Jan Board Part one

Thu 28 January 2021, 09:00 - 12:00

Agenda

09:00 - 09:05
5 min

1. Welcome and Introductions

Verbal *Donna Hall*

01 Meeting cover page Jan 2021 version 1.pdf (4 pages)

09:05 - 09:20
15 min

2. Staff Story

Verbal

02 Part one Agenda Board meeting January 2021.pdf (3 pages)

09:20 - 09:21
1 min

3. Apologies for Absence

Verbal *Esther Steel*

09:21 - 09:22
1 min

4. Declarations of Interest

Verbal *Donna Hall*

09:22 - 09:23
1 min

5. Minutes of the meeting held on 26 Nov 2020

Minutes *Donna Hall*

05 final Board of Directors Minutes - 26.11.2020 Part 1.pdf (13 pages)

09:23 - 09:24
1 min

6. Action Sheet

Action Sheet *Donna Hall*

06 Board actions November 2020.pdf (1 pages)

09:24 - 09:25
1 min

7. Matters Arising

Verbal *Donna Hall*

09:25 - 09:35
10 min

8. CEO Report

Report *Fiona Noden*

08 CEO report January 21_v2.pdf (7 pages)

09:35 - 10:00
25 min

9. Covid Update and Reset

Presentation *Andy Ennis*

9.1. Integrated Performance Report

09 Trust Board Report M9 v1.1.pdf (50 pages)

10:00 - 10:10
10 min

10. Quality Assurance Committee Chair Report

Chair Report *Andrew Thornton*

10 QA Chair report Jan 2021.pdf (7 pages)

10:10 - 10:20
10 min

11. Finance and Investment Committee Chair Report

Chair Report *Jackie Njoroge*

10:20 - 10:30
10 min

12. People Committee Chair Report

Chair Report *Malcolm Brown*

12 BoD - People Committee Chair's Reports (December 20 & January 21).pdf (9 pages)

10:30 - 10:40
10 min

10:40 - 10:50
10 min

13. Ockenden Report

Report

13 Ockenden Report Response FINAL with appendices January 2021.pdf (46 pages)

10:50 - 11:00
10 min

14. Learning from Deaths Report

Report *Francis Andrews*

14 BoD Learning From Deaths report Jan 21.pdf (17 pages)

11:00 - 11:10
10 min

15. Workforce and OD strategy

Report *James Mawrey*

15 BoD - Annual WOD Update - JM final v3 (with Strategy attached).pdf (18 pages)

11:10 - 11:20
10 min

16. Health and Safety Annual Report

16 Health and Safety Annual Report 19-20 for BoD v 2.pdf (8 pages)

11:20 - 11:30
10 min

17. Anti Slavery Statement

Esther Steel

17 anti Slavery statement 2020.pdf (4 pages)

11:30 - 11:35
5 min

18. Any Other Business

Verbal *Donna Hall*

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NHS
Bolton
NHS Foundation Trust

BOLTON NHS FOUNDATION TRUST

Public Board Meeting January 2021

Version one
22 January 2020

Finance and Investment Committee Chair report to follow

WebEx meeting etiquette

1. Ensure you have downloaded the correct app for the meeting – within the Trust we are using Citrix WebEx. If this is your first time using the app please take time to familiarise yourself with the functions before the meeting starts.

2. Please take time to read papers in advance of the meeting – if you have questions for clarification please raise them before the meeting by emailing the author of the paper or the administrator for the meeting.

3. Use the WebEx link in the meeting invite or the link within the app to connect to the meeting.

4. Please check that you can mute and unmute your microphone before the meeting starts. There have been examples where the settings on an individual's PC, laptop or tablet have prevented this and it has only become apparent when the individual attempts to speak.

5. Ensure that your microphone is muted at all times unless you are speaking in the meeting – this helps reduce background noise. The microphone can be muted by pressing the symbol as shown on the image

6. During each agenda item, please use the chat function to indicate if you would like to come in or make any specific comments in the discussion rather than intervening directly. After each agenda item the Chair of the meeting will allow time for questions posted via the chat function. Please try to avoid asking questions that are for general information.

7. If it becomes apparent that your connection to the meeting is poor and other participants are having difficulty hearing you, please use the option to turn off video and use the audio only. We have noted this helps where Wi-Fi connectivity is reduced.

Guidance for observers and members of the public

Attending Board Meetings held in Public – virtual meetings

The Board of Bolton NHS foundation Trust holds its monthly Board meeting in public – these meetings usually take place in the Trust Boardroom but may take place in other Trust locations or in the form of a virtual meeting hosted through an online meeting room.

Members of the public are welcome to attend these public meetings but must be aware that although the meeting is being held in public, it is not a public meeting.

Details of dates are published on our website and members of the public and press are welcome to attend these meetings to observe, but not to speak. If a member of the public wishes to raise a question they must do so in writing, submitted to the Trust Secretary a minimum of 24 hours before the start of the meeting

There are times when the Board will need to consider agenda items which are confidential and cannot be discussed in public. The Public Bodies (Admission to Meetings Act) 1960 permits the Board to pass a resolution at the meeting to exclude the public and press from the meeting 'whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business, or for other special reasons stated in the resolution'

Agenda and papers

The agenda and papers are published on the Trust website prior to the meeting; a copy of papers will also be provided on request – please contact the secretariat office for further information.

How to attend a virtual Board meeting

Ensure you have downloaded the correct app for the meeting – within the Trust we are using Citrix WebEx. If this is your first time using the app please take time to familiarise yourself with the functions before the meeting starts.

Use the WebEx link in the meeting invite or the link within the app to connect to the meeting.

The online meeting room registers all attendees – there is no need to sign in or announce your name. **Please make sure your microphone is muted at all times** – you may also wish to use the app option to turn off video recording.

The board discussion

The Board considers the items on the agenda in turn and each paper includes a summary cover sheet which makes a recommendation for the Board to consider.

You can take written notes of the meeting, but cannot record the proceedings in other ways.

Recording the discussion and decision

A summary of the key items discussed and decisions taken is recorded in the minutes, which the Board will be asked to approve as a correct record at its next meeting. The agreed minutes are added to the website.

If you are unable to attend the meeting

An issue will not be deferred because members of the public cannot be present for the meeting.

Bolton NHS Foundation Trust – Board Meeting 28 January 2021

Location: WebEx **Time: 09.00**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00	1.	Welcome and Introductions	Chair	**V**erbal	
09.05	2.	Staff Story		Video	To hear from a member of staff about the impact of working during Covid
09.25	3.	Apologies for Absence	DCG	Verbal	Apologies noted
	4.	Declarations of Interest	Chair	Verbal	To note any new declarations of interest or declarations in relation to items on the agenda
	5.	Minutes of meeting held 26 November 2020	Chair	Minutes	To approve the previous minutes
	6.	Action sheet	Chair	Action log	To note progress on agreed actions
	7.	Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
Safety Quality and Effectiveness					
09.30	8.	CEO Report	CEO	Report	To receive
	9.	Integrated Performance Report	COO	Report and presentation	To receive an update on the current operational position
	9.1	Covid Update and reset	COO	Presentation	
10.00	10.	Quality Assurance Committee Chair Report – 16 December 2020 and 20 January 2021	QA Chair	Report	To provide assurance on work delegated to the sub committee
	11.	Finance and Investment Committee Chair Report – December and January	F&I Chair	Report	To provide assurance on work delegated to the sub committee
	12.	People Committee Chair Report – December and January	PC Chair	Report	To provide assurance on work delegated to the sub committee

Coffee 10.30

10.45	13	Assurance on the provision of Maternity Services (response to Ockenden report)	Chief Nurse	Report	To note the Trust's response to the Ockenden report

11.00	14.	Learning from deaths report	Medical Director	Report	To receive the quarterly report
Strategy					
11.15	15.	Workforce and OD Strategy	Director of People	Report	To receive update
Governance					
11.30	16	Health and Safety Annual Report	Chief Nurse	Report	To receive for information
11.45	17	Anti - Slavery Statement	DCG	Report	To approve
11.50	18	Any other business			
Questions from Members of the Public					
	19	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					
12.00		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			

Meeting:	**Board of Directors**
Date:	**Thursday 26th November 2020**
Time:	**09:00**
Venue:	**Via Webex**

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
Marie Forshaw	Director of Nursing	MF
Annette Walker	Director of Finance	AW
James Mawrey	Director of People	JM
Sharon Martin	Director of Strategy & Transformation	SM
Andrew Thornton	Non Executive Director	AT
Malcolm Brown	Non Executive Director	MB
Rebecca Ganz	Non Executive Director	RG
Jackie Njoroge	Non Executive Director	JN
Martin North	Non Executive Director	MN
Alan Stuttard	Non Executive Director	AS
Bilkis Ismail	Non Executive Director	BI

In Attendance:

Esther Steel	Director of Corporate Governance	ES
Ibrahim Ismail	Shadow NED	II
Kimberley Güzel (Minutes)	Personal Assistant	KG

Observers:

Tracy Joynson	Patient Experience Manager	TJ
Lianne Robinson	Divisional Nurse Director, Anaesthetics & Surgery	LR
Andy Butler	Matron, Family Care	AB
Kathy Stacey	Assistant Directors, Communications & Engagement	KS
Dawn Fletcher-Wilde	Data Protection Officer	DFW
Rachel Carter	Head of Communications	RC
Chris Gee	Bolton News	CG
	Governors	
	Members of the Public	

Meeting:	**Board of Directors**
Date:	**Thursday 26th November 2020**
Time:	**09:00**
Venue:	**Via Webex**

NHS Bolton NHS Foundation Trust

1. Welcome and Introductions

The Chair welcomed everyone to the meeting together with all observers and Chris Gee of the Bolton News. The Chair also reminded observers they are unable to make contributions to the meeting. The Chair thanked everyone for their continued hard work during these unprecedented times.

1.1 A Poem by Ibrahim Ismail

II recited a poem of his own work, Bolton Hand. Everyone applauded II and thanked him for his beautiful words.

2. Patient Story

The Chair reminded everyone the patient story should remain confidential. MF introduced AB from Acute Paediatrics who in turn introduced Mr G who delivered his own patient story following his family's personal experience of Bolton FT.

Mr G explained how his son, 'J', was born 6 weeks premature in July 2019. 'J' was unfortunately diagnosed with Alagille Syndrome and underwent an 8-hour Kasai procedure. The procedure was unsuccessful and in March 2020 'J' underwent a liver transplant. 'J' suffered a set-back in June 2020 when he contracted Sepsis for a second time.

However Mr G praised the co-ordination between Leeds (where 'J' underwent some of his treatment) and Bolton. James is currently doing well and Mr G wanted to take the time to explain how he and his family feel about Bolton FT and the treatment they received. When 'J' was at Leeds, staff from Bolton were in contact to find out how James was doing. The family were made to feel as if Bolton staff

genuinely cared for James and he was not just another patient. When the family were in hospital they were very well looked after and importantly staff were always checking on Mr G's partner as for obvious reasons her mental health was of concern to them. Staff remembered the family from when James had previously been in hospital and they treated Mr G and his family as friends and showed genuine concern. Bolton acted swiftly upon information received from Leeds. The family were made to feel as if it was 'their' hospital. The family could not be more grateful for the care James received and for the work of each and every member of staff involved with James' care as nothing was too much trouble for them. Mr G made a special note of thanks to Ian Freeman and Elaine.

The Chair and the Chief Executive thanked Mr G for delivering his family's story which was so touching and the Board were thrilled to hear the high praise for the Trust.

3. Apologies for Absence

No apologies received.

4. Declarations of Interest

None.

5. Minutes of the previous meeting on 24th September 2020

The minutes of 24th September 2020 were approved as a true and accurate reflection of the meeting.

6. Action Sheet

FT/20/30 Proposal on dashboard changes. AE to provide update later in the meeting.

FT/19/84 Report back on the offer for children with special needs. MF advised this will go through the PEIP Committee.

FT/20/02 Student involvement in environmental and sustainability developments. AE advised the intention is to re-start this next year.

FT/20/27 Actions in response to patient story from September 2020 board meeting. MF advised this will be followed up through the PEIP Committee.

7. Matters Arising

There were no matters arising.

8. CEO Report ***Noted*** ***Board Assured***

The Chief Executive presented the CEO report [see slides 16 – 21 of the pack] to provide an overview of the current climate in which we are operating, a summary of key issues including risks, incidents/achievements and key updates from stakeholders and regulatory bodies which the Board of Directors need to be aware.

Comments/Questions in response:

- Appreciation was expressed for continuance of the BAF.
- Estate and Partnerships. Consider iFM being included.

9. COVID and Reset Update Presentation ***Noted***

The Chief Operating Officer and Director of Strategy & Transformation delivered a presentation. Headlines:

- Remain at Level 4 (internal escalation).
- 6 wards open (increased from 4).
- 3 bays in critical care.
- Keeping cancer and clinical urgent work going.
- Working with NWAS on ambulance wait times.

- 1-2 year recovery to get 52 week back in place.
- Nosocomial outbreak due to inability to cohort patients in usual way. Actions taken and spread decreasing (6 this week as opposed to 15 last week).
- Panther now in place and running which has doubled testing capacity.
- Elective programme will be reintroduced when Covid numbers in hospital reduce.

9.1 Covid Health & Wellbeing Report ***Noted***

The Director of People delivered a summary of the report [see slides 22 – 26 of the pack]. Headlines:

- Focus on supporting staff with kindness and compassionate leadership.
- Support is reflected in absence levels as Bolton is best in GM and second in NW.

Comments/Questions in response:

- Neyber is in all staff communications with links to wellbeing support however we will try to invigorate this and encourage uptake.
- Staff Survey closes on 27th November 2020 and we expecting a fall in results generally within the NHS, in the main due to the Covid situation.

Actions:

JM to respond by email with detail of take-up of Neyber and start date for Schwartz rounds [due December 2020]. ***FT/20/37***

JM to ensure update on launch of Behaviours through People Committee [due January 2021]. ***FT/20/38***

10. Flu Vaccination Update ***Noted***

Board Assured

The Director of Nursing delivered a summary of the report [see pages 27 – 28 of the pack] which articulates the Trust position in relation to the NHS England best practice checklist and confirms compliance with all 18 points.

11. Integrated Performance Report ***Noted***

Board Assured

The Chief Operating Officer delivered a summary of the report [see slides 29 – 78 of the pack] which is provided to support the Board's oversight of performance and progress towards strategic goals and to ensure responsiveness and a clear line of sight from ward to Board. COVID-19 has resulted in significant operational challenges that have impacted significantly on many of the metrics included in the report. The Board are asked to consider the key metrics noting the impact of COVID-19 and consider if any further scrutiny is required through one of the Board Committees.

Comments/Questions in response:

- The Board are assured we report quarterly on falls through QA Committee. We have a Falls Co-Ordinator working across the Trust and the Assistant Director of Nursing chairs the Falls Steering Group. Falls are classed as a low priority due to the significant oversight previously detailed. BI would consider this to be a medium priority.
- Nationally there has been a rise in stillbirths. We have appointed a BAME midwife who is working very closely with local communities. She will be providing a full report of her activities and will specifically ask for information regarding language issues.

Actions:

AE to revert to RG with clarifications on charts 217 and 199 [slides 41 & 42 of the pack] [due December 2020]. ***FT/20/39***

AE to ensure case study or patient story be shared to celebrate deflection/home first success [due January 2021]. ***FT/20/40***

DH requested Benash Nazeem be invited to one of our future Board meetings. ***FT/20/46***

12. Quality Assurance Committee Chair Report

Noted

Board Assured

AT delivered a summary of the report [see slides 79 – 84 of the pack].

Headlines:

- 5 SIs across two meetings. Major piece of work ongoing in the Trust to re-enforce procedures and implementation of guidelines. The SIs do not appear to be Covid related.
- No risks to be escalated.

Actions:

BI asked for clarity on the procedure for registering a death which MF kindly provided. MF will follow up on the issue raised by BI [due December 2020]. ***FT/20/41***

13. Finance & Investment Committee Chair Report

Noted

Board Assured

JN delivered a summary of the report [slides 85 – 93 of the pack].

- Locality System Savings. This is amber because of its infancy. There are no concerns regarding the quality of work undertaken.
- Capital monies received for Covid. This relates to same day emergency care and ICU/HDU capital. We receive regular updates through Strategic Estates and are making good progress on these schemes.
- No risks to be escalated.

14. People Committee Chair Report ***Noted*** ***Board Assured***

MB delivered a summary of the report [slides 94 – 101 of the pack]. Headlines:

- We have managed to fill some difficult roles.
- Maternity Workforce Improvement (WFI) is getting better but still not where we would like it to be.
- Staff experience has declined but this is largely as a result of Covid.
- Currently only 32 apprentices rather than 196 due to Covid. Could look at Bolton at Home in the future.
- Guardian of Safe Working (GOSW) – still an in issue in Surgery. The Surgical Division has recruited 4 doctors to provide an increased resource.
- No risks to be escalated.

Actions:

JM to ensure update be provided on Apprentice scheme at People committee and then to Board via Chair's Report [due January 2021]. ***FT/20/42***

* ***Note of thanks to Marie Forshaw, Director of Nursing***

At this point in the meeting the Chair wished to formally make a note of thanks to MF as this would be her final Board meeting before leaving the Trust to commence a new post. MF was thanked for all her diligent work over the years at Bolton and the Board expressed their very best wishes to MF for the future, noting she would be greatly missed.

15. Safeguarding Annual Report ***Noted*** ***Board Assured***

MF delivered a summary of the report [slides 102 – 131 of the pack]. MF acknowledged the magnificent work of Sandra Crompton and

Fiona Farnworth on this report. The report provides an overview and assurance of the Trust's Safeguarding provision and activity. The Trust is mandated to provide assurance to NHS England against 81 safeguarding standards on an annual basis. The report presents the principal standards and provides an overview of assurance required for the principal standard's subcategories. The report includes both quantitative data and narrative summaries as this best meets the assurance requirements in this complex area of work. ES will arrange for Board members to undertake safeguarding training so Members are fully aware of their unique responsibilities.

Comments/Questions in response:

II commented the work carried out by Fiona Farnworth and her team was outstanding and they had gone beyond safeguarding to also encompass work in the community to tackle FGM and speaking out.

16. Mortality Report ***Noted*** ***Board Assured***

FA delivered a summary of the report [slides 132 – 144 of the pack] and a presentation. Mortality data is presented in terms of crude mortality, RAMI, SHMI and HSMR and underlying analysis. The impact of the first wave of Covid-19 is described briefly. Work undertaken to understand the higher than expected figures is detailed and a conclusion drawn around co-morbidity recording and further work required for this.

The conclusion is we have higher than expected mortality rates but FA assured the Board he is satisfied there is no issue with the quality of our care. Our latest breakdown of mortality for 10 specialist areas is not higher than average.

17. Learning from Deaths Report ***Noted***

Board Assured

FA delivered a summary of the report [slides 145 – 151 of the pack]. Trusts are required to collect and publish, on a quarterly basis, specified information on deaths. This data includes the total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Up to January 2020 we have managed to review 75% of all deaths. We need to prioritise learning disability deaths and mental health deaths. Going forward we will also be concentrating on Covid deaths.

18. Refresh of 2019/24 Strategy ***Noted***

Board Approved

SM delivered a summary of the report [slides 152 – 172 of the pack]. In our 2019-24 Strategy…for a better Bolton, the Trust committed to conducting an annual review of progress against the six strategic ambitions and associated objectives. The report describes achievements in 2019-20, 2020-21 and priorities for 2021-22. It includes an updated Strategy into Action section which details progress against objectives and highlights any changes in their timescales for delivery. The review is informed by extensive consultation with staff and Foundation Trust members (results presented to the Board in October). The BAME Forum suggested refreshing the online video to have staff discussing the strategy. SM also took the opportunity to thank Rachel Noble and Kathy Stacey for their hard work and contributions to this project. Board approval for this document to be circulated to staff, made available on the Trust website and shared with key stakeholders is requested.

Comments/Questions in response:

The issue of staff engagement with this 21 page document was raised and it was suggested it be condensed to one page. SM will look into this. Slight amendments to wording were also suggested. SM will check the accuracy of existing wording and thereafter action suggested amendments where necessary.

Actions:

SM to deal with the suggestions above re condensing the paper and amending wording. Also discuss in Execs to identify our top three investment priorities [due February 2021]. ***FT/20/43***

19. Audit Committee Chair Report ***Noted***

AS delivered a summary of the report [slides 173 – 179 of the pack]. ***Board Assured***

20. Standing Orders and Matters Reserved ***Noted***

ES delivered a summary of the report [slides 180 – 232 of the pack]. ***Board Approved***

These documents, together with the Trust's Constitution, the Standing Financial Instructions and the Scheme of Delegation provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents. The version provided within the Board pack was scheduled for discussion at the Audit Committee meeting on 24th November 2020. Any further changes proposed as a result of Audit Committee debate will be included as a late addendum to this paper. Board approval of the revised Standing Orders and Matters Reserved documents is requested.

21. Standing Financial Instructions and Scheme of Delegation ***Noted*** ***Board Approved***

AW delivered a summary of the report [slides 233 – 313 of the pack]. The Standing Financial Instructions are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. The Financial Scheme of Delegation sits sets out the powers and financial levels of authority or the Board, its Committees and the Executive. The Standing Financial Instructions and Financial Scheme of Delegation combine to form part of the Standing Orders of the organisation and are reviewed periodically. Both of these documents have been significantly redrafted to improve usability. Included in this agenda item is a covering paper to summarise the changes made along with the current versions to aid comparison. It should be noted that minor changes may continue to be made following the publication of committee papers. Board approval of the Standing Financial Instructions and Scheme of Delegation documents as requested with a proposal for AW, ES and AS to sign off the final version.

22. Infection Prevention and Control Annual Report ***Noted*** ***Board Assured***

MF delivered a summary of the report [slides 314 – 345 of the pack]. Headlines:

- HCAI performance largely remained unchanged year-to-year.
- There was a significant spike in CDT cases in the summer of 2019 which has been extensively reviewed and performance has improved to baseline.
- The Trust achieved 81.9% frontline staff seasonal flu uptake in 19/20 – the joint highest in Greater Manchester.
- The activities of the Trust were significantly affected at the end of the year and into 2020/21 by the emergence of a global pandemic caused by SARS-CoV-2.

- No national objectives for HCAI have been set by NHS England due to the impact of COVID-19.

23. Revalidation Annual Report ***Noted*** ***Board Approved***

FA delivered a summary of the report [slides 346 – 371 of the pack]. The medical appraisal and revalidation quarterly update includes changes resulting from Covid-19 and an update of the action plan. Board approval of the report and action plan is requested.

24. Any Other Business

RG advised she had recently made a site visit and visited various departments. Staff are obviously tired but in the main keeping in good spirits. Good progress is also being made on building works.

25. Questions from Members of the Public

No questions.

26. Resolution to Exclude the Press and Public

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.

22. Date and Time of Next Meeting

Thursday 28th January 2021 @ 09:00.

November 2020 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/20/37	26/11/2020	Wellbeing update	JM to respond by email with detail of take up of Neybor and start date for Schwartz rounds	JM	Dec-20	for email follow up - complete
FT/20/44	26/11/2020	Council budget	further debate on impact on FT at December development session	SM	Dec-20	complete
FT/20/45	26/11/2020	system finances	Presentation from F&I committee to be shared with all Board members	AW	Dec-20	complete
FT/20/09	27/02/2020	Seven Day services	Further discussion on implications of guidance through Execs then WAC and back to Board in three months	FA/JM	Jan-21	deferred nationally due to Covid-19 pressures - close action as new action will be required post covid
FT/20/38	26/11/2020	Wellbeing update	update on launch of behaviours through People Committee	JM	Jan-21	people committee chair report - agenda item
FT/20/42	26/11/2020	People Committee	update to be provided on Apprentice scheme - to People committee	JM	Jan-21	Board to be updated through People Committee Chair report
FT/20/39	26/11/2020	performance report	queries on charts 217 and 199 - response to be provided by email	AE	Dec-20	
FT/20/41	26/11/2020	QA Chair report	MF to follow up on issue raised by BI	MF	Dec-20	for follow up outside meeting
FT/20/17	30/04/2020	performance report	Repeat SPC education session		Jan-21	Defer for incorporation in 21/22 development plan
FT/20/43	26/11/2020	Strategy update	Discussion in Execs with regard to identifying top three investment priorities	SM	Feb-21	update in Strategy session
FT/20/35	24/09/2020	inclusion	continue development of policy and implementation of policy through further debate in development session	ES	Mar-21	Annual EDI focus included within Board workplan, EDI strategy agenda item - complete
FT/20/36	24/09/2020	inclusion	review cover page to include inclusivity impact review	ES	Mar-21	
FT/20/40	26/11/2020	performance report	Case study or patient story to be shared to celebrate deflection/home first success	AE	May-21	
FT/19/82	28/11/2019	iFM business plan	Carbon Neutral strategy and update on the work of the sustainability group	AE	Sep-21	

Key

complete	agenda item	due	overdue	not due

Agenda Item

Title:	Chief Executive Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th January 2021		Discussion	
Exec Sponsor	Fiona Noden		Decision	
Summary:	The Chief Executive report: • Provides an overview of the current climate in which we are operating. • Includes a summary of key issues including risks, incidents and achievements. • Includes any key updates from stakeholders and regulatory bodies which the Board of Directors need to be aware.			
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 Lindsay Dunn	**Presented by:**	Fiona Noden Chief Executive

1. Context

Since the last meeting of the Board we have continued to see a steady increase in the number of patients who need to be admitted to hospital with COVID-19, with approximately 1 in 4 of our beds taken up with COVID patients at the time of writing. This is very much in line with the rest of the country, which is dealing with the third wave of the pandemic. Our modelling suggests that we have not yet hit the peak, and we are implementing our plans to manage this situation.

This has meant that unfortunately we have had to pause elective work, though we continue to deliver urgent patient treatments and cancer procedures.

We are focussing efforts on how we discharge patients more quickly, working with NHSE to increase discharge by up to 25% in readiness for a continued increase of COVID patients, on top of our usual acute demand. Some of our community teams have been redeployed to support this work to improve patient flow and keep our patients safe.

Sustaining our capability to handle emergency non-COVID related treatment is also a priority. Our Same Day Emergency Centre is edging closer to completion which will mean we will be better able to treat emergencies on the same day without resulting in a hospital stay for our patients.

We have offered the vaccination to all our staff and vaccinated over 5,530 staff with the first dose of the COVID vaccine, and have now begun a vaccination programme with health and social care staff from across the Bolton Integrated Care Partnership footprint.

We continue to make efforts to improve communication with relatives during this tough time. Working with colleagues at the Bolton Council of Mosques, we have appointed two new volunteers, who have now joined us in our hospital to support communication with patients and their families.

We also continue to focus our efforts on helping our staff to access support where needed for their emotional, mental and physical health as they work through these challenging times. I have set up twice weekly WebEx briefing sessions where staff can drop in and ask any COVID questions they might have, in addition to a comprehensive support offer available to all staff.

2. This month's Board papers

Our Board story this month comes from one of our staff members who will be attending to share his experiences working in our Critical Care unit during the first wave of the pandemic.

Although COVID continues to dominate all our lives both in and out of work it is important that we maintain our standards providing the best care we can. In December 2020, Donna Ockenden published her initial findings from the independent review of maternity services in Shrewsbury and Telford. As we are a major centre for maternity services it is vital that we take whatever learning we can from this report – the papers provide our initial response to the actions required of all maternity providers, we discussed this in detail and will continue to review both through our Quality Assurance Committee and in our Board meetings.

Other Board papers continue this theme of focusing on our standards including our annual update on the Workforce and Organisational Development Strategy and our annual Health and Safety Report.

3. Awards & Recognition

- Martina Kingscott (Nursing) - Cavell Star Award
- Dr Harni Bharaj, MBE - Services to people with diabetes
- Dr Sharran Grey, OBE - Services to blood transfusion and patient care

FABB Awards

Since our last Board the following areas have been presented with our 'For a Better Bolton' award:

- High Meadows Nursery
    - For keeping our children safe and entertained in order that our staff can stay in work.
- Paediatric Diabetic Service
    - For their work with children and their families.
- Clinical Haematology
    - To protect our patients and continue to treat potentially curable cancers and maintain the safety of our other patients who require intervention and care, this service relocated to the Beaumont Hospital on Good Friday. Clinical Haematology treat 95% of all patients referred to us locally for all the blood cancers (Lymphoma, Myeloma and Leukaemia) plus many other haematological conditions.
- Cancer Services
    - For working closely as a team to achieve and dramatically changing patient pathways to embrace new ways of working to keep our vulnerable patients safe.

4. Reportable Issues Log

Issues occurring between 26th November 2020 to current:

4.1 Serious Incidents & Never Events

In the period since our last Board meeting we reported one serious incident:

4.2 Red Complaints

There has been one Red complaint since the last report.

4.3 Regulatory Notices

We are currently working with the CQC to respond to a regulatory enquiry regarding the provision of inpatient mental health care for young adults.

There have been no coroner's letters or regulation 28 reports.

4.4 Health & Safety

- Seven incidents have been reported to the HSE since 15th November 20 to 15th January 2021. One incident relates to a violent patient which resulted in soft tissue damage to the staff's finger and being left unable to complete normal duties for six weeks.
- Three incidents relate to a slip, trip or fall resulting in injury.
- One incident relates to a needle-stick injury, this is being treated with prophylactic medication.

RIDDOR

- One incident relates to a member of staff wearing PPE without training, this has resulted in an investigation regarding COVID diagnosis.
- One incident relates to a small number of staff in NNU having possible contact dermatitis.

4.5 Maternity Incidents

- During November and December, we have had 3 still births and 1 early neonatal death. Two of these were expected deaths due to foetal abnormality.

4.6 Whistleblowing & Freedom to Speak Up

The FTSU Guardian continues to meet with myself, Director of People and the Non-Executive Director on a monthly basis. Our Freedom to Speak up cases continue to rise which is really positive as this demonstrates an open, honest culture and that staff have confidence in the process.

4.7 Media coverage

Key media activity since the last meeting includes:

- Coverage of the COVID vaccination roll-out.
- Continued reporting of operational pressures, visiting restrictions and changes to services across the organisation as a result of COVID.

- Continued interest from national news outlets to cover the pandemic, we continue to determine and respond to these in accordance with national NHS sign off.
- Dr Francis Andrews took part in Bolton FM radio interview to talk about wave 3 preparations, and to reinforce public health messaging.
- Manchester Evening News article interviewing three NHS staff anonymously about what it is currently like working in hospital, one of whom worked in our Emergency Department.
- Responded to a Press Association article regarding the amount trusts paid in litigation in the last financial year.
- Various Christmas pieces relating to donations and activities, particularly for our younger patients.
- Coverage of Dr Harni Bharaj and Dr Sharran Grey being awarded New Year's Honours.
- Introduction feature of our new Chief Nurse, Karen Meadowcroft.

5 Board Assurance Framework Summary

The Board Assurance Framework (BAF) Summary is attached. This shows the key risks to the achievement of our strategic ambitions, the actions required to reduce or mitigate these risks and the governance in place to provide the required oversight.

Our most significant strategic risk relates to the impact that COVID continue to have on ambition 1, to provide safe, high quality and compassionate care to every person, every time.

Board Assurance Framework Summary – January 2021

This summary provides a high level overview of the key risks and issues that could impact on the delivery of our strategic objectives, it summarises the more detailed description of the assurance and controls in place or planned to mitigate these risks and issues.

	Ambition	Lead	I	L		Key Risks/issues	Key actions	Oversight
1.1	**To give every person the best treatment, every time** **1)Reducing deaths in hospital**	FA	4	4	16	HSMR/RAMI above expected level Prompt identification and escalation of ill patients Depth of coding Coding of ACU patients	Work with AQUA and NHS Northwest on pneumonia Root cause analysis of avoidable cardiac arrests Delivery of MRG Workstream HED benchmarking Q1 2021/22	QA committee Mortality Reduction Group Learning from Deaths
1.2	**To give every person the best treatment, every time** **2)Delivery of Operational Performance**	AE	4	5	20	Capacity – physical and staffing exacerbated by COVID 19 infection control requirements Patient confidence to use services following COVID 19 Impact of COVID 19 on pathways, including risks associated with overcrowding Back log of work as a result of the cessation of activity during initial outbreak	Redesign of pathways for COVID compliance Urgent Care programme plan to ensure best practice, e.g. SAFER Enhanced pathways as part of the new streaming model Cancer and RTT Patient treatment list management Review of OPD and Theatre capacity and transformation Detailed capacity and demand management Joint working with GM on cancer pathways	Urgent care programme board Covid Reset Group Contract and Performance GM Cancer Board
2	**To be a great place to work**	JM	4	4	16	Sickness rates (particular increase of stress related issues as a result of Covid) Recruitment and retention in key staffing groups Over reliance on Agency staff Staff experience (particular focus required maternity) Inclusion – workforce not reflective of population	Health and Wellbeing plan in place and positive impact, on-going monitoring in place Recruitment work plan in place and positive impact, on-going monitoring in place Staff experience plan in place and positive impact, on-going Maternity cultural improvement plan, implementation on-going with some improvements being shown Inclusion programme in place, with mixed delivery outputs	IPM People committee
3	**To continue to use our resources wisely so that we can invest in and improve our services**	AW	4	4	16	Failure to deliver financial balance and surpluses for reinvestment	Development of place based approach to service and financial planning Sep 21 5 year financial strategy and trajectories agreed with GM and NHSI June 21	F&I committee IPM Contract and Performance Group

	Ambition	Lead	I	L		Key Risks/issues	Key actions	Oversight
4	**Our estate will be sustainable and developed in a way that supports staff and community health and wellbeing**	AW	4	4	16	Availability of capital funding and changes to capital regime. Lack of revenue to support capital Controllability of non FT estate in community	Fully costed estates strategy over 5 years, Dec 21 Hospital Improvement Plan bid, Mar 21 Agile Working programme – ongoing	Strategic Estates Board Strategic Estates Group Finance Committee
5	**To join up services to improve the health of the people of Bolton**	SM	4	3	12	Failure to Deliver Integrated Care Partnership	Appointment of ICP Chair – now complete Communication and Engagement Plan across all providers in place - complete Development of an OD Framework to support cultural change, Develop Alliance Agreement to support the governance of the partnership, Embed ICP Community Focused Transformation Programme (including Public Sector Reform) within the ICP, on-going Commence development of a public health framework, February 21	Trust Management Committee QA Board ICP Board
6	**To develop partnerships across Greater Manchester to improve services**	SM	4	4	16	GM Improving Specialist Care (ISC) programme paused in response to COVID-19, halting planned transformation of services including Breast, T&O, Urology etc. No date for programme restart NWS Healthier Together (HT) programme has received capital funding from HM Treasury to progress construction of the Acute Receiving Centre at SRFT with anticipated completion in 2023 New approach to partnership working in GM in response to COVID-19 GM Radiology and Pathology Cells in development	Watching brief at GM-level and GM collaboration on pinch-point specialties through operational restart (i.e T&O and breast) - ongoing Assessment of the changes required for delivery of HT in context of C-19 - ongoing Continued involvement of executives at a GM level - ongoing Continued involvement of executives and operational/clinical leads at a GM level - ongoing	Trust Management Committee F & I Board

Bolton NHS Foundation Trust

Integrated Performance Report

December 2020

Guide to Statistical Process Control

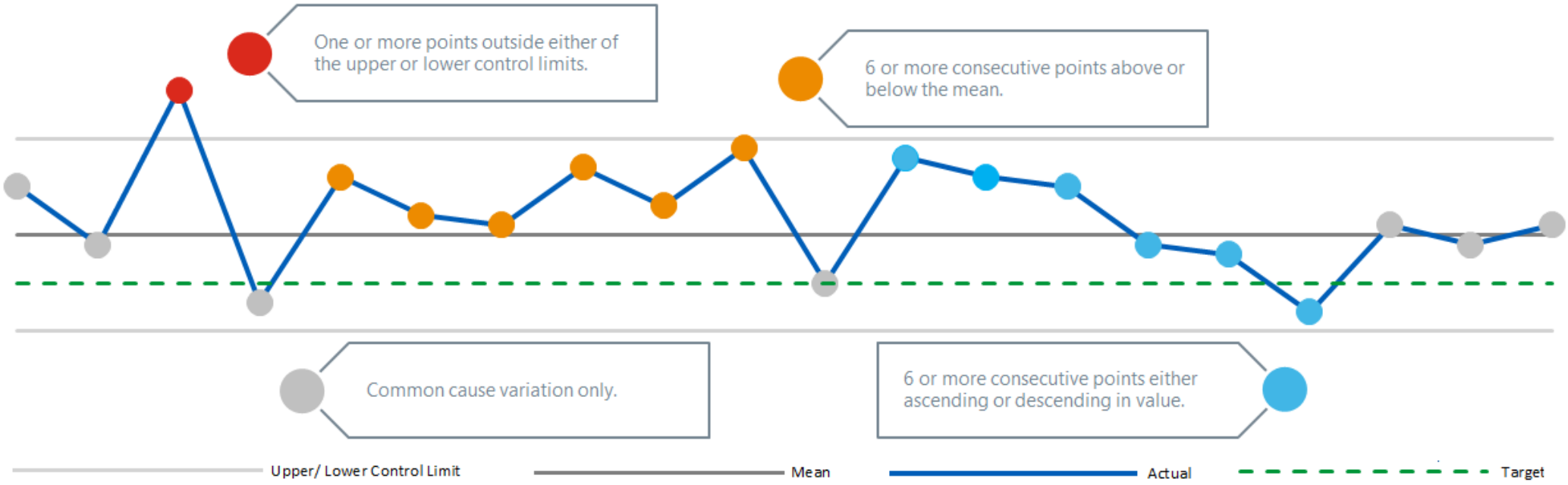
NHS Bolton NHS Foundation Trust

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	9	2	3	1	1	1	2	13
Infection Prevention and Control	9	0	0	0	0	0	0	9
Mortality	4	0	0	0	0	0	0	4
Patient Experience	11	3	0	0	2	4	0	12
Maternity	8	1	1	0	0	1	0	9
Operational Performance								
Access	4	0	1	4	2	0	6	5
Productivity	9	0	1	0	2	2	1	9
Cancer	4	1	0	0	2	2	0	5
Community	3	0	0	1	0	1	0	3
Workforce								
Sickness, Vacancy and Turnover	1	0	0	2	0	0	1	2
Organisational Development	2	1	0	0	1	1	0	3
Agency	2	0	0	1	0	0	0	3
Finance								
Finance	1	1	1	0	1	2	1	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

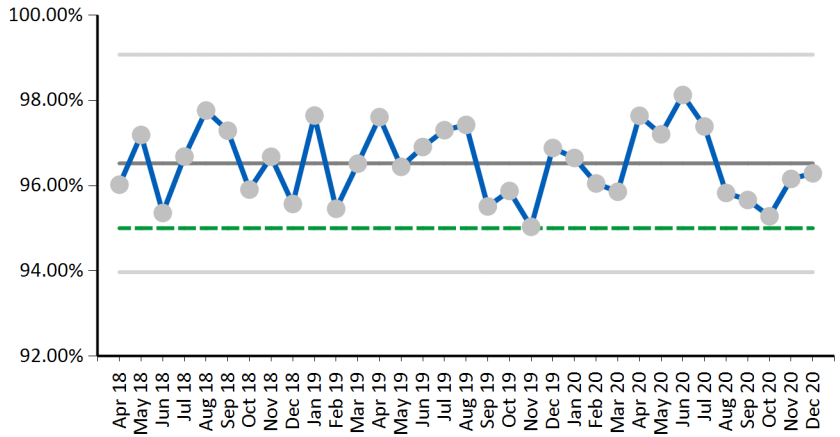
Pressure Ulcers
In December there were seven hospital acquired category 2 pressure ulcers, which is over our planned threshold, and an increase since the previous month. It should be noted that four of these were device related pressure ulcers that developed in our most unwell patients in the Critical Care Unit. There were also no lapses in care noted for any of these patients.
In the community there was an increase in the number of category 2 pressure ulcers, with 13 identified, again this is over our monthly threshold. There were also two category 3 pressure ulcers that developed in the community, this remains below our threshold. There were no lapses in care for any of these patients.
No category 4 pressure ulcers developed under our care in December.

Falls
Inpatient falls have continued to reduce in December despite the increase in bed occupancy and the ongoing pressures as a result of COVID–19. In month we remain below the national benchmark of 6.6 falls per 1000 bed days.
We had 2 falls with harm in December. The number of harms is a significant reduction of 2 on the previous month.

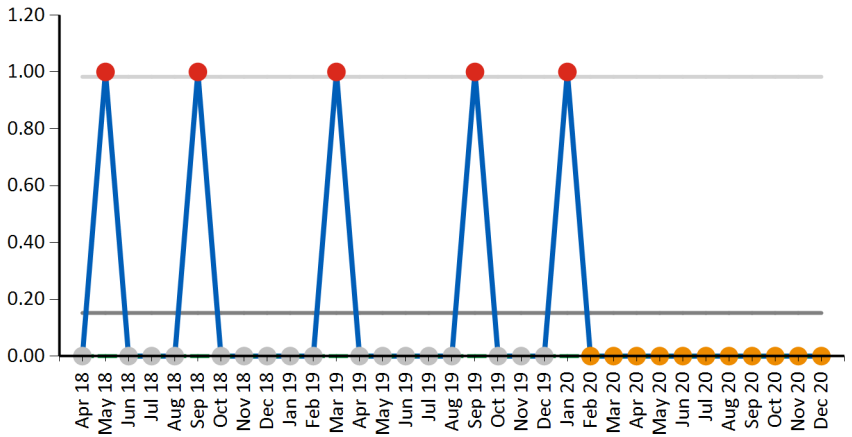
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.3%	Dec-20		>= 95%	96.2%	Nov-20	>= 95%	96.5%	
9 - Never Events	= 0	0	Dec-20	L	= 0	0	Nov-20	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.87	Dec-20	H	<= 5.30	6.41	Nov-20	<= 5.30	7.10	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	Dec-20		<= 1.6	4	Nov-20	<= 14.4	17	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	7.0	Dec-20		<= 6.0	4.0	Nov-20	<= 54.0	44.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Dec-20	L	<= 0.5	0.0	Nov-20	<= 4.5	4.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Dec-20		= 0.0	0.0	Nov-20	= 0.0	0.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	13.0	Dec-20		<= 7.0	7.0	Nov-20	<= 63.0	97.0	?
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	2.0	Dec-20		<= 4.0	0.0	Nov-20	<= 36.0	33.0	?
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Dec-20		<= 1.0	0.0	Nov-20	<= 9.0	1.0	?
21 - Total Pressure Damage due to lapses in care	<= 6	0	Dec-20	L	<= 6	2	Nov-20	<= 50	19	?
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	82.0%	Q2 2020/21		>= 90%	83.3%	Q4 2019/20	>= 90%	82.0%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q2 2020/21		>= 90%	33.3%	Q4 2019/20	>= 90%	100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	80.0%	Dec-20	H	>= 95%	84.4%	Nov-20	>= 95%	82.3%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	60.6%	Dec-20		>= 95.0%	72.6%	Nov-20	>= 95.0%	75.8%	F
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	100.0%	Dec-20	H	= 100%	100.0%	Nov-20	= 100%	92.9%	?
88 - Nursing KPI Audits	>= 85%	93.3%	Dec-20		>= 85%	93.3%	Nov-20	>= 85%	91.9%	P
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	Dec-20	L	= 100%	0.0%	Oct-20	= 100%		?

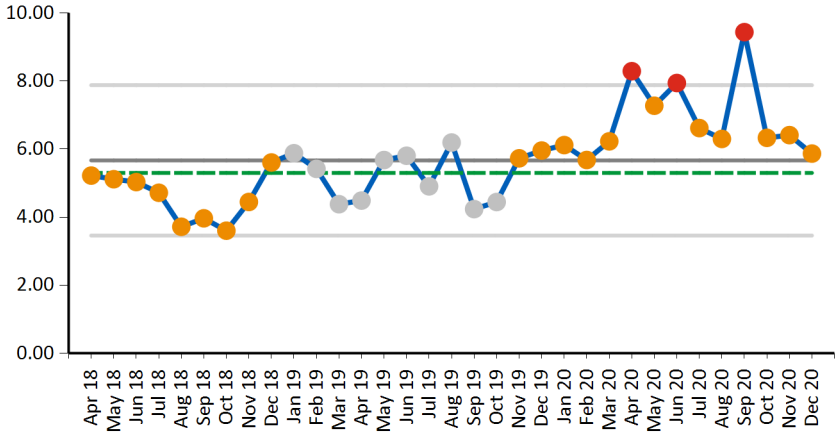
6 - Compliance with preventative measure for VTE



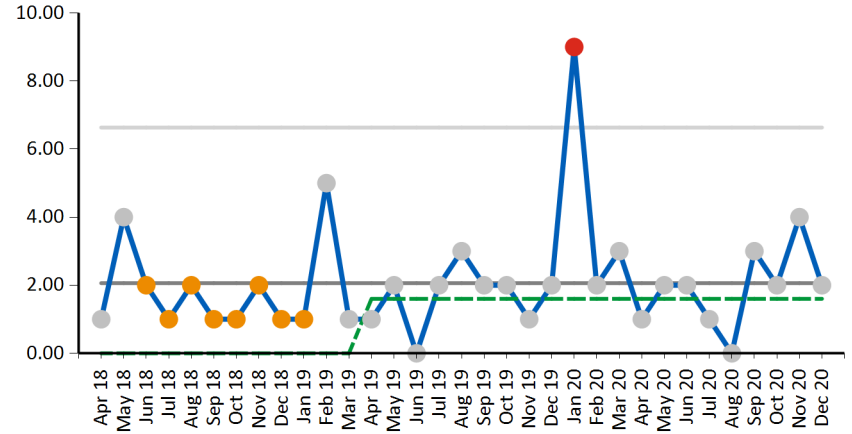
9 - Never Events



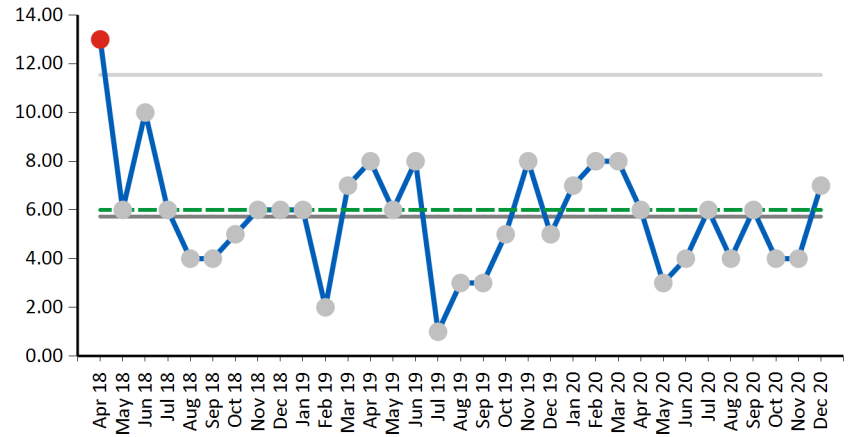
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



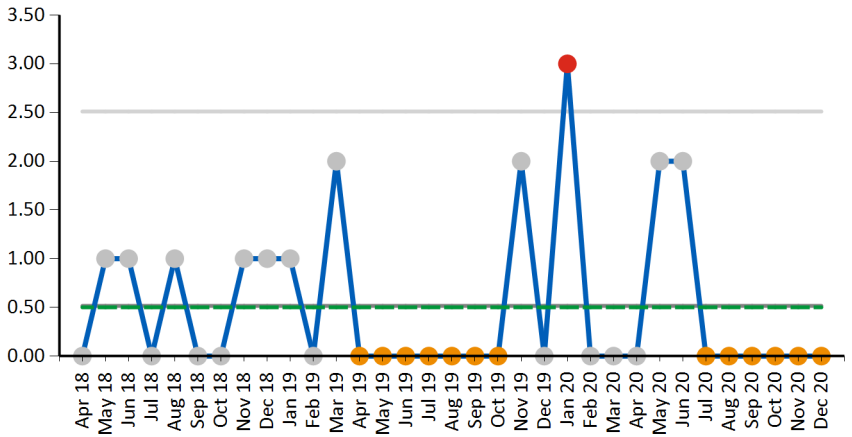
14 - Inpatient falls resulting in Harm (Moderate +)



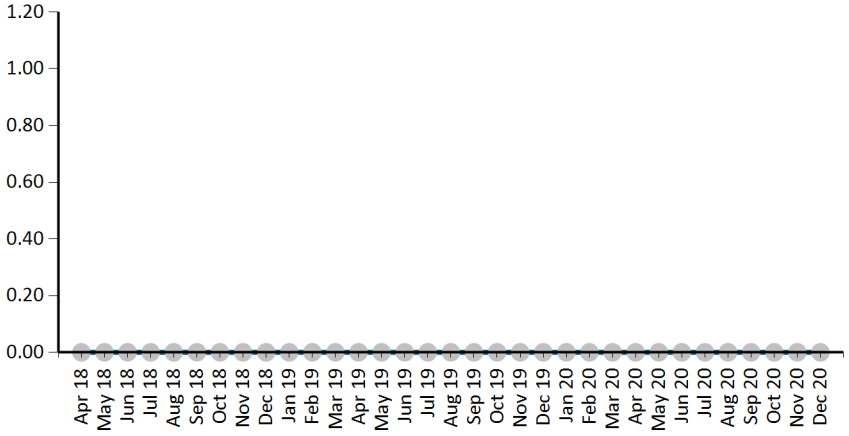
15 - Acute Inpatients acquiring pressure damage (category 2)



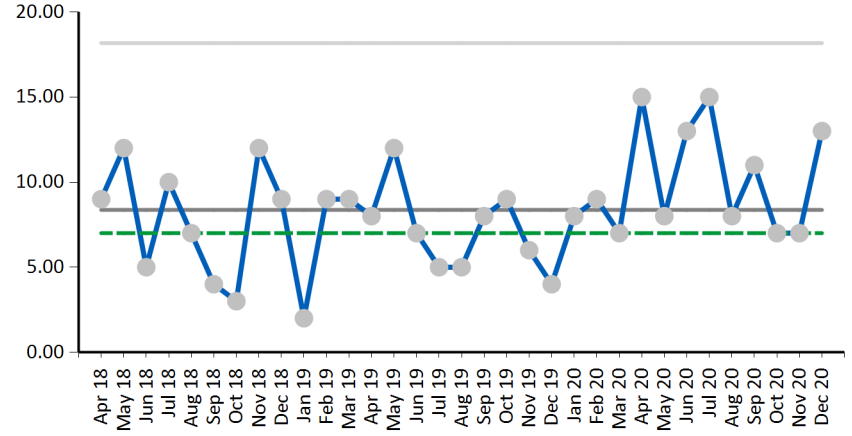
16 - Acute Inpatients acquiring pressure damage (category 3)



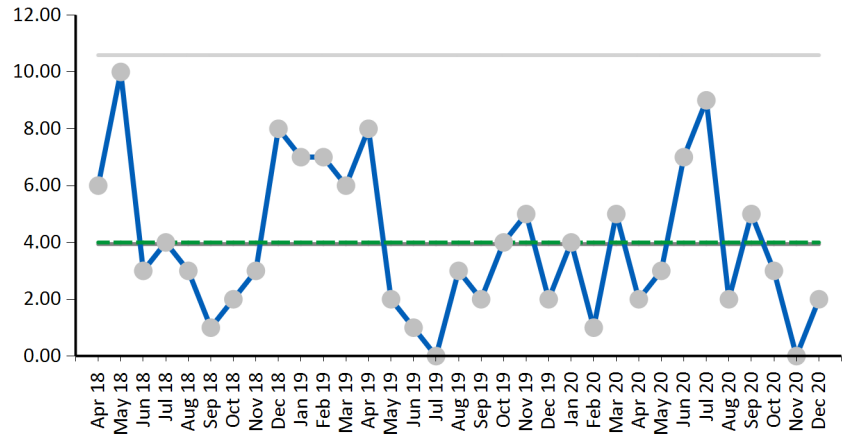
17 - Acute Inpatients acquiring pressure damage (category 4)



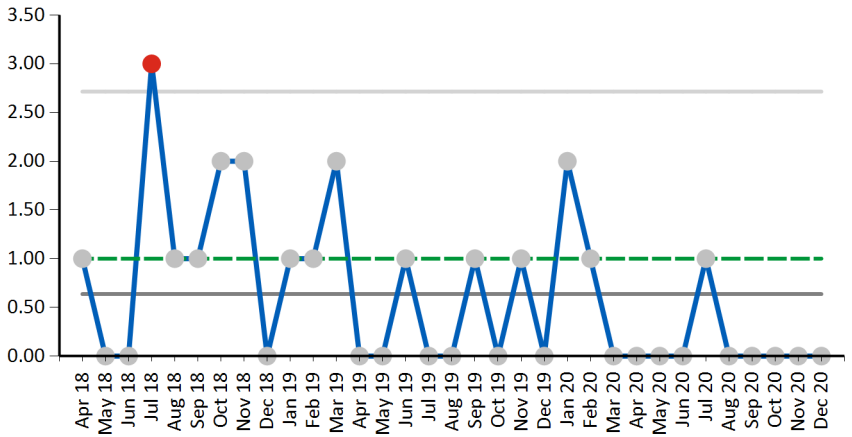
18 - Community patients acquiring pressure damage (category 2)



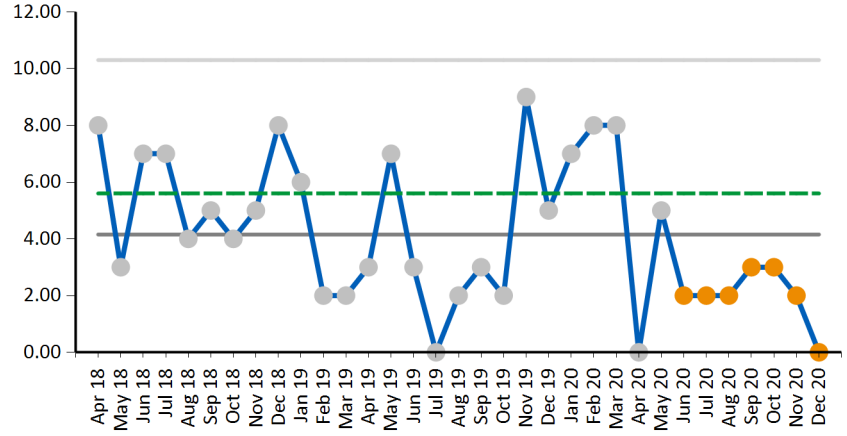
19 - Community patients acquiring pressure damage (category 3)



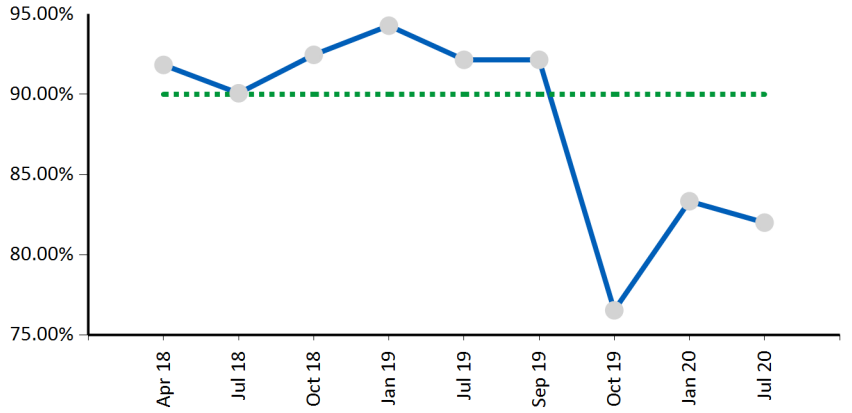
20 - Community patients acquiring pressure damage (category 4)



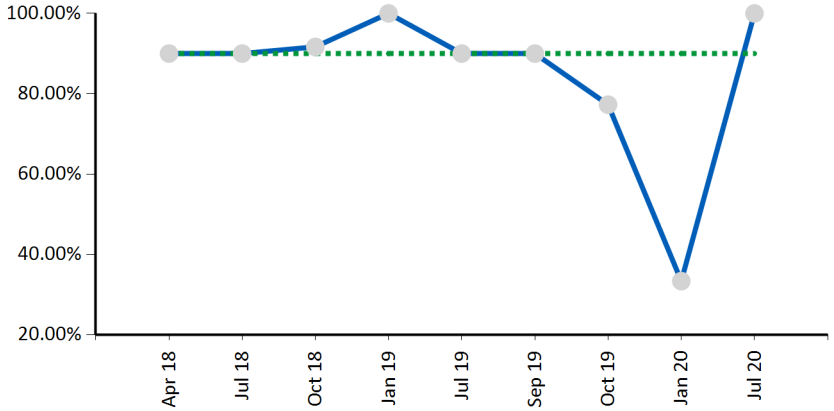
21 - Total Pressure Damage due to lapses in care



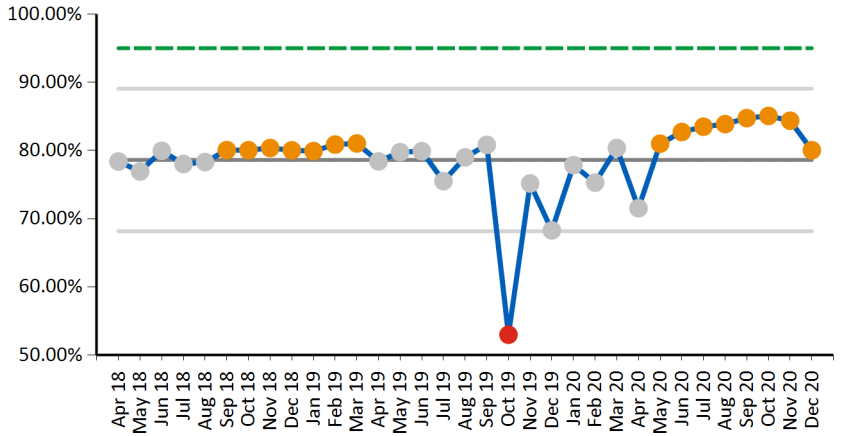
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points



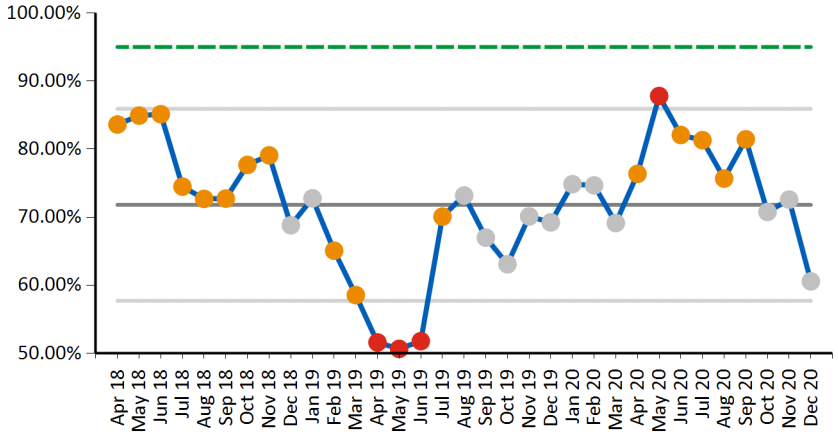
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



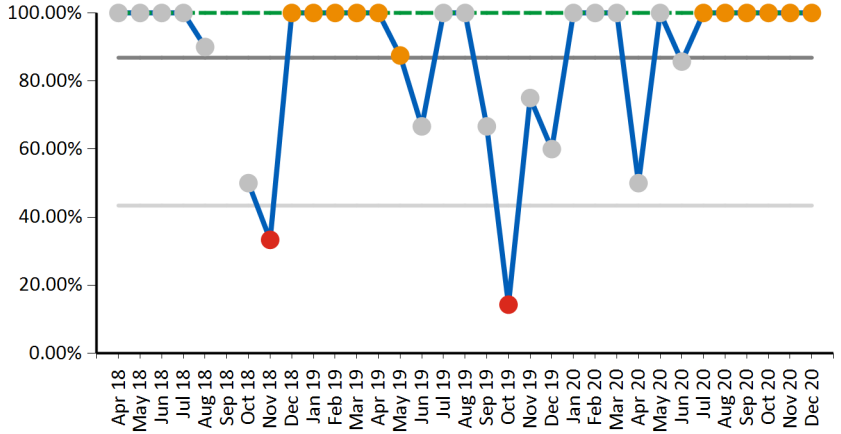
30 - Clinical Correspondence - Inpatients %<1 working day



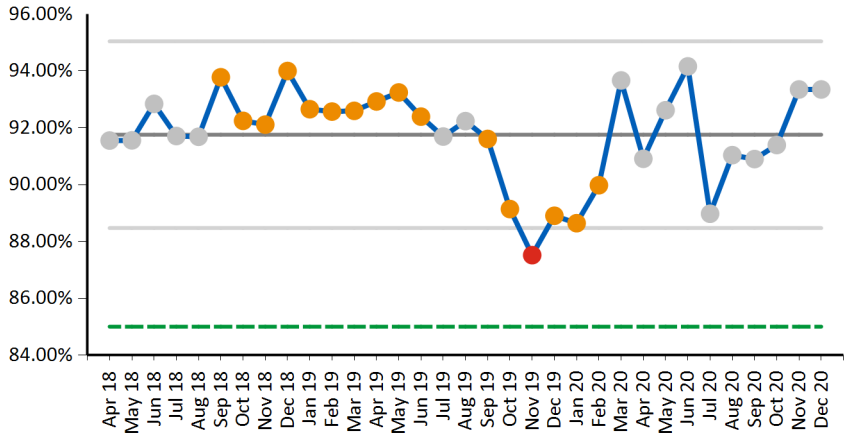
31 - Clinical Correspondence - Outpatients %<5 working days



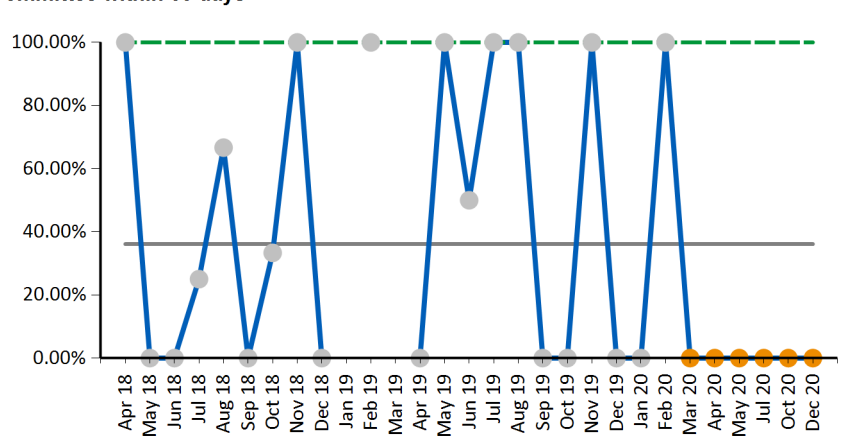
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



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

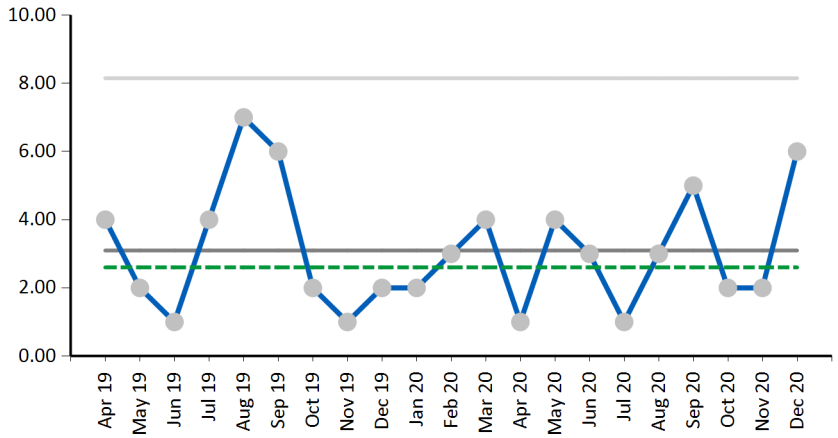


Infection Prevention and Control

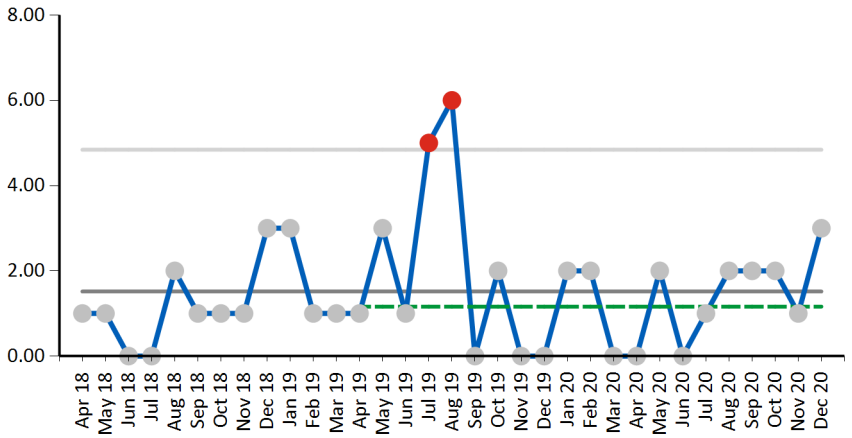
The number of nosocomial COVID-19 cases has reduced month-on-month and has reduced further in January. There has been a marked increase in Clostridium difficile cases apportioned to the Trust in December which is currently being investigated by the IPC/microbiology team.

	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	<= 3	6	Dec-20		<= 3	2	Nov-20	<= 23	27	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	3	Dec-20		<= 1	1	Nov-20	<= 10	13	
347 - Total C.diff infections contributing to objective	<= 3	9	Dec-20		<= 3	3	Nov-20	<= 23	40	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Dec-20		= 0	0	Nov-20	= 0	2	
218 - Total Trust apportioned E. coli BSI	<= 3	1	Dec-20		<= 3	2	Nov-20	<= 27	14	
219 - Blood Culture Contaminants (rate)	<= 3%	3.2%	Dec-20		<= 3%	5.5%	Nov-20	<= 3%	4.5%	
199 - Compliance with antibiotic prescribing standards	>= 95%	73.0%	Q3 2020/21		>= 95%	76.0%	Q1 2020/21	>= 95%	74.5%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	2.0	Dec-20		<= 1.3	0.0	Nov-20	<= 11.7	11.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 1	1	Dec-20		<= 1	0	Nov-20	<= 10	5	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	0	Dec-20		= 0	0	Nov-20	= 0	3	
491 - Nosocomial COVID-19 cases		65	Dec-20			97	Nov-20		293	

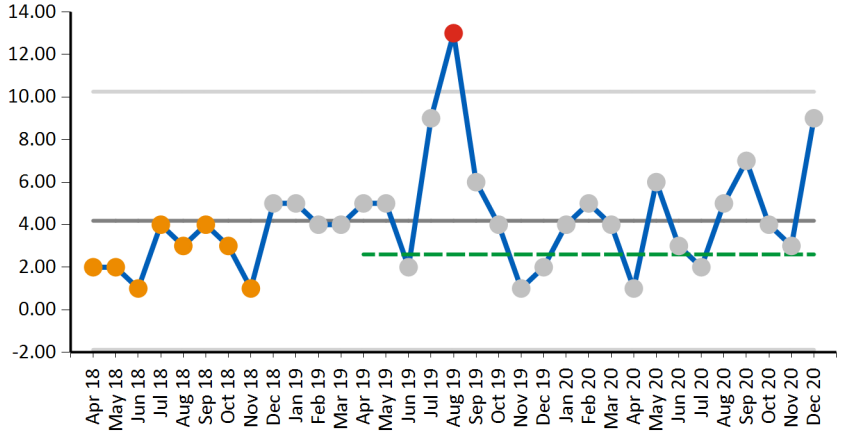
215 - Total Hospital Onset C.diff infections



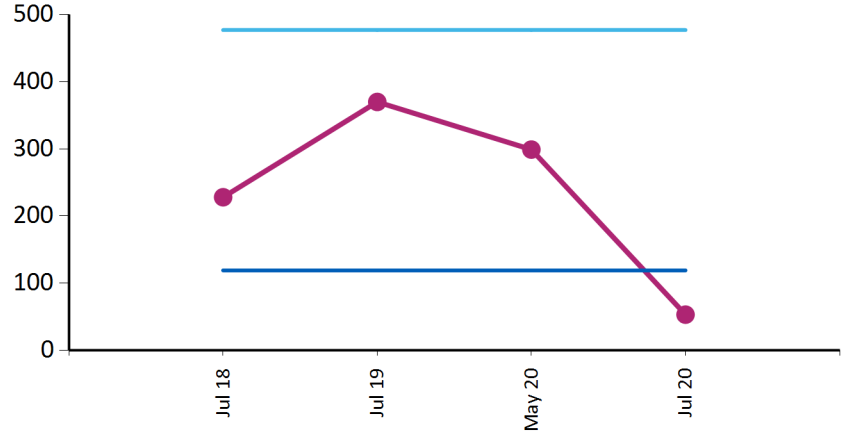
346 - Total Community Onset Hospital Associated C.diff infections



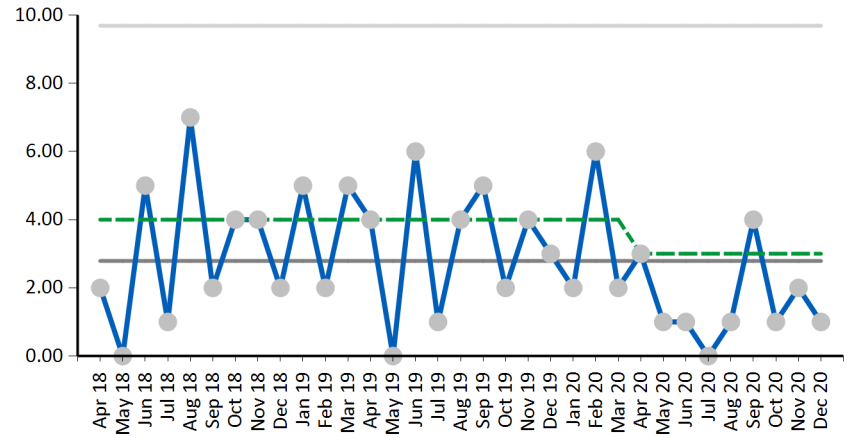
347 - Total C.diff infections contributing to objective



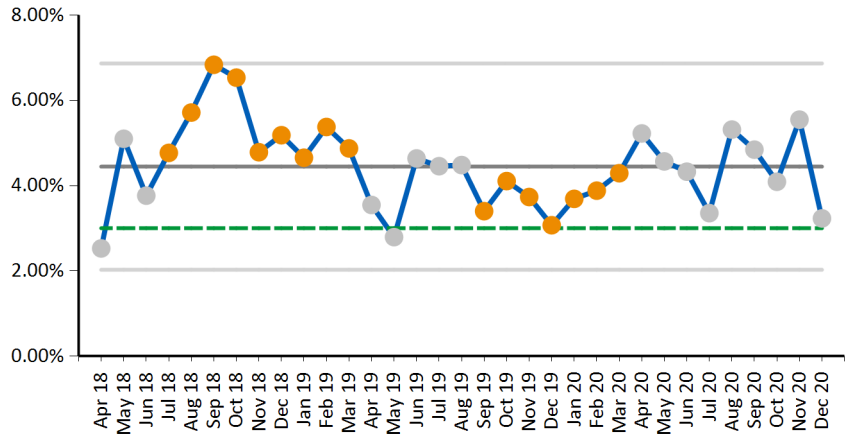
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



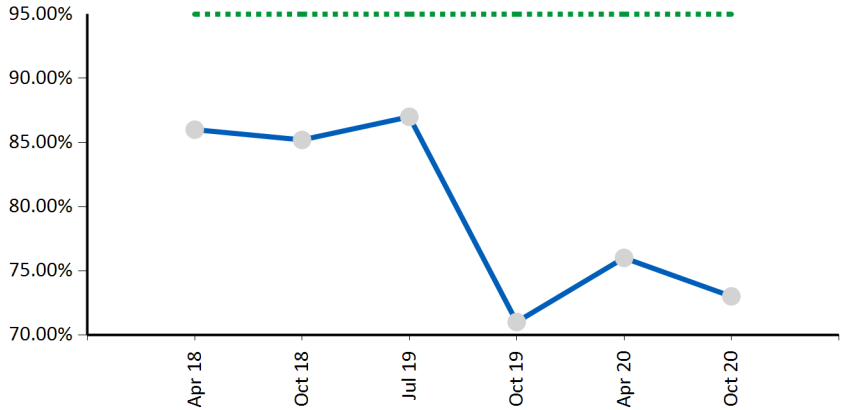
218 - Total Trust apportioned E. coli BSI



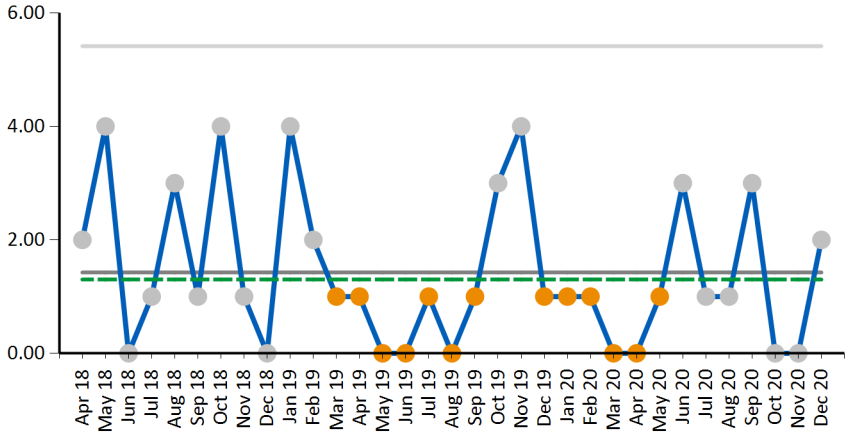
219 - Blood Culture Contaminants (rate)



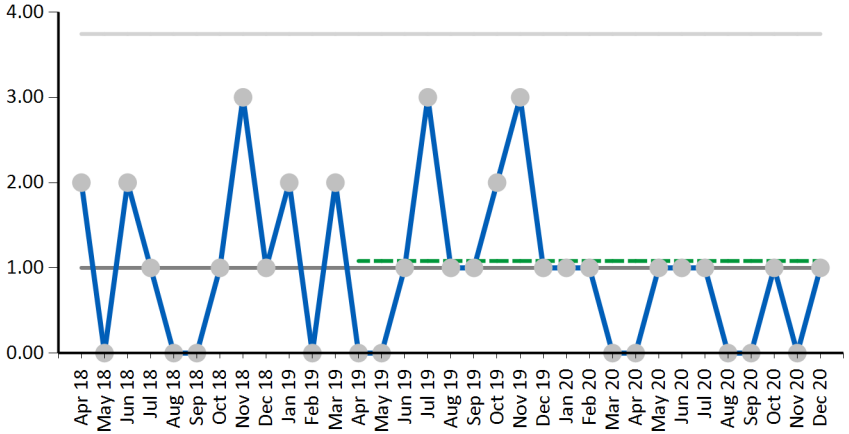
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



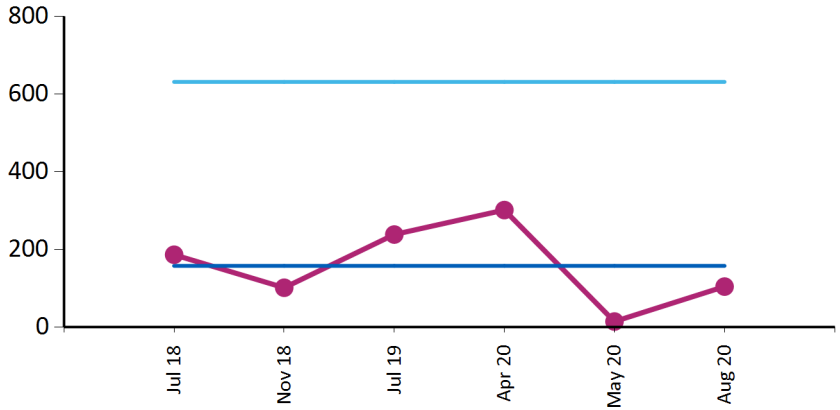
304 - Total Trust apportioned MSSA BSIs



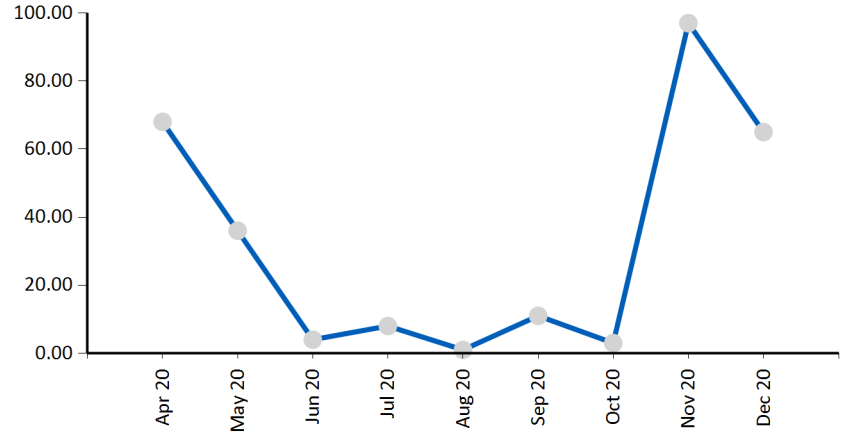
305 - Total Trust apportioned Klebsiella spp. BSIs



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



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



Mortality

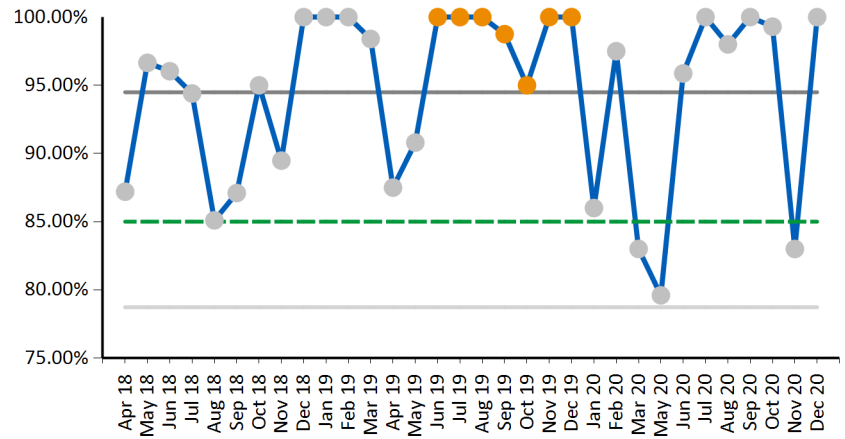
SHMI – The published NHS Digital data is up to July 2020 and remains within the confidence limits and shows no special cause. However, SHMI remains higher than expected when compared to the national average with a rolling 12 month average to July 2020 of 118.8. Pneumonia remains within the expected range and work is continuing to improve the coding recording. Investigations into the levels of comorbidities which directly impacts the risk scores of patients which in turn impacts upon SHMI are continuing.

Crude – The rate is back within expected range and has fallen slightly from November where the rate was outside the upper confidence interval. November was the second peak of the Covid-19 pandemic so a higher crude rate was expected.

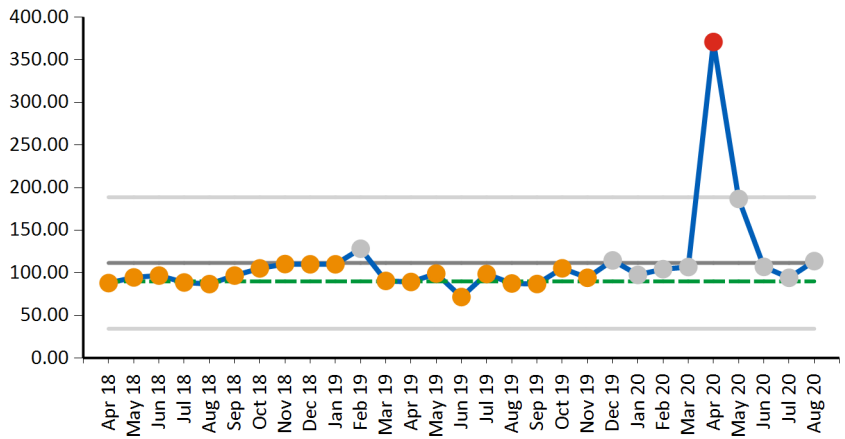
RAMI – this indicator is no longer available as the Trust has purchased a new system for Mortality Indicators and this indicator is obsolete. The Medical Director will decide upon a new Mortality indicator for inclusion in the Board reporting.

	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%	Dec-20		>= 85%	83.0%	Nov-20	>= 85%	94.5%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	113.8	Aug-20		<= 90	94.2	Jul-20	<= 90	113.8	
11 - Standardised Hospital Mortality (ratio)	<= 100.00	119.00	Jul-20		<= 100.00	105.03	Jun-20	<= 100.00	119.00	
12 - Crude Mortality %	<= 2.9%	3.8%	Dec-20		<= 2.9%	4.4%	Nov-20	<= 2.9%	3.4%	

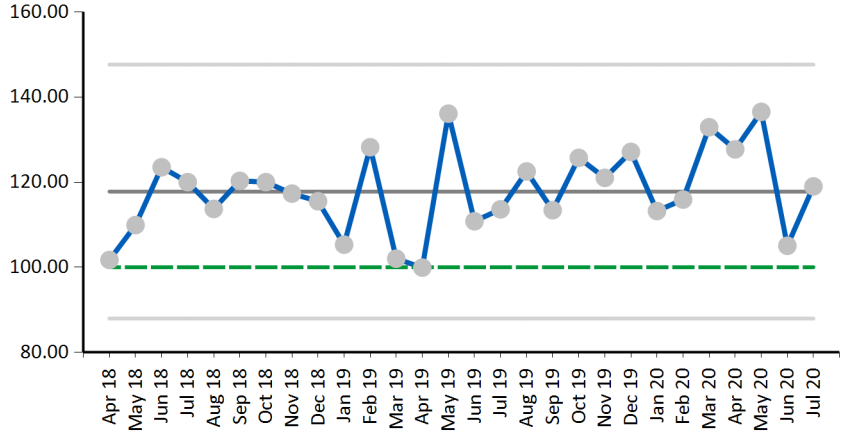
3 - National Early Warning Scores to Gold standard



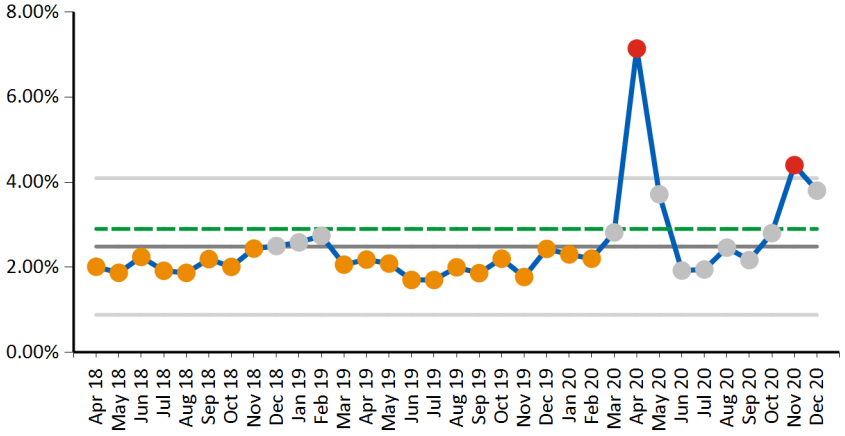
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)



11 - Standardised Hospital Mortality (ratio)



12 - Crude Mortality %



Patient Experience

FFT
NHSE advised providers in September 2020 to formally collect FFT from December 2020 for us to report in January and for publication in February 2021.

As a result of Tier 4 and then national lockdown, further guidance was provided which was to collect only where safe to do so – NHSE did not advise to suspend as with the first lockdown.

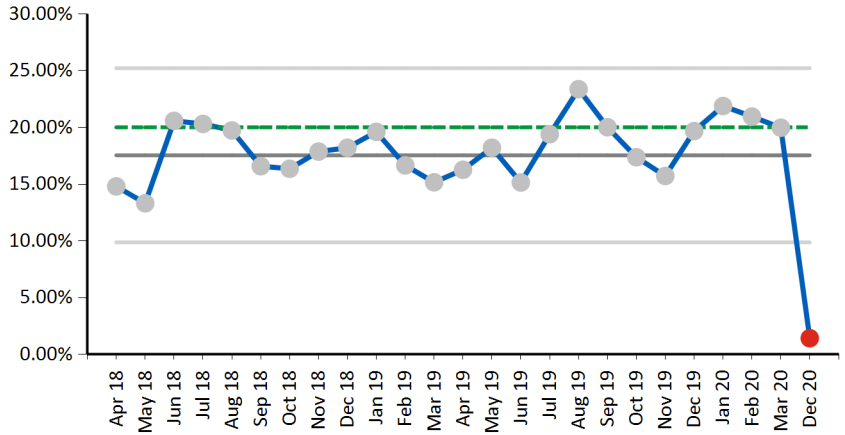
As a result, there has been a variety of response rates across the services which was to be expected with wards and departments being asked to focus on reviewing and acting upon the narratives provided to aid learning.

COMPLAINTS
100% of complaints were acknowledged within 3 days of receipt and only 1 complaint response being issued outside of the timeframe providing a performance of 96.3% against the Trust 95% target. The Patient Experience Manager and the Director of Quality Governance are working with the Divisions to establish if there are any inefficiencies within the complaint response pathway this work should be completed by 31/03/2021. In addition there is a need to review the processes associated with the gathering of evidence that demonstrates completion of actions arising from complaints, this too will be undertaken by 31/03/2021 and considered by the CG&QC.

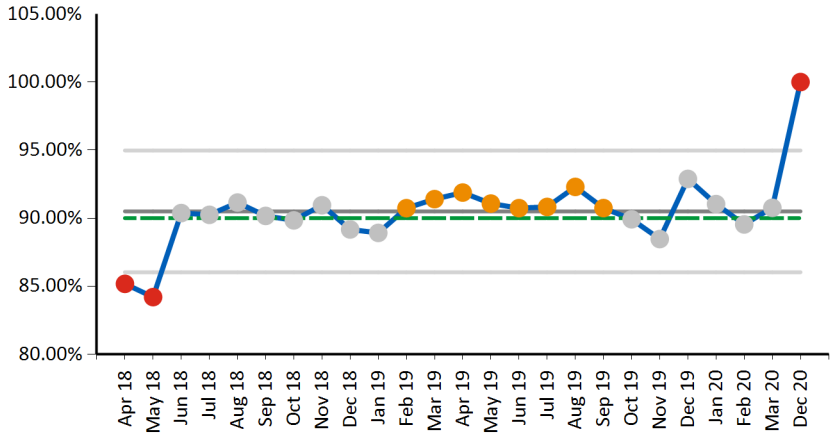
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	1.4%	Dec-20	L	>= 20%	20.0%	Mar-20	>= 20%	1.4%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	100.0%	Dec-20	H	>= 90%	90.8%	Mar-20	>= 90%	100.0%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	38.2%	Dec-20	H	>= 30%	24.4%	Mar-20	>= 30%	38.2%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.2%	Dec-20		>= 90%	97.9%	Mar-20	>= 90%	97.2%	P
81 - Maternity Friends and Family Response Rate	>= 15%	12.4%	Dec-20		>= 15%	12.4%	Mar-20	>= 15%	12.4%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	90.2%	Dec-20		>= 90%	94.3%	Mar-20	>= 90%	90.2%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	0.0%	Dec-20		>= 15%	0.0%	Mar-20	>= 15%	0.0%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%		Dec-20		>= 90%		Mar-20	>= 90%	100.0%	P
83 - Birth - Friends and Family Response Rate	>= 15%	37.5%	Dec-20		>= 15%	26.5%	Mar-20	>= 15%	37.5%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	90.2%	Dec-20		>= 90%	93.1%	Mar-20	>= 90%	90.2%	?

	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%		Dec-20		>= 15%	15.8%	Mar-20	>= 15%	100.0%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%		Dec-20		>= 90%	96.4%	Mar-20	>= 90%	100.0%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	0.0%	Dec-20	L	>= 15%	8.7%	Mar-20	>= 15%	0.0%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%		Dec-20		>= 90%	95.1%	Mar-20	>= 90%	100.0%	P
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Dec-20	H	= 100%	100.0%	Nov-20	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	96.3%	Dec-20		>= 95%	92.3%	Nov-20	>= 95%	89.9%	

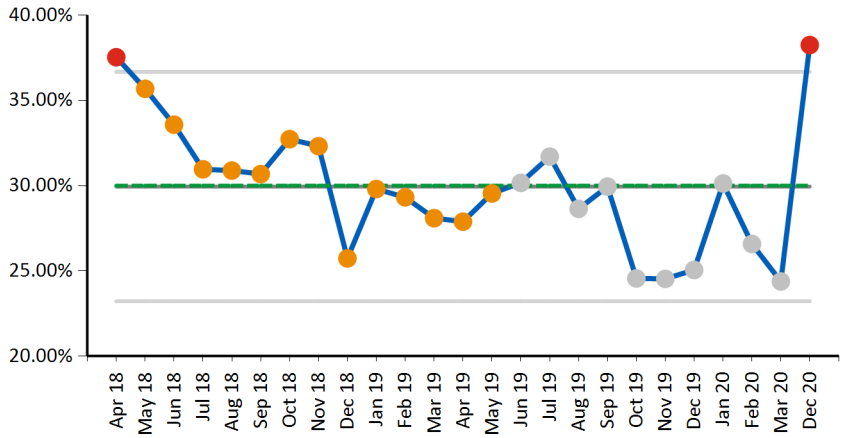
200 - A&E Friends and Family Response Rate



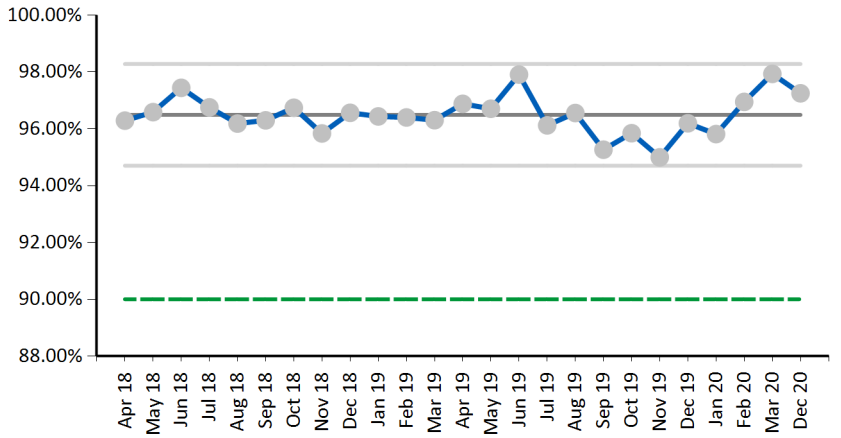
294 - A&E Friends and Family Satisfaction Rates %



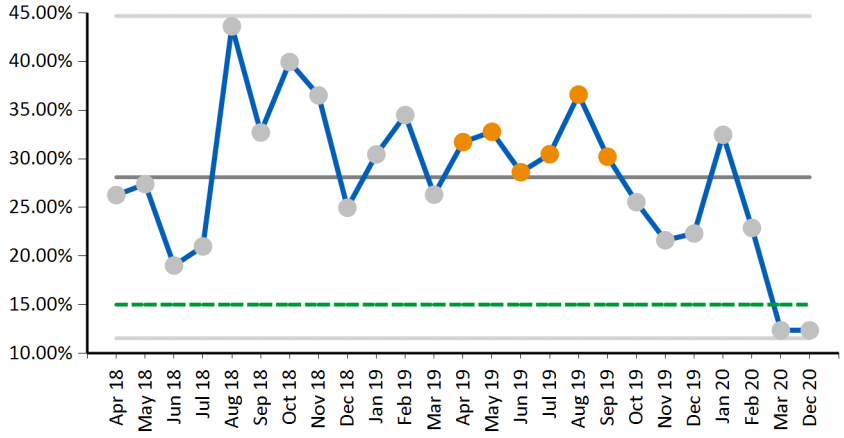
80 - Inpatient Friends and Family Response Rate



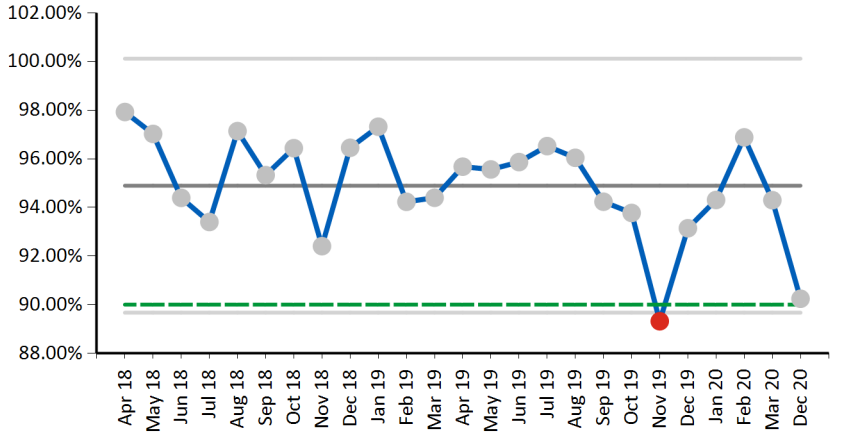
240 - Friends and Family Test (Inpatients) - Satisfaction %



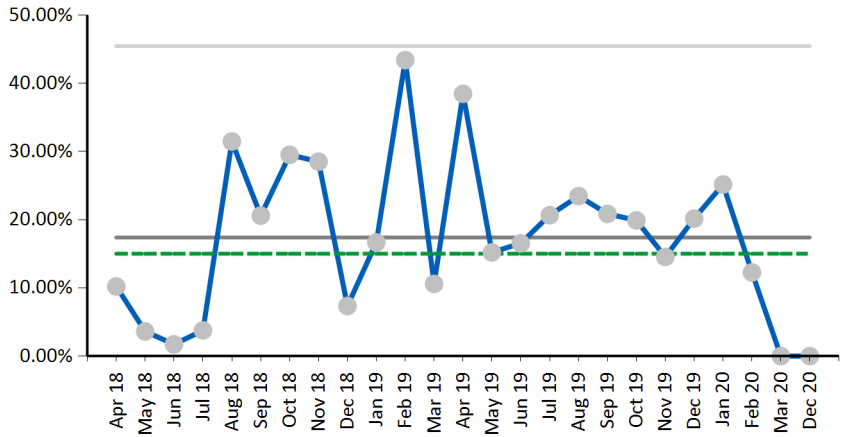
81 - Maternity Friends and Family Response Rate



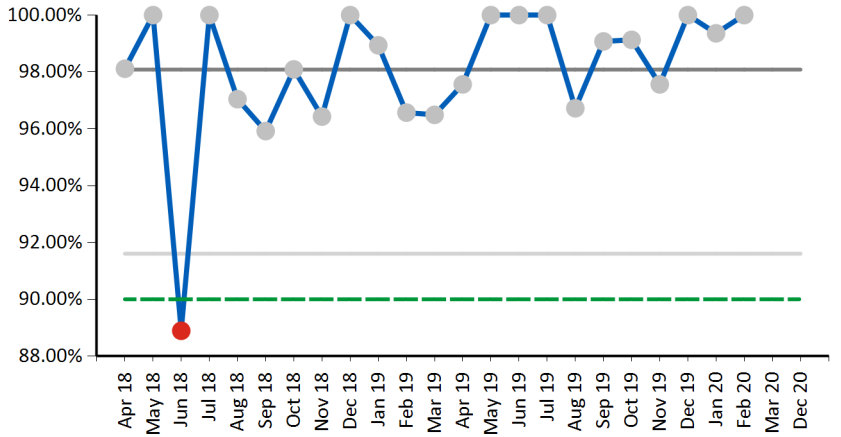
241 - Maternity Friends and Family Test - Satisfaction %



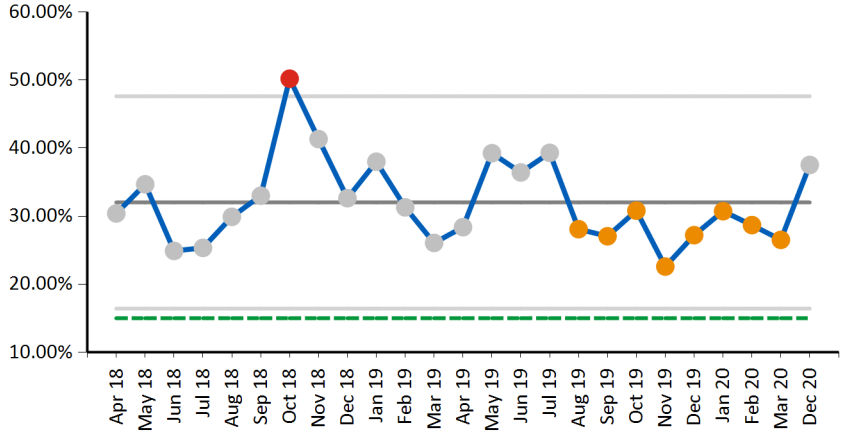
82 - Antenatal - Friends and Family Response Rate



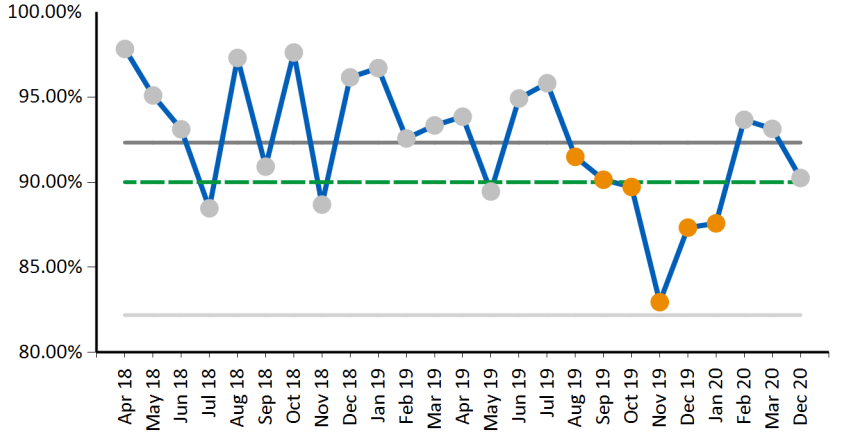
242 - Antenatal Friends and Family Test - Satisfaction %



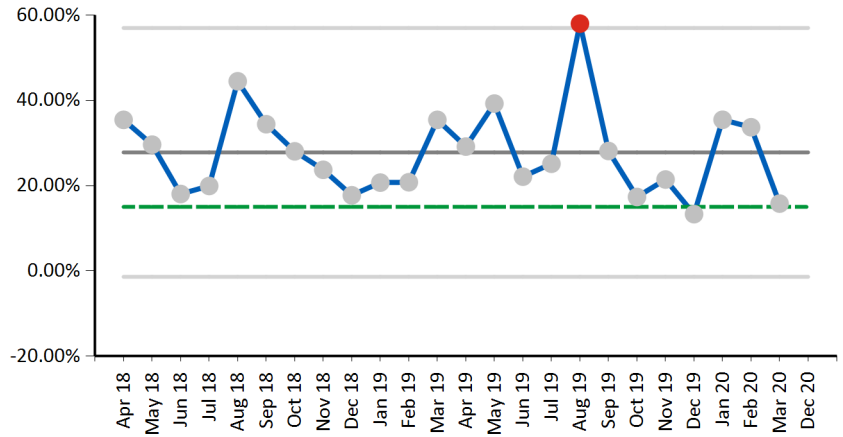
83 - Birth - Friends and Family Response Rate



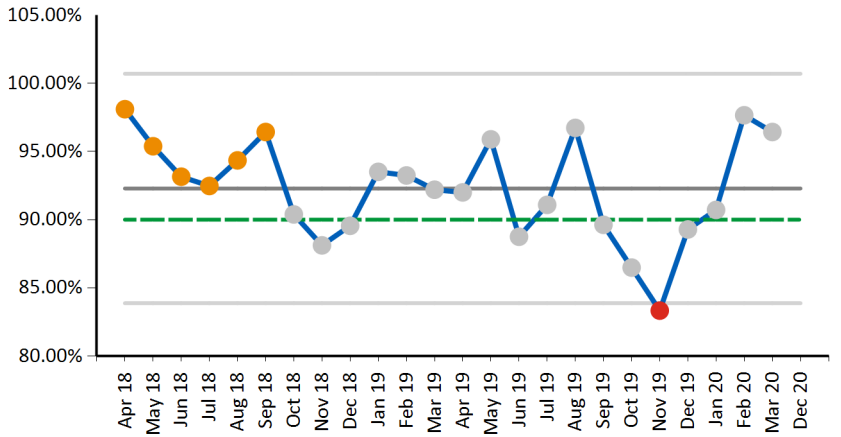
243 - Birth Friends and Family Test - Satisfaction %



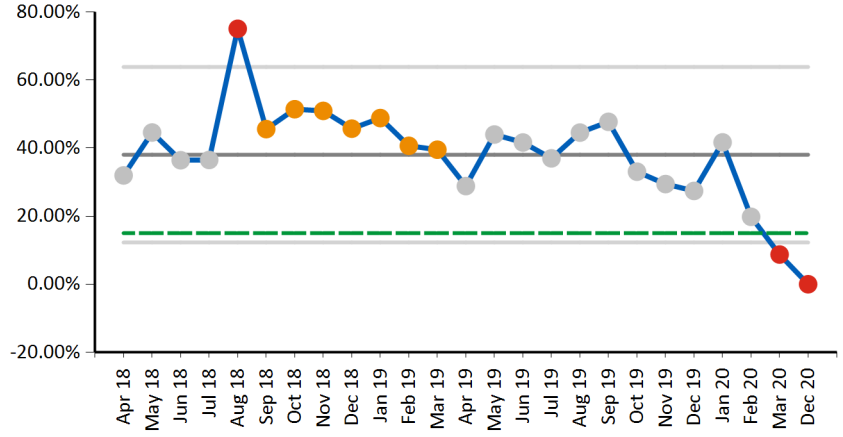
84 - Hospital Postnatal - Friends and Family Response Rate



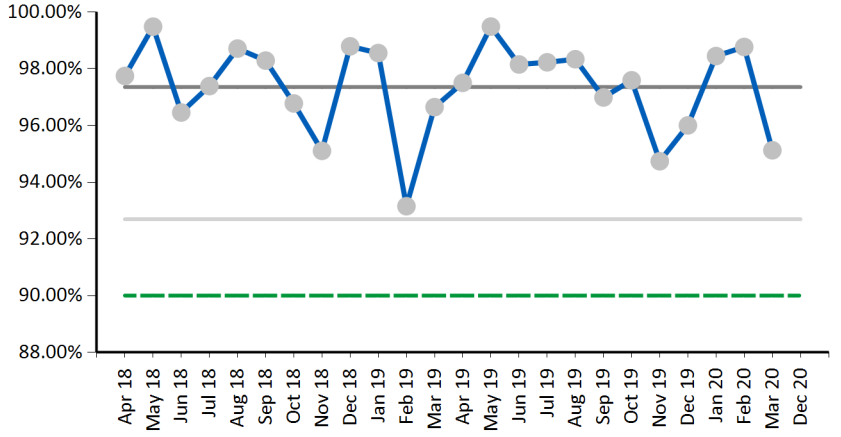
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



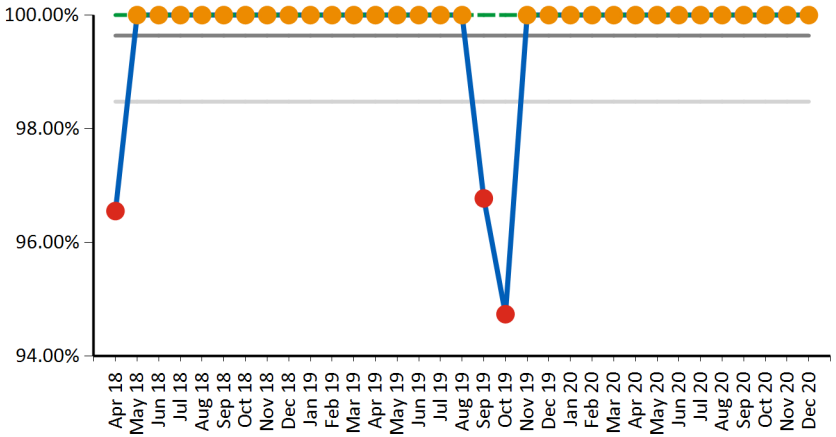
85 - Community Postnatal - Friend and Family Response Rate



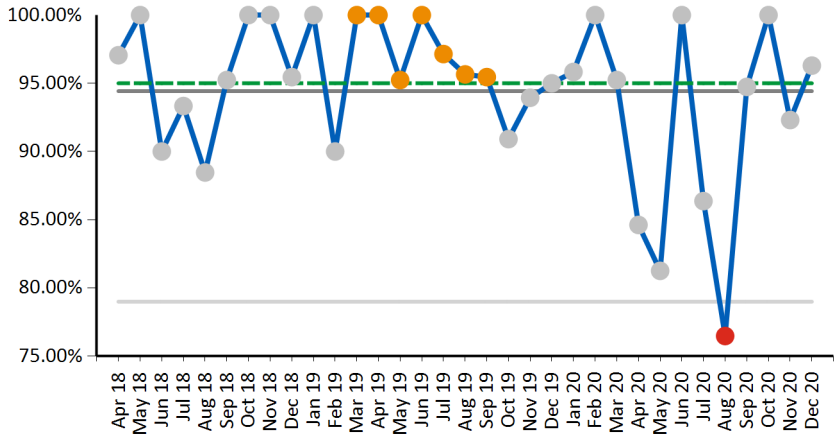
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

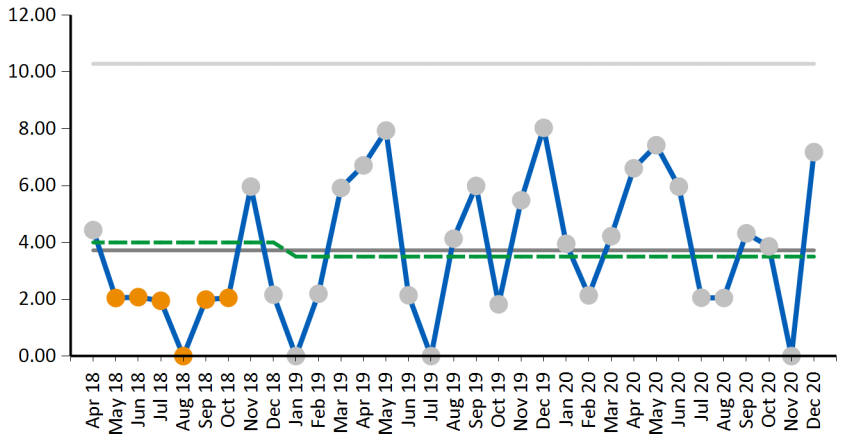
There was one still birth with two compassionate inductions for fetal abnormalities. Good 1:1 care in labour reflective of our 1:27 midwife to birth ratio.

Work is underway for reduction of preterm birth. In December 2020 the Ockenden Report was published - the Trust position against the recommendations was discussed in detail at QAC 20/01/2021 and will be signed off at Board of Directors 28/01/2021. The CG&QC on 03/02/2021 will discuss still births and 3rd and 4th degree tears in detail to better understand the current performance.

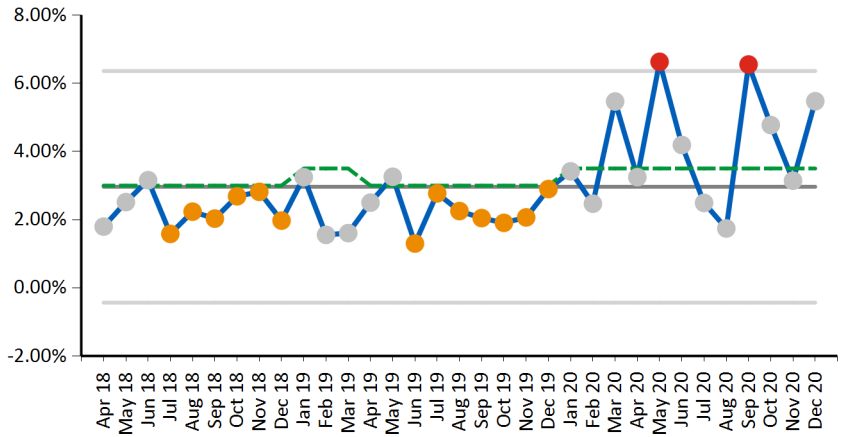
CQC Insight published on 20/01/2021 identified breastfeeding as an area for improvement.

	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	7.18	Dec-20		<= 3.50	0.00	Nov-20	<= 3.50	4.39	
23 - Maternity -3rd/4th degree tears	<= 3.5%	5.5%	Dec-20		<= 3.5%	3.1%	Nov-20	<= 3.5%	4.2%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.4%	Dec-20		>= 95.0%	97.1%	Nov-20	>= 95.0%	97.9%	
203 - Booked 12+6	>= 90.0%	92.5%	Dec-20		>= 90.0%	91.5%	Nov-20	>= 90.0%	91.2%	
204 - Inductions of labour	<= 40%	39.7%	Dec-20		<= 40%	39.1%	Nov-20	<= 40%	39.1%	
208 - Total C section	<= 33.0%	33.7%	Dec-20		<= 33.0%	29.8%	Nov-20	<= 33.0%	32.0%	
210 - Initiation breast feeding	>= 65%	67.56%	Dec-20		>= 65%	69.32%	Nov-20	>= 65%	68.91%	
213 - Maternity complaints	<= 5	3	Dec-20		<= 5	1	Nov-20	<= 45	14	
319 - Maternal deaths (direct)	= 0	0	Nov-20		= 0	0	Oct-20	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.8%	Dec-20		<= 6%	8.1%	Nov-20	<= 6%	7.9%	

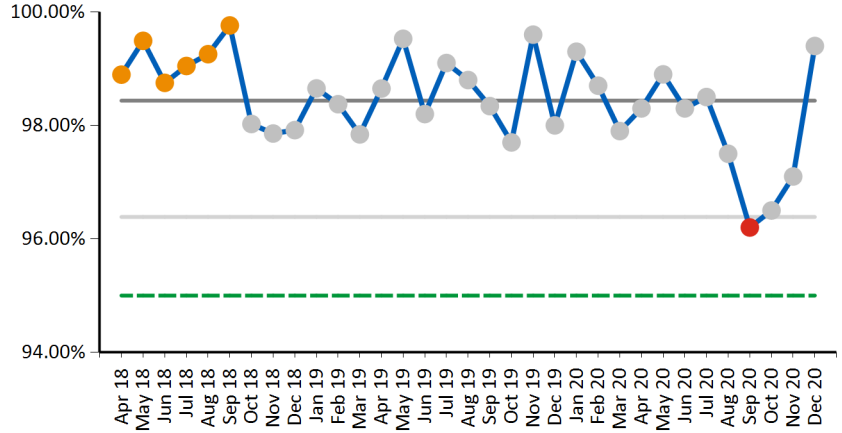
322 - Maternity - Stillbirths per 1000 births



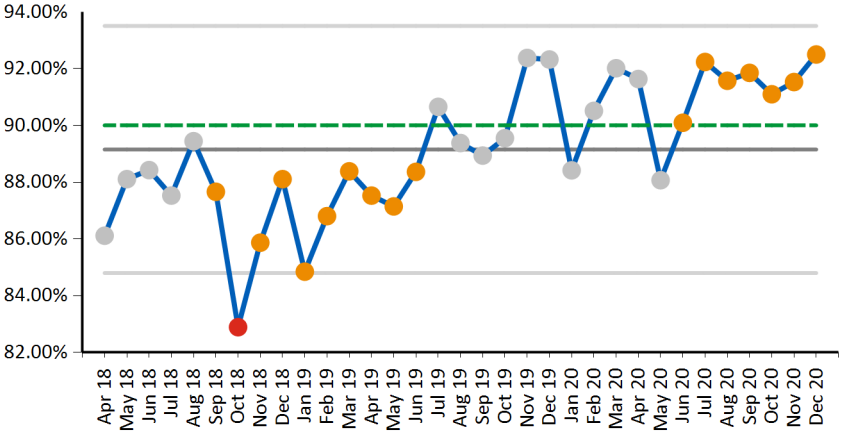
23 - Maternity -3rd/4th degree tears



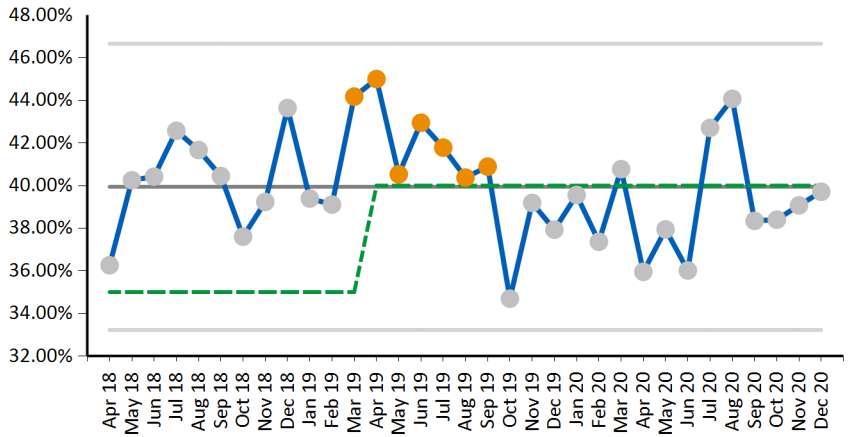
202 - 1:1 Midwifery care in labour



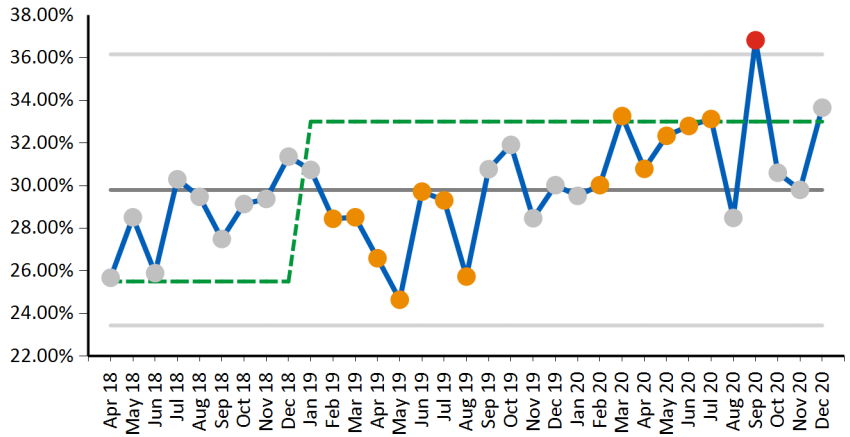
203 - Booked 12+6



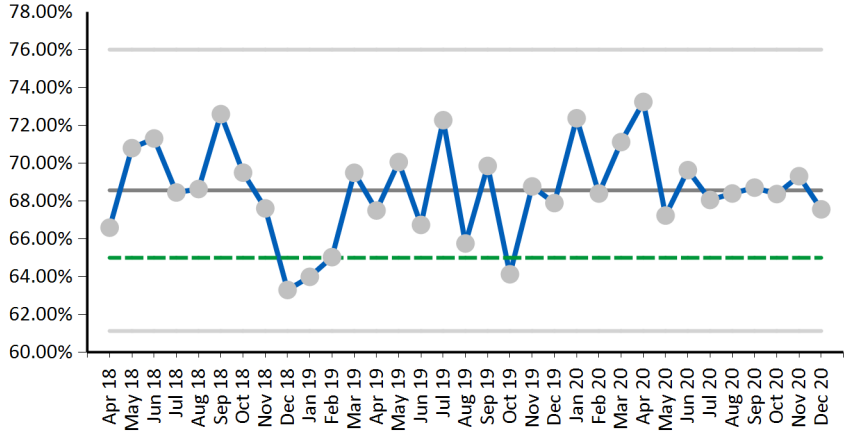
204 - Inductions of labour



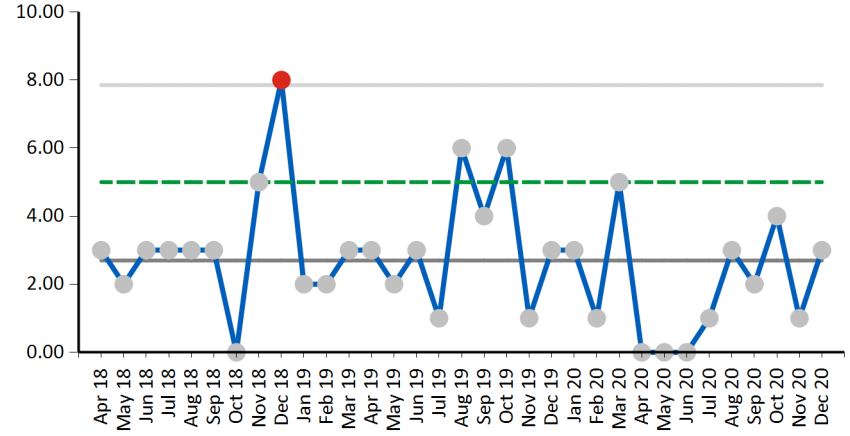
208 - Total C section



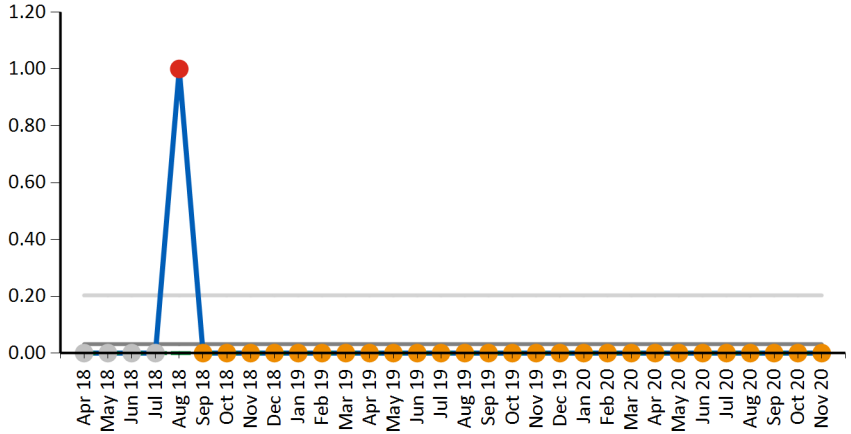
210 - Initiation breast feeding



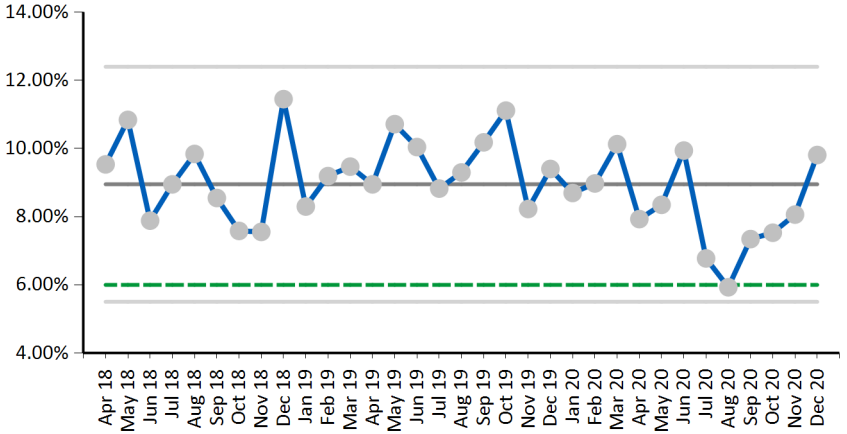
213 - Maternity complaints



319 - Maternal deaths (direct)



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

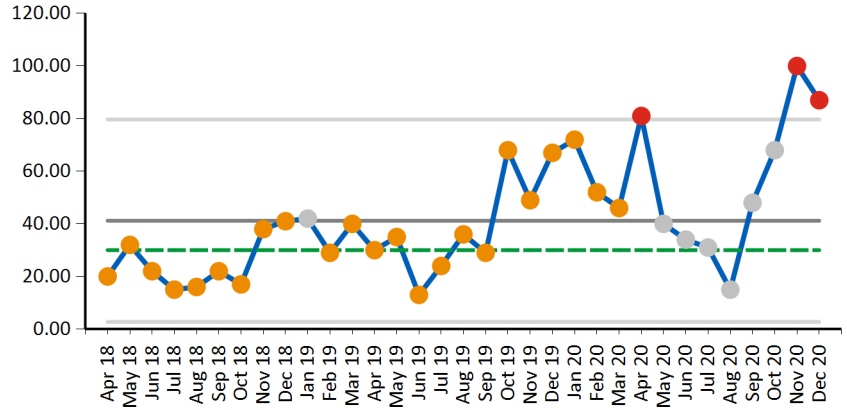


Operational Performance

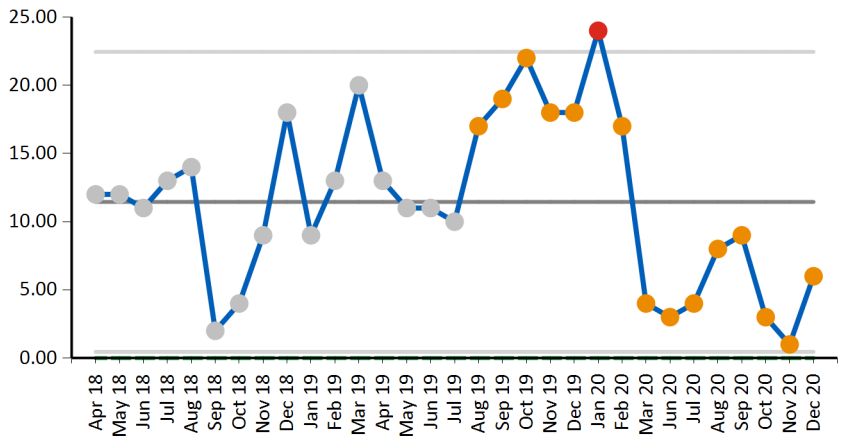
Access

	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	87	Dec-20		<= 30	100	Nov-20	<= 270	504	
8 - Same sex accommodation breaches	= 0	6	Dec-20		= 0	1	Nov-20	= 0	34	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	67.9%	Dec-20		>= 75%	73.3%	Nov-20	>= 75%	75.8%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	59.4%	Dec-20		>= 92%	61.6%	Nov-20	>= 92%	56.0%	
42 - RTT 52 week waits (incomplete pathways)	= 0	2,130	Dec-20		= 0	1,794	Nov-20	= 0	8,911	
314 - RTT 18 week waiting list	<= 25,530	27,054	Dec-20		<= 25,530	26,206	Nov-20	<= 25,530	27,054	
53 - A&E 4 hour target	>= 95%	73.0%	Dec-20		>= 95%	72.6%	Nov-20	>= 95%	82.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	14.0%	Dec-20		= 0.0%	16.8%	Nov-20	= 0.0%	10.2%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	7.63%	Dec-20		= 0.00%	10.28%	Nov-20	= 0.00%	3.96%	
72 - Diagnostic Waits >6 weeks %	<= 1%	45.6%	Dec-20		<= 1%	45.4%	Nov-20	<= 1%	50.0%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	46.7%	Dec-20		= 100%	70.6%	Nov-20	= 100%	68.4%	

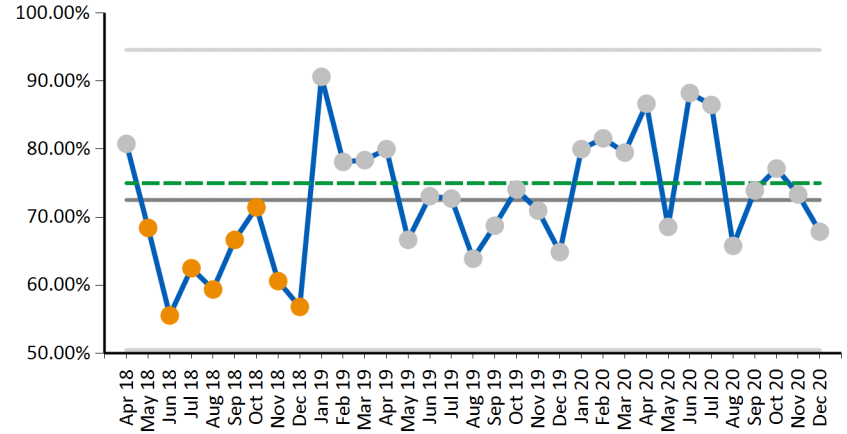
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



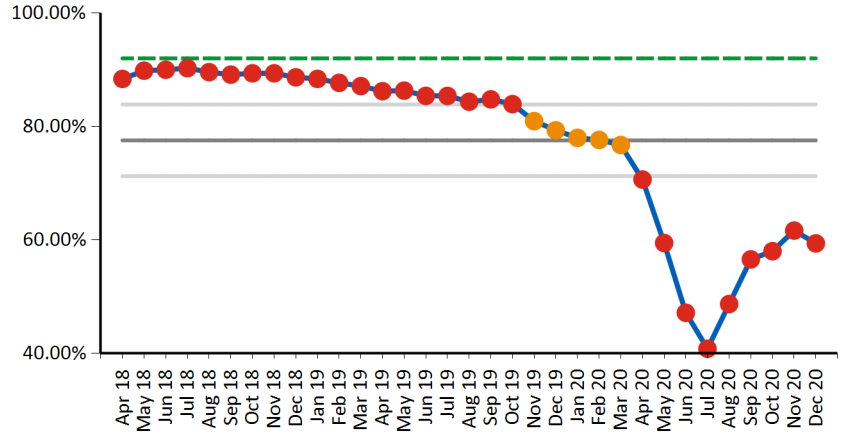
8 - Same sex accommodation breaches



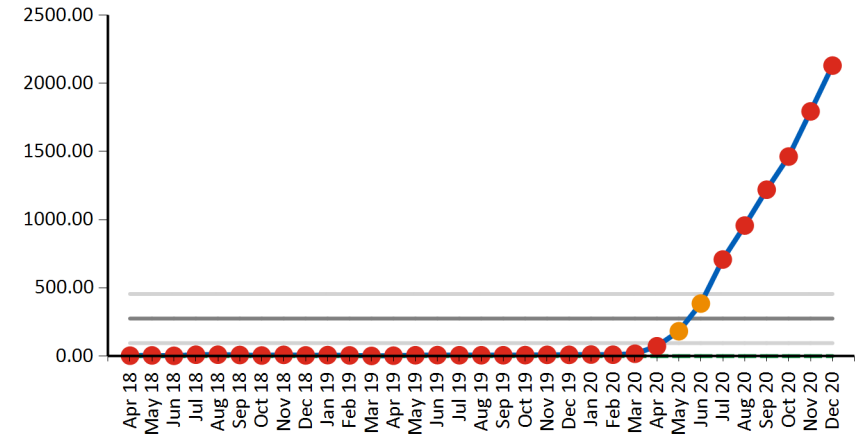
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



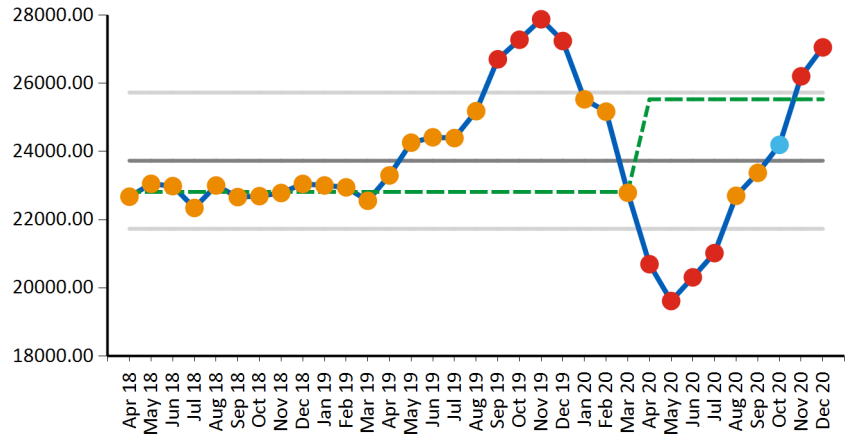
41 - RTT Incomplete pathways within 18 weeks %



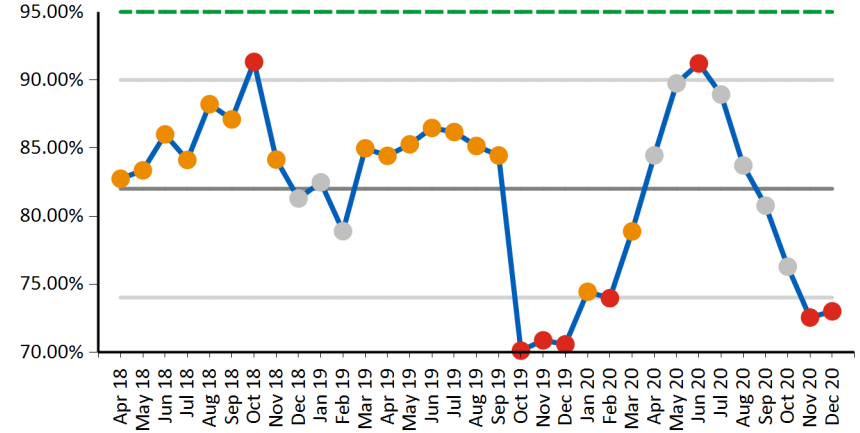
42 - RTT 52 week waits (incomplete pathways)



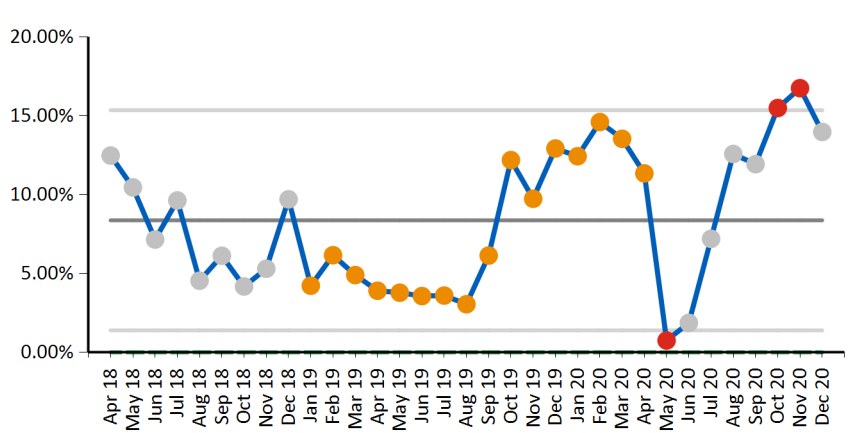
314 - RTT 18 week waiting list



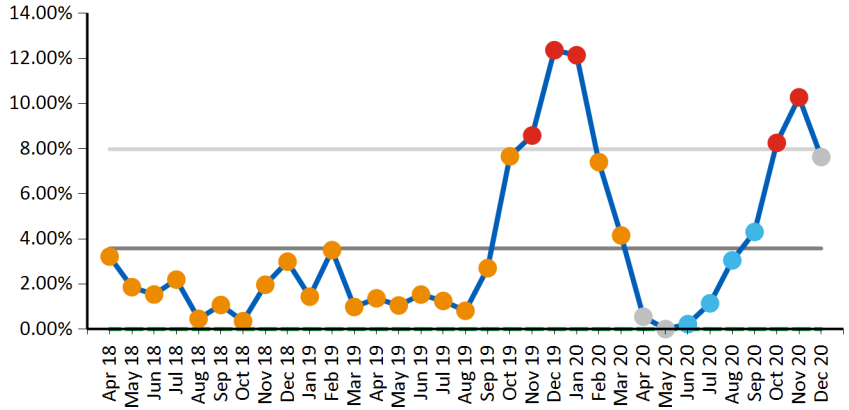
53 - A&E 4 hour target



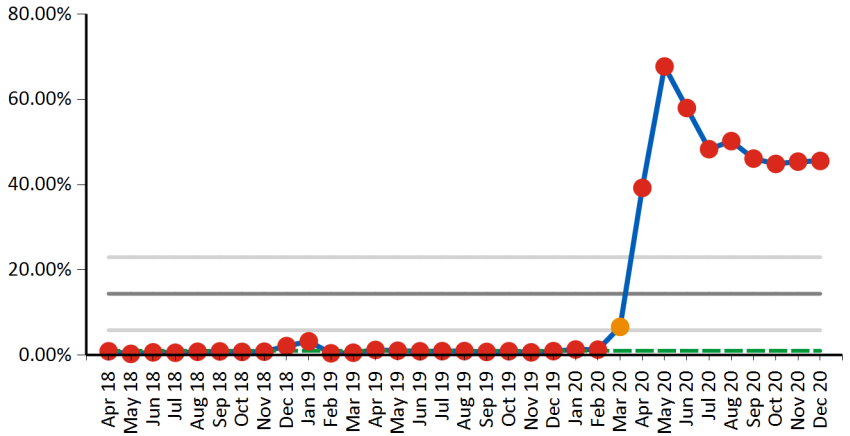
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



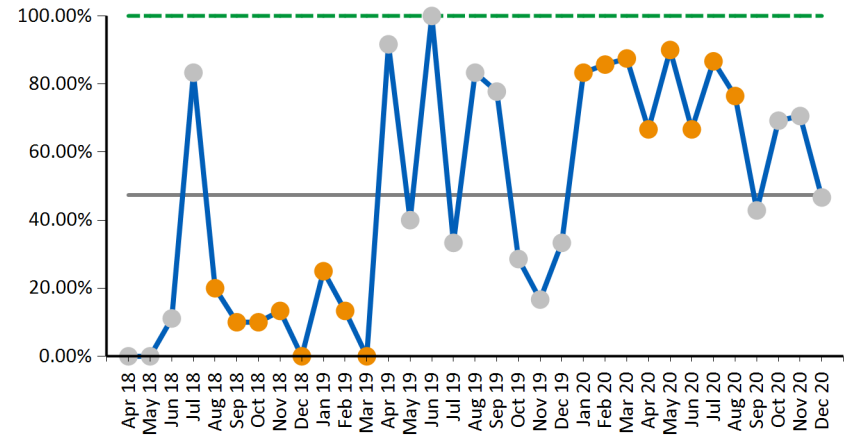
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



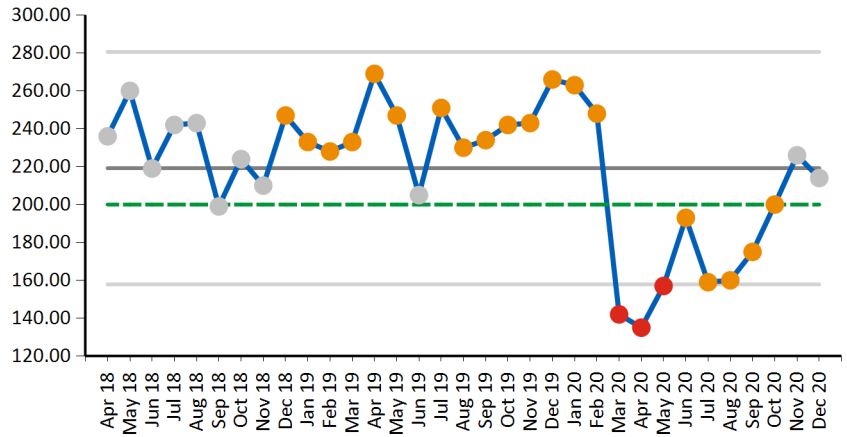
27 - TIA (Transient Ischaemic attack) patients seen <24hrs



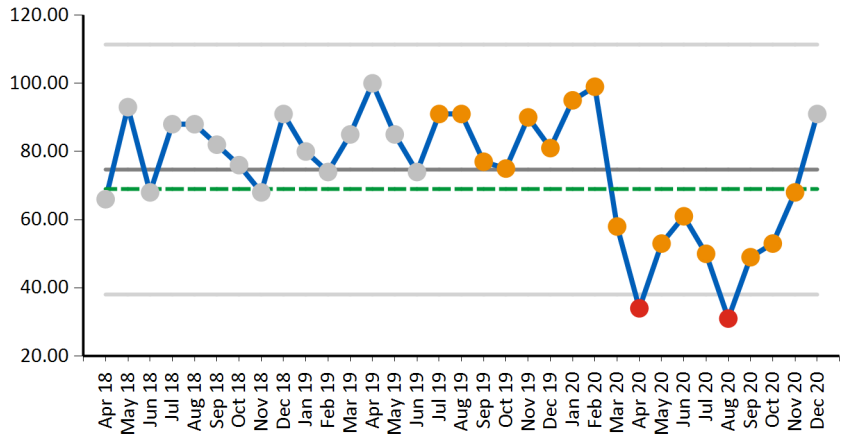
Productivity

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	214	Dec-20		<= 200	226	Nov-20	<= 200	214	
307 - Stranded Patients - LOS 21 days and over	<= 69	91	Dec-20		<= 69	68	Nov-20	<= 69	91	
57 - Discharges by Midday	>= 30%	20.8%	Dec-20		>= 30%	17.6%	Nov-20	>= 30%	20.7%	
58 - Discharges by 4pm	>= 70%	56.6%	Dec-20		>= 70%	56.7%	Nov-20	>= 70%	60.7%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	11.8%	Nov-20		<= 13.5%	12.0%	Oct-20	<= 13.5%	12.4%	
489 - Daycase Rates	>= 80%	89.4%	Dec-20		>= 80%	90.6%	Nov-20	>= 80%	88.3%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Dec-20		<= 1%	1.8%	Nov-20	<= 1%	1.2%	
62 - Cancelled operations re-booked within 28 days	= 100%	90.5%	Dec-20		= 100%	88.5%	Nov-20	= 100%	30.2%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	1.8%	Oct-20		<= 3.3%	1.7%	Sep-20	<= 3.3%	1.2%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.61	Dec-20		<= 2.00	2.24	Nov-20	<= 2.00	2.40	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.16	Dec-20		<= 3.70	5.14	Nov-20	<= 3.70	4.74	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	81.8%	Jul-20		>= 80%	83.3%	Jun-20	>= 80%	77.1%	

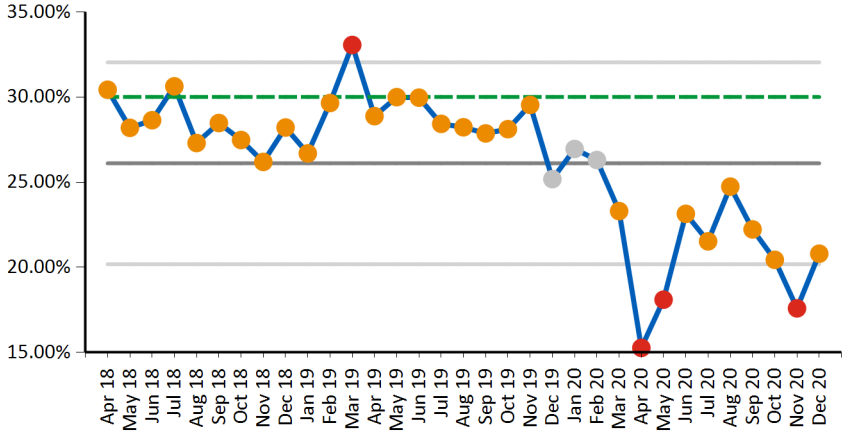
56 - Stranded patients



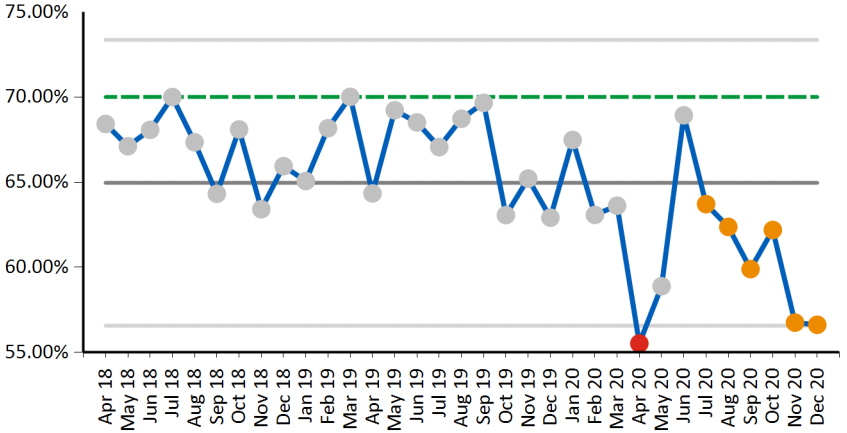
307 - Stranded Patients - LOS 21 days and over



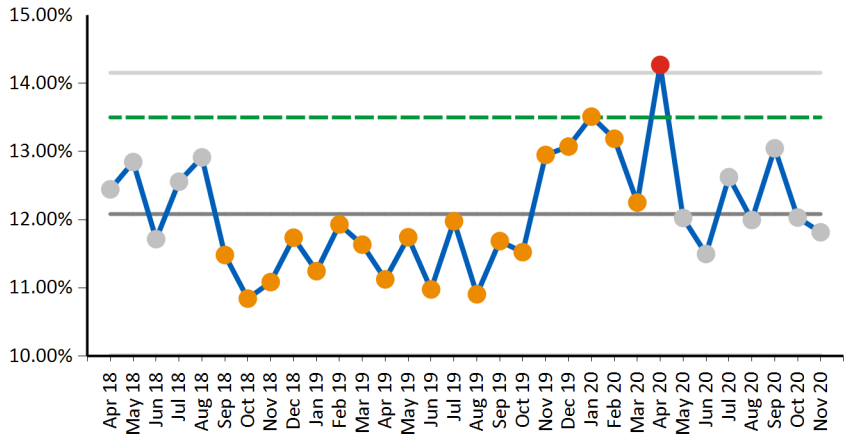
57 - Discharges by Midday



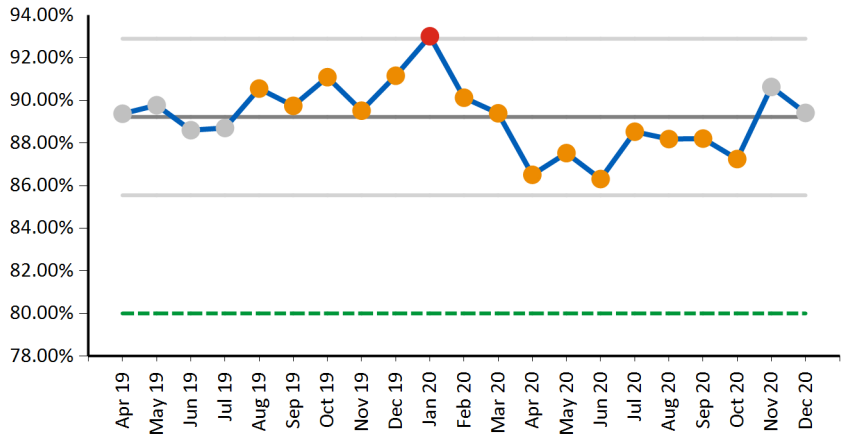
58 - Discharges by 4pm



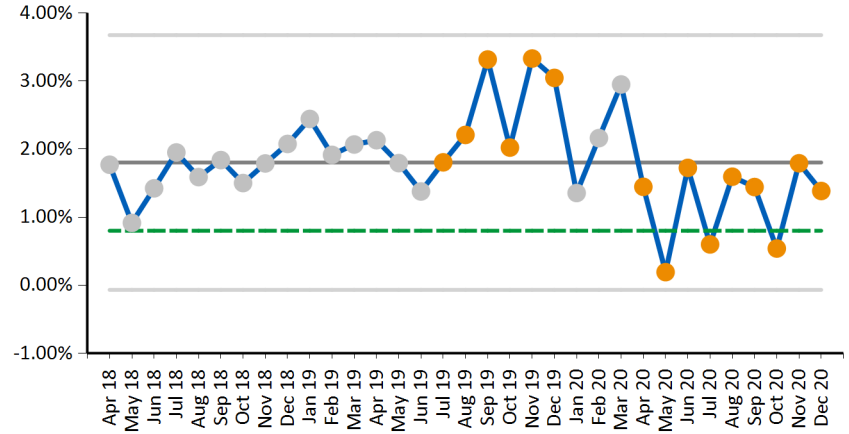
59 - Re-admission within 30 days of discharge (1 mth in arrears)



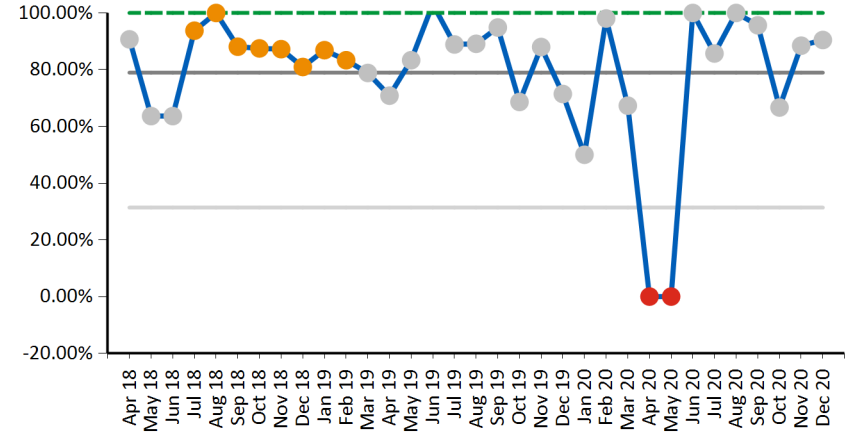
489 - Daycase Rates



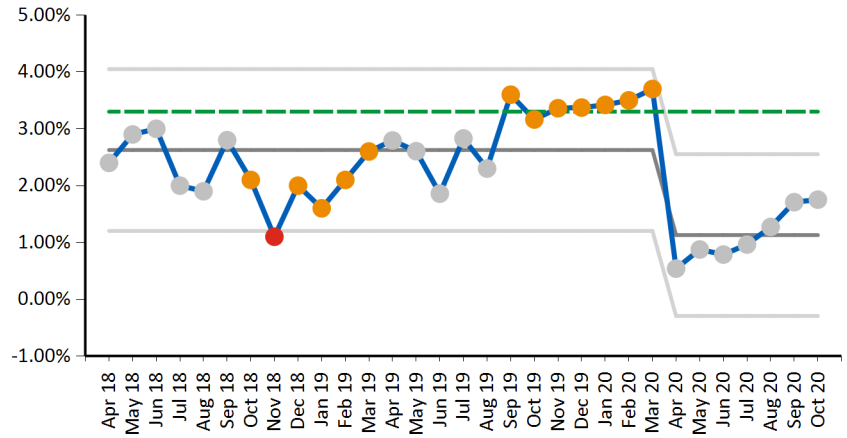
61 - Operations cancelled on the day for non-clinical reasons



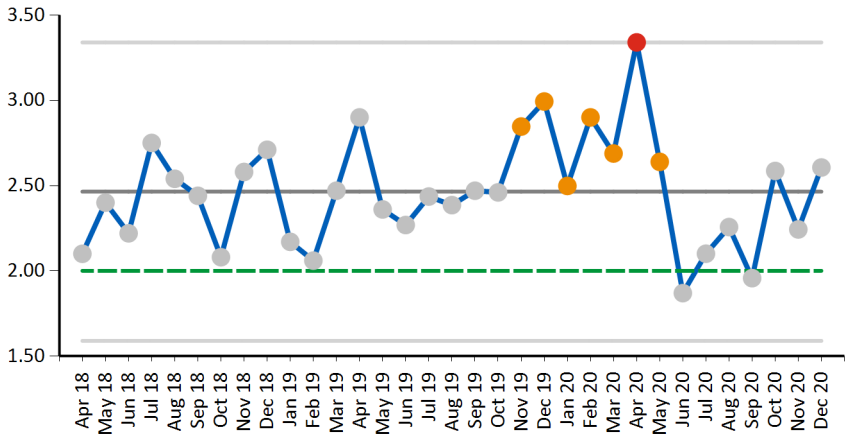
62 - Cancelled operations re-booked within 28 days



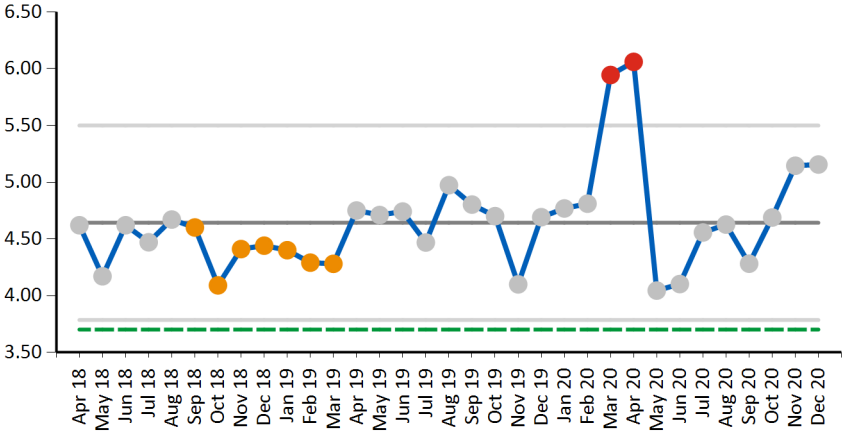
318 - Delayed Transfers Of Care (Trust Total)



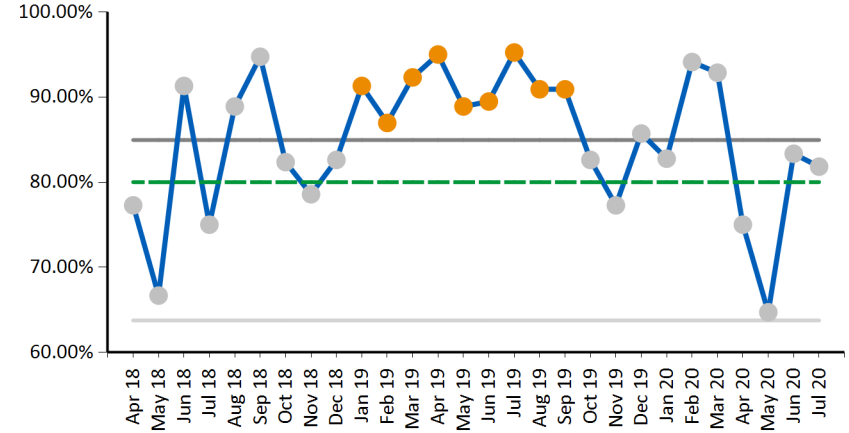
65 - Elective Length of Stay (Discharges in month)



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



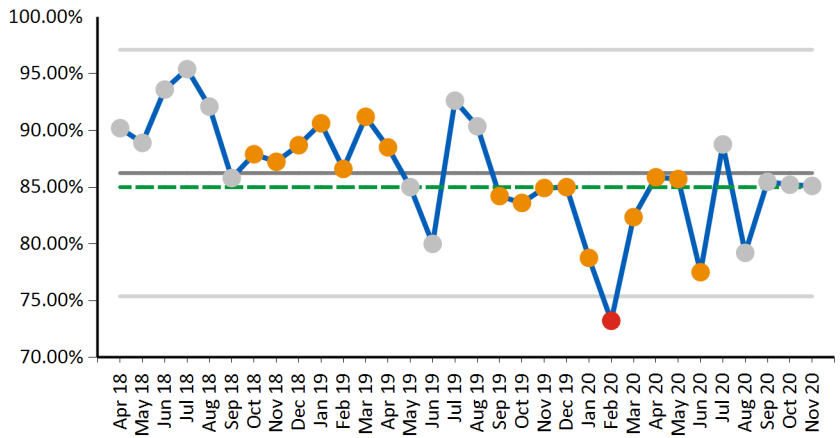
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



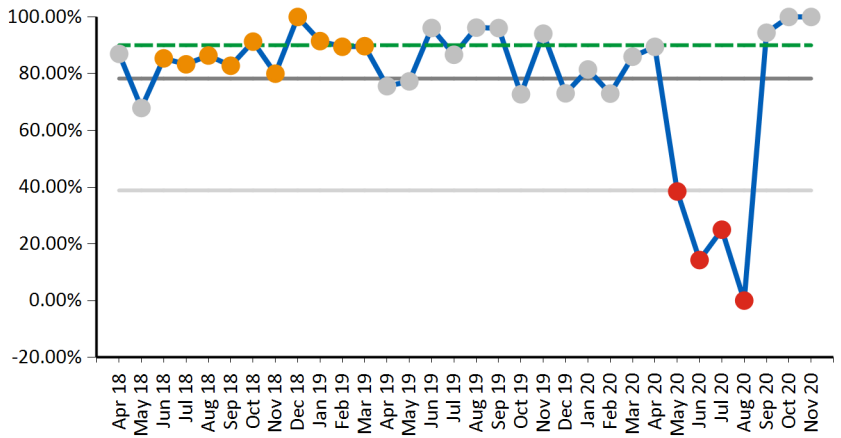
Cancer

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%	85.1%	Nov-20		>= 85%	85.2%	Oct-20	>= 85%	84.2%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	100.0%	Nov-20		>= 90%	100.0%	Oct-20	>= 90%	78.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	98.0%	Nov-20		>= 96%	100.0%	Oct-20	>= 96%	98.4%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Nov-20		>= 94%	100.0%	Oct-20	>= 94%	100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Nov-20		>= 98%	100.0%	Oct-20	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	95.7%	Nov-20		>= 93%	96.4%	Oct-20	>= 93%	96.0%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	21.2%	Nov-20		>= 93%	16.3%	Oct-20	>= 93%	63.4%	

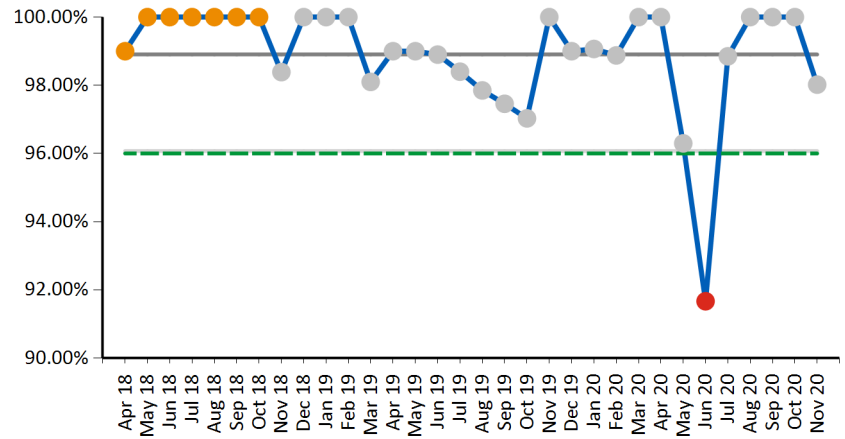
46 - 62 day standard % (1 mth in arrears)



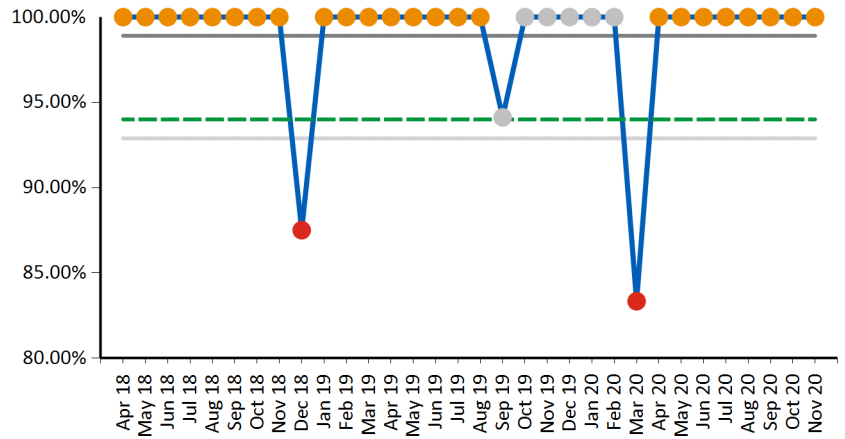
47 - 62 day screening % (1 mth in arrears)



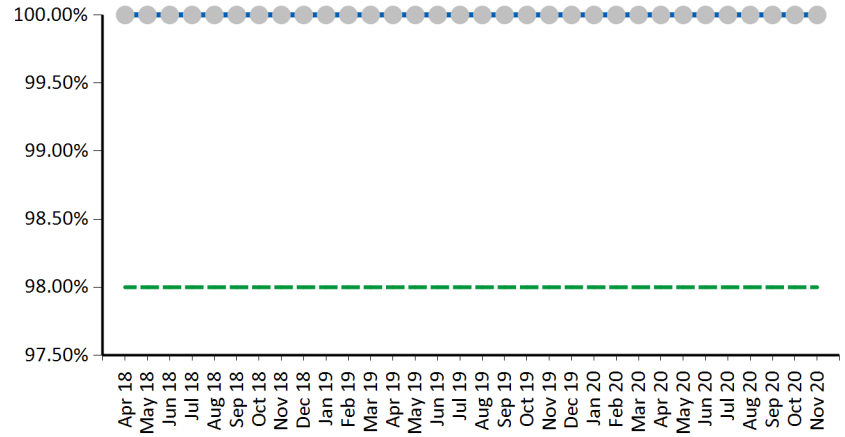
48 - 31 days to first treatment % (1 mth in arrears)



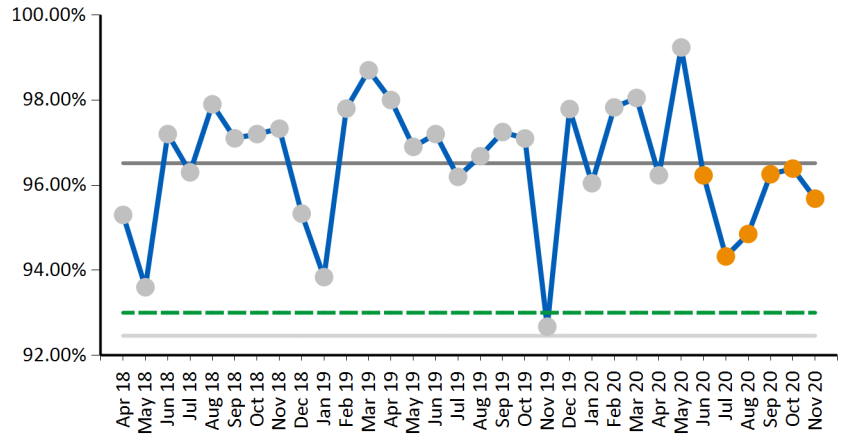
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



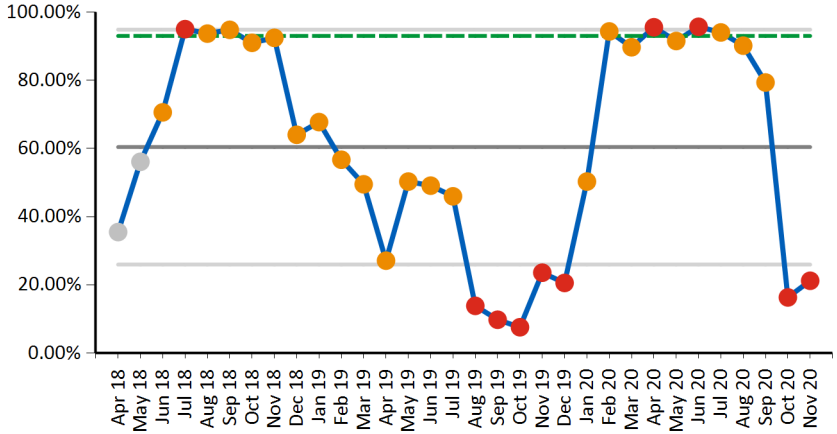
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



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



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

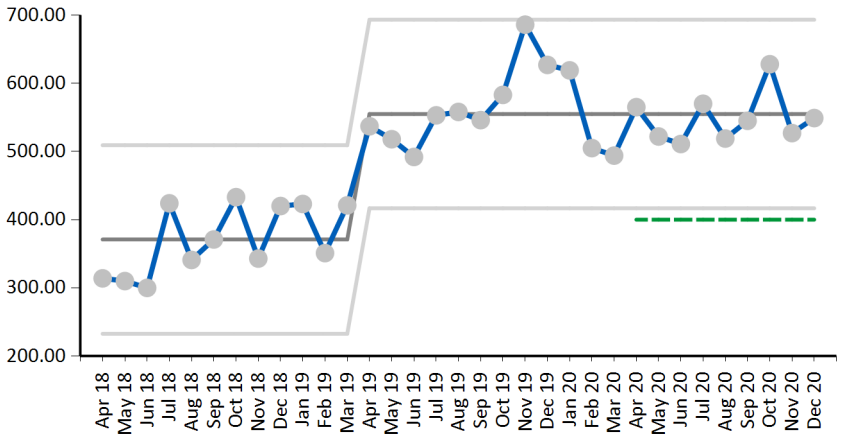


Community

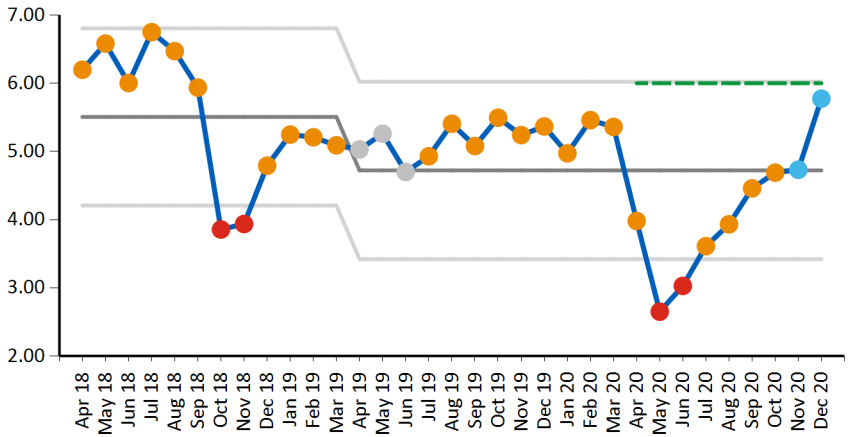
The implementation of the discharge service requirements which were mandated for hospital and community providers in March, continue to have a positive impact by helping people leave hospital in a timely way. The impact of this may be seen in continued low numbers of medically optimised patients and bed days. From November 2020, the Trust will be monitoring and reporting against the new criteria to reside indicator.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	549	Dec-20		>= 400	527	Nov-20	>= 3,600	4,936	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.78	Dec-20		<= 6.00	4.73	Nov-20	<= 6.00	5.78	
230 - Medically Optimised Numbers	<= 50	28	Oct-20		<= 50	11	Sep-20	<= 350	123	
231 - Medically Optimised Days	<= 209	123	Oct-20		<= 209	57	Sep-20	<= 1,463	355	

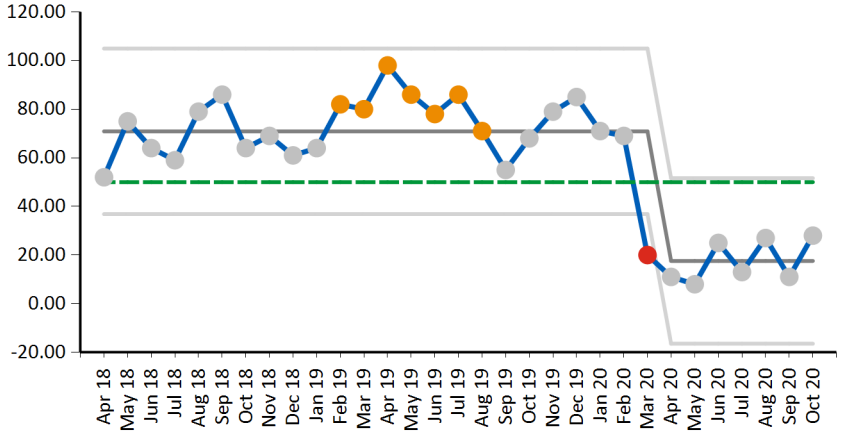
334 - Total Deflections from ED



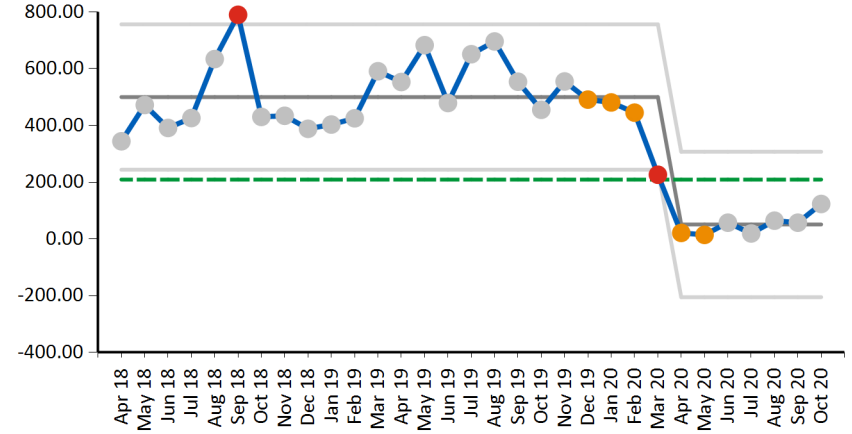
335 - Total Intermediate Tier LOS (weeks)



230 - Medically Optimised Numbers



231 - Medically Optimised Days



Workforce

Sickness, Vacancy and Turnover

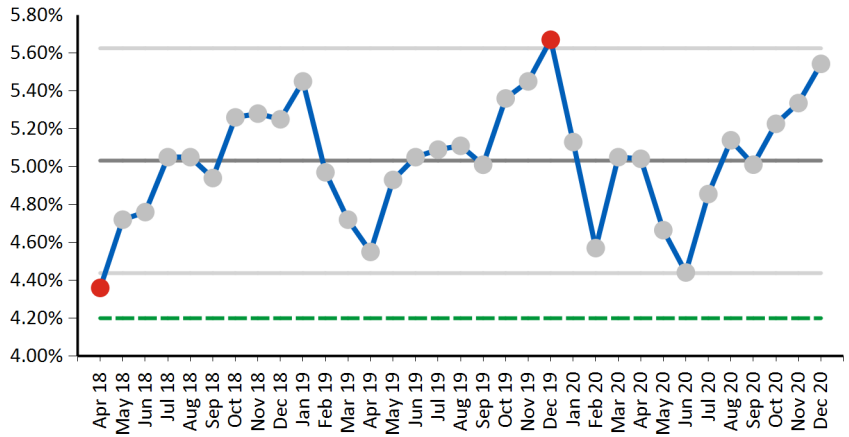
Whilst Board members will note that the higher than normal sickness rate, when looking at the GM benchmarking position then Bolton continues to have a lower absence rates and one of the lowest in the North West.

The Trust has ensured that 100% of our BAME & High Risk Workforce have had the opportunity of a Risk Assessment with their Line Manager (94% for all staff).

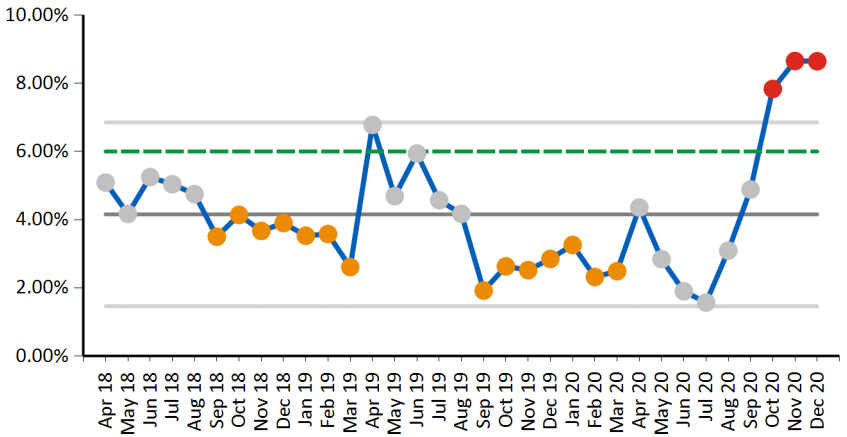
Colleagues are reminded that the reason for the high turnover rate is due to a number of staff taking up post during Wave 1 (students) and then naturally moving back to their normal career. The People Committee will review the reasons for the more recent increase in the Trust vacancy level.

	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%	5.54%	Dec-20		<= 4.20%	5.34%	Nov-20	<= 4.20%	5.03%	F
120 - Vacancy level - Trust	<= 6%	8.65%	Dec-20	H	<= 6%	8.65%	Nov-20	<= 6%	4.87%	?
121 - Turnover	<= 9.90%	13.01%	Dec-20	H	<= 9.90%	12.42%	Nov-20	<= 9.90%	11.84%	?
366 - Ongoing formal investigation cases over 8 weeks		4	Oct-20			3	Sep-20		16	

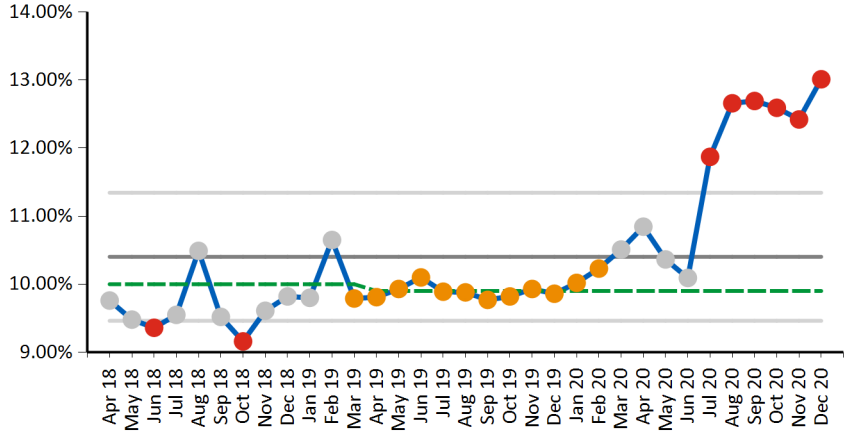
117 - Sickness absence level - Trust



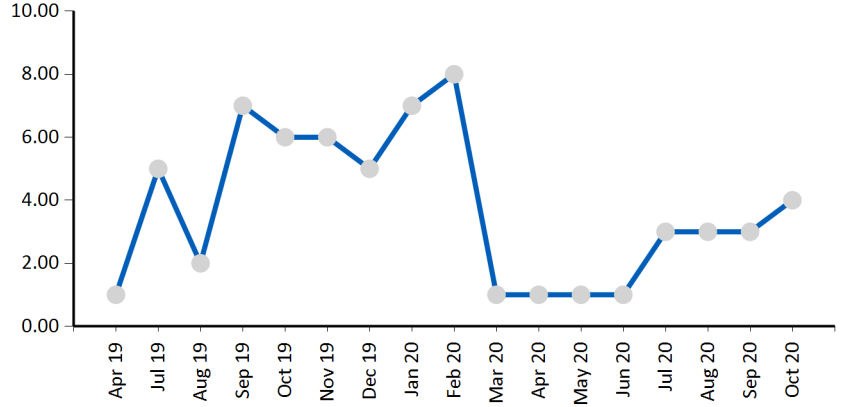
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks - SPC data available after 20 data points



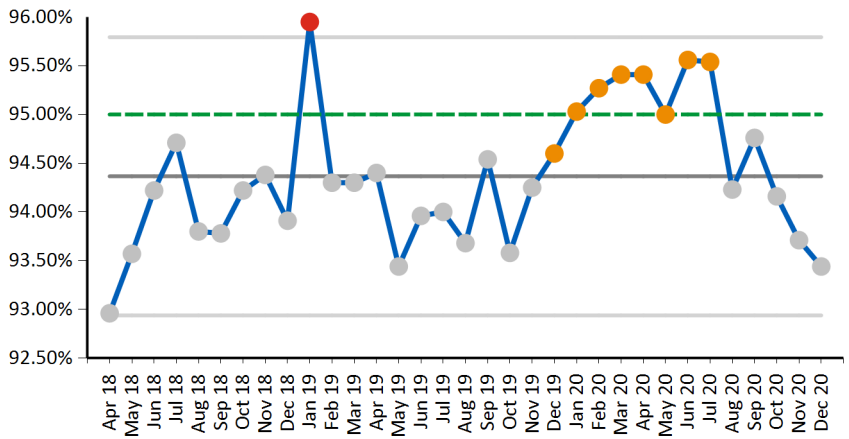
Organisational Development

Despite the pressures of Covid the OD indicators remain strong, particularly Mandatory Training, Statutory Training. Board members will recall that they had been advised that there has understandable been a dip in the number of Appraisal being undertaken, the OD team work with the Divisions on recovery actions.

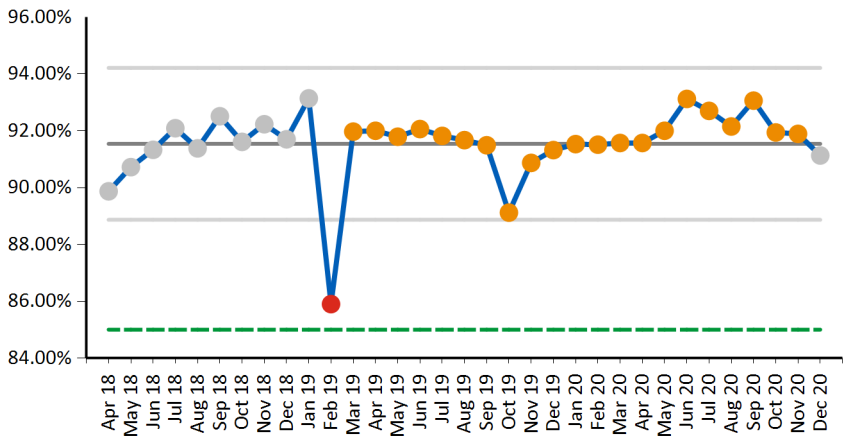
The Trust has received the raw findings from the NHS staff Survey 2020 with the full report being received on 28th January (then under embargo until end of February). BoD will receive a full update on the findings in March and this will address the dip in some of the metrics noted in recent quarters.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	93.4%	Dec-20		>= 95%	93.7%	Nov-20	>= 95%	94.6%	
38 - Staff completing Mandatory Training	>= 85%	91.1%	Dec-20		>= 85%	91.9%	Nov-20	>= 85%	92.2%	
39 - Staff completing Safeguarding Training	>= 95%	96.63%	Nov-20		>= 95%	96.76%	Oct-20	>= 95%	96.50%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	77.4%	Dec-20		>= 85%	77.5%	Nov-20	>= 85%	77.8%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	70.0%	Q3 2019/20		>= 66%	78.5%	Q2 2019/20	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	66.0%	Q3 2019/20		>= 80%	74.9%	Q2 2019/20	>= 80%		

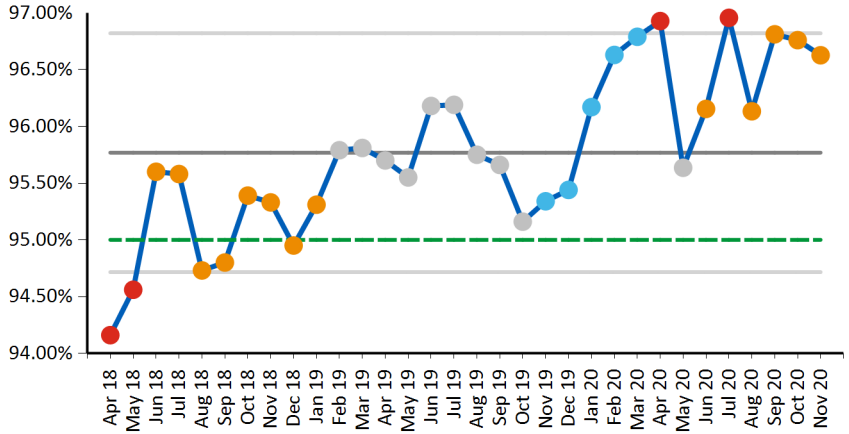
37 - Staff completing Statutory Training



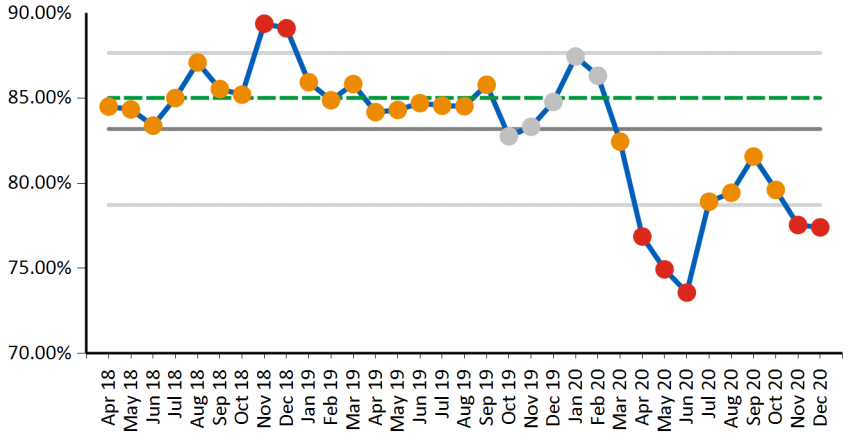
38 - Staff completing Mandatory Training



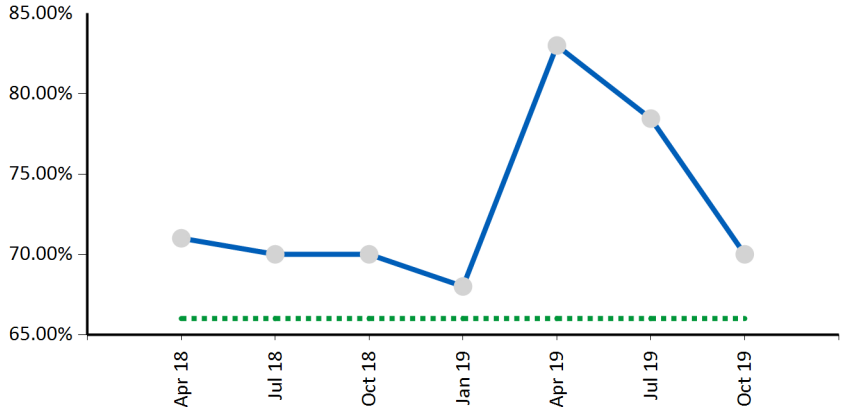
39 - Staff completing Safeguarding Training



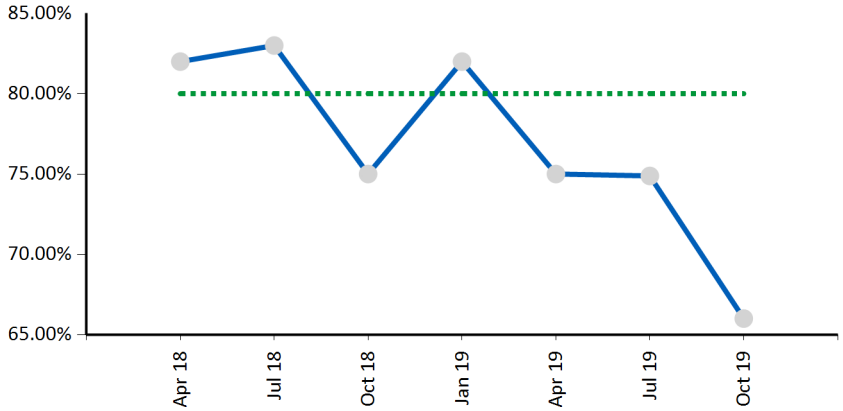
101 - Increased numbers of staff undertaking an appraisal



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

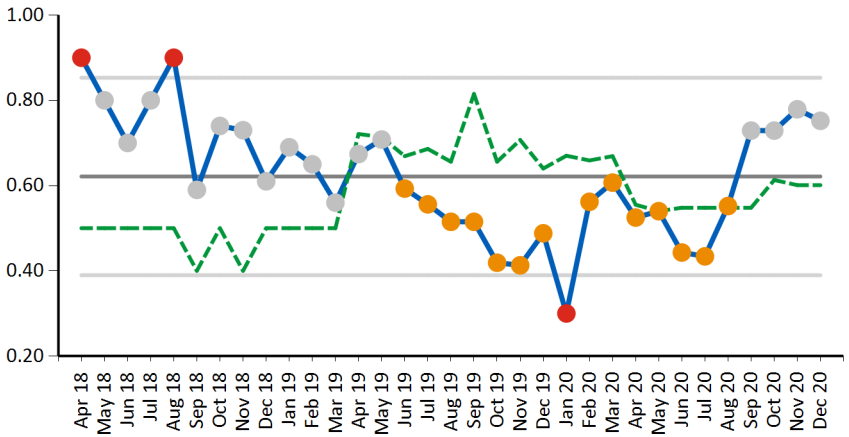


Agency

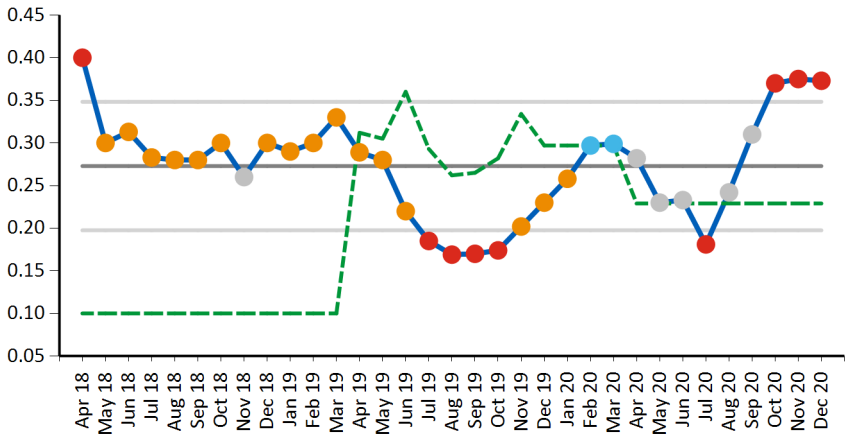
Colleagues will note the increase in agency spend for Nursing, which is anticipated due to Covid pressures. The Executive team are working with colleagues in the Trust to consider how we can reduce reliance on Agency spend. Of note the Trust continues to benchmark positively on reliance on agency spend when compared to peer organisations.

	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)	<= 0.60	0.75	Dec-20		<= 0.60	0.78	Nov-20	<= 5.10	5.48	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.23	0.37	Dec-20		<= 0.23	0.38	Nov-20	<= 2.06	2.60	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.30	0.27	Dec-20		<= 0.30	0.31	Nov-20	<= 2.39	2.02	

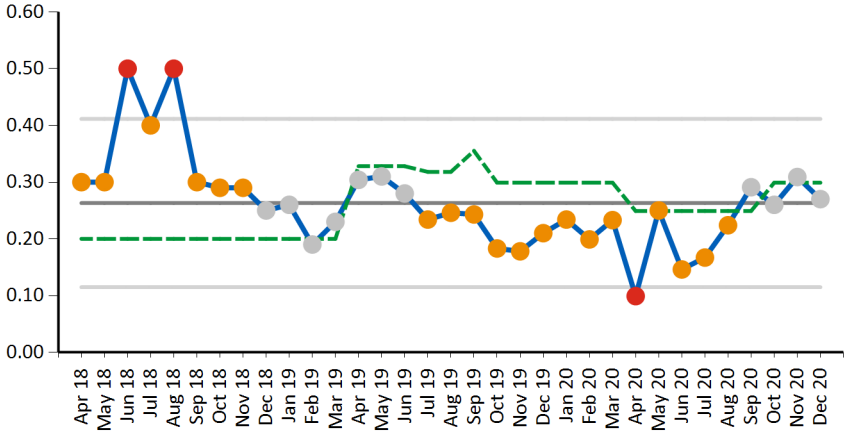
198 - Trust Annual ceiling for agency spend (£m)



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



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



Finance

Finance

Revenue Performance - The position for the month was a deficit of £582k after receiving £3.6m of top up funds, £152k better than plan. We spent £1.9m on Covid in the month and had a small income shortfall against plan of £0.36m. Revenue performance is currently rated green due to performance in Q3 being better than plan.

Forecast Outturn - We are continuing to forecast a £2.4m deficit for M7-12 to GM/NHSI. We have forecast scenarios showing a range between a worse case deficit of £8.75m and a best case of break-even. The forecast outturn is rated amber until we have more certainty on the scenarios.

Cost Improvement - There is an expectation from NHSI of a minimum level of cost improvement of 1.1% for M7-12. We have set a plan of £2.7m which equates to 1.4%, exceeding the minimum ask. The current trackers indicate that savings of £2.9m has been delivered with a further £0.7m expected to be delivered this year, thus exceeding the plan. Cost improvement is rated green due to achieving the target.

Variable Pay - We spent £2.5m on variable pay in month 9, £0.2m less than November. Of this, we spent £438k during the month on Covid. Variable pay is rated amber because all costs including agency spend have risen due to the impact of Covid and spending levels are above plan.

Capital Spend - Year to date spend is £7.1m of which £3.3m relates to Covid. Our plan for the year has increased to £13.9m including Covid funded schemes. Given the year to date spend is relatively low compared to the plan and the scale and required speed of a number of projects, Capital has been rated amber.

Cash Position - We had cash of £56.1m at the end of the month. This is much higher than normal due to cash payments from CCGs being made in advance, a healthy year-end balance and additional PSF funds from 2019/20. Cash is rated green as there are no concerns around cash flow this year.

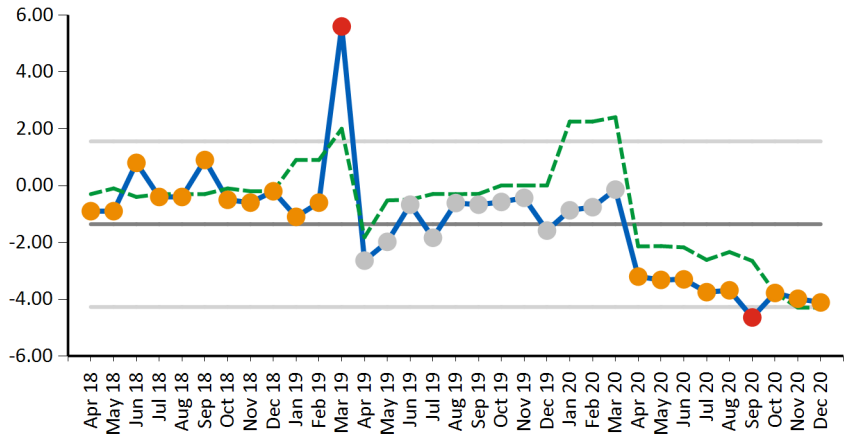
Loans and PDC - We have loans of £42.5m outstanding with a further £3.2m expected to be drawn this year. PDC will be drawn down to cover Covid capital costs and the balance of the LED lighting project. Rated green as there are no concerns in this area.

Better Payment Practices Code - We have paid 90.4% of our invoices within 30 days. This continues to be strong performance but is still below the target of 95%, hence rated amber.

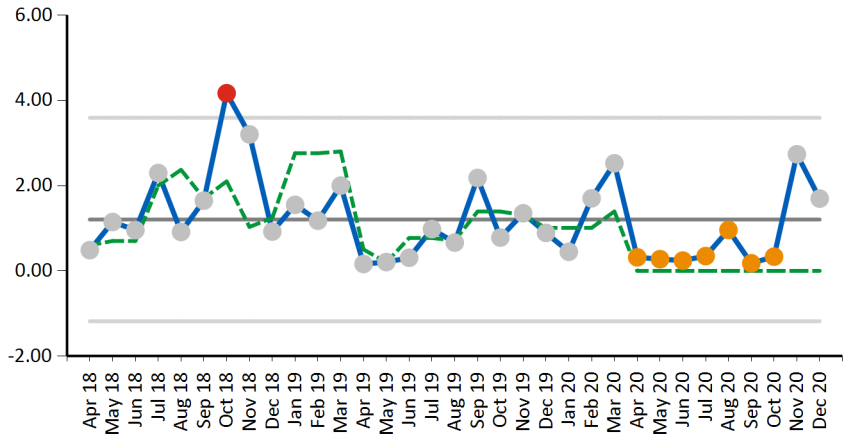
Use of Resources Rating - This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -4.3	-4.1	Dec-20		>= -4.3	-4.0	Nov-20	>= -26.4	-33.8	
222 - Capital (£ millions)	= 0.0	1.7	Dec-20		= 0.0	2.7	Nov-20	= 0.0	7.1	
223 - Cash (£ millions)	= 0.0	56.1	Dec-20		= 0.0	51.2	Nov-20	= 0.0	56.1	
224 - Use of Resources	= 0	0	Dec-20		= 0	0	Nov-20	= 0	0	

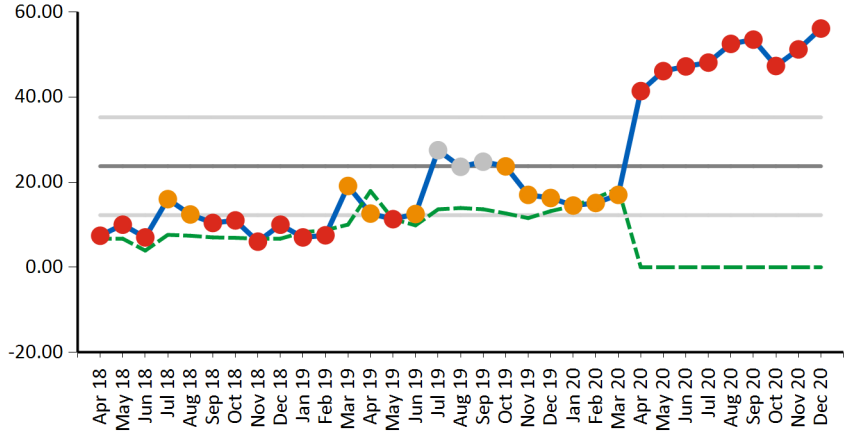
220 - Control Total (£ millions)



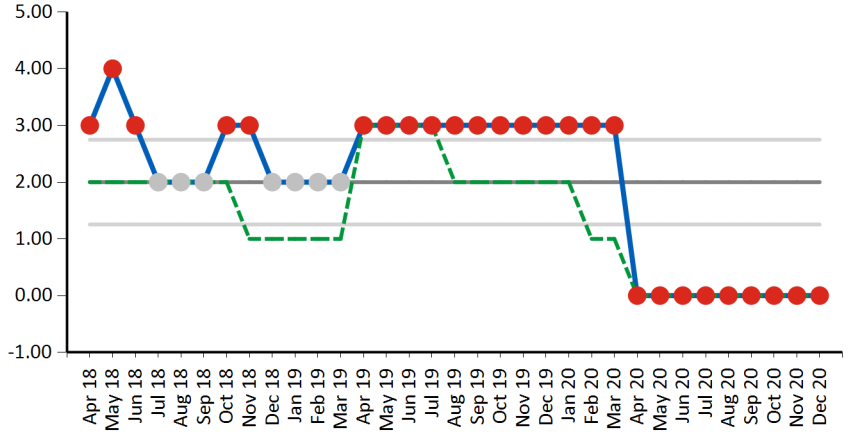
222 - Capital (£ millions)



223 - Cash (£ millions)



224 - Use of Resources



oard Assurance Heat Map - Hospital

	Indicator	Target	Council Lab Lodge	ICSD Darley Court	Acute Division: AED-Adults	AED-Paeds	ACU	B1 (Frailty Unit)	B2	B3	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	Critical Care	E3	E4	F3	F4	G3/TSU	G4/TSU	DCU (daycare)	H2 (daycare)	UU (daycare)	Families Division: E5 (Paed HDU and Obs)	F5	M2	CDS	M3 (Birth)	Ingleside	M4	M5	M6 & M6 STY	NICU	Overall
	Total Beds	*N/a*	32	0	0	0	10	23	26	21	25	26	26	25	10	14	24	22	25	27	12	5	22	19	25	25	25	24	24	24	25	11	4	38	7	26	15	5	4	22	22	20	38	746
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%		90.0%	95.0%	100.0%	100.0%	100.0%	70.0%	85.0%	90.0%	90.0%	75.0%	100.0%	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%		95.0%	100.0%	100.0%	100.0%	100.0%						100.0%	95.0%	95.0%	97.5%
	IPC Rapid Improvement Tool % (Gen)	*Target = 95%*	100.0%		83.3%	86.7%		95.0%	90.0%		100.0%	87.5%		90.0%	100.0%	88.9%	90.0%	90.0%	100.0%	85.0%	94.1%	100.0%	89.5%		73.7%	94.4%	89.5%	84.2%	100.0%	100.0%	94.1%	100.0%		88.9%	88.9%	93.3%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	94.5%
	IPC Rapid Improvement Tool % (Med)	*Target = 95%*				100.0%		100.0%	95.7%		95.5%	82.6%			100.0%	95.2%	90.5%	91.3%	100.0%	91.3%	88.9%	93.3%			91.3%	95.7%	91.3%	91.3%	95.8%	100.0%	100.0%	95.7%		90.0%	90.0%									84.2%	94.3%
	Mattress Audit Compliance %	*Target = 100%*	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%	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%
Harm Free Care	C - Diff	*Target = 0*	0	0	0	0	0	2	0	0	0	1	1	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	6
	MSSA BSIs	*Target = 0*	0	0	0	0	0	0	1	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
	E.Coli BSIs	*Target = 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
	All Inpatient Falls (Safeguard)	*Target = 0*	4	0	3	0	0	8	7	7	5	13	8	6	1	2	4	4	1	3	0	0	3	0	3	1	1	1	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	86
	Harms related to falls (moderate+)	*Target = 1.6*																																										0
	VTE Assessment Compliance	*Target = 95%*					91.9%	33.3%	35.7%	0.0%	100.0%	100.0%	89.9%	0.0%	100.0%	99.3%	99.1%	98.8%	100.0%	86.5%		99.5%	90.5%	100.0%	57.1%	96.1%	97.8%	47.2%	100.0%	100.0%	98.9%	93.9%	98.6%			99.5%	95.8%	100.0%	76.6%	84.6%	94.4%	98.5%		96.2%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
	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	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 (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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	PU due to lapses in care	*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
Audit	Monthly KPI Audit %	*Target = 95%*			95.5%	97.5%			86.0%		72.4%	87.4%	90.7%	84.9%	90.0%	94.9%		78.9%	93.1%	79.1%		100.0%	89.3%	80.7%	93.8%	91.6%	97.5%	83.1%	92.1%	91.5%	100.0%	85.3%	100.0%	98.6%	98.6%	98.8%	98.8%		91.1%	98.6%	99.6%	98.4%		94.1%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*		92.3%	75.3%	75.3%		64.2%	58.3%	81.4%	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%	92.1%	86.8%	81.7%	90.8%	77.7%	90.4%	90.9%			88.2%	90.1%	90.1%	91.9%	90.3%	90.4%		71.4%	71.4%	81.3%	90.3%	83.0%
	BoSCA Rating			platinum	silver	silver		bronze	bronze	silver	silver	silver	silver	silver	silver	silver	silver	silver	platinum	gold	bronze	silver	silver	platinum	bronze	silver	platinum	silver	platinum	gold			silver	platinum	platinum	platinum	gold	gold		bronze	bronze	silver	gold	Silver
Patient Experience	FFT Response Rate	*Target = 30%*	100.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	
	FFT Recommended Rate	*Target = 97%*	88.2%											100.0%		100.0%									100.0%	100.0%	100.0%	90.0%	100.0%					100.0%	100.0%									100.0%	
Govern-ance	Number of complaints received	*Target = 0*	0	0	4	0	0	0	2	0	0	0	0	0	0	0	2	1	1	1	0	0	0	0	0	0	1	2	0	0	0	0	0	1	0	1	0	0	0	0	0	1	0	17
	Serious Incidents in Month	*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
	Incidents > 20 days, not yet signed off	*Target = 0*	1	0	26	1	0	1	11	3	1	6	4	9	0	1	7	0	5	1	0	4	1	0	1	0	0	0	1	0	0	0	0	0	0	0	10	1	0	1	3	0	0	101
	Harm related to Incident (Moderate+)	*Target = 0*	0	0	0	0	0	1	0	0	1	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	0	0	0	0	0	0	5
Staff Dev elopment	Appraisals	*Target = 85%*		89.6%	68.5%		85.2%	75.0%	51.2%		81.5%	76.1%	76.3%	65.8%	67.9%	75.0%	58.8%	83.9%	85.7%	78.6%	100.0%	85.1%	73.5%	88.4%	76.3%	82.8%	87.5%	75.0%	87.5%	95.6%	90.6%	76.5%	88.2%	81.8%		3.1%	67.0%	42.3%	50.0%	52.8%	65.6%		85.7%	77.4%
	Statutory Training	*Target = 95%*		96.26%	93.11%		95.92%	85.56%	86.49%		85.48%	86.81%	89.08%	89.49%	96.91%	94.05%	87.81%	91.93%	96.28%	93.91%	97.62%	96.53%	90.84%	95.34%	94.24%	93.43%	94.48%	88.12%	93.10%	95.35%	96.95%	94.33%	95.79%	94.0%		86.3%	87.0%	91.5%		90.7%	94.4%		93.32%	93.4%
	Mandatory Training	*Target = 85%*		94.4%	91.42%		98.0%	83.2%	83.1%		85.7%	87.3%	85.9%	89.6%	95.1%	92.3%	82.6%	87.6%	98.6%	91.0%	100.0%	96.8%	87.7%	95.6%	90.4%	91.4%	94.0%	89.1%	93.5%	94.7%	96.4%	89.8%	100.0%	94.5%		80.2%	81.6%	90.7%		88.9%	94.3%		94.1%	93.1%
Staffing & Workforce	% Qualified Staff (Day)							83.0%			84.0%	73.0%	85.0%	87.0%	102.0%				101.0%	92.0%			92.0%	102.0%	88.0%	67.0%		81.0%	77.0%	75.0%				74.0%	74.0%	79.0%	98.0%			84.0%	91.0%			
	% Qualified Staff (Night)							137.0%			104.0%	99.0%	144.0%	106.0%	100.0%				103.0%	98.0%			102.0%	100.0%	87.0%	118.0%		118.0%	86.0%	101.0%				79.0%	79.0%	97.0%	90.0%			87.0%	92.0%			
	% un-Qualified Staff (Day)							102.0%			96.0%	78.0%	101.0%	95.0%	107.0%				68.0%	90.0%			92.0%	107.0%	86.0%	84.0%		114.0%	101.0%	108.0%				17.0%	17.0%	94.0%	94.0%			86.0%	98.0%			
	% un-Qualified Staff (Night)							151.0%			93.0%	108.0%	108.0%	111.0%	103.0%				73.0%	93.0%			116.0%	103.0%	100.0%	73.0%		124.0%	108.0%	102.0%						93.0%	85.0%			97.0%	94.0%			
	Budgeted Nurse: Bed Ratio (WTE)			7.08	0.68	0.68	0.00	0.68	4.47	0.00	1.55	-1.67	6.46	3.09	4.22	-0.94	-6.09	8.48	0.42	0.81	0.00	14.85	2.09	0.30	-2.12	0.77	-3.44	2.62	-0.07	-2.87	0.86	0.76	0.65	0.79	0.79	-2.12	2.92	3.69	8.76	-6.12	2.34	2.27	8.48	77.82
	Current Budgeted WTE (Ledger)			50.78	73.28	73.28		38.03	43.34		33.71	41.23	42.69	40.70	26.93	19.97	50.82	40.30	40.01	39.97		60.93	36.15	93.60	35.52	30.21	37.79	30.21	44.50	44.49	32.75	50.92	15.92	33.57	33.57	22.00	86.31	24.64	66.93	26.34	26.34	46.89	105.69	1658.36
	Actual WTE In-Post (Ledger)			43.70	72.60	72.60		37.35	38.87		32.16	42.90	36.23	37.61	22.71	20.91	56.91	31.82	39.59	39.16		46.08	34.06	93.30	37.64	29.44	41.23	27.59	44.57	47.36	31.89	50.16	15.27	32.78	32.78	24.12	83.39	20.95	58.17	32.46	24.00	44.62	97.21	1580.54
	Actual Worked (Ledger)			48.84	90.49	90.49		60.49	50.24		39.80	50.67	46.37	49.89	25.64	25.68	56.63	43.69	44.52	49.84		50.39	46.22	99.81	47.47	33.63	49.61	36.71	52.61	54.56	31.16	52.91	15.46	31.57	31.57	26.55	91.11	20.78	61.44	40.85	30.01	45.83	87.54	1818.18
	Sickness (%)	*Target is < 4.2%*		1.90%	9.86%		6.49%	10.31%	18.29%		23.25%	11.13%	6.72%	12.12%	0.84%	5.78%	7.40%	4.51%	8.31%	5.50%	7.55%	9.01%	12.13%	3.95%	6.78%	5.68%	5.43%	7.37%	12.32%	13.53%	22.79%	8.57%	3.66%	5.33%	5.33%	1.09%	9.68%	4.53%	0.00%	2.27%	0.34%		5.01%	5.54%
	Current Budgeted Vacancies			-5.14	-17.89	-17.89	0.00	-23.14	-11.37	0.00	-7.64	-7.77	-10.14	-12.28	-2.93	-4.77	0.28	-11.87	-4.93	-10.68	0.00	-4.31	-12.16	-6.51	-9.83	-4.19	-8.38	-9.12	-8.04	-7.20	0.73	-2.75	-0.19	1.21	1.21	-2.43	-7.72	0.17	-3.27	-8.39	-6.01	-1.21	9.67	77.82
	Pending Appointment																																											0.00
	Substantive Staff Turnover	*Target is < 10%*		6.2%	5.0%		3.8%	23.1%	12.0%		11.3%	6.3%	7.2%	16.7%	714.0%	4.4%	15.9%	5.3%	14.3%	23.9%	0.0%	8.0%	12.5%	13.4%	2.6%	8.5%	9.3%	19.1%	14.4%	7.9%	7.8%	8.7%	11.4%	9.1%	9.1%	30.3%	16.1%	14.8%	0.0%	5.0%	24.2%		4.2%	13.01%

Data Legend

No data returned	
No Eligible patients	

NB: M6 & M6 STY was M1 & M1A

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

	Indicator	Target	ICS Division												
			Avondale and Chorley old Road	Breightmet & Little Lever	Crompton with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Treatment Rooms	Overall
Infection Control & Harm Free Care	Hand Washing Compliance %	*Target = 100%*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%			100.0%	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	2	3	0	0	2	0	0	2	3	0		12
	Monthly New pressure Ulcers (Grade 3)	*Target = 0*	0	0	0	0	0	2	0	0	0	0	0		2
	Monthly New pressure Ulcers (Grade 4)	*Target = 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
	PU due to lapses in care	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0		0
Audit	Monthly KPI Audit %	*Target = 95%*	100.00%	98.69%	98.31%	96.64%	92.86%	98.39%		99.24%	97.98%	96.88%	96.03%	97.29%	97.13%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*	92.41%	94.93%	91.10%	94.23%	93.60%	94.33%	97.23%	97.55%	91.74%	97.11%	96.93%	87.10%	94%
	BoSCA Rating		platinum	platinum	gold	gold	platinum	platinum	platinum	gold	platinum	platinum	gold	silver	gold
Patient Experience	Friends and Family Response Rate %	*Target = 30%*												15.0%	
	Friends and Family Recommended Rate %	*Target = 97%*												100.0%	
	Number of Complaints received	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0
Staffing & Workforce	Current Budgeted WTE														0.00
	Actual WTE In-Post														0.00
	Actual WTE Worked														0.00
	Pending Appointment														0.00
	Current Budgeted Vacancies (WTE)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff Development	Sickness (%) (November)	*Target is < 4.2%*	0.0%	0.0%	7.9%	1.4%	5.7%	1.8%	5.2%		270.0%	0.0%	6.6%	8.7%	6.62%
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	7.1%	6.1%	10.5%	24.2%	0.0%	14.3%	0.0%		12.5%	9.5%	3.3%	21.8%	3.28%
	12 month Appraisal	*Target = 85%*	100.0%	100.0%	94.4%	76.5%	100.0%	85.7%	92.3%		100.0%	100.0%	89.7%	95.5%	89.66%
	12 month Statutory Training	*Target = 95%*	96.4%	94.9%	99.1%	93.9%	95.8%	96.4%	96.2%		98.0%	100.0%	94.4%	95.5%	94.44%
	12 month Mandatory Training	*Target = 85%*	100.0%	100.0%	97.1%	93.1%	95.7%	100.0%	93.8%		98.5%	100.0%	92.7%	96.0%	92.66%

Data Legend

No data returned	
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

Title	Quality Assurance Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	January 28 2021		Discussion	
NED Sponsor	Andrew Thornton		Decision	✓

Summary:	The Quality Assurance Committee has met twice since the last Board of Directors' meeting. In December the Committee approved three SI reports and extended apologies on behalf of the Board to those affected by these incidents. The Committee are seeking ongoing assurance with regard to the system actions after the tragic suicide of a patient in our care, actions will include the development of a mental health strategy. The Committee received the Trust's response to the Ockenden report and were happy to recommend this for Board approval. The Learning from Deaths report and the annual Health and Safety Report were also reviewed by the QA Committee in advance of the January Board. Further detail provided in the reports attached.

Previously considered by:	The Quality Assurance Committee

Proposed Resolution	Board members are asked to note this 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:	Esther Steel Director of Corporate Governance	**Presented by:**	Andrew Thornton Chair of the QA Committee

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

CQC	Care Quality Commission
SI	Serious Incident

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	16 December 2020	Date of next meeting:	20 January 2021
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	F Noden, A Ennis, F Andrews, M Forshaw, J Njoroge, R Ganz, M Brown, E Steel, R Sachs. Representation from the five clinical divisions D Sankey CQC observing	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
The Quality Assurance Committee met by WebEx on Wednesday 16 December 202. The meeting was well attended despite an ongoing internal business continuity incident affecting IT across the Trust. The meeting was observed by a CQC inspector as part of their routine monitoring of the Trust.			
Patient Story		The Integrated Care division shared a patient story illustrating the importance of wheel chair services to patients with long term mobility issues	The story was noted with agreement that when possible the team would be included in Board visits
Covid update		The Chief Operating Officer presented an update on the current operational position managing the Covid-19 pandemic including a sit-rep of the latest position and an update on the actions taken to reduce nosomial infections	
Divisional Updates from the Diagnostics and Support Division and the Anaesthetics and Surgical Division		Comprehensive reports received from divisions – commended for candour and detail. The Committee welcomed the opportunity to hear more from services within the Diagnostics and Support division and noted the work of the Anaesthetics and Surgical division towards the continuation of cancer services and the recovery of the elective programme	Reports 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

Quality Account Report update Hydration		Update provided on actions and progress in relation to the Quality Account priority for hydration. Although progress has been made in supporting hydration further work is still required on fluid balance charts to improve access to and completion of electronic charts	Report noted
Quality Account Report update Radiology		Update provided on actions and progress in relation to the Quality Account priority for radiology turnaround – although the Covid-19 pandemic has presented challenges, progress has been made in each area. Further action is required to continue to improve performance	Report noted
Quarterly complaints report		The Committee commended the team for providing a clear well-presented report setting out a summary of complaints and PALS contacts during Q2 of 2020/21	Report noted
QI Strategy		Update provided on progress made relating to the Trust QI Strategy	Report noted
Health and Safety Annual Report		Comprehensive report received	Committee requested six monthly updates
Learning from Deaths Policy		New policy presented setting out the procedures for identifying, recording, reviewing, investigating and learning from deaths of people in the care of Bolton NHS FT	The Committee APPROVED the Learning from Deaths Policy
SI report approval		The committee received and approved three final SI reports and expressed apologies on behalf of the Trust to those affected by each incident. One report related to the suicide of a patient in our care, and two related to concerns about care delivery	Reports approved - Committee members agreed that the report relating to the suicide of a patient should be shared with the full Board

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Committee/Group Chair's Report

Health and Safety Committee Chair report		The Health and Safety situation report identified a number of H&S works that have been prioritised including a number of environmental concerns	No risks escalated but concerns noted
Risk Management Committee Chair report		New format of risk register reports well received Risk of Aspergillosis escalated – building work paused to allow for cleaning and environmental testing. Maternity Fire Safety – noted need for closing of corridor spaces to allow for asbestos removal.	
Safeguarding Committee Chair Report		Safeguarding activities remain high – significant increase in adult safeguarding referrals with an increase in domestic abuse and violence attributed to the ongoing pandemic	
Comments			
Risks Escalated –			

	No assurance – could have a significant impact on quality, operational or financial performance;
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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

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	20 January 2020	Date of next meeting:	20 January 2021
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	F Noden, A Ennis, F Andrews, K Meadwocroft, J Njoroge, R Ganz, M Brown, E Steel, R Sachs. Representation from the five clinical divisions D Sankey (CCG)	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
The Quality Assurance Committee met by WebEx on Wednesday 20 January 2020. The meeting was well attended despite the ongoing global pandemic.			
Patient Story		The Trust Safeguarding lead shared the story of a young adult with mental health challenges being cared for on an acute adult ward.	The story illustrated the learning from a previous case but also highlighted that appropriate mental health provision is still a significant system concern
Covid update		The Chief Operating Officer presented an update on the current operational challenges resulting from the Covid-19 pandemic. This remains a significant issue with the biggest challenges being in relation to the supply of oxygen and the management of flow	Update noted – further update to be provided in the Board meeting
Divisional Updates from the Acute Adult Division and the Integrated Care Division		The two divisions presented detailed reports with clear recognition of challenges, issues for improvement and areas of celebration.	Committee members commended the candour in the reports and specific recognition for the ongoing work to care for patients with Covid-19
Quality Account Report update Pneumonia		The Medical Director presented an update on the achievement of the Quality Account priority for the management of pneumonia. Committee members noted that good progress has been made particularly with the piloting of a pneumonia nurse and embedding the pneumonia care bundle	Report 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

Learning from deaths report		The Medical Director presented the quarterly Learning from Deaths report – the Committee noted that good progress had been made with regard to establishing a robust process however operational challenges do have an impact on reviewer availability	Progress noted
Ockenden response report		The Chief Nurse supported by the Head of Midwifery presented the Trust's response initial response to the Ockenden report – while the Trust are compliant with a number of the actions further work will be required to audit evidence the Trust's response	Report noted – and recommended for Board approval
Claims profile Bolton NHS FT		Following a media FOI request the Trust's claims profile had been published and had attracted questions from the local MP. The profile shows that claims might not fall in the year in which the incident occurred and also reflect the Trust's position as a maternity centre	Report noted, the Trust's patient safety specialist will be working with a newly appointed analyst to provide benchmarking and learning from others
Response to CQC re SI report		Following the SI report approved at the December Board the CQC requested further information for assurance on the safety of patients receiving mental health care in the Trust. The committee discussed the ongoing challenge of caring for patients, particularly young patients with mental health needs.	On-going action including working with GMMH to develop a mental health strategy for the Trust.
Quality Account arrangements		Arrangements for the production of the Quality Account noted	
Risk Management Committee Chair report		New format of risk register reports continues to be well received.	Action to open a second maternity theatre in response to escalated risk noted
Safeguarding Committee Chair Report		Safeguarding activities remain high – significant increase in adult safeguarding referrals with an increase in domestic abuse and violence attributed to the ongoing pandemic	Report noted
Risks Escalated –			

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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

Agenda Item: 12

Title:	People Committee Chair's Reports (December 2020 & January 2021)

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	28th January 2021		Discussion	✓
Exec Sponsor:	James Mawrey		Decision	

Summary:	The People Committee has met twice since the last Board of Directors meeting and although there are no risks to escalate there are a number of items to bring to the Board's attention. Of particular note is that the Committee fully endorses the paper to the Board of Directors on the Workforce & OD Strategy; the organisation's Workforce & OD response to the pandemic is positive (Engagement, Wellbeing, Resourcing, Recognition) - all KPI's benchmarking positively when compared to peer organisations; the NHS Staff Survey has closed with over 2400 staff completing the survey which will provide a source of rich data. In accordance with its delegated responsibilities, the Committee approved the quarterly Freedom to Speak Up report. Further details are provided in the attached meeting reports.

Previously considered by:	People Committee

Proposed Resolution:	The Board are asked to note the papers.

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, Chair of People Committee

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	December, 2020	Date of next meeting:	January, 2020
Chair:	M Brown	Parent Committee:	Trust Board
Members present/attendees:	A Stuttard, M North, I Ismail, J Mawrey, A Ennis, S Martin, M Forshaw, F Andrews, E Steel, A Chilton, P Henshaw, C Sheard, L Gammack and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & OD Annual review		• The Committee welcomed the annual review of the Workforce & OD Strategy. • Given this paper will be included in the January BoD papers then no further narrative is included in the Chair report.	**Actions agreed:-** • The report is commended for discussion and approval at the BoD in January
Covid Workforce report		• It was noted that our vacancy rates are low when compared to peer organisations (Bolton 3.98%, National average 7.63% • 100% of our High risk staff have received a Risk Assessment and 91% of all staff. • Flu vaccination rate sat at 62% (above the same time last year) • Staff Swabbing service saw 812 staff tested in November. • Attendance figures remain best in GM and one of best in North West. • Lateral testing will commence from 30th November (all staff). • Plans are being developed to support the roll-out of the vaccine for all front line workers. • The NHS Staff Survey closes end of November.	**Actions agreed:-** • The report was noted. • Staff Survey results to be presented to the Committee in February and then BoD in March.

	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

Leadership & Management Development		• This Committee received an update on the intention to co-design an over-arching Leadership and Management Development Strategy that incorporates our current and future development programmes/interventions. This co-design will take place in January & February with the intention of the People Committee receiving the Strategy in March/April • Of note, alongside the strategy development work, a programme of masterclasses will be commissioned. Plans to run a second Shadow Board Development Programme will continue to be progressed. The aim is to open the nomination window around mid-January with a view to deliver the 3-month programme from April to June 2021.	**Actions agreed:-** • The report was noted and agreed that the Strategy will be reviewed by the Committee in March/April.
Medical Leadership Development		• The Committee received the newly developed Medical Leadership Strategy and supporting development programme specifically designed for senior doctors in the Trust. It was recognised that whilst there is a clear need for multidisciplinary leadership programmes the situation in Bolton is such that a focused work programme is required at this time. • Given this paper will be included in the January BoD papers then no further narrative is included in the Chair report.	**Actions agreed:-** • The report is commended for discussion and approval at the BoD in January

	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

HENW Action plan update		• Colleagues will recall that following poor GMC trainee survey results and HEE NW review in July 2019, O&G was placed under enhanced monitoring. A detailed, comprehensive action plan for improvement was then initiated with support from HEE NW. • In August 2020 a trainee survey confirmed many improvements had been made. However, and this is acknowledged by the Trust, there are still a number of areas where improvements need to be either made or sustained. The Committee received the update on the remaining actions. A report detailing the updated action plan is to be provided by the Medical Director to HEE NW by 1st March 2021.	**Actions agreed:-** • The report was noted and a further update to be provided to the Committee in February.
Transfer of Occupational Health Department from Wellbeing Partners to Bolton NHS FT		• The Committee noted that the Executive team had supported the transfer to bring the service back in-house. The rationale for this decision was discussed, along with the timescales for implementation (shadow form from 1st January, 2021 and TUPE 1st April, 2021).	**Actions agreed:-** • The 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

Letter from NHSI regarding the North West BAME Strategic Priorities		• The Committee gave the Director of People delegated responsibility to respond to the NHSI return by 22nd December, 2020. The Committee didn't identify any areas of concern and it was felt all aspects were being appropriately managed within the organisation. • The Director of People noted that the People Committee is due to receive a full update on the EDI Strategy in February, 21, with BoD discussion in March, 2021. • The Committee were informed that at the recent HPMA Awards (NHS UK HR awards) the inclusion team were highly commended for their work over the last 18 months.	**Actions agreed:-** • Director of People given delegated authority to respond to NHSI return by 22nd December. • EDI Strategy to be received in February, in advance of BoD discussion in March.
Workforce & OD Dashboard		• The report triangulated key workforce data to support informed discussions. • Members positively noted that the Trust benchmarked well on key Workforce & OD metrics.	**Actions agreed:-** • The report was noted.
Risks escalated None – matters being managed within 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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	January, 2021	Date of next meeting:	February, 2021
Chair:	M Brown	Parent Committee:	Trust Board
Members present/attendees:	A Stuttard, M North, J Mawrey, F Noden, A Ennis, S Martin, K Meadowcroft, E Steel, A Chilton, P Henshaw, C Sheard, L Gammack and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	I Ismail, F Andrews

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & OD Integrated Dashboard		• The report triangulated key workforce data to support informed discussions. • Members positively noted that the Trust benchmarked well on key Workforce & OD metrics. • Whilst it was noted that there had been a recent spike in the vacancy rate it was noted that this was due to an accounting 'in month' matter however, further detail was requested at the next meeting.	**Actions agreed:-** • The report was noted. • Update on vacancy rates at the next meeting
Covid Workforce report		• 100% of our High risk staff have received a Risk Assessment and 94% of all staff. • Flu vaccination rate sat at 80% • Whilst attendance figures have increased they remain best in GM (Acute) and one of best in North West (Acute). • Over 5200 staff have received the vaccine	**Actions agreed:-** • The report was 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

Staff Health & wellbeing		• The measures to in-house our Occupational Health Service are being taken in a timely manner. We operated in Shadow Form as planned on 1st January and TUPE 1st April, 2021. • Current numbers. 7.8% sickness (4.07% Covid related, 3.73% Normal sickness). Overall availability running at around 20%. • Additional support been put in place. Clinical Psychologists are working in Critical Care and Covid Ward areas to ensure immediate support if required; Additional counselling commissioned in Occupational Health; Caring for your teams programme in place (managing teams); Caring for yourself programme in place (managing self); Chaplaincy Service; Shinyminds & National APP signposting support.	**Actions agreed:-** • The report was noted.
Staff Experience Update		• It was noted that the NHS Staff Survey has closed. • Over 2400 staff have completed the survey which will provide a rich array of information. This information will then be used to understand what we do well and areas that we can improve. • The findings will be coming to the BoD in March, 2021	**Actions agreed:-** • The update was 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

FTSU Quarterly		• Positively the number of FTSU continues to increase with 33 in Quarter 3. The Committee noted that interpersonal skills / behaviours was the top reason for concerns raised and that a number of the concerns were raised by HCSW. • The number of FTSU continues to grow with a further 6 recruited in Quarter 3 – including from IFM Bolton. • Fiona, Malcolm, Bilkis, James and Tracey continue to meet on monthly basis to ensure all appropriate support is in place • There were no matters that the FTSU Guardian felt needed escalation.	**Action agreed** **1.** The report was noted **2.** Update in March on the OD support that will be put in place to further understand the enabling actions that can be taken to support our HCSW.
Inclusion Update		• The report provided a brief summary of completed and planned actions that will further strengthen the Trust's capacity and capability to deliver the EDI agenda. The Committee supported the immediate key EDI priorities and timescales. • It was noted that a EDI Report will be provided to the BoD in March.	**Action agreed** 1. The report was noted 2. Report to BoD in March

	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

Apprenticeship programme update		1. Due to significant operational pressures resulting from Covid 19, it has been difficult for NHS organisations to meet their apprenticeships target. This picture is replicated in Bolton with just 55 staff starting an apprenticeships programme from 1st April-December (target 200 for 20/21). 2. Enabling actions being taken were discussed and of note there are 243 employees across the Trust who have either expressed an interest or applied to undertake an apprenticeship qualification. 3. The Deputy DoF provided an update on the Levy position. This will be noted at the Finance & Investment Committee	**Action agreed** 1. The report was noted
Risks escalated None – matters being managed within 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

Agenda Item

Title:	Bolton NHS Foundation Trust benchmark of the Maternity Services in response to the Ockenden report requested by NHS England.

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th January 2021		Discussion	✓
Exec Sponsor	Karen Meadowcroft Chief Nurse		Decision	

Summary:	Following the first publication of the Ockenden Report in December 2020, NHS England requested that each Trust immediately review its Maternity service against the 12 urgent actions. Bolton NHS Foundation Trust have completed the requested benchmarking tools; some aspects are only partial complaint due to lack of audit evidence to demonstrate the standard is in place. A number of actions require either the National or regional team to undertake action and then Bolton NHS Foundation Trust will implement these to achieve full compliance.

Previously considered by:	18/01/2021 Execs 20/01/2021 Quality Assurance Committee

Proposed Resolution	To highlight the Trust position and work required to achieve full compliance.

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:	Natasha Macdonald Head of Midwifery Divisional Nurse Director	**Presented by:**	Karen Meadowcroft, Chief Nurse

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

IEA	**Immediate Essential Actions**
LMS	**Local Maternity System**
CNST	**Clinical Negligence Scheme Trusts**
MDT	**Multidisciplinary Team**
PROMPT	**Practical Obstetric Multi-Professional Training**
HSIB	**Healthcare Safety Investigation Branch**
SaTH	**Shrewsbury and Telford Hospital NHS Trust**
NHSE	**NHS England**
MVP	**Maternity Voice Partnership**

Appendices:

Appendix 1:	**Ockenden Review December 2020: 12 Urgent Clinical Priorities**
Appendix 2:	**Maternity Services Assessment and Assurance Tool**
Appendix 3:	**Birthrate Plus® Midwifery Services Workforce Planning and Decision Making**
Appendix 4:	**December 2020 Review and Benchmark of Previous Kirkup Report**
Appendix 5:	**Letter from NHS England and Improvement to NHS Foundation Trust Chief Executives – Ockenden Review of Maternity Services – Urgent Action**

1. Executive Summary

The Ockenden report has raised the profile of Maternity care. The aim of the report is not simply to condemn past care and management at SaTH but to inform all maternity services with the overriding objective of improving maternity care and safety for all.

Themes identified in previous reports have not been actioned therefore the findings identify the need for maternity services to learn and improve.

This report sets out a summary of the findings of the report, the actions required of all maternity providers and additional detail of actions previously taken in Bolton. The national and regional teams are still developing some aspects of the 12 urgent actions that incorporate the seven IEA. Bolton NHS Foundation Trust have complied with the request to offer a commitment to the implementation of the Perinatal Quality Surveillance model and the national risk assessment tool. The national team are developing a portal where Bolton NHS Foundation Trust will submit data.

Leadership and culture are identified within the Ockenden report this has been an areas of focus in 2019-20 within the Maternity service as Bolton which is led by an executive with a clear action plan in order to achieve the desired improvements.

2. Introduction

The Ockenden Report was published December 2020 following the independent maternity review of the Maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH). The review focused on maternal and Neonatal harm between 2000 and 2019. The report identified poor practice and areas of concern and recognises the deep and lasting impact on those families who have lost loved ones and those who live with the injury and trauma caused.

3. Report Findings

Perhaps the most significant finding and learning point is the recommendation to put an end to investigations, reviews and reports that do not lead to lasting meaningful change. Problems with care at Northwick Park in North London were identified between 2002 and 2005, the review into this showed that the trust had failed to learn from adverse incidents. Similarly, in 2015 when care at Morecambe Bay was investigated the findings also suggested that ‘normal’ childbirth was pursued at any cost and there was a repeated failure to investigate adverse incidents properly and to learn lessons. The story of SaTH is unfortunately not new and the report confirms that had the recommendations of these previous investigations been implemented harm and lives could have been saved.

Notwithstanding this, the report sets-out a clear picture of a trust which had been functioning incorrectly overall for an extensive period of time.

Ockenden Report Key Findings

- Compassion and kindness:
  - there were cases where women felt blamed for their loss and this further compounded their grief.
  - women and their families raised concerns about their care and were dismissed or not listened to at all.
- Assessment of risk and place of birth:
  - mothers were given insufficient information about their suitability for giving birth at a midwifery-led centre rather than an obstetric-led centre.
  - there was insufficient information given on what would happen if they were birthing at a midwifery-led unit and a complication arose.
- Managing complex care:
  - there was a failure to identify where a mother's presentation was outside the norm and to refer for specialist input.
  - high risk pregnancies were left under midwifery and not referred to an Obstetrician care or inappropriately managed by obstetricians in training.
- Escalation of concerns:
  - midwives failed to recognise deterioration in a mother and to obtain specialist input.
- Management of labour:
  - there were problems with how baby's heartbeats were listened to and the interpretation of results; both intermittent auscultation (listening to the heartbeat) at certain intervals or by continuous fetal monitoring using a cardiotocograph (CTG).
  - There was an inappropriate use of oxytocin a drug, used to increase the frequency, strength and length of contractions, was used inappropriately and this continued consistently across the timeline being investigated by the inquiry.
- Traumatic birth:
  - the incorrect use of oxytocin led to women needing to be assessed for instrumental delivery (delivery with ventouse or forceps).
  - Repeated attempts at delivery with forceps, sometimes using excessive force with traumatic consequences;
  - failing to abandon attempted vaginal delivery and moving to caesarean section at the appropriate and safest time.
- A desire to keep caesarean section rates low (leading to the problems with the management of labour and traumatic births listed above):
  - caesarean section rates at the trust were consistently 8% to 12% lower than the national average over the years in question;
  - There was a perception that the essence of good maternity care was having a 'normal' birth.
  - there was a lack of freedom to express a preference for caesarean section or to have any choice in the mode of the baby's delivery.
- Bereavement care:

- Some of the comments from families was there were inappropriate comments were made to family members after the loss of a baby.
- Several examples of mothers being made to feel responsible for their loss.
- poor bereavement care provision in relation to Maternal deaths.
- teams failed to work together to plan care for those who were at higher risk of complications.
- there was a failure to use basic nursing practice to identify deteriorating patients.
- there are concerns about the standard of investigations into serious incidents such as maternal deaths, with no investigation at all in some circumstances, meaning no opportunity to learn.

- Obstetric anaesthesia:
  - a failure to holistically consider the mother when providing obstetric anaesthesia.
  - there were errors in providing obstetric anaesthesia.
  - a lack of escalation to and involvement of senior anaesthetists.
  - failure to incorporate anaesthetists into incident investigations to ensure multidisciplinary learning.

4. Actions Required

Seven immediate and essential actions (IEA) arising from the above findings were identified, NHS England subsequently requested that Trusts address 12 urgent actions that incorporate the seven IEA. Bolton NHS Foundation Trust were requested to benchmark against these and return the results to NHSE by the 18th of December. The submission was completed and returned as requested.

Table 1

Bolton NHS Foundation Trusts compliance with the seven IEA

1: Enhanced Safety	
a) Perinatal Clinical Quality Surveillance Model	Non-compliant
b) SI's shared with Boards/LMS/HSIB	Partially compliant
2: Listening to Women and their Families	
a) Robust service feedback mechanisms	Compliant
b) Exec/Non-Exec directors in place	Compliant
3: Staff training and working together	
a) Consultant led ward rounds twice daily	Partially compliant
b) MDT training scheduled	Compliant
c) CNST funding ring-fenced for maternity	Partially compliant
4: Managing complex pregnancy	
a) Named consultant lead/audit	Partially compliant

b) Development of Maternal Medicine Centres	Partially compliant
5: Risk assessment throughout pregnancy	
a) Risk assessment recorded at every contact	Partially compliant
6: Monitoring Fetal Wellbeing	
a) Second lead identified	Compliant
7: Informed Consent	
a) Pathways of care clearly described, on website	Compliant

See appendix 1 for the full template and full narrative

We have completed a full assessment tool (appendix 2) which incorporates a self-assessment. The assurance assessment tool incorporates the immediate and essential actions (IEA) and relevant Maternity Safety actions for Clinical negligence scheme for trust CNST. The tool requests self-assessment against the following:

- What the we currently have in place
- Evidence against each standard
- Details of any further actions required
- Details of support required (internally or externally)
- The mitigation of any risks in the short term.

The document seeks to provide NHSE narrative around what support will be required across the system to improve maternity safety. In order to support self-assessment, there is a recommendation to provide additional assurance to the Board including the following;

- A maternity workforce plan benchmarked against the RCM leadership recommendations
- The approach to NICE guidance in relation to relation to maternity care
- Compliance against CNST
- Action plan compliance against the Morecambe Bay recommendations in the Kirkup report.

5. Findings

Our review of the 12 urgent safety actions demonstrates no areas of safety concern however there are areas where improvement is needed, predominantly around auditing compliance with standards.

- We are fully compliant with five of the actions
- We are partially compliant with six actions where we need to introduce an audit process
- the one action where we are non-compliant requires the introduction of a national perinatal clinical model

6. Quality and safety ensuring transparency and scrutiny

We have been fully compliant with the maternity safety actions for CNST for the previous two years 2018-2019 2019 -2019 2010-21 (suspended due to Covid). The Trust engages with National bodies such as NHS resolution and Healthcare Safety Investigation Branch (HSIB).

We are active members of the Local Maternity System (LMS), and submit data as requested and input into the regional guidelines. Fiona Noden Chief Executive is the Chair of the LMS, Karen Meadowcroft Chief Nurse also did represent the Greater Manchester Chief Nurses at the LMS.

The Chief Nurse, previously the Director of Nursing, has been the Board Level Safety Champion. The champion ensures board level focus on improving safety and to ensure Maternity is a priority at board. The Chief Nurse is supported by the local safety champions, the Clinical lead for Obstetrics and the Head of Midwifery.

The following Maternity metrics are reviewed by Trust board at their bi-monthly meetings and by the Quality Assurance Committee at each monthly meeting:

- Stillbirth
- 3rd and 4th degree tears
- 1:1 care in labour
- Booking figures before 12+6
- Induction of labour rates
- Total Caesarean section rate
- Breast feeding initial rates
- Maternity Complaints
- Maternal deaths
- Preterm births

7. Kirkup Report

Part of our response includes an updated to our position in response to the 2015 Kirkup Report. The Kirkup report details a chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, which is part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The result was found to be avoidable harm being caused to mothers and babies, including tragic and unnecessary deaths. What followed was a pattern of failure to recognise the nature and severity of the problem, with in some cases, denial that any problem existed and a series of missed opportunities to intervene, that involved almost every level of the NHS. The Report includes detailed and damning criticisms of the maternity unit, the Trust and the regulatory and supervisory system.

Table 2

Summary of Kirkup action plan

1 Midwives have an understanding of the significance of hypothermia in the neonate	Compliant
2. The Trust should ensure HES data is complete	Compliant
3. The division should seek assurance that risk assessment and care planning are accurate and are not resulting in unsafe care	Partially Compliant
4. Processes in place to investigate clinical incidents appropriately and learn from them	Compliant
5. 'Midwives not to pursue 'normality' at all costs' does not apply.	Compliant
6. Potential conflict of interest when Governance Manager also Supervisor of Midwives	Compliant
7. Review its governance processes	Compliant
8. Assurance that the number of supervisors and their competence is monitored.	SOM no longer statutory as per the NMC
9. The safety culture within the division should be assessed through the utilisation of MAPSAF	Compliant
10. Review how concerns about individual clinicians are escalated, ensure staff aware of their responsibilities.	Compliant
11. Ensure that all perinatal deaths of babies born here are visible	Compliant
12. Produce annual structured perinatal mortality report	Compliant
13. Supervisors of Midwives to ensure that all governance meetings SOM there in that capacity only to ensure independence of SOM role	SOM no longer statutory as per the NMC

See appendix 4 for the full report

8. Staff

A key issue highlighted by the Ockenden report is the failure at a leadership level to identify and tackle the patient safety issues. Good leadership plays a key role in shaping an organisation's culture. Leaders need to drive patient safety performance, support learning from unsafe care and put in place clear governance processes to enable this. Leaders need to be accountable for patient safety.

Action 3: staff training

Bolton Hospital NHS Foundation Trust, are committed to MDT Practical Obstetric multi professional training course (PROMT training). Compliance has been monitored annually via CNST. The request is now for it to be monitored by the LMS quarterly.

Action 4: all women have a named consultant

The Trust have appropriate Consultant provision to ensure all women have a named Consultant, however there is a need to conduct an audit to provide the evidence. In 2020 investment was made to increase the Obstetric Consultant body by 5 full time consultants which will support the implementation.

Midwifery work force review

Bolton Maternity services had a full birth rate plus assessment undertaken in August 2020 (see appendix 3). This assessment highlighted a gap of 6 whole time equivalents in specialist Midwives. Specialist Midwives are extra to those required for safe staffing to deliver direct Midwifery care. The Maternity team will benchmark against other providers to identify potential gaps in the specialist teams. In order to improve the specialist care provision for women.

The Trust are awaiting the national job description for the Senior Advocacy role, in the interim the Trust has opted to request the MVP to take-up role to advocate for women and families and offer independent support and scrutiny. In the future the Trust will be required to support both the chair of the MVP and Senior advisory role.

9. Reputation

The IEA initial assessment was reported through the LMS and submitted to the regional team on the 18th of December 2020. In the North West no actions were reported as non-compliant and where there were partial compliances narratives were submitted. There is no trust within the LMS that submitted full compliance with the IEA. All trusts in the North West that submitted partial compliance felt this was due to lack of established audits and a change in process. The most compliant Trust was East Lancashire NHS Trust who reported compliance with 9 actions and partial compliance with 3.

10 Financial

The recommendation is the CNST rebate, if awarded, is ring fenced for maternity, services Bolton FT have already committed to pump prime additional medical staffing to the value of £900k for 21/22. Other planned investment at this stage includes 2 cohorts of front-line leadership development and a quality improvement programme for Black, Asian and Minority Ethnic BME women led by the Cultural Liaison Midwife. The team is also currently reviewing governance and bereavement support for maternity, neonatal and children's services which may require an additional resource. The Trust and CCG aspire to improve maternity and neonatal services from good to outstanding rating by the CQC.

In previous years, investment to maternity has included additional medical equipment, additional midwifery staff and additional leadership roles with appropriate banding.

11. Summary

Bolton FT are committed to achieving full compliance, some actions are dependent on regional and national standards being implemented. No guidance has been provided regarding expected timescales or whether there will be external support or funding to aid compliance. Non-complaint areas are due to lack of audit will have benchmark audits completed by the end of January as requested by the regional team.

The publication of the interim findings are welcomed and the sharing of early actions that have been identified to make improvements to patient safety in Bolton NHS Foundation Trust Maternity Services. Reflecting on the report, there are a number of broad patient safety themes, many of which have been made time and time again in other reports and inquiries. Strong leadership at all levels within the organisation is essential as is leading with kindness and compassion. We must actively listen to the women and families and ensure that they are the decisions makers in planning their care. We must offer women opportunity to make informed choices and therefore information should be readily available and accessible for women.

12 Recommendations

The national and regional teams are still developing some aspects of the 12 urgent actions that incorporate the seven IEA. Bolton NHS Foundation Trust have complied with the request to offer a commitment to the implementation of the Perinatal Quality Surveillance model and the national risk assessment tool. The national team are developing a portal where Bolton NHS Foundation Trust will submit data. At the time of writing this report there are no request for evidence submissions, this information is being collated ready for the submission.

The Ockenden report has raised the profile of Maternity care. The aim of the report is not simply to condemn past care and management at SaTH but to inform all maternity services with the overriding objective of improving maternity care and safety for all.

On the 28th January the Board of Directors will be required to approve the Assurance assessment tool (Appendix 2), Quality Assurance Committee should therefore scrutinise Appendix 2 and make its recommendation to the Board of Directors via the Chairs report.

Ockenden Review December 2020: 12 Urgent Clinical Priorities

Introduction

This document contains the 12 urgent clinical priorities identified in the letter dated 14th December 2020 from Amanda Pritchard, Ruth May and Prof Steve Powis to the NHS Trust and Foundations Trust Chief Executives sets out the immediate response required by all Trusts providing maternity services.

Immediate Actions

Trusts should proceed to implement the full set of the Ockenden Immediate and Essential Actions. However, 12 urgent clinical priorities from the IEAs were identified which they are asking Trust Chief Executives to confirm they have implemented **by 5pm on 21st December 2020 to Regional Chief Midwives - email communication sent to LMS SRO & PMO's 16 December 2020 setting out this ask.**

These 12 priorities are taken from the 7 Immediate and Essential Actions:

1. Enhanced Safety
2. Listening to women and their families
3. Staff Training and working together
4. Managing Complex Pregnancies
5. Risk Assessment through Pregnancy
6. Monitoring Fetal well-being
7. Informed Consent

Confirmation of the Trusts compliance with these immediate actions signed off by the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support Trusts with this request. The individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term

Please note this template is to support and inform your response to the 12 Clinical Priorities for the initial 21st December 2020 submission. A further national template will be circulated which will include all the actions from the 'Immediate and Essential Actions'. Date to be confirmed.

Ockenden Review December 2020: 12 Urgent Clinical Priorities

Trust Name:	Bolton FT Trust
Tool completed by - Name:	Natasha Macdonald
Role:	Head of Midwifery
Contact email address:	Natasha.Macdonald@boltonft.nhs.uk

Essential Action		Action required	**Current status** - compliant, partially compliant, not compliant *(drop down box available)*	Action to be taken if partially or not compliant	Lead	Timescale for completion
Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	1a)	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	Non compliant	We are awaiting further detail nationally as to commencement but the understanding is that the LMS should support the ICS to oversee perinatal quality and that the onus should be on trusts to share responsibility for making improvements.	Governance Lead - Family Division	Jan-21
	1b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Partial compliant	SI incidents are shared with Quality Assurance Committee which has Executive and Non-Executive board members, SIs are then summarised to Board of Directors via the Chairs Report. Board of Directors accept the proposal of sign off of each indivdual Maternity SI with immediate effect along side a quarterly summary of key issues. Action The trust will work with the LMS to ensure a process is commenced to share all serious maternity incidents to optimise learning which can be shared across the system to prevent harm. Board of Directors accept the proposal of sign off.	Governance Lead - Family Division	Jan-21
Listening to Women and their Families: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	2a)	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Compliant	We have an active MVP with a remunerated chair. We also gather feedback via Friends and family test and social media.	Head of Midwifery	
	2b)	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	Compliant	The Trust has both an executive and non-executive director.	Director of Nursing	
Staff training and working together: Staff who work together must train together.	3a)	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Partial compliant	Consultant presence 24hrs a day Monday to Friday Morning. Friday to Sunday 08:00 -22:00. With ward rounds 4 hourly. Audit required to ensure compliance.	Clincial lead Obstetrics	
	3b)	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	Compliant	PROMT training in place, MDT compliance ensured when allocating training days.	Clincial lead Obstetrics/Head of Midiwfery	
	3c)	Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Partial compliant	Ring fenced maternity training funding is only spent on staff training, Partial compliance as the total CNST rebate is not exclusively used for improving maternity services, however any investment requests to become complaint with the MIS are funded by the Trust.	Clincial lead Obstetrics/Head of Midiwfery/Deputy Divisional Manager	
Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	4a)	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Partial compliant	All women with obstetric risks have a named Consultant, partial compliance as audit not currently performed Action Audit to be conducted Jan 2020 (with input from the Trust Audit & Effectness Team)	Clincial lead Obstetrics/Head of Midiwfery	Jan-21

	4b)	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Partial compliant	For Greater Manchester and Eastern Cheshire, it has been agreed that St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine Centre via a hub and spoke model. Two physicians with special interest in Obstetrics have commenced Maternal Medicine training. Following a meeting held with the national policy team on 7th December, a proposal to agree funding through a system led commissioner model is to be taken through GM commissioning governance and to the joint commissioning board. Also a request has been made for pump prime funding in Q4, to initiate project support and clinical leadership. There are pathways to refer to tertiary unit- st Mary's. We do have cardiology department to whom we refer those not needing referral to st Mary's. Neurology and Nephrology referrals done to Salford-Overall, pathways exist for medical conditions.	Clincial lead Obstetrics	Apr-21
Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a)	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Partial compliant	We currently formally risk assess a woman's risk at the initial booking appointment then if any deviations occur. The risk assessment is formally repeated at 36/40 when discussing place of birth options and again at the onset of labour. If a woman presents at Triage with a concern her risk assessment is repeated. ACTION Email memo sent to all staff requesting formal assessment of Obstertirc risks to be documented in maternity records. Audit to be undertaken to monitor compliance, this will need to be paper based as we use hand held records. The earliest opportunity will be April.	Consultant Midwife	Apr-21
Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	6a)	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Compliant	BFT has both a Midwife and Obstetric lead in place.	Fetal Monitoring Lead Consultant	
Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	7a)	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Compliant	Intranet offers evidence based guidance for decision making.	Consultant Midwife	

Ockenden Review December 2020: 12 Urgent Clinical Priorities

LMS Name:	
Tool completed by - Name:	
Role:	
Contact email address:	

Essential Action		Action required	Overall LMS Position **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 1 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 2 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 3 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 4 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 5 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 6 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 7 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*	TRUST 8 **Current status -** compliant, partially compliant, not compliant *(drop down box available)*
Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS)	1a)	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly									
	1b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB									
Listening to Women and their Families: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	2a)	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services									
	2b)	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.									
Staff training and working together: Staff who work together must train together.	3a)	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.									
	3b)	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.									
	3c)	Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety									
Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine	4a)	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place									
	4b)	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres									
Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a)	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance									
Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	6a)	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.									
Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	7a)	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.									

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

Data and reports submitted to the LMS as requested for discussion **Regional guidelines adopted and accepted at rust level provided to LMS** **SI process changed, will now be presented at Trust Board and then to the LMS** **To work with Divisional governance lead and regional Maternity Safety lead to ensure external representation at PMRT**	**Benchmarking against peers** **Transparency and challenge by the board**	**Learning from each other** **Improved working relations** **Issues identified not repeated in other units**	**BAU** **LMS to work as a system for external presence at reviews**	**Regional maternity safety lead to coordinate PMRT mutual assistance**	**Regional maternity safety lead to coordinate PMRT mutual assistance** **Funding will be required for clinicians to attend**	**All SI have an an executive at scoping either the Chief Nurse or Medical Director Continue using** **PMRT tool, Governance manager to seek external representation mutual aid to be provided by Pennine acute Trust**

GAP analysis undertaken for perinatal Clinical quality surveillance Model	**Trust committed to following this model**		**Await national guidance**			**GAP anaylsis undertaken any local actions that can be implemented to be adopted by end of Jan 21**

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.						
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Karen Meadowcroft Chief Nurse executive level safety champion **Martin North Non exec Director Board Maternity Champion** **MVP in place with a remunerated chair**	**Schedule of meeting Agenda of previous meetings** **Schedule of meeting Appointed December 2020** **Schedule of meeting Agenda of previous meetings** **Annual report highlighting the key success of the MVP A summary at the start which covers the**	**Clear communication Challenge Feedback from safety champions** **Feedback from MVP Engagement by local community Actions completed by MVP**	**BAU** **BAU**		**Potential extra remuneration required**	**Chief Nurse, and HOM to escalate any concerns to NED** **MVP and HOM have scheduled monthly meetings, separate to the MVP meetings.**

	highlights/key points. **How feedback from families has been collected and reviewed.** **What co-production work the MVP has been involved in.** **Plans for the following year**					
Senior advocacy role.	**Position to be recruited to when JD created** **The national team are working with a group of service users to develop**	**It is expected that the Maternity Services Advocate role will be fulfilled by a senior person who is not employed or linked to the organisation.**	**Await the national team**	**Await the national team**	**Funding will need to be identified**	**The Trust have requested the MVP chair provide this role as an interim solution. This has been discussed with**

	an outline of a job description for this role. Will be advised to develop this role when you have received further information from the national team, which you are aware is in development	**There will be further clarity coming from the national team**				**Regional Midwife who is in full support.**

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
SOP for consultant ward rounds on CDS to confirm day and night presence	Audit commenced t	Women's Quality forum	Annual Audit Jan 22	Sangeeta Das Clinical lead	BAU	Monthly report to Women's quality forum
Quarterly training report to be submitted to the LMS to include breakdown of percentage of staff groups trained and MDT mix for each session	Audit submission quarterly to Trust then LMS	Divisional board Trust then LMS	LMS to arrange reporting schedule	PEF to produce quarterly reports	BAU	Compliance discussed at Maternity IPM. Uplift currently 23%
Finance statement confirming the maternity training fund spending	Spend evidenced at IPM	Divisional board then LMS	LMS to arrange reporting schedule	BAU		
Commitment from Trust to ring fence CNST rebate 21/22 for use within Maternity services	Statement of commitment from Director of Finance and Divisional Director of Operation	Divisional board then LMS	LMS to arrange reporting schedule	BAU		

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

All complex pregnancies have a named consultant **St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine Centre via a hub and spoke model. There are pathways to refer to tertiary unit- st Mary's.**	**Initial audit in progress to be completed Feb 2021** **Monitor current referral numbers Incident report any missed referrals**	**Women's quality forum** **Divisional review panel**	**Annual audit** **Await development of Maternal medicine centre continue to refer as required**	**Obstetric Clinical lead** **CCG to commission initial stakeholder call scheduled for Jan 21**	**Compliance would be easier to monitor with an end to end EPR**	**Referral pathway in place Clear sop. Audit compliance with SOP. Monitor and review any incidents related to lack of referrals**

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.						
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Women not risk assessed at every appointment process changed Dec 2021 **Risk assessment for place of Birth** **We are Committed to sign up to the National Antenatal**	**Audit to commence June 21 (evidence not available until then, due to no EPR)** **Audit to be undertaken Feb 21**	**Women's quality forum** **Women's quality forum**	**This was previously informal now a formal risk assessment** **Evidence around transfer from low risk to high risk birth setting**	**Midwifery Audit lead** **Midwifery Audit lead**	**Compliance would be easier to monitor with an end to end EPR** **National ask is unclear re tool to be implemented**	**Spot check audit to be completed, limitations due to hand held maternity records Feb 21** **Risk assessments for place of birth currently undertaken. Consultant Midwife reviewing current birth place criteria to confirm in line with national standards. Incidents forms completed for inappropriate.**

Risk Assessment process when available.						

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Tahir Naheed Consultant lead Caroline Finch AMP Midwifery Lead in post	**Schedule for teaching sessions Attendance monitoring Feedback from attendees Reduction in CTG misinterpretation**	**Reduction in CTG misinterpretation Improved outcomes**	**BAU**			**Monitor SBLV2 compliance at Divisional board. Report CTG training compliance at SBL meetings.**

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
The Trust is represented at MVP meetings **HOM and Chair have scheduled meetings** **Website offers clear consistent advice https://www.boltonft.nhs.uk/services/maternity/**	**MVP chairs report to be discussed at Quality forum** **Website to be reviewed by the consultant midwife and Comms team** **No complaints about the web page need to look at accessibility**	**Evidence of joint decision making** **Service user feedback**	**BAU** **MVP to review information provided on the website**	**MVP and Consultant MW** **Feb 21**		**Annual report** **Chief Nurse to receive feedback from MVP chair re actions and joint working.** **To work with Communication team to publish maternity data around section and instrumental rates monthly.**

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Birthrate Plus undertaken in August 2020 Deficit 7 WTE non Clinical roles.	Midwife to birth ratio monitored monthly Escalation and closures monitored 1:1 care in labour monitored at Trust board level 6 monthly staffing review	Reviewed at Divisional board	Review Midwife to birth ratio and at Divisional board	HOM Divisional Medical director	NIL	Monthly review of Midwife to birth ratio monitored monthly Escalation and closures monitored 1:1 care in labour

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care
The Head of Midwifery is professional accountable to the Chief Nurse (who is also a Registered Midwife) **Experienced HOM in post** **Consultant Midwife in post since December 2014** **Specialist roles** **Safeguarding, Bereavement, Diabetes, Infant feeding. IT, Practice education, Governance, Screening and Smoking Cessation.** **12.44 WTE** **Commitment to leadership funds** **RCM and Reginald Chief Midwife involved in recruitment of HOM** **Non complaint** **Development of future leadership and research**

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Benchmarked and ratified at AQuiL –	**As soon as relevant new**	**Updated every 3 years in line with**				

Trust level meeting. Any caveats are detailed. Guidelines and Audits include NICE standards Any funding related issues are escalated via Trust Board to CCG	**NICE is published or updated. Clinical effectiveness has the full details of all benchmarked documents**	**most up to date standard- NICE/ RCOG/ national reports etc. Number of GM wide guidelines in obstetrics is in use.**				

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

GREATER MANCHESTER WORKFORCE REVIEW / CONTINUITY OF CARER MODELS

BOLTON NHS FOUNDATION TRUST

This work has been commissioned by Greater Manchester Local Maternity System (LMS), to obtain the baseline staffing requirements for all Maternity Services in Greater Manchester & East Cheshire, and also to inform the Continuity of Carer plans in order to meet the national targets set by the Maternity Transformation Programme. This paper provides the baseline staffing requirements, further work to follow regarding Continuity of Carer model.

1. These are the draft results as of 26/08/2020. *A final report will be provided on confirmation of the results*

2. Three months' casemix data was used from the months of October - December 2019.

	Cat I	Cat II	Cat III	Cat IV	Cat V
CASEMIX					
DS %Casemix	3.1	15.6	18.3	33.7	29.3
Generic %Casemix	5.1	18.0	17.3	31.9	27.7

3. Annual activity data was obtained including community and outpatient services for the period 2019/20 and provided by the senior midwifery team.

4. 23% uplift for annual, sick & study leave, and 15% community travel are included in the draft staffing figures.

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

6. The total clinical wte with 23% uplift is 219.90wte. This figure will contain the contribution from suitably qualified and competent support staff in hospital and community postnatal services.

7. Applying a 90/10% skill mix to the total of 219.90wte equates to 197.91wte RMs & 21.99wte MSWs.

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

adjustment greater than 85/15% would not ensure that midwives are available to cover peak activity on the delivery suite.

9. In addition, there is a requirement for other support staff on the DS, Outpatients and Maternity Ward, usually Band 2s. The wte is calculated based on numbers per shift and not on a clinical dependency method.

10. The total clinical establishments do not include the following roles:
    - Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
    - Practice Development role
    - Clinical Governance role
    - Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
    - Additional hours for antenatal screening over & above the time provided in actual clinics
    - Time for specialist midwives to undertake training, produce information, carry out audits, etc.
    - Coordination for such work as Safeguarding Children
    - PMAs (A-Equip)

11. The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 19.79wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties. Adding in a % means there is no duplication of roles between clinical and non-clinical.

12. The overall ratio for Bolton Foundation Trust of 1.27.5 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte. This overall ratio is based on extensive data from Birthrate Plus studies and whilst published so seen as ‘up to date’, more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes. The final report will contain a detailed explanation.

COMPARISON OF BR+ WTE WITH CURRENT FUNDED WTE (23% UPLIFT)

	RMs	**MSWs**	**Bands 3 - 7**
Current Total Clinical	**212.14**	**5.20**	**219.67**
Contribution from Specialist MWs	**2.33**		
Total Current Funded	**214.47**	**5.20**	**219.67**
BR+ Clinical wte			**219.90**
			`
Skill Mix Adjustment (90/10)	**197.91**	**21.99**	
TOTAL CLINICAL VARIANCE +/-	**16.56**	**-16.79**	**-0.23**
Skill Mix Adjustment (98/2) as current	**215.50**	**4.40**	
TOTAL CLINICAL VARIANCE +/-	**-1.03**	**0.80**	**-0.23**
	BR+	**Current**	**Variance**
NON CLINICAL (9%)	**19.79**	**13.04**	**-6.75**

NB. These figures are calculated from the data provided and requires the Head of Midwifery to check and confirm that the current funded establishment information is correct.

IN SUMMARY

Combining the Birthrate Plus Total Clinical wte and Non Clinical wte = 259.48wte

The current funded establishment wte is 232.71wte, which means the overall variance is a shortfall of – 6.98wte. The HoM is aware of the current skill mix and is working towards upskilling and developing the role of the MSW to meet the 90/10 ratio for skill mix.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Princess Anne Maternity Unit Bolton NHSFT

Second draft 26/08/2020

Data collected April 2019 - March 2020

Total births in service **5984**

CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	3.1	15.6	18.3	33.7	29.3
Generic %Casemix	5.1	18.0	17.3	31.9	27.7

	Annual Nos.	Required WTE	
Delivery Suite			
Delivery Suite Births	*5288*	61.47	**61.47**
Other DS Activity			
Antenatal Cases	*730*	4.17	**6.26**
PN Readmissions	*36*	0.13	
Escorted Transfers OUT	*23*	0.12	
Non-viables	*105*	1.29	
Inductions (*10%)*	*301*	0.55	
Triage	*7650*	11.02	**11.02**
Beehive Birth Suite			
Births & PN Care	*475*	6.90	**8.01**
Transfers to D/S	*159*	1.11	
Maternity Ward(s)			
Antenatal Care			
Antenatal admissions	*350*	2.79	**7.87**
Antenatal ward attenders	*252*	0.17	
Inductions (*90%*)	*2710*	4.91	
Postnatal Care			
Postnatal women	*5382*	47.36	**51.12**
Postnatal Ward Attenders	*360*	0.24	
Postnatal Re-admissions	*29*	0.15	
NIPE	*4380*	2.19	
Extra Care Babies	*177*	1.18	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife booking clinics		1.84	**8.21**
Specialist Midwife clinics		1.69	
Obstetric clinics		1.97	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	*11680*	4.59	**4.59**
COMMUNITY SERVICES			
Home Births	*85*	2.51	**56.91**
Community Cases	*5103*	53.60	
Community Bookings ONLY	*598*	0.80	
Additional Safeguarding	*0*	0.00	
INGLESIDE BIRTH & COMMUNITY CENTRE			
Births (Total AN/ IP & PN Care)	*136*	3.96	**4.44**
Transfers to PAH Bolton	*61*	0.48	
		219.90	

CLINICAL MIDWIFERY WTE REQUIRED **219.90**

Additional non-clinical midwifery wte @ 9% **19.79**

TOTAL WTE REQUIRED **239.70**

APPENDIX 1

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

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

CATEGORY I **Score = 6**

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

CATEGORY II **Score = 7 – 9**

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

CATEGORY III **Score = 10 – 13**

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

CATEGORY IV **Score = 14 –18**

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

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

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

Appendix 4

December 2020 Review and Benchmark of previous Kirkup Report

Divisional actions from the Morecambe Bay Investigation Report (Kirkup)

Red: action has not been commenced	Amber: action has been commenced but not completed	Green: action is complete and evidence is available to demonstrate

No.	Actions	Detail	Responsibility/ Timeframe	Requirement to Scale up across the Trust & achieve 'Green' status	Benchmark December 2020
1	The division should ensure midwives have an understanding of the significance of hypothermia in the neonate	This information needs to be disseminated to every midwife to ensure the importance of this symptom is recognised. Review documentation of this and NEWS process.	Head of Midwifery	June 2015	Quality Improvement programme undertaken and learning cascaded: Time Out MatNeo Presentation V1.1.pp Copy of HATs data.xlsx Mandatory training for all clinical staff includes Transitional Care Observation and Assessment Tool T-COAT v14 with daily check.pdf As of December 2020 91.7 % of staff compliant with Mandatory training. This training includes:

					• Human Factors (Teamwork & Communication, situational Awareness and decision making) from Anaesthetists, • Fetal monitoring lecture and case reviews training by Obstetric staff • Obstetric emergency Simulations – Shoulder Dystocia and PPH • Neonatal sepsis and Transitional Care Neonatal Hypoglycaemia Guideline  Hypoglycaemia in the Newborn SP 28.(
2	The Trust should ensure HES data is complete	HES Data – check with information regarding the compliance against this and escalate any concerns regarding this data.	Divisional Information officer	June 2015	CNST Safety Actions Delivery Plan as of December 2020  CNST 2020.xlsx
3	The division should seek assurance that risk assessment and care planning are accurate and are not resulting in unsafe care	Audit accuracy of risk assessment and care planning. Audit program agreed.	Consultant audit lead	Nov 2015	 Family Care Governance Policy 1(

				1336 - Report.docx CA reg form risk assessment.doc Risk Assessment Audit Report and ac	Maternity Database system, Euroking (E3) has recently added sections to risk assess each woman at every contact and care planning. The challenge is not all staff have access to E3 due to geographical location and wifi access and doctors do not have access to record contacts, assessments and plans. In the absence of IT the records are inserted in tot the perinatal ante natal, intrapartum and post natal records
4	The division should seek assurance that they have processes in place to investigate clinical incidents appropriately and learn from them	Review guideline for incident reporting/ investigating. To include trigger list, family input (evidence and feedback), consistent grading of suboptimal care (eg CESDI or Leicester), classification of suboptimal care, multidisciplinary review, dissemination of learning	Labour Care Lead, Lead for Perinatal Mortality, Governance Lead	Dec 2015 Guideline currently going through review Trigger list reviewed Classification of suboptimal care agreed Review of governance procedures completed	Family Care Governance Policy 1 Weekly risk assessment and review panels consisting of quorate senior MDT members review clinical incidents, rapid reviews and identify if reports require Divisional review or escalation to SUI Scoping and or HSIB
5	The division should ensure that the statement made in the report 'Midwives appearing to pursue 'normality' at all costs' does not apply.	Discuss this issue and the potential impact on safe care at the normality session on the MET study days.	Head of Midwifery PEF Midwives	July 2015	All incident reports monitored . Any midwifery practice issues are highlighted at review panels and supported to undertake

					clinical reflection with their Professional Midwifery Advocate
		Undertake a clinical audit of the deliveries performed by midwives.	Head of Midwifery	Nov 15 commenced	Routine Audits inclusive of intrapartum care undertaken which would reflect midwifery practice Maternity audit plan 20 21.docx
6	The division should assess the potential conflict of interest when Governance Manager also Supervisor of Midwives	Review Job Description	Head of Division Divisional Nurses	May 2015	Supervisor of Midwives no longer statutory this NA
7	The division should review its governance processes	Divisional review of governance processes to occur including a review of current roles and responsibilities.	Head of Division, Divisional Directors of Nursing, Governance Lead	August 2015	Family Care Governance Policy 1
8	The division should provide assurance that the number of supervisors and their competence is monitored.	Audit of supervision practice to ensure that supervisors are competent and that recurrent issues are escalated through the Trust performance management processes.	Head of Midwifery	September 2015 Supervisor of Midwives Benchmarl	Statutory Supervision of midwives no longer statutory
9	The safety culture within the division should be assessed through the utilisation of MAPSAF	MAPSAF assessment undertaken	Head of Division Head of Midwifery Head of Governance	September 2015 Dates being organised for Nov/ Dec 15	Time Out MatNeo Presentation V1.1.p
10	The division needs to review how concerns about individual clinicians are escalated, ensure	Discuss at Clinical Leads meeting and ensure	Head of Division	June 15	Individual clinicians are highlighted following escalation to midwifery

	staff aware of their responsibilities.	cascaded through consultant teams Divisional Directors of Nursing to cascade through Matrons	Divisional Directors of Nursing,	July 15	matron or consultant/medical supervisor, incident reviews and review panel. Midwives supported by PMA to undertake professional reflection and where required practice action plan. Medical staff are supported by Clinical Educator to write professional reflection for portfolio and or supported in clinical practice to achieve competency.
11	The division needs to ensure that all perinatal deaths of babies born here are visible	Ensure a mechanism in place for recording outcomes for neonates born here and transferred elsewhere for continuing care, to be included in metrics for Neonatal or Maternity dashboard	Clinical Lead Neonates, Labour Care Lead	July 15	Neonatal Dashboard  GM Q2 Neonal Locality Dashboard .i
12	The division needs to ensure an annual structured perinatal mortality report is produced	Agree a timetable for this to be produced annually	Clinical Lead Neonates, Lead for Perinatal Mortality	Dec 15	 Q2 2020 Perinatal Mortality Report and
13	Supervisors of Midwives to ensure that all governance meetings ie WQF, CLIP, SUI and case reviews are attended by SOM there in that capacity only to ensure independence of SOM role	To be agreed via SOM meeting	SOM's	August 15	Midwifery Supervision non longer statutory. Professional midwifery Associates support midwives in clinical practice

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21 December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) **Monitoring Fetal Wellbeing**
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) **Informed Consent**
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

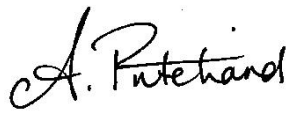
Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15 January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely



Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May
Chief Nursing Officer, England

Professor Steve Powis

National Medical Director

NHS England and NHS Improvement

Agenda Item

Title:	Learning from Deaths Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th January 2021		Discussion	✓
Exec Sponsor	Dr Francis Andrews		Decision	

Summary:	This paper provides a summary of progress made in Q3 20/21 relating to the Learning from Deaths Programme, plus a summary of data relating to the learning from deaths and lessons learned as a result

Previously considered by:	Quality Assurance Committee

Proposed Resolution	The Committee is asked to discuss and approve this 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:	Debbie Redfern, QI Programme Manager	**Presented by:**	Dr Francis Andrews, Medical Director

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

LFD	**Learning from Deaths**
SJR	**Structured Judgement Review**
Ledger	**Learning Disabilities Mortality Review Programme**
RCP	**Royal College of Physicians**
NQB	**National Quality Board**
LFDC	**Learning from Deaths Committee**
QAC	**Quality Assurance Committee**
PDOC	**Procedural Documentation Committee**
GMMH	**Greater Manchester Mental Health Trust**

1. Background

In line with recommendations from the National Quality Board (NQB) – the Learning from Deaths process has been established to review and understand areas for improvement and excellence for learning purposes following the death of a patient (adult inpatient)

From which trusts are required to collect and publish, on a quarterly basis, specified information on deaths, including:

- Total number of inpatient deaths (including ED deaths for acute trusts)
- Total number of deaths subject to case review (SJR)
- of those deaths subject to SJRs the number of deaths judged more likely than not to have occurred due to problems in care

Plus, capture and share actions and learning points from the SJRs conducted for continuous improvement purposes.

This report provides the above information for adult inpatient deaths only, noting that maternal, neonatal and paediatric deaths are subject to different nationally directed processes, this information has been included in this report to give a comprehensive overview (see appendix 2).

Methodology

The comprehensive Learning from Deaths process (adult inpatient only) can be found in appendix 4

In summary the process involves taking a sample of adult inpatient deaths as well as looking at mandated categories such as deaths in patients with a learning disability, family concern, alert diagnosis etc. using a validated 'Structured Judgement Review' tool to assess the quality of care, whilst providing tangible evidence of learning from deaths.

The benefits realised by this approach include:

- Targeting of reviews to areas of mortality concern to improve patient care e.g. Pneumonia, COVID-19
- Use of a validated judgement tool
- Mutual support for reviewers
- Use of an electronic form that can be stored on a new database with easy retrieval for audit purposes
- Learning from good practice in care as well as learning from practice where things could have been better

Initial (primary) reviews are conducted by one of the trained multidisciplinary reviewers and are randomly allocated. Individual components of care are scored on a 5-point scale and an overall score is also determined by the reviewer. For any patient who is scored as 1 or 2 (very poor or poor) overall then the LFDC members collectively undertake a secondary review to determine whether the reviewer scores, especially the overall score are justified. Each case is also reviewed to determine whether on balance the death was more likely than not to have resulted from problems in care. If after the secondary review the overall score is 1 or 2 then the case is scoped to determine whether a divisional review or serious incident report needs to occur.

Cases deemed to be uniformly excellent are also reviewed at LFDC and any actions and learning points are captured are shared monthly via Learning from Deaths Learning slides (LFD slides from November 2020 can be found in appendix 3)

2. Summary of progress to Q3 2020/21:

- Currently there are 27 SJR trained reviewers forming the corporate learning from deaths reviewer group.
- Additional SJR train the trainer to increase training capacity and sustainability of the training going forward
- Corporate support from Business Intelligence, Patient Services and Clinical Effectiveness – to facilitate the process and highlight inclusive patients
- Over 425 deaths reviewed using structured judgement methodology
- Learning from Deaths Policy in reviewed and ratified by QAC and PDOC – December 20
- Bereaved Family and Carer Engagement Policy ratified December 20
- Establishment of Learning from Deaths Committee with oversight of the trust process, mortality metrics, collating and tracking actions and learning from reviews.
- Process for information provision to assist with LeDer reviews, Serious Incidences, investigations, complaints and GMMH reviews.
- Collation and distribution of monthly learning slides to share trust wide – see appendix 3 for example
- Establishment of Medical Examiner and Medical Examiner Officer roles - whilst impartial to the Trust and independent to the Trust's governance arrangements Medical Examiners will aim to scrutinise and review all deaths within the Trust identifying and referring any deaths of concern via the structured judgement review or direct for divisional review; whilst also identifying learning points, areas of excellence and opportunities for improvement. The Medical Examiners Officers will have the ability to cross reference intelligence from incidents (Safeguard) with known facts from the medical records
- NHS England and Improvement COVID-19 BAME Review - national guidance issued in October 2020 has advised trusts to switch focus from previous priority patient alert groups to COVID-19 patients, consideration given to including a specific focus on deaths from BAME communities and other groups suffering disproportionate impacts from COVID-19. Therefore, during the COVID19 pandemic, from November 2020, deaths from COVID-19 have been added to the mandated deaths as an alert group with an emphasis on identifying BAME groups as a priority for review, until further notice.
- Participation in RCP COVID Review Programme – led by Consultants Dr R Lennon, Dr L Edwards and Dr J Ruddlesdin.

3. Learning from Deaths Process - Adult Inpatient Deaths only - Data

A comprehensive summary of data from the adult inpatient learning from deaths process can be found in appendix 1. Please seem summary and narrative below:

	Q4 19/20			Q1 20/21			Q2 20/21			Q3 20/21 to date*	
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov
No of deaths	135	114	143	245	144	88	90	111	106	148	82
No of SJR allocated (sample)	24	6	19	27	35	21	14	23	16	29	26
No of SJRs completed	24	5	19	27	32	16	12	22	9	12	4
% SJR completion rate	100	83	100	100	91	76	85	95	56	41	15
From completed SJR No of deaths caused by problems in care	0	0	0	0	0	0	1	0	0	0	0

Please note information relating to adult inpatient deaths is provided one month in retrospect by Business Intelligence e.g. November's death are provided mid- December. SJRs are then allocated by Clinical Effectiveness within one week of receipt of this information. SJR reviewers are then given four weeks from allocation to complete the reviews, this is then followed up by an escalation process should the SJR not be completed in the initial four-week timeframe.

**At the time of report production December's death data had not yet been received by BI – therefore is not included. Furthermore, SJR allocation of November's deaths have not yet surpassed the four-week deadline for completion, so the percentage completion rate will increase and this table will be updated in subsequent reports.*

SJR Allocation and Completion rate:

In March 20, due to the emerging COVID-19 pandemic NHS England and Improvement suggested the postponement of trusts' LFD processes. This therefore affected the allocated of SJR from deaths in February onwards and the LFDC was also postponed.

In Q2 20/21 we took the decision to recommence the LFD process, prioritising patients who died in Q4 19/20 and Q1 20/21 from mandated criteria groups e.g. learning disabilities – hence why lower numbers for February and March. LFDC restarted in July 20.

Continuing operational pressures due to the continuing COVID-19 pandemic has affected some reviewer's ability to complete reviews within the initial four-week timeframe. The escalation process is followed and where requested reviews are re-allocated to ensure action and learning can be captured from all allocated reviews.

However, despite the above significant challenges, SJR completion rate for 2020 is currently 77% which is higher than national average.

Adult inpatients where death was more likely to have occurred due to problems in care

Of the deaths occurring in 2020 (to November 20) reviewed using SJR methodology, the following were considered to be more than likely due to problems in care:

- Q4 19/20 – 0
- Q1 20/21 – 0
- Q2 20/21 – 1*
- Q3 20/21 - 0

** Patient died 05/07/20 – on SJR primary and secondary review the LFDC concluded death was as a direct result of problems in care. Case referred for SI which was completed and presented at QAC in November 2020, please see meeting papers for further detail (Safeguard ref 159000, StEIS ref is 2020/13135). Learning and actions captured at the LFDC is summarised on the learning slides appendix 3, patient 7.*

An Anticoagulation Task and Finish Group chaired by the Medical Director and led by Chief Pharmacist is being established to address issues highlighted in the SI and further themes from SJRs.

SJRs referred for Divisional Review by the LFDC – Actions and Learning points

Since January 2020 there have been seven SJRs which the LFDC sent for Divisional Review. Of those:

- 3 have a completed divisional review
- 1 has a completed divisional review in draft
- 3 have been acknowledged by the division and are awaiting review

A summary of action and learning points from the completed divisional reviews are below:

- Reinforce that NEWS2/NEWS scores are escalated and documented appropriately as per RCP guidance.
- Staff education and training re falls risk assessment and implementation of fall management plans.
- During COVID19 visiting restrictions, family members to receive regular updates on relative's condition from MDT. This is especially true for patients with sensory and cognitive impairment who might struggle to keep in touch with their families remotely.
- Minimising ward transfers occurring late in the night/early hours of the morning. The majority of patients who are admitted into hospital are at risk of delirium and moving these individuals at such hours will precipitate delirium and ultimately increase the risk of falls.
- Follow Trust anticoagulation guidelines with regards to atrial fibrillation and venothromboembolism management.
- Ward pharmacists to review the inpatients prescription daily, to help identify prescribing errors.
- Better communication between the doctors, nurses, hospital at night team with regards to review and management of unwell patients.
- Recognition of the acutely ill patient by ward staff, to facilitate timely escalation to senior medical team and the clinical nurse practitioner.
- Ensure that medical admissions are reviewed by consultant within 14 hours of admission
- Highlight Importance of blood culture as part of septic screen

Sharing Learning from Deaths:

At each LFDC each case where the care was judged to be poor or very poor, a secondary review is completed by the committee, plus the opportunity to review a case of excellence. Actions and learning points from each case reviewed are collated and disseminated to the organisation via the Learning from Deaths Learning Slides (see appendix 3 for example). The slides are distributed each month to the divisional triumvirate, governance leads and medical education for dissemination, plus included in the papers at Mortality Reduction Group. A condensed version is also included in the

wider Governance Learning Slides which are distributed via Clinical Governance and Quality Assurance Committees.

4. Challenges:

COVID-19

As mentioned above the COVID-19 pandemic has posed significant challenges to the LFD process, mainly in the following ways:

- NHS England and Improvement suggested postponement of trusts' LFD processes – this led to a drop in cases reviewed and a backlog once the process recommenced in July 20. Priority is given to those deaths from the mandatory criteria e.g. learning disabilities to ensure at a minimum these deaths are reviewed.
- SJR reviewer capacity – operational pressures have meant some reviews have not been completed in the initial four-week timeframe. An escalation process is followed and cases are reallocated where required.
- SJR training sessions – whilst interest in becoming part of the SJR corporate reviewing team remains high. COVID-19 and social distancing restrictions have led to cancellation of training sessions and severe restriction in capacity of those that have taken place. However, we have an additional SJR Train the Trainer which will help training capacity and the sustainment of training going forward in 2021.

Reduction in the number of corporate SJR reviewers

To date 45 members of clinical staff have received the SJR training, however there is currently 27 trained reviewers operating – an attrition rate of 40%. This is due to a variety of reasons including, staff have left the trust, changed roles or have withdrawn from the programme due to operational pressures. Please note time to complete reviews is not built into job plan. It typically takes 1-2 hour to complete a review and whilst every attempt is made to allocate only one review each per month, if there are insufficient reviewers this is not always possible and may cause overburden of the current SJR reviewers. This is currently on the risk register.

However, interest in becoming a SJR reviewer remains high and as soon as operational pressure allow training sessions can be arranged to translate this interest into SJR capacity – this is unlikely to happen until Q1 21/22 at the earliest.

Additional/changing requirements from NHS England and Improvement

National guidance advised trusts to switch focus from previous priority patient areas to COVID-19 patients, with consideration given to a specific focus on deaths of individuals from BAME communities and other groups who are suffering disproportionate impacts from COVID-19. This has been actioned from November 2020, however if the number of patients is significant this may affect our ability to complete reviews from other mandated groups. Prioritisation is in action and any issues will be escalated to the Medical Director for discussion and decision.

Medical Examiners referring into SJR

Whilst impartial to the Trust and independent to the Trust's governance arrangements Medical Examiners can refer any deaths of concern for structured judgement review. This had led to an increase in demand for SJR in a pool of limited reviewers e.g. December 10 SJR requests from Medical Examiner, equating to approximately 20% of additional demand. This links back to the points above and action being to offer SJR training to interested parties once operational pressures allow.

5. Summary and Recommendations

The learning from deaths programme continues to evolve and strengthen, with key areas of progress in Q3 20/21 being:

- Additional SJR train the trainer
- Learning from Deaths policy ratified
- Bereaved Family and Carer Engagement Policy ratified
- Establishment of Medical Examiner and Medical Examiner Officer roles
- NHS England and Improvement COVID-19 BAME Review
- RCP COVID-19 Review Programme

However, current challenges to the LFD programme are:

- COVID-19 and operational pressures
- Reduction in the number of corporate SJR reviewers
- Additional/changing requirements from NHS England and Improvement
- Medical Examiners referring into SJR

Recommendation

The recommendation is that Board of Directors discuss and approve the contents of this paper.

Appendix 1

Learning from Deaths – data breakdown (adult inpatient)

	Quarter 4 19-20			Quarter 1 20-21			Quarter 2 20-21			Quarter 3 20-21	
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov
Number of In-patient Deaths	135	114	143	245	144	88	90	111	106	148	82
Number Cases (Sample)	24	6	19	27	35	21	14	23	16	29	26
COMPLETED	24	5	19	27	32	16	12	22	9	12	4
%	**100**	**83**	**100**	**100**	**91**	**76**	**85**	**95**	**56**	**41**	**15**
Source											
Mandated Death (Alert Diagnosis)	4	1	8	0	4	2	6	3	5	3	0
LD Death	2	0	1	3	1	1	1	1	0	3	1
Mental Health Death	12	5	9	19	17	11	5	9	10	10	15
sample	6	0	1	0	12	7	0	10	0	10	0
Requested by cons/matron/Family	0	0	0	5	1	0	1	0	1	2	3
Diabetes Death	0	0	0	0	0	0	0	0	0	0	0
NELA Death	0	0	0	0	0	0	0	0	0	0	0
MEDICAL REVIEWER	0	0	0	0	0	0	1	0	0	1	0
BAME + COVID-19 Death	0	0	0	0	0	0	0	0	0	0	7
TOTAL	24	6	19	27	35	21	14	23	16	29	26
Overall Score											
1 (Very Poor)	2	0	1	0	0	0	0	0	0	0	0
2 (Poor)	1	0	3	4	5	2	1	5	2	2	0
3 (Adequate)	4	2	1	9	4	3	3	3	3	1	2
4 (Good)	12	2	14	10	21	7	8	11	4	5	1
5 Excellent	5	1	0	4	2	4	0	3	0	4	1
	24	5	19	27	32	16	12	22	9	12	4

Appendix 2 – Maternal, still birth and neonatal deaths

Details of maternal deaths, still births, neonatal deaths and childhood deaths are given in the table below to provide an overall position of Trust mortality and it should be noted that these cases are subject to a separate process of investigation and reporting

Deaths for Q4 2019-2020 to Q3 2020-2021: Maternal, stillbirths, neonatal and childhood deaths

	Q4 Jan-March 20	Q1 April-June 20	Q2 July-Sept 20	Q3 Oct – Dec 20
Maternal Deaths	0	0	0	0
Still births	5	9	4	5
Neonatal deaths	3	5	1	2
Child deaths (excluding stillbirth and neonatal death)	0	0	0	0

Details of stillbirths
Q4: Rapid review of all cases and all unavoidable
Q1: Rapid review of all cases, 2 had further divisional reviews and 1 referred to HSIB. All deemed unavoidable following reviews including HSIB. Some learning points identified following divisional reviews
Q2: Rapid review of all cases, 3 unavoidable, one currently under investigation by HSIB. Scoped as an SI. May have been unavoidable – awaiting outcome.
Q3: Rapid review of all cases, 2 unavoidable, one stillbirth at 38 + 2 weeks. Appropriate pathways followed but with some non-compliance with Diabetic pathway. Serial scans and regular monitoring. There were 2 cases of congenital abnormality both referred to St Mary's and offered medical termination of pregnancy which was decline and opted for conservative management – fetal demise at 26+3 weeks and at 30 weeks.

Details of neonatal deaths
Q4: Rapid review of all cases, one divisional review, all deemed unavoidable
Q1: Rapid review of all cases, all deemed unavoidable.
Q2: Non-viable baby born at home prematurely with signs of life-rapidly died before ambulance arrived. Coroner since agreed to class as a stillbirth
Q3: Rapid review of all cases, one expected early neonatal death unavoidable, one Cord prolapse at 23 weeks – baby did not survive.

Appendix 3: Learning from Deaths Learning Slides – November 2020

Governance Learning Slides 2020-2021
November 2020 – Learning from Deaths

NHS Bolton NHS Foundation Trust

- Structured Judgement Review (SJR) methodology is used to perform an objective review of the patient's last episode of care as an inpatient, in order to understand areas of good practice and elements of improvement for sharing and learning purposes.
- Certain groups of patients and clinical conditions are mandated to have a SJR performed, plus a random sample per month.
- There are a group of corporate SJR trained reviewers who represent the clinical MDT and perform reviews on a monthly basis.
- >390 deaths reviewed to date 10/11/20 – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive learning
- Learning from Deaths Committee took place on 05/11/20. SJRs put forward for secondary reviews:
- seven cases rated as poor/very poor (Pt 1 deferred from October), plus one case rated as excellent to share learning, plus two deferred to December's meeting (pt 2 & 6)

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LFD meeting 05/11/20
Slides Approved
02/12/20

- Patient 10 – overall rating – **EXCELLENT**
- Male – 66 y/o with Learning disability
- Died Main theatres - October
- Sudden unexpected cardiac arrest intraoperatively

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Positives:

- Good A&E assessment and then thorough clerking by FY2 in A&E department.
- Seen by consultant on post take ward round and clear plan made for surgery the following day.
- Seen by Orthogeriatrician following orthopaedic ward round and medication optimised along with referral to Learning Disabilities Specialist Nurse
- Clear and legible anaesthetic records for case, sudden unexplained cardiac arrest with appropriate efforts made for resuscitation.

Summary:

- Excellent clinical care with thorough and comprehensive reviews. In the first 24 hours clerked, seen by an Orthopaedic Consultant and Orthogeriatrician. Reviewed by Podiatry and the Acute Pain Team as well as having an MDT discussion around his care. An early referral was made to the learning disabilities specialist nurse. This should be seen as a model for excellent care in trauma patients.
- This is a sad case with an unpredictable cardiac arrest in what was otherwise an excellent patient journey through the organisation. The standards of care were high at all times and the treating teams should be proud of the care delivered despite the final outcome.

Actions:

- M Parry – share SJR with cardiac arrest RCA team to aid with review
- F Andrews – write to clinical team and MDT to thank for exemplary care

Learning:

- Importance of early assessment by senior clinicians
- Consideration of MDT e.g. podiatry, acute pain and Learning Disability Team

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- Patient 1 (deferred from October) – overall rating –**poor**
- Male – 71 y/o - Learning disability
- Died Jan B1
- Advanced care planning commenced in community
- Cause of death - 1a aspiration pneumonia 1b epileptic fit 1c ischaemic cerebrovascular disease

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Positives:
- ED immediate review and treatment e.g. sepsis screening, waterlow & dietary requirements.
- Clear diagnosis/mgmt. plan - Family discussion with escalation plan
- Admitting ward – timely and daily consultant review, clear plan, med recs and ref to IDT
- family participating in care with nursing staff assistance
- Referred to LD Team at earliest opportunity. MDT review by consultant, TVN &hospital podiatry.
- Daily consultant review on contingency ward
- Passport of care & moved to B1 main ward to facilitate continuity of care and discharge planning.
- Much effort made to transfer home for palliation - very complex discharge requiring involvement of multiple agencies to pull together 24-hour care, the difficulties that arose from family concerns and district nurses which changed and the variability in the patient's clinical condition which made it difficult to determine if a safe transfer home could be achieved.

Negatives:
- Delay to abx - possibly due to 2 failed attempts to obtain bloods cultures by correct method and delayed documentation around time of administration.
- Delay to ward bed, extended period in resus
- Contingency ward whilst not ideal for LD pt.
- Despite a lot of very clear documentation from the teams above, SBAR created by agency nurse for transfer to B1 was poor quality.

Summary:
- This patient was approaching end of life, (acp in community)
- Delay to abx first dose incurred by difficulty taking blood cultures prior to administration.
- LDT referral at earliest opportunity (service is not 24/7)
- Clear reference to established dysphagia and special considerations documented in ED and subsequent SALT assessments - conflict arose when a family member attempting to feed when patient was too drowsy resulting in medical team suggesting NBM for 24 hrs.
- The patient was transferred to a contingency ward, whilst not ideal for a LD patient – did have daily consultant input. Given complexity of discharge planning and pts clinical condition did not feel this hampered care progression.
- Very complex discharge, involving multiple agencies, changing clinical condition and family dynamics and concerns. Much effort was made to attempt a safe transfer home

Actions
- Outlier policy drafted including safeguard that all LD patients should not to be out-lied

Learning points:
- Patients with Learning difficulty should not be outlied or placed on a contingency ward.
- Adherence to Sepsis 6 remains an important target to be achieved within 60 minutes but blood cultures should be taken correctly to be of value and avoid contamination

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- Patient 3 – overall rating –**poor**
- Male – 74 y/o
- Died March D3
- ? GP referral to ED
- Patient out of area

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Positives:
- Appropriate escalation to med reg and excellent review ooh when deteriorated and EWS 15, clear discussion with family and ref to ICU for specific treatment interventions despite poor prognosis
- Frequent communication with family, particularly in ICU discussion re family's distress at the change in nursing intensity on step-down was clear and well documented.
- Palliative care was appropriately instituted at the last rapid episode of acute illness and the palliative care team involved.
- Appropriately remained in hospital with the agreement of his family once the window of opportunity for discharge had been missed.

Negatives:
- No escalation/resus discussion on admission despite info re functional status & comorbidities.
- Delay to CXR and CT head despite sepsis & consideration of subdural haemorrhage as on NOAC, acute confusion, & presented 2 days earlier to ED with a head injury.
- No evidence of consideration of physiological parameters on PTWR, including significantly raised blood glucose, or again of escalation status/DNACPR.
- Moved to ward without further review - did not see consultant within 12 hours
- No documentation of urine output, no escalation of raised blood glucose.
- Regular insulin not given - documented as unavailable, but no evidence of what attempt was made to source it, or to consider alternative options.
- No evidence of post-falls safety huddles done on the ward.
- Documentation regarding communication with the family was less thorough towards the rest of the admission
- Prescribing omissions re meds suspended/stopped and not restarted, - picked up and addressed by ward pharmacists
- No proactive advance care planning e.g. limits of treatment
- Obs continued until final 24 hrs - but persistently raised EWS was not acted on
- Delay in discharge to PPoC due to failings in referral systems - plans for a fast track discharge - delayed due to equipment not being ordered despite sufficient time - the correct referrals/paperwork not been completed on a number of occasions

Summary:
Overall the bulk of the care provided for this patient throughout a very long and complex admission was adequate or better. However, the failings on admission as documented, and the inability to achieve discharge due to delays in the required referrals are significant issues in the quality of care provided

Actions
- M Robinson - to discuss with peers at Wigan and Salford re discharge turnaround times for OOA patients to understand if this is a common experience

Learning points:
- The importance of early consideration of escalation and resus status
- The importance of senior review with 12 hours of arrival
- The importance of early advanced care planning to highlight patient's wishes regarding active treatment
- The importance of early discharge planning and ensure correct referrals

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- Patient 4 – overall rating –**poor**
- Male – 72 y/o
- Died April D1
- Cause of death - Carcinoma of pancreas
- GP referral to ED

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Positives:
- Seen by ED then by medical junior, in a timely manner.
- Attempted DNACPR discussions by clerking junior - patient did not want to discuss
- Seen by palliative care quickly after admission - syringe driver started for symptoms.
- Subsequently DNACPR put in place by palliative care consultant after discussion with family
- End of life phase only a few hours. Symptoms well managed with medications.
- Family updated over the phone by medical team and declined to come in, staff sat with patient and used twin hearts system.
- Good management of complex family situation

Negatives:
- Patient's initial reluctance to discuss DNACPR was not readdressed on the PTWR.
- Lack of holistic approach– e.g. individual actions appropriate but bigger palliative situation overlooked missed - There was a mention in the NWAS sheet that the family were concerned at him attending A+E, and it can be seen on Graphnet that he was GSF yellow (weeks prognosis), but neither of these cues were identified and there is no evidence of discussion with his family at the time of admission.
- Family under the impression attending for symptom control only and upset at the investigations patient was having.
- Continued active treatment, obs and investigations despite plans for palliation and consideration of rapid discharge to PPD
- Communication across acute / palliative / primary care services poor

Summary:
- The overall picture appears to be a man who was known to community palliative care and was at the end of his life. His family were keen to keep him at home, but ended up being admitted to hospital and having multiple unnecessary investigations due to lack of communication between GP / palliative care / hospital. Please note this case occurred prior to EPACCS implemented

Actions
- RS raise accessibility of EPR to Bolton Hospice - EPR design committee
- Bolton Care Record - EPACCS will be accessible

Learning points:
- The importance of accessibility of information to enable decision making at pace e.g. Graphnet for GSF status - this case occurred pre EPACCS which may have enhanced decision making if had been in situ at the time

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- Patient 5 – overall rating –**poor**
- Male – 20 y/o
- Died May G5
- Referred to coroner
- History of serious mental health issue - Previous admissions for mental health issues, including self-harm and overdoses

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Positives:
- Good initial assessment initially on first presentation (day before) to ED and referral onto MHLT.
- Arrived in ED – suicide attempt excellent care around cardiac arrest, management in ED and critical care.
- CVC line inserted appropriately
- Family kept well informed and sensitively communicated with re poor prognosis, evidence the critical care team took their time, appreciating that parents were shocked and giving them time to come to terms with the news before discussing organ donation. Family to be present at time of death. family needs appear to have been met. communication excellent.

Negatives:
- EoL in critical care lacked a complete holistic assessment and management e.g. no mention of spiritual needs having been explored. no documentation that bereavement support or mementos offered.

Actions
- R Sachs/Governance - to share SJR with GMMH for their information and considered opinion - to assist with their mortality review process
- F Andrews to contact RAID for a representative to sit on LFD committee
- F Andrews – feedback thanks to ED and Critical Care team

Learning points:
- The importance of honest yet sensitive communication with families
- The importance of holistic assessment and management of end of life care including spiritual needs, bereavement support etc.

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- Patient 7 – overall rating –**poor**
- Female – 87 y/o
- Died July B3
- Cause of death 1a) congestive cardiac failure, 2) COPD -?

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Positives:
- very good initial assessment and treatment plan with senior and specialist input and decision making regarding ceilings of care and DNACPR discussions had
- prompt senior input and advice from cardiology.
- deteriorated acutely 24 hours after admission. prompt review by the night practitioner who escalated it to the medical registrar.
- body map re-done following omission below to document changes
- acute deterioration managed well and surgical support was prompt and thorough. again good decision making about ceilings of care.
- Dr accompanied for CT scan as unstable
- Appropriate raising of medication error incident done - medical management appeared satisfactory and duty of candour with family.
- Good communication with family – offered visiting
- At end of life obs and medications stopped. anticipatories prescribed.

Negatives:
- Medication error - clexane prescribed wrong which led to iatrogenic injury and directly led to this patient's death.
- During admission daily weights not recorded. given being treated for heart failure this is poor.
- Evidence of over-coagulation - extensive bruising & large haematomas - contrasting opinion on whether present day before or not.
- record of care started, but very poorly filled in - nothing but the initial MDT section.
- end of life care could have been better with a holistic assessment - no family needs assessed or spiritual needs documented

Summary:
marked as poor because even though medical care good, the drug error directly led to this patient's death and end of life care could have been better - no family needs assessed or spiritual needs documented

Actions
Refer for SI Scoping - SI completed - report to November's QAC

Learning points:
In report to November's QAC

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- Patient 8 – overall rating –**poor**
- Male – 55 y/o
- Died August D3
- Cause of death 1a) sepsis of unknown aetiology b) chronic alcohol dependency 2) Obesity

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Positives:
- Good practice in clear plan from ED and medicine
- Prompt input from alcohol team
- Community acquired pressure ulcers identified
- Ongoing patient and relative discussions well documented throughout
- Ongoing input from both ALD and diabetic nurse
- In hospital fall managed appropriately
- Deterioration recognised and escalated as per policy
- Early review by critical care and escalation decisions in place
- Early microbiology input to sepsis treatment
- Rapid and unexpected deterioration but all efforts seem to have been made to keep family informed

Negatives:
- Failings around sepsis and failure to give abx within 1 hour
- Raised bilirubin - no consideration of imaging to exclude biliary sepsis
- CT should have been requested earlier given the context of sepsis of unknown source

Summary:
Many aspects of care are good or very good but overall areas of concern being:
1) Failure to manage sepsis within agreed policy at admission
2) Failure to adequately image, in a reasonable timeframe (>48hrs), to investigate the source of sepsis in a very obese man where clinical signs can be unreliable

Actions:
- F Andrews to invite Sepsis work stream lead to LFD committee membership - Marta Martinez-Iglesias
- Y Gurney share Sepsis work stream updated presented to MRG in October 20
- F Andrews - Feedback to team re quality of family discussion documentation and also regarding the importance of early imaging to identify the source of sepsis seems appropriate.

Learning points:
- Consistent themes around sepsis management, particularly around time to first dose of abx within 1 hour
- SJR reviewers - wait for the blue notes (record of care) where a comprehensive record of end of life care is found and can be reviewed - currently not on EPR.

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- Patient 9 – overall rating –**poor**
- Female – 63 y/o
- Died August B2
- Cause of death 1a Respiratory Failure 1b Lung cancer and COPD 2 Gram positive bacteraemia
- Frequent attender due to lung cancer and falls/fracture – no community acp/DNACPR
- 999 - Admitted due to breathlessness/tight chest

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Positives:
- Timely review, triage and sepsis screening
- Prompt review by ED Spr who tried to explore ACP with patient
- Attempt to discuss ceilings of care - but then arrest and CPR - appropriate at the time
- Good discussions with family regarding prognosis
- Timely consultant review and referral to palliative care
- Timely palliative care input on day of admission - PPoC established, patient and family not ready to discuss further
- Palliative care support to family every day-excellent

Negatives:
- Moved to D1-nursing admission document completed but section on dying inaccurate
- Moved to B2 at 13:30-not ideal but to manage flow-adequate

Summary:
Elements of care were good and excellent in places. Patient was dying, but despite attempts to engage in advanced care planning was not accepting of this and active treatment was in line with wishes.

Actions:
- MB/RL - pull some examples of euphemisms/subtle sentences used in notes that do not encourage transparency/reflect interventions made – see next slides

Learning Points:
- Importance of documenting all attempts/discussions/interventions in a concise manner - that adequately reflect the nature of what was done
- Patients may still wish to receive active treatment, even if acp is more appropriate from a medical perspective

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Euphemisms surrounding care of deteriorating patients

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If you tend to write these phrases, please do not assume others understand what you mean. We need to provide more information for the out of hours' team and our juniors to make appropriate decisions about care.

- Guarded prognosis
- For comfort care
- TLC
- Unlikely to survive
- Terminal event
- Poor prognosis
- Best supportive care
- Passed away

Consider these alternatives or adding information to make your comments clearer. Remember you can use the acronym function in EPR to pre-populate your notes to make documenting quicker.

- "X is sick enough to die."
- "X is at their ceiling of care. If they deteriorate, then active treatment should be stopped and they are dying."
- "No further disease-modifying treatments are possible/desired by X. Aim for patient's goals, which are:
  - 1. 2. 3.
  - For example, these goals could be rapid discharge home to die, well managed symptoms or to sit out of bed.
- Never be afraid to use the words die, dying or dead in your notes and in communication with patients and families. These terms are clear and understandable. You can then modify your communication if you can see these words are making someone feel uncomfortable.

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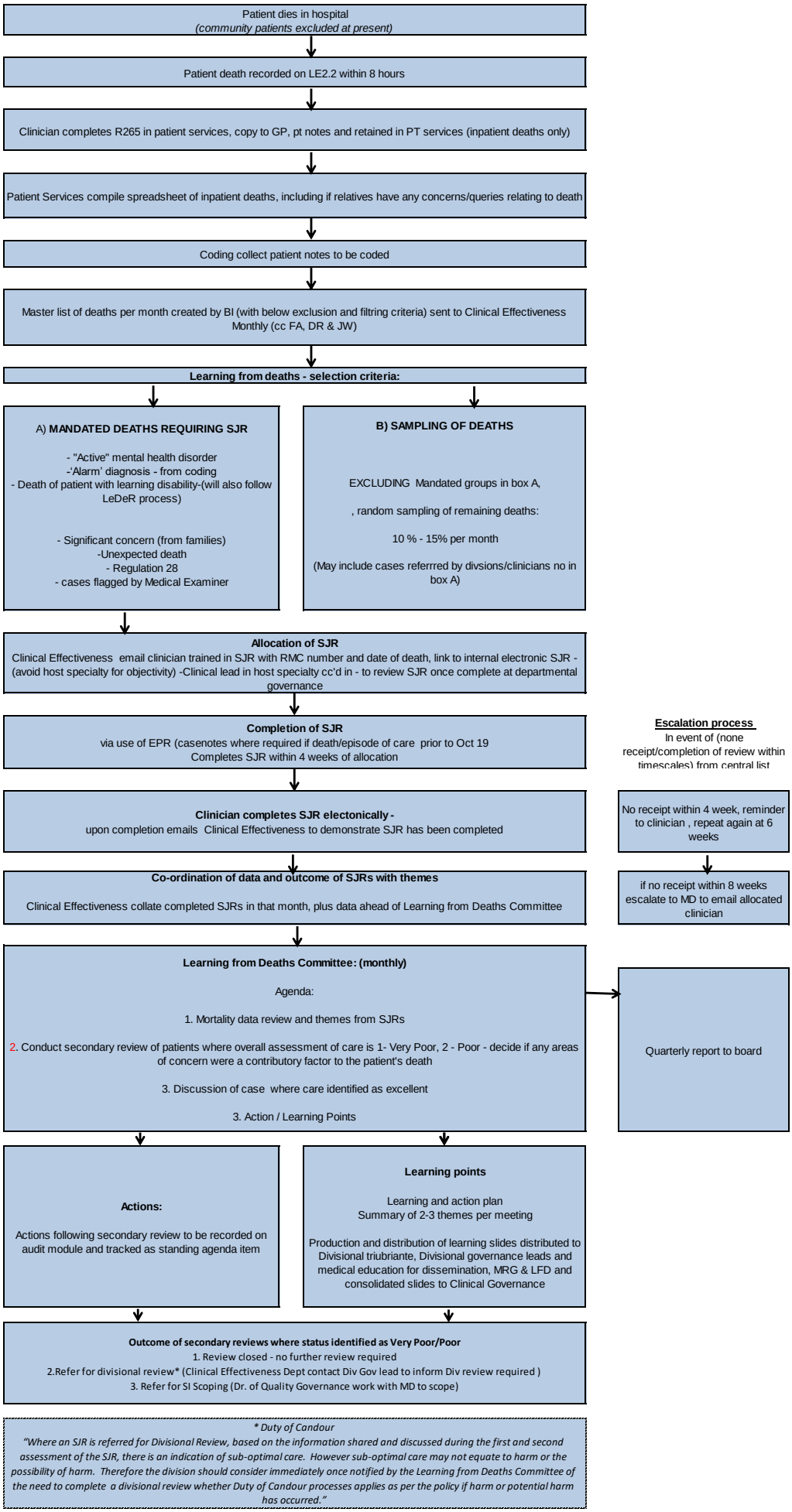
Appendix 4: Learning from Deaths Process (adult inpatients)


Patient dies in hospital
(community patients excluded at present)
Patient death recorded on LE2.2 within 8 hours
Clinician completes R265 in patient services, copy to GP, pt notes and retained in PT services (inpatient deaths only)
Patient Services compile spreadsheet of inpatient deaths, including if relatives have any concerns/queries relating to death
Coding collect patient notes to be coded
Master list of deaths per month created by BI (with below exclusion and filtring criteria) sent to Clinical Effectiveness Monthly (cc FA, DR & JW)
Learning from deaths - selection criteria:
A) MANDATED DEATHS REQUIRING SJR
- "Active" mental health disorder
-'Alarm' diagnosis - from coding
- Death of patient with learning disability-(will also follow LeDeR process)
- Significant concern (from families)
-Unexpected death
- Regulation 28
- cases flagged by Medical Examiner
B) SAMPLING OF DEATHS
EXCLUDING Mandated groups in box A,
, random sampling of remaining deaths:
10 % - 15% per month
(May include cases referrred by divsions/clinicians no in box A)
Allocation of SJR
Clinical Effectiveness email clinician trained in SJR with RMC number and date of death, link to internal electronic SJR - (avoid host specialty for objectivity) -Clinical lead in host specialty cc'd in - to review SJR once complete at departmental governance
Completion of SJR
via use of EPR (casenotes where required if death/episode of care prior to Oct 19
Completes SJR within 4 weeks of allocation
Escalation process
In event of (none receipt/completion of review within timescales) from central list
Clinician completes SJR electonically -
upon completion emails Clinical Effectiveness to demonstrate SJR has been completed
No receipt within 4 week, reminder to clinician , repeat again at 6 weeks
Co-ordination of data and outcome of SJRs with themes
Clinical Effectiveness collate completed SJRs in that month, plus data ahead of Learning from Deaths Committee
if no receipt within 8 weeks escalate to MD to email allocated clinician
Learning from Deaths Committee: (monthly)
Agenda:
1. Mortality data review and themes from SJRs
2. Conduct secondary review of patients where overall assessment of care is 1- Very Poor, 2 - Poor - decide if any areas of concern were a contributory factor to the patient's death
3. Discussion of case where care identified as excellent
3. Action / Learning Points
Quarterly report to board
Actions:
Actions following secondary review to be recorded on audit module and tracked as standing agenda item
Learning points
Learning and action plan
Summary of 2-3 themes per meeting
Production and distribution of learning slides distributed to Divisional triubriante, Divisional governance leads and medical education for dissemination, MRG & LFD and consolidated slides to Clinical Governance
Outcome of secondary reviews where status identified as Very Poor/Poor
1. Review closed - no further review required
2.Refer for divisional review* (Clinical Effectiveness Dept contact Div Gov lead to inform Div review required)
3. Refer for SI Scoping (Dr. of Quality Governance work with MD to scope)
* Duty of Candour
"Where an SJR is referred for Divisional Review, based on the information shared and discussed during the first and second assessment of the SJR, there is an indication of sub-optimal care. However sub-optimal care may not equate to harm or the possibility of harm. Therefore the division should consider immediately once notified by the Learning from Deaths Committee of the need to complete a divisional review whether Duty of Candour processes applies as per the policy if harm or potential harm has occurred."

Agenda Item: 15

Title:	Annual Update on the Workforce and OD Strategy (2018-2021)

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	28th January 2021		Discussion	
Exec Sponsor:	James Mawrey		Decision	

Summary:	This report provides an annual update on the Workforce & Organisational Development Strategy (attached). The paper is intended to provide assurance to the Board of Directors that the Workforce & Organisational Development strategy remains fit for purpose and that traction is being maintained in terms of implementation. The paper notes a number of key achievements against our Workforce and OD Strategy and the more recent, national NHS People Plan. Where further improvements are required this is noted in the paper. The People Committee endorses the paper and are assured that it remains fit for purpose. As such it is not proposed we make any significant changes to the Strategy. The People Committee will continue to receive regular updates to ensure traction remains in place.

Previously considered by:	People Committee

Proposed Resolution:	It is recommended that the current Workforce & OD strategy work-stream action plans continue to be implemented and evaluated during the 3 year life cycle of the strategy. The Board of Directors is asked to accept this report as assurance that the required progress is being made in respect of delivering the Workforce & OD strategy.

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 Carol Sheard, Deputy Director of People Lisa Gammack, Associate Director of OD	**Presented by:**	James Mawrey, Director of People

Annual Update on the Workforce and OD Strategy (2018-2021)

Introduction

This report provides an annual update on the Workforce & Organisational Development Strategy (attached). The action plan which supports the strategy's implementation is very detailed and has not been included within this paper but it is monitored very closely by the Senior Workforce and OD team.

The paper is intended to provide assurance to the Board of Directors that the Workforce & Organisational Development strategy remains fit for purpose and that traction is being maintained in terms of implementation.

The update is given in the context of the NHS People Plan and the updates to the Trust Strategy. It builds on the papers considered by the People Committee which clarified the alignment between the NHS People Plan and the Workforce and OD Strategy.

Background

The Workforce and OD Strategy underpins our mission, vision, values and strategic objectives. It sets out an enabling framework that provides a clear mechanism for engaging and developing our leaders and staff to enable the cultural shift necessary to deliver our vision. Our aims are to have a healthy organisational culture, a sustainable and capable workforce, working in an integrated way with partners. Our leadership and management of our people is effective and improves staff experience and puts our values into action. Striving to be an employer of choice, we want to attract, recruit and retain a compassionate, skilled and engaged workforce, to deliver excellent patient care and continuously improve the quality of care we provide.
Members will recall that our Workforce and OD Strategy is delivered through four priorities for action:

- **Healthy Organisational Culture** - by developing and sustaining a healthy organisational culture we will create the conditions for high quality care. This includes ensuring a clear focus on the health and well- being of our workforce to prepare them to meet future service need. The strategy was further strengthened last year to ensure increased focus on the Inclusion agenda.
- **Sustainable workforce** - our workforce will need to change to match new ways of delivering services and new ways of working. Critical will be attracting, recruiting and retaining high calibre staff.
- **Capable workforce** - all staff need to be appropriately trained and developed in a positive learning environment. We will ensure our education and development offering delivers a competent workforce who provide a responsive, equitable, safe and compassionate service.
- **Effective Leadership and Managers** - all our managers and leaders have a key role to play in driving service improvement and cultural change. They need to be valued and supported to flourish in their roles, so that they can support and develop their own teams. Focus will be placed on strengthening the leadership and management interventions and developing improved management and succession planning.

As previously noted the People Committee received an update on the alignment between the NHS People Plan and the Workforce & OD Strategy. Whilst there were some notable

differences e.g. refreshed focus on international recruitment, appointment of a NED Health & Wellbeing lead, deeper focus on inclusion, it was clear that the majority of work programmes overlapped. As a reminder for members the NHS People Plan sets out the actions:

- **Looking After Our People**- particularly the actions we must all take to keep our people safe, healthy and well both physically and psychologically.
- **Belonging in the NHS**-highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- **New Ways of Working and Delivering Care**- emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care.
- **Growing for the Future**- particularly by building on the renewed interest in NHS careers to develop and expand our workforce as well as retaining colleagues for longer.

Worthy of note is that the Director of People and the Director of Strategy have fully considered the Workforce & OD Strategy in light of our refreshed organisational strategy and whilst tweaks will need to be made the main body of the strategy remains unchanged.

Progress to Date

The related work plans aligned to the Workforce & OD Strategy are enacted by the respective steering groups and progress is monitored by the People Committee. The key achievements over the last twelve months, are highlighted below (non-exhaustive):

1. **Healthy Organisational Culture**

- VOICE values – the new VOICE Behaviour Framework has been developed and launched that sets out clearly the behaviours that do and don't support our values. Aligned to a refreshed appraisal and 121 process (known as the 'For a Better Bolton Conversation Toolkit') and to be linked to awards and recognition, the behaviours articulate expectations that continue to shape a positive culture and embed values in a meaningful way across the organisation.

- Freedom to Speak Up concerns have continued to increase and this year we have seen the embedding and further development of the Freedom to Speak Up Champions Network, including recruitment of champions from our medical and BAME staff groups. We actively promoted the national FTSU month in October 2020 and we are working hard to continue creating a culture of psychological safety,

- Diversity and Inclusion – the BAME staff forum continues to go from strength to strength and a new chair has been appointed, to build on the progress to date. Plans are in place to develop other representative staff forums (e.g LGBT, Disability) by encouraging ownership and development from the staff themselves. The BAME Leadership Development Programme was initially paused due to Covid, but has now re-commenced in a new look, Covid secure format. We have more actively promoted the inclusion workstreams via Fiona's Friday, Team Brief, and senior leaders have been visible in their support for celebrations such as Black History Month. Recruitment

processes have been reviewed to ensure inclusion is included within all aspects of the recruitment cycle, this includes the introduction of a toolkit to helps managers to develop inclusive practice at every step of the recruitment process, with a selection of inclusive interview questions. We were the first in Greater Manchester to ensure risk assessments were completed for high-risk group - as colleagues with a protective characteristics are potentially more likely to contract and suffer from Covid. We were highly commended by the HPMA for an Inclusion Award recognising the work that has been conducted to develop a golden thread of inclusion throughout our performance and governance functions.

- **Staff Experience** – whilst many Trusts stood down their staff survey processes during the pandemic, we continued with our local approach as we felt now more than ever it is important to listen to staff and understand to what extent they feel engaged and supported. In addition, we conducted a bespoke staff survey for the Maternity Department and the results are being actioned by the divisional management team with support from the Workforce and OD Directorate. Staff reward and recognition has been a key area of focus and in April 2020 we launched the 'For a Better Bolton Staff Awards'. In addition, we have distributed thank you gifts to staff staying in alternative accommodation and those that were shielding. In June 2020 we launched the refreshed Trust Induction sessions and in the Autumn the Chief Executive started to host induction check-in meetings with new employees around two months after they join the organisation. It is important that new staff receive a warm welcome and that they feel supported to succeed in their new role and feel safe working during this challenging period. There has been a plethora of support put in place to help improve staff experience including the provision of free staff car parking, distributing donations and thank you gifts, enhanced staff restaurant discounts, designing and facilitating team building sessions, and developing a Homeworking Policy and supporting guidance.

- **Staff Health and Wellbeing** – the pandemic has created unprecedented pressure on our workforce and so we have continued to adapt and expand our wellness solutions to address a variety of health and wellness concerns and enhance employee engagement. We have and continue to regularly communicate our staff mental health support package. This includes providing the Shinymind resilience App to all staff, increasing the utilisation of the Employee Assistance Programme that provides telephone counselling and general advice, accessible chaplaincy and spiritual support, delivering further Caring for Yourself Programmes (virtual & face to face), launching the new Caring for Your Teams Programme, free online physical fitness classes, arranging alternative accommodation for staff where required, providing free financial wellbeing webinars, establishing a drop-in clinic delivered by our Clinical Health Psychology Team, providing additional onsite staff changing facilities, developing a Menopause Support Policy and setting up lavender rooms (known as wobble rooms elsewhere). Work is underway to maximise the NHS Charities Together funding to enhance staff rest facilities, upgrade cycle storage and improve onsite staff showering facilities. The Staff Health and Wellbeing Steering Group have continued to be responsible for monitoring the delivery of our Staff Wellness Programme and seeking funding from the Executive Team and Charitable Funds Committee where necessary via the normal business case process. The Staff Wellness Programme will continue to

evolve to ensure that we continue to support staff through winter and the pandemic. The NHS People Plan asks all NHS organisations to have a Wellbeing Guardian to act as a 'critical friend' and so this will be addressed through the Staff Health and Wellbeing Steering Group and People Committee.

2. Sustainable Workforce

- This last year has seen the fruition of work to fill hard to recruit to posts across the Trust, at a time when demands on our staff have never been higher. Appointments have been made to consultant roles in Emergency Medicine (which is now fully established at consultant level) Gastroenterology, Elderly Medicine, Anaesthetics, Haematology, Histopathology and Obstetrics and Gynaecology. The table below shows our comparative vacancy position.

Comparison of Trust Vacancy Rates to National and Regional Averages			
Vacancy level	**Trust Sep-20**	**National Average – Mar 20 (Model Hospital)**	**Regional Average – Mar 20 (Model Hospital)**
Trust	3.98%	7.63%	6.09%
Band 5 Nurses	4.05%	9.05%	8.36%
Medical Staff	0.39%	6.34%	7.10%

- At national level NHSE/I are working to increase ethical international recruitment and build partnerships with new countries to benefit the individuals, the country as well as the NHS. We are part of the GM international recruitment hub to maximise the potential overseas opportunities available to fill clinical vacancies.

- Further development of emerging roles has taken place; Training Nurse Associates, Physician Associates, Advanced Nurse Practitioners, MTI Doctors, Trust Grade Associate Specialists.

- Many Nursing, Midwifery, AHP and Medical students all stepped off training and into paid employment to support us during the first wave of the pandemic and we recruited 287 such students into paid employment during wave 1, this is a figure that compares very well with neighbouring NHS Trusts. Trainee Nurse Associate places were paused to maximise the time available for contribution to service delivery however, the development of new roles, apprenticeships and advanced practice remains a key component of developing a sustainable workforce for the future.

- A further Job Planning Round has taken place. The Job Planning reviews has helped to further ensure the efficient and effective use of consultants' time which is critical during a period of operational challenge, change in medical technology and evolving healthcare delivery systems.

- Importantly the strategy was developed in the knowledge of a changing and emerging landscape. The Bolton system has introduced a Virtual Workforce Information System (VWIS) which is being designed to help Bolton ICP be sighted on workforce data across the system, which will then help in system-wide Workforce Planning. Workforce

Planning has also taken place across the North West Sector to help inform the discussions that are taking place across Greater Manchester.

- The workforce digitalisation work programme has gained traction in the last year despite the pandemic and the roll out of the ESR project and e-roster continues. We continue to lead the way across GM on workforce modelling and availability reporting and this is reflected in the strong comparative position against other Trusts in relation to, for example, sickness absence. We have been shortlisted for an HSJ Award for our work on the Workforce Digital agenda.

- Agile working and supporting working from home where possible is another area where progress has been accelerated by the 'burning platform' of the pandemic and is now part of our plans for further developing agile working, maximising our estate and capitalising on technological solutions to release capacity, as well as keep people safe.

3. Capable Workforce

- Clinical and Professional Development – it was imperative from the outset of the pandemic that we continued to deliver high quality training to new and existing staff. Although some elements of mandatory training were stepped down for a 3-month period, we delivered at pace the 'Prepare to Care' and 'Prepare to Nurse' upskilling programmes to new, returning to practice and redeployed staff. In addition, we delivered bespoke training to support our flu immunisation programme, provided intramuscular injection training for the forthcoming Covid-19 vaccine programme, continued to deliver the Care Certificate and Preceptorship Programmes and supported the first intake of direct entry self-funding Trainee Nursing Associates. We have also delivered clinical skills training for around 60 students adopting new delivery approaches to ensure that we adhere to Covid-19 safe working guidance.

- Apprenticeship Programme – the pandemic has significantly hindered our ability to meet the public sector apprenticeship target and maximise levy spend. From March 2020 to August 2020 apprenticeship training delivery and study leave were paused which has disappointingly led to an increase in our 'lost' levy spend. The People Development Team is working collaboratively with divisions to implement a series of enabling actions to re-invigorate apprenticeship activity within the context of increased operational pressures. As the largest employer within Bolton, we remain fully committed to utilising apprenticeships across the organisation to help address skills gaps, provide career pathways and support the development of new job roles whilst maximising our levy fund.

- Mandatory Training delivery – during the period from January 2020 to December 2020 approximately 2142 clinical staff completed their annual clinical mandatory training which covers basic life support, fire safety and manual handling. We did suspend face to face training delivery during April, May and June 2020 during wave 1 of the pandemic but we were able to restart training sessions, adhering to Covid-safe working arrangements from the end of June and we continue to do so. It is imperative that our

staff are competency assessed to complete the job roles and that we do not increase clinical risk by suspending vital training.

- Knowledge and Library Service – the service has remained busy throughout the pandemic. Our Clinical Librarian has completed 166 searches since March 2020 which has greatly benefited clinical and managerial decision making. In addition, 1020 full texts documents have been supplied to staff that have been unable to access them, saving time and money.

4. Leadership and Development

- Our Leadership and Management Development Framework continues to be very well received. This clearly articulates the internal and external training offered to our staff at all levels. In addition to this more focused leadership programmes have been developed where we have determined additional focus is required e.g. Operational Managers Leadership Programme, BAME Leadership Development Programme and Medical Leadership Programme.

- The Shadow Board Development Programme was very successful. This is a programme for aspirant Board members and senior managers, but it is also much more than that, offering both experiential and modular learning which equips participants with the right level of knowledge and understanding of working at Board level. A number of staff have already used this as a springboard to further their career. The intention is to run a further cohort in Spring 2021.

- Our Leadership Masterclass Programme, delivered by reputable and inspirational leaders, created a real buzz in the organisation and gave our leaders the opportunity to learn from experts about how they can further develop on their own leadership journey. Plans to restart the programme in Autumn 2020 was unfortunately paused due to the second wave of the pandemic but work is underway to have a new virtual masterclasses programme in place in early 2021.

- Visible leadership – strong visible leadership has continued to be a top priority during the pandemic and leaders at all levels have been finding new ways to connect with staff, provide direction, clarity and support, and address areas of concern voiced by employees. Examples include the implementation of the Covid-19 Command Structure, Chief Executive weekly blogs, monthly virtual team briefs delivered by the Executive Team, regular staff communications and walkabouts/team visits.

- Coaching and mentoring – we are continuing to work hard to embed a coaching culture that further embeds our values, increases employee engagement and performance, builds authentic relationships and retains talent. This had included delivering coaching skills training for managers at all levels and investment in increasing our internal pool of qualified coaches. A new BAME reverse mentoring programme has been launched as part of the BAME leadership development programme. A pool of senior leaders have been trained and matched with the 15 participants on the BAME development programme.

Measuring the progress

A key measure of the success of the strategy continues to be the national staff survey results, which based on last years results remain very positive. Of course the most recent NHS Staff Survey closed in November, 2020 and these findings will be reported to the Board of Directors in March 2021.

Strong performance across a number of key workforce metrics has been demonstrated (Recruitment, Agency, Workforce Inclusion, Appraisal and Mandatory Training). Perhaps most pleasing this year has seen us move from having one of the highest sickness absence rates in the region to now having one of the lowest.

Conclusion

The paper sets out some of the key achievements against our Workforce & OD Strategy and the more recent, national NHS People Plan, and confirms that it is aligned with the NHS People Plan and the refreshed Trust Strategy. The governance through People Committee and the component sub groups will ensure traction on implementation.

Recommendation

It is recommended that the current Workforce & OD Strategy work-stream action plans continue to be implemented and continue to be evaluated during the 3 year life cycle of the strategy.

The Board of Directors is asked to accept this report as assurance that the required progress is being made in respect of delivering the Workforce & OD strategy.

NHS
Bolton
NHS Foundation Trust

Workforce and Organisational Development Strategy

2018 – 2021

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Acronyms

AHP	Allied health professionals
BFT	Bolton NHS Foundation Trust
GM	Greater Manchester
HR	Human resources
LDA	Learning and development agreement
OD	Organisational development
PSED	Public Sector Equality Duty
VOICE	Vision, Openness, Integrity, Compassion, Excellence
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Document information

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Audience	Bolton NHS Foundation Trust Board
Status	Final
Authors	James Mawrey – Director of Workforce

1> Foreword and introduction

We are delighted to be introducing our sharpened Workforce and Organisational Development Strategy. This strategy identifies the trust's workforce priorities for the next three years.

Our aim is to deliver high quality patient care which is supported by a workforce who are engaged, highly skilled and competent. The quality of experience and clinical outcomes of the people who use our services are a direct result of interactions with staff.

Our staff really are our greatest asset and this strategy describes the support and opportunities that we will make available to them. The strategy is underpinned by our VOICE values. These values form the basis of our expectations of how we will operate on a day-to-day basis to deliver the highest quality of care for each and every patient we serve.

Our thanks go out to the number of stakeholders that have been involved in the development of this document (staff, staff side partners, managers, and executive / non-executive directors).

We will regularly review progress being made against this strategy at the trust's Workforce Assurance Committee and in doing so updates will be provided to the Trust Board.

NHS Bolton NHS Foundation Trust

Jackie Bene
Chief Executive

James Mawrey
Director of Workforce

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

2> Framework for the strategy

The strategy will be delivered through four priorities for action:

1. Healthy organisational culture

By developing and sustaining a healthy organisational culture (based on VOICE values) we will create the conditions for high quality care. This includes ensuring a clear focus is given on the health and well-being of our workforce to prepare them to meet future service needs.

2. Sustainable workforce

Our workforce will need to change to match new ways of delivering services and new ways of working. Critical will be attracting, recruiting and retaining high calibre skilled staff.

3. Capable workforce

All staff need to be appropriately trained and developed in a positive learning environment. We will ensure our education and development offering delivers a competent workforce who then in turn provide a responsive, equitable, safe and compassionate service.

4. Effective leadership and managers

Our managers and leaders have a key role to play in driving service improvement and cultural change. They need to be valued and supported to flourish in their roles, so that they can support and develop their own teams. Focus will be placed on strengthening the leadership and management interventions and developing improved talent management and succession planning.

3> Healthy organisational culture

What we will do

We will:

- Implement the health and wellbeing strategy and ensure that our staff sickness rate is below 4.2%.
- Review and refresh the occupational health specification. This will include developing a more proactive service that delivers improved health awareness programmes such as mental health support, alcohol management, weight management, smoking cessation, mindfulness and resilience programmes.
- Engage and involve staff in decisions and change that affects them. This will include full implementation of *Go-Engage* and the delivery of the staff engagement plan.
- Take action to ensure that staff are clear about the values and behaviours expected of them and align these with HR practices
- Re-energise our *Freedom to Speak Up* approach to ensure that our staff know how to raise concerns and have the confidence that these will be managed in a confidential manner.
- Revitalise our commitment to diversity and inclusion (from Ward to Board) to ensure that our workforce better reflects the community that we serve.
- Ensure that there is a zero tolerance policy in relation to bullying, harassment and discrimination.

How outcomes will be measured

- Sickness absence rates
- National staff survey engagement scores
- *Go-Engage* pulse surveys
- Whistleblowing data
- WRES data
- Reporting of bullying and harassment in the national staff survey

4> Sustainable workforce

What we will do

We will:

- Demonstrate that workforce planning includes a long term perspective and supports new and emerging service delivery models, ensuring that the workforce plan is integrated in to the trust's strategy and financial plans. Where appropriate this will be across the Bolton locality.
- Ensure a refreshed approach to recruitment and retention is undertaken to deliver a strong Bolton brand. This will include innovative plans to address medical, nursing and allied health professional (AHP) staffing pressures.
- Develop a total reward package that provides a positive offering – both pay and non-pay benefits. This includes ensuring that there are appropriately balanced flexible working opportunities to support attracting staff to work within the trust.
- Create a flexible workforce utilising our human resource effectively to provide fully established services and reduce the requirement for temporary staff.
- Ensure consultant job plans match service demand and support 24/7 delivery. Extend the use of job plans to other staff who manage caseloads, for example AHPs and nurse consultants.

How outcomes will be measured

- Recruitment data
- Vacancy rates
- Turnover rates
- Exit interview data
- Bank and agency usage data
- E-Rostering key performance indicators
- NHS staff survey data

5> Capable workforce

What we will do

We will:

- Maximise sources of funding to support our commitment to learning and development.
- Maintain and improve the quality and compliance levels of appraisal, mandatory training and statutory training.
- Further enhance working relationships with local education providers, to ensure strong academic links and the translation of new clinical roles into service delivery.
- Develop a more bespoke approach to learning and development that recognises the local challenges the organisation faces. This will include ensuring that all divisions have developed a training needs analysis.
- Provide a suite of multidisciplinary clinical skills training to ensure clinical competency in practice.
- Expand and develop the apprenticeship workforce in all areas creating roles that are patient centred and provide a career structure.

How outcomes will be measured

- Increase in learning and development agreement (LDA) funding
- National staff survey engagement scores
- Appraisal, mandatory and statutory training data
- Apprenticeship data
- Learning and development outcomes (return on investment)

6> Effective leadership and managers

What we will do

We will:

- Develop a robust talent and succession planning programme that identifies future leaders.
- Build leadership capacity and capability as part of our workforce plan. This will involve developing a breadth of leadership development opportunities both internally and externally to the organisation.
- Develop a transformational leadership framework that ensures a robust process of coaching, mentoring and supervision for leaders at all levels.
- Implement the *Trust Alumni* made up of staff who have been supported through various development programmes to support other staff and trust projects

How outcomes will be measured

- NHS staff survey data
- Internal promotion
- Leadership and development data – including return on investment

7> Delivering the strategy

Infrastructure

Appropriate infrastructure is required to support the delivery of the strategy and plans include:

- Active engagement of the Trust Board, clinical and managerial leadership.
- Effective workforce systems and processes that utilise latest technology to support, measure, and assure.
- Productive, proactive workforce and organisational development professionals.
- Targeted communication that effectively utilises technology and social media.
- Effective partnership working with trade unions.
- Productive partnerships with universities, further education providers, schools and wider local and national networks.

Risks

It is important to note that there are workforce and organisational development risks that could pose a risk to delivery of business outcomes and outputs. These key workforce risks are included on risk register and to avoid duplication are not included within this document. The work programmes associated with the workforce and organisational development strategy will aim to mitigate these risks.

High level Strategic targets

The key workforce and organisational development targets that the strategy will aim to deliver are:

- An achieved sickness rates of under 4.2%
- An achieved and sustained appraisal rate of 85% (88% from 1st April, 2018).
- An achieved mandatory training rate of 92%.
- An achieved statutory training rate of 95%
- An achieved turnover rate of 8-10%
- Reduced reliance on premium variable spend – specifically delivering the agency forecast set out in the trust's annual plan
- To be in the top 20% of NHS organisations for staff engagement scores (as measured by NHS staff survey)
- To have a workforce which reflects the population that we serve – specifically ensuring that the organisation is as diverse as the population we serve (as measured by the Workforce Race Equality Standard)

7> Delivering the strategy

Monitoring the targets

The workforce and organisational development senior management team will lead the implementation of the workforce and organisational development strategy, ensuring that the strategic workforce plans are converted into deliverable operational actions. A very detailed year one monitoring action plan has been presented to the Workforce Assurance Committee. This action plan will be finalised subject to Trust Board approval.

Delivery against the strategy and related action plan will be formally monitored through the Workforce Assurance Committee with an annual report to the Trust Board.

8> Concluding comments

There is no doubting the challenge and 'stretch' detailed within this document but committing to meeting this challenge will in itself send a message to staff about our determination to continue to provide safe effective services in which there is a recognition of the importance of every individual.

This is not just a strategy or work programme for the workforce and organisational development department – it requires real commitment and input from the whole organisation, particularly those in a leadership position.

Agenda Item
16

NHS Bolton NHS Foundation Trust

Title:	Group Health and Safety Annual Report 2019/2020

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th January 2021		Discussion	
Exec Sponsor	Karen Meadowcroft		Decision	✓

Summary:	• The Annual Health & Safety Report was received by QAC in December 2020. QAC noted the ambitious recommendations and action plan and asked that the action plan was priortised. This was completed in December 2020 by the Director of Quality Governance and the Health & Safety Manager. The action plan will be operationally supervised by the Group H&S Committee and presented to QAC for progress regularly in 2021/22. • Supplementing this a business case for a H&S Advisor is in the final stages of preparation for consideration by Execs/CRIG • To note that the Group Health and Safety Annual Report 2020/21 will be processed through the committee structure faster, ideally arriving at Board of Directors in September 2021 (rather than January 2022)

Previously considered by:	Group Health and Safety Committee 27th November 2020 Quality Assurance Committee 18th December 2020

Proposed Resolution	The Board of Directors in asked to note the 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:	Shirley Ryan, Health & Safety Manager Richard Sachs, Director of Quality Governance	**Presented by:**	Richard Sachs, Director of Quality Governance

1. INTRODUCTION

The Health & Safety report primarily covers the period 1st April 2019 to 31st March 2020.

The annual report outlines key developments and the work that has been undertaken during this reporting period, and is an opportunity to consider work planned, and the objectives for the year(s) ahead.

It reflects the Trust's level of compliance with the Executive Directors' approved 'Statement of Intent' in the Health & Safety Policy, which broadly requires those responsible for health and safety to:

- Comply with health and safety legislation;
- Implement health and safety arrangements;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;
- Cooperate with landlords, contractors and other external stakeholders to ensure health and safety arrangements are maintained for all
- To ensure that the health and safety agenda is not only embedded but embraced throughout the Trust using a variety of monitoring methods, including:
  - Quality Assurance
  - Health and Safety Committee
  - Workplace Health and Wellbeing
  - Health & Safety Sub groups – e.g. Fire Safety, Security, Sharps

2. LEGAL AND BEST PRACTICE COMPLIANCE OVERVIEW

The table in appendix one provides an overview of compliance with statutory requirements and HSE approved codes of practice.

3. KEY 19/20 HEALTH AND SAFETY ACHIEVEMENTS SUMMARY

- Appointment of a Health and Safety Manager for the Trust
- Review and re-write of Health and Safety Policy
- Remedy of material breaches identified by HSE (principally related to sharps safety) to HSE's satisfaction).
- Set up of Fire Safety committee including development of a scheme to replace detection and alarm infrastructure.
- Set up of Security Committee and a review of training for conflict, violence and aggression.
- Review of RIDDOR processes and strengthened monitoring
- Strengthened the work plan of the Health and Safety Committee
- Development of a health and safety contract specification with iFM which was approved at Health and Safety committee in 20/21
- A review of the structure within the Risk Management team including a continuous review of how Safeguard supports Health & Safety incident reporting and risk compliance
- Review of the safety learning slides to ensure learning from incidents is widely shared.

- Started preparations to strengthen PPE and RPE fit testing standards in readiness for the Covid pandemic which have been further strengthened in 20/21 to deal with the many challenges related to PPE supply
- Various measures to strengthen psychological support for staff via the Health and Well-Being committee
- Development of an assurance reporting template for medical devices committee. (A large part of MDSO role is about compliance with Provision and Use of Work Equipment Regulations 1998 PUWER)
- iFM developed their branding in readiness for their "vision zero" safety initiative to be launched in 20/21
- Approved revised processes for safer transportation of deliveries to Pharmacy including the implementation of banksman responsibilities following HSE feedback.

4. HEALTH AND SAFETY DELIVERY

Health and safety is delivered in the Trust in several ways:

- Trust Health and Safety Department – Provides occupational safety advice and leadership to drive the agenda of non-clinical safety ensuring compliance with legal standards and best practice.
- iFM Fire, Health and Safety Department – who are contracted to provide safety advice and support to meet the non-clinical safety agenda and provide leadership in relation to iFM occupational safety and Group fire safety.
- Health and Well-Being Service – Occupational Health and Health Surveillance
- Governance leads – Primary focus on patient safety, but includes occupational safety

Trust Health and Safety		**iFM Health and Safety**	
WTE	**Role**	**WTE**	**Role**
1:00	H&S Manager	1:00	General Manager
1:00	Manual Handling Advisor	1:00	Compliance Manager (due to commence Jan 21)
		1:00	Fire Safety Officers x2
		1:00	Health & Safety Advisor
		1:00	Asset Register Manager
		0:50	Asset Officer

The Trust Health and Safety Manager, who was new in post in April 2019 has responsibility for both strategic and operational elements of Health and Safety. Given that several policies remain out of date and numerous improvements are required to optimise the service, this has proven extremely challenging and leaves the Trust at risk in terms of the resilience of the service.

Recommendation: Review the capacity within Trust Health and Safety

5. DATA

The table and accompanying Pareto chart in appendix 2 provides information on the number and type of incidents during this period.

It is not always possible to discern whether an incident belongs within a patient safety category or an occupational or general safety category. Many incidents may fall into both categories – for example when a patient who presents with challenging behaviour assaults a member of staff or an assisted fall. The HSE column on the table in appendix 2 indicates the likelihood of HSE involvement if a serious incident were to occur in that category. For example, a medication incident would fall into a category which would fall into the remit of the CQC regulator rather than the HSE.

The causes are the broader categorisations. Under these sit a large number of more detailed categories – for example "exposure to hazardous substance" would fall in the accident cause group.

Appendix 3 provides is an SPC chart to compare incidents during this period with previous years. The multiple columns above the mean from April 18 indicate a special cause variation which can most likely be attributed to improvements in the incident reporting process which have continued in this period. The data during 20/21 appears to be indicating a reduction in reporting in the early part of the year which can most likely be attributed to the effects of the Covid pandemic.

Appendix 4 compares RIDDOR reporting between 2018/19 and 2019/20. The results are indicative of the improved reporting processes implemented at the start of 2019/20

Sickness and absence
Although data on the reasons for staff sickness and absences are collated it is not currently possible to link this with whether the cause is work-related.

Recommendation: Review how sickness and absence data is collated to determine whether the cause is linked to occupational harm (Definitely, possibly / partially or not-linked), so that activity can be targeted to reduce the most likely causes of harm and to ensure we are not missing any RIDDOR reportable diseases (such as contact dermatitis)

6. HAZARDOUS SUBSTANCES

The Trust is required to comply with the control of substances hazardous to health regulations (COSHH). With this in mind a self-assessment audit took place during 19/20 which identified a number of issues including:

- Not all departments had capacity to complete the audit, (this has subsequently been put on hold due to the pandemic response effort).
- Most departments answered that they use no chemicals with exposure limits and yet several chemicals with known exposure limits are used commonly within the Trust.

Several other Trusts utilise dedicated software (approximate cost £10k plus licencing) to document the management of hazardous substances. The benefits of this include:

- Assurance that COSHH assessments are completed and are reviewed annually without the need for cumbersome manual audits.

- When a COSHH incident occurs in one department, learning may be shared with others who use the same substance.
- Less repetition of work, departments can copy standardised generic assessments
- Ensures all staff are working to the latest classification, labelling and packaging regulations (CLP) material safety data sheets
- Receive regular updates when manufacturers' safety data sheets are updated
- Triggers a review of assessments to ensure they're completed in a timely manner
- Centralised system will enable super-users to see at a glance what is up to date and what is not.
- Central team can see at a glance the most hazardous substances used (e.g. carcinogens, respiratory sensitisers, allergens, flammables etc.)
- Health and Well-Being team will be able to easily see COSHH assessments to enable them to see where Health Surveillance is required (e.g. for some respiratory and skin sensitisers), which is a legal requirement.
- iFM will be able to see exposure limits of chemicals used in specific areas to enable them to ensure the correct ventilation and in place in compliance with approved codes of practise.
- Fire Officers will be able to view to support fire risk assessment process where flammables are present.
- Safety data sheets can quickly be accessed in the event of a fire.
- Health and Safety can review when incidents occur and can link COSHH register references back to incidents and oblige a review in line with H&S law.

Recommendation: Implement centralised COSHH register utilising dedicated software. (Note this will require either additional capacity with H&S or a project team to manage set up)

7. HEALTH SURVEILLANCE

The Trust has a legal requirement as specified in section 6 of the Management of Health and Safety at Work Regulations 1999 to provide health surveillance. Health surveillance is carried out by the Health and Well-Being team on a contracted basis. The team are SEQOHS accredited and provide a range of well-being services including considerable support services for psychological harm.

There may be a gap in the provision of services linked to COSHH (see section 6 above), which may leave the Trust at risk of harm where staff utilising hazardous substances or over use of products such as soap without adequate controls or some products with exposure limits which can lead to respiratory harm if used without adequate controls over long periods of time.

Recommendation: Review provision of service to ensure all health surveillance meets regulatory requirements as determined by risk assessments.

8. ESTATES & CONSTRUCTION

The management of the Trust's aging Estates presents a number of risks in relation to health and safety. These risks are managed via iFM Bolton. It is essential that the Trust proactively continues to seek assurance via systematic evaluation of information provided and required.

The Trust cannot robustly evidence that it is compliant with Construction, Design and Management regulations (CDM) since the transfer of services to iFM. The CDM regulations set out very specifically the "client" role (i.e. the Trust's role) within the regulations and defines the "client" as the organisation who provides funding for a particular activity. This can be large construction projects or small commissions. The requirement is for the client organisation to ensure it is receipt of a health and safety files for every project and also to provide details of any safety risks to the contractor (i.e. iFM or third party contractor). For example, some patient groups may have more sensitivity to noise or chemicals used in construction representing a greater risk

Recommendation 1: Ensure there is a dedicated process and documented governance route for all construction projects. Smaller projects could be evidenced through generic risk assessments on a shared drive including COSHH and location risk assessments to define specific risks in specific locations (e.g. contractors can have greater risk of encountering patients with visual impairments in Ophthalmology therefore standard safety signage may not be sufficient)

Recommendation 2: Seek a copy of the overall summary report document as set out in the national premises assurance model and continue to seek progress against agreed targets.

9. POLICIES

Whilst several policies have been updated during this period, there are a number which remain outstanding (refer to appendix one)

Recommendation: Continue to review and ensure all safety related policies are updated.

10. SLIPS, TRIPS AND FALLS

Slips, trips and falls remains the number one cause of RIDDOR reportable incidents for staff and visitors. A slips, trips and falls assessment is available on BOB for all managers to review to support efforts to ensure all control measures are in place. In the past 10 years there have been 23 successful claims made by staff within the Group relating to slips, trips and falls which has resulted in pay-outs totalling £230,000.

Recommendation: Carry out a risk profiling exercise to reduce the incidence of slips, trips and falls and ensure there are robust processes in place to check that risks are adequately controlled.

11. AUDIT & KEY PERFORMANCE INDICATORS

Auditing performance against key targets have proved challenging during this period partially because at the start of this period many policies were out of date and sub-groups of the Health and Safety Committee were not yet sufficiently matured.

The table in appendix one demonstrates where KPIs are now being measured. The creation of a revised safety inspection policy and implementation of the environmental audits agreed in the contract specification with iFM will not resolve all audit requirements but will go a significant way towards improving performance monitoring.

Recommendation: Develop safety inspection policy and tools and establish environmental audits.

12. CONCLUSIONS

A significant amount of work has been done during this period to improve upon the health and safety arrangements of the Trust and it is hoped that the Trust is assured of ongoing progress. We cannot of course stand still and it is recommended that the Health and Safety Committee and the Trust Board agrees to objectives based on the recommendations in this document.

Agenda Item

Title	Modern Anti-Slavery Statement

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 January 2020		Discussion	
Exec Sponsor	Esther Steel		Decision	✓

Summary:	From October 2015, there has been a requirement for all UK businesses with a turnover of £36m or more to complete a slavery and trafficking statement for each financial year. The attached statement is published in our annual report on an annual basis and should also be published on our website.

Previously considered by:	Previous statement approved by the Board of Directors

Proposed Resolution	Board members are asked to approve the anti-slavery statement

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:**	Esther Steel Director of Corporate Governance

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

Background

All organisations carrying on business in the UK with turnover of £36m or more must from October 2015 complete a slavery and human trafficking statement for each financial year.

The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). It includes a provision for large businesses to publicly state each year the actions they are taking to ensure their supply chains are slavery free.

The 'slavery and human trafficking statement' must include either an account of the steps being taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any part of its business or its supply chains. Or a statement that the organisation is not taking any such steps (although this is permitted under the Act, it is likely to have public relations repercussions).

The statement must be formally approved by the organisation, and must be published on its website. Failure to do so may lead to enforcement proceedings being taken by the Secretary of State by way of civil proceedings in the High Court.

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team

Modern Slavery and Human Trafficking Act 2015 Annual Statement 2020/21

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

Bolton NHS Foundation Trust is a major provider of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital and also providing a wide range of community services from locations across Bolton. The Royal Bolton Hospital is a major hub within Greater Manchester for women's and children's services and is the second busiest ambulance-receiving site in Greater Manchester. We employ approximately 6000 staff and in 2019/20 had a turnover of xxx

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking. All staff are required to undertake level one adult safeguarding training which includes an awareness of the risks of modern slavery and human trafficking.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our subsidiary organisation iFM Bolton and through any managed service provider contract arrangements.

The Trust employs solely within the UK and how we treat our employees is managed consistently across the Trust by the Human Resources Directorate. The Trust pays above the national living wage i.e. the minimum wage set by the Government.

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2020

Signed

28 January 2020