Minimol was offered a post as Ward Manager on the winter ward. She accepted this opportunity and created a strong team which has now become an established ward with Minimol as the permanent manager. Staff feedback from the ward is positive and Minimol encourages all to Dream of a new tomorrow.

Although Minimol initially had a bad experience during her time at the Trust, she believes it is the best hospital for support provided by the management team and she is very proud to work at Bolton Hospital. Minimol feels exceptionally proud that she has proved an immigrant from the BAME community can run a ward smoothly in the role as Ward Manager.

The Chief Executive Officer thanked Minimol for sharing her story and advised she felt privileged to present Minimol with her certificate for the Leadership Programme.

The Board of Directors found this a powerful story – it highlights how we need to do much more work at the Trust around BAME issues.

Lisa Gammack expressed how proud she is of Minimol.

ACTION: JM will speak with Minimol Santhosh to discuss her individual BAME experience.	JM FT/21/62

Resolved: The Board of Directors thanked Lisa Gammack, Adam Ilyas and Minimol Santhosh for this update and apologised to Minimol for the bad experience she has been through.

15. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2021

Lisa Gammack and Adam Ilyas provided the following update:

- The report was taken as read.
- WRES and WDES is about improving the experience for disabled and BAME colleagues.
- WRES:
  - The figures in this report are positive and we are moving in the right direction.
  - The Trust has increased its BAME workforce by 1% this year, reducing the gap from 6% to 5% when comparing diversity in the Bolton population.
  - BAME staff in 2020/21 felt more engaged compared to white staff.
  - White staff are still more likely to be appointed roles than BAME staff, but this is reducing.
  - The number of BAME staff who reported bulling at the Trust had reduced in this period from 29% to 24%, but there has been an increase in reported incidents from white staff.
  - More BAME staff have raised concerns with Freedom To Speak Up than in the previous year.
  - The Chief Executive Officer will be attending the next BAME staff meeting.
  - The BAME Leadership Programme has proved a success and this has now been confirmed as an ongoing programme which will help embed behaviours around the Trust.
- WDES:
  - There are 170 staff in ESR with a disability, and 430 staff on the staff survey with a disability. Work is being done to understand the actual number.
  - Disability Listening Sessions will be taking place over the next few months, and the Chief Executive Officer has been asked to host these sessions.
  - Positive work is taking place around staff harassment and bullying.

- There is a focus taking place around the likelihood of disabled staff being shortlisted or appointed into new roles. This is something which the Trust is aiming to improve on over the next 12 months.
- A lot of work has taken place around shielding staff.
- The Chief Executive Officer hosted an emotional session with staff who have shielded throughout Covid.
- Work is being done around the Wheelchair Group to see where improvements can be made.

- The WRES and WDES Standards for 2021 will be published and a report will be provided to Steering Groups.

Resolved: The Board of Directors thanked Lisa Gammack and Adam Ilyas for all their work in this area and noted this update.

16. Equality, Diversity and Inclusion (EDI) Plan 2021-2025

Lisa Gammack provided an update on the EDI plan. Main points to note:

- The paper was taken as read.
- This plan involved a lot of hard work from staff in various areas of the Trust.
- The plan sets out the next four years focus and priorities, KPIs etc.
- The plan links with the staff survey, listening services and various group meetings.
- There is still work to be done with the community in this area.
- OD have received lots of positive feedback on this plan and are keen to receive input from Board.
- If this plan is approved by Board, a communications plan will be implemented around this.
- The EDI Steering Group will bring quarterly updates to Board (via People Committee) on how things are progressing – it is about changing behaviours.
- The EDI Plan will be taken to the Executive Directors meeting with a request for funding.

ACTION: LG to amend page 5 in the EDI Plan so that BI's photo is more prominent than JM's photo.	LG FT/21/63
ACTION: LG to amend the key performance indicator in the EDI Plan to say 'we will have 18% BAME employees' by the indicated time and not 'we will aim to have 18% BAME employees' by the indicated time.	LG FT/21/64

Resolved: The Board of Directors thanked Lisa Gammack and Bilkis Ismail for this fantastic piece of work and approved the Equality, Diversity and Inclusion Plan 2021-2025.

17. People Committee Chair Report

The People Committee Chair provided the following update:

- The People Committee met in September 2021. There was no meeting in August as this had been stepped down due to work pressures.
- Thanks was given to Paul Henshaw and his team for all the hard work they are doing around recruitment.
- The Trust has recruited critical care nurses from India and there are also nurses being recruited from Hong Kong.
- Flu and Covid Booster vaccinations are now available for staff.
- The concern around agency spend was discussed. This cannot be avoided at the moment due to pressures on the system following Covid – we need to ensure quality of care is provided at all times, even though this brings extra costs.
- Useful information is being learnt at exit interviews.
- Stay interviews are now taking place to encourage staff to move into different roles rather than leaving the Trust.
- There is a lot of work going on around staff wellbeing. There has been a decrease in the number of staff getting involved in these initiatives.
- It was acknowledged the Trust needs to help junior doctors know the Trust is working on changes to improve for the future.
- The AHP Report is graded red in some areas – this is regarding IT hardware requirements for staff.
- Medical Education Board is graded red in relation to IT challenges.
- There are delays with dictated letters being transcribed and issued to GPs and patients due to issues with IT. This will be looked at with the Trust's new Director of Digital who commenced work at the Trust yesterday.

A new Medical Leadership Programme commences next week – this is for 14 senior members of the medical team. This is a positive move forward for development and leadership.

Resolved: The Board of Directors acknowledged this update.

18. Freedom To Speak Up (FTSU) Annual Report 2020/21

The Freedom To Speak Up Guardian provided the following update:

- The report was taken as read.
- There are now 30 FTSU champions at the Trust. This number has decreased slightly due to staff retirements.
- The team are looking to recruit more FTSU champions by the end of the year.
- The FTSU Team are really proud to have won the Be Honest category in the FABB awards.
- October 2020 was speak up month – and this will take place again this October.

- 13th October 2021 is wear green to work day to show support for FTSU.
- FTSU e-learning is available online for all staff.
- There has been an increase in the number of concerns raised since last year. A decrease was seen in Q4 but this have gone up again in 2021.
- Attitude and behaviours is a regular theme and this reflects the national picture.
- Registered nurses raise the most concerns - they are also our largest number of staff.
- BAME staff are approaching FTSU more than they previously did – but there is still work to do in this area.
- Bolton achieved the highest FTSU in the North West.
- In 2020 there were a number of staff who raised issues, but who did not want to go through the formal process due to concerns about repercussions.

Resolved: The Board of Directors noted this report and thanked Tracey Garde for the important work she is doing for staff, along with other members of the FTSU Team.

19. Trust Transformation Board Chair Report

The Trust Transformation Board Chair provided the following update:

- There were Trust Transformation Board meetings in July and September. The August meeting was cancelled due to operational pressures.
- TTB meeting on 12th July:
  - The format of the Chair Report has been changed slightly. There are now new headings to give structure and consistency through the main pillars in transformation.
  - There is a lot of good work taking place around maternity transformation. Ockenden is just one of 27 key pieces of transformation going on in maternity.
- TTB meeting on 13th September:
  - There was an update on outpatient transformation. The Trust is currently underperforming in terms of the request for 25% of outpatient appointments to be virtual. This is due to issues with Attend Anywhere and other digital problems and is currently being looked into.
  - GIRFT is progressing well.
  - Once all staff members have been migrated onto Microsoft 365 it is essential everyone learns the functionalities of what it can do so they can benefit within their roles.
  - Greater Manchester make many requests on our digital resources with big projects. There is only a certain amount of resource and staff are overstretched. MN will speak with the new Head of Digital to address this.

- A risk was raised around the updates needed to our systems. Work is being done on these risks to ensure they are prioritised in the right order.

Resolved: The Board of Directors noted this report.

20. Finance and Investment Committee Chair Report

The Finance and Investment Committee Chair provided the following update:

- The report was taken as read.
- The Trust is still awaiting guidelines on the approach for H2 finances.
- There was a great system update – especially around estates.
- An update was shared around cost improvements. The Trust is behind where we want to be but this is being looked at and is work in progress.

Resolved: The Board of Directors noted this report.

21. Audit Committee Chair Report

The Audit Committee Chair provided the following update:

- The last Audit Committee meeting was in June 2021.
- Internal Audit – PwC do our internal audit and the performance from their side has improved a lot over the last 12 months.
- The Internal Audit opinion is satisfactory – there are five ratings and this is the second highest rating.
- KPMG presented their review of the 2020/21 accounts.
- There is technical deficit and this is largely due to the amount of investment.

Resolved: The Board of Directors noted this report.

22. Any other business

The Director of Corporate Governance confirmed she has already received feedback from M who provided the patient story earlier in this meeting. M is pleased the Board of Directors were interested in hearing her story, and she feels unburdened for the first time in a long time.

Resolved: The Board of Directors were pleased to hear this feedback and to learn M found sharing her patient story so beneficial.

23. Next meeting

The next Board meeting will take place on the 25th November 2021.

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.

November 2021 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/21/50	30/09/2021	BAF	ES will bring the full BAF to the Board meeting in November.	ES	Nov-21	Agenda item.
FT/21/59	30/09/2021	Update on workforce, winter planning and finance	AE/JM/AW will bring an update on workforce, winter planning and finance.	AE/JM/ AW	Nov-21	Agenda item.
FT/19/82	28/11/2019	iFM business plan	Carbon Neutral strategy and update on the work of the sustainability group.	AE	Nov-21	Agenda item.
FT/21/37	29/07/2021	Maternity initiatives	Update on all maternity safety and improvement initiatives to Board.	KM	Nov-21	Being presented at QAC 17/11/21, then agenda item at Board 25/11/21.
FT/21/66	30/09/2021	GM Health and Care Board	DH will raise at the GM Health and Care Board on 01/10/21 the request for clear workplans to be put in place.	DH	Oct-21	Verbal update.
FT/21/56	30/09/2021	GP referrals for tests at BFT	Bilkis will update AE and FA on GPs experience of referring patients for scans / tests to hopsital.	BI	Nov-21	
FT/21/57	30/09/2021	Pathways between GP's and BFT	AE will liaise with CCG so GPs can be updated on pathways (i.e. they can send a patient to be scanned/tested by a	AE	Nov-21	
FT/21/51	30/09/2021	Mortality	An update will be provided, via the next Mortality report, around review of mortality cases (red and amber).	FA	Jan-22	
FT/21/61	30/09/2021	ICP Business Plan	ICP Business Plan update.	RT	Jan-22	
FT/21/54	30/09/2021	A&E waiting times	Study on impact of A&E waits to QA Committee.	AE	Dec-21	
FT/21/29	29/07/2021	Patient Story	KM to revisit MT's patient story in six months time to check if the actions put in place are continuing to be carried out to improve patient care and provide an update through QA Committee to Board.	KM	Jan-22	
FT/21/58	30/09/2021	Care Agency Framework	Rachel Tanner to speak with BI with details on the Care Agency Framework.	RT/BI	Nov-21	Complete.
FT/21/48	30/09/2021	Social Care	Following patient story, ES will pass Bilkis Ismail's mobile number to Tracey Joynson so she can arrange for Bilkis and Margaret to speak.	ES/BI/ TJ	Oct-21	Complete.
FT/21/52	30/09/2021	Clinical Governance	Update on Clinical Correspondance to QA Committee.	FA	Nov-21	Complete.
FT/21/53	30/09/2021	Secretarial sick leave	JM will see what can be done to forecast around secretarial sick leave, as currently it is causing delays in getting correspondence out to patients.	JM	Nov-21	Discussions already taking place and managed via IPM - Complete.
FT/21/55	30/09/2021	Sepsis	Update on Sepsis to QA Committee.	FA	Nov-21	Complete.
FT/21/60	30/09/2021	Nosocimial infections	A Hansen, R Catlin and BI will have a conversation around nosocomial infections.	AH/RC/ BI	Oct-21	Complete.
FT/21/62	30/09/2021	BAME experience	JM will speak with Minimol Santhosh to discuss her individual BAME experience.	JM	Nov-21	Complete.
FT/21/63	30/09/2021	EDI Plan	LG to amend page 5 in the EDI Plan so that BI's photo is more prominent than JM's photo.	LG	Nov-21	Complete.
FT/21/64	30/09/2021	EDI Plan	LG to amend the key performance indicator in the EDI Plan to say 'we will have 18% BAME employees' by the indicated time and not 'we will aim to have 18% BAME employees' by the indicated time.	LG	Nov-21	Complete.

FT/21/68	30/09/2021	Board meetings	ES will speak with Rachel Tanner to explain detail around Board of Directors meetings.	ES/RT	Nov-21	Complete.
FT/21/35	29/07/2021	Recruitment	JM is undertaking a detailed recruitment review -report through people committee to Board.	JM	Nov-21	Completed in September 2021 People Committee.

Key

complete	agenda item	due	overdue	not due

AGENDA ITEM 9

Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th November 2021		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Summary:	The Chief Executive's report provides an update about key activity that has taken place since the last meeting, in line with our strategic ambitions.

Previously considered by:	Prepared in consultation with the Executive Team.

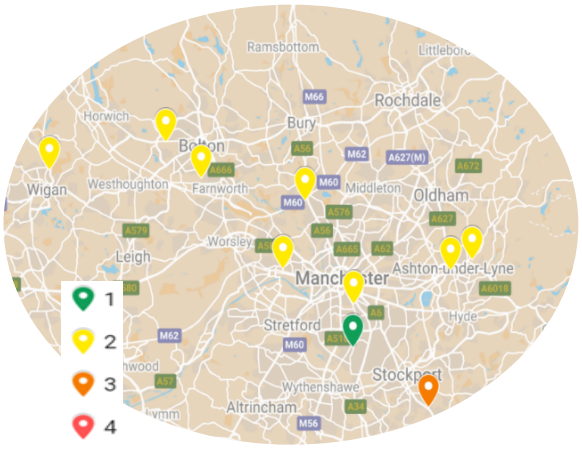
Proposed Resolution	To note the update.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Fiona Noden Chief Executive	**Presented by:**	Fiona Noden Chief Executive

Ambition 1
Provide safe, high quality care

Along with all Integrated Care Systems (ICS), Clinical Commissioning Groups (CCG) and NHS trusts, we are now being assessed through the NHS System Oversight Framework 2021/22. The framework reinforces system-led delivery of integrated care and provides a rating from one to four, with one being the highest. We have been rated as a 'two', the ratings of other trusts across Greater Manchester range from one to three. There are many different ratings within the NHS to highlight how an organisation functions, this rating provides an overarching rating which combines quality, safety, access standards and productivity.



We have undertaken a review of the medical records of all of our patients who contracted COVID-19 whilst in our care so that we are able to fully understand each individual case, and learn from anything we could have done differently. Personal letters have been written to the relatives of all the 92 patients who died, as a consequence of acquiring the nosocomial infection, to tell them how truly sorry we are and offer further support and information. Our next step is that we will be contacting the patients who were infected by COVID-19 whilst in our hospital to offer our apologies and help them understand how this happened.

There are significant pressures on our health system and our focus is managing improvements in the delivery of our emergency services, continuing to maintain an elective programme and ensuring safe and supportive discharge with our community and social care colleagues. This is the winter where our transformation and innovation efforts, along with our partners, will be needed more than ever.

Ambition 2
To be a great place to work

We have made some new director appointments since the last Board of Director's meeting; Vikki Lewis will be joining us from Worcestershire Acute Hospitals NHS Trust as our new Director of Digital and Joanne Street has been appointed to the Director of Operations role. Both will start in post in the new year.

This month Greater Manchester Health and Care Champion Awards gave special recognition to some amazing people who have stood out over the past 18 months. Our cultural support volunteers Hassan Patel and Imran Musa won in the volunteer champion category and members of the Virgin Atlantic flight crew Sue Povey, Mia Povey, Katie Mainwaring, Laura Sutton, Fran Grundy won the collaborative champion award for the work they did with us throughout the pandemic. Really well deserved recognition for such important work to support our patients.

Earlier this month, our Schwartz rounds sessions launched and are open to all staff. The sessions aim to provide a safe environment for people to discuss the emotional and social aspects of work in a healthcare setting. The first round was held online and featured two staff members who shared their experiences of working during the pandemic, and offered the opportunity for participants to reflect and share their experiences too. Schwartz rounds are an internationally recognised tool to support people who have experienced adversity and stress in their working environment, and we are really pleased to be able to offer them to our workforce.

Ambition 3
To use our resources wisely

We are now able to confirm that we finished the first half of the financial year in a balanced position, which is excellent news. Although we are planning to break even in the second half of the financial year, we recognise this will be a significant challenge for us.

Staff from across the Trust attended the first 'Ideas with Impact' workshop this month to share their views on how we can provide the best care for our patients with the resources we have available. Staff are encouraged to share any ideas they have about what could be done to reduce duplication or waste, create sustainable services and ultimately improve the care we provide to our patients. The Board of Directors is invited to share ideas too by emailing ITT@boltonft.nhs.uk.

Ambition 4
To develop an estate that is fit for the future

Recently, we were successful in our bid to increase our ability to provide diagnostic services for the people of Bolton with the use of use of mobile CT and MRI equipment. Our new CT scanning unit is now fully operational and is expected to have a positive impact on ensuring faster CT diagnostic provision. Working in partnership with the independent sector provider, InHealth, the CT mobile scanner will be available on the hospital site through to the end of March, with a MRI mobile scanner joining at the start of January 2022.

This month, the Chancellor revealed the budget spending review and we were notified that we will be receiving some of the 'levelling up' funding to support the development of the Bolton College of Medical Sciences on our hospital site. The state-of-the-art vocational and professional skills and training facility will transform how NHS and social care workforces are educated, alleviate staffing pressures and will enable us to train and develop our existing and future workforce.

Ambition 5
To integrate care

Recognising the ongoing pressures on the delivery of our patient services, we have reinstated the Integrated Care Partnership (ICP) Bronze meeting, taking place every fortnight to agree and implement key actions that form part of the overall winter plan. The group membership includes a range of partners across Bolton including the Trust, Bolton Clinical Commissioning Group (CCG), social care colleagues, Greater Manchester Mental Health NHS Foundation Trust, Bolton Community and Voluntary Services (CVS) and Bolton at Home. Our priority is to support people to get home from hospital, ensuring people stay as well as possible at home and developing new workforce capacity.

Ambition 6
To develop partnerships

We continue to develop our shared vision to improve the health and wellbeing for Bolton people by working together to design and deliver a very different approach to health and care, making tangible improvements for everyone in Bolton. This development is the next step in Bolton's progress towards integration bringing together the commissioning and delivery of services to improve outcomes for all Bolton people and enabling the best use of our limited resources.

As part of a system approach we and Wrightington, Wigan & Leigh Teaching Hospitals NHSFT have completed a 'check and challenge' to review each other's planned performance for the second half of the year (H2). This has been completed as a GM exercise prior to submission to NHS England and Improvement. The session was extremely productive and outcomes were very positive. Through this, we were able to reduce the number of patients assessed to be waiting over 104 weeks from 471 to 403.

This month we launched '*The Small Things'* winter appeal with our official charity partner, Our Bolton NHS Charity. The charity has already funded improvements to our parent accommodation for families of babies and children in our care, portable sensory toys to distract young children during treatment, and specialist kit to minimise the risk of hair loss during cancer treatment.

AGENDA ITEM 11

Title:	Quality Assurance Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	25th November 2021		Discussion	
Exec Sponsor	Esther Steel		Decision	

Summary:	Attached are the Quality Assurance Committee Chair Reports from the following meetings: 20th October 2021. 17th November 2021.

Previously considered by:	N/A.

Proposed Resolution	For noting and assurance.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Esther Steel Director of Corporate Governance	**Presented by:**	Andrew Thornton Non-Executive Director and Quality Assurance Committee Chair

Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	20th October 2021	Date of Next Meeting	17th November 2021
Chair	Andrew Thornton NED	Quorate (Yes/No)	Yes
Members present	Andrew Thornton, Fiona Noden, Francis Andrews, Karen Meadowcroft, Esther Steel, Andy Ennis, Malcolm Brown, Sharon Martin, Donna Hall,	Key Members not present:	

Meeting overview/context

Owing to conflicting external events requiring executive attendance the Chief Nurse and Medical Director items on the agenda were taken early in the meeting. Some attendees experienced connection/IT difficulties.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Chief Nurse / Medical Director update		Medical Director / Chief Nurse	• The CQC TMA meeting with Executive Directors took place in September. A large amount of work was submitted around this and the CQC have confirmed they don't need further information from us. Thanks was acknowledged to everyone involved. • Mortality from sepsis at the Trust is within range. • There is still work required to improve screening for sepsis at the Trust. Screening has included in A&E for sepsis and we have recently seen an improvement.	• A&E are working hard on this and will update QAC in due course.
Chief Operating Officer update – A&E current work pressures		Chief Operating Officer	• There is a lot of pressure in A&E currently and this is being shared with QAC and Board of Directors to ensure they are aware of the full picture. Waiting times are long, and this is a significant risk for us	• The Chief Operating Officer is attending a meeting later today and will highlight that current operational pressures.

	No assurance – WILL have a significant impact on quality, operational or financial performance of the organisation if left unaddressed within 1 month;
	Moderate assurance – potential moderate impact on quality, operational or financial performance of the organisation if left unaddressed within 3 months
	Assured – no or minor impact on quality, operational or financial performance which can be managed through well documented controls/mitigation

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Divisional Governance Report - ICSD		Michaela Toms	• The division are working on improving their management of harm free care • The new BOSCA template has been signed off and will be implemented across the wider teams, starting in December 2021. • Concern was raised around the number of errors re insulin injections. .	• A plan is in place for improvements to be made over the next 12 months. • MT to provide evidence to the Quality Assurance Committee which provides assurance that the number of errors re insulin injections is decreasing, and that we are making good improvements in this area.
Clinical Governance and Quality Committee Chair Report		Chief Nurse	• There is one amber item on the report – Vascular Patient Plan.	• This was discussed extensively in the governance meeting and this is a work in progress.
Divisional Governance Report – Acute Adult Division		Clare Wiliams	• The number of patients with pressure ulcers is decreasing – with nine in this quarter. The new masks being used to treat Covid patients on oxygen is helping with this.	•
Update on Mr C Action Plan		Dawn Murray	• The action plan is now all implemented and is green.	• The division continue to audit the green areas on the action plan to provide assurance.
Quality Account Update - Pneumonia		Rauf Munshi	• The team aim to continue to achieve a target of 80% of patients receiving antibiotics within four hours. • There is a focus on improving documents for the CURB 65 score re pneumonia.	• The coding team and respiratory team have received training around the importance of accurate records.
Quality Account Update – Diabetes		Moulinath Banerjee	• Q1 survey progress compliance is 85% which remains lower than the target. • For Q2 the team are working with BOSCA on safety and making sure elderly patients are safe – particularly around dementia.	• There is a meeting taking place next week around this.

	No assurance – WILL have a significant impact on quality, operational or financial performance of the organisation if left unaddressed within 1 month;
	Moderate assurance – potential moderate impact on quality, operational or financial performance of the organisation if left unaddressed within 3 months
	Assured – no or minor impact on quality, operational or financial performance which can be managed through well documented controls/mitigation

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Mortality Report		Associate Medical Director	• There is a lot of work taking place following Know Your Patient week and the team are working with Ward Clerks in this area. • The team recognise the corporate risk of not always having staff available immediately. There is a staffing shortage and Ward Clerks are really making a different to patients and patients families. • The Counting and Recording Group are developing training for Ward Clerks, and there will need to be a mandatory element to this training. • Work is being undertaken with the EPR team to improve the EPR system and make it easier to record and pull data.	• CS will discuss Ward Clerk training with the People Development Steering Group to see where improvements can be made.
Learning from Deaths Report		Associate Medical Director	• The Deputy Medical Director, Nicola Caffrey and team have addressed a significant backlog of Structured Judgement Reviews (SJRs) • The team are developing processes for thematic analysis of the SJR database to inform wider organisational learning.	• The team are addressing a now much smaller backlog with SJR case records by increasing reviewer numbers. • The aim is for the Learning from Deaths Committee to determine the areas of concern and then produce reports for other Working Groups so action plans can be put in place.
Nosocomial Covid Deaths Review Panel		Deputy Medical Director	• The paper and its accompanying action plan provide an update on progress and work undertaken to date. • Nosocomial rates at the Trust were 9% - the second best result in GM. • Nosocomial Covid deaths are now rare, with only one nosocomial death at the Trust since March 2021. That is still one death too many though and work is being done around the Trust to aim towards zero nosocomial deaths going forward. • There will be a national enquiry into nosocomial Covid deaths next year and the Quality Assurance Committee agreed we need to address this now rather than waiting for the enquiry to take place.	• The team are in discussion with Communications around this as it is likely to be highlighted in the media. •

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Committee/Group Chair's Report

Annual Infection Control Report 2020/21		Richard Catlin	• There has been significant improvement around regular blood transfusion. • There has been 470 days between the last two MRSA cases – this is 100 days longer than the last longest gap between cases. • Covid is a dominant feature of the report.	• Preparations are being put in place for this year as there have been changes in the UK Health and Safety Agency who review cases.
National Inpatient Survey 2020		Director of Quality Governance	• 85% of those surveyed said they were always treated with dignity. • There were quite a few instances in this survey which relate discharge. • Noise during the night was also highlighted in the report. Staff need to interact with each other and to be alert and this has been highlighted to the Patient Experience Team. • It was highlighted bed moves cause noise at night, and these cannot be avoided currently due to late discharges. • There was a concern in the report around patient medication and discharge and this needs to be worked on to ensure improvements are made going forward. • It was noted this patient survey relates to patient feedback from a year ago.	• A lot of work is taking place around discharge and we need to think about pulling this all together in a plan so nothing is missed. • SM/RC/AE will meet to discuss discharge and the Adult Inpatient Survey.
SI Reports and HSIB Report		Director of Quality Governance	• There were four SI Reports and one HSIB Report shared at this meeting and they were all approved.	
Integrated Performance Report		Chief Operating Officer	• Maternity was highlighted in August. The Chief Nurse confirmed she has asked for a comprehensive report on this and that will be brought to the Clinical Governance and Quality Committee in January 2022. • More sections are taking place in maternity than previously. Ten years ago 23% of births were by section, now it is 30% and this creates extra pressure on the system.	

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Committee/Group Chair's Report

Excellence Reporting		Director of Quality Governance	• Divisions have provided their input. • Excellence Reporting has now gone through a number of Family Care and Integrated Care Services and we have gained lots of learning from this which will be used for ideas for quality initiation.	
Risk Management Committee Chair Report		Chief Operating Officer	• There was concern re iFM and high voltage but we now have assurance we are getting there. • The fire escapes will be finished today.	
Mortality Reduction Group Chair Report		Associate Medical Director	• A query was raised around the Laburnum Lodge Report. The report confirmed the Trust provides data on observation recording, but not on mortality.	• The team are looking to include this in future reports for MRG.
Group Health and Safety Committee Chair Report		Director of Quality Governance	• The D3 fire escape will be finished today and ready for use tomorrow.	
For Escalation: Pressures in A&E were highlighted, and Nosocomial Covid Deaths and Inpatient Survey were highlighted as amber.				

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Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	17th November 2021	Date of Next Meeting	15th December 2021
Chair	Andrew Thornton NED	Quorate (Yes/No)	Yes
Members present	Andrew Thornton, Fiona Noden, Francis Andrews, Karen Meadowcroft, Jackie Njoroge Esther Steel, Andy Ennis, Malcolm Brown, Sharon Martin, all Clinical Divisions in attendance	Key Members not present:	

Meeting overview/context

Owing to conflicting external events requiring executive attendance the Chief Nurse and Medical Director items on the agenda were taken early in the meeting. Some attendees experienced connection/IT difficulties.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Chief Nurse / Medical Director update		Medical Director / Chief Nurse	• All next of kins (where possible) have been contacted re patients who sadly died of nosocomial Covid. A task force has been set up for this which includes H Baraj, N Caffrey and R Catlin. • A lot of work has taken place around training for trainees. • Work has taken place to get SI Reports up to date and we are now almost through the backlog.	• A further update will be provided to QAC in due course. • F Andrews now attends monthly meetings with trainees to ensure training is continuing at the appropriate level.
Chief Operating Officer update – A&E current work pressures		Chief Operating Officer	• A system check and challenge on elective recovery has taken place and Bolton have done well. • Bolton has the most productive theatre in GM. • There are still long waiting times. • Cancer is performing well and we are offering support to other Trusts elsewhere. • Covid is taking up approximately 10% of bed capacity and this creates extra pressures. • No criteria to reside has decreased by 20-25% (down from approximately 100 to approximately 70 beds).	

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Committee/Group Chair's Report

Clinical Governance and Quality Committee Chair Report		Chief Nurse	• The Trust has had very few maternity closures but there is an issue with over reporting as neonatal closed.	
Sepsis update		Medical Director	• Work is ongoing to get us to 90% of emergency admissions being checked for sepsis. • Pilot work is taking place on the EPR system. • Sepsis SHMI mortality is well within normal range. • Training around Sepsis is being undertaken.	• F Andrews will prepare a paper on paediatric Sepsis.
Clinical Correspondence – Performance Review and Action Plan		Medical Director	• For inpatients we are at 80% for one working day electronic discharge, but need to aim for 100%. • For outpatients, correspondence varies between 70-80% and it was noted that the Family Care Division have done very well in this area.	• There are plans in all divisions to make further improvements with Clinical Correspondence.
Mortuary Security – HTA Compliance Update		Richard Catlin	• A full assessment of mortuary security has taken place. • A plan has been agreed to increase CCTV and have a more auditable locking system.	• These plans will be in place by the end of November 2021.
Divisional Governance Report – Family Care Division		Paul Settle	• The division are performing well. • There has been an improvement with training and this will continue. • Improvements have been made around responding to complaints. • This report was discussed in detail at the Clinical Governance meeting and assurance was provided.	
Maternity Transformation Plan		Natasha McDonald	• The team are proud to be taking part in the national project for Tommy's App which is expected to help with reducing the number of still births. • There are 30 work streams and a huge amount of work is taking place in maternity.	• The work plan is being monitored through Maternity Safety meetings.
Quality Account Update – Maternity Safety		Natasha McDonald	• The following five elements of safety have been picked out as a focus, but a focus on safety also remains in all other areas: – Ockenden compliance. – CNST compliance. – Still birth and early/late neonatal deaths. – Brain damage at birth. – Third and fourth degree tears.	• Work is being done in all areas to ensure we continue to improve safety.

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Committee/Group Chair's Report

SI Reports		Medical Director / Deputy Medical Director	• There were seven SI reports discussed at this meeting and the following outcome was agreed. – SI Report 174420 was approved. – SI Report 180808 was approved. – SI Report 180467 was approved. – SI Report 173924 needs updates to the actions and then will be approved. – SI Report 180044 needs updates to the actions and then will be approved. – SI Report 182097 needs a correction to the report and then will be approved. – SI Report 181677 needs to come back to QAC in December 2021 with information to provide assurance the action plan has been completed.	• The requested detail for SI Reports will be provided and these will be approved as soon as appropriate.
Integrated Performance Report - Quality		Chief Operating Officer	• There were no issues to report.	
Safeguarding Adult, Children and Looked After Children Annual Report 2020-21		Chief Nurse	• This is a small team and they have done a tremendous amount of work, keeping face to face meetings where possible during the pandemic. • There are areas of Bolton with high levels of depravation and mental health issues.	• There is a review taking place to establish if this team needs extra staff to deal with the growing concerns in this area.
Risk Management Committee Chair		Chief Operating Officer	• This was a positive report.	Report noted no issues escalated
Mortality Reduction Group Chair Report		Associate Medical Director	• Amendments will be made to the electronic system around asking for three to six month's assurance.	Report noted no issues escalated
Group Health and Safety Committee Chair Report		Director of Corporate Governance	• There is a lot of good work taking place around occupational health. • A focus is underway around trips and falls to see where improvements can be made. • An update was provided on fire escapes.	Report noted no issues escalated

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Committee/Group Chair's Report

Safeguarding Committee Chair Report		Chief Nurse	• More work and training is required around domestic abuse and identifying a lead for the Safeguarding team.	Report noted no issues escalated
For Escalation: Pressures in A&E were highlighted as amber.				

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AGENDA ITEM 12

Title:	Nursing, Midwifery and AHP Staffing Report			
Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	Nov 2021		Discussion	✓
Exec Sponsor	Karen Meadowcroft		Decision	
Summary:	NHS Trusts have a duty to ensure safe staffing levels are in place and patients are cared for by appropriately qualified and experienced staff. Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and NICE guidelines. This biannual nursing, midwifery and Allied Health Professional (AHP) staffing report outlines the organisations position with regards to Nursing, Midwifery and AHP staffing and provides analysis of our workforce position at the end of June 2021. This report is provided as an update to the comprehensive report submitted in May 2021. Included in the report are Divisional reviews undertaken covering the period January 2021 to June 2021. Professional judgement has been utilised to align safe staffing against national guidance relevant to the individual speciality areas. The report also provides on update on the implementation of the Safer Nursing Care Tool (SNCT) up until October 2021. Staffing levels, nurse recruitment and retention are challenging nationally and regionally this report demonstrates the work done in Bolton Foundation Trust to support the ambition to deliver safe staffing levels.			
Previously considered by:				
Proposed Resolution	The Board of Directors is requested to: 1. Approve the content of this staffing review 2. Recognise the work undertaken over the past 6 months 3. Support the review of nurse staffing establishments following the validation of data collated from 2nd SNCT consensus in February 2022			

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	A Hansen, Deputy Chief Nurse	**Presented by:**	K Meadowcroft Chief Nurse

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1. Introduction

This bi-annual, report is provided to the Board of Directors on Nursing, Midwifery and AHP staffing as an update to the comprehensive report in May 2021. The report details our position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[2]. The Guidance recommends that the Board of Directors receive a bi- annual report on staffing in order to comply with the CQC fundamental standards on staffing[3] and compliance outlined in the well-led framework. The report provides an analysis of our nursing, midwifery and AHP workforce position at the end of **June 2021** and the actions being taken to mitigate and reduce the vacancy position.

1.NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
2.NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
3.https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led

2 Bolton Workforce Position

2.1 At the end of June 2021, there were a total of **113.73 Whole-Time Equivalent (WTE)** qualified nursing and midwifery vacancies (numbers below include Health Visitors, Midwives, Qualified Nurses and School Nurses) across the Trust compared to **27.20 WTE** at the end of December 2020. This is an **increase** in the overall nursing and midwifery vacancies of **86.54 WTE** since December 2020. Approximately 40wte have been a result of substantively establishing our 2 winter wards. The 2 winter wards have remained open for the whole of 2021utilising staff from the base wards and bank staff as historically these wards were temporarily staffed for the winter however due to the need for capacity the Trust have worked to substantively establish the 2 ward areas.

Table 1 Nursing and Midwifery Registered Vacancies

Year / Month	Vacancies	Contracted WTE	Established WTE
2020 / 07	68.99	1803.64	1872.63
2020 / 08	75.58	1803.46	1879.04
2020 / 09	79.27	1796.54	1875.81
2020 / 10	20.38	1839.45	1859.83
2020 / 11	25.31	1840.05	1865.36
2020 / 12	27.19	1838.24	1865.43
2021 / 01	60.06	1828.89	1888.95
2021 / 02	64.20	1826.18	1890.38
2021 / 03	60.71	1834.56	1895.27
2021 / 04	56.52	1832.75	1889.27
2021 / 05	102.15	1842.59	1944.74
2021 / 06	113.73	1833.51	1947.24

2.2 The Trust continues to ensure we have a strong pipeline of Newly Qualified Nurses by interviewing and offering posts at the earliest stage; 89 newly qualified nurses and midwives commenced employment in September 2021 which is the Trusts largest intake in a number of years. We have also made 38 offers of employment to student nurses (who are part of the Trust's non-commissioned nurse training programme which we run in partnership with the University of Bolton) due to qualify in February and April 2022. Previous reports had outlined funding received from NHS England/Improvement to support international nurse recruitment with funds received to support 15 WTE general nurse and 11 critical care nurse appointments from overseas. Currently we have 6 nurses who are working in the Trust following successful completion of their Objective Structured Clinical Examination (OSCE) and registration with the NMC, a further 10 candidates are undergoing training and plan to undertake their OSCE with the anticipation they will be registered and employed in November). Three more candidates are due to arrive in the UK in early December. We have a strong support package in place for our nurses once they arrive in Bolton after completion of their necessary training and this includes the provision of accommodation on-site at the Royal Bolton Hospital. Due to the lack of domestic supply of nurses there will be more reliance on ethical international recruitment to fill nursing vacancies, with further National Health Service England Improvement (NHSEI) funding expected to be released in support of this. Previous reports have outlined the efforts to reduce vacancies and expand the recruitment of Health Care Support Workers (HCSW). These efforts include; recruitment of candidates without experience but with the right caring and compassion qualities. The employment of HCSW without previous experience is supported nationally to promote local recruitment and widening participation in healthcare careers. Trusts are required to increase this staff group by

6%. The Trust secured funding £114,980 from NHSEI to support HCSW recruitment activity, and the provision of pastoral support for our newly appointed HCSWs. This funding has enabled the introduction of a dedicated Matron (22.5 wte) role with responsibilities for training, development and retention of our HCSWs.

The current HCSW vacancy rate is 8.4% (56.2 wte). Following a number of HCSW recruitment days 47.84 WTE candidates are commencing employment between October and December 2021, with a further 55.23 wte candidates currently undertaking pre-employment checks. If all candidates are appointed, accounting for a 12% turnover rate, our vacancy position will be less than the NHSEI target of 1.0% by December 2021.

2.3 Nursing Midwifery and AHP Turnover

Table 2 below shows turnover split by staffing groups; this is shown as in month. Colleagues will note that the trends for both Nursing and Midwifery and Allied Health Professionals are on a slightly downward trajectory; however, the Additional Clinical Services staff group shows an increasing trend and this is being analysed and addressed in Divisions with workforce support.

Table 2 Staff Turnover

Year / Month	Staff Group		
	Nursing & Midwifery Registered	Allied Health Professionals	Additional Clinical Services
2020 / 07	12.79%	13.07%	9.69%
2020 / 08	12.95%	12.75%	9.87%
2020 / 09	12.24%	12.98%	10.78%
2020 / 10	12.49%	13.81%	10.77%
2020 / 11	11.98%	13.72%	10.98%
2020 / 12	12.86%	13.17%	10.95%
2021 / 01	12.36%	12.88%	11.64%
2021 / 02	12.00%	12.77%	11.55%
2021 / 03	11.08%	10.96%	11.85%
2021 / 04	11.06%	10.88%	12.22%
2021 / 05	10.93%	10.84%	12.47%
2021 / 06	11.24%	11.87%	12.97%

2.4 Retention

Retention is a key work stream for the Nursing Midwifery and AHP (NMAHP) Workforce Forum which reports to the NMAHP Professional Forum which reports to the Quality Assurance Committee. Retention is monitored at the Resourcing and Talent Management Sub-group which reports to the People Committee. These Forums continue to monitor rates and actions in support of retention. The Professional Education Forum monitors the allocation of continuous professional development funding secured by the Trust from Health Education England to support staff development which is a key factor to retain staff. The Trust is also actively looking at our existing appraisal and conversation toolkits to add in regular discussions with our workforce to ensure they are happy in their roles, and are supported if they have any questions or concerns.

2.5 Sickness and Absence

Table 3 below demonstrates that Nursing and Midwifery sickness absence rates compared to the rest of the Trust are on an increasing trend from April 2021 to date. Nursing sickness rate continues to exceed 5%. The main driver for this change has been the increased number of staff reporting anxiety / mental health conditions, along with a high number of staff off with muscular skeletal problems. Whilst this sickness rate is higher than we would like, it is worthy of note that Bolton continues to benchmark positively when compared to other organisations within Greater Manchester. Allied Health Professionals show a much lower rate of sickness absence when compared to the overall Trust rates – and sickness percentages for this staffing group have been relatively stable in 2021. For the Additional Clinical Services staff group sickness rates are above the overall Trust rates and, similarly to Nursing and Midwifery, show an increasing trend from April 2021 onwards. The initiation of staff testing and impact of the successful vaccination programme has impacted positively on reduction of the COVID-19 absences; the recent combined COVID-19 booster and Flu vaccination campaign has been well received by Trust staff.

Table 3 Staff Sickness Absence

Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	**5.53%**	**4.87%**	**2.84%**	**7.57%**
2020 / 07	**5.30%**	4.61%	2.47%	7.16%
2020 / 08	**5.95%**	5.30%	2.85%	7.98%
2020 / 09	**5.98%**	5.37%	3.04%	7.99%
2020 / 10	**6.15%**	5.52%	3.28%	8.27%
2020 / 11	**5.84%**	5.17%	3.68%	7.78%
2020 / 12	**6.05%**	5.29%	2.97%	8.53%
2021 / 01	**5.42%**	4.63%	2.62%	7.83%
2021 / 02	**4.89%**	4.27%	2.92%	6.62%
2021 / 03	**4.49%**	4.10%	2.46%	5.87%
2021 / 04	**4.98%**	4.47%	2.58%	6.72%
2021 / 05	**5.28%**	4.72%	2.56%	7.30%
2021 / 06	**5.98%**	4.99%	2.71%	8.90%

2.6 Recruitment

Recruitment is a key challenge to the Trust in light of national shortages of nurses and AHPs, coupled with a dynamic and competitive jobs market. Clinical and Workforce teams have ensured a continued focus on recruitment of our Nursing, AHP, and Additional Clinical Services workforce. In addition to the Trust wide recruitment of HCSW and Newly Qualified Nurses a rolling recruitment programme has been undertaken for complex care wards in our Acute Adult Care Division (AACD). Accident and Emergency (A&E), Specialist and difficult to recruit to areas such as Theatres, and Paediatrics also run their own bespoke recruitment campaigns and activity with support from the Employee Service Centre. A significant focus has been placed on the business critical themes to ensure robust winter plans for Trust services as we move towards our typically busiest time; a number of work-streams have been implemented and one of these focusses on staffing. Weekly meetings are in place and include key Divisional and Workforce representatives. Actions include a refreshed communications approach focusing on new and innovative social media

activity (including paid-for advertising) and a review of our recruitment pathway in order to minimise recruitment timescales. A series of stretch targets for each stage of the recruitment journey (from advertisement to completion of pre-employment checks) has been agreed these are expected to deliver a reduction in the recruitment timescale (from advert placed to completion of all pre-employment checks) of 57 working days to 43 working days.

3 Trainee Nurse Associates, Student Nurses & Professional Nurse/ Midwifery Advocates

3.1 From January 2021 training cohorts for Nursing Associates (NA) with Bolton University has been re-established. The Senior Nursing teams are continuing to review establishments and skill mix as the NA workforce continues to grow and be introduced into clinical areas. The NA role is to be introduced in theatre areas following a Quality Impact Assessment (QIA) and agreed competency training framework. The community team have successfully piloted the Nursing Associate within their workforce and intend to expand this skill mix further. Within the Acute Adult Care Division there are plans to embed this new role by having wards with 24-hour cover of NAs within the rosters. The Trainee NA intake for September 2021 has a total of 12 trainees with the next intake commencing April 2022. There are 5 Trainee Nurse Associates within the organisation via the independent route, these have applied directly to the University of Bolton (UOB), are self-funding the programme and are offered clinical placements with our Trust rather than coming from our own established workforce. It is acknowledged that there are more opportunities to be explored for the Nursing Associate role within the organisation.

3.2 The Chief Nursing Office for England have recognised the negative impact the last 5 years reduction in the commissioning of undergraduate places had on the NHS and have recently announced a 34% increase in Undergraduate placements with the aim to increase the domestic supply in 3 years' time (2024). Following contract negotiations with the UOB we have moved to two intakes of 90 student nurses per annum. We continue to take a further 30 student nurses from the University of Salford. Greater Manchester was successful in their bid to increase student numbers via the Clinical Placement Expansion Programme (CPEP) initiative throughout the region. As a result of this Bolton NHS FT have committed to a capacity increase of additional 45 adults, 10 children and young person's, 10 Mental Health and 2 learning disabilities student nurses. There will also be an increase in midwifery and AHP student numbers but Bolton NHS FT allocation is yet to be disclosed. Health Education England (HEE) have released £45,390 to Bolton NHS FT to fund a Band 7 PEF (Practice Education Facilitator) to manage the Clinical Placement Expansion Programme (CPEP).
Nursing Degree Apprenticeships and NA conversion courses are being shortened to assist Trusts to utilise this potential market. The benefits of a Nurse Apprenticeship programme within the hospital setting are yet to be realised. However, within the community settings there are 3 Registered Nurse Degree Apprenticeships commencing their top up to Registered Nurse status in August/ September 2021.

3.3 The National Retention Board have recently published data which demonstrates that high numbers of newly qualified nurses and midwives leave their respective professions at the early parts of their careers (1st and 2nd year). In response to this, The Professional Nurse Advocate (PNA) Programme was launched in March 2021 to provide training and restorative supervision for NHS staff. Following a successful pilot of this role in the Anaesthetic and Surgical Services Division (AASD) they now have 3 qualified and a further 2 in training. The Family Care Division also has 1 PNA who has just qualified in the Children's Community Nursing Team, and 3 staff from the

Acute Paediatric Team commenced their training in September 2021. We continue to progress plans to integrate this role in all areas which will provide professional clinical supervision to support staff.

3.4 The Professional Midwifery Advocate (PMA) Programme is already established in NHS Maternity services where there have been improvements noted in staff well-being and retention. Currently in our Maternity services we have 10 PMAs with a further 2 in training. The established PMAs have supported the new PNAs who undergo the same training course

4 Safe Staffing

4.1 The NHSI's Developing Workforce Safeguards Guidance (2018) builds upon the NQB Safe Staffing Guidance (2016) and is designed to help Trusts manage workforce planning. The recommendations focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance supports a triangulated approach to staffing decisions, combining evidence based tools such as the Safer Nursing Care Tool (SNCT), professional judgement and outcomes that are based on patient needs, acuity, dependency and risks.

4.2 NHSE/I were contracted to implement the SNCT census in the Trust. A project plan, including training and capture of information was written and agreed. Inter-reliability training from NHSE/I was cascaded to Matrons, Ward Managers and members of the Education Team. The first consensus of patient-level acuity and dependency data was submitted with 100% compliance and is currently undergoing analysis using the Safer Nursing Care Tool (SNCT) models. Initial analysis of the first set of data collected demonstrates **significant shortfalls in establishments.** A second period of data capture will take place in February 2022 in line with NHSE/I recommendations, and once the 2 census periods are validated the data may necessitate investment in establishments. Averaging the two periods of data collection will provide a reliable basis for safe establishment setting.

The SafeCare system is a module of the Allocate Health Roster. Data is collected three times daily to record the patient acuity and dependency along with confirmation of attendance of staff and finalisation of the previous duties. A process is put in place to have a second person to validate the clinical acuity of the patient in order to remove bias and support consistent data submission. The SNCT tool supports Managers and Matrons with staffing decisions. Training was delivered to all ward-based nursing staff to understand and utilise the system. Further utilisation of the system to record 'red flags' and 'professional judgement' will also be rolled out over the coming months. We are also commencing the element of the project where we utilise SNCT within our emergency department areas'.

4.3 A 'Safe Staffing Report' is submitted monthly to NHSE/I detailing the planned and actual staffing levels and care hours per patient day (CHPPD). Planned and Actual staffing is extracted from the Health Roster System and patient occupied bed days are supplied by Business Intelligence colleagues before submission. **Table 4** details our registered (nursing and midwifery), non-registered (healthcare assistants and support staff) and overall fill rates for the period July 2020 to June 2021. This shows that whilst there has been variation in fill-rates over the course of the year, average of these is 86.98% (registered staff), 94.04% (non-registered staff) and 89.89% (overall).

Table 4 Fill Rates

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	**91.70%**	**90.64%**	**93.23%**
2020/07	**97.64%**	83.06%	120.76%
2020/08	**93.98%**	87.62%	102.85%
2020/09	**93.41%**	92.50%	94.75%
2020/10	**92.20%**	92.36%	91.97%
2020/11	**91.36%**	94.22%	87.22%
2020/12	**91.45%**	92.48%	89.91%
2021/01	**93.18%**	93.45%	92.82%
2021/02	**91.80%**	93.73%	89.06%
2021/03	**87.75%**	91.54%	82.67%
2021/04	**91.14%**	91.50%	90.60%
2021/05	**89.75%**	90.12%	89.20%
2021/06	**85.55%**	87.48%	82.51%

5 Care Hours Per Patient Day (CHPPD)

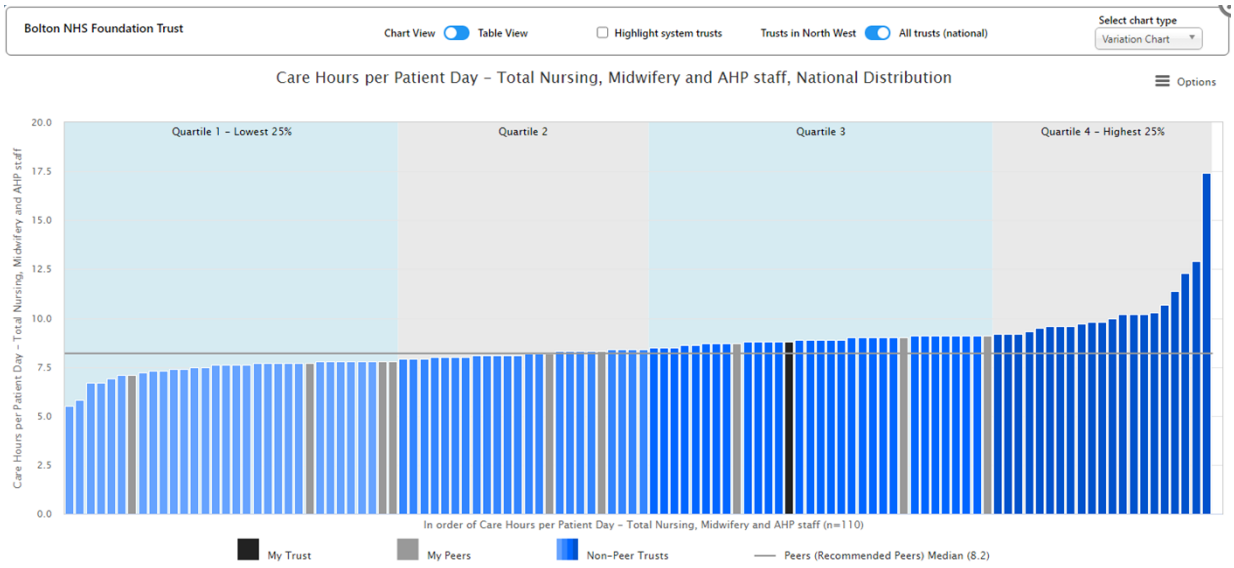
5.1 Care Hours per Patient Day (CHPPD) is a nationally comparable metric for recording and reporting nursing and care staff deployment. CHPPD is calculated by dividing the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward over a 24-hour period by the number of patients occupying a bed at midnight. It is widely acknowledged that CHPPD does not take into account hour by hour fluctuations in ward activity which can be more limiting to wards that have a high level of day case patient flow activity. However, the CHPPD does provide a consistent figure for benchmarking nurse staffing levels against other Trusts.

5.2 **Table 5** outlines the Trust CHPPD trend over the 12-month period. **Table 6** benchmarks CHPPD at Bolton NHS FT to all other equivalent organisations, with regional peers highlighted grey. This is presented with caution when completing workforce reviews due to the make-up of services within each individual organisation making it not always a 'like-with-like' comparison. Very low CHPPD figures may indicate a potential patient safety risk. This is an area we will explore in the future with the SNCT.

Table 5 Trust CHPPD

Year / Month	Total CHPPD No.	Reg. CHPPD No.	Non Reg. CHPPD No.
Total	9.95	5.84	4.12
2020/07	12.77	6.66	6.11
2020/08	9.51	5.17	4.35
2020/09	10.01	5.93	4.08
2020/10	9.30	5.54	3.76
2020/11	9.59	5.86	3.73
2020/12	9.92	6.00	3.93
2021/01	9.83	5.69	4.14
2021/02	9.41	5.63	3.78
2021/03	10.09	6.02	4.07
2021/04	9.82	5.85	3.97
2021/05	9.97	5.99	3.97
2021/06	9.33	5.83	3.50

Table 6 CHPPD Benchmarking (source: Model Hospital)



6 Daily Staffing

6.1 Daily staffing levels continue to be assessed across each shift by senior nursing and midwifery through a daily staffing meeting. A weekly roster review meeting also takes place in each division attended by workforce where the coming week is reviewed to optimise staffing levels. Structured roster approval meeting's take place on a monthly basis where all rosters are scrutinised by senior nurses and workforce prior to approval taking place. Nurse staffing is a standing agenda item at each of the Trusts corporate flow meetings. Escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved to ensure the safe delivery of care.

6.2 Funding to pilot a Trust-wide Enhanced Care Team has been approved by the Trust. Recruitment of new staff members is almost complete and staff are expected to commence in post over the next 2 months. It is anticipated that the introduction of this team will reduce the bank and agency spend and improve the quality of the support to the in-patient wards.

7.0 Nursing Leadership

7.1 We know that clear visible nurse leadership is paramount to the delivery of safe effective care. At Bolton Foundation Trust Senior Nurse Walkabouts (SNW) have previously been undertaken collectively by a team of nurse leaders. However, in recent years mainly due to the impact of covid scheduled SNWs were paused. This pause afforded the Chief Nurse the opportunity to review Bolton's process and approach. SNWs have been remodelled and relaunched utilising the ethos within the NHSI 15 step challenge which is about empowering leadership at the front line. o

7.2 In order to establish a consistent approach to nursing leadership on all wards a standardised protected management time for all Band 7 Ward Managers has been introduced.

7.3 A Ward Managers/Matrons Forum has been established, feedback to date has been positive.

7.4 A clear leadership Framework and reporting structure has been introduced under the Professional Forum underpinned by 5 subgroups including workforce and education streams.

8 Family Care Division

8.1 Acute Paediatrics Staffing Review

Since May 2021, the unit has been preparing for a national surge in RSV type infections in children which was predicted to surge in July/August. In addition, national modelling suggested that winter 2021/22 activity in paediatrics is likely to see a surge 20-50% greater than the worst winter with regard to respiratory infections. Therefore, a staffing review was undertaken in May 2021 to ensure that sufficient arrangements were in place to manage a potential surge, this also formed part of a Summer Surge plan and subsequently a Winter Plan which is linked to the GM plan. In addition, the continued increase in the number of children and young people with complex mental health, social and behavioural issues being admitted to the acute children's ward continue. This also impacts on staffing in particular where young people require 1:1 care and supervision.

Winter and Summer model for staffing (seasonal modelling)

Public Health England (PHE) are modelling has predicted the likely impact of Respiratory Syncytial Virus (RSV) particularly Bronchiolitis on children's admissions and has predicted a prolonged 2021/22 season lasting from week 32 (August 2021) to week 10 (March 2022) with peak at week 47 (November 2021).

In anticipation of an RSV surge, Trusts were asked to base planning assumptions on the first scenario. GM has asked each provider to develop plans to identify surge beds of 50%. In addition to planning and increase in bed capacity to meet expected demand, staffing was reviewed alongside this.

In line with National guidance the unit operates a seasonal staffing model which is reviewed twice per year. In addition, staffing levels are monitored daily with the staffing huddles and reviewed 3 times per week to ensure safe staffing.

8.2 Staffing Reviews and Staffing KPI's

Twice yearly staffing modelling to cover seasonal variation, along with staffing reviews 3 times per week. During winter pressures, staffing is reviewed daily.

From January 2021 to June 2021 the unit predominantly met requirements as outlined by NHSI/E and the Care Quality Commission (CQC).

Table 7 Family Care Division Staffing KPIs

April - Sept – 2021 Compliance	Nurse to Child Ratio – all ages 0-16 years.	Super-numerary Ward Manager Mon - Fri	Super-numerary Shift Co-ordinator	APLS trained Band 6/7	7-day play team cover
January 2021	1.2.1	100%	100%	100%	100%
February 2021	1:2.1	100%	100%	100%	100%
March 2021	1:2.3	100%	98%	100%	100%
January 2021	1.2.1	100%	100%	100%	100%
April 2021	1:2.2	100%	98%	100%	100%
May 2021	1:2.4	100%	100%	100%	100%
June 2021	1:3.0	100%	97%	100%	100%

The exceptions are as follows:

April 2021 – June 2021 – There has been a reduction in the ability to provide 100% supernumerary band 6 shift coordinator cover. This has since been resolved.

June 2021 – 97% Play team cover - this was due to short term unexpected sickness.

Sickness target
Sickness levels have remained fairly consistent. However, work is ongoing with HR support individual staff to back to work.

8.3 Recruitment and retention

Despite an agreement to over-recruit on the band 5 line to 3 additional posts to cover winter pressures, in September 2021 we have had 4 band 5s leave the unit, the additional vacancies are now out to recruitment. In Bands 3 and 4 we see the greatest turnover. However, we have recruited 3 new HCSWs. We currently have 4 Nurse Associates on Acute Paediatrics and currently no vacancies. There have been no changes to the Nurse Associate workforce since the previous report.

Turnover

Trust turnover target is 10%, staff turnover on Ward E5 is 7.14%. This is the accumulative turnover from October 2020 to September 2021. This is lower than the turnover for the rest of the Division which is above target at 11.08% but below Trust turnover at 12.97%.

Actions taken since last review

There have not been significant numbers of COVID19 related admissions in the past 6 months. Significant work has taken place to ensure a robust plan is in place for an expected RSV surge and this includes planning for increased bed capacity, additional staffing and mutual aid from adult critical care.

9. Family Care Division Maternity, Gynaecology and Neonatal Staffing review

Bolton NHS FT provides acute and community Maternity services, inpatient and Outpatient Gynecology and Neonatal care within the Family Care Division. This paper reviews the staffing of these three separate areas.

Maternity

Bolton NHS FT provides maternity care for 5800 pregnant people. Antenatal care in the community is provided within GP surgeries, children centers, the BCOM Hub and on site at the Royal Bolton Hospital site. This review has taken into consideration NICE recommendations such as NICE recommended Birthrate Plus (BR+) tool for midwifery staffing, and professional judgment. BR + is considered valid for 3 years in 2021 the LMS funded a Birthrate Plus review for all maternity units in GM. In response to the initial Ockenden report (2020) NHS England granted funding for 4.6 extra WTE. Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. This means that taken overall to provide safe high quality maternity services, the NHS in England needs 1 clinical midwife for every 28 births.

Table 8 Midwife to Birth Ratios

Indicator	Goal	Red Flag	Apr-21	May-21	Jun-21
1:1 Midwifery Care in Labour	95%	<90%	98.00%	98.30%	98.60%
Number of births	Information only		486	441	456
Unit Closures	0	1	1	1	1
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	01:30	01:30	01:30.3
Midwife /birth ratio (rolling) actual worked incl. bank	information only		01:26.6	01:28.4	01:28.4
Monthly percentage sickness	4%	>=4.75%	4.39%	5.38%	6.60%

Additional Roles, Initiatives and Innovation

Midwifery have launched a maternity Hub in collaboration with Bolton Council of Mosques (BCOM). We have increased our Practice Educator Midwives to increase staff support in clinical practice and to improve recruitment and retention. We are also working with the Greater Manchester Local Maternity Service to recruit international Midwives.

Current cot base within Family Division

We provide level 3 neonatal care as part of the North West operational delivery network. With 37 cots, (7 Level 3, 9 level 2 and 19 special care). Our neonatal staffing consistently achieves British Association of Perinatal Medicine compliance, whilst maintaining a supernumerary coordinator. Changes to government restrictions have also had an inadvertent effect on staffing levels with increased cases of COVID19 being recorded on the Neonatal unit. Increased cases within infants has in turn impacted on the need for more 1:1 nurse ratio thus increasing staffing demand. Increased cases within staff members has resulted in staffing shortages and high absence rates. Despite the challenges posed and high rates of sickness /absence the Neonatal Unit has maintained a supernumery coordinator >95% of the time.

Recruitment and retention

Covid19 has negatively impacted on recruitment and retention on the Neonatal Unit In recent months the Neonatal unit had had difficulty in recruiting new starters. Whilst there are few gaps within the senior positions, recruiting newly qualified staff and/or band 5s with experience has proved challenging. To mitigate this Bolton Neonatal Unit has explored alternative ways to recruit utilising remote interviews and using social media to display the work that is undertaken in a tertiary Neonatal centre. The Bolton NNU has also asked for the support of the Neonatal Operational Delivery Network in creating a unified Neonatal service advertisement to aid recruitment.

Gynaecology Services

The Trust provides emergency, ambulatory and inpatient care for Gynaecology and Early pregnancy (up to 16 weeks' gestation) and Outpatient activity including diagnostics, treatments and day case procedures. M6 Emergency and Urgent care for Early Pregnancy and Gynaecology (M6 EAC) continues to provide Emergency Gynaecology and emergency assessments for early pregnancy up to 16 weeks' gestation.

Staffing Review - Recruitment and retention

We are now recruited to our establishment with appropriate skill mix of all nursing and support roles including Triage Nurse and Nurse Associate. We are currently reviewing the current skill mix and plan to recruit Nurse Associates to the Outpatient setting in the future.

Nurse Associates, Advanced Practitioners and Additional Roles

We have successfully recruited a Nurse Associate and as part of future proofing of gynaecology services, we hope to recruit more Nurse Associates. The recruitment of an Advanced Nurse Practitioner in Gynaecology is a key priority.

10 Acute Adult Care Division

Recruitment continues to remain challenging in light of the pandemic with a divisional recruitment calendar being utilised to achieve safe staffing in all areas. The current 'live' vacancy (as of Sept 21) rate across AACD is 7.2%

Contingency/winter wards (B4 and A4) are open, B4 opened in November 2020 and Ward A4 opened in May 2021.

10.1 Staffing Reviews Undertaken

During the pandemic the staffing reviews considered and subsequently uplifted staffing establishments for the red pathway wards to support the level of acuity and dependency of patients in those areas. The uplift also supported the additional time it takes between patients for staff to safely don and doff PPE.

10.3 Additional Roles, Initiatives and Innovation

AACD has been extremely proactive in recruiting and training TNA's with a commitment to give ongoing support to NA's. The Division currently has 4 TNA's on B1, B2, C4 and D4. NAs have been successfully embedded in the workforce particularly within the Emergency Department, currently employing 5 NAs in Minors and 1 in Paediatrics.

10.4 Analysis of workforce data

The following data reflects the divisional position in relation to staffing, sickness, fill rates, bank and agency usage and CHPPD.

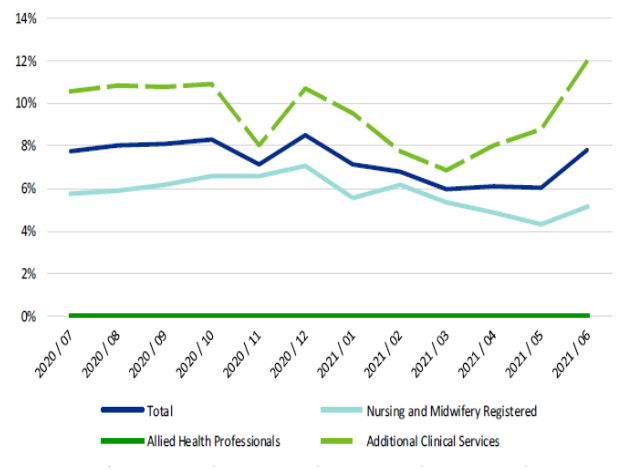
Staff Group	Employee FTE by Month												12 Month Trend
	FY20 M04	FY20 M05	FY20 M06	FY20 M07	FY20 M08	FY20 M09	FY20 M10	FY20 M11	FY20 M12	FY21 M01	FY21 M02	FY21 M03	
Total	1056.99	1080.44	1073.71	1070.95	1064.77	1059.01	1061.03	1066.94	1075.52	1074.39	1077.22	1080.71	
Add Prof Scientific and Technic	2.00	2.00	2.00	2.00	2.00	1.00	2.00	2.00	3.00	3.00	5.07	5.07	
Additional Clinical Services	340.72	372.59	340.97	336.77	326.45	330.80	329.77	328.64	332.87	332.77	333.03	335.07	
Administrative and Clerical	126.47	125.82	124.02	127.08	129.03	126.03	124.16	125.19	127.13	124.00	123.48	121.81	
Allied Health Professionals	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	
Estates and Ancillary	0.00	0.00	0.00	0.00	0.00	0.00	1.00	1.00	1.00	0.00	0.00	0.00	
Healthcare Scientists	10.35	9.77	10.09	10.69	10.69	10.69	10.69	10.69	10.69	10.69	10.51	10.51	
Medical and Dental	91.38	90.88	93.03	94.13	95.83	95.13	95.33	93.03	94.52	92.50	91.10	91.10	
Nursing and Midwifery Registered	484.08	477.38	501.60	498.28	498.77	493.36	496.08	504.38	504.30	509.42	512.04	515.16	
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

Table 9 Staff in Post (12-month trend)

Table 9 reflects all staff groups including nursing. The data demonstrates an increase in nursing and midwifery staffing which reflects the commencement of newly qualified nurses employed in month 9.

Table 10 Sickness Absence (12-month trend)

Sickness Per Month by Staff Group (Non-Covid-19 Related)				
Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	7.32%	5.79%	0.00%	9.62%
2020 / 07	7.72%	5.77%	0.00%	10.57%
2020 / 08	8.04%	5.91%	0.00%	10.83%
2020 / 09	8.10%	6.17%	0.00%	10.76%
2020 / 10	8.33%	6.61%	0.00%	10.93%
2020 / 11	7.13%	6.58%	0.00%	8.00%
2020 / 12	8.51%	7.07%	0.00%	10.73%
2021 / 01	7.15%	5.59%	0.00%	9.55%
2021 / 02	6.78%	6.18%	0.00%	7.74%
2021 / 03	5.96%	5.38%	0.00%	6.89%
2021 / 04	6.12%	4.88%	0.00%	8.03%
2021 / 05	6.07%	4.29%	0.00%	8.82%
2021 / 06	7.83%	5.11%	0.00%	12.03%

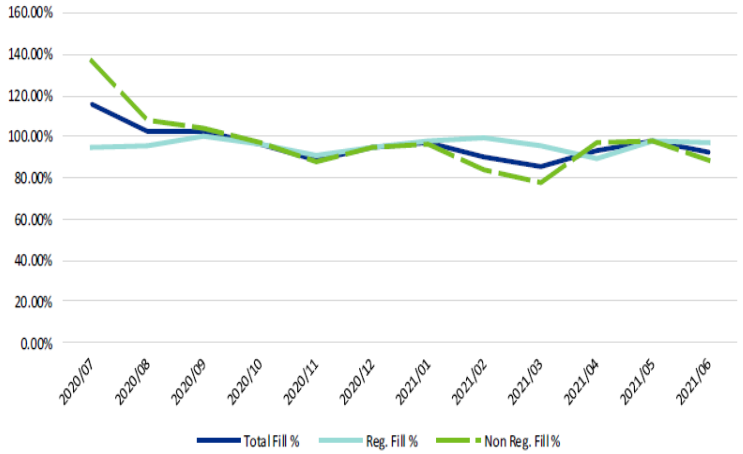


The sickness noted in Table 10 reflects the Divisional position for all staff (including nursing), with the removal of any Covid 19 related sickness from the data shown. The Covid sickness rates for the corresponding period is 2.76% for Nursing and Midwifery Staff and 2.13% for AHPs. The data reflects that the highest rate of sickness was seen in Bands 4 and below. The top 3 reasons for absence related to Stress, Muscular Skeletal strain and gastroenterology over the 12 months. All sickness absence is closely monitored and managed in line with the Trust Attendance Management policy.

Table 11 Fill rate

The data in graph 10 reflects fill rates against pre-agreed establishments. The position for April – June 21 appears to have now stabilised, with a fill rate above 90%.

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	97.17%	95.67%	98.45%
2020/07	115.47%	94.68%	136.57%
2020/08	102.64%	95.52%	108.45%
2020/09	102.49%	100.28%	104.39%
2020/10	96.72%	96.06%	97.29%
2020/11	89.04%	90.77%	87.55%
2020/12	94.63%	94.71%	94.57%
2021/01	97.19%	98.07%	96.48%
2021/02	90.52%	99.20%	83.88%
2021/03	85.24%	95.46%	77.79%
2021/04	93.54%	89.76%	96.82%
2021/05	97.84%	97.60%	98.05%
2021/06	92.64%	96.95%	88.78%



10.5 **CHPPD**

The CHPPD position has been variable throughout the past 12 months (minimum of 6.95 and maximum of 12.68). However, since August 20 – June 21 it has stabilised between 8.73 – 6.95.

11 Anaesthetic and Surgical Services Division Staffing Review

11.1 **Ward & Department Areas**

The Anaesthetic and Surgical Services Division (ASSD) staffing has demonstrated immense flexibility over the last twelve months with staff flexing across the Division to support across critical care, maintain cancer performance and recommence elective activity.

11.2 **National Staffing Guidelines**

The Division has adhered to the standards in place for the management of Critical care patients and escalating of capacity within critical care. This has been supported using agreed standards nationally to ensure safe care ratios were upheld and Critical care nurses were exceeding recommended patient ratios.

11.3 **Sickness, Staffing KPIs & Agency usage**

Staffing has remained mainly static in relation to staff in post at all grades. The chart below shows a degree of correlation which is attributable to recruitment of student nurses into registered nurses and staff in post in response to the pandemic demand. High levels of sickness across the HCSW workforce have been noted and can be correlated across waves of post Covid surge.

Agency fill rate fluctuated across the last twelve months and this correlated with the continuing flex of staffing required to meet operational demand. The lack of suitably available critical care agency nurses is reflected in the fill rate as national demand increased for ITU staff. Utilisation of staff from other areas such as theatres and specialist nurses support critical care staffing.

Shift Fill Rate by Month			
Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	91.41%	93.08%	89.39%
2020/07	87.77%	82.58%	94.79%
2020/08	88.09%	86.90%	89.63%
2020/09	88.44%	88.34%	88.55%
2020/10	94.02%	95.53%	92.14%
2020/11	97.25%	103.03%	89.84%
2020/12	90.42%	92.42%	87.84%
2021/01	94.46%	97.05%	91.13%
2021/02	100.73%	101.12%	100.27%
2021/03	92.03%	93.95%	89.99%
2021/04	89.88%	91.93%	87.57%
2021/05	86.69%	89.61%	83.48%
2021/06	87.57%	95.15%	79.08%

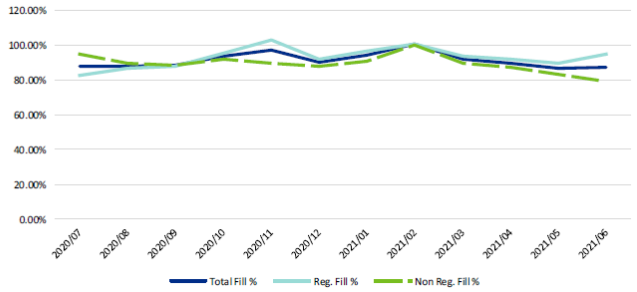


Table 12 Fill Rate

11.4 Additional Roles, Initiatives and Innovation

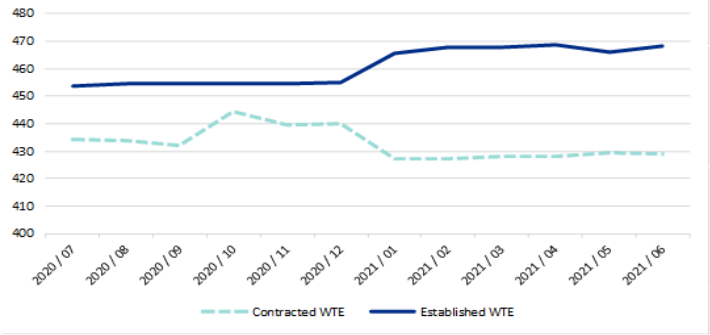
The Division has utilised the skill mix of staff intensively over the last twelve months. The priority has been over the last 6 months to rest and have available resources for elective recovery. We have strengthened and recruited into cancer services specialist teams to ensure the demand for cancer referrals can be maintained. Since August ASSD has been at a full complement of Matrons.

11.7 Recruitment & Retention

ASSD turnover of staff has been consistent over the last twelve months with staff leaving for promotion, retirement and some to seek agency posts only. The Division continue to support leaving staff with alternative employment within the Trust.

Table 13 Nursing and Midwifery Registered Vacancies

Nursing & Midwifery Registered Establishment, Staff in Post and Vacancy by Month			
Year / Month	Vacancies	Contracted WTE	Established WTE
2020 / 07	19.38	434.35	453.73
2020 / 08	20.90	433.81	454.71
2020 / 09	22.57	432.14	454.71
2020 / 10	10.45	444.25	454.70
2020 / 11	15.24	439.48	454.72
2020 / 12	14.64	440.15	454.79
2021 / 01	38.35	427.22	465.57
2021 / 02	40.21	427.32	467.53
2021 / 03	39.55	428.00	467.55
2021 / 04	40.50	427.91	468.41
2021 / 05	36.60	429.51	466.11
2021 / 06	38.91	429.17	468.08



11.8 Advanced Practitioners

ASSD has supported further qualification of ACP across surgical ambulatory unit and have a trainee ACP in breast services. The demand for trained ACP's is high and therefore training positions are being sought for the Surgical Assessment Unit and Acute Oncology Services to support our cancer teams and develop our own staff.

11.9 Student Nurses/ TNAs/ NAs

The Division is currently focusing on reset and the demand to increase activity for Referral to Treatment. We have successfully appointed 3 NA's in the last six months and have 5 seconded currently across the footprint. There are also plans to offer

educational opportunities for the HCSWs to support retention and utilise the apprenticeship levy.

12. Integrated Community Services Division Staffing Review (ICSD)

The community bed base as Darley Court has been decommissioned and ICSD currently has a Memorandum of Understanding with Bolton Council to provide 24 hour nursing care to 16 beds at Laburnum Lodge. The CQC registration is with the local authority and not Bolton NHS Foundation Trust.

12.1 National Staffing Guidelines

The Division uses Model Hospital to support establishment reviews within the community bed base alongside other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements and national staffing guidance.

12.2 Staffing Reviews Undertaken

- Community intravenous therapy service – review of working patterns for staff to maximise clinical time, skill mix of staff to maximise skills of registered nurse and increase clinical availability
- Review of the delivery model of the evening and nights service was undertaken in this time period – recommendations to be delivered in second half of the year
- Review of Neurological long terms conditions delivery model to maximise clinical time and embed the digital opportunities created by the pandemic.

12.3 Metrics & Staffing KPIs

The overall non Covid 19 related sickness absence for the first 6 months of 2021 was 4.75% (2019 4.85%). The Division takes a proactive approach to managing sickness related absence and monthly long term sickness clinics are held with the Divisional Nurse Director and HR business partners.

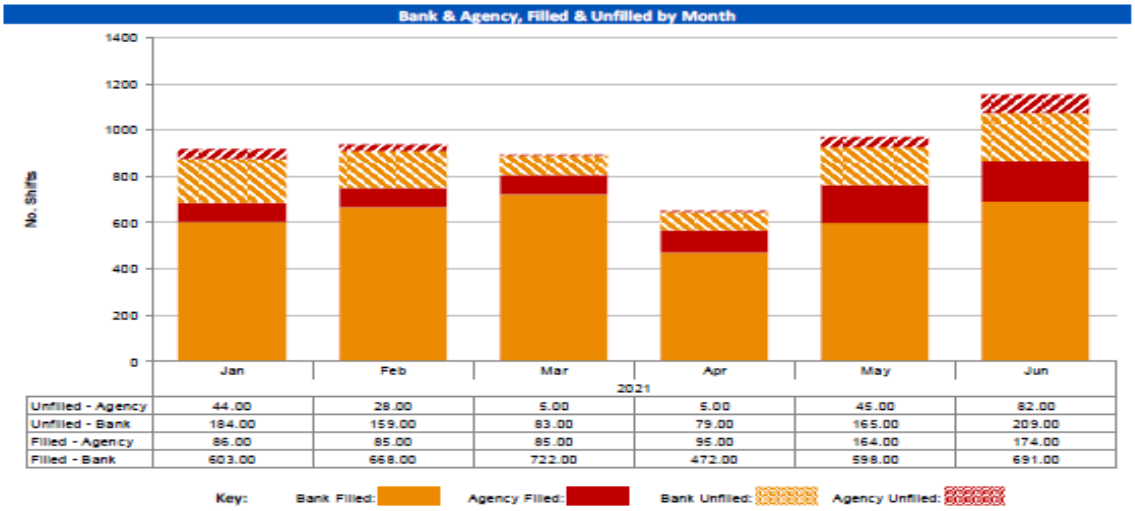
12.4 ICSD Employee staff FTE

There has been a slight reduction in overall registered nurses in the first 6 months of the year and the turnover rate was 11.25% (11.12% in 2020).

12.5 Bank and Agency Useage

ICSD uses bank and agency where necessary to cover gaps in the service. The majority of those shifts are filled using bank shifts and just over a quarter filled by agency, with 13% left unfilled. Non-registered and ‘other’ grade types account for the remaining requests, the majority of which are filled by bank, with very little agency (31 shifts total in 6 months combined) however a proportion still goes unfilled. The demand for temporary staff was consistent for the last quarter of FY 20/21 and saw a reduction in April 2021 (this is normal, due to low annual leave levels in that month) before rising in both May and June.

Table 14 Bank and Agency



	Jan	Feb	Mar	Apr	May	Jun
Unfilled - Agency	44.00	28.00	5.00	5.00	45.00	82.00
Unfilled - Bank	184.00	159.00	83.00	79.00	165.00	209.00
Filled - Agency	86.00	85.00	85.00	95.00	164.00	174.00
Filled - Bank	603.00	668.00	722.00	472.00	598.00	691.00

12.6 Divisional Recruitment and Retention

To support the retention of staff within the Division implemented the following:

- Fortnightly meetings with all Matrons and Principles Service Leads for escalation of staffing concerns and recruitment challenges
- Commencement of talent management and succession planning considerations for grades 7 and 8a investment
- Success in application for 5 Health Education North West places for the Specialist Practice Qualification-District Nurse course to ensure the community caseloads are led by qualified district nurses.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level.

13 Diagnostic & Support Services Division

13.1 **The Division provides services under four general specialties supporting clinical services across the Trust:**

Imaging
Laboratory medicine
Centralise support services
Pharmacy

13.2 Sickness, staffing KPIS and Metrics

There are no specific themes in staff sickness in any of the evaluated roles during the period in question. The WTE for nursing staff in the division is small.

Staff Group	Employee FTE by Month												12 Month Trend
	FY20 M04	FY20 M05	FY20 M06	FY20 M07	FY20 M08	FY20 M09	FY20 M10	FY20 M11	FY20 M12	FY21 M01	FY21 M02	FY21 M03	
Total	650.27	644.59	648.55	652.71	665.61	660.31	662.77	661.05	664.26	652.80	652.55	651.40	
Add Prof Scientific and Technic	84.15	86.75	85.28	84.35	87.93	87.93	87.85	89.81	91.09	91.09	89.89	90.43	
Additional Clinical Services	145.92	141.42	140.57	140.57	143.71	144.04	143.84	142.73	144.60	144.39	148.68	148.98	
Administrative and Clerical	191.63	188.63	192.23	195.39	201.86	197.33	197.27	194.47	194.14	188.31	185.85	185.94	
Allied Health Professionals	87.99	87.71	88.35	88.85	88.57	88.47	89.12	88.47	89.67	88.67	88.69	86.51	
Estates and Ancillary	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Healthcare Scientists	80.91	79.91	81.44	80.44	80.44	80.44	81.44	80.22	78.72	77.63	77.13	77.13	
Medical and Dental	27.39	29.79	30.29	31.19	31.19	30.59	31.59	32.59	33.29	32.29	32.89	31.99	
Nursing and Midwifery Registered	32.28	30.37	30.37	31.91	31.91	31.51	31.65	32.75	32.75	30.41	29.41	30.41	
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

Table 15 Staff in Post (12-month trend)

Staff in Post

There are no particular trends in the related period in terms of staff in post.

Registered Nurse & Additional Clinical Services Vacancy

There is minimal registered nurse vacancy in the division.

13.3 Additional roles Initiatives and Innovation

The service with the greatest uncertainty is ultrasound. A number of staff have chosen to leave due to offers with improved terms and conditions in the private sector. The service leads are reviewing methods of recruiting and retaining staff or engaging locum staff on medium term contracts to fulfil the service needs.

14 Allied Health Professionals

Background and Context

The current ESR data for Bolton FT indicates we employ 525 whole time equivalent (WTE) AHPs. The largest professional group is Physiotherapy, followed by Radiography and Occupational Therapy.

Table 16 Number of AHPs employed by Bolton NHS FT

AHP Profession	Trust ESR data WTE (June 2021)
Physiotherapy	172
Diagnostic Radiographers	101
Occupational therapy	90
Speech and language therapy	61
Dietetics	24
Other	77
Podiatry	36
Operating Department Practitioners	31
Orthoptists	9
Paramedics	1
Total registered staff	525

AHP Staff Sickness

AHP sickness levels are low compared to the Trust average, national and regional median and sub-region peers. Model Hospital shows that Bolton AHPs sickness absence is in the lowest quartile nationally. (Bolton AHPs 2.6%; Trust target 4.2%; Trust median; 4.87% national median; 3.7%; peer median 4.6%).

AHP turnover and staff retention

Our combined AHP turnover data reveals that we lose a higher proportion of Band 5 staff than those at higher bands. In terms of reasons for leaving a high proportion of staff cite relocation. The higher numbers of Bands 5 and 6 staff leaving (74% of the total number of AHPs leaving the Trust) means that it is more likely for these generally younger staff to be moving out of the area but a more detailed review of the data including exit interview data would be required to understand this fully. This will be explored further including a review of the stage at which Band 5 staff leave the organisation. This will enable the Assistant Director of AHPs to make more specific recommendations for actions regarding staff retention.

AHP Support staff

In order to grow our own pipeline of talent in Bolton we have worked to make pre-registration apprenticeships available for our Trust AHP support staff. The Physiotherapy apprentice recruitment process demonstrated a high desire for this career pathway amongst support staff and also a high level of talent. Bolton University has an Operating Department Practitioner (ODP) pre-registration apprenticeship course which has been co-designed, developed and delivered with Trust staff and is proving a helpful model to aim to imitate in order to grow our own staff.

Workforce developments

The NHSE/I workforce improvement framework covers the 6 national workforce priorities to enable improved recruitment to AHP careers and retention of AHP staff over the next 3 years. We are working on each of these priorities.
Future Supply Position
The national workforce improvement framework divides how we secure our future supply position into i) how we stimulate demand and ii) how we increase capacity. As an organisation and with partners across Greater Manchester we are addressing both of these areas.

Increase Capacity

Bolton AHPs have actively engaged with GM increasing student capacity initiatives and have increased AHP placement capacity for this year by 20% through introducing the Synergy coaching model used by nursing, through peer placements, introducing technology and placements in new areas.

Support and Pathways

We are prioritising the apprenticeship route in Bolton for a number of workforce reasons which include:

- recognising the talent of our support staff
- growing our own registered AHPs
- increasing retention of Band 5 staff
- responding to areas where roles are hard to fill
- Increasing diversity of staff in AHPs professions through the apprenticeship route.

Apprenticeship standards for AHPs are being developed at pace and we continue to work with the NW HEE Apprenticeship lead regarding demand and procurement of Apprenticeship courses. Learning from those teams, service leads and individuals that have embarked on this route is shared across AHP services and work with the Divisions, the Trust Apprenticeship lead and the Education team as well as Finance and Workforce should enable an apprenticeship route for AHPs to develop over the next 12 months.

15. Conclusion

Research evidence of the association between nurse staffing levels and patient outcomes is compelling and improved nurse and midwifery staffing is associated with reduced risk of patient harms and lower mortality rates. Over the last 6 months there has been much work undertaken to improve our staffing levels including:

- Building leadership capability through the development of a leadership development programme for Ward Managers and Matrons
- The establishment of Nursing, Midwifery and AHP Professional Forum
- Protected standardised management time for Ward Managers
- Introduction of weekly Chief Nurse Walkrounds
- HCSW zero vacancy focus
- Increased Student Nurse placement opportunities
- New role development (Nursing Associates/ Advanced Nurse Practitioners)
- Implementation of Enhanced Care Team
- Increased support for qualified and unqualified staff through the implementation of the PNA/PMA role
- Pastoral support with introduction of the new post of the HCSW Matron.

This paper has established our Trust-wide staffing position and that all Divisions are cognisant of key issues and analyses in the consideration of nurse, midwife and AHP staffing levels. Reviews of staffing numbers and skill mix are ongoing and changes are based on triangulation of acuity, current quality indicators and professional judgement, whilst taking into account national guidance as it becomes available.

The paper provides assurance of the work undertaken by the nursing and HR teams to ensure safe staffing, it is recognised that this is a very challenged workforce market with well documented shortages in all professions identified in this report. Whilst staffing levels and staffing establishments in place currently across the organisation are under incredible pressure work is underway with the SNCT work to understand the areas where care needs are greater this data will inform optimum deployment of the staffing resource using a recognised methodology. It is recognised that decisions regarding the correct staffing establishments for different types of wards can be ambiguous and therefore national guidance advises the use of an evidence based workforce tool in the consideration of staffing levels. We are utilising the Safer Nursing Care Tool (SNCT) and have completed the first data collection. The next staffing report will have the results of the 2 SNCT collection periods. The results will provide the organisation with a validated establishment review to inform the workforce needs. Initial information obtained from the first consensus indicates that our wards are under established however, this information is invalidated until the second data collection consensus has been completed in a different season.

The LMS supported assessment of maternity staffing in line with Birth-rate Plus and whilst holding vacancies over the summer for the newly qualified midwives due to take up posts in September 2021 was a challenge safe staffing ratios were maintained with the dedication of the Maternity teams undertaking bank and overtime shifts. There has been recognised pressure on all maternity services regionally and nationally.

There are recognised pressures within the workforce recently NHSI have issued a winter preparedness Board Assurance Framework to all trusts this will be added as an appendix to this board paper.

The Trust Board are asked to:

- Approve the content of this staffing review

- Recognise the work undertaken over the last 6 months
- Support the review of nurse staffing establishments as dictated by validated SNCT consensus.

AGENDA ITEM 13

Title:	Sustainability Development Management Plan (Green Plan)

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	25 November 2021		Discussion	
Exec Sponsor:	Annette Walker		Decision	✓

Summary:	All NHS organisations are mandated to have a Board approved Sustainable Development Plan that will enable the Trust to achieve zero carbon emission by 2038. Following the sustainability review it has been identified the Trust has a carbon footprint of 12,515 TCO_2e and the key environmental impacts associated with energy use, travel, water, use of natural resources, waste, and carbon emissions can now be measured. A sustainability plan has been developed to achieve a target reduction of 3,500 TCO_2e by 2025 and zero carbon by 2038. A Project Board will be established and 7 working groups which will allow the management plan to progress and reduce our carbon footprint. The PWC internal audit plan for Q4 of 21/22 includes an assurance audit on the SDMP.

Previously considered by:	Trust Executive August 2021

Proposed Resolution	The Board is asked to approve the Sustainability Development Management Plan. Findings from the PWC internal audit will be presented to the Group Audit Committee.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Annette Walker, Director of Finance	**Presented by:**	Annette Walker, Director of Finance

Glossary – definitions for technical terms and acronyms used within this document

SDMP	Sustainability Development Management Plan
GMHSCP	Greater Manchester Health and Social Care Partnership
TCO_2e	Tonnes (t) of carbon dioxide (CO2) equivalent (e) - Carbon dioxide equivalent" is a standard unit for counting greenhouse gas (GHG) emissions regardless of whether they're from carbon dioxide or another gas, such as methane

Bolton NHS Foundation Trust Environmental Strategy – Green Plan

Prepared by: iFM Bolton and Maloney Associates

Date: 7th June 2021

Sustainability Review: The Key Objectives

Key Objectives of the Review:

- ✓ Identify and appraise the **key environmental aspect and impacts** of Bolton NHS FT
- ✓ **Appraise key sustainability legislation**
- ✓ **Establish** and produce a detailed Trust **operational carbon footprint** and baseline
- ✓ Establish key baseline data for key environmental impacts and strands for stakeholder and compliance reporting
- ✓ Provide **performance appraisal** on the key sustainability strands
- ✓ Review **net zero target and establish strategic milestones**
- ✓ Provide a **sustainability road map** (now aligned to GMHSCP SMDP objectives)

Sustainability Review: The Key Strategic Drivers

Key Strategic Drivers for Environmental & Sustainability Improvement

Key Strategic Drivers: Key Overarching Legislation & Mandate:

- Climate Change Act – Net zero emissions by 2050
- Energy Performance of Buildings Directive (EPBD)
- Public Services (Social Values) Act
- HM Sustainability Reporting Framework
- NHS STC requirements for Sustainable Development (2019)
- Public Health Outcomes Framework
- The Stern Review; the Economics of Climate Change
- The Marmot Review; Fair Society, Healthy Lives
- Sustainable Development Strategy for Health and Social Care System 2020
- The Carter Review 2016
- Sustainable Transformation Partnerships (STP) Plans

Strategic: Legislation

Climate Change Act

"NHS Climate Change Emergency Declaration"

Net Zero Carbon Strategy

Fossil Fuel Avoidance

Clean Air Act

MEES & Fuel Poverty Act

NHS and Sustainability:

The NHS contributes to **5%** of the total UK GHG emissions.

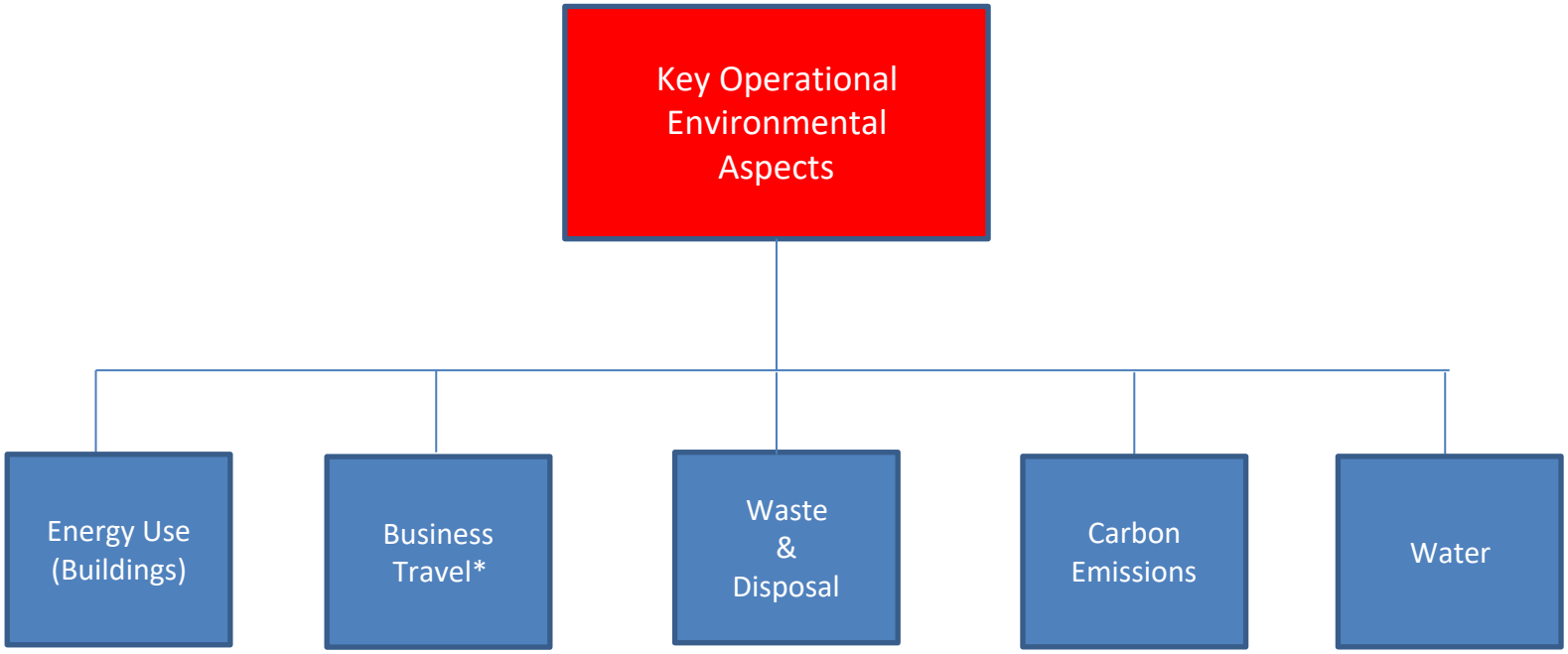
The NHS consumes **>72,000** Tonnes of single use plastic per annum.

GMHSCP declared **"Climate Change Emergency"**

GMHSCP have set a Zero Carbon Emission target by **2038**

NHS Trusts are required to have a full carbon footprint report and a Sustainability Development Plan.

Sustainability Review: Key Environmental Impacts

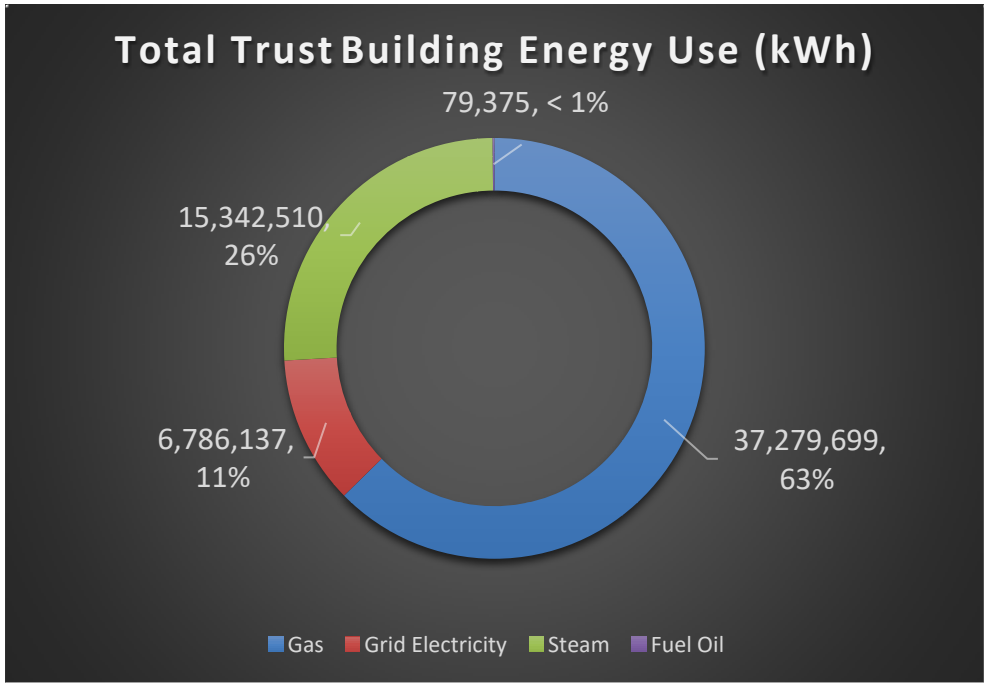


The sustainability review has included the key identified environmental impacts. This includes full data collection, baseline data, performance review and the calculation of a **full operational carbon footprint.** You can not manage what you can not measure The foundation & bedrock of the journey …….

Total Trust Building Energy Use:

The Trust's Total annual use equates to **59,487,721 kWh**
(aligned to GHG reporting)

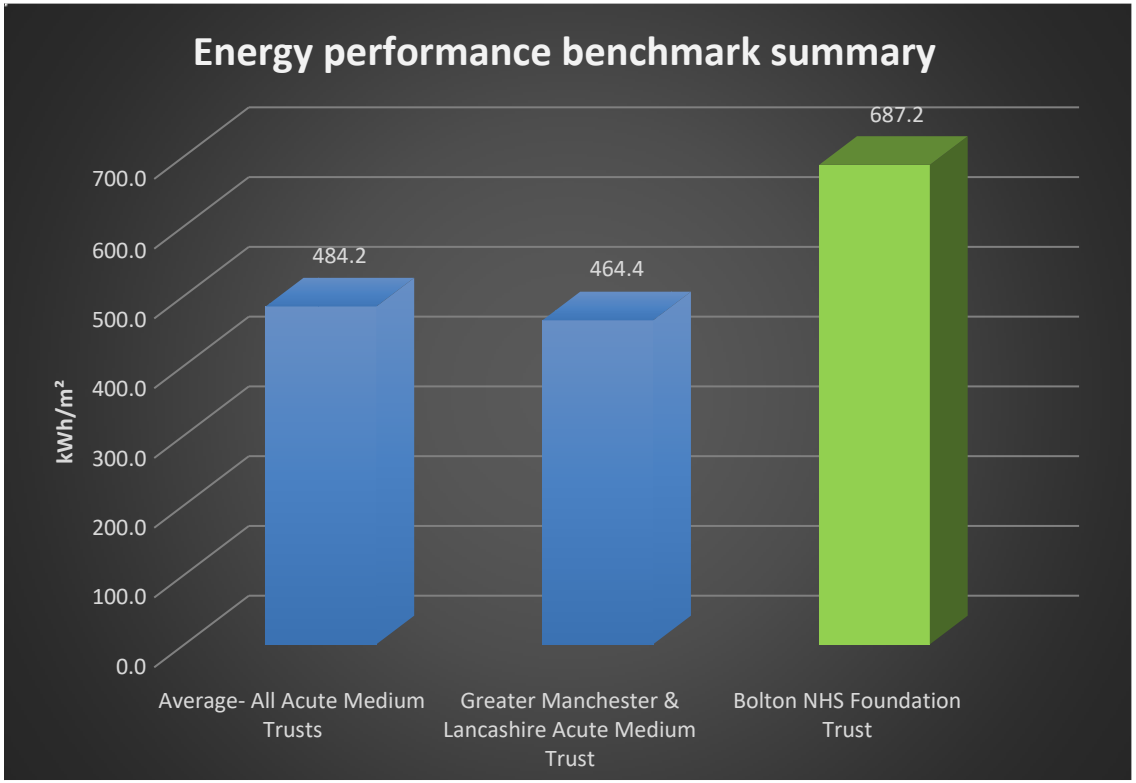
Energy Source	Annual Energy Consumption (kWh)
Grid Electricity	6,786,137
Gas (inc CHP)	37,279,699
Steam Consumption	15,342,510
Fuel Oil Consumption	79,375
Total	59,487,721



The Trust's Building Energy use equates to **>59GWH & £1,550,000.**
This would provide full energy for **5,950 homes** for a year

CHP Electricity Output = **7,920,000 kWh***
CHP Thermal Heat Use = **21,114,000 kWh***
***The above figures have not been included in the baseline**

Bolton FT: Measuring & Appraising Building Energy Performance:



The energy usage for Bolton NHS Foundation Trust equates to **687 kWh/m²** which is **35% greater** than the energy usage at Acute Medium Trusts and **39% greater** than the energy usage at Greater Manchester & Lancashire Acute Medium Trusts.

Building Energy Use Measuring Performance: Headline Points

The Trust's annual total Building Energy use equates to **>59,000,000 kWh & £1,550,000**

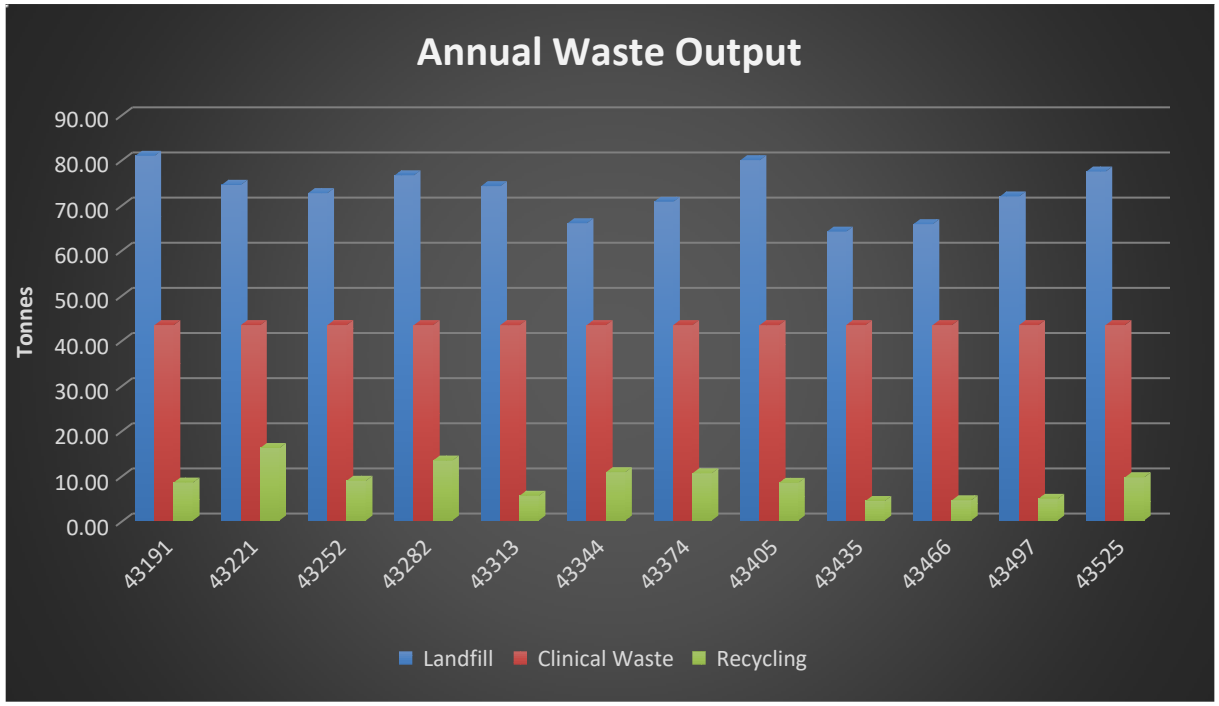
The building energy performance for Bolton FT equates to **687 kWh/m²** which is **39% greater** than Manchester & Lancashire Acute Trusts. This is a substantial difference in energy use. Future KPI

The carbon performance is better due to the CHP operation.

The Trust's individual building energy use measurement is problematic and can not be readily evaluated. There is also statutory requirements to complete Building Energy performance assessments. There are significant heat network losses that can not readily measured.

There are Significant opportunities to improve energy building performance. Through asset replacement (end of life cycle) strategy, cost effective energy saving interventions (technology and operational) and carbon reduction strategy supported by renewable energy generation.

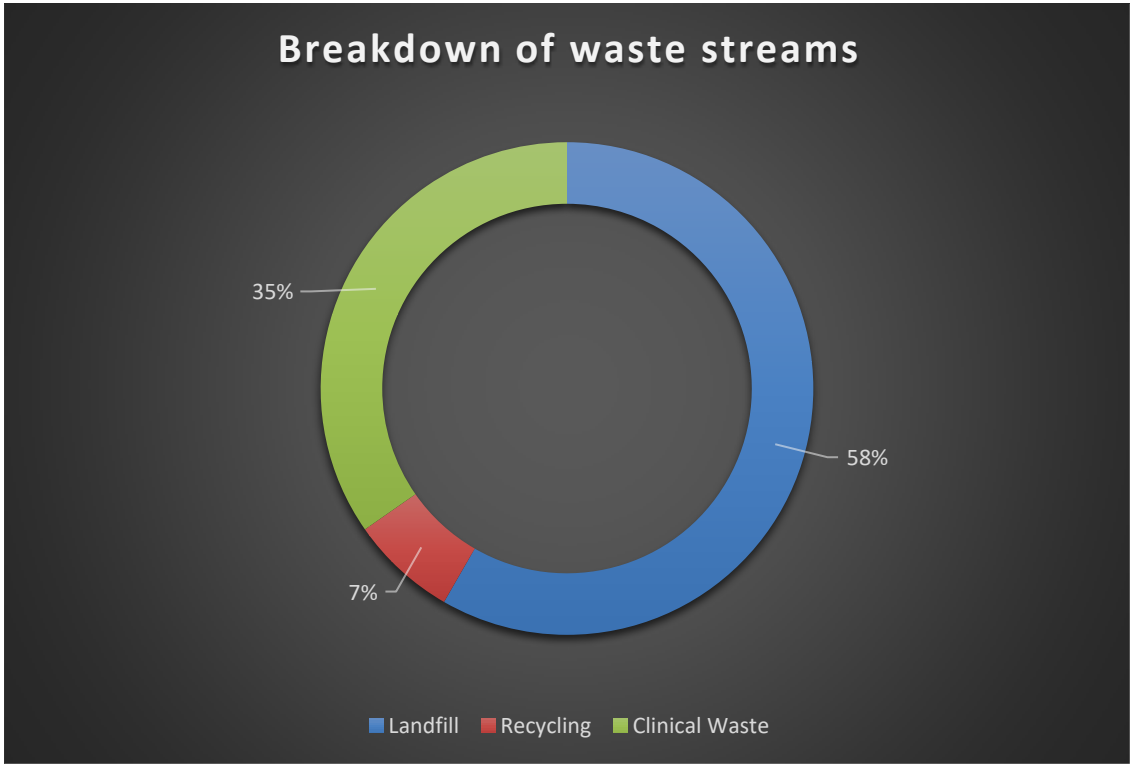
Baseline Data: Waste and Recycling



Landfill Tonnes	Clinical Waste Tonnes	Recycling Tonnes	Food Waste Tonnes	Total Tonnes
873	519	104	111	**1,607**

Total waste and recycled waste costs equate to £438,000 per annum.

Measuring Performance: Waste Streams



58% of the total Trust waste is going to Landfill
This equates to **873 Tonnes**. Equivalent to the weight of **67 double decker buses**.

Waste Measuring Performance: Headline Points

The total waste output for Royal Bolton Hospital equates to **0.02 Tonnes/m² per year (future KPI)***

Recycling rate accounts for **only 7%. <50%** comparison (future KPI)

Landfill accounts for **58%** of total waste (**873 Tonnes**) (future KPI) and disposal costs equate to **£85,000** per annum.

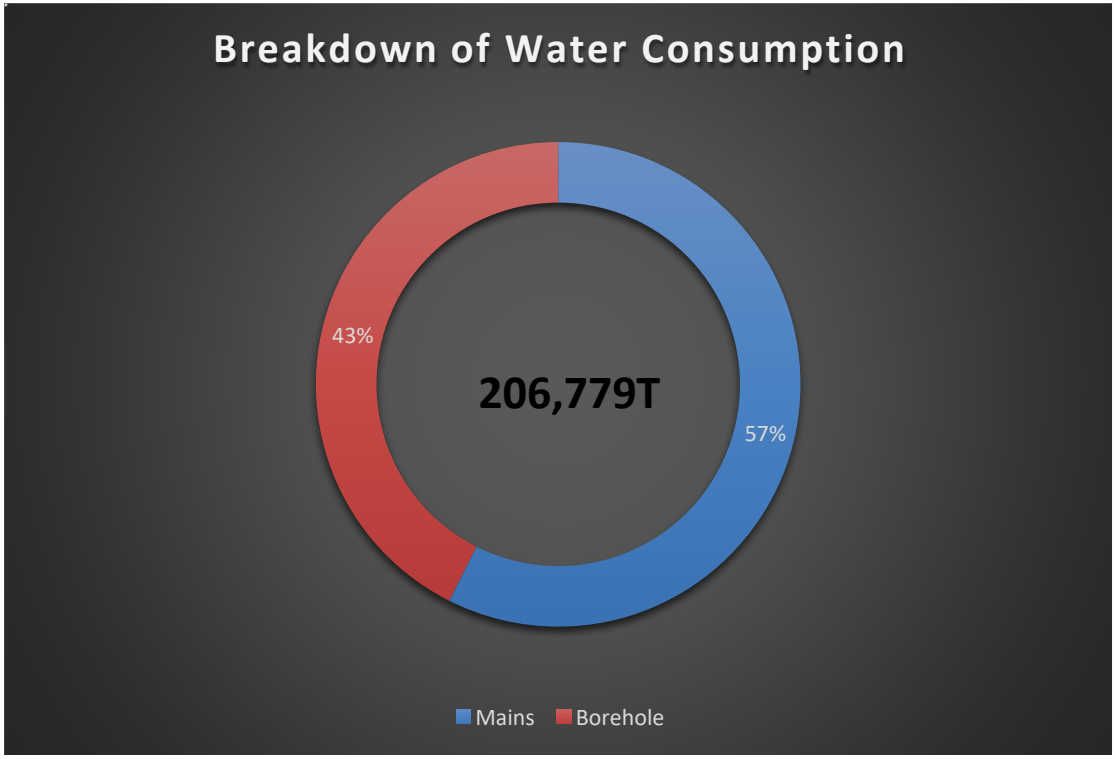
Significant opportunity to improve waste environmental performance, reduce landfill and single use plastic.

Clinical waste provides heat energy energy reused – positive output

*Note: There is currently no benchmark available to compare waste output, however we are seeking
through the GMHSCP to develop a collaborative benchmark for waste output/m²or waste output/patient

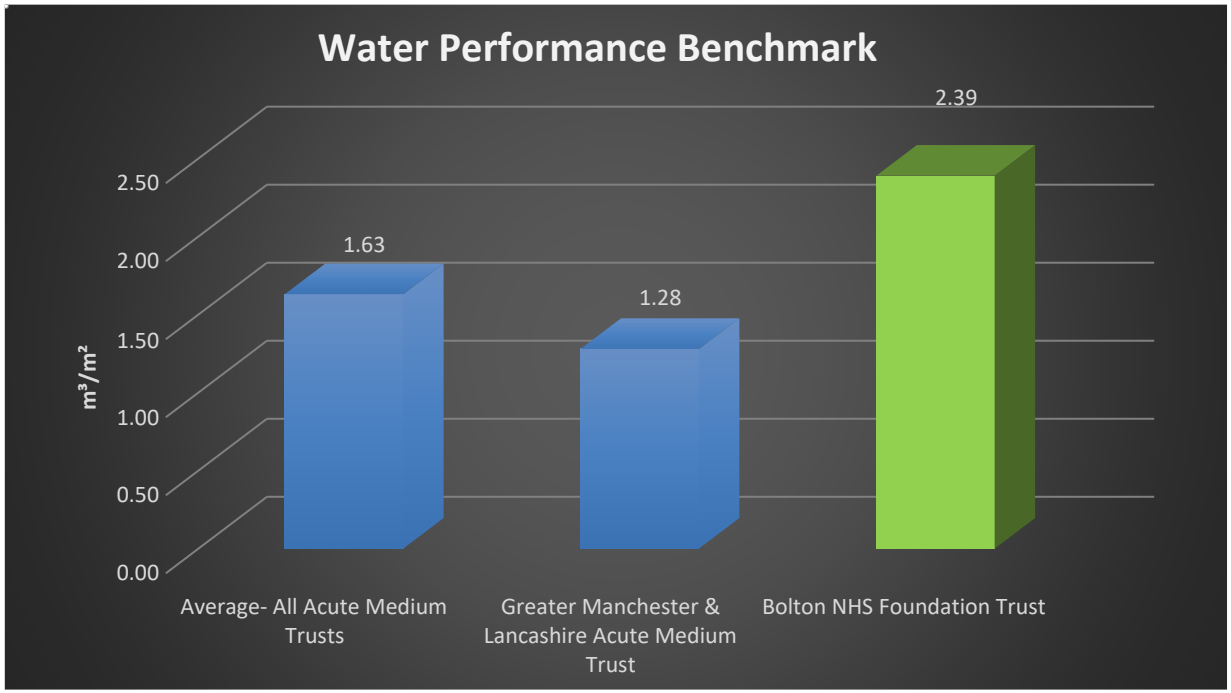
Measuring Performance: Water

You can not manage what you can not measure – the Journey



The greatest source of water consumption at the Trust is from the mains at **57%.** The total annual water use equates to 206,779m^3 .
This is a water volume that would fill 83 Olympic sized swimming pools.
The annual town water and disposal costs equate to circa **£485,00**0

Measuring Performance: Water Use



The water consumption at Bolton FT equates **2.39 m³ per m²**
From data sourced through – this is **38% greater** than the water consumption at all Acute Medium Trusts and is **60% greater** than the water consumption at Greater Manchester & Lancashire Acute Medium Trusts.

*Note: We are seeking through the GMHSCP to develop a collaborative benchmark for water output/bed and water output/patient

Bolton FT Business Travel:

The Bolton FT operational business travel comprises of **Vehicles (fuel)** and **grey fleet employee travel**. A summary of the calculated equivalent business miles is provided below and equates to **1,552,636 miles** for the baseline period

Number of employees	Vehicles Mileage	Grey fleet Mileage	Total Mileage
5,000	190,635	1,362,001	1,552,636

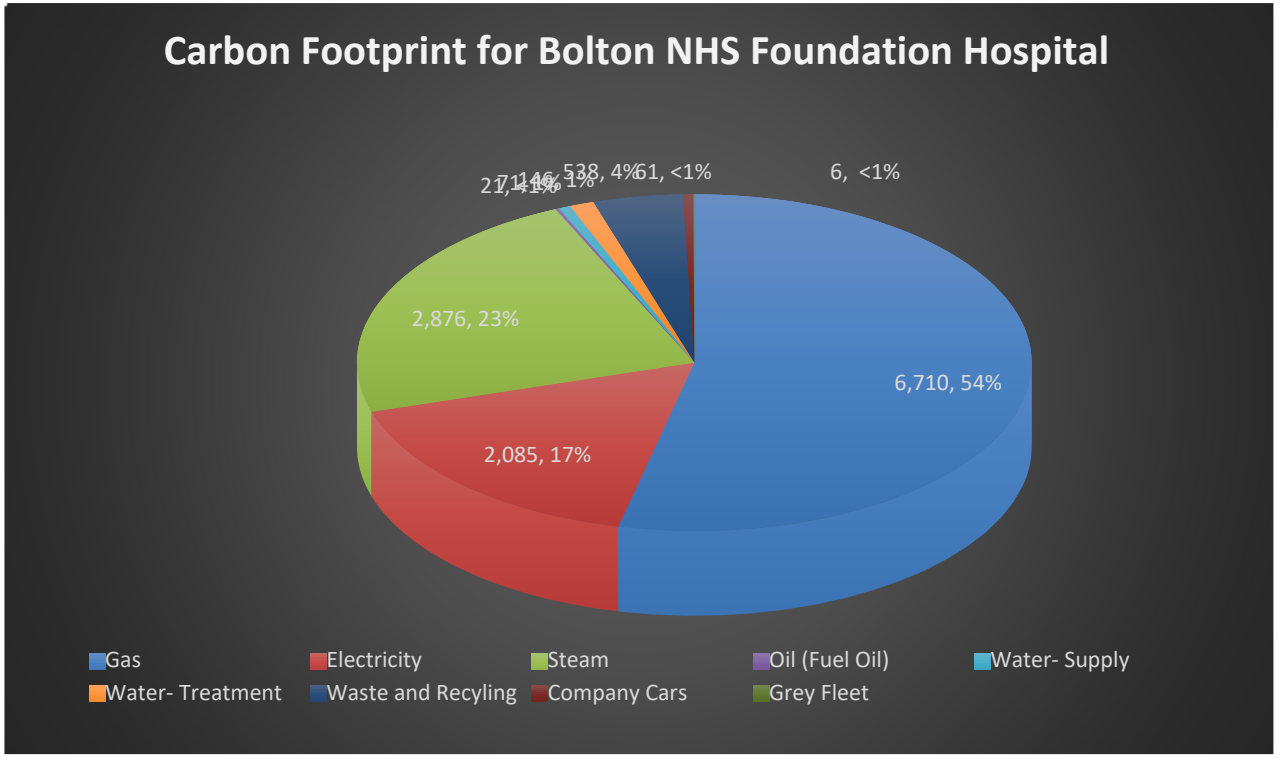
Performance Indicators :

Mileage per employee equates to **310 (Future KPI)**

Also 0.32 kg CO_2e per mile travelled (Future KPI)

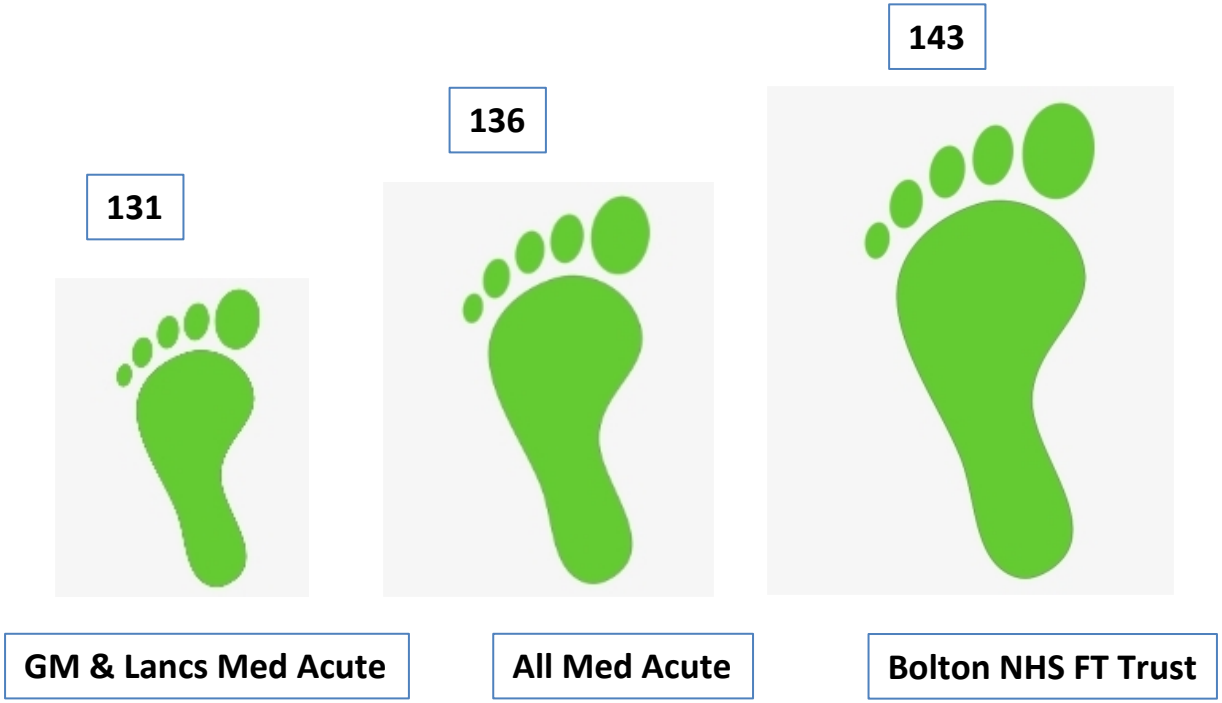
Note: There is currently no benchmark available to compare mileage, however we are seeking through the GMHSCP to develop a collaborative benchmark for mileage/employee

Bolton FT: Operational Carbon Footprint



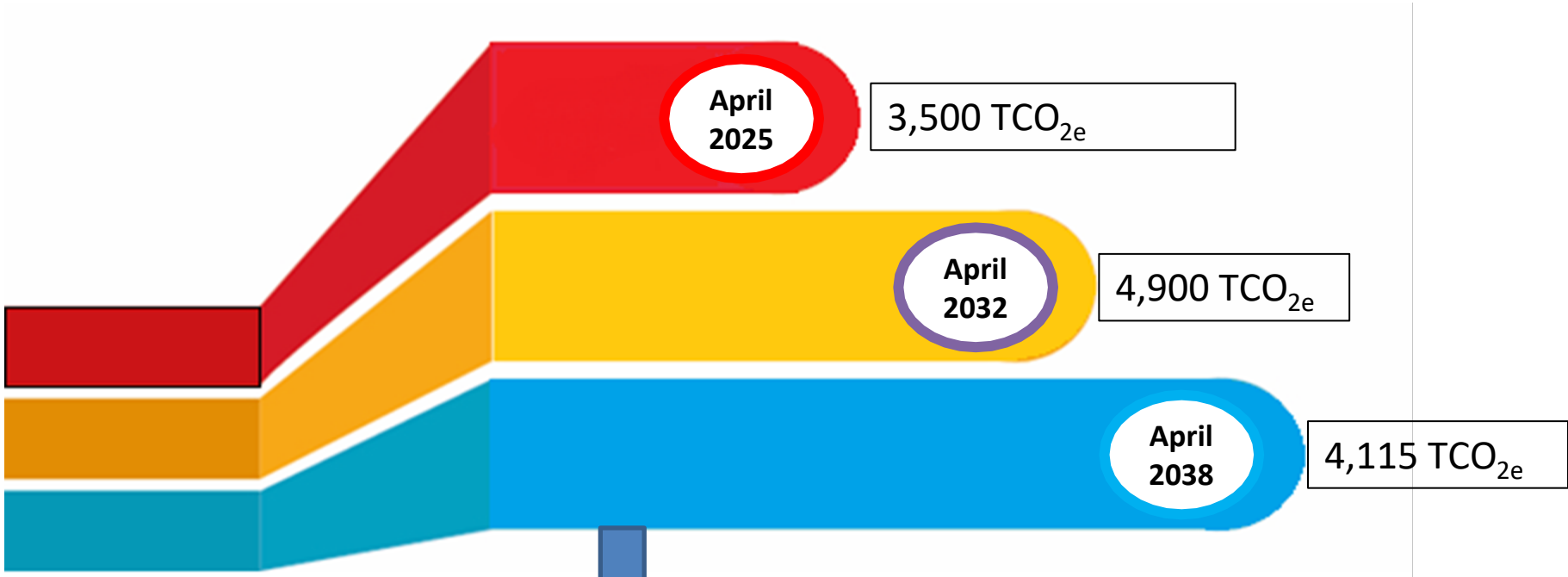
The total carbon footprint for the Trust is **12,515 TCO_2e**

Operational Carbon Footprint: Comparison *

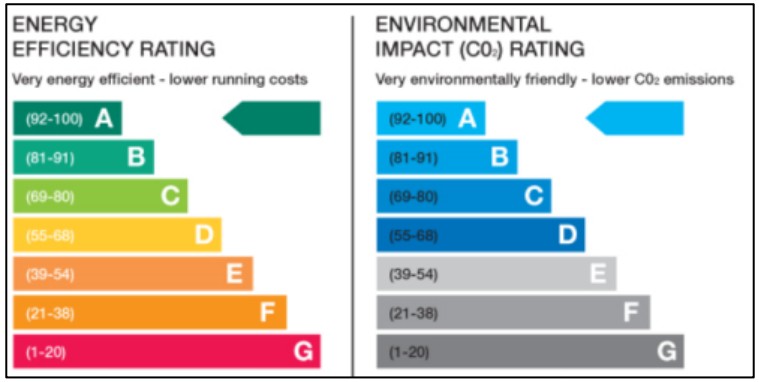


The total carbon footprint for the Trust is **12,515 TCO_2e**

Carbon Reduction Targets and Milestones for Carbon Net Zero



Total Carbon Reduction target = 12,515 TCO_2e



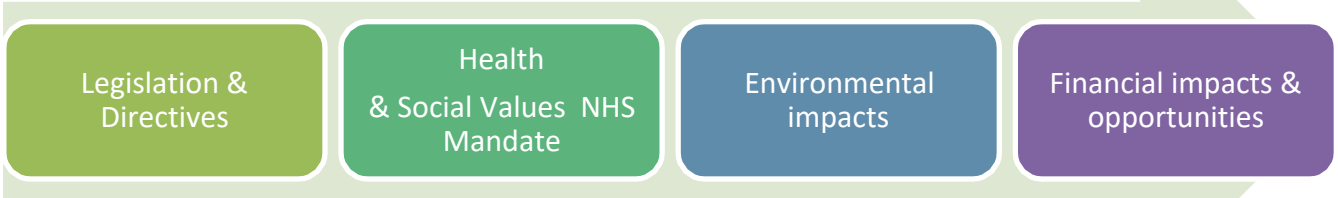
Bolton FT Review: Strategic Review

The Trust have introduced **many good tactical measures**.
There is an absence of Strategic measures.

This includes the absence of environmental management strategies, policies, sustainability management plans, environmental management objectives, targets and reporting.

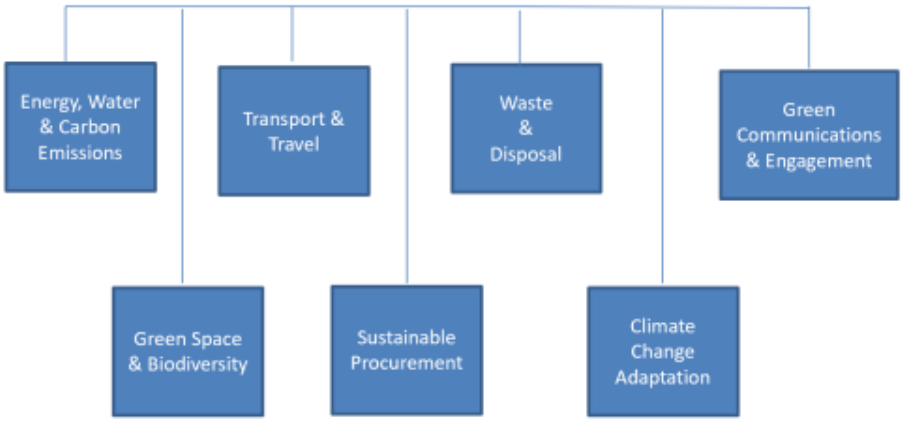
All required under NHS mandate. It should be noted that close liaison with other GM Trust (though the GMHSCP) has identified that several Trusts are similar. However our Base and starting point is much lower than the norm.

Key NHS mandate requirement includes:
Reporting of carbon emissions plus key environmental aspects and now a "Green Plan' (formerly a Sustainability Development Management Plan)
The review output will provided a working framework to provide these requirements. It was to provide a staged approach over a two year period.

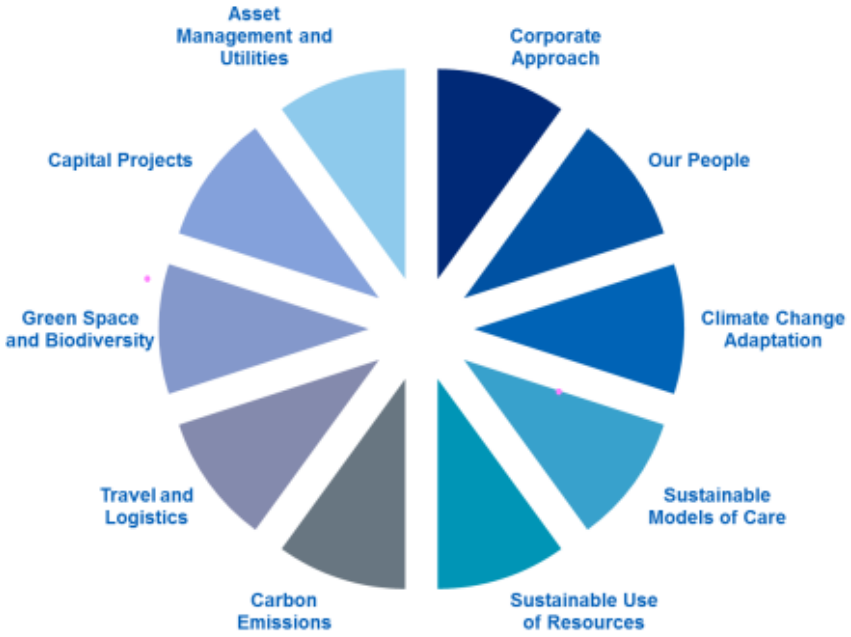


Sustainability Development Action Plan

Stage 1 Sustainability Development Action Plan (Embedding key Environmental Strands)

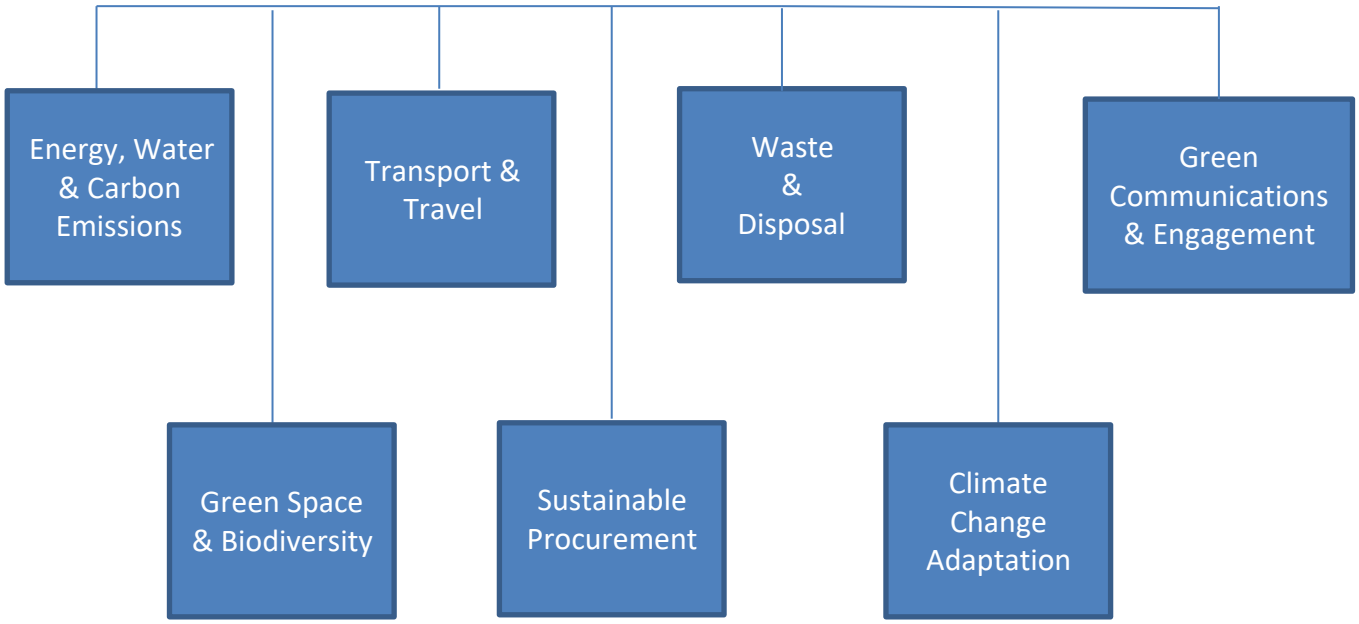


Stage 2 Development of Plan Green (aligned to NHS SDAT*)



Sustainability Development Action Plan

Stage 1 Sustainability Development Action Plan
(Embedding key Environmental Strands)



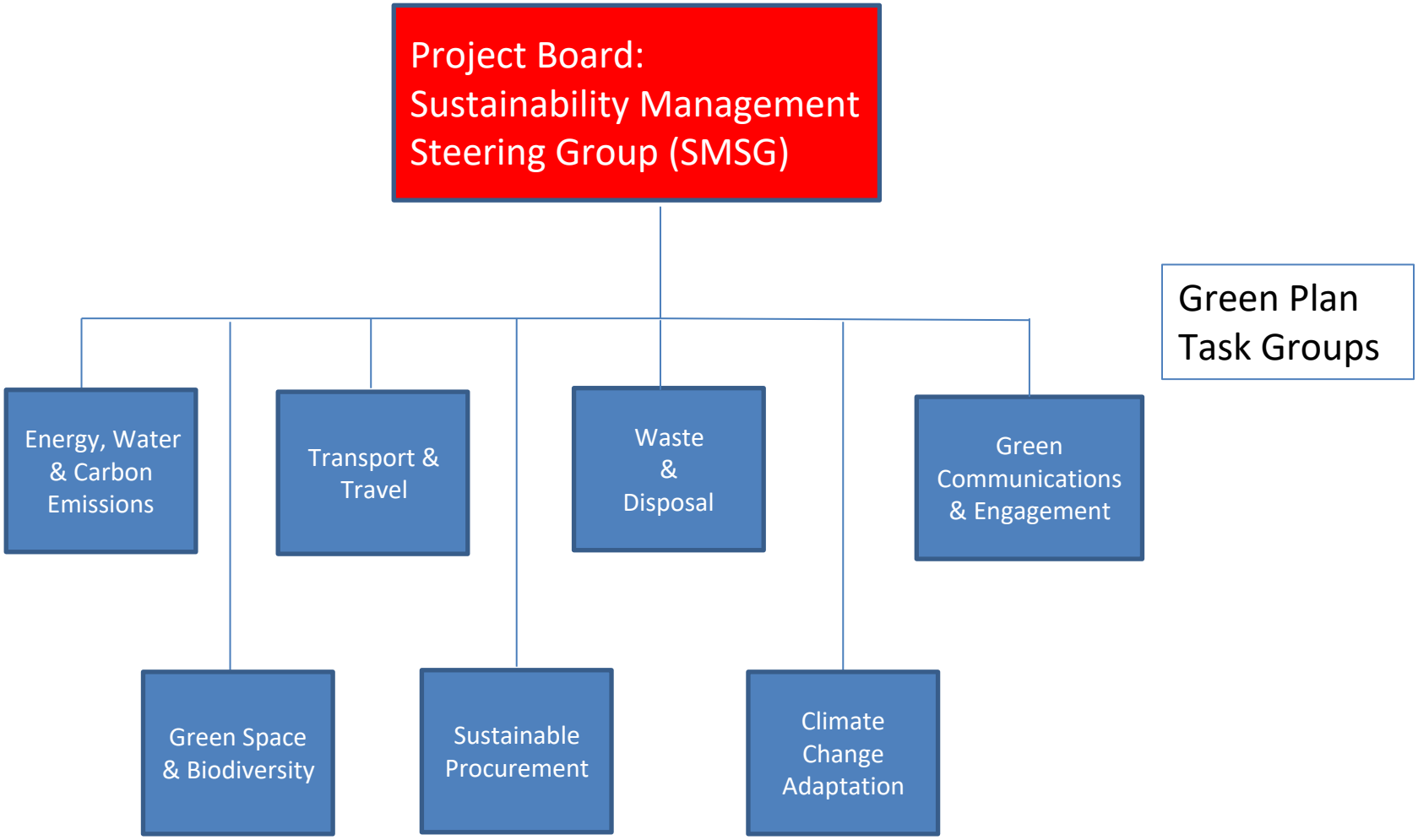
Sustainability Delivery Plan: Stage 1

The Sustainability Management Action Plan (S1) include the following key items for each Sustainability Strand:

Objectives:	Aligned to NHS and GMHSCP Sustainability objectives & overarching legislation
Improvement Targets:	Quantitively and Qualitive Environmental Performance Improvement Targets and delivery plans
Key Performance Indicators:	KPI for each sustainability strands
Policy	Developed summarising and submitted for Executive approval
Reporting	Performance Reporting system, data system ,baseline data, KPIs
Action Plan	Defined delivery plans, responsibilities, measures, timescales

Sustainability Delivery: Stage 1 Action Plan

Sustainability Management: Delivery Structure



Project Board: Sustainability Management Steering Group SMSG

Sustainability Management Steering Group:

- ✓ Key strategic Management Team
- ✓ Provide diverse skills & strategic support for integration of Green Plan
- ✓ Review strategic plans, objectives, policy development, Sustainability progress
- ✓ Provide visible outward support – Trust Green Zero Ambassadors
- ✓ Provide project Governance and essential Board link for key policy/communication/ approval
- ✓ Support strategical alignment of Trust with Bolton Council & GMHSCP

Action plan – next steps

- ✓ Seek SMSG (Project board Approval)
- ✓ Brief & Seek Board & Executive approval
- ✓ Populate & confirm Green Plan Delivery Task Group Representatives
- ✓ Mobilise Green Plan Task Groups (GPTG)
- ✓ Arrange briefing meeting with GPTG Leads
- ✓ Mobilise Stage 1 Action Plans
- ✓ Arrange Meeting programme and support plan

Meeting Frequency: Dates programmed
SMSG – Quarterly
Green Plan Task Groups - Bi-monthly
Trust Board: Six monthly progress reports

AGENDA ITEM 15

Title:	People Committee Chairs' Reports October/November 2021

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th November 2021		Discussion	
Exec Sponsor	James Mawrey		Decision	

Summary:	This report provides an update on the People Committee. The following matters are worthy of noting in this summary section: The following matters are worthy of noting in this summary section: • Positive work is being undertaken on Recruitment, Health & Wellbeing and Medical Leadership & Education Agenda. That said the People Committee wish to highlight that staffing pressures are acute and our staff are tired. This may impact our results for the NHS Staff Survey • Agency trajectories where discussed at the Committee (along with the Finance Committee). Whilst Agency remains high a number of actions have recently been taken to control spend. Of note though high Agency spend is being seen Nationally, Regionally and locally and is not expected to subside any time soon due to quality pressures.

Previously considered by:	n/a

Proposed Resolution	The Board is requested to note and be assured that all appropriate measures are being taken.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	James Mawrey, Director of People	**Presented by:**	Malcolm Brown, Non-Executive Director

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21st October	Date of next meeting:	18th November
Chair:	Malcolm Brown	Parent Committee:	Trust Board
Members present/attendees:	James Mawrey, Martin North, Alan Stuttard, Fiona Noden, Francis Andrews, Sharon Martin, Andrew Chilton, Clare Williams, Michelle Cox, Lianne Robinson, Natasha McDonald, James Logue, Bridget Thomas, Esther Steel, Sharon Martin, Claire McPeake, Lisa Gammack, Paul Henshaw, Carol Sheard, Nicola Caffrey, Rachel Carter, Angela Hansen, Karen Meadowcroft	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing		• Student Nurses recruitment day on 25th September 2021 saw 33 offers or employment. • 11 Overseas nurses will join in October/November. Strong support package in place to support transition. • Committee received an update on recruitment KPI's. Whilst KPI's benchmark well it was noted that the aspiration was to move from 57 workings days to 43 working days (advert to employment checks completed). • Update on Volunteer Services was provided. Noting that we have 203 volunteers, with 54 active – working in A&E, Pharmacy, Churchill Unit, Maternity and Meet and Greet. The committee noted the plans to increase the number of volunteers. • Updates where provided on the vaccination programme.	• The paper was noted. Monthly updates to remain in place.
Workforce Digital Update		• The Committee received an update on key Workforce Digital programmes (ESR utilisation; E-rostering; E Job Planning; Temporary staffing). Conversation ensued about the massive demands being placed on Staffing / Temporary staffing and how it is important all digital solutions explored.	• The paper was noted. B—annual reports to be provided to the Committee

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Headcount/Agency Paper		• It was noted that with the exception of Families and Community then all Divisions have shown an increase in Headcount. Adult – 99; Surgical 95; Diagnostics 39. • Noted that agency continues to increase due to extreme operational pressures (pattern seen throughout the NHS). • An outline of actions being taken to control agenda spend discussed. Including Agency Market Management; Escalation controls, Health Roster training, Implementation of increased bank payments. • Members noted that it would be helpful to undertaken analysis on potential trajectories of Agency spend for financial year.	• Report noted • Monthly update to be provided and in the next meeting a financial trajectory to be included.
Apprenticeship Programme Update		• With COVID pressures then demands for Apprenticeships have dropped due to 'release issues'. This is being experienced throughout the NHS. • 32 staff are undertaking Apprenticeships, with a further 100 expressing an interest. Divisional actions to improve were considered. • Used / Unused Levy spend is being monitored closely and the Committee noted that we would not spend all our Levy (lost £0.69m). • Positive conversations have taken place with Bolton CVS about establishing a Bolton Coaching Academy. The Trust's levy will be used to fund coaching qualifications from CVS paid staff and Trust staff. Once qualified these individuals, along with Bolton Council's qualified coaches, will provide coaching support to the wider Bolton health and social care system. The aims is to extend the academy to other public service employers in Bolton and potentially GM.	• Report noted • Report back in January on partnerships that are being developed throughout Bolton locality and beyond to support this agenda.

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FTSU Quarterly Report		• 49 cases were recorded during quarter, with behavioural issues being the major reason for a referral. • 49 cases is the highest amount ever which is considered positive as the 'reach' of the FTSU service is clearly increasing. • Now have 30 Champions and monthly meetings with FTSU Guardian, CEO, NED, DOP remain in place. • Assurance provided that all referrals received where within the agreed timescales.	• The report was noted and quarterly updates to remain in place.
Staff Experience		• NHS Staff Survey is live and the communication plan / activities were discussed at the meeting. • All agreed that the response rate is important as need to learn what went well/ could be better. As such weekly updates are provided as to response rates (Trust / Divisional level) and all welcome the Divisional competition that was taking place. • It was noted that given the pressures our staff have faced over the last 12 months, then this may impact engagement levels.	• Presentation was noted. Verbal update on response rate at next meeting.
Medical Leadership Plan		• The Committee welcomed the presentation by the Medical Director on this item. This is the first time such a plan has been put in place in recent years and all members welcome the approach. Given the importance of this agenda item then NED's may wish to peruse this document directly, as such then Esther Steele will send out the details in a separate paper for information.	• The plan was commended and would welcome an update on implementation in 6 months' time.
Integrated Workforce Report		• The report triangulated the key workforce data at a Trust and Divisional level.	• Report was noted

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	18th November 202	Date of next meeting:	18th November
Chair:	Malcolm Brown	Parent Committee:	Trust Board
Members present/attendees:	James Mawrey, Martin North, Alan Stuttard, Fiona Noden, Francis Andrews, Sharon Martin, Andrew Chilton, Clare Williams, Michelle Cox, Lianne Robinson, Natasha McDonald, James Logue, Bridget Thomas, Esther Steel, Sharon Martin, Claire McPeake, Lisa Gammack, Paul Henshaw, Carol Sheard, Nicola Caffrey, Rachel Carter, Angela Hansen, Karen Meadowcroft	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing		• Updates where provided on the vaccination programme (73% had both vaccines and 57% had booster), along with the preparations that are being taken to ensure all staff have received a vaccine by 1st April, 2022 (as per national guidance). • Working alongside the COVID Vaccination programme we have the flu vaccination programme (currently 55% of staff) • International Recruitment (Nursing) taking place on both local level and GM level. • Rolling advert in place for Nursing and HCSW posts. • Appointed four Medical Support Workers (new role) – these roles operate at pre-foundation level under supervision. this post is aimed at Doctors returning from retirement, international graduates and refugee doctors who do not have full GMC.	• The paper was noted. Monthly updates to remain in place. In the next paper then it would be helpful to have greater clarity on the establishment vrs actuals gap. • Update on Mandatory Vaccination programme at next meeting.
Agency		• The Committee received an update on the Agency Trajectories until the end of the financial year. These trajectories being based on the enabling actions that are in place (as outlined in previous Committee Chair report).	• The paper was noted. Monthly updates to remain in place.

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		• Bolton's dependency on Agency spend is representative of the wider NHS and is driven by the growth in service demands.	
Staff Experience, Health & Wellbeing Update		• Absence rates whilst above 5% remain one of the lowest in GM. • Updates were provided on the enabling actions (non-exhaustive):- Trauma Risk management programme; Schwartz Round, Improved Occupational Health Service, Divisional Wellbeing activities, closer management of absence policy. • Discussion ensued regarding the bespoke wellbeing activities taking place over the next few months. • Concern was raised that the pressures facing our staff may result in reductions in engagement levels in the NHS Staff Survey – closes end of November with results reported to BoD in March/April (delay due to nationally set embargo).	• The paper was noted. Monthly updates to remain in place.
Smoking Cessation Update		• The update set out the latest developments in supporting smoking cessation in the Trust. • It was noted that additional support for Smoking cessation for our staff were being provided by out Health Improvement Practitioners. • The Trust is working with the CURE Project (GM approach) to help reduce smoking in both our staff and patients. External funding is linked to this work programme.	• The paper was noted and it was agreed that this important work programme would be managed via the Health & Wellbeing subgroups with regular reporting to the Committee.
Medical Education Plan		• Plan was commended and sets out the priorities for Medical Education for the next five years. It provides a blue print for supporting clinical staff, trainees, and trainers in delivering good medical care to our patients.	• The Plan was commended and requested bi-annual updates to the People Development Group and annual updates to the People Committee.

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

HEENW Action Plan		• The paper provided an update on the actions since the last visit on 13th August. • The action plan has 63 actions covering – Unit Induction, Workload/rotas, training opportunities, Clinics, Clinical Supervision and Educationally Unproductive tasks. 2 of the 63 actions are deemed to not be on track. • The programme is being personally led by the Medical Director. Although conversation ensued about the need to make this business as usual within the Division	• The paper was updated. Further update to be provided to the Committee when required but no later than 6 months' time.
Guardian of Safe Working		• A very well received report. • The GOSW has oversight of all exception reports (84 in quarter – 70 related to additional hours and not taking breaks, 11 missed educational opportunities and 3 related to both). Zero escalations are awaiting action. Two safety concerns were raised in Medicine and O&G. All safety issues are escalated to the Divisional Medical Director and Medical Director. • The GOSW remains very active within the organisation	• The paper was noted. Quarterly updates to remain in place. • Divisional People Committees to oversee actions raised in report.
Trust/People Strategy Development		• The Trust's 2018-21 People Strategy is due for refresh and renewal. The Committee supported that the People Plan should run in parallel with the development of the new corporate strategy to ensure alignment of ambitions and objectives. Therefore development taking place in Q4 of 2021/2022	• Timescales for production approved.
IWR		• The report triangulated the key workforce data at a Trust and Divisional level. • The Committee were pleased to hear that the Exit interview return rate had considerable improved – the themes / findings will be reported on a quarterly basis.	• Report was noted.

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Chairs reports • People Development Steering Group • Staff Experience Steering Group • EDI Steering Group • Resource & Talent Planning Steering Group • Divisional People Committee		• No risks were escalated • The Chair commended the work by the People Development Group on the many leadership activities overseen / delivered.	•

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AGENDA ITEM 16

Title	2021-22 Emergency Preparedness, Resilience and Response (EPRR) Assurance. Statement of compliance

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th Nov 2021		Discussion	
Exec Sponsor	A. Ennis		Decision	

Summary:	NHS England require all health organisations participating in the 2021 – 2022 EPRR Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period.

Previously considered by:	This is presented annually to the Board.

Proposed Resolution	To note compliance level and document in the minutes as a matter of public record

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	J. Tunn	**Presented by:**	J. Tunn

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response assurance 2021-22

STATEMENT OF COMPLIANCE

Bolton NHS FT has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Bolton NHS FT 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 an EPRR assurance rating of **Substantial** (from the four options 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.

Signed by the organisation's Accountable Emergency Officer: 26/10/2021

25/11/2021	25/11/2021	01/09/2022
Date of Board Meeting	Date of Public Board	Date published in annual report

1. Background:

   As a category 1 responder organisation the trust is required by NHS England to self-assess its level of EPRR compliance annually against 46 (2021) pre-determined criteria as set out in the NHS England EPRR Core Standards. These criteria are grouped in 10 specific domains:

   i. Governance
   ii. Duty to risk assess
   iii. Duty to maintain plans
   iv. Command and control
   v. Training and Exercising (not included in 2021 return)
   vi. Response
   vii. Warning and informing
   viii. Co-operation
   ix. Business Continuity
   x. CBRN

   The process was postponed last year during the height of the pandemic as many trusts suspended training and re-deployed staff during the response phase to maintain the ability to provide patient care and staff safety.

   The training and exercising domain has not been included, again this year however the EPRR department has undertaken a number of exercises and training events over the last 18 months including a major Incident exercise at the request of GM Gold Command.

2. Compliance:

   Following this year's self-assessment against the 46 criteria the trust is fully compliant with 42 and partially compliant with 4, giving and overall assurance rating of Substantial (91%) as per the statement of compliance.

   The self-assessments and statements of compliance are returned by all G.M. trusts to the G.M. Shared Service Resilience Team for collation and oversight by the Greater Manchester Local Health Resilience Partnership (LHRP).

3. Work plan:

   Going forward a work plan has been compiled by the EPRR manager to address the 4 areas of partial compliance. Progress will be monitored by the Deputy Chief Operations Officer. (Director of Operations from Jan 2021)

Domain	Detail	Action	Lead	Timescale
Duty to maintain plans	Critical Incident management	The current ERT policy which outlines the process to manage a Critical Incident requires review and update.	EPRR Mgr.	End Dec 2021
Duty to maintain plans	Evacuation	Evacuation plans are in place at unit level but not currently for a whole site evacuation: Develop a tactical level plan for whole site evacuation in line with Evacuation and Shelter Guidance for the NHS in England (amended V3) received Nov 2021	EPRR Mgr.	End March 2022
CBRN	HAZMAT/ CBRN planning and response arrangements.	Requires Update to current version.	EPRR Mgr.	End Dec 2021
CBRN	Decontamination capability availability 24 /7	Training reduced / suspended due to pandemic. Restart of training required	ED CBRN Training Lead / NWAS	On-going / in process

AGENDA ITEM 17

Title:	Board Assurance Framework (BAF)

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 November 2021		Discussion	✓
Exec Sponsor	Director Corporate Gov		Decision	

Summary:	All NHS organisations are expected to have a Board Assurance Framework setting out the risks to the achievements of strategic objectives. BAFs have been in place for almost 20 years and over time organisations have adapted the standard template to develop a version that suits. However, all must contain the key elements of risks to objectives, the controls in place to mitigate the risk, the assurance that the controls are effective (or not) and actions to address any gaps in controls or assurance. Most but not all BAFs score risks using the commonly used 5 x 5 risk matrix. Our BAF has been through many iterations, the current version is understood and liked by the NEDs but nevertheless should continue to be reviewed both for content and format. As a mature organisation with well-established risk and assurance processes our use of the BAF should be focused on the actions to take to mitigate gaps and the ongoing development of a mature approach to risk-appetite particularly in terms of innovation. In addition to the full board Assurance Framework we have previously considered an IPC Assurance Framework prior to submission to NHSI and are now considering a new Assurance Framework for Winter Preparedness. This was received for population last week and will be shared with Board members once completed – the template is included as an appendix to this paper for information.

Previously considered by:	Reviewed on a regular basis by Executive leads

Proposed Resolution	Board members are asked to note the controls to mitigate the risks and issues which have the potential to impact on our strategic objectives. Board members are also asked to consider if the BAF provides assurance that the risks to the achievement of our strategic objectives are managed.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Esther Steel Director Corporate Governance	**Presented by:**	Esther Steel Director Corporate Governance

Glossary – definitions for technical terms and acronyms used within this document

BAF	Board Assurance Framework
RTT	Referral to Treatment
SHMI	Standardised Hospital Mortality Indicator
EPR	Electronic Patient Record
CGQC	Clinical Governance and Quality
RAG	Red Amber Green

Background

The Board Assurance Framework is a document setting out:

- The Trust's strategic objectives,
- the risks and issues that might impact on the achievement of those objectives
- A score reflecting the **current** likelihood and impact of not achieving the objective
- The controls that exist to limit the identified risks/issues
- the mitigations and actions to reduce the likelihood or impact of the identified risks
- The assurance that the controls, actions and mitigations are effective
- Any gaps in controls or assurance
- Any further actions to close the gaps in controls and/or assurances.

The full BAF used in Bolton has developed over time and also includes:

- details on the committee that has oversight of the BAF,
- a RAG rating for each risk or issue that could impact on the achievement of the objective
- A risk appetite statement
- A graph to track the score over time
- Narrative/comments for population to provide additional information if required.

Current practice for review of the BAF

In order to be meaningful the BAF should be reviewed and updated on a regular basis

Recommendation

Board members are asked to consider if the Board Assurance Framework remains reflective of the key risks impacting on the organisation.

Bolton NHS Foundation Trust

Board Assurance Framework 2019/24

Updated November 2021

Board Assurance Framework Explanatory Notes

- The ambitions for the Trust have been agreed in consultation with the Board and wider stakeholders. The ambition description used within this BAF is as set out in the summary Strategic Plan 2019 – 2024
- For each objective the Executive team consider the risks and issues that could impact on the achievement of the ambition, the BAF is then populated with these risks/issues, the controls in place and the assurance that the controls are having the desired impact. Actions to address gaps in controls and assurance are identified.
- Actions should be SMART and should include an expected date of completion.
- The "oversight" column is used to provide details of the key operational and assurance committee.
- The RAG column is used to indicate the level of assurance the Executive has that the risk is being managed.

	No or limited assurance– could have a significant impact on the achievement of the objective;
	Moderate assurance – potential moderate impact on the achievement of the objective
	Assured – no or minor impact on the achievement of the objective

- The full BAF should be reviewed at least once a year at Board and twice a year at the Audit Committee
- The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF;
- Executive Leads are responsible for providing regular updates to the risks within their portfolio including if necessary the escalation of the risks to the achievement of objectives not previously included on the BAF

Change Log (risk scores) –				
Date	**Objective risk**	**Score change from/to**	**Rationale**	**Approved at**
25/02/20	Added full page risk description for objectives To make our hospital and our buildings fit for the future and To join up services to improve the health of the people of Bolton			
05/06/20	Added additional summary of Covid Assurance			
06/06/20	Full refresh of all areas of the BAF			
10/07/20	Increase to risk of delivery of operational performance	20 to 25	to reflect the impact of Covid 19 on RTT and cancer	
16/11/20	Reduction to the risk that we will fail to achieve our objective "To continue to use our resources wisely so that we can invest in and improve our services"	20 to 16	Likelihood of failing to achieve the objective reduced in light of current financial position and Covid finance regime	
16/11/20	Increase to the risk that we will fail to achieve our objective "To develop our estate in a sustainable way that supports staff and community health and wellbeing"	12 to 16	Likelihood of failing to achieve this objective increased in light of national financial challenge post Covid-19	
06/01/2021	Review of all elements no changes to score			
April 2021	Review of all elements			
July/August 2021	Full review		No changes to score Mental health impact incorporated into risks	
Nov 2021	Full review		Removed summary	

1	Ambition – To give every person the best care every time – reducing deaths in hospital	Lead Director	Medical Director	
		Date updated	November 2021	

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
HSMR higher than expected (SHMI within range)	Monitored quarterly at Trust Mortality Reduction Group (MRG) Learning from deaths SJRs for high mortality groups	Quarterly SHMI (2 quarters in arrears) Secondary review of SJRs at learning from deaths committee HED analysis of mortality patterns MRG commissioned audits of higher than expected mortality groups	Delivery of MRG Work stream Audit of cases and coding to understand cause Assessment of quality of care through SJRs Work with AQUA and NHS Northwest on pneumonia	Mortality Reduction Group Learning from deaths committee Quality Assurance Committee	
Recording of diagnosis and co-morbidities not accurate	Access to Bolton Care Record now fully available for comorbidities Recording and coding action plan	Monthly monitoring of co-morbidity recording via HED AQUA NW mortality report	Implementation of recording and coding plan Education package developed for medical staff	Mortality Reduction Group Clinical Governance Committee Quality Assurance Committee	
Learning from deaths actions not implemented	Learning from death process/policy Tracking of actions from learning from deaths committee complaints intelligence (where a death has occurred) is reviewed and reported to the LfD Committee	Quarterly reports Tracking template for LfD actions and feedback	New healthcare intelligence provider appointed (HED) LfD audit action plan	Mortality Reduction Group Trust Board Learning from deaths committee	
NEWS compliance currently under 90%	Clinical incident reporting and Root cause analysis Policies Quarterly KPI's include sepsis screening tool Revised fluid balance charts on EPR	Quarterly Audit via Nursing care Indicators.	New reporting suite for EPR NEWS Divisional Action plans for aiding improvement in NEWS including hydration programme	Mortality Reduction Group Mortality included in Divisional Quality reports	
Clear escalation of ill patients	Root cause analysis of cardiac arrests and critical care escalation- data shows year on year reduction in avoidable cardiac arrests Failure to recognise or respond to a deteriorating patient generates a clinical incident report Learning from deaths SJR process	Sepsis performance report Quarterly cardiac arrest RCA reports Deteriorating patient lead in post	Root cause analysis of avoidable cardiac arrests Audit of medical handover arrangements being monitored for improvement and eventual assurance via CGQA Design and implement a robust quarterly audit of response using patient track data- needs reactivation	Mortality Reduction Group Clinical Governance and Quality Assurance Group Mortality Reduction Group	
Documentation of DNACPR	DNA CPR audits	Cardiac arrest RCA audits DNAR-CPR audit quarterly	Audit of capacity and DNAR-CPR by division quarterly Updated DNAR-CPR policy Capacity assessment link now on EPR Appointment of DNAR-CPR clinical lead	End of Life Steering Group Clinical Governance and Quality Assurance Group	
Sepsis performance not at 100%	Sepsis improvement work stream	Sepsis quarterly performance SHMI for sepsis within normal limits A&E screening on upward trajectory	Delivery of sepsis plan for in patients 21-22 Revision of sepsis policy Incorporation of SAFER principle into training Education for clinical staff programme Implementation of EPR sepsis bundle	Mortality Reduction Group	

1.1	Ambition	To give every person the best care every time – reducing deaths in hospital

Risk appetite

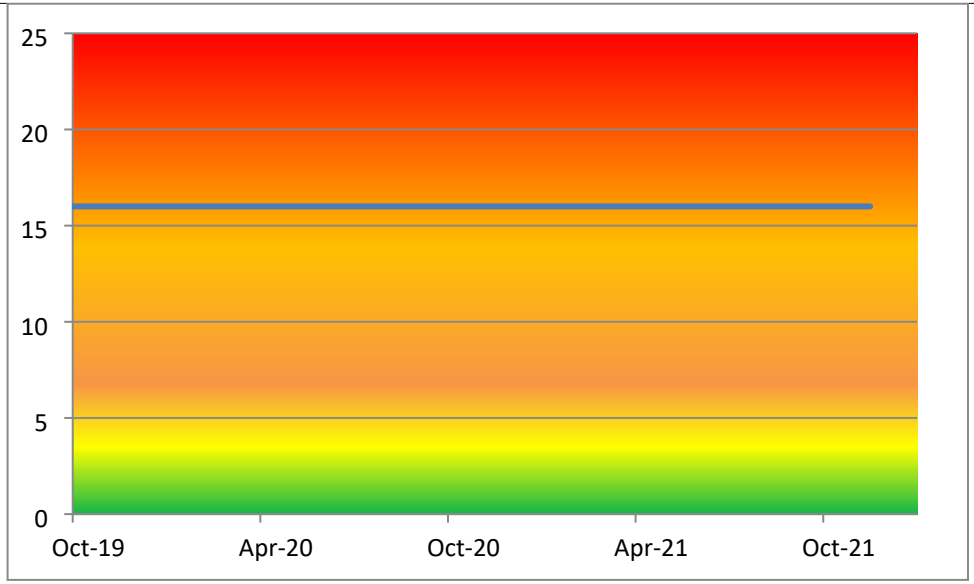
Risk levels ▶ / Key elements ▼	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Mortality reduction remains a key strategic and operational objective for the Trust.

Over the years good progress has been made to reduce mortality rates towards the end of 2018 and in the first months of 2019 there was an increase in SHMI and there is still work to do particularly with regard to the escalation and response to NEWS and the treatment of ACU activity. Assurance on the overall quality of care is provided by Lfd process and the focus on mortality indicators is on co-morbidity recording

Risk tracking



date:	comments	Risk Score	I	L	
05/11/20	Risk narrative updated		4	4	16
29/06/21	Narrative updated		4	4	16
01/11/21	Narrative updated		4	4	16

1.2	Ambition – To give every person the best care every time – Delivery of Operational Performance	Lead Director	Chief Operating Officer
		Date updated	01/11/21

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
failure to admit patients in a timely manner Key causes • Volume of attendances • Late decision to admit from A/E • Failure to discharge patients in a timely manner • Failure to discharge enough patients at weekends • Bed capacity in hospital and community • Impact of COVID 19 on pathways, including risks associated with overcrowding	Escalation policy, flow meetings and reports(four a day) SAFER principles Joint working with CCG through Urgent Care Board Escalation beds opened in community Development of integrated discharge team	Daily/weekly/ Monthly monitoring of performance Working with GM to agreed standards	Urgent care programme plan Continued work through Divisions on SAFER – ongoing Focus on reducing LOS Revised streaming model to ensure patients go the appropriate service Revised CDU and ACU model as part of streaming Creation of SDEC services to redirect work away from A/E	System Resilience Board - Trust Urgent Care Board- Locality -Board reports - GM reviews CQC reports Regional reporting	
Staffing – risk of not having appropriate numbers and grades/roles of staff Impact of Covid on staff – increased sickness absence	Incident reporting Workforce plan	Daily/weekly/ Monthly monitoring of performance including staff absences	Recruit Nursing/ EMP –ongoing Developing teams for each for the specific areas within ED	IPM Workforce committee	
RTT and cancer Capacity – physical and staffing exacerbated by COVID 19 infection control requirements Patient confidence to use services following COVID 19 Increase in Cancer referrals Multi centre pathways and capacity in diagnostics	Cancer and RTT Patient treatment list management Detailed capacity and demand management Joint working with GM on cancer pathways Joint working with GM to ensure equality of access across GM Validation of waiting lists Clinical review of all long waiters Mutual aid in GM	Daily/weekly/ Monthly monitoring of performance	Review of OPD and Theatre capacity and transformation Redesign of pathways for COVID compliance Significant increase in digital options for care	Contract and Performance GM Cancer Board IPC reviews GM single system management	

1.2 Ambition – To give every person the best care every time – Delivery of Operational Performance

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

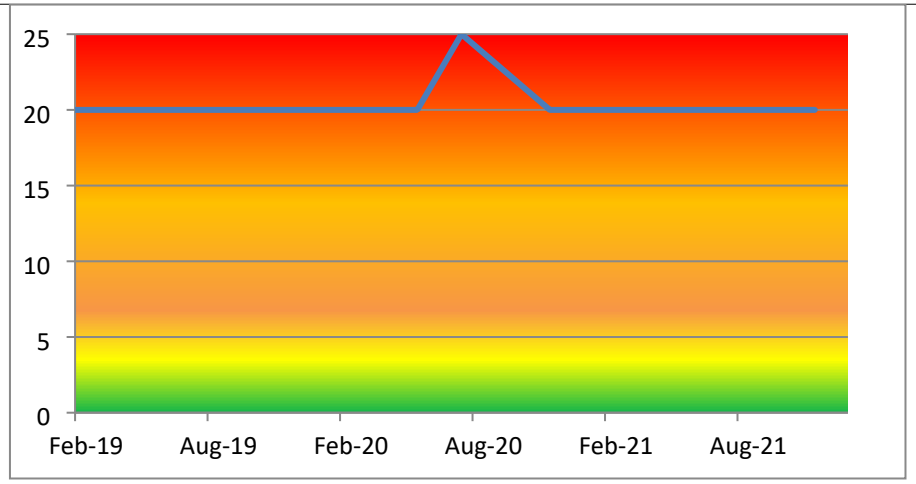
The Trust has for some time, struggled to maintain the standard

There is now acceptance that this is an issue which needs to be addressed by the whole health economy, the Urgent Care Programme Board has been established to provide this oversight.

The impact of Covid -19, particularly in the second wave has impacted further on pressures in urgent care, actions including the development of a Same Day Emergency Care Centre (SDEC) are planned to alleviate this pressure.

Nationally pressure in urgent care is resulting in vary few Trust achieving and maintaining the 4 hour standard

Risk tracking



date:	comments	Risk Score	I	L	
20.02.20	Risk updated to reflect challenges to RTT and cancer performance		4	5	20
10/7/20	Risks updated in light of pandemic		5	5	25
16/11/20	Risk moderated and agreed although extremely high should remain at 20		4	5	20
29/06/21	Risk narrative reviewed and updated		4	5	20

2	Ambition – To be a great place to work		Lead Director	Workforce Director	
			Date updated	10/11/21	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Health and Wellbeing of workforce – If the Trust does not reduce sickness absence rates there will be a service delivery and financial impact Increased risk as a result of Covid related absence. Impact of Covid and work pressures on staff mental health	H&W Strategy Local, Regional & national Benchmarking Workforce & OD Strategy. Occupational Health Staff Health and Wellbeing programme	Attendance KPI Staff survey Friends and Family Go Engage Ward to Board heat map Covid sitrep	Pillar Healthy Organisation Culture and Pillar Workforce Capacity. Both have full action plan on measures being taken across full organisation. Regular updates provided to Subgroups and People Committee on controls being taken Extensive actions within the H&W Action plan	People Committee, Health & Wellbeing group Board of Directors Monthly review of action plans at Health and Well-being steering group	
Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will be a potential impact on improvement initiatives, discretionary effort and attendance Increase risk of stress related issues for staff as a result of Covid-19	Great Plan to Work Plan Go Engage Pioneer Programme Workforce & OD Strategy.	Staff Survey Friends and Family Go Engage NHS Staff Survey Local, Regional & national Benchmarking Covid sitrep	Pillar Healthy Organisation Culture Full action plan on measures being taken across full organisation. Regular updates provided to Subgroups and People Committee on controls being taken Extensive actions within the Staff Engagement Action plan	Monthly review of action plans at Staff Engagement Group People Committee Board of Directors	
Recruitment and retention – if the Trust does not recruit and retain staff with the right skills and values the delivery of all other objectives will be at risk.	Recruitment & retention Strategy Weekly / Monthly Safe Staffing meeting Job planning Workforce & OD Strategy.	Integrated Workforce Report. Includes recruitment KPI, Agency, Bank, sickness, retention. Staffing report, HR reports on vacancies	Pillar Workforce Capacity has full action plan on measures being taken across full organisation. Regular updates provided to People Committee on controls being taken Review Workforce and OD strategy Dec People Committee	People Committee and Board of Directors	
Agency use – failure to reduce reliance on agency staff has a financial impact but also a potential impact on the wellbeing of substantive staff and the care of our patients	Recruitment & retention Strategy Weekly / Monthly Safe Staffing meeting Job planning Workforce & OD Strategy.	Integrated Workforce Report. Includes recruitment KPI, Agency, Bank, sickness, retention. Staffing report, HR reports on vacancies	Pillar Workforce Capacity has full action plan on measures being taken across full organisation. Regular updates provided to People Committee on controls being taken Review Workforce and OD strategy Dec People Committee	People Committee and Board of Directors	
Inclusion – if the Trust workforce does not represent the diversity of the population we serve this can impact on care provision, reputation and future recruitment and retention	EDI Strategy Workforce & OD Strategy.	WRES, WDES, Gender Pay gap and Annual Quality report	Pillar Healthy Organisation Culture (inclusive of inclusion) action plan. Regular updates provided to Subgroups (EDI Steering group) and People Committee EDI Action plan	EDI Steering Group BME Staff network, LGBT group People Committee	

Education and Development – if the Trust does not provide opportunities for education and development this will impact on retention, engagement and wellbeing of staff and the future capability of the workforce Covid-19 has resulted in significant reduction in training opportunities	Revalidation Appraisals Workforce & OD Strategy.	Workforce dashboard Integrated Workforce Report. Includes some Education metrics.	Pillar Education & leadership. Full action plan on measures being taken across full organisation. Regular updates provided to Subgroups (Education Group) and People Committee on controls being taken Extensive actions within the Education Action plan	People Committee, Monthly review of action plans at Subgroup (Education group)	
Failure to maximise digital HR systems could lead to lost opportunities for increased efficiency and effectiveness	ESR / ERS Benefits realisation plan Job planning roll out plan	Workforce Digital group (just formed) People Committee signed off on plan December 2020	This action plan is in the early form of development.	People Committee, Workforce Digital Group	

2 Ambition - To be a great place to work

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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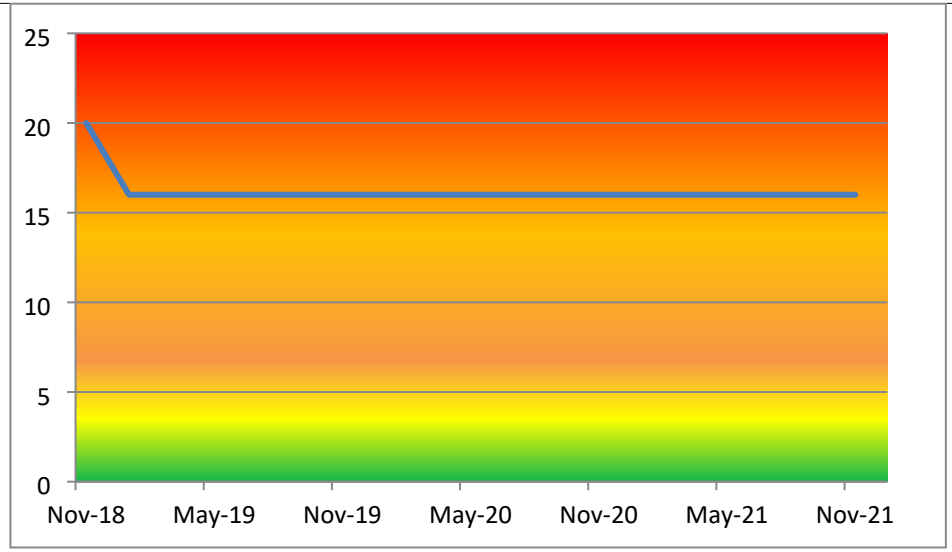
Background

Maintaining safe staffing levels through recruitment and retention and reducing sickness absence is a key objective to ensure delivery of the Trust's strategy.

The Workforce Assurance Committee chaired by the CEO has oversight of the challenges and risks to achieve our ambition of being a great place to work

Risk tracking



date:	comments	Risk Score	I	L	
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy		4	4	16
05.11.20	Risk reviewed – no changes made		4	4	16
06.01.21	Risk reviewed, minor changes made to content and to summary		4	4	16
28/06/21	Risk reviewed, minor changes to narrative		4	4	16

3	**Ambition –** To continue to use our resources wisely so that we can invest in and improve our services	**Lead Director**	**Annette Walker**
		Date updated	**29.07.21**

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Delivery of year on year cost improvements Cost control and managing inflation effects Shortage of revenue and capital funding	CRIG approval of business cases PMO coordination of ICIP Monthly financial reporting to budget holders Divisional accountability through IPM Annual budget setting and planning processes Finance department annual business planning process Development of annual procurement savings plans Monthly accountability reporting to DOF	Monthly Finance Report to Finance Committee Quarterly reporting on Trust staffing levels to Finance Committee Reporting to Finance committee from the system finance group PLICs reporting and updates to Finance committee Cost improvement progress reports to Finance committee Quarterly benchmarking reporting to finance Committee SFI breach report to Audit committee Quarterly procurement report to Finance Committee	2021/22 Exit run rate Development of place based approach to service and financial planning April 22 Understand cost and income base through active use of patient level costing December 21 5 year financial strategy refresh subject to clarity on financial regime from 22/23 onwards June 21	Board Finance Committee Audit Committee CRIG	
Development of commercial opportunities for growth of services			Development of commercial strategy April 22	Board	

3 Ambition - To continue to use our resources wisely so that we can invest in and improve our services

Risk appetite

Risk levels / Key elements	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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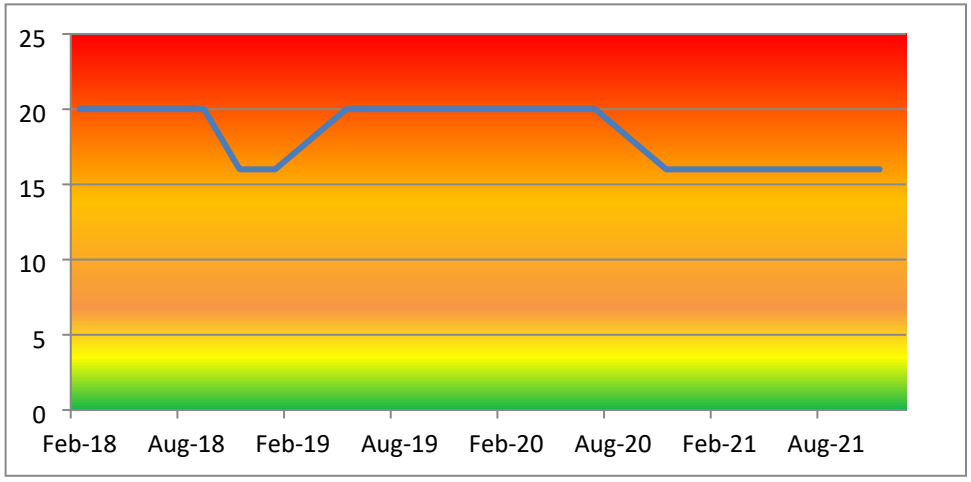
Background

Risk tracking



date:	Comments	Risk Score	I	L	
20.02.20	Full update to risk		4	5	20
May 20	Risk narrative updated		4	5	20
Nov 20	General Update – risk score reduced		4	4	16

Jan 21	Review to focus on strategic risks	4	4	16

4	Ambition – To make our hospital and our buildings fit for the future	Lead Director	Director of Finance
		Date updated	29.06.21

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Shortage of capital and revenue funding Changes to capital regime High levels of backlog maintenance	Estates Strategy and supporting Business Cases to make the case for external capital Established links to GM and NHSI Capital processes to ensure correct prioritisation Links with local partners including LA, University etc. Membership of Bolton Strategic Estates Group Premises Assurance Model Enterprise Asset Management Backtrac system	Estates masterplan in place Reports to F&I and Strategic Estates Board Annual capital plan and reporting ERIC reports Model Hospital estates and facilities metrics Use of resources benchmarking	Fully costed estates strategy over 5 years, Develop bids for HIP programme, March 21 April 22 New Hospital Bid one of 2 supported by GM ICS for submission to new hospital team 6 facet survey has commenced will be completed February 2022 Demolition and disposal strategy, April 22	Board Executive Strategic Estates Board Strategic Estates Group Finance Committee Executive	
Planning, traffic constraints to the site	Working with LA and other partners Estates strategy Traffic surveys	Estates strategy updates	Environmental sustainability strategy, November 21	Strategic Estates Board Executive	
Controllability of community estates not owned by Bolton FT	Bolton Strategic Estates Group IFM asset management CCG/FT asset groups		Community estates strategy, April 22	Strategic Estates Board	

4	To make our hospital and our buildings fit for the future

Risk appetite

Risk levels / Key elements	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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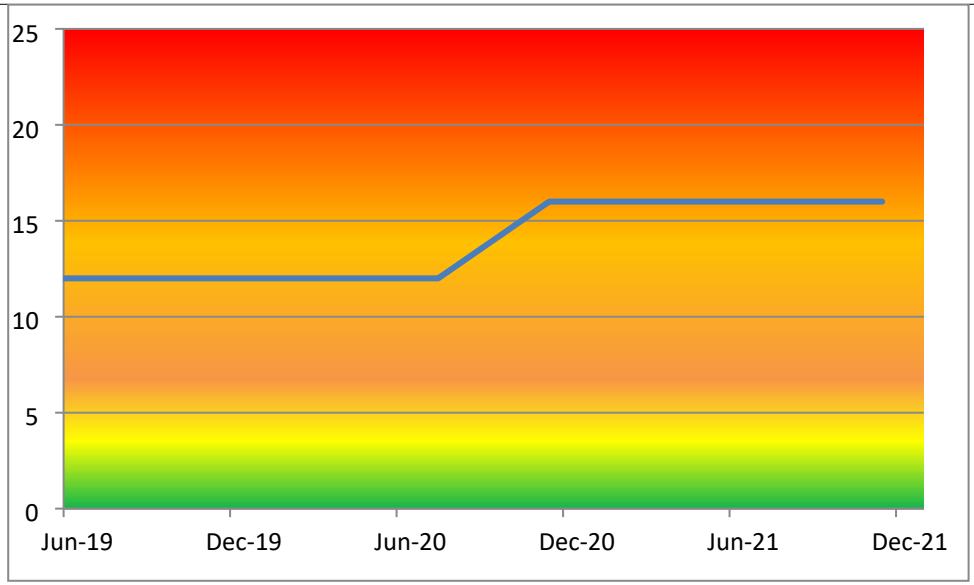
Background

Risk tracking



date:	Comments	Risk Score	I	L	
25/02/20	Full page risk description added		4	3	12
15/05/20	Narrative updated		4	3	12
16/11/20	Update – risk score increased		4	4	16
06/01/2021	Review to focus on strategic risks/issues		4	4	16

5	Ambition – To join up services to improve the health of the people of Bolton	Lead Director	Director of Strategy and Transformation
		Date updated	29.06.21

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Impact of external system pressures and changes in wider health economy on the development of the Integrated Care Partnership	Stakeholder engagement plan Bolton System and other formal engagement meetings Oversight of delivery through the ICP Alliance Board	ICP Business plan developed and approved by Board February 2020 MD Post recruited and coherent approach to system management developed through the Bolton ICP Board. Continue to embed processes for engagement in local reconfiguration activity Continue with ICP Organisational Development Programme ICP Chair commence in role October 2020	Develop Alliance Agreement to support the governance of the partnership Develop the section 75 Embed ICP Community Focused Transformation Programme (including Public Sector Reform) within the ICP	ICP Board Bolton Partnership Board Bolton FT Executive Directors	
Impact of COVID on the delivery of the Integrated Care Partnership	Management of the COVID outbreak through a using the ICP Board as Oversight, led by the MD.	COVID Partnership leadership group in place which includes all ICP organisations with a clear action plan and clear task and finish groups. The plan ensures the acceleration of ICP transformation which was already planned where possible.	Reset plan developed which moves the delivery of socially distanced services into a longer term plan.	ICP Board Bolton Partnership Board Bolton FT Executive Directors	
Impact of organisations financial Cost Improvement Programmes on the development of the ICP	Development of an Alliance Agreement which ensures shared responsibility around delivering organisational Cost Improvement Savings.	ICP Alliance Board will provide the platform and framework to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the ICP to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.	Alliance Agreement to be developed April 2022 Organisations working together to develop a System Financial recovery Plan	ICP Board Bolton FT FIP Committee Bolton FT Executive Directors	

5 To join up services to improve the health of the people of Bolton

Risk appetite

Risk levels / Key elements	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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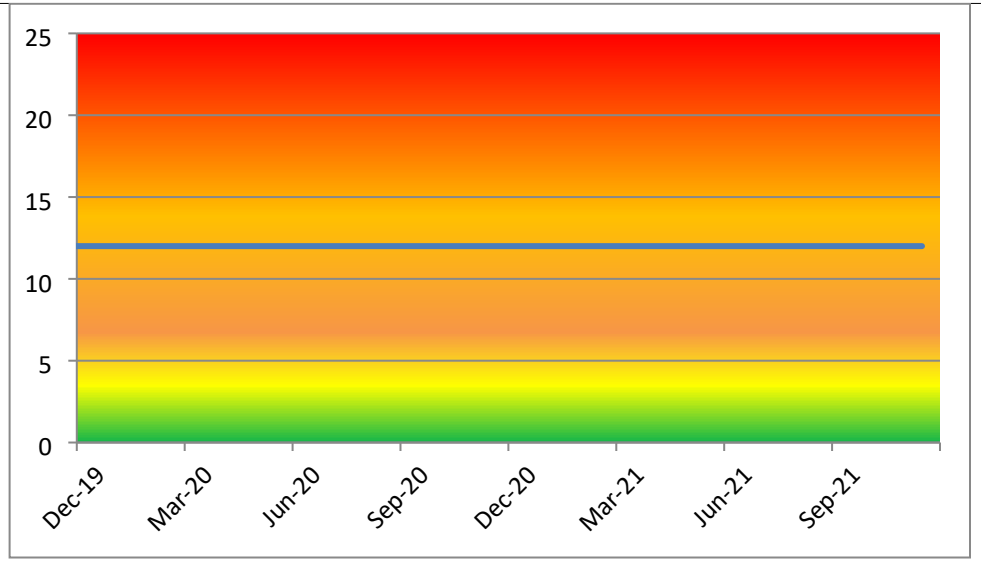
Background

Risk tracking



date:	comments	Risk Score	I	L	
10/5/20	Risk Narrative Reviewed		4	3	12
16/11/20	Risk Narrative Reviewed		4	3	12
10/08/21	Reviewed		4	3	12
16/11/21	Risk Reviewed		4	3	12

6	Ambition – To develop partnerships across GM to improve services	Lead Director	Director of Strategy and Transformation	
		Date updated	29.06.21	

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Risks to ability to implement Healthier Together for emergency and high risk general surgery due to the time since original decision / consultation	NWS PMO Programme plan Reporting into the NW sector Partnership Board Plan for delivery, engagement of clinicians and the public Plan for delivering the capital requirements of the programme	Review and further develop communications strategy for clinicians and public Direct Executive and senior management engagement Partnership Board level oversight of the programme Implementation of sector wide MDT Approval of Capital Business Case – Treasury Engagement with clinical teams	HT capital plan for Bolton being finalised Review of HT aims and ambitions	Exec Directors	
Resilience of sector and GM Radiology / Pathology to support reconfigured services	NWS PMO Programme plan Reporting into the NW sector Partnership Board GM Radiology and Pathology Cells	GM wide procurement of collaborative image sharing project in place Establishment of Radiology/Pathology Cells	Review of Radiology / pathology plans across Greater Manchester by DOS on behalf of Provider Federation Board. Radiology and Pathology cells now established across GMs GM PACs and Laboratory Information Management System procurements	Exec Directors Trust Transformation Board	
Develop Provider Collaborative across GM	Provider Federation Board GM Gold	PFB overseeing elective recovery and supporting GM capacity issues PFB overseeing system escalation to support urgent care capacity issues PFB workstream around fragile services	GM provider collaborative delivery being developed linked to GM • Financial Plan • Digital Plan	Exec Directors	

6 Ambition – To develop partnerships across GM to improve services

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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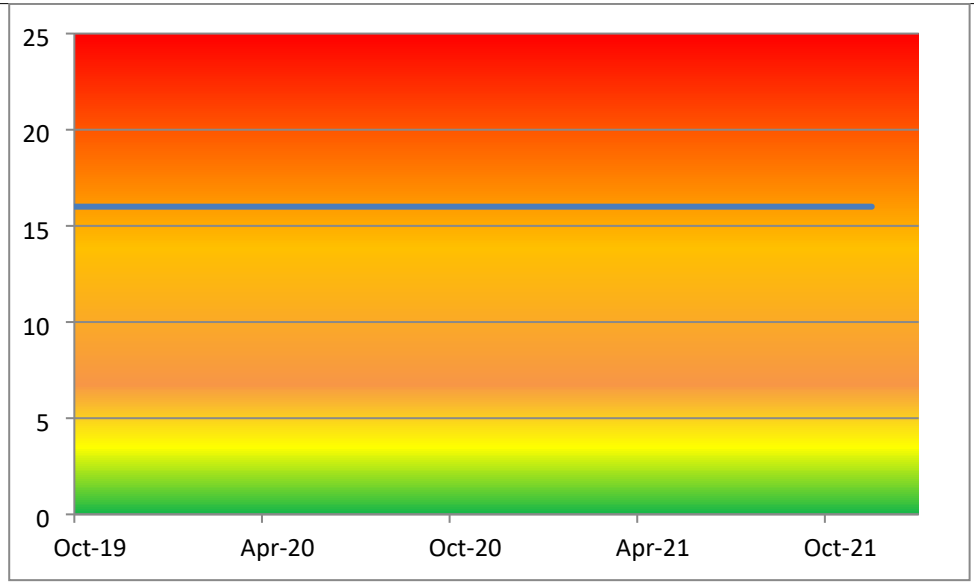
Background

As a partner in the Greater Manchester Health and Social Care Partnership and the Bolton Locality we have prioritised the key actions we must take to achieve a sustainable Health and Social Care System by 2021 and beyond.

The changes proposed by the Healthier Together programme will significantly change the landscape of service delivery. We recognise there are services where the best solution to the challenge of limited resource is to work in partnership with other organisations.

As a foundation trust we have a duty to the public of Bolton to ensure their access to essential services is not compromised.

Risk tracking



date:	comments	Risk Score	I	L	
21/10/19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy		4	4	16
20/02/20	Risk reviewed		4	4	16
05/11/20	Risk reviewed		4	4	16
08/01/21	Risk reviewed		4	4	16

16/11/21	Risk Reviewed	4	4	16

Covid Assurance Framework	Lead Director	Chief Operating Officer
	Date updated	29.06.21

The framework below summarises the risks and issues associated with the operational impact ofCovid-19. Each of the strategic objective assurance frameworks has also been updated to reflect the impact of Covid-19 on the achievement or our strategic objectives.

Alongside this framework there is also a more detailed NHSI Framework focusing on the IPC aspect of Covid

Risks/issues	Controls	Assurance	Actions	Lead
Staff morale low because of anxiety and levels of work. Potential PTSD and more serious mental health implications a risk for some staff	Wellbeing provision for staff – including practical and psychological support Staff communications – daily update Recognition of staff efforts	Monitoring of feedback and social media content	Continued wellbeing programme	Director of Workforce
Staffing levels – potential impact of staff self isolating or ill because of Covid-19	Attendance team in place – daily support Increased recruitment – return to work, fast-track students, volunteers Screening programme to enable staff to return if not Covid positive Redeployment programme Working from home where possible	Daily sit rep Daily Workforce Dashboard on all controls	Refreshed attendance programme to respond to changing national guidance Regular recruitment programme Staff testing programme Redeployment programme Reward packages reviewed	Director of People
Supply of oxygen Currently have sufficient oxygen provision for 40 ICU beds and all ward beds	Daily monitoring of use/levels	Telemetry installed to report on levels	Continue to monitor	Director of Finance
If the Trust do not have adequate PPE, staff and/or patients may be at increased risk of infection	National and GM Coordination of PPE supplies PPE stock levels monitored by procurement Alternative supplies identified by procurement Training for staff in correct donning and doffing procedure Staff information leaflets	Daily sitrep	Procurement continue to work with supply chain to secure provision. Alternative solutions developed	Chief Nurse (as DIPC)
If staff do not use PPE appropriately including within non clinical areas there may be an increased risk of nosocomial infection	Communication to staff Provision of PPE in key areas	Covid reporting	Outbreak report/review	
If staff are not fit tested for masks or are fit tested for masks no longer available there may be increased risk of staff infection	Fit testing programme	Fit testing records	Fit testing programme extended. Reusable masks being introduced	Chief Nurse (as DIPC)

Availability of critical medicines During the first wave, demand was exceeded supply for some of the medications used in critical care	Pharmacy have provided guidance to identify suitable alternatives	Pharmacy reporting	Pharmacy/procurement continuing to work with the supply chain	Medical Director
due to increased number of critically ill patients requiring renal replacement therapy nationally on ICU, may not be able to provide for all eligible patients as shortage of consumables	national guidance issued to take measures to reduce risk of renal failure in critically ill, consider alternative treatment strategies e.g. peritoneal dialysis and ordering as per national guidance if less than 4 days stock	GM Gold reporting Sitrep	shortages escalated to GM gold and GM renal network for mutual aid	Medical Director
Visiting restrictions may heighten public anxieties with potential for adverse impact on patient/relative experience	Alternative forms of contact- “letter to a loved one” Ipads provided for Face time with relatives Anytime/Anywhere used for virtual discussions with medical staff	Monitoring of feedback	Continuing to monitor and provide virtual support	Chief Nurse
People with other health issues may avoid the hospital because of fear of infection - Potential increase in deaths from existing long term conditions and new acute onset conditions eg CVA and MI	Communications to general public through FT and CCG. Working with community leaders to encourage people to attend hospital	Monitoring of attendance levels	Communication campaign in liaison with the CCG	Medical Director

Classification: Official

Publication approval reference: PAR1068

Key actions

Winter 2021 preparedness: Nursing and midwifery safer staffing

12 November 2021, Version 1

Trust board members are collectively responsible for workforce planning, practice and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.

- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.

- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.

- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.

- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic – and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

- Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

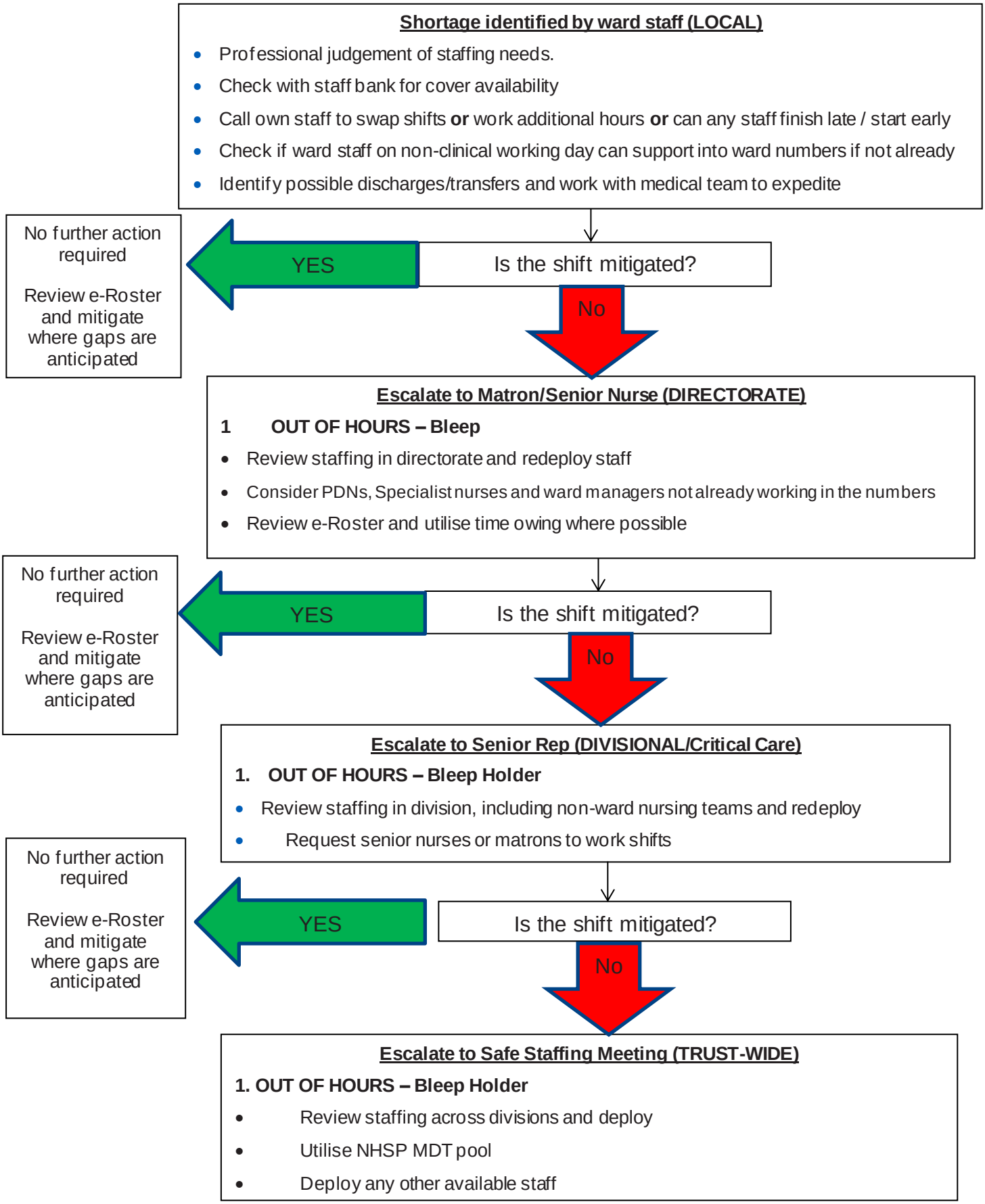
Useful links:

Alongside the formal guidance that has previously been issued in this area, a collection of additional resources has been collated for use by providers. These resources are attached as appendices and/or via the following links:

Planning • NHS England and NHS Improvement: Advice on acute sector workforce models during COVID-19 • NHS England – Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals • NHS England – Nursing and midwifery e-rostering: a good practice guide • Safe midwifery staffing for maternity settings	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessments for staff	**Decision making and escalation** • Appendix 1: Decision and escalation framework tool • Appendix 2: Quality impact assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting
Governance and assurance • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards • Care Quality Commission	**Indemnity and regulation** • NHS Resolution Clinical Negligence Scheme for Coronavirus (CNSC)	**Additional resources** • Report template - NHSI website (england.nhs.uk)

Appendix 1: Decision tool and escalation framework

Flow chart for resolution of staff shortages, to support nurse(s) in charge and matrons on a shift-by-shift basis.



Appendix 2: Example quality impact assessment

Follow this link to view (FutureNHS account required):
https://future.nhs.uk/BeneficialChangesCOVID19/view?objectId=93995109

Appendix 3: Example staffing SBAR Tool

Staffing communication tool using situation, background, assessment, recommendation (SBAR) principles to ensure critical staffing issues are received and actioned.

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

How long has the shift been out to the Hospital Nurse Bank:

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

For boards and senior leaders outlining the pressures on the service and any potential changes in the level of accepted risk.

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Appendix 5: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	**Details**	**Controls**	**Assurance (positive and Negative)**	**Residual Risk Score / Risk register reference**	**Further action needed**	**Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell**	**Ongoing Monitoring / Review**
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*
1.	**Staffing Escalation / Surge and Super Surge Plans**						

1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance						
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.						
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee						
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate						

	shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.						
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.						
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.						

2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.						
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.						
2.9	The trust has robust mechanisms for understanding the current staffing						

	levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver						

	and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.						
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and						

	medium term solutions to mitigate the risks.						
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.						
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.						
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.						

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.						
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework						

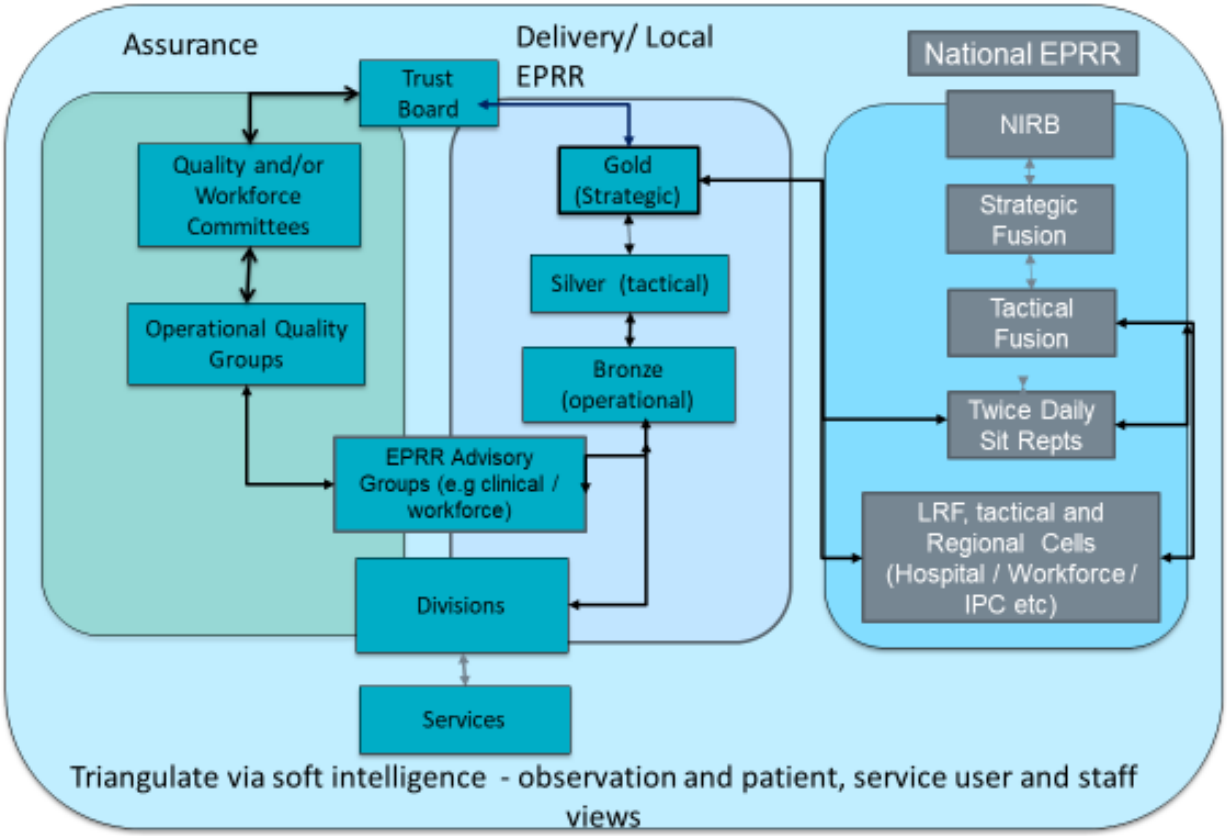
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

The flowchart below is a general illustrative example. It outlines the two arms of a provider governance framework (assurance and delivery) and further indicates the relationships with the national emergency preparedness, resilience and response (EPRR) structures.

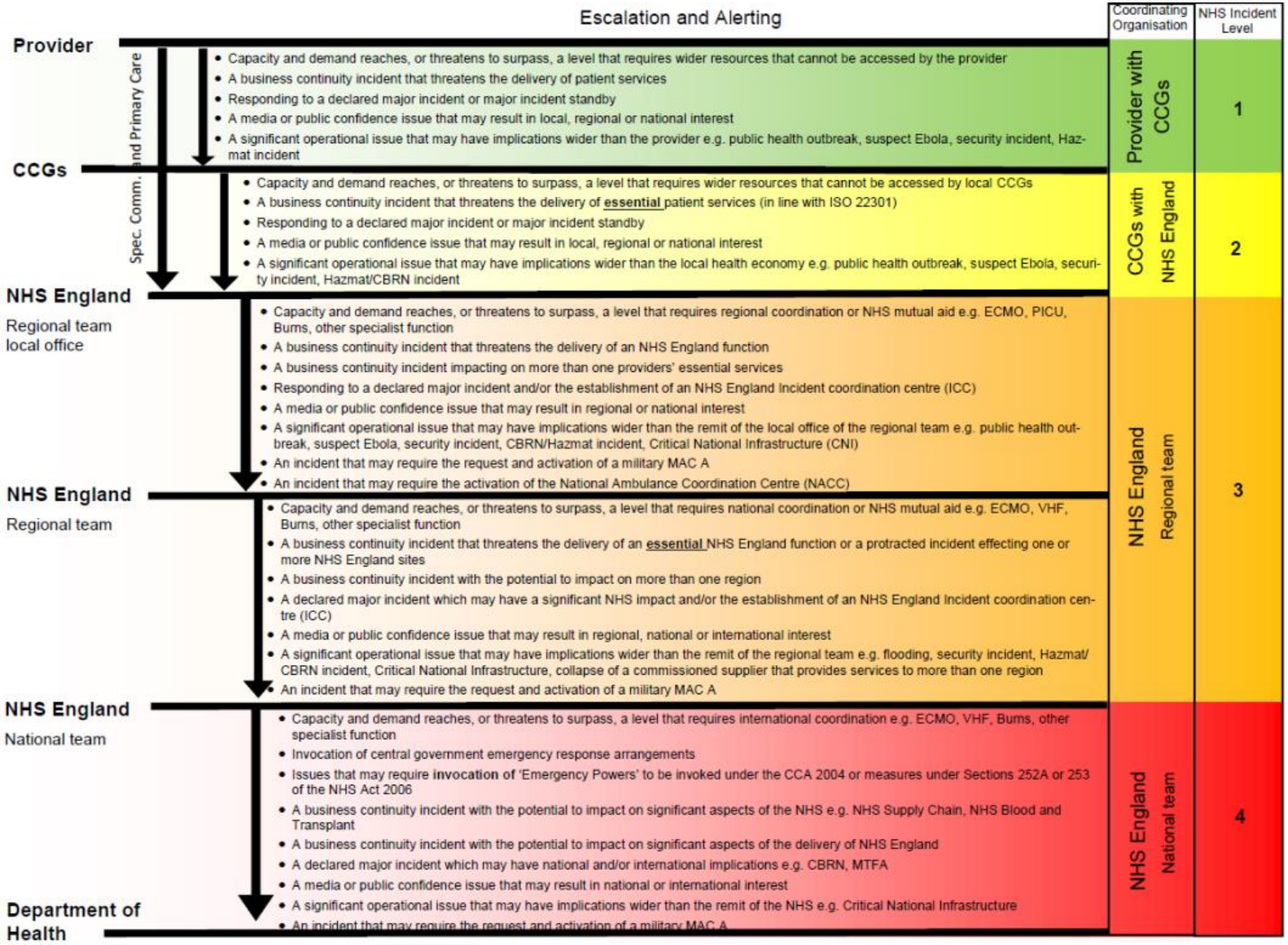
Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

This should be through their existing board assurance routes (ie quality committee, strategic workforce and organisational development committee to the board), to allow the non-executive directors to adequately fulfil their duties of holding the executive director members to account so that quality care is maintained.



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework



AGENDA ITEM 18

Title:	Finance and Investment Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th November 2021		Discussion	
Exec Sponsor	Annette Walker		Decision	

Summary:	To update the Committee on the work and activities of the Finance & Investment Committee in October 2021.

Previously considered by:	N/A

Proposed Resolution	To note the updates from Chairs' Report.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Annette Walker Director of Finance	**Presented by:**	Annette Walker Director of Finance

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	19th October 2021	Date of next meeting:	23rd November 2021
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Becks Ganz, Bilkis Ismail, Fiona Noden, Donna Hall, Annette Walker, Sharon Martin, James Mawrey, Lesley Wallace, Andy Chilton, Catherine Hulme, Rachel Noble, Sam Ball	Quorate (Yes/No):	Yes
		Key Members not present:	Andy Ennis, Esther Steel

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
2021/22 Financial Planning Update H2		Director of Finance	The committee received an update on the 2021/22 financial plan for H2. Key points were noted as follows: • There has been a 1.8% (£53m) net increase in funding in H2 compared to H1. This includes H2 pay award funding and backdated funding for H1 pay, other growth funding, netted off against targeted efficiency savings and general efficiency on system Covid funding. • £411m was allocated for GM in H1, of which Bolton received £21m. £405m has been allocated for GM in H2 with agreement required on how this is split. • A gap of £39m is now forecast. There was discussion around strategic transformation within Bolton and at GM level.	• Noted.
Electrical Infrastructure Business Case		Director of Finance	• The committee were informed that this business case had been approved at the CRIG meeting on 5th October and now required the approval of the Finance and Investment Committee as, at £1.9m, it was over the limit for CRIG. • The work is to be done over 2 years with the potential to bring some forward subject to capital availability.	• Approved.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Month 6 Finance Report		Deputy Director of Finance	The committee received an update on the financial position as at month 6. Key points were noted as follows: • There was an in month deficit of £1.5m after receipt of top up funds of £3.5m. • There is a year to date deficit of £2.4m after Elective Recovery Fund (ERF) income of £2.4m and top up funds of £20.8m. The deficit is £2.4m worse than planned. • Capital of £3.8m has been spent year to date. • Cash is currently £42.4m. There was a discussion on agency spend going into winter. J Mawrey advised that a trajectory is currently being worked on and will be brought to a future meeting.	• Noted.
Month 6 iFM Finance Report		iFM Director of Finance	The committee received an update on the financial position of iFM as at month 6. Key points were noted as follows: • There was a pre-tax profit of £331k based on OHF contract income of £11.55m. This is £51k favourable to budget. The post-tax profit was £183k • The month end cash position was £6.18m. • The AFC pay award was paid in September with a proposal submitted to Staffside proposing 3% for the remainder of staff. It was confirmed that this has been accounted for in the Trusts forecast.	• Noted.
Month 6 Cost Improvement Update		Associate Director of Improvement and Transformation	The committee received an update on the Cost Improvement Programme for 2021/22. Key points were noted as follows: • Some good progress has been made and planning and preparation is now in place with each division to focus on H2. • Savings of £3.1m for the full year have been identified to date with further work ongoing within divisions to identify new schemes moving into H2. H1 has delivered £1.6m to date against a target of £2.9m (1.5%). • Financial/saving arrangements for H2 have not yet been confirmed. • It was agreed that this would be a split rating of Green in recognition of the work done and Amber due to the current value of the CIP delivered.	• Noted.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Insurance Update		Head of Financial Services	• The committee received an update on the Trust's insurance cover which has been renewed for the period 27th September 2021 – 26th September 2022. • It was agreed that the list of uninsured risks would be reviewed with an update to be provided at the next meeting.	• Noted. • Uninsured risks to be reviewed.
Procurement Strategy		iFM Director of Finance	• The committee approved the Procurement Strategy. It was noted that it had been to Finance and Investment Committee in July 2021 and had subsequently received the approval of the Procurement Steering Group and iFM Board of Directors.	• Approved.
Chairs' Reports		Director of Finance	• The committee noted the Chair's Reports from the following meetings: o CRIG – 5th October. o Contract & Performance Review Group - 6th September and 4th October.	• Noted.
Risks escalated None.				

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

AGENDA ITEM 19

Title:	Audit Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th November 2021		Discussion	
Exec Sponsor	Annette Walker		Decision	

Summary:	To update the Committee on the work and activities of the Audit Committee in October 2021.

Previously considered by:	N/A

Proposed Resolution	To note the updates from Chairs' Report.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Annette Walker Director of Finance	**Presented by:**	Annette Walker Director of Finance

Committee/Group Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	5th October 2021	Date of next meeting:	7th December 2021
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Alan Stuttard, Bilkis Ismail, Malcolm Brown, Martin North, Annette Walker, Esther Steel, Richard Sachs, Lesley Wallace, Tom White, Internal and external Auditors	Quorate (Yes/No):	Yes
		Key Members not present:	N/A

Key Agenda Items:	RAG	Key Points	Action/decision
Internal Audit Plan 2021/22		• The committee received an update on the internal audit plan for 2021/22 which had been approved by the Executive Directors. The plan covers the following: ○ Governance, regulation and compliance. ○ Financial systems and controls. ○ Information Technology. ○ Clinical, patient safety and operational areas. ○ iFM Bolton. ○ Other (planning, management and attendance at Audit Committee and follow up on recommendations due). • It was noted that, during the Covid-19 pandemic, it had not been possible to audit clinical patient safety and operational areas but it is hoped to be able to reintroduce it this year.	Noted.
Internal Audit Progress Report 2021/22		• The committee received an update on the progress made. The following reports have been issued as final as part of the 2021/22 plan: ○ Risk Management (low risk). ○ Key Finance Controls (low risk). ○ Payroll (medium risk). ○ IT Disaster Recovery (medium risk). ○ Cyber (Mobile Device Management) (medium risk).	Noted.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

		○ Enterprise Asset Management – iFM (high risk). • Planning meetings have been held for the following reviews with fieldwork planned to commence in October/November: ○ Workforce. ○ Complaints. ○ Budgetary Controls. ○ IT General Controls. ○ Capital Projects. • It was noted that there were 27 overdue recommendations at the Audit Committee meeting in May and that 14 of these have now been closed, 12 have been partially implemented and only 1 has not yet been implemented.	
Internal Audit Reports		The committee received an update on the completed reports. The main focus of the discussion was on the two IT reports on Disaster Recovery and Cyber (mobile device management).Although it was noted that the two reports were shown as medium risk, taken as a whole the question was asked whether they constituted a high risk. This was also in the context of difficulties that had been experienced with IT across the Trust. There was also a concern over the long lead time for the target dates on the actions. It was acknowledged that the IT department had been under significant pressure during the pandemic and there had been staff changes at a senior level. There was a query on how often the Trust has a simulated disaster recovery. The DoCG advised that there is a Head of Emergency Planning at the Trust and it was agreed that he would be invited to attend a future Board meeting to do a presentation on this.	Internal Audit to further review the IT findings and Executive Directors to review the risk rating and target dates. Future Board presentation to be arranged on Disaster Planning.
External Audit Update		KPMG provided an update on the iFM Bolton and Charitable Funds audits. Work has effectively been completed on the iFM audit ahead of the iFM Annual General Meeting on 14th October. Charitable Funds is slightly less advanced. It is	Noted.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

		hoped to close off the final queries in the next couple of weeks. KPMG will shortly be starting to plan their work for the current year.	
Local Counter Fraud Specialist Progress Report		The committee received an update from the Local Counter Fraud Specialist. The main points noted were as follows: • Awareness and education continued despite the challenges of the Covid-19 pandemic. • Fraud risk assessments have been undertaken and CR will work with RS on how the Trust review and assess fraud risk. Recommendations have been fed back to the owners of the risks. • The national procurement exercise has been completed and submitted to the NHS Anti-Fraud Authority. The report is expected shortly and will be shared when received. There was a discussion on salary overpayments. Two former members of staff were overpaid and both have now agreed to pay the money back. It was noted that the Payroll Department engage with CR if they feel there is an intention to retain a salary overpayment. It was suggested that the Trust introduce an initiative through the new starter process to ensure that new starters have not been overpaid by their previous Trust/Employer. The DoCG agreed to discuss this with the Director of People. Overall the number of referrals to the LFCS had increased during the pandemic which demonstrated a positive awareness across the Trust by staff of potential fraud and the openness and transparency in reporting any concerns.	Noted.
Review of Audit Committee Effectiveness		The DoCG advised that she would be sending out a link to a questionnaire within the next two weeks with the aim to bring a paper to the next meeting along with the draft Audit Committee Annual Report. She requested that everyone complete the questionnaire when they receive it.	Noted.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Register of Interests, Gifts and Hospitality		The DoCG advised that the Corporate Governance Team is picking this up and will be contacting staff to ensure that they have completed their declarations. Work is also underway to reconcile the register of interests with the waivers report.	Noted.
Bolton FT Register of Waivers		The committee received a report on waivers for the period April to August 2021. It was noted that there were 30 waivers compare to 24 at the same time last year. AW advised that there is currently a focus on reducing the number of waivers particularly those which were done retrospectively.	Noted.
iFM Bolton Register of Waivers		The committee received a report on waivers for the period April to August 2021. LW advised that there is currently a focus on reducing the number of waivers	Noted.
Bolton FT Losses and Special Payments Report		The committee received a report on losses and special payments for the period April to 31st July. The main discussion was in relation to a compensation payment for a breach of the General Data Protection Regulations as this was the first one of its kind that had been reported to the Audit Committee. The DoQG agreed to provide further information.	The Director of Quality Governance to provide further information.
iFM Bolton Losses and Special Payments Report		LW updated that there were no losses and special payments to report for the period of 1st April to 31st July.	Noted.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

AGENDA ITEM 20

Title:	Trust Transformation Board Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	25th November 2021		Discussion	
Exec Sponsor	Sharon Martin		Decision	

Summary:	Attached is the Trust Transformation Board Chair Report from the meeting held on 11th October 2021.

Previously considered by:	N/A.

Proposed Resolution	For noting and assurance.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Sharon Martin Director of Strategy and Transformation	**Presented by:**	Martin North Non-Executive Director and Trust Transformation Board Chair

Trust Transformation Board Chair Report

Name of Committee/Group:	Trust Transformation Board	Report to:	Trust Board
Date of Meeting:	11th October 2021	Date of next meeting:	13th December 2021
Chair:	Martin North Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Michelle Cox, Andy Ennis, Angela Hansen, James Logue, Claire McPeake, Rachel Noble, Fiona Noden, Lianne Robinson, Richard Sachs, Phil Scott, Esther Steel, Joanne Street, Annette Walker *In attendance:* Sara Booth, Ryan Calderbank, Rachel Carter, Rayaz Chel, Kate Forrest, Linda Martin, James Mawrey, Debbie Redfern, Judith Richardson (minute taker), Amanda Shaw, Rae Wheatcroft	Quorate (Yes/No):	Yes
		Key Members not present:	Francis Andrews, Lisa Gammack, Sharon Martin, Karen Meadowcroft, Samantha Ball

For 2021-22, Trust Transformation and Digital Board has identified five standing themes which form the basis of agenda and drive all activity within the Board's remit.

1. **Service improvement and transformation:** Innovations, improvements and transformation led and undertaken by Bolton NHS FT i.e. outpatient transformation, urgent care transformation and improvements driven by Model Hospital and GIRFT data
2. **Infrastructure and corporate transformation:** Transformation and innovation relating to ways of working and space i.e. agile working, space utilisation
3. **System transformation and partnership working:** System-led transformation projects and programmes which have an impact on BFT i.e. Improving Specialist Care
4. **Digital strategy and transformation:** Digital strategy development and all digital transformation projects i.e. Microsoft 365
5. **Informatics operations and governance:** All Informatics governance and operational committees report as part of this theme i.e. Clinical Design Committee, Informatics Ops Board

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Trust Transformation Board Chair Report

Transformation pillars	RAG	Lead	Key Points	Action/decision
1. Service improvement and transformation				
Outpatient Transformation Steering Group Chair Report		Amanda Shaw	• Good overall progress reported for Phase 1 of the outpatient transformation programme with specialty project plans in place across all Divisions • 12 specialties currently live with Patient Initiated Follow Ups (PIFU). • 10 specialties currently live with Advice and Guidance (A&G) • Focus continues on the roll out of the Local Rapid Adopter programme which targets PIFU and A&G • The operational planning guidance may include further national expectation for PIFU and A&G • Options appraisal underway for medicine dispensing following a virtual appointment to ascertain whether a model delivered by an independent sector provider or an internal model delivered by iFM is the most appropriate • There are early signs that the implementation of A&G is having a positive impact. However, whilst there are a number of patients returning to primary care, the full impact of PIFU will not be seen for a few months yet as this is a 12 month pathway.	• Primary care comms being developed to increase GP uptake of Advice and Guidance (A&G) service.

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Booking Centre Modernisation Programme (Digital Letters and Text Reminders)		Ryan Calderbank	• Positive patient feedback received on the SMS reminder messages system. Due to Covid, a comparison of DNA rates had been made against the Trust average for 2019/20 rather than 2020/21 and this now more accurately reflects the impact of the current SMS reminder system showing a DNA reduction of 22% over the last 3 months. • The Digital Appointment Letters project to reduce paper letters is due to be launched in November 2021. It was noted that there were challenges in achieving the expected launch date of October 2021 due to the integration work with IT and the sheer volume of work being experienced by IT. • The platform used has the ability to translate into multiple languages and should a patient/service user not access their digital letter within a 24-48 hour period then the Trust will automatically send out a paper letter in their preferred language.	• The programme was received as an excellent example of how the Trust is improving its efficiency despite the current challenges in recovery post-Covid and will be included in our reporting metrics going forwards.
LIMS (Laboratory Information Management System) Platform update		Ryan Calderbank	• Originally this was part of a GM collaborative procurement exercise which highlighted potential cost savings. However, due to collaborative procurement concerns and specific timeframes, the Trust has now reverted to individual procurement and is currently awaiting legal advice prior to this preferred procurement option. • The current system ceases operation on 1 April 2023 which provides sufficient time to implement a new system.	• AW added that some of the funding streams coming from GM are unclear and she was currently exploring this to ensure that the allocated funding of £2.8m for this project is secured.

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

2. Infrastructure and corporate transformation				
Quality Improvement Skills Development - progress and option review, plus draft Patient Safety Strategy		Debbie Redfern	• In comparison to other corporate functions and other trusts, QI is significantly underfunded with no investment in the infrastructure since 2016. • Internal demand for QI is increasing and this demand cannot be met due to the capacity limitations of our current QI resource. • In line with the national patient safety strategy and the drafting of the Trust's patient safety strategy, options appraisal process carried out and the Executive Team had agreed to pursue Option 6, as the model to embed QI into the organisation.	• The report was received and noted as a comprehensive update.
3. System transformation and partnership working				
ICP Business Plan		Joanne Street	• The Bolton Integrated Care Partnership (ICP) Business Plan 2021/22 priorities linked to the Bolton 2030 Vision are Urgent Care in the Community (sub-priority Care Homes), Neighbourhood/Place-Based Model (sub-priority No Wrong Front Door/SPA) and Communities & VCSE with each having high level impact measures for performance over the coming year.	• Comms to be issued advising of the successes to date and the plans going forwards.
Agile Working		Rayaz Chel	• Estates exercise currently being undertaken to understand the capacity available • Use of laptops and docking stations is an enabler to making agile working happen • Agile/hybrid working is closely linked in with the roll out of Windows 365 which provides real opportunities to utilise the functions of 365 to support the organisation with agile working.	• Issues highlighted pertaining to the challenges experienced in obtaining laptops/IT kit which is hindering agile working. A different approach may need to considered for a 12-24 month period as a solution to enable agile working.
4. Digital strategy and transformation				

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Clinical Systems Update		Sara Booth	• Roll out of EPR to Paediatric Services in Community/OPD: – Overall this was a positive roll out which now enables a single child record for all children and the joining up of inpatient record documentation with 0-19's, nursing, therapy, schools and paediatric services – Has enabled 200+ staff to work mobile with 400 staff now on laptops and mobiles – Some areas for learning and improvement from the new functionality which will support the roll out to Adult Outpatients and wider community services. • Other areas of clinical systems activity currently being progressed: – ICSD Bedded Units – EPR – Diabetes Pathway – EPR and Know Your Patient – IPM/ORMIS Upgrade – Allscripts EPR Upgrade/Bossnet Upgrade – Pharmacy EMIS system Upgrade – Ascom SMART devices – Greater Manchester Care Record – Inpatient – Mobile Device Pilot – Mobile Telephony/Lone worker solution – Windows 10 • The Trust is currently the biggest user of the Greater Manchester Care Record by some margin despite not being the largest trust in the region and it was noted that access to the Greater Manchester Care Record would be crucial going forwards as part of the standardisation of clinical systems across Greater Manchester. • Currently the Project Boards and chairing responsibilities for the various EPR phases sit within the respective divisions. However, as the EPR Phase 5a Outpatients and Community Clinics moves forward, it will cross-cut all divisions. The	

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			Board approved the proposal for the Project Board for EPR Phase 5a Outpatients and Community Clinics to be embedded within the Trusts Outpatient and Transformation Group with overall Chairing responsibility being provided by the Divisional Director of Operations for Diagnostics and Support Division. The Terms of Reference would also need to be reviewed in light of this proposal.	
5. Informatics operations and governance				
Informatics Update		Phil Scott	• Approval received to operate with virtual smartcards which will allow new starters to be provided with registration capabilities to clinical systems in a fraction of the time that it would traditionally take • Investment approved for Phase 1 WiFi deployment into a number of key community sites and also at Musgrave House • Funding approved for the provision of laptops to support the agile working programme which will predominantly facilitate corporate staff to work in a more hybrid model and will free up space capacity across the estate for clinical purposes • Approval of the business case for ward devices equipment on wheels replacing the legacy PC hardware in ward areas. Due to the national problem in sourcing hardware a schedule for the roll out was currently unavailable.	• This will be monitored by the Informatics Department. • The following risks were raised: – There is a global issue with availability of hardware nationally which is having an impact on the FT – Major risk pertaining to PAS. The Trust has still yet to be migrated to a third party cloud service provider. Additionally, there will now be a levy charge of a minimum of £50k for the new PAS hosting agent to provide the test environment to enable us to do any future testing. – Comms will be issued to staff to improve the messaging around any delays in IT upgrades
Comments				
Risks escalated • It was highlighted there are a number of risks around Informatics/Digital at the moment.				

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AGENDA ITEM 21

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	25/11/2021		Discussion	X
Exec Sponsor	Andy Ennis		Decision	

Summary:	Integrated Performance Report detailing high level metrics and their performance across the Trust

Previously considered by:	Divisional IPMs

Proposed Resolution	The Board are requested to note and be assured that all appropriate actions are being taken.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	Andy Ennis

Bolton NHS Foundation Trust

Integrated Performance Report

October 2021

Guide to Statistical Process Control

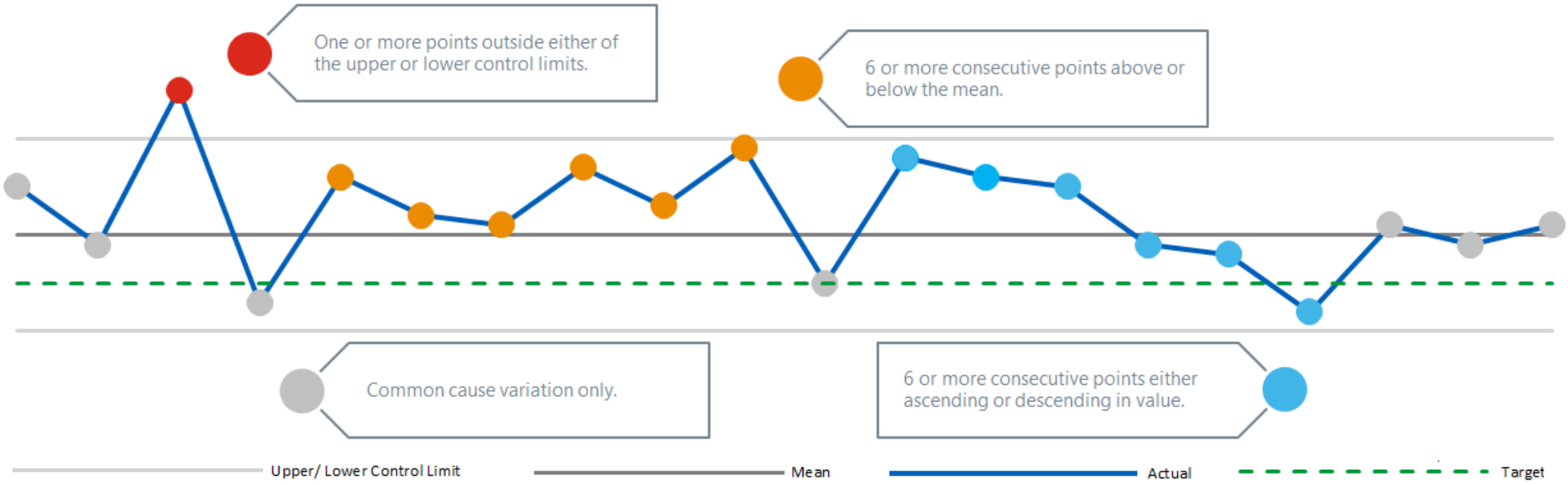
NHS Bolton NHS Foundation Trust

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

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

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	1	0	0	1	1	2	12
Infection Prevention and Control	6	0	3	0	0	0	0	7
Mortality	4	0	0	0	0	0	0	3
Patient Experience	6	1	0	0	9	3	0	13
Maternity	8	0	2	0	0	1	0	9
Operational Performance								
Access	4	0	2	3	2	0	5	6
Productivity	7	0	1	0	3	1	0	10
Cancer	7	0	0	0	0	1	1	5
Community	0	1	0	1	0	1	0	1
Workforce								
Sickness, Vacancy and Turnover	1	0	0	3	0	0	2	1
Organisational Development	0	0	0	0	4	1	0	3
Agency	0	0	0	3	0	0	0	3
Finance								
Finance	1	1	0	0	1	2	0	1
Appendices								
Heat Maps								

Variation

	Common cause variation.
H	Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
L	Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
H	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
L	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.

Assurance

P	Indicates that we are consistently meeting the target for the indicator in question.
F	Indicates that we are consistently falling short of the target for the indicator in question.
?	Indicates that we will not consistently meet the target for this indicator as the target is within the range of common cause variation.

Quality and Safety

Harm Free Care

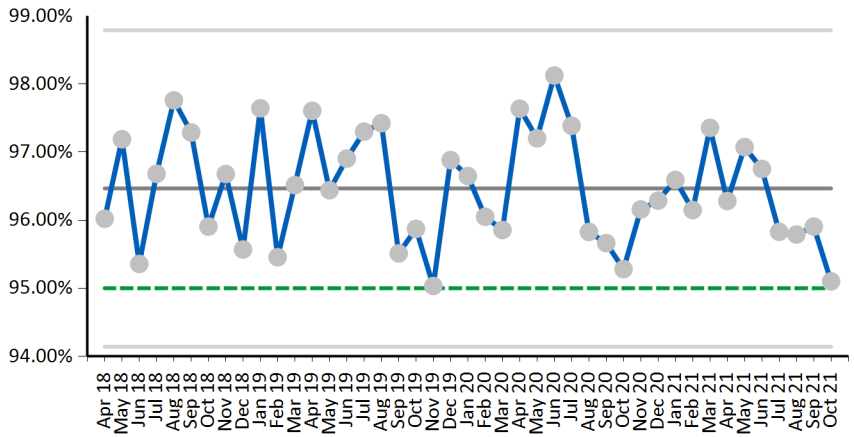
Pressure ulcers
The number of pressure ulcers overall reduced in October in comparison to September in both hospital and community. The harm free care process continues across the Trust, and learning is identified and shared within the divisions.

Falls
Falls in October have reduced again in month and we remain well within our target parameters, similarly our overall YTD figure remains within our local target of 5.3. Falls with harm have remained stable again this month with 1 which again maintains us within our target of 1.6.

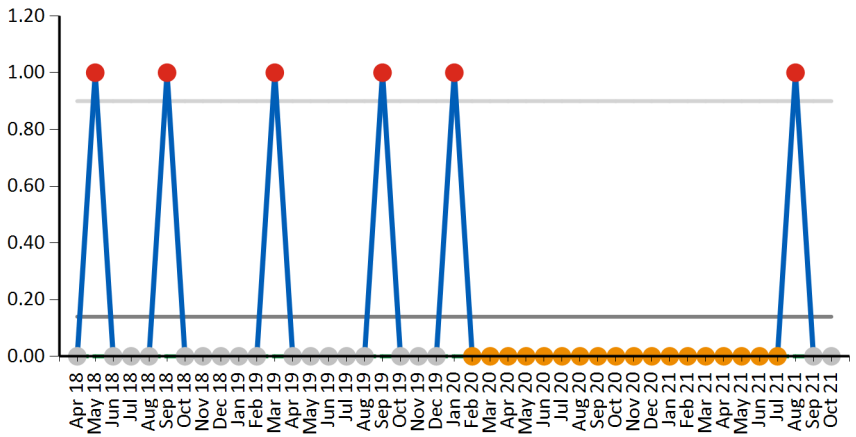
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	95.1%	Oct-21		>= 95%	95.9%	Sep-21	>= 95%	96.1%	
9 - Never Events	= 0	0	Oct-21		= 0	0	Sep-21	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.45	Oct-21		<= 5.30	5.05	Sep-21	<= 5.30	5.05	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Oct-21		<= 1.6	1	Sep-21	<= 11.2	18	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	3.0	Oct-21		<= 6.0	9.0	Sep-21	<= 42.0	39.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	1.0	Oct-21		<= 0.5	0.0	Sep-21	<= 3.5	2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Oct-21		= 0.0	0.0	Sep-21	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	3.0	Oct-21		<= 7.0	3.0	Sep-21	<= 49.0	63.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	4.0	Oct-21		<= 4.0	10.0	Sep-21	<= 28.0	71.0	

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	3.0	Oct-21		<= 1.0	0.0	Sep-21	<= 7.0	17.0	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	82.1%	Q2 2021/22		>= 90%	66.7%	Q1 2021/22	>= 90%	74.3%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q2 2021/22		>= 90%	80.0%	Q1 2021/22	>= 90%	90.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	67.7%	Oct-21	L	>= 95%	71.5%	Sep-21	>= 95%	71.4%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	67.4%	Oct-21		>= 95.0%	64.8%	Sep-21	>= 95.0%	64.6%	F
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	100.0%	Oct-21		= 100%	100.0%	Sep-21	= 100%	52.4%	
88 - Nursing KPI Audits	>= 85%	92.0%	Oct-21	H	>= 85%	92.8%	Sep-21	>= 85%	92.6%	P
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	60.0%	Oct-21		= 100%	33.3%	Sep-21	= 100%	80.0%	

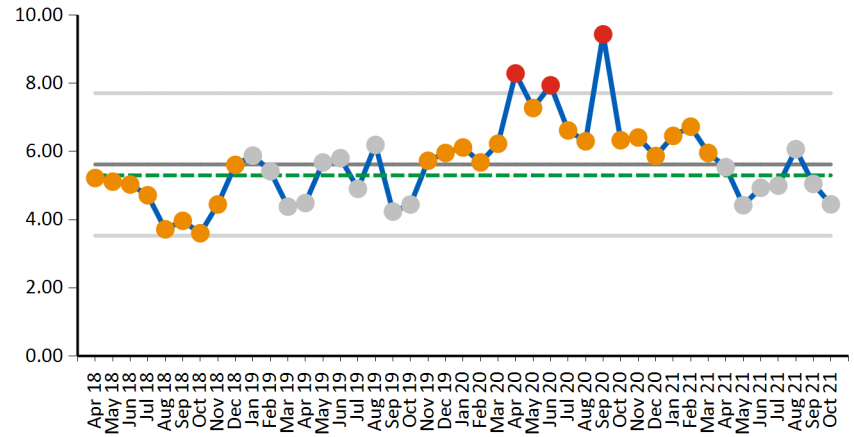
6 - Compliance with preventative measure for VTE



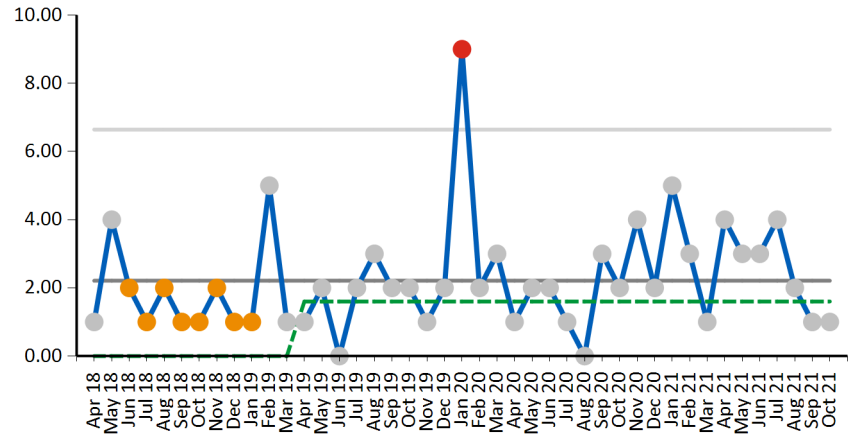
9 - Never Events



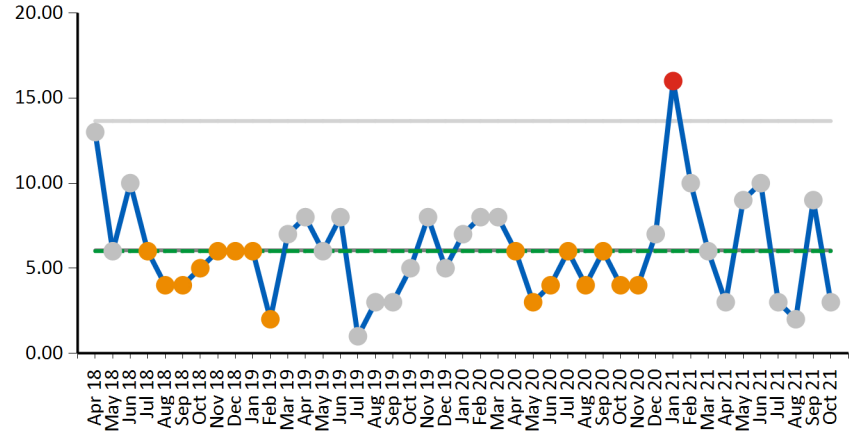
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



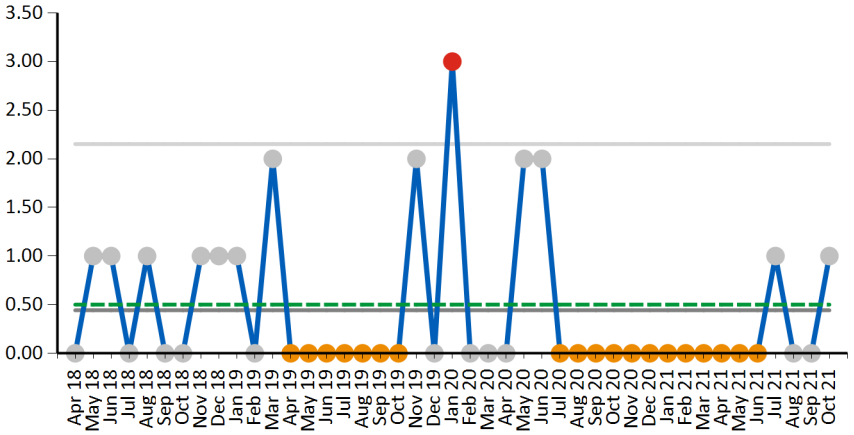
14 - Inpatient falls resulting in Harm (Moderate +)



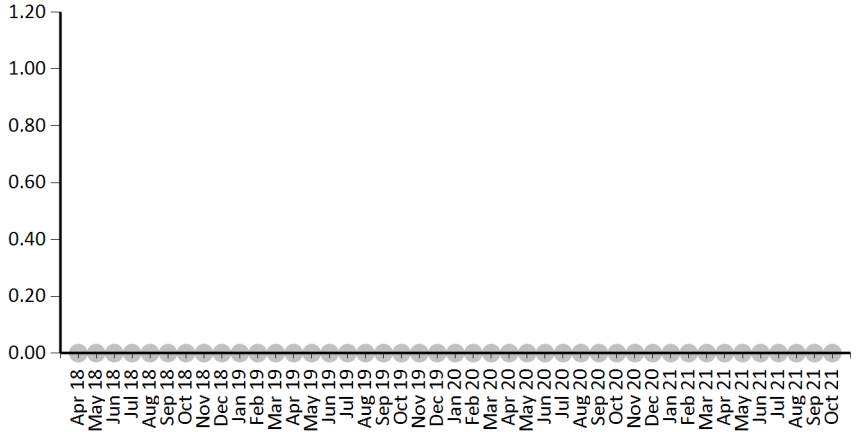
15 - Acute Inpatients acquiring pressure damage (category 2)



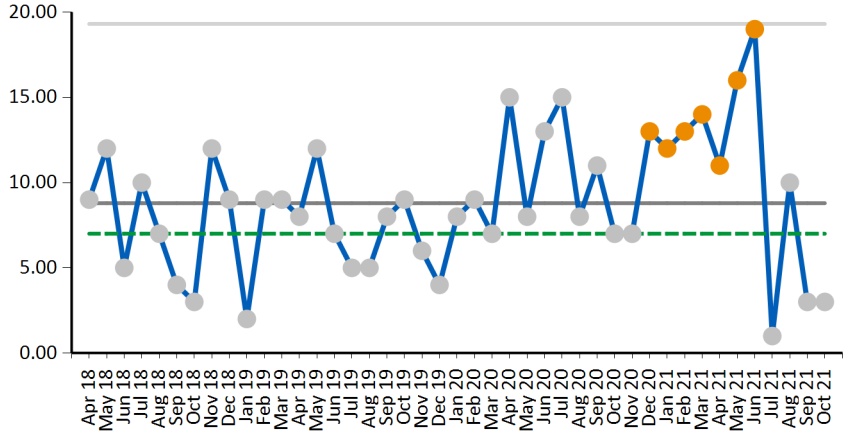
16 - Acute Inpatients acquiring pressure damage (category 3)



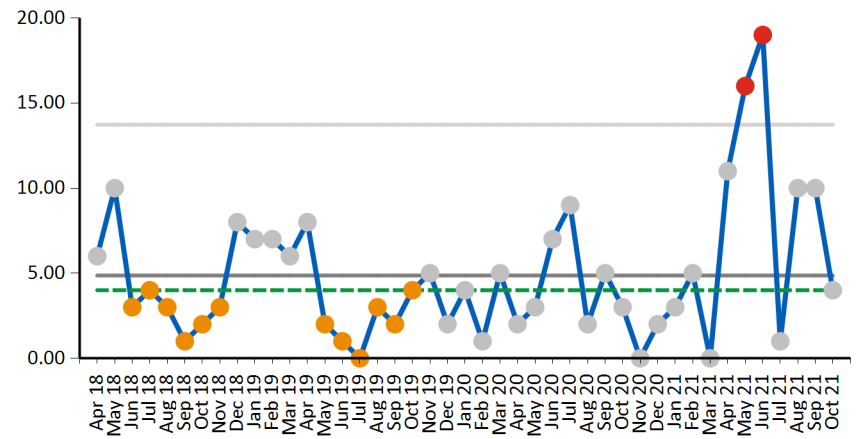
17 - Acute Inpatients acquiring pressure damage (category 4)



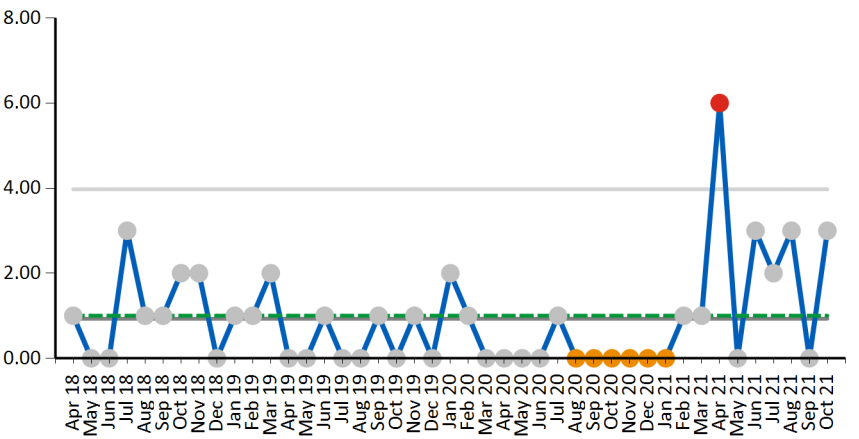
18 - Community patients acquiring pressure damage (category 2)



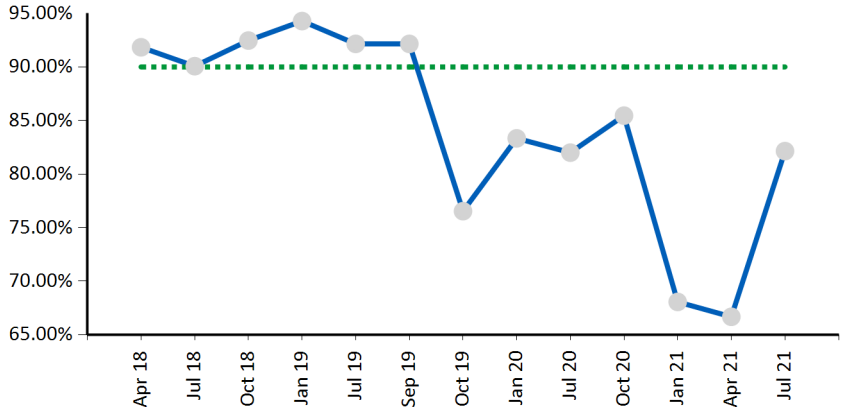
19 - Community patients acquiring pressure damage (category 3)



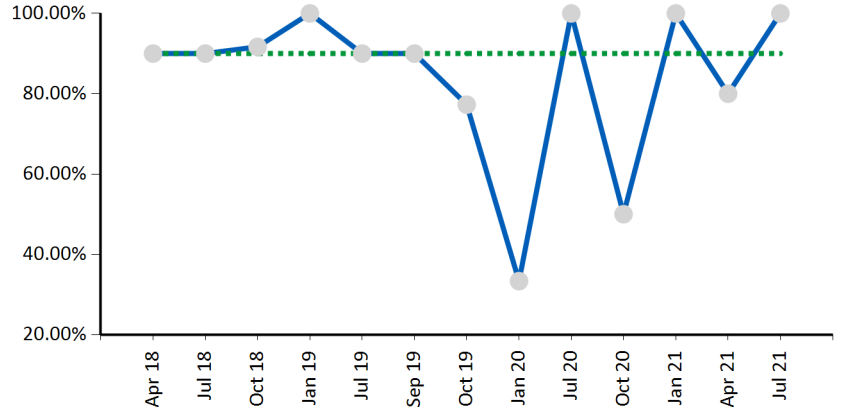
20 - Community patients acquiring pressure damage (category 4)



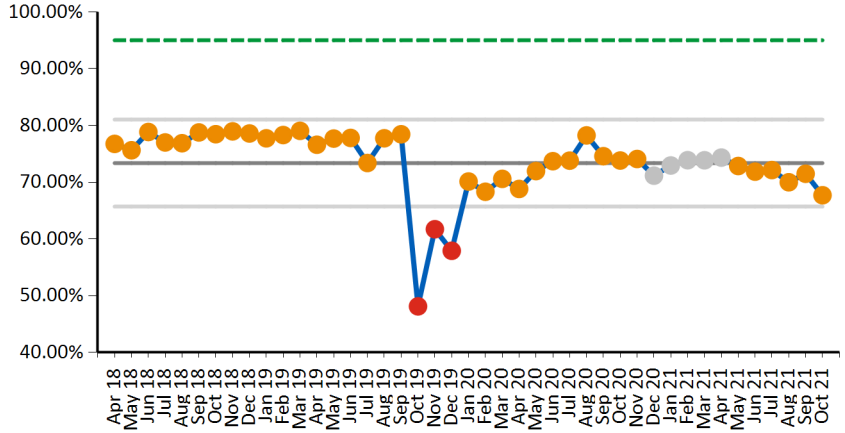
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points



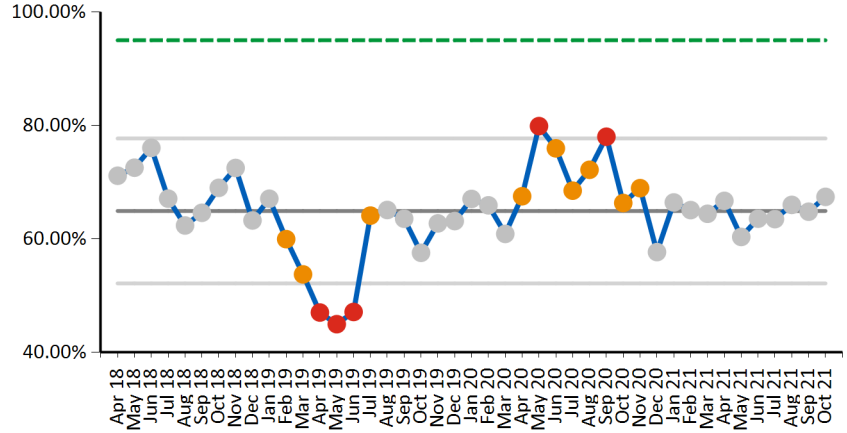
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



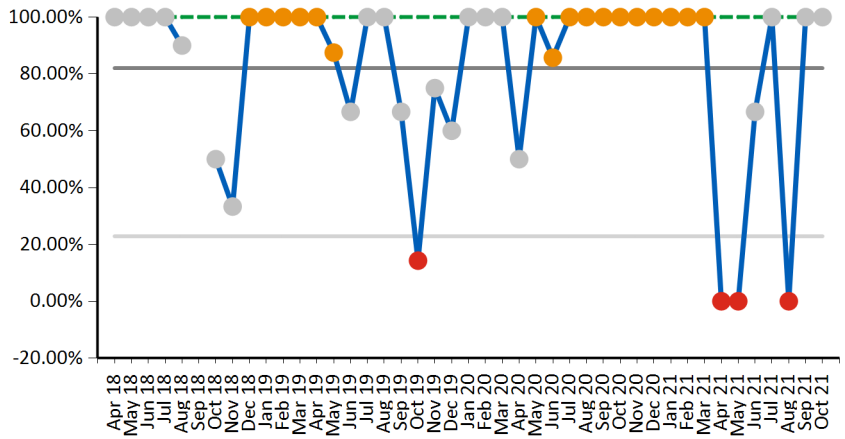
30 - Clinical Correspondence - Inpatients %<1 working day



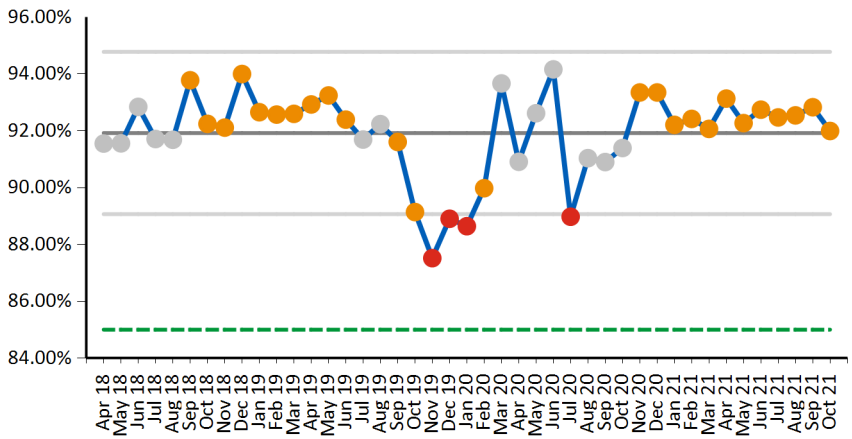
31 - Clinical Correspondence - Outpatients %<5 working days



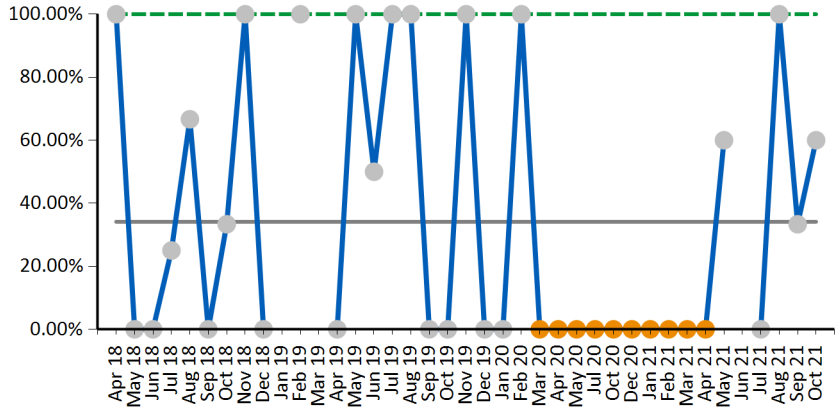
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days



Infection Prevention and Control

Nosocomial COVID-19 rates remain low and the Trust is performing favourably in comparison with other providers in GM.

At the end of October, it had been more than 478 days since there had been a hospital-onset MRSA bloodstream infection and more than 427 days since the last hospital-onset pseudomonas aeruginosa bloodstream infection.

The Trust remains under trajectory for E. coli bloodstream infections (by 11 cases to the end of October) and under trajectory for Klebsiella spp. bloodstream infections (by six cases to the end of October). The Trust is also under its internal trajectory for MSSA bloodstream infections by one case.

The Trust remains an outlier for Clostridium difficile infections being 11 cases over trajectory by the end of October. The Deputy DIPC has met with Professor Mark Wilcox (National Clinical Director Infection Prevention & Control and Antimicrobial Resistance, Medical Advisor to Chief Nurse, National Infection Prevention & Control Lead for NHSE/I and Lead on C. difficile infection for PHE/UKHSA) who has offered some insight and support. A plan will be tabled at December IPC Committee for implementation in line with the discussion with Professor Wilcox.

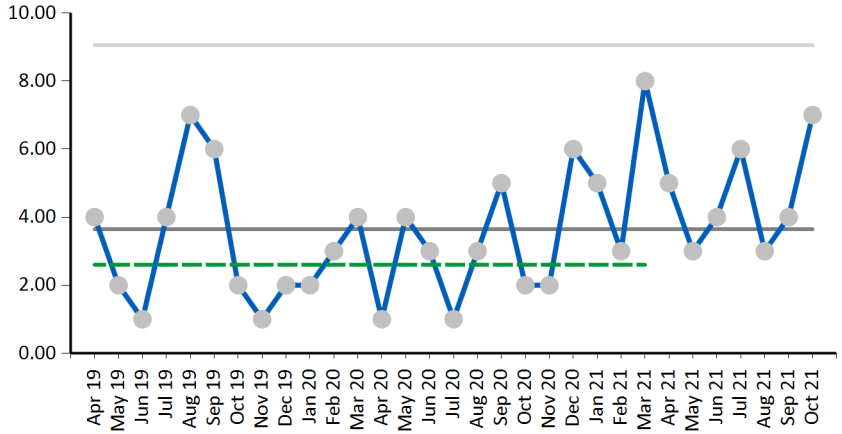
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

Chart 217 and 306 - These are SPC G Charts. These are time series charts that plot the time intervals between infrequent events such as MRSA bacteraemias. This chart demonstrates that the Trust is seeing progressively longer gaps between hospital onset MRSA bacteraemias.

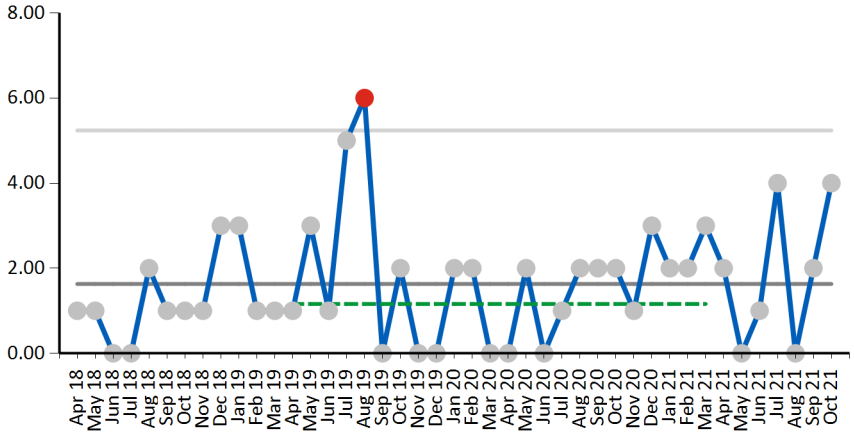
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		7	Oct-21			4	Sep-21		32	
346 - Total Community Onset Hospital Associated C.diff infections		4	Oct-21			2	Sep-21		13	
347 - Total C.diff infections contributing to objective	<= 3	11	Oct-21		<= 3	6	Sep-21	<= 18	45	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Oct-21		= 0	0	Sep-21	= 0	0	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	5	Oct-21		<= 2	1	Sep-21	<= 13	33	
219 - Blood Culture Contaminants (rate)	<= 3%	3.7%	Oct-21		<= 3%	3.5%	Sep-21	<= 3%	3.3%	
199 - Compliance with antibiotic prescribing standards	>= 95%	84.0%	Q1 2021/22		>= 95%	75.4%	Q4 2020/21	>= 95%	84.0%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Oct-21		<= 1.0	1.0	Sep-21	<= 7.0	4.0	

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	0	Oct-21		<= 1	0	Sep-21	<= 4	4	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Oct-21		= 0	0	Sep-21	= 0	0	
491 - Nosocomial COVID-19 cases		2	Oct-21			1	Sep-21		21	

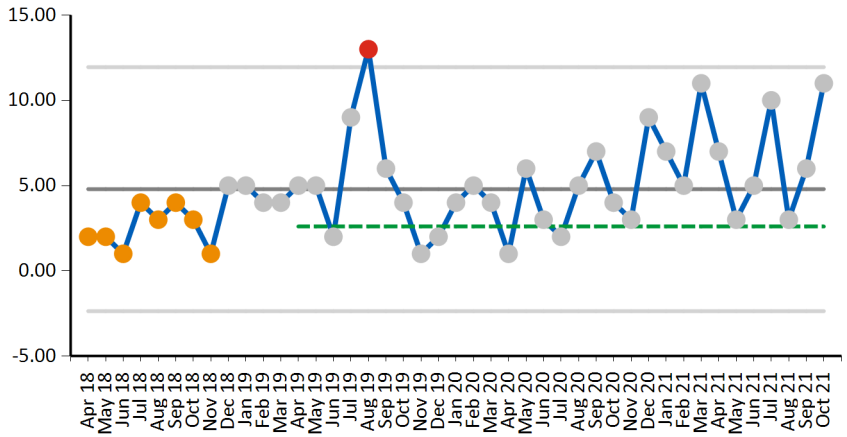
215 - Total Hospital Onset C.diff infections



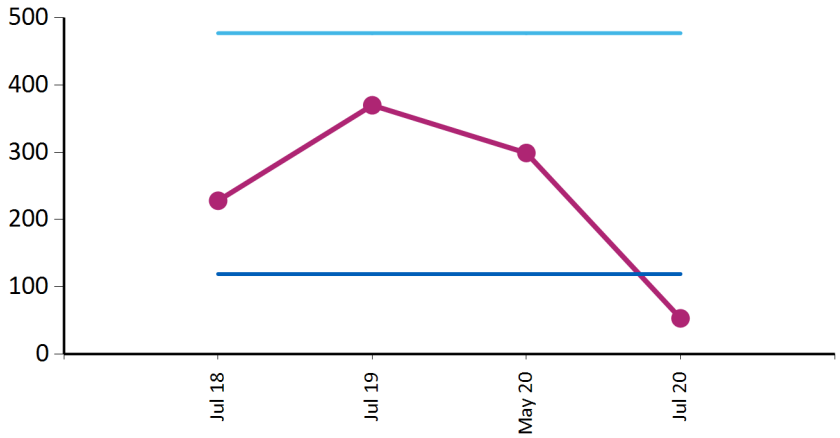
346 - Total Community Onset Hospital Associated C.diff infections



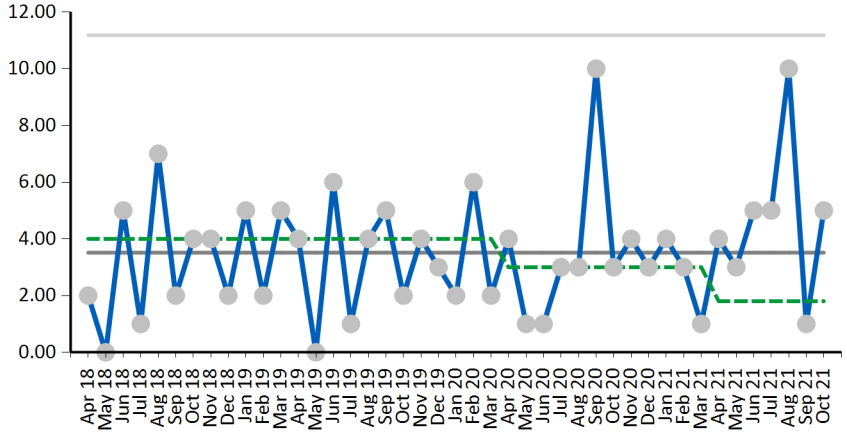
347 - Total C.diff infections contributing to objective



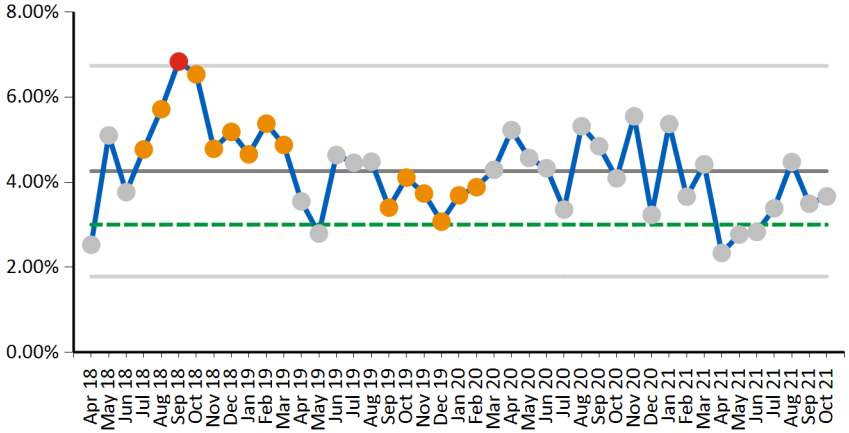
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



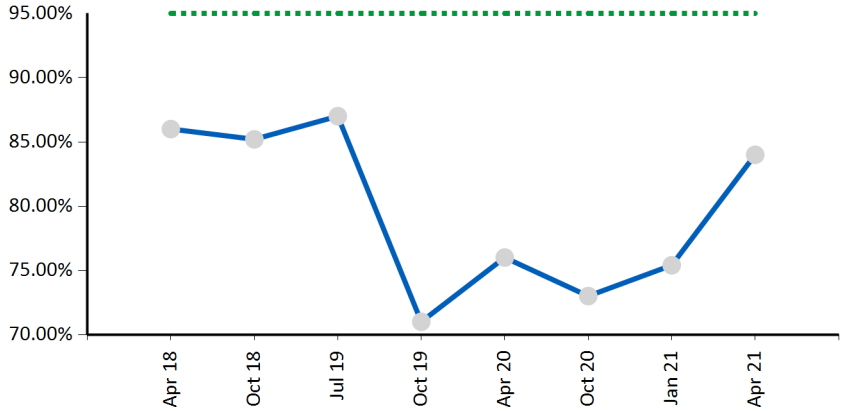
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)



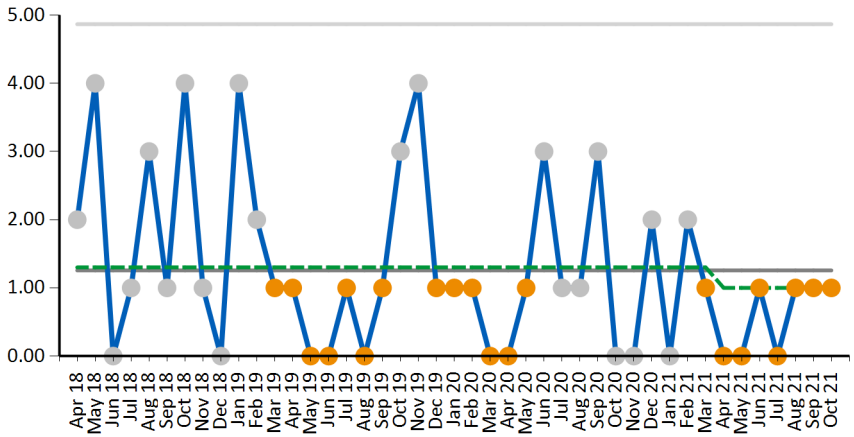
219 - Blood Culture Contaminants (rate)



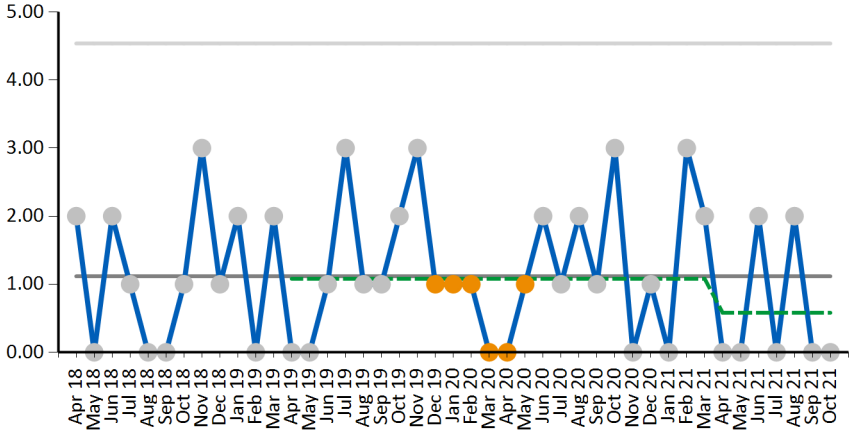
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



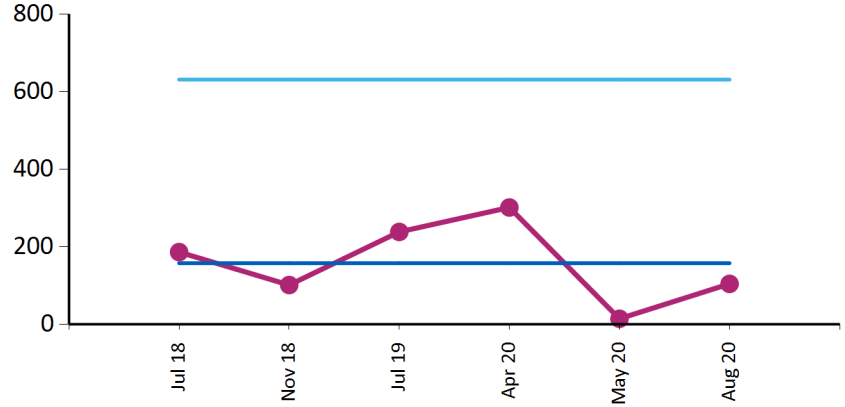
304 - Total Trust apportioned MSSA BSIs



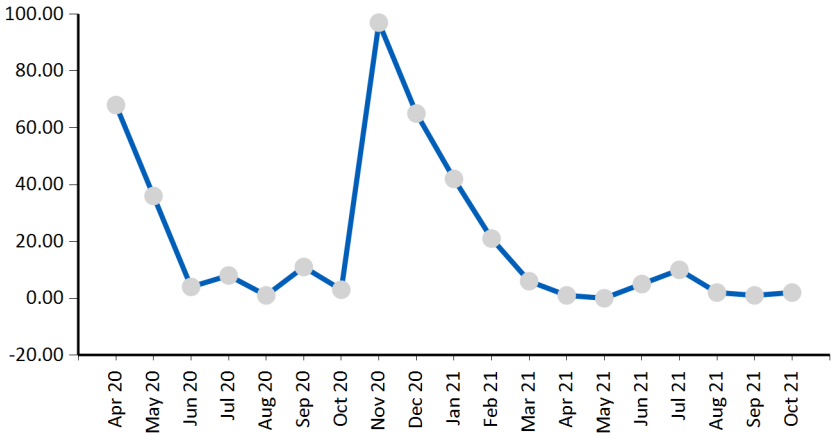
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)



306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA) - G Chart (Days Between Cases)



491 - Nosocomial COVID-19 cases - SPC data available after 20 data points



Mortality

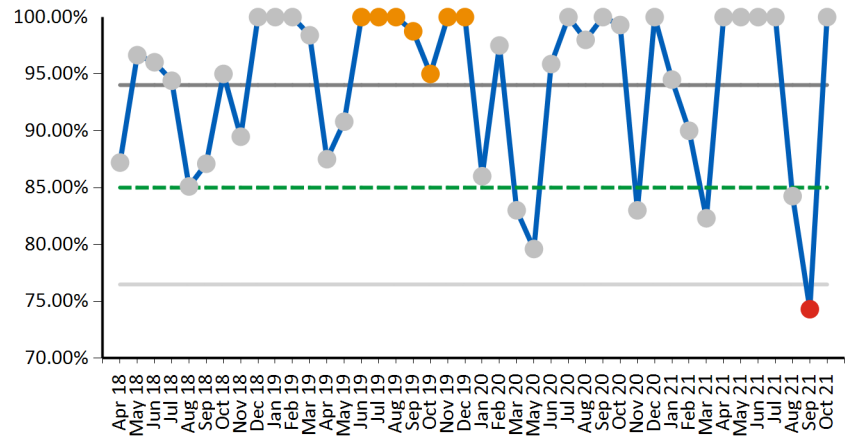
There have been significant delays in the data transfer from NHS Digital which has delayed the calculation of more recent SHMI and HSMR. No update from the previous Board report is available.

Crude – remains within control and below the Trust target and mean for the time period. The two obvious spikes relate to the Covid waves in the organisation.

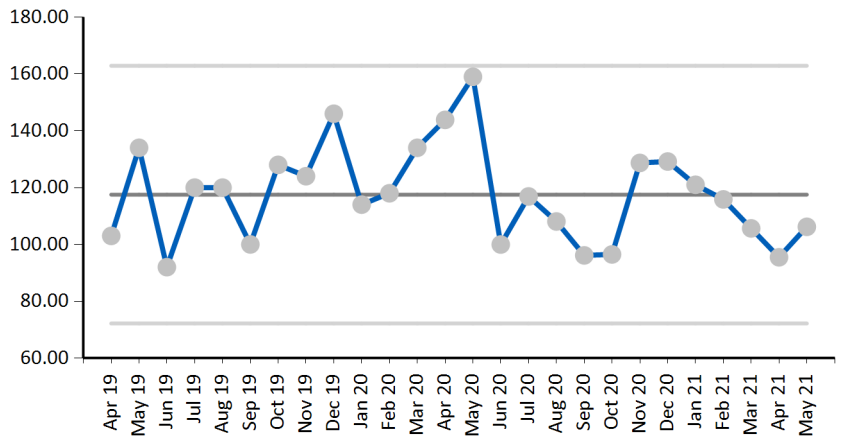
SHMI – the most recent published 12 month average for the Trust is 111 for the period July 2020 to June 2021, this is within the expected range but the Trust is still one of the highest amongst peers.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Oct-21		>= 85%	74.3%	Sep-21	>= 85%	94.1%	
495 - HSMR		106.20	May-21			95.47	Apr-21		106.20	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	109.96	Apr-21		<= 100.00	96.13	Mar-21	<= 100.00	109.96	
12 - Crude Mortality %	<= 2.9%	2.3%	Oct-21		<= 2.9%	2.3%	Sep-21	<= 2.9%	2.4%	

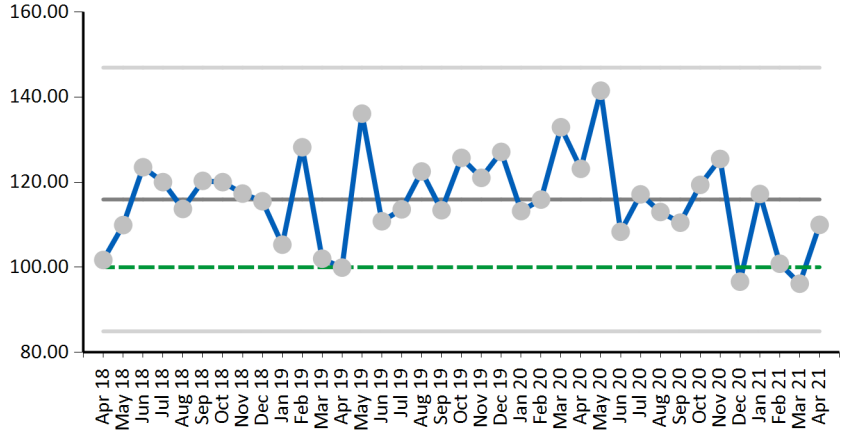
3 - National Early Warning Scores to Gold standard



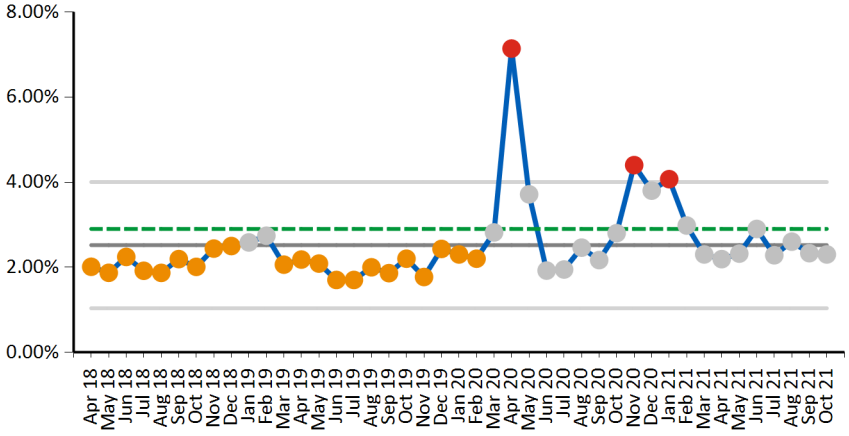
495 - HSMR



11 - Summary Hospital-level Mortality Indicator (SHMI)



12 - Crude Mortality %



Patient Experience

FFT
NHSE continue to publish FFT data on their website and all areas within the Trust have improved their collection methods as safely as possible using QR codes and available devices. The response rates continue to be varied with some areas showing high response rates. All Divisions have established Quality Patient Experience Forums where FFT is discussed to enable sharing of good practice and to share learning. This is reported into the Trust QPEF.

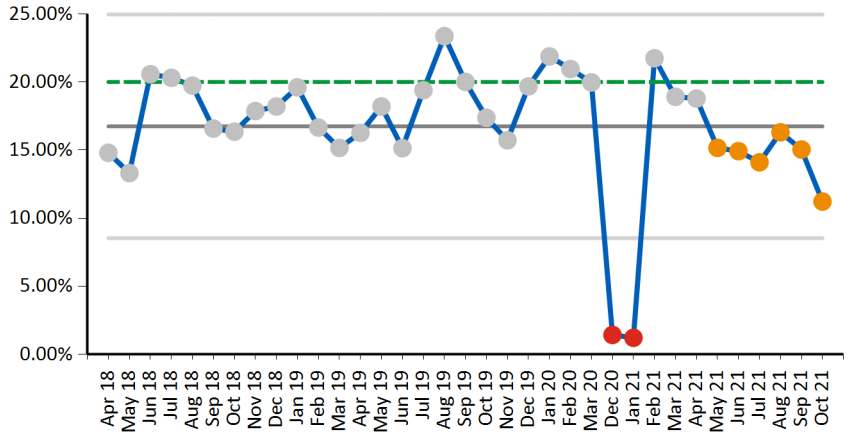
All areas who traditionally collect FFT by paper now have access to QR codes with the expectation that response rates will steadily improve. Some areas within the Maternity return have shown low response rates and the Patient Experience Manager is working with the Head of Midwifery and wider team to support achieving improved response rates for November.

Complaints
The Trust rate for acknowledging complaints during October was 100%. The response rate was 72.2% with cases breaching. A review of the breached cases are being undertaken to establish the cause and whether these could have been avoided. The Patient Experience Team are in the process of planning a number of small workshops with the teams involved with the breached cases to better understand the cause of the breach and to improve the quality of responses.

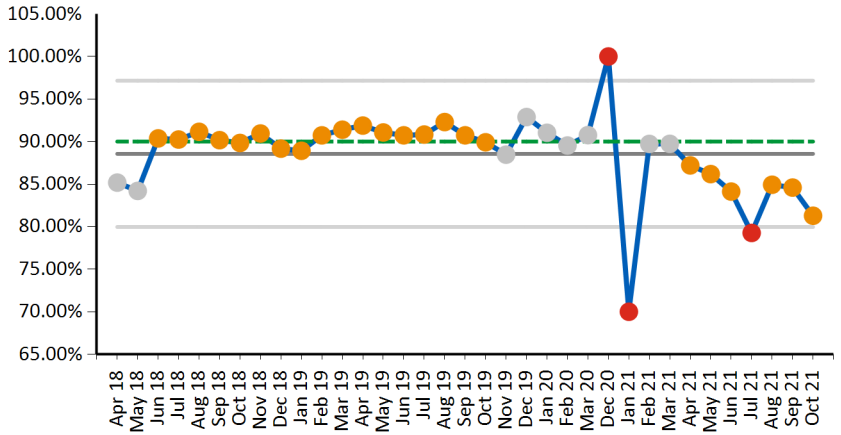
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	11.2%	Oct-21		>= 20%	15.0%	Sep-21	>= 20%	15.1%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	81.3%	Oct-21		>= 90%	84.6%	Sep-21	>= 90%	84.2%	
80 - Inpatient Friends and Family Response Rate	>= 30%	19.1%	Oct-21		>= 30%	21.0%	Sep-21	>= 30%	20.6%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.0%	Oct-21		>= 90%	95.5%	Sep-21	>= 90%	96.7%	
81 - Maternity Friends and Family Response Rate	>= 15%	11.6%	Oct-21		>= 15%	13.3%	Sep-21	>= 15%	12.4%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	83.3%	Oct-21		>= 90%	85.8%	Sep-21	>= 90%	87.5%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	0.0%	Oct-21		>= 15%	4.2%	Sep-21	>= 15%	1.3%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%		Oct-21		>= 90%		Sep-21	>= 90%	100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	26.5%	Oct-21		>= 15%	28.4%	Sep-21	>= 15%	27.0%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	82.4%	Oct-21		>= 90%	84.4%	Sep-21	>= 90%	88.0%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	11.2%	Oct-21		>= 15%	13.2%	Sep-21	>= 15%	13.0%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	83.3%	Oct-21		>= 90%	80.7%	Sep-21	>= 90%	84.3%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	7.6%	Oct-21		>= 15%	6.8%	Sep-21	>= 15%	8.3%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	87.1%	Oct-21		>= 90%	92.6%	Sep-21	>= 90%	88.2%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Oct-21		= 100%	100.0%	Sep-21	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	72.2%	Oct-21		>= 95%	90.9%	Sep-21	>= 95%	78.1%	

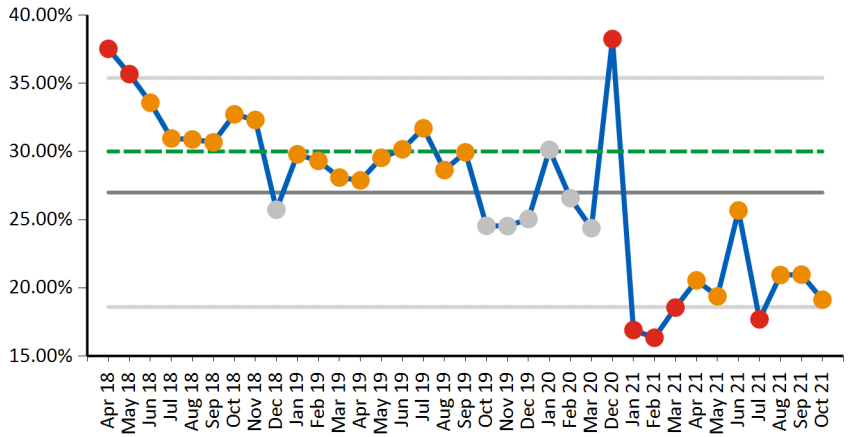
200 - A&E Friends and Family Response Rate



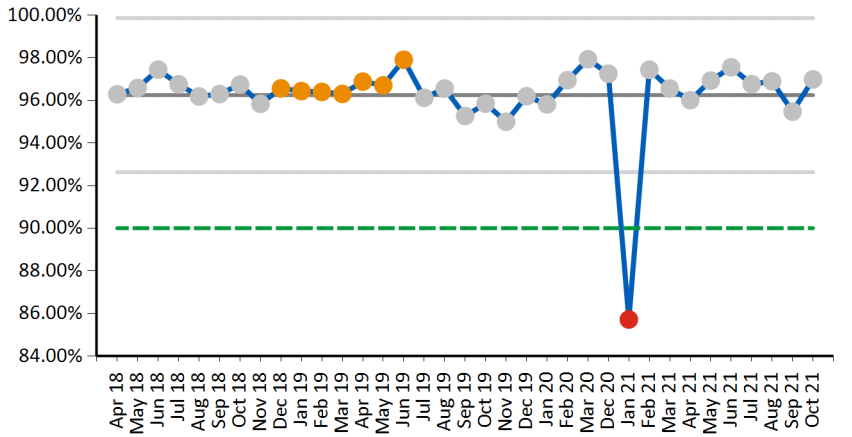
294 - A&E Friends and Family Satisfaction Rates %



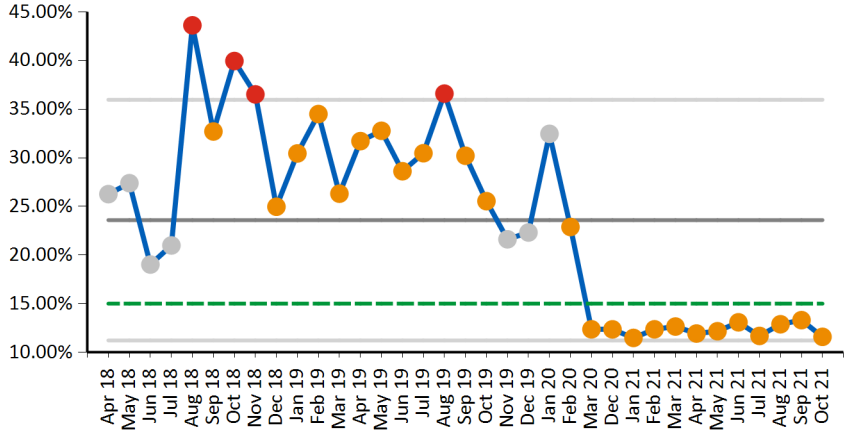
80 - Inpatient Friends and Family Response Rate



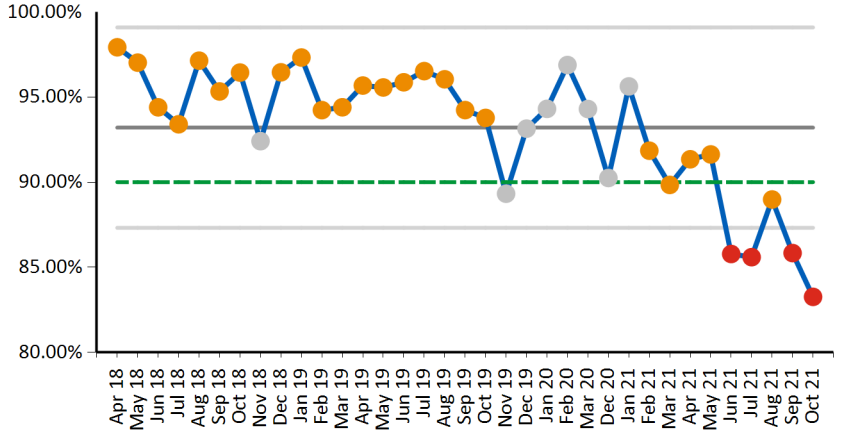
240 - Friends and Family Test (Inpatients) - Satisfaction %



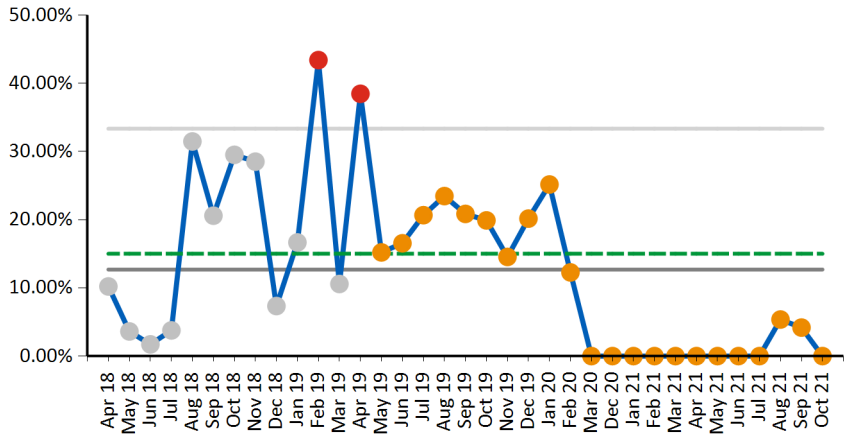
81 - Maternity Friends and Family Response Rate



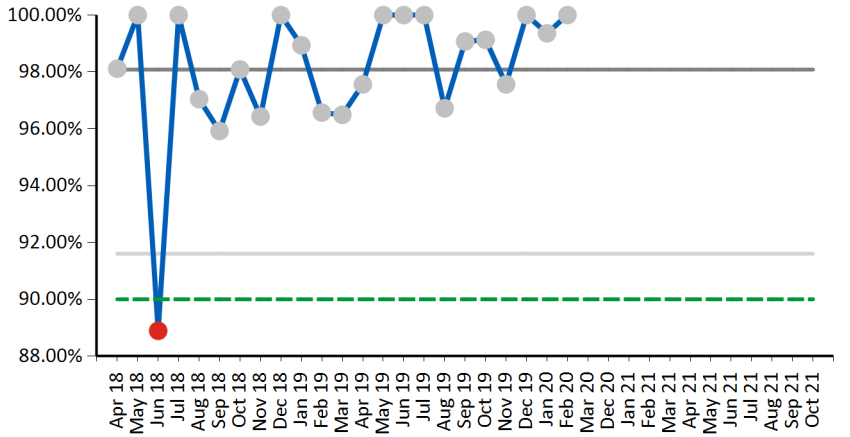
241 - Maternity Friends and Family Test - Satisfaction %



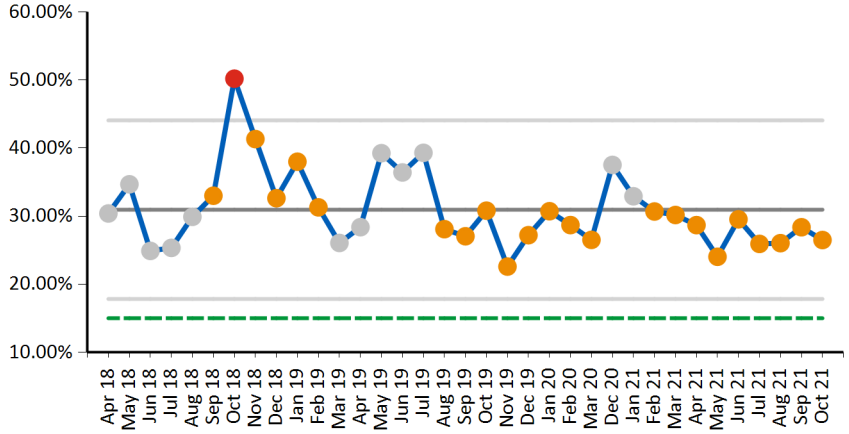
82 - Antenatal - Friends and Family Response Rate



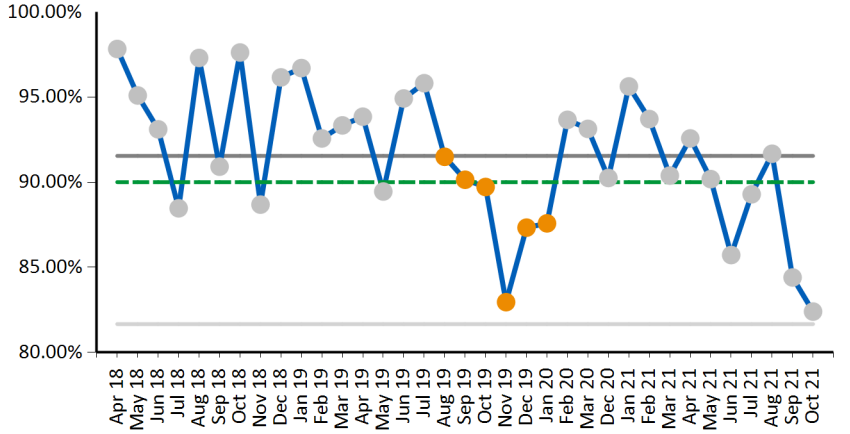
242 - Antenatal Friends and Family Test - Satisfaction %



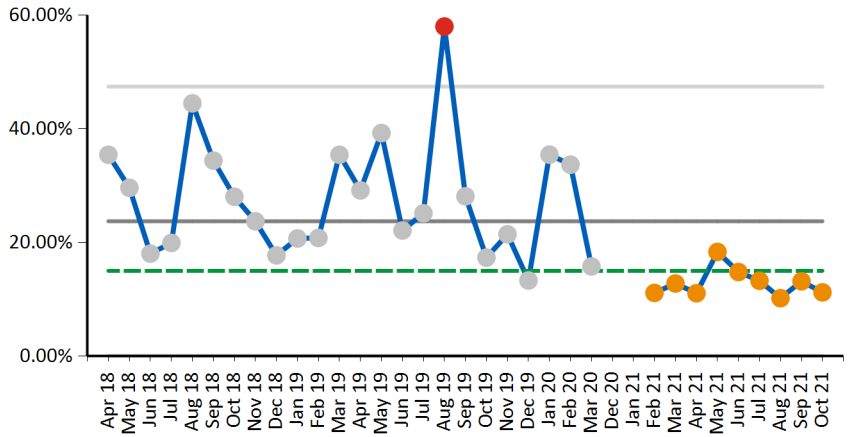
83 - Birth - Friends and Family Response Rate



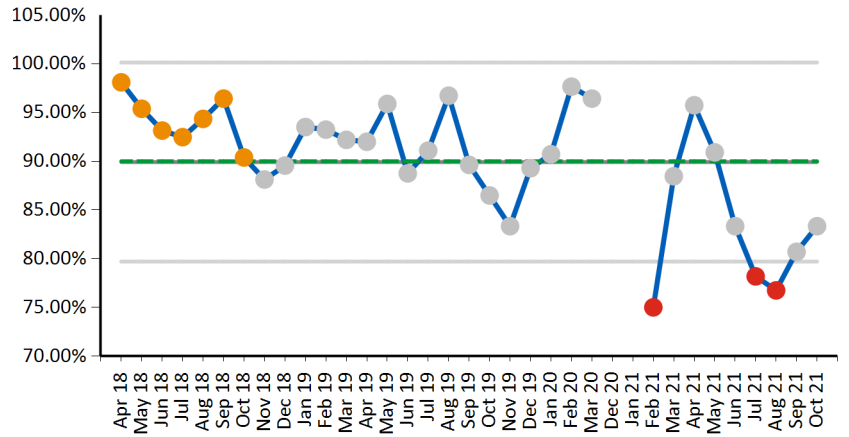
243 - Birth Friends and Family Test - Satisfaction %



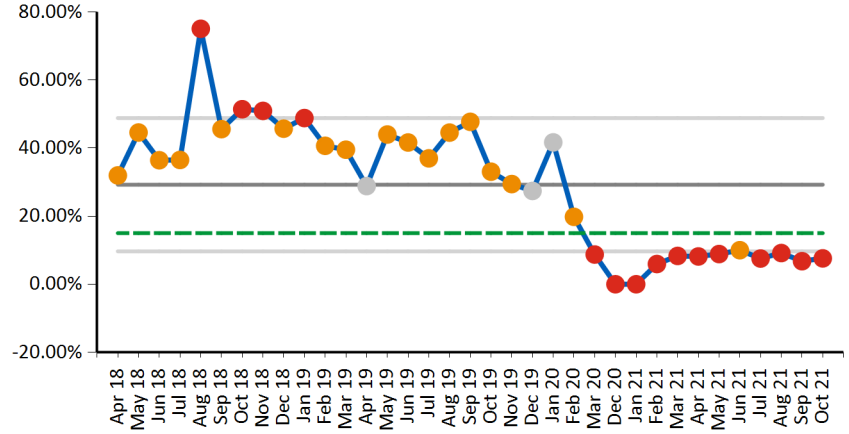
84 - Hospital Postnatal - Friends and Family Response Rate



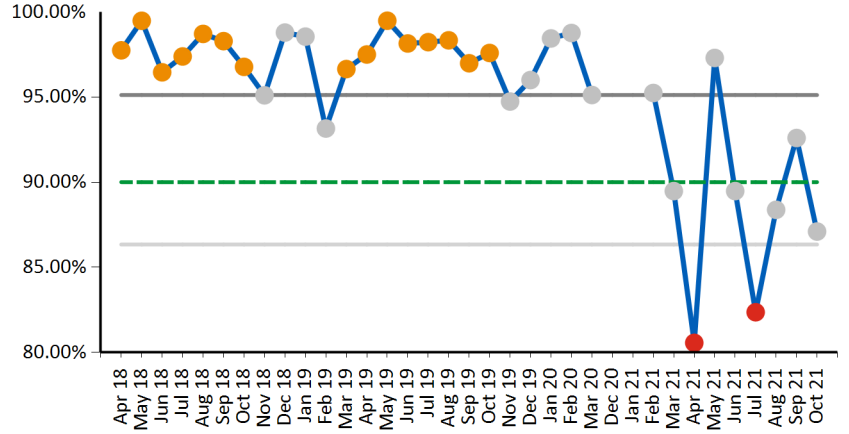
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



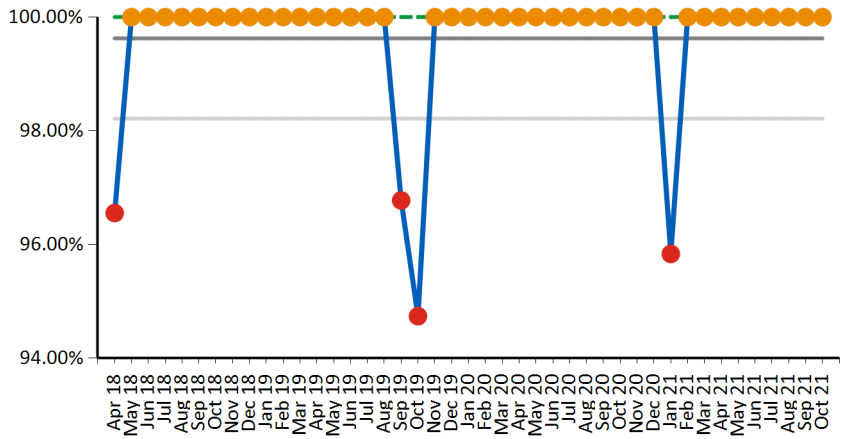
85 - Community Postnatal - Friend and Family Response Rate



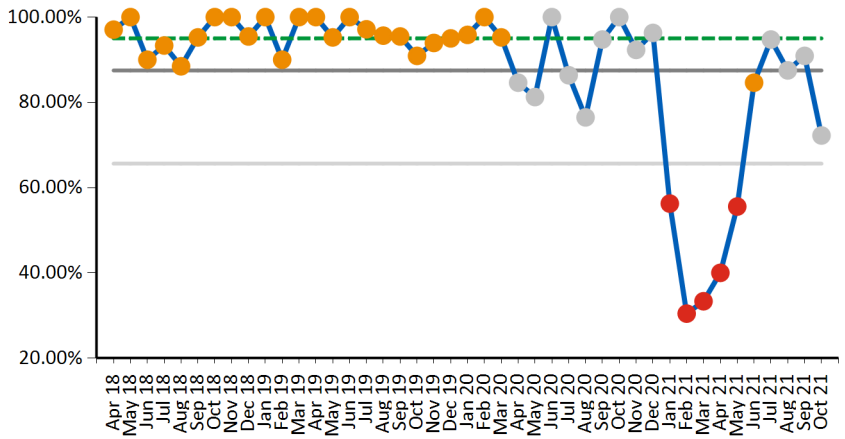
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



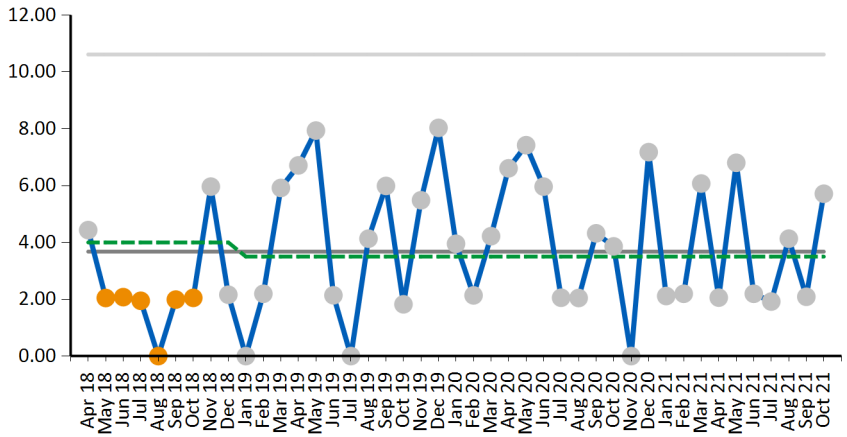
Maternity

The team have an action plan to improve both Friends and family response rate and satisfaction, we have now using QR codes to improve accessibility. Our response rate is consistently between 12.9 -11.6%. However work has been undertaken to cleanse the option as a number response were attributed to codes that were no longer active. The implementation of QR codes won't be seen until next month. We now request three touch points. However the recommendation rate has increased from 60.7 to 83.3

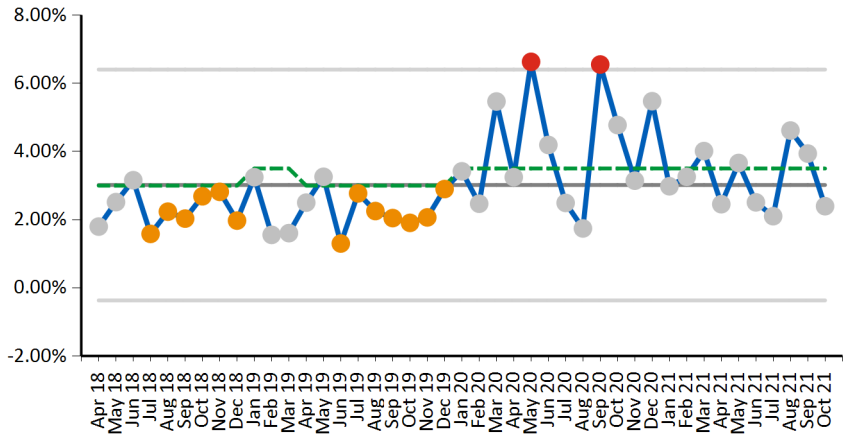
It should be noted the birth rate increased this month but 1:1 care was maintained at 98%. The induction rate and 3rd degree tear rate show an improved picture in month.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	5.71	Oct-21		<= 3.50	2.09	Sep-21	<= 3.50	3.54	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.4%	Oct-21		<= 3.5%	3.9%	Sep-21	<= 3.5%	3.1%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.2%	Aug-21		>= 95.0%	98.5%	Jul-21	>= 95.0%	98.3%	
203 - Booked 12+6	>= 90.0%	88.6%	Oct-21		>= 90.0%	87.5%	Sep-21	>= 90.0%	90.7%	
204 - Inductions of labour	<= 40%	33.7%	Oct-21		<= 40%	35.7%	Sep-21	<= 40%	37.3%	
208 - Total C section	<= 33.0%	35.6%	Oct-21		<= 33.0%	30.7%	Sep-21	<= 33.0%	34.3%	
210 - Initiation breast feeding	>= 65%	70.16%	Oct-21		>= 65%	66.95%	Sep-21	>= 65%	69.84%	
213 - Maternity complaints	<= 5	0	Oct-21		<= 5	0	Sep-21	<= 35	11	
319 - Maternal deaths (direct)	= 0	0	Oct-21		= 0	0	Sep-21	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.6%	Sep-21		<= 6%	7.2%	Aug-21	<= 6%	7.6%	

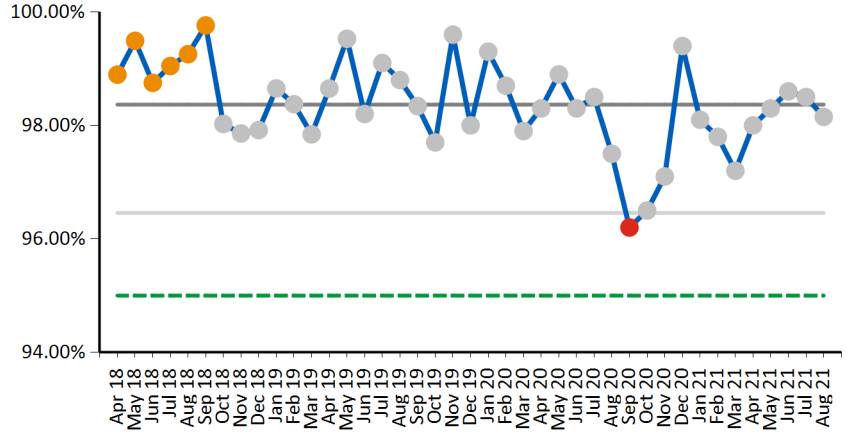
322 - Maternity - Stillbirths per 1000 births



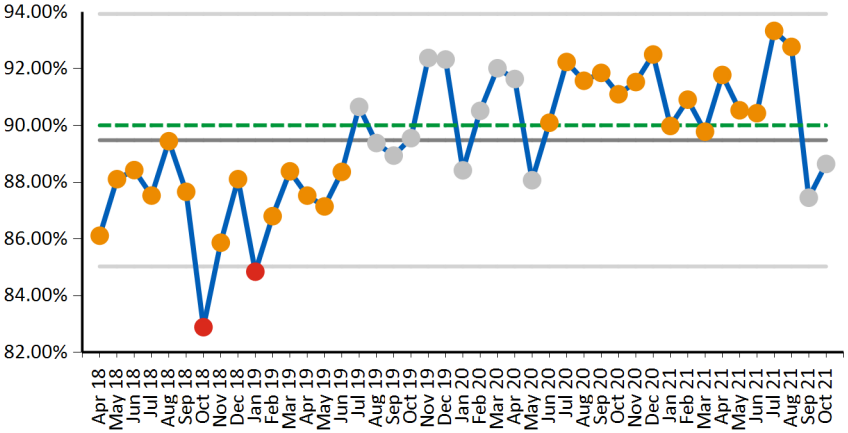
23 - Maternity -3rd/4th degree tears



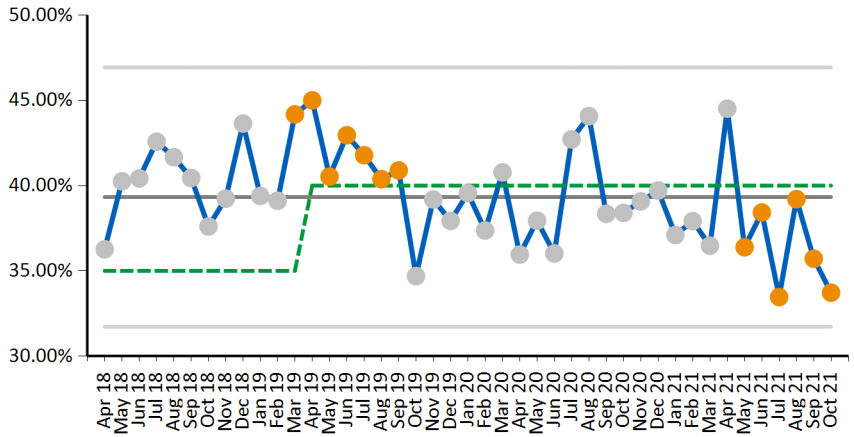
202 - 1:1 Midwifery care in labour



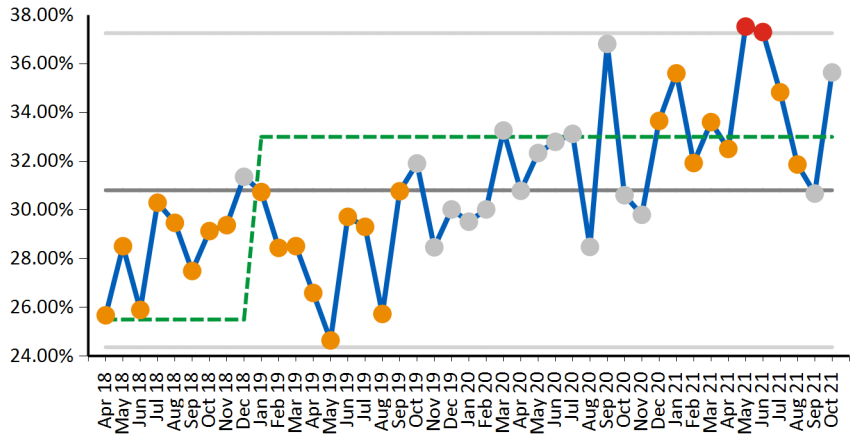
203 - Booked 12+6



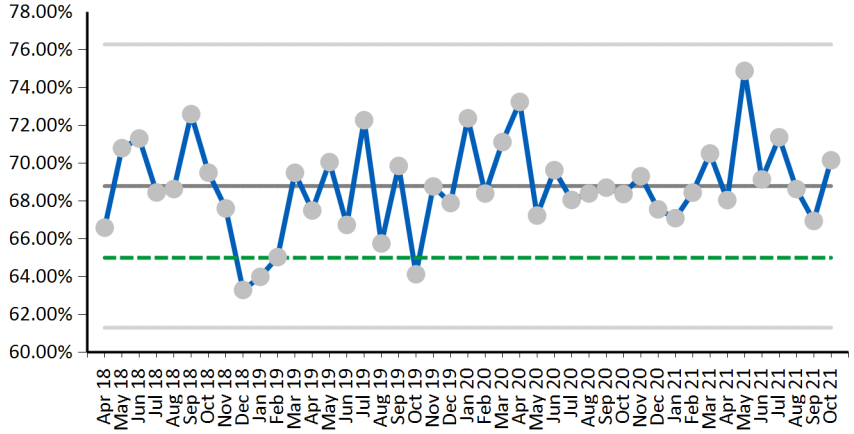
204 - Inductions of labour



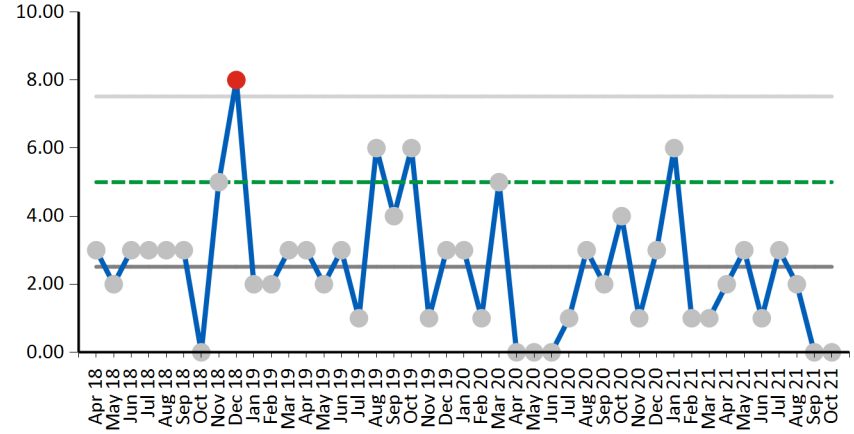
208 - Total C section



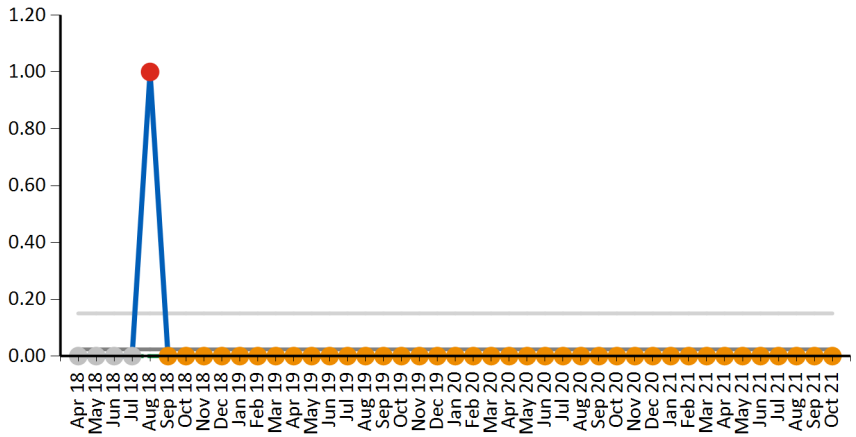
210 - Initiation breast feeding



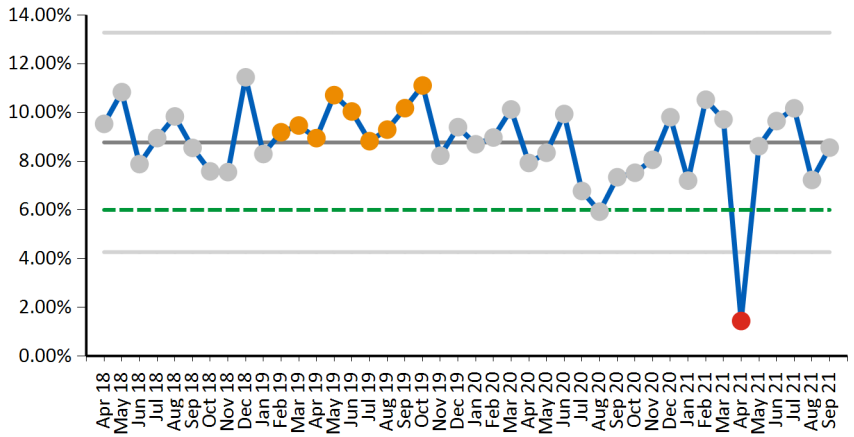
213 - Maternity complaints



319 - Maternal deaths (direct)



320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)

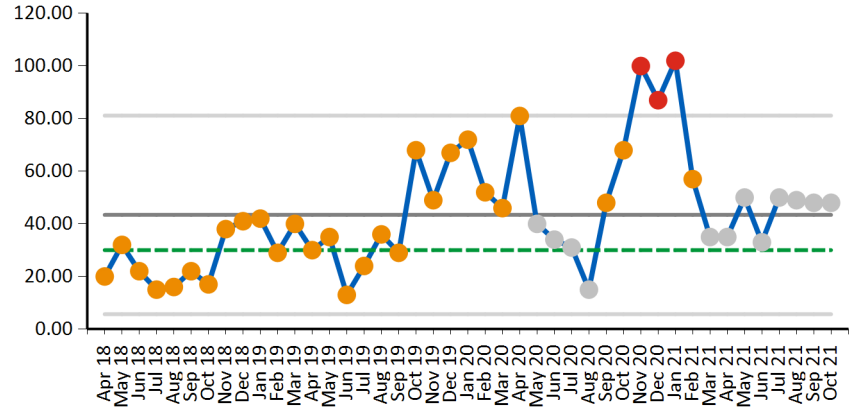


Operational Performance

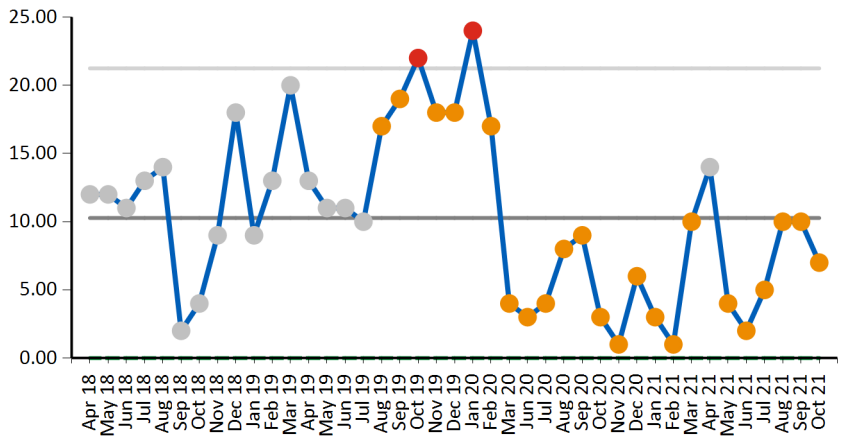
Access

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	48	Oct-21		<= 30	48	Sep-21	<= 210	313	?
8 - Same sex accommodation breaches	= 0	7	Oct-21	L	= 0	10	Sep-21	= 0	52	?
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	74.2%	Oct-21		>= 75%	64.5%	Sep-21	>= 75%	72.1%	?
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	65.3%	Oct-21	L	>= 92%	65.6%	Sep-21	>= 92%	66.3%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	1,903	Oct-21	H	= 0	1,998	Sep-21	= 0	15,370	F
314 - RTT 18 week waiting list	<= 25,530	27,319	Oct-21	H	<= 25,530	28,005	Sep-21	<= 25,530	27,319	?
53 - A&E 4 hour target	>= 95%	66.4%	Oct-21	L	>= 95%	71.2%	Sep-21	>= 95%	70.9%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	11.9%	Oct-21		= 0.0%	12.7%	Sep-21	= 0.0%	9.7%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	10.00%	Oct-21	H	= 0.00%	8.21%	Sep-21	= 0.00%	5.89%	?
72 - Diagnostic Waits >6 weeks %	<= 1%	26.1%	Oct-21	L	<= 1%	30.3%	Sep-21	<= 1%	31.5%	F
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	57.1%	Oct-21		= 100%	100.0%	Sep-21	= 100%	80.2%	?

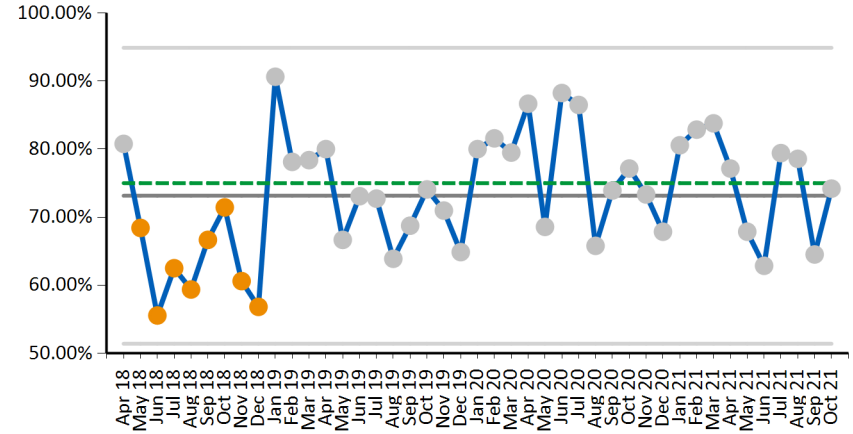
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



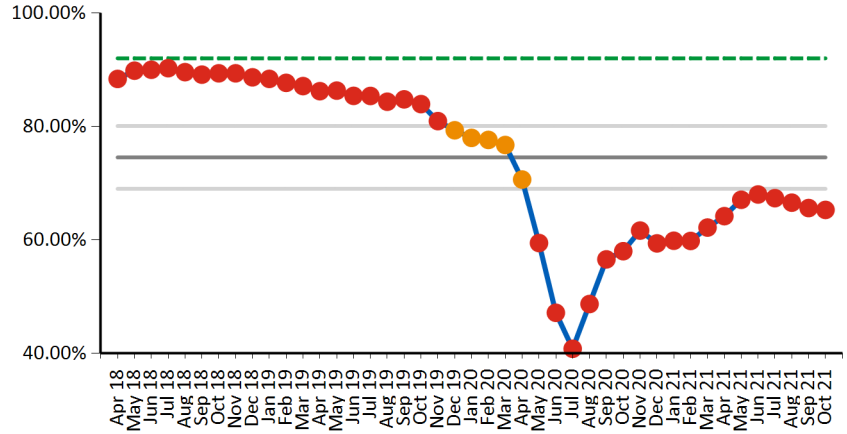
8 - Same sex accommodation breaches



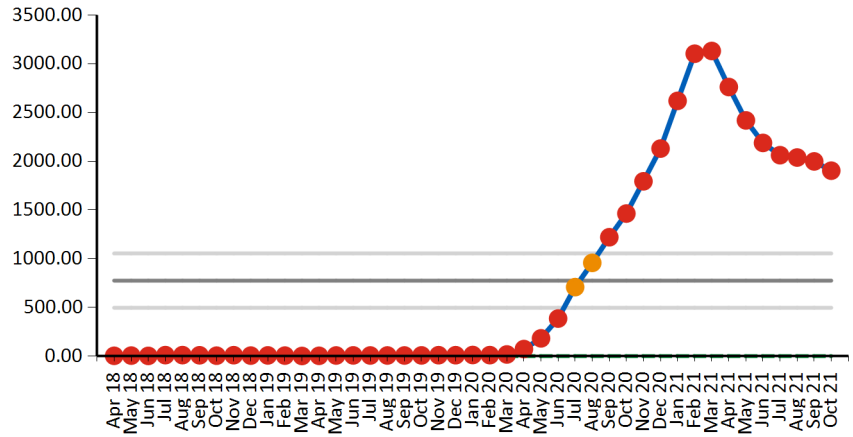
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



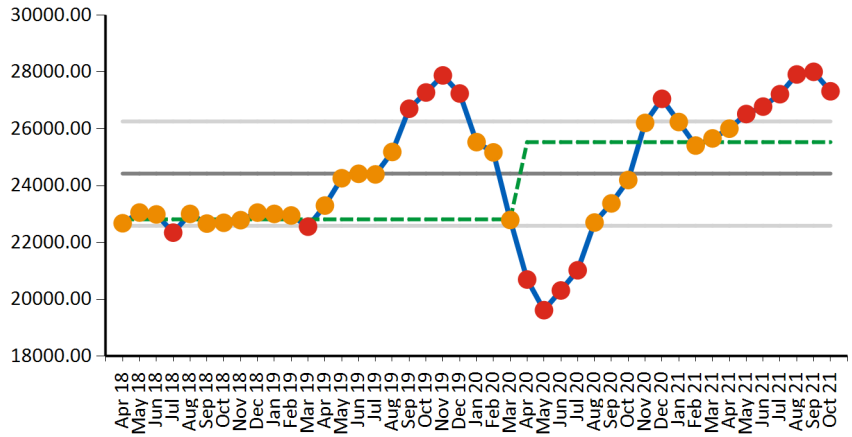
41 - RTT Incomplete pathways within 18 weeks %



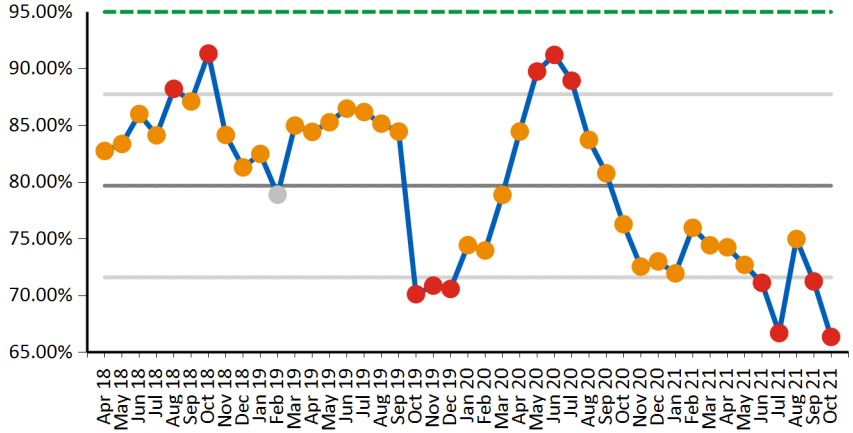
42 - RTT 52 week waits (incomplete pathways)



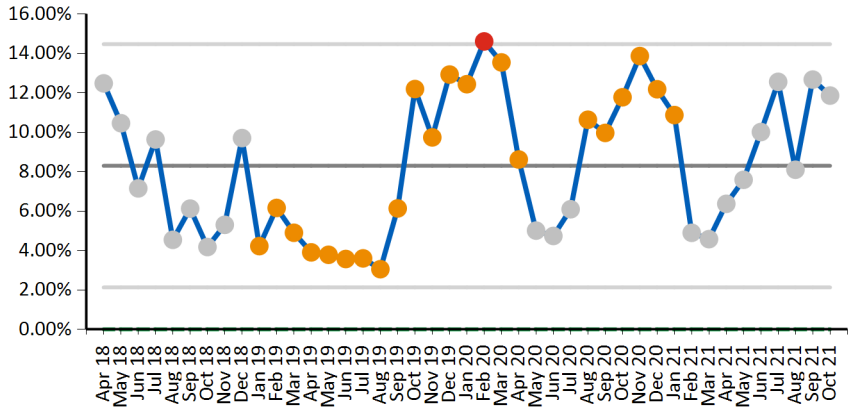
314 - RTT 18 week waiting list



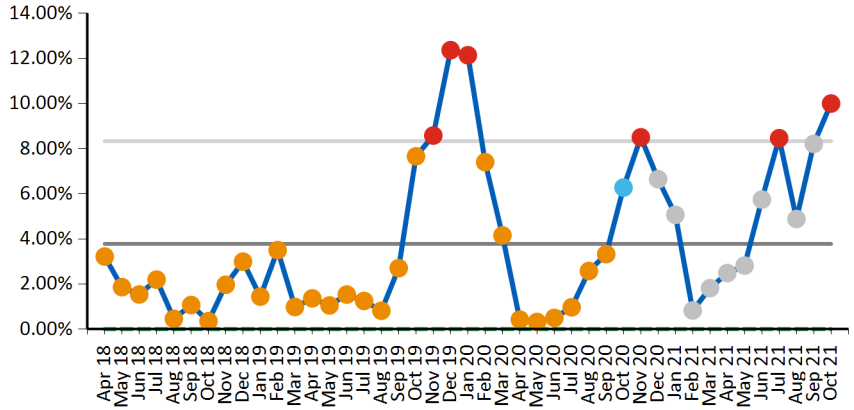
53 - A&E 4 hour target



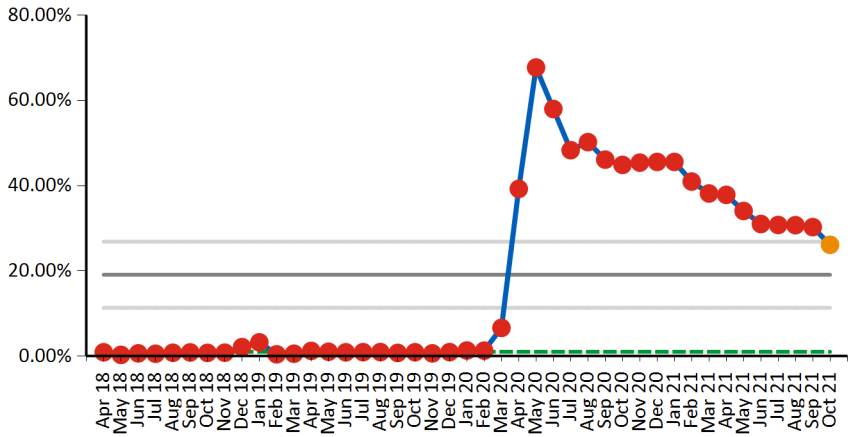
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



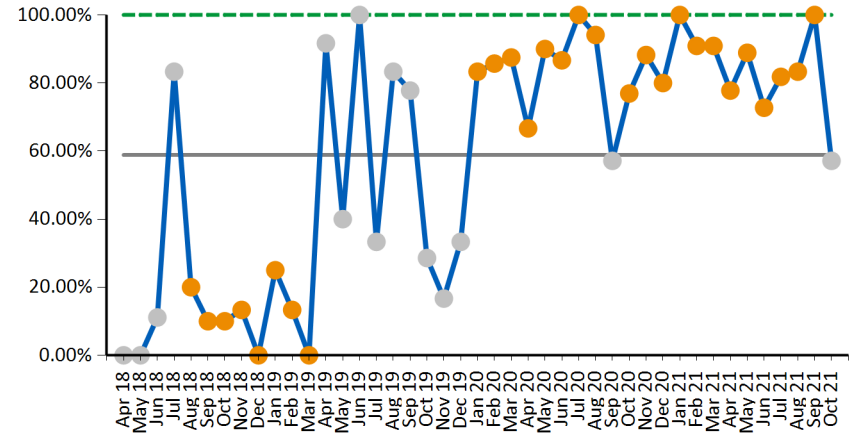
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



27 - TIA (Transient Ischaemic attack) patients seen <24hrs

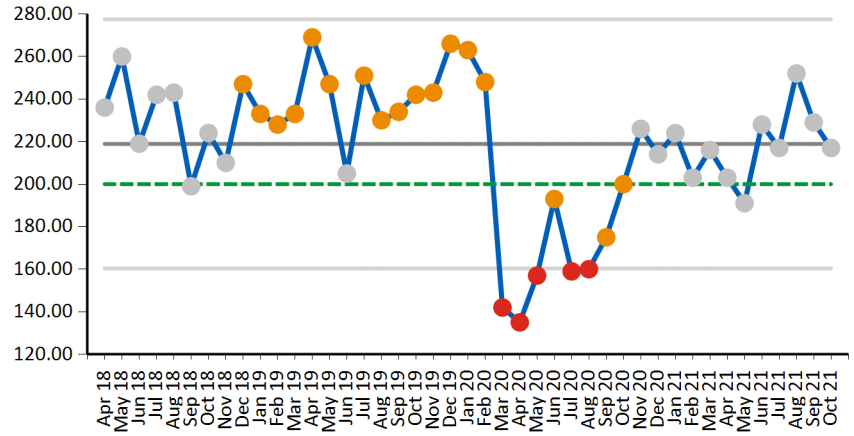


Productivity

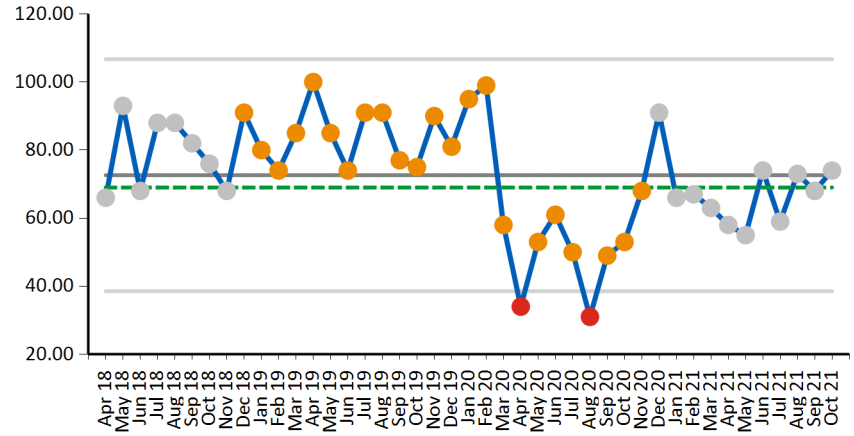
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	217	Oct-21		<= 200	229	Sep-21	<= 200	217	
307 - Stranded Patients - LOS 21 days and over	<= 69	74	Oct-21		<= 69	68	Sep-21	<= 69	74	
57 - Discharges by Midday	>= 30%	19.0%	Oct-21		>= 30%	22.5%	Sep-21	>= 30%	22.1%	
58 - Discharges by 4pm	>= 70%	54.1%	Oct-21		>= 70%	58.0%	Sep-21	>= 70%	59.9%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	12.3%	Sep-21		<= 13.5%	11.2%	Aug-21	<= 13.5%	11.7%	
489 - Daycase Rates	>= 80%	90.6%	Oct-21		>= 80%	90.3%	Sep-21	>= 80%	89.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.2%	Oct-21		<= 1%	0.9%	Sep-21	<= 1%	1.0%	
62 - Cancelled operations re-booked within 28 days	= 100%	80.6%	Oct-21		= 100%	87.5%	Sep-21	= 100%	14.6%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.22	Oct-21		<= 2.00	2.96	Sep-21	<= 2.00	2.88	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	3.79	Oct-21		<= 3.70	3.84	Sep-21	<= 3.70	3.84	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	76.5%	Jun-21		>= 80%	71.4%	May-21	>= 80%	75.9%	
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision	= 0	30	Oct-21		= 0	28	Sep-21	= 0	126	
493 - Average Number of Patients: with no Criteria to Reside	>= 35	99	Oct-21		>= 45	88	Sep-21	>= 335	517	
494 - Average Occupied Days - for no Criteria to Reside		618	Oct-21			569	Sep-21		2,519	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
496 - Average number of excess bed days incurred since patients with a LoS of 14 days+ were declared as no longer meeting the reasons to reaside criteria (ready for dicharge/medically fit)	>= 110	511	Oct-21		>= 160	480	Sep-21	>= 1,160	2,005	

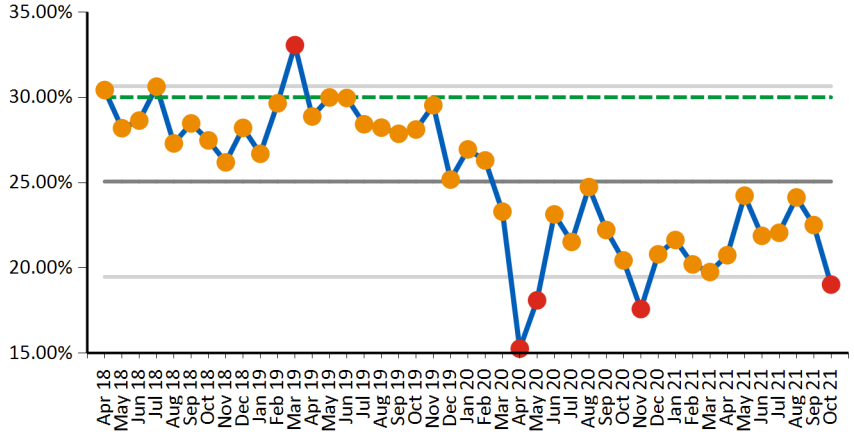
56 - Stranded patients



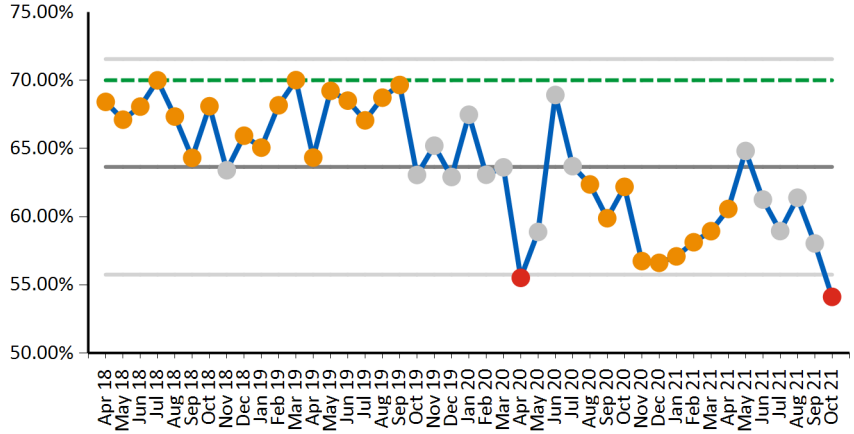
307 - Stranded Patients - LOS 21 days and over



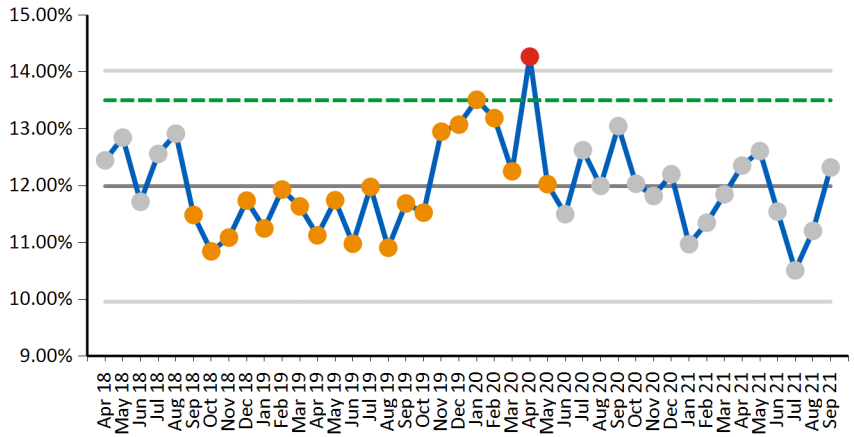
57 - Discharges by Midday



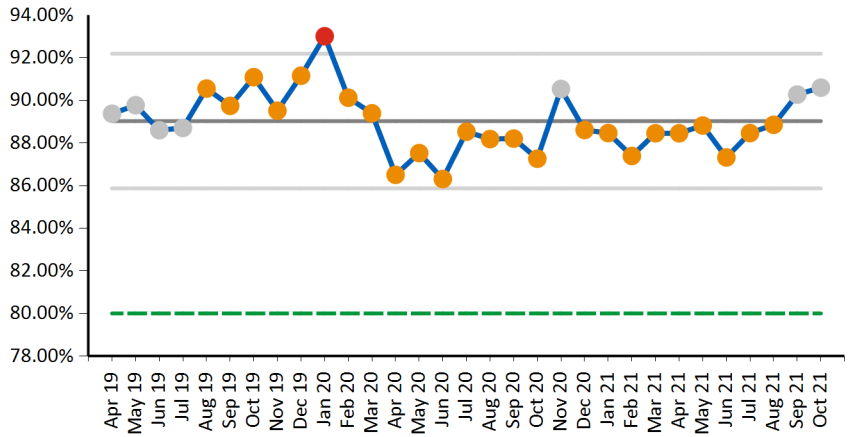
58 - Discharges by 4pm



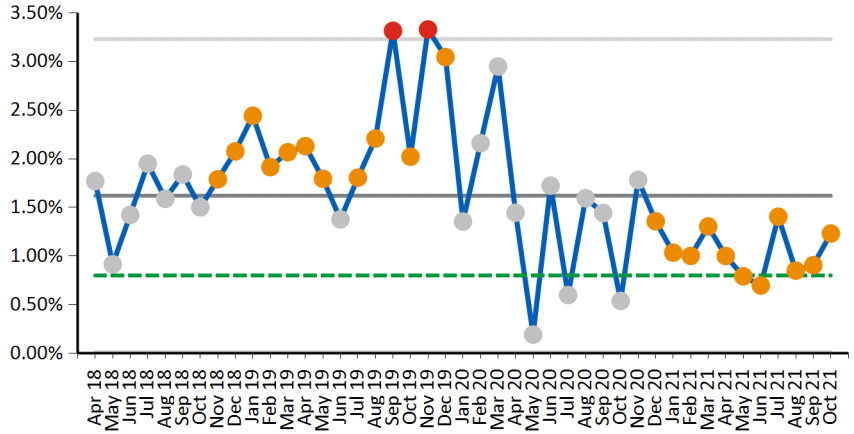
59 - Re-admission within 30 days of discharge (1 mth in arrears)



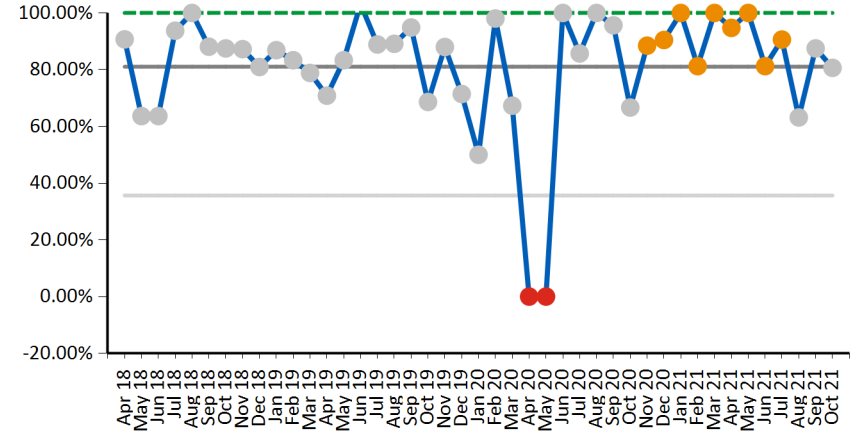
489 - Daycase Rates



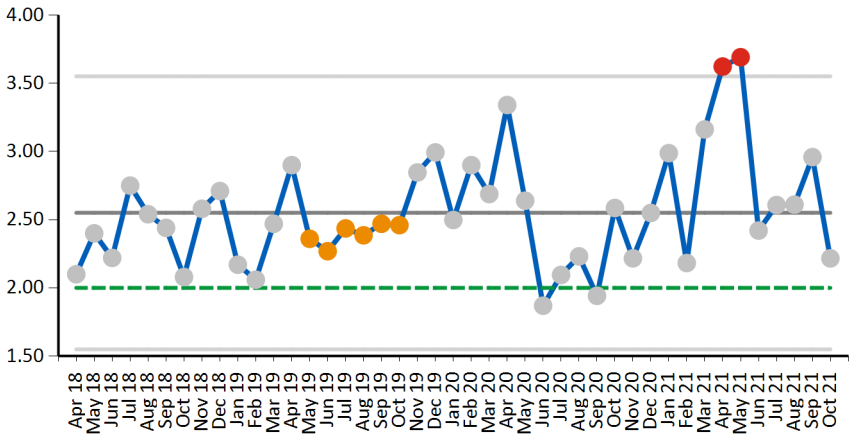
61 - Operations cancelled on the day for non-clinical reasons



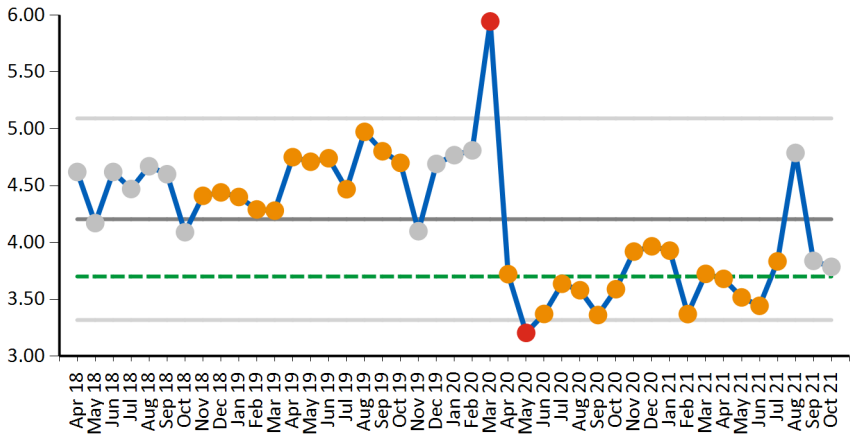
62 - Cancelled operations re-booked within 28 days



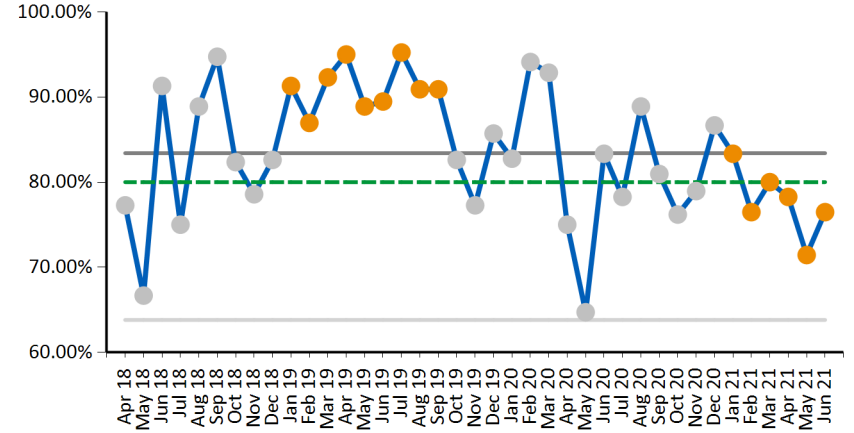
65 - Elective Length of Stay (Discharges in month)



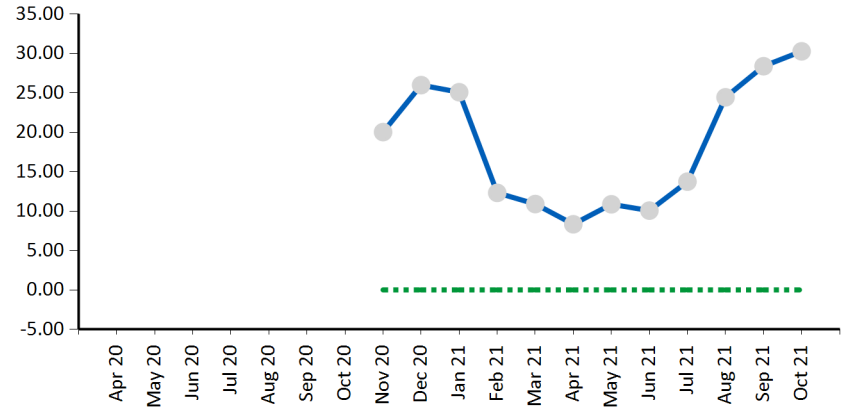
66 - Non Elective Length of Stay (Discharges in month)



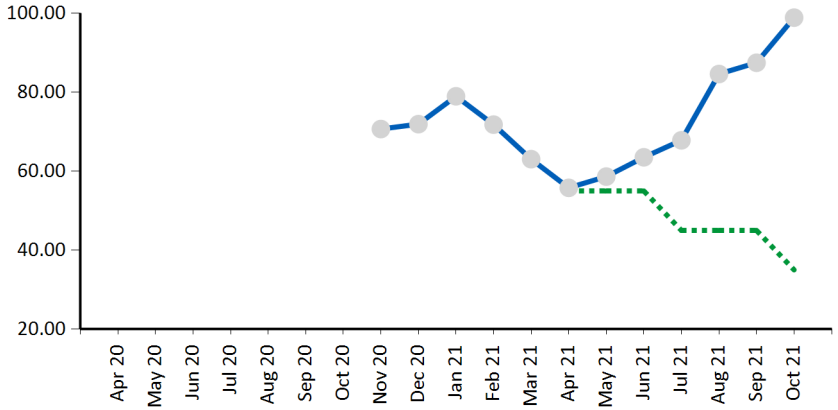
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



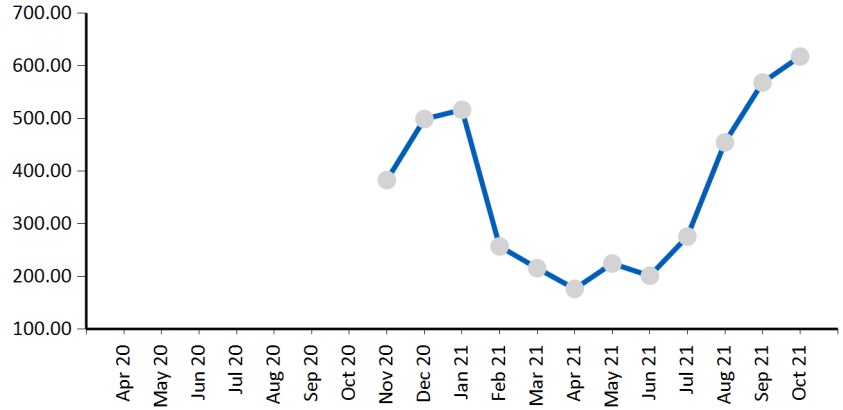
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision - SPC data available after 20 data points



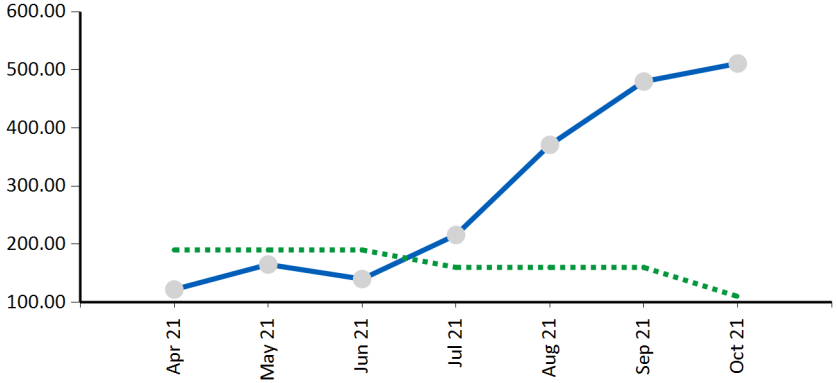
493 - Average Number of Patients: with no Criteria to Reside - SPC data available after 20 data points



494 - Average Occupied Days - for no Criteria to Reside - SPC data available after 20 data points



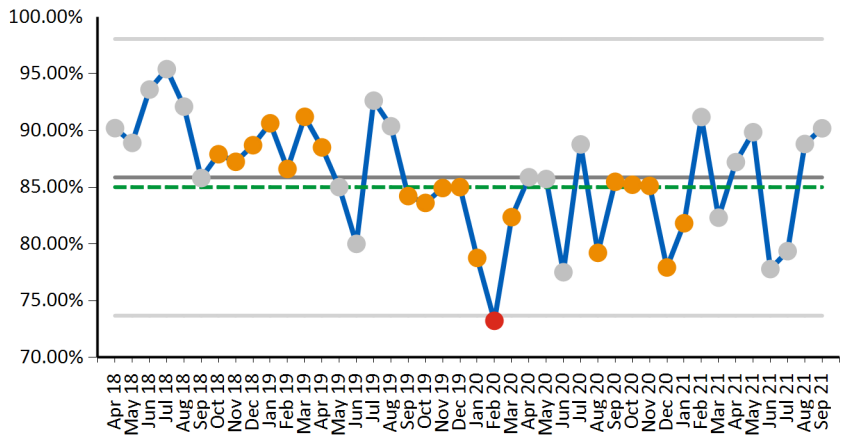
496 - Average number of excess bed days incurred since patients with a LoS of 14 days+ were declared as no longer meeting the reasons to reaside criteria (ready for dicharge/medically fit) - SPC data available after 20 data points



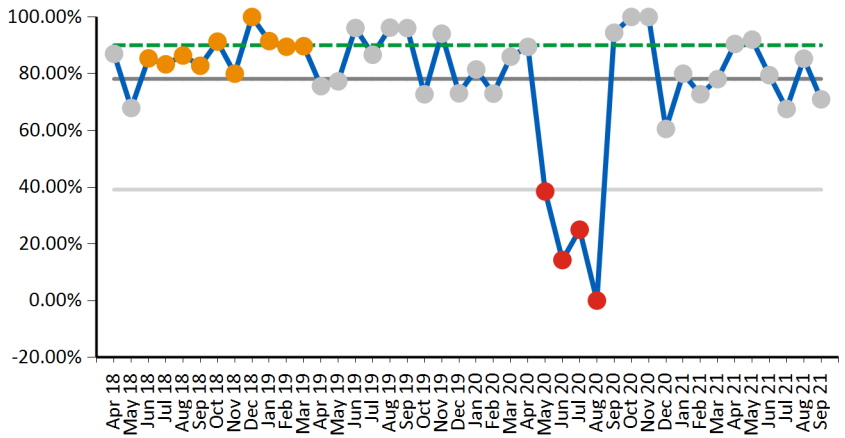
Cancer

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	90.2%	Sep-21		>= 85%	88.8%	Aug-21	>= 85%	85.6%	?
47 - 62 day screening % (1 mth in arrears)	>= 90%	71.0%	Sep-21		>= 90%	85.3%	Aug-21	>= 90%	80.8%	?
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	98.4%	Sep-21		>= 96%	100.0%	Aug-21	>= 96%	98.6%	?
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Sep-21		>= 94%	84.6%	Aug-21	>= 94%	95.3%	?
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Sep-21		>= 98%	100.0%	Aug-21	>= 98%	100.0%	P
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	97.3%	Sep-21		>= 93%	97.0%	Aug-21	>= 93%	96.8%	?
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	22.9%	Sep-21		>= 93%	66.4%	Aug-21	>= 93%	32.2%	F

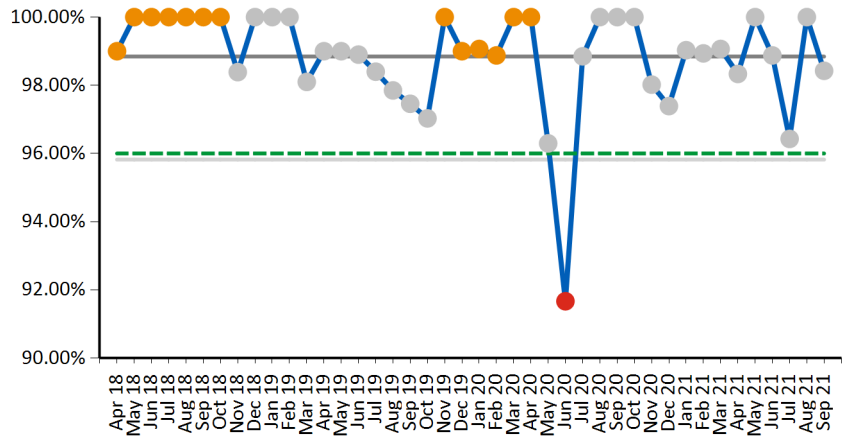
46 - 62 day standard % (1 mth in arrears)



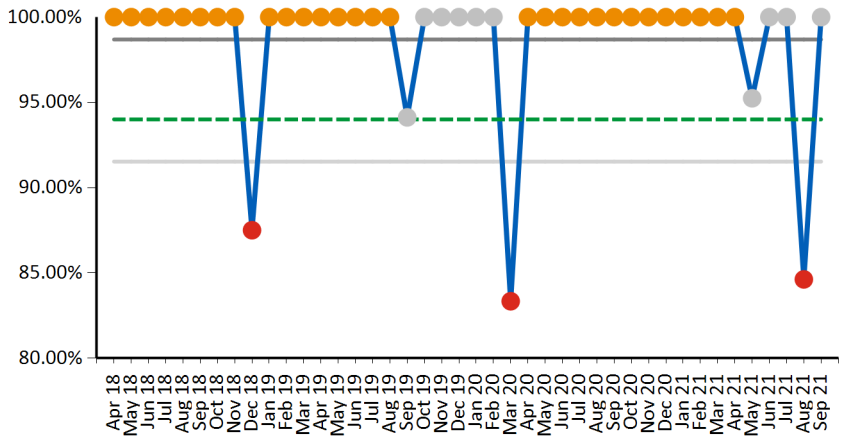
47 - 62 day screening % (1 mth in arrears)



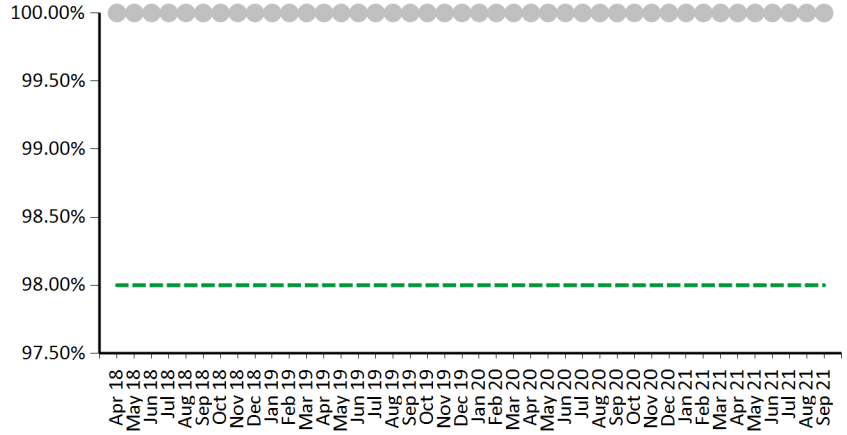
48 - 31 days to first treatment % (1 mth in arrears)



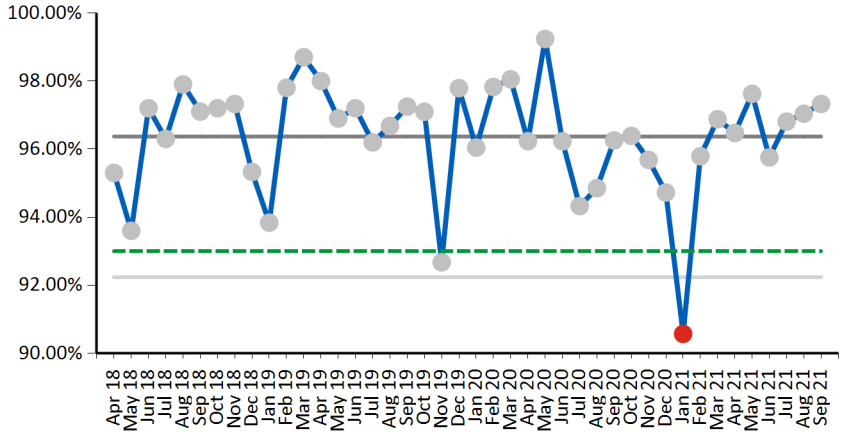
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



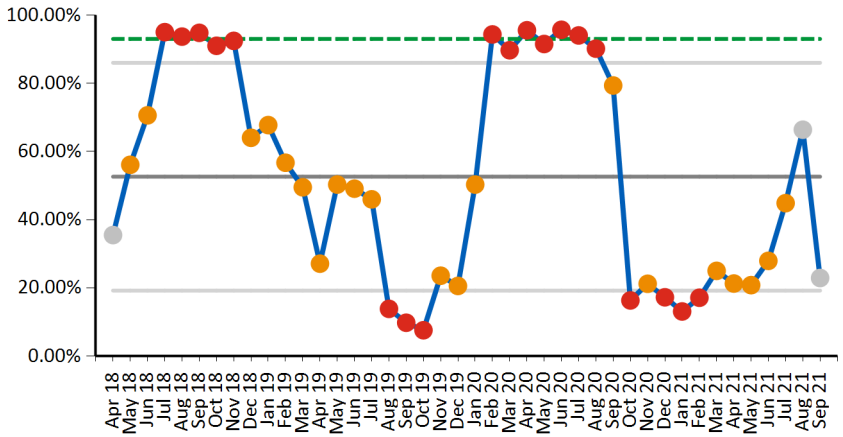
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



51 - Patients 2 week wait (all cancers) % (1 mth in arrears)



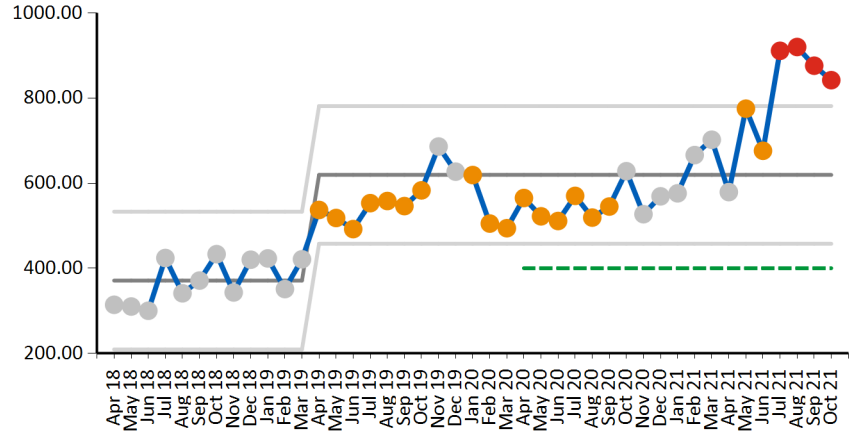
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)



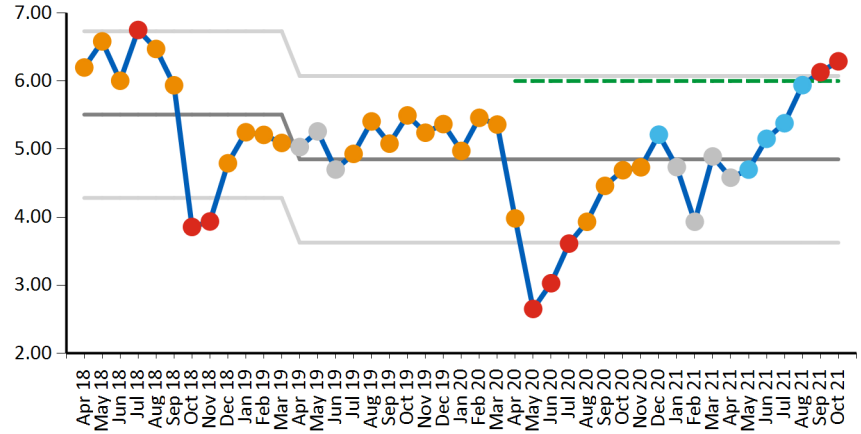
Community

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	842	Oct-21	H	>= 400	876	Sep-21	>= 2,800	5,579	P
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	6.29	Oct-21	H	<= 6.00	6.13	Sep-21	<= 6.00	6.29	?

334 - Total Deflections from ED



335 - Total Intermediate Tier LOS (weeks)



Workforce

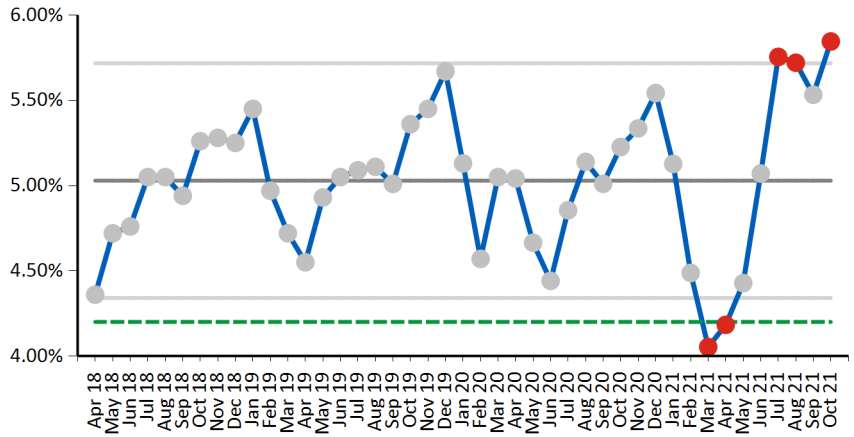
Sickness, Vacancy and Turnover

Board members will note that the sickness rate continues to exceed 5%. The main driver for this change has been the increased number of staff reporting anxiety / mental health conditions, along with a high number of staff off with muscular skeletal problems. People Committee members are sighted on the plethora of activity that is taking place to ensure sickness remains at a manageable level. Bolton continues to benchmark positively when compared to other organisations within Greater Manchester.

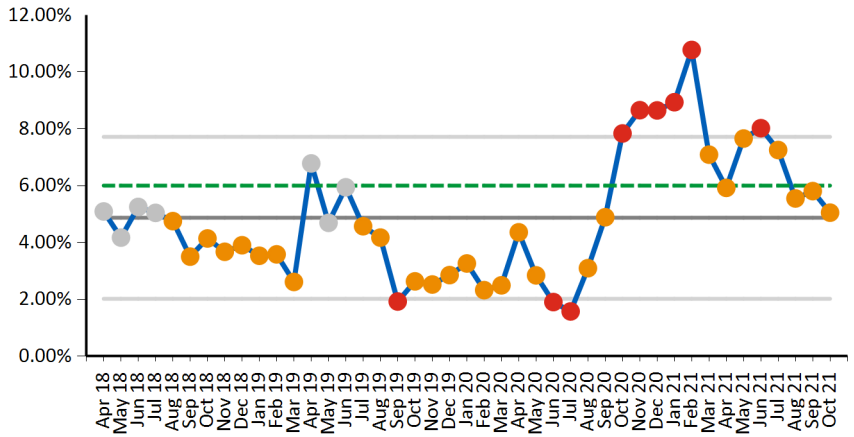
The People Committee receives monthly updates on the recruitment position, and in particular those hard to fill posts. Given the increased level of recruitment activity to support the recovery and urgent care position, staff shortages remain a concern. As previously noted the Executive team have recently supported an over-recruitment plan to support organisational pressures and as detailed within the papers our Bank rates have been reviewed to support fill rates.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.85%	Oct-21	H	<= 4.20%	5.53%	Sep-21	<= 4.20%	5.22%	F
120 - Vacancy level - Trust	<= 6%	5.05%	Oct-21	H	<= 6%	5.81%	Sep-21	<= 6%	6.46%	?
121 - Turnover	<= 9.90%	13.17%	Oct-21	H	<= 9.90%	12.97%	Sep-21	<= 9.90%	13.41%	F
366 - Ongoing formal investigation cases over 8 weeks		2	Oct-21			6	Sep-21		17	

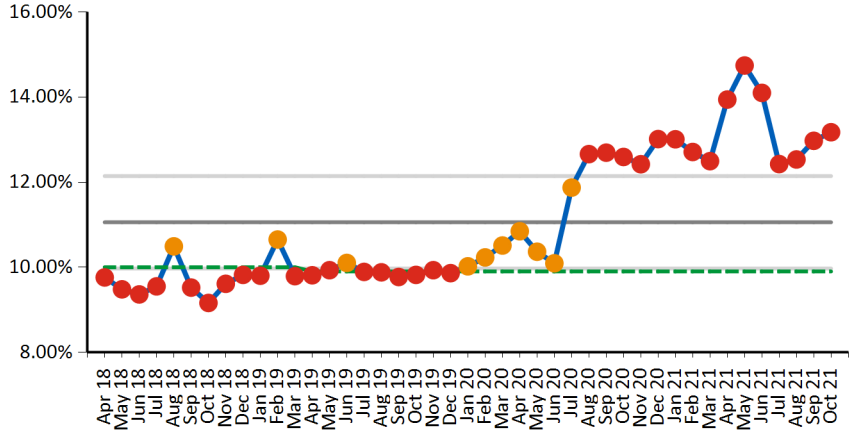
117 - Sickness absence level - Trust



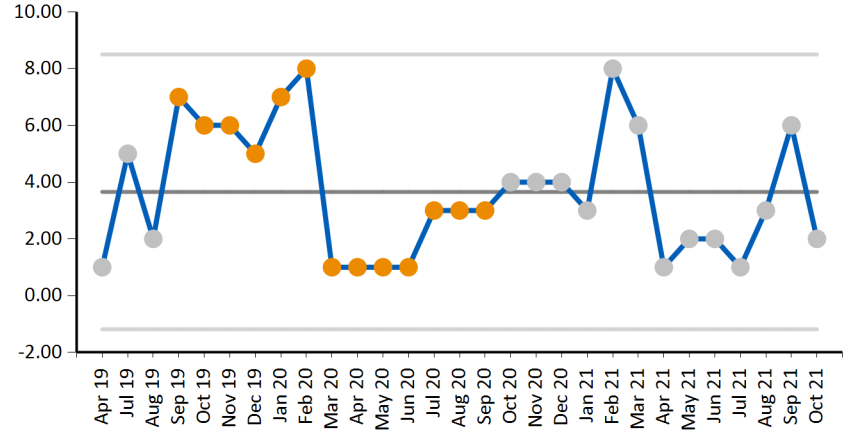
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks



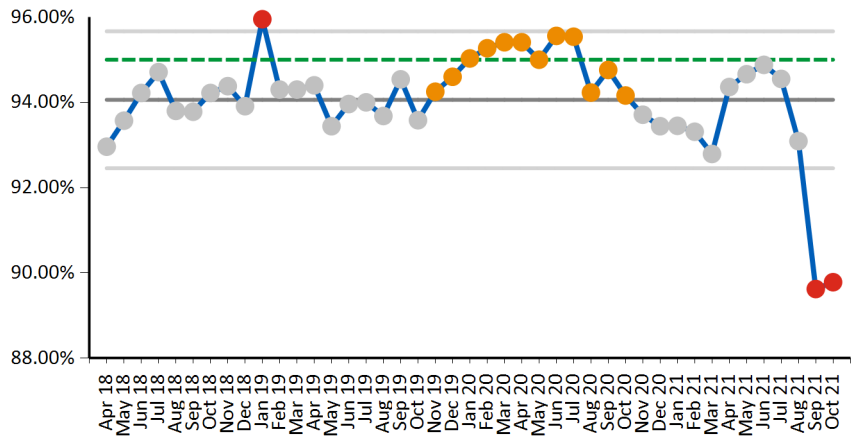
Organisational Development

Against a backdrop of significant operational pressures the completion of statutory and mandatory training has remained a priority. Appraisal rates remain stable and work is being undertaken with the Divisions to increase response rates. Whilst this is proving difficult due to operational pressures all do recognise the importance that our staff continue to benefit from an annual FABB appraisal.

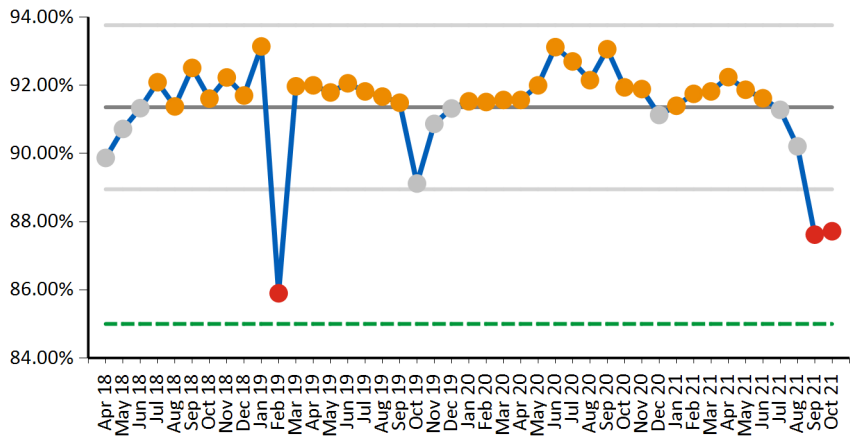
A full update on Staff Engagement was discussed at a previous BoD meeting and regular updates on the Go Engage results are provided to the People Committee. The NHS Staff Survey 2021 was launched on 1st October, 2021 and closes end of November, 2021. It was noted in the People Committee that staff are exhausted and this may have adverse impact on our results.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	89.8%	Oct-21		>= 95%	89.6%	Sep-21	>= 95%	93.0%	
38 - Staff completing Mandatory Training	>= 85%	87.7%	Oct-21		>= 85%	87.6%	Sep-21	>= 85%	90.4%	
39 - Staff completing Safeguarding Training	>= 95%	90.77%	Oct-21		>= 95%	91.66%	Sep-21	>= 95%	94.68%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	79.8%	Oct-21		>= 85%	78.7%	Sep-21	>= 85%	79.9%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	70.8%	Q2 2021/22		>= 66%	74.0%	Q1 2021/22	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	63.3%	Q2 2021/22		>= 80%	65.4%	Q1 2021/22	>= 80%		

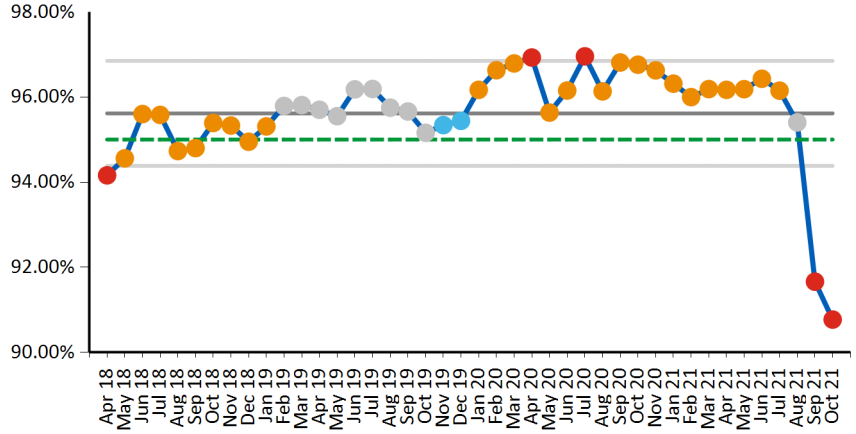
37 - Staff completing Statutory Training



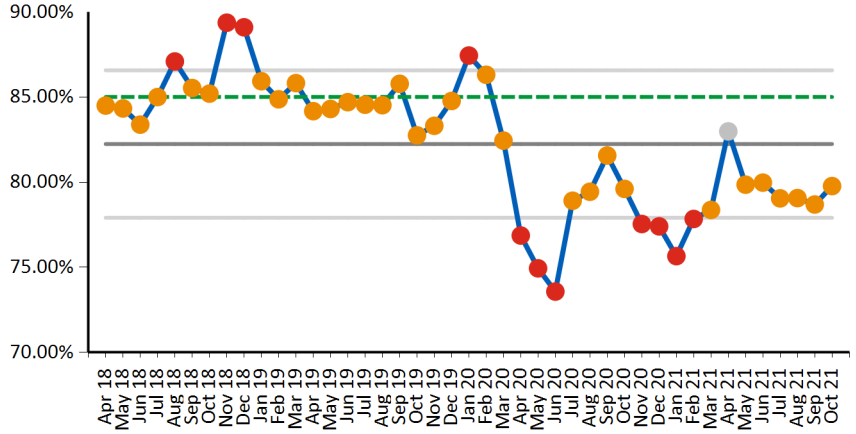
38 - Staff completing Mandatory Training



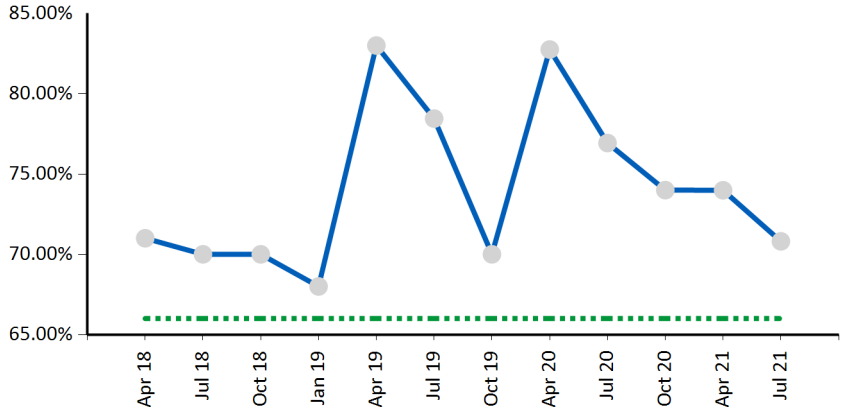
39 - Staff completing Safeguarding Training



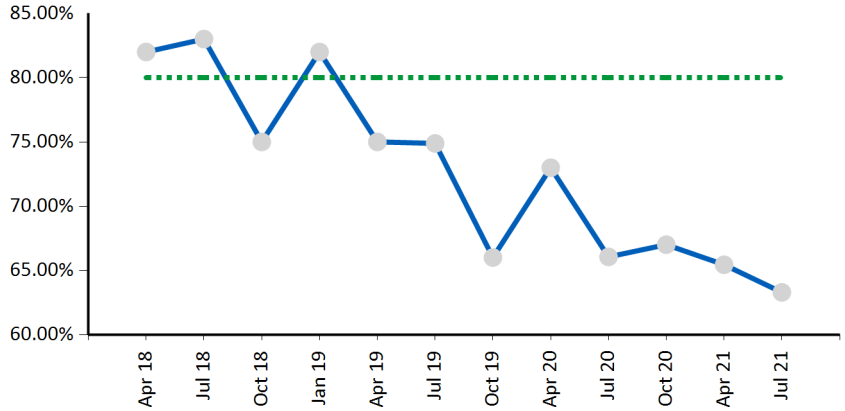
101 - Increased numbers of staff undertaking an appraisal



78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) - SPC data available after 20 data points



79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) - SPC data available after 20 data points

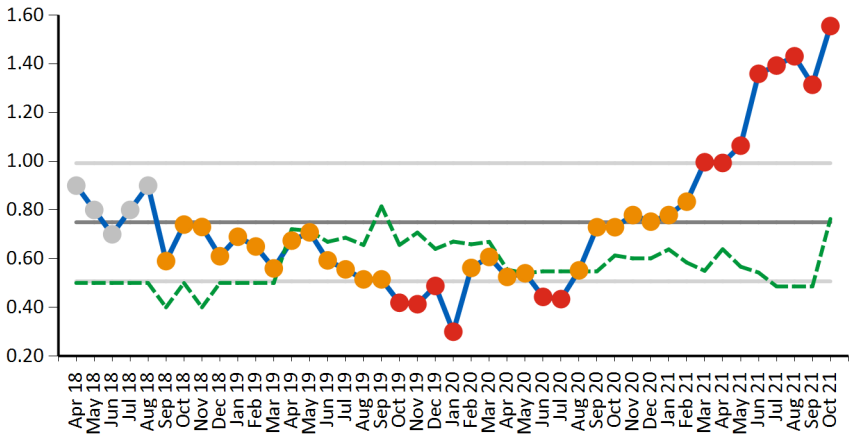


Agency

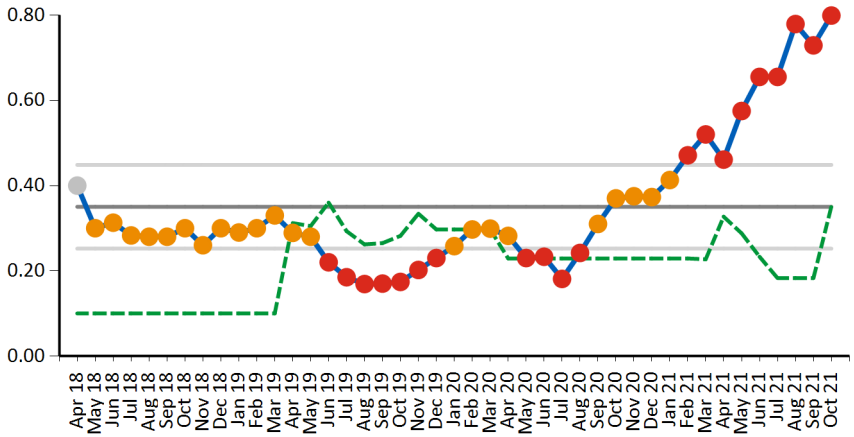
Both the Finance Committee and the People Committee received a forecasted Agency spend trajectory until the financial year end. This trajectory is based on the actions that have been taken to control agenda spend. Including Agency Market Management; Escalation controls, Health Roster training, Implementation of increased bank payments. Despite the above, Agency payment remains high – a position that is being replicated nationally, regionally and locally. Significantly more shifts were being sent to Agency, largely due to escalation areas with some linked to the recovery work.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.76	1.56	Oct-21		<= 0.49	1.31	Sep-21	<= 3.97	9.11	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.35	0.80	Oct-21		<= 0.18	0.73	Sep-21	<= 1.75	4.65	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.34	0.63	Oct-21		<= 0.23	0.41	Sep-21	<= 1.88	3.40	

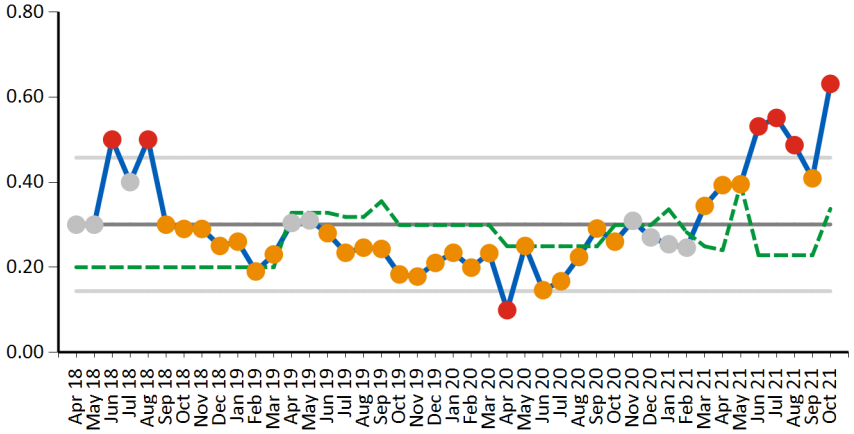
198 - Trust Annual ceiling for agency spend (£m)



111 - Annual ceiling for Nursing Staff agency spend (£m)



112 - Annual ceiling for Medical Staff agency spend (£m)



Finance

Finance

Revenue Performance Year to Date
• We have a year to date deficit of £4.9m. The Trust will receive an additional £2.4m of funding from GM to offset the H1 deficit adjusting the year to date position to a £2.5m deficit.
• Revenue performance is currently rated red.
• Action to increase CIP delivery and improve controls on variable pay

Revenue Performance Forecast Outturn
• A forecast is not available this month as national financial planning guidance for the H2 has only just been issued. The Trust is working through this guidance with GM partners to confirm funding allocations for H2. A forecast will be included in Month 8.

Cost Improvement
• The current trackers indicate that savings of £2m has been delivered YTD. Targets for H2 will be finalised for Month 8.
• CIP is rated amber as there is a significant reliance on non-recurrent schemes.
• Action to focus on identifying and delivering recurrent CIP

Variable Pay
• We spent £3.4m on variable pay in month 7, which was a reduction of £0.3m compared to last month.
• Variable pay is rated red as spend is significantly above plan.
• Action to improve controls

Capital Spend
• Year to date spend is £4.5m.
• Forecast spend for 2021/2022 has been reduced to £13.1m assuming GM slippage is available.
• Capital is rated as red as a result of the associated risks.

Cash Position
• We had cash of £35.8m at the end of the month.
• Cash is rated green as there are no concerns around cash flow this year.

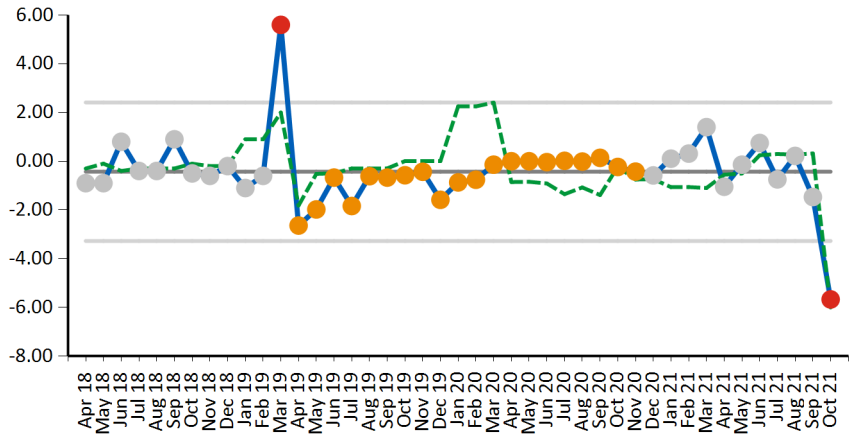
Loans and PDC
• We have loans of £40.8m.
• Rated green as there are no concerns in this area.

Better Payment Practices Code
• Year to date we have paid 88.0% of our invoices within 30 days. This is below the target of 95%, hence rated amber.
• Action to review and improve performance is underway

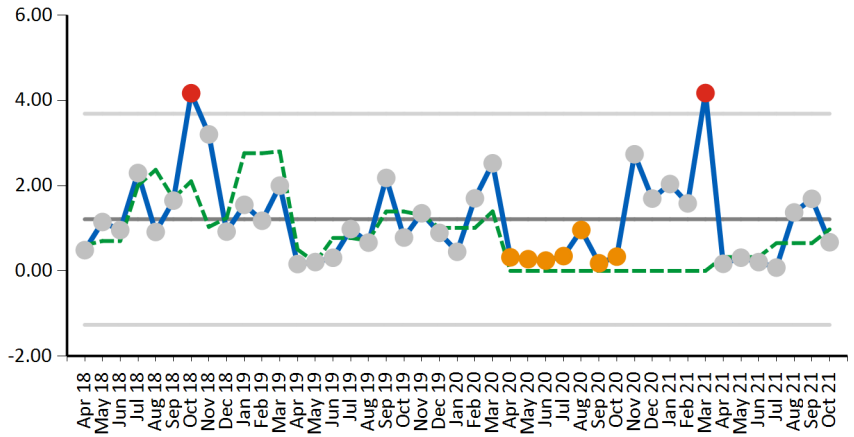
Use of Resources Rating
• This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -6.0	-5.7	Oct-21		>= 0.3	-1.5	Sep-21	>= -5.9	-8.1	
222 - Capital (£ millions)	>= 1.0	0.7	Oct-21		>= 0.6	1.7	Sep-21	>= 3.9	4.5	
223 - Cash (£ millions)	= 0.0	35.8	Oct-21		= 0.0	42.4	Sep-21	= 0.0	35.8	

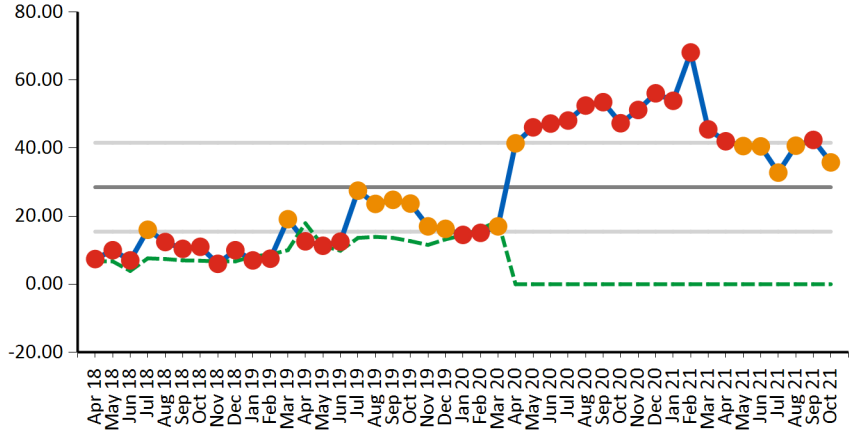
220 - Control Total (£ millions)



222 - Capital (£ millions)



223 - Cash (£ millions)



oard Assurance Heat Map - Hospital

	Indicator	Target	Council	Acute Division																														Families Division									
			Lab Lodge	AED-Adults	AED-Paeds	A4	ACU	B1 (Frailty Unit)	B2	B3	B4	BCAU	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	Critical Care	DCU (daycare)	E3	E4	F3	F4	F6	G3/TSU	G4/TSU	H2 (daycare)	R1	UU (daycare)	CDS	E5	F5	Ingleside	M2 (AN)	M3 (Birth)	M4 (PN)	M5 (PN)	M6	NICU	Overall
	Average Beds Available per day	*N/a*	32	0	0	20	10	22	26	21	21	19	25	26	26	25	10	13	24	23	5	26	12	5	22	18	25	25	25	25	24	10	24	25	11	3	4	15	38	7	4	26	closed	22	22	17	38	789
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%	85.0%	100.0%		100.0%	95.0%	95.0%	100.0%	95.0%	100.0%	100.0%	80.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	95.0%	100.0%	85.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		95.0%	97.2%
	IPC Rapid Improvement Tool % (Gen)	*Target = 95%*	100.0%	94.4%	100.0%			95.0%	65.0%	100.0%	94.7%		90.0%	83.3%	100.0%	89.5%	100.0%	100.0%	90.0%	94.7%	94.7%	95.0%	94.1%	83.3%	83.3%	100.0%	100.0%	85.0%	100.0%	94.7%	95.0%	85.0%	89.5%	93.8%		95.0%	94.7%	100.0%	100.0%	93.8%	94.7%		89.5%	95.0%	94.7%	100.0%	93.6%
	IPC Rapid Improvement Tool % (Med)	*Target = 95%*		81.0%	94.7%			91.3%		100.0%	95.7%		90.9%	72.7%	100.0%	87.5%	100.0%	95.8%	95.2%	86.4%	100.0%	93.8%	95.0%		96.0%	100.0%	100.0%	97.0%	100.0%	95.7%	95.8%	91.7%	82.6%	73.9%	100.0%		92.0%	94.7%	85.0%	85.0%	100.0%	95.7%		95.5%	95.5%	96.0%	100.0%	93.3%
	Mattress Audit Compliance %	*Target = 100%*	100.0%					100.0%	100.0%	100.0%	100.0%	100.0%	53.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				98.2%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.6%
	C - Diff	*Target = 0*	0	0	0	0	0	1	0	0	2	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
	MSSA BSIs	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	E.Coli BSIs	*Target = 0*	0	0	0	0	0	0	0	0	0	0	1	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	0	0	0	0	0	0	0	1
	MRSA acquisitions	*Target = 0*	0	0	0	0	0	1	0	0	2	0	1	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	7	1	0	4	0	8	12	4	6	0	2	8	3	5	1	2	0	5	1	0	1	1	1	1	0	0	1	1	3	1	2	2	0	0	0	0	0	0	0	0	0	1	0	84
	Harms related to falls (moderate+)	*Target = 1.6*																																													0
	VTE Assessment Compliance	*Target = 95%*				92.9%	100.0%	0.0%		100.0%		99.8%	80.0%	50.0%	93.0%		94.3%	100.0%	99.6%	100.0%	25.0%	52.9%		98.6%	0.0%	100.0%	98.3%	100.0%	95.1%	94.1%	73.9%	99.0%	91.9%	100.0%	99.2%	0.0%	83.3%	90.0%			37.5%	99.6%		58.5%	58.5%	91.9%		95.3%
	New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	3
	New pressure Ulcers (Grade 3)	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New pressure Ulcers (Grade 4)	*Target = 0*	0	0	0	0	0	1	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	0	0	0	0	0	0	0	0	0	0	0	0	1
	New pressure Ulcers (unstageable)	*Target = 0*	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Audit	Monthly KPI Audit %	*Target = 95%*	98.2%	88.6%	98.1%			95.5%	81.3%	90.7%	74.6%		84.4%	90.9%	95.0%	79.4%	89.7%	98.9%	93.6%	79.4%	82.4%	82.9%		97.2%	90.6%	100.0%	100.0%	93.2%	73.2%	96.2%	92.4%	89.2%	90.3%	73.3%	100.0%		98.4%	98.7%	100.0%	100.0%	95.2%	99.5%		97.4%	98.6%	95.5%	95.5%	92.4%
	BoSCA Overall Score %	*w=<55,b=55, s>75,g>90*		75.3%	75.3%			64.2%	58.3%	84.4%			81.6%	75.6%	82.3%	75.8%	84.3%	76.4%	75.1%	83.2%	92.9%	90.2%	71.8%	86.3%	85.7%	94.3%		86.8%	81.7%	91.8%	77.7%		91.4%	90.9%			88.2%	90.3%	90.1%	90.1%		91.9%	90.4%	71.4%	71.4%	80.3%	90.3%	82.5%
	BoSCA Rating			silver	silver			bronze	bronze	silver			silver	silver	silver	silver	silver	silver	silver	silver	platinum	gold	bronze	silver	silver	platinum		silver	silver	platinum	silver		platinum	platinum			silver	gold	platinum	platinum		platinum	gold	bronze	bronze	silver	gold	Silver
Patient Experience	FFT Response Rate	*Target = 30%*	100.0%	17.7%	0.5%	45.7%		30.2%	2.4%	20.0%	33.3%		52.5%	1.5%	15.5%	20.8%	34.6%	37.1%	9.9%	1.7%	0.0%	30.8%		16.6%	45.0%	0.0%	38.9%	20.8%	17.6%	21.9%	18.4%	25.0%	17.8%	44.8%	36.4%		35.3%	26.5%	0.3%	1.1%	26.5%	0.0%		11.2%	11.2%	100.0%	50.0%	19.1%
	FFT Recommended Rate	*Target = 97%*	75.0%	81.2%	53.8%	100.0%		94.7%	100.0%	100.0%	92.3%		93.8%	100.0%	86.7%	90.9%	100.0%	95.6%	100.0%	100.0%		95.0%		97.3%	100.0%		98.6%	100.0%	97.3%	100.0%	95.2%	100.0%	93.8%	92.3%	97.6%		100.0%	82.4%	100.0%	75.0%	82.4%			83.3%	83.3%	100.0%	100.0%	97.0%
	Number of complaints received	*Target = 0*	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Governance	Serious Incidents in Month	*Target = 0*	0	0	1	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Incidents > 20 days, not yet signed off	*Target = 0*	0	58	3	0	0	4	1	0	10	1	2	3	2	8	1	0	0	2	0	0	1	3	0	0	0	1	1	1	0	0	2	1	0	0	0	36	0	0	5	1	0	3	6	3	2	161
	Harm related to Incident (Moderate+)	*Target = 0*	0	0	0	0	0	0	0	1	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	0	1	0	0	0	0	0	0	0	0	2
Staff Dev / Equipment	Appraisals	*Target = 85%*		77.8%			92.0%	71.0%	76.2%	72.7%	60.9%	63.2%	54.8%	55.6%	79.4%	76.7%	79.2%	87.5%	87.2%	93.9%	97.4%	76.2%	100.0%	78.8%	70.6%	92.2%	78.3%	86.5%	92.3%	73.9%	83.3%	64.3%	81.0%	72.7%	80.0%		81.0%	65.6%	93.0%		100.0%	100.0%	57.1%	94.6%	81.0%		70.9%	79.8%
	Statutory Training	*Target = 95%*		83.45%		94.96%	80.59%	69.54%	67.15%	69.68%	88.0%	82.71%	85.44%	78.70%	80.86%	93.93%	82.27%	87.53%	84.89%	93.39%	85.96%	98.21%	92.13%	80.25%	88.88%	96.01%	91.81%	92.34%	94.63%	79.15%	93.23%	85.64%	86.75%	95.00%		91.43%	86.2%	89.0%		85.7%	85.8%	73.5%	86.1%	86.3%		87.78%	89.8%
	Mandatory Training	*Target = 85%*		89.61%		91.2%	82.9%	75.9%	72.5%	76.3%	90.3%	81.3%	83.2%	80.4%	79.1%	93.8%	88.6%	88.2%	82.3%	93.8%	84.8%	100.0%	93.9%	81.0%	90.5%	97.1%	90.2%	90.6%	98.3%	74.9%	92.9%	85.3%	91.5%	91.5%		96.6%	87.8%	89.3%		100.0%	87.4%	82.5%	89.6%	89.1%		87.2%	87.7%
Staffing & Workforce	% Qualified Staff (Day)							96.9%	96.1%	92.7%	82.7%		95.5%	79.9%	97.7%	93.7%	98.2%				72.9%	100.5%			84.7%	93.9%		96.3%		98.9%	96.8%		99.8%					88.9%	89.0%	15.6%		90.6%		90.0%	86.7%			
	% Qualified Staff (Night)							96.7%	98.6%	88.1%	77.6%		102.9%	95.4%	91.4%	81.2%	78.3%				88.8%	104.0%			94.7%	99.1%		87.7%		51.5%	65.0%		91.9%					70.6%	10.9%	56.5%		109.6%		52.1%	55.4%			
	% un-Qualified Staff (Day)							144.5%	146.8%	141.9%	100.0%		137.2%	151.8%	149.2%	142.7%	100.0%				102.2%	108.6%			122.6%	84.2%		99.1%		96.9%	150.1%		99.2%					84.6%	96.9%	10.6%		74.0%		70.9%	82.3%			
	% un-Qualified Staff (Night)							136.6%	103.4%	99.1%	90.8%		99.2%	96.8%	99.2%	92.7%	93.5%				91.4%	109.4%			109.7%	86.7%		94.7%		62.9%	102.3%		100.8%					95.5%	23.5%	0.5%		139.3%		69.1%	56.4%			
	Budgeted Nurse: Bed Ratio (WTE)			8.87	-2.77	-2.77	0.00	0.00	2.49	8.91	7.56	0.00	0.00	2.38	4.21	4.34	4.18	-12.62	2.33	1.66	3.34	1.72	2.96	0.00	3.36	2.03	7.67	-0.58	3.78	4.07	-2.86	3.56	7.61	5.75	0.56	-0.17	0.00	-2.75	7.45	0.48	0.48	14.29	-0.74	5.62	-3.24	2.70	0.85	9.49	97.33
	Current Budgeted WTE (Ledger)			50.78	73.28	73.28			38.03	63.59	43.34	0.00		33.71	41.23	42.69	40.70	0.00	19.97	50.82	40.30	40.01	39.97		24.27	36.15	107.36	32.75	35.52	30.21	37.79	30.21	44.49	18.07	44.50	50.86		16.01	86.31	33.42	33.42	66.93	22.00	22.12	26.34	26.34	46.87	105.69	1669.31
	Actual WTE In-Post (Ledger)			41.91	76.05	76.05			35.54	54.68	35.78	0.00		31.33	37.02	38.35	36.52	12.62	17.64	49.16	36.96	38.29	37.01		20.91	34.12	99.69	33.33	31.74	26.14	40.65	26.65	36.88	12.32	43.94	51.03		18.76	78.86	32.94	32.94	52.64	22.74	16.50	29.58	23.64	46.02	96.20	1563.11
	Actual Worked (Ledger)			47.90	88.51	88.51			55.68	56.78	48.67	0.00		41.31	51.69	48.19	48.85	43.58	29.11	58.25	47.03	42.58	45.66		20.92	43.42	114.89	33.26	40.85	34.13	47.88	45.77	48.55	18.06	53.64	50.12		17.54	93.37	34.67	34.67	61.51	26.63	15.41	36.70	32.87	53.28	94.82	1895.25
	Sickness (%)	*Target < 4.2%*			5.54%		11.25%	13.19%	13.07%	10.82%	11.52%	5.98%	8.27%	14.30%	2.84%	12.14%	10.85%	9.15%	5.59%	7.62%	5.34%	3.14%	1.37%	8.39%	16.03%	8.54%	15.48%	4.60%	12.26%	6.39%	5.81%	9.93%	11.18%	13.71%	8.86%		3.66%	10.72%	6.26%		6.45%	6.15%	1.42%	9.45%	3.68%		5.79%	5.85%
	Current Budgeted Vacancies		-5.99	-12.46	-12.46	0.00	0.00	-20.14	-2.10	-12.89	0.00	0.00	-9.98	-14.67	-9.84	-12.33	-30.96	-11.47	-9.09	-10.07	-4.29	-8.65	0.00	-0.01	-9.30	-15.20	0.07	-9.11	-7.99	-7.23	-19.12	-11.67	-5.74	-9.70	0.91	0.00	1.22	-14.51	-1.74	-1.74	-8.87	-3.89	1.09	-7.12	-9.23	-7.26	1.38	106.20
	Pending Appointment																																														0.00
	Substantive Staff Turnover	*Target < 10%*			6.4%		0.0%	12.2%	12.5%	7.4%	0.0%	9.1%	28.2%	9.4%	16.3%	16.7%	3.4%	5.1%	15.9%	21.05%	17.8%	12.1%	0.0%	12.1%	9.5%	10.1%	11.8%	17.3%	15.9%	4.4%	35.5%	5.9%	14.0%	17.6%	8.6%		9.8%	13.5%	5.9%		66.7%	6.3%	32.6%	12.5%	10.7%		8.4%	13.17%

Data Legend

No data returned	N/R
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists or Doctors.

BOSCA Colours - white, bronze, silver, gold, platinum

Board Assurance Heat Map - District Nursing Domiciliary & ICS Services

	Indicator	Target	ICS Services														DN Teams										Treatment Rooms		Overall
			Admission Avoidance	Acute Therapies	Anti-coagulant Team	Asylum & Refugee/ Homeless & Vunerable	Bladder & Bowel Service	Community IV Therapy	Diabetes & Endo	Dietetics	Falls	Neurology & LTC	Podiatry	Rheum-atology	SLT	Stroke	Wheel-chair Service	Avondale	Breightmet & Little Lever	Crompton	Farnworth	Great Lever	Horwich	Pikes Lane	Waters Meeting	West-houghton	Evening Service	North	South	
Infection Control & Harm Free	Hand Washing Compliance %	*Target = 100%*	N/R		100.0%	N/R	N/R	N/R				N/R		100.0%				100.0%	N/R	N/R	N/R	100.0%	N/R	N/R	N/R	N/R	N/R	N/R	N/R	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	2	0	0	4
	Monthly New pressure Ulcers (Grade 3)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	0	0	3
	Monthly New pressure Ulcers (Grade 4)	*Target = 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	0	0
	Monthly New pressure Ulcers (Unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	3
Audit	Monthly KPI Audit %	*Target = 95%*	97.5%			98.3%	100.0%	99.0%		91.7%		90.5%	98.7%		85.5%		94.7%	99.6%	98.8%	98.7%	95.7%	99.6%	97.4%	97.8%	97.7%	94.9%	99.2%	95.6%	94.9%	96.46%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*																94.74%	91.01%	94.22%	85.51%	93.60%	94.33%	97.23%	83.06%	97.11%	94.79%	95.60%	89.86%	93%
	BoSCA Rating																	platinum	platinum	platinum	silver	platinum	platinum	platinum	silver	platinum	platinum	gold	silver	platinum
Patient Experienc	Friends and Family Response Rate %	*Target = 30%*	100.0%		37.5%	95.0%	85.0%	85.0%	3.2%	1.5%	0.0%	20.0%	5.5%	7.8%	30.0%	0.0%	0.0%					37.7%							0.0%		28.00%
	Friends and Family Recommended Rate %	*Target = 97%*	96.6%		100.0%	100.0%	100.0%	100.0%	85.2%	83.3%		100.0%	90.7%	88.7%	100.0%							100.0%								98.80%
	Number of Complaints received	*Target = 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	0		0
Staffing & Workforce	Current Budgeted WTE		39.00	37.85	7.21	4.05	4.60	13.45	22.75	21.24	66.98	27.97	34.28	22.10	14.73	25.92	7.89	11.24	16.00	17.18	17.81	11.44	13.40	12.60	13.33	11.40	19.97	24.36		518.75
	Actual WTE In-Post		37.66	36.50	6.94	6.20	4.60	12.18	21.62	20.44	63.98	26.67	34.55	19.70	15.42	26.12	7.60	18.24	15.20	16.30	19.40	10.44	11.69	11.20	11.88	11.20	17.26	23.73		506.72
	Actual WTE Worked		38.35	34.39	6.94	6.20	4.60	12.49	24.59	20.44	64.44	26.85	34.51	21.69	15.73	24.70	7.18	17.75	13.69	15.49	17.30	11.39	13.68	13.34	12.89	10.91	18.26	22.37		510.17
	Pending Appointment		5.8		1				2.8	1	2	4	1	3.8	3.9	2.1	1.8		1.8	1	1	1			0.8		2.01	0.8		37.61
	Current Budgeted Vacancies (WTE)		1.34	1.35	0.27	-2.15	0.00	1.27	1.13	0.80	3.00	1.30	-0.27	2.40	-0.69	-0.20	0.29	-7.00	0.80	0.88	-1.59	1.00	1.71	1.40	1.45	0.20	2.71	0.63		12.03
Staff Development	Sickness (%)	*Target is < 4.2%*	12.6%	1.9%	0.5%	15.15%	0.0%	0.6%	1.5%	0.16%	8.8%	7.1%	0.4%	4.7%	4.9%	3.2%	0.0%	4.1%	0.4%	3.8%	0.7%	0.0%	11.6%	2.6%	18.5%	3.4%	1.7%	10.7%		4.90%
	Total WTE with 19.81% Headroom (Sickness, Training etc)																													
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	9.9%	8.7%	10.0%	30.8%	0.0%	14.3%	17.2%	24.0%	9.0%	18.5%	5.5%	9.3%	5.6%	12.5%	21.1%	14.8%	19.4%	9.8%	0.0%	8.3%	7.1%	0.0%	5.9%	8.0%	16.1%	14.3%		11.02%
	12 month Appraisal	*Target = 85%*	68.4%	93.2%	90.0%	85.7%	100.0%	92.9%	70.0%	78.3%	63.9%	83.3%	97.4%	88.9%	82.4%	93.8%	50.0%	100.0%	100.0%	94.4%	72.2%	91.7%	84.6%	100.0%	93.3%	100.0%	86.7%	74.1%		84.37%
	12 month Statutory Training	*Target = 95%*	87.1%	90.8%	98.6%	93.9%	91.4%	99.0%	92.6%	95.2%	85.4%	93.9%	96.1%	91.7%	95.8%	92.9%	95.0%	96.2%	98.1%	98.1%	92.1%	97.9%	92.3%	96.4%	93.3%	97.9%	95.7%	93.3%		93.64%
	12 month Mandatory Training	*Target = 85%*	93.2%	91.9%	94.4%	95.1%	86.2%	98.7%	89.4%	94.9%	85.9%	93.6%	94.9%	88.0%	97.6%	97.4%	97.0%	96.6%	98.9%	97.1%	96.2%	98.8%	95.6%	96.9%	95.1%	97.6%	98.6%	96.2%		95.51%

Data Legend

No data returned	N/R
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists, Relief Team or Doctors & so will not marry up with the community performance report.
Home visits on this report excludes Groups so will not marry up with the community performance report.

BOSCA Colours - white, bronze, silver, gold, platinum

AGENDA ITEM 22

Title:	Safeguarding Adult, Children and Looked After Children Annual Report 2020-21

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25th November 2021		Discussion	
Exec Sponsor	Karen Meadowcroft		Decision	

Summary:

It is a statutory requirement that the Trust Board receives an annual Safeguarding report, which outlines compliance against statutory and regulatory standards for safeguarding adults and children. The report will highlight that despite the COVID-19 pandemic, the Trust has maintained compliance with these requirements, however due to the constraints of the pandemic the safeguarding services has had to adapt and be flexible to meet these requirements.

2020-2021 has been a challenging year in safeguarding against the backdrop of the COVID-19 pandemic. In wave 1 of the pandemic, when the country went into lockdown, this increased vulnerability for both adults and children with schools and nurseries closing, parents working from home, on furlough or losing their jobs and the elderly becoming isolated. For children who are already experiencing abuse and neglect the pandemic has further increased their risk and vulnerability. Details of the increase in volume and complexity of cases are included within this report. The increase in workload has impacted on teams both within the hospital and community and they have ensured our patients have been safeguarded at a difficult time.

The pandemic has had an impact on health and emotional wellbeing for all however in the lives of vulnerable adults and children this has been exacerbated. During this time, in Bolton, services have had to work differently to identify and meet the needs of our vulnerable population. This is against a backdrop in Bolton in the top 20 of the most deprived areas in England, and 26% of the population are under 19 years with 20% of children living in poverty.

This report will highlight a 42% increase in children subject to Child protection plans in the last 5 years with significant increase in emotional abuse and neglect many cases related to the high levels of Domestic Abuse in Bolton. The report with also highlight the increase in both children and adult Mental Health issues resulting in a 42% increased number attending Accident and Emergency.

The report also highlights the safeguarding reviews that have taken place and the learning for the organisation.

The safeguarding children and adult team and pleased to be able to report that despite being very small teams, they have been able to provide safeguarding advice and support to staff along with being fully involved in partnership working to address the complexities of safeguarding during the pandemic and while there is always learning and development work, the team are proud of their achievements during a very difficult period.

Following review of the content of this report the Chief Nurse will be reviewing the safeguarding structure to ensure the team are adequately resourced to support the increasing demands to safeguard our patients.

Previously considered by:	Safeguarding Committee

Proposed Resolution	Continued scrutiny and compliance with statutory and regulatory standards.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Bridget Thomas	**Presented by:**	Karen Meadowcroft

Bolton NHS Foundation Trust

Part 1

Safeguarding Children

and

Looked After Children Annual Report 2020/21

Author:

Fiona Farnworth

Named Nurse Safeguarding and Looked after Children

1. Introduction Safeguarding and Looked after Children

1.1 Safeguarding and Looked after Children practice is governed by a range of legal and regulatory requirements including Working Together to Safeguard Children 2018, the Children Act 1989 and duties set out in Section 11 of the Children Act 2004.

1.2 Safeguarding is a complex area of practice. The potential cohort is wide, abuse or risk of harm can occur in any context and takes many forms, some of which may not be obvious. The duties of NHS providers to ensure children in our care and who use our services are safeguarded is outlined in the NHS England - Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSE August 2019).

1.3 Effective safeguarding arrangements seek to protect individuals from harm or abuse, regardless of their circumstances. In the UK, safeguarding children legislation is underpinned by the United Nations Convention on the Rights of the Child. The arrangements are set out within the NHSE framework, and will apply whenever a child or young person is at risk of abuse or neglect, regardless of the source of that risk.

2. Purpose of the Annual Report

2.1 The Safeguarding and Looked after Children Annual Report reflects arrangements and activity to safeguard and promote the welfare of children and young people for the period of April 2020 to March 2021.The report provides assurance that safeguarding practice across the organisation meets mandatory and statutory requirements.

2.2 Statutory Responsibilities for NHS Trusts

It is the responsibility of every Trust, and each individual professional working in the Trust, to ensure that the principles and duties of safeguarding children are consistently applied and the well-being of those children at the heart of what we do.

Table 1 – Safeguarding Children Statutory Duties

Statutory Duty	NHS Provider Requirement	Underpinning Legislation /Statutory Guidance
Regularly review arrangements for Safeguarding Children	The Trust Board is required to assure itself that these systems are working effectively.	• Children Act 1989/2004 • Working Together (2018) Statutory Guidance • Promoting the Heath of Looked After Children (2015) Statutory Guidance • Safeguarding Children and Young People Roles and Competencies for Health Care staff (2019) • Looked After Children, Skills and Competencies for healthcare Staff (2015)
Disclosure and Barring	Following the Lampard Inquiry 2015 recommendations were made that all NHS trusts must undertake DBS checks on their staff and volunteers.	• Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) • Lampard Inquiry (2015)
Partnership Working	The Trust is required to co-operate and work with other organisations to seek common solutions to the changing context of safeguarding to deliver the NHS Long Term Plan (LTP). The Children Act 2004 places a duty on agencies to work together to safeguard	• Children Act 1989/2004 • Working Together (2018) Statutory Guidance

	children and promote the welfare of all children in their area, and to monitor and ensure the effectiveness of those arrangements. They will be equally accountable for the system they create.	
Duty of candour	Safeguarding requires openness, advocacy, transparency and trust (Francis Inquiry).	• Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
Information sharing	Robust information-sharing is at the heart of safe and effective safeguarding practice. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children, young people safe.	• General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. • Working Together (2018)
Statutory Reviews	There is a requirement for professionals to contribute, participate and share information for the purpose of statutory reviews.	• Children Act 1989/2004 • Working Together (2018) Statutory Guidance

3. Legislation

3.1 Legislation

The list below is an example of the legislation that all NHS providers are required to work within. This also includes legislation which requires mandatory reporting by Trusts for example FGM. This is not an exhaustive list but provides the main legislation applicable to Safeguarding Children.

4. Safeguarding Children

4.1 What is Safeguarding?

Working Together 2018 is very clear regarding the range of responsibilities placed upon organisations to keep children safe. This is underpinned by the following –

The UN Convention on the Rights of the Child (1989) includes the requirement that –

- Children live in a safe environment,
- Be protected from harm
- Have access to the highest attainable standard of health.

Children Act 1989/2004

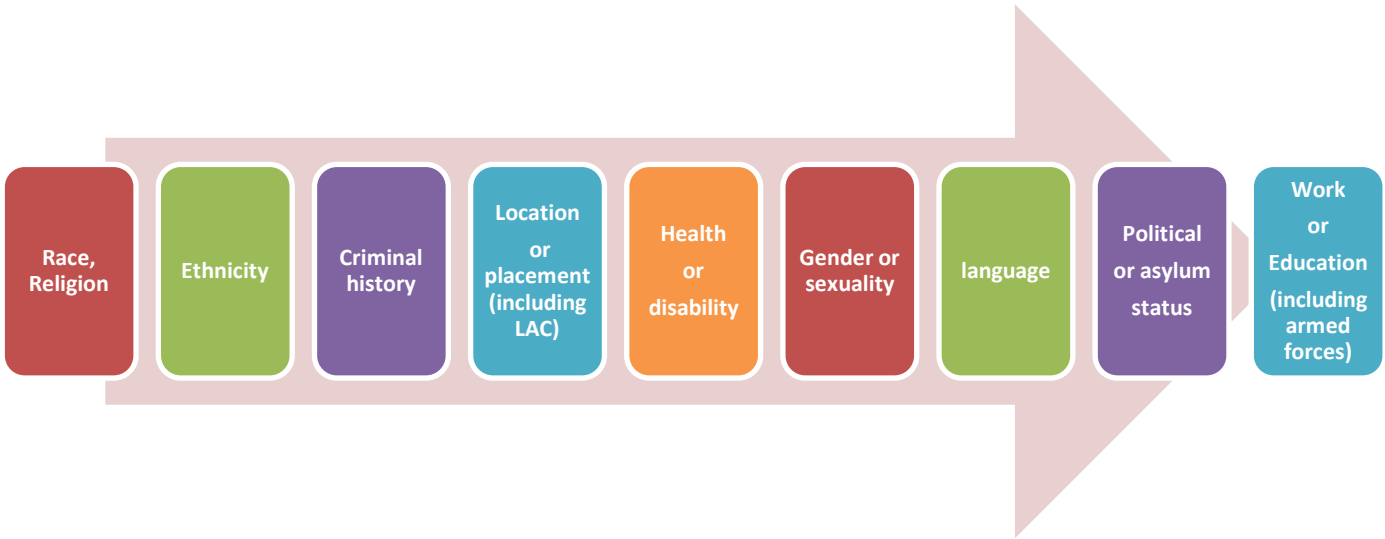
- Section 11 states that health organisations having a duty to cooperate with social services under section 27 of the Children Act 1989.
- These duties are an explicit part of NHS employment contracts, with Chief Executives having responsibility to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children within organisations.

4.2 Definitions

Table 2 - Definitions

Safeguarding Children (Working Together 2018)	• Protecting children from maltreatment; • Preventing impairment of children's health or development; • Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; • Taking action to enable all children to have the best outcomes
Child Protection	Is part of safeguarding refers specifically to children who are suffering, or at risk of significant harm.
Early Help	Is part of the safeguarding process – the Framework for Action is the continuum used in Bolton.
Looked after Children (LAC)	A child under the care of the Local Authority for more than 24 hours. Children can be in care by agreement of their parents or by an order of the court.
A Child	Is defined as having not reached 18 years, up to 19/25 years if SEND (Special Educational Needs and Disability) (Children Act 1989)

All children have the right to be safeguarded from harm and exploitation regardless Of the following factors: (UNCRC)



4.3 Other considerations

Safeguarding children responsibilities for the Trust extends beyond services that work with children up to age 16, to include 16 and 17 year olds in the following circumstances –

- Those who are admitted to adult wards
- Those in transition to adult services,
- Pregnant 16-17 year olds,
- Unborn babies
- Siblings and dependent children of adult patients who access Trust services.



Throughout 2020/21 staff in services based in the community and on the hospital site as well as those with a Specialist Safeguarding or LAC role have continued to work with partner agencies to ensure the safety of children and young people.

Key services with “case holder” responsibilities for safeguarding include –

- **0-19 service** (Health Visiting, School Nursing, Adolescent Health and Enhancing Families) all who hold child protection caseloads in addition to their universal offer and are required to attend all safeguarding and child protection meetings and co-ordinate interventions for children and families on their caseload.

- **Enhanced Midwives** in community based services who manage women with complex safeguarding, domestic abuse and mental health concerns and have a reduced generic caseload due to the complexity of the cases that they manage.

These services have continued to meet their safeguarding responsibilities in challenging circumstances during the COVID-19 Pandemic. This has required a flexible and prompt response in some cases with a commitment to continue existing work streams – for example contributing to the Partnership Neglect Strategy.

Children and adults who are not Bolton residents may access services within the Trust including urgent care. The Safeguarding Children team work closely with health colleagues and partner agencies in other areas across Greater Manchester, Lancashire and further afield as required.

5. Safeguarding Assurance and Contractual Standards

5.1 Contractual Standards

Clinical Commissioning Groups (CCG) across Greater Manchester provide an annual safeguarding children, young people and adults at risk contractual standards collaborative document to all health providers. Healthcare providers are monitored to ensure that systems and processes are in place to protect services users from abuse or the risk of abuse. These standards are built on the principles outlined in the *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework* (NHS England 2015).

The 2020/2021 contractual standards consist of 81 safeguarding standards with which the Trust are required to comply with. The Trust is required to complete an annual self-assessment / audit against the standards and submit to the CCG. Evidence and RAG rating is provided for each standard. Actions are identified and monitored via the Trust Safeguarding Committee.

There is collaborative working between the CCG Safeguarding team and the Trust Safeguarding Children team to explore the assurance provided.

The safeguarding team works with other departments across the Trust who have responsibilities for arrangements that support safeguarding – e.g. liaison with HR to

embed Safer Recruitment. The chart below outlines Bolton FT compliance against the main contractual standards for 2020-2021. It is of note that Bolton FT has met all the contractual standards for this reporting period which align to Section 11 Statutory requirements as outlined in the Children Act 1989.

Table 3 - Compliance against Safeguarding Contractual Standards

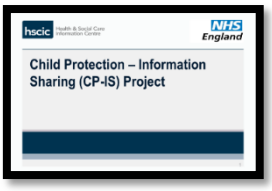
Statutory Duty	NHS Provider Requirement	Trust Compliance with standards	RAG
Organisational Governance	• Board lead for safeguarding children • Safeguarding in Job Descriptions • Safeguarding Governance structure • Annual Report for Safeguarding and LAC • Links to the Safeguarding Partnership Board and subgroups • Regular reports to Board	Bi monthly updates from Safeguarding Committee to Quality Assurance Committee New Safeguarding Assurance framework to be launched in Q2 2021/22. Robust partnership arrangements in place including joint working training and audit at all levels.	
Leadership	• Identification of a named doctor and named nurse (and a named midwife) • The leads should be 'one step away' from the Board so as to ensure sufficient strategic influence. • Work closely with CCG and other partners.	Trust has a Named Nurse, Doctor and Midwife for Safeguarding and a Named Nurse and doctor for LAC. All posts adhere to statutory requirements for the role.	
Safeguarding Processes	• Incident Reporting Systems in place • Learning from SIs embedded • All complaints that refer to the safety of children are investigated in accordance with the Duty of Candour (Care Act, 2014) • A programme of safeguarding audit and review is in place. • Process for ensuring that patients are routinely asked about dependents or caring responsibilities. • Agreed protocols for sharing information	All incidents are reported on the Safeguard system and investigated as per The Trust policy. The Trust contributes to all safeguarding Statutory Reviews such as SCR, DHR etc. and ensures learning is embedded in practice and monitored via the Safeguarding Committee. In line with GDPR and Information Sharing guidelines, the Trust shares relevant information with partner agencies to keep children safe.	
Policies	• Staff have easy access to safeguarding and policies and procedures. • Policies and procedures consistent with statutory, national and local guidance • Safer recruitment policy • Guidance on managing allegations	Standard and Enhanced DBS checks undertaken for all new starters depending on role and regulated activity with children Compliance with Lampard recommendations in place.	
Supervision	• Staff working directly with children and adults at risk have access to advice support and supervision. • Safeguarding supervision policy	Safeguarding Supervision is in place for all caseload holders and compliance is monitored via the Safeguarding Committee.	
Training and development	• Training framework in place in line with the Intercollegiate Guidance for safeguarding children and Looked After Children.	TNA as per Intercollegiate Guidance	

5.2 Additional Statutory Reporting Requirements

Bolton FT are required to comply with the following as part of contractual standards.

5.2.1 Child Protection - Information Sharing (CP- IS)

The Child Protection Information Sharing (CP-IS) programme links the IT systems used across health and social care to securely share basic information via a child's NHS number for children and unborn children who are subject to Child Protection Plans or are Looked After. It is endorsed by the Care Quality Commission (CQC) and is included in the key lines of enquiry during CQC inspections. It is also included in the 2019 NHS Standard Contract for providers of NHS unscheduled care.



The CP-IS is in place in Urgent Care, Paediatrics and Maternity and involves staff checking on the National Spine when a child or young person attends A/E or the ward or is pregnant to see if the child is subject to a Child Protection Plan or is Looked After. On accessing this information an alert is sent to the allocated Social Worker to inform them that the child has had access with a health provider and the Social Worker will then contact the provider for information. For Bolton FT contact is made with the corporate Safeguarding Team to provide information about the attendance.

5.2.2 Female Genital Mutilation (FGM)

There are three distinct arrangements in place for Trusts to meet statutory requirements. All of these are in place in Bolton FT. These include:

a) <u>FGM Mandatory reporting duty.</u>

Section 5B of the FGM Act 2003 includes a mandatory reporting duty for regulated professionals to report known cases in under 18s. This has been in place since October 2015. This requirement is a personal duty to report and refer. Failure to make appropriate safeguarding referrals could result in fitness to practice proceedings.

b) <u>FGM Risk Indicator System (FGM RIS).</u>

This system includes the display of an indicator on a child's Summary Care Record following a risk assessment by a healthcare professional. This alert is added to the National Spine by the Trust Safeguarding Children Team.

c) FGM Enhanced dataset.

Known cases of FGM are collated from all Trust services and reported to the Department of Health on a monthly basis. The monthly report is collated by Business Intelligence and approved prior to submission by the Safeguarding Children Team.

5.2.3 FGM Legislation

It is an offence under the FGM act 2003 to:

- Perform FGM in the UK or take a girl abroad to be subjected to FGM
- Assist in the carrying out of FGM in the UK or abroad
- Assist from the UK a non-UK person to carry out FGM
- To aid, abet, counsel or procure FGM outside the UK

Section 3A of the 2003 Act describes an offence of failure to protect a girl from having FGM by a responsible person. This includes anyone with parental responsibility or anyone caring for the girl "in the manner of a parent".

5.2.4 Safeguarding and FGM

If anyone in the family has had FGM it is a requirement to consider the implications for all female children in the family by completing an FGM risk assessment. The risk assessment includes discussions about parent's knowledge of UK FGM legislation and to explore their wishes and views about FGM for children in the family.

Bolton FT has an FGM SOP in place to reflect recording and reporting responsibilities of all staff.

5.2.5 Bolton FGM Statistics

	April 2020 - March 2021	April 2019 – March 2020
FGM Cases	**172**	**186**

2020 - 2021 has seen a small reduction in the number of FGM cases identified. This may be due to COVID-19 lockdown when some services were suspended therefore the same numbers of patients were not seen and therefore reduced opportunity to identify FGM. However, the monthly numbers can be variable.

In addition, the Trust works with the police particularly at airports to prevent children leaving the country for the purposes of FGM. During 2020-21 travel has been suspended due to COVID-19 restrictions therefore the numbers picked up through this intervention will not be seen as previous years.

In Bolton we see the majority of cases identified in Maternity services with smaller numbers in 0-19 service and Sexual Health. All cases identified by Trust services have been for adults who report that FGM is historical and was carried out in country of origin not the UK.

5.2.6 Local learning on FGM prevalence

For the majority of women identified in Bolton as having been a victim of FGM, there have been no concerns identified or risks of FGM for female children in the family. Parents are aware of UK legislation and state they do not support the practice of FGM. In previous years, where concerns have been identified in a small number of cases, following multi-agency procedures there has been a small number of FGM Prevention Orders put in place for children, however these have been prior to the timeframe of this report.

No completed FGM risk assessments have identified a child in the family at risk of FGM/significant harm during the timeframe of this report.

5.3 Allegations against staff involving child abuse

Working Together (2018) states that information must be shared with the Designated Officer (Local Authority Designated Officer (LADO) where it is considered that a member of health staff poses a risk to children or might have committed a criminal offence against one or more children. The safeguarding team work closely with Divisions and HR when an allegation is made against a member of staff to assist the Designated Officer with any investigations.

5.6 Disclosure and Barring Checks

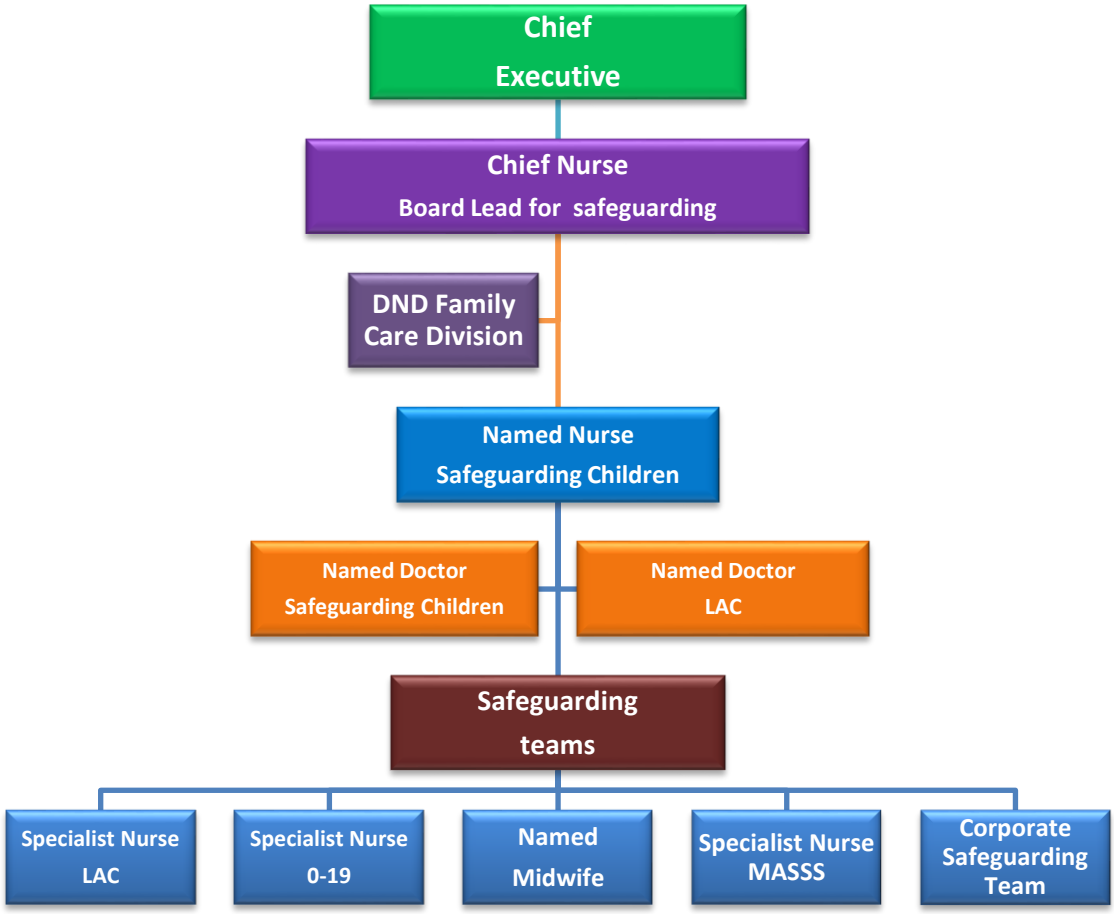
All Trusts must ensure that all staff and volunteers are checked via the Disclosure and Barring service to check their suitability to work with children and families. This is a requirement for compliance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which stipulates what information is required for people employed or appointed for the purpose of regulated activity.

5.7 Named professionals

All Trusts are required to have Named professionals in post who have a key role in promoting good safeguarding practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding supervision and training is in place.

Named professionals should work closely with their organisation's safeguarding lead, designated professionals in the CCGs and the local safeguarding children's partnership.

5.8 The following Safeguarding Children Accountability Structure is in place in Bolton.



6. Safeguarding Alignment with Trust Values

6.1 Trust Values

Preventing child abuse takes leadership, accountability and culture change. It means listening to children and young people and ensuring a culture in the Trust to put their rights, safety and dignity at the heart of every decision.

Safeguarding is firmly embedded within the core duties of all organisations across the health system. The role of health providers is to provide safe and high-quality care for all. The context of safeguarding changes in line with societal risks both locally and nationally, large scale inquiries and legislative reforms.

Safeguarding encompasses prevention of harm; exploitation and abuse through provision of high quality care, effective response to allegations and ensuring staff have the appropriate skills, confidence and knowledge to address safeguarding concerns. Trust values are incorporated in all aspect of the Trust's safeguarding provision, ensuring that children have a 'voice'.

The expected outcomes of embedding Trust values into safeguarding children practice include:

Table 4 – Alignment to Trust Values

	Trust Values	Safeguarding aligned to Trust Values
Vision	**We have a plan that will deliver excellent health and care for future generations, working with partners to ensure our services are sustainable. We make decisions that are best for long term health and social care outcomes for our communities**	We ensure that we learn from past practice to improve future provision to keep children safe. We make decisions with our partners to ensure the best outcomes for children.
Openness	**We communicate clearly to our patients, families and our staff with transparency and honesty We encourage feedback from everyone to help drive innovation and Improvements**	We ensure the voice of the child is heard in all decisions regarding care and protection. We are open and honest with parents and carer regarding child protection procedures.
Integrity	**We demonstrate fairness, respect and empathy in our interactions with people We take responsibility for our actions, speaking out and learning from our mistakes**	We respectfully and professionally challenge where concerns arise in the child's best interest. We learn from local and national incidents and investigations and share the learning across services.
Compassion	**We take a person-centred approach in all our interactions with patients, families and our staff We provide compassionate care and demonstrate understanding to everyone**	We place the needs of the child central in all we do while recognising the importance of a partnership approach with parents and carers
Excellence	**We put quality and safety at the heart of all our services and processes We continuously improve our standards of healthcare with the patient in mind**	We ensure that our service provides quality advice and support to all staff to ensure safeguarding standards are maintained and everyone is aware of their role in keeping children safe.

7. National and Local context of Safeguarding

7.1 National Overview

Child abuse existed in the UK prior to the COVID-19 pandemic, however, the stressors identified for vulnerable children and families during the COVID-19 pandemic have increased these stressors and subsequently vulnerability has increased.

Research by the NSPCC (2020) identified the following for children and families –

- **Increase in stressors to parents and care givers**
  - Financial insecurity,
  - Alterations to their routine,
  - Juggling multiple responsibilities including work,
  - Full-time childcare and care for family members who may be shielding or ill.

When adequate support is not available, such tensions may lead to mental and emotional health issues and the use of negative coping strategies which link to child maltreatment. This can increase the risk of physical, emotional, and domestic abuse, neglect, as well as online harm.

- **Increase in children's and young people's vulnerabilities**
  - Longest time in their lives spent away from friends and trusted adults outside the home.
  - The impact of lockdown on children's emotional and mental health,
  - Full-time confinement at home
  - Changes to their routines,
  - Young people with digital access are spending more time using social media and online resources putting them at increased risk of online grooming or other online harms,
  - Online child sexual material is known to be on the rise.

For children who are already experiencing abuse or neglect by household members, being at home full-time has increased their exposure to potential harm. In addition, children have not had access to trusted adults outside the home, which has increased their vulnerability and reduced protective factors for the child.

- **Reduction in normal protective services**
    - Fewer interactions with health and social care services designed to help them
    - Receiving only a fraction of the support and scrutiny that would normally be available to protect children.
    - Limited social support from friends, relatives, neighbours who would normally check on a child's welfare.
    - Limited availability of resources and services for detecting, preventing, and responding to maltreatment,

Keeping services running as near as possible to 'business as usual', adapting new ways of working to provide continuity during lockdown, has been found to be essential to limit the negative outcomes of the COVID-19 pandemic.

7.2 The Bolton Picture

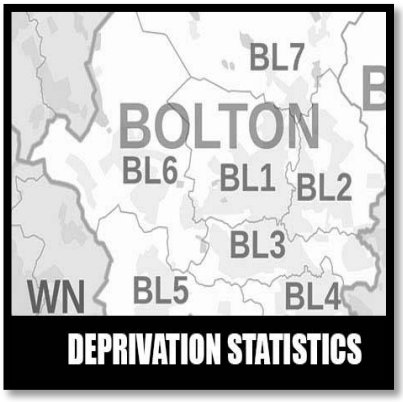
Bolton has a diverse population, however with this diversity comes significant factors that affect the health and safety of children and young people. Children and young people aged 0-19 years make up 26% of the population of Bolton and all those up to the age of 18 years and 19 years if they have a disability should be protected from significant harm, under child statutory safeguarding procedures.

7.2.1 Bolton Statistics

Bolton Population **288,248**

There are **67,433**
Children in Bolton aged 0-18 years

23% of Bolton Population



Top 20% most deprived areas in England.	20.1% (12,120) of children live in low income families
In Reception, 10.3% children are classified as obese rising to 20.8% in year 6.	Over one fifth of the population from a Black, Asian or Minority ethnic (BAME) background
Life expectancy is 10.6 years lower for men and 8.5 years lower for women in the most deprived areas	Health of people in Bolton is generally worse than the average for England

Table 5 - Child protection increases in Bolton 2020-21

Children in Bolton 0-19	• 26% of Bolton population • 21.3% England	3.7% Higher than England	↑
Poverty	• 20.1% of children living in poverty • 17% England	3.1% higher than England	↑
Domestic abuse	• DA Incidents involving children/recorded as having a child present 2719	Increased from 2019/20	↑
Child Protection Plan (CPP)	• 381 children on CPP under the categories of physical, sexual and emotional abuse and neglect	15% increase from 2019/20 42% increase since 2017	↑
Looked after Children	• 647 LAC in Bolton this has increased,	Numbers are fluid but a year on year increase is seen across Bolton.	↑
Neglect	• 180 Children on a CPP for Neglect	20% increase from 2019/20 43% increase since 2017	↑
Sexual abuse	• 28 Children on a CPP for sexual abuse	15% increase from 2019/20 43% increase since 2017	↑
Physical abuse	• 20 Children on a CPP for Physical Abuse	5% decrease since 2019/20	↓
Emotional abuse	• 136 Children on a CPP for Emotional Abuse	8% increase from 2019/20 52% increase since 2017	↑
Multiple categories	• 17 Children on a CPP for multiple categories of abuse	58% increase since 2019/20 36% increase since 2017	↑

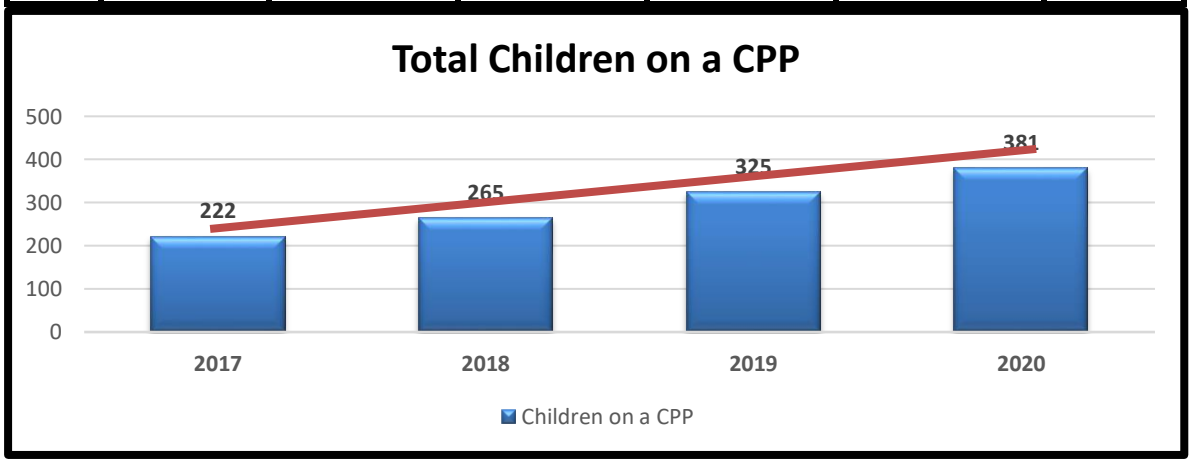
7.3 Bolton Child Protection Data

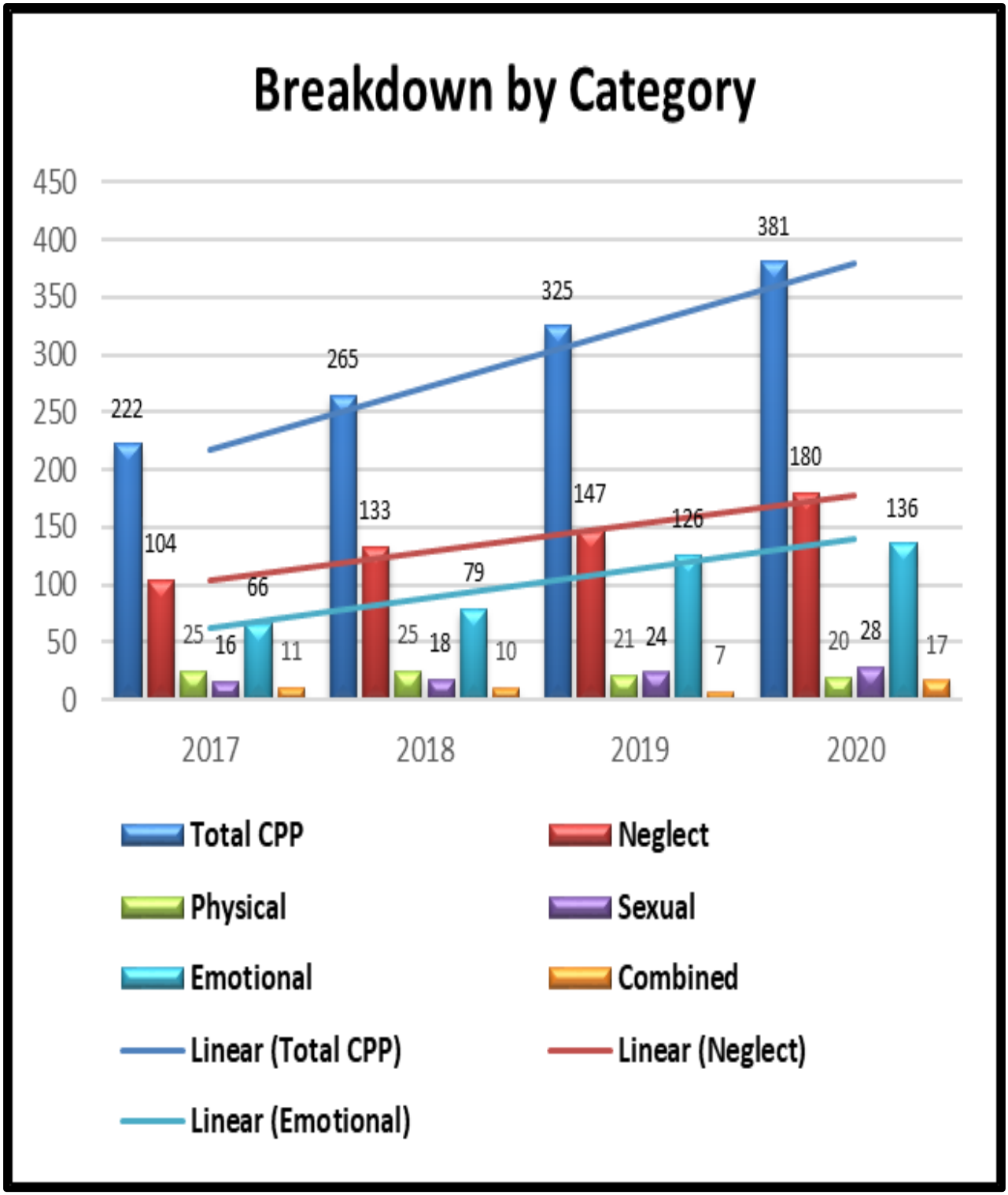
Data from the Office for National Statistics (ONS) shows that **children in Bolton subject to Child Protection Plans have increased year on with a 42% increase since 2017.** This means that social care has had to intervene to protect a child where they are at risk of or are suffering from significant harm. Safeguarding children practice takes place within a wider context for the child, family and community where the child lives. Safeguarding services span both hospital acute provision and the 9 Bolton Neighbourhoods.

The chart below gives an overview of the year on year Bolton Child Protection numbers, while physical abuse cases reported have slightly reduced, all other categories have increased in particular Neglect. This has had a significant impact on the team who have management oversight of all of these cases. In 2020/21 work has started across the partnership to strengthen the Neglect strategy and offer to families.

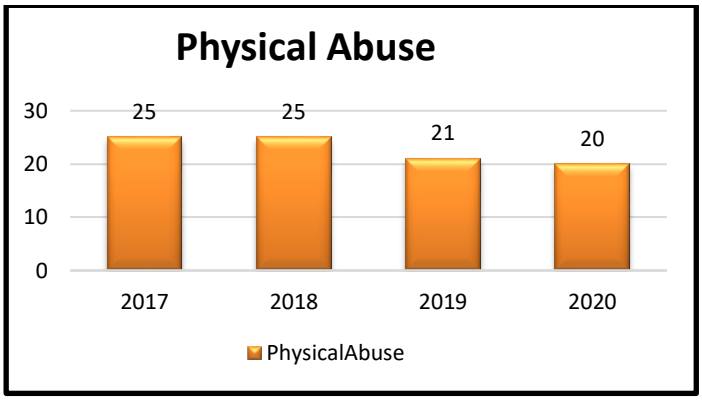
Table 6 – Categories of Abuse

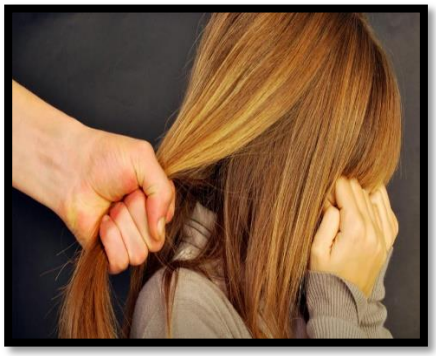
Child Protection Plan at 31st March		Category of Abuse				
Year	**Total CPP**	**Neglect**	**Physical**	**Sexual**	**Emotional**	**Multiple**
2020	381	180	20	28	136	17
2019	325	147	21	24	126	7
2018	265	133	25	18	79	10
2017	222	104	25	16	66	11

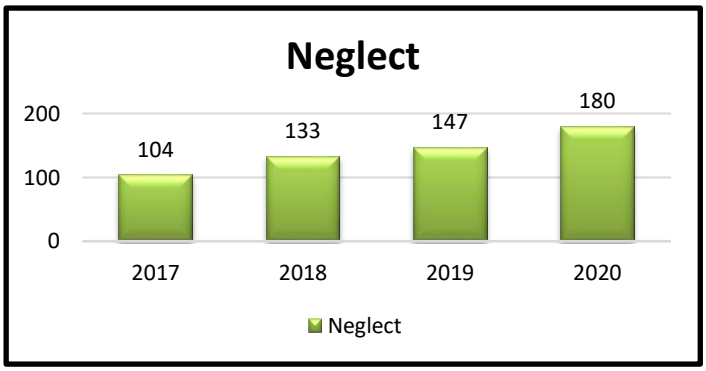


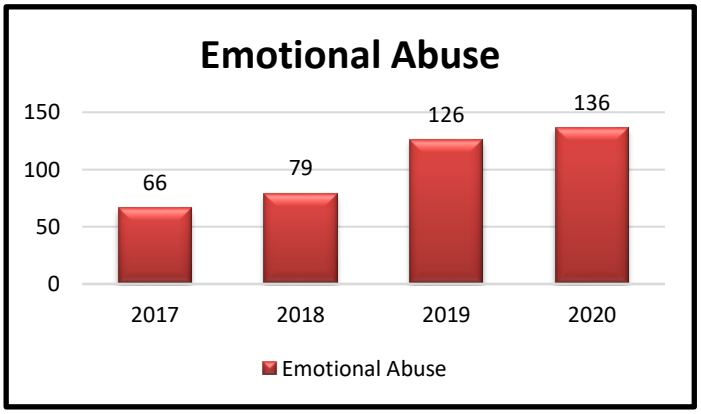

Breakdown by Category
450
400
350
300
250
200
150
100
50
0
222
104
25
16
66
11
265
133
25
18
79
10
325
147
21
24
126
7
381
180
20
28
136
17
2017
2018
2019
2020
Total CPP
Neglect
Physical
Sexual
Emotional
Combined
Linear (Total CPP)
Linear (Neglect)
Linear (Emotional)

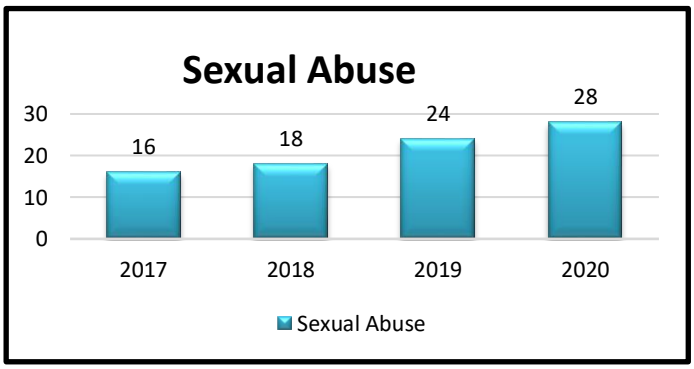
7.4 Breakdown of individual categories of abuse











7.5 Arrangements to support vulnerable children and families during COVID-19

During the timeframe of this annual report the COVID-19 pandemic has resulted in national lockdowns, re-instatement and easing of restrictions and school and nursey closures. All of these arrangements have had an impact on children, their families and services. In March 2020 NHS England guidance was clear regarding Provider roles and responsibilities and stated –

"Safeguarding children and adults is as critical during COVID-19 as it is statutory at other times"

"It is particularly important to safeguard children who due to the pandemic may be at increased risk of abuse, harm and exploitation from a range of sources"

7.6 COVID-19 Bolton Safeguarding Response

The COVID-19 pandemic saw a national focus on the risks to infants and families during COVID-19 with two formal letters sent to Local Authorities and Health Providers including one from Vicky Ford MP, Minister for Children in the UK and one from the GMCA (reminder of the GM Perinatal and Parent/Infant Mental Health Service). There was a continued focus on safeguarding children responsibilities highlighted in correspondence with local areas. Vicky Ford MP Minister for Children in the UK wrote to all Local Authorities areas to request –

"to focus on children recently stepped down from Child Protection Plans or families with new babies where there have been previous child protection concerns. There is an expectation that this is done in conjunction with health providers".

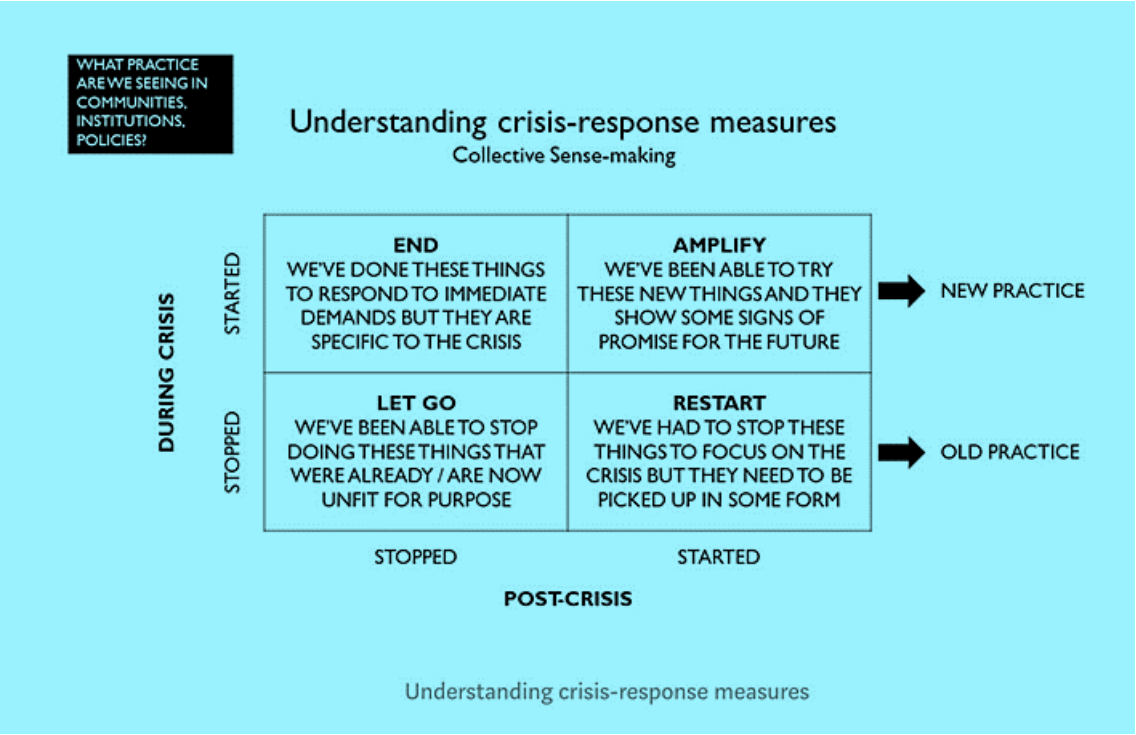
In Bolton this work was co-ordinated through the Safeguarding Children Partnership. The GMCA (reminder of the GM Perinatal and Parent/Infant Mental Health Service) stated that as we went into the second wave of the virus, we needed to learn lessons from the first. National emerging statistics during Lockdown were alarming with information being published as follows –

- **20% rise in babies being killed or harmed**
- **64 babies were deliberately harmed in England - 8 of whom died**
- **40% of the 300 incidents reported involved infants, ↑ ⅕ from 2019**

7.7 Bolton Call to Action – COVID-19

By April 2020 all agencies across the Bolton Safeguarding Children Partnership were asked to consider crisis response measures. This was both as individual agencies and as a whole safeguarding system. This proved a useful starting point to be able to continue to safeguard and promote the welfare of children in unprecedented times.

The chart below explains the crisis response model used. This included consideration of new practice arrangements in response to immediate demands specific to the pandemic, and the pause or end of practice and arrangements unfit for purpose.



7.8 Bolton FT COVID-19 Plan

All health providers interpreted national guidance about working with vulnerable children in different ways. However, in April 2020 a decision was made in the Family Care Division that keeping vulnerable children safe would be a priority for services. It was agreed that all identified vulnerable children would continue to be seen face to face. In situations where someone in the home had COVID-19 or was symptomatic and COVID-19 status was unknown, an initial telephone contact would be followed by a face to face appointment/visit if appropriate.

Bolton Safeguarding Children Partnership drafted a COVID-19 Risk Response and

Assurance Plan. The areas of highest concern included children living in families where domestic abuse was known and children living in households where there is known abuse and neglect. All agencies were able to contribute to actions to mitigate risk and this was reviewed and updated.

The risk of services not being available for vulnerable children in school or nursery provision was placed on the Trust Risk Register and reviewed and updated throughout 2020 and continues after March 2021.

Based on national and local agreements and guidance a number of measures were put in place in Bolton FT in April 2020 as follows –

Bolton FT Safeguarding activity	• Continued the same level of safeguarding activity as pre-COVID-19. • Cases continued in Family Court • Case Conferences and LAC reviews continued virtually.
	• Staff continued to access advice and guidance for complex cases from the Safeguarding and LAC specialist medical and nursing staff.
	• New arrangements for LAC health assessments • Initial telephone contact with some continued face to face appointments.
	• Embedded the IHV guidance including the new birth visit and criteria for individual assessment of need for face to face contact
	• New arrangements for Child Protection Medicals shared with Social Work colleagues including contact with hot week Paediatrician. • Children seen in community settings and not at the hospital. • The numbers of requests for Child Protection medicals during COVID-19 was similar to pre COVID-19.
New process for multi-agency working and communication	• Weekly telephone contact with partners to review areas of risk and identify support for individual children and families including - LAC, Missing or children at risk of exploitation.
	• Fortnightly virtual permanency panel meetings with support from the Trust and CCG to discuss placements for children in borough and LAC placed out of borough.
	• Weekly calls with the CCG Designated Nurse for Safeguarding and Looked after Children.
	• Virtual meetings to monitor and co-ordinate the response to Domestic Abuse.
	• Virtual arrangements for high risk panels including Multi Agency Risk Assessment Conference MARAC, MAPPA, CEAM and Channel.
	• Due to concerns about the increased likelihood of infants sustaining non-accidental injuries or trauma due to isolation and accumulative stressors, the ICON programme was introduced as a preventative measure to provide information and support for new parents to manage a crying or unsettled infant.
	• Strategic Safeguarding Children and LAC meetings and working groups restarted virtually to ensure priority areas of work continued to support practice.

7.9 Themes and trends identified from the point of lockdown

Increased numbers of children subject to a Child Protection Plan and LAC.

This has led to further scrutiny of direct work done with children and families.

Increasing reported Police activity and immediate removal of children due to violent incidents in the home.

Parents found to be intoxicated or dangerous home conditions.

Increased Strategy meetings attended by 0-19 service or Enhanced Midwifery team

For example, in one week usually 15-18 but in total 29 Strategy meetings were held.

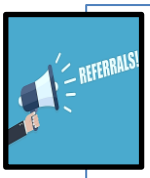
Increase in Children attending A&E following incidents in the home

including burns, dog bites and accidental ingestion of substances, with mental health or behavioural concerns.

National increase incidence of head trauma/shaken baby

This was not seen in Bolton but staff were aware of the national picture and vigilant.

Decrease in numbers of vulnerable children taking up allocated school places



At the beginning of lock-down a reduction in the number of referrals to MASSS –

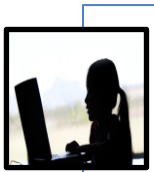
however numbers increased above pre-lockdown levels.

Increased pressure on placements for LAC

Increased pressure on young carers

Increased requests from families for financial assistance

Changing patterns of county lines and criminal exploitation



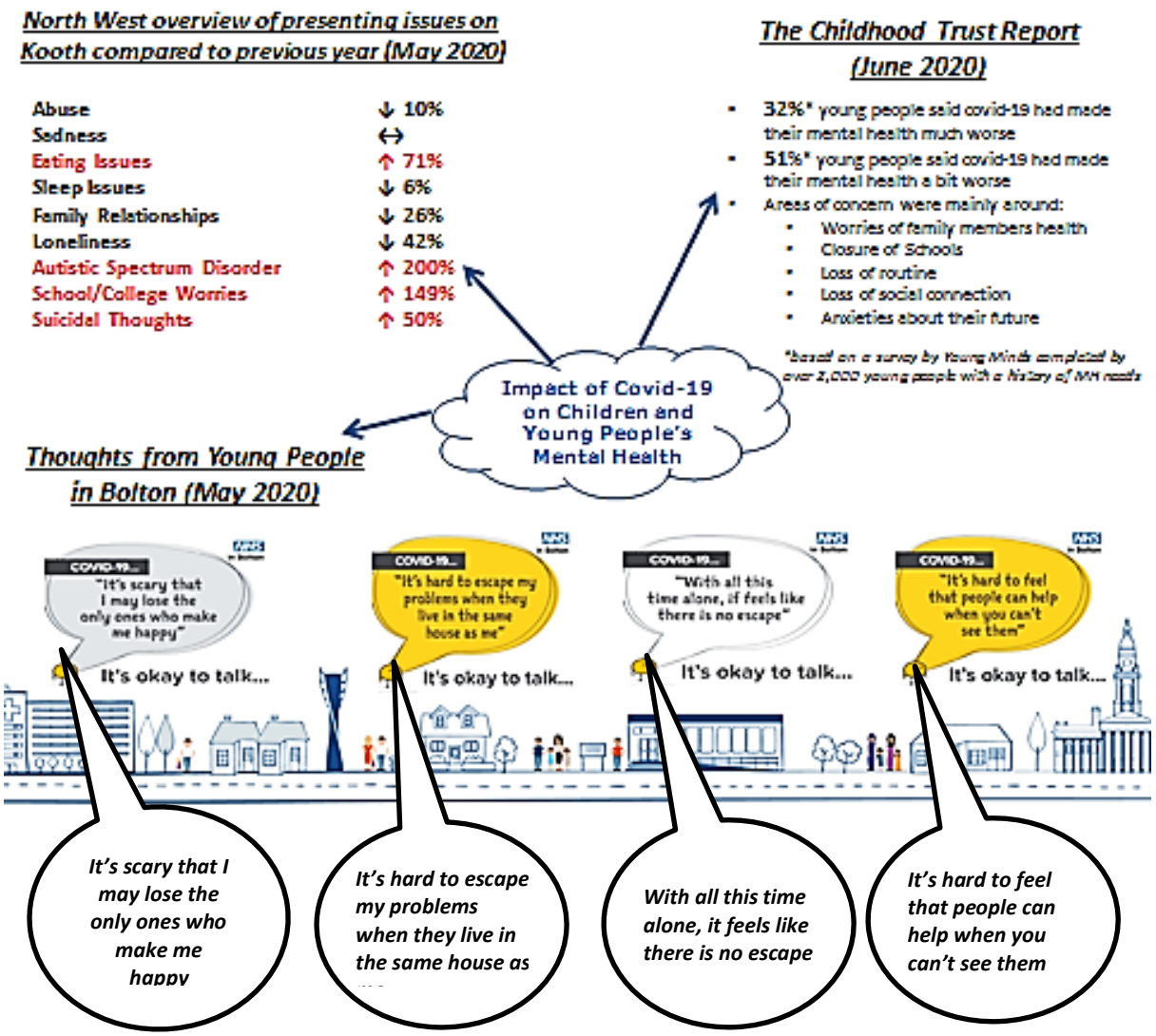
Increasing concerns about digital safety -

Risk of on-line exploitation and radicalisation of children.

7.10 The impact of COVID-19 on the mental health and emotional well-being of children and young people

There has been much published on the effects of the national lockdowns on children and young peoples mental and emotional health and well-being and we have seen the impact of this in Bolton, in particularly attendances at A/E and admissions to the Children's ward.

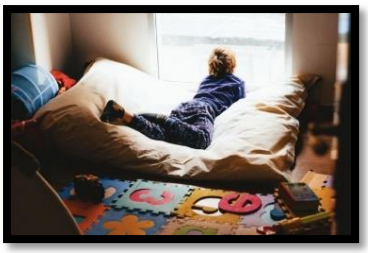
The information below highlights the impact of COVID-19 on young people's mental health and incudes the thoughts of some of our Bolton young people. The quotes below from young peopleare powerful as they reflect that young people are affected by what may be happening in ther homelife as well as external factors.



7.11 Domestic Abuse

National guidance supported the message that "Every contact counts" and briefings were shared to support services across the Health Economy. This included enquiries about children and family's personal safety in relation to the identification of Domestic Abuse which greatly increased during the Pandemic. Professionals were focussed on the need to be able to support children in Domestic Abuse situations and mindful of the NHS England description of "***pressure cooker families".***

7.12 Health and Welfare of Children



Concerns about the health and welfare of children and young people during lockdown have been shared at national, regional and local level. Regular communication between agencies has supported prompt multi-agency response and review where individual or groups of children have been identified as a concern.

All agencies acknowledged there were identified/known cohorts of vulnerable children including children subject to a Child Protection Plan, Looked After Children, Unborn infants and very young infants and children with complex or significant health needs. It was also a concern that there were children not already known to services who would become at risk as they would become unseen during lockdown.

8. Safeguarding response to referrals from Paediatric Emergency Department (PED)

8.1 Attendance at PED

The number of children attending PED from April 2020 was noted to be significantly reduced, a picture replicated across GM and Nationally due to the first lockdown. There were concerns that children with significant and acute illnesses were not being brought to Hospital by parents who were concerned about the transmission of COVID-19. Advice was provided across Trust services and to the public to highlight that children should attend hospital in specific circumstances.

While the numbers of children attending hospital were initially smaller the Safeguarding Team identified, the increasing complexity for some of those attending included –

- Escalating behavioural and mental health concerns,
- Children presenting with increasingly complex social circumstances including children from out of area.

Since the end of the first lockdown, attendances at the PED has greatly increased and with that there has been an increase in the number of children attending where there are safeguarding concerns.

The Safeguarding Children Team receive daily referrals for:

- Children (up to 18 years)
- Vulnerable adults who may be parents or carers of children
- Mental Health Liaison Team share all assessments for children up to the age of 18
- Mental Health Liaison Team share all assessments of adults who may be parents or carers of children
- Concerns about an attendance for an adult in a position of trust if they work with children.

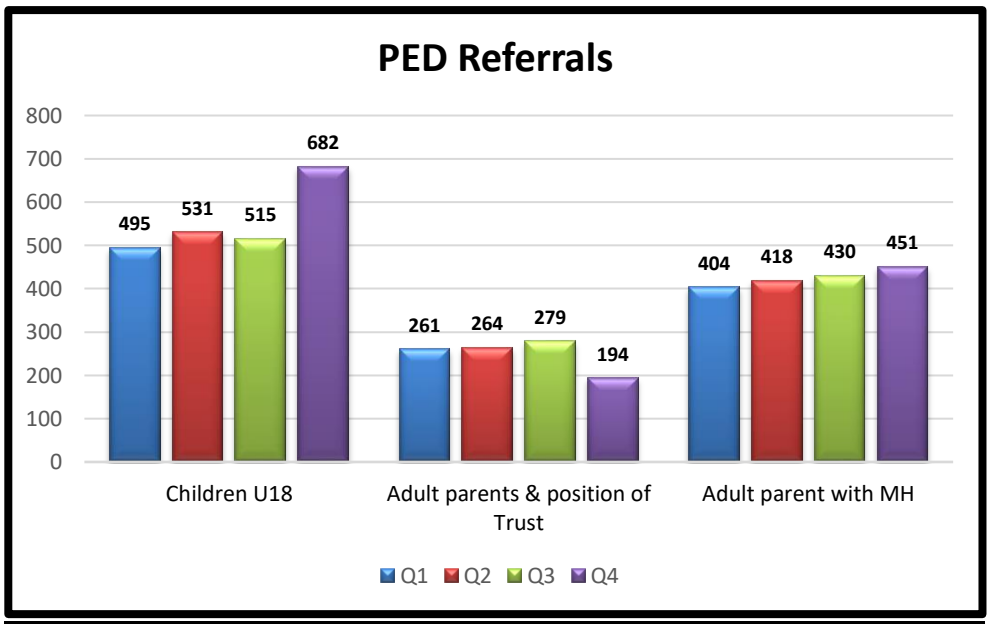
8.2 Safeguarding Referrals from PED

From Quarter 3 the numbers of children referred from PED to the Safeguarding Children Team have increased. It is important to note an increase in presentation of adults who are parents or carers including mental health presentations.

The chart below shows the number of safeguarding referrals from PED that the Safeguarding team have managed in this reporting period.

Table 7 PED Safeguarding Referrals

Month	Children (under 18)	Adults who are parents/carers or in a position of trust	Mental Health (adults who are carers)
April 2020	141	79	147
May	156	88	121
June	198	94	136
Q1 Total	**495**	**261**	**404**
July	165	91	139
August	187	88	136
September	179	85	143
Q2 Total	**531**	**264**	**418**
October	155	87	144
November	178	98	139
December	182	94	147
Q3 Total	**515**	**279**	**430**
January 2021	182	86	137
February	201	49	133
March	299	59	181
Q4 Total	**682**	**194**	**451**
TOTAL	**2,223**	**998**	**1,703**



From April 2020- March 2021-

28% increase - Children Under 18 attending A/E where there are safeguarding concerns.

11% increase – Adult Mental Health attendance where the adult has caring responsibilities for a child.

9. Learning from Reviews

9.1 Statutory Reviews

It is a statutory requirement for the Trust to contributed to the following reviews –

- Statutory Reviews
- Rapid Reviews
- Child Safeguarding Practice Review
- Serious Case Reviews
- Child Death Review
- Domestic Homicide Review

As outlined in Working Together Statutory Guidance (2018), all NHS organisations that are asked to participate in any statutory review process must do so and be supported by the Trust and managers to do so. This will involve meeting regularly with colleagues and attending panels or review group meetings throughout the investigative phase. This related to any child/young person up to age 18 years. All health providers, are required to provide and share information relevant to any statutory review process.

9.2 Safeguarding Children Reviews

The safeguarding children team have contributed to a number of statutory reviews within the time frame of the Annual Report. This includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust services.

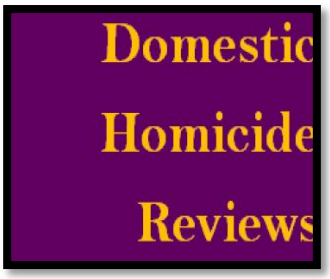
There is also a requirement to attend panel meetings, practitioner learning events, sign off panels to agree final reports and meetings about publication and publicity arrangements. All reviews include children and families that reside in Bolton and also those who live in other areas but who have accessed Bolton FT services.

In addition to writing reports there is a requirement to meet with staff who have provided services to the family. It should be noted that often a serious injury or death has prompted the review and staff need to be updated about identified learning and offered support.

9.3 Domestic Homicide Reviews (DHR)

A DHR is convened by the Community Safety Partnership as a multi-agency review into

the circumstances of the death of a person over the age of 16 that has been as a result of violence, abuse or neglect by a person to whom they were related or who they have been in an intimate relationship with or another family or household member.



There have been two reviews within the timeframe of this report. These reports have not yet been completed or published.

- One DHR was in relation to the death of a female in Bolton
- One in relation to the death of a female out of area.

9.4 Rapid Reviews and Child Safeguarding Practice Reviews

These are held to consider serious child safeguarding cases where a child has died or has suffered serious harm from abuse or neglect.

A number of reviews have taken place within the timeframe of the Annual Report (4 local reviews and 2 reviews out of area), these include –

- The death of a mother and her children;
- Suicide of a young person;
- Historical sexual abuse of a child already known to services;
- Infant death
- Injuries to a child where parents were known to mental health services.

In addition to local reviews, the safeguarding children team have contributed to **3** Child Safeguarding Reviews out of the Bolton area where children and/or family members have accessed Trust services.

- **2** reviews followed the death of a child
- **1** review where a child sustained significant brain injury.

9.4.1 Analysis of Local Reviews April 2020 to March 2021

In total there were **8** referrals made for consideration.

7 progressed to notification to Child Safeguarding Practice Review (CSPR) Panel and Rapid Review.

5 were related to serious harm to a child and 2 were related to child deaths.

2 males

5 females

Categories of harm/abuse included

Physical Abuse 2 cases

Sexual Abuse 2 cases

Neglect 1 case

Death by suicide 1 case

9.5 Themes and Trends

Identifying themes and trends in multi-agency reviews and comparison with regional and national findings allows for the identification of good practice and also gaps where there are single or multi-agency learning points.

The findings below are comparative themes that have featured in reviews at national and local level, and show how Bolton compares with national data and trends.

Out of 12 identified National themes, 8 were seen in higher levels in Bolton.

This analysis allows learning to be targeted in specific areas such as Adverse Childhood Experiences (ACES), Parental Drug misuse.

Table 8 - Themes identified from Reviews

Themes identified from Reviews	National	Local	Comparison with National
Parental alcohol use	18%	0	↓
Parental drug misuse	24%	43%	↑
Parental ACEs	12%	71%	↑
Parental criminal record	18%	28%	↑
Parental mental ill health	28%	43%	↑
Parental LD	3%	0	↓
Parental separation	46%	57%	↑
Domestic Abuse	42%	14%	↓
Elective home education	3%	0	↓
Child with a disability	7%	14%	↑
Child with mental health concerns	16%	28%	↑
Previous Social Care involvement	64%	86%	↑

9.6 Embedding learning in practice

The following is an example of the work undertaken to embed learning and develop practice from a review which will support 16 and 17 year olds admitted to adult wards.

The following Actions were put in place across the Trust to support and underpin this learning –

- New and additional practice Guidance developed and ratified.
- Additional staff training across all areas
- New admission process added on EPR
- Joint working with Mental Health and Social Care to improve practice
- Safeguarding Children team co-ordinate safe discharge of 16 and 17 year olds
- Programme of audit and review

10. Looked After Children (LAC)

10.1 LAC Arrangements

The function of the named Nurse for LAC sits with the Named Nurse for Safeguarding, this arrangement in Bolton is not in line with Intercollegiate Guidance which states that a separate named Nurse for LAC should be in place in Trusts.

This arrangement is subject to review; however, oversight form the Named Nurse for safeguarding with the support of a Named Doctor for LAC and Specialist LAC nurse, ensures services are safe. The Trust LAC group drives the LAC agenda for the Trust. The group has a distinct action plan based on the LAC standards and this feeds into the Trust Safeguarding Committee.

10.2 Adoption and Fostering

Named professionals and those in a specialist role contribute to multi-agency working as advisors to the adoption and fostering panels and are linked to the Corporate Parenting Board and Permanency Panel and health economy wide meetings and forums.

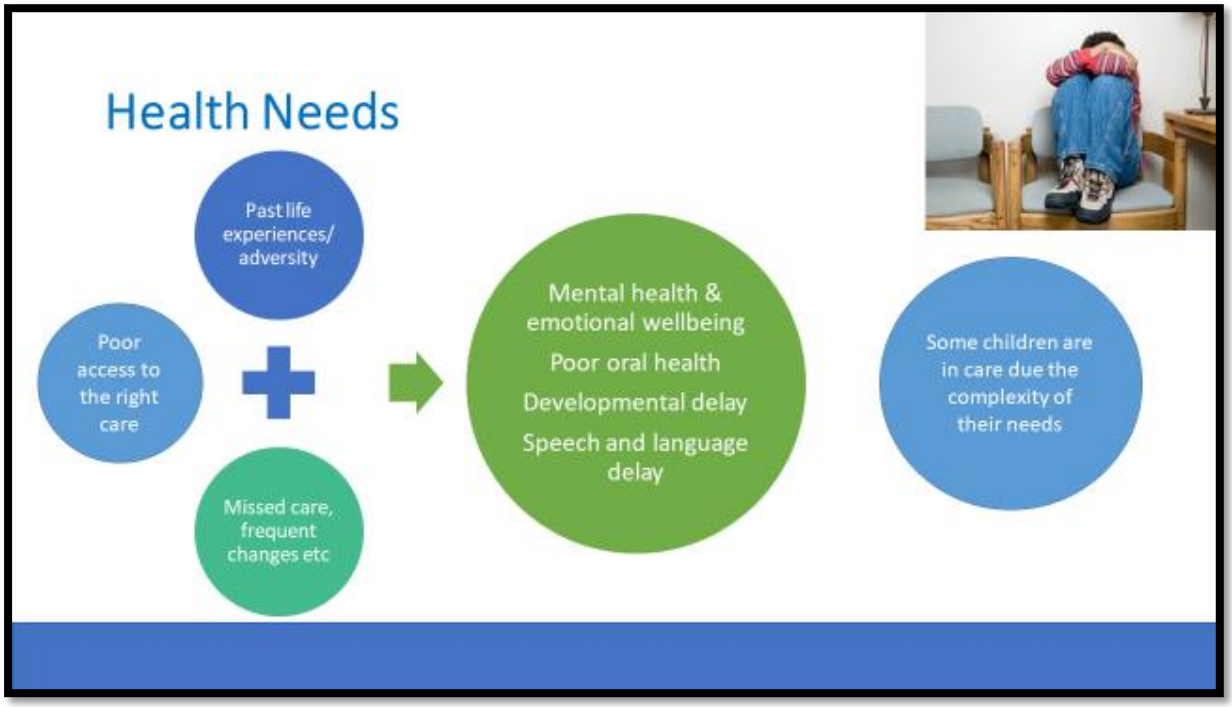
There has been a challenge in linking with Young People's groups due to a lack of face to face meetings during COVID-19restrictions however the Specialist Nurse for LAC joined the Voice 4 U annual celebration in February 2021 and the Named Nurse attends the Corporate Parenting Board where LAC contribute to the agenda at each meeting.

10.3 Data

Monthly LAC data is gathered in relation to the compliance with timescales for statutory health assessments for children in care and it is reviewed within the Trust and submitted to the CCG. The majority of Looked after Children in Bolton enter care due to abuse and neglect, therefore the timeliness and quality of statutory health assessments is an area of practice that requires scrutiny and prompt action if concerns arise. The compliance data provides evidence of the effectiveness of agreed LAC pathways. On a monthly basis actions are taken where barriers are identified with a new focus for managers and staff in a specialist role taking action to prevent breaches of health assessments.

Most children who are looked after in Bolton previously resided locally however there are children who enter placements in Bolton from other areas and responsibility for the provision of health assessments is with the Trust.

The numbers of children who require statutory health assessments varies widely every month depending on the circumstances of children identified to be suffering significant harm.



10.4 Initial Health Assessments (IHA)

An IHA should be completed within 20 working days of a child becoming looked after. The ability to complete this assessment within timescales is dependent on a number of factors out of the control of Bolton FT, however the Safeguarding team works closely with Children's Social Care to ensure that parental consent and all other paperwork is available to ensure the IHA can be undertaken within timescales.

On occasion the service needs to be flexible to response to the number of children requiring an IHA and additional appointments are offered which demonstrates prioritising the importance of assessment of health needs of children entering care. The landscape in relation to Looked after Children can fluctuate rapidly based on admissions and discharges.

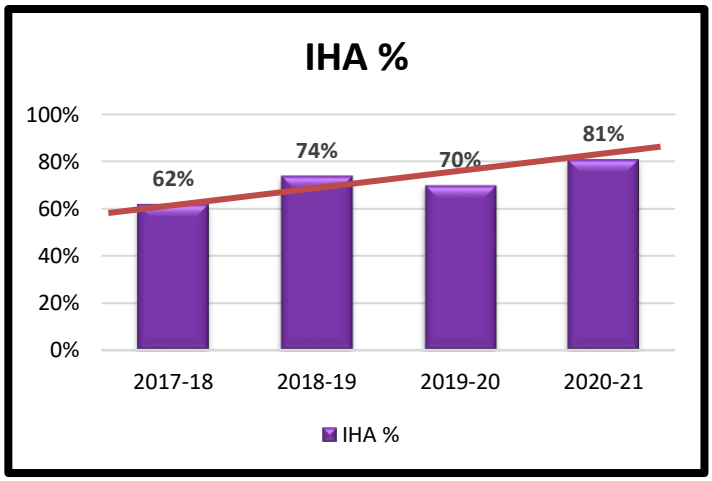
In addition, the IHA process was one of the few face to face assessment that was prioritised to continued face to face as much as possible during COVID-19. This was due to the vulnerability of the children and young people being removed from abusive situations who may have never had their health needs identified or met.

10.4.1 Initial Health Assessments April 2020 to March 2021

Total Initial Health Assessments due	**141**
Number completed within 20 working days	**115 (81%)**
Number of additional IHA completed within the month but outside timescales	**16 (11%)**
Total % on time /within month	**92%**

10.4.2 Comparison with previous years' compliance

2020/12 shows improved compliance from previous years



10.4.3 Reason for not completing assessments within timescales

There are a number of factors that can influence compliance with completion of LAC health assessments within timescales and these are reported in the monthly LAC data submission to the CCG. These include –

- Delay in notification by Social Care,
- Parental consent not available or late,
- Part A of the statutory paperwork not completed by Social Worker,
- Cancelled by Carer,

- Child not brought,
- Cancelled by young person,
- Unable to engage with young person,
- Health staffing/capacity/staff sickness,
- Delay in paperwork/health issue,
- Health admin error,
- Quality issue/assessment not returned on time.

The following shows the **3** most common reasons why an IHA is not completed within timescales in Bolton in 2020/21. All of these cases are followed up by the Consultant Paediatrician and LAC team. Social Care are alerted when children are not brought or an appointment is cancelled by a parent or carer as this is a statutory assessment.

Delayed information from the Local Authority	**56%**
Child not brought/appointment cancelled	**25%**
Staff/admin issues Bolton FT	**19%**

10.5 Review Health Assessments (RHA)

RHA are completed by community based nurses (0-19 service, Special School Nurses, Specialist Nurse LAC) either every 6 months for children under the age of 5 or annually for children over the age of 5.

In 2020/21 the compliance rate for RHA has only slightly decreased from previous years and can be linked to the effects of COVID-19 restrictions with many schools and nurseries closed therefore the opportunity to complete the RHA has not been as flexible. However, despite this, the team have worked hard and there is a plan in place to clear the backlog which is expected to be cleared by Q2 2021/22.

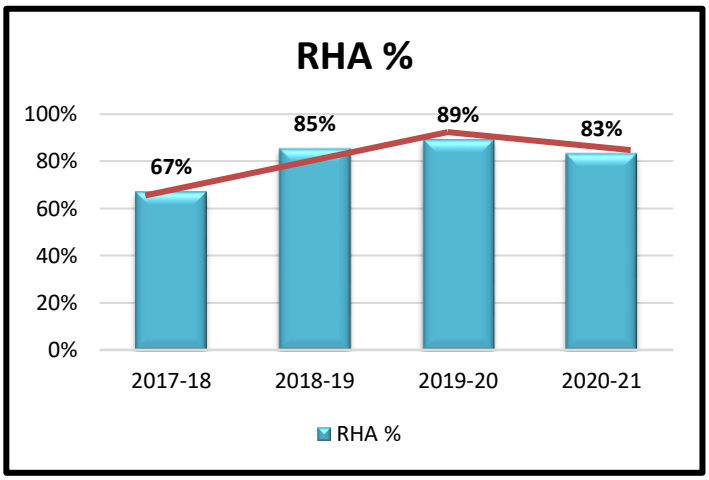
10.5.1 Review Health Assessments April 2020 to March 2021

Total Review Health Assessments completed	**489**
Number completed within timescales (6 monthly Under 5s, annually over 5s)	**407 (83%)**

Number of additional RHA completed within the month but outside timescales	**28 (6%)**
Total % on time /within month	**88%**

10.5.2 Comparison with previous years' compliance

2020/12 shows a decrease in compliance from previous years as described above.



10.5.3 Reason for not completing assessments within timescales

There are many reasons why RHA do not get completed within times scales, all similar to those outlined in 9.3.2.

The following shows the most common reasons why RHA are not completed within timescales in Bolton in 2020/21, the issue with staff capacity is directly linked to COVID-19 unavailability and staff deployment to other areas in the Trust during COVID-19 waves.

Child not brought/appointment cancelled	**23%**
Staff capacity/admin issue Bolton FT	**77%**

10.6 Quality Assurance process

During the timeframe of the Annual Report, the Quality Assurance process has changed. Historically, every RHA was Quality Assured by the LAC Nurse, in Bolton this has a positive effect in driving the quality of the assessments and over time the majority of LAC RHA consistently met the required quality standards.

In 2020/21 the service has moved to undertake a dip-sample audit on a quarterly basis. This proposal was take to by the Designated Nurse for LAC to the GM Designated LAC group and has now been agreed to be adopted across GM. If there are any trends on dip sampling that suggests that the quality is not maintained, the team will revert to the previous process.

10.7 Health Profile

The annual safeguarding and LAC standards include a standard specifically for providers to gather health profile information about Looked after Children. A health profile tool has been developed and reviewed and is used to guide discussions between Named and Specialist professionals for every child who enters care.

10.8 Audit

There is an annual LAC audit undertaken with the CCG Deputy Designated Nurse for Safeguarding and LAC. The aim of all audit activity is to show continuous learning and improvement rather than being purely a focus on compliance with timescales.

10.8.1 Outcome of LAC Audit completed in November 2020

This audit was carried out by Trust staff and the CCG Deputy Designated Nurse Feedback from the Deputy Designated Nurse was as follows –

"It was a pleasure to read such quality health assessments and share the child/young person's journey.

It was through this high standard; I was able to understand what life was like for that child/young person.

It is testament to the ongoing training, support and quality assurance measures that BFT have in place and I thank everyone for their valued contribution in making this happen".

10.8.2 Learning /Themes from Audit

Most were of an excellent standard	Evidence of signposting to services	Evidence of health professionals using their deeper analytical skills
Good use of questions and level of age appropriate engagement	Voice of the child strongly evidenced in 95% of cases	Transitional information included

These have been shared with the Trust LAC group and shared with staff who complete LAC health assessments and these will be added to the Trust LAC Action Plan

10.9 Corporate Parenting

The Named Nurse for Safeguarding and Looked after Children attends the Corporate Parenting Board in Bolton and contributes to an annual wider health economy presentation to the Board in March 2021 to provide overview and assurance.

Corporate parenting principles are described in the Children and Social Work Act 2017 and are central to effective provision for Looked after Children. These principles have been highlighted as a reminder at the Trust Safeguarding Committee and include -

- To act in the best interests, and promote the physical and mental health and well-being, of those children and young people;
- To encourage those children and young people to express their views, wishes and feelings;
- To take into account the views, wishes and feelings of those children and young people;
- To help those children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners;
- To promote high aspirations, and seek to secure the best outcomes, for those children and young people;
- For those children and young people to be safe, and for stability in their home lives, relationships and education or work;
- To prepare those children and young people for adulthood and independent living.

11 Safeguarding Children Supervision

11.1 Risk

It is recognised that working in the field of Safeguarding entails making difficult and risky professional judgements. It is demanding work that can be distressing and stressful. Therefore, all front line practitioners must be well supported by effective Safeguarding Supervision, advice and support.

Safeguarding Supervision is mandatory for all Health Professionals who hold a case load of children and families. Safeguarding supervision has been demonstrated, to be fundamental in supporting frontline practitioners in deliver high quality care, providing risk analysis and individual action plans. It provides a framework for examining and reflecting on a case from different perspectives and facilitates analysis of the risk and protective (resilience) factors involved. Safeguarding children supervision is defined as –

"an accountable formal process which supports, assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed outcomes". Providing effective supervision (Skills for Care 2017)

Safeguarding supervision is separate from but complimentary to other forms of management or nursing supervision.

The Trust Safeguarding Children Supervision Framework has the following components:

- Management/Child Protection and LAC Supervision
- Specialist Supervision
- Mentor/Peer/Preceptorship Supervision
- Advice and Guidance/Reactive Supervision/Consultation
- Group Supervision including Medical Peer Review
- Restorative Supervision
- Supervision for staff in specific safeguarding roles

11.2 Aims of the Bolton Safeguarding Children Supervision Framework

- **Support the safeguarding children supervision process for all staff regardless of role**
- **Ensure child centred practice**
- **Promote research and evidence based practice**
- **Ensure that practice is based on Trust and Safeguarding Partnership procedures**
- **Promote critical thinking and analysis in practice**
- **Support identification of actions and interventions that are SMART**
- **Clarify worker role and responsibility within interagency working**
- **Provide regular, constructive feedback to the member of staff**
- **Promote professional development by identifying training needs**
- **Provide staff with support and fulfil restorative function**
- **Embed supervision as part of the intervention process**
- **Identify and challenge practice which is considered to be unsafe, unprofessional or unethical**
- **Ensure that staff take a proactive and persistent approach including escalating concerns where indicated**
- **Ensure that practice issues raised in supervision for example in relation to capacity issues, themes and trends or evidence of good practice are shared with service managers and the Trust Safeguarding Committee.**

Arrangements for Safeguarding Children supervision are agreed between Service Managers and Named Professionals in the first instance and formally between the Supervisor and the Supervisee/s. Safeguarding supervisors are required to have attended training specific to the role. The type of safeguarding supervision required by staff will depend upon their role, responsibilities and level of contact with children.

A range of safeguarding supervision provision has been identified to meet practitioners' needs. Some supervision is individual (one to one) other sessions are in small groups.

The Framework states as a minimum requirement, safeguarding supervision should be based on individual needs (staff and service users) in order to reduce risks to clients, improve outcomes to clients, support professionals and minimise the risk to the organisation.

Safeguarding children supervision has continued throughout COVID-19 however staff and managers have had to be flexible in provision based on staff location, agile working and capacity of managers and team leaders.

The Safeguarding Children team, named professionals and staff in a specialist role have remained available to offer staff support and where possible face to face and group support has recommenced. Review of the Safeguarding Children Supervision policy, training and compliance is underway due to be completed by the end of December 2021.

The ability to deliver both one to one and group supervision during COVID-19has been a challenge due to the need to maintain social distancing. Virtual supervision has been held, however this had its limitations mainly due to connectivity to IT systems. Where in recent years, supervision compliance has always been 100%, in 2020/21 this has dropped to 80% across the 9 neighbourhood teams. However, utilisation of peer supervision from the Enhancing Families team in community has continued along with access to advice and support via the phone from the Safeguarding team.

12 Safeguarding and Looked after Children Training

12.1 Assurance

The Trust needs to ensure that is all staff are compliant with statutory safeguarding as outlined in the Intercollegiate Guidance Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and Looked after Children: roles and competencies of healthcare staff (2020).

This includes statutory training as follows -

- **Level 1 Safeguarding Children**
- **Level 2 Safeguarding Children**
- **Level 3 Safeguarding Children**
- **Level 3 LAC training**

12.2 Safeguarding Children Training

New arrangements for Level 3 Safeguarding Children training were implemented in April 2020 as all face to face training had been suspended due to COVID-19 social distancing arrangements.

Staff who required Level 3 Safeguarding Children training were identified and linked to an approved e-learning training package using criteria in Intercollegiate Guidance which required -

all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Training is required to include the following topics -

- Sudden or unexpected death in childhood,
- Parental risk factors,
- Unexplained injuries,
- Disability
- Neglect,
- Fabricated and induced illness
- Adolescents presenting with intoxication.

The aim of the Level 3 e-learning modules is to provide information that will help to demonstrate competency in accordance with the majority of requirements outlined in the intercollegiate guidance. Additional learning opportunities have been identified including staff briefings and key messages through team meetings and safety huddles.

A training needs analysis was completed in August 2020 with a plan for a graduated approach for completion of Level 3 training across all divisions accepting that the largest number of staff who are required to complete Level 3 training are within the Family Care Division.

12.3 Safeguarding Children Training Compliance

The Trust Compliance for Statutory Safeguarding training is 95%. In March 2021, compliance was as follows -

12.4 Looked after Children training

New arrangements for Level 3 LAC training were implemented in May 2020. A comprehensive workbook was devised and sent out to a number of services including both medical and nursing staff in the community or based at the hospital to maintain staff knowledge and skills in working with LAC.

Some 1-1 and small group sessions have been carried out during the timeframe of this report noting the restrictions of COVID-19 and reduced capacity for face to face training. These sessions have been provided to new staff and staff who complete LAC Health Assessments and Care Leaver summaries.

13 Achievements and priority areas for 2021/22

13.1 Looked after Children and Care Leavers	
Key Achievements 2020/21	• Services for LAC and recognition as a priority area of work has continued throughout COVID-19 • Effective communication during COVID-19with partner agencies and across Trust services including continued virtual Trust LAC group meetings • Identified focus to prevent breaches of timescales for LAC health assessments – this has shown increased and maintained compliance in 2021 • Compliance now rated green as part of Safeguarding Standards • Health economy pathways updated and agreed • Suggested new QA pathway and audit tool – suggested by Bolton FT has now been adopted across GM • Continued development of the health profile tool for LAC and its use in LAC clinical meetings • Link with Permanency Panel to support health interventions for children where there are concerns about placement breakdown • Identification of a Trust Care Leaver Champion as part of annual Safeguarding Standards • Continued training in the form of a LAC workbook across Paediatrics, Maternity and Community services and small group face to face sessions • Audit activity – quality of completed health assessments and Care Leaver summaries
What needs Further development	• Trust LAC guidance requires updating based on work across GM • Report from Health Profile tool needs to be completed • For the Trust to seek the views of LAC to improve Trust services • Continued focus of the Voice of the Child
Plans for 2021/22	• Review of roles and responsibilities and capacity of staff in a specialist role to consider volume and complexity • Continued use of health profile tool / to add to EPR • Link with third sector to gain views of LAC • Audit schedule for LAC health assessments in place for 2021/22 • Link with Trust Communications Team for key messages • LAC Standards for assurance to be completed • Review LAC training requirements
13.2 Safeguarding Children	
Key Achievements 2020/21	• Services for safeguarding children and child protection practice have continued as a priority for all services during COVID-19 • Contribution to a significant number of Safeguarding Children reviews including reports and attendance at panel meetings • Arrangements for flexible provision of Level 3 training following Trust wide analysis of training needs • Safeguarding team

	• Contribution to a number of work streams including Contextual Safeguarding provision and multi-agency Neglect Strategy
What needs Further development	• Continued focus on Voice of the child within practice. • Development in key practice areas including domestic abuse, exploitation, neglect, children affected by violent crime,16 and 17 year olds admitted to adult wards • Gathering examples of good practice to share learning
Plans for 2021/22	• Strengthen key areas of practice – domestic abuse, exploitation,16 and 17 year olds admitted to adult wards, Children affected by violent crime • Review all Safeguarding Children policies • Maintain audit schedule and present findings to Trust Safeguarding Committee • Link with Communications team to agree dissemination of key safeguarding children messages • Review the Trust Safeguarding Supervision Framework and the effectiveness of current arrangements • Safeguarding Standards assurance to be completed • Review staff safeguarding children training requirements

14 Conclusion

14.1 This report provides evidence of the breadth and depth of work undertaken by the safeguarding and LAC team within the Trust to provide assurance to Trust Board that we are compliant with our statutory responsibilities for safeguarding vulnerable children. There is a plethora of evidence that the pandemic has had a disproportionate impact in areas of deprivation, and Bolton has been no exception. Evidence is contained within this report that details the impact of the pandemic on already vulnerable children and families and the impact on the safeguarding team in managing these complex safeguarding cases.

14.2 Flexible and focussed work has continued by a large number of staff and services to ensure that there is a robust repose where abuse or neglect is suspected or known. 2020/21 has been a very challenging year against a backdrop of national regional and local COVID-19 responses and challenges. The COVID-19 pandemic has had a devastating effect on vulnerable children and families and this report highlights the significant increases in both child protection and domestic abuse cases in Bolton. In addition, the ability to work in partnership with other agencies to safeguard children was greatly reduced.

14.3 The challenges for safeguarding amidst this backdrop of change will continue in 2021/2022 and we look to continue with effective working relationships and collaboration with our multiagency partners to support the growing safeguarding agenda for children.

14.4 This report also celebrates what we are proud of and our ability as a team and service to rise to the challenges we faced, continue to provide advice and support to all services and continue to be visible in services.

14.5 As we continue to develop practice and increase the knowledge and skills of all staff we will ensure that “safeguarding children is everyone’s responsibility” and is embedded in the culture of the Trust and integral to safe practice.

Part 2

Safeguarding Adult Annual Report 2020/21

Author – Sandra Crompton – Named Nurse Safeguarding Adults

1. Introduction

Bolton NHS Foundation Trust is committed to safeguarding adults and carers as per the requirements of the 'Care Act' 2014 and the NHS Contractual Standards for Safeguarding.

The Trust has continued to provide a comprehensive service and adhere to all statutory requirements during the global pandemic. This has been achieved by excellent team and partnership working and the commitment to care delivery to promote patient safety. The Trust, from a safeguarding perspective, has responded to an increased number of referrals including some cases and circumstances that have been purely a result of the pandemic and would not have normally occurred.

2. Care Act 2014

2.1 Definition

The Trust is required to comply with the legislation outlined in the Care Act 2014 when responding to and managing Safeguarding Adult concerns. The Care Act defines an 'Adult at Risk' (previously referred to as a 'vulnerable adult') -

A Vulnerable Adult is defined as any person aged 18 years or over with the following 3 criteria -

- Has needs for care and support (whether or not a Local Authority is meeting any of those needs) and;
- Is experiencing, or at risk of abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either risk of or the experience of abuse and neglect.

The Trust recognises that abuse may have occurred before admission to hospital but that it may become evident during a hospital stay. Therefore the first priority should always be to ensure the safety, wellbeing and protection of adults at risk in the care of Bolton FT and it is the responsibility of all staff working within the Trust to safeguard any person where it is suspected or there is evidence of abuse or neglect. The Trust has a duty to report their concerns to the local Authority and Police.

2.2 Key Principles of the Care Act

The key principles of Safeguarding Adults as stated in the Care Act are;

- **Empowerment** - presumption of person-led decisions and informed consent
- **Prevention** - it is better to take action before harm occurs
- **Proportionality** - the least intrusive response matching the risk presented
- **Protection** - support and representation for those in greatest need
- **Partnerships** - local solutions through services working with their communities
- **Accountability** - accountability and transparency in delivering safeguarding

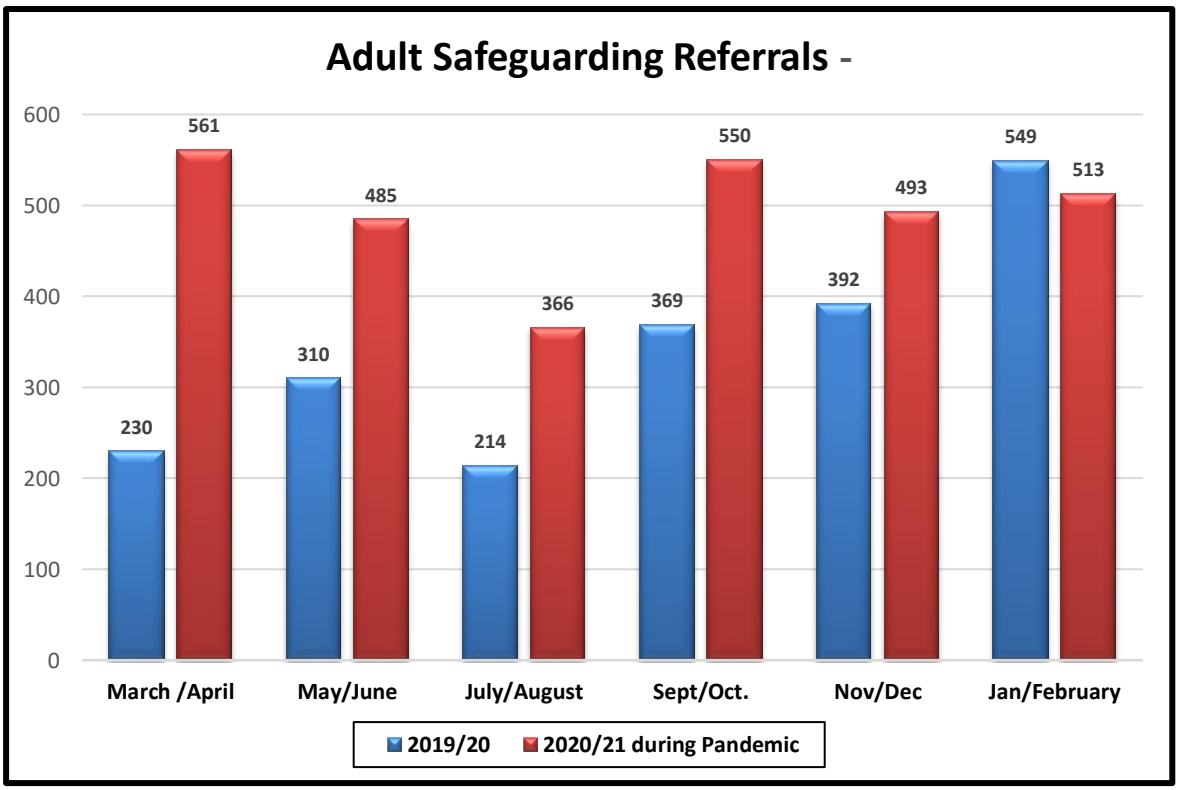
2.2 Categories of abuse as described by The Care Act 2014

3. Safeguarding Adults at Risk during the Pandemic

The Trust has continued to provide a Trustwide, safeguarding service during the COVID 19 pandemic, supporting all services in both the community and hospital services. The Trust has been able to continue to provide face to face support for vulnerable patients especially within the Emergency Department and Community settings.

Through both the first and second wave of the Pandemic, the Trust witnessed a significant increase in safeguarding referrals with an **average of 247 referrals per month compared with 180 per month pre-pandemic. 37% increase on the previous year**

From 1st April 2020 until 31st March 2021, the Trust received 2968 safeguarding referrals a 26% increase on the previous year.



3.1 Effects of COVID 19 on Adult Safeguarding

The Pandemic has added complexity to existing welfare concerns, especially to those in the community who have little or no family, already alone or who struggle with day to day life. The Trust has seen the following incident during the pandemic –

Young adults presenting with some degree of self-neglect as they have had little contact with adult role models or have struggled with mental health issues.

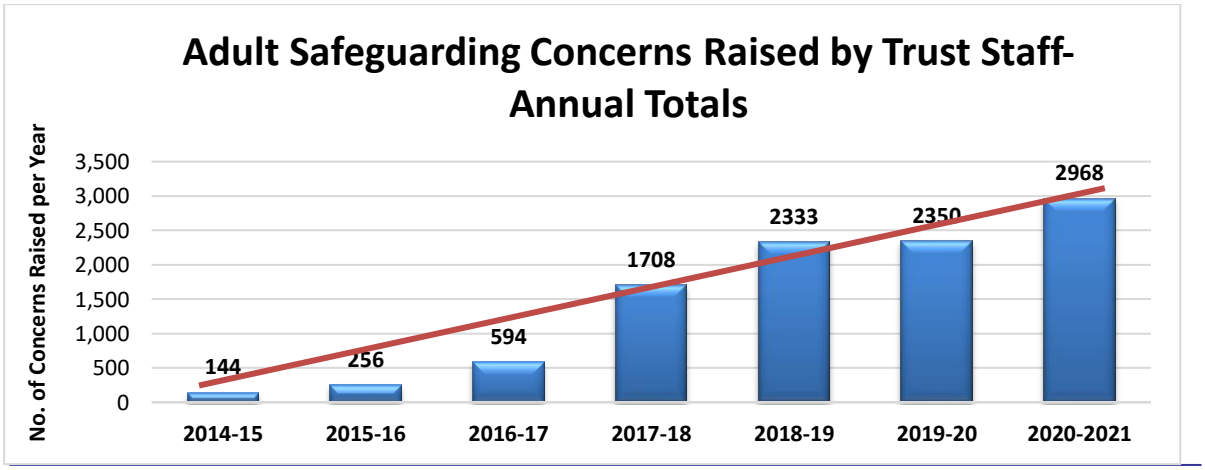
Increase in opportunities for financial abuse of older people by family, friends, rogue traders, neighbours, and internet scams

Significant increase in Domestic abuse and violence within families due to change in social dynamic, financial concerns, increased alcohol consumption and spending lengthy periods of time together.

Increased incidence of domestic violence in victims over the age of 70 years or where the victim has care and support needs as there have not been the usual social safety nets around them.

Significant increase in mental health referrals as people have become overwhelmed by the effects on society by the pandemic and potential influences of mis-information on social media.

Reluctance of some people with care needs to allow carer into their homes or access medical resulting in delay of treatment leading to significant decline in physical health e.g. development of pressure ulcers, uncontrolled diabetes, deterioration of mobility – reducing their ability to cope.



The trend over the past 6 years has seen a significant increase in referrals further accelerated by the Pandemic.

3.2 Initiatives taken to reduce risk of safeguarding cases during the pandemic

The Trust continued to provide face to face care for patients in the Community and in the Hospital identifying numerous, potential safeguarding concerns that have evolved as a result of so many people with care needs suddenly being isolated. The teams, took on numerous additional roles as for some people they were the only people some patients had contact with as many had no or little contact with family and friends.

Examples include but are not limited to the following -

- District Nursing Teams were given supplies of food by Urban Outreach to distribute as needed as they supported patients in the community
- Hospital Teams facilitating communication with families because of the inability to visit in hospital
- Trust teams working on behalf of partner agencies when they were unable to visit the patient in the hospital or in their own home
- Identifying increasing mental health concerns when attending the Emergency Department
- Arranging care for those who were without their usual, regular carers
- Advocating for patients in the absence of usual support networks

There have been numerous examples of excellent multi-agency working to achieve positive outcomes for vulnerable patients and to reduce risk of further abuse and in many cases further self –neglect which was a common theme.

3.3 Areas of success and celebration in relation to Adult Safeguarding

The Trust, despite the pandemic has still provided an on-site holistic and responsive service working closely with integrated partnership services.

The service provision has been responsive but especially in response to victims of Domestic Abuse and Violence where a number of female victims required urgent

relocation. Temporary, safe accommodation was found with a view to ensuring positive and safe outcomes

In partnership with Greater Manchester Mental Health Trust, the Trust has responded to a significant increase in patients with Mental Health concerns. **At the height of the first wave there was a 42% increase in attendance to the Emergency Department for those experiencing Mental Health crises**

The Trust has ensured that it has maintained mandatory safeguarding training for all staff, adapting provision by using virtual platforms to ensure safeguarding remains a priority and integral to all services. Whilst the provision of safeguarding has been a challenge and required adaptation during the pandemic the Trust has continued to respond effectively to Safeguarding concerns raised by victims and those identified by Staff and Partner agencies.

4. NHS Contractual Standards for Safeguarding Adults

Each year the Trust has to assure NHS England via Bolton Clinical Commissioning Group that all required 81 standards for adult and child safeguarding are being met.

The Greater Manchester Safeguarding Assurance Framework separates the required standards into 6 Safeguarding categories which have been agreed and will be evaluated as a minimum:

Standard	Compliance	
Is there a Safeguarding lead in place?	Dedicated Lead for safeguarding Adults	
Are the appropriate Safeguarding policies in place?	All required policies in place and reviewed regularly	
Do staff have access to Safeguarding training at the appropriate level for their role?	Statutory Safeguarding training is mandatory for all staff with a 95% compliance requirement.	
Is there appropriate Supervision available for staff?	All staff have access to supervision from the Safeguarding team.	
Does the organisation have Safer recruitment processes in place?	All staff are required to have an Enhanced DBS check	
Does the organisation have appropriate pathways to report Serious incidents?	Incidents are managed vis the Trust Governance and Risk Management structure	

The Trust submitted all evidence required for the assurance process in November 2020 to the Clinical Commissioning Group. The Trust was assessed as compliant in all domains for Adult Safeguarding.

5. Mandatory Adult Safeguarding Training

The Trust is mandated to ensure all staff are compliant at Level 1 Safeguarding Adult training and all Clinical Staff are compliant with Level 2. A target of 95% or above compliance is required despite the Pandemic the Trust has continued to maintain full compliance

As of March 31st 2021:-

- **Level 1** compliance **97.3% (1555/1598 employees)**
- **Level 2** compliance **96.1% (3656/3803 employees)**
- Face to face Level 3 training was suspended during the initial lockdowns due to acuity of the pandemic and availability of designated cohorts.

A revised Level 3 training needs analysis has been agreed for 2021-22 to prioritise training for the appropriate cohorts.

The safeguarding Team have continued to provide face to face training for student nurses, working in partnership with the University of Bolton department of Health Studies especially year 3 students who complimented the workforce during the pandemic

6. Bolton Adult Safeguarding Board

Bolton Safeguarding Adults Board (BSAB) has a statutory responsibility or legal duty to ensure that Bolton has an effective multi-agency response to safeguard our most vulnerable adults that fall into the criteria of the Care Act 2014 and ensure measures are in place to prevent abuse.

The board has a statutory responsibility to have a strategy and business plan that reflects the views of service users the wider community and to report back on its work each year in the annual report The board is also legally responsible for carrying out reviews of

serious cases to ensure that lessons are learnt and to ensure a more joined up partnership approach to safeguarding issues.

Bolton NHS Foundation Trust is committed to working in partnership with Bolton Safeguarding Adults Board to help protect 'adults at risk' from abuse and have in place systems and processes to support the BSAB interagency policy and procedures.

6.1 Board Strategic priorities 2020-2023

1. People in Bolton have a voice in the service they receive

Improve engagement with all partners and the different sections of the community to strengthen adult safeguarding in Bolton. Ensuring that the voice of the adult is central to safeguarding adults practice across the whole partnership in Bolton.

2. Reduce the Prevalence and impact of hoarding

Develop an integrated approach to identifying and responding to the prevalence and impact that hoarding has on the community and on services

3. Domestic Abuse

Develop and deliver on the on the new joint partnership strategy and business plan. Focus on Prevent, Protect and Repair.

4. Workforce Development with Effective Practice

Develop more multi -agency audits with key lines of enquires to help highlight good practice and identify gaps in in processes but single agency and multi -agency.

5. Improve Board Effectiveness

Ensure that learning is captured from Safeguarding Adult Reviews both locally and nationally to improve outcomes from the people of Bolton. Strive to have more sophisticated data sets which help to demonstrate the what is happening across Bolton in relation to safeguarding adults

7. Contribution to Safeguarding Adult Reviews (SAR)/Domestic Homicide Reviews (DHR)

7.1 Domestic Homicide Review

During the past year there has been no new Domestic Homicide Reviews however there has been a continued response in respect of the learning and action plans from cases from other areas with learning relevant to Bolton. The themes and learning are as follows -

- **Action 1** - To continue to ensure comprehensive assessment of mental capacity following episodes/incidents of violence and aggression or where capacity is in doubt when significant decisions have to be made e.g. discharge planning
- **Action 2** - Ensure all agencies are aware of how to respond to/ escalate disclosure of Domestic Abuse and Violence (DAV).

Both Actions have been addressed and completed by the Trust. The Trust, as part of the response has commissioned bespoke training for Community Practitioners in respect of domestic violence and aggression which has been provided by 'Fortalice'. This will continue in 2021 until the autumn.

7.2 Safeguarding Adult Review

There has been two Safeguarding Adult Reviews (SAR) commissioned by the Bolton Adult Safeguarding Board -

1. Related to a house fire where the occupant was rendered homeless. The Trust was not involved in the review as the Trust had not been involved in care delivery but was consulted in the initial scoping process

2. Joint SAR with Bury Adult Safeguarding Board following the death of a patient whilst in the care of a Bury Care Provider. The Trust had considerable information on this patient who had been under the care of Bolton FT some months earlier.

8. National Prevent Agenda

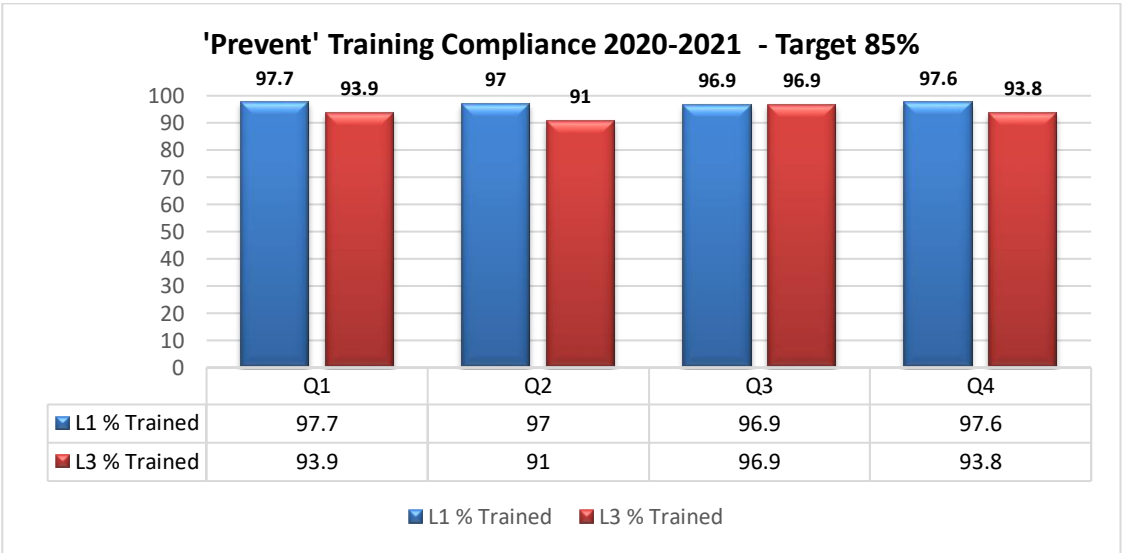
The Prevent strategy, published by the Government in 2011, is part of our overall counter-terrorism strategy, CONTEST. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Act this has simply been expressed as the need to "prevent people from being drawn into terrorism".

The 2011 Prevent strategy has three specific strategic objectives:

- *Respond to the ideological challenge of terrorism and the threat we face from those who promote it*
- *Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support*
- *Work with sectors and institutions where there are risks of radicalisation that we need to address*

The Trust is mandated to ensure the whole workforce has an awareness of the strategy and that all Clinical Staff have skills and knowledge in respect to recognising those vulnerable adults who may be at risk of radicalisation

Despite the Pandemic the Trust has achieved and maintained the NHS England training requirements, constantly exceeding the 85% compliance Target. The Trust has reported the training data on a quarterly basis to both to NHS England and Bolton Clinical Commissioning group as mandated under the NHS England Safeguarding Contractual Standards.



8.1 Channel Panel

Channel focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The Counter Terrorism and Sentencing Act 2021 relates to a Channel panel in England and Wales and should be a multi-agency partnership. Channel uses a multi-agency approach to:

- Identify individuals at risk
- Assess the nature and extent of that risk
- Develop the most appropriate support plan for the individuals concerned

Channel provides early support for anyone who is vulnerable to being drawn into any form of terrorism or supporting terrorist organisations, regardless of age, faith, ethnicity or background. Individuals can receive support before their vulnerabilities are exploited by those who want them to embrace terrorism, and before they become involved in criminal terrorist-related activity.

8.1.2 Bolton Channel Panel

Bolton Channel Panel, meets on a monthly basis and is chaired by the Local Authority with Bolton Counter Terrorism Police support. The Trust is represented on the Panel by The Lead Nurse for Adult Safeguarding and the Named Nursed for Safeguarding Children and Looked After Children. Other partners on the panel are:-

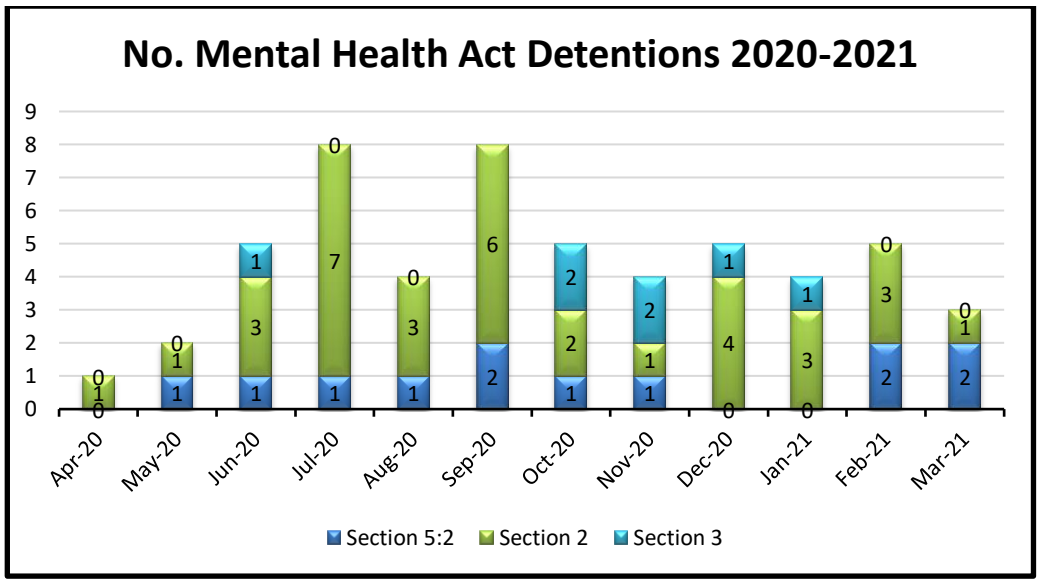
- Greater Manchester Mental Health Trust
- Clinical Commissioning Group
- Education providers as required
- Local Authority – Service Lead for Adult Safeguarding

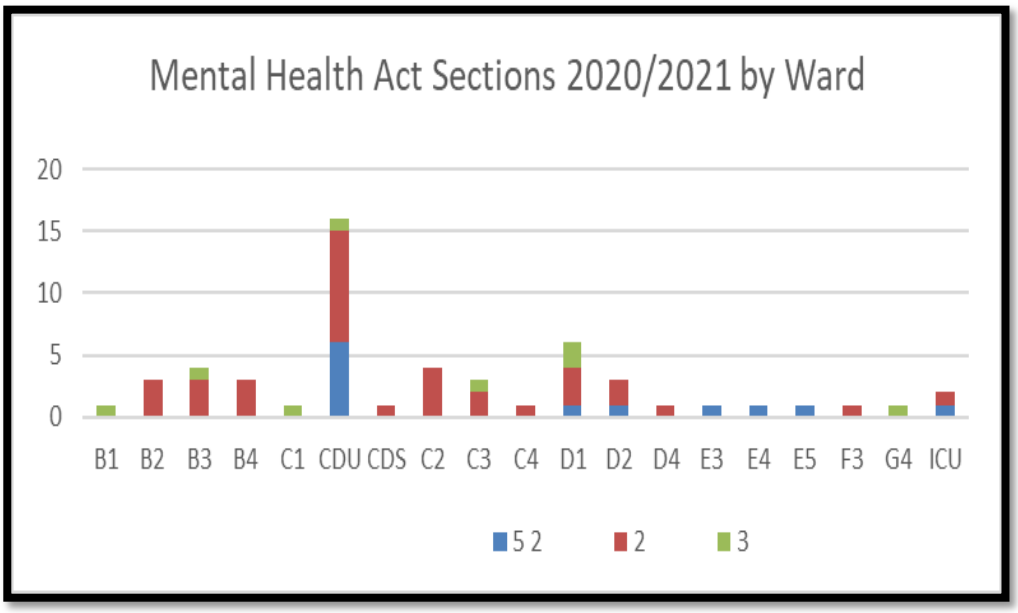
In the past 12 months, during the pandemic the majority of referrals to Channel Panel a have been in respect of children under the age of 18. At any given time, the Panel are managing to more than 10 cases. The Trust has made 1 referral to the panel in the past 12 months. The majority of referrals are made by Schools and Colleges.

9. Mental Health Act 2007 - Management of Patients detained to Bolton FT

The Trust is registered with the Care Quality Commission to detain patients under the Mental Health Act 2007.

Bolton NHS Foundation Trust has a 'Service Level Agreement' with Greater Manchester Mental Health Trust to detain patients to the Royal Bolton Hospital and to ensure the Mental Health Act 1983 legislative framework and subsequent amendments are adhered to in conjunction with the associated Code of Practice 2015





In the period April 2020-March 2021, **54** patients were detained to the Trust as opposed to 46 in the previous year. There has been an increase in Mental Health referrals the pandemic with a corresponding 11% increased the number of detentions to the Trust.

The Lead Nurse for Adult Safeguarding represents the Trust on the joint partnership Mental Health Act Steering group and co-ordinates day to day detention activity and recording of detentions as per CQC registration requirements.

10. Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

10.1 Mental Capacity Act 2005

The Mental Capacity Act and related Deprivation of Liberty Safeguards have not been altered by the emergency Coronavirus Act which went through Parliament in the week 23 March 2020.

In April 2020, the legislation was reviewed by the Department of Health to ensure the framework would be completely adhered as part of the response to ensure vulnerable adults in society would still be afforded their rights and freedoms in all health settings including Acute Trusts. The objective was to ensure optimal care provision, especially for those with cognitive impairment who required advocacy in respect of clinical management and place of care delivery. The Trust's Medical Director and MCA lead ensured that all clinical staff were aware of their ongoing responsibilities and revised assessment documentation on the Electronic Patient Record – EPR.

The use of the MCA was especially evident in the Trust's Critical Care Settings where difficult 'Best Interest Decisions' were being taken on a daily basis in respect of ceilings of care delivery, ensuring where possible the patient was involved in that process along with their families. In a small number of cases, some patients had no one outside the Trust to advocate for them. In those cases, independent mental capacity advocates (IMCA) were appointed as per the legislative requirements.

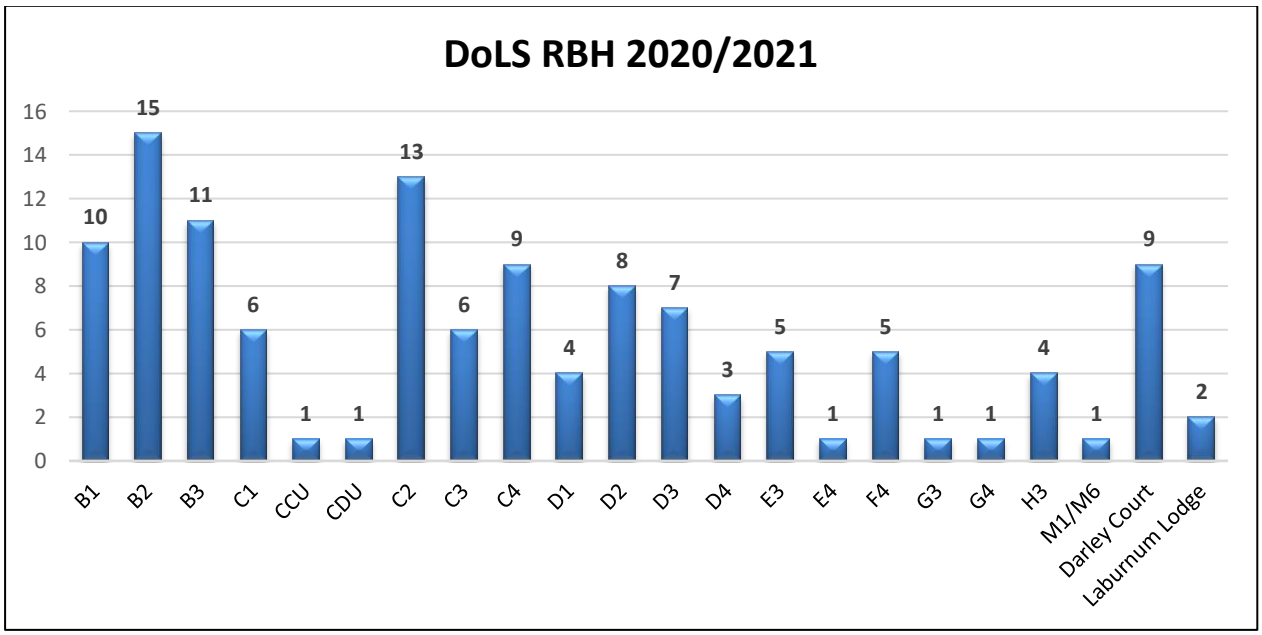
10.2 Deprivation of Liberty Safeguards (DoLS)

During the pandemic there has been no change to the criteria for the detention of patients who require treatment and care in acute settings, who are lacking capacity to make informed decisions regarding the care they require and who are unable to protect themselves.

The Trust, as a 'Managing Authority' for such detentions has continued to work in partnership with a number of Local Authority DoLS Teams 'Supervisory Authority' especially Bolton, Bury, Salford and Wigan to ensure patients receive optimal care and detentions are appropriate and lawful.

The only amendment permitted by the Department of Health was the development and implementation of abridged documentation to ease some burden on process for both care providers and Local Authorities.

Each detention during the pandemic has been monitored by the Adult Safeguarding Team to ensure each detention is lawful, appropriate and due process has been followed.



Deprivation of Liberty Safeguards are soon to be superseded with new legislation – 'Liberty Protection Safeguards' but due to the pandemic there has been a delay in National implementation. Once agreement is made Nationally the Safeguarding team will be

required to implement the new standards this will involve policy and guideline changes with the accompanied training rollout programme.

10.3 Liberty Protection Safeguards (LPS)

The Mental Capacity Act 2019 received Royal assent on 16 May 2009. In 2018 the legislation including Deprivation of Liberty Safeguards was reviewed and replaced with a new framework 'Liberty Protection Safeguards'(LPS). The intention was to implement the new framework in April 2021 but this has been deferred due to the pandemic

Main Changes

- **Responsible body –**
  - NHS Hospital Trusts will become the responsible manager (body) not the Local Authority for in-patients. Essentially the Trust will become autonomous whereas currently the Local Authority where the patient lives authorises ongoing DoLS and as such work independently from the Trust as a safeguard for the patient.
  - Each Trust will be required to train staff on the implications of the new framework.
  - CCG's will be responsible for those persons who are in receipt of Continuing Health Care Funding
  - Local Authorities will be responsible for all other persons in 24-hour care e.g. Care Homes, Private Hospitals, persons in their own home. A Local Authority can delegate the assessment process to Registered Care Home Manager if needed

- **Assessments (and Determinations)**

  Under the new framework the criteria for a DoLS application will not change, however the new LPS will apply to aged 16 and over, currently a DoLS only applies to age 18 and over.

  DoLS Criteria -
  - Lacking Mental capacity to consent to care, treatment and place of care.
  - There will need to be a medical assessment to ensure the person is not suffering from a mental disorder that may require treatment under the Mental Health Act.
  - The person must be 16 years and over (as opposed to 18 for DoL's)
  - Staff will need to consider how much freedom they are removing from individuals and if this is proportionate and indeed necessary

- Staff must consult the person and their family and others, including people chosen by the person, about their wishes and feelings of the person

- **Pre-Authorisation review**

  Before the responsible body authorises the Deprivation, a pre-authorisation review is undertaken to check all the evidence and the paperwork to see if the conditions are met for authorisations. It is unclear at present which designations/practitioners will be able to impose detentions, as currently both senior nurses and clinicians are allowed to do so.

  In complex cases or when a person is objecting to a deprivation of liberty, the pre-authorisation review is done by an Approved Mental Capacity Professional (AMCP)
  The Local Authority must approve all AMCP's for all the Responsible Bodies in the area.

- **Life sustaining treatment or Vital Act**

  For significant treatment or while awaiting a decision from the Responsible Body or Court of Protection (in the case of a challenge or objection), a deprivation of liberty is authorised if there is reasonable belief the person lacks capacity to consent and steps are necessary to deliver life sustaining treatment or carry out a vital act. There is no process as such for emergency situations.

- **Code of Practice**

  A code of practice to under pin the new framework is currently in development (6 work streams-regulations, process/implementation, documentation, training, oversight, transition of persons already subject to DoLS / AMCP/IMCA's
  The draft guidance is not expected before July 2021 with implementation expected between April and October 2022 with training tools being developed and provided by NHS England.
  Implementation will be a significant undertaking for Acute Trusts due to the change in legislation and process and subsequent training need.

11. National Adult Safeguarding Week - November 2020

The partners of the Bolton Adult Safeguarding Board agreed to prioritise Domestic Abuse and Violence as the main area for concern due to the increase in incidence during the Pandemic.

The Trust supported the implementation of 'The Eyes Wide Open' campaign across all partner agencies which aims to raise awareness about the signs of domestic abuse. In conjunction with the Community Safety Partnership, The Children's Safeguarding Partnership, The Bolton Adult Safeguarding Board has supported the roll out of the new Domestic Abuse and Violence Protocol for Bolton which was launched.

12. Conclusion

This report provides evidence of the breadth and depth of work undertaken by the adult safeguarding team within the Trust to provide assurance to Trust Board that we are compliant with our statutory responsibilities for safeguarding vulnerable adults.

There is a wealth of evidence that the pandemic has had a disproportionate impact in areas of deprivation, evidence is contained within this report to detail the impact on vulnerable adults and families within Bolton resulting in an increase in the number and complexity safeguarding cases.

2020/21 has been a very challenging year against a backdrop of national regional and local COVID-19 responses and challenges. The COVID-19 pandemic has had an impact with the number of domestic abuse cases in Bolton and the increase in mental health crisis referrals and substance misuse cases. Vulnerable adults have had less face to face support during the pandemic with a reduced level of support permissible from volunteer agencies neighbours and extended family or friends due to the various lockdowns.

The Bolton community have been hit with 5 waves of COVID-19 and being the forefront of the emergence of the Delta variant this with the underlying deprivation rated within the community have resulted in the disproportionate effect on adults and their corresponding safeguarding needs.

The challenges for safeguarding amidst this backdrop of change will continue in 2021/2022 and we look to continue with effective working relationships and collaboration with our multiagency partners to support the growing safeguarding agenda for adults.

This report also celebrates what we are proud of and our ability as a team and service to rise to the challenges we faced, continue to provide advice and support to all services and continue to be visible in services.
As we continue to develop practice and increase the knowledge and skills of all staff we will ensure that “safeguarding children is everyone’s responsibility” and is embedded in the culture of the Trust and integral to safe practice.