BOARD OF DIRECTORS MEETING

Date: 28 July 2022
Time: 09.00-13.00
Venue: MS Teams

NHS Bolton NHS Foundation Trust

AGENDA - PART 1

TIME	SUBJECT	LEAD	PROCESS	EXPECTED OUTCOME
09.00	1. Welcome and Apologies for Absence	Chair	Verbal	To note
09.05	2. Patient Story	DoN	Verbal	To note
09:10	3. Staff Story	DoP	Verbal	To note
09.15	4. Declarations of Interest	Chair	Verbal	To note declarations of interest in relation to items on the agenda
	5. Minutes of meeting held on 26 May 2022	Chair	Minutes	To approve the previous minutes
	6. Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
	7. Action Log	Chair	Action log	To note progress on agreed actions
09.25	8. Chair's update	Chair	Verbal	To receive a report on current issues
09.30	9. Chief Executive's Report	CEO	Report	To receive and note
Strategy and Performance				
09:40	10. Board Assurance Framework	DCG	Report	To receive the BAF
09:55	11. 2022/23 Strategic Programme	DoST	Report	To note strategic programme and priorities and approve the establishment of Strategic Operations Sub Committee
10:05	12. Operational Update	COO	Presentation	To receive and note
10:15	13. Integrated Performance Report a. Operational Performance b. Quality and Safety	COO	Presentation	To receive and note

	c. Workforce d. Finance			
10:25	14. Finance and Investment Committee Chair Report	F&I Chair	Report	To receive for assurance
Quality and Safety				
10:35	**BREAK**			
10.45	15. Quality Assurance Committee Chair Report	QAC Chair	Report	To provide assurance on work delegated to the Committee
10:55	16. Midwifery Continuity of Care	Chief Nurse/ Interim Director of Midwifery	Report and Presentation	To receive and note
11:25	17. Learning from Deaths	MD	Report	To receive the Learning from Deaths Report
11:35	18. Mortality Board Report	MD	Report	To receive the Mortality Board Report
Workforce				
11:45	19. People Committee Chair Report	People Chair	Report	To provide assurance on work delegated to the Committee
11.50	20. Nursing, Midwifery and AHP Staffing Paper	Chief Nurse	Report	To receive and note
12:00	21. Guardian of Safe Working	MD	Report	To receive and note
12:10	22. Freedom to Speak Up Annual Report	Deputy DoP	Report	To note
Risk and Governance				
12:20	23. Audit Committee Chair Report	Audit Chair	Report	To provide assurance on work delegated to the Committee
12:25	24. Charitable Fund Committee Chair Report	CFC Chair	Report	To receive for assurance
12.30	25. Committee Update	DCG	Presentation	To receive and approve the update
12:40	26. Message from the Board	Chair	Verbal	To agree messages from the Board to be shared with all staff

12:50	27. Any Other Business	Chair	Verbal	To note
Questions from Members of the Public				
	28. 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				
13.00	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			

Date of next meeting: 29 September 2022

Board of Directors Register of Interests – Updated July 2022

Name:	Position:	Interest Declared	Type of Interest
Donna Hall	Chair	Honorary Professor University of Manchester	Non-Financial Professional Interest
		Donna Hall Consulting Ltd	Financial Interest
		Chair New Local (not remunerated position)	Non-Financial Professional Interest
		System Advisor NHS England	Financial Interest
		Board Member Carnall Farrarr (from 1st April 2020)	Financial Interest
		Chair PossAbilities learning disability social enterprise	Financial Interest
		CIPFA C Co Ltd (previously CIPFA NEWCO Limited	Financial Interest
		Sibling employed by the Trust	Non-Financial Personal Interest
Fiona Noden	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		The Foundation Trust Network (Trustee NHS Providers	Non-Financial Professional Interest
Zieda Ali	Non-Executive Director	CO of Equalities & Justice NW	Financial Interest
		HR director/Consultant Inclusive HR Solutions	Financial Interest
		Trustee Homestart Chorley	Non-Financial Professional Interest
		E&Di Grant Advisor Lord Shuttleworth Belevant Fund	Financial Interest
		Associate Hospital Manager LSCF NHS Trust	Financial Interest
		OS Scrutiny Committee Rossendale Council	Non-Financial Professional Interest
		EDI Football Advisor Lancashire Football Club	Non-Financial Professional Interest
		National Board Advisor for race discrimination for IOPC (Independent Office of Police Conduct)	Financial Interest
Francis Andrews	Medical Director	Holt Doctors (locum agency) payments for appraisals	Financial Interest
		Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest

Board of Directors Register of Interests – Updated July 2022

Name:	Position:	Interest Declared	Type of Interest
Malcolm Brown	Non-Executive Director	Nothing to declare	
Rebecca Ganz	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
Bilkis Ismail	Non-Executive Director	Director of Bornite Legal Limited, Bornite Holdings Limited, Bornite Holdings (1) Limited and Bornite Consulting Ltd	Financial Interest
		Director of Zeke Holdings (1) Limited	Financial Interest
		Director of Azurite Holdings Limited	Financial Interest
		Director of Rightdeal Insurance and Mortgage Services Limited	Financial Interest
		Governor Bolton Sixth Form College and The Valley Community Primary School	Non-Financial Personal Interest
Sharon Katema	Interim Director of Corporate Governance	Substantively employed by Southport and Ormskirk NHS Trust	Financial Interest
Sharon Martin	Director of Strategy	Trustee at Fort Alice Bolton	Non-Financial Professional Interest
		Trustee George House Trust	Non-Financial Professional Interest
		Judge on Inspire Awards	Non-Financial Professional Interest
		Board Member of Bolton College	Financial Interest
James Mawrey	Workforce Director	Trustee at Stammer	Non-Financial Personal Interest
Jackie Njoroge	Non-Executive Director	Director – Salford University	Financial Interest
		Deputy Chair HESPA (non-remunerated position)	Non-Financial Professional Interest
Martin North	Non-Executive Director	Wife is a director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest

Board of Directors Register of Interests – Updated July 2022

Name:	Position:	Interest Declared	Type of Interest
Tyrone Roberts	Chief Nurse	Nothing to declare	
Alan Stuttard	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
		NED Blackpool Operating Company Ltd (Blackpool Sandcastle Waterpark)	Financial Interest
		Non-Executive Director - Blackpool Waste Services Ltd (trading as Enveco)	Financial Interest
Annette Walker	Director of Finance	Chief Finance Officer of both Bolton Foundation Trusts and NHS Bolton	Non-Financial Professional Interest
		Bolton Fundco 1 Limited; Bolton Holdco Limited	Non-Financial Professional Interest
		BRAHM FundCo 2 Limited; BRAHM FUNDCO 1 LIMITED; BRAHM INTERMEDIATE HOLDCO 1 LIMITED; BRAHM Intermediate Holdco 2 limited; BRAHM LIFT LIMITED	Non-Financial Professional Interest
Rae Wheatcroft	Chief Operating Officer	Nothing to declare	

GUIDANCE NOTES ON DECLARING INTERESTS

The Board believes that interests should be declared if they are material and relevant to the business of the Board and should, in any case, include:

- Directorship, including non-executive directorships held in private companies or private limited companies
- Ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for services with NHS services.

NB If there is any doubt as to the relevance of an interest, this should be discussed with the Trust Chair.

Meeting:	**Board of Directors (Part 1)**
Date:	**Thursday 26 May 2022**
Time:	**09:00-12 noon**
Venue:	**Via Zoom**

PRESENT:

Donna Hall	Chair	DH
Fiona Noden	Chief Executive	FN
Francis Andrews	Medical Director	FA
Sharon Martin	Director of Strategy and Transformation	SM
James Mawrey	Director of People	JM
Annette Walker	Director of Finance	AW
Rae Wheatcroft	Chief Operating Officer	RW
Tyrone Roberts	Chief Nurse	TR
Malcolm Brown	Non-Executive Director	MB
Rebecca Ganz	Non-Executive Director	RG
Martin North	Non-Executive Director	MN
Alan Stuttard	Non-Executive Director	AS
Jackie Njoroge	Non-Executive Director	JN
Bilkis Ismail	Non-Executive Director	BI

IN ATTENDANCE:

Sharon Katema	Interim Director of Corporate Governance	SK
Helen Lowey	Director of Public Health	HL
Rachel Tanner	Managing Director, Integrated Care Partnership	RT
Victoria Crompton	Corporate Governance Manager	VC
Tracey Joynson	Patient Experience Manager (item 2 only)	TJ
Michelle Cox	DDO, Anaesthetics and Surgical Services Division and Diagnostic and Support Services Division	MC
Rachel Carter	Associate Director of Communications and Engagement	RC
Louise Tucker	Interim Head of Midwifery (for item 14)	LT
Tracy Iles	Divisional Director of Operations, Family Care Division (for item 14)	TI

1. Welcome

Donna Hall welcomed everyone to the meeting and formally welcomed Rachel Tanner, Managing Director, Integrated Care Partnership and Helen Lowey, Director of Public Health to their first Board of Directors meeting.

2. Patient Story

Board members received the patient story from Mr D who in May 2022 became unwell whilst at home. His wife contacted 111 who assessed him over the phone and sent an ambulance to collect him to take him to Accident and Emergency. Mr D was seen in Resus where he was well looked after by the team before being transferred to Critical Care.

Unfortunately, his wife was unable to go to Critical Care with him at that time, but shortly after transfer she was contacted by the Consultant who provided an

update on her husband's condition advising they had inserted a central line so he could receive dialysis and that he had Sepsis. The Consultant also checked on Mrs D's welfare including how she was looking after herself and that she had had something to eat and was resting. He advised that he would update her again and allowed her to book a visiting slot for the following day. As the visiting slot was most convenient, she kept the same time slot for the entirety of her husband's stay in Critical Care and did not travel at night.

Mr D was seen by a Pharmacist and Physiotherapist, the latter providing paperwork for them to give to the Local Authority so they could prepare the necessary support for when he returns home.

Both Mr D and his wife expressed how well they were treated throughout his hospital admission and how good the communication has been. They commented their treatment could not have been any better.

The process for obtaining mobility equipment from the Local Authority following a hospital admission was discussed and it was agreed the process could be improved and made quicker by the Trust forwarding the paperwork directly to the Local Authority.

The Board of Directors thanked Mr D and his wife for sharing their patient story.

Staff Story

Board members heard the story of the staff who cared for Mr D whilst he was an in-patient in the Critical Care unit. It was noted that relationships with patient families were key within Critical Care and that staff had welcomed the lifting of visiting restrictions within the unit. The teams had observing emerging challenges concerning a cohort of staff who have never dealt directly with visitors and were actively managing this and stressing the importance of patients receiving visits.

Board members queried whether this issue had also been picked up in other areas, and it was confirmed it has been highlighted by some other senior staff who were monitoring this locally and ensuring there was greater awareness and support for staff and students.

An issue was highlighted regarding the difficulty of stepping down patients from Critical Care with reports that some patients were asking to be transferred to the wards from the department. It was confirmed that the Integrated Discharge Team had provided some support and the situation was improving, but there was more than could be done. Any patients who are particularly distressed whilst on Critical Care are being moved to other areas such as side wards where possible and the issues are being escalated to the Flow Team regularly.

In response to a query it was explained that there was ongoing work within the Integrated Care Division and by the ICP which focussed on the needs of patients who were being admitted as in-patients. There are a number of initiatives already in place for patients with learning difficulties and patients on the end of life care pathway and the process is constantly evolving.

It was noted that with the exception of issues around patient flow and the build of the department, the team was very happy and rarely received any complaints.

Board members thanked the staff from Critical Care for their feedback.

Resolved: The Board of Directors received and noted the patient and staff stories.

3. Apologies for Absence

The Board noted apologies for absence from Zed Ali.

4. Declarations of Interest

There were no declarations of interests relating to the agenda items.

5. Minutes of last meeting

The minutes of the meeting held on 31 March 2022 were approved as a correct record.

6. Action log

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

7. Matters arising

There were no matters arising to report.

8. Chair's Update

No update provided.

9. Chief Executive Report

The Chief Executive presented the Chief Executive Report and the following key points were highlighted:

- The recent engagement event was well attended and had Non-Executive Director and Governor representation. Discussions included conversations around experiences of care and about the workforce and how it should be representative of the public we serve. A lot of people were involved in the event ensuring that all areas were represented.
- Patients who contracted Covid whilst in hospital have now been contacted and two themes have been identified following this work which include lost property, and a Personal Property Policy is now being developed, and around communication.
- In order to ensure good communication links with the different communities in Bolton, work was being done to build on the links which have already been established particularly those established during Covid.

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

10. Operational Update

The Chief Operating Officer provided an update on urgent care, Covid-19, recovery and community care. The following key points were highlighted:

- Average A&E daily attendances in the last 30 days has been 390 with 26% of attendances from outside of Bolton. A&E performance is in line with the rest of GM. Ambulance handovers remains the greatest challenge and we remain focussed on actions to improve this.
- There are 39 in-patients who have tested positive for Covid-19 none of which are in Critical Care. There is one Covid positive ward and changes have been made to Infection Prevention Control measures to bring us line with national guidance.
- There are 20 confirmed cases of Monkeypox in the UK and there are not currently any cases in Bolton.
- Cancer performance continues to be the best in GM and whilst we failed Q4 of the 62-day standard it is expected to be back on track for April.

- In our Integrated Community Services Division, district nursing and district therapy teams had more contacts in the month than attendances at A&E.
- The Admission Avoidance Team saw 268 patients - 74% of their referrals within two hours and prevented 134 from being admitted to hospital.

In response to the update Board members raised a number of queries and the following responses were provided:

- The Trust has engaged Archus, a healthcare infrastructure specialist, to work with the urgent care team. There are more actions which can be taken in order to redirect patients away from A&E and to make the best use of ambulatory care and BARDOC. Updates on the work will be provided in future operational updates.
- There is an immense amount of scrutiny over the elective care waiting lists with every case undergoing both administrative and medical validation.
- There have been some improvements on the number of patients with no criteria to reside due to lower cases of Covid and through good partnership working.

The Chief Operating Officer advised that she would endeavour to provide more assurance in future community working updates and provide system wide updates in future meetings.

Resolved: The Board of Directors received the Operational update.

11. Quality Assurance Committee Chair Reports

The Quality Assurance Committee Chair delivered the report from the April meeting highlighting that discussions have taken place around streamlining future agendas as this meeting had significantly overran.

It was also noted that six serious Incident Reports were received at the meeting which were all approved.

The Deputy Chair of the Quality Assurance Committee presented the May report highlighting the key points from the meeting.

Board members were informed the process for investigating and approving Serious Untoward Incidents is being reviewed by the Director of Clinical Governance. The Chief Nurse explained the change is to ensure timely investigations and that the Trust reports back to patients and families in a timely manner. The Director of Clinical Governance is working through the process and the findings of the review will be communicated shortly.

It was clarified that it is a stipulation that Never Events should be Chaired by a Non-Executive Director and Serious Incidents Panels should be Chaired by either the Chief Nurse or Medical Director.

It was agreed that the proposed new process should be brought back to the next Quality Assurance Committee for approval.

SI reviewed investigation process to be taken to next Quality Assurance Committee for approval.	**TR FT/22/10**

In response to a query it was confirmed that the business case for mobile phone for community staff covered both employees in the Family Care and Integrated Care Divisions.

Resolved: The Board of Directors received the Quality Assurance Committee Chair Reports.

12. Staff Story

Laura Anton, Operational Business Manager, delivered a staff story which detailed the benefits of Tier 1 on call shifts. She outlined that being on the Tier 1 rota was a major motivator for staff most of whom welcomed the opportunity to expand on skills and gain beneficial experience. However, there was support for colleagues who found the responsibilities emotional.

The Board thanked Laura for sharing her experiences and commended those on the Tier one rota for their hard work as they were re some of the unsung heroes in the Trust..

Resolved: The Board of Directors received and noted the staff story.

13. People Committee Chair Report

The Chair of the People Committee presented the reports from meetings held in April and May highlighting the key points.

Board members discussed apprenticeships and

It was noted that whilst the majority of apprenticeships were being undertaken by existing staff, work with Bolton College to develop further apprenticeships was progressing. This would focus on different areas where the Trust required a staff pipeline for example an apprenticeship in Informatics which would meet business need. Furthermore, a whole system approach was being taken around the development of education pathways fit for the future. An Apprenticeship Plan is being refreshed and would be presented at the People Committee once completed.

A query was raised regarding a current NMC consultation regarding internationally qualified staff who were working in unregistered roles due to falling short on English language requirements. It was agreed that JN will send further information on this to the Director of People and Chief Nurse in order for them to investigate the Trusts position and respond to the People Committee.

Resolved: The Board received and noted the People Committee Chair Report.

14. Maternity Update

The Chief Nurse advised Board members that due to him being new in post and the staffing changes within the Family Care Division he felt it was important to provide Board members with an update on the work taking place within maternity. Assurance was provided by the Chief Nurse that although there are some areas of concern within maternity he is confident that the care being delivered within the unit is safe.

The Divisional Director of Operations and Interim Head of Midwifery from the Family Care Division presented an update on maternity services and the current issues.

Assurance was given that the divisional team are meeting weekly with the Chief Nurse to ensure there was consistency of information being provided both internally and externally It was noted that the presentation provided a high level overview and was a true reflection of the situation.

The Board was advised that the Trust was working closely with commissioners with a view to fully reopen services at Ingleside following the temporary pause on to delivery service at Ingleside in January due to staffing issues, However, antenatal classes had continued to take place within the

unit. Additionally, the staffing of the unit was being closely managed with recruitment plans in place for newly qualified midwives into roles across the division.

With regards to the leadership challenges within Maternity, it was acknowledged that the divisional management team were working to address the issues and there were a number of changes within the Division which sought to improve the management structure and morale within the department.

It was queried whether there was an issue in Bolton with regards to maternal mortality rates for Black, Asian and Minority Ethnic (BAME) patients, and it was confirmed the Trust has a Cultural Liaison Midwife who is leading on work to practise and embed recommendations which have been made and to ensure there was adherence to best practice.

In response to concerns regarding the Trust's response to the Ockenden Report subsequent highlighted issues, it was confirmed the division was undertaking an in-depth review of the actions as an assessment would be taking place shortly.

The Chief Nurse highlighted that the Head of Midwifery has recently received the ABC Award for her good attitude and behaviour.

Board members thanked the division for their continued focus to improve the service.

Resolved: The Board noted the maternity update.

15. Governance Self Certification 2022

The Director of Corporate Governance presented the Governance Self Certification 2022, outlining that the Board was required to sign off on:

- General condition 6 The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.
- Continuity of service condition 7 – the provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement.
- Condition FT4 (8) of the NHS provider licence – the provider has completed with required governance arrangements.
- Training of governors

The Board considers the declaration on an annual basis and is asked to review the evidence and confirm compliance with the NHS self-certification for the NHS Provider Licence.

Resolved: The Board approved the Governance Self Certification 2022.

16. ICP Business Plan

The Managing Director of the Integrated Care Partnership presented the ICP Business Plan which sets out the outcomes to date and priorities for the next 12 months. The plan outlined how the partnership would continue to work together across public, community and voluntary services, including acute and primary care, to deliver integrated health and care with the aim of improving outcomes for Bolton people. Board members were asked to comment and note the plan.

In response to a number of queries the following responses were provided:

- There are some challenges associated with the roll out in the districts, but these are within our control. Work needs to be done to ensure communities are aware of when and how services can be accessed.

- There will be a devolved budget and as we move through the year there will be a greater overview and we will need to consider how we use and deploy the Bolton pound.
- MDTs are a short discussion regarding each patient and the practicality around including the patient voice is difficult, but this is an important challenge and teams need to hear the patient voice within these discussions.
- It is still planned to move to nine neighbourhood teams, although there may not be sufficient resources for each team to have their own link for some specialities with small teams, but each neighbourhood will be aware of what resources are available and how to contact them.
- Within the delivery plan there is a delivery plan which includes KPIs and metrics for success.
- Choices will have who system discussion at Locality Board as to where money is spent and invested. There may not be evidence to support some decisions due to investments in healthy communities not leading to any benefits for years, but the Board will be aware of situations and know the right thing to do.

Resolved: the presentation was noted.

17. Audit Committee Chair Report

Board members received and noted the Chair Report from the Audit Committee.

Resolved: The Board noted the Audit Committee Chair Report.

18. Finance and Investment Committee Chair Report

Board members received and noted the Chair Report from the April Finance and Investment Committee.

Resolved: The Board noted the Finance and Investment Committee Chair Report.

19. Integrated Performance Report

Board members received and discussed the Integrated Performance Report and the following responses were provided to the queries raised:

- The 50% figure referring to the receipt of antibiotics in 60 minutes in Accident and Emergency was from a period of high pressure resulting in the target not being met. These pressures are now easing slightly and it is anticipated the percentage will improve. The percentage achieved is usually around 80%.
- The target for clinical correspondence is one day for inpatients and five days for outpatients. Improvements have been made and the Trust is now close to achieving these targets.
- Staff turnover is increasing in the NHS as a whole, the main reason is retirement and the second highest reason is due to promotion, and there is no evidence to suggest there are any cultural reasons. Concern was raised that the high staff turnover figures do not correlate with the somewhat good staff survey results that were received, it was agreed to complete a deep dive on turnover and take the findings through the People Committee.

Deep dive on staff turnover to be completed and the findings to be taken through the People Committee. **JM FT/22/11**

The Chief Nurse advised that the Deputy Chief Nurse was leading on a piece of work to retain and support Healthcare Assistants in Maternity with career development.

It was noted that the percentage of staff who responded to the staff survey was lower than usual, so it may be beneficial to consider exit interviews to ascertain what themes there are for staff who are leaving the Trust.

Resolved: The Board received and noted the Integrated Performance Report.

20. Any other business

In response to a query around presentation of the Board Assurance Framework (BAF) which was previously included in the CEO report, the Director of Corporate Governance confirmed that a review of the BAF and process by which it was presented at Board and Committees was underway. It was noted that the BAF would be presented quarterly at Board.

21. Next meeting

The next Board meeting will take place on the 28 July 2022.

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.

January 2022 actions

Code	Date	Context	Action	Who	Due	Comments
FT/22/02	27/01/2022	Operational Plan Update	Presentation to Board regarding piece of work being completed on changes to community working	JM/SM	Jul-22	Complete - presentation provided to People committee and noted in Chair Report
FT/22/10	26/05/2022	Quality Assurance Committee Chair Report	SI review investigation process to be taken to next Quality Assurance Committee for approval.	TR	Jul-22	Complete - and discussed with relevant Non-executive
FT/22/11	26/05/2022	Integrated Performance Report	Deep dive on staff turnover to be completed and the findings to be taken through the People Committee.	JM	Sep-22	Complete - noted in People Committee Chair Report and LCT update
FT/11/12	26/05/2022	Maternity update	TR to provide an update to the Board following the Stakeholder meeting on Maternity Services.	TR	Jul-22	Complete

Key

complete	agenda item	due	overdue	not due

Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Fiona Noden		Decision	

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

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

Proposed Resolution	To note the update.

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

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

Ambition 1
Provide safe, high quality care

This month I am proud of the way our teams and services responded to the heatwave to make sure that the quality of our care was not compromised. Our IFM colleagues distributed over 2000 water bottles to our community hubs and via a hydration station at our hospital site, and installed over 300 portable air conditioning units to make sure our patients and staff were as comfortable as possible. Our community teams distributed information to patients about what they could do to stay safe and well in the heat and additional measures taken also included adjustments to our uniform policy and an increased focus on making sure our staff were taking regular breaks.

We continue to manage another wave of COVID-19 in our communities and in our hospital. Our approach to dealing with this wave has been different to others because we operating under different infection prevention and control (IPC) measures and the majority of our patients are being treated with COVID, rather than for it. At the moment, this is not having an impact on our ability to provide other services and our teams have stepped up to the challenge and continued to provide the best care possible for our patients.

Our focus remains on making sure that patients who need treatment are being seen as soon as possible. Our Endoscopy and Bowel Cancer Screening Service surpassed one of their milestones this month when they managed to reduce waiting times for routine diagnostics to less than four weeks in Bolton against the national six-week target. The clinical team developed a recovery plan, which included purchasing new equipment and opening a fifth room for endoscopy procedures to aid faster diagnosis and treatment.

A free standing prescription collection point has been installed on our hospital site, giving patients 24-hour access to collect their outpatient prescriptions at a time that suits them. This safe, secure and fast way of collecting medication will not replace the pharmacy service within the hospital, but provide an additional outlet for patients to access their medication without entering the hospital, when it's most convenient.

Ambition 2
To be a great place to work

On 5th July we celebrated the NHS' 74th year and took a moment to reflect on how much services have evolved since its inception, and how much incredible work our teams have been doing across Bolton so far this year. Our overall ambitions and values still remain and our services celebrated the work they do to provide the best possible care and experience to our patients when they need it.

Exactly one week later on 12th July, the NHS was presented with the George Cross at Windsor Castle by Her Majesty The Queen. The George Cross recognises the courage, compassion and dedication of staff during the pandemic and their service to the public for the last 74 years.

We held a celebration event this month to welcome our latest international nurses and their children who have joined us from countries including India, Hong Kong, and Kenya to work in clinical areas such as medicine, theatres and critical care. We have recruited 21 international nurses so far and are on track to recruit another 72 nurses before the end of

August this year. To help our new recruits settle into life in Bolton more than sixty flats have also been secured to provide a safe and comfortable space for them to live.

Our annual For a Better Bolton (FABB) Awards are now open for nominations. This year a new People's Choice category has been introduced and welcomes nominations from members of the public, patients and their families who want to nominate an individual or team who has made a difference to them. The deadline for nominations is Friday 12th August.

Ambition 3
To use our resources wisely

An annual financial plan has been agreed for Greater Manchester which relies on trusts across the system to achieve efficiency savings of £21 million. In Bolton, our teams have been coming up with some innovative solutions to using our resources wisely and we will continue to support teams to think and operate in this way. To support our divisions to feel confident in making the right decisions, our Finance Team has been running financial training for senior managers and feedback has been really positive.

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

We have been given the green light to start working on the Bolton College of Medical Sciences (BCMS) professional skills and training facility which will be built on our hospital site in Farnworth. This pioneering joint venture between ourselves, the University of Bolton, Bolton Council and Bolton College, is the first of its kind in the UK and will transform how NHS and social care workforces are trained. Work is expected to start early next month.

We are still awaiting the outcome of our bid to receive a share of the government's health infrastructure funding (HIP) which we submitted back in September 2021. The funding will allow us to build improved maternity, neonatal, gynecology and breast services on our existing grounds and while we remain hopeful, if we are not successful will be exploring alternative ways to fund this work.

Ambition 5
To integrate care

Our ambition to truly integrate health and care services in Bolton remains and we know that supporting people in the community, closer to home will benefit our local communities. The Department of Health and Social Care (DHSC) has announced that more than £15m of funding will be given to local authorities across England, to help LA's implement new social care charging reforms.

This is the first portion of funding for local authorities, and further support will be made available later to strengthen capacity and to support implementation of technology that can support changing reform in due course.

On 9th February 2022 the government published the health and social care integration white paper, Joining up care for people, places and populations detailing plans for a single accountable person, to deliver the key ambitions to accelerate the delivery of joined-up health and social care at place level as a way of improving health and care outcomes, and making best use of public resources.

From 1st July 2022 each of the 10 localities in Greater Manchester have established roles known as Place Lead for Health and Care Integration – convening and coordinating the locality, bringing the parties together, driving the changes to improve health, tackle health inequalities and improving everybody's access to, experience of, and outcomes from care.

The Place Lead for Health and Care Integration for the Bolton locality is Fiona Noden and she will be accountable to the Chief Executive of Greater Manchester Integrated Care and Bolton Council through the Locality Board. This role is supplementary and complimentary to the substantive chief executive of Bolton NHS Foundation Trust.

Ambition 6
To develop partnerships

As a direct result of feedback from one of our service users, our Midwives have launched a new group for mums-to-be who feel socially isolated. The service user was struggling with loneliness, and could only find local social groups for mums who have already given birth. To help ensure people who are pregnant have access to mental health support during pregnancy, the team will host a social group once a month at Oxford Grove Children's Centre.

Our 0-19 youth services have been working with Bolton Together and partners across Bolton to engage with over 600 children, young people and their families to understand their experience of health services, and what we can do to shape services around their needs. A summary report including the recommendations gathered from the engagement with Bolton's young people and parents about the health and wellbeing services they receive has recently been published. Read the full report on the Bolton Together website. Our teams have been working through the feedback to understand the short, medium and long term actions we will be taking in response to the feedback will be coming to the September Board of Director's meeting.

AGENDA ITEM: 10

Title:	Board Assurance Framework (BAF)

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 July 2022		Discussion	✓
Exec Sponsor	Interim Director of Corporate Governance		Decision	

Summary:	The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. As a mature organisation with well-established risk and assurance processes, our use of the BAF should be focused on the actions to take to mitigate gaps and the ongoing development of a mature approach to risk-appetite particularly in terms of innovation Since the last presentation of the BAF to the Board, there have been no changes to the risk scores. However, a review of the BAF is underway which will ensure that the BAF progressively develops in line with our planned Strategy refresh. This will be reflected in the next iteration that will be presented in October. *Key to proposed changes:* ~~*Score through*~~ *= proposed deletions/completed* *Blue Text = proposed additions*

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

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

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓

*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Sharon Katema, Interim Director Corporate Governance	**Presented by:**	Sharon Katema, Interim Director Corporate Governance

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

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

Background

The Board Assurance Framework is a document setting out:

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

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

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

Current practice for review of the BAF

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

Recommendation

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

a Item

Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Board Assurance Framework 2019/24

Board Assurance Framework Explanatory Notes

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

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

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

1	Ambition – To give every person the best care every time – reducing deaths in hospital		Lead Director	Medical Director	
			Date updated	June 2022	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
HSMR higher than expected (SHMI within range)	Monitored quarterly at Trust Mortality Reduction Group (MRG) Learning from deaths SJRs for high mortality groups HED analysis mortality patterns	Quarterly SHMI (2 quarters in arrears) ~~Secondary review of SJRs at learning from deaths committee~~ ~~Head HED analysis of mortality patterns~~ MRG commissioned audits of higher than expected mortality groups HSMR appropriate actions referred to palliative care specialist.	Delivery of MRG Work stream designed to support higher SHMI and HSMR Audit of cases and coding to understand cause – Delivery of the coding workplan Assessment of quality of care through SJRs Work with AQUA and NHS Northwest on pneumonia, liver disease and sepsis.	Mortality Reduction Group Learning from deaths committee Quality Assurance Committee Board	
Recording of diagnosis and co-morbidities not accurate	Access to Bolton Care Record now fully available for comorbidities Recording and coding action plan	Monthly monitoring of co-morbidity recording via HED – monitored by MRG AQUA NW mortality report	Implementation of recording and coding plan. MRG currently reviewing Education package developed for medical staff. Overseen by MRG	Mortality Reduction Group Quality Assurance Committee	
Learning from deaths actions not implemented	Learning from death process/policy Tracking of actions from learning from deaths committee complaints intelligence (where a death has occurred) is reviewed and reported to the LfD Committee Medical Examiner will request SJR	Quarterly reports to QAC and Board alternately. Tracking template for LfD actions and feedback	New healthcare intelligence provider appointed (HED) LfD audit action plan examined for themes with thematic analysis is embedded.	Mortality Reduction Group Trust Board Learning from deaths committee	
NEWS compliance currently under 90%	Clinical incident reporting and Root cause analysis Quarterly KPI's include sepsis screening tool Revised fluid balance charts on EPR	Quarterly Audit via Nursing care Indicators reported at MRG.	New reporting suite for EPR NEWS Divisional Action plans for aiding improvement in NEWS including hydration programme (not part of NEWS) *Included in QA for next year going forward.*	Mortality Reduction Group Mortality included in Divisional Quality reports (move to HSMR)	
Avoidable cardiac arrest Root cause analysis of cardiac arrests and critical care escalation- data shows year on year reduction in avoidable cardiac arrests Failure to recognise or respond to a deteriorating patient generates a clinical incident report	Sepsis performance report to MRG and would sit better under NEWS compliance – move up! Quarterly cardiac arrest RCA reports Deteriorating patient lead in post	Learning from deaths SJR process Learning from deaths quarterly reports to Board	Root cause analysis of avoidable cardiac arrests Audit of medical handover arrangements being monitored for improvement and eventual assurance via CGQA Design and implement a robust quarterly audit of response using patient track data- needs reactivation	Mortality Reduction Group Clinical Governance and Quality Assurance Group Mortality Reduction Group	
Documentation of DNACPR	DNA CPR audits	Cardiac arrest RCA audits DNAR-CPR audit quarterly	Audit of capacity and DNAR-CPR by division quarterly Updated DNAR-CPR policy Capacity assessment link now on EPR Appointment of DNAR-CPR clinical lead	End of Life Steering Group Clinical Governance and Quality Assurance Group	

Sepsis performance not at 100%	Sepsis improvement work stream	Sepsis quarterly performance SHMI for sepsis within normal limits A&E screening on upward trajectory	Delivery of sepsis plan for in patients 21-22 Revision of sepsis policy Incorporation of SAFER principle into training Education for clinical staff programme Implementation of EPR sepsis bundle	Mortality Reduction Group

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

Risk appetite

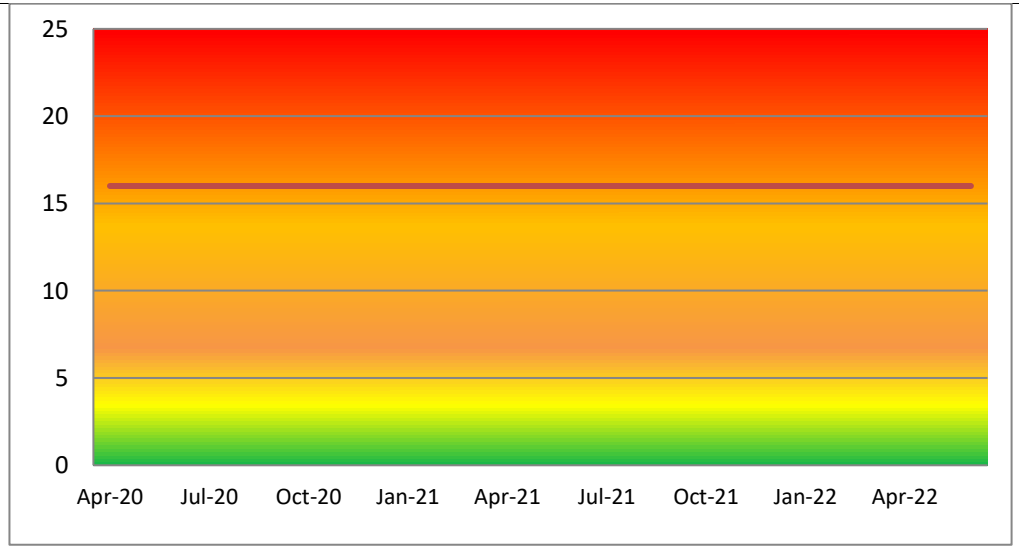
Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward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

Background

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

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

Risk tracking



date:	comments	Risk Score	I	L	
05/11/20	Risk narrative updated		4	4	**16**
29/06/21	Narrative updated		4	4	**16**
01/11/21	Narrative updated		4	4	**16**
30/06/22	The narrative has been updated and reviewed. This remains a high risk with no change in risk score.		4	4	**16**

1.2	Ambition – To give every person the best care every time – Delivery of Operational Performance	Lead Director	Chief Operating Officer
		Date updated	June 2022

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

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

Risk appetite

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

Background

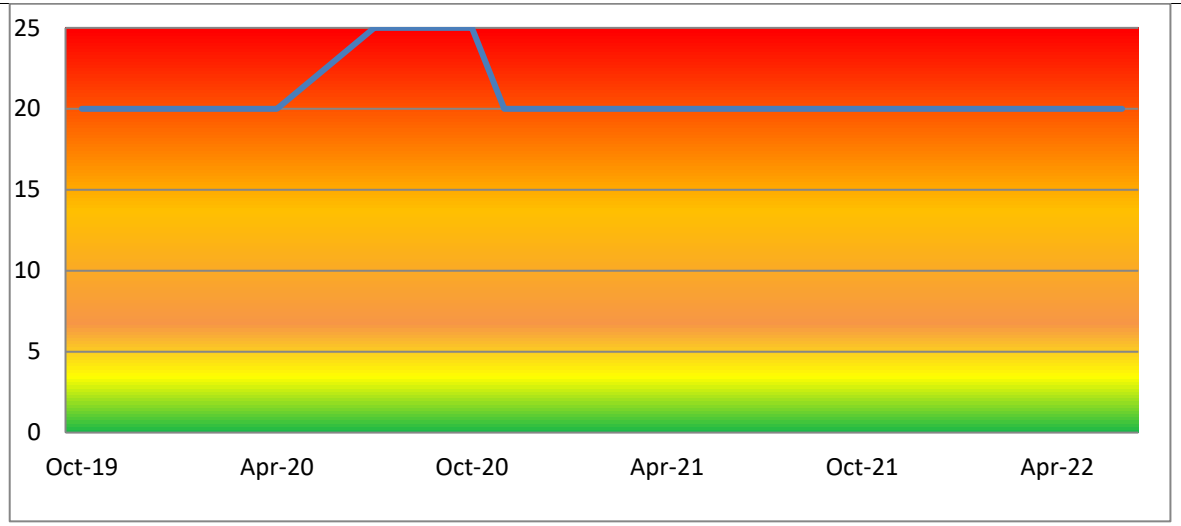
The Trust has for some time, struggled to maintain the standard

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

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

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

Risk tracking



date:	comments	Risk Score	I	L	
20.02.20	Risk updated to reflect challenges to RTT and cancer performance		4	5	20
10/7/20	Risks updated in light of pandemic		5	5	25
16/11/20	Risk moderated and agreed although extremely high should remain at 20		4	5	20
29/06/21	Risk narrative reviewed and updated		4	5	20
30/06/22	The narrative has been updated and reviewed. This remains an Extremely High risk with no change in risk score.		4	5	20

2	Ambition – To be a great place to work		Lead Director	Workforce Director	
			Date updated	June 2022	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Health and Wellbeing of workforce – If the Trust does not reduce sickness absence rates there will be a service delivery and financial impact Increased risk as a result of Covid related absence. Impact of Covid and work pressures on staff mental health	H&W Strategy Local, Regional & national Benchmarking Workforce & OD Strategy. Occupational Health Staff Health and Wellbeing programme	Attendance KPI Staff survey Friends and Family Go Engage Ward to Board heat map Covid sitrep	Pillar Healthy Organisation Culture and Pillar Workforce Capacity. Both have full action plan on measures being taken across full organisation. Regular updates provided to Subgroups and People Committee on controls being taken Extensive actions within the H&W Action plan	People Committee, Health & Wellbeing group Board of Directors Monthly review of action plans at Health and Well-being steering group	
Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will be a potential impact on improvement initiatives, discretionary effort and attendance Increase risk of stress related issues for staff as a result of Covid-19	Great Plan to Work Plan Go Engage Pioneer Programme Workforce & OD Strategy.	Staff Survey Friends and Family Go Engage NHS Staff Survey Local, Regional & national Benchmarking Covid sitrep	Pillar Healthy Organisation Culture Full action plan on measures being taken across full organisation. Regular updates provided to Subgroups and People Committee on controls being taken Extensive actions within the Staff Engagement Action plan	Monthly review of action plans at Staff Engagement Group People Committee Board of Directors	
Recruitment and retention – if the Trust does not recruit and retain staff with the right skills and values the delivery of all other objectives will be at risk.	Recruitment & retention Strategy Weekly / Monthly Safe Staffing meeting Job planning Workforce & OD Strategy.	Integrated Workforce Report. Includes recruitment KPI, Agency, Bank, sickness, retention. Staffing report, HR reports on vacancies	Pillar Workforce Capacity has full action plan on measures being taken across full organisation. Regular updates provided to People Committee on controls being taken ~~Review Workforce and OD strategy Dec People Committee~~	People Committee and Board of Directors	
Agency use – failure to reduce reliance on agency staff has a financial impact but also a potential impact on the wellbeing of substantive staff and the care of our patients	Recruitment & retention Strategy Weekly / Monthly Safe Staffing meeting Job planning Workforce & OD Strategy.	Integrated Workforce Report. Includes recruitment KPI, Agency, Bank, sickness, retention. Staffing report, HR reports on vacancies	Pillar Workforce Capacity has full action plan on measures being taken across full organisation. Regular updates provided to People Committee on controls being taken Review Workforce and OD strategy Dec People Committee	People Committee and Board of Directors	
Inclusion – if the Trust workforce does not represent the diversity of the population we serve this can impact on care provision, reputation and future recruitment and retention	EDI Strategy Workforce & OD Strategy.	WRES, WDES, Gender Pay gap and Annual Quality report	Pillar Healthy Organisation Culture (inclusive of inclusion) action plan. Regular updates provided to Subgroups (EDI Steering group) and People Committee EDI Action plan	EDI Steering Group BME Staff network, LGBT group People Committee	

Education and Development – if the Trust does not provide opportunities for education and development this will impact on retention, engagement and wellbeing of staff and the future capability of the workforce Covid-19 has resulted in significant reduction in training opportunities	Revalidation Appraisals Workforce & OD Strategy.	Workforce dashboard Integrated Workforce Report. Includes some Education metrics.	Pillar Education & leadership. Full action plan on measures being taken across full organisation. Regular updates provided to Subgroups (Education Group) and People Committee on controls being taken Extensive actions within the Education Action plan	People Committee, Monthly review of action plans at Subgroup (Education group)	
Failure to maximise digital HR systems could lead to lost opportunities for increased efficiency and effectiveness	ESR / ERS Benefits realisation plan Job planning roll out plan	Workforce Digital group (just formed) People Committee signed off on plan December 2020	This action plan is in the early form of development.	People Committee, Workforce Digital Group	
Agile Working – if the Trust does not have the right policies and procedures to allow people to work from home this will impact on the wellbeing of our staff	Agile Working policy Appropriate risk assessments Appropriate equipment	Agile working steering group in place	Full action plan in place overseen by the agile working group Policy being finalised Roll out plan for equipment Risk assessment developed	Agile working group People Committee	

2 Ambition - To be a great place to work

Risk appetite

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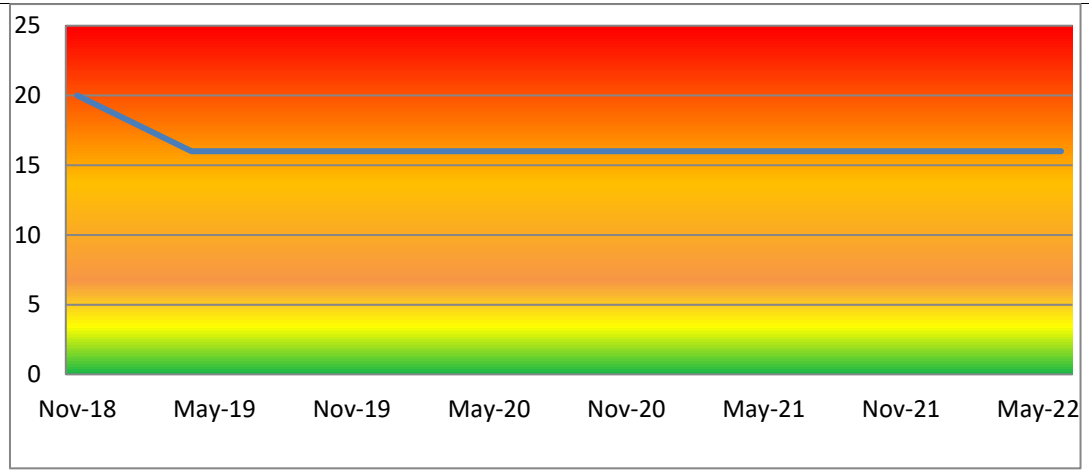
Background

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

The People Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of being a great place to work

Risk tracking



date:	comments	Risk Score	I	L	
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy		4	4	16
05.11.20	Risk reviewed – no changes made		4	4	16
06.01.21	Risk reviewed, minor changes made to content and to summary		4	4	16
28/06/21	Risk reviewed, minor changes to narrative		4	4	16
30/06/22	Risk reviewed, no proposed changes to score		4	4	16

3	**Ambition –** **To continue to use our resources wisely so that we can invest in and improve our services**	**Lead Director**	**Annette Walker**
		Date updated	**June 2022**

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

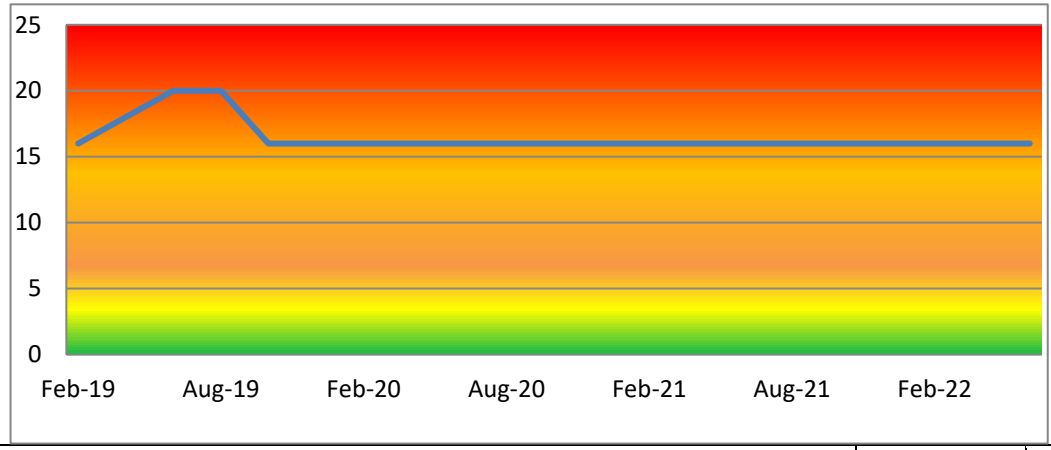
3 Ambition - To continue to use our resources wisely so that we can invest in and improve our services

Risk appetite

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

Background

Risk tracking



date:	Comments	Risk Score	I	L	
20.02.20	Full update to risk		4	5	20
May 20	Risk narrative updated		4	5	20
Nov 20	General Update – risk score reduced		4	4	16
Jan 21	Review to focus on strategic risks		4	4	16

4	Ambition – To make our hospital and our buildings fit for the future	Lead Director	Director of Finance
		Date updated	June 2022

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Shortage of capital and revenue funding Changes to capital regime High levels of backlog maintenance	Estates Strategy and supporting Business Cases to make the case for external capital Established links to GM and NHSI Capital processes to ensure correct prioritisation Links with local partners including LA, University etc. Membership of Bolton Strategic Estates Group Premises Assurance Model Enterprise Asset Management Backtrac system Agile Working Programme New Hospital Programme Bid Refreshed Clinical Strategy	Estates masterplan in place Reports to F&I and Strategic Estates Board Annual capital plan and reporting ERIC reports Model Hospital estates and facilities metrics Use of resources benchmarking	Fully costed estates strategy over 5 years, Develop bids for HIP programme, March 21 April 22 New Hospital Bid one of 2 supported by GM ICS for submission to new hospital team 6 facet survey has commenced will be completed ~~February~~ June 2022 ~~Demolition and disposal strategy, April 22~~ Clinical Strategy, May 2023	Board Executive Strategic Estates Board Strategic Estates Group Finance Committee Executive	
Planning, traffic constraints to the site	Working with LA and other partners Estates strategy Traffic surveys	Estates strategy updates	~~Environmental sustainability strategy, November 21~~	Strategic Estates Board Executive	
Controllability of community estates not owned by Bolton FT	Bolton Strategic Estates Group IFM asset management CCG/FT asset groups	Locality Board oversight Bolton Strategic Estates Group	Community estates strategy, ~~April~~ December 22 Establishment of Locality Plans	Strategic Estates Board	
If the Trust does not have a robust digital transformation and delivery plan, the organisation will be unable to function	Digital plan that maps back to the Trust strategy Digital performance and transformation Board which reports into sub-committees of the Board	Digital Plan Digital performance Management Framework IG Toolkit Cyber Security national assessments	Digital Plan in final stages of development and will be complete by September 2022 Digital Performance Management Framework being developed Digital Project Management Officer oversight of all programmes IG Toolkit will be submitted June 2022	Digital Performance and Transformation Board Finance Investment Committee	

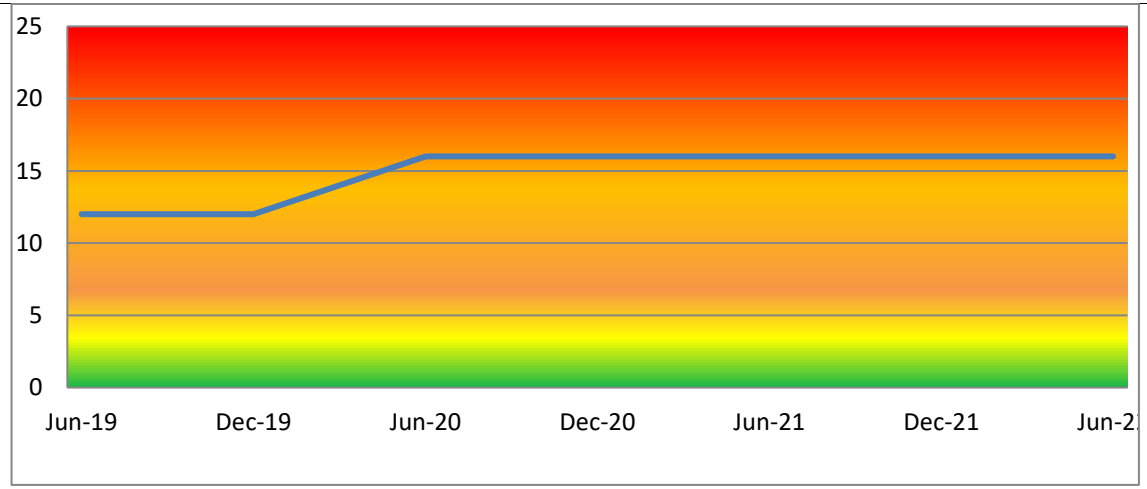
4	To make our hospital and our buildings fit for the future

Risk appetite

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

Background

Risk tracking



date:	Comments	Risk Score	I	L	
25/02/20	Full page risk description added		4	3	12
15/05/20	Narrative updated		4	3	12
16/11/20	Update – risk score increased		4	4	16
06/01/2021	Review to focus on strategic risks/issues		4	4	16
30/06/22	Risk reviewed - no changes proposed		4	4	16

5	Ambition – To join up services to improve the health of the people of Bolton	Lead Director	Director of Strategy and Transformation
		Date updated	June 2022

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
If the impact of changes to the Health and Care Act are not understood and appropriate plans not developed, then changes in the wider health economy may destabilise our organisation	Development of Locality Board Development of Local Care Trust Embed the ICP Business Plan and ensure delivery of the Business Plan. Stakeholder engagement plan Accountability of the LCT into the Bolton System and the ICB. Accountability through the Place Based Lead Section 75 Agreement to support the governance of the partnership Alliance Agreement to support the governance of the partnership (completed move to control)	MD Post recruited and coherent approach to system management developed through the Bolton ICP Board. Transformation programme across neighbourhoods, workforce and communities ICP Organisational Development Programme Independent ICP Chair	• Transfer of Adult Social Care teams into the FT which is linked with the formation of the LCT. • Develop the section 75 (under development awaiting guidance) • BFT CEO appointed to role of Place Based Lead • Development of a new Strategy for the LCT • Appoint additional members and advisors to the Board • Develop the revised governance for the LCT • Work with the ICB to agree the model for delivery under the Place Based Lead	BFT Board Bolton Locality Board ICP Board ICB Board	
~~Impact of COVID on the delivery of the Integrated Care Partnership~~	~~Management of the COVID outbreak through a using the ICP Board as Oversight, led by the MD.~~	~~COVID Partnership leadership group in place which includes all ICP organisations with a clear action plan and clear task and finish groups. The plan ensures the acceleration of ICP transformation which was already planned where possible.~~ .	~~Reset plan developed which moves the delivery of socially distanced services into a longer term plan~~. Covid delayed the acceleration of the ICP. However, the restrictions are now being lifted and the ICP Business Plan has been developed which outlines actions to move forward with the integration agenda over the next 12 months. This risk is therefore now closed and progress will be monitored through the delivery of the ICP Business Plan	~~ICP Board~~ ~~Bolton Partnership Board~~ ~~Bolton FT Executive Direct~~ors	
Impact of organisations financial Cost Improvement Programmes on the development of the ICP	Development of an Alliance Agreement which ensures shared responsibility around delivering organisational Cost Improvement Savings.	ICP Alliance Board will provide the platform and framework to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the ICP to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.	Alliance Agreement developed April 2022 Organisations working together to develop a System Financial recovery Plan	ICP Board Bolton FT FIP Committee Bolton FT Executive Directors	

If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development	The Locality Board will have oversight of the Bolton £ and a system finance Board will put structure in place to allow organisation to ensure controls are in place.	System finance plan System transformation plan to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the system to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.	Organisations working together to develop a System Financial recovery Plan	Locality Board Bolton FT FIP Committee Bolton FT Board	

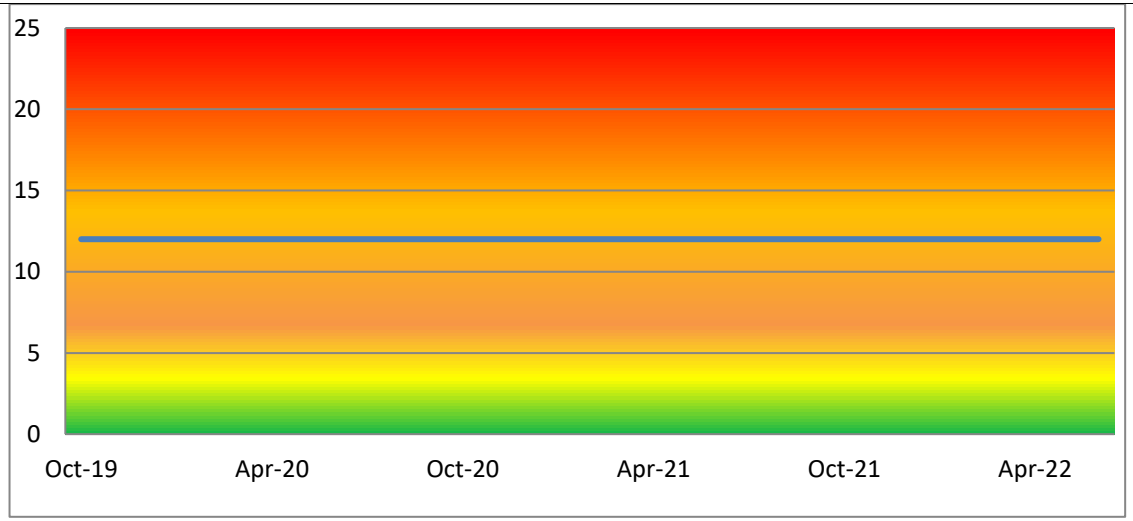
5 To join up services to improve the health of the people of Bolton

Risk appetite

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

Background

Risk tracking



date:	comments	Risk Score	I	L	
10/5/20	Risk Narrative Reviewed		4	3	12
16/11/20	Risk Narrative Reviewed		4	3	12
10/08/21	Reviewed		4	3	12
16/11/21	Risk Reviewed		4	3	12
17 May 22	Risk reviewed and updated following changes to national and local policies		4	3	12

6	Ambition – To develop partnerships across GM to improve services	Lead Director	Director of Strategy and Transformation
		Date updated	June 2022

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Risks to ability to implement Healthier Together for emergency and high risk general surgery due to the time since original decision / consultation	NWS PMO Programme plan Reporting into the NW sector Partnership Board Plan for delivery, engagement of clinicians and the public Plan for delivering the capital requirements of the programme	Review and further develop communications strategy for clinicians and public Direct Executive and senior management engagement Partnership Board level oversight of the programme Implementation of sector wide MDT Approval of Capital Business Case – Treasury Engagement with clinical teams	HT capital plan for Bolton being finalised Review of HT aims and ambitions	Exec Directors	
		During the covid period, all Improving Specialist Care programmes were put on hold, and the landscape has now changed. This risk will therefore be closed and the oversight of Greater Manchester system transformation risks will be recorded separately under the provider collaborative.			
Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services	Greater Manchester clinical services programme in place ~~NWS PMO~~ ~~Programme plan~~ ~~Reporting into the NW sector Partnership Board~~ GM Radiology and Pathology Cells Reporting into Provider Federation Board (PFB) GM wide procurement of collaborative image sharing project in place completed Development of Community Diagnostic Centre	~~GM wide procurement of collaborative image sharing project in place~~ ~~Establishment of~~ Attendance at Radiology/Pathology Cells Development of a laboratory information management system (LIMS) Development of workforce plans for radiology and pathology Pharmacy transformation programme	~~Review of Radiology / pathology plans across Greater Manchester by DOS on behalf of Provider Federation Board.~~ ~~Radiology and Pathology cells now established across GMs~~ Implementation of GM PACs and Laboratory Information Management System procurements Contribution to the workforce plans Local pathology, radiology and pharmacy clinical service strategies Board approval of Phase 2 of the CDC programme	Exec Directors Trust Performance and Transformation Board (which reports to F&I) Trust Transformation Board	
Develop Provider Collaborative across GM	Provider Federation Board GM Gold	PFB recovery plan in development overseeing elective recovery and supporting GM capacity issues	GM provider collaborative delivery being developed linked to GM • Financial Plan • Digital Plan	Exec Directors	

		Greater Manchester wide operating plan in place PFB overseeing system escalation to support urgent care capacity issues ~~PFB workstream around fragile services~~			
If the Trust does not have a workforce pipeline, we will be unable to deliver safe, effective care. A strong partnership with local academic providers is essential to deliver this	Bolton Health and Academic Partnership Board	Functioning and developing working relationship with Bolton University and College with staff from the FT working into and supporting University provision Development of BCMS	Development plan with Bolton University to become a teaching hospital Working group to move towards medical school Expansion of clinical courses and programmes mapped to workforce demand Development of new programmes where the Trust has recruitment issues e.g. health informatics	BFT Health and Academic Execs	

6 Ambition – To develop partnerships across GM to improve services

Risk appetite

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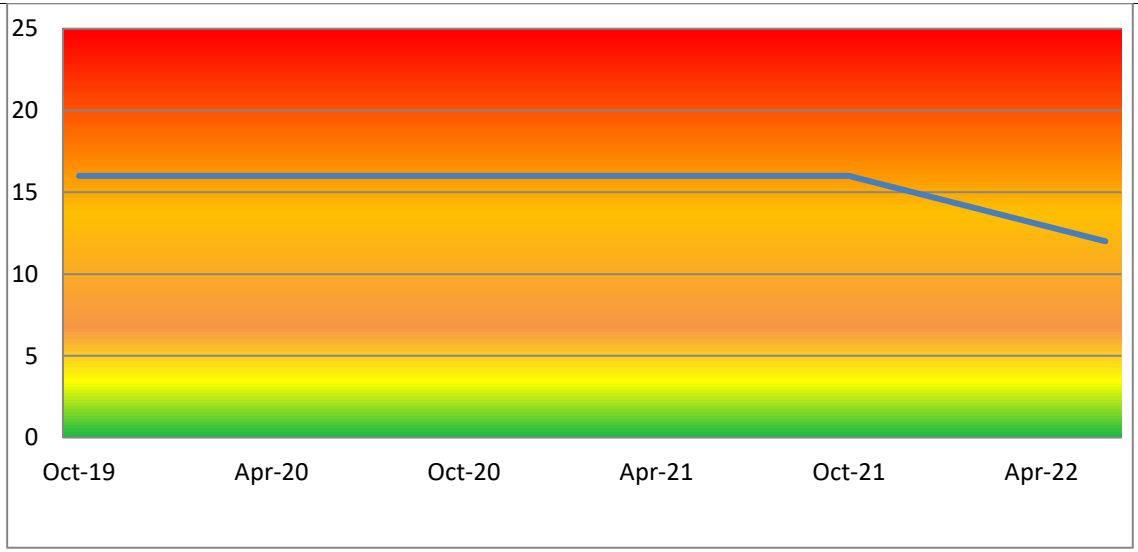
Background

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

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

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

Risk tracking



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

16/11/21	Risk Reviewed	4	4	**16**
17/05/22	Risk Reviewed and Likelihood reduced to 3	4	3	12

Covid Assurance Framework		Lead Director	Chief Operating Officer	
		Date updated	29.06.21	
The framework below summarises the risks and issues associated with the operational impact ofCovid-19. Each of the strategic objective assurance frameworks has also been updated to reflect the impact of Covid-19 on the achievement or our strategic objectives. Alongside this framework there is also a more detailed NHSI Framework focusing on the IPC aspect of Covid				
Risks/issues	**Controls**	**Assurance**	**Actions**	**Lead**
Staff morale low because of anxiety and levels of work. Potential PTSD and more serious mental health implications a risk for some staff	Wellbeing provision for staff – including practical and psychological support Staff communications – daily update Recognition of staff efforts	Monitoring of feedback and social media content	Continued wellbeing programme	Director of Workforce
Staffing levels – potential impact of staff self isolating or ill because of Covid-19	Attendance team in place – daily support Increased recruitment – return to work, fast-track students, volunteers Screening programme to enable staff to return if not Covid positive Redeployment programme Working from home where possible	Daily sit rep Daily Workforce Dashboard on all controls	Refreshed attendance programme to respond to changing national guidance Regular recruitment programme Staff testing programme Redeployment programme Reward packages reviewed	Director of People
Supply of oxygen Currently have sufficient oxygen provision for 40 ICU beds and all ward beds	Daily monitoring of use/levels	Telemetry installed to report on levels	Continue to monitor	Director of Finance
If the Trust do not have adequate PPE, staff and/or patients may be at increased risk of infection	National and GM Coordination of PPE supplies PPE stock levels monitored by procurement Alternative supplies identified by procurement Training for staff in correct donning and doffing procedure Staff information leaflets	Daily sitrep	Procurement continue to work with supply chain to secure provision. Alternative solutions developed	Chief Nurse (as DIPC)
If staff do not use PPE appropriately including within non clinical areas there may be an increased risk of nosocomial infection	Communication to staff Provision of PPE in key areas	Covid reporting	Outbreak report/review	
If staff are not fit tested for masks or are fit tested for masks no longer available there may be increased risk of staff infection	Fit testing programme	Fit testing records	Fit testing programme extended. Reusable masks being introduced	Chief Nurse (as DIPC)

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

Change Log (risk scores) –				
Date	**Objective risk**	**Score change from/to**	**Rationale**	**Approved at**
25/02/20	Added full page risk description for objectives To make our hospital and our buildings fit for the future and To join up services to improve the health of the people of Bolton			
05/06/20	Added additional summary of Covid Assurance			
06/06/20	Full refresh of all areas of the BAF			
10/07/20	Increase to risk of delivery of operational performance	20 to 25	to reflect the impact of Covid 19 on RTT and cancer	
16/11/20	Reduction to the risk that we will fail to achieve our objective "To continue to use our resources wisely so that we can invest in and improve our services"	20 to 16	Likelihood of failing to achieve the objective reduced in light of current financial position and Covid finance regime	
16/11/20	Increase to the risk that we will fail to achieve our objective "To develop our estate in a sustainable way that supports staff and community health and wellbeing"	12 to 16	Likelihood of failing to achieve this objective increased in light of national financial challenge post Covid-19	
06/01/2021	Review of all elements no changes to score			
April 2021	Review of all elements			
July/August 2021	Full review		No changes to score Mental health impact incorporated into risks	
Nov 2021	Full review		Removed summary	
July 2022	Full Review			

Agenda item: 11

Title:	2022/23 Strategic Programme

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28th July 2022		Discussion	
Exec Sponsor	Sharon Martin and Rae Wheatcroft		Decision	✓

Summary:	This paper provides a summary of the 2022/23 strategic programme of work and key milestones for the year. It describes an associated approach to the delivery of our strategy, and how we will identify, drive and deliver the organisation's top priorities. Finally it proposes a revised governance structure to oversee the Trusts Strategy, Digital, Transformation and Operational delivery.

Previously considered by:	Executive Directors

Proposed Resolution	The Board is asked to • Note the Strategic programme • Note the Transformational Priorities • Approve the establishment of a Strategic Operations Sub Committee of the Board

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:	Rachel Noble, Deputy Director of Strategy Joanne Street, Director of Operations Francesca Dean, Head of Strategy and Planning	**Presented by:**	Sharon Martin, Director of Strategy, Digital & Transformation Rae Wheatcroft, Chief Operating Officer

1. Introduction

2022/23 will see the review, development and publication of a number of Trust corporate strategies and plans, including:

- Clinical Strategy
- Corporate Strategy
- Interim Digital Plan and Digital Strategy
- People Plan

The development of such a large volume of foundational corporate documentation requires careful planning, management and monitoring to ensure alignment and consistency of outcome and purpose. This paper describes the proposed oversight and accountability for delivery of this complex work programme.

Additionally, it sets out key milestones for the strategic programme over the next 12 months, and provides an update on process to identify, oversee and deliver on our top priorities.

2. Strategic programme benefits and expected outcomes

The expected outcomes of this programme is to create a simplified approach to strategy that is singularly focused on achieving our aspirations. Rather than setting high-level ambitions that feel distant to our staff, it will be rooted in the concept of strategic operations: that is, a strategic programme that is responsive to our population's needs, focused on delivery and improvement, and supported by a programme management-style delivery framework. It will go beyond the traditional approach of setting objectives and leaving delivery up to chance, and will instead break down our aspirations and objectives into prioritised, deliverable work programmes which are shared between clinical and corporate divisions. It will be clinically and operationally-led, will draw on our known risks and issues – both operational and strategic – ensuring that our efforts are focused on what is most important. In this way, the strategic work programme will lay the foundations for a future of delivery and improvement, where everyone knows our top priorities, and energy is focused on their achievement. Critically, it will provide a means of assuring the Board on our progress towards delivery of our top priorities, both strategic and operational.

This approach will create a shared sense of purpose across the organisation and true organisational ownership of the strategy. By empowering our teams to highlight their priorities and by collectively agreeing our focus, we will create an energy around delivery as we will be confident in the fact that we are pulling in the same direction.

Beyond this, and as the programme evolves into a new approach to delivery, there will be opportunities to align our capital plans to the delivery programme, giving us a longer term view of how and where we need to invest to maintain, improve and transform our services.

3. Strategic programme milestone plan

The below timeline provides a high-level view of the timescales for delivery of each of the documents in the strategic programme and it is proposed that this timeline is used to inform Board and associated Committee agendas:

4. Golden threads

The Corporate and Clinical Strategies, the People Plan and Digital Strategy encompass the vast majority of what we do as an organisation. They act as roadmaps and enablers to delivery, and together, they set our direction for the coming five years. In aligning their development, we have the opportunity to develop an underpinning programme of work that draws together the golden threads of what we do. In summary:

- Our Corporate Strategy sets our strategic vision and describes where we are going. It is naturally aspirational but rooted in the reality of what we do, and responsive to the population we serve. It is an important piece of the system jigsaw, and will be co-designed to reflect our part in the vision for Bolton
- Our Clinical Strategy will articulate our aspirations for the future, and how we will meet the growing demand for our services. It will describe transformational opportunities to do things differently, again, rooted in and responding to the needs of the people we serve. It will inform our future workforce and estates requirements
- Our People Plan sets out our vision for our workforce, specifically how we will attract, develop and retain a high-performing team that enables us to collectively achieve our vision
- Our Interim Digital Plan and Digital Strategy will describe the roadmap and our ambitions for digital transformation, improvement and delivery to ensure that we support our workforce to work to deliver safe, effective care

To ensure that our strategic documents are aligned in purpose and approach, and describe a cohesive programme to deliver against our ambitions, programme oversight will sit with the Strategy team and would be reported to the newly-proposed Strategic Operations Committee*:

**Details of the proposed committee can be found in section 5.*

Document	Author(s)	Programme oversight	SRO	Committee oversight
Clinical Strategy	Clinical Specialities / Division Rayaz Chel Archus	Dr Sophie Kimber Craig Dr Harni Bharaj Angela Hansen Rachel Noble	Clinical lead Dr Francis Andrews and Tyrone Roberts SRO - Sharon Martin	Proposed to sit with Strategic Operations Committee
Corporate Strategy	Rachel Noble Francesca Dean	Rachel Noble	Sharon Martin	Proposed to sit with Strategic Operations Committee
Interim Digital Plan	Brett Walmsley	Sharon Martin	Sharon Martin	Proposed to sit with Strategic Operations Committee with input from Digital Performance & Transformation Board
Digital Strategy	Brett Walmsley Rachel Noble	Sharon Martin/Rachel Noble	Sharon Martin	Proposed to sit with Strategic Operations Committee with input from Digital Performance & Transformation Board
People Plan	Rachel Noble Jake Mairs Carol Sheard Francesca Dean	James Mawrey/Rachel Noble	James Mawrey	People Committee

With consistent oversight through the Strategy team, we will deliver a complimentary set of documentation which provides a unified vision for strategic delivery. This is likely also to be supported by a small, internal, programme group.

5. Governance

In January 2022, there was a realignment of committee meetings which oversee operational performance, transformation and digital performance. This resulted in the creation of the Executive-led Performance and Transformation Board, chaired by the Chief Operating Officer, and also the Digital Performance and Transformation Board, chaired by the Director of Strategy, Digital & Transformation. Their parent sub-Board of Directors committee was identified as Finance and Investment Committee; this decision was made based on an understanding of best fit, compared to Quality Assurance Committee and People Committee.

The operational Integrated Board Report, and the chairs reports from the Performance and Transformation Board and Digital Performance and Transformation Board, have been going to Finance and Investment committee since March 2022. During this time, it has become clear that more time is needed for discussion and oversight of the

Trust's operational performance and that greater Board oversight and scrutiny is required of the strategy, transformation and digital workstreams.

An options appraisal has been conducted and is summarised as below:

	Option	Pros	Cons
1	Do Nothing- maintain status quo with operational IPM Board report and both Performance and Transformation Board and Digital Performance and Transformation Board chairs reports coming to Finance and Investment Committee	• No change required • No additional burden on Executive Directors and Non-Executive Directors time	• Lack of congruence with existing Finance and Investment Committee Terms Of Reference • Limited time for meaningful scrutiny within Finance and Investment agenda
2	Adapt Finance and Investment Committee TOR to reflect new role and responsibilities for overseeing performance and transformation	• Clarifies expectations and responsibilities of Finance and Investment Committee members • Formalises status quo	• Limited time for meaningful scrutiny within Finance and Investment agenda • Impact on air time for other established Finance and Investment Committee agenda items
3	Performance and Transformation Board, Digital Performance and Transformation Board and operational IPM Board report go straight to Board Of Directors	• No additional burden on Executive Directors and Non-Executive Directors time • Returns Finance and Investment Committee to pre-March state	• Breadth and depth of scrutiny by Non-Executive Directors limited due to space on public Board Of Directors • Lack of parity and alignment with other pillars of the IPM Framework
4	Establish an additional Sub-Board of Directors committee (Strategic Operations Committee) to oversee operational performance, digital performance, strategy and transformation	• Parity and alignment with other pillars of IPM Framework • Ensures Finance and Investment can focus on the Trusts financial position requirement for greater engagement and oversight of transformation	• Impact on Executive Directors and Non-Executive Directors time for membership at additional sub- Board Of Directors committee • Requires alteration to Board Of Directors Terms of Reference

Option 4 is recommended as the preferred option and draft Terms of Reference have been developed for the proposed Strategic Operations Committee, which is included as appendix A to this paper, to support Board decision making with regard to option 4.

6. Prioritisation and Delivery – Top 5

Through the pandemic, we saw the benefits of organisational efforts being focused on shared problem areas, and our new strategic programme will harness this approach.

The June Trust Management Committee (TMC) session, and further Board Development session, built on this approach and saw each Division identify and pitch their top priorities, with senior colleagues from divisions and corporate directorates; voting for the issues they believed to be the most important. This approach, which engaged a wide range of stakeholders from across the Trust, along with external stakeholders, has a positive impact on our workforce and increases the Trusts likelihood of identifying and delivering against its strategic ambitions. The tables in

appendix B show that we have a clear set of shared high-level priorities that are categorised as must dos, transformational, and enabling.

Reflecting TMC and these service review sessions, the priority programmes have been identified as:

- Children and Young People services
- Digital and Data
- Operational plan and recovery programmes
- People
- System Transformation

Although work has already been undertaken/commenced with some of these programmes, these priorities, along with TMC identified priorities, are naturally high-level, so further work will be undertaken to describe:

- Current state (including baseline data) and the change we need to make
- The benefits we expect these priorities to realise (which will be tracked through the Trust's benefits realisation programme)
- The risks that will be resolved or mitigated by addressing these priorities
- Any cost associated with delivery
- Timescales for delivery
- High priority projects

This work will be led by the Director of Strategy, Digital & Transformation and the Chief Operating Officer and, once completed, priority programmes will be established, tracked and monitored through the proposed Strategic Operations Committee. For each project, deliverables will be set for each quarter and this '90-day delivery' model will be used to track and report progress up to the Board.

The table below summarises our initial priority programmes and provides a high-level summary of the work undertaken, or planned to be undertaken. The common change themes, as identified by TMC, are woven throughout. These themes include digital, improving access, business intelligence, workforce, prevention and collaboration.

7. Recommendation

The Board is asked to note that the full work programmes, including clear mapping of anticipated benefits and '90-day delivery' priorities, will be developed in partnership with the divisions.

Table One

Priority	Prioritisation Theme	Current situation	Objectives/activities
Children & Young People Services	Transformational	Children and Young People have been impacted in multiple ways by the pandemic, with associated risks to their mental and physical health, as well as their wider development. 1 in 6 young people now has a diagnosable mental health problem and considerable backlogs exist for physical health services. There is a risk that the inequalities gap for our Children and Young People will widen as a result of the pandemic. Prevention is key to the sustainability and future of services; along with future health of the population. Although prevention can be tackled at all stages in the patient journey, true prevention starts with our children and young people.	• 0-19 service engagement programme • Family hubs • SEND and LD offer • Transition to adult services • Establish Bolton as a surgical elective Paediatric Hub for the North West sector in GM
Digital & Data	Enabling	Improving the way we use digital technology is essential to the modern health system. There is significant potential for the transformation of health care through better and widespread use of digital technologies. This includes a growing role for technology in supporting people to monitor and manage their own health and wellbeing. But the NHS has a poor track record when it comes to adopting digital technologies at scale. Patient data is not only vital for managing an individual's care, it also plays an important role in other ways: planning health services, improving diagnosis and treatment and	• New Interim Digital Plan followed by Digital Strategy • Digital patient journey • Invest in Robotics processes/AI systems • Upgrade or replacement of core clinical systems • Integrated records and systems; internally and externally • Data Quality, improving recording and education

		evaluating the effectiveness of policy. These 'secondary uses' of data offer significant opportunities to improve care, especially if advances in technology and data analysis can be harnessed. Data quality is key to this.	• Work with partners to deliver a strong locality intelligence service • Deliver easy and transparent self-service access to intelligence • Pioneer new data tools and techniques to enable better intelligence
Operational Plan & Recovery Programmes	Must Do	<u>Summary</u> Although the programme is considered to be a must do in order to manage immediate pressures and keep patients safe, each theme below has a number of transformational elements. <u>Operational Plan</u> The NHS Operational Planning and Contracting Guidance is an annual plan, with associated KPIs, that we are expected to deliver against as an NHS Trust. The 2022/23 priorities and operational planning guidance sets out our priorities for the year ahead. <u>Urgent Care</u> The number of people attending the emergency department (ED) has increased by 40% over the past 15 years, alongside an overall reduction in the number of inpatient beds over the same period. This continued increase in demand, coupled with the quality and safety risks associated with long waits in ED, means that a truly transformational approach is required. We are under-performing against national standards, staff morale is low, associated with an exhausted workforce in a system that	<u>Summary</u> N/A <u>Operational Plan</u> • Delivery against high priority targets • Alignment to GM targets, working as a 'GM system' • Incorporation of KPIs, and any supporting actions to deliver, into existing programmes of work/governance structures <u>Urgent Care</u> This programme will form an overarching urgent care transformation programme. The programme will span across AACD, ISCD, Primary care and Social care and work in collaboration with system stakeholders to improve urgent care provision. It includes projects such as: • Neighbourhood risk stratification • System workforce transformation • Improving access, efficiency and integration through use of Digital

		requires improvement and transformation, and there is poor patient experience associated with challenges across the urgent care delivery model. <u>Elective Recovery</u> Waiting lists the for NHS have reached a new high. Health inequalities and poorer outcomes for vulnerable groups have worsened during the pandemic. There are national workforce shortages of key staff groups, demand outstripping capacity and escalating problem with later diagnosis and treatment having impact in both the immediate and long term. <u>Maternity</u> The Ockenden review has put a lens on maternity services across the country, with the preliminary report resulting in 7 essential actions and 147 individual actions for Trusts to comply with across two major themes; listening to families and transparent governance from floor to board. Health inequalities across maternity outcomes are significant in Bolton and with challenges across workforce this required immediate action.	• Development of an Urgent Treatment Centre (UTC) • Reconfiguration of the ED footprint • Same day emergency care (SDEC) <u>Elective Recovery</u> This is large scale, divisionally cross cutting, programme which looks at cancer, diagnostics, RTT, admitted and non-admitted pathways. Key projects include: • Virtual activity • Advice and guidance • Well while you wait • Theatre estate expansion • Wider system and GM Partnerships • Digital solutions for waiting list management • Community Diagnostic Hubs <u>Maternity</u> There is a large scale maternity transformation underway with a key focus on: • Compliance, evidence, assurance and actions against essential and individual actions from the Ockenden review • Personalised care planning • Workforce and alternative roles • Bespoke EPR (Electronic Patient Record) • Targeted interventions through use of data – (i.e. tommy's pathway)
People & workforce	Enabling	Workforce shortages across all staffing groups in the health and care system are putting NHS	• New People Plan

		hospitals, mental health services, community providers and general practice under significant strain. These vacancies do not affect only clinical staff but also the roles required to keep the NHS running, including leaders and managers. Competing vacancies within GM for high demand areas is also a real issue. Unfilled vacancies increase the pressure on staff, leading to high levels of stress and absenteeism, and high staff turnover. The Covid-19 pandemic has also exacerbated long-term issues such as chronic excessive workload, burnout and inequalities experienced by staff from ethnic minority backgrounds. Workforce shortages are having a direct impact on the quality of people's care.	• Diverse and inclusive workforce representative of population we serve • Workforce transformation to support changing landscape • Recruit and retain • Further develop leadership capability and lifelong education and professional development (talent management) • Establishment as a University hospital
System Transformation	Transformational	Becoming a Local Care Trust is an opportunity to refocus on our population's health needs, review and improve pathways with social care services and build on other key relationships in the system - such as primary care and CVS etc. We will re-look at how we deliver our services to ensure that we are responding to the needs of our population. It's an opportunity to be truly transformational. The scale of the challenge, as a result of COVID and prior, requires us all to work together differently. Recovery is long term, so our approach must look beyond immediate operational planning. Social care and community services will play a key role in this work.	• Establishment as a Local Care Trust; and supporting governance • System Workforce Transformation • Co-Production of Health and Care Services; *with a focus on supporting people to live well at home* • System Approach to Engaging with our Population • Health inequalities - *considered as part of service design and delivery; focusing on equitable access* • Place based, strength based and preventative care models • Clinical strategy development and vulnerable services review

8. Outcomes

In order for us to know that we have been successful in our delivery we will co-develop a set of outcomes that reflects our strategic aims. Each outcome will include a set of measurable indicators to monitor our progress.

It is important to note the differences between outcomes and outputs - outcomes are ultimately where we want to get to, what we want to deliver and are a measure of change, while outputs are the actions and activities that will get us there. Examples of outcomes taken from the NHS Outcomes Framework are:

- Preventing people from dying prematurely (measures include Life expectancy at 75; one-year survival rate from breast, lung, and colorectal cancer; Neonatal mortality and stillbirths rate)
- Enhancing quality of life for people with long-term conditions (measures include % of people who feel supported to manage their long-term condition; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)
- Helping people to recover from episodes of ill health or following injury (measures include Proportion of patients with a hip fracture recovering to their previous levels of mobility at 30 days /120 days)
- Ensuring that people have a positive experience of care (measures include a variety of metrics taken from GP, out-of-hours, dental, inpatient, A&E etc services)
- Treating and caring for people in a safe environment and protecting them from avoidable harm (measures include deaths from VTE related events within 90 days of discharge)

Our work to develop outcomes will complement existing / developing frameworks in the locality including the Active Connected and Prosperous Framework and the Integrated Care Partnership outcomes, amongst others. The initial work to scope the areas of particular need has commenced, in the form of a data "sprint" (a multi-disciplinary event designed to gather intelligence, both qualitative and quantitative). Following this, the outcomes and their associated measures can be formed"

September TMC will see a focused session to define these outcomes.

9. Recommendations

This paper provides a summary of the 2022/23 strategic programme of work and key milestones for the year. It also describes an associated approach to the delivery of our strategy, and how we will identify and deliver the organisation's top priorities. Finally, it proposes a revised governance structure to oversee the Trust's Strategy, Digital, Transformation and Operational delivery. The Board is asked to:

- Note the Strategic programme for 2022/23
- Note the identified transformational priorities and the proposal to develop a work programme around these priorities
- Approve the establishment of a Strategic Operations Sub Committee of the Board

Appendix A - Strategic Operations Committee – DRAFT Terms of Reference

1. **Authority**

   The Strategic Operations Committee is authorised by the Board of Directors (Board) to provide assurance on the operational performance and strategic planning functions of the Trust. In addition, it will provide oversight and assurance of the enabling digital and transformational work programmes.

2. **Reporting Arrangements**

   The Committee will be accountable to the Board.

   The minutes of Committee meetings shall be formally recorded by the Secretary. The Chair of the committee will issue a Chair's report to the Board and shall draw to the attention of the Board any issues that require disclosure to the full Board, or require action by the Trust Executive.

   The Committee will refer to other Board governance committees, matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by other governance committees.

3. **Main Duties and Responsibilities**
   - To oversee and provide assurance on the monthly operational Integrated Board Report
   - To oversee performance against the Trust's strategic ambitions and objectives and ensure that the strategic programme is aligned and responsive to operational priorities
   - To approve and monitor the transformation and digital plans, ensuring their ongoing alignment to operational priorities
   - To provide assurance to the Board on the progress and delivery of transformational and digital projects and programmes
   - To maintain an understanding of wider local and national strategic drivers, ambitions, targets and policies to ensure that BFT is responding to wider NHS challenges and priorities
   - To receive the Chair's reports from the Performance & Transformation and Digital Performance & Transformation Boards and provide assurance to the Board of Directors on their work programmes

Performance

- To review the monthly Integrated Board Report and provide assurance to the Board on the operational performance of the Trust
- To understand organisational operational pressures, priorities and opportunities, and oversee the development and delivery of plans and programmes that support optimal operation performance
- Provide assurance to the Board on progress towards delivery of annual operational planning targets
- Provide assurance to the Board on organisational resilience

Strategy

- To oversee the development and delivery of the corporate strategy, and the deployment of the annual strategic business plan
- To receive a quarterly performance report on progress against strategic ambitions and objectives as described in the strategic business plan
- Oversee the continued evolution of the corporate strategy to ensure a focus on future operational resilience
- To oversee the development and deployment of the Trust's clinical strategy

Digital

- To review and approve the Digital Plan, and associated annual digital business plans
- To receive quarterly updates on delivery against the Digital Plan
- To provide scrutiny of strategic or transformational digital business cases
- To ensure that digital priorities and activities are aligned to operational risks and priorities
- To oversee the development and delivery of the 5 year digital strategy

Transformation

- To review and approve divisional and corporate transformation plans
- To receive monthly updates on progress and delivery of transformational priorities
- To ensure the ongoing alignment of transformation plans with operational priorities
- To oversee programmes of organisational transformation including the transformation to an LCT

4. Membership

- Three Non-Executive Directors, with one of this number to act as Chair of the Committee
- Chief Operating Officer
- Director of Strategy, Digital & Transformation
- Director of People
- Chief Nurse / Medical Director

In attendance:

- Director of Operations
- Deputy Director of Strategy
- Chief Data Officer
- Director of Digital
- Associate Director of Organisational Development
- Deputy Director of Finance

5. Chair

The Committee is chaired by a non-executive director as appointed by the Chair of the Board of Directors. In the absence of the committee chair another non-executive will chair.

6. Frequency of Meetings

Monthly

7. Quorum

At least three members; one of whom must be the Chief Operating Officer (or Director of Operations – if deputising), one of whom must be the Director of Strategy, Digital & Transformation (or the Deputy Director of Strategy – if deputising) and one of whom must be a Non-Executive Director.

8. Attendance

If a member fails to attend two consecutive meetings the Chair of the committee will speak to the individual. The Chair will also be required to act if they feel that lack of attendance has not enabled adequate discussion or decision-making.

10. Agenda and Papers

An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive no later than 4 working days before the meeting.

11. Standard Agenda Items

- Integrated Performance Report
- Minutes and actions from the Performance & Transformation Board
- Minutes and actions from the Digital Performance & Transformation Board
- Divisional Transformation plan
- Quarterly review of strategic objectives

12. Organisation

The Committee will be supported by a member of the Executive secretariat, whose duties in this respect will include:

Organisation of the agenda in consultation with the Chief Operating Officer, the Director of Strategy, Digital & Transformation and Chair if necessary, attendees and collation of papers

Taking the minutes and keeping a record of matters arising and issues to be carried forwards

Minutes of the meeting will be approved by the committee members.

13. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its annual work plan which will go to the Board for review.

14. Review of Terms of Reference

These Terms of Reference will be reviewed at least annually.

Appendix B – Top 5 TMC priorities

Must Do- Top 5

Area	Priority description
People	Recruit and retain
ICSD	Cross divisional ICP collaboration and co-production to support people to live well at home
AACD	Preventing harm
IT	Upgrade or replacement of core clinical systems
BI & Coding	Data Quality, improving recording and education

Transformational- Top 5

Area	Priority description
People	Diverse and inclusive workforce representative of the population we serve
FCD	Integration of children's services
IT	Invest in Robotics processes/AI systems and re skilling admin/clerical workforce to support demand services
ASSD	Expanding our services
DSSD	Digital maturity (covers all 3 points)

Enabling- Top 5

Area	Priority description
IT	Upgrade or replacement of core clinical systems
BI & Coding	Data Quality, improving recording and education
DSSD	Digital maturity
People	Engaged, healthy and motivated workforce
iFM	Combine capital and estates departments

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	28/07/2022		Discussion	X
Exec Sponsor	James Mawrey		Decision	

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

Previously considered by:	Divisional IPMs

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

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

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	Rae Wheatcroft

Bolton NHS Foundation Trust

Integrated Performance Report

June 2022

Guide to Statistical Process Control

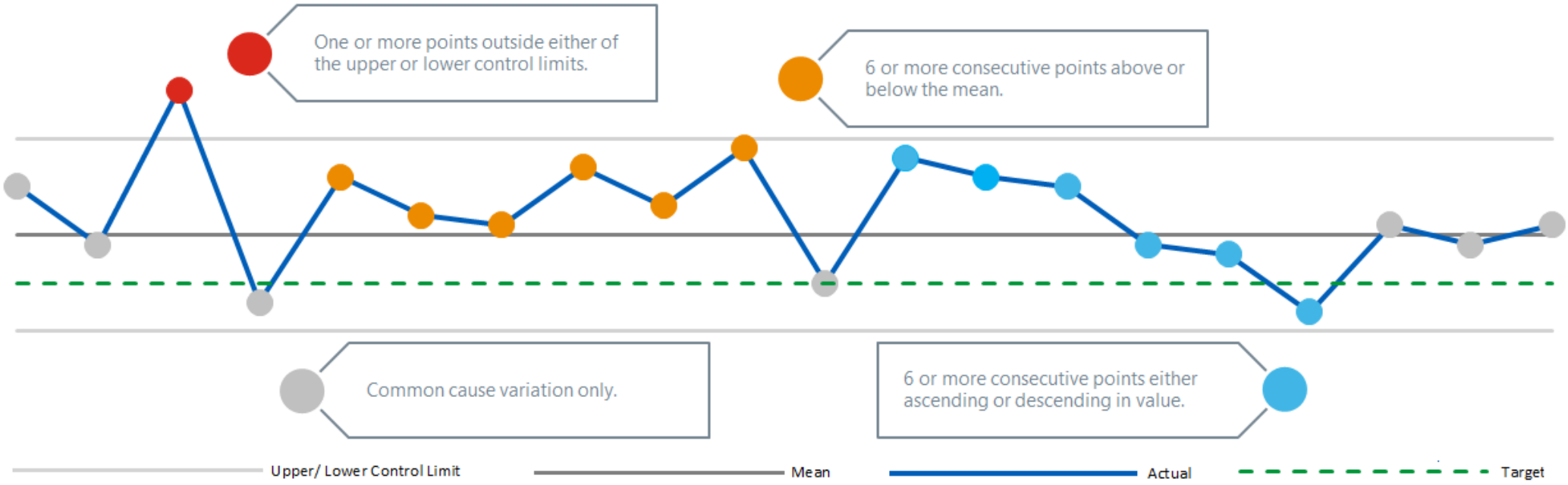
Bolton
NHS Foundation Trust

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		
	Common cause	H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	11	1	0	3	0	1	2	12
Infection Prevention and Control	6	0	2	2	0	0	0	7
Mortality	3	1	0	0	0	0	0	3
Patient Experience	8	0	0	0	8	2	0	14
Maternity	7	0	0	0	2	1	0	8
Operational Performance								
Access	3	0	0	6	2	0	6	5
Productivity	7	1	1	4	1	2	3	8
Cancer	4	0	0	0	3	0	1	6
Community	1	0	0	1	0	0	0	2
Workforce								
Sickness, Vacancy and Turnover	1	0	0	3	0	0	2	1
Organisational Development	0	0	0	0	4	1	2	1
Agency	0	0	0	3	0	3	0	0
Finance								
Finance	3	0	0	0	0	0	0	3
Appendices								
Heat Maps								

Variation

Common cause	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.

NHS
Bolton
NHS Foundation Trust

Quality and Safety

Harm Free Care

Pressure Ulcers
In patient
In June there has been an increase in pressure ulcer development both in the hospital and in the community settings which is demonstrated as special cause variation. The number of hospital acquired category 2 pressure ulcers was 11 (5 in AACD and 6 in ASSD). 3 of these category 2 pressure ulcers were device related. This month we also saw one category 3 device related pressure ulcer in ASSD. Of the 4 unstageable pressure ulcers reported in the hospital one of these was also device related. The clinical teams have recognised the importance of focusing on the prevention of device related pressure ulcers and significant learning is already apparent. It was noted that 3 of these pressure ulcers had developed in one patient who had a Thomas splint and a Plaster of Paris on following an orthopaedic injury. Divisional learning centred around communication with the Orthopaedic Surgeons regarding early removal of plaster when leg is oedematous and improved review of x-rays including weekends and bank holidays. The organisation will be commencing a pressure ulcer reduction quality improvement collaborative in September 2022

Community
June has seen an increase from 10 to 15 in category 2 pressure ulcers demonstrated as special cause variation in the community. In addition to these there was also a category 3 pressure ulcer in the community in June and 3 unstageable pressure ulcers. A new pressure ulcer risk assessment tool (Purpose T) has been successfully piloted in 3 district nursing teams. This is being supported by a programme of education delivered by the Tissue Viability Service and it is anticipated that when fully embedded this will enable the teams to recognise patients at risk earlier in the process. Community services will form part of the QI collaborative launching in September 2022.

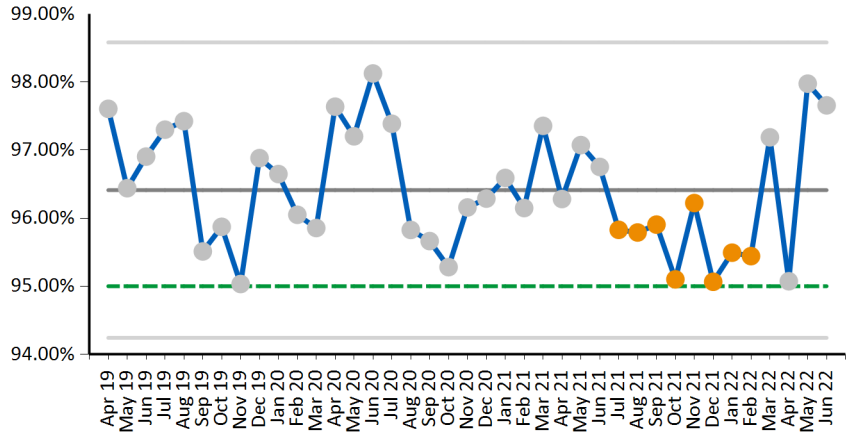
Falls
Our YTD performance is currently at 4.39 falls per 1000 bed days. This means we remain under our local target which is 5.3 falls per 1000 bed days. Falls with harm have increased to 4 in June which is still within common cause variation. However all falls with harm are cause for concern and the lessons learned following a thematic review has identified a gap in some of our falls management plans which is currently being addressed through a Trust wide audit and action plan.

	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%	97.7%	Jun-22		>= 95%	98.0%	May-22	>= 95%	96.9%	
9 - Never Events	= 0	1	Jun-22		= 0	0	May-22	= 0	2	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.58	Jun-22		<= 5.30	4.12	May-22	<= 5.30	4.39	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	4	Jun-22		<= 1.6	0	May-22	<= 4.8	7	

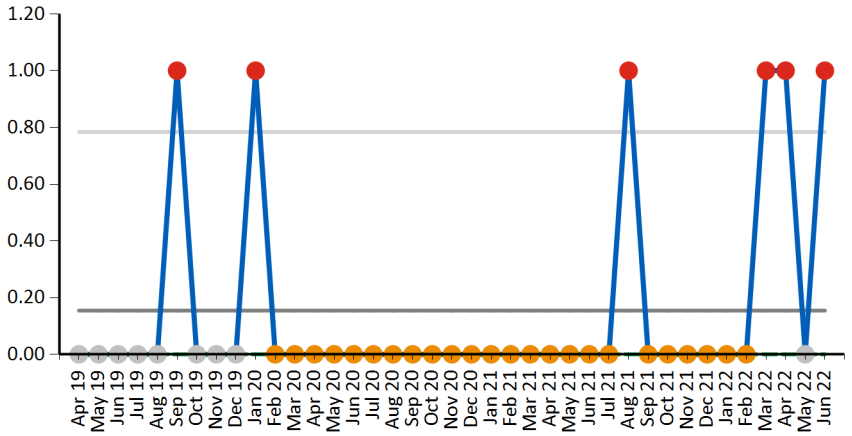
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	11.0	Jun-22		<= 6.0	12.0	May-22	<= 18.0	32.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	1.0	Jun-22		<= 0.5	0.0	May-22	<= 1.5	1.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Jun-22		= 0.0	0.0	May-22	= 0.0	0.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		4	Jun-22			1	May-22		10	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	15.0	Jun-22		<= 7.0	10.0	May-22	<= 21.0	37.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	1.0	Jun-22		<= 4.0	0.0	May-22	<= 12.0	1.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Jun-22		<= 1.0	1.0	May-22	<= 3.0	1.0	
516 - Community patients acquiring pressure damage (unstagable)		3	Jun-22			6	May-22		15	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	86.9%	Q4 2021/22		>= 90%	88.5%	Q3 2021/22	>= 90%		
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	50.0%	Q4 2021/22		>= 90%	50.0%	Q3 2021/22	>= 90%		
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	38.0%	Q1 2022/23		>= 90%	22.0%	Q4 2021/22	>= 90%	38.0%	
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q1 2022/23		>= 90%		Q4 2021/22	>= 90%	100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	79.4%	Jun-22		>= 95%	77.1%	May-22	>= 95%	78.4%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	65.2%	Jun-22		>= 95.0%	65.4%	May-22	>= 95.0%	65.9%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	50.0%	Jun-22		= 100%	70.0%	May-22	= 100%	69.2%	
88 - Nursing KPI Audits	>= 85%	92.6%	Jun-22		>= 85%	91.6%	May-22	>= 85%	92.2%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	Jun-22		= 100%	25.0%	May-22	= 100%	33.3%	

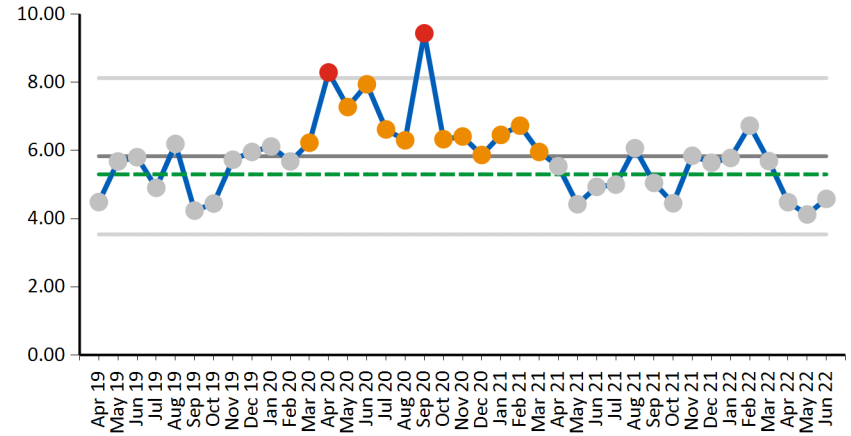
6 - Compliance with preventative measure for VTE



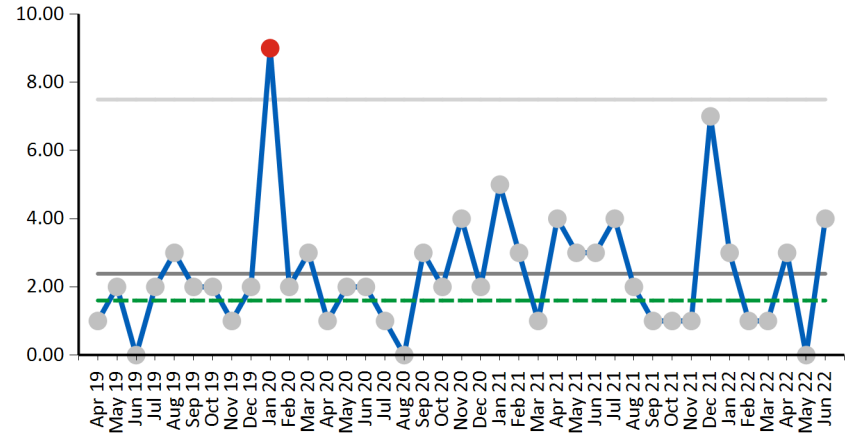
9 - Never Events



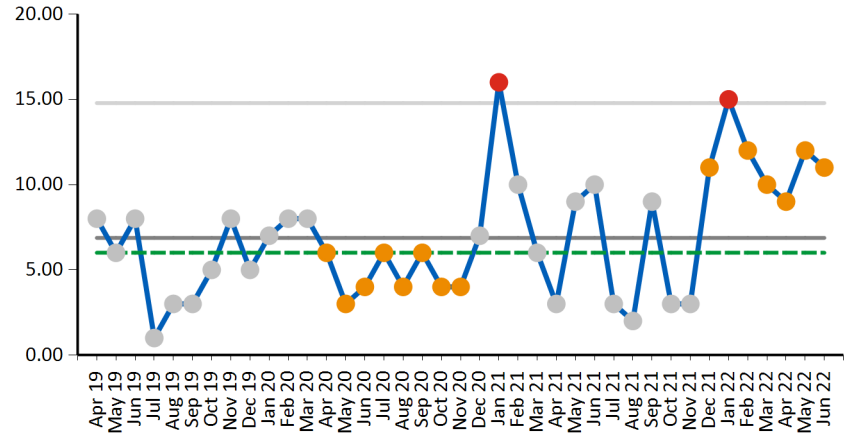
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



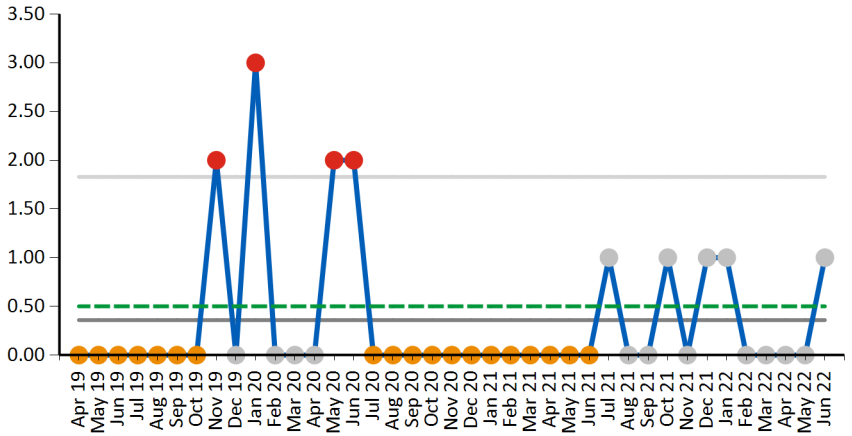
14 - Inpatient falls resulting in Harm (Moderate +)



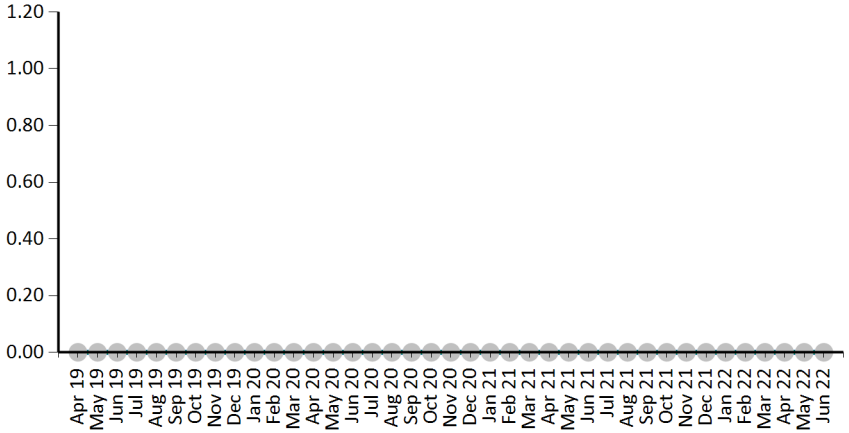
15 - Acute Inpatients acquiring pressure damage (category 2)



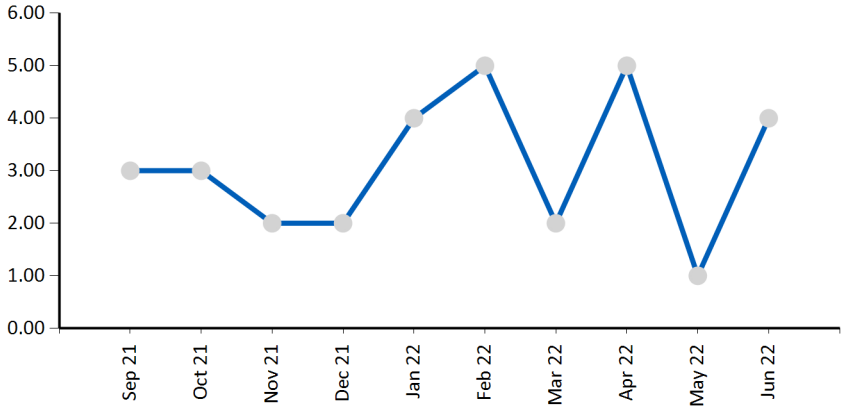
16 - Acute Inpatients acquiring pressure damage (category 3)



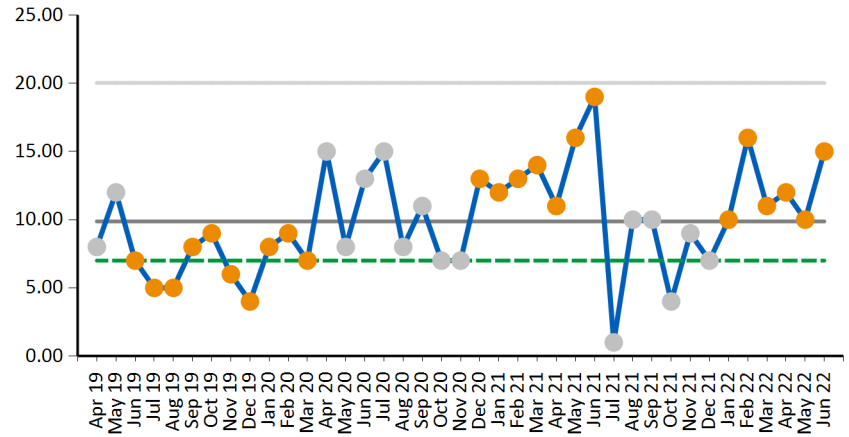
17 - Acute Inpatients acquiring pressure damage (category 4)



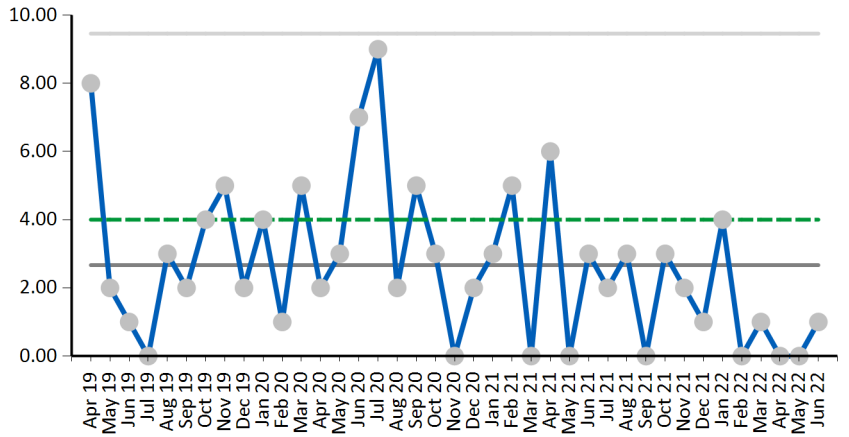
515 - Acute Inpatients acquiring pressure damage (unstagable) - SPC data available after 20 data points



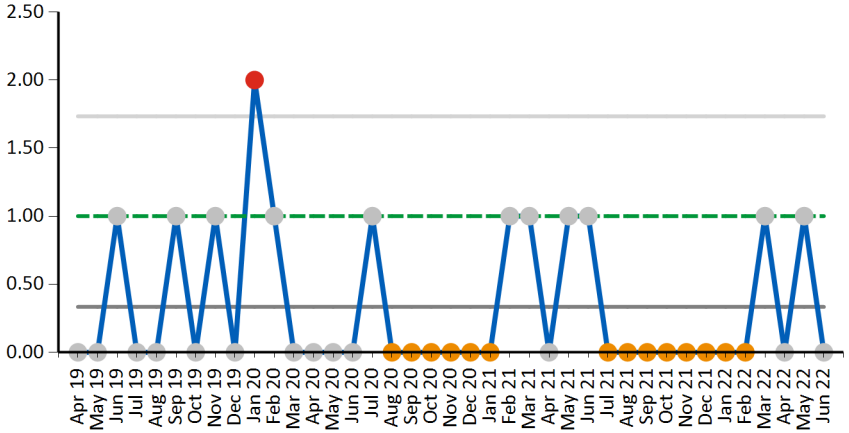
18 - Community patients acquiring pressure damage (category 2)



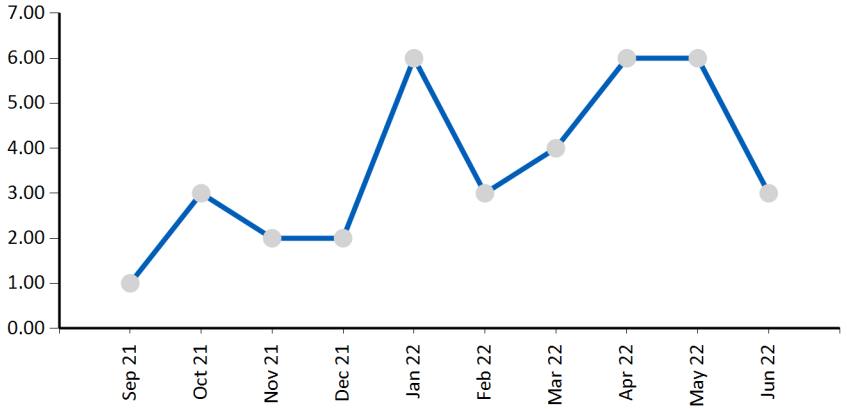
19 - Community patients acquiring pressure damage (category 3)



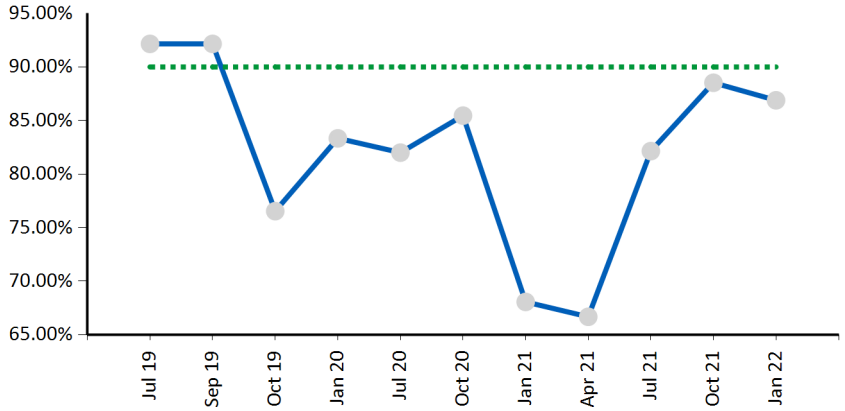
20 - Community patients acquiring pressure damage (category 4)



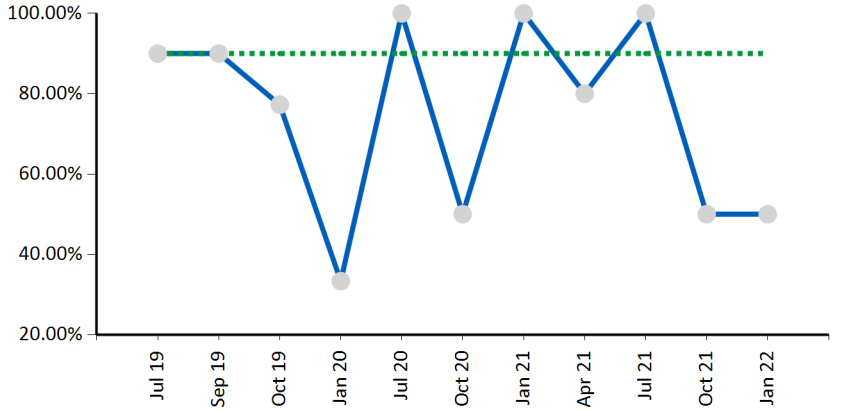
516 - Community patients acquiring pressure damage (unstagable) - SPC data available after 20 data points



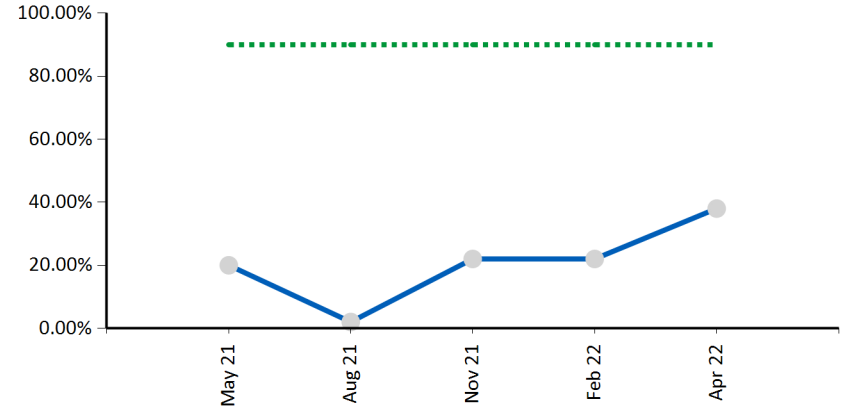
28 - Emergency patients - screened for Sepsis (quarterly) - SPC data available after 20 data points



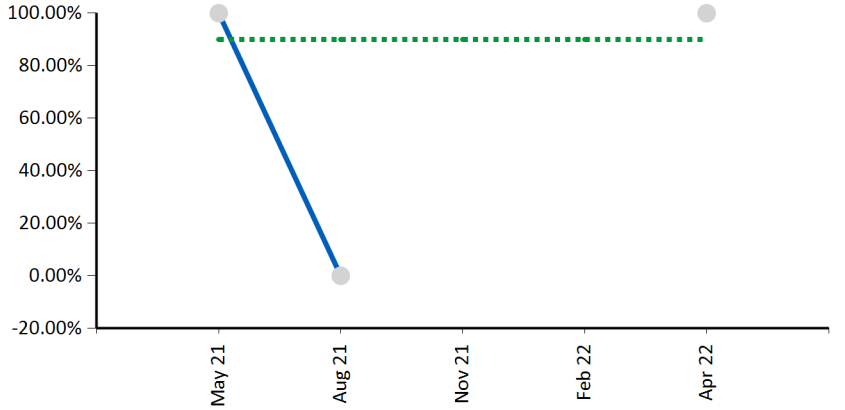
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



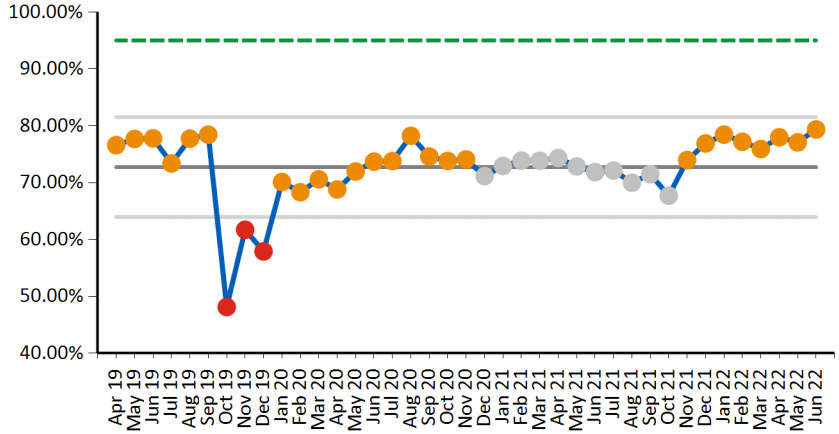
513 - Inpatients - screened for Sepsis (quarterly) - SPC data available after 20 data points



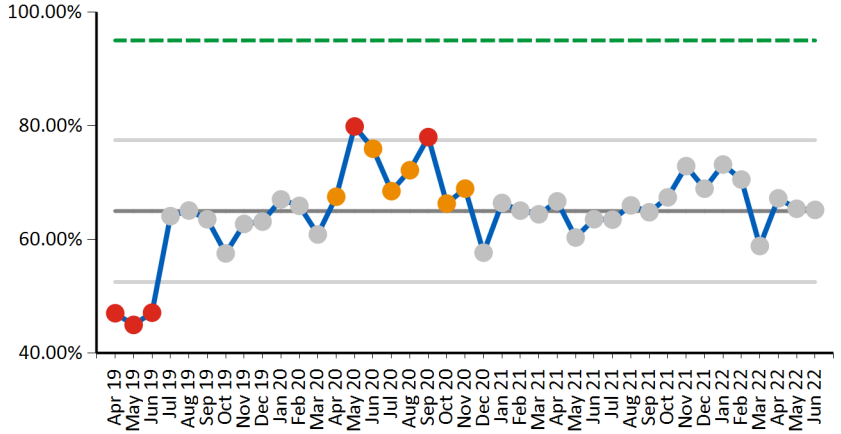
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



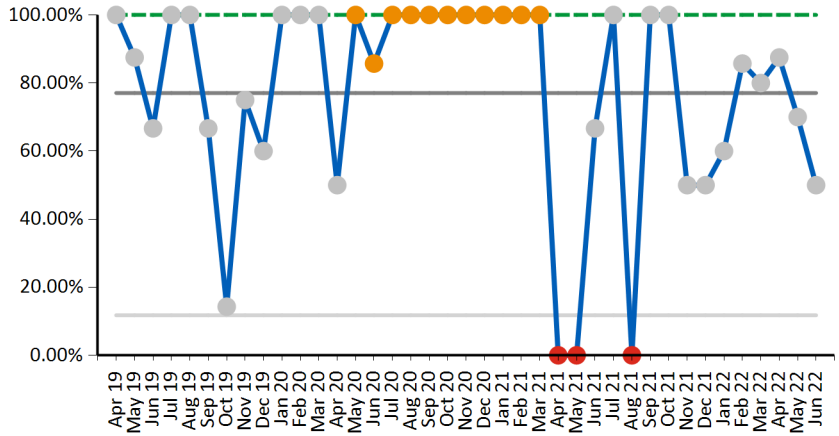
30 - Clinical Correspondence - Inpatients %<1 working day



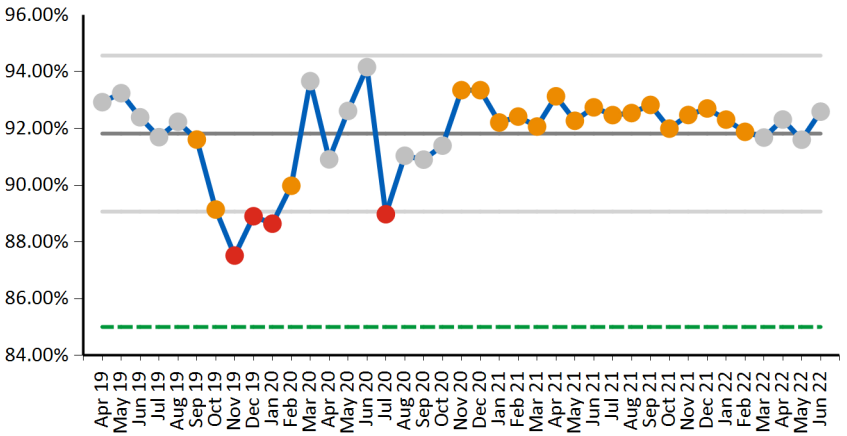
31 - Clinical Correspondence - Outpatients %<5 working days



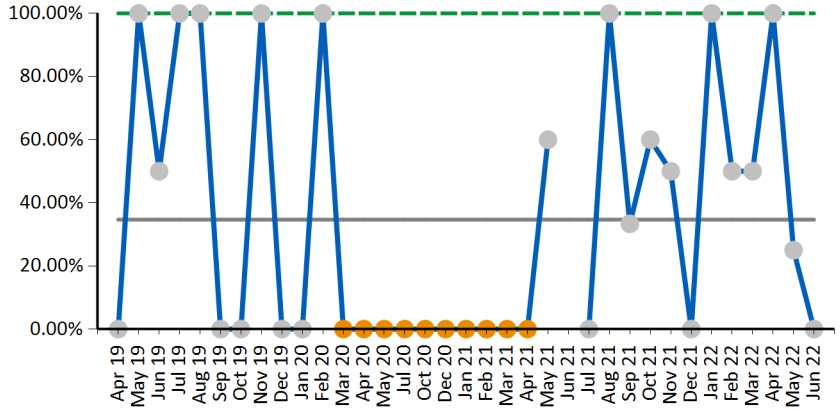
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



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



Infection Prevention and Control

Clostridium difficile infections remain the key IPC challenge with nine healthcare associated cases being reported in June. A working group reviewing antibiotic stewardship is ongoing as part of AACD's Quality Account for 2022/23 which has two broad aims:
1) Reduce the total consumption of antibiotics
2) Improve compliance with antibiotic choice against prescribing guidance. Separately the antimicrobial pharmacists and microbiologists are reviewing the guidelines to broaden the choice of antibiotics and making the guidelines less reliant on a smaller number of antibiotics. It is anticipated that these actions will lead to a reduction cases.

In addition, the IPC service continues to deliver face-to-face training sessions with clinical staff about key practices such as applying SIGHT (Suspect, Isolate, Gloves, Hand washing, Test)

Cleaning standards have already been improved following the implementation of the new NHS Cleaning Standards and once the essential fire escape works have been completed, we will commence our planned programme of decant and deep clean for wards.

There has been an increase in the number of nosocomial COVID-19 cases in June. This is indicative of a new wave of COVID-19 that is now impacting England; this wave is anticipated to be more severe than the last wave. The efficacy of the vaccine still seems to be effective for severe disease with fewer critical care patients and a low number of patients on the ward with signs and symptoms; most patients remain asymptomatic or are identified through incidental findings.

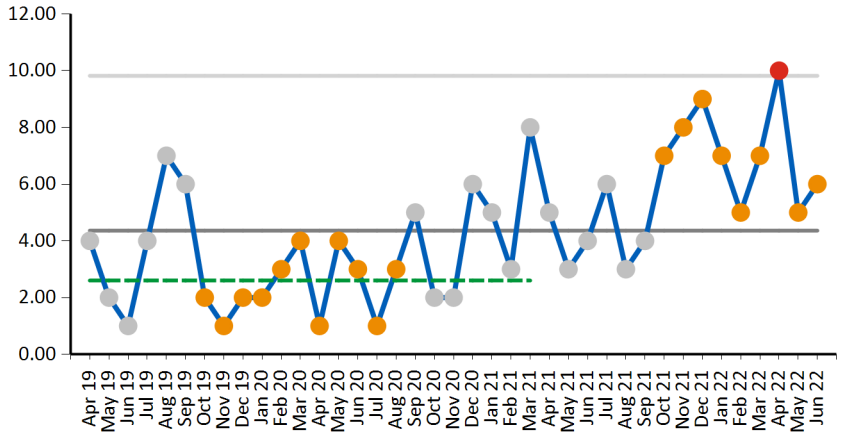
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

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

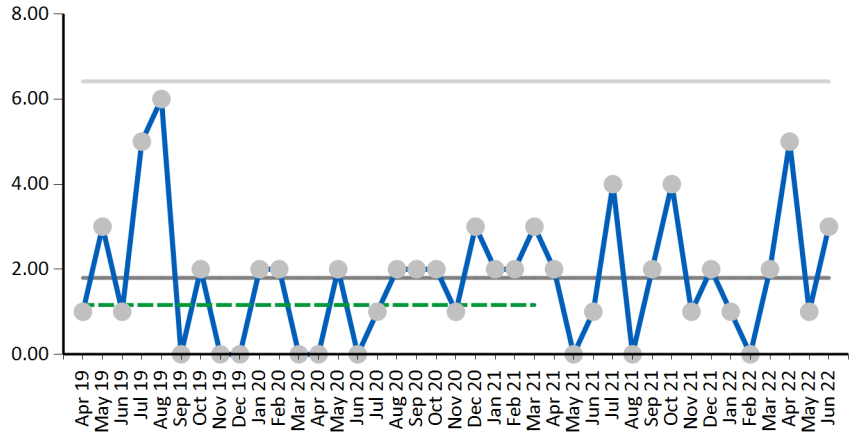
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		6	Jun-22			5	May-22		21	
346 - Total Community Onset Hospital Associated C.diff infections		3	Jun-22			1	May-22		9	
347 - Total C.diff infections contributing to objective	<= 3	9	Jun-22		<= 3	6	May-22	<= 8	30	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Jun-22		= 0	0	May-22	= 0	0	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	4	Jun-22		<= 2	3	May-22	<= 5	15	
219 - Blood Culture Contaminants (rate)	<= 3%	2.8%	Jun-22		<= 3%	3.2%	May-22	<= 3%	2.9%	
199 - Compliance with antibiotic prescribing standards	>= 95%	74.8%	Q2 2021/22		>= 95%	84.0%	Q1 2021/22	>= 95%		

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Jun-22		<= 1.0	5.0	May-22	<= 3.0	11.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Jun-22		<= 1	0	May-22	<= 2	6	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Jun-22		= 0	0	May-22	= 0	1	
491 - Nosocomial COVID-19 cases		45	Jun-22			8	May-22		101	

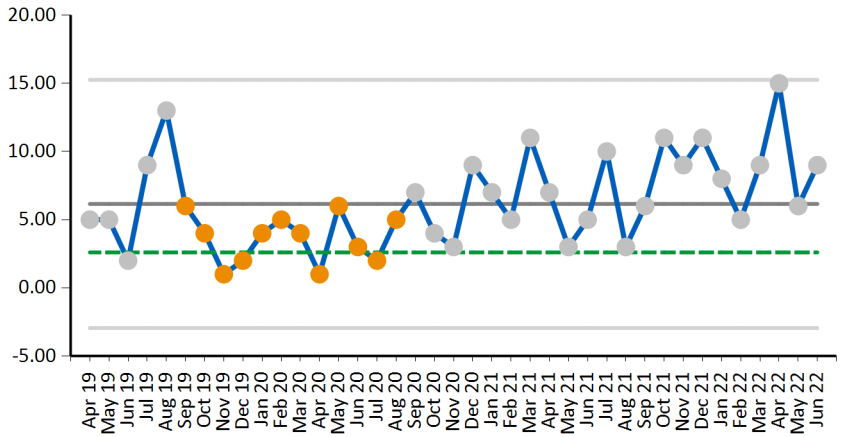
215 - Total Hospital Onset C.diff infections



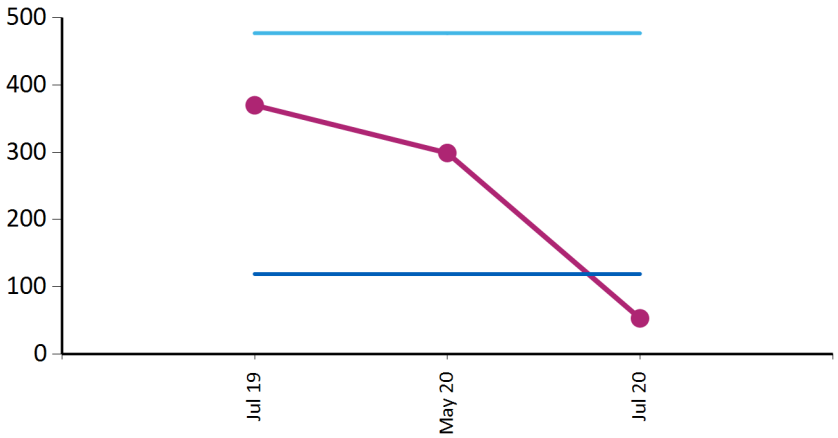
346 - Total Community Onset Hospital Associated C.diff infections



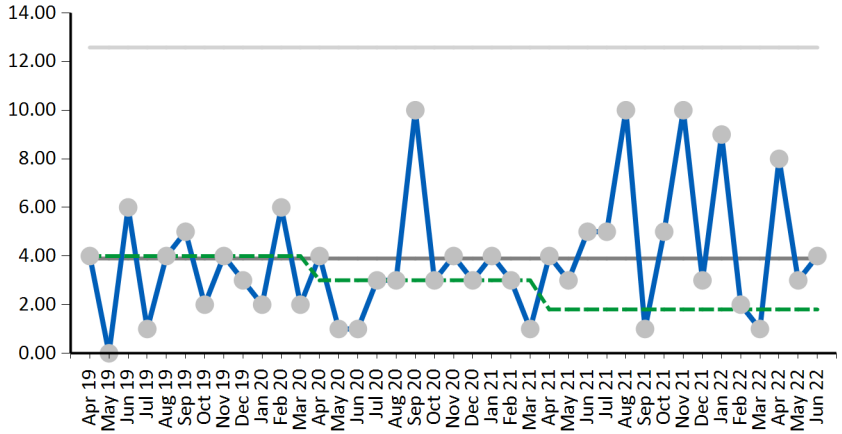
347 - Total C.diff infections contributing to objective



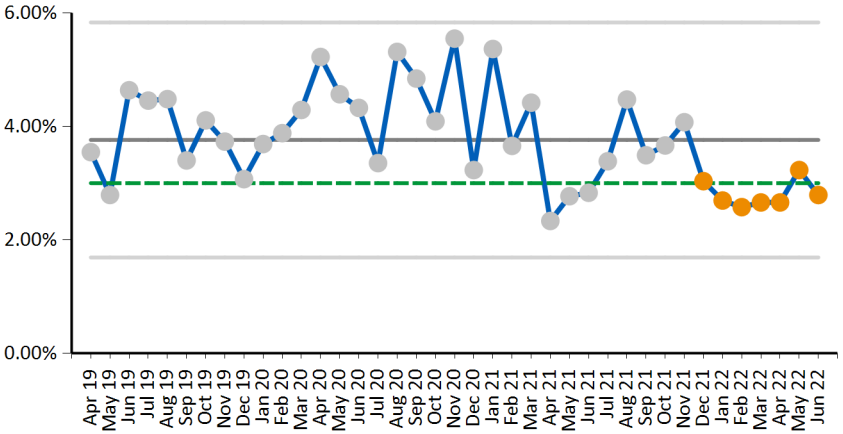
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



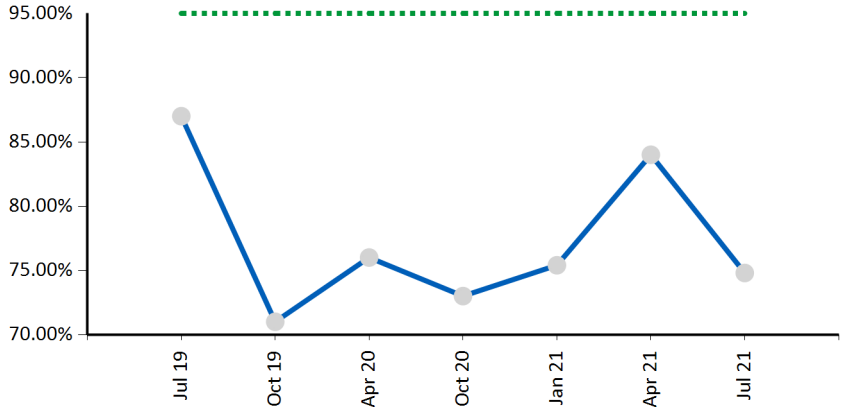
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)



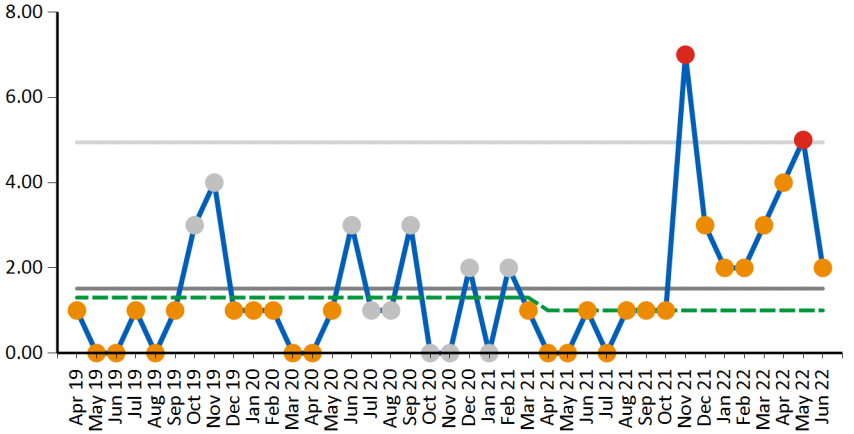
219 - Blood Culture Contaminants (rate)



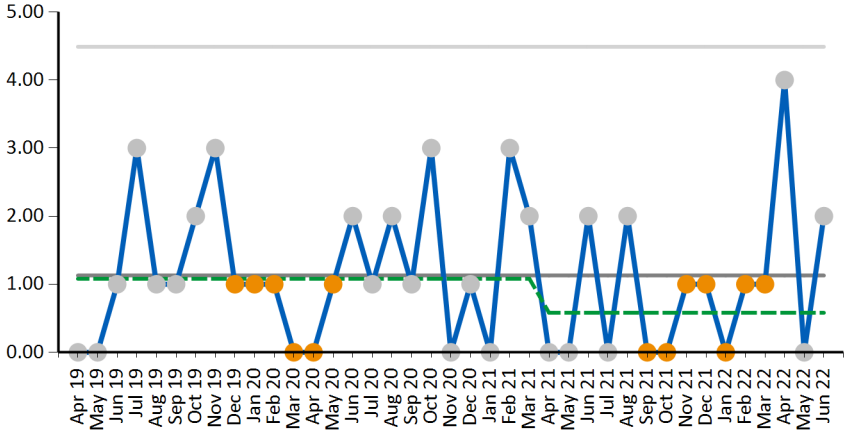
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



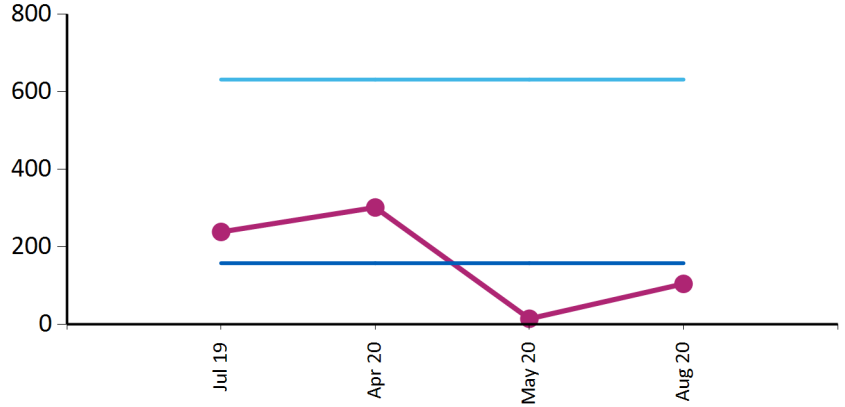
304 - Total Trust apportioned MSSA BSIs



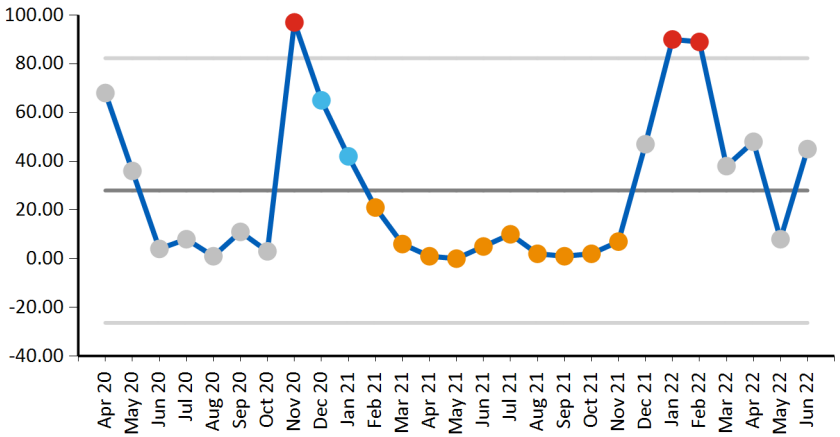
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)



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



491 - Nosocomial COVID-19 cases



Mortality

Crude – in month position remains below the average and target for the time period.

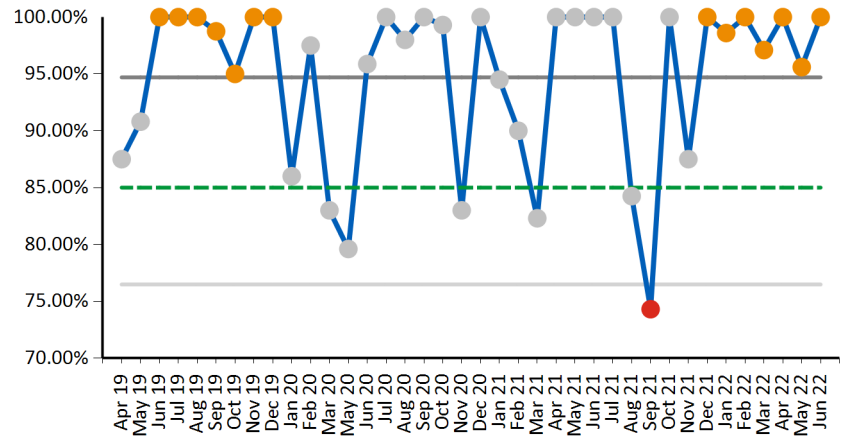
SHMI – in month position is in line with the average for the time period. The rolling average for the period March 2021 to February 2022 is 'within range'. Business Intelligence is investigating this drop, it is thought to be because of the annual refresh of 2021/2022 dataset to NHS Digital which now includes a fully coded dataset and the removal of other DQ errors. The rolling average information should be viewed with caution until can be fully explained.

HSMR – in month position is below average for the time period. The rolling average for the period March 2021 to February 2022 is alerting 'red' and is highest amongst peers.

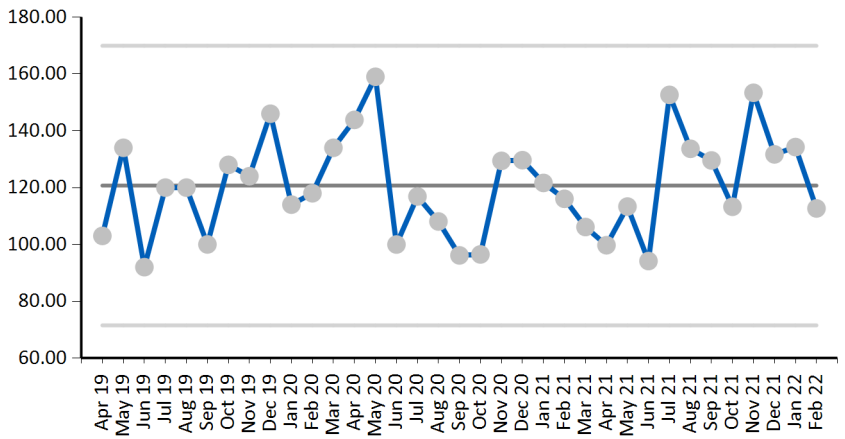
Please note there is a significant delay in receiving the data from NHSD which is always the case at this time of year and has made the time lag for SHMI and HSMR longer than usual. This is due to the national annual refresh of the financial year data. This is not expected until 21st July.

	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%	Jun-22		>= 85%	95.6%	May-22	>= 85%	98.5%	
495 - HSMR		112.67	Feb-22			134.26	Jan-22			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	117.76	Feb-22		<= 100.00	108.05	Jan-22	<= 100.00		
12 - Crude Mortality %	<= 2.9%	1.8%	Jun-22		<= 2.9%	2.1%	May-22	<= 2.9%	2.1%	
519 - Average Charlson comorbidity Score (First episode of care)		3	Feb-22			3	Jan-22			
520 - Depth of recording (First episode of care)		6	Feb-22			5	Jan-22			
521 - Proportion of fully coded records (Inpatients)		96.4%	Apr-22			96.0%	Mar-22		96.4%	

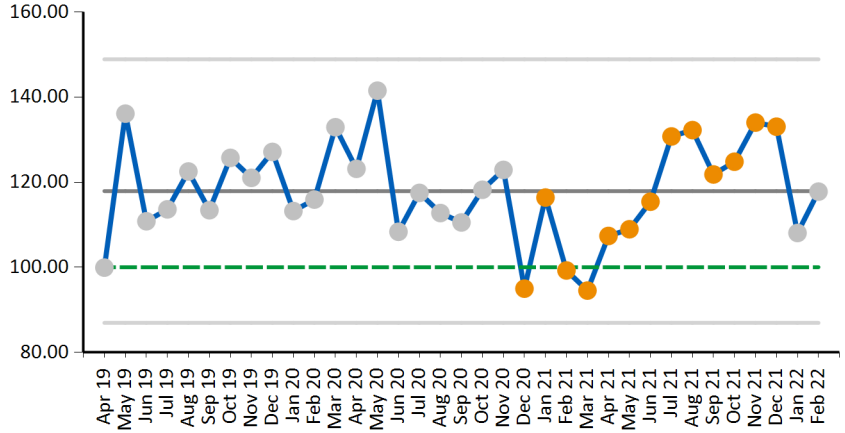
3 - National Early Warning Scores to Gold standard



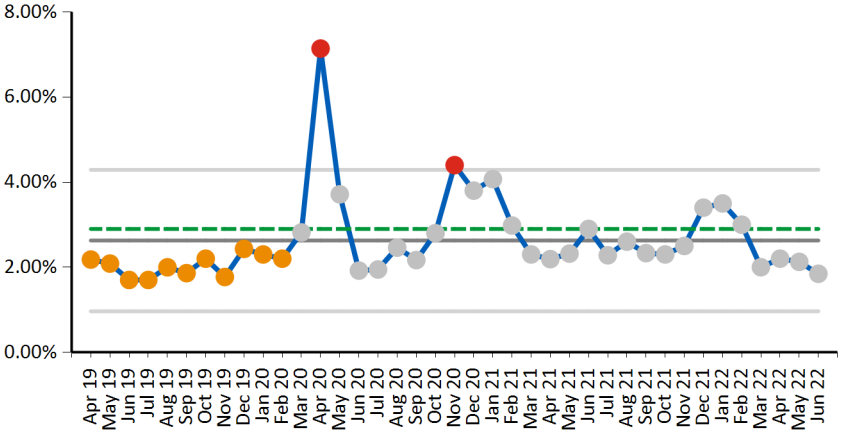
495 - HSMR



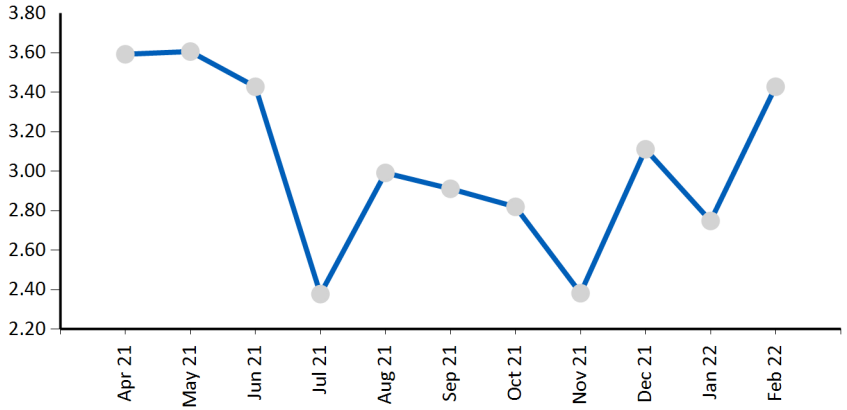
11 - Summary Hospital-level Mortality Indicator (SHMI)



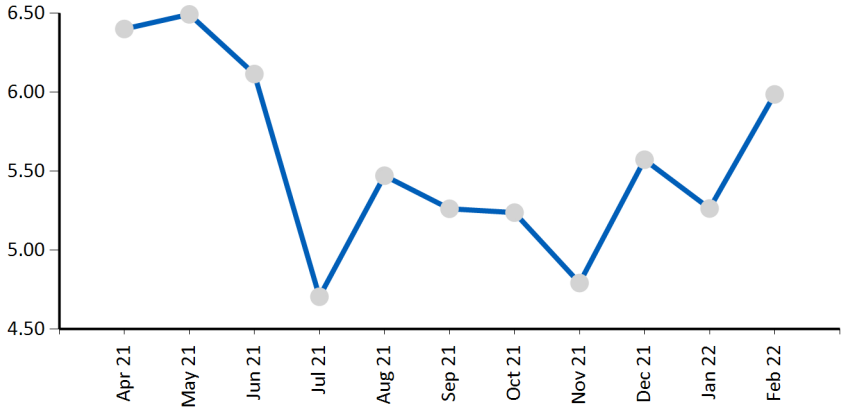
12 - Crude Mortality %



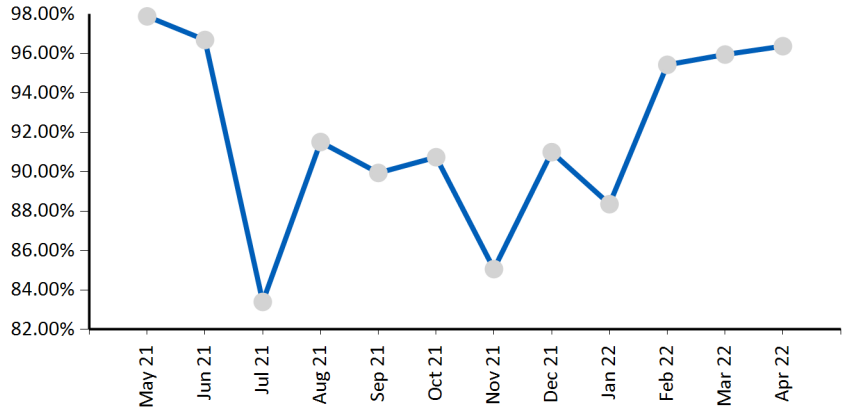
519 - Average Charlson comorbidity Score (First episode of care) - SPC data available after 20 data points



520 - Depth of recording (First episode of care) - SPC data available after 20 data points



521 - Proportion of fully coded records (Inpatients) - SPC data available after 20 data points



Patient Experience

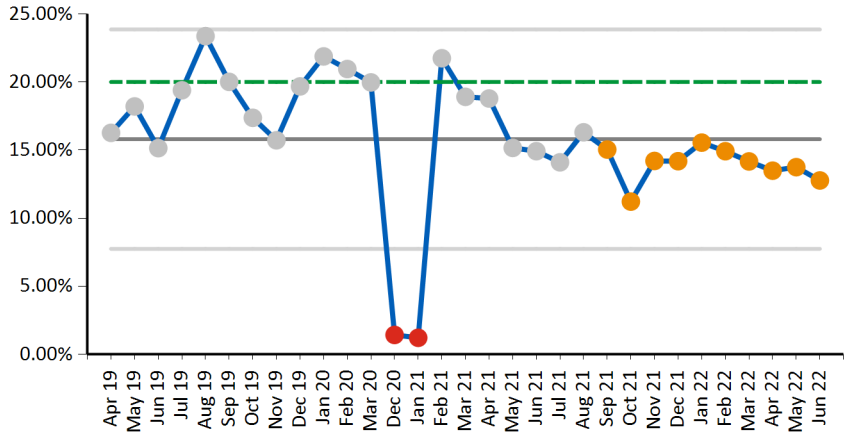
Complaints
Acknowledgment rate for June was 100% within 3 working days and the response rate was 15%. The focus continues to be on quality which has impacted on the ability to respond sooner. A number of initiatives are underway to review the complaints process at all stages with the objective of developing a revised complaints management process.

FFT
There continues to be a variation in the response and recommendation rates for the different areas of FFT. All Divisions are focussed on improving their collection methods and response rates and are discussing recommendation rates and negative feedback as part of their governance meetings.

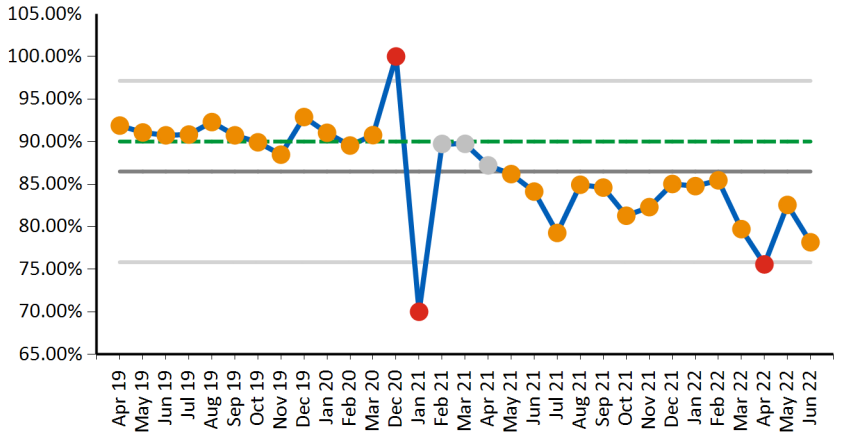
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	12.8%	Jun-22		>= 20%	13.7%	May-22	>= 20%	13.3%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	78.2%	Jun-22		>= 90%	82.6%	May-22	>= 90%	79.0%	
80 - Inpatient Friends and Family Response Rate	>= 30%	25.0%	Jun-22		>= 30%	24.8%	May-22	>= 30%	23.6%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.7%	Jun-22		>= 90%	96.7%	May-22	>= 90%	96.8%	
81 - Maternity Friends and Family Response Rate	>= 15%	14.3%	Jun-22		>= 15%	17.9%	May-22	>= 15%	17.3%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	84.8%	Jun-22		>= 90%	87.7%	May-22	>= 90%	84.6%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	4.1%	Jun-22		>= 15%	8.6%	May-22	>= 15%	9.7%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	85.7%	Jun-22		>= 90%	72.7%	May-22	>= 90%	82.8%	
83 - Birth - Friends and Family Response Rate	>= 15%	28.2%	Jun-22		>= 15%	31.4%	May-22	>= 15%	30.4%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	86.8%	Jun-22		>= 90%	91.6%	May-22	>= 90%	87.2%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	13.6%	Jun-22		>= 15%	16.2%	May-22	>= 15%	15.4%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	84.8%	Jun-22		>= 90%	91.2%	May-22	>= 90%	81.9%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	13.0%	Jun-22		>= 15%	15.1%	May-22	>= 15%	13.4%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	78.7%	Jun-22		>= 90%	85.0%	May-22	>= 90%	82.1%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Jun-22		= 100%	96.4%	May-22	= 100%	98.7%	
90 - Complaints responded to within the period	>= 95%	14.7%	Jun-22		>= 95%	28.0%	May-22	>= 95%	23.7%	

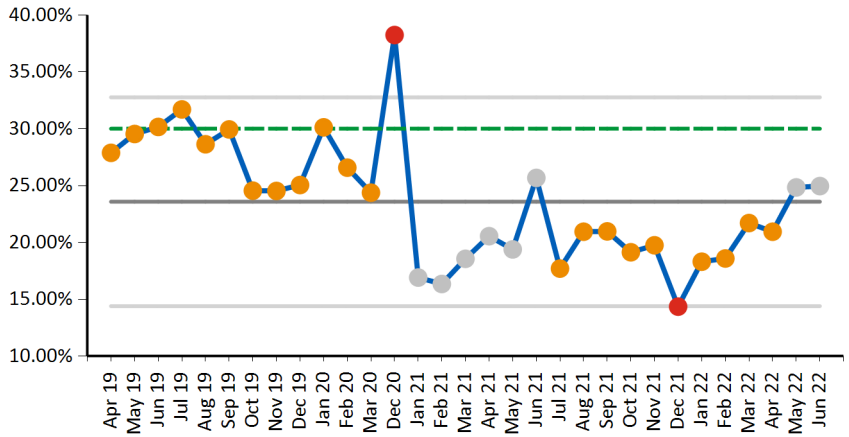
200 - A&E Friends and Family Response Rate



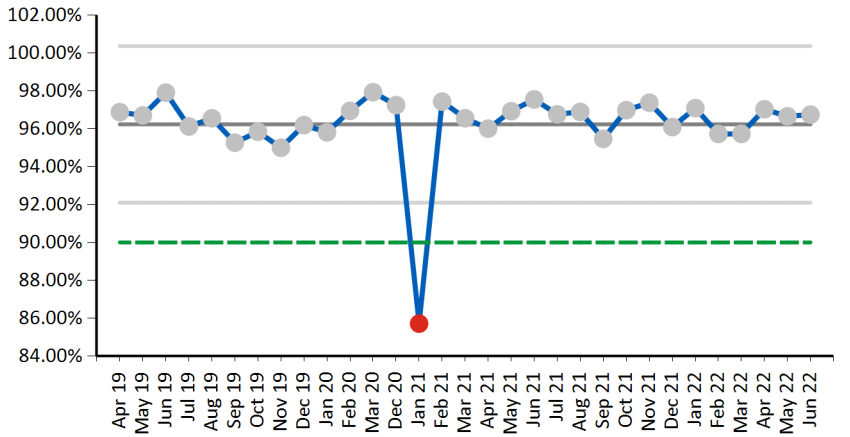
294 - A&E Friends and Family Satisfaction Rates %



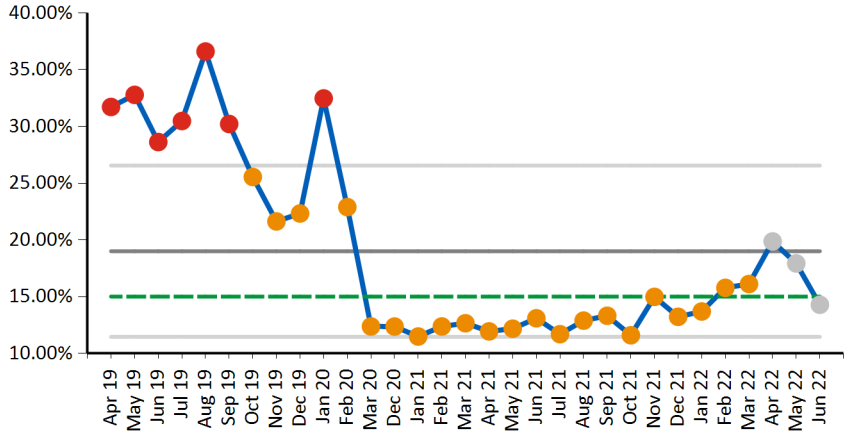
80 - Inpatient Friends and Family Response Rate



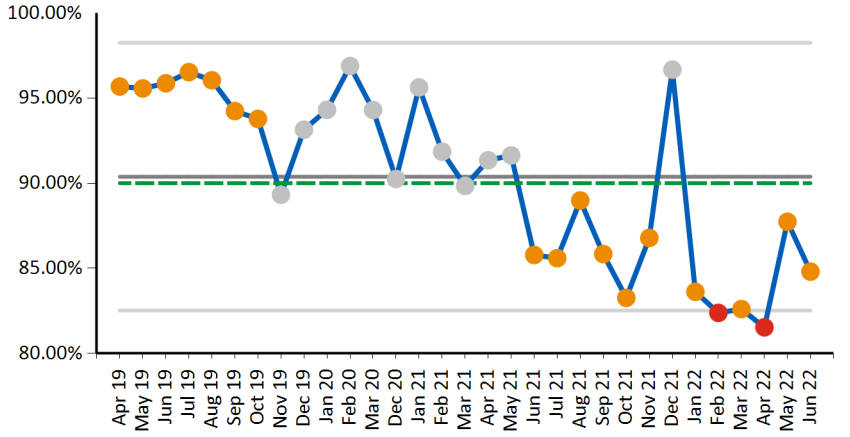
240 - Friends and Family Test (Inpatients) - Satisfaction %



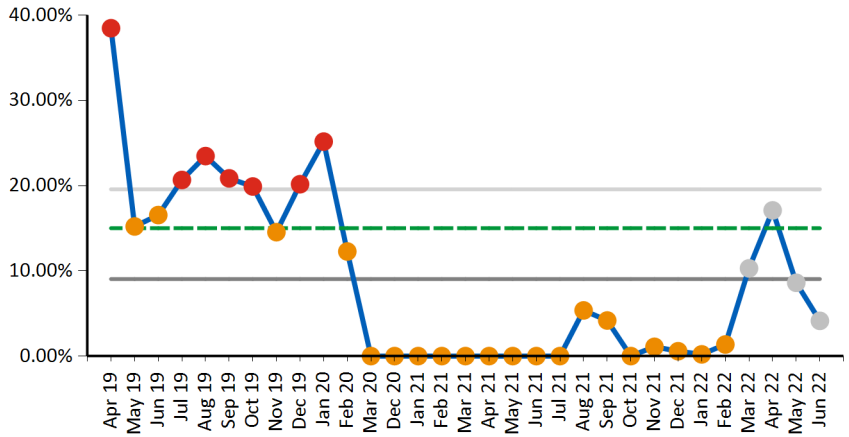
81 - Maternity Friends and Family Response Rate



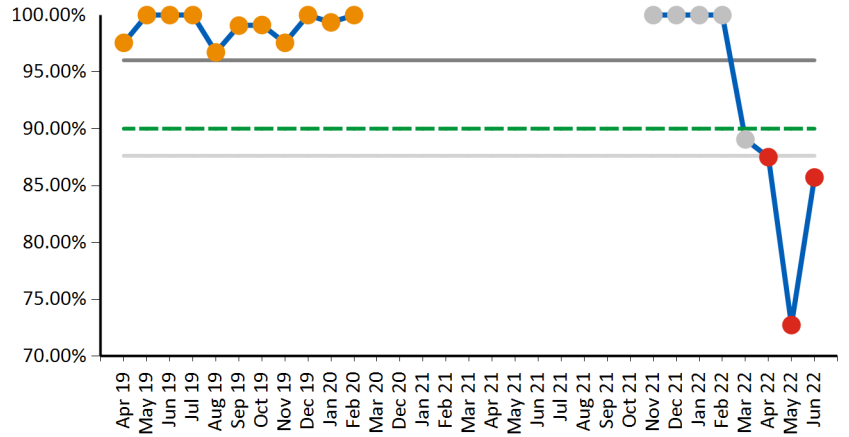
241 - Maternity Friends and Family Test - Satisfaction %



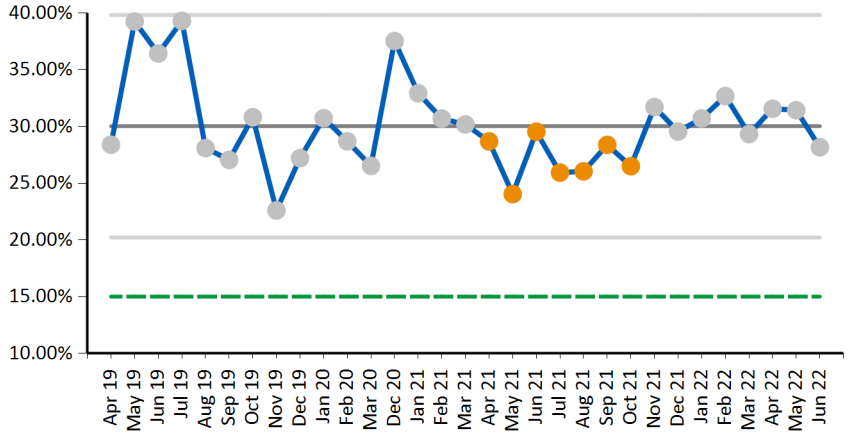
82 - Antenatal - Friends and Family Response Rate



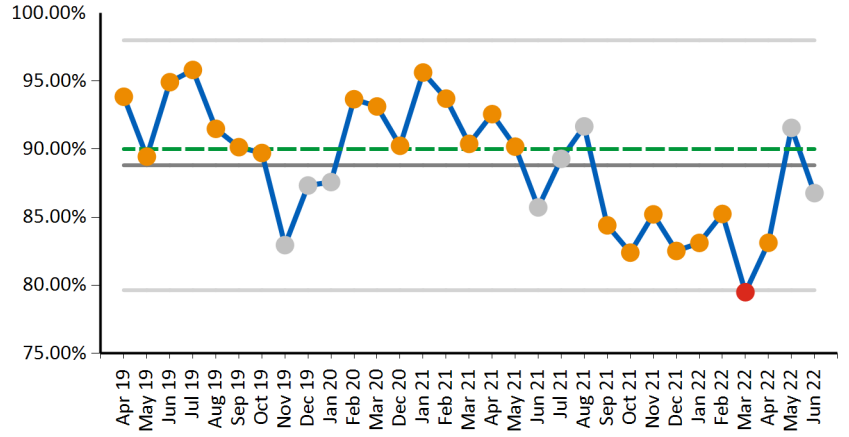
242 - Antenatal Friends and Family Test - Satisfaction %



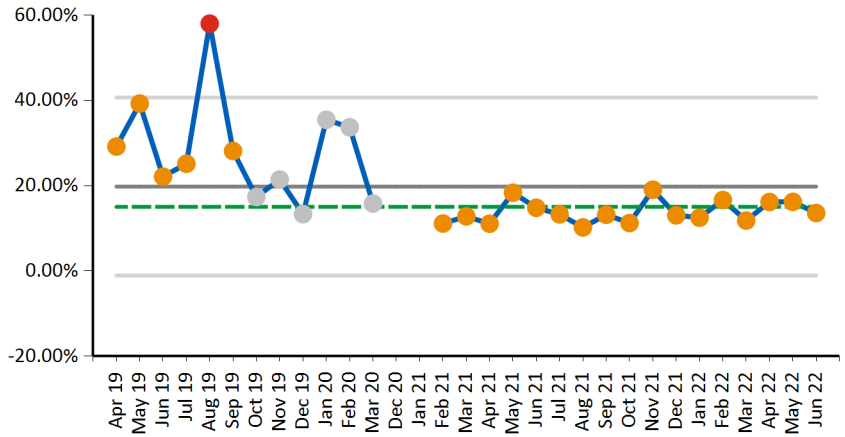
83 - Birth - Friends and Family Response Rate



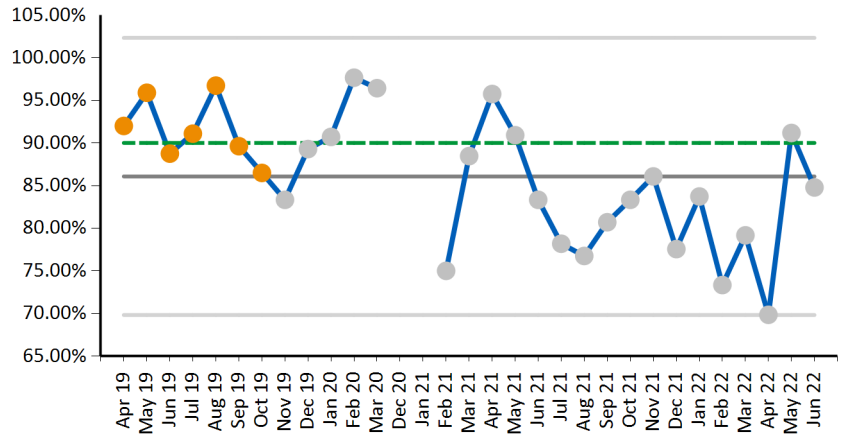
243 - Birth Friends and Family Test - Satisfaction %



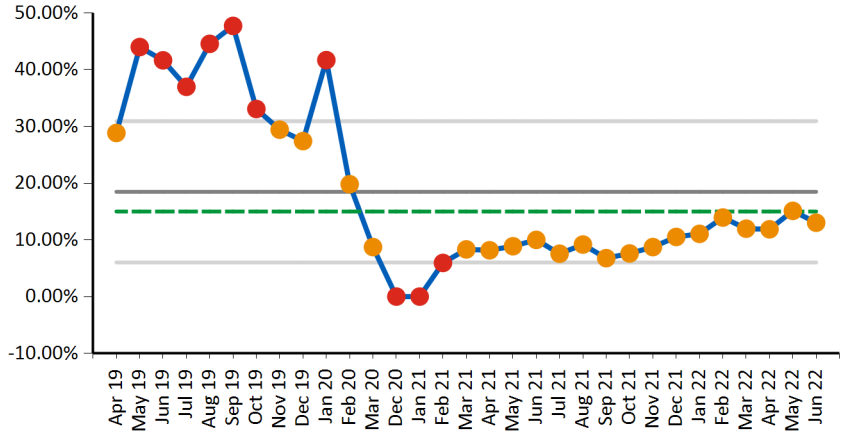
84 - Hospital Postnatal - Friends and Family Response Rate



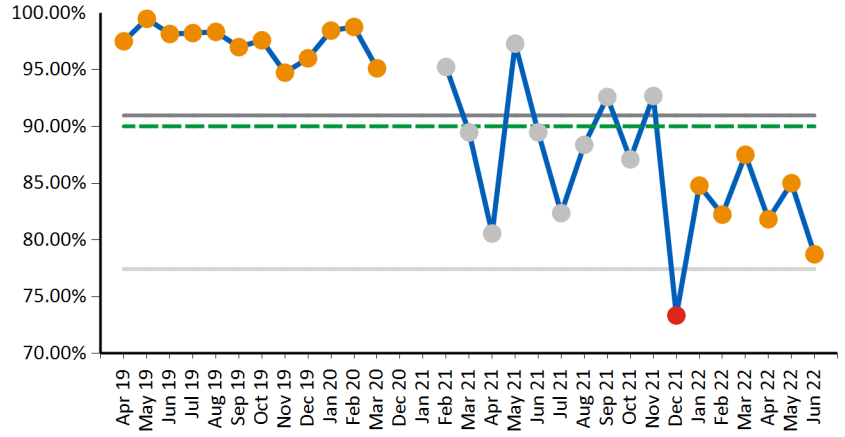
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



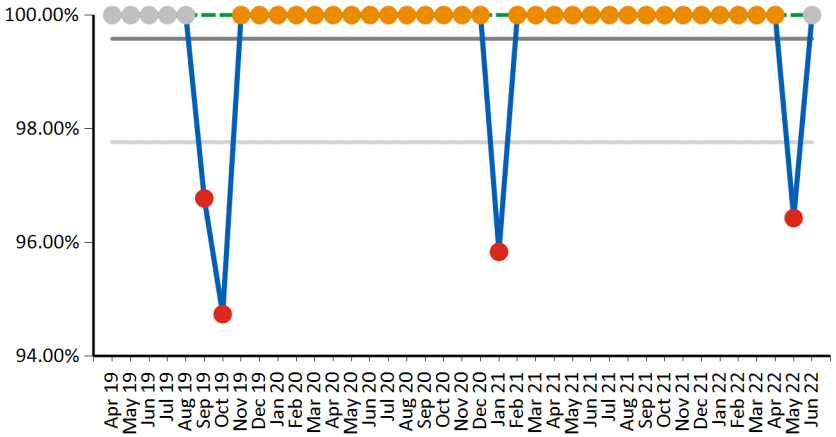
85 - Community Postnatal - Friend and Family Response Rate



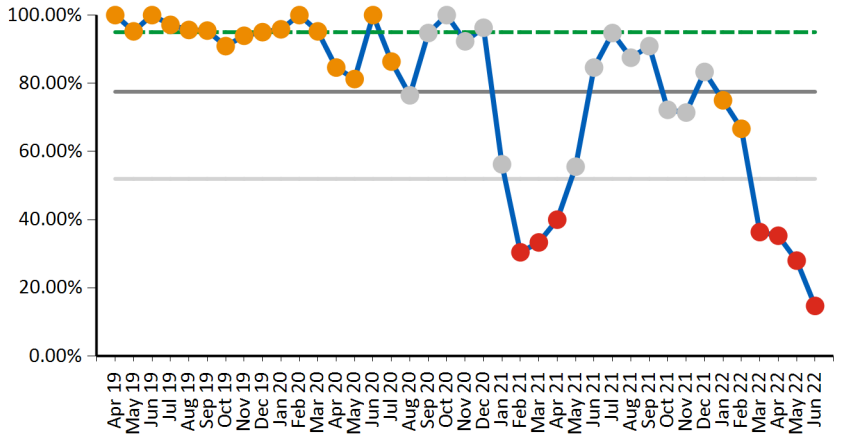
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

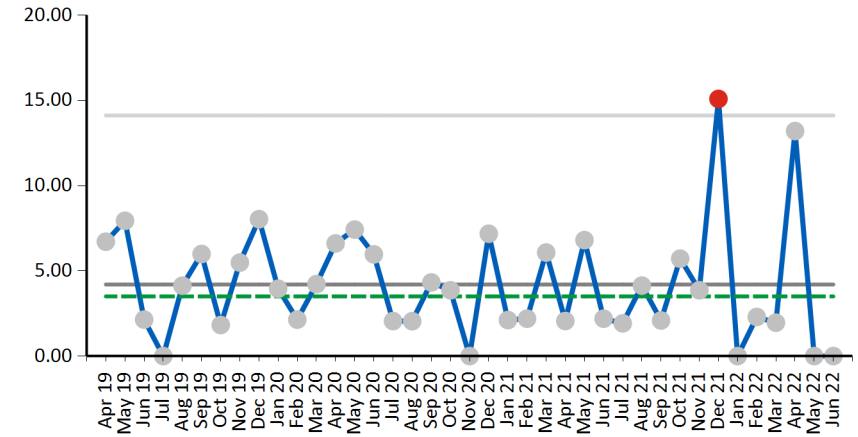
Complaints responded within the time period – significant improvement in complaints responded within the time period (28%-96.4%), and formal complaints acknowledged within 3 working days (96.4%-100%). Acknowledge the support from complaints and wider governance teams. Implementing new processes to ensure seamless service. 4 new complaints, 18 ongoing

Maternity friends and family response – Overall reduction in response rate across all areas (17.9%-14.3%). Most notable antenatal (8.6%-4.1%). Implemented QR stickers in all areas, available at relevant touch points, in maternal records. Reward for best performing areas
Maternity F&F satisfaction – Satisfaction rate no change (96.7%). All areas satisfaction except Antenatal which saw increased rates. Postnatal community rates reduced from 85%-78.7%.
Maternity 3rd and 4th degree tears – Significant reduction following implementation of oasi care bundle- lowest rate in 7 months. 2.4%
Booked 12+6 increase in compliance noted 82.4%-86.1%. 11.7% late presentation, 2.2% scan date changed. Targeted work in BL3 area continues. Implementing online referral process to facilitate early direct booking 25.7.22

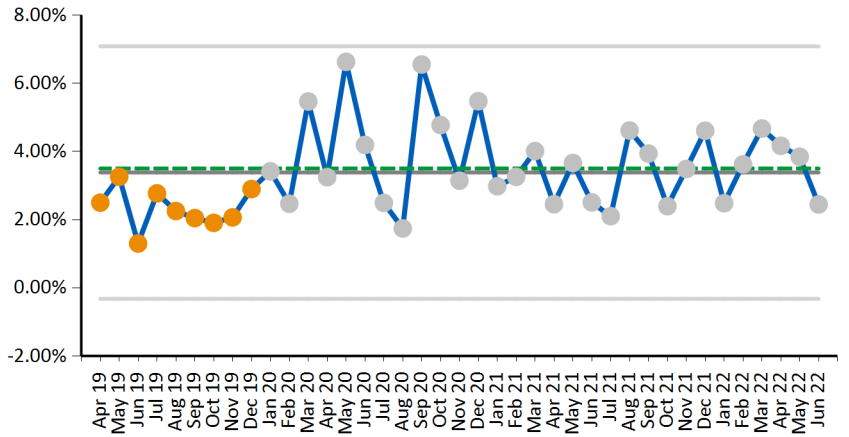
Stillbirths – 0 to report this month- actual rate 4.32 higher than planned. Annual review in progress
Midwifery care in labour maintained 97-98% last 7 months, above target. Midwife to birth rate ratio 1:30.1 (worked 1:28.6). Higher than current Birth Rate plus
Breastfeeding initiation reduced below target. Review of Baby Friendly Initiative standards and targeted intervention during the antenatal and postnatal period.

	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	0.00	Jun-22		<= 3.50	0.00	May-22	<= 3.50	4.32	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.4%	Jun-22		<= 3.5%	3.8%	May-22	<= 3.5%	3.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	97.7%	Jun-22		>= 95.0%	98.3%	May-22	>= 95.0%	97.8%	
203 - Booked 12+6	>= 90.0%	86.1%	Jun-22		>= 90.0%	82.4%	May-22	>= 90.0%	84.8%	
204 - Inductions of labour	<= 40%	37.3%	Jun-22		<= 40%	38.2%	May-22	<= 40%	37.2%	
210 - Initiation breast feeding	>= 65%	63.80%	Jun-22		>= 65%	65.67%	May-22	>= 65%	65.13%	
213 - Maternity complaints	<= 5	4	Jun-22		<= 5	6	May-22	<= 15	20	
319 - Maternal deaths (direct)	= 0	0	Jun-22		= 0	0	May-22	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	10.0%	Jun-22		<= 6%	6.8%	May-22	<= 6%	8.9%	

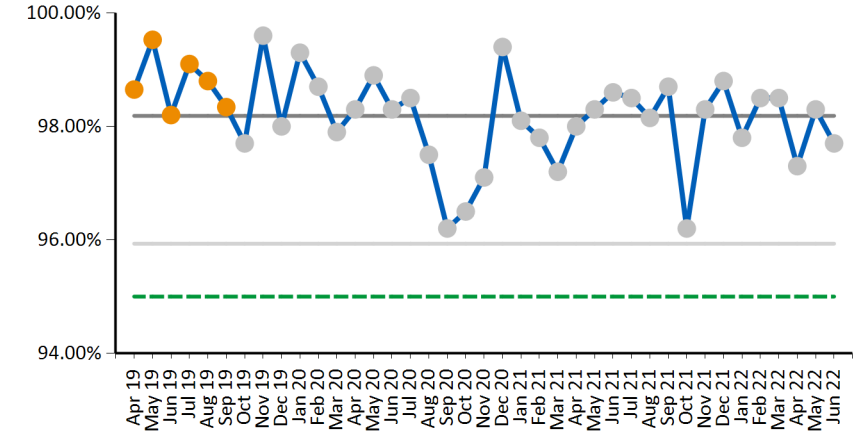
322 - Maternity - Stillbirths per 1000 births



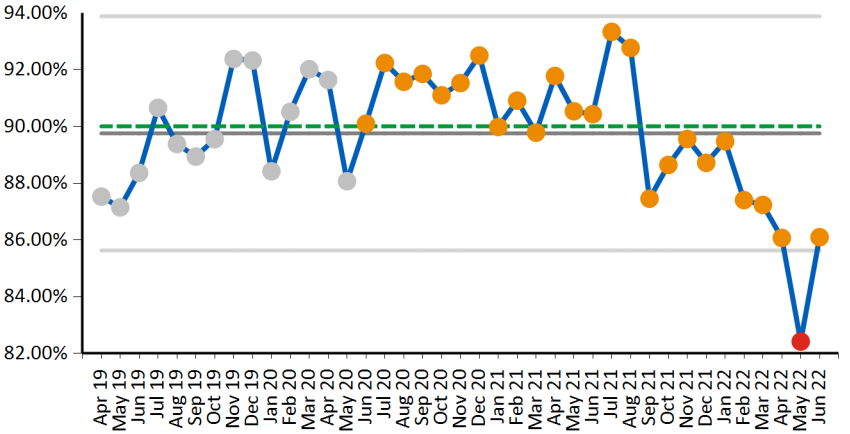
23 - Maternity -3rd/4th degree tears



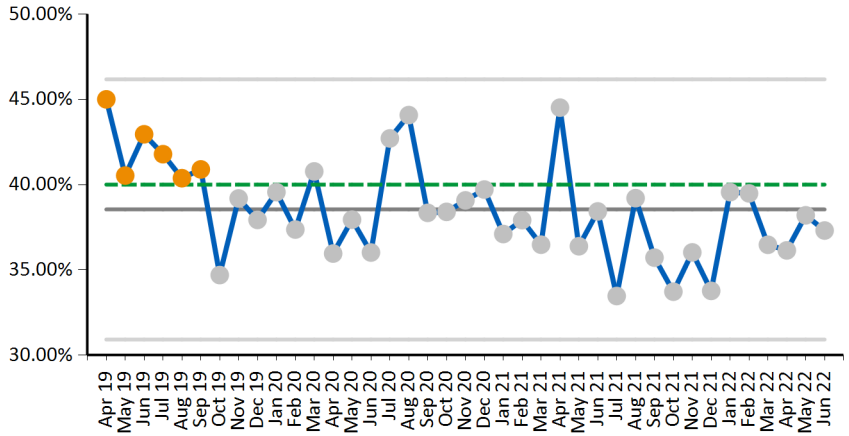
202 - 1:1 Midwifery care in labour



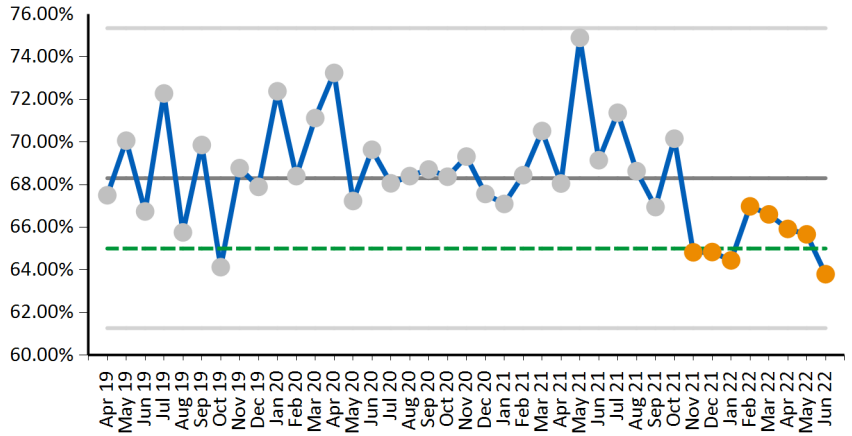
203 - Booked 12+6



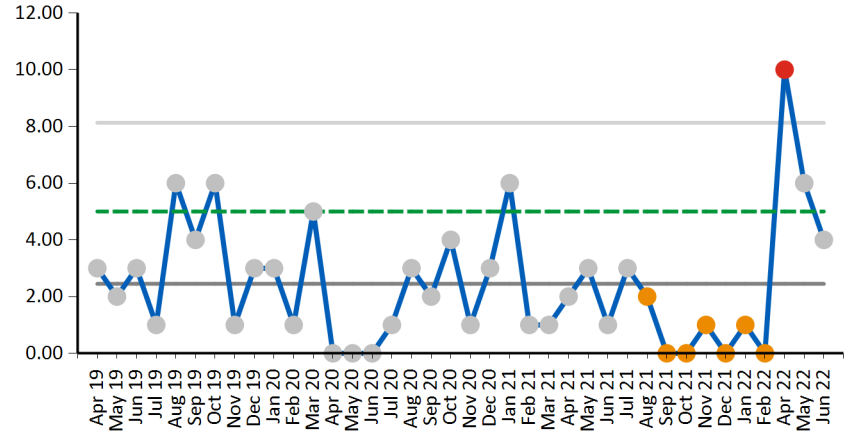
204 - Inductions of labour



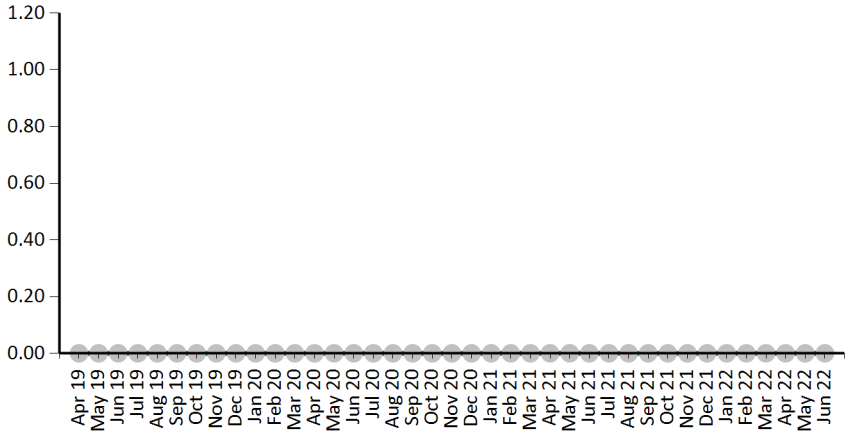
210 - Initiation breast feeding



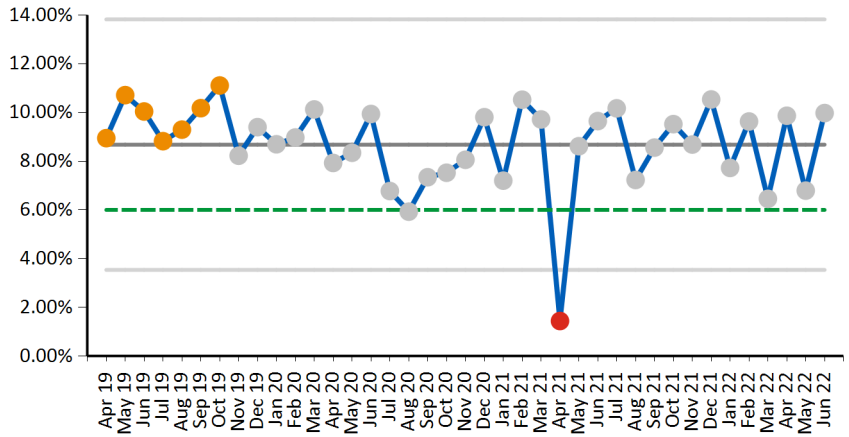
213 - Maternity complaints



319 - Maternal deaths (direct)



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



Operational Performance

Access

Ambulance handovers over 60 mins deteriorated in June against May perfromance. Additional work is beginning in July with external support targeting quality improvement with ambulance handovers being a key area of focus. This will also be attended by NWAS colleagues as a collaborative approach to improving patient handovers.
As a Trust we are also working as part of a pilot within the north west sector to improve the ambulance divert policy.

TIA – There has been a deterioration on TIA performance in Month due to vacancy at Consultant level. A new locum has been sourced who will commence at the Trust on the 25th July '22. In order to mitigate any risk in the interim all referrals are screened and prioritised in order of clinical need.

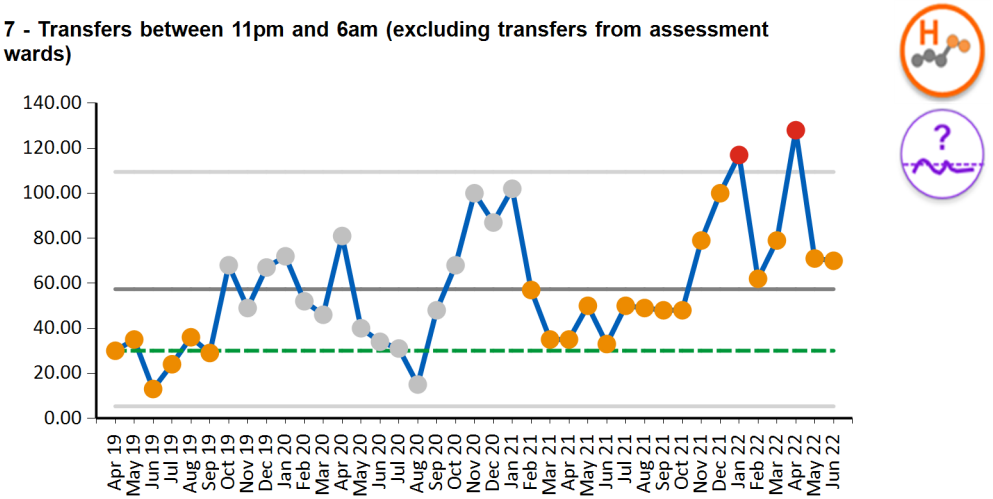
Stroke – The number of patients that spend 90% of their time on a stroke unit is in decline. This is multi-factoral due to a reduction in the number of acute stroke patients who are accepted by SRFT and the requirement from the stroke network to prioritise stroke repatriations from SRFT rather than move patients internally from acute medical wards to the Stroke unit. There is a meeting with the Stroke network lead and the Neuro MD in August to discuss stroke capacity and improving patients getting to the right bed at the right time.

DM01 - The percentage of patients breaching a 6-weeks wait for their diagnostic test increased by 2.0% in June, with the final position for the Trust being 30.8% DM01 compliance. The diagnotic PTL decreased by 159 in month, however, the number of breached patients increased by 33 (1,246 breaches in total).
The 4-day bank holiday at the start of the month, coupled increased annual leave across the Trust over school holiday periods, had an impact on overall performance

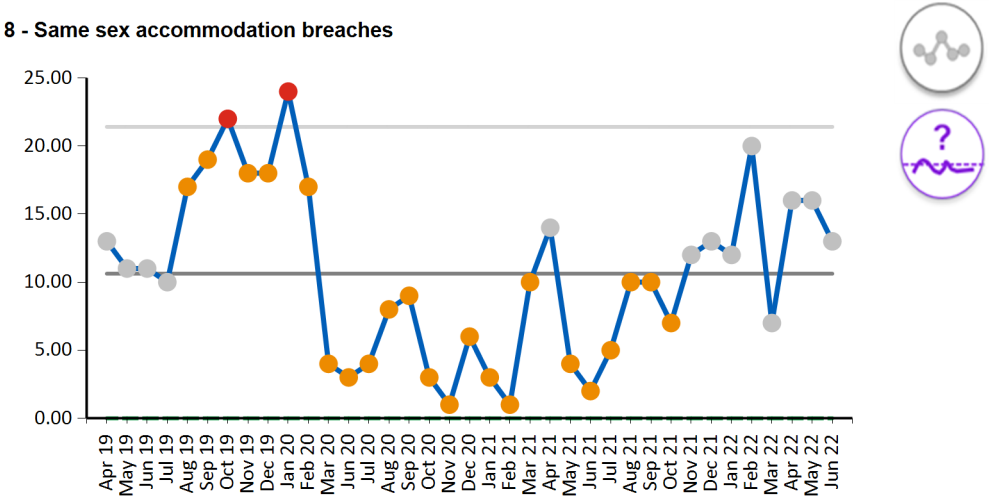
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	70	Jun-22	H	<= 30	71	May-22	<= 90	269	?
8 - Same sex accommodation breaches	= 0	13	Jun-22		= 0	16	May-22	= 0	45	?
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	50.0%	Jun-22		>= 75%	54.3%	May-22	>= 75%	50.5%	?
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	65.0%	Jun-22	L	>= 92%	67.4%	May-22	>= 92%	65.9%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	1,825	Jun-22	H	= 0	1,626	May-22	= 0	5,111	F
314 - RTT 18 week waiting list	<= 25,530	35,142	Jun-22	H	<= 25,530	33,625	May-22	<= 25,530	35,142	?
53 - A&E 4 hour target	>= 95%	60.9%	Jun-22	L	>= 95%	61.5%	May-22	>= 95%	60.3%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	14.2%	Jun-22	H	= 0.0%	13.4%	May-22	= 0.0%	14.0%	F

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	14.93%	Jun-22	H	= 0.00%	8.68%	May-22	= 0.00%	12.87%	F
72 - Diagnostic Waits >6 weeks %	<= 1%	30.8%	Jun-22	H	<= 1%	28.8%	May-22	<= 1%	31.8%	F
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	50.0%	Jun-22		= 100%	76.9%	May-22	= 100%	71.5%	?

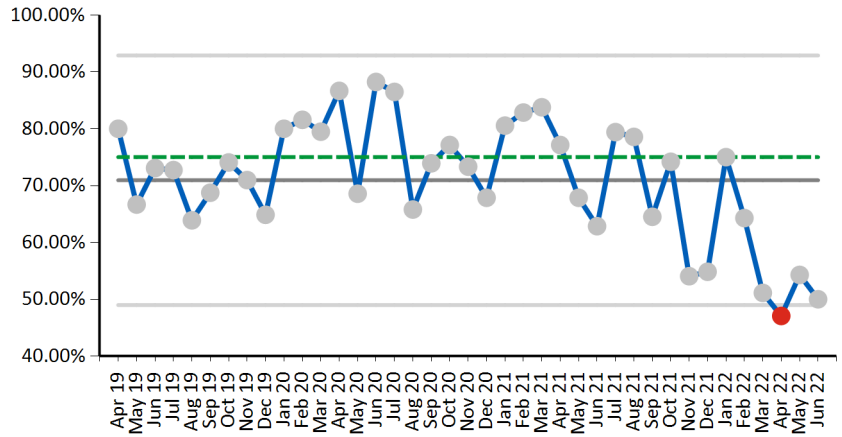
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



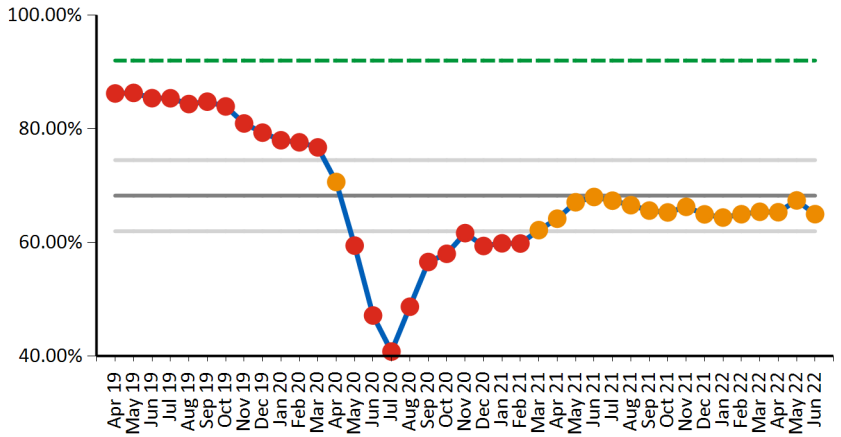
8 - Same sex accommodation breaches



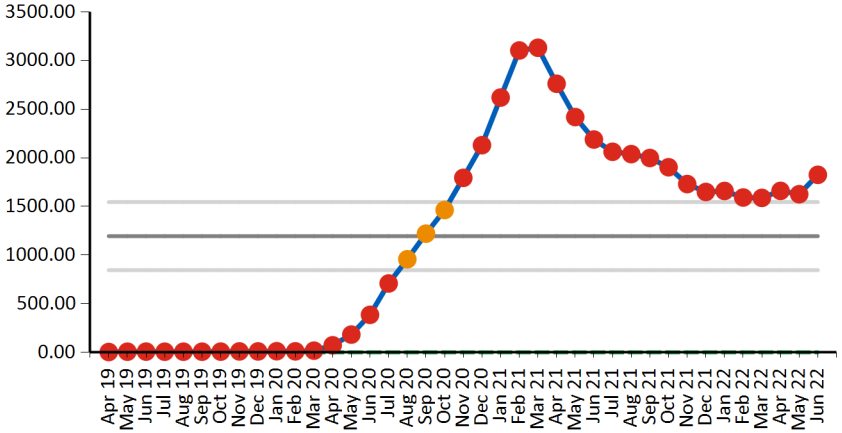
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



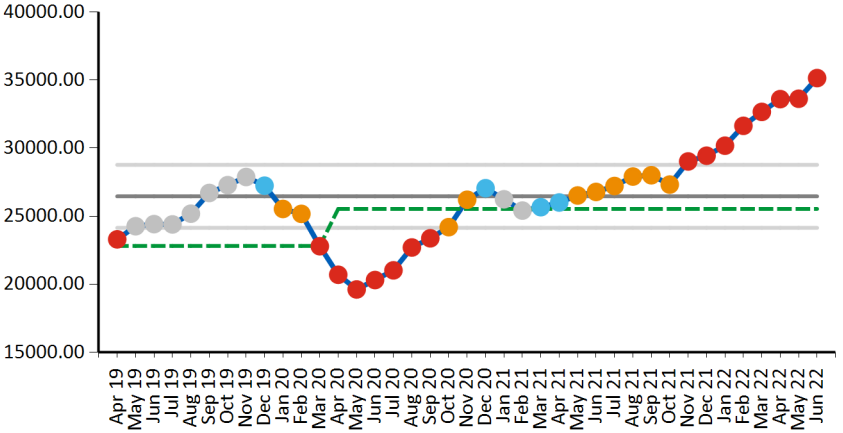
41 - RTT Incomplete pathways within 18 weeks %



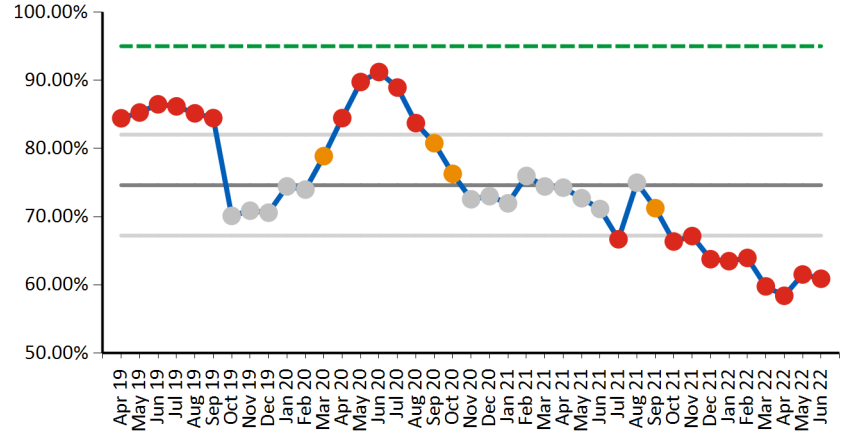
42 - RTT 52 week waits (incomplete pathways)



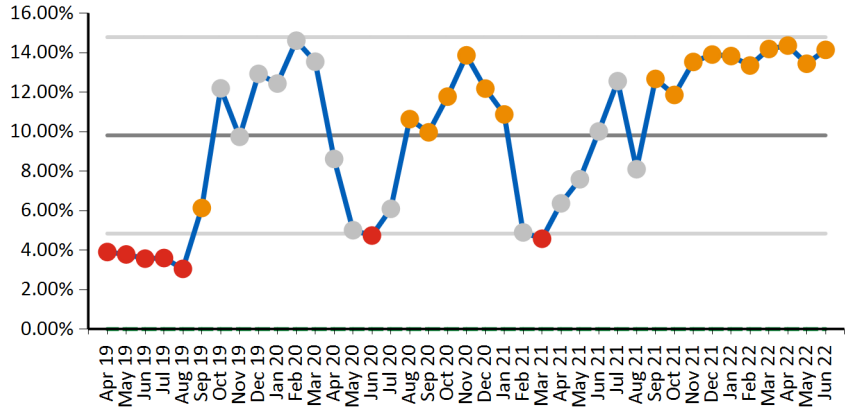
314 - RTT 18 week waiting list



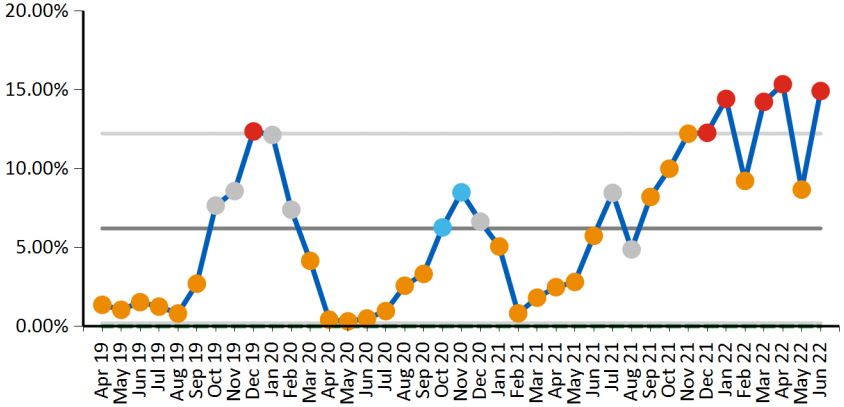
53 - A&E 4 hour target



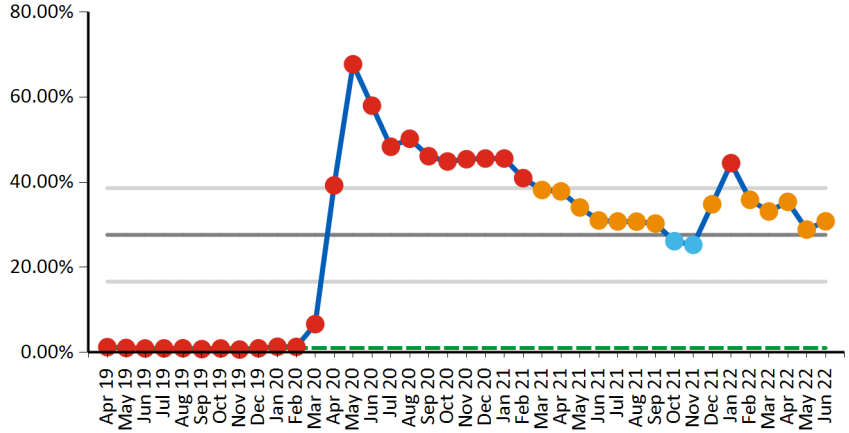
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



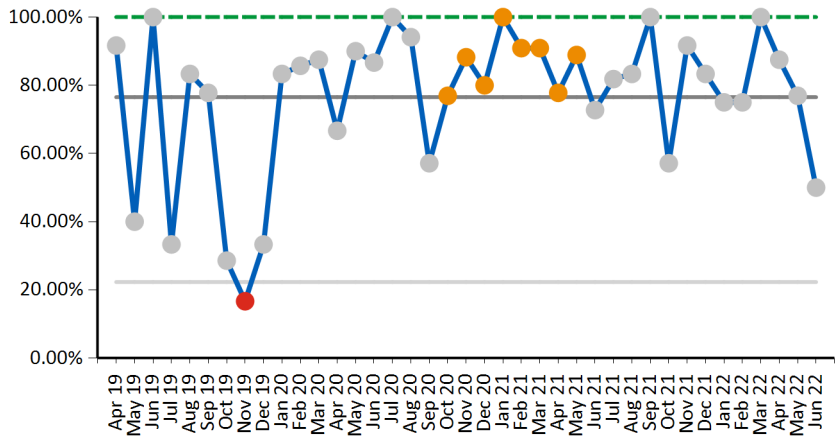
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



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



Productivity

The Trust continues to experience pressure in relation to reducing the number of patients at any one time with no Criteria to Reside (NCTR); in M3 NCTR has increased slightly along with occupied bed days. We continue to work with system partners to support the improvement of this indicator and there is currently specific focus on pathway 1 patients with NCTR in order to support early discharge home with support. The Integrated Care Partnership has commissioned AQuA to work with us to review whole system flow. The diagnostic phase is complete, tests of change are under way and a system visibility event is being held in July.

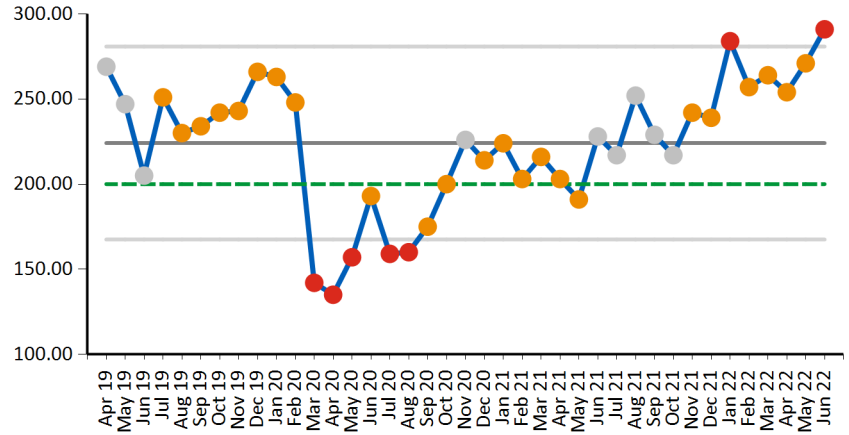
RTT
The trust delivered zero 104 week waits outside the national exception criteria by 1stJuly.

18 week RTT performance has reduced this month, however the trust continues to make progress to date all patients over 78 weeks waiting for surgery.
Key areas of concern are Ophthalmology which has seen reduced outpatient activity due to increased patient complexity, this is a national issue and work is being undertaken by GM PFB to review this. Paediatric and vascular surgery have long waiting times to first appointment as a result of reduced capacity against demand, this is regularly discussed with MFT as the SLA provider, however the waits are reflective of the overall GM position.

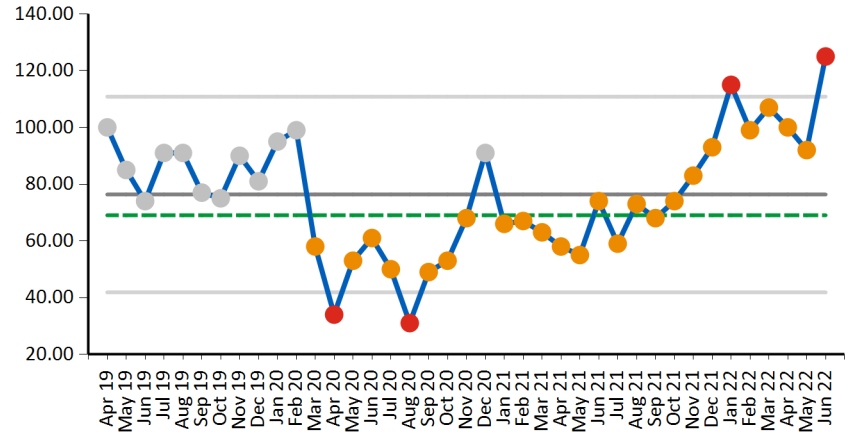
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	291	Jun-22	H	<= 200	271	May-22	<= 200	291	?
307 - Stranded Patients - LOS 21 days and over	<= 69	125	Jun-22	H	<= 69	92	May-22	<= 69	125	?
57 - Discharges by Midday	>= 30%	21.7%	Jun-22		>= 30%	22.5%	May-22	>= 30%	21.5%	F
58 - Discharges by 4pm	>= 70%	59.9%	Jun-22	L	>= 70%	54.6%	May-22	>= 70%	57.8%	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.2%	May-22	L	<= 13.5%	10.1%	Apr-22	<= 13.5%	10.1%	?
489 - Daycase Rates	>= 80%	89.1%	Jun-22		>= 80%	88.3%	May-22	>= 80%	88.8%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.9%	Jun-22		<= 1%	1.3%	May-22	<= 1%	1.9%	?
62 - Cancelled operations re-booked within 28 days	= 100%	95.4%	Jun-22		= 100%	82.4%	May-22	= 100%	13.4%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.39	Jun-22		<= 2.00	2.29	May-22	<= 2.00	2.87	?
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.10	Jun-22		<= 3.70	4.35	May-22	<= 3.70	4.27	?
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	63.2%	Mar-22		>= 80%	66.7%	Feb-22	>= 80%		?

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision	= 0	46	Jun-22		= 0	41	May-22	= 0	128	
493 - Average Number of Patients: with no Criteria to Reside	<= 55	121	Jun-22		<= 55	111	May-22	<= 165	342	
494 - Average Occupied Days - for no Criteria to Reside		990	Jun-22			924	May-22		3,098	
496 - Average bed days since patients with LOS >14 days moved onto NCTR list	>= 190	901	Jun-22		>= 190	826	May-22	>= 570	2,827	

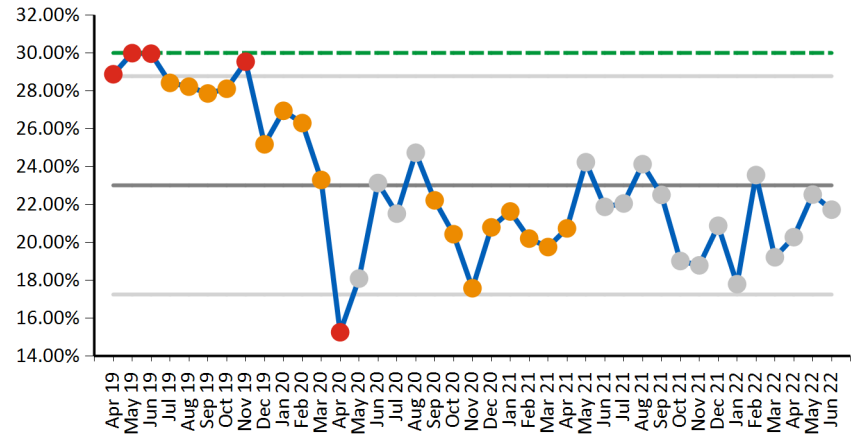
56 - Stranded patients



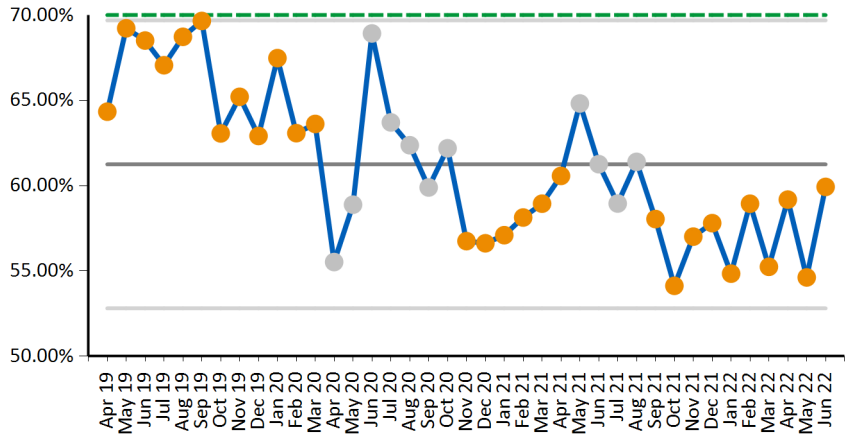
307 - Stranded Patients - LOS 21 days and over



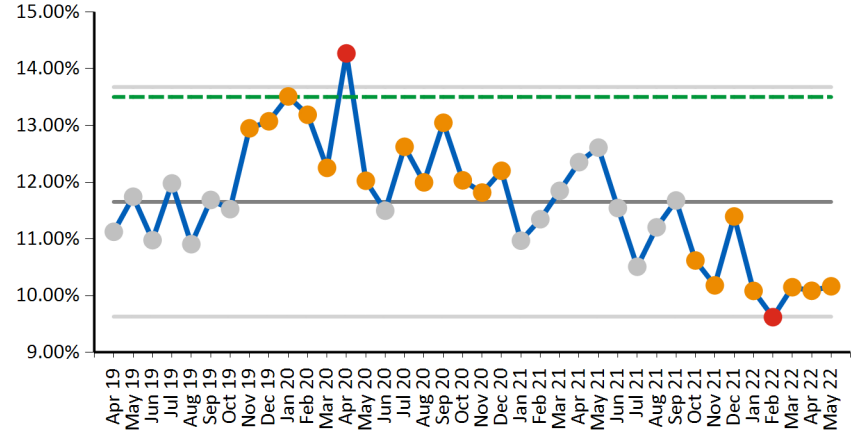
57 - Discharges by Midday



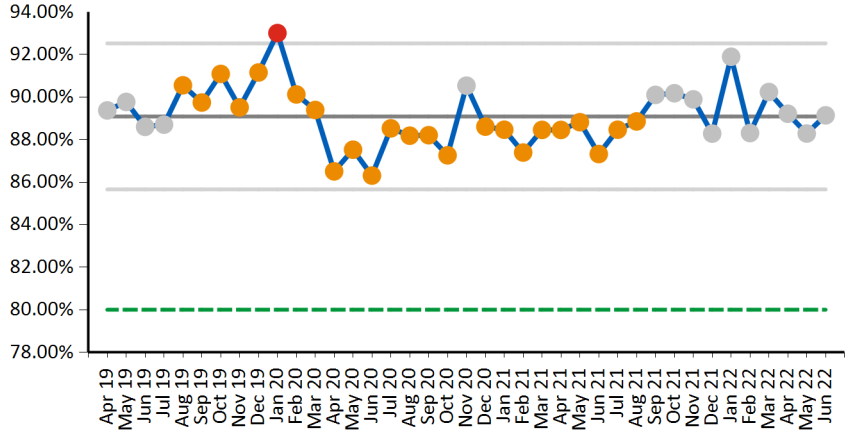
58 - Discharges by 4pm



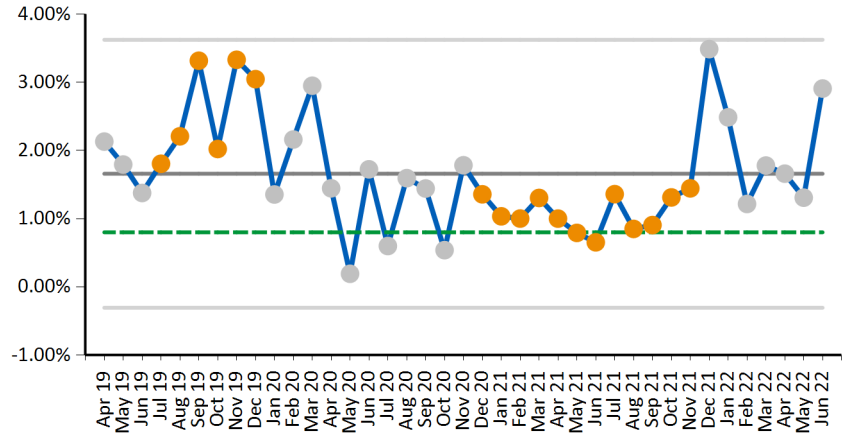
59 - Re-admission within 30 days of discharge (1 mth in arrears)



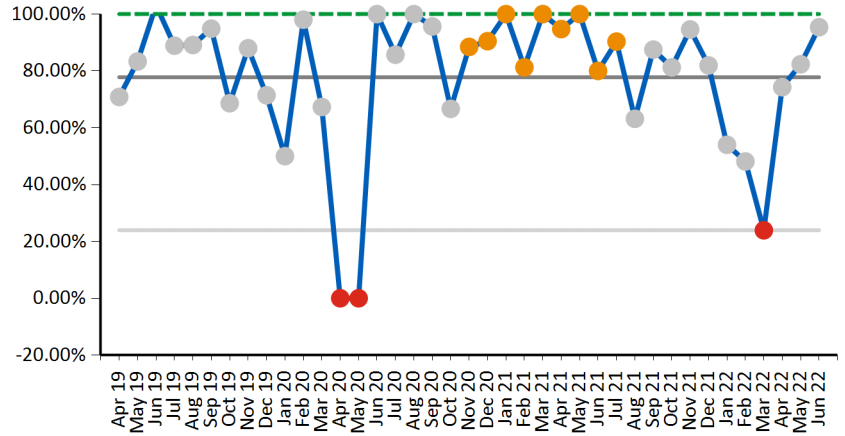
489 - Daycase Rates



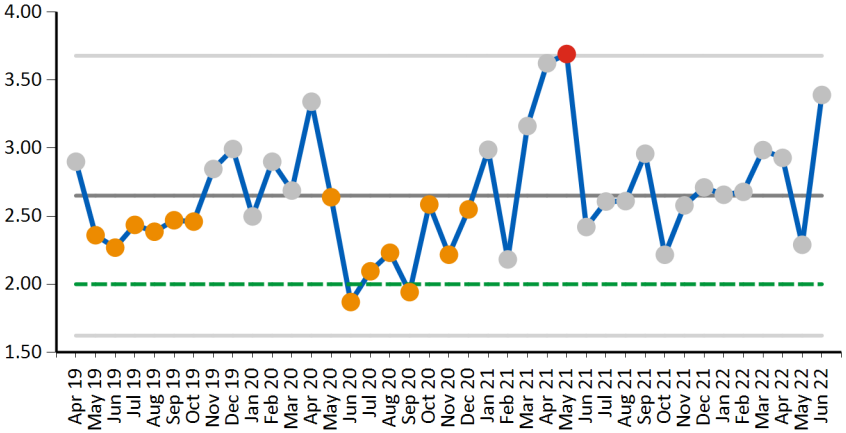
61 - Operations cancelled on the day for non-clinical reasons



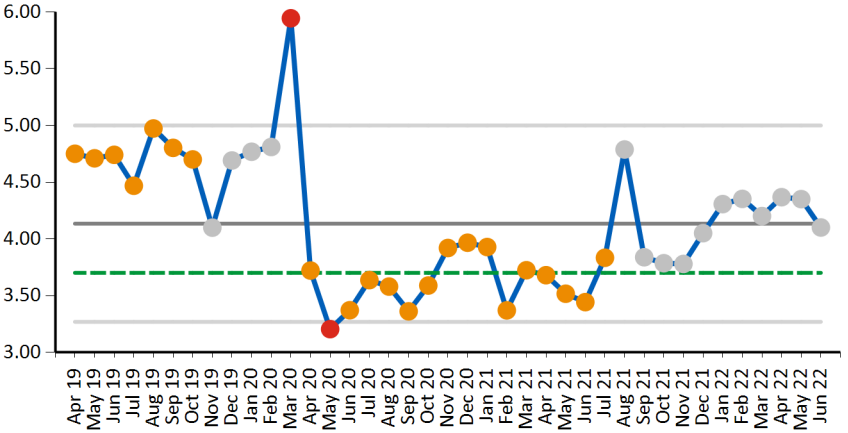
62 - Cancelled operations re-booked within 28 days



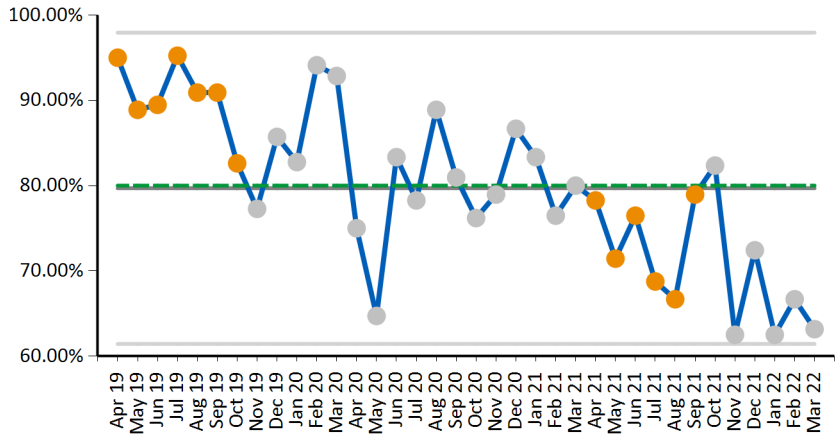
65 - Elective Length of Stay (Discharges in month)



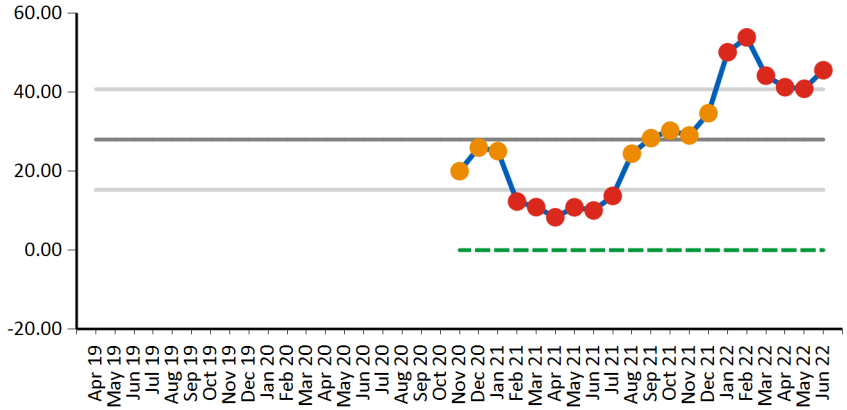
66 - Non Elective Length of Stay (Discharges in month)



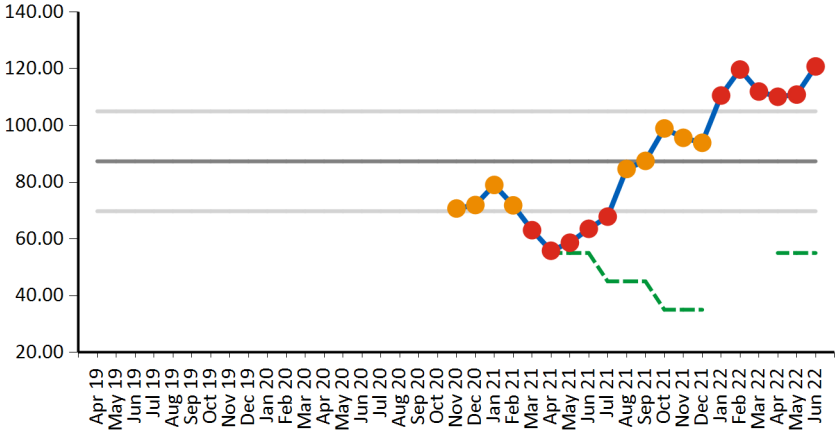
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



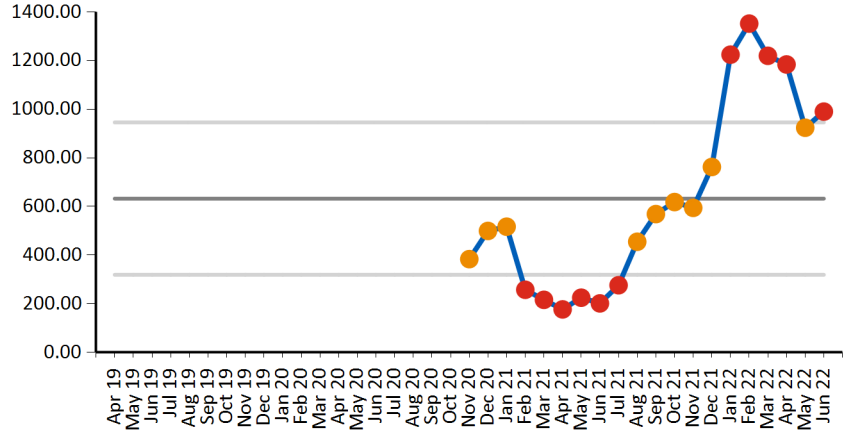
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision



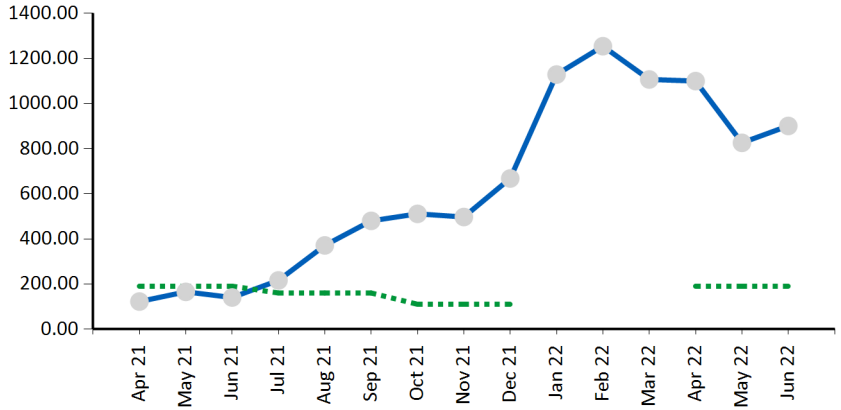
493 - Average Number of Patients: with no Criteria to Reside



494 - Average Occupied Days - for no Criteria to Reside



496 - Average bed days since patients with LOS >14 days moved onto NCTR list - SPC data available after 20 data points

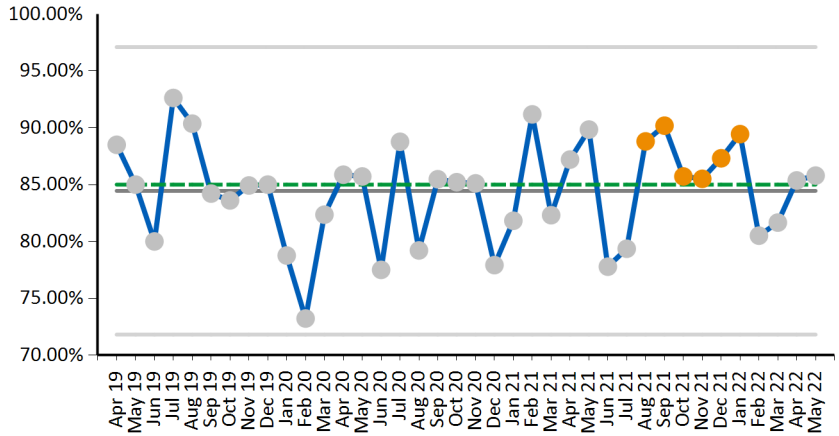


Cancer

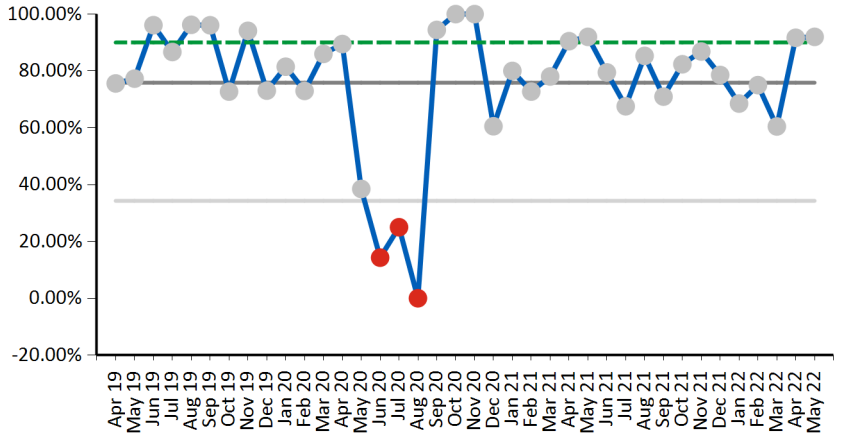
Two week-wait performance for May is improving at 89.25% this is following targeted work in Breast services, work continues to improve this position.
The trust passed the 62 day standard for May at 85.79%.
Areas of low performance continue to be Breast, Urology and Lung and action plans remain in place for these specialties.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	85.8%	May-22		>= 85%	85.4%	Apr-22	>= 85%	85.6%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	92.0%	May-22		>= 90%	91.7%	Apr-22	>= 90%	91.8%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.3%	May-22		>= 96%	98.9%	Apr-22	>= 96%	99.2%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	66.7%	May-22		>= 94%	75.0%	Apr-22	>= 94%	71.4%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%		May-22		>= 98%	100.0%	Apr-22	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	89.0%	May-22		>= 93%	86.3%	Apr-22	>= 93%	87.8%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	29.7%	May-22		>= 93%	33.1%	Apr-22	>= 93%	31.5%	

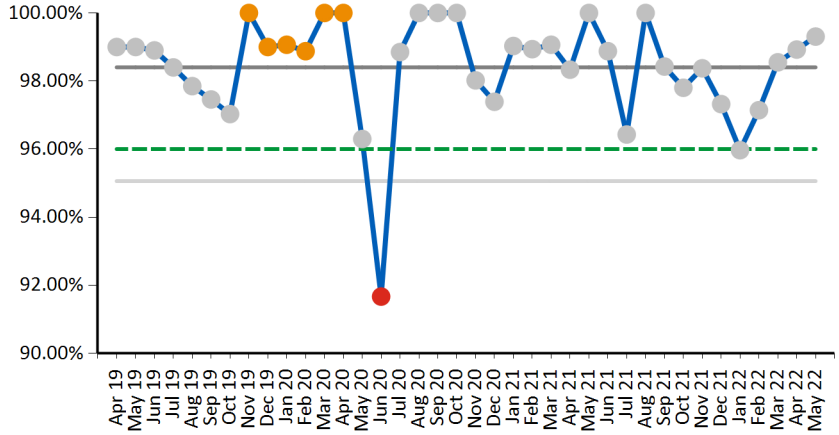
46 - 62 day standard % (1 mth in arrears)



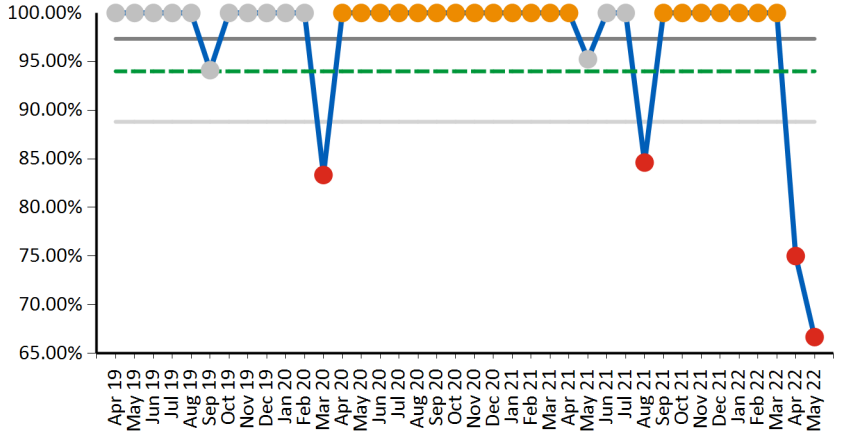
47 - 62 day screening % (1 mth in arrears)



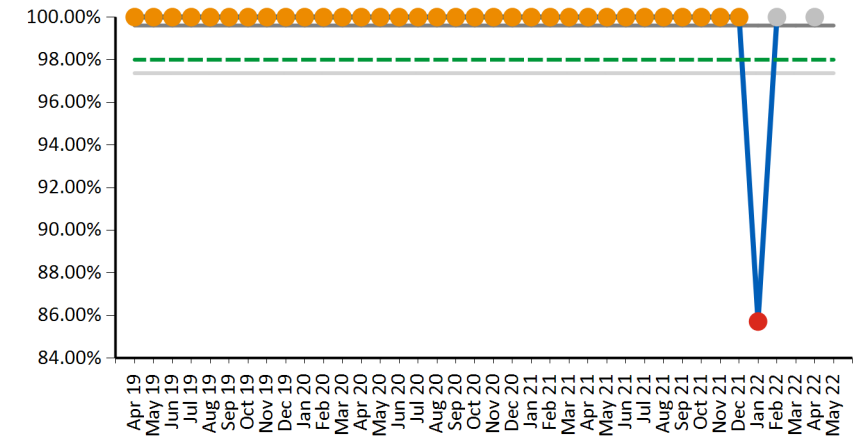
48 - 31 days to first treatment % (1 mth in arrears)



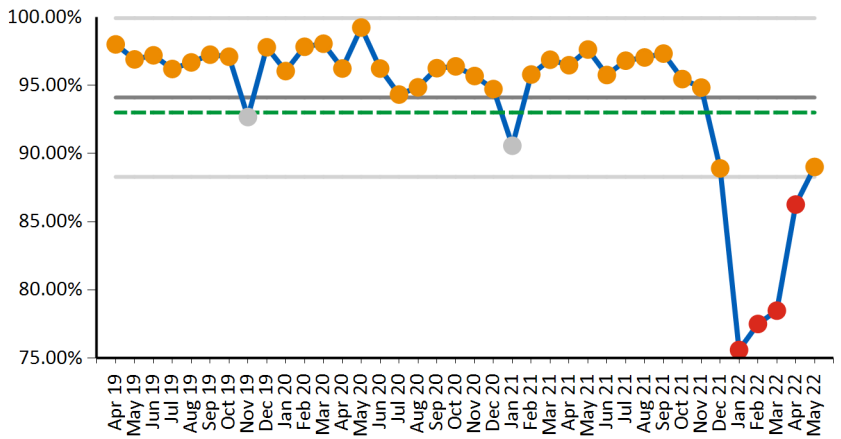
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



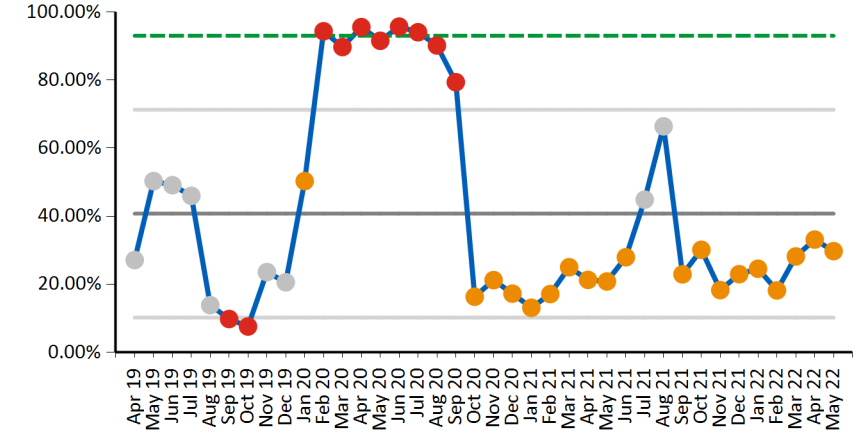
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



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



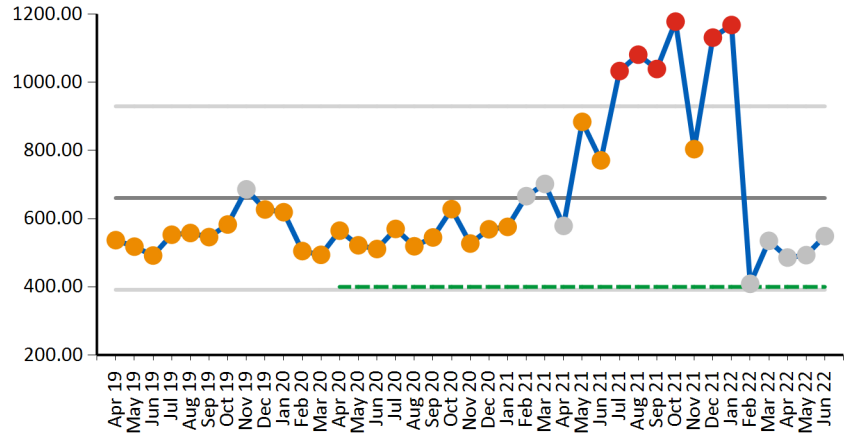
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)



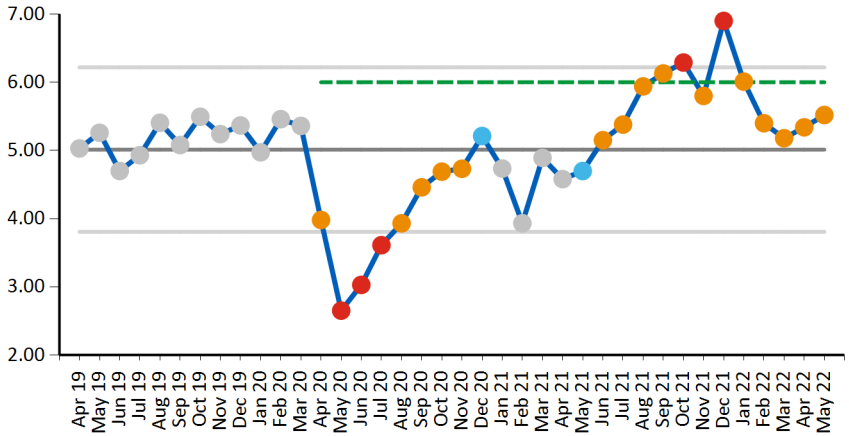
Community

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	549	Jun-22		>= 400	493	May-22	>= 1,200	1,528	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.52	May-22	H	<= 6.00	5.34	Apr-22	<= 6.00	5.52	

334 - Total Deflections from ED



335 - Total Intermediate Tier LOS (weeks)



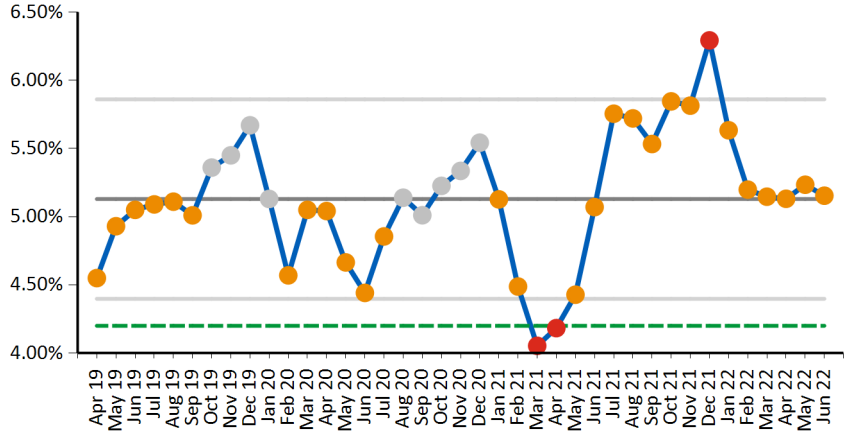
Workforce

Sickness, Vacancy and Turnover

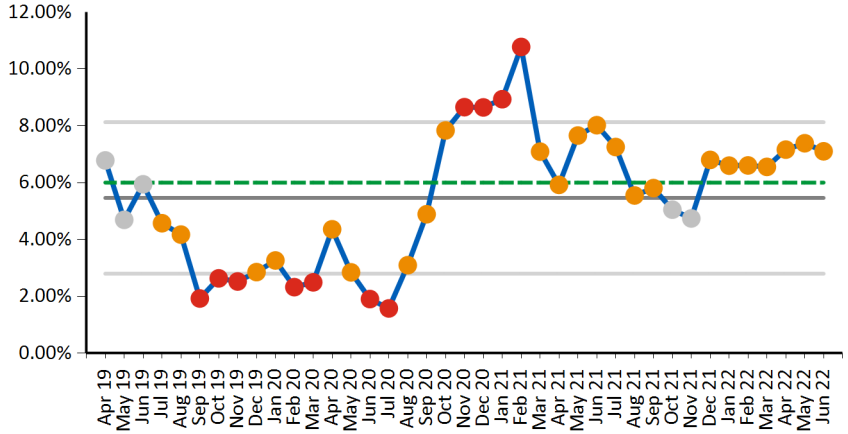
Sickness absence shows a reduction on last month. Comprehensive oversight of all absence cases continues, with close working with the Divisions. The recruitment market remains challenging and the pipeline in for new starters, options for hard to recruit to posts and the impact on agency spend remain a key focus. Planned international recruitment continues apace with the Trust on track to achieve the projected RN recruits. 13 nurses arrived in early July and are settling into their areas of work. 20 nurses are currently in the UK undertaking OSCE preparation training, with another 18 due to arrive at various points in July. We are also utilising international recruitment to support the shortage of midwives in the UK; two offers of employment have been made, and a further four candidates for interview in July.

	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%	5.15%	Jun-22		<= 4.20%	5.23%	May-22	<= 4.20%	5.17%	
120 - Vacancy level - Trust	<= 6%	7.10%	Jun-22		<= 6%	7.38%	May-22	<= 6%	7.21%	
121 - Turnover	<= 9.90%	14.26%	Jun-22		<= 9.90%	14.06%	May-22	<= 9.90%	14.12%	
366 - Ongoing formal investigation cases over 8 weeks		3	Jun-22			4	May-22		10	

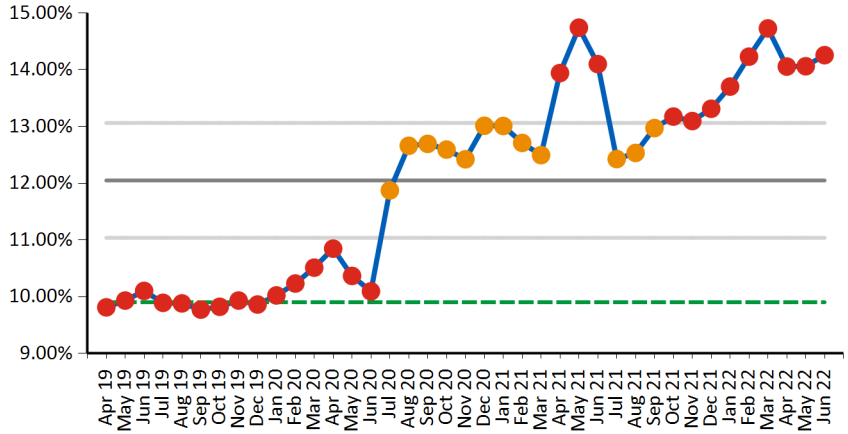
117 - Sickness absence level - Trust



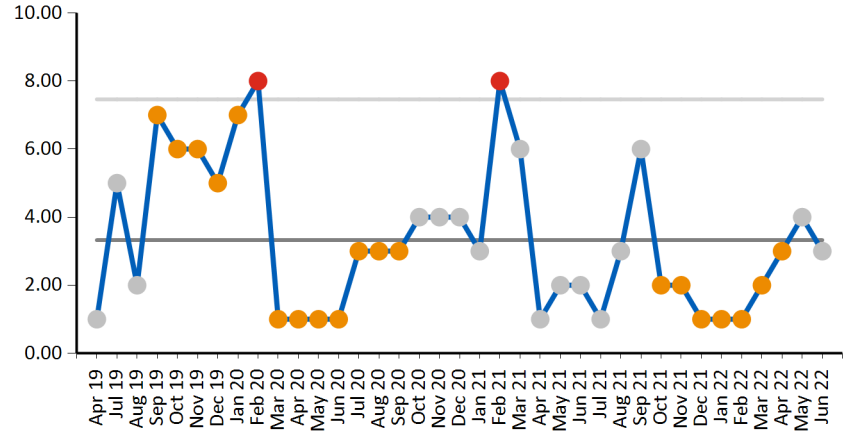
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks

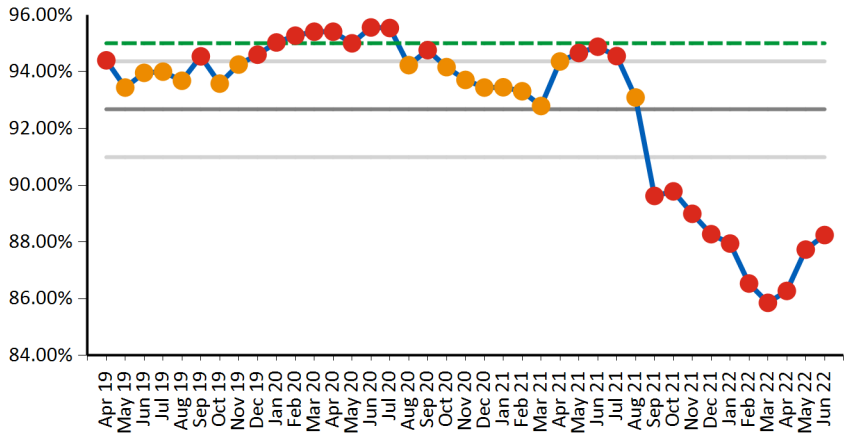


Organisational Development

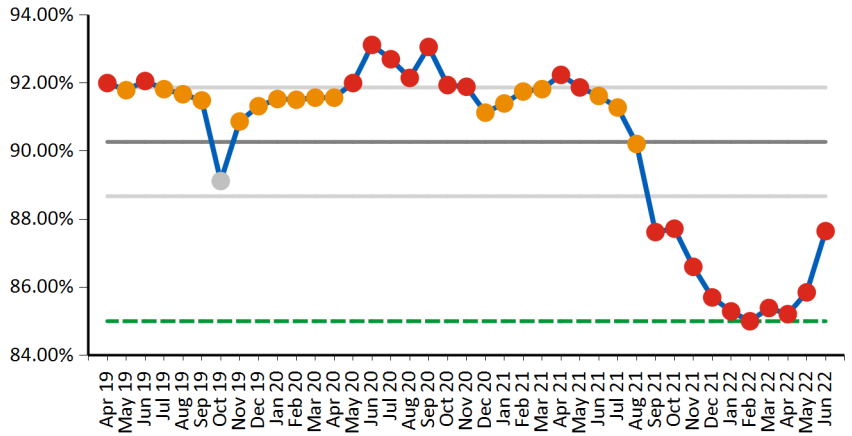
The Trust's overall compliance level for mandatory training was 87.7% (2.7% above our corporate target of 85%) and statutory training was 88.2% (6.8% below our corporate target of 95%), an improvement on the last three months and the highest completion rates since December 2021. Further work underway to ensure return to required targets. Appraisal compliance has seen a slight drop since last month with ongoing discussions with divisional leadership on plans to address.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	88.2%	Jun-22	L	>= 95%	87.7%	May-22	>= 95%	87.4%	F
38 - Staff completing Mandatory Training	>= 85%	87.6%	Jun-22	L	>= 85%	85.8%	May-22	>= 85%	86.2%	P
39 - Staff completing Safeguarding Training	>= 95%	89.55%	Jun-22	L	>= 95%	89.14%	May-22	>= 95%	89.12%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	76.5%	Jun-22	L	>= 85%	78.9%	May-22	>= 85%	77.4%	F
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	69.0%	Q4 2021/22		>= 66%	67.0%	Q3 2021/22	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	61.5%	Q4 2021/22		>= 80%	62.0%	Q3 2021/22	>= 80%		

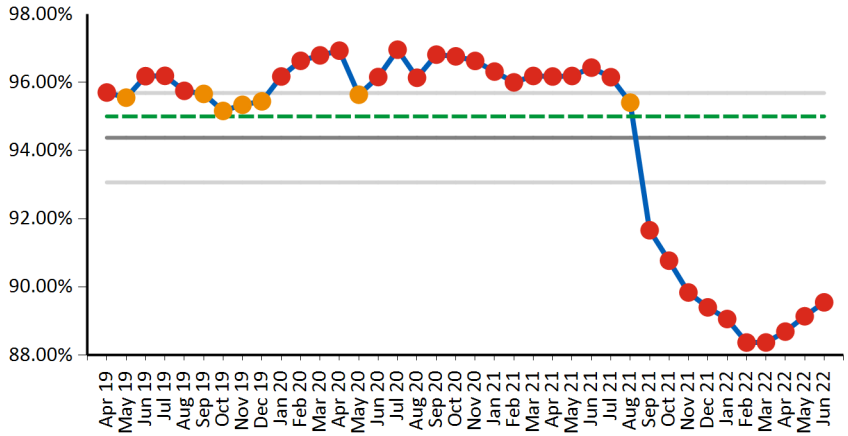
37 - Staff completing Statutory Training



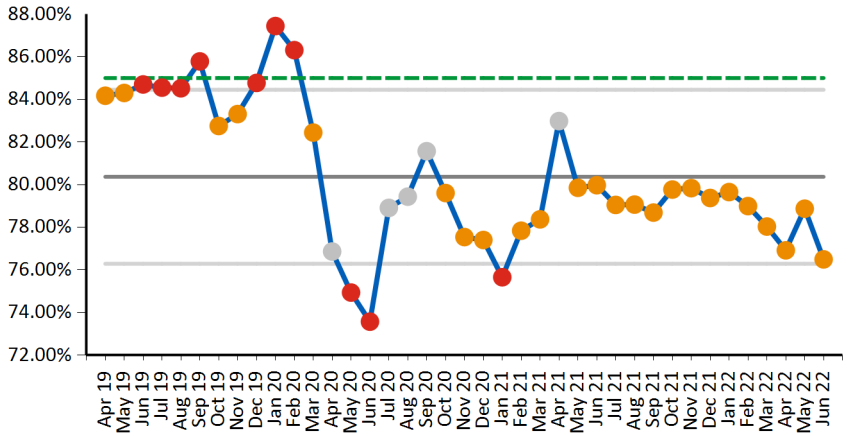
38 - Staff completing Mandatory Training



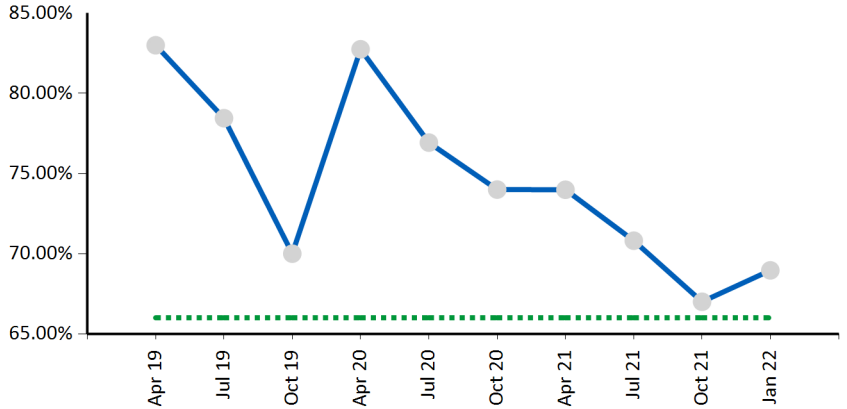
39 - Staff completing Safeguarding Training



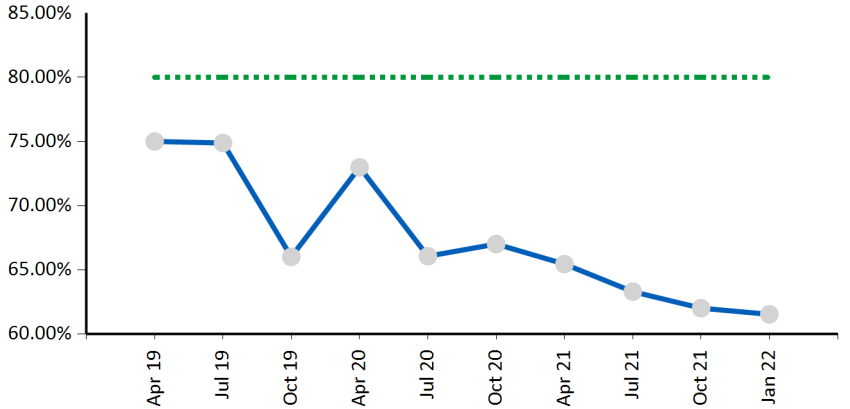
101 - Increased numbers of staff undertaking an appraisal



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



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

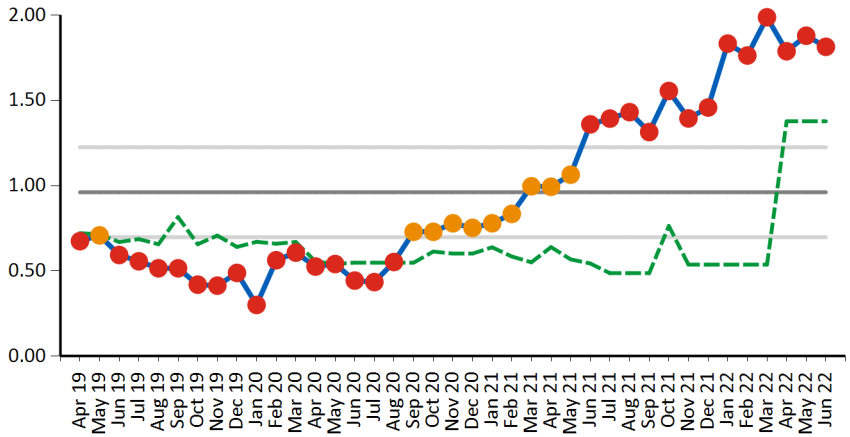


Agency

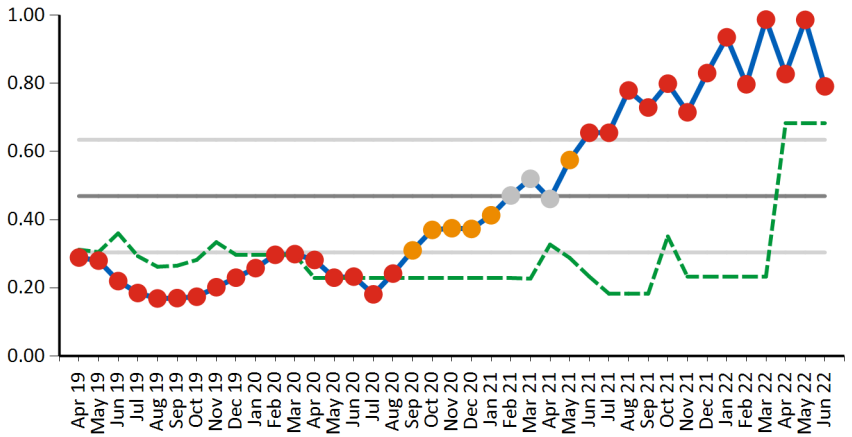
The Trusts overall agency spending reduced by £64k in M3 when compared to M2. Nursing agency showed a decrease of £196k in-month when compared to M2, Medical showed an increase in spend of £40k in month, and 'other' agency increased by £91k in-month. Work continues to progress to ensure a close scrutiny on all agency expenditure, ensuring 'grip and control' on nursing agency expenditure, and reduction of medical agency spend by substantively tracking and filling medical vacancies which are being covered by high-cost agency locums. A deep dive is also being undertaken into 'other agency' spend.

	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)	<= 1.38	1.81	Jun-22		<= 1.38	1.88	May-22	<= 4.13	5.48	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.68	0.79	Jun-22		<= 0.68	0.99	May-22	<= 2.05	2.60	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.79	Jun-22		<= 0.62	0.75	May-22	<= 1.85	2.35	

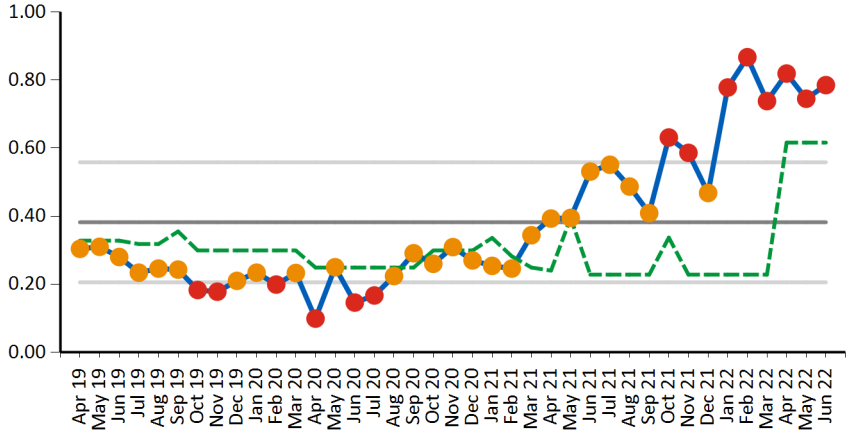
198 - Trust Annual ceiling for agency spend (£m)



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



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



Finance

Finance

Revenue Performance Year to Date
• We have a year to date deficit of £4.2m compared with a planned deficit of £1.5m. The in-month position was a £0.2m surplus.
• GM is not achieving the ERF, so the income assumed for this is at risk of clawback.
• Revenue performance is currently rated amber

Revenue Performance Forecast Outturn
• The forecast scenarios range from a deficit of £20.4m to a break even position, with a likely deficit of £12.8m.
• Forecast Outturn is currently rated amber

Cost Improvement
• The current trackers indicate that £2.6m of recurrent savings have been delivered against a target of £7.2m
• FYE £10.4m of schemes has been identified.
• CIP is currently rated amber

Variable Pay
• We spent £3.9m on variable pay in month 3 compared to £4.1m in month 2.
• Variable pay is rated red as spend is significantly above plan.

Capital Spend
• Year to date spend is £5.7m; of which £2.2m is on Theatres.
• Currently none of the PDC elements in the plan have approval.
• Further discussions continue with NHSI and GM around the 22/23 plan.
• Capital is rated red for the risk associated with the plan.

Cash Position
• We had cash of £36.3m at the end of the month.
• Cash is rated green.

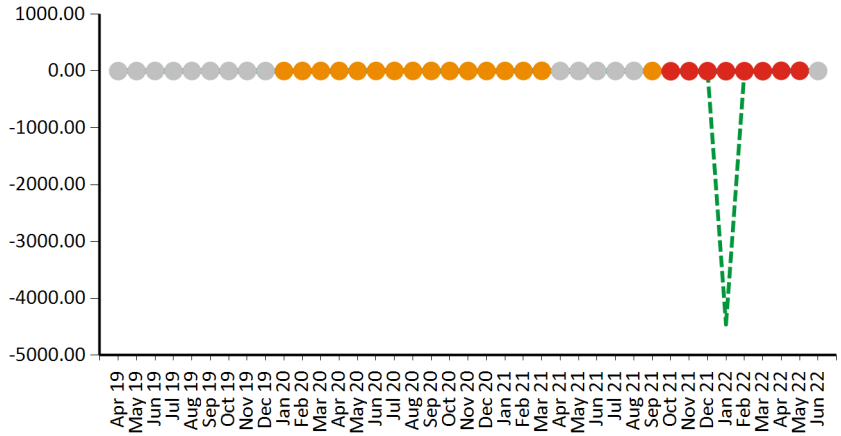
Loans and PDC
• We have loans of £37.5m.
• Rated green as there are no concerns in this area.

Better Payment Practices Code
• Year to date we have paid 80.7% of our invoices within 30 days.
• Non NHS performance is 87.0% YTD with 93.6% in month.
• This is below the target of 95%, hence rated amber.
• Action to improve performance is underway

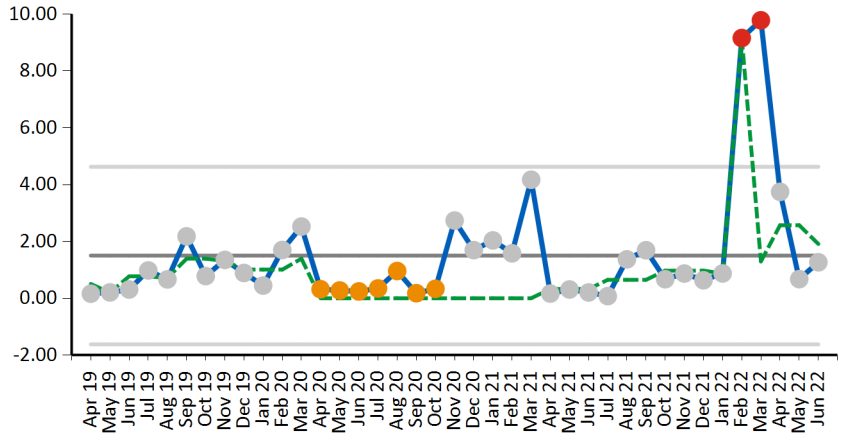
Use of Resources Rating
• This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -0.2	-0.2	Jun-22		>= 0.7	2.2	May-22	>= 1.5	4.2	
222 - Capital (£ millions)	>= 1.9	1.3	Jun-22		>= 2.6	0.7	May-22	>= 7.0	5.7	
223 - Cash (£ millions)	>= 37.2	36.3	Jun-22		>= 37.9	45.0	May-22	>= 37.2	36.3	

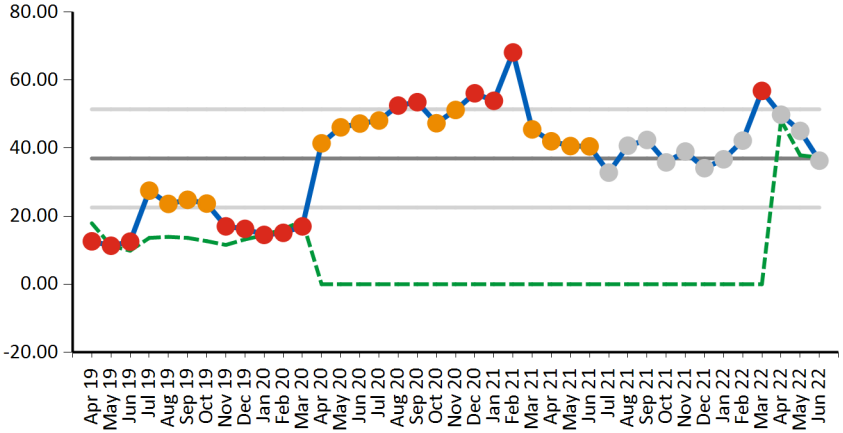
220 - Control Total (£ millions)



222 - Capital (£ millions)



223 - Cash (£ millions)



oard Assurance Heat Map - Hospital

	Indicator	Target	Council	Acute Division																																				Families Division										Overall
			Lab Lodge	AED-Adults	AED-Paeds	A4	ACU	B1 (Frailty Unit)	B2	B3	B4	BCAU	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	Critical Care	DCU (daycare)	E3	E4	F3	F4	F6	G3/TSU	G4/TSU	H2 (daycare)	R1	UU (daycare)	CDS	E5	F5	Ingleside	M2 (AN)	M3 (Birth)	M4 (PN)	M5 (PN)	M6	NICU	
	Average Beds Available per day	*N/a*	32	N/R	N/R	22	10	23	26	21	24	19	25	26	26	15	10	13	24	22	24	27	12	5	22	18	25	25	25	25	24	16	24	25	11	9	4	15	38	9	4	26	5	22	22	17	38	855
Infection Prevention & Control	Hand Washing Compliance %	*Target = 100%*	N/R	95.0%	95.0%	100.0%	100.0%	N/R	95.0%	100.0%	100.0%	N/R	100.0%	90.0%	95.0%	75.0%	95.0%	100.0%	95.0%	100.0%	80.0%	100.0%	N/R	85.0%	95.0%	90.0%	100.0%	100.0%	85.0%	95.0%	90.0%	100.0%	90.0%	N/R	100.0%	N/R	100.0%	95.0%	100.0%	100.0%	100.0%	N/R		100.0%	100.0%	100.0%	95.0%	96.7%
	C - Diff	*Target = 0*	0	0	0	0	0	0	0	0	3	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
	MSSA BSIs	*Target = 0*	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	MRSA acquisitions	*Target = 0*	0	0	0	0	0	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
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	7	7	0	2	0	0	5	11	4	5	5	3	7	0	0	3	3	3	3	3	1	0	2	0	0	0	1	1	0	0	4	2	0	4	0	0	1	0	0	0	0	0	0	0	0	87
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	0	1	0	0	0	0	1	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	4
	VTE Assessment Compliance	*Target = 95%*				100.0%	99.7%	97.1%	33.3%	75.0%	100.0%	98.5%	100.0%	100.0%	100.0%	96.0%	100.0%	99.1%	97.7%	98.3%	100.0%	100.0%		99.7%	100.0%	100.0%	98.2%	50.0%	98.5%	98.4%	87.5%	100.0%	96.0%	100.0%	96.9%	50.0%	94.6%	90.5%			N/R	99.6%	N/R	91.4%	96.5%	99.7%		97.7%
	New pressure Ulcers (Grade 2)	*Target = 0*	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	1	0	2	3	0	0	0	0	0	0	0	0	0	0	0	0	0	11
	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	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	0	0	0	0
	New pressure Ulcers (unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Audit	Monthly KPI Audit %	*Target = 95%*	N/R	92.9%	95.0%	95.1%	N/R	92.6%	84.7%	91.4%	82.5%	N/R	96.5%	80.5%	86.4%	N/R	91.5%	91.5%	82.5%	99.4%	88.9%	92.2%	N/R	100.0%	98.8%	98.8%	98.0%	83.7%	93.1%	89.1%	66.7%	82.1%	84.4%	87.3%	86.1%	N/R	100.0%	97.2%	N/R	N/R	N/R	99.0%	N/R	N/R	N/R	N/R	N/R	92.0%
	BoSCA Overall Score %	*w=<55,b>55, s>75,g>90*	73.7%					69.0%	59.4%	56.8%	64.3%		76.8%	63.4%	72.7%	71.7%	84.2%	73.9%	61.2%	73.7%	79.9%	73.5%			75.3%	85.3%		71.0%	72.8%	81.1%	67.1%	75.5%	75.1%	67.0%								62.5%						71.4%
	BoSCA Rating		bronze					bronze	bronze	bronze	bronze		silver	bronze	bronze	bronze	silver	bronze	bronze	bronze	silver	bronze			silver	silver		bronze	bronze	silver	bronze	silver	silver	bronze								bronze						Bronze
Patient Experience	FFT Response Rate	*Target = 30%*		18.0%	0.4%	74.3%	0.0%	43.9%	40.3%	157.1%	57.7%	0.0%	51.2%	2.2%	56.4%	0.0%	44.8%	115.5%	14.5%	18.2%	39.7%	90.6%		27.8%	21.1%	0.0%	0.0%	36.1%	26.5%	20.3%	12.0%	47.5%	33.9%	57.7%	15.2%			24.1%		26.5%	0.3%		4.1%	28.2%	11.5%	11.5%	100.0%	65.0%	24.4%
	FFT Recommended Rate	*Target = 97%*		78.2%	30.0%	92.3%		100.0%	92.6%	92.7%	86.7%		85.7%	100.0%	96.8%		100.0%	100.0%	100.0%	100.0%	100.0%	94.8%		97.0%	100.0%			92.3%	100.0%	100.0%	100.0%	100.0%	85.0%	100.0%	94.1%			100.0%		100.0%	0.0%		85.7%	86.8%	84.8%	84.8%	100.0%	96.2%	96.7%
Govern-ance	Number of complaints received	*Target = 0*	0	3	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0	0	0	0	2	1	1	0	0	0	2	0	0	0	0	2	0	0	2	0	0	0	0	0	2	0	0	0	18
	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	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	5
	Incidents > 20 days, not yet signed off	*Target = 0*	7	51	12	12	1	11	0	1	1	3	7	29	5	8	0	0	1	2	6	4	2	1	4	0	2	6	2	10	2	1	4	4	3	1	2	93	1	1	0	3	6	22	1	7	6	345
	Harm related to Incident (Moderate+)	*Target = 0*	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	3	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	9
Staff Development	Appraisals	*Target = 85%*			83.3%			84.6%	82.1%	54.5%	81.0%	97.0%	70.0%	45.7%	71.1%	86.5%	51.2%	88.9%	93.8%	68.2%	97.1%	76.5%	94.4%	83.3%	78.0%	45.2%	83.2%	76.9%	71.4%	56.7%	92.5%	76.0%	78.6%	79.5%	75.0%	33.3%		84.2%	72.6%	73.7%		66.7%	57.7%	50.0%	58.6%	43.8%		76.8%	72.8%
	Statutory Training	*Target = 95%*			76.87%			92.44%	78.68%	62.15%	84.60%	86.01%	91.0%	85.81%	80.68%	84.91%	78.80%	92.00%	93.46%	90.32%	88.41%	88.44%	90.58%	76.79%	89.65%	74.41%	92.80%	90.14%	85.50%	88.00%	92.74%	71.19%	84.68%	83.04%	80.77%	87.34%		98.68%	76.1%	86.8%		60.0%	80.6%	83.3%	72.7%	79.2%		82.30%	83.6%
	Mandatory Training	*Target = 85%*			83.26%			90.3%	77.4%	63.2%	89.7%	81.6%	86.7%	86.6%	81.0%	80.0%	79.9%	93.0%	90.7%	88.3%	84.7%	88.5%	88.8%	79.5%	87.5%	76.3%	91.2%	91.9%	88.4%	81.1%	93.2%	69.5%	87.2%	85.4%	75.2%	88.7%		99.1%	76.9%	88.5%		66.7%	79.1%	75.0%	79.5%	77.7%		82.6%	83.4%
Staffing & Workforce	% Qualified Staff (Day)							99.1%	95.5%	97.9%	97.4%		93.8%	100.3%	100.6%	58.7%	100.5%				101.7%	99.3%			89.2%	78.5%		100.3%		110.8%	113.3%		102.4%					90.7%	87.8%	0.0%		83.6%		85.7%	102.8%			
	% Qualified Staff (Night)							112.0%	106.8%	106.7%	105.1%		100.0%	108.5%	142.7%	75.9%	100.3%				108.0%	101.1%			100.0%	77.9%		145.3%		112.0%	193.3%		98.6%					81.0%	110.8%	0.0%		98.3%		76.9%	78.3%			
	% un-Qualified Staff (Day)							94.1%	162.3%	98.9%	82.7%		96.5%	99.0%	92.7%	45.8%	116.0%				80.9%	95.7%			96.4%	82.5%		98.1%		127.1%	125.3%		96.6%					107.8%	98.3%	0.0%		100.0%		48.9%	48.1%			
	% un-Qualified Staff (Night)							130.2%	219.9%	113.3%	108.0%		101.1%	102.8%	103.7%	60.0%	103.3%				100.0%	97.8%			101.4%	74.4%		103.9%		157.8%	161.2%		106.8%					97.2%	100.0%	0.0%		100.0%		48.4%	40.6%			
	Sickness (%)	*Target < 4.2%*			7.73%		1.44%	16.78%	4.16%	5.74%	11.40%	0.00%	11.73%	16.35%	3.93%	7.79%	5.43%	5.71%	3.15%	4.51%	5.18%	9.27%	13.81%	5.10%	5.42%	7.32%	4.59%	8.70%	9.65%	9.88%	3.12%	11.17%	8.23%	8.60%	8.69%		0.41%	4.57%	8.68%		0.00%	5.79%	0.00%	10.73%	3.37%		9.78%	6.87%

Data Legend

No data returned	N/R
No Eligible patients	

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

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

Board Assurance Heat Map - District Nursing Domiciliary & ICS Services

			ICS Services														DN Teams										Treatment Rooms		
	Indicator	Target	Admission Avoidance	Acute Therapies	Anti-coagulant Team	Asylum & Refugee/ Homeless & Vunerable	Bladder & Bowel Service	Community IV Therapy	Diabetes & Endo	Dietetics	Falls	Neurology & LTC	Podiatry	Rheum-atology	SLT	Stroke	Wheel-chair Service	Avondale	Breightmet & Little Lever	Crompton	Farnworth	Great Lever	Horwich	Pikes Lane	Waters Meeting	West-houghton	Evening Service	North	South	Overall
Infection Control & Harm Free	Hand Washing Compliance %	*Target = 100%*	N/R		100.0%	N/R	N/R	N/R				N/R		100.0%				100.0%	N/R	N/R	N/R	100.0%	N/R	N/R	N/R	N/R	N/R	N/R	N/R	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	2	0	0	1	1	4	0	0		14
	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	1	0	0		1
	Monthly New pressure Ulcers (Grade 4)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
	Monthly New pressure Ulcers (Unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	1	0	0	0	0	0		3
Audit	Monthly KPI Audit %	*Target = 95%*	96.8%			97.5%	98.8%			N/R			95.2%		N/R		95.2%	99.1%	97.9%	98.4%	97.1%	98.8%	98.5%	97.9%	98.0%	96.8%	98.7%	95.6%	95.8%	97.00%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*																94.74%	91.01%	94.22%	85.51%	93.60%	94.33%	97.23%	83.06%	82.00%	94.79%	95.60%	89.86%	93%
	BoSCA Rating																	platinum	platinum	platinum	silver	platinum	platinum	platinum	silver	silver	platinum	gold	silver	platinum
Patient Experienc	Friends and Family Response Rate %	*Target = 30%*	95.0%		55.0%	100.0%	25.0%	60.0%	40.0%	10.0%	100.0%	100.0%	4.8%	8.0%	10.0%	100.0%	100.0%					61.8%						0.0%		58.90%
	Friends and Family Recommended Rate %	*Target = 97%*	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.1%	93.8%	100.0%	100.0%	100.0%					99.3%								99.50%
	Number of Complaints received	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Staff Development	Sickness (%)	*Target is < 4.2%*	6.1%	10.3%	0.0%	0.00%	3.6%	7.4%	1.6%	1.46%	2.4%	4.4%	3.6%	0.5%	0.0%	0.6%	0.5%	0.9%	0.4%	3.4%	4.5%	5.1%	5.1%	1.6%	1.7%	0.0%	7.6%	12.9%		3.8%
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	9.6%	23.7%	31.6%	0.0%	0.0%	7.4%	7.0%	17.4%	8.8%	30.3%	7.3%	18.6%	5.7%	6.5%	11.8%	35.7%	11.8%	0.0%	4.9%	16.7%	0.0%	14.3%	6.9%	8.0%	5.9%	14.3%		12.04%
	12 month Appraisal	*Target = 85%*	78.3%	85.7%	88.9%	71.4%	100.0%	100.0%	75.0%	90.9%	81.9%	66.7%	86.8%	88.2%	88.2%	90.0%	75.0%	73.3%	81.3%	100.0%	100.0%	100.0%	66.7%	85.7%	84.6%	100.0%	91.2%	95.8%		85.27%
	12 month Statutory Training	*Target = 95%*	94.7%	97.9%	100.0%	94.1%	100.0%	100.0%	93.3%	98.2%	96.6%	97.9%	95.6%	96.6%	96.6%	97.4%	83.3%	91.4%	95.3%	98.0%	97.9%	100.0%	97.7%	100.0%	92.3%	100.0%	99.7%	85.6%		96.21%
	12 month Mandatory Training	*Target = 85%*	94.2%	93.9%	100.0%	94.1%	100.0%	98.3%	92.6%	99.0%	97.0%	93.7%	91.1%	98.6%	96.9%	96.5%	100.0%	94.4%	86.2%	95.5%	99.1%	98.2%	95.4%	96.3%	89.2%	98.5%	99.0%	89.8%		95.14%

Data Legend

No data returned	N/R
No Eligible patients	

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

Home visits on this report excludes Groups so will not marry up with the community performance report.

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

Agenda Item 14

Title:	Finance and Investment Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Annette Walker, Director of Finance		Decision	

Summary:	Chair's Report from the Finance and Investment Committee meeting held on the 22nd June 2022.

Previously considered by:	

Proposed Resolution	

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:	Finance and Investment Committee Chair	**Presented by:**	Finance and Investment Committee Chair

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	22nd June 2022	Date of next meeting:	27th of July 2022
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Rebecca Ganz, Bilkis Ismail, Rae Wheatcroft, Sharon Katema, James Mawrey, Sharon Martin, Andrew Chilton, Joanne Street, Lesley Wallace, Rachel Noble, Catherine Hulme, Matthew Greene	Quorate (Yes/No):	Yes
		Key Members not present:	Fiona Noden

Key Agenda Items:	RAG	Key Points	Action/ decision
Financial Plan		• Deficit plan of £7.2m submitted to NHS. • GM position is balanced confirmed today in GM DoFs though with significant risk. • Significant financial risk to be noted for Bolton FT. • Another key risk is availability of Capital.	Noted
System Finance Update		• The Chief Finance Officer reported that yesterday's meeting had to be stepped down due to attending the GM pre ICB meeting in her capacity as CFO for the CCG. • The CFO reported attending the Locality Board meeting today chaired by Andy Morgan and attended by the Trust's Chief Executive as Place Best Lead along with our Director of Strategic Transformation. • It is proposed that the System Finance Group will feed into the Locality Board and other Committees within the Locality Authority which the CFO feels is a positive move. The System Finance meeting will be formally minuted going forward with the Chair's report feeding through to this Committee.	Noted

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	Moderate assurance – potential moderate 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

Month 2 Finance Report		• Deficit in month of £2.2m with a year to date deficit of £4.4m compared with a planned deficit of £1.7m largely due to under recovery of CIP. • Discussions with the CCGs suggest there could be additional revenue of £1.5m which could flow into the FT. • Forecast scenarios range from a deficit of £18.4m to a break even position with a plan deficit of £7.2m. • In relation to CIP each division has been challenged with identifying 3% recurrent savings and opportunities have been identified of £4.7m against a target £12m. • Variable pay is still high at £4m. A lot of work has been done. Agency spend should start to reduce following best practice which should spread across other divisions. • Capital spend to date just over £4m. • No PDC funding approved yet. • Cash has decreased but remains healthy at £45m. • Shortlisted for HFMA award but did not win. Voted second and highly commended which the Committee congratulated the team on.	Noted.
Month 2 IPM Report – Operations		Positive Performance points to note: • Improvement in ambulance 60 minute breaches • Improvement in DM01 percentage • Passed April Cancer 62-day standard • Improvement in cancer 2 week wait standard • Reduction in days occupied by people with no criteria to reside. Negative Performance points to note: • ED 4-hour access standard • Discharges by midday and 4pm • 2 week wait for breast symptomatic patients	Noted

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Committee/Group Chair's Report

Procurement Quarterly Update		• The Associate Director of Finance (LW) reported on an amazing year for the procurement team who achieved savings of £4.71m, £1.94m above the year previous. Savings made in cash releasing, cost avoidance and inflation avoidance. • This year's work is focused on compliance with work being undertaken on reducing waivers and working with divisions to provide savings within contracts, part of the ICIP meetings and ICIP sprints. Very positive news. • In terms of GM, the Trust is working collaboratively leading on a number of projects. The main one identified as the Linen and Laundry Contract. Collaborating on recycling also. GM are estimating to make a further £1.2m which will help with our saving projections. In terms of strategy signed off previously the team have received some good progress achieving procurement standards which is good news for the teams. • The Committee asked for congratulations to be passed onto the team.	Noted
Tender Update		• There were no tender updates.	
Chairs' Reports		• Some points were raised which are reported on in the minutes.	

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Agenda Item 15

Title:	Quality Assurance Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Medical Director / Chief Nurse		Decision	

Summary:	Submitted are the Quality Assurance Committee Chair Reports for June and July 2022 for noting.

Previously considered by:	N/A

Proposed Resolution	Chairs reports submitted for noting and assurance.

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

Prepared by:	Malcolm Brown, Non-Executive Director	**Presented by:**	Malcolm Brown, Non-Executive Director

Committee/Group Chair's Report

(Version 4.0 October 2021, Review: October 2022)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	15th June 2022	Date of Next Meeting	20th July 2022
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Malcolm Brown, Harni Bharaj, Jackie Njoroge, Rae Wheatcroft, Tyrone Roberts and Zed Ali. Divisions were in attendance.	Key Members not present:	Fiona Noden, Francis Andrews, Sophie Kimber-Craig, Sharon Martin and James Mawrey.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Integrated Performance Report		Chief Nurse /Medical Director	• Harm Free Care/ Pressure Ulcers – Full assurance cannot be provided as a category 4 has been reviewed and there are a number of un-stageable pressure ulcers. • Infection Control – There has been a reduction in c-difficile from April to May 2022 and will report to the Clinical Governance & Quality Committee next month. • Chair noted that the complaints response rate had been dropping and the Chief Nurse confirmed that the focus was on the quality of the responses as opposed to getting them sent on time at present. • Maternity - The Trust is an outlier for third and fourth degree tears. However, it is pleasing to note that although there were 11 cases reported, in May,10 of these were from spontaneous vaginal delivery and not due to instrumental deliveries. • It was noted that an engagement meeting had taken place with stakeholder including the CQC who were assured by the information shared. In addition, a revised Ockenden report would be submitted to the Local Maternity Service on 1 July 2022.	• Clinical Correspondence - The DMD for ASSD described frustrations felt by staff to rationalise paperwork regarding clinical correspondence. Diane Sankey of Bolton CCG reminded the Committee of a Clinical Correspondence Task and Finish Group and agreed to discuss this with colleagues to see if there is an appetite to re-engage this.

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Committee/Group Chair's Report

			• Emergency patients screened for sepsis was noted as being steady at 86.9%, with inpatient screening for sepsis at 22%. It was noted that patients being administered antibiotics within 60minutes of sepsis screening was 90%. • Clinical correspondence was 77% averaging between 75-78%. • Nosocomial Covid cases have reduced with eight cases being reported in May 2022. However, there was an increase in confirmed Covid cases at present so this may be reflected in the figures presented the following month. • HSMR/SHMI figures were noted and the Committee were advised that these figures may worsen before the Trust can see an improvement due to the significant vacancies that have been experienced in the Coding team in the last few months.	
Clinical Governance and Quality Committee		Chief Nurse	• ASSD shared their divisional quarterly report and the CGQC were impressed with the unified and shared level of understanding of issues. • There was a request by the Nutritional Steering Group for the Committee approval of a business case in relation to Oral Health, this was declined by the Committee and Divisions were asked to go back and discuss with Matrons and ward staff as this is fundamental routine care. • Blood product traceability was discussed as a concern and the Committee have asked to see this monthly until assured.	• Deputy Director of People to take forward suggestion of being able to leave mandatory training platform part way through the session to help staff complete modules.

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Committee/Group Chair's Report

Divisional Quality Report – Anaesthetics & Surgical Services		ASSD	• The report which covered January-March as the division experienced significant staff shortages were able to identify themselves as 'good' in all areas excluding responsible for which they 'require improvement'. • Noted that the division was assured that specialties are doing everything possible in relation to RTT but this needs to keep progressing. • Theatre space and staffing is also affecting 104 week breaches and so the division's focus is now on long waiters as these cases are becoming more complex with higher comorbidities.	• The Chair noted the report was contemporaneous and accurate and is pleased to see the division moving forward.
BoSCA Annual Report		Chief Nurse	• The summary tables for each division highlighted the positive areas with the Committee noting that medicine management and nutrition are some of the main themes that have been identified for addressing in upcoming audits. • The audit frequency was slow due to staff availability but work to address this was progressing.	• It was discussed whether the wards were able to comment or challenge the report once completed to which it was confirmed that this was not currently the standard practice but could be explored further by the Chief Nurse.
Risk Management Committee Chair Report		Chief Nurse	• Acute Adult Division discussed the likelihood scores of 5. • Strategy & Digital have 5 risks identified but one risks is that demand is outstripping capacity. The Digital team will meet with divisions to revise these risks.	• The Committee challenged AACD risks with likelihood score of 5 with an ask for the division to provide corresponding evidence and mitigation.

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Committee/Group Chair's Report

Mortality Reduction Group Chair Report		Deputy Medical Director	• Both Pneumonia and Heart Failure workstreams were progressing well. • NEWS and Fluid Balance were being addressed as part of the Quality Account and so updates on progress would be shared with the Committee. • The terms of reference for the group were under review and would look at workstreams requiring focus, incorporating KPIs into the updates but also to reduce duplication for the divisions.	• The Divisional Medical Director for Acute Adult Care asked that there be a consideration for how the information submitted to the group can be coordinated with the divisions and feedback shared. • Terms or reference were noted to be out of date.
Group Health & Safety Chair Report		Associate Chief Nurse	• Going forward this meeting will be chaired by the Director of Quality Governance. • The Transport and Site Safety discussion was escalated following a previous notice for site safety being issued by the Health & Safety Executive. • The group felt that they could not be assured by IFM that actions were being addressed and sought a full review of the actions identified and cost implications involved.	• The wording used within the Chair Report was asked to reflect that the Trust should prevent incidents from occurring and not reference how the Trust would 'defend itself should an incident occur'.

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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

(Version 4.0 October 2021, Review: October 2022)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	20th July 2022	Date of Next Meeting	17th August 2022
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	No
Members present	Malcolm Brown, Francis Andrews, Fiona Noden, James Mawrey, Lianne Robinson, Jo Street, Sharon Katema, Zed Ali.	Key Members not present:	Jackie Njoroge, Sophie Kimber-Craig, Sharon Martin, Rae Wheatcroft, Tyrone Roberts.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Integrated Performance Report		Associate Chief Nurse /Medical Director	• Pressure Ulcers – Continue to have concerns and further increase this month. Lot of learning to be taken from device related pressure ulcer. Discussed the increase in these within ED given the overcrowding in the department. • Falls – There have been falls with harm with an overarching theme of lack of falls management in care plans. Falls nurse is undertaking an audit and will await results. • Clinical Correspondence – Full report will be presented in August but currently making some improvement for those discharged and those seen as outpatients. ASSD have challenges but this is being addressed. • Sepsis – Almost achieved 90% but data is limited to January so is out of date. • IPC – C-Difficile is above where it needs to be but cannot afford to take for granted and need to be prudent about antibiotic usage and not selecting out c-difficile by using same antibiotic.	• Discussed the C-Section figures and requested these be added to the report for assurance but without targets. It was agreed that this would also include data for vaginal births and instrumental vaginal births.

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Committee/Group Chair's Report

			• There was a never event involving the wrong site block – there was no harm as a result of this but it is going through the usual Serious Incident process. • SHMI – Since the report was produced SHMI has since improved to within range. • Complaints – Divisions have been asked to look at the robustness of their processes. • Maternity – There has been some good work with timeliness in response to complaints. The Corporate Team were thanked for their support in this. • Third and Fourth degree tears – This has significantly improved following increased training and supervision.	
Clinical Governance and Quality Committee		Associate Chief Nurse	• Maternity thematic review identified key themes as; communication, training and education although there were no concerns regarding risks. • ASSD discussed the never events that had taken place in Theatres. Agreed that staffing of all theatres could not be maintained and so made decision to take down some theatres and review this regularly to manage capacity and demand.	• There was an ask for the Committee to led by example in showing the Trust values around the challenges being discussed to allow staff to be open and honest.

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Committee/Group Chair's Report

Quality Account Update - Diabetes		ICSD	• Report showcased that progress had been maintained with regarding to hypoglycaemia episodes and that these are monitored monthly and shared with individual teams. • The diabetes parameters continue to be a part of the BoSCA process with varying results ranging between 20% - 100%. In those areas where compliance needs to be improved the DSNs will work with the Link Workers to help improve this with ward managers and matrons. • Query was raised regarding Diabetes Type 2 and how accessible help and support is for patients. It was noted that there is a pool of Diabetes Champions covering all demographic groups who are working with the Advance Healthcare Practitioners to provide education. There is also my Way Diabetes which is available in multiple languages and the Champions will have received training on this to help those who struggle to access.	• Noted that despite the Quality Account coming to an end the actions will still be picked up and addressed within the Division.
Maternity Continuity of Care (MCoC)		Interim Head of Midwifery	• Bolton FT has currently suspended MCoC in line with Ockenden recommendations but has developed a five year roll out plan, commencing March 2023. • A preliminary increase in Midwife establishment by 39.69 wte is anticipated although the Trust currently has vacancy equivalent to 30. It was noted that there are plans to look into transferable skills and being creative with recruitment and retention but this is a national challenge and not just local to Bolton.	• The report was received and was noted that this will be shared with Board of Director and will update quarterly.

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Committee/Group Chair's Report

Nosocomial Covid Deaths Review		Medical Director	• The report addressed how nosocomial deaths were reviewed and the learning taken from them. • Themes identified were communication, infection control and lost property. • Communication – this was in relation to not provided updates in the absence of visiting but this has been reviewed and opened up again where appropriate. • Infection control – Rick Catlin provided assurance and information in support of the reviews. • Lost property – New and innovative ways to store patient belongings have been implemented as this was a Trust wide issue. • The public facing report was shared as part of this report and was well received.	• Commendation and praise were given to all those involved in the reviews; Nicola Caffrey, Harni Bharaj, Kevin Jones and Rick Catlin. • Amendment to be made on Page 2 of the public report as this varies to that in the main report with regards to the different phases.
Mortality Update		Medical Director	• At the time the report was written the SHMI figures were in the 'higher than expected' range which is a further increase from the last result and can see from the timeline that this has been an ongoing challenge. • HSMR is more inferenced on palliative care which the CQC prefer which is slightly better in that the trend has followed that of national peer groups but there are still problems to address. • It is not clear what has caused the rise for ASSD but this is likely to be due to the elective recovery programme but is being looked into by the DMD and Business Intelligence. • Early indicators are received each month and these determine the workstreams that are commenced which then report into the Mortality Reduction Group. • Data can be influenced if coding and recording of comorbidities are completed fully as provides an accurate picture.	• The action plan was noted by the Committee. • It was noted that since the report was written the SHMI figures have improved at the Trust is now within the expected range and it is thought this is likely due to the better and more accurate coding.

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Committee/Group Chair's Report

Learning from Death Update		Medical Director	• Since 2019 there have been 965 reviews carried out via structured judgement reviews and then discussion at the Learning from Deaths Committee. • The Committee are now moving towards thematic analysis and starting to discuss mental health inclusion criteria more accurately. • The percentage of cases completed for review is currently behind target but this will be achieved. • Recent challenges and themes identified in reviews were; EPR, DNACPR and complexion of cases and specialist services. • Query raised by the Chair regarding Bluespier and the details being duplicated or inconsistent to EPR. Associate Chief nurse advised that this is being picked up already by Informatics but everything on EPR needs to be duplicated onto Bluespier as this is where patient is referred into the service.	• Medical Director agreed to provide a paper on the Bluespier risks, issues and resolution in three months.
Risk Management Committee Chair Report		Associate Chief Nurse	• Noted that the meeting was well attended and had good focussed discussion. • There was an overall reduction of risks rated 12+. • IFM risk register was really strong and fully updated.	• A piece of work is being undertaken to align the Board Assurance Framework to the Risk Register.
Safeguarding Committee Chair Report		Associate Chief Nurse	• New Safeguarding Adult Nurse is in post and have discovered not all DoLs had been completed and so looking to get these completed ahead of the new framework coming in later this year. • Noted lack of compliance with Level 3 Safeguarding training. • DBS referrals information was received by HR but further information now required so awaiting this. • Noted that there are not enough staff in all aspects of Safeguarding and a business case has recently been approved so is being processed.	• There will be one large quarterly meeting with assurance reports and each month in-between will be escalation meetings. A monthly report will still be brought to QAC for assurance.
Group Health & Safety Chair Report		Director of Quality Gov	• Noted that this was a light meeting as some reports were not received or were received late.	• There is to be a review of the workplan and reporting schedule to increase attendance and engagement.

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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 16

Title:	Midwifery continuity of care (MCOC)

Meeting:	Board Of Directors	**Purpose**	Assurance	x
Date:	27th July 2022		Discussion	x
Exec Sponsor:	Tyrone Roberts, Chief Nurse		Decision	

Summary:	• Midwifery continuity of care (MCoC) as a default model of care for all women is a national requirement of NHSE/I by March 2024, and where this cannot be achieved individual Trusts to agree an implementation plan with the LMS. • MCOC is evidenced to improve outcomes for mothers and babies including a 24% in preterm birth and a 16% reduction in pregnancy loss, and has significant health benefits for ethnic diverse groups and social deprivation • In order to achieve the 10 safety actions outlined in The NHS Resolution Maternity Incentive Scheme, compliance to NHSE/I MCoC targets must be met to achieve Actions 2 & 9. • Bolton FT has currently suspended MCoC in line with Ockenden recommendations to ensure safe staffing provision • A five year roll out plan, commencing March 2023 is outlined in this paper • A preliminary increase in Midwife establishment by 39.69 wte is anticipated, this remains subject to a refreshed birth rate plus review (completion expected by September 2022) • There is potential for additional funding via Local maternity system (LMS) • Quarterly roll-out monitoring reports are required at Board of Directors (BoD), and an update will be provided to BoD July

Previously considered by:	Clinical Governance and Quality Committee 6.7.22 Quality Assurance Committee 20.7.22

Proposed Resolution:	The committee is asked to consider the content of this report, to note the planned roll-out and potential increase in establishment required.

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:	Interim Head of Midwifery	**Presented by:**	Interim Head of Midwifery

Bolton NHS Foundation Trust's Implementation plan for Midwifery Continuity of Carer (MCoC) as the default model of maternity care provision

Version 2 June 2022

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Version	Presented to	
1	Trust Quality Assurance Committee	16.2.22
1	Trust Board of Directors	31.3.22
2	Trust Quality Assurance Committee	20.7.22
2	Trust Board of Directors	28.7.22

Bolton NHS Foundation Trust's Implementation plan for Midwifery Continuity of Carer (MCoC) as the default model of maternity care provision

Introduction

In October 2021 NHS England and NHS improvement published Continuity of Care Guidance 'Delivering Continuity of Carer at full scale' to set the standards for implementation

NHS England and NHS Improvement required all maternity services to submit an action plan on 31st January 2022 to demonstrate how Maternity Continuity of Carer (MCoC) will be implemented and achieved as the default model of maternity care by March 2023. Bolton's MCoC plans were reviewed by Quality Assurance Committee on 16.2.22 and Trust Board of Directors on 31.3.22 prior to submission to the Local Maternity Services.

Following the publication of the Ockenden findings in March 2022, Maternity providers were instructed to review current MCoC plans as one of the immediate and essential actions (IEA's) to include suspension where necessary any MCoC teams in order to ensure safe staffing levels.

Providers were requested to review their MCoC implementation plan in line with Ockenden requirements; with projected timescales for implementation of MCoC as the default model, present any changes to Trust Board of Directors, and submit BOD paper to NHSE via the Local Maternity Services by 15.6.22. This paper will be presented to the Trust Quality Assurance Committee on 20.7.22 and Trust Board of Directors on 27.7.22

In order to achieve the 10 safety actions outlined in The NHS Resolution Maternity Incentive Scheme, compliance to NHSE/I MCoC targets must be met to achieve Actions 2 & 9.

This paper outlines

- Bolton NHS Foundation Trust's Maternity Service response to the NHHE/I requirements and recommendations
- Background information regarding MCoC
- Bolton NHS Foundation Trust's current maternity clinical service position on matters relating to MCoC
- Current maternity service care provision including
    - Activity
    - Imports and exports
    - Current staffing
    - Changes to MCoC following Ockenden 2022 Recommendations
- Safe staffing levels required to provide MCoC as the default model of care together with Staffing deployment and recruitment plan
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process to achieve the target for completion of March 2023. Where this is not possible, providers are requested to demonstrate a timeline for implementation which will be reviewed on a case by case basis by NHSE and monitored by the LMS. This plan recommends implementation in 6 waves. In order to progress through the waves, recruitment to establishments as outlined in Appendices 1 is required.

The implementation outlined in this document proposes rollout commencing in March 2023 when safe staffing levels have been achieved.

In order to implement MCoC as the default model of care, an uplift to the midwifery establishment will be required. Although all current substantive post holders will be accommodated in the new structure, a consultation process to review all roles across the maternity workforce will be required as part of the action plan to support the new way of working and ensure financial, operational and clinical effectiveness and sustainability of the MCoC model. On the basis of this plan, it is projected that the implementation will take 5 years to achieve MCoC as the default model of maternity care.

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

MCoC	**Midwifery Continuity of Carer** Antenatal, intrapartum and postnatal care provided by the woman's named midwife or team (maximum of 8 midwives in a team). Continuity of carer is achieved when a minimum of 70% of antenatal and postnatal appointments have been carried out by the woman's named midwife / team, and the named midwife / team is also present during labour/birth. Each team must be allocated a named linked obstetrician. Each woman will be allocated a named midwife within the team. Each midwife (1.0 WTE) will be responsible for a caseload of 36 women per year (prorata for part time midwives) and aims to provide all antenatal, intrapartum and postnatal care to those women. The woman may meet other members of the team during her pregnancy in order to increase the chance of her knowing her midwife during labour and at the time of birth and therefore increasing the opportunity to achieve continuity.
MCoC as the default model of care	Providing Continuity of Carer by default means: • Offering all women booked for antenatal, intrapartum and postnatal care at Bolton FT MCoC as early as possible during pregnancy • Putting in place clinical capacity to provide MCoC to all those receiving antenatal, intrapartum and postnatal care at Bolton FT
Imports	Women who are booked for intrapartum care at Bolton FT. These women receive their antenatal and postnatal care from another provider
Exports	Women who reside within the Bolton FT catchment area and receive antenatal and postnatal care from Bolton Midwives, and choose to give birth elsewhere

Background

Rationale for Midwifery Continuity of Carer

1.1.2 Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for NHS England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England by March 2023

1.1.3 MCoC has been shown to lead to improved outcomes for women and their babies, as well as offering a more positive and personal experience for women and midwives. MCoC is associated with

- 24% reduction in preterm birth
- 16% reduction in pregnancy loss (overall)

- 19% reduction in pregnancy loss before 24 weeks
- Significant benefits including reduced preterm birth and caesarean section for women living in deprived areas and of diverse ethnicity (Hadebe et al 2021)
- 15% reduction in regional analgesia
- 10% reduction in instrumental vaginal birth

Background- MCoC Service provision at Bolton FT

1.1.4 MCoC can only be offered as a default model to women who remain with the provider for the duration of the childbirth continuum to include the antenatal, intrapartum and postnatal period. Women who choose to give birth at another unit, or those who receive their antenatal and postnatal care from another provider are not eligible for MCoC.

1.1.5 Bolton Hospital currently delivers a traditional model of community midwifery care to all women. The traditional model provides antenatal and postnatal care to women, as well as an on-call system for home birth provision. The majority of women therefore receive Intrapartum care at Bolton Hospital on either the alongside midwifery led unit (Beehive), freestanding birth centre (Ingleside), or the delivery suite. Intrapartum care is provided by core hospital staff. Although our current staffing model is safe and provides a quality service, it does not comply with the recommendations and core components outlined in Better Births and will therefore not achieve the improved maternal and neonatal outcomes associated with MCoC or Safety Actions 2 and 9 in the NHS resolutions Maternity Incentive Scheme.

1.1.6 Implementing MCoC teams whilst continuing to provide a traditional model of community care, and maintaining safe staffing levels and care provision in all clinical areas during the transition has been challenging, especially in light of the current significant staffing pressures resultant from the COVID-19 Pandemic.

1.1.7 Since the recommendations of the National Maternity Review relating to MCoC, Bolton FT has trialled a variety of MCoC options to support the recommendations. This includes two low risk geographically based MCoC teams (Beehive team and Ingleside team), and a mixed risk geographically based team in the BL3 area. The BL3 team was established to target vulnerable women from BAME backgrounds and those living in the lowest decile of deprivation. Both the BL3 and Beehive MCoC teams were discontinued and the staff redeployed back to clinical areas due to significant staffing pressures in 2021. The pandemic has had a huge impact on service delivery, with midwives having to adapt their work practices and core services to ensure that safety is prioritised.

1.1.8 The Ingleside MCoC team continued to provide MCoC for women choosing to give birth at Ingleside, however this team was temporarily suspended in January 2022 due to extreme staffing pressures resulting in the temporary closure of Ingleside Birth Centre for intrapartum activity. This team will not be reinstated and will be replaced by a mixed risk caseloading model which will provide greater chance of continuity.

1.1.9 There is a need for change as Bolton FT will not meet any of the core components of MCoC or achieve the improved outcomes for mothers and babies. Failure to provide MCoC will result in Bolton FT not achieving the standards outlined in Safety Actions 2 and 9 in the NHS resolution Maternity Incentive Scheme

MCoC Implementation plan

1.1.10 As a first step, Local Maternity Systems will agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer; so that Continuity of Carer is the default model of care offered to all women.

1.1.11 This plan will include:

- The number of women that will receive MCoC as the default model of care
- Staffing requirements to provide MCoC at whole scale
- Redeployment plan to implement MCoC in waves to ensure safe staffing levels are maintained
- How continuity of carer teams will be established in compliance with national principles and standards, to ensure high levels of relational continuity
- How rollout will be prioritised to those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- How care will be monitored locally, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set

1.1.12 This plan provides a framework for safe and improved maternity services at Bolton FT that recognises and reflects the individualised personal needs and choices of women in Bolton and the surrounding area

1.1.13 Through co-production, the plan will reflect how the Trust will engage with women and families, staff, and other stakeholders who will be involved in the commissioning, provision and support of the local community to ensure that an accurate assessment of current services has been met. This will ensure a shared vision of what best practice is, and how it can be achieved.

1.1.14 Bolton FT is looking to embrace inclusive ways of involving our diverse communities. The Trust will actively involve our local Maternity Voices Partnership in developing the model, and work in collaboration with the local maternity systems (LMS) who will provide leadership, Governance and clinical commitment required to ensure safe, sustainable and clinically effective services

Prioritising Equality

1.1.15 It is necessary to improve care for populations most at risk of poor outcomes and MCoC plays a critical role in driving this priority. Whist mortality rates are reducing for the population overall; significant health inequalities exist. Evidence suggests that maternal mortality is more than four times higher for Black women and almost twice as high for Asian women (MBRRACE UK 2021). Stillbirth rates and neonatal deaths are also higher in these groups of women.

1.1.16 The 2020 UK obstetric surveillance System (UKOSS) report confirmed that 56% of pregnant women admitted to hospital with COVID-19 were from a Black, Asian and Minority Ethnic (BAME) background.

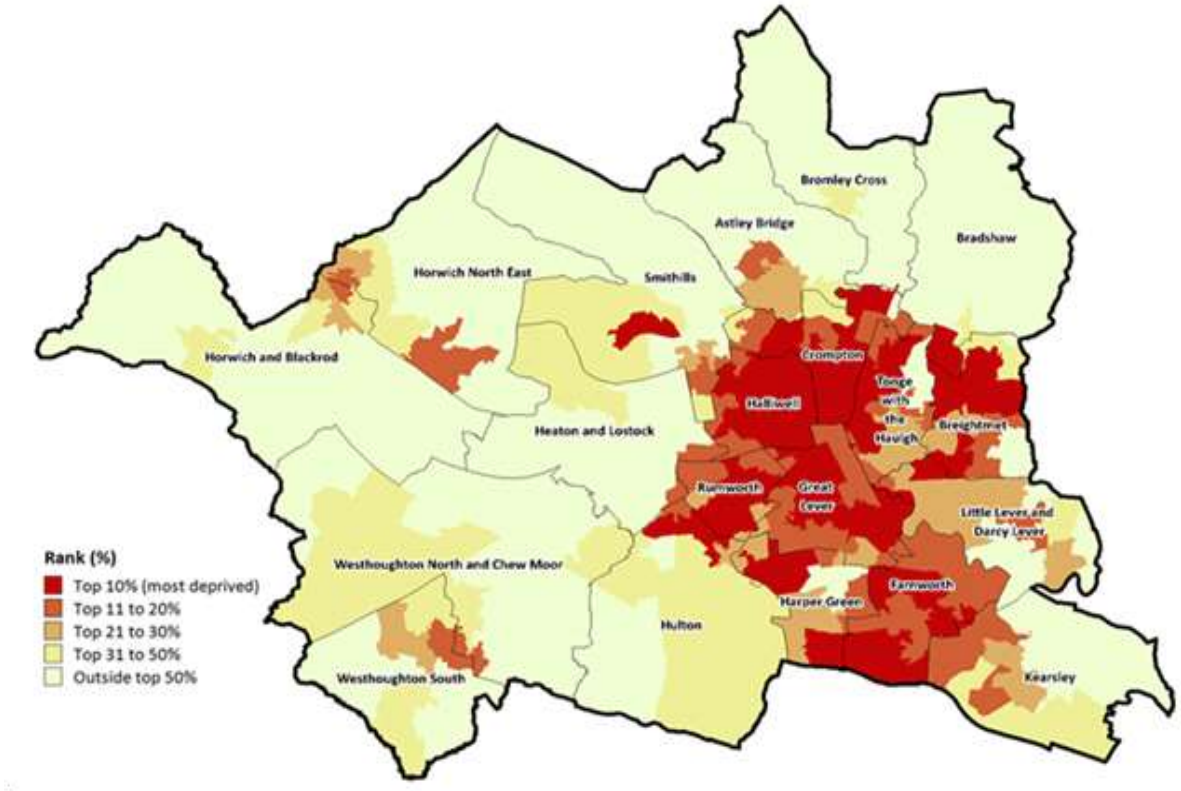
1.1.17 In order to meet the NHS Long Term Plan >51% of women from Black, Asian and Mixed Ethnic minority backgrounds and women from the most deprived areas are to be placed on a MCoC pathway, and 75% of CoC achieved in these groups of women by March 2024. Maternity service providers are required to prioritise the roll out of MCoC to those women most likely to experience poorer outcomes. The proposed implementation plan will achieve 75% compliance by March 2024.

1.1.18 Improving care for these women is therefore a priority action for maternity services. The implementation of a continuity of carer pathway will have an impact towards reducing adverse outcomes amongst these groups.

1.1.19 When considering safety, attention must be placed on both perinatal and maternal morbidity and mortality and emotional, psychological and social safety. Continuity of carer promotes a model of care where all aspects of safety are integral to care provision.

1.1.20 Approximately 36% of women that Bolton FT provides care for are form a Black, Asian, or Minority ethnic background, with the highest % of women residing in the postcodes BL1 and BL3

1.1.21 Approximately 29% of women that Bolton FT provides care for live in the lowest decile of deprivation, and a further 19% in Deprivation code 2; with the highest % of women residing in the postcodes BL1-4 (**see Figure 1 below**).



1.1.22 Data analysis shows the following health inequalities and Birth outcomes for women residing in BL3 compared to BL1 and BL4 (2019 Data- 811 women)

- Higher than Trust Average Induction of labour rate (43.1%)
- Lower rate of waterbirth (1.74%)
- Higher rate of emergency caesarean section
- Higher rate of 3rd and 4th degree tears
- Higher number of women identified as having a language barrier (16.7%),
- 32% of women requiring interpretation services.
- Higher rates of FGM

1.1.23 MCoC rollout will prioritise those most likely to experience poorer outcomes.

Current Position- clinical activity, bookings and births

1.1.24 During the period 01.04.2021 and 31.3.22- 6286 women booked for maternity care at Bolton Hospital, and there were 933 women who received antenatal and postnatal care only. The overall attrition rate has been calculated as 9%

	Total women cared for	**Births**
All care – eligible for MCoC	**5094**	**4666**
Imports - Minimal antenatal and Intrapartum care only	**1192**	**1114**
Exports –AN and PN care only by community midwifery teams	**933**	**NA**
TOTAL	**7219**	**5780**

1.1.25 Women who are booked for intrapartum care only are referred to as 'Imports' throughout the remainder of this document, and are not eligible for MCoC. Imports receive some elements of antenatal care from Bolton FT for example booking appointment, obstetric review, US scans, together with any intrapartum related care including triage admission, induction of labour, intrapartum care, and postnatal stay in hospital. Birth rate Plus and the MCoC modelling tool recommends the staffing establishments for imports being 1:96 (prorata for part time staff). This activity has been included in the core staffing establishment as this element of care provision is currently delivered by ANC.

1.1.26 Women who reside within the Bolton FT catchment area who receive antenatal and postnatal care from Bolton Midwives, and choose to give birth at another provider are referred to as **Exports** throughout this document. Initial scoping work based on community midwives paper records and diaries indicates that there are approximately 933 exports per annum. These are not currently included in the number of women booking for maternity services, and must be taken into consideration when calculating staffing requirements for community midwifery services.

Building blocks and actions plan

a. Safe staffing

1.1.27 The NHS England Continuity planning document and toolkit sets out the building blocks that need to be in place prior to, and during rollout of MCoC. https://continuityofcarer-tools.nhs.uk/tools/midwifery-workforce-modelling-tool?layout=workforcetool

1.1.28 The guidance indicates that having the correct number of midwives in post is one of the fundamental building blocks for safety and must be in place prior to scaling up and implementing MCoC teams

1.1.29 The Birthrate Plus (BR+) workplace planning methodology is a recognised toolkit for planning midwifery staffing and is supported by the National Institute for Clinical Excellence (NICE). Bolton FT undertook a BR+ assessment in August 2020.

1.1.30 The MCoC Guidance documents recommends a recent BR+ assessment to support implementation. A Birth Rate plus refresh has been scheduled for July 2022.

1.1.31 The BR+ report provides a detailed breakdown of safe staffing requirements in each clinical area and is based on activity and acuity. It calculates recommended clinical establishments and proposes a skill mix ratio of 90% midwives and 10% Maternity Support Workers (MSW) within the clinical establishment.

1.1.32 In addition to the clinical establishment, the BR+ tool also includes recommended establishments for non-clinical midwifery roles (specialist and management), which equates to approximately 9% of the clinical midwifery establishment.

1.1.33 A BR+ report was carried out at Bolton FT in August 2020 and recommended 219.9 WTE clinical midwives / MSW's and 19.7WTE additional non-clinical specialist midwifery / management roles. The report recommended a total establishment of **239.70WTE**

1.1.34 The report also identified that the midwife / MSW ratio was 98/2, and recommended that a review of skill mix was undertaken and MSW's upskilled in order to work towards the 90/10 Midwife / MSW ratio. This work is currently in progress.

1.1.35 Our current funded establishment is 241.94 (total), **230.19wte (midwives band 5-8**).

1.1.36 However, it is noted that the recommended midwife to Birth Ratio in the 2020 Birth rate plus report is 1:27.5, which is higher than the national recommended average of 1:24.1. It is also noted that when calculating the community establishment, the exports were not included. This has resulted in a deficit of 9.72WTE midwives in the current community establishment. Based on a recalculation using a midwife to woman ratio of 1:24.1, it is predicted that the recommended total establishment will be **261.42** of which approximately **239.83wte** (clinical midwives/specialists/managers), and 21.6 MSW This will be confirmed when we repeat the BR+ refresh.

1.1.37 It has been identified that prior to implementing MCoC there is a need to undertake a deep dive into current maternity establishments, skill mix, identify appropriate midwife / MSW ratios based on ward acuity, review specialist midwifery roles, and recruit to current vacancies to ensure that we have a safe and solid foundation in place on which to implement MCoC at scale.

1.1.38 In order to support the number of staff required for core in inpatient areas, an acuity tool will be implemented in July 2022 within M2, M4, M5 and the alongside midwife led unit. This will allow acuity in each area to be monitored, review skill mix required, assist in quantification of roles that may be delegated (i.e. transitional care) and ensure appropriate identification and escalation of high acuity. This will provide data that will support the BR+ refresh report. This will be overseen by the interim Head of Midwifery and the Chief Nurse, in line with all staffing acuity reviews.

1.1.39 Since undertaking the BR+ report, although the birth rate has slightly decreased, both an increase in induction of labour and complexity resulting from COVID-19 has resulted in higher activity and acuity in the inpatient/outpatient services. This increased acuity is likely to be reflected in the staffing requirements in the BR+ refresh.

1.1.40 The findings of the staffing review and refresh BR+ report will identify whether any uplift in establishments are required to continue to deliver care within the traditional model. Should this be the case, a further Board paper will be submitted for consideration in September 2022.

Staffing establishments required for the implementation of whole scale MCoC

1.1.41 The guidance from NHS England recommends that approximately 45-65% of midwives are likely to be deployed to MCoC teams, with around 35-55% remaining in the core areas to provide care for those who do not meet the MCoC pathways

1.1.42 Guidance from NHSE recommends that MCoC is implemented in waves to ensure that safe staffing levels are maintained, and staff are engaged in the process.

1.1.43 Each team will consist of a maximum of 8 midwives (headcount). The technical Annex of the NHSE/I Delivering continuity of care toolkit recommends a minimum of 6.8WTE midwives per team to ensure out of hours' care provision. This would require 19 teams.

1.1.44 The latest MCoC guidance from NHS England recommends the use of the MCOC NHS England and NHS Improvement workforce tool (available online https://contunuityofcarer-tools.nhs/tools) or the NHS Spreadsheet to calculate staffing requirements and plan implementation. Both tools were used to sense check calculations and implementation plan. Both tools calculated the required establishment within formula calculations within a variance of 0.96wte (see appendices 1 and 2)

1.1.45 The NHS Spreadsheet (appendices 2) is being used as the basis for implementation and calculation of staffing establishments as it accurately demonstrates the staffing requirements through the implementation waves.

1.1.46 The starting point is the current total funded establishment is **241.94wte** of which 11.75wte is Band 3 MSW (95% clinical midwife / 5% MSW ratio within the clinical establishment), and 20.57wte specialist non clinical/ management roles.

1.1.47 The tool only includes clinical and non-clinical Midwife establishments in the calculations, therefore the establishment has been adjusted accordingly to remove the MSW posts from the total establishment (**230.19wte**). The spreadsheet indicates that

- There are approximately 4666 women who will receive full MCoC annually
- 130.62wte midwives are required to provide MCoC as a default model (based on the recommended 1:36 ratio
- 113.77wte midwives are required to provide safe core staffing levels and care for OOA women (antenatal and intrapartum) and all inpatient areas including ANC (including 1192 imports), ANDU, M2 (antenatal ward), M4, M5 (postnatal wards), Triage, Induction of Labour, and the core intrapartum areas (Delivery Suite, Birth Suite Alongside Midwife led unit, Ingleside Freestanding Birth centre). These figures may change following the BR+ refresh
- 25.49wte specialist / managers are required
- To provide 100% MCoC at full scale (to the women eligible for MCoC), and to maximise the experience of our service users whilst simultaneously assuring provision of safe and effective care, a workforce establishment of **269.88wte** is required
- The tool indicates that an **additional 39.69wte above the current funded establishment** is required to enable Bolton FT maternity services to offer MCoC as the default model of maternity care

1.1.48 It is important to note that staffing requirements may change based on the outcome of the staffing review, BR+ refresh, and implementation of ward acuity tools

1.1.49 Without additional funding to support the increase in midwifery establishment of 39.69wte it is not possible for Bolton FT to scale up and provide MCoC as the default model of maternity care.

1.1.50 Support and funding will be sought from the Integrated Care System to increase midwifery establishment on a recurrent basis over the next 5 years. It is predicted that the implementation of 6 waves to achieve MCoC as the default model will be approximately 5 years. See paragraphs 1.1.62 for recruitment and retention plan, and appendices 2 for implementation waves.

Midwifery vacancies

1.1.51 The current midwifery vacancy rate 30.82 which accounts for 16.5% of the band 5/6 clinical midwifery workforce. Until the vacancy rate is recruited to establishment, we will be unable to implement and roll out MCoC safely. Please refer to the Midwifery workforce strategy and recruitment and retention plan for detailed information.

Action plan

1.1.52 The table in appendices 2 outlines a staged approach to scale-up and implement MCoC to all eligible women. A timeline and summary of key milestones for implementation are presented in appendices 3. A detailed action plan is in place which is monitored locally against set objectives and outcome measures through the Maternity Transformation programme board, and reported to the Trust Board of Directors on a quarterly basis.

1.1.53 MCoC teams will be prioritised for roll out in areas with high numbers of Black, Asian and Minority ethnic populations and the postcodes included in the lowest deciles of deprivation.

1.1.54 Implementing MCoC will be divided into two phases.

Phase 1 – Pre-implementation June 2022- December 2022

1.1.55 Phase 1 will consist of the following actions

- Deep dive into maternity establishments, skill mix, identify appropriate midwife / MSW ratios based on ward acuity, and review specialist midwifery roles
- Complete Birth Rate Plus refresh to determine safe staffing levels in all areas
- Present Birth Rate plus recommendations to Trust Board of Directors in September 2022 to obtain funding for recommended birth rate plus establishments if required
- Recruit to establishment to ensure that we have a safe and solid foundation in place on which to implement MCoC at scale.
- Develop an enhanced model of MCoC that provides additional support for women from the most deprived areas
- Develop a training needs analysis / Staff 'Skills, Training, self-Assessment, and Reflection (STAR) document in order to ensure staff are confident and competent to work in MCoC teams. This includes providing care throughout the pregnancy and childbirth continuum, and delivering intrapartum care in all four place of birth settings (Home, Midwife led unit, Birth centre, Delivery suite). The STAR document will be implemented prior to each wave to identified staff in readiness for implementation of MCoC at whole scale.
- Promote collaboration and engagement with representative service users, MVP's, wider clinicians, GP's, voluntary and community sectors

1.1.56 Bolton FT was successful in obtaining £63,650 funding from the GMEC Local Maternity system to pilot an enhanced model of MCoC. The project includes the development of Bi-lingual support worker roles, training volunteers from the local community to provide targeted peer support, and service user engagement events encourage co-creation of educational resources for staff and service users in order to tackle health inequalities. This work will commence during phase 1.

1.1.57 Phase 1 will end when we have reached recruitment to establishment. Based on current staffing establishments and professional judgment, this would require the recruitment of an additional 20WTE midwives above the current establishment as indicated in appendices 2 before rollout can safely commence.

Phase 2- Implementation of MCoC waves 1-6 march 2023 to March 2027

1.1.58 MCoC teams will be implemented in 6 waves, prioritising roll out of MCoC to women most likely to experience poor outcomes. There are 1640 women residing within the lowest decile of deprivation (32% of women eligible for MCoC). There are approximately 1782 women from BAME backgrounds (35% of all women eligible for MCoC). Refer to Appendices 2 & 4 for team implementation plan.

1.1.59 There will be 7 enhanced teams, specifically targeting women residing in the lowest decile of deprivation. Approximately 1640 women will be booked onto the Enhanced MCoC pathway. These teams will also include approximately 1438 women from BAME backgrounds (81% of the BAME population eligible for McoC). Funding can be obtained via expression of interest for each enhanced continuity of care team to provide additional support / administration roles (see appendices 5).

1.1.60 There will be 12 additional teams providing continuity of carer based on a geographical mixed risk model. Approximately 3454 women will be booked onto the standard MCoC pathway (68% of all women eligible for MCoC). These teams also include approx. 344 women from BAME backgrounds (19% of the BAME population eligible for MCoC)

1.1.61 Approximately 2185 women (1192 Imports and 993 Exports) will receive the traditional model of midwifery care as they are not eligible for MCoC.

1.1.62 Rollout will be in line with the recruitment plan outlined below

Target completion date	Wave	WTE Midwives required
Dec 2022	Pre-implementation	20
March 2023	1	5
March 2024	2	7
March 2025	3	1
Sep 2025	4	2
March 2026	5	4.69
March 2027	0	0
Total		39.69

1.1.63 An evaluation will be undertaken prior to commencing a new wave to review current staff in post, additional workforce requirements, and acuity in core areas in order to ensure safe staffing levels are maintained during the transition and implementation of MCoC. Outcomes will be monitored and reported throughout implementation. Staff

will be redeployed from core inpatient areas to the MCoC teams if activity in the area decreases (ie if an increase in midwife led births results in a reduction in postnatal inpatient stay) to support the implementation of MCoC teams.

1.1.64 At each phase and wave we will use the PDSA cycle to determine if the plans require amending, and make changes accordingly.

1.1.65 MCoC teams will be implemented in areas with high numbers of Black, Asian and Minority ethnic populations and the postcodes associated with the lowest decile of deprivation. This plan will achieve the required target of 75% of the above groups receiving MCoC March 2024.

Recruitment

1.1.66 Recruiting to midwifery posts is a regional and national challenge due to the shortage of midwives. Despite an active ongoing and continuous recruitment process at Bolton FT, there is a current vacancy rate of 30.82 WTE midwives, accounting for 16.5% of the clinical midwifery workforce. Actions to address the current workforce challenges are outlined in the **Maternity Workforce, Recruitment and Retention Strategy.** This includes the increased use of Maternity support worker roles to provide postnatal care and increased use of nurses to provide specialist care including Transitional care and HDU/ critical care postnatally to maximise midwifery resources.

Communication and Engagement Plan

1.1.67 Developing a communication and consultation strategy will ensure that senior management, clinical staff (both internal and external staff), and service users and their families are kept informed at all stages of development and implementation

1.1.68 Bolton FT will engage with the Maternity Voices Partnership (MVP) throughout, encouraging involvement from those hard to reach groups to ensure that all voices are heard and represented.

1.1.69 Involvement of Human resources, RCM union and staff side will be initiated from the offset of the plan

1.1.70 In response to the previous unsuccessful attempts at implementing MCoC teams, and the discontinuation of MCoC teams due to current and historical staffing challenges; midwifery staff have identified a reluctance to engage in further attempts to implement MCoC models. Listening events were conducted in 2020/2021 which identified issues and concerns relating to working across all four intrapartum areas, fear of increased on-call commitments, increased travel, childcare pressures, and fear of burnout. The initial listening events were attended mainly by community midwives, with minimal core hospital midwife attendance due to the perception that MCoC teams were a community based project.

1.1.71 The themes identified in the listening events were similar to the findings from a wider survey of midwives conducted by Birmingham University which demonstrated a reluctance from midwives to work in MCoC models (Taylor et al 2019).

1.1.72 Staff engagement is essential in order to successfully implement MCoC

1.1.73 A comprehensive staff engagement project has already commenced, and will continue during phase 1 and throughout the implementation journey. The engagement project will build trust and confidence in MCoC and involve all clinical and support staff working in the community and hospital setting to ensure that the vision is shared amongst the whole team. This includes Obstetricians, Neonatologists, paediatric services, anaesthetics, and support staff. Clinical outcomes will be shared with the team, together with evidence about the benefits of working in a MCoC team, including how successful implementation can support improved work life balance, autonomy, clinical skills, and job satisfaction. This evidence will be obtained from sharing case studies, experiences, and outcomes from successful MCoC teams regionally and nationally.

1.1.74 The staff engagement plan will be undertaken with the wider support from the GMEC LMS, Trade Unions (RCM), and Human resources

1.1.75 The implementation plan will be co-created with representative service users, and in collaboration with the Maternity Voices Partnership (MVP) to ensure that care is inclusive and meets the needs of the local demographic population.

1.1.76 Outcomes, experiences and feedback from the implementation of each wave, will be shared with staff and service users through newsletters, social media, local publications or events, and on the Trust maternity website.

Skill Mix Planning

Wider midwifery workforce

1.1.77 It is widely recognised that Maternity support workers (MSWs) are an integral part of the maternity workforce and play an important role in supporting women and babies', midwives, and the wider maternity teams. Birth Rate Plus recommends an overall ratio of 90% midwives and 10% maternity support workers within the clinical establishment, recognising that overall ratios may be higher in areas including the postnatal ward, and lower in areas including intrapartum.

1.1.78 Bolton FT has proactively increased the number of MSW's, and implemented an in-house competency based MSW training programme to upskill current MSW's. We have recently advertised training MSW positions and soon to appoint to post in order to achieve the 90/10 split.

1.1.79 In order to address the national midwifery workforce challenges, we have implemented / are implementing the following to ensure that staff are confident, resilient, skilled in their roles and we have sustainable safe staffing and skill mix in all areas

- Appropriate and planned use of maternity support workers on the postnatal ward and community setting
- Preceptorship programme with designated pastoral support midwives
- Birth Rate plus refresh
- Implementing acuity tools on ward areas to monitor activity and skill mix required

- Reviewing services and duties that may be undertaken by nurses to maximise midwifery resources, this includes transitional care, vaccinations, high dependency care, and parent education provision
- Developing support and training packages for succession planning for specialist / leadership and management roles to ensure preparedness and effective workforce forward planning. This includes band 7 delivery suite coordinators in line with Ockenden recommendations.
- Review of current uplift (23%) allocation to ensure it meets the current mandatory training requirements
- Dedicated time allocated for team building and softer midwifery development incorporated into MCoC rollout and ongoing implementation plans.

Skill mix- MCoC teams

1.1.80 The new MCoC guidance recommends the implementation of mixed risk geographically based MCoC teams. Midwives working within MCoC teams will therefore provide antenatal, intrapartum and postnatal care to women with varying complexity and clinical need. Intrapartum care will be provided in all birth settings. Staff will be supported by an individual training needs analysis.

1.1.81 The MCoC teams will consist of 6-8 midwives, with a minimum of 6.8WTE, and a minimum of one band 5 midwife as recommended in the NHSE/I continuity toolkit. In line with Ockenden 2022, newly qualified midwives will remain within the hospital setting for a minimum period of one-year post qualification. All band 5 midwives will complete a comprehensive preceptorship package, with pastoral support provided by the practice educators and designated pastoral midwives. This will ensure there is an opportunity for newly qualified midwives to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience, and provide a structured period of transition from student to accountable midwife prior to orientation to MCoC teams.

1.1.82 Maternity Support workers will work alongside the MCoC teams in order to support the midwives in the delivery of care. Enhanced MCoC teams, and teams located in areas with high BAME population will have a designated bi-lingual maternity support worker to ensure effective communication and provide targeted health promotion activities in order to improve health inequalities and poor outcomes. This initiative will be funded through the LMS (see appendices 5)

Training and Development

1.1.83 It is acknowledged that some midwives moving into the MCoC teams may require varying amounts of training, development and exposure to clinical care in order to become confident in delivering care throughout the childbirth continuum and in all birth settings.

1.1.84 Core staff in the intrapartum areas (Delivery suite, Midwifery led unit, and Freestanding birth centre) will provide support to those midwives working in MCoC teams who require

additional support or confidence building. Individual midwives will also be supported by the Practice Development Midwives, pastoral midwives, or PMA's where individual training needs have been identified.

1.1.85 A Skills, Training, self-Assessment and Reflection Log (STAR) will be developed during phase 1. The STAR will allow staff to identify any additional education or training needs, making the document personalised and individualised for all staff, and ensure that learning is tailored to individual needs.

1.1.86 The STAR document will be evaluated following the implementation of wave 1.

1.1.87 Approval of the STAR document will follow Bolton FT Governance processes

1.1.88 All midwives working within the MCoC team will complete the STAR document prior to commencing their alloacted wave. Dedicated time will be allocated for team building and midwifery development prior to MCoC rollout. This will continue through the implementation to encourage midwives to integrate to the new way of working.

1.1.89 All staff will be responsible for meeting these learning needs prior to working in MCoC team.

Standard operating Procedure (SOP)

1.1.90 A MCoC SOP has been developed to provide clarity around roles and responsibilities, guidance on staffing and rota requirements within the team (to include annual leave allocation, on call requirements, intrapartum shift allocation, mandatory training and additional training requirements, referral processes, service delivery, place of birth information, audit requirements, and transfers of care, linked obstetrician). The SOP will be agreed via BFT Governance processes prior to implementation of the MCoC teams.

Midwifery Pay

1.1.91 During phase 1, and prior to roll out of MCoC teams, a workforce consultation process and management of change will be implemented. This will include financial consideration / implications for midwives working in MCoC teams, to ensure that no midwife is financially disadvantaged for working in MCoC teams. In developing services that deliver continuity of carer midwives providers have adopted an inclusive pay arrangement, also known as salary 'uplift' as an alternative to standard on-call payments. This approach is sometimes used as a way to support the development of more flexible working. Paying 4.5% uplift is most closely aligned to current pay for a midwife working a shift system and would represent a pay rise for some community midwives who only do limited unsociable hours. An options appraisal will be developed in collaboration with staff, RCM and Trade union representatives, and Human Resources as part of the consultation process.

Linked Obstetrician

1.1.92 Each MCoC will have a linked named obstetrician who is an integral member of the team in providing a clear well-defined route for obstetric or other specialist referral.

1.1.93 The linked obstetrician will be available to the MCoC team by an agreed process and attends team meetings in a regular basis. The midwives and obstetricians agree their method of communication and way of working. This is outlined in the SOP.

1.1.94 Obstetricians may be linked to more than one team.

Estate and Equipment

1.1.95 Each wave of MCoC team will be based within the existing community Hubs, with easy access to other healthcare providers including services such as primary care, health visiting, social services and mental health.

1.1.96 Following wave 1, the location, provision and effectiveness of community satellite clinics will be evaluated. As the number of MCoC teams expand, additional community Hubs may be required. This may require additional resource, project planning and investment. Should this be the case, a further Board paper will be submitted for consideration.

1.1.97 It is also acknowledged that providing MCoC at scale will require an investment in IT infrastructure and equipment. This will include mobile phones, Laptops or Tablet devices, clinical equipment (dopplers, stethoscopes, home birth kits etc). Should this be the case, a further Board paper will be submitted for consideration.

Review Process

1.1.98 It is a requirement of the MCoC guidance for all providers to submit an update to the Trust Board of Directors on progress against the action plan each quarter.

1.1.99 The action plan will be monitored monthly at the Transformation steering group and then submitted as an assurance paper to the Quality Assurance Committee (QAC). Each Quarter it is expected that the action plan will be on the QAC agenda for review prior to onward submission to Bolton FT Board of Directors.

1.1.100 The next presentation of MCoC at Trust Board of Directors will be July 2022.

Recommendations

- Trust Board of Directors to acknowledge the information and current position and future plans relating to MCoC
- Trust Board of Directors to acknowledge the additional workforce requirements needed to implement MCoC as the default model of care
- Trust Board of Directors to support the maternity service in delivery of the transformed MCoC model of care, aiming to implement MCoC by default by March 2027
- National guidance requires quarterly monitoring of this plan – agree for return of plan to Trust Board of Director's on a quarterly basis

References

Hadebe, R et al (2021) Can birth outcome inequality be reduced using targeted caseload midwifery? A retrospective cohort study. BMJ Open 11(1)

NHS England and NHS Improvement (2021) Delivering Midwifery of Continuity of carer at full scale: guidance on planning, implementation and monitoring 2021/2022

NHS England and NHS Improvement (2021) Delivering Midwifery of Continuity of carer at full scale: Technical Annex

NHS England (2016) Better Births: Improving outcomes of maternity services in England

NHS England (2019) The NHS Long term Plan

Ockenden D (2020) Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust

Sandall, Soltani et al (2016) Midwifery led continuity models versus other models of care for childbearing women. Cochrane dataset of systematic reviews (2016) Issue 4.

Taylor, B et al (2019) Midwives perspectives of continuity based working in the UK: A cross sectional survey (https://doi.org/10.1016/j.midw.2019.05.005)

Appendices 1

Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care: 7219

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	933
Out of area referrals	1192
Attrition	428
Total women not eligible	2553

Total women eligible for full Continuity of Carer pathways: 4666

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway: 4,666 Women

Number of eligible women not on full C of C pathway: 0 Women

Current budgeted establishment: 230.19 WTE

Midwives for 4,666 women on full Continuity of Carer pathway

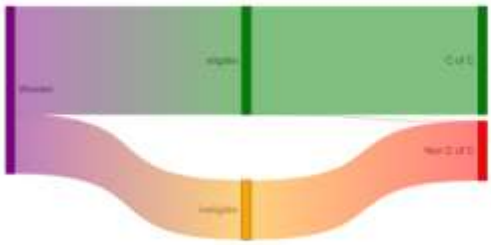
Midwife to woman ratio: one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE MWs per team (between 4 & 8): 6.8

You will need **129.61 Midwives** to look after **4,666 Women** on full Continuity of Carer pathway, working in **19 teams** of **6.8**

Service Breakdown



Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	7,219 Women
- of which number not eligible for C of C pathway	2,553 Women
- of which number eligible for C of C pathway	4,666 Women
In this scenario 100 % of eligible women receive care on C of C pathway	4,666 Women
- Midwives required to provide C of C @ 1:36 ratio	129.61 Midwives
- No. of C of C teams required @ team size of 6.8	19 Teams
Total not cared for on Continuity of Carer pathway	2,553 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	138.31 Midwives
Workforce establishment required to provide care for all women	268.92 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 230.19 WTE	-38.73 Midwives

Midwives for 2,553 women not on full C of C pathway

These are the 2,553 women who are not eligible for C of C plus the 0% (0) not on full pathway

Midwife to woman ratio for 933 women requiring postnatal and antenatal care: one to 96

This will be **9.72 midwives** looking after **933 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 1192 out of area referrals (care for birth only): 0

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	91.53
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, PMU)	12.57
Specialist midwives (breast feeding, bereavement, etc.)	20.57
Midwives in non clinical management (ward sisters, matrons)	4.92
Other	0
Total needed for minimum safe staffing	129.5899999999997

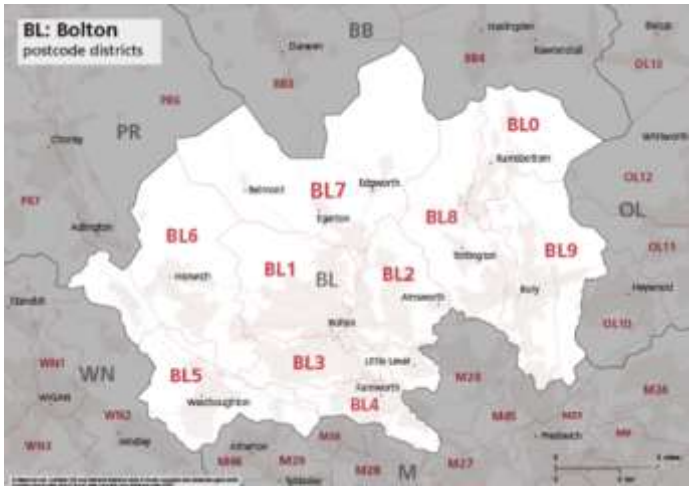
Appendices 2 NHSE/I MCoC workforce modelling spreadsheet and implementation plan

Bolton FT NHSE
and McCoC Staffing

Appendices 3. Timeline and key milestones

	Key actions and deliverables					
	2022	2023	2024	2025	2026	2027
Deep dive into workforce	July					
Complete Birth Rate Pus assessment- Safe staffing assurance	Aug -& Sep					
MCoc updates to QAC & BOD	July & Nov	March / July / Nov	March / July / Nov	March / July / Nov	March / July / Nov	March / July / Nov
Recruitment Phase 1 to BR+ establishment	Dec 2022					
Recruitment Phase 2 / Waves		Wave 1 March	Wave 2 March	Wave 3 March / Wave 4 Sep	Wave 5 March	Wave 6 March
Develop enhanced model of MCoC	Aug & Sep					
Recruit to Bilingual support workers	Aug & Sep					
Training for peer supporters	Oct & Dec					
Training needs analysis and STAR document	Oct & Dec	Implementation throughout waves				
MVP / service user collaboration and engagement events	July & Sep	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
Staff communication and engagement		1 month prior to each wave, and throughout implementation				
Workforce Consultation	Nov to Dec					
Implementation of MCOC waves		Wave 1 March	Wave 2 March	Wave 3 March / Wave 4 Sep	Wave 5 March	Wave 6 March
Audit, evaluation and outcome reports		Sep	Sep	sep	March & sep	Sep

Appendices 4- MCoC Team implementation plan



Wave	Team Name Based on 6.8wte midwives per team (max 8 x headcount) Booking 39 women per year	Postcode / Number of women booked standard Mixed risk geographical MCoC Pathway	Postcode (lower decile) / Enhanced Team number of women on enhanced pathway	Number of BAME women (NB may reside in lower decile)	Total women booked
1 March 2023	ENH 1 ENH 2 ENH 3	BL1 = 143	BL1 = 365 + BL2= 279 BL8 = 9	Approx. 625	796 / 39 = 20.41 3 Teams
2 March 2024	ENH 4 ENH 5 ENH 6		BL3 = 450 BL4 = 200 M38 = 141	Approx. 627	791 / 39 = 20.28 3 Teams
3 March 2024	Team 1 Team 2 Team 3	BL1= 438 BL2 = 309 BL3 = 49	NA	Approx. 49	796 / 39 = 20.41 3 Teams
4 Sep 2025	Team 4 Team 5 Team 6	BL3= 579 BL4= 264		Approx. 221	843 /39 = 21.62 3 teams
5 March 2026	ENH 7	M28=88	M26 = 27 M27 = 70 M28 = 99	Approx. 186	284 / 39 = 7.28 1 team
	Team 7	BL8 = 162 BL7= 92 BL0 = 50	NA	Approx. 22	304 /39 = 7.79 = 1 team

	Team 8	BL6= 268	NA	27	268 / 39 = 6.87 1 team
6 March 2027	Team 9	BL5 = 237 M38 = 50	NA	25	287 / 39 = 7.36 1 team
	Team 10 Team 11 Team 12	M28 = 249 M26= 224 M27= 252	NA	0	725/39 = 18.6 3 teams
TOTAL	Teams x19	Standard Pathway 3454	Enhanced Pathway 1640	BAME Total 1782	WTE 19 teams 130.62wte Total
	OOA Bookings	All areas 292	900	118	1192 NA Core
	In area Exports Traditional community model	Catchment = 933 UNKNOWN			1:96 9.72wte

Based on minimum 6.8wte midwives per team (max 8 x headcount) Booking 39 women per year

Appendices 5 Expression of Interest to the LMS for Funding for enhanced MCoC teams

Bolton proposes the implementation of 7 Enhanced Midwifery Continuity of care teams as outlined below. Wave 1 cannot commence until recruitment to staffing establishments has been achieved. Wave 1 will commence no later than March 2023. If funding is successful, Bolton FT will notify the LMS if implementation is likely to start sooner than predicted.

Wave	Team Name Based on 6.8wte midwives per team (max 8 x headcount) Booking 39 women per year	Postcode / Number of women booked standard Mixed risk geographical MCoC Pathway	Postcode (lower decile) / Enhanced Team number of women on enhanced pathway	Number of BAME women (NB may reside in lower decile)	Total women booked
1 March 2023	ENH 1 ENH 2 ENH 3	BL1 = 143	BL1 = 365 + BL2= 279 BL8 = 9	Approx. 625	796 / 39 = 20.41 3 Teams
2 March 2024	ENH 4 ENH 5 ENH 6		BL3 = 450 BL4 = 200 M38 = 141	Approx. 627	791 / 39 = 20.28 3 Teams
5 March 2026	ENH 7	NA	M26 = 27 M27 = 70 M28 = 99	Approx. 186	284 / 39 = 7.28 1 team

Overall aims of the enhanced MCoC teams include

- Test the concept of the enhanced midwifery team (EMT) midwife providing continuity of carer as part of the mixed risk continuity team
- Prioritise the roll out of continuity of carer models to women most likely to experience poor outcomes, therefore having a greater impact on public health and reducing health inequalities
- Develop an enhanced model of continuity of care that provides additional support for women from the most deprived areas
- Promote collaboration and engagement with representative service users, MVP's, wider clinicians, GP's, voluntary and community sectors in order to identify the support needs of the demographic population.
- Co-create educational resources for staff and service users in order to target inequalities in health, promote general health and wellbeing, and to ensure equality in access to maternity services. This could include the co-creation of a localised APP, available in the languages representative to the local population in order to improve access to midwifery and third sector services and provide targeted intervention to promote health and wellbeing and reduce health inequalities.
- Digital poverty and exclusion are more prevalent in this area and the project would allow Bolton Hospital NHS Foundation Trust to co-create and develop resources and implement actions to address these barriers

- Implement and pilot a cultural liaison link worker role / bilingual maternity support worker to support the enhanced MCoC team. The cultural liaison link worker will be able to speak community languages, understand the cultural barriers and needs through lived experiences, and support the midwifery team with targeted interventions in line with KPI's and pilot aims in order to improve access to care and improve clinical outcomes.
- Increase choice, access and utilisation of all four places of birth (Home birth, Freestanding Birth centre (Ingleside), Alongside birth centre (Beehive), and obstetric unit (delivery suite at Bolton) and to ensure equity in service provision based on choice and clinical need
- Encourage engagement and collaboration with third-sector organisations in order to promote a seamless service between community and hospital settings
- Increase utilisation of the Bolton Council of Mosque Community Maternity hub in order to provide accessible maternity services within the local community
- Provide bespoke education and training to the continuity midwifery team to ensure that midwives are able to provide culturally sensitive care and are confident and competent in supporting the diverse needs of our most vulnerable groups. Targeted training will include FGM, Cultural safety, identifying mental health in ethnic minority communities, and health promotion to tackle inequalities in health
- Increase staff satisfaction and retention through effective service delivery and models of care, and investment in staff development.
- Develop and implement a training programme for peer support volunteers from representative backgrounds to work in collaboration with the continuity team. The volunteers will work alongside the midwives and cultural liaison link workers to provide additional resources and holistic care. The aim of the role is to encourage women and families to develop independence in self-care and problem solving, and take a proactive role in managing their own health and wellbeing. Evidence suggests that appropriate peer support reduces poor health outcomes.
- The training of volunteers from representative backgrounds within the BL1-BL3 area aims to further tackle inequality by encouraging educational and employment development. It is anticipated that some volunteers may progress to paid employment in NHS roles (for example cultural liaison roles)

Measurable outcomes for the Enhanced MCoC teams (based on local benchmark data and national data)

- Number of women placed on MCoC pathway at booking, 28 weeks gestation, and postnatal discharge
- Women have received continuity from their lead/team midwife during antenatal and postnatal care (minimum 70% of appointments) and during labour (in line with local and national targets)
- Reduction in preterm birth
- Reduction in stillbirth and pregnancy loss
- Reduction in induction of labour
- Reduction in emergency caesarean section rate
- Reduction in 3rd and 4th degree tears
- Increased compliance in risk assessment and place of birth discussion carried out at 36 weeks gestation
- Increased use of interpretation services
- Increased compliance in personalised care plans during pregnancy, labour and the postnatal period
- Increased access and utilisation of all 4 places of birth
- Increase in breastfeeding initiation rates

- Increase in breastfeeding rates @ 6 weeks
- Increased use of water for labour and birth (water birth) and reduction in epidural use
- Increased referral and access to mental health services
- Service user evaluation of the cultural liaison link worker role
- Service user evaluation of the peer support volunteer role
- Increased ability of midwives to identify FGM (measured through a reduction in the "unclassified or unknown" documentation of FGM at booking)
- Staff satisfaction through feedback, attrition, sickness absence

FUNDING REQUEST FOR 7 ENHANCED TEAMS (£46,000 PER TEAM) =£322,000

Date	Descriptor	Funding requested (approximate)	Available funding
Wave 1 **3 teams** **March 2023**	**1.0 x band 7 cultural liaison midwife** **3 x 1.0 WTE band 3 Bi-lingual maternity support workers** **Training and development costs (Enhanced team midwives and support workers)** **Service user engagement events**	**£45,839 (based on top band 7)** **£21,777 (based on top band 3)** **£21,777 (based on top band 3)** **£21,777 (based on top band 3)** **Approximately £16,985** **TOTAL Approximately £129,155 plus staffing on costs**	**£138,000**
Wave 3 **3 teams Sep 2023**	**3 x 1.0 WTE band 3 Bi-lingual maternity support workers** **Training and development costs (Enhanced team midwives and support workers)** **Service user engagement events**	**£21,777 (based on top band 3)** **£21,777 (based on top band 3)** **£21,777 (based on top band 3)** **Approximately £16,985**	**£138,000**

		TOTAL Approximately £129,155 plus staffing on costs	
Wave 5 **1 team March 2024**	**1 x 1.0 WTE band 3 Bi-lingual maternity support worker** **Research support and data anlysis (university)**	**£21,777 (based on top band 3)** **Approximately £5662** **Approximately £5000** **TOTAL Approximately £32,439**	**£46,000**

Funding has been requested as part of implementation of the Enhanced MCoC teams to provide backfill to enable the MCoC team to attend bespoke training within the intrapartum areas prior to implementation of the continuity teams.

Achieving funding to support staff training and development will instill confidence in the teams, and engage and empower staff in embracing the new models of working.

It is expected that the MCoC team will complete a bespoke training package consisting of 3 days of theoretical and practical training (to include enhanced safeguarding and complex social care, safeguarding, mental health in diverse ethnic communities, health inequalities relevant to target population, community based skills and drills, FGM facilitating culturally sensitive discussion, recognition and management), and 5 days supernumerary clinical practice to orientate to all 4 intrapartum areas and meet individual clinical competencies.

Backfill is also requested for the maternity support worker to attend the 3 bespoke training days prior to the implementation of the team.

Midwives x8- each midwife allocated 3 training days and 2 clinical days (total 5 x 7.5 hour days 37.5 hours). Band 6 midwife hourly rate = £17.48. Backfill required Total= 37.5 x 8 x £17.48 = £5,244

Maternity Support Worker x1 allocated 3 bespoke training days and 2 clinical days to meet key learning objectives and orientate to all intrapartum areas. 37.5 Hrs x £11.14 per hour = £417.75

Agenda Item 17

Title:	Learning from Deaths Q1 Report 2022/23

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	✓
Exec Sponsor	Dr Francis Andrews		Decision	

Summary:	This report includes the most recent information on deaths in adult patients, including data on: • Total number of inpatient deaths (including ED deaths) • Total number of deaths subject to Structured Judgement 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 Actions and learning that has arisen from these cases is outlined, as is the proposed change to using thematic analysis in the future as the output for these reviews.

Previously considered by:	Quarterly reporting QAC and Board – last update May 2022 (Q4 21/22)

Proposed Resolution	The Committee is asked to discuss the content of the report and approve the proposal regarding amendments to the reporting schedule

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; Michelle Parry, Clinical Effectiveness Manager; Sophie Kimber Craig, AMD	**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**
LeDeR	**Learning Disabilities Mortality Review Programme**
RCP	**Royal College of Physicians**
NQB	**National Quality Board**
LFDC	**Learning from Deaths Committee**
QAC	**Quality Assurance Committee**
NCDRP	**Nosocomial Covid Deaths review panel**
GMMH	**Greater Manchester Mental Health Trust**

1. Background

The SJR process is outlined in detail in Appendix 1.

The Maternity report usually included as an Appendix has been omitted from this quarterly report, as a paper is being produced on a deep dive into stillbirth cases.

2. Summary of progress in Q1 2021/22:

- Additional dates for SJR training for May and June 2022
- Corporate support from Business Intelligence, Patient Services and Clinical Effectiveness – to facilitate the process and highlight inclusive patients
- Over 965 deaths to date have been reviewed using structured judgement methodology
- Changes to SJR online platform to enable thematic analysis and enhanced reporting functionality – it is expected enhanced thematic analysis will be available from Q2 22/23 and the offer is made to departments and divisions to submit requests for analysis to support deep dives
- Development (in progress) of Mortality and LFD dashboards – to enable clearer visualisation of LFD process against mortality indicators and divisional/departmental oversight of own indices and cases
- Change of alert diagnosis from COVID to Alcohol Liver Disease to explore mortality alerting diagnostic groups and to better understand the impact of alcohol on the Bolton population
- Improvements made to the mental health inclusion criteria to more accurately identify those patients with existing MH conditions

3. Learning from Deaths Data – Adult inpatient deaths only

A comprehensive summary of data from the adult inpatient learning from deaths process can be found in appendix 2. Please see summary and narrative below, which does not include cases for June as these are yet to be allocated:

	Q2 21-22			Q3 21/22			Q4 21/22			Q1 22/23 to date *	
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Number of in-patient deaths (excluding ED & paeds)	106	111	111	116	121	140	141	119	90	162	
Number SJR Cases identified	21	22	17	19	25	44	44	13	15	49	
% completed	86	86	100	90	76	80	64	62	64	22	
Number of deaths caused by problems in care (of those who had an SJR)	0	2	1	0	0	1	1	2	0	TBC	

**Please note information relating to adult inpatient deaths is provided one month in retrospect by Business Intelligence e.g. May's deaths are provided late June. 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*

4. SJR Allocation and Completion rate

Continuing operational pressures due to the COVID-19 pandemic and recovery 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 in a timely fashion. However, despite these significant challenges, the average SJR completion rate for July 21 – March 2022 is currently 79% (not including April's data, as this is not expected to be at completion as yet), which is consistent with the national average. Despite benchmarking well against national levels, we want to improve our completion rate. Training has been completed and more is planned to increase the numbers of reviewers within the organisation to achieve this aim. To further reduce any particular pressure on staff, the LFD administrative team now allocate just one SJR per month per person as a maximum.

We have also enhanced support to our SJR reviewers by developing a learning from deaths reference page on BOB and the SJR review latest news and top tips bulletin and an open offer to attend the LFD committee whenever a reviewer's case is being reviewed by the group. We will also look to enhance our support further by implementing a peer-review process, where staff can "buddy up" to quality assure each other's work

5. Case referral

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

The following deaths have been identified since the last LFD report as cases where care concerns may have influenced outcome and/or have been sent for scoping or review:

Quarter	Patient number	Details
Q3		• Patient 1 (died December) – Failure to administer appropriate antibiotics in the early stages of the illness and lack of source control for the infection. Consultant/Senior review not routinely done and some documentation in BlueSpier system, not EPR. Referred for concise Investigation – Review drafted and to be approved at A&S Divisional Governance July 2022
Q4 21/22	3	• Pt 2 (died January) - MFFD day 2 of admission and based on the documentation available, lack of senior oversight on remainder of admission. Patient missed face to face reviews as a member of the team was not mask fit tested but this wasn't escalated or allocated to another member of the team (registrar/consultant). Failure to review, escalate and action concerns in fluid balance which may have led to earlier detection of electrolyte disturbance and instigation of appropriate management. Referred for concise investigation under

		ASSD to address fluid balance management, senior ward rounds, mask fit testing. • Pt 3 (died January) – Patient admitted via clinic. Poor clerking on admission and lack of recognition/recording of key comorbidities. Referred for concise investigation; report drafted for approval at A&S Divisional Governance July 2022.
Q1 22/23		• Pt 4 (died June) – escalated to Scoping Panel; concern around oxygen therapy.

SJRs referred for Divisional Review/Serious Incident scoping by the LFD Committee – feedback on actions and learning points

The following feedback on referred cases has been received at committee:

Date Identified	Review Required		Status and Key Learning
08/07/2021	Concise Investigation	MS-948	Action Required: 1. The Action Plan recommends an Alert need to be placed on EPMA for when paper records are used in combination with EPR 2. EPR Medical Handover process is being introduced which will further support Investigation findings
09/11/2021	Divisional Review	JH-386	Report signed off. Key contributory factors identified are: 1. Lack of clinical ownership whilst patient in the Emergency Department (ED) 2. Lack of documented communication between medical staff and next of kin 3. Management of Sepsis in ED Action Required Includes: 1. Development of bladder washout guidance 2. Review out of hour structure in the surgical team to ensure there is appropriate onsite senior cover 3. Ensure surgical and ward nursing staff have received End of Life training Report fed back at LfDC May 2022

Cases of excellence

In cases where the overall care is rated as excellent, feedback and commendation is provided to the team. 2 such reports have been sent to the Critical Care team in the last quarter and we consistently see good reports about their provision of care.

6. Recent challenges and themes identified in LFD case reviews

Changes to EPR – The committee members recognise that the decision-making and management support functionality of the EPR is not being utilised effectively to support clinical staff to deliver improved patient care. Changes are made by divisions or corporately and managed through the Clinical Design Committee.

Communication about DNACPR – The LFDC recognise that a number of cases highlight challenges around advanced care planning and DNACPR decision-making; much of this relates to communication in these difficult conversations. This is being addressed by the Advanced Care Planning Committee.

Complexity of cases – The LFDC see many cases where patients have co-existing surgical and medical problems, with challenges about where best they can be cared for. This has been recognised as a potential challenge for some nursing staff, as there is limited rotational experience between surgical and medical specialities; this training need and mitigations is being incorporated into the work on NEWS and escalation in the QA for the AASD.

Specialist services – In the 2021/22 Q4 report, the following specialist services were highlighted:

- Renal transplant services
- Non-vascular interventional radiology services

Links have been made between our radiology department and that at NCA to determine the feasibility of a shared on call rota. Improved access to renal transplant teams is being explored with the team at MFT.

7. Summary and Recommendations

The learning from deaths programme continues to evolve and strengthen, with key areas of progress in Q1 22/23 being:

- Additional SJR training dates took place May and June 2022, with planned improved peer support and feedback to reviewers
- Changes to SJR online platform to enable thematic analysis and enhanced reporting functionality and development of LFD and mortality dashboards for divisions to access
- Aim to improve feedback of learning to departments and divisions and improved understanding of case review mix

Recommendation

The Committee is asked to receive the content of the report for assurance purposes.

8. Appendix 1

Learning from Deaths Methodology – adult inpatient only

In summary the process involves using a validated 'Structured Judgement Review' tool to assess the quality of care from a sample of adult inpatient deaths, in addition to mandated categories of deaths, which are those with a learning disability, mental health issue or where a family concern has been raised. The trust can also designate particular alert diagnostic groups for investigation (e.g. nosocomial Covid-19 cases) and the Medical Examiners can refer for a review. The aim is to provide tangible evidence of learning from deaths.

Initial (primary) reviews are conducted by a trained reviewer; individual components of care are scored on a 5-point scale and an overall score is also determined. 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.

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

9. Appendix 2 - Learning from Deaths – data breakdown (adult inpatient)

NHS Bolton NHS Foundation Trust

	2021/2022												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Apr
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Number of In-patient Deaths	97	103	102	106	111	111	116	121	140	141	119	90	49
Number Cases (Sample)	26	28	28	21	23	21	22	27	48	51	16	15	n/a
COMPLETED	19	25	27	18	19	17	17	18	29	8	2	2	11
Outstanding Cases	**7**	**3**	**1**	**3**	**4**	**4**	**5**	**9**	**19**	**43**	**14**	**13**	**38**
Not Yet Received - Within Deadline	7	3	1	3	4	4	5	9	19	28	0	13	38
Outstanding -Supassed Deadline	0	0	0	0	0	0	0	0	0	0	7	0	0
Missing notes unable to find	0	0	0	0	0	0	0	0	0	0	0	0	0
Cases requiring reallocation	0	0	0	0	0	0	0	0	0	15	7	0	0
%	73.1	89.3	96.4	85.7	82.6	81.0	77.3	66.7	60.4	15.7	12.5	13.3	22.4
Source													
Mandated Death (Alert Diagnosis)	1	0	2	1	0	2	0	5	5	26	4	2	3
LD Death	1	1	1	1	1	1	0	1	0	0	2	0	0
Mental Health Death	10	10	12	5	12	13	14	16	9	18	1	3	27
sample	0	14	10	8	0	0	6	0	9	0	0	0	14
Requested by cons/matron	1	0	0	0	0	0	0	0	0	0	0	0	2
Diabetes Death	0	0	0	0	0	0	0	0	0	0	0	0	0
NELA Death	0	0	0	0	0	0	0	0	0	0	0	0	0
MEDICAL REVIEWER	2	3	3	6	10	5	2	5	6	7	7	0	3
BAME + COVID Death	0	0	0	0	0	0	0	0	0	0	0	0	0
	15	**28**	**28**	**21**	**23**	**21**	**22**	**27**	**29**	**51**	**14**	**15**	**49**
Overall Score													
1 (Very Poor)	0	0	0	1	0	1	0	0	0	0	0	0	0
2 (Poor)	4	3	4	3	2	2	1	2	5	1	1	0	1
3 (Adequate)	1	4	4	4	6	4	7	2	6	3	1	0	4
4 (Good)	13	17	15	8	11	9	8	11	13	3	0	1	6
5 Excellent	1	1	4	2	0	1	1	3	5	1	0	1	0
	19	25	27	18	19	17	17	18	29	8	2	2	

Agenda Item 19

Title:	Trust Mortality Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	✓
Exec Sponsor	Dr Francis Andrews		Decision	

Summary:	This quarterly report provides an update on recent mortality metrics and provides details of key actions and priorities for improving these metrics. **Key indices** • SHMI (NHS Digital published figures, not HED) show Bolton at 117.61 for February 2021 to January 2022. This is 'Higher than Expected' • HSMR ratio is 120.83 for the 12 months to February 2022. Bolton is the highest amongst mortality peers • In hospital crude mortality fell to 2.1% in May 2022 from 2.2% in April 2022, which is in line with the seasonal cyclical pattern seen in previous years (excluding during Covid in Spring 2020) **Key challenges and achievements** • Improving our denominator data (the "expected" deaths) – which will be achieved by improving comorbidity recording and overall depth of coding for patients – being addressed through EPR changes, best practice guidance for clinicians and implementation of *permanent codes* for patients • Maintaining Clinical Coding completeness – which has recovered after a challenging time in the latter part of 2021 and early 2021; time is now available for liaison between Coders and Clinicians

Previously considered by:	Quality Assurance Committee
Proposed Resolution:	N/A – report provided for information and assurance.

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

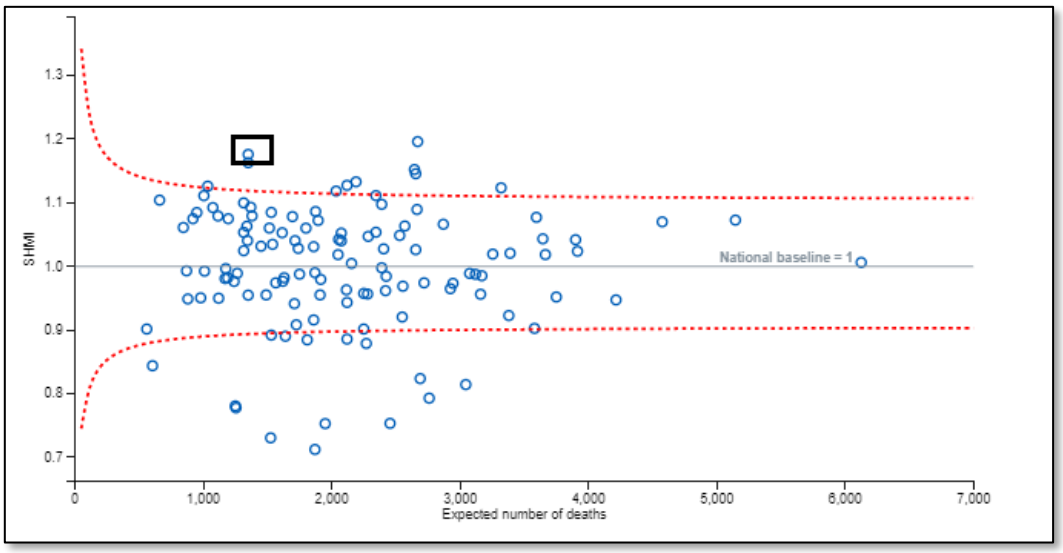
Prepared by:	Liza Scanlon (BI) and Sophie Kimber Craig (AMD)	**Presented by:**	Dr Francis Andrews

1. Current key mortality metrics for Bolton

A glossary and explanation of methodology for calculating these metrics are included as an appendix.

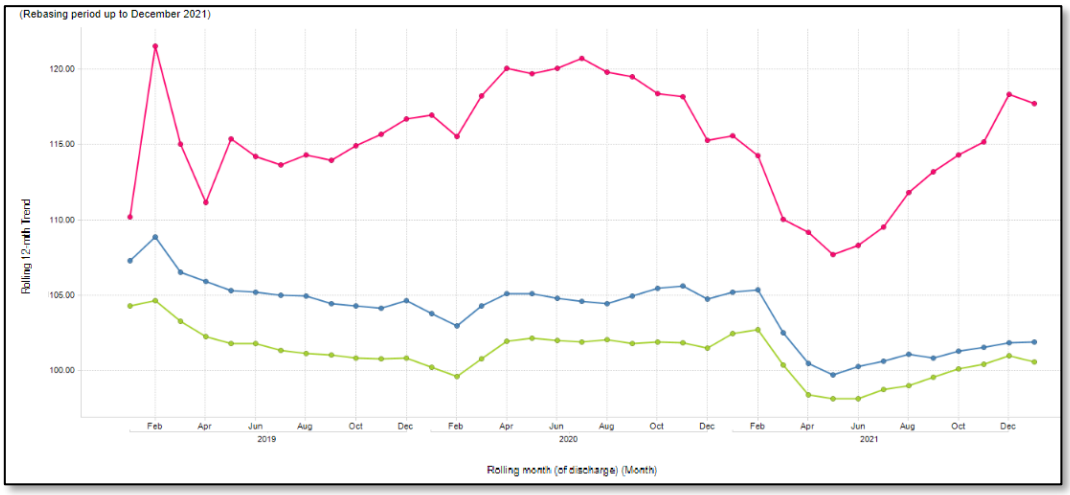
1.1 Summary Hospital-level Mortality indicator – SHMI

NHS Digital data for SHMI (February 2021 to January 2022) shows Bolton at 117.61, which remains in the 'Higher than Expected' range, and is an increase on previous data presented in the last report of 113.38.[1]



Time series to January 2022[2]

This chart shows the rolling average for Bolton (pink), the peer group (blue) and all acute trusts (green). This does show a slight downward trend in the most recent month's data.



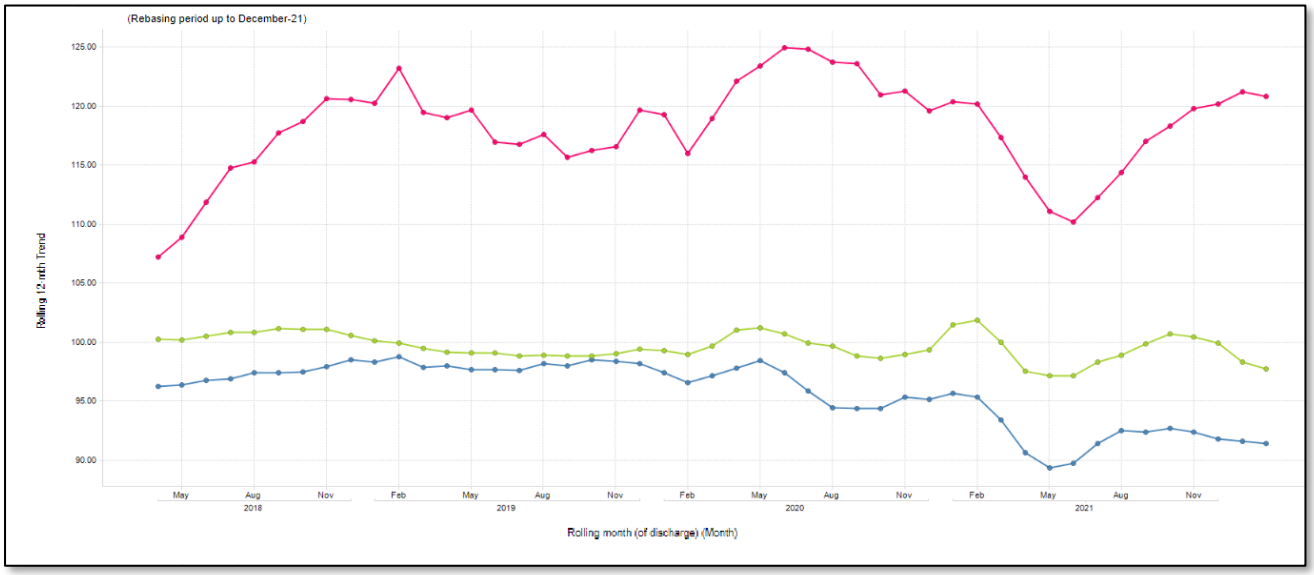
[1] Patients with Covid are excluded from the SHMI calculation (ie the spell is removed in its entirity regardless of whether the patient died or not).

[2] The rest of the report uses the SHMI figures as calculated using HES and ONS linked datasets via the HED system and is therefore more up to date than NHS Digital published figures to give an earlier indication of the indicator.

Note that the start of the chart is a *cumulative* position until 12 months when it becomes the *rolling average* for the previous 12 months.

1.2 Hospital Standardised Mortality Ratio (HSMR)

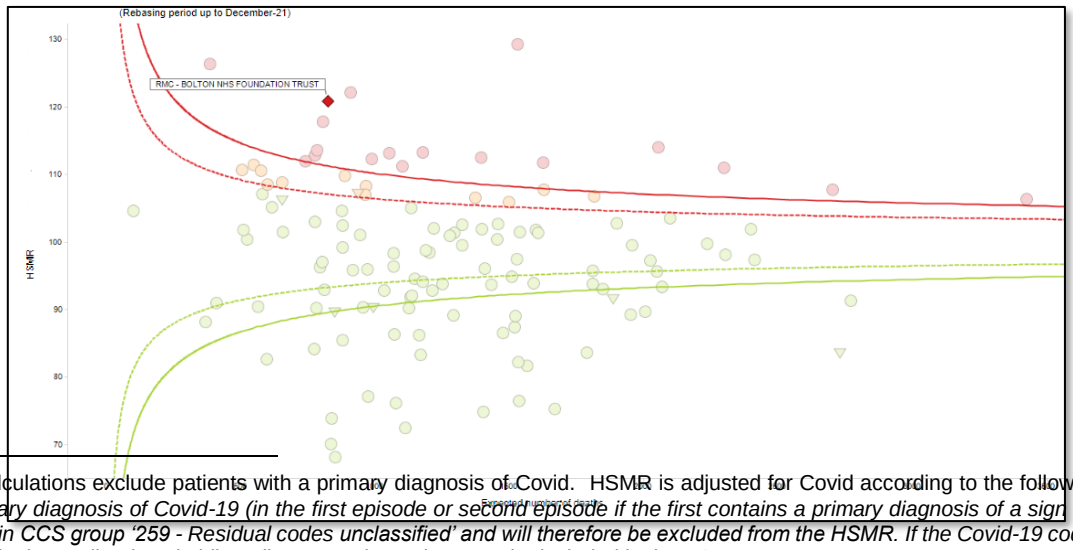
The HSMR ratio is 120.83 for the 12 months to February 2022 (shown as a 12 month rolling average in the graph); Bolton is the highest amongst mortality peers.[3]



As with SHMI, the start of the chart is a cumulative position until 12 months when it becomes the rolling average for the previous 12 months. Bolton (pink), the peer group (blue) and all acute trusts (green).

The trend in the HSMR has followed the national and peer group pattern which is reassuring, but our HSMR had been trending upwards in recent months, until a small reduction this month, and we do continue to compare poorly against our comparators and acute trusts. Bolton is the highest amongst its selected peer group and is the only Trust in this group outside the control limits.

Our selected mortality peer group are indicated on the chart below by a triangle, all other Trusts are indicated by a circle.

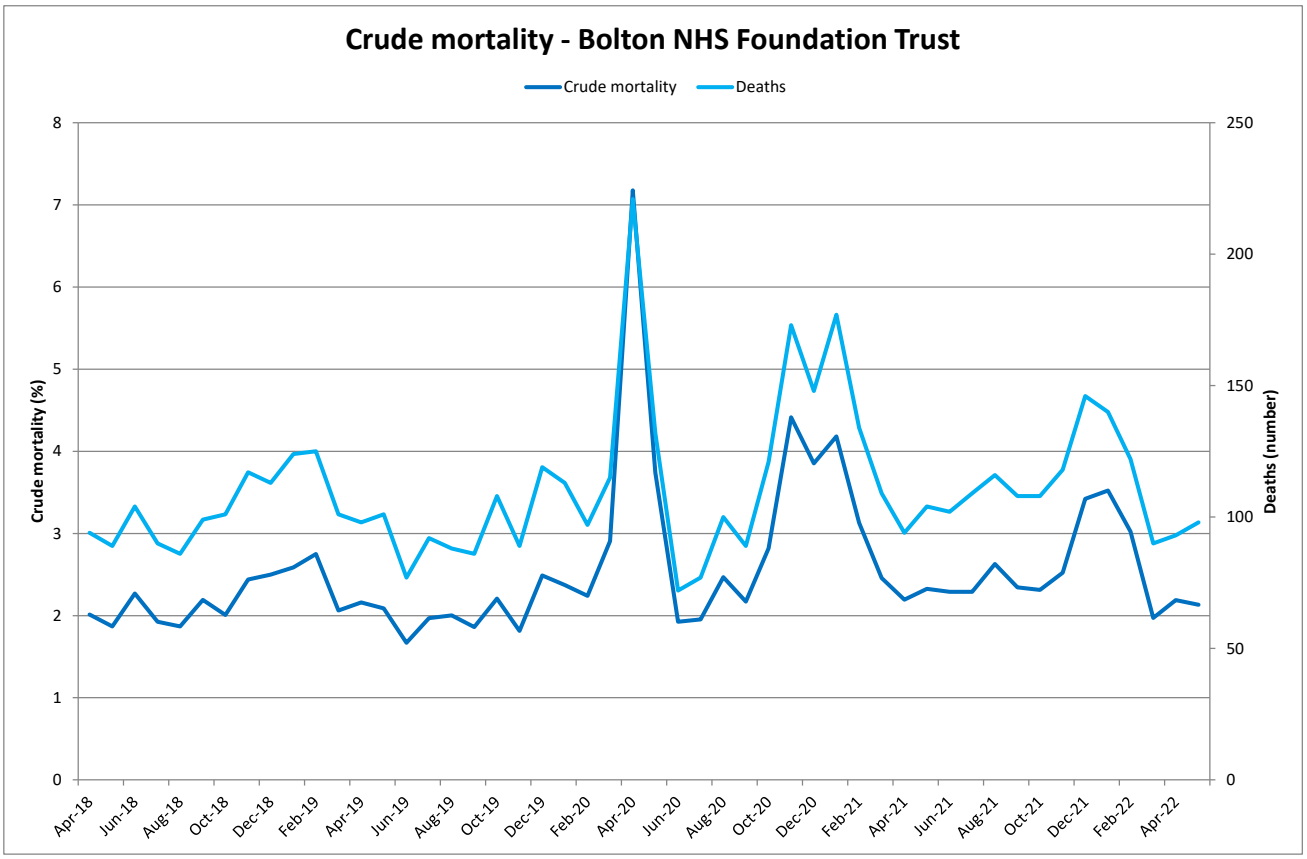


[3] HSMR calculations exclude patients with a primary diagnosis of Covid. HSMR is adjusted for Covid according to the following: *Patients with a primary diagnosis of Covid-19 (in the first episode or second episode if the first contains a primary diagnosis of a sign or symptom) are placed in CCS group '259 - Residual codes unclassified' and will therefore be excluded from the HSMR. If the Covid-19 coding appears elsewhere in the spell or in subsidiary diagnoses the patient may be included in the HSMR.*

1.3 Crude mortality – Day Cases excluded

In hospital crude mortality fell to 2.1% in May 2022 from 2.2% in April 2022, which is in line with the seasonal cyclical pattern seen over previous years (excluding the Covid wave in Spring 2020).

The crude rate is not adjusted for Covid mortality or spell activity. The rate peaks in April 2020 due to the first wave of the COVID pandemic with a subsequent second wave peak to November 2020 and rising again into January 2021. Nationally, crude mortality fell in Summer 2020 (following the impact of Covid on the death rates before then). We now need to be mindful of the mortality rate and the causes of death we see at times where Covid is not peaking, as it may be that we will see the impact of the pause on other work during the pandemic and its effects on patients' outcomes.



2. Dashboard views

2.1 Mortality Indicators

The HED dashboard is shown this includes the NHS Digital published information and a more up to date externally calculated SHMI using HES and ONS data.[4]

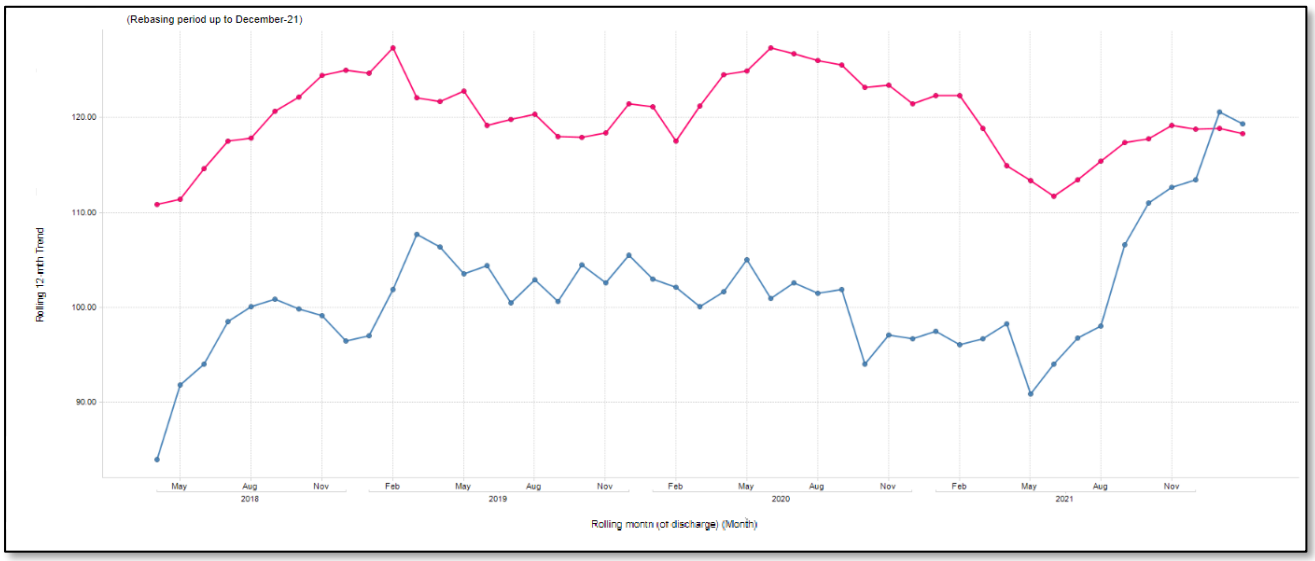
Indicator	Current	Previous	Change	Peer	National	Position
SHMI - NHS Digital (12 mth rolling) NHS Digital SHMI Dataset (Jun 2022)	117.61 (Feb 2021 - Jan 2022)	117.92 (Jan 2021 - Dec 2021)	-0.31	101.32	100.00	High (>95%)
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (May 2022)	117.26 (Mar 2021 - Feb 2022)	117.73 (Feb 2021 - Jan 2022)	-0.47	101.76	100.65	High (>95%)

2.2 Mortality Indicators by Division[5]

As with the other trend charts above, the rate is cumulative for 12 months and then is the rolling average. Acute Adult Division is in pink and ASSD in blue for both HSMR and SHMI. The Divisional split is based on the specialties of the first consultant episode and will include both elective and emergency patients.

HSMR (lagged model, December 2021)

The increasing rate for ASSD is thought to be due, in part, to the elective recovery programme as activity has increased. This is also being investigated by Business Intelligence and the Divisional Medical Director.

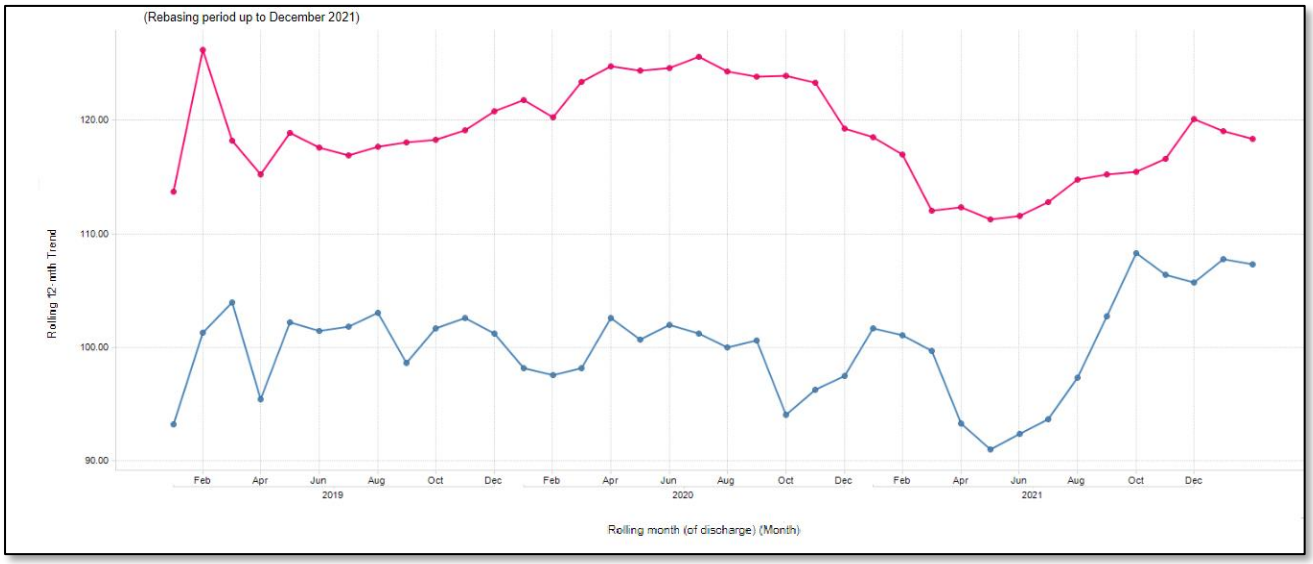


[4] Important note: HSMR has not been included in the dashboard as this is created using the 'Flex' position of SUS data. This is not viable to use for Bolton until the coding is completed at the 'Freeze' position as it bases the HSMR on incomplete records which skews the indicator.

[5] SHMI figures included here are those calculated using HES and ONS linked datasets via the HED system and is therefore more up to date than NHS Digital published figures.

SHMI

There was an upward trend in both ASSD and Acute Adult Care Division in both the SHMI and HSMR over the last few months, but there was a slight reduction in the last month; further time periods will need to be included to establish whether this downward shift is sustained. AACD has a higher SHMI than ASSD, which is typical due to the nature of the work.



3. Outlier CQC alerts

The trust composite is a pilot indicator created from 12 specific indicators within insight. The composite indicator score helps to assess a trusts overall performance but it is neither a rating nor a judgement. The composite should be used alongside other evidence in monitoring Trusts. This is taken from the *CQC Insight for Acute NHS Trust, June 2022* release. Please note the time lag in publications used.

KLOE	Indicator	National average	Performance			National comparison
			Previous	Latest	Change	
	Hospital Standardised Mortality Ratio (HSMR) Dr Foster - Dr Foster - HSMR (28 Mar 2022)	100.0	126.7 Oct 19 - Sep 20	119.5 Oct 20 - Sep 21	→	MW
	Hospital Standardised Mortality Ratio (Weekday) Dr Foster - Dr Foster - HSMR (28 Mar 2022)	100.0	127.5 Oct 19 - Sep 20	116.4 Oct 20 - Sep 21	→	MW
	Summary Hospital-level Mortality Indicator (SHMI) NHS Digital - SHMI (28 Mar 2022)	1.00	1.18 Oct 19 - Sep 20	1.13 Oct 20 - Sep 21	→	MW

4. Diagnostic groups

4.1 SHMI Red alerts by diagnosis group (12 months to February 2022)

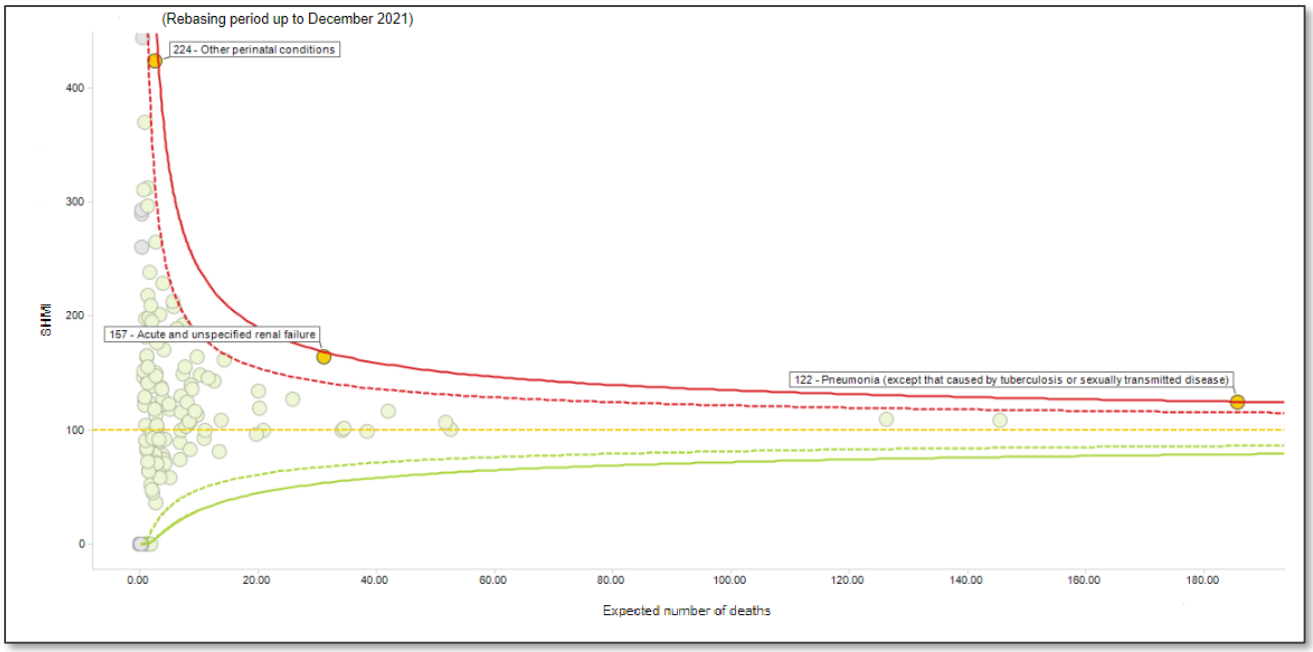
SHMI can be split by CCS diagnosis group. Outlying diagnostic groups falling outside of the 99.8% control limits for SHMI are indicated as 'Red' Alerts.

There are no red alerts for this period.

4.2 SHMI Amber alerts by diagnosis group (12 months to November 2021)

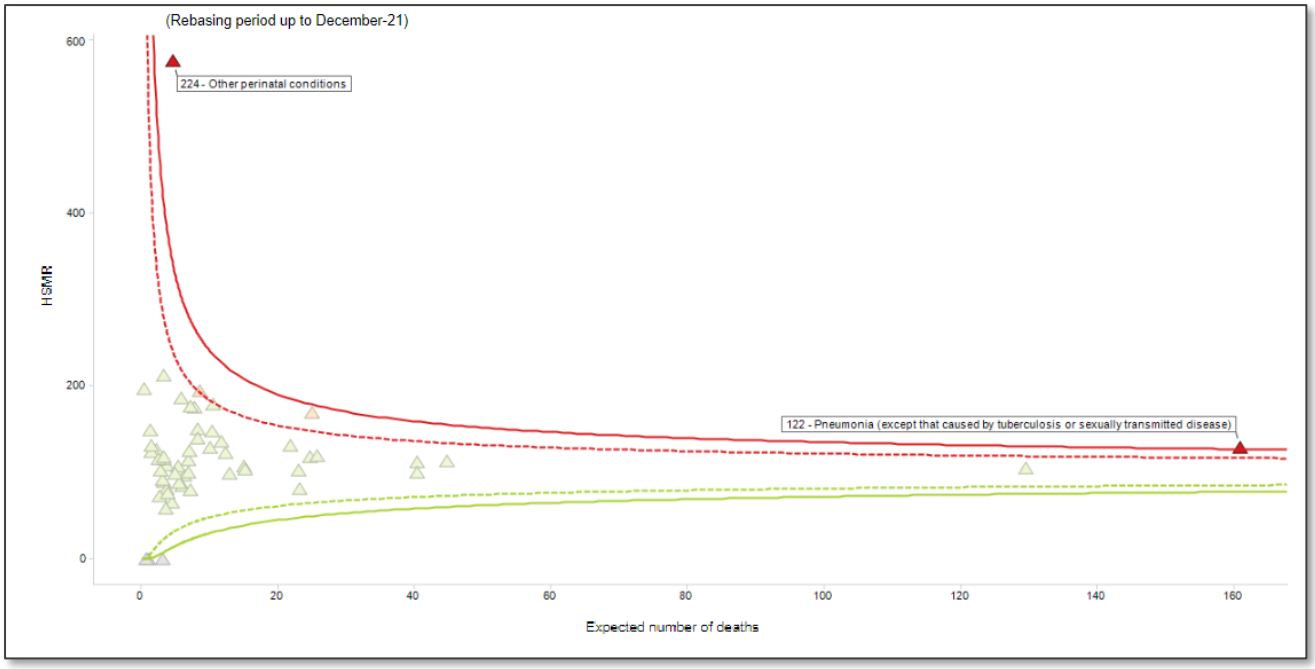
These are the CCS diagnostic groups alerting as Amber for this period; this equates to them being outside the 95% control limits (but within the 99.8% limits). *Pneumonia* was previously a red alert group, so this has improved. Pneumonia care is subject to scrutiny by AQuA and there is good assurance that true cases of pneumonia are being managed well with a SHMI that lies within range; work is ongoing to address those that are included in this diagnostic group who are ultimately shown not to have pneumonia.

Other perinatal conditions is known to be due to the incorrect data entry around some stillbirths in 2021, incorrectly identified in the discharge method, but additional assurance work on the cases involved is being done to ensure the quality of care has not been contributed to this alert.



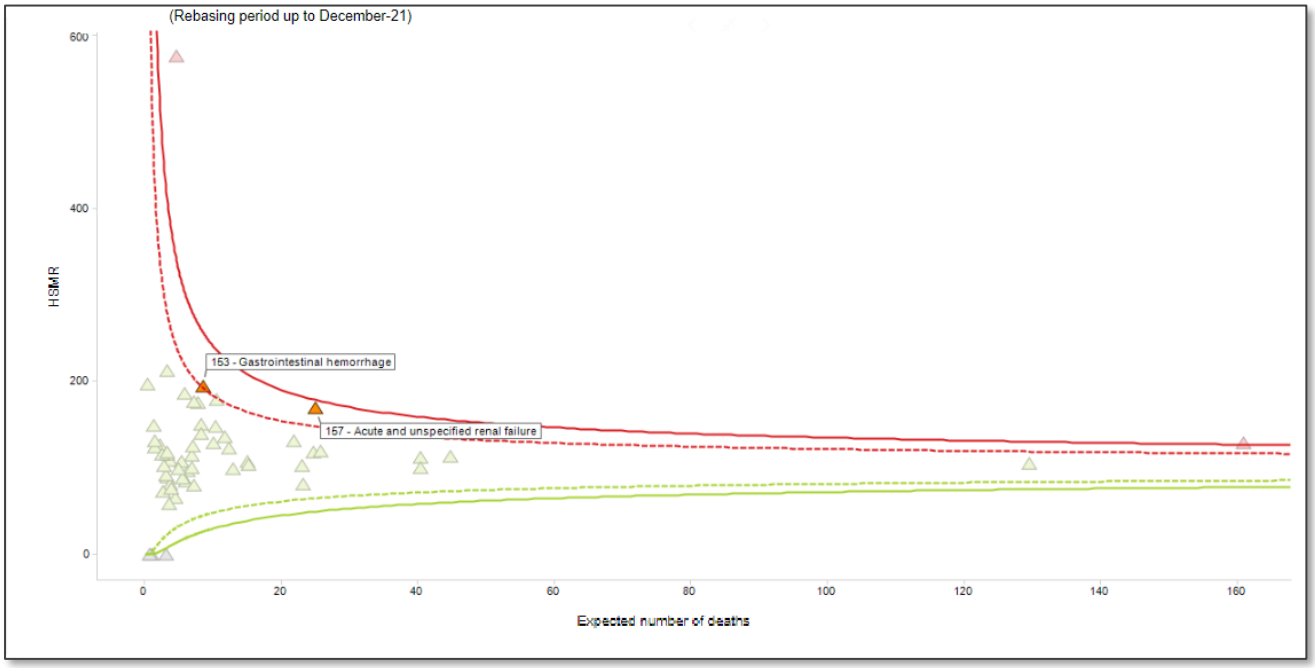
4.3 HSMR Red alerts by diagnosis group (12 months to November 2021)

For HSMR, similar diagnostic groups have triggered as outliers this quarter. The actions to address these are outlined above.



4.4 HSMR Amber alerts by diagnosis group (12 months to November 2021)

Acute renal failure is alerting as amber in the HSMR and this has been escalated to the AKI team for review. Gastrointestinal haemorrhage is just outside the expected range and will be monitored over the next quarter to determine whether it persists as an alert. If so, it will be referred for clinical review by the Gastroenterology team.

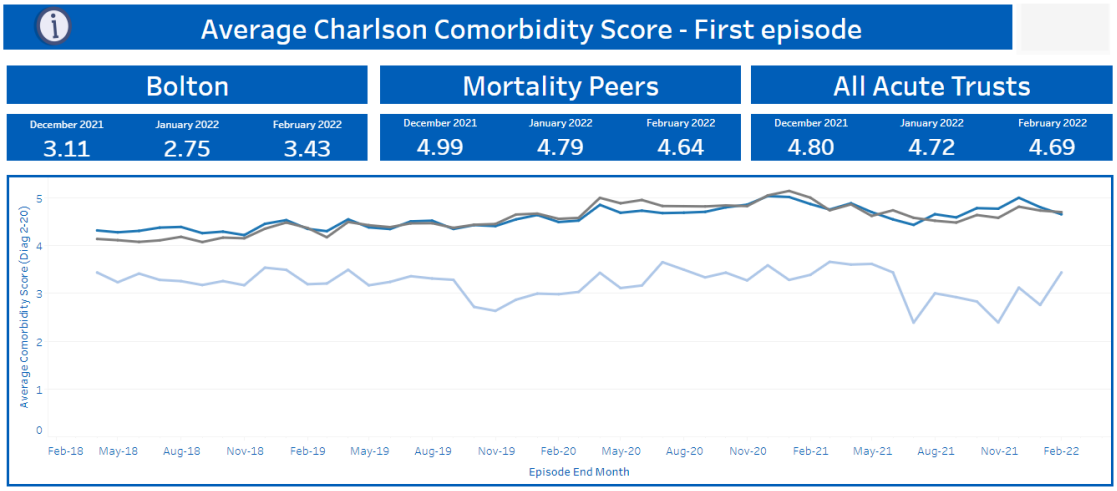


5. Key KPIs

The key KPIs for tracking progress in improving the mortality data are now included. The aim is for improved Charlson comorbidity scoring (in line at least with national average) and depth of recording. These are associated with a more accurate prediction of the number of expected deaths and, in Bolton Hospital NHS Foundation Trust's case, a reduced SHMI and HSMR. Coding completeness at 'freeze' date impacts upon the risk prediction for patients as without all the diagnoses being input the risk will not adjust accordingly.

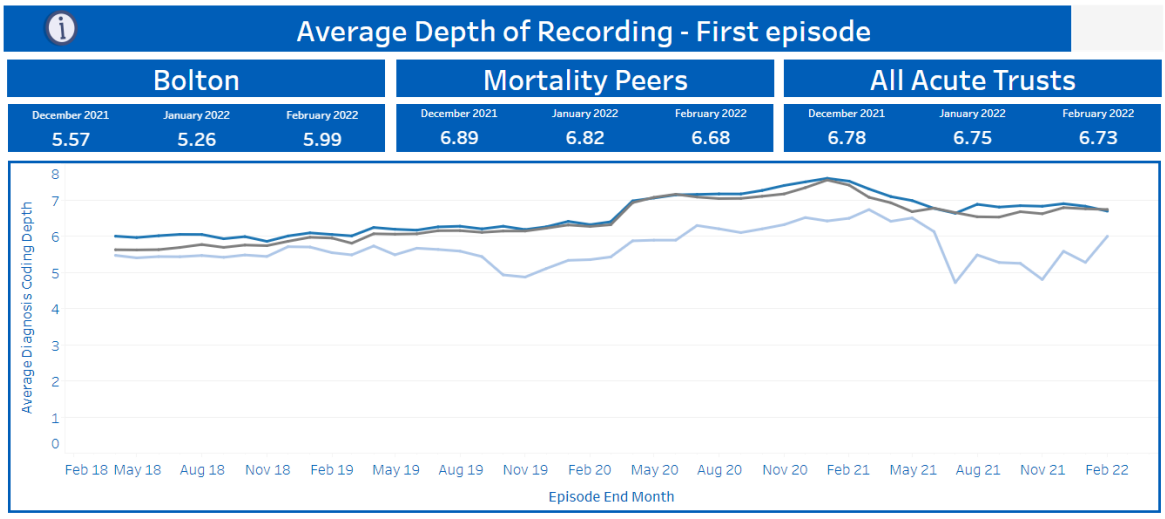
5.1 Average Charlson score

On average, Bolton patients have a recorded Charlson score of around 2-3 lower than peers and the national average. This suggests our patients are *more* healthy than those in the rest of the country, which does not equate with what we know about our patient population and the deprivation in the locale. This is slowly improving since a decline in July 2021, which was due to lower levels of coded activity at that time.



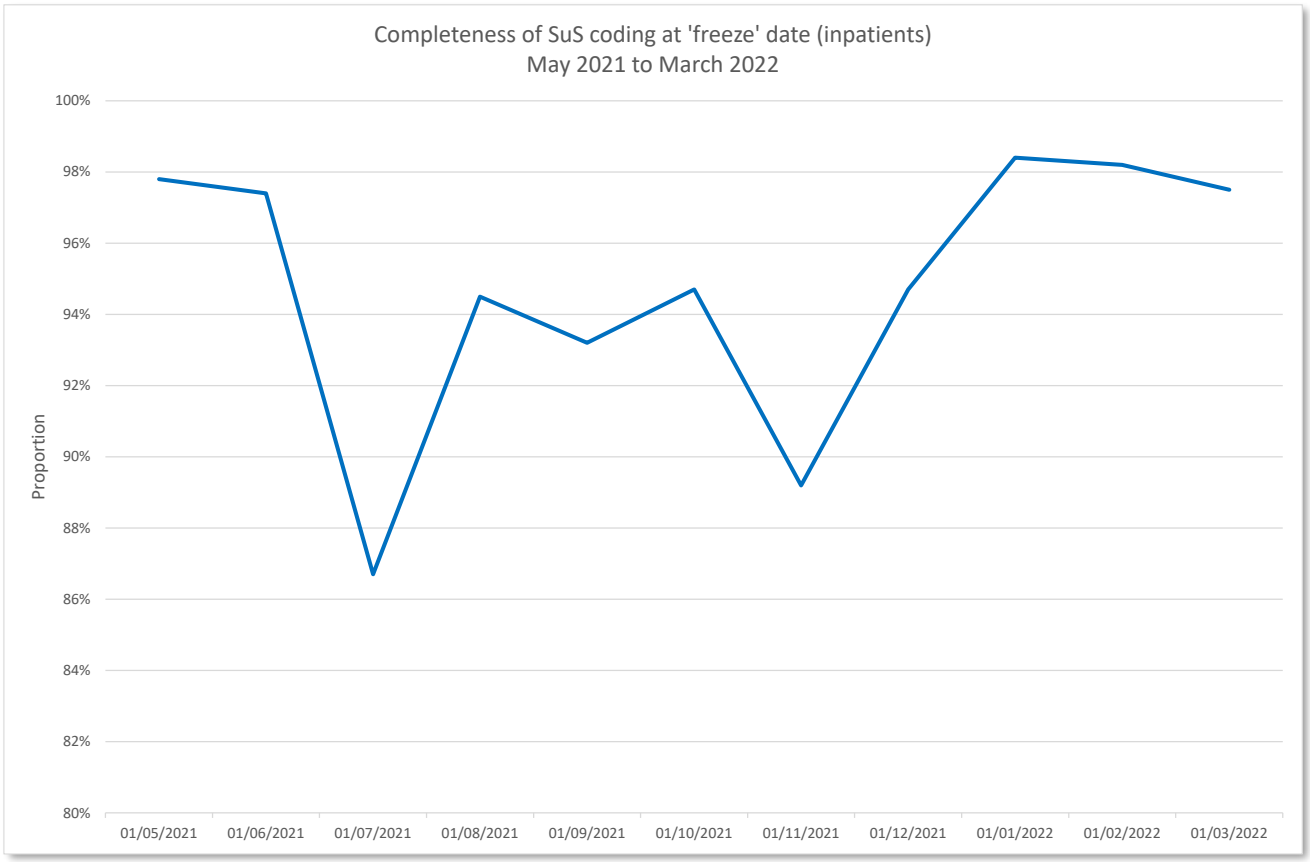
5.2 Average depth of recording

Depth of recording indicates the extent of the patients' health issues; this again currently suggests that compared to average, people in Bolton are healthier. This position appears to be slowly recovering since a drop during the period of reduced coded activity.



5.3 Completeness of coding at ‘Freeze’ date

The Trust target is 98% of inpatient records to be fully coded at SUS ‘Freeze’ date. Recent improvements have been made in the Clinical Coding team establishment which have resulted in improvement in completeness.



6. Narrative on the metrics

We sit as an outlier for both SHMI and HSMR, but our crude mortality is in range and in fact is less than national average. While crude mortality never tells the whole story, given that we know our patient population is in a high deprivation area, it could be expected that our crude mortality would be high. This is not the case and suggests that we are not observing unexpected deaths. This means that the high SHMI and HSMR are due to an under-prediction of the expected deaths. The action plan is designed to address this with improvement in the key KPIs.

Work across the organisation continues to be done on improving the quality of care and we have robust systems now in place to review clinical cases when they alert on our metrics, such as with acute kidney failure and pneumonia.

7. Ongoing work to improve the mortality indices

7.1 Comorbidity recording

We are not consistently recording all patients' comorbidities comprehensively and with enough specificity to indicate severity. We must ensure staff identify the key Charlson Comorbidities that are used to build the risk prediction for mortality metrics. To achieve this, we have already made improvements to the EPR to make it easier for clinicians to record comorbidities. Further work will be done to make this even better when the new EPR software update is completed. We need to make it easier for staff to be able to find information about patient comorbidities and to make it flow through our records more effectively. We are working with the GMCR team on a *Charlson Comorbidity Tile* in the patients' GP records.

A Best Practice Guide for clinicians has been developed to inform doctors on how to ensure data is recorded in the best way for it to be easily coded. A draft list of permanent codes has also been developed and, following clinical scrutiny, will be agreed with the Coding Team. This will mean that even when a permanent condition is not recorded on a current admission, if it has been identified in a previous admission, it will be included.

7.2 Clinical coding

After a reduction in coding completeness in recent months, our coding completeness is now recovering after extensive work in the Clinical Coding team to recover from this position. Challenges remain in the team, as it takes 2 years to train a Coder and we have a high proportion of these newly appointed staff now. It will take time for the improvement in completeness to be reflected in the SHMI and HSMR, as these are presented as rolling averages.

The improved staffing levels has afforded our Clinical Information Assurance Leads time to spend liaising with clinicians, working collaboratively to improve our recording and data quality. This work continues, with the CIALs having planned meetings across the trust with various teams.

7.3 Assurance on our quality of care

The mechanisms for reviewing and ensuring high quality of care are reported in many ways across the organisation and are scrutinised in various forums, which include:

- Via IPM and Clinical Governance and Quality Assurance Group
- Delivery of divisional and trustwide Quality Accounts
- Reporting to GIRFT and AQuA and internal audit
- Serious Incident reports and recommendations
- Structured Judgement Reviews via the Learning from Deaths Committee
- Reports to Mortality Reduction Group

Given the crude mortality, in combination with the IPM reports, we can be assured that our care is safe, with opportunities always available for improvement.

This report highlights diagnostic groups that are and have alerted, but when reviewing the clinical care, we are assured that we are actually performing very well in comparison to our peers. Pneumonia cases reviewed by AQuA continue to sit with the expected range for mortality metrics, as do the cardiac failure cases. We also know that the our SHMI for the top ten conditions are all 'as expected' which is an important assurer of care.[6]

While we have this good assurance on our care, we will continue to undertake clinical reviews of these outlying cases to ensure that our care is not below expected standards. Our ability to do that does depend on clinician availability, which is variable. Clinical case reviews are currently being undertaken with cases of *electrolyte disturbance* and *acute kidney injury*. Plans to work with AQuA on reviewing emergency admissions with sepsis is underway.

There is also ongoing work to make improvements in:

- Recognition and treatment of sepsis
- Recognition and response to deterioration in patients (including appropriate escalation to senior colleagues and/or critical care)
- Advanced care planning and discussions around the provision of end of life care

It is expected that these projects will further enhance our care and may influence the observed numbers of deaths, which will improve our mortality metrics.

7.4 Education and training

The following are being done to improve education and training:

- Increased clinical liaison with Coding teams and BI to better understand the issues
- Development of the Best Practice Guide on recording clinical data for clinicians
- A second Know your Patient learning week in September
- Planned Grand Round session
- Addition of Data Quality information slides to Corporate and Medical Induction slide deck

[6] See Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2020 - October 2021 - NHS Digital

8. Actions summary

Specific actions to address the issues in the Clinical Coding team are presented to Board by Julie Ryan and will not be repeated here.

8.1. Improve comorbidity recording

Issue: On average, Bolton Hospital NHS Foundation Trust's patients have 3 less comorbidities recorded per patient compared to other acute trusts, suggesting a high level of general health in our patients which is not consistent with what we know about the impact deprivation has on our community

Aim: To accurately represent the complexity and severity of patients, both those that die and that survive to discharge (and for 30 days afterwards) to ensure accurate numerator and denominator data for calculation of SHMI and HSMR;

To improve clinical understanding of the coding processes to ensure interventions will have the desired effect on mortality indices

	Action	Recent progress	Status / due date
1	Meet with team from North Tees (previously worst in country for SHMI) to discuss improvement steps (Sophie Kimber Craig and Liza Scanlon)		
2	Clinical, Coding and Business Intelligence staff to collaborate to identify practice that influences this difference (Sara Booth, Julie Ryan and Liza Scanlon)	Meetings between clinicians, BI and Clinical Information Assurance Leads (CIALs) recommenced. SKC meeting with DMDs regarding best practice for clinical teams.	
3	Amend EPR to mandate input of high risk conditions (Charlson Comorbidities) on admission (Sophie Kimber Craig, Simon Irving, Sara Booth)	Mandatory field implemented.	
4	Amend EPR to automatically transfer high risk conditions (Charlson Comorbidities) into Health Issues section of record (to ensure transfer between records) – Request for work submitted and IT team understand need – Delay due to upgrade of EPR software (due for completion July 2022) (Sophie Kimber Craig, Simon Irving, Sara Booth)	Update to mandatory field section will be completed once EPR software upgrade completed.	30/09/22

5	Work with Coding team to improve local Standard Operating Procedures to ensure data not missed when coding records, including implementation of permanent codes (Sophie Kimber Craig, Liza Scanlon, Kim Fearnley, Jonathan Benn, Janet Wilkinson)	Permanent code list developed – clinical validation in progress; implement once agreed with Coding and clinicians.	31/07/22
6	In collaboration with GMCR team, improve visibility of the key Charlson Comorbidities with the GMCR to improve communication between community and acute care teams, with concomitant improvement in SHMI and HSMR (Sophie Kimber Craig, Simon Irving, Sara Booth, Barbara Hart)	BI team collaborating with GMCR team to align different clinical coding systems.	31/12/22
7	Improved access to IT equipment on wards for clinical staff to ensure timely and easier input of data – Kit purchased and being distributed to wards in June (Corporate and IT teams)	IT equipment procured and being distributed across organisation.	
8	Improve input of comorbidities for elective care patients by training non-medical teams to enter key Health Issues – Breast nurses collaborating with team to learn how to upload data gleaned during preoperative assessment (Sophie Kimber Craig, Annette Trengove)	Breast pre-operative nurses now inputting into Health Issues. Impact will be audited.	
9	Work with clinicians to improve recording of information and recognition of severity and complexity at the earliest opportunity in their admission – Survey of current practice amongst consultants – Documentation at the Post-take Ward Round to be done by consultant – Work with consultant colleagues to highlight need for specificity about severity (e.g. document “pneumonia requiring oxygen therapy”, not just pneumonia) (Sophie Kimber Craig, Simon Irving + divisional teams)	Need for specificity included in Best Practice Guide, with examples.	31/07/22

8.2. Improve training and education

Issue: Clinical staff continue to record information in free text form in the EPR and not use the Health Issues section

Aim: Improve understanding amongst staff of importance and methods for recording morbidities accurately and in an extractable way

Responsibility: Sophie Kimber Craig

	Action	Recent progress	Status / due date
1	Reminder sent to all Junior Doctors on need for uploading information to Health Issues		
2	Educational sessions for staff of all grades in departments across Trust to explain mortality indices and need for accurate data		
3	Add slides to the corporate and medical induction packages about data quality and (where appropriate) the clinical need for this information to be held in our EPR		
4	Additional ESR training packages in development, including video to explain clinical need for this data		30/04/22
5	Undertake a second Know Your Patient learning week	KYP planning team meeting to develop timetable, learning materials, etc.	15/09/22
6	Uploading of comorbidities to Health Issues after admission by Know Your Patient team – Remote access has been provided to staff to improve the productivity of this team	No longer in progress; JD team unable to do this with other work commitments as they are currently.	

Issue: Serious Incident reports and SJRs highlight that we do not always recognise or respond appropriately to patients with sepsis and/or who are deteriorating; this may impact on the observed number of deaths seen in the Trust

Aim: Improve recognition of and response to sepsis and those that are deteriorating, to ensure early clinical intervention and reduced mortality

Note that the responsibility for completion of many of these actions, while monitored via the mortality working party and MRG and presented here for completeness, lie with other groups, such as the Sepsis Forum or the Deteriorating Patient Group.

	Action	Recent progress	Status / due date
1	Introduce the RR-SAFER programme across the organisation – Improve the early response to deterioration of patients on the wards by nursing staff – Implementation of a clear way of documenting and communicating concern about deterioration (Anne Gerrard)	In progress – tracked at Sepsis Forum and Deteriorating Patient Group.	Tracked on alternative action plans
2	Improve the educational offer for the JDs and SAS doctors in the Trust – Undertake a review of current provision (which includes the current Foundation Simulation Programme) – Review available options (such as AIMS course) – Implement a mandatory training programme (Sophie Kimber Craig, Simon Irving, Carl Oakden)	Link with AASD QA work on NEWS – developing offer of AIMS for JDs and SAS doctors.	Tracked on alternative action plans
3	Explore submission of our sepsis data by AQuA for review – Done previously but funding withdrawn (Sophie Kimber Craig, Debbie Redfern, Michelle Parry)	Plan to commence ED Sepsis review by AQuA when staff back from leave.	
4	Implement the use of the Sepsis Screening Tool via the EPR (Divisional teams)	In progress – tracked at Sepsis Forum.	Tracked on alternative action plans

9. Appendix – Glossary

CCS and SHMI groupings available from (see SHMI specification):

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data

See below for mortality rates explanation and comparison table.

'As Expected' mortality: This is usually expressed as a funnel chart, using confidence intervals. Using the 'official' SHMI definitions, 'as expected' mortality is explained within the 95% confidence intervals. Outside of the 'as expected' grouping means an organisation is either an outlier in terms of mortality performance.

Common Cause Variation: is fluctuation caused by unknown factors resulting in a steady but random distribution of output around the average of the data. It is a measure of the process potential, or how well the process can perform when **special cause variation** removed. A common characteristic is to be stable and "in control". We can make predictions about the future behaviour of the process within limits. When a system is stable, displaying only common cause variation, only a change in the system will have an impact.

Control Limits: indicate the range of plausible variation within a process. They provide an additional tool for detecting special cause variation. A stable process will operate within the range set by the upper and lower control limits which are determined mathematically (three standard deviations above and below the mean).

Crude Mortality Rate: The crude mortality rate is based on actual numbers. It is calculated by the number of deaths divided by the number of discharges (not including day cases, still births and well born babies). A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in a specific time period and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. It tells you how a Trust's mortality rate changes over time; however, it cannot be used to compare or contrast between hospitals. This differs from SHMI, which features adjustment based on population demographics and related mortality expectations.

CUSUM: CUSUM statistical process control techniques are commonly applied to mortality monitoring to detect changes in mortality rates over time. The CUSUM value increases when patients die and decreases when they survive. They are calibrated with a 'trigger' value, and if a CUSUM exceeds its trigger, it should be investigated. A CUSUM chart is 'reset' after each trigger and continues monitoring. A trigger value of 5.48 is used for all of the 56 disease groups within the aggregated CUSUM and has been confirmed by CQC. The chart will rest to zero after a trigger. When the CUSUM drops it is showing less deaths than the previous month compared to expected.

HED: Healthcare Evaluation Data is an online benchmarking tool, designed to deliver intelligence to enable healthcare organisations to drive clinical performance improvement and financial savings. It allows the organisation to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets.

Hospital Standardised Mortality Rate (HSMR): The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for all diagnostic (CCS) groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. The HSMR is a method of comparing mortality levels in different years, or between different hospitals. Thus, if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking

HSMR methodology: Collated via Healthcare Evaluation Data (HED), HSMR information is calculated using the 'lagged' model. This ensures a more stable rate despite the model being calculated on the 10 years to three months behind the most recent in HED. This removes any skewing caused by inconsistencies or incomplete data at SUS 'Flex' deadline.

Rolling average: The most recent months' performance with the previous 11 months included thus providing an annual average. This is an effective way of presenting monthly performance data in a way that reduces some of the expected variation in the system i.e. seasonal factors providing a much smoother view of performance allowing trends to be more easily discerned.

National Peer Group: All other UK NHS acute Trusts (i.e. not including specialist, community or mental health trusts), enabling the Trust to benchmark itself against all other UK hospitals.

Peer group: The comparison peer group identifying the most similar (overall) Trusts to Bolton. The activity with other trusts has been compared and those identifying as most similar using the distribution of activity by HRGs are as below:

- Airedale NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Pennine Acute Hospitals NHS Trust
- Rotherham NHS Foundation Trust
- Stockport NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Wye Valley NHS Trust

Summary Hospital-Level Mortality Indicator (SHMI): The nationally developed mortality ratio designed to be used to allow comparison between NHS organisations. This indicator also includes mortality within 30 days of discharge, so represents in hospital and out of hospital (within 30 days) mortality. The SHMI is the NHS 'Official' marker of mortality and is Glossary Directorate of Performance Assurance, published on a quarterly basis. Because of its inclusion of mortality data within 30 days of hospital discharge, when published, the most recent information available is quite historic, sometimes up to 6 months behind present day.

Sigma: A sigma value is a description of how far a sample or point of data is away from its mean, expressed in standard deviations. A data point with a higher sigma value will have a higher standard deviation, meaning it is further away from the mean.

Special Cause Variation: the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather recently experienced) can result in special cause variation. Systems which display special cause variation are said to be unstable and unpredictable. When systems display special cause variation, the process needs sorting out to stabilise it. There are usually two types of special cause variation, trends and outliers. If a trend, the process has changed in some way and we need to understand and adopt if the change is beneficial or act if the change is deterioration. The outlier is a one-off condition which should not result in a process change. These must be understood and dealt with on their own (i.e. response to a major incident).

Standard Deviation: Standard deviation is a widely used measurement of variability or diversity used in statistics and probability theory. It shows how much variation or "dispersion" there is from the "average" (mean, or expected value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data are spread out over a large range of values.

Understanding Mortality Rates – CRUDE, HSMR and SHMI

	Crude	SHMI	HSMR
Numerator	Actual number of deaths	Total number of observed deaths in hospital and within 30 days of discharge from the hospital	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England
Denominator	Number of discharges	Expected number of deaths	Expected number of deaths
Adjustments		• Sex • Age group • Admission method • Co-morbidities based on Charlson score • Year index • Diagnosis group No adjustment is made for palliative care. Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summar y-hospital-level-mortality-indictorshmi	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge
Exclusions	Excludes day cases, still births and well born babies.	Excludes specialist, community, mental health and independent sector hospitals; Stillbirths, Day cases, regular day and night attenders. Palliative care patients not excluded.	Excludes day cases and regular attendees. Palliative care patients not excluded
Whose data is included		All England non-specialist acute trusts except mental health, community and independent sector hospitals via SUS/HES and linked to ONS data for out of hospital deaths. Deaths that occur within 30 days are allocated to the last hospital the patient was discharged from.	England provider trusts via SUS/HES

Agenda Item 19

Title:	People Committee Chair Report June/July 2022

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	James Mawrey, Director of People/Deputy CEO		Decision	

Summary:	This report provides an update on the People Committee.

Previously considered by:	N/A

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

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

Prepared by:	Chair People Committee	**Presented by:**	Chair of People Committee

Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	23rd June 2022	Date of next meeting:	21st July 2022
Chair:	Bilkis Ismail	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Fiona Noden, Sharon Martin, Tyrone Roberts, Francis Andrews, Martin North, Carol Sheard, Paul Henshaw, Jake Mairs, Andy Chilton, Sharon Katema, Lianne Robinson, Alan Stuttard, Rae Wheatcroft and Sam Ball.	Quorate (Yes/No):	Yes
		Key Members not present:	Rachel Carter

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & Communities Transformation Update		The Associate Director of Improvement and Transformation, Sam Ball, provided an update on the progress being made in developing the System Transformation Programme. An update on the Workforce workstream was provided as follows (non-exhaustive):- Mapping of current workforce across health and adult social care (to understand what we have, capacity, maximise skill mix and avoid duplication); Further development of generic roles and community worker roles; Understanding and maximising potential within voluntary services; Support the shift of cultural change to assets based conversations including of Every Contact Counts; Expansion of "Asset based conversation" concept; Expansion of "shared decision making" concept and Roll out of the Bolton Pledge.	• The Committee welcomed the progress being made, requested that the design of the programme have input from the Community and requested quarterly updates.
Resourcing/Agency	Agency	The Committee commended PH on a very detailed and helpful paper. Updates were provided on the plethora of positive resourcing actions that are taking place throughout the organisation. It was noted that Bolton remains in a positive position in filling recruitment pressures. As such particular focus was given in the meeting on the deep dive for Retention and Agency - as these remain two areas of concern.	• Report was noted. • It was agreed that the Resourcing paper should be a standing item on the Finance Committee given the very close alignment of some of the key issues. • Update in the next meeting on Exit Interview return rates.

	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

		Matters for noting:- a. Nursing and HCA Agency spend had increased and generated a large amount of debate. Lianne Robinson outlined the grip and control measures put in place for nursing and HCA agency spend including focus on ensuring that Allied Health Professionals, Trainee Nurse Associates and the Enhanced Care Team are utilised effectively. Lianne was confident this spend would decrease based on the actions being taken. b. Medical Agency reduced in month and the paper outlined the potential fill dates when this agency spend will cease (based on recruitment/absence). c. A Deep dive was provided on all of the Wards on the heat-map that showed as an outliner. These details (and actions being taken) have been shared with BoD members. d. Concerted effort had resulted in a reduction of HCA vacancies from 140 to 71 but further work needed to be done to reduce this further. e. Concerns remain about the Exit Interview return rate. It was noted that a Task and Finish Group had been established to address the issue. The Committee requested continuing updates and trajectories for improvement. f. Updates were provided on hard to fill roles – non exhaustive - Maternity, Nursing, Theatres and senior medical roles.	
Nursing, Midwifery & AHP Staffing Report		The Chief Nurse presented the very detailed biannual Nursing, Midwifery and Allied Health Professional (AHP) staffing report. The paper gave assurance to the Committee that the Divisional teams are fully aware of key issues in relation to staffing. The	• The report was noted. • Whilst the Committee felt assured that our staffing levels were safe, it was noted that this was a result of the mitigating actions being taken by the Wards. • The next biannual report to include outliers in the executive summary.

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	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

		Divisional reviews demonstrate that each area have their own specific challenges and that leaders within the Divisions are fully cited on these and are addressing recruitment, retention and sickness management as appropriate. The Chief Nurse noted that whilst staffing remained a key challenge within the organisation, he confirmed that our current establishment were safe. Where staffing levels were lower than budgeted establishments, that there were clear reliable systems and processes to mitigate risk (Bank/Overtime/Agency/Staff movements). Going forward, the focus will be on pipeline and an increase in capacity for student nurses. The Chair requested the Chief Nurse provide further detail outside of the meeting on a specific Ward, with focus on fill rates, vacancies, safe staffing levels and breaches to provide further assurance.	
Maternity Engagement Update		The Chief Nurse and Director of People provided an update on the ongoing People & Culture actions that were being taken within the Midwifery Department. Sam Carney, Deputy DDO, was commended on his leadership and the actions being taken. Jake Mairs, Associate Director of OD, assured the Committee that his team were already engaged with the Division and discussing what additional support could be provided. The Committee were informed that the previously outlined detailed action plan, which has been shared with the BoD, was being progressed in a timely manner.	• The update was noted.
EDI Quarterly Update		The Committee welcomed a very helpful paper on the actions that had been taken in this last quarter, along with the actions that will be taken in the forthcoming quarter.	• The update was noted. • Update to be provided at the July meeting on AIS compliance.

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	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

		A non-exhaustive overview of the quarter is as follows:- EDI Plan 2022-2026 has now been published on our internal and external websites; Transgender Patient Policy produced; inclusive recruitment action plan been enhanced; 50 Ramadan Packs were distributed to patients across all of the hospital sites. To celebrate Equality, Human Rights and Diversity Week in April, the Team hosted an online Community Voices Event. The event was focused on race and culture and held to discuss our EDI Plan ambitions, to engage with our diverse community groups and to identify their needs and how we can support them. It was confirmed that the WRES and WDES report would be coming to the September BoD. The Committee were advised that progress had been slow on the Accessible Information Standard ("AIS") but this work was being prioritised by the EDI Steering Group.	
Guardian of Safe Working Annual Report		The Committee welcomed the new GOSW, Dr Ian Webster, to the meeting and thanked him for his very helpful update. The number of exception reports submitted has remained consistent with 260 being submitted this year compared to 259 in the previous year. The primary reason for exception reporting related to junior doctors working above their contracted hours due to high workload and/or low staffing levels and this pattern has been consistent over the years. Exception reports submitted by junior doctors highlighting missed educational sessions as a result of service pressures were escalated to the Director of Medical Education as per protocol. No work schedule reviews have taken place during the reporting period. No fines have been levied by the GOSW during the reporting period.	• The report was noted.

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	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

Freedom to Speak Up Annual Report		The Committee commended the Annual FTSU report and thanked Tracey Garde for the fantastic progress made under her stewardship. As this item will be on the BoD papers, to avoid duplication, no further information is provided in this Chair update.	• Commended the report for BoD approval.
Assurance reporting Groups		• Staff Experience Group • EDI Steering Group • Resource & Talent Planning Steering Group • Health & Academic Partnership • All Divisional People Committees	

New risks to be escalated: none.

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

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

Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21st July 2022	Date of next meeting:	18th August 2022
Chair:	Bilkis Ismail	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Fiona Noden, Rachel Noble, Angie Hansen, Francis Andrews, Martin North, Carol Sheard, Paul Henshaw, Jake Mairs, Andy Chilton, Sharon Katema, Lianne Robinson, Alan Stuttard, Tracey Garde, Rachel Adamson, Rachel Carter, Jo Street	Quorate (Yes/No):	Yes
		Key Members not present:	Sharon Martin, Tyrone Roberts, Alan Stuttard, Rae Wheatcroft

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing/Agency	Agency	Agency – The Committee were informed that NHSEI Agency control levels are expected to be reintroduced. The Corporate Director of Nursing highlighted the actions and close monitoring on agency spend and was pleased to report a decrease of nursing agency spend of £196k in-month when compared to the previous month. Both AACD and ASSD showed significant reductions, partially due to the closure of C4, but this was offset by increased agency spend in the Families Division. It was noted that a deeper review is required on 'other Agency Spend' and it was requested that these details be included in the next paper. Retention – Following last month's deep dive on retention rates, the Committee endorsed the Trust's new retention framework and priorities. Whilst it was positive that Bolton has some of the lowest turnover rates in the North West, the Committee noted that this must remain an area of deep focus. Recruitment – The Head of Resourcing discussed the actions we are taking locally, regionally and internationally. It was noted that the Acute Division reported the lowest level of vacancy rate since pre-Covid periods. Concern was raised regarding staffing levels within Family Division. The Committee noted the strong work being taken in a very difficult jobs market.	• The report was noted. It was agreed that the temporary staffing management meetings to reintroduce grip and control on nursing agency would become permanent. Further information on the take up of the Wagestream system for bank staff to be included in the August PC report • Deep dive on the following to be actioned: (i) agency spend in all 'other staffing groups' to be focused on in the next meeting; (ii) retention, especially for the hotspot areas as detailed on the BoD heat map, to be produced quarterly; (iii) financial trajectory for medical agency spend in light of appointment of 6 consultants with measurable monthly KPIs; and (iv) further detailed analysis of hard to fill posts and the associated costs to the Trust.

	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

Freedom to Speak Up Q1 Update		Rachel Sanderson has been appointed as FTSU Guardian. She will work alongside Tracey our existing FTSU Guardian. During the period from 1st April 2022 to 30th June 20022 (Q1) a total of 35 cases were reported through the FTSU route. This is an increase of 10 from the previous quarter. All cases are broken down by staffing group, gender, division, and ethnicity. Concerns relating to behaviour remain the biggest cause for concern. The issue of behaviour was not isolated to one division but seen across all divisions. The Guardians were asked for their feedback on the recommendations of the FTSU National Guardian Survey 2021 and what additional actions the Trust needed to take including on detriment to speak up. The FTSU Guardian continue to meet the CEO, DoP, Chair of the People Committee/FTSU Board Champion and Chair of the QAC on a monthly basis in order to provide all possible support and advice.	• The report was noted.
Apprenticeship Programme Strategy		The Committee commented that further work was needed on the Trust's new Apprenticeship Strategy, revised approach and priorities, in particular on trajectories, actions and timescales being taken.	• The report was noted. • Further report in September to the People Committee.
Mandatory & Statutory (M&S) Training Update		The Committee noted that the level for mandatory training was 87.7% (2.7% above our corporate target of 85%) and statutory training was 88.2% (6.8% below our corporate target of 95%), an improvement on the last three months. The Committee noted the additional resources that have been put in place to support improvements and it was requested that further work be undertaken on trajectories for improvement / delivery. The Committee asked for assurance that appropriate M&S training was in place throughout the organisation and was tailored for the different staffing groups. Further work was	• The report was noted. • Mandatory & Statutory training group to report monthly to the Professional Development Group and detailed updates be provided in the Chair report to the People Committee. • Update report to be provided to the August People Committee.

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

		requested on outlining levels of clinical engagement within the organisation.	
Maternity Engagement Update		The Chief Nurse provided a further update on the ongoing People & Culture actions that were being taken within the Midwifery Department. He noted that 'green shoots' had emerged, albeit further work is required.	• The presentation was noted and the Committee welcomed the progress being made.
WRES/WDES Timetable Update		The report noted that we are continuing to improve and progress our EDI journey. The paper noted a timeline of key milestones relating to the WRES and WDES work programme - when the EDI Steering Group, People Committee and Trust Board will have oversight of the findings. Full details of the WRES findings will be considered at the BoD on 29th September.	• The timescales were noted.
Assurance reporting Groups		• Staff Experience Group • EDI Steering Group • Resource & Talent Planning Steering Group • Health & Academic Partnership • All Divisional People Committees	• The Committee noted the Chairs reports and requested the following: (i) Guidance and/or templates be provided to the Divisional People Committees as there was a lot of variance between the reporting, issues covered and level of detail. (ii) Further assurance on the 30% turnover rate of therapists in the Neuro team in ICSD.

New risks to escalate to the Board: (i) Mandatory and Statutory Training compliance rates and (ii) Agency Spend as NHSEI controls to be reintroduced.

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

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

Agenda Item: 20

Title:	Nursing, Midwifery and AHP Staffing Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Summary	NHS Trusts have a duty to ensure safe staffing levels are in place and patients are cared for by appropriately qualified and experienced staff. Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and NICE guidelines. This biannual Nursing, Midwifery and Allied Health Professional (AHP) staffing report outlines the organisations staffing and provides analysis of our workforce position at the end of Dec 2021. Divisional reviews covering the period Jul 2021 to Dec 2021 are included demonstrating that professional judgement has been utilised to align safe staffing against national guidance relevant to individual speciality areas. Ensuring safe staffing levels within the national and regional context of staff shortages continues to be a Trust priority. This is recognised on the Trust risk register. NSHE/I also recognise this risk and published the first Winter Workforce Board Assurance Framework (BAF) in Nov 2021. This was completed and presented to Trust Board in December 2021 (Appendix 1). A gap analysis was subsequently undertaken and the accompanying action plan is currently being monitored to completion. The report also provides on update on the progress to date following the implementation of the Safer Nursing Care Tool (SNCT) up until April 2022. Staffing levels, nurse recruitment and retention are challenging nationally and regionally this report demonstrates the work done in Bolton Foundation Trust to support the ambition to deliver safe staffing levels.

Previously considered by:	People Committee on 23 June 2022

Proposed Resolution	The Board of Directors are requested to: 1. Approve the content of the Staffing Report 2. Recognise the work undertaken over the period July-December 2021 3. Support a third quarter capture using SCNT.

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:	**S Griffin/A Hansen**	**Presented by:**	**Tyrone Roberts, Chief Nurse**

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1. Introduction

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

2. Bolton Workforce Position

2.1 At the end of Dec 2021, there were a total of **114.29 (5.75%) Whole-Time Equivalent (WTE)** qualified nursing and midwifery vacancies (numbers below include Health Visitors, Midwives, Qualified Nurses and School Nurses) across the Trust compared to **38.56 (2.06%) WTE** at the end of June 2021. The increase in vacancies showing for the winter period is due to the staffing of winter pressure wards.

Table 1 Nursing and Midwifery Registered Vacancies

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	161.42	1829.81	1991.23
2021 / 02	168.32	1826.18	1994.50
2021 / 03	136.30	1834.56	1970.86
2021 / 04	58.98	1832.75	1891.73
2021 / 05	55.90	1842.59	1898.49
2021 / 06	38.56	1833.51	1872.07
2021 / 07	53.68	1828.97	1882.65
2021 / 08	56.50	1827.07	1883.57
2021 / 09	76.10	1832.65	1908.75
2021 / 10	77.35	1859.91	1937.26
2021 / 11	-13.98	1867.57	1853.59
2021 / 12	114.29	1872.97	1987.26

2.2 The Trust continues to ensure we have a strong pipeline of Newly Qualified Nurses by interviewing and offering posts at the earliest stage; 89 newly qualified nurses and midwives commenced employment in September 2021 which is the Trusts largest intake in a number of years. In addition to this 38 student nurses, who were part of the Trust's non-commissioned nurse training programme which we run in partnership with the University of Bolton, commenced employment between February and April 2022. We have also made offers of employment to 56 students nurses due to qualify in September 2022 with more interviews scheduled with that cohort. Previous reports confirmed that the Trust had successfully utilised NHSEI funding received in 2021 to recruit international nurses with 20 WTE nurses joining the Trust in-year. We ensured that a strong support package was in place for these nurses to ensure they received the best care and support both in and outside of work (training, accommodation, pastoral support etc.). This support has

been recognised by NHSEI in the region as an exemplar. Because of the successes of our international recruitment, NHSEI have also approved bids from the Trust to recruit up to 72 international nurses in 2022.

This funding is circa £250k and this will be used to support training for the nurses to become fully NMC registered in the UK, immigration charges, and some pastoral support. We have already commenced interviews and have made formal offers of employment to 27 WTE overseas nurses (there are approximately another 23 WTE nurses we require further information from to make a formal offer). The figure of 72 WTE international nurses was approved on the basis of current and expected levels of nurse vacancies, and also will not have an adverse impact on opportunities for our pipeline of newly qualified nurses available to recruit. We are at the stage of arranging flights for a number of the candidates who have been offered roles and the first arrivals are expected in late April 2022. We are also utilising international recruitment to address the shortage of midwives in the UK; we have an internal target of 11 WTE appointments through this route and the first round of interviews have been held. We are working through the required immigration and pre-employment checks and expect our first arrivals in May 2022.

Previous reports have outlined the efforts to reduce vacancies and expand the recruitment of Health Care Support Workers (HCSW). These efforts include; recruitment of candidates without experience but with the right caring and compassion qualities. The employment of HCSW without previous experience is supported nationally to promote local recruitment and widening participation in healthcare careers. Trusts are required to increase this staff group by 6%. The Trust secured £114,980 funding from NHSEI to support HCSW recruitment activity, and the provision of pastoral support for our newly appointed HCSWs. This funding has enabled the appointment of a dedicated Matron (22.5 wte) role with responsibilities for training, development and retention of our HCSWs.

The HCSW vacancy at the end of December 2021 was **64.14 (5.65%) wte**. Following a number of HCSW recruitment days **56.34 wte** candidates are expected to join the Trust by May 2022. If all candidates are appointed, accounting for a 12% turnover rate, our vacancy position will be less than the NHSEI target of 1.0% by June 2022.

Bolton is also involved with the NHSE/I North West HCSW Programme Collaborative to improve recruitment and retention within the role. Improving our use of temporary staffing in this area and providing greater continuity of care for patients as well as ensuring that we support people to progress into nursing and midwifery roles.

2.3 **Nursing Midwifery and AHP Turnover**

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

Table 2 – Staff Turnover (12 month rolling)

Year / Month	Staff Group		
	Nursing & Midwifery Registered	Allied Health Professionals	Additional Clinical Services
2021 / 03	22.38%	17.17%	12.96%
2021 / 04	22.28%	17.22%	9.59%
2021 / 05	22.03%	6.67%	22.31%
2021 / 06	13.97%	23.44%	24.35%
2021 / 07	19.01%	11.22%	27.02%
2021 / 08	19.31%	25.29%	14.80%
2021 / 09	24.13%	5.18%	10.37%
2021 / 10	23.14%	7.66%	13.52%
2021 / 11	21.37%	6.72%	28.32%
2021 / 12	20.10%	14.11%	20.29%
2022 / 01	24.66%	25.09%	14.34%
2022 / 02	25.86%	7.61%	27.68%

2.4 Retention

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

2.5 Sickness and Absence

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

Table 3 Staff Sickness Absence

Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professional ;	Additional Clinical Services
Total	**5.84%**	**5.33%**	**2.73%**	**7.91%**
2021 / 01	**5.41%**	4.62%	2.62%	7.83%
2021 / 02	**4.89%**	4.27%	2.92%	6.63%
2021 / 03	**4.45%**	4.02%	2.49%	5.85%
2021 / 04	**4.96%**	4.43%	2.69%	6.69%
2021 / 05	**5.24%**	4.68%	2.55%	7.23%
2021 / 06	**5.97%**	5.01%	2.71%	8.83%
2021 / 07	**6.63%**	5.70%	2.93%	9.64%
2021 / 08	**6.51%**	6.17%	2.58%	8.62%
2021 / 09	**6.26%**	6.07%	2.88%	7.95%
2021 / 10	**6.46%**	6.26%	3.04%	8.19%
2021 / 11	**6.29%**	5.88%	2.81%	8.39%
2021 / 12	**6.85%**	6.63%	2.50%	9.03%

2.6 **Recruitment**

Recruitment is a key challenge to the Trust in light of national shortages of nurses, midwives & AHPs, coupled with a dynamic and competitive jobs market. Clinical and Workforce teams have ensured a continued focus on recruitment of our Nursing, AHP, and Additional Clinical Services workforce. In addition to the Trust wide recruitment of HCSW and Newly Qualified Nurses a rolling recruitment programme has been undertaken for complex care wards within our Acute Adult Care Division (AACD). Accident and Emergency (A&E), Specialist and difficult to recruit to areas such as Theatres, and Paediatrics also run their own bespoke recruitment campaigns and activity with support from the Employee Service Centre. A significant focus has been placed on the business critical themes to ensure robust winter plans for Trust services as we move towards our typically busiest time; a number of work-streams have been implemented. Weekly meetings are in place and include key Divisional and Workforce representatives. Actions include a refreshed communications approach focusing on new and innovative social media activity (including paid-for advertising) and a review of our recruitment pathway in order to minimise recruitment timescales. A series of stretch targets for each stage of the recruitment journey (from advertisement to completion of pre-employment checks) has been agreed these are expected to deliver a reduction in the recruitment timescale (from advert placed to completion of all pre-employment checks) of 57 working days to 43 working days. This is monitored by the Resourcing & Talent Management group which is a Sub-group of People Committee.

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

3.1 From January 2021 training cohorts for Nursing Associates (NA) with University of Bolton (UoB) have been re-established. The Senior Nursing teams are continuing to review establishments and skill mix as the NA workforce continues to grow and be introduced into clinical areas. The NA role is to be introduced in theatre areas following a Quality Impact Assessment (QIA) and agreed competency training framework. Within the Acute Adult Care Division there are plans to embed this new role by having acute wards with 24- hour cover of NAs within the rosters. The Trainee NA intake for September 2021 has a total of 9 trainees and the next intake commencing April 2022 has enrolled a further 12 (across the organisation):

Placement Area	Headcount
AACD (C2 Hub)	5
ASSD (F3 hub)	2
ICSD	2
FCD (paediatric)	1
Women's Health	2

There are 6 with 2 having taken a break in learning (BIL) Trainee Nurse Associates within the organisation via the independent route, these have applied directly to the University of Bolton (UOB), are self-funding the programme and are offered clinical placements with our Trust rather than coming from our own established workforce. It is acknowledged that there are more opportunities to be explored for the Nursing Associate role within the organisation. The Trust has agreed as part of a GM initiative to take 36 TNAs over the next couple of years. The first 12 of these will arrive in September 2022. Plans are in place to support. Following this we expect 6 in April 2023, 13 in September 2023 and 5 in April 2024.

3.2 The Chief Nursing Office for England has recognised the negative impact the last 5 years' reduction in the commissioning of undergraduate places had on the NHS and have recently announced a 34% increase in Undergraduate placements with the aim to increase the domestic supply in 3 years' time (2024). Greater Manchester was successful in their bid to increase pre-registration student numbers via the Clinical Placement Expansion Programme (CPEP) initiative throughout the region in 2021. As a result of this Bolton NHS FT have committed to a capacity increase of additional 45 adults, 10 children and young person's, 10 Mental Health, 2 learning disabilities and 10 Midwifery students. There will also be an increase in AHP student numbers 1 Operating department practitioner, 16 Occupational therapists, 23 Physiotherapy, 2 Radiology and 9 Speech & Language students.

Health Education England (HEE) have released £45,390 to Bolton NHS FT and, as a result, a Band 7 PEF (Practice Education Facilitator) has been appointed to manage the Clinical Placement Expansion Programme (CPEP).

Nursing Degree Apprenticeships and NA conversion courses are being shortened to assist Trusts to utilise this potential market, however these have yet to be agreed

as a way forward within the Trust and a paper is being prepared for the Education Profession forum for discussion around nurse scholarships.

3.3 The National Retention Board have recently published data which demonstrates that high numbers of newly qualified nurses and midwives leave their respective professions at the early parts of their careers (1st and 2nd year). In response to this, The Professional Nurse Advocate (PNA) Programme was launched in March 2021 to provide training and restorative supervision for NHS staff. Following a successful pilot of this role in Critical Care in the Anaesthetic and Surgical Services Division (ASSD) they now have 19 qualified PNAs with 1 awaiting results and a further 3 undergoing training at UCLAN (due to qualify June 2022). The Trust now has a nominated lead Claire Partridge, Lead for Nursing, Midwifery and AHP Education. Priorities identified as follows:

- Plan a celebration event for 2022
- Capture the data to demonstrate impact and feedback into the organization
- Promote the role and access to PNA/PMA via the Trusts intranet
- Share outcomes
- Work to and align the North West standard to Bolton NHS FT.

3.4 The Professional Midwifery Advocate (PMA) Programme is established in Bolton NHS Maternity services but nationally no longer mandatory. Currently in our Maternity services we have 10 PMAs with a further 2 in training. The established PMAs have supported the new PNAs who undergo the same training course and have agreed will all work together to promote the PNA/PMA invaluable support service.

4. Safe Staffing

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

4.2 The first census of patient-level acuity and dependency data was submitted with 100% compliance in September 2021 and analysis of the data using the Safer Nursing Care Tool (SNCT) model was carried out. The data collection period covered 20 days Monday to Friday. The second period of data capture took place in February 2022 in line with NHSE/I recommendations, and the 2 census periods have been validated. All Senior Nursing teams and clinical areas involved in the SNCT data collections were fully engaged with the process thus ensuring the data was collected to the highest standard. NHSE recommend a minimum of two census collections. However, in order to further validate our data, the newly appointed Chief Nurse has requested a third census collection which is scheduled for October 2022.

The Trust has also commenced the next stage of the project which is to implement the SNCT census in the Emergency Department. Training has commenced and the finer detail of the data collection is currently being worked through. This census will also comprise of 2 periods of data capture.

Work is being undertaken to model the tool to fit areas such as Laburnum Lodge (ICSD), E5/F5 Paediatrics (FCD) and M1/M6 Gynaecology (FCD). These areas have specific nuances within the services whereby the tool does not fit typically.

We have also recently been granted a license to undertake an SNCT analysis for our Community services.

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

Table 4 Fill Rates

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	**89.54%**	**91.47%**	**86.79%**
2021/01	**93.18%**	93.45%	92.82%
2021/02	**91.80%**	93.73%	89.06%
2021/03	**87.75%**	91.54%	82.67%
2021/04	**91.14%**	91.50%	90.60%
2021/05	**89.75%**	90.12%	89.20%
2021/06	**85.55%**	87.48%	82.51%
2021/07	**85.66%**	85.19%	86.39%
2021/08	**85.91%**	86.59%	84.92%
2021/09	**92.67%**	95.40%	88.84%
2021/10	**92.33%**	97.31%	85.77%
2021/11	**91.08%**	94.98%	85.81%
2021/12	**88.24%**	91.81%	83.39%

5 Care Hours Per Patient Day (CHPPD)

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

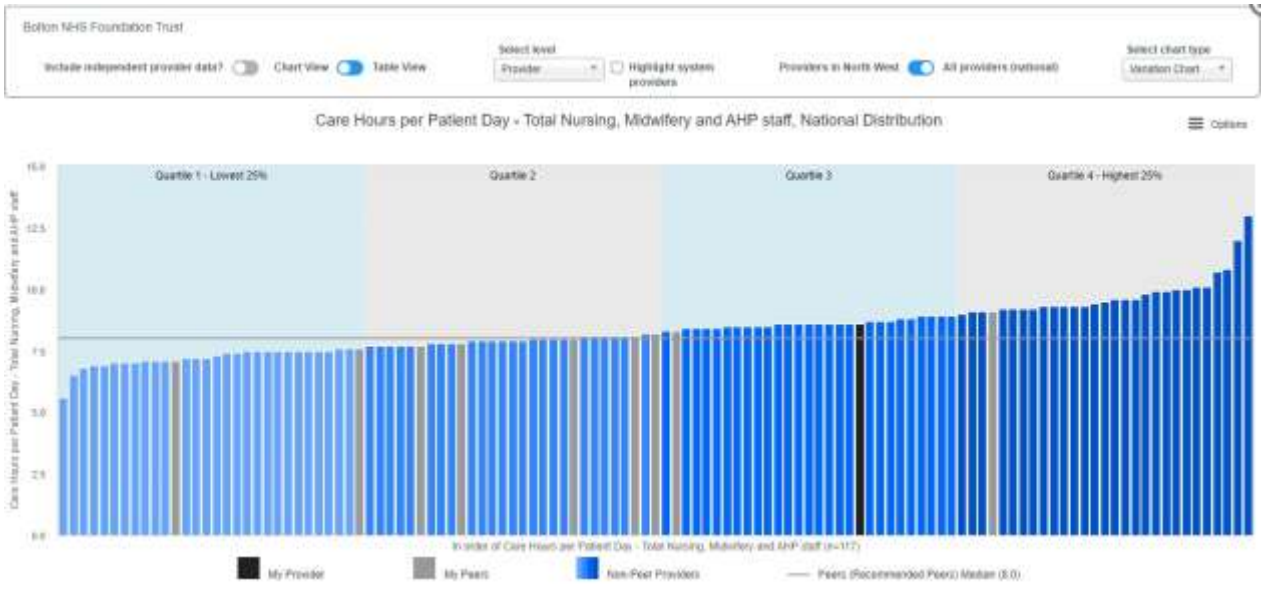
of day case patient flow activity. However, the CHPPD does provide a consistent figure for benchmarking nurse staffing levels against other Trusts.

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

Table 5 Trust CHPPD

Year / Month	Total CHPPD	Reg. CHPPD	Non Reg. CHPPD
	No.	No.	No.
Total	**9.49**	**5.69**	**3.80**
2021/01	**9.83**	5.69	4.14
2021/02	**9.41**	5.63	3.78
2021/03	**10.09**	6.02	4.07
2021/04	**9.82**	5.85	3.97
2021/05	**9.97**	5.99	3.97
2021/06	**9.33**	5.83	3.50
2021/07	**8.75**	5.29	3.46
2021/08	**8.38**	5.02	3.37
2021/09	**8.84**	5.31	3.53
2021/10	**9.78**	5.85	3.92
2021/11	**9.50**	5.70	3.80
2021/12	**10.73**	6.43	4.30

Table 6 CHPPD Benchmarking (source: Model Hospital)



6. Daily Staffing

6.1 Daily staffing levels continue to be assessed across each shift by senior nursing and midwifery through a twice daily staffing meeting. The SafeCare system is utilised during the meeting. The system allows for the review of staffing levels in relation to patient acuity and dependency on the wards. This gives an overall picture of the in- patient bed base and shows areas of concern through a rag rated system. Staffing issues are escalated to Matrons and Senior Nurses and they are able to show decisions and professional judgements made on the system. This enables the trust to have a documented risk assessment and QIA completed twice daily.

6.2 Funding to pilot a Trust-wide Enhanced Care Team was approved by the Trust. Recruitment of new staff members is complete. It is anticipated that the introduction of this team will reduce the bank and agency spend and improve the quality of the support to the in-patient wards. Further work is underway to review the impact of this initiative.

7. Nursing Leadership

7.1 We have recently invested in the production of a development programme for Ward Managers and Team Leaders. The vision of the 'Bridging the Gap' programme is to support, nurture and equip our nurse manager workforce with the right skills to lead a safe, effective, patient centred team to provide high quality patient care and leadership 'For a Better Bolton'. The development of nurse managers is fundamental to providing safe clinical care and driving improvements to help create compassionate cultures for our teams to thrive. Nurse leaders play a fundamental role in delivering the Trust's strategic aims and vision for the future – to be recognised as an excellent provider of health and care services, and a great place to work. As a trust we are dedicated to developing our people to grow, be stretched and to reach their potential.

The programme has a blended approach to learning and consists of the following key elements:

- Competency based taught learning sessions
- A set of core competencies of learning that will ensure consistency of what a 'good' clinical manager looks like
- Shadowing opportunities, including Divisional board observation, and buddying up to observe at strategic meetings
- Access to a mentor or key buddy to go to for help and support
- Equality, Diversity and Inclusion to include access to the Trust's 'Be Inclusive' programme which ensures all our managers are champions of inclusion
- Part of being a great leader is knowing yourself and prior to the programme commencing we will invite you to undertake a NHS 360 feedback assessment
- Access to the Coach Me Trust 1-day programme to enable great conversations
- Access to the Be Inclusive bite size modular EDI programme

7.2 In order to establish a consistent approach to nursing leadership on all wards and community nursing teams a review was undertaken of management time for all Band 7 Ward Managers. Following a review to ensure equity standardisation of protected

time was introduced. Each Band 7 is allocated supernumerary status. This can be allocated to Band 6's to provide development opportunities.

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

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

7.5 Bolton NHS Foundation Trust Workforce Board Assurance Framework (BAF) summarises our self-assessment and compliance to NHSE/I workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. This provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of staffing issues with the planning and preparation of the nursing and midwifery workforce.

Using this framework is not a regulatory requirement; however, it helps us to maintain quality standards and provide assurance to the Bolton NHS Foundation Trust Board that organisational compliance is systematically reviewed. The Board were first sighted on this in January 2022.

Initial completion of the framework was undertaken by the Deputy Chief Nurse, and Assistant Director of Nursing for Nursing and Midwifery Workforce. (appendix 1)

The NHSE/I first published the framework in November 2021 therefore this is the first instance the Trust has mapped their policies, procedures, systems and processes in this format. A gap analysis was undertaken and the subsequent action plan is reviewed bi-monthly. This action plan is currently being monitored to completion.

The Framework provides the Trust Board with a clear line of sight to the point of care delivery in relation to nursing and midwifery staffing decisions and challenges. This includes quality and workforce risks and mitigations.

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

8. Family Care Division Acute Paediatrics Staffing Review

8.1 Ward & Department Areas

The Acute Paediatric inpatient unit is configured as follows –

- E5 Ward consisting of 28 beds configured as 17 cubicles, a 4 bedded bay, a 7 bedded bay.
- High Dependency Unit containing 3 Paediatric Critical Care Level 2 bed spaces.
- Surgical Elective Day Case Unit which is an additional 7 bedded bay for minor elective and day case surgery.

- F5 - Short Stay Paediatric Assessment Unit (SSPAU) and Rapid Access Clinic (RAC) Consisting of a 7 bedded bay with 4 cubicles & 3 bed spaces. One triage room and a Red and Green waiting area is also available.

The unit works as part of the GM Paediatric network and accepts admissions for Bolton and surrounding areas such as Bury and Wigan, and also takes direct referrals for the PANDA short stay paediatric assessment unit in Hope Hospital A/E department.

8.2 **National Staffing Guidance**

The unit aligns to national guidance outlined in the National Quality Board guidance - Safe, Sustainable and Productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals. The unit also uses the Shelford Group - Safer Nursing Care Tool Children's & Young People's In-patient Wards Implementation Resource Pack to ensure safe staffing levels. This Children's & Young People's Safer Nursing Care Tool (SNCT) is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards.

This guidance includes Nurse Sensitive Indicators (NSIs). These quality indicators can be linked to nurse staffing issues, which include leadership, establishment levels, skill-mix and training and development of staff. This information is used to further support ward staffing requirements identified through acuity and dependency measurement. It recognises that many organisations have identified their own indicators, which when used consistently, provide local intelligence on the link between nurse staffing, patient outcomes and experience.

The NHSEI guidance is used alongside the Shelford Safer Nursing Care Tool and as with both guidance, staffing levels are reviewed twice per year in order to operate a winter and summer model of staffing to meet acuity levels expected during winter RSV surge periods and other seasonal activity.

These standards take into account the age of the child along with acuity and the little difference between day and night care on a children's unit which is reflected in staffing models and plans. This includes the need for the children to be cared for by staff with the right knowledge, skills, expertise and competence to meet their needs. In addition, Nurse Associates and unregistered staff work on children's wards to meet the demands of inpatient areas, however these staff are not included in the nursing ratio establishment as per guidance recommendation.

In line with the guidance, the unit has a supernumerary ward manager and shift coordinator covering a 24-hour period who is not included in the baseline bedside establishment. Staffing plans also include a nurse on each shift with Advanced Paediatric Life support (APLS) qualifications and 7-day play worker cover.
The children's unit as far as possible work within the Greater Manchester Network agreed nurse / patient ratio of 1:5 24/7 across all age groups. The Escalation have processes in place to identify when acuity and staffing levels are such that these rations

exceed the expected standard and a process is in place within the Division, Trust and GM for escalation.

8.3 Staffing Reviews

Twice yearly staffing modelling to cover seasonal variation, along with staffing reviews 3 times per week are undertaken. During winter pressures, staffing is reviewed daily which ensures the following is in place:

- Nursing staffing ratios to meet acuity in both ward, HDU and assessment supported by a wider team of Advanced Paediatric Nurse Practitioners (APNP's) on F5 Assessment Unit, Nurse Associates (NA), Health Care Assistants (HCA's), Assistant Practitioners (AP's) and Play Specialists provide cover.
- Additional support from the wider multi-disciplinary team
- Close working with the Children's Community Nursing Team to support flow and early discharge particularly during the winter pressure period.
- Supernumerary band 6 shift lead
- Supernumerary band 7 ward manager
- Minimum of 1 paediatric nurse per shift with the Advanced Paediatric Life Support course (APLS).
- High Dependency Unit staffed on a ratio of 1:2 (as per Critical Care network) by paediatric nurses with the appropriate skills and expertise with access to support from paediatric medical staff and senior nurses.
- Short Stay Paediatric Assessment Unit (F5) is staffed 24 hrs per day with at least one registered children's nurse. Advanced Paediatric Nurse Practitioners cover the service from 0730 – midnight, with a middle grade doctor covering overnight.
- Play Specialists are available 7 days a week, 0730 – 2000 to provide distraction or prepare children undergoing procedures.

Staffing KPIs

Table 7 shows that from April 2021 to March 2022 the unit predominantly met requirements as outlined by NHSI/E and the CQC.

PLEASE NOTE – This only covers E5 children's ward, when staff are taken from these number for F5 assessment unit, day case surgery, scans, ward attenders and CAMHS 1:1 this greatly increases the ratio but the ratio's below are based on E5 28 bedded - bed base only.

Table 7 - Compliance with Staffing KPIs –

April 21– March 22 Compliance	Nurse to Child Ratio – all ages 0-16 years.	Super-numerary Ward manager Mon-Fri	Super-numerary shift coordinator	APLS trained Band 6/7	7-day play team cover
April 2021	1:2:2	100%	98%	100%	100%
May 2021	1:2:4	100%	100%	100%	100%
June 2021	1:3:0	100%	97%	100%	100%
July 2021	1:3.7	100%	91%	100%	97%
August 2021	1:2:8	100%	92%	100%	100%
September 2021	1:3.3	100%	93%	96%	100%
Oct 2021	1:3.4	100%	94%	100%	100%
Nov 2021	1:3.7	100%	98%	100%	100%
Dec 2021	1:3:6	100%	100%	100%	100%
Jan 2022	1:2.8	100%	98%	100%	100%
Feb 2022	1:3:8	100%	98%	100%	100%
March 2022	1:3.8	100%	100%	100%	100%

8.4 **Sickness & Staffing KPIs & Agency Usage**

Table 8a and 8b below reflects the whole of the Family Care Division including community and maternity services.

Vacancies - In Acute Paediatrics, all vacancies apart from 2 band 4 NA have been recruited to.

Table 8a Nursing & Midwifery Registered Establishment, Staff in post and vacancy by month

Nursing & Midwifery Registered Establishment, Staff in Post and Vacancy by Month

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	7.82	568.90	576.72
2021 / 02	10.67	568.95	579.62
2021 / 03	22.04	556.57	578.61
2021 / 04	24.38	554.23	578.61
2021 / 05	29.07	551.99	581.06
2021 / 06	27.54	557.69	585.23
2021 / 07	27.33	557.90	585.23
2021 / 08	23.92	560.31	584.23
2021 / 09	23.63	560.60	584.23
2021 / 10	6.75	573.17	579.92
2021 / 11	12.82	568.01	580.83
2021 / 12	5.98	572.48	578.46

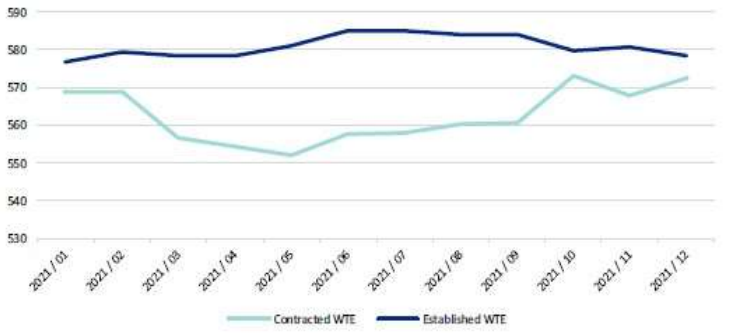


Table 8b Additional Clinical Services Establishment, Staff in Post and Vacancy by Month

Additional Clinical Services Establishment, Staff in Post and Vacancy by Month

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	19.57	187.90	207.47
2021 / 02	16.63	188.60	205.23
2021 / 03	18.95	186.76	205.71
2021 / 04	18.52	187.19	205.71
2021 / 05	15.05	190.66	205.71
2021 / 06	16.43	189.05	205.48
2021 / 07	15.06	190.22	205.28
2021 / 08	17.54	190.37	207.91
2021 / 09	25.85	182.13	207.98
2021 / 10	15.99	192.81	208.80
2021 / 11	19.52	189.28	208.80
2021 / 12	20.29	188.14	208.43

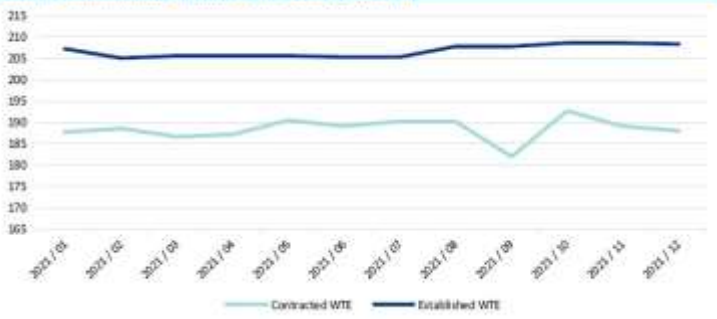


Table 9 below reflects sickness across the whole Division.

Table 9 Sickness Absence

Sickness Per Month by Staff Group (Non-Covid-19 Related)

Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	4.85%	4.70%	1.03%	6.67%
2021 / 01	4.42%	3.93%	2.06%	6.72%
2021 / 02	4.21%	3.72%	0.46%	7.06%
2021 / 03	3.24%	3.19%	0.22%	4.53%
2021 / 04	3.60%	3.43%	0.84%	5.18%
2021 / 05	4.29%	4.23%	2.00%	5.35%
2021 / 06	4.43%	4.38%	1.62%	5.57%
2021 / 07	4.73%	4.42%	0.79%	7.04%
2021 / 08	5.41%	5.03%	0.25%	8.33%
2021 / 09	5.43%	5.52%	0.80%	6.82%
2021 / 10	5.34%	5.42%	1.26%	6.56%
2021 / 11	6.45%	6.36%	1.16%	8.58%
2021 / 12	6.69%	6.85%	0.91%	8.32%

Table 10 provides a breakdown of sickness in Acute Paediatrics. This is a combination of long and short-term sickness and pregnancy related sickness. In addition, COVID has impacted on short term absence. Deep dives into each individual on sick leave has been undertaken with HR and we are assured that sickness policy is being followed. The highest staff group for short-term and long-term sickness is Health Care Support Workers and the Ward Manager and Matron are working with HR to try and facilitate return to work for those staff.

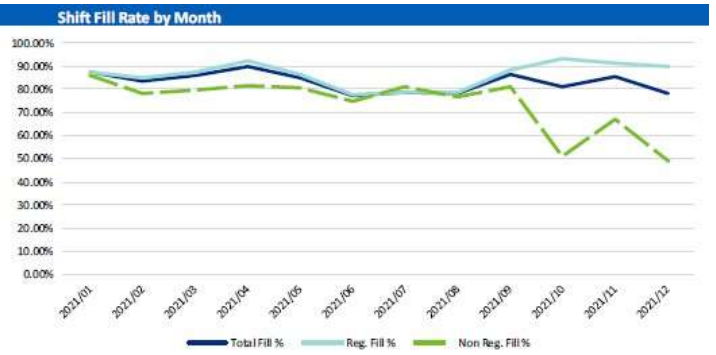
Table 10 Breakdown of Sickness

April –Sept 2021 Compliance	% Sickness Target 4.2%
April 2021	1.73%
May 2021	2.69%
June 2021	4.59%
July 2021	5.59%
Aug 2021	4.89%
Sept 2021	4.52%
Oct 2021	5.14%
Nov 2021	5.35%
Dec 2021	3.75%
Jan 2022	4.81%
Feb 2022	6.20%
March 2022	7.56%

Table 11 below outlines the fill rate for all wards in Division. In Acute paediatrics a winter and summer model of staffing is in place to reflect seasonal pressures in children's admissions. The team are working with workforce to ensure this is reflected in Health Roster to ensure the Fill rate can be further understood.

Table 11 Fill Rate

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	83.02%	86.06%	72.47%
2021/01	87.23%	87.60%	86.15%
2021/02	83.75%	85.19%	78.13%
2021/03	85.97%	87.63%	79.56%
2021/04	90.05%	92.23%	81.76%
2021/05	85.25%	86.42%	80.52%
2021/06	77.32%	77.93%	74.69%
2021/07	78.95%	78.51%	80.95%
2021/08	78.21%	78.51%	76.80%
2021/09	86.51%	88.29%	80.93%
2021/10	81.14%	93.41%	51.16%
2021/11	85.32%	91.20%	66.87%
2021/12	78.02%	89.67%	49.21%



CHPPD is not captured for acute paediatrics due to the number of short stay patients and the high flow of patients into the unit. The average length of stay is 2 days and parents are normally resident to care for their child.

Table 12 CHPPD

Year / Month	Total CHPPD No.	Reg. CHPPD No.	Non Reg. CHPPD No.
Total	11.29	9.08	2.20
2021/01	12.38	9.25	3.14
2021/02	11.32	9.16	2.15
2021/03	13.00	10.52	2.48
2021/04	13.08	10.62	2.47
2021/05	13.37	10.86	2.51
2021/06	12.34	10.11	2.24
2021/07	11.09	9.05	2.04
2021/08	9.46	7.79	1.66
2021/09	10.12	7.83	2.30
2021/10	10.43	8.52	1.91
2021/11	10.25	8.31	1.94
2021/12	10.35	8.47	1.88

8.5 Additional Roles. Initiatives & Innovations

Currently the unit has 2 nurses on the PNA course which will benefit the unit. Joint working with the Adolescent Health team to support staff in caring for young people with Mental health problems has been a success. One of the band 6 sisters who leads on Mental Health has completed the STORM suicide prevention train the trainer course and this will be incorporated into the ward training programme for 2022/23.

All band 6 sisters are leading on a QI project and band 5 champions have been identified to lead on various initiatives on the ward such as oral health, staff health and wellbeing and patient experience.

8.6 **Recruitment & Retention**

The unit experiences very few issues with recruitment and retention and is a unit of choice for students to gain their first post. Student nurses evaluate their placement very positively and many return for elective placements.
Turnover in band 6 grades and above is fairly static with staff choosing to stay on the unit for many years, leading to skilled core staff on the unit.

3 additional posts were established to cover winter pressures and all have been recruited to. The unit has an excellent track record of recruiting past students and rarely have vacancies on any line.

We currently have a vacancy for 2 NA as 2 of the 4 original are undertaking their nurse training. These posts have been difficult to recruit to and we are currently exploring other options.

8.7 **Advanced Practitioners**

The unit currently has 4 Advanced Paediatric Nurse Practitioners who predominantly work in F5 assessment unit. We have seconded another nurse to undertake this training and this started in September 2021, one of our APNPs is due to retire in the next 12 months so the new APNP when qualified will be able to fill this vacancy.

8.8 **Student Nurses/ TNAs/ NAs**

Currently we have no TNA on the unit as no-one expressed an interest in undertaking the course. We take children's nursing students from both Salford and Bolton Universities with 15 students in total over a 12-month period. There is a dedicated Practice Educator who works closely with students and the university and the placement is always well evaluated.

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

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

9.1 **Wards Department Areas**

The Trust provides maternity care for approximately 6800 pregnant people, with an annual birth rate of 5843 in 2021. Antenatal care in the community is provided within GP surgeries, children centres, Ingleside birth centre, the BCOM Hub, and on site at the Royal Bolton Hospital site.

9.2 **National Staffing Guidance**

This review has taken into consideration NICE recommendations such as NICE recommended Birth-rate Plus (BR+) tool for midwifery staffing, and professional judgment. A staffing report is presented to board bi annually Birth-rate Plus® provides any given service with a recommended ratio of clinical

midwives to births in order to assure safe staffing levels. Bolton FT maternity Birth-rate Plus® establishment was set at 1:27 during July 2021- December 2021.

The Trust undertook a full BR+ assessment in August 2020, and this is considered valid for 3 years. The BR+ report provides a detailed breakdown of safe staffing requirements in each clinical area and is based on activity and acuity. It calculates recommended clinical establishments and proposes a skill mix ratio of 90% Midwives and 10% Maternity Support Workers (MSW) within the clinical establishment. In addition to the clinical establishment, the BR+ tool also includes recommended establishments for non-clinical midwifery roles, which equates to approximately 9% of the clinical midwifery establishment

The funded establishment between the period July 2021 and December 2021 was 239.70wte (Midwives and maternity support workers) of which 219.90wte are working in clinical roles, are 19.79wte in specialists or non-clinical roles which is in line with BR+ recommendations.

Daily safe staffing levels across the in-patient intrapartum area (central delivery suite) is monitored using the Birth Rate Plus Acuity Tool. This is a nationally recognised tool to assess 'real time" workload arising from the numbers of women needing care and their condition on admission and during the processes of labour and birth. The delivery suite acuity tool advises how many midwives are required to provide intrapartum care, and achieve one to one care in labour and is used to inform and pre-empt unit closure in line with the escalation and divert guideline. Currently there are no acuity tools to monitor activity and calculate staffing requirements in the inpatient tor outpatient setting.

Table 13

Indicator	Goal	Red Flag	July 21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
1:1 Midwifery Care in Labour	95%	<90%	90.5%	98.2%	98.7%	96.2%	98.3%	98.8%
Number of births	Information only			484	479	525	518	464
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:30.7	1:30.5	1:30.7	1:30	1:30.5	1:29.4
Midwife /birth ratio (rolling) actual worked inc bank	information only		1:29.1	1:26.2	1:26.6	1:27	1:28.4	1:28.4
Monthly percentage sickness	4%	>=4.75%	6.93%	7.44%	7.42%	7.86%	8.69%	9.02%

Monthly Midwifery Vacancy Rate wte	information only	21.13	20.05	21.21	28.65	29.88	31.57

It should be noted that one to one care in labour was only achieved by depleting midwives from other essential care such as the community and wards. This has an effect on the quality of the service overall and whilst safety is paramount, we are observing an impact on staff morale.

9.3 **Sickness & Staffing KPIs & Agency Usage**

Sickness & Staffing KPIs for maternity services are included in Table 1 above. Despite considerable staffing challenges resulting from high levels of sickness absence and midwifery vacancy rates one to one care in labour has been achieved consistently above the 95% target.

9.4 **Additional Roles, Initiatives & Innovations**

Training and development of 5 additional maternity support workers to work towards the recommended midwife to MSW ration 90/10 (Currently 95/5). Successful in obtaining £63,000 from the local maternity services to implement a pilot maternity continuity of carer project.
The ratio of maternity support workers was assessed in the Birth Rate Plus assessment as valid at 10% but this ratio is only applicable to postnatal care. The maternity service has been asked to repeat the Birth Rate Plus assessment for assurance by region in light of the Ockenden report. This will be undertaken as soon as there is availability from the company as it is supported with funding from the strategic clinical network.

9.5 **Recruitment & Retention**

Recruiting to midwifery posts is a regional and national challenge due to the shortage of midwives. Despite an active ongoing and continuous recruitment process at the Trust, there was a current vacancy rate of **31.57wte** (4.04%) midwives during the time period July 2021- December 2021. Poor staffing is having an impact on staff morale which in turn is leading to further turnover. There is a staffing risk of 20 on the Divisional risk register so a high level of focus is currently being placed on this. The new Director of Midwifery has a wealth of experience with strategic workforce management and is working closely with the NHSE/I lead for midwifery staffing.

Neonatal Services

Current Cot Base within Family Division

The Trust provides level 3 neonatal care as part of the North West operational delivery network. With 37 cots, (7 intensives, 9 high dependencies and 19 special care) The table below demonstrates Neonatal staffing against BAPM compliance, whilst maintaining a supernumerary coordinator. Changes to government restrictions have had an inadvertent effect on staffing levels with increased cases of COVID19 being recorded on the Neonatal unit (NNU). Increased cases within infants has in turn impacted on the need for more 1:1 nurse ratio thus increasing staffing demand.

Increased cases within staff members has resulted in staffing shortages and high absence rates. Despite the challenges posed and high rates of sickness /absence the NNU has maintained a supernummary coordinator >100% of the time.

Table 14

Indicator	Goal	Red Flag	Aug-21	Sep-21	Oct-21	Nov-21	Dec 21
BAPM Nursing levels	95%	90%	89.0%	97.7%	89.3%	95.3%	96%
Neonatal NLS shift cover	95%	90%	100.0%	100.0%	100.0%	100.0%	100%
Monthly percentage sickness red flag Nov 19	4.20%	>=4.75%	7.27%	7.05%	5.79%	9.67%	9.02%

Covid19 has negatively impacted on recruitment and retention on the NNU

In recent months the NNU had had difficulty in recruiting new starters. Whilst there are few gaps within the senior positions, recruiting newly qualified staff and/or band 5s with experience has proved challenging.

To mitigate this the NNU have explored alternative ways to recruit utilising remote interviews and using social media to display the work that is undertaken in a tertiary Neonatal centre. The Bolton NNU has also asked for the support of the ODN in creating a unified Neonatal service advertisement to aid recruitment.

Gynaecology Services

Current Ward/Department based areas within Family Division

M6 Emergency and Urgent care for Early Pregnancy and Gynaecology continues to provide Emergency Gynaecology and assessments for early pregnancy, including subsequent admissions for urgent diagnostics and treatments.

Women's Health Care (WHC) Gynaecology Out-patient Department providing Diagnostics and Treatments.

Staffing Review - Recruitment and retention

On M6 is now recruited to establishment with appropriate skill mix of all nursing and support roles including Triage Nurse and Nurse Associate.

WHC is currently undergoing a staffing review skill mix and contingency planning for the future.

Gaps in staffing are because of preceptorship, isolation and sickness.

Additional Roles, Initiatives and Innovation

Nurse Associates

As part of future proofing gynaecology services, the recruitment of more Nurse Associates (NA) is planned across Gynaecology for 2022.

9.6 **Advanced Practitioners**

The recruitment of an Advanced Nurse Practitioner in Gynaecology is still proposed within the Gynaecology Nursing and Support Workforce Review Paper.

Table 15 Quality and Safety Focus on Sickness and Absence

Indicator	Goal	Red Flag	May -21	Jun-21	Jul-21	Aug -21	Sep -21	Oct-21	Nov -21	Dec -21	Source	Sparklines
Monthly percentage sickness red flag changed Nov 19	4.20 %	>=4.75%	4.14 %	6.94 %	4.74 %	8.81 %	6.76 %	7.24 %	8.08 %	6.2 %	Work	

From June onwards, sickness absence in gynaecology escalated above the KPI threshold, with a high 8.81% for nursing and support staff. Recorded absence cause was cancer surgery and orthopaedic surgery, trauma and Covid isolation. All staff were supported in their wellbeing to facilitate their return to work.

Safe staffing levels are closely monitored by the Gynaecology Matron, with clear escalation processes to enable response to concerns about staffing gaps.

Gynaecology continues to be successful at filling vacancies, continues to have great retention and a low turnover of staff with demonstrating that we have a happy workforce and are a sought after place to work especially by student nurses.

10. Acute Adult Care Division

10.1 **Ward & Department Areas**

The Acute Adult Care Division (AACD) currently has a bed base of 340 which includes two additional escalation wards (B4 and A4). B4 opened in November 2020 and ward A4 opened in May 2021. Funding for these escalation areas was agreed by the executive team as of March 2022 staff in post on A4 now B2 was -11.53 WTE for registered nurses and -16.84 health care support workers, we have recruited 12.66 WTE who are awaiting start dates following recruitment checks. On B4 they are -7.92 registered nurses and –11.09 health care support workers with 11 who have been recruited but also awaiting start dates. In addition, AACD encompasses the accident and emergency department and clinical assessment areas.

10.2 Staffing Reviews

Staffing reviews were considered by AACD Divisional board and subsequently uplifted staffing establishments within the accident and emergency department. This was to support the increased number of attendances and level of acuity and dependency of patients in the waiting areas requiring treatment. This requires an additional 31 WTE's which is currently a cost pressure pending a business case.

10.3 Sickness, Staffing KPIs & Agency Usage

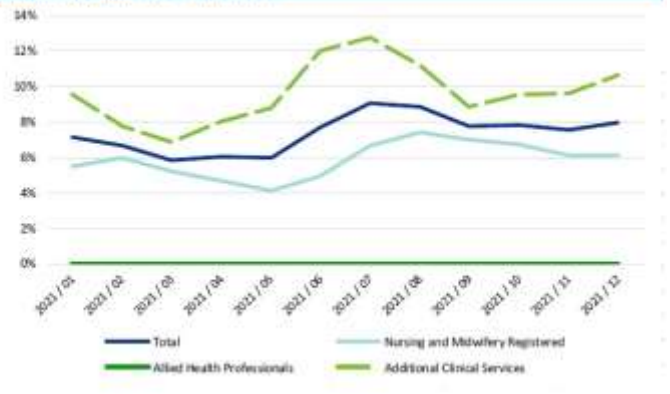
Table 16 Staff in Post

Staff Group	Employee FTE by Month												12 Month Trend
	FY20 M10	FY20 M11	FY20 M12	FY21 M01	FY21 M02	FY21 M03	FY21 M04	FY21 M05	FY21 M06	FY21 M07	FY21 M08	FY21 M09	
Total	1061.03	1066.94	1075.52	1074.30	1077.16	1080.65	1096.83	1088.36	1137.95	1156.33	1167.64	1160.52	
Add Prof Scientific and Technic	2.00	2.00	3.00	3.00	5.07	5.07	5.07	6.07	6.07	6.07	5.07	5.60	
Additional Clinical Services	329.78	328.64	332.87	332.77	333.04	335.07	331.52	336.31	364.63	375.95	381.07	374.28	
Administrative and Clerical	124.16	125.20	127.14	124.00	123.48	121.82	124.16	122.30	123.44	123.65	127.33	127.21	
Allied Health Professionals	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	1.00	1.00	0.00	
Estates and Ancillary	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Healthcare Scientists	10.69	10.69	10.69	10.69	10.51	10.51	11.91	11.91	11.91	10.73	10.73	10.73	
Medical and Dental	95.33	93.03	94.52	92.49	91.09	91.09	107.39	95.12	96.08	96.90	96.90	95.08	
Nursing and Midwifery Registered	496.07	504.38	504.30	509.35	511.97	515.09	514.78	514.65	533.82	542.03	545.54	547.62	
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

Table 16 reflects all staff groups including nursing. The data demonstrates a gradual increase in nursing and midwifery staffing which reflects the commencement of new starters following the successful recruitment events. Turnover has been due to staff leaving for promotion, retirement and some to seek agency posts. The Division continues to support staff leaving for alternative employment in another Division.

Table 17 Sickness Absence

Sickness Per Month by Staff Group (Non-Covid-19 Related)				
Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	7.38%	5.88%	0.00%	9.67%
2021 / 01	7.10%	5.50%	0.00%	9.55%
2021 / 02	6.67%	6.00%	0.00%	7.74%
2021 / 03	5.85%	5.19%	0.00%	6.89%
2021 / 04	6.01%	4.70%	0.00%	8.03%
2021 / 05	5.96%	4.12%	0.00%	8.82%
2021 / 06	7.71%	4.93%	0.00%	12.01%
2021 / 07	9.06%	6.67%	0.00%	12.80%
2021 / 08	8.89%	7.43%	0.00%	11.21%
2021 / 09	7.72%	6.97%	0.00%	8.85%
2021 / 10	7.85%	6.70%	0.00%	9.54%
2021 / 11	7.56%	6.13%	0.00%	9.63%
2021 / 12	7.94%	6.08%	0.00%	10.64%



The sickness noted in Table 17 reflects the Divisional position for all staff (including nursing), with the removal of any Covid 19 related sickness from the data shown. All sickness absence is closely monitored and managed in line with the Trust Attendance Management policy

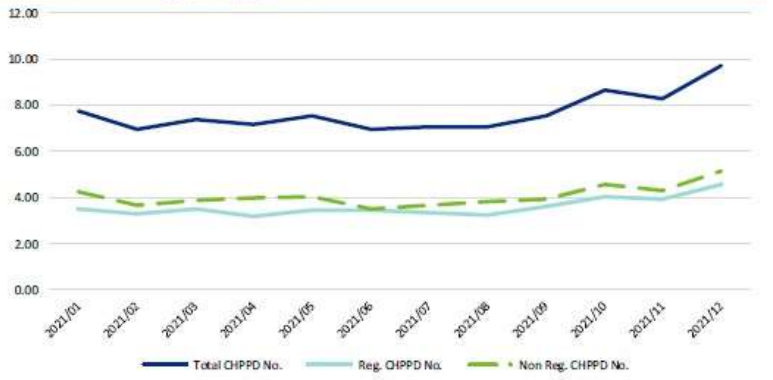
Table 18 Fill rate

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	93.59%	95.37%	92.07%
2021/01	97.19%	98.07%	96.48%
2021/02	90.52%	99.20%	83.88%
2021/03	85.24%	95.46%	77.79%
2021/04	93.54%	89.76%	96.82%
2021/05	97.84%	97.60%	98.05%
2021/06	92.64%	96.95%	88.78%
2021/07	88.85%	87.31%	90.32%
2021/08	90.10%	92.13%	88.43%
2021/09	97.73%	102.07%	94.03%
2021/10	100.12%	98.68%	101.42%
2021/11	95.56%	97.97%	93.46%
2021/12	93.56%	91.98%	95.00%

The data in graph 18 reflects fill rates against pre-agreed establishments. The position appears to have now stabilised, with a fill rate above 90%.

Table 19 CHPPD

Year / Month	Total CHPPD No.	Reg. CHPPD No.	Non Reg. CHPPD No.
Total	7.66	3.60	4.06
2021/01	7.78	3.53	4.25
2021/02	6.95	3.30	3.65
2021/03	7.39	3.49	3.90
2021/04	7.18	3.20	3.98
2021/05	7.52	3.47	4.06
2021/06	6.97	3.45	3.53
2021/07	7.05	3.38	3.68
2021/08	7.07	3.26	3.82
2021/09	7.54	3.63	3.92
2021/10	8.65	4.06	4.59
2021/11	8.29	3.96	4.33
2021/12	9.72	4.57	5.15



10.4 Additional Roles, Initiatives & Innovation

AACD remain proactive in recruiting and training TNA's with a commitment to give ongoing support to NA's. NAs have been successfully embedded in the workforce particularly within the Emergency Department, currently employing 5 NAs in Minors and 1 in Paediatrics. Advanced Nurse Practitioners are an established part of the workforce in the Division with 14 WTE's qualified ANP's and 5 WTE's currently in training.

11. Anaesthetics and Surgical Services Division Staffing Review

11.1 Ward & Department Areas

The ASSD comprises of Critical care, Theatres & Day-care, Urology Breast, Trauma and Orthopaedics, General Surgery, Audiology, Oral Surgery, and Ophthalmology with an in-patient bed base.

11.2 Staffing Reviews

A review was undertaken of the Matron nursing roles in the Division due to Junior Matrons joining the teams. This included reviewing the areas covered and identifying

the most appropriate skilled staff to cover each area in their portfolios. This has ensured that areas where more support was needed have knowledgeable and experienced Matrons supporting them.

Ward E3 General Surgery was noted having high acuity due to the volume of clinical nursing interventions being undertaken affecting patient safety. As a trial, establishment of Registered Nurses was increased to 3 on night duty. This was a positive trail and a business case is in process.

11.3 Sickness, Staffing KPIs & Agency usage

Table 20 Nursing & Midwifery Registered Establishment staff in post and vacancy

Nursing & Midwifery Registered Establishment, Staff in Post and Vacancy by Month

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	38.35	427.22	465.57
2021 / 02	40.21	427.32	467.53
2021 / 03	39.55	428.00	467.55
2021 / 04	40.50	427.91	468.41
2021 / 05	36.60	429.51	466.11
2021 / 06	38.91	429.17	468.08
2021 / 07	35.50	430.22	465.72
2021 / 08	36.05	427.93	463.98
2021 / 09	43.14	422.57	465.71
2021 / 10	23.45	440.09	463.54
2021 / 11	32.28	438.77	471.05
2021 / 12	46.60	440.98	487.58

Following successful recruitment events Registered Nurse vacancies have decreased across all specialties within the Division.

Table 21 Additional Clinical Services Establishment, staff in post and vacancy

Additional Clinical Services Establishment, Staff in Post and Vacancy by Month

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	8.37	230.58	238.95
2021 / 02	9.33	230.02	239.35
2021 / 03	7.63	231.65	239.28
2021 / 04	13.39	225.88	239.27
2021 / 05	6.42	228.81	235.23
2021 / 06	4.42	231.26	235.68
2021 / 07	6.41	229.26	235.67
2021 / 08	5.47	232.19	237.66
2021 / 09	-4.36	242.04	237.68
2021 / 10	-11.31	248.98	237.67
2021 / 11	-8.55	246.54	237.99
2021 / 12	16.07	232.94	249.01

Health Care Assistants in the Division have the highest sickness and turnover rates this is reflected in table 21. Leavers are asked to complete leaver questionnaires and the Division works hard to understand causes and what can be done to change this.

Table 22 Sickness Absence

Sickness Per Month by Staff Group (Non-Covid-19 Related)

Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	6.61%	5.20%	3.74%	9.31%
2021 / 01	6.85%	5.11%	7.59%	9.75%
2021 / 02	5.72%	3.88%	11.16%	8.35%
2021 / 03	5.42%	3.26%	7.34%	8.92%
2021 / 04	5.76%	4.22%	5.06%	8.45%
2021 / 05	5.49%	4.21%	3.44%	7.85%
2021 / 06	6.37%	4.32%	6.43%	9.85%
2021 / 07	7.15%	4.72%	4.43%	11.52%
2021 / 08	7.05%	5.94%	0.00%	9.50%
2021 / 09	6.80%	5.85%	0.66%	9.44%
2021 / 10	7.62%	7.33%	2.42%	8.96%
2021 / 11	6.68%	5.75%	2.63%	8.94%
2021 / 12	8.09%	7.51%	2.15%	10.15%

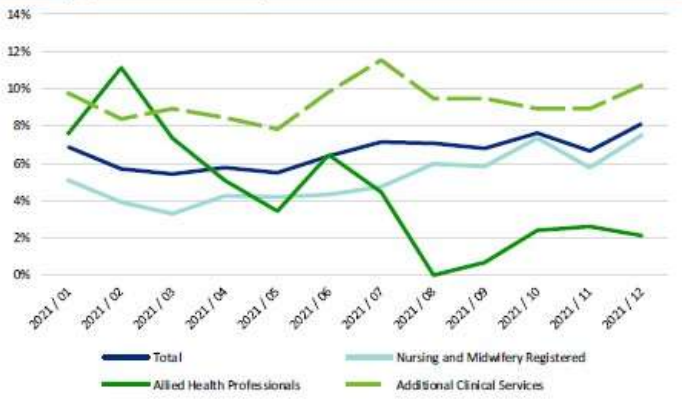
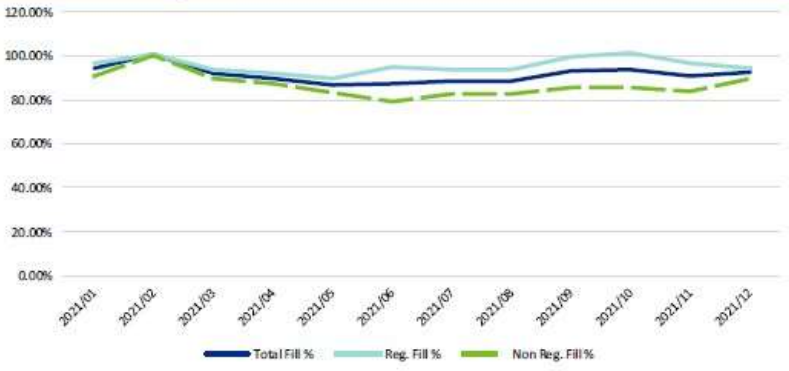


Table 22 shows an increase over the period Jul 21- Dec 21 in sickness, there is a high proportion of staff with depression, stress and anxiety related sickness. This is both work and non-work related. All staff are managed in line with policy and referred to appropriate services.

Table 23 Fill Rate

Shift Fill Rate by Month

Year / Month	Total Fill %	Reg. Fill %	Non Reg. Fill %
Total	91.58%	95.75%	86.75%
2021/01	94.46%	97.05%	91.13%
2021/02	100.73%	101.12%	100.27%
2021/03	92.03%	93.95%	89.99%
2021/04	89.88%	91.93%	87.57%
2021/05	86.69%	89.61%	83.48%
2021/06	87.57%	95.15%	79.08%
2021/07	88.76%	94.05%	82.60%
2021/08	88.76%	94.05%	82.60%
2021/09	93.39%	99.86%	85.93%
2021/10	94.10%	101.34%	85.70%
2021/11	90.98%	97.00%	84.06%
2021/12	92.45%	94.72%	89.58%



Fill rate in Table 23 shows an increase over the 6-month period. This has been improved with early roster approval and escalation of shifts at the earliest opportunity.

Table 24 CHPPD

Care Hours Per Patient Day (CHPPD) by Month

Year / Month	Total CHPPD No.	Reg. CHPPD No.	Non Reg. CHPPD No.
Total	7.66	3.60	4.06
2021/01	7.78	3.53	4.25
2021/02	6.95	3.30	3.65
2021/03	7.39	3.49	3.90
2021/04	7.18	3.20	3.98
2021/05	7.52	3.47	4.06
2021/06	6.97	3.45	3.53
2021/07	7.05	3.38	3.68
2021/08	7.07	3.26	3.82
2021/09	7.54	3.63	3.92
2021/10	8.65	4.06	4.59
2021/11	8.29	3.96	4.33
2021/12	9.72	4.57	5.15

11.4 **Recruitment & Retention**

We have held recruitment events for difficult to fill roles in theatres this has been successful and we continue to have rolling adverts to ensure turnover is covered.

11.5 **Advanced Practitioners**

Within the Division we have 10 Advanced Clinical Practitioners. 2 in Trauma Orthopaedics, 4 in General Surgery, 1 in Urology, 1 in Breast and 2 in Ophthalmology. We have applied for funding for a further 2 Trainee Advanced Clinical Practitioners.

12. Integrated Community Services Division Staffing Review (ICSD)

12.1 **Ward & Department Areas**

The Division comprises 40+ different clinical services compromising of a both nursing and AHPs. Providing both hospital and community based case with integrated care partners.

12.2 **National Staffing Guidelines**

Community nursing does not currently have robust staffing guidelines. There are plans in place for ICSD to implement the Community Nursing Safer Staffing Tool (CNSST) in 2022-23. This tool

- Supports capacity demand that recommends community nurse staffing levels
- Is sensitive to changing community workload.
- Supports community managers striving to meet Developing Workforce Safeguards (NHSI, 2018)
- Supports six-monthly Board reporting and annual staff establishment resetting requirements specifically for community nursing.
- Will determine best practice community teams using an established service quality audit.
- Compares funded, actual, temporary, and recommended community nursing staffing.
- CNSST implementation is a key deliverable of the national Community Nursing Plan.

12.3 **Staffing Reviews Undertaken**

There has been a thorough review of all nursing and AHPs staffing health rosters with the digital workforce team. This has enabled robust scrutiny of all rosters, agreed safe staffing numbers and subsequently ensuring monitoring of the agreed KPIs. During the winter months staffing is reviewed daily which ensures the following is in place:

- Nursing staffing ratios to meet acuity in both team, district and town with staff flexing across all 3 to ensure the patients nursing needs were met
- Additional support from the wider multi-disciplinary team to prevent duplication of visits and maximise clinical time

12.4 Metrics & Staffing KPIs

Table 25 Staff in Post

Nursing & Midwifery Registered Establishment, Staff in Post and Vacancy by Month			
Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	9.53	256.16	265.69
2021 / 02	15.82	253.32	269.14
2021 / 03	15.32	252.89	268.21
2021 / 04	16.84	251.36	268.20
2021 / 05	16.31	251.91	268.22
2021 / 06	11.11	254.88	265.99
2021 / 07	14.32	251.51	265.83
2021 / 08	18.37	247.58	265.95
2021 / 09	18.84	244.86	263.70
2021 / 10	4.00	258.02	262.02
2021 / 11	4.29	256.32	260.61
2021 / 12	9.30	258.52	267.82

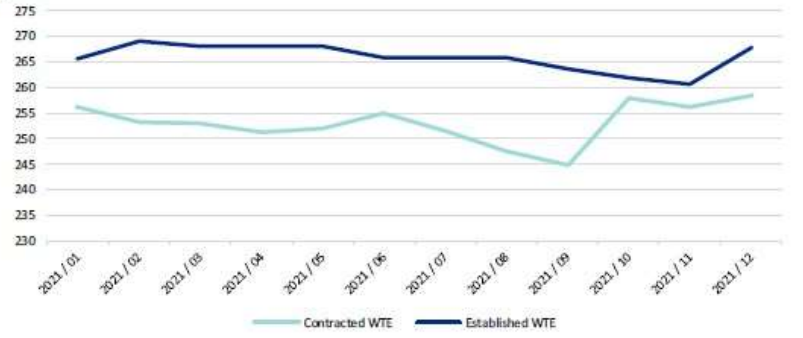
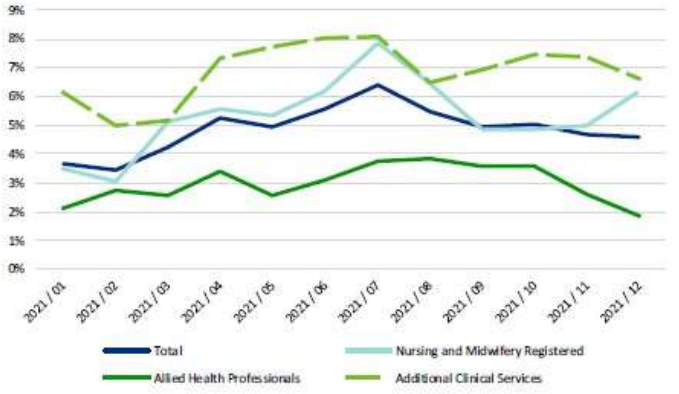


Table 26 Sickness Absence

The overall non Covid 19 related nursing sickness absence from July 2021 to Dec 2021 was 5.18% (Jan- Jun 21: 4.51%). The Division takes a proactive approach to managing sickness related absence and monthly long term sickness clinics are held with the DND and HR business partners and every effort is made to support staff to be well in work through a variety of flexible and supportive options.

Sickness Per Month by Staff Group (Non-Covid-19 Related)				
Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	4.86%	5.34%	2.96%	6.87%
2021 / 01	3.66%	3.46%	2.10%	6.12%
2021 / 02	3.43%	3.02%	2.73%	4.96%
2021 / 03	4.22%	5.14%	2.57%	5.18%
2021 / 04	5.25%	5.57%	3.40%	7.31%
2021 / 05	4.96%	5.33%	2.57%	7.73%
2021 / 06	5.55%	6.20%	3.08%	8.02%
2021 / 07	6.40%	7.84%	3.73%	8.08%
2021 / 08	5.48%	6.45%	3.81%	6.47%
2021 / 09	4.93%	4.87%	3.58%	6.94%
2021 / 10	5.02%	4.83%	3.56%	7.45%
2021 / 11	4.69%	5.00%	2.61%	7.39%
2021 / 12	4.58%	6.17%	1.83%	6.60%



12.5 Recruitment & Retention

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

- Fortnightly meetings with all Matrons and Principles Service Leads for escalation of staffing concerns and recruitment challenges
- Meetings with recruitment partners to escalate concerns related to delays in recruitment
- Commencement of talent management and succession planning considerations for grades 7 and 8a investment
- 6 staff successfully completed the Specialist Practitioner Qualification in District Nursing (SPQ-DN)

- Training commissioned to support with upskilling to support delivery of care; including but not exclusive: palliative care training, ear syringing, leg ulcer management, Non-Medical Prescribing (NMP) and clinical skills
- Working with UoB to develop a specific community nursing module
- Investment for additional wound care educator
- Success in application for 4 Health Education England North West (HEENW) places for the SPQ-DN course to ensure the community caseloads are led by qualified district nurses
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level.

12.6 **Nursing Associates (NA)**

The Division continues to embed the role of the NA in the community nursing teams and continues to consider it as a role switch when a RN vacancy becomes available. The NA is a core team member in AAT, community nursing teams, homeless and vulnerable adult team, treatment room and the district therapy hubs.

12.7 **Student Nurse**

ICSD welcomes students and prides itself in creating an environment for students to learn in an optimal environment and develop the skills they need for their future nursing careers. We are proactive in encouraging newly qualified nurses and nursing associates to join the Division as a primary career destination.
From April 2022 placement capacity is 100, this is an increase from pre-covid capacity of 89. ICSD also propose to offer a new community specialist service placement where students will rotate across 8 specialist teams.

13. Diagnostic & Support Services Division Staffing Review (ICSD)

13.1 **Ward & Department Areas**

There are no wards in the Division. The only patient care departments in the Division are pre-operative assessment and general outpatients.

Outside of this, care is delivered in numerous outpatient radiology departments much of which is delivered by AHPs rather than nursing staff.

13.2 **National Staffing Guidance**

The departments are staffed safely to the requirements of the services delivered in Division.

13.3 **Staffing Reviews**

Not applicable.

13.4 Sickness/ Staffing KPIs & Agency Usage

In nursing the use of agency and bank staff is negligible. The critical agency spend in the Division is on sonography staff as outlined in 13.5 due to a known staffing issue in this staff group.

Table 27 Staff in Post

Nursing & Midwifery Registered Establishment, Staff in Post and Vacancy by Month

Year / Month	Vacancies	Contracted WTE	Established WTE
2021 / 01	1.74	28.30	30.04
2021 / 02	1.17	28.30	29.47
2021 / 03	0.26	28.45	28.71
2021 / 04	0.26	28.45	28.71
2021 / 05	0.26	29.45	29.71
2021 / 06	-0.74	30.45	29.71
2021 / 07	2.60	29.45	32.05
2021 / 08	-0.76	30.45	29.69
2021 / 09	-1.54	32.25	30.71
2021 / 10	1.00	29.04	30.04
2021 / 11	-0.50	30.54	30.04
2021 / 12	-1.09	31.13	30.04

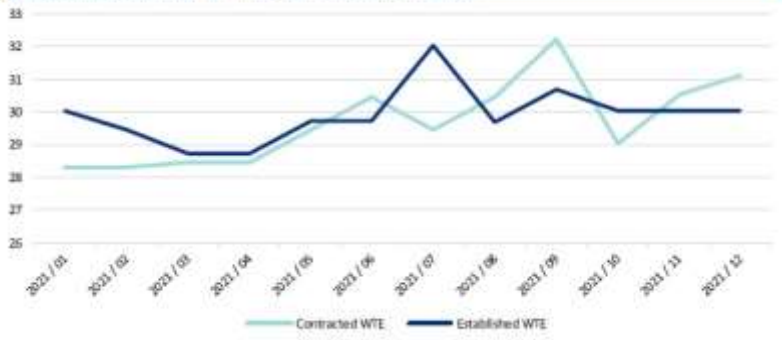


Table 21 Sickness Absence

Sickness Per Month by Staff Group (Non-Covid-19 Related)

Year / Month	Total	Nursing and Midwifery Registered	Allied Health Professionals	Additional Clinical Services
Total	4.77%	7.12%	3.12%	5.24%
2021 / 01	4.09%	4.21%	3.53%	4.41%
2021 / 02	3.89%	2.86%	3.66%	4.26%
2021 / 03	3.18%	5.94%	3.09%	2.60%
2021 / 04	3.74%	8.23%	1.68%	4.02%
2021 / 05	4.93%	12.21%	2.78%	4.75%
2021 / 06	4.37%	7.20%	1.70%	5.37%
2021 / 07	4.22%	5.55%	1.97%	5.25%
2021 / 08	3.86%	6.75%	1.33%	4.69%
2021 / 09	5.49%	7.29%	3.54%	6.25%
2021 / 10	5.77%	7.72%	3.12%	6.91%
2021 / 11	5.44%	5.51%	4.81%	5.79%
2021 / 12	7.86%	11.63%	6.00%	8.12%

The Division is unduly impacted by sickness when viewed as a proportion because of the relatively small number of staff. Small numbers of staff being absent from work have a significant impact on the proportion of staff off sick due to this.
There are no specific issues related to staff sickness and this is closely monitored through the Divisional IPMs.

13.5 Additional Roles, Initiatives & Innovations

There are no specific innovations regarding the nursing/AHP/clinical services workforce currently.

13.6 Recruitment & Retention

The Division is embarking on directorate listening events to improve the opportunities to understand the challenges within departments that generate difficulties in recruiting or retaining staff.

The key challenge in the Division in relation to both recruitment and retention is in relation to sonographers. There is a regional shortage of these staff in NHS organisations as they are being recruited into the private sector for pay and conditions that are nominally better than Agenda for Change. Approval has been granted to tender these services externally under a managed service contract and the Division has engaged two agencies to meet the needs of the service with limited success. This drain of staff generates a vicious cycle as the remaining staff feel unduly pressured due to the staffing deficit.

The Division is engaging with the staff supported by OD&L to support resilience and try and manage the stresses being experienced by the staff. A business case is in development to offer additional and new incentives for this staff group.

13.7 **Advanced Practitioners**

There are currently advanced practitioners in the Division, but a review is going to be undertaken of opportunities within Radiology as part of the Divisional Peoples committee.

13.8 **Student Nurses/ TNAs/ NAs**

Students are hosted in outpatients as hub placements and across various departments as spoke placements. The nursing team in the Division have worked closely with the Head of Clinical and Professional Development to ensure that placements are maximised under the Synergy scheme to grow the nursing workforce. In line with CPEP we are working on developing placement opportunities in cancer pathways and radiology.

14. Allied Health Professionals

The Trust employs nine different Allied Health Professions and these are employed across the organisation in most Divisions. The staff groups employed are: podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics (1 advanced clinical practitioner), physiotherapists, diagnostic radiographers and speech and language therapists. We have a contract with a private provider for our Orthotics service.

Our ESR data is within a high degree of accuracy for registered AHPs but is not yet accurate for AHP support staff. We have identified that there are 130 AHP support staff working across the organisation; ESR data identifies only 80 of these and work is being carried out in line with the HEE document
Allied Health Professions support workforce: readiness toolkit 2021 (hee.nhs.uk)
to cleanse and improve this data. In this way, our support staff will be more visible in Trust data enabling us to gain a better understanding of this workforce.

14.1 **AHP Staff Sickness**

AHP sickness rates remain low compared with other staff groups (2.73% average compared with Trust average of 5.84%). AHPs tend to be employed in small specialist teams with clear service aims and supportive supervisory structures. These are sickness

rates of Registered AHPs staff. As mentioned above with the inaccuracies on ESR with AHP support staff we do not have oversight on support staff sickness. The work to improve this is continuing.

14.2 AHP turnover and staff retention

AHP turnover and retention data is available through the Divisions but would also benefit from further scrutiny. The Assistant Director of AHPs is reviewing AHP vacancy data over the next quarter to identify areas of concern and good practice and to contribute to an effective AHP workforce plan.

14.3 AHP Workforce Risks

As identified in previous staffing reports to Board and People Committee there are not yet nationally recognised figures for safe AHP staffing establishment other than for Stroke (Stroke Sentinel Audit) and Critical Care (GPIICS).

14.4 Workforce developments

Bolton NHS FT has been part of a national HEE funded project since October 2021 to better understand and measure the AHP workforce and to develop an AHP strategic workforce plan.

The investment aims to help the NHS achieve its target, as set out in the pre-pandemic NHS People Plan, of having 27,000 additional AHPs by 2024 to meet future AHP workforce demand. This is considered a conservative estimate given the additional workforce demand arising from the pandemic and recovery plan and from the 2020 Diagnostics Review (Richards Review).

The intended legacy of this investment is to provide organisations with dedicated insight into AHP workforce issues.

The nationally mandated strategic aims are to:

- Demonstrate financial accountability and value for money
- Support effective short and long-term AHP workforce planning through timely access to accurate AHP workforce supply and demand data and intelligence
- Support the continued growth of band 5 posts
- Reduce AHP student attrition and improve retention of students and new graduates
- Deliver HEE Return to Practice national mandate of 250 completers returned to the HCPC register plus a further 250 AHPs through International recruitment by March 2022
- Explore the potential for further workforce growth through targeted international recruitment
- Support workforce growth and widening participation by maximising access routes into pre-registration level 6 AHP apprenticeship
- Support the National AHP Support Workforce Programme to achieve deliverables

The Bolton AHP Strategic workforce team were recruited in October 2021 and commenced their roles in November and December 2021.

The outcomes and outputs of the project will be summarised in the next Safe Staffing paper and reported to the People Committee.

15. Conclusion

The paper clearly articulates the Trusts Nursing Midwifery and Allied Health Professionals staffing position. Research evidence of the association between nurse staffing levels and patient outcomes is compelling. We know that improved nurse and midwifery staffing is associated with reduced risk of patient harms and lower mortality rates.

Reviews of staffing numbers and skill mix are almost continuous and changes are based on triangulation of acuity, current quality indicators, outcomes and professional judgement, whilst taking into account national guidance as this becomes available.

The paper gives assurance that the Divisional teams are fully aware of key issues in relation to staffing. The Divisional reviews demonstrate that each area have their own specific challenges and that leaders within the Divisions are fully cited on these and are addressing recruitment, retention and sickness management as appropriate.

The paper also alludes to the work that was undertaken following the NHSE/I publication for the Winter Workforce Board Assurance Framework (BAF). This allows us to plan and have a preparedness for future winter workforce planning at what we know is our most difficult time.

Staffing papers presented to Board over the last 12 months have provided assurance that current staffing establishments were safe but could be further optimised. The SNCT has been implemented over the previous 12 months and 2 date two data capture census periods have been completed. In order to further validate our findings, the newly appointed Chief Nurse has requested a further and in order to validate our findings further a third data capture census is scheduled for October 2022.

The Board of Directors are requested to:

1. Approve the content of this staffing review
2. Recognise the work undertaken in the period July to December 2021
3. Support a third data capture using the SNCT

16. References

NQB (2016) *Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time*

NHSI (2018) *Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing* NHS Improvement, London

CQC (2020) *https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led*

NHSE&I (2021) *Winter Workforce Board Assurance Framework*

NMC (2016) *Safe Staffing Guidance.* NMC Org.uk

Richards (2020) *Diagnostics Review*

Appendix 1

BOARD ASSURANCE FRAMEWORK-NURSING AND MIDWIFERY STAFFING

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

Ref	Details	Controls	Assurance (positive and Negative)	Risk Score / ref	Further action needed	Issues currently escalated	Ongoing Monitoring / Review
1.0	Staffing Escalation / Surge and Super Surge Plans						
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e. intensive care) or as per the NQB	Plans in place to support surge and super surge. Retraining of theatre staff to support ITU. Divisional escalation SOPs. staff lists of non-ward based nurses to include competencies. Managing mutual aid across network. Within Maternity services acuity is checked four hourly in line with GM Maternity escalation policy and escalation enacted appropriately as identified Following Critical care guidelines and implementation of Surge plans across Trust and within network to give a balance of safe staffing levels.	Bank Pay and incentives for bands 2-8 approved and implemented from November 2021 Funding received from NHSE/I to support International nursing team. 6 have already joined us and a further 10 are in training. 3 more are expected to arrive in UK December 2021. Ever changing pandemic travel restrictions may cause delays. Theatre staff available but only if elective activity is stood down to support. Draft GM Escalation Framework agreed at GM Chief Nurses re: the management of mutual aid across the GM Network when	5166/9 2126/6 4777/15 2503/8 5005/15 4636/9	Divisional staffing escalation SOPs finalised. Changes to be communicated to all staff Non- ward based nurses' availability lists to be reviewed and signed off at December Divisional Board meetings. Over recruitment in Critical Care will support surge planning. Currently recruiting to Matron for critical care Supporting induction of 6 overseas nurses with Practice Educators in Critical Care. Framework to be finalised and embedded	Surge and Super Surge plans discussed at Greater Manchester Chief Nurses Forum as required.	Agenda item at Chief Nurse SMT as required GM Chief Nurses

			escalation needs arise.				
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Divisional escalation plans will be supported by Non ward- based nurses if required. Review of Covid nursing list is currently underway and Practice Educators will support review of skills passports.	Staff lists on agenda for formal review at Chief Nurse SMT 07/12/21 Process in place reviewing all non-ward based nursing roles to back fill if required	5166/9 2126/6 4777/15 2503/8 5005/15 4636/9	On-going Management of sickness absence and well-being to maintain established workforce levels		Absences monitored via Divisional Dashboards and People Committee
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	The Trust has agreed improved Nursing bank rates for both substantive plus bank as well as bank only staff, effective from 4.10.2021. This includes premium for Band 5 which will increase capacity. Escalated rates are also in place for certain service areas and in response to numbers and impact of these of shortages.	The rates were supported at Workforce Partnership Forum meeting 09/21	N/A	Nurse Associate pay rate available to be used as Band 4 for core enhanced rate and escalated rates. and further work is being undertaken to review Nurse Associate bank rates and Medical pay rates.		Continued engagement with staff side

1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	There is a Quality Impact Assessment (QIA) process which requires them to be signed off by MD and CN. The process would be applied to ward changes carried out for these reasons e.g. reduction in establishment or re-configuration of the wards. The corporate checklist for QIA is available and there is training that the PMO run on how to complete a QIA.	To date we have not applied the QIA process for any ward changes this year as there have been no significant changes to the function and configuration. Any further escalation will be subject to a QIA signed off by Chief Nurse Age of current estate may impact on the time and amount of work needed to re model areas.		Testing and review of QIA process as further winter planning work gets underway.		QIA reviewed at CNSMT
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality	Daily staffing meeting takes place chaired by AND for Workforce and with Divisional representation reviewing the following 24hrs. Shortfalls in staffing are discussed and plans to mitigate and escalate made.	Positive- Staffing across the whole site is discussed and documented four times a day at each Bronze bed meeting. Negative- No documented risk assessments and	5166/9 2126/6 4777/15 2503/8 5005/15 4636/9	Implement a documented risk assessment and quality impact as part of daily meeting.	Staffing availability is reported through the command and control structure and escalated to GOLD as required and in line with the trust escalation matrix. Critical	Escalated to Silver and subsequent Gold meetings as required

	impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Weekly Senior Nurse Walk rounds have been re-established and take place weekly	quality impact recorded.			Care staffing is reported as per network processes across the North West region. A critical Care sit rep is reported through to GM gold on a daily basis. Local risks are escalated through GM meetings attended by Chief Nurse, Medical Director and HR Directors to provide a Greater Manchester overview.	
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in	Daily and weekly calls take place with Divisional representation from AACD & ASSD. Gaps in staffing are discussed and escalated to Bank/Agency as appropriate.	Positive- Meetings are minuted by Workforce Team with clear actions for Divisions. Negative- Not in place for all Divisions		DND oversight and escalation		

	the incident logs and assurance is gained that this is successful and that safe care is sustained.		Full DND over sight not in place.				
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	Digital SBAR handover tool This would also be reviewed at ward handovers and safety huddles. Strong presence of Practice Educators on Clinical areas	Positive- Digital SBAR handover tool embedded and utilised for patients transferring from Emergency Department Negative- Digital SBAR handover tool not used on patient transfer across hospital site. Incident reports reviewed by Divisional Management Teams		Review digital SBAR handover tool and explore if there is potential to utilise for all in-hospital transfers.		
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	This would be escalated at the point of occurrence and also reviewed at ward handovers and safety huddles. SafeCare system currently being rolled out.	Positive- Embedded practice includes escalation to Matrons for area. Out of hours this would be escalated to On-call Matron until 9pm and the Site- Co-ordinator Overnight. Negative- Site-Co-ordinator is also		Project underway for Matrons to utilise SafeCare to review acuity and dependency and professional judgement before making staffing decisions SafeCare project successfully implemented in Children and Young people		

			managing flow as well as staffing.		assessment areas and all adult inpatient wards. Plans in place to commence using the tool within the Accident and Emergency Department February 2022. Job role review of H@N and Flow Teams being undertaken by newly appointed interim Corporate Director of Nursing.		
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	All Temporary Agency Staff taking up a short term contract of less than 3 months are not required to attend Corporate Induction but are required to complete Local Induction Checklists. Those contracts longer than 3 months attend Corporate Induction and complete a Local Induction Checklist within two weeks of appointment. These are led by the Line Manager as per the	Corporate and Local Induction policy in place and retained on file at service level. Agency Nurses have the checklist completed on arrival to first duty when new to any ward area and copy retained on file. Current Fit mask testing services for agency staff has been reduced a solution for	2641/12	Review of current Local Induction checklist for Temporary Workers. Review processes around agency workers who take on 3 month contracts as these are not currently attending Corporate Induction. Re-educate Ward Managers on policy expectations.	Not required Agenda item Ward Managers /Matrons Forum. 15-12-21	Reviewed and monitored via Corporate workforce meetings

		Corporate and Local Induction Policy.	this is currently being sought.				
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Incident reporting via Ulysses Additional support can be sought from Senior Nursing Leadership Team in core hours and to Staffing matron out of hours Corporate Specialist teams including Safeguarding offer support trust wide. All staff have access to these teams For student Nurses there are in addition to the Practice Educator Facilitators also Divisional Educational Leads covering all clinical areas	Process is recorded via Incident reporting system. Negative- No formal clinical supervision process in place for staff. Supervision is currently ad-hoc				The NMAHP Professional Forum via the Educational Sub group

2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.	Staffing concerns reported via Ulysses Incident reporting system. Monitored at Divisional Board meetings and subsequent Trust Integrated Performance Meetings	Staffing Incident Reports circulated and include automated group email to Senior Nurse leaders and Executive Directors				Trust IPM Risk Management Committee
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	The Trust has a comprehensive health and well- being offer which also includes the GM offer. Locally at Bolton we have in-housed the OH service which has improved timescales and quality as well as increasing the capacity for staff counselling and OH Physician and OH Nurse capacity. The Vivup portal offers a one stop shop for staff health and well- being and staff benefits, including the	Reports to People Committee and Board of Directors Staffing metrics – the Trust benchmarks favourably with comparatively low sickness absence and good staff survey metrics		Ongoing focus on staff wellbeing		People Committee

		24/7 EAP and telephone counselling. Mental Well Being drop in service is also offered via OHS. The Trust subscribes to the Shiny Mind app which is available to all staff. Local health and well -being champions are in place.	Full details of all actions included in Board report				
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self-Isolation, shielding, and those that are off sick. Leaders and board members therefore have a	Covid and non Covid absence/sickness is captured within the HealthRoster system. More than 80% of the Trust also use the same system to capture all other employee unavailability.	Positive: Reports using all employee 'unavailability' data in the system is shared at Trust and Divisional level 5 days per week The data includes; annual leave, sickness, Covid-19 related unavailability, study leave, other leave. Negative: Not all teams use the system (<20%).	3088/12	Plans in place to include medical staff from March 2022		People Committee

	holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g. use of arrest or peri arrest debriefs, use of	Staffing incident reporting embedded. Schwartz Rounds are now implemented in the trust for staff to reflect on emotional aspects of their work, this could include staffing implications. We have numerous staff from varied professional and clinical areas who have completed TRIM training, they are trained to undertake risk assessments and sign post staff for support as required. We have engaged with the national	Positive- 14 TRIM assessors trained. Negative- Plans not finalised for further training. Positive- To date there are currently 6				The NMAHP Professional Forum

	outreach team feedback etc.) and learns from this intelligence.	Professional Nurse Advocate Programme. Commenced senior Nurse walk rounds. Process in place to include rota and weekly feedback meetings	qualified PNAs with a further 5 in training. Maternity services have 10 qualified PMAs with 2 in training.		Continue to train further PNA/PMAs		via the Educational Sub group
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or	The Deputy Director of OD and Deputy Director of Workforce sit on the Silver Command Group and advise the group on workforce/wellbeing matters. Monthly Staff Experience Steering Group meetings take place – the group is responsible for monitoring the delivery of the Trust's staff wellness programme.	Minutes of Staff Experience Steering Group meetings and Silver Command Group meetings are taken.				Staff Experience Steering Group

	notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Daily staffing meeting takes place chaired by AND for Workforce and with Divisional representation reviewing the following 24hrs. Shortfalls in staffing are discussed and plans to mitigate and escalate made. Staffing across the whole site is discussed and documented four times a day at each Bronze bed meeting.	Embedded process for daily staffing meeting with workforce and Divisional representation				Flow meetings Bronze
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation	Preparedness and mutual aid across GM The Trust has adopted the GM Staff Digital Passport which supports temporary use of staff across organisational boundaries.					

	routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	Divisional Data- Introduced SAFECARE. SNCT Census Data collection	Positive- Training for all Ward Mangers and Band 6's completed, Negative- Matrons training session planned 17/11/21 & 22/11/21. Band 5 staff training sessions running weekly but not all fully trained Trust is currently in phase 2 of SafeCare project		Continuation of SafeCare project which will involve a further data census collection period in Feb 2022. Introduction and utilisation of the tool in the Emergency Department. Continuing training for the Band 5 workforce. Staff not yet utilising data to inform staffing decisions.		
4.0	Board oversight and Assurance (BAU structures)						
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing	Staffing concerns discussed at Executive Director weekly meeting The biannual Nursing, Midwifery & AHP Staffing report Business Case for Enhanced Care Team	The Nursing, Midwifery & AHP Staffing report is presented twice yearly to the Board of Directors. Board and People Committee reports and minutes				

	hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	supported by EDs and at CRIG	Ward to Board heatmap Recruitment in process- Full staff compliment not yet in post				
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Committee structure/membership designed to enable triangulation of metrics – Non Exec members cover two committees and cross reference debate IPRs – include harm free care, complaints management, SI's	Ward to Board Heatmap Board and QA Committee meetings				
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care	The Integrated Performance dashboard IPM meetings and the Committee structure	The Integrated Performance dashboard does not include Covid winter focused metrics but does include Sickness and Covid absence.		The Integrated Performance Dashboard is currently being reviewed.		

	alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.	Staff are encouraged to log all staffing incidents on Ulysses incident reporting system. Staffing incidents are collated and shared via email to all senior nurses and Board members Ward to Board heat map	Positive- We have positive reporting on staff reporting issues. Managers action incidents timely this is reflected in our NRLS deadlines. Discussed at IPM and quality report this can then be another measure. Board sighted through this.				
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur	Quality Committee terms of reference and agenda setting Covid governance structure	Divisional Governance reports				

	delivering care through staffing in extremis.						
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	Risk Management Committee chairs report goes to QAC Each Division on rolling programme to report quarterly to QAC this includes staffing and operational challenges - this is also reported at Clinical Governance and Quality Committee.	Positive- Risk committee provides an opportunity for any escalation or an emerging risk outside of the rolling programme. To ensure there are no missed opportunities to highlight staffing issues.				
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed	Risk Register has a staffing category for teams to input staffing risks. All staffing risks were Subject to a deep dive thematic summary report 9/21 for the risk management committee Support from Head of HR to support staff recruitment risks	Positive- Staffing Thematic Deep dive has allowed to focus purely on staffing for that meeting. It also greater scrutiny on this topic at this committee. Regular operational updates to Board include workforce challenge Rolling agenda item at QAC ensures standing agenda item		To re-run thematic report to ensure all actions completed.		

	via the trusts risk register process.	Risk Management Chairs report goes to QAC monthly	Collaborative working with HR.				
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e. risks outside of the desired appetite are not tolerated without clear discussion and rationale	Divisions have their own internal processes/committees to check risks DDO present at RMC so high level reporting 12+ discussed monthly with all Divisions on rolling programme to present. Also cover new/emerging risks outside this schedule at RMC Summary report covers long term risks	Divisions have their own internal governance processes to monitor risks and ensure constructive challenge. DDO represents at RMC which ensures high level reporting. There is a high level of exec attendance and chaired by executive member All risks above 12+ are discussed monthly; with all Divisions presenting on rolling programme The committee also covers new and emerging risks outside this schedule				

	and are challenged if longstanding)	(year risk added) for extra scrutiny	The governance team provide trust wide summary report which also highlights long-term and the dynamic movement of all risks. Collaboration with PWC as an external auditor to maximise the efficacy of the RMC. (Positive Feedback).				
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	Board Assurance Framework includes staffing and workforce health and wellbeing. BAF is reviewed regularly by execs and is discussed in Board and in Audit Committee. Staffing assurance framework shared with Board members	Board minutes Board Assurance Framework	BAF risk 2 Score 16			Regular BAF updates to Board
4.10	Any active significant workforce risks on the Board Assurance Framework	Board work plan and assurance mapping to ensure BAF risks inform the Board agenda	Board minutes Board Assurance Framework	BAF risk 2			Regular BAF updates to Board

	inform the board agenda and focus			Score 16			
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	Chief Nurse oversees relationship management with CQC and NHSE/I updates at Executive meetings and informs Board members	Chief Nurse updates to QA Committee and Board - minutes				

Agenda Item

21

Title:	Guardian of Safe Working (GOSW) Annual Report

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28th July 2022		Discussion	
Exec Sponsor	Francis Andrews		Decision	

Summary:	All doctors in training at Bolton NHS FT are working under the 2017 Terms and Conditions of Service (TCS). The contract requires then to report all exceptional hours worked outside of their contractual hours. The data gathered from exception reports provides useful information about the intensity of the workload on each rota. It is a useful tool to alert the Trust to unsafe practices that may lead to a reduction in patient safety. The data from this process is presented in this report. Conclusions drawn from the data should take into account that non engagement in the process could lead to underestimation of junior doctor safe working. It is recognised nationally that not all junior doctors report the extra hours that they work outside their contracted hours for a variety of reasons.

Previously considered by:	People Committee

Proposed Resolution	For the Board of Directors to note for assurance.

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

Prepared by:	Ian Webster, GOSW	**Presented by:**	Ian Webster, GOSW

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

BMA	**British Medical Association**
COW	**Consultant of the week**
DMD	**Divisional Medical Director**
DRS	**Doctors Rostering System**
ER	**Exception Report**
ES/CS	**Educational Supervisor/Clinical Supervisor**
FY1/2	**Foundation Year 1/2**
GMC	**General Medical Council**
GMMH	**Greater Manchester Mental Health**
GOSW	**Guardian of Safe Working**
JDF	**Junior Doctor Forum**
JLNC	**Joint Local Negotiating Committee**
MEM	**Medical Education Manager**
NETS	**National Education and Training Survey**
NWGOSW	**North West Guardian of Safe Working**
ST	**Specialty Trainee**
TCS	**Terms and Conditions of Service**
WTR	**Working Time Regulations**

Guardian of Safe Working Hours (GOSW)

Annual Report: 1st April 2021 – 31st March 2022

1. Introduction

1.1 The Terms and Conditions of Service (TCS), of the junior doctor contract (2016) requires the Guardian of Safe Working (GOSW) to submit quarterly reports as well as an annual report to the Trust Board via the People Committee.

1.2 Quarterly reports have been submitted to the committee and this is the annual report to reflect the findings for the period 1st April 2021 to 31st March 2022.

1.3 All doctors in training are now working on the 2016 TCS.

1.4 Due to COVID 19, rota patterns may have changed to emergency 12 hour on call in some specialties and hence WTR 1998 would have been the fall-back position, as per advice issued by the BMA. This may have led to less exception reports being generated.

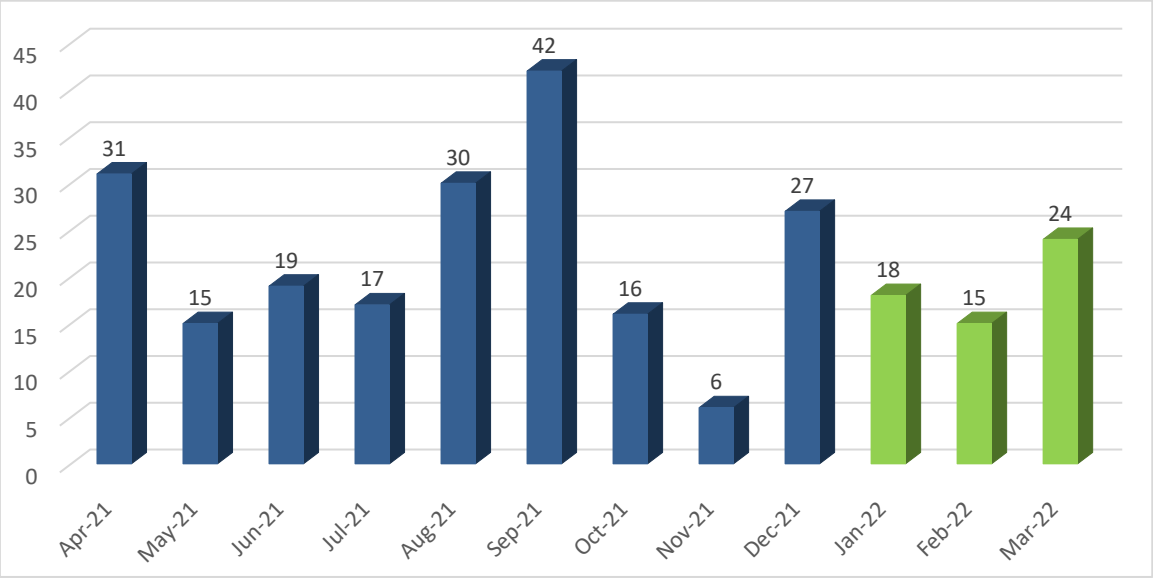
2. High level data

Number of doctors in training	**214 WTE**
Number of doctors working less than full time	**56**
Time available in job plan for GOSW	**1 PA/week**
Administration support provided to GOSW	**7.5 hours/week**
Number of recognised Educational/Clinical Supervisors	**157 both ES/CS** **61 CS only**

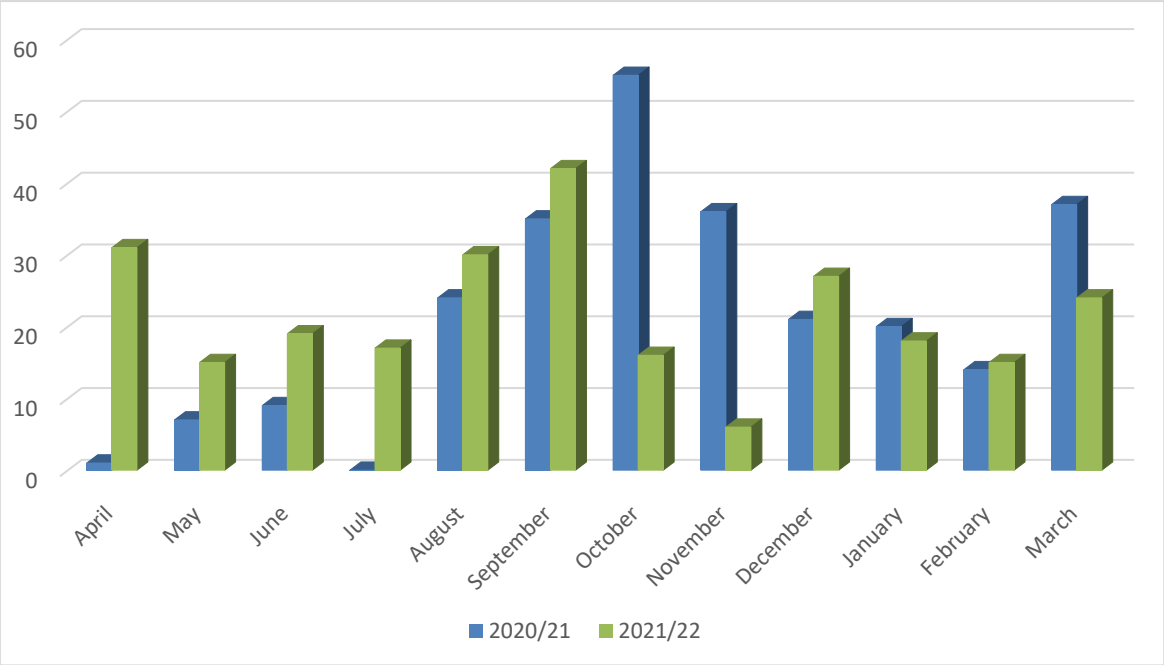
3. Exception Reporting Activity

3.1 Doctors in training are asked to electronically submit exception reports when they work over their contracted hours, when they are unable to achieve breaks/rest periods or for missed educational opportunities. Within the reporting period there were **260** exception reports submitted.

3.2 Exception reports submitted by month.

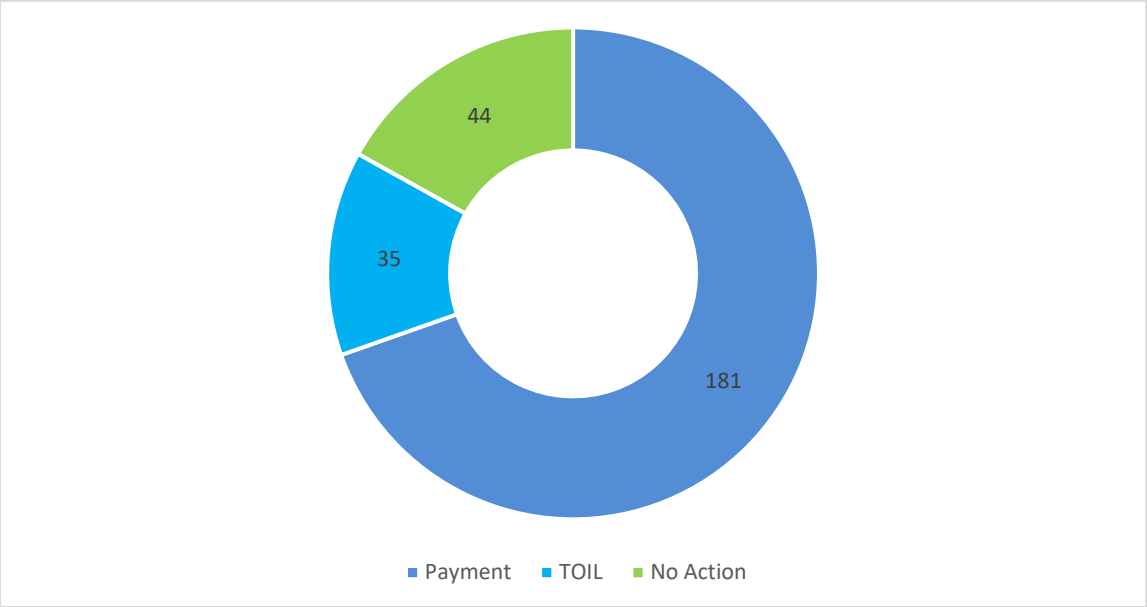


3.3 Exception reports submitted by month compared with the previous year.



3.4 Exception reports submitted by outcome.

Outcome	No of exception reports raised in this period	%	Number of extra hours equates to
Payment for additional hours	181	70%	227
Time off in lieu	35	13%	73.5
No action required	44	17%	
Total	**260**	**100%**	**300.50**



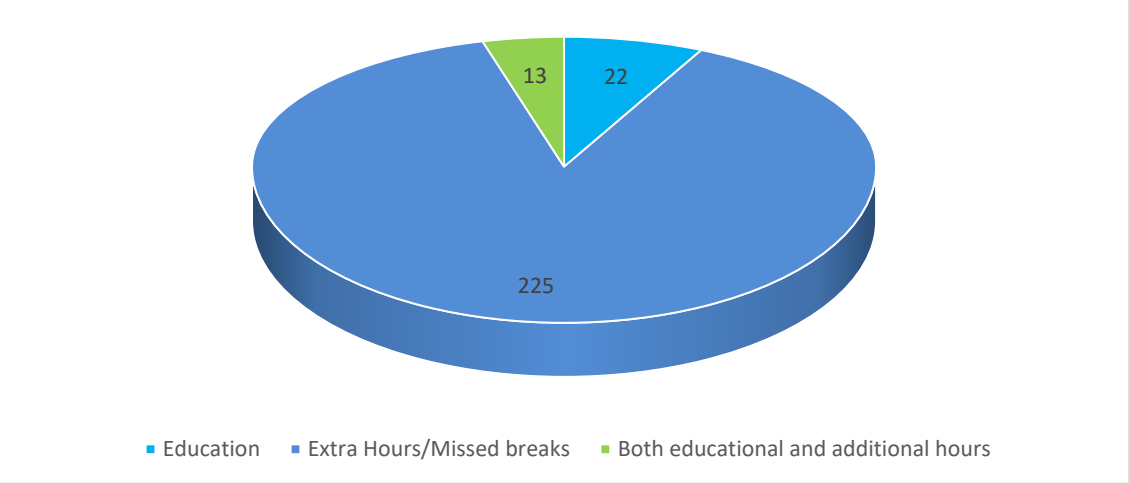
3.5 The costing of exception reports for the year 2021-2022 (**for RBH payroll only**) is shown below:

Quarter	Number of hours claimed	Value
Quarter 1	48.5	896.09
Quarter 2	35.25	687.96
Quarter 3	49	877.10
Quarter 4	44.25	795.24
Total	**177 hours**	**£3,256.39**

The remaining hours are for lead employer doctors for whom we don't have costings from St Helens & Knowsley payroll.

3.6 Exception reports submitted by type.

Type	No of exception reports submitted in this period	%
Educational	22	8%
Extra hours/missed breaks	225	87%
Both educational and additional hours	13	5%
Total	**260**	**100%**



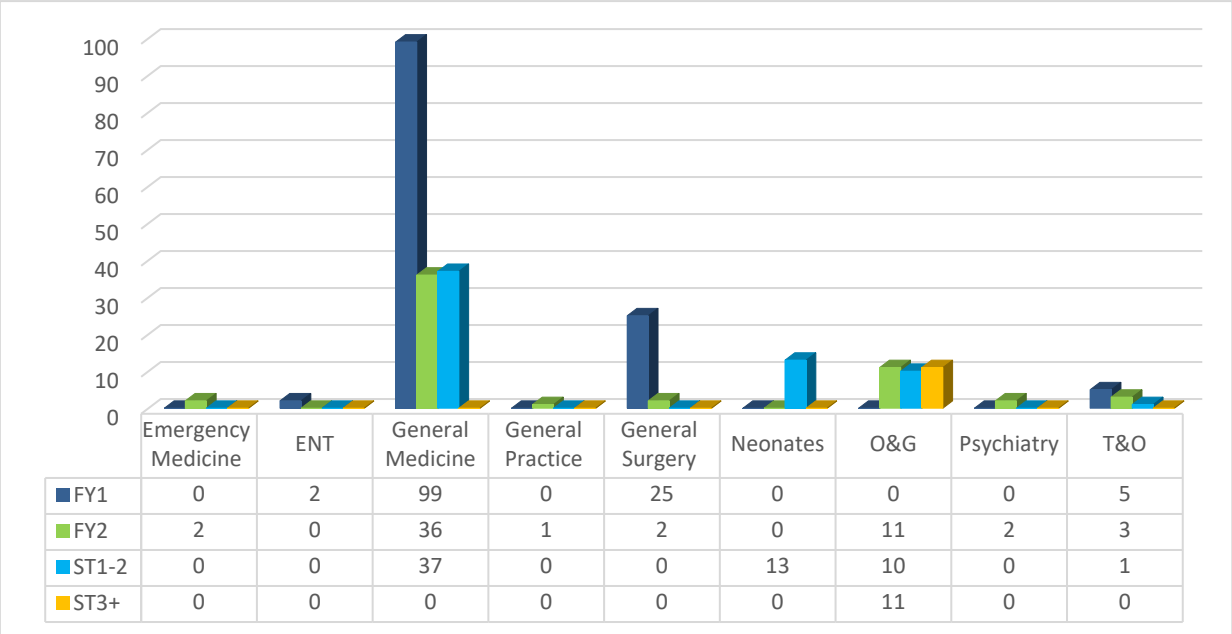
3.7 Number of exception reports submitted by specialty.

Specialty	No or ER submitted
Emergency Medicine	2
ENT	2
General Medicine	172
General Practice	1
General Surgery	27
Neonatal Medicine	13
Obstetrics & Gynaecology	32
Psychiatry (GMMH)	2
Trauma & Orthopaedics	9

3.8 Number of exception reports submitted by grade.

Grade	No of ER submitted
FY1	131
FY2	57
ST1-2	60
ST3+	12

3.9 Exception reports submitted by specialty and grade



	Emergency Medicine	ENT	General Medicine	General Practice	General Surgery	Neonates	O&G	Psychiatry	T&O
FY1	0	2	99	0	25	0	0	0	5
FY2	2	0	36	1	2	0	11	2	3
ST1-2	0	0	37	0	0	13	10	0	1
ST3+	0	0	0	0	0	0	11	0	0

4. Work Schedule/Rota Reviews

4.1 No work schedule reviews have taken place during the reporting period.

5. Immediate Safety Concerns

5.1 In the last 12 months 8 exception reports were identified by doctors as being an 'immediate safety concern'.

Specialty	Number of safety concerns submitted	Reason
General Medicine	3	Staff shortages and heavy workload
O&G	4	Staff shortages and heavy workload
Psychiatry	1	Staff shortage

5.2 The information from the 'immediate safety concern' exception reports concur with those obtained from the GMC and NETS survey results relating to staff shortages and heavy workload in Medicine and O&G which affects the doctors overall satisfaction.

6. Fines

6.1 To date the GOSW has not levied any fines.

7. Junior Doctor Forum

7.1 As part of the TCS (2016) there is a requirement to hold a regular Junior Doctor Forum (JDF). The main purpose of the forum is to provide doctors in training with the opportunity to feedback about the contract and also to agree to how any monies accrued from fines should be spent.

7.2 The JDF meets on a quarterly basis at Bolton NHS FT. Meetings were held in June, September and December 2021. The meeting scheduled for March 2022 was cancelled as the GOSW had reached the end of her tenure. The attendance has been poor, possibly due to Covid, staffing

shortages and an increased workload. The junior doctor BMA representative was present for all meetings. More engagement from all grades would be welcomed.

8. GOSW Activity

8.1 Quarterly reports have been presented to the People Committee and JLNC. The GOSW has attended Medical Education Board and the NW GOSW meetings when clinical commitments have allowed.

8.2 Following requests to attend Divisional People Committee meetings the GOSW attended regular meetings across all divisions. The meetings have been successful and help the GOSW and team to understand the division's response towards monthly reports and to also have direct communication with the divisions.

8.3 Dr Qamrunnisa Yunus-Usmani ended her tenure as GOSW in March 2022.

9. Summary

9.1 The Trust appointed a new Guardian of Safe Working, Dr Ian Webster, to take over from Dr Qamrunnisa Yunus-Usmani in April 2022.

9.2 The number of exception reports submitted has remained consistent with 260 being submitted this year compared to 259 in the previous year.

9.3 The primary reason for exception reporting related to junior doctors working above their contracted hours due to high workload and/or low staffing levels and this pattern has been consistent over the years.

9.4 Exception reports submitted by junior doctors highlighting missed educational sessions as a result of service pressures were escalated to the Director of Medical Education as per protocol.

9.5 Eight exception reports were identified by the doctors as being an 'immediate safety concern'. These were reviewed by the relevant educational supervisor and GOSW and concerns escalated as appropriate.

9.6 No work schedule reviews have taken place during the reporting period.

9.7 No fines have been levied by the GOSW during the reporting period.

9.8 The majority of exception reports submitted by junior doctors who have worked extra hours have been actioned for payment. The GOSW will continue to liaise with doctors, particularly those grades and specialties who are not currently exception reporting, to encourage use of the system.

9.9 Attendance at the Junior Doctor Forum has been poor throughout the year. The JDF have provided oversight on how the £30k awarded to Bolton NHS FT, to support the BMA Fatigue and Facilities Charter, should be spent. It is intended that the funds will be spent during the 2022-2023 financial year.

10. Recommendation

10.1 The Committee is asked to note the contents of this report.

Agenda Item: 22

Title:	Freedom to Speak Up Annual Report 2021-22

Meeting:	Board of Directors	**Purpose:**	Assurance	X
Date:	28th July 2022		Discussion	
Exec Sponsor:	James Mawrey, Director of People		Decision	

Summary:	This report provides an annual update on Freedom to Speak Up (FTSU) activity within the Trust during the period from 1st April 2021 to 31st March 2022. Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement. The Trust's FTSU approach continues to be embedded to support the organisation to develop an inclusive and transparent culture. The positive work that has been undertaken has been evidenced by the Trust's impressive 2021 NHS national staff survey results.

Previously considered by:	People Committee

Proposed Resolution:	Commended to Trust Board for approval.

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:	Tracey Garde, FTSU Guardian	**Presented by:**	Tracey Garde, FTSU Guardian

1. Introduction

1.1 Speaking up is about raising a concern about anything that gets in the way of doing a great job. Freedom to Speak Up (FTSU) Guardians support workers to speak up when they feel that they are unable to in the usual ways. There are currently over 800 FTSU Guardians in the NHS and independent sector organisations, national bodies and elsewhere. Our own mental health can be affected if we do not feel we can speak up whether it is about our own mental health, ways of working, ideas for improvement or patient safety. Teams that are psychologically safe, work with a growth mind-set and an eager to learn culture that makes everyone feel included and less alone. These are key elements to a successful speaking up culture.

In December 2021 a new National FTSU Guardian was appointed- Dr Jayne Chidgey Clark.

"Speaking up on its own cannot lead to improvement and change without the voice of change being listened to and action taken." Dr Jayne Chidgey-Clark National Guardian

1.2 We currently have a network of 37 FTSU Champions across the Trust. The FTSU Champions all expressed an interest in this important voluntary role and were interviewed individually alongside their manager to ensure they had the necessary skills and attributes to listen and support their colleagues. These Champions, who come from a variety of roles and backgrounds and reflect the diversity of our organisation, have been trained by the Guardian and are available to support and encourage workers to speak up and raise their concerns. 31 FTSU Champions are employed by the Trust and 6 by IFM. The Guardian hosts regular meetings with the FTSU Champions and is available to them for advice and support whenever required. **Appendix one** shows the current list of FTSU Champions. The Guardian will be looking to recruit further FTSU Champions later in the year particularly from areas and departments that currently are not represented including more individuals from our Black, Asian and Minority Ethnic community, our LGBTQ+ Community and workers who have a disability.

1.3 The Guardian continues to be available to support all workers working within the Trust and IFM including NEDs, volunteers, students and contractors.

1.4 The FTSU approach continues to be promoted via the Trust's normal internal communication channels, Trust induction sessions, presentations, and workplace visits although the latter have been limited over the last few years due to the pandemic. The Guardian also regularly presents on preceptorship programmes, care certificate training and other training sessions to ensure the message of speaking up is communicated widely across the organisation. Due to Covid-19 restrictions visits to clinical areas were put on hold but are starting to resume as soon as permitted. A FTSU communication strategy has been developed and implemented to ensure speaking up becomes business as usual.

1.5 The Guardian continues to meet monthly with the Chief Executive, Director of People, Non-Executive Lead for the FTSU approach and the Chair of the People Committee. At these meetings the Guardian provides an overview of the new cases reported, the themes identified and actions taken. The Guardian also provides updates on ongoing cases. The Chief Executive and Director of People ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases in a timely manner and ensure that good practice and learning is shared across the organisation.

1.6 The Guardian remains fully engaged with the National Guardian's Office and the North West FTSU Guardians Network to learn and share best practice. The NW Guardians

meet virtually on a monthly basis to share practice, discuss any issues and provide peer support. The Guardian has also provided 'buddy' support to new FTSU Guardians in neighbouring organisations.

1.7 The fourth National Speak Up Month took place in October 2021. Health organisations across England were involved in raising awareness of speaking up and demonstrating their willingness to listen to workers. The campaign provided an opportunity to promote our FTSU Champions and for the Champions to raise awareness in their respective departments/teams which was very positively received. We also used the opportunity to promote the FTSU e- Learning Package to workers.

1.8 The National Guardian Office has launched a FTSU e-learning package for all healthcare workers called 'Speak Up, Listen Up, Follow Up'. It has been developed in association with Health Education England and is divided into three modules to explain what speaking up is and how it can improve patient care and staff experience. The training is aimed at anyone who works in healthcare, including volunteers and students. The first module, 'Speak Up', was launched in October 2020 as part of the National Speak Up Month and all staff are expected to complete as an introduction to speaking up. The second module 'Listen up' is aimed at line managers and is also available on ESR. All line managers are encouraged to complete the training. The third module 'Follow up' is aimed at senior managers and Executives and was launched earlier this year. This is key to ensure lessons are learned and that speaking up becomes business as usual.

2. FTSU Cases

2.1 During the period from 1st April 2021 to 31st March 2022 a total of 154 cases were reported through the FTSU route. This is a significant increase from the previous year when 111 cases were reported and demonstrates that the FTSU approach is working as more staff are using the FTSU approach to speak up.

2.2 The graph below shows the number of cases during 2021-22 in Bolton compared to the number of cases reported since April 2018 (Figure 1).

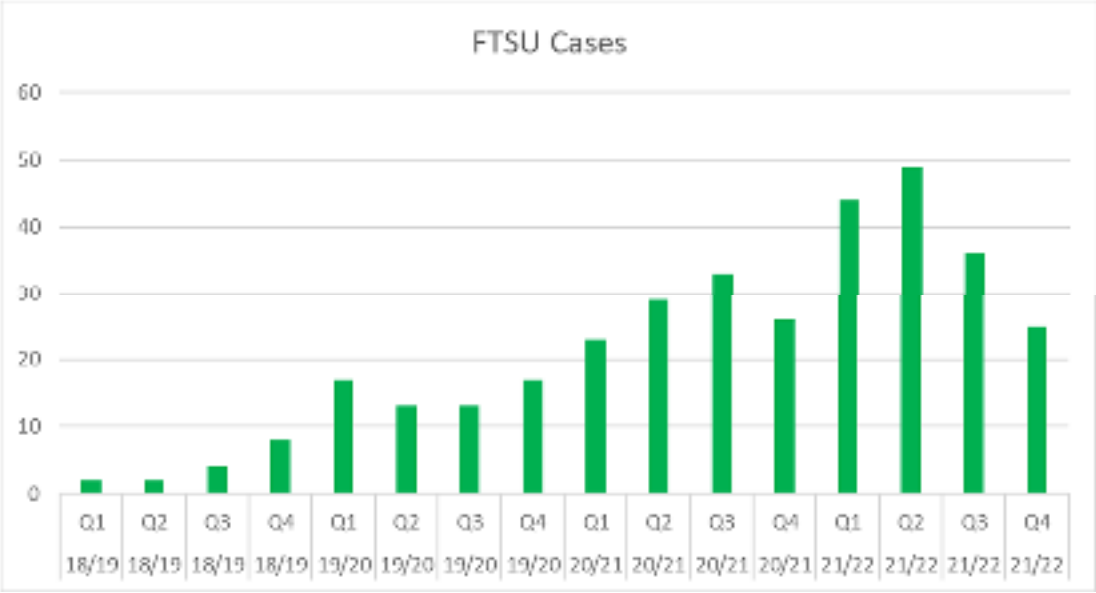


Figure 1: Number of FTSU cases within Bolton FT

Figure 2 below shows how Bolton Hospital NHS Foundation Trust compares nationally and shows the increase in concerns raised during the recent pandemic. During the pandemic many Guardians who have dual roles were pulled back into clinical practice which could have resulted in a drop of cases in some areas. In Bolton the Guardian spent some time supporting the bereavement team but returned to the Guardian role as numbers of speak up concerns started to increase.

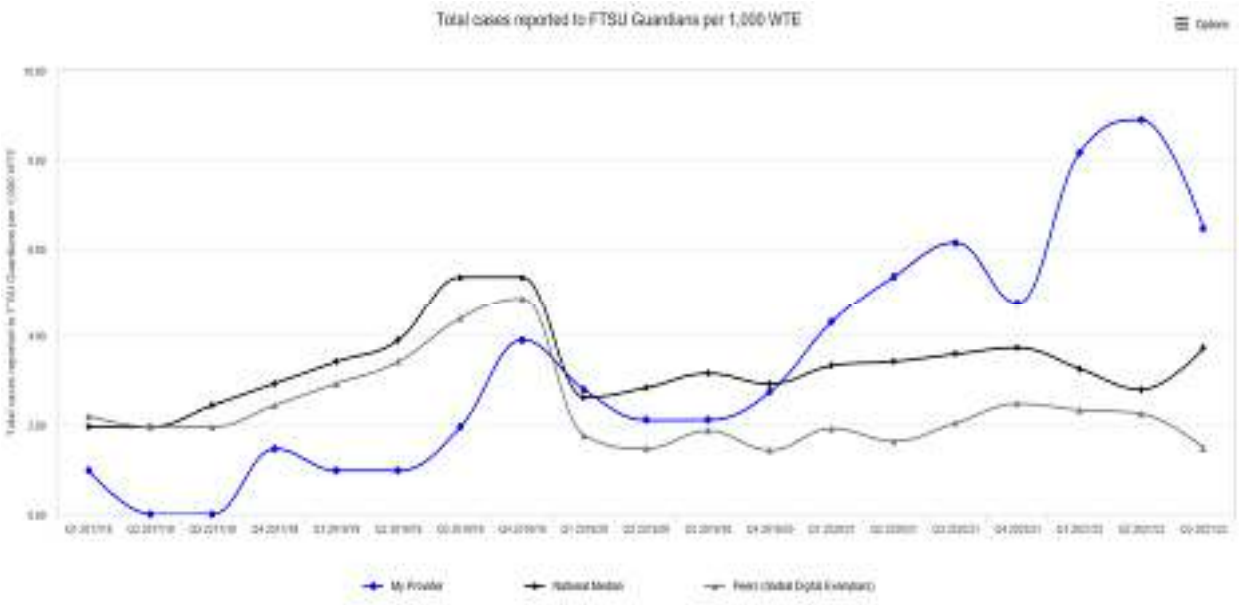


Figure 2: Number of FTSU cases within Bolton FT per 1000WTE compared to national data

2.3 The Guardian formally reports the number of cases and themes for each quarterly period to the National Guardian Office. The Guardian has taken appropriate steps to ensure that the workers are being supported and their concerns are being addressed appropriately and swiftly.

2.4 The graph below shows a breakdown of the 154 cases raised in 2021/2022 by Division or organisation in the case of IFM. (Figure 3).

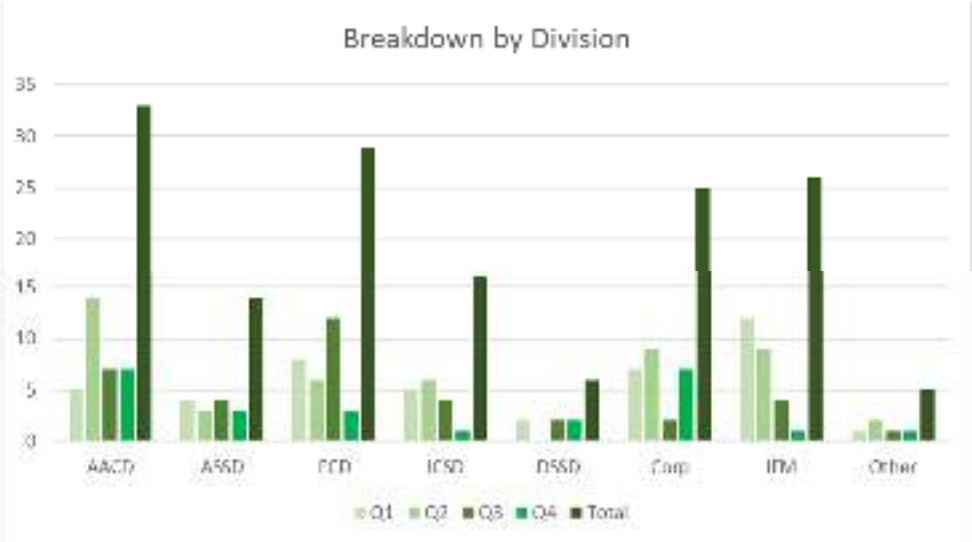


Figure 3: Breakdown of the number of concerns raised by Division/ Organisation

2.5 The graph below (Figure 4) provides a breakdown of the themes of concerns raised during 2021-22. Some concerns covered more than one theme. Issues with behaviour were clearly the largest concern that workers raised and this has been seen nationally and demonstrates that we still have work to do as an organisation to embed our trust values and behaviours. (The themes from IFM will be included in their own annual report.)

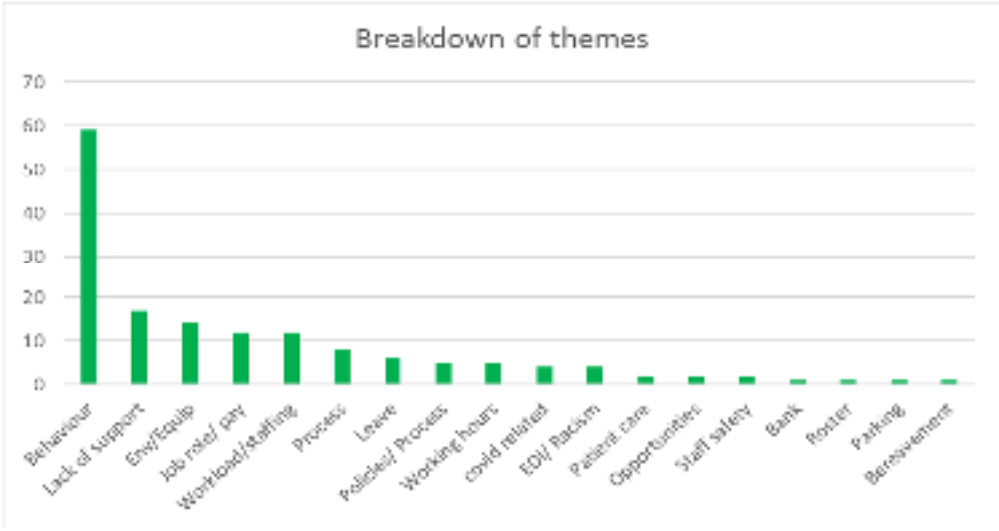


Figure 4: Breakdown of theme of concerns raised in 2021/2022 excluding IFM

2.6 The graphs below (Figure 5-8) show a breakdown of themes per Division and per quarter.

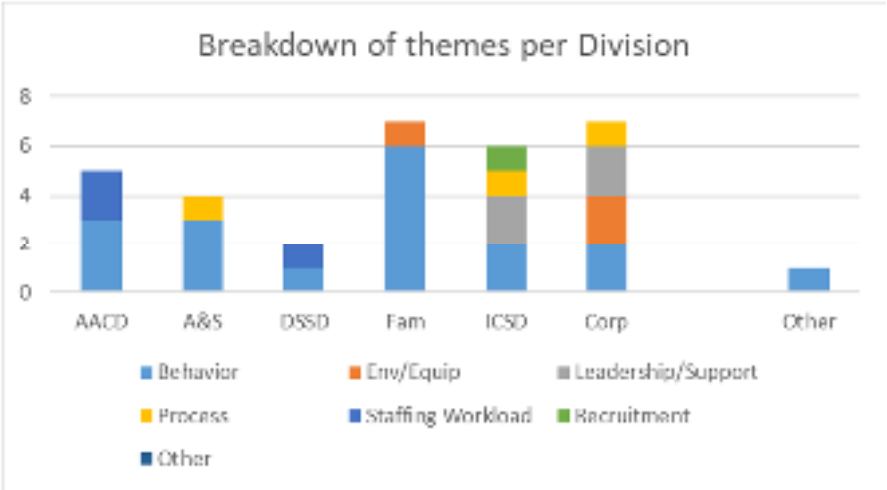


Figure 5: Breakdown of Themes by Division Q1 2021/2022

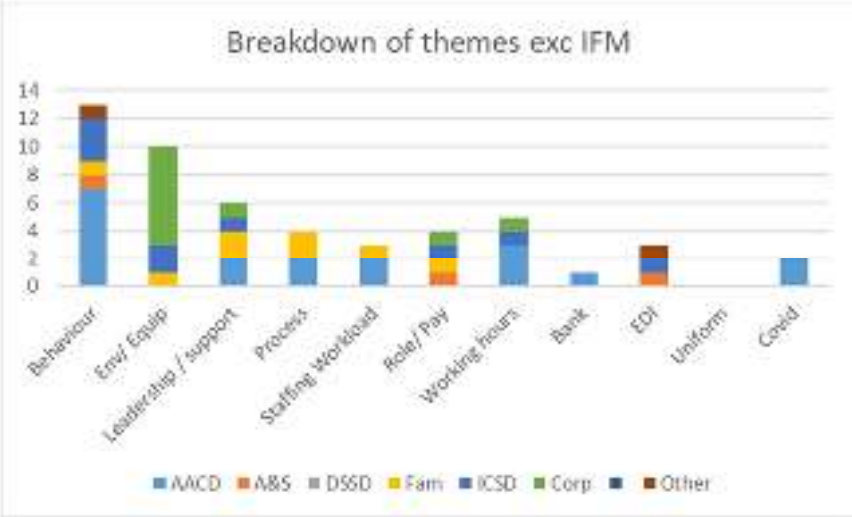


Figure 6: Breakdown of Themes by Division Q2 2021/2022

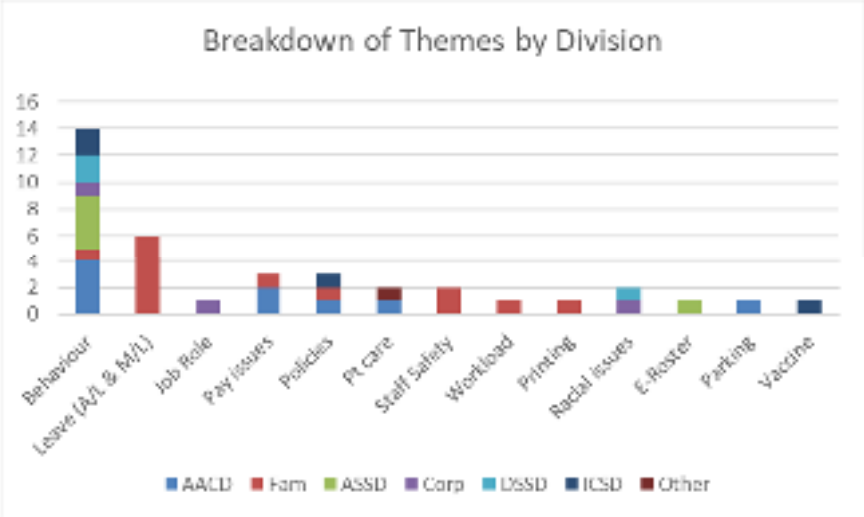


Figure 7: Breakdown of Themes by Division Q3 2021/2022

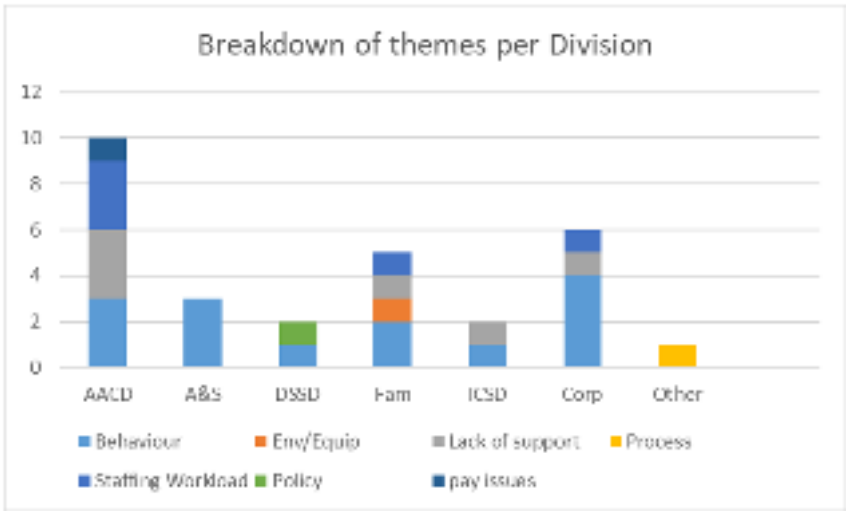


Figure 8: Breakdown of Themes by Division Q4 2021/2022

2.7 The graph below (Figure 9) provides a breakdown of the concerns raised in 2021-22 by staff group. One of the largest group of staff that raised their concerns was registered nurses which is our largest staff group and this is also reflected in other NHS organisations. This was mirrored by our admin and clerical teams.

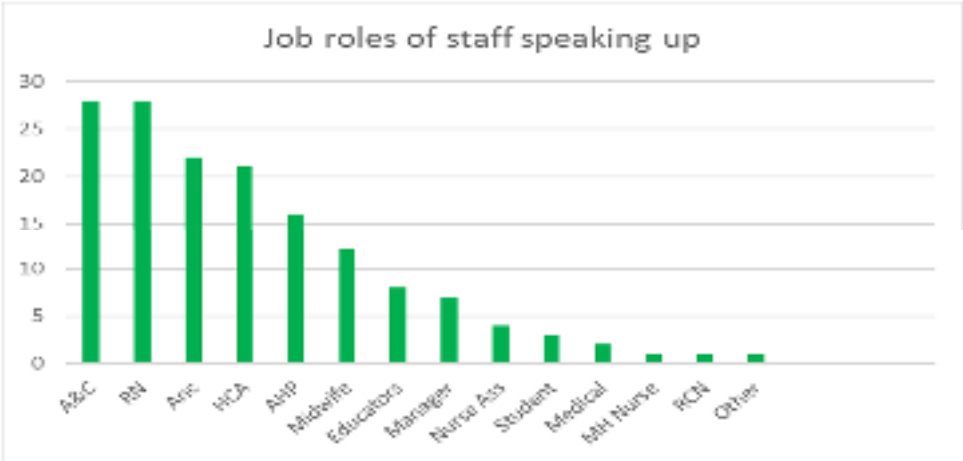


Figure 9: Breakdown by staffing group

2.8 During 2021/22 a total of 24 concerns (15.6%) were raised by workers from a Black, Asian or Minority Ethnic background (BAME). This is an ongoing improvement compared to the previous year but there is still room for improvement as we know that our BAME colleagues account for 13- 15% of our workforce and historically research shows that they are less likely to speak up and less likely to be treated positively at work. The Guardian and Champions will continue to ensure that BAME staff are aware of the FTSU approach to ensure that they feel safe to speak up. Currently 5 of the 37 champions (13.5%) are from a BAME background as unfortunately 2 of our BAME FTSU Champions have left the organisation- 1 due to retirement and the other gained a position working with HEE. The FTSU Guardian regularly attends the BAME Staff Forum and the Chair of the Forum featured in the FTSU video which is shown at Trust induction sessions. The Guardian also works closely with the EDI Team and is a member of the EDI Steering Group. Figure 10 below demonstrates the proportion of staff from a BAME background that have spoken up via the FTSU approach.

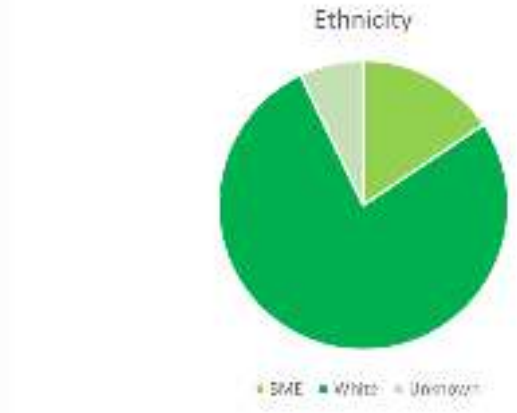


Figure 10: Proportion of BAME staff speaking up

2.9 Speaking up takes courage and it is important that the Guardian and Champions respond to individuals in a timely manner. In 2020 a set of KPIs were developed to measure the efficacy of the FTSU approach. One of the KPIs was that workers would receive an initial acknowledgement of their concern within 48 hours. In 2021/2022 69% of workers received an initial acknowledgment within 1 hour. 87% of staff received an initial acknowledgement within 4 hours of reaching out using the FTSU approach. This swift response has shown to workers that their concerns matter and are taken seriously. Figure 11 below shows a breakdown of the initial acknowledgement of concerns.

Figure 11: FTSU Response Times

3. Measuring Impact

3.1 The Trust's 2021 NHS national staff survey results were once again very encouraging and demonstrate that our FTSU approach is working effectively and workers feel more confident to raise their concerns and more importantly that their concerns will be listened to.

3.2 In order to ensure the FTSU approach are meeting the needs of the workers, individuals are sent a survey within 3 months of their concern being closed. The results of the feedback have been very positive. Staff were asked about accessing the FTSU Guardian and 100% said it was either easy or very easy to make contact (Fig 12). 97% of staff found the response either extremely or very helpful (Fig 13). 100% of staff felt their concerns were taken seriously (Fig 14) which reflects on the way the senior managers have taken workers concerns seriously and acted on them. 97% of staff felt their concern had been fully or partly addressed (Fig 15). From all the staff who responded no staff said they would not speak up again (Fig 16)- 91% agreed that they would. Again this is very encouraging.

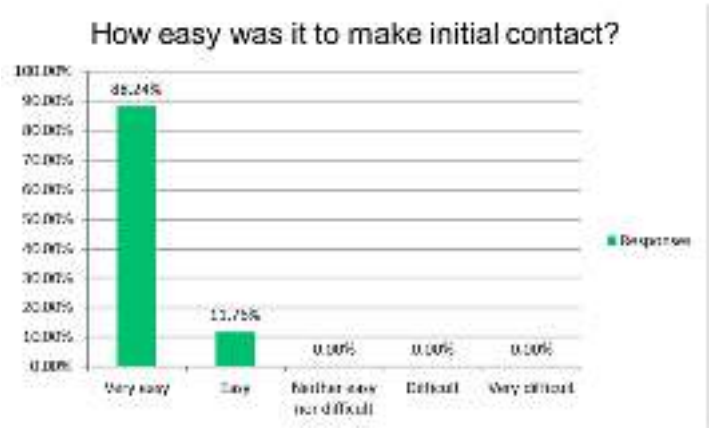


Figure 12- Ease of making contact

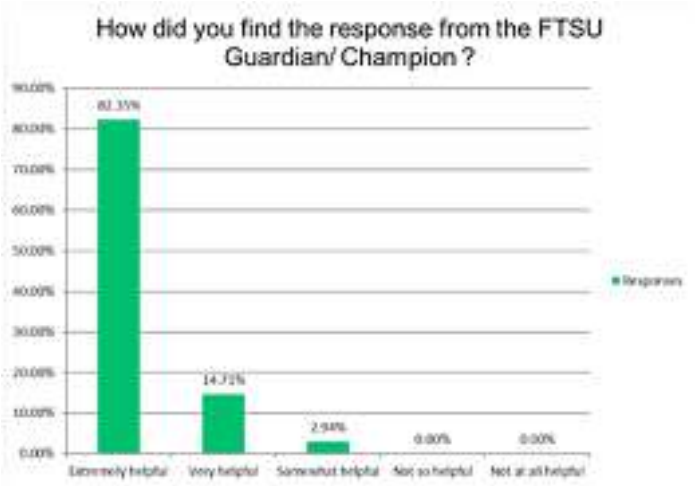


Figure 13- Response from FTSU Guardian/ Champion

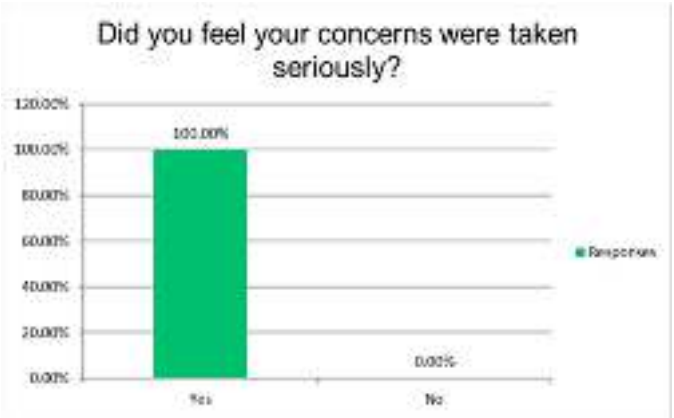


Figure 14- Concerns taken seriously

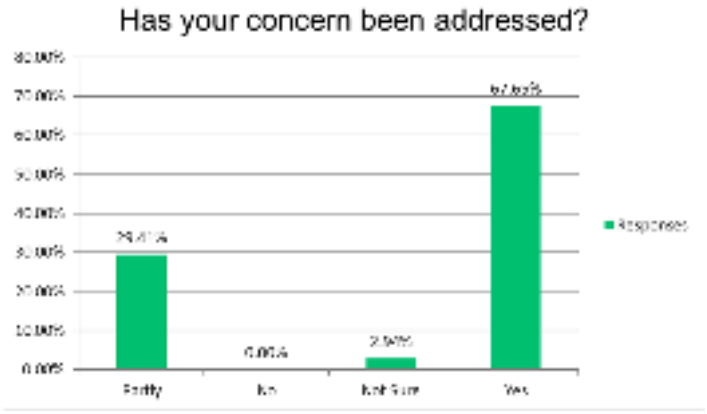


Figure15- concerns addressed

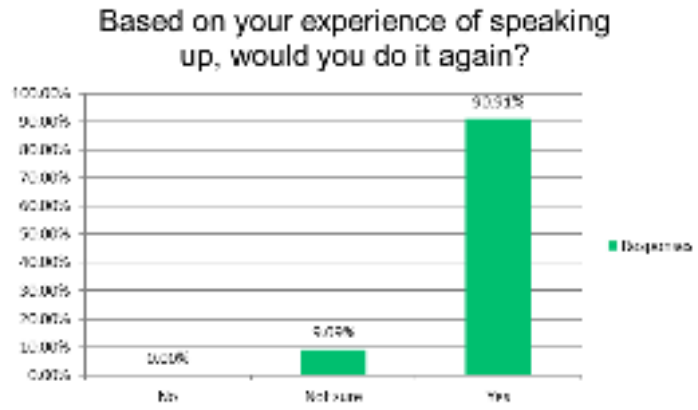


Figure 16- Speaking up again

3.3 Results from the Go Engage Survey in Jan 2022 show that 78% of workers answered that they were aware of how to raise a concern under the FTSU process. A further16% of workers said they were somewhat aware. Only 2% of workers who completed the survey had no idea how to raise a concern via the FTSU route. The Guardian and Champions will continue to raise awareness about the FTSU process.

4. Enhancing our Approach

4.1 It is clear that the FTSU approach is helping to create an open and honest culture within the organisation and supports individuals to 'Be Honest' one of the Trust's VOICE behaviours. However, there are concerns about the standards of behaviour that some workers are facing and it is clear further work on behavioural standards are required

4.2 One of the Trust's values is compassion and this is not just about how we behave with our patients/service users but also how workers behave with each other. The Civility Saves Lives Campaign (CSLC) is a national initiative with a mission to promote positive behaviours and share the evidence base around positive and negative behaviours within the healthcare setting. Our A&E Department have introduced the CSLC within their department led by Dr Catherine Williams, one of their consultants. Dr Williams has shared their work with the Staff Experience Steering Group and some Divisional People Committees. The intention is to roll-out the approach and resources across the organisation. The Guardian and champions are keen to support this work to overall improve behaviour across the organisation.

4.3 The Guardian recognised that there are low numbers of concerns raised via the FTSU process from our junior medical staff across the organisation. It is thought that there are a number of reasons for this. The Guardian discussed this at a recent North West Regional FTSU Guardian Network meeting and this was an issue faced by other FTSU Guardians. The Guardian has been working with Consultant Ophthalmologist Dr Clare Inkster and our EDI Programme Manager, Caron Martin on this matter. A group of doctors from across the North West attended a training session, led by Dr Clare Inkster, with presentations by the Bolton FTSU Guardian and Bolton EDI Programme manager to promote these Doctors to act as 'champions' providing peer support and signpost colleagues to the most appropriate individual e.g. FTSU Guardians, EDI Leads, Guardian of Safe Working etc. The Guardian is also keen to strengthen the support to medical staff and is thrilled that each Division now has a Consultant FTSU Champion to help this work going forward

4.4 From April 2022, in accordance with guidance from the National Guardian Office, FTSU Champions will no longer be permitted to manage cases. Their role will focus solely on supporting staff, encouraging staff to speak up and signposting them to the Guardian or other appropriate colleagues such as HR. This change will have a significant impact on the Guardian's capacity. The Guardian's role is currently 0.6 WTE worked over 3 days per week. In light of the changes to the Champions' role the Executive Team agreed to establish an additional part-time Guardian role. This will ensure that we have continuity of support and aid succession planning. The additional Guardian role will be recruited via a fair and robust recruitment process with an additional FTSU Guardian to commence summer 2022.

4.5 Following the recent case review of Blackpool Teaching Hospitals NHS Foundation Trust's speaking up culture and arrangements (Appendix 2), we have analysed the recommendations of the FTSU review and the actions for our Trust are included in Appendix 3.

5. Conclusion

5.1 Listening to our workers is everyone's business – it helps to reduce risk, prevent harm and make improvements. It also helps people to feel valued, supported at work and ensures staff feel psychologically safe. Continuing to strengthen our organisation's FTSU approach will help make Bolton FT an even better place to work, a safer place for our patients and ensures that we are committed to demonstrating the Trust's values and behaviours.

6. Recommendations

6.1 The Trust Board is asked to:

- Reflect and comment on the FTSU 2021-21 annual report.
- Continue to support the FTSU approach and enable the Guardian and Champions to carry out their important roles.

Appendix 1: Current FTSU Champions Network

Kirsty Buckley	Haematology Specialist Nurse	Adult Acute Division
Dr Natalie Walker	Acute Physician	Adult Acute Division
Karen Keighley	Divisional Governance Lead	Adult Acute Division
Shauna Barnes	Practice Development Lead Nurse	Adult Acute Division
Julie Pilkington	Acting Divisional Nurse Director	Anaesthetics & Surgical Division
Cath Marrion	Theatre Sister	Anaesthetics & Surgical Division
Ruth Adamson	Anaesthetics/Ops Support Manager	Anaesthetics & Surgical Division
Dr Emma Wheatley	Consultant Anaesthetics/ Critical Care	Anaesthetics & Surgical Division
Rahila Ahmed	Equality, Diversity & Inclusion Lead	Corporate Services Division
Neville Markham	Chaplain	Corporate Services Division
Sharon Lythgoe	EPR Project Manager	Corporate Services Division
Charlotte Anderson (on M/L)	Business Analyst	Corporate Services Division
Gina Riley	Associate Director of Governance/ Patient Safety Lead	Corporate Services Division
Nicola Caffrey	Corporate Business Manager for Medical Director	Corporate Services Division
Robin Davis	Core skills trainer MPVA	Corporate Services Division
Rachel Davidson	Senior Radiographer	Diagnostic and Support Services
Louise Quigley	Health Records Reception Coordinator	Diagnostic and Support Services
Suzanne Lomax	Clinical Service Lead – Palliative & End of Life Care	Diagnostic and Support Services
Dr Katy Edwards	Consultant Microbiologist	Diagnostic and Support Services
Jeanette Fielding	Midwife	Families Care Division
Vicky O'Dowd	Midwife	Families Care Division
Dr Bim Williams	Obstetrics & Gynaecology Consultant	Families Care Division

Maria Lawton	Pelvic Health Physiotherapist	Families Care Division
Firyal Atcha	Paediatric SALT	Families Care Division
Anne-Marie Price	Medical Secretary	Families Care Division
Simon Crozier	Principle Service Lead / Advanced Physiotherapist- Stroke	Integrated Community Services
Dr Atir Khan	Consultant Physician Diabetes & Endocrinology	Integrated Community Services
Chris Vernon	Integrated Neighbourhood Team Lead	Integrated Community Services
Gareth Valentine	Staff Nurse	Integrated Community Services
Lisa Grognet	Nursing Associate - Homeless & Vulnerable Adult	Integrated Community Services
Jenni Makin	Specialist Physiotherapist Community Learning Disabilities Team	Integrated Community Services
Keeley Barlow	Switchboard/ Uniforms Department	IFM
Ryan Brown	Security Operative	IFM
Michelle Barber	Personal Secretary	IFM
David Waite	Materials Management Assistant	IFM
Lorraine Makinson	Catering Supervisor	IFM
Kelly Wallis	Community Supervisor	IFM

National Guardian

Freedom to Speak Up

A case review of speaking up culture and arrangements

by the National Guardian's Office

October 2021

Contents

National Guardian's Office

The National Guardian's Office (NGO) provides support and challenge to the healthcare system in England on speaking up.

The NGO leads, develops and supports Freedom to Speak Up Guardians, who support workers to speak up and work within their organisation to tackle barriers to speaking up.

Speaking up and why it matters

Speaking up may take many forms, including a discussion with a line manager, an idea for improvement submitted as part of a suggestion scheme, raising an issue with a Freedom to Speak Up Guardian, or bringing a matter to the attention of a regulator.

If we think something might go wrong, it is important that we feel able to speak up so potential harm may be prevented. When things are good but could be better, we should feel able to say something and expect our suggestion is listened to and used as an opportunity for improvement. Speaking up is about all these things.

Case reviews

The National Guardian's Office carries out reviews where it has information suggesting speaking up has not been handled following good practice.

Reviews seek to identify learning, recognise innovation and support improvement.

Case review at Blackpool Teaching Hospitals NHS Foundation Trust

The trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria, supporting a population of 1.6 million. The trust has a workforce, by headcount, of over 10,000. Further information about the trust can be found on its website.

The NGO received information indicating that a speaking up case may have not been handled following good practice. The information also suggested black and minority ethnic workers had potentially worse experiences when speaking up compared to their white colleagues.

We reviewed this and other information about the trust's speaking up culture and arrangements and undertook a review of the trust's support for its workers to speak up.

Following its inspection in June 2019, the Care Quality Commission (CQC) gave the trust an overall rating of 'requires improvement'.[1] In response to whether the service was 'well-led', the CQC rated the trust overall as 'inadequate'. The inspection found:

- a 'top-down' and 'directive' culture that was not always 'fair', 'open' or 'transparent'
- a culture that was not always supportive of challenge or candour
- limited engagement with staff
- staff did not always feel respected, valued or appreciated
- staff said that they would not speak up. Those who had spoken up reported not being taken seriously, supported or treated with respect
- some groups of workers, including black and ethnic minority workers, felt ignored and disenfranchised.

NHS England and Improvement (NHS E/I) designated the trust as requiring significant support to address a range of quality issues, including workforce, governance, culture and safety. An improvement board was set up to facilitate changes in the trust, in partnership with local commissioners, NHS E/I, the CQC and others.

Following the inspection in June 2019, the trust leadership underwent changes to support the trust's improvement.

[1] The CQC asks whether the services it inspects are they safe, effective caring, responsive and well-led. In response, services receive a rating: outstanding, good, requires improvement or inadequate.

How the review was undertaken

The review was undertaken during the COVID-19 pandemic when there was significant pressure on the trust and its workforce.

The review was carried out virtually to minimise additional pressure and allow the participation of those involved. Focus groups and interviews were held with trust workers and senior leaders through October to December 2020.[2]

Eight focus groups were held, including specific sessions for black and minority ethnic workers. The focus groups sought to create a space where workers felt able to speak up freely. Attendance at the focus groups was impacted, among other things, by the COVID-19 pandemic. Those who had booked to attend sessions were not always able to do so. However, workers were also able to approach the NGO directly to share their thoughts and experiences.

We reviewed specific experiences of speaking up in the trust. We heard from over 70 workers through these focus groups and interviews.[3]

We reviewed documents relating to the trust's speaking up culture and arrangements, including policies and procedures, reports and action plans. We also reviewed relevant data from the NHS Staff Survey and other metrics.

We liaised with the Care Quality Commission, and NHS England and Improvement.

About this report

Our findings are split into three areas: Speaking Up Culture, Freedom to Speak Up Guardian and Leadership.

We also refer in the report to specific experiences of speaking up in the trust. To capture any potential learning and minimise the risk of identifying individuals, we refer to anonymised segments from these experiences under relevant themes.

Our recommendations can be found throughout the report and the full list is also provided at the end (Annex 1).

Acknowledgements

We want to thank trust workers – those who contributed to our review and those who did not – for everything they have done and continue to do for patients.

We want to thank leaders at the trust and other organisations for making this review possible, particularly during the pandemic.

[2] These were held virtually for the health and safety of workers and to comply with the pandemic-related restrictions.

[3] The NGO does not disclose identifiable information shared by trust workers during its review with others within the trust or in other organisations without the consent of those relevant workers. In some circumstances - for instance, if there is an immediate risk of harm to an individual – we may need to take further action. In such cases, we will take any necessary action while, as much as possible, protecting confidentiality. In all cases where confidentiality may be affected, this is discussed with the individual.

Key findings

Speak Up Culture

- The Freedom to Speak Up Index score had improved every year since 2016 and was above average compared to similar trusts and the national average.
- Work was underway to improve the speaking up culture and workers spoke of signs of improvement.

However:

- Most workers we spoke to described long-standing issues with the speaking up culture.
- Speaking up had not always been responded to in accordance with good practice.
- Speaking up training had variable reach and uptake and was not always in line with good practice.
- Some groups of workers faced barriers to speaking up not necessarily experienced by other workers.

Freedom to Speak Up Guardian

- Steps had been taken to bring the arrangements for the Freedom to Speak Up Guardian role in line with National Guardian's Office (NGO) guidance, including the provision of ring-fenced time for the Freedom to Speak Up Guardian.
- The Freedom to Speak Up Guardian was an important additional route for workers to speak up. Most of those who had spoken up to Freedom to Speak Up Guardian and had provided feedback said they would speak up again.

However:

- Understanding of and support for the Freedom to Speak Guardian role was not always consistent.
- There was ineffective continuity planning for the Freedom to Speak Up Guardian role.
- The Freedom to Speak Up Champions/Ambassadors network was not functioning effectively.

Leadership

- The leadership team had changed in a drive to support and improve the trust. Leaders expressed a strong and shared desire to improve the speaking up culture.

- Trust leaders demonstrated awareness of concerns workers raised about the speaking up culture, as well as many of the specific issues that workers raised during our review.
- The speaking up policy was mostly in line with the national minimum standards.

However:

- The speaking up strategy required updating, including a comprehensive speaking up communications strategy.
- The positioning of the Freedom to Speak Up executive lead role was perceived by some workers as a conflict of interest.
- Workers who had spoken to national bodies had variable and sometimes less than good experiences.

Speak Up Culture

The speaking up culture varied across the trust.

Most workers we spoke with described challenges with the speaking up culture. Many explained that these were longstanding issues going back several years.

Workers also referred to improvements.

Speak up process

In this section, we have grouped the feedback from workers along the lines of the Freedom to Speak Up process described in the Freedom to Speak Up Review (2015), which considered the speaking up culture in the NHS in England.

In text boxes, we have included anonymised summaries of the speaking up experiences of some of those who contributed to the review.

1. Identifying that something might be wrong

Engagement

Changes were announced to clinical practice in a meeting attended by a worker. The worker said this was the first time they had heard about these changes.

The worker was concerned about the potential impact of the changes on patient care. They said that when they voiced their concerns they were met with hostility, and their concerns were dismissed.

An investigation by the trust found that the changes did not pose a risk to patient safety. However, the investigation found that the communication and handling of the changes could have been managed better.

A trust leader said there were policies and processes regarding changes to services, including appropriate involvement of team members.

At the National Guardian's Office, we know that changes to services, how these are handled and how they are communicated to workers is a common subject of speaking up.

Recommendation
Within three months, the trust should:

- Continue to demonstrate that it values the views of its workers, including consulting staff about changes to their services as appropriate, in line with its policies and procedures and good practice.

2. Speaking up (‘raising a concern’)

Visibility and accessibility

Workers said that those in leadership roles, including trust leaders, were not always visible and accessible.

Some spoke about workload and other pressures, particularly on middle-managers, and the impact this had on their visibility and accessibility.

Workers based in the trust’s community sites said they faced challenges in this regard as well, as they were ‘out of sight’.

The trust had been particularly affected by the pandemic, putting significant pressures on leaders. Trust leaders said that this invariably impacted on their visibility across the trust.

The trust leadership team had run events (‘Big Conversations’) to reach out and listen to workers, including two events aimed at colleagues from black and minority ethnic backgrounds.

Other methods of communication were being used to reach workers during the pandemic, but many noted this was not the same as meeting people in person.

Trust leaders referred to joint roles with organisations in the local integrated care system that were supported by ‘deputies’ in each organisation, and how these arrangements allowed for cover and continuity.

Recommendation
Within three months, the trust should:

- Continue to take appropriate steps to promote a culture of visible and accessible leadership.

Behaviours

Workers spoke about the existence of poor behaviours in the trust, including examples of aggressive communication, and how these had not always been appropriately addressed. This was perceived as having a detrimental impact on the speaking up culture.

Trust leaders acknowledge that poor behaviour had historically not always been addressed appropriately. They referred to ongoing work to promote compassionate leadership and staff retention.

The trust was developing its capacity and promotion of mediation, including in speaking up cases. Trust leaders hoped that mediation would facilitate swifter and more amicable resolution of issues going forward.

Recommendation
Within six months, the trust should:

- Continue with and review the effectiveness of its programme of work to challenge unwanted and/or unprofessional behaviours.
- Continue to promote and facilitate the use of mediation where appropriate.

Action in response to speaking up

Many of those we spoke with were of the view that speaking up did not always result in appropriate action being taken. This led to thinking there was no point in speaking up. This was the feedback we heard most often from workers concerned about the speaking up culture.

"I wanted to speak up about certain things, but I was not confident … these would be properly escalated, whether I will be victimised."

Trust worker

Trust leaders said that the trust's governance arrangements had not historically supported the development of an effective speaking up culture. They said that suggestions for improvement often stalled, leading to apathy.

The trust was taking steps to improve the effectiveness of its governance arrangements.

A worker spoke up on multiple occasions about a range of issues, including to senior leaders. However, they believed they were not listened to, and they were not aware of any action that may have been taken.

The worker did not always receive a response in line with the trust's policies and processes and good practice when they spoke up.

Recommendation
Within three months, the trust should:

- Take appropriate steps so that issues about which workers speak up are responded to in accordance with trust policies and procedures and good practice.

Recommendation
Within six months, the trust should:

- Continue to improve effectiveness of its governance arrangements, including the communication of information from and to 'board to ward'.

Being thanked for speaking up

Workers said that they were not always thanked when they spoke up.

At the National Guardian's Office, we often refer to speaking up as a 'gift'. Speaking up provides invaluable information for leaders to enable them to provide high quality and safe services, and to continuously improve. Workers should be thanked for

speaking up, and this should not be a tick box exercise. This is part and parcel of an environment that cherishes workers' views, ultimately for the benefit of patients.

A worker said they were not thanked when they spoke up. An exception to this was when they spoke up to the trust's previous Freedom to Speak Up Guardian.

The trust's speaking up policy at the time these events did not comment on whether workers should be thanked for speaking up. However, the trust's speaking up policy at the time of our review said that those speaking up would be treated with *"respect at all times and will thank you for raising your concerns."*

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure workers who speak up are meaningfully thanked for doing so, in accordance with trust policies and procedures and good practice.

Groups facing barriers to speaking up

There was a perception among some workers that groups of workers faced barriers to speaking up. This is discussed later in the report.

3. Examining the facts

Where cases are handled well, the likelihood of a good outcome for everyone is higher.

Processes

Workers described human resources policies and processes as sometimes being 'slow', 'bureaucratic' and 'adversarial', and that this had an unhelpful effect on the trust's speaking up culture.

Some workers said that outcomes when workers speak up depended on whether 'your face fits'.

Many said they lacked confidence that they would be treated fairly if they were involved in a human resources process.

A worker was called to a meeting where they were told that concerns had been raised about them. However, they claimed that no further information was provided about the alleged concerns, and requests for further details were rejected.

The worker said the way the meeting was arranged and conducted – and the lack of information about the alleged concerns – caused them a lot of anxiety and stress. They said there was a lack of consideration of the potential impact on them being told this information in this way.

The worker also said the lack of information about the alleged concerns meant it was not possible for them to reflect on and take any interim remedial steps to address any issues.

An investigation found that the way the matter had been raised with the worker was not appropriate or in line with trust policies.

It is important to take appropriate action when someone speaks up. However, it is important to think of not only the person speaking up but the impact of any action on other potential parties, including those who may be the subject of allegations.

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure its policies and procedures are fair and supportive of all workers in the speaking up process, including those who are the subject of matters that are raised.

A worker alleged bias in communication between colleagues in the trust's human resources team.

The worker spoke up about this to senior leaders. However, the worker did not receive a response.

Recommendation
Within six months, the trust should:

- Continue to take appropriate steps to ensure human resources policies and processes have the confidence of its workforce, including effective training for workers in human resources.

Communication

Clarity and effective communication with a person speaking up is crucial. There should be effective communication to manage expectations.

A worker said they experienced bullying and harassment and that there was a bullying culture. They spoke up about these issues, including with senior leaders.

The worker was told a review would be commissioned that would look into these issues. However, they were later informed that the review would not be looking into their individual experience of bullying. The worker said they were asked to pursue personal grievances through other channels.

An investigation by the trust found this caused delays in the worker being able to progress with their speaking up concerns.

A worker raised a grievance. They said they were informed that a review of concerns about their practice would be paused pending the handling of this grievance. This was to avoid any suggestion of retaliatory action being taken against the worker.

The worker said they subsequently discovered that the review into their professional practice had taken place, contrary to what they had been told.

A senior leader explained there had not been a commitment to pause the review of concerns about the worker's practice.

The trust's speaking up policy at the time of our review contained the following:

"If you make a disclosure under this policy during the course of disciplinary proceedings against you, we will normally continue with the disciplinary proceedings whilst investigating your disclosures concurrently."

This stance remained in the trust's updated policy at the time of our review.

It is important that consideration is given to situations where an individual says that such proceedings are attempts to subject them to a detriment for speaking up such as occurred in this case. We discuss the trust's speaking up policy in detail later on in the report.

Recommendation
Within three months, the trust should:

- Take appropriate steps to promote effective communication with those speaking up in order to effectively manage expectations.

Confidentiality

A worker may speak up openly, confidentially or anonymously.

Speaking up confidentially is when the worker speaking up reveals their identity to someone on the condition that it will not be disclosed further without their consent (unless legally required to do so).

Some workers we spoke with expressed concern about whether their confidentiality would be respected if they spoke up.

A worker alleged that their identity was disclosed to the person about whom they had spoken up, breaching their confidentiality.

The event occurred several years ago.

The trust's speaking up policy at the time of the events included assurances about confidentiality. However, the policy suggested that the person speaking up would need to be explicit about wanting their identity to be kept confidential.

The trust's updated policy at the time of our review used the terms 'confidentiality' and 'anonymity' interchangeably and, similar to the earlier version of the policy, it was not clear whether confidentiality was assumed or had to be explicitly requested by the person speaking up. (We discuss the trust's speaking up policy in detail later in the report.)

A trust leader said confidentiality was taken seriously and referred to action taken regarding alleged breaches.

Recommendation
Within three months, the trust should:

- Take appropriate steps to assure themselves that speaking up practices ensure that the confidentiality of workers who speak up is appropriately supported – including looking into cases where a breach of confidentiality is reported.

Terms of reference

A worker alleged that they were not given an opportunity to input into the terms of reference to investigate the matter they had raised.

This was in breach of the trust's investigations policy according to a review carried out by the trust.

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure that workers who speak up can have input into the terms of reference for any subsequent investigations, in accordance with trust policies and procedures and good practice.

Impartiality

The independence of investigations was a reoccurring theme in feedback we received during our review.

A worker spoke up about what they perceived to be the lack of independence and impartiality of those involved in handling their speaking up case.

We found examples to demonstrate that the trust was aware of the risks that investigations would be perceived as not being independent and steps they had taken to address this.

It is important that investigations are not only conducted appropriately but that workers are provided with the reassurance they need to avoid perceptions of a lack of independence and impartiality.

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent and trained investigators.

Timeliness

The timeliness of investigations was a theme in feedback from workers during the review.

It took several months for a grievance raised by a worker to be investigated and the outcome shared with them.

A senior leader said that the timeliness of the handling of this case was affected by a range of factors, including the complexity of some of the investigations.

A worker raised a matter to which, as per policy, they should have received a response within 14 days. However, it took three months for a substantive response to be shared.

As mentioned earlier, the trust was developing its capacity and promotion of mediation, including in speaking up cases, to facilitate swifter and more amicable resolution of issues.

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure matters arising from cases of speaking up are investigated within reasonable timescales and without undue delay.

The handling of investigations arising from speaking up cases has been a reoccurring theme in case reviews.

In a case review report published in June 2018, we noted a lack of guidance on the handling of investigations. We recommended guidance be commissioned by the Department for Health and Social Care:

"Within 12 months, the Department for Health and Social Care should commission NHS Employers to develop and communicate guidance to NHS trusts and foundation trusts that will help ensure HR policies and processes do not present real or perceived barriers to speaking up. This should focus on how trusts can ensure that investigations into speaking up matters are undertaken by suitably independent persons and are completed within reasonable timescales, to enable workers who speak up to have trust and confidence in the process.

Guidance should also be provided on how to support individuals who are speaking up about a grievance to prevent undue burdens being placed on those individuals and to ensure that they receive the support they need at what is likely to be a difficult and stressful time."

In advance of the publication of this report, DHSC referred us to a range of activities that have taken place across the system, which collectively support this recommendation:

- *In November 2019, NHS Improvement requested that NHS trusts review their processes and procedures. Alongside this request, NHS Improvement included guidance to reinforce the need for greater consistency and an inclusive, compassionate and person-centred approach, whatever the circumstances, and to ensure that those involved in investigations should be fully trained and competent to carry out the role they have been assigned.*
- *NHS Employers published a Professionalism and Cultural Transformation toolkit to educate and empower staff to improve professionalism in their organisation. NHS England and NHS Employers have published good practice examples to implement a just and learning culture, which aims to remove barriers, encourage speaking up and learning from experiences to improve future practices and culture.*
- *In December 2020, NHS England and Improvement wrote to NHS trusts about the importance of raising concerns at the earliest opportunity. They shared a collaboratively developed disciplinary policy focussed on promoting dignity and respect.*

DHSC also highlighted that 'looking after our people' and 'fostering a culture of inclusion and belonging' were central themes in the People Plan 2020/21 and continued to be central to ongoing work across the healthcare system.

We will work in partnership with others in the system to support the consistent embedding of good practice in this area across the healthcare system.

4. Outcomes and feedback

Feedback

Feedback is an important part of the speaking up process. Workers who speak up should receive feedback on the outcome of the matters they have raised.

Many workers contributing to the review said that they often did not receive feedback when they spoke up. This supported the perception that action had perhaps not been taken in response to them speaking up.

A worker said they did not always receive feedback after speaking up.

There was not always a discussion about whether and how they might want to receive feedback.

Recommendations
Within three months, the trust should:

- Take appropriate steps to ensure that workers who speak up receive meaningful and timely feedback in accordance with trust policies and procedures and good practice.

Disadvantageous and/or demeaning treatment for speaking up

Many workers expressed concern about the potential negative consequences for their job satisfaction and security if they were to speak up.

This worry was also expressed in the focus groups we had arranged. Some workers requested one-on-one calls to share their thoughts and experiences because they were afraid to speak up in the group sessions.

"Like writing a P45 coming here [to a focus group arranged as part of the review by the NGO]"

Trust worker

A worker said a derogatory remark had been made against them when they spoke up. They also alleged that they were told that they could be performance managed and that statements could be obtained against them.

The worker said they were later informed that concerns had been raised about them, though they were made aware of these concerns at least two months after they had first been raised. The worker claimed that the handling of the concerns about them was also retaliation.

The worker spoke up to say they believed they were suffering detriment. They said that the alleged detriment was negatively impacting them, including on their wellbeing.

An investigation was carried out. It found that detriment for speaking up had not occurred. However, the investigation found that potentially unprofessional or unwanted behaviours, along with the potential failure to follow the correct processes when responding to concerns about the worker's professional practice, meant that the situation could have been interpreted in the way it was by the worker.

Recommendation
Within three months, the trust should:

- Communicate that detriment for speaking up will not be tolerated, act to prevent detriment occurring, and put in place procedures that would enable cases of detriment to be looked into effectively when they are reported.

5. Reflecting and moving forward

Reflective practice

Workers referred to a culture of blame that had existed in the trust. This discouraged a culture of transparency and learning. This was echoed in feedback from senior leaders as well.

"As in other trusts, we had a blame culture for so long… I see improvements; I don't know if others are seeing it yet."

Trust worker

A 'just culture' approach to incidents was being embedded in the trust. This approach sought to shine light on systemic issues and learning, rather than blaming individuals.

Support

A worker said there was a lack of support for them during their speaking up experience. They said there was a lack of information about potential sources of support they could use during this time.

The worker also said the handling of their speaking up cases negatively impacted their wellbeing. They alleged there was a lack of consideration in the handling of their case. This included, for instance, receiving communication regarding their case at the end of the week when they could not contact their union representative or others for support.

The worker said they self-referred to the trust's occupational health service for support, including counselling support and that they received support from the Freedom to Speak Up Guardian.

Recommendation
Within three months, the trust should:

- Take appropriate steps so that those who speak up have access to appropriate support and are made aware of and appropriately supported to access this support in a timely way.

Other indicators of speaking up culture

The Freedom to Speak Up (FTSU) Index[4] is an indicator of speaking up culture and can be used, alongside other metrics, to understand and improve the speaking up culture in an organisation.

[4] The Freedom to Speak Up (FTSU) Index brings together questions from the NHS Staff Survey that relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident.

The trust's score had improved year on year (see table 1, below). The trust's score was above average compared to similar trusts and the national average.

Table 1. FTSU Index results

	2016	2017	2018	2019	2020
Blackpool Teaching Hospitals NHS Foundation Trust	76.4%	78.1% ↑	79.1% ↑	79.2% ↑	79.7% ↑
Combined Acute and Community Trusts	76.4%	76.5% ↑	78.1% ↑	78.5% ↑	79.0% ↑
National average for all trusts	76.7%	76.8% ↑	78.1% ↑	78.7% ↑	79.2% ↑

The NHS Staff Survey (2020) also asked respondents whether they feel safe to speak up about anything that concerns them in their organisation. Just over two thirds of respondents at the trust (66.8%) agreed with this statement. This was better than the national average (65.5%).

In the most recent national NHS staff survey (2020), the trust saw improvements in staff perceptions in multiple areas. The trust scored above average compared to similar trusts in five of the ten themes captured by the survey, including staff engagement, morale, equity diversity, and inclusion.

The leadership team had changed considerably in a drive to support and improve the challenged trust.

We asked leaders at the trust about the speaking up culture and discussed some of the feedback shared with us through the review.
Trust leaders said there were historic cultural issues that they were working to address.

The leadership team expressed a strong and shared desire to improve the speaking up culture. They explained that the organisation was on an improvement journey and referred to initiatives to improve the speaking up culture. Many commented that it takes years to change organisational culture and that they were in the early stages of their journey, and that there was much more to do to make speaking up business

"To me, it is unacceptable – even a single person in the trust – to feel that they will be discriminated against or there will be detriment, or they don't feel that they can speak up because of something that has happened."

Trust leader

as usual. Trust leaders referred to ongoing work to encourage dispersed leadership, accountability and ownership.

Trust leaders referred to the trust's high vacancy and sickness levels and how this had a negative impact on staff morale and, quite possibly, on the speaking up culture as well.[5]

Most trust leaders with whom we spoke demonstrated awareness of concerns workers raised with us about the speaking up culture, as well as many of the specific issues that workers raised during our review. Trust leaders explained the channels through which these issues were being escalated and the steps taken to look into these matters.

However, we observed certain behaviours, including defensiveness, among some leaders in the trust. There seemed to be a readiness to dismiss concerns raised by some workers who were viewed as serial complainants, though this was expressed by a minority of the leaders we spoke to. These behaviours indicated that the mindset that recognises the importance of speaking up and appreciates feedback as an opportunity for improvement – rather than an issue that generates a defensive reaction – was not fully embedded across the trust.

"The only way to learn and improve the organisation is if people speak up".

Trust leader

The information we reviewed suggested that the trust's speaking up culture was seeing improvements. This was echoed in feedback from some of the workers contributing to our review. However, the work to bring about improvements in this area was not always progressing at pace, including action on the effective use of the Freedom to Speak Up Champions and the development of the trust's Freedom to Speak Up strategy, both of which are discussed later. This was impacted by the COVID–19 pandemic.

Groups facing barriers to speaking up

The Freedom to Speak Up Review (2015), which considered the speaking up culture in the NHS in England, identified groups that faced particular barriers to speaking up. This included black and minority ethnic workers, trainees, locums and agency workers. Any worker group could potentially face barriers to speaking up.[6]

Black and minority ethnic workers

Eleven per cent (11.2%) of the trust's workforce were from a black and minority ethnic background.

The trust's FTSU Index (2021) results showed black and minority ethnic workers at the trust had less confidence in the trust's speaking up culture.[7] The results echoed feedback we received from black and minority ethnic workers who contributed to our

[5] The trust's sickness level at the time of the review was consistent with the benchmark average for the region.
[6] Following the Freedom to Speak Up Guardian Survey 2019, we recommended that leaders, working with their Freedom to Speak Up Guardian(s), should identify potential groups that face barriers to speaking up and take action to address those barriers.
[7] 2021 FTSU index scores are based on the 2020 NHS Staff Survey.

review. Many believed that there was greater reluctance to speak up among black and minority workers and those that spoke up felt that they were more likely to experience unfavourable outcomes compared to their white colleagues.

A common theme we heard was that black and minority workers felt that they had less favourable access to training and promotion opportunities and were more likely to be involved in human resource processes. Workers explained that these factors made speaking up more of a risk for them. We also heard from workers on work permits who kept their 'heads down' to avoid potentially risking their right to stay in the country.

Workers also spoke up to us about the lack of representation on the trust board as a reason for decisions that, in their views, did not always consider the needs of black and minority ethnic workers.

A range of indicators showed that black and minority ethnic workers at the trust generally had less favourable perceptions and outcomes. However, information we reviewed showed improvements.

NHS organisations are required to demonstrate how they are addressing equality issues in staffing through the Workforce Race Equality Standard (WRES). The trust saw improvements in the WRES indicators drawn from the national NHS Staff Survey. Across all four of these indicators, there were marked improvements in the perceptions of black and minority ethnic staff who took part in the most recent survey (2020).

The trust's training records showed an improvement in the relative likelihood of black and minority ethnic staff accessing non-mandatory training in 2020/21.

Other groups facing barriers

Other groups that regularly came up in feedback as facing potential barriers to speaking up were:

- Workers with disabilities and long-term health conditions
- Lesbian, gay, bisexual and transgender workers
- Workers on lower pay bands.

"Look at the senior managers to see a reason for why the decisions are made that disproportionately affect us over other groups… No representation [among executive directors]."

Trust worker

Workers shared examples of speaking up about equality, diversity and inclusion issues, and how these were not always handled well.

Some workers said they had witnessed sexist, racist and homophobic remarks being made in the workplace and that more effective training was needed to change behaviours.

Steps had been taken to facilitate speaking up for groups that may face barriers. For example, the trust had a network of Freedom to Speak Up Champions from a range

of professional and other backgrounds.[8] The Freedom to Speak Up Champion role had been advertised through trust-wide communications and presentations at meetings of the trust's equality and diversity network to attract a cross-section of people. Further information about the trust's Freedom to Speak Up Champion network can be found later in this report.

Recommendations
Within three months, the trust should:

- Work with their Freedom to Speak Up Guardian to identify potential groups that face particular barriers to speaking up, and work towards addressing those barriers.

Within six months, the trust should:

- Update and implement the trust's equality, diversity and inclusion strategy considering the findings of this review.

Speaking up training

Workers need to know how to speak up and how to respond well to others speaking up.

The National Guardian's Office has issued guidance on speaking up training for workers. In addition, in partnership with Health Education England, it has launched two of three Freedom to Speak Up training modules ('Speak Up, Listen Up, Follow Up') for healthcare workers. The three modules seek to clearly and consistently explain what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

The trust had speaking up training for workers at the time of our review. However, this training did not reach all workers - specifically, existing managers, and this appeared to be reflected in cases that had been raised with the Freedom to Speak Up Guardian. We also found that understanding of speaking up and the remit of the Freedom to Speak Up Guardian was lacking among some senior leaders, discussed later in this report.

We reviewed slides used during inductions to raise awareness about Freedom to Speak Up and found that some of the messages were not in line with NGO guidelines.

The development of the trust's own speaking up training had been put on hold in anticipation of the Freedom to Speak Up training to be launched by the NGO.

[8] Some organisations have Freedom to Speak Up Champions or Ambassadors who work alongside Freedom to Speak Up Guardians to complement their work. These internal Freedom to Speak Up networks seek to raise awareness and promote the value of speaking up, listening up and following up. Many Freedom to Speak Up Guardians rely on these networks to address challenges posed by organisation size, geography and the nature of their work and help them support workers, especially those who may face barriers to speaking up.

Recommendation
Within six months, the trust should:

- Provide and monitor the uptake of effective speaking up training for all workers, ensuring this meets the expectations set out in guidelines from the National Guardian's Office.

Freedom to Speak Up Guardian

Among other things, Freedom to Speak Up Guardians:

- support workers to speak up
- work in partnership with others in their organisation to tackle barriers to speaking up.

The National Guardian's Office published the Freedom to Speak Up Guardian Job Description.

The implementation of the role varies among organisations. For example, some organisations have one Freedom to Speak Up Guardian, while others have multiple Freedom to Speak Up Guardians.

The trust had a Freedom to Speak Up Guardian.

Steps had been taken by the trust to bring the arrangements for the Freedom to Speak Up Guardian role in line with National Guardian's Office (NGO) guidance, including the:

- appointment of the Freedom to Speak Up Guardian through open and fair process
- provision of ring-fenced time for the Freedom to Speak Up Guardian.

Interim and planned arrangements

A trust leader explained they were setting up a joint Freedom to Speak Up Guardian arrangement with another organisation in the local care system. Once in place, the arrangement would mean that there would be:

- a deputy Freedom to Speak Up Guardian dedicated to each organisation, and
- a lead Freedom to Speak Up Guardian that would work across both organisations.

The deputy Freedom to Speak Up Guardians dedicated to each organisation would focus on the reactive side of the role (i.e. receiving cases), freeing up the lead Freedom to Speak Up Guardian working across both organisations to focus their efforts on the proactive part of the Freedom to Speak Up Guardian role.

They explained the arrangement would, among other things, strengthen the resilience of the Freedom to Speak Up Guardian support available to workers. Also, whereas previously there was a single Freedom to Speak Up Guardian, the planned arrangements meant workers would have options when speaking up to a Freedom to Speak Up Guardian.

The NGO recognises that the balance of a Freedom to Speak Up Guardian's role needs to reflect the needs of the workforce. Every Freedom to Speak Up Guardian is trained and expected to meet the full requirements set out in the universal Job

Description. This ensures that there is consistency of support for any worker who approaches a Freedom to Speak Up Guardian.

Recommendations
Within three months, the trust should:

- Provide assurance that all three FTSU guardians that support workers at the trust are able to meet the requirements of the universal job description.

- Revert to using the term ‘Freedom to Speak Up Guardian for all three guardians. It may, locally, consider how it communicates the primary functions of the individuals in each of the roles though, at all times, the individuals should be able to fulfil the requirements of the universal job description.

At the time of our review, the trust's Freedom to Speak Up Guardian stepped down. From here on, we refer to them as the trust's previous Freedom to Speak Up Guardian.

On an interim basis, arrangements were made to ensure that the Freedom to Speak Up Guardian role continued to be filled for workers to access support (from here on called the 'interim Freedom to Speak Up Guardian').

Many of the workers we spoke with were not aware of the details of the interim arrangements. There were plans for further communication of the changes, but this was pending the joint Freedom to Speak Up Guardian arrangements coming into effect.

Senior leaders discussed steps being taken to support the interim arrangements, including meetings between the Freedom to Speak Up Champions and the interim Freedom to Speak Up Guardian.

There are benefits in building resilience into an organisation's Freedom to Speak Up Guardian function, and there are various ways this could be achieved. It is important that changes to arrangements are communicated effectively to ensure that workers have the awareness and confidence to approach a Freedom to Speak Up Guardian.

There was a drop in the number of cases brought to the trust’s Freedom to Speak Up Guardians around the time that the trust’s Freedom to Speak Up Guardian arrangements were in flux (see table 3, below). Trust leaders referred to challenges during this transitionary period and efforts to ensure workers had access to a Freedom to Speak Up Guardian. They explained some cases could have been raised during this time which may not have been captured to allow the trust to report correctly.

Recommendation
Within three months, the trust should:

- Ensure that that changes to the Freedom to Speak Up arrangements are communicated to workers in a timely way.

Appointment

In accordance with NGO guidance, the previous Freedom to Speak Up Guardian had been appointed through a fair and open process.

Some workers expressed concern about the appointment process for the interim arrangements that had been put in place following the departure of the previous Freedom to Speak Up Guardian.

A trust leader explained that the circumstances meant they had to act quickly to fill the vacancy to ensure continuity of the Freedom to Speak Up Guardian function. They stressed that the arrangement was temporary pending the appointment of a deputy Freedom to Speak Up Guardian.

In March 2021, the trust launched its recruitment for a deputy Freedom to Speak Up Guardian. The position holder would work within the Joint Freedom to Speak Up office – based at Blackpool Teaching Hospitals NHS Foundation Trust – to provide support across both organisations.

Independence, impartiality and objectivity

In accordance with the Freedom to Speak Up Guardian Job Description, Freedom to Speak Up Guardians are expected to ... *"Operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team"*.

Some workers told us that they did not approach the trust's previous Freedom to Speak Up Guardian - not because of concerns about the person in that role - but due to a lack of confidence in the speaking up culture more generally. For example, workers expressed concern that their confidentiality could be breached. These concerns were particularly pronounced in comments about the interim and future Freedom to Speak Up Guardian arrangements.

Some workers felt that the Freedom to Speak Up Guardian should be appointed from within the trust. Others felt that the Freedom to Speak Up Guardian should not be a trust employee and should be ‘external’. They suggested such an arrangement would provide confidence that the Freedom to Speak Up Guardian could operate without pressure from leaders within the organisation.

Trust leaders explained that the need for the Freedom to Speak Up Guardian to operate independently, impartially and objectively was well understood. Leaders explained that, whereas previously there was a single Freedom to Speak Up Guardian, the planned arrangements meant workers would have options when speaking up to a Freedom to Speak Up Guardian.

The Freedom to Speak Up Guardian does not have to sit outside an organisation to operate independently, impartially and objectively. Nonetheless, there were concerns among workers we spoke with on this issue and trust leaders should listen to and engage with workers about these concerns.

Recommendation
Within three months, the trust should:

- Take appropriate steps to assure themselves that their Freedom to Speak Up Guardian arrangements have the confidence of the workforce.

Ring-fenced time

The National Guardian's Office recommends ring-fenced time should be allocated to those in a speaking up role.

The previous Freedom to Speak Up Guardian initially had 22 hours a week for the role. This was later increased to 30 hours a week.

The previous Freedom to Speak Up Guardian explained that as the Freedom to Speak Up Guardian role became embedded in the trust, the number and complexity of the cases raised with them increased, meaning they had less time to carry out the proactive parts of the role. They said they spoke up about this but that this had not been actioned.

A trust leader explained that the planned arrangements for the Freedom to Speak Up Guardian role would build greater capacity into the Freedom to Speak Up Guardian function.

Recommendation
Within three months, the trust should:

- Provide the Freedom to Speak Up Guardian(s) with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.

Understanding of the role

We found misunderstandings among some leaders about the Freedom to Speak Up Guardian role, including:

  - the type of cases about which workers may and may not speak up about to a Freedom to Speak Up Guardian
  - the misunderstanding that the Freedom to Speak Up Guardian was to signpost individuals who had approached them to speak up
  - the preconception that the Freedom to Speak Up Guardian should not proactively encourage workers to speak up.

In most cases, workers are likely to speak up within their line management chain or use other channels. However, the Freedom to Speak Up Guardian is an essential additional route for workers to speak up about any suggestions or concerns.

In line with the proactive part of their role, Freedom to Speak Up Guardians work in partnership with others in their organisation to tackle barriers to speaking up. This may include reaching out to different parts of their organisation to make themselves known, particularly if indicators suggest such work may be helpful for reassurance about the speaking up culture.

Recommendation
Within three months, the trust should:

- Take appropriate action to ensure the Freedom to Speak Up Guardian(s) are appropriately supported to carry out their role, in line with guidance from the National Guardian's Office and NHS England & Improvement.

Also, see recommendation above regarding the provision and monitoring of effective speaking up training for all workers.

Case handling

We encountered misunderstandings about the role of the Freedom to Speak Up Guardian in relation to investigations.

According to the universal job description, Freedom to Speak Up Guardians are responsible for promoting certain outcomes, including individuals being supported when they speak up. This includes taking appropriate action when an issue is brought to the attention of a Freedom to Speak Up Guardian, with confidentiality being respected as appropriate and regular feedback on progress being given.

Matters raised with Freedom to Speak Up Guardians may require investigation and when this is the case, a fair and effective process should be used. However, Freedom to Speak Up Guardians themselves are not responsible for investigating matters brought to them.

Leaders need to ensure that Freedom to Speak Up Guardians are supported to carry out these responsibilities.

Freedom to Speak Up Guardians must not take part in investigations or make decisions on the issues connected to speaking up cases brought to them. There is a difference between being assured that investigations are happening well and taking decisions about the scope and conduct of investigations.

Freedom to Speak Up Guardians should ensure that everyone understands their role is to support rather than solve. By taking the lead from the person they are supporting, Freedom to Speak Up Guardians help maintain their impartiality and avoid creating barriers to others wanting to speak up to them.

Recording cases and reporting data

Freedom to Speak Up Guardians are expected to record[9] all cases of speaking up raised with them, including the number of cases brought to them where detriment as a result of speaking up was indicated.[10]

In line with NGO guidance, the trust's Freedom to Speak Up Guardian submitted non-identifiable[11] information about the speaking up cases raised with them to the NGO.

The information submitted showed that workers were speaking up to the Freedom to Speak Up Guardian (please see tables 2 and 3, below). However, the number of cases fell in Q2 and Q3 2020/21.

Table 2. FTSU Guardian Speaking Up Cases

Number of cases…	2018/19	2019/20	Change
… brought to FTSU Guardians / Champions	124	176	↑
… raised anonymously	11	10	↓
… with an element of patient safety/quality	57	87	↑
… related to behaviours, including bullying/harassment	68	71	↑
… where people indicate that they are suffering detriment as a result of speaking up	3	6	↑

[9] This serves many purposes, including helping Freedom to Speak Up Guardians keep track of individual cases and promoting consistency in the handling of cases. It provides a measure of the speaking up culture and the use of the Freedom to Speak Up Guardian route in an organisation.

[10]Detriment can be described as any disadvantageous or demeaning treatment. It may include being ostracised, given unfavourable shifts, being overlooked for promotion and moved from a team.

[11] Freedom to Speak Up Guardians should always respect confidentiality. The details of individual cases should not be shared outside the bounds of the agreement between Freedom to Speak Up Guardians and the individual they support.

Table 3. FTSU Guardian Speaking Up Cases[12]

No. of cases…	Q1 2020/21	Q2 2020/21	Q3 2020/21
… brought to FTSU Guardians / Champions	54	15	11
… raised anonymously	54	14	0
… with an element of patient safety/quality	33	0	0
… related to behaviours, including bullying/harassment[13]	21	0	4
… where people indicate that they are suffering detriment as a result of speaking up	0	0	0

We found misunderstandings about the NGO's guidance on recording cases and reporting data, specifically the recording of cases where detriment as a result of speaking up was indicated.

In accordance with NGO guidance, a case being recorded as indicating detriment is based on the perceptions of the person speaking up. Occurrence of detriment does not have to be definitively proven.

Recommendation
Within three months, the trust should:

- Take appropriate steps to ensure cases brought to the Freedom to Speak Up Guardian are recorded and reported in accordance with guidelines from the National Guardian's Office.

Board reports

Working with the National Guardian's Office, NHS Improvement published guidance for NHS and foundation trust boards on Freedom to Speak Up. In line with this guidance, the trust's previous Freedom to Speak Up Guardian was presenting their reports to the trust board in person.

[12] The data in this report is based on interim figures for Q1 – 2 2020/21. Freedom to Speak Up Guardians will have an opportunity to reconcile their data for the year (2020/21) in April – May 2021.
[13] A case may include an element of patient safety/quality as well as an element of bullying and harassment.

We reviewed board reports. We found these had improved over time. However, we noted the following points for improvement, including a level of detail about cases that could pose or be seen to pose a risk of identifying individuals.

Freedom to Speak Up reports to the board play an important role in providing assurance to the board about the speaking up culture, and the trust should continue to improve the quality of its reports.

Supplementary information that accompanies NHS E/I's Guidance for Boards on Freedom to Speak Up includes suggestions for information that should be included in reports.

Recommendation
Within six months, the trust should:

- Continue to improve the board reports presented by the Freedom to Speak Up Guardian, ensuring this is in line with guidelines from NHS England and Improvement.

Succession planning

Following the departure of the previous Freedom to Speak Up Guardian, trust leaders put in interim arrangements to ensure continuity of the Freedom to Speak Up Guardian function.

The interim Freedom to Speak Up Guardian said they were keen to review themes and trends to understand the speaking up culture in the trust and inform how they can best support workers. They explained that the board reports did not support them in developing this understanding.

New Freedom to Speak Up Guardians need to understand the emerging picture with regards to their organisation's speaking up culture.

Succession planning, including, where possible, effective handovers, can support incoming Freedom to Speak Up Guardians and minimise any disruption to an organisation's Freedom to Speak Up arrangements.

Leaders need to work with their Freedom to Speak Up Guardian(s) to support effective planning in this regard in order to provide a successor with adequate information and a plan for an effective handover.

The NGO is developing guidance to help Freedom to Speak Up Guardians consider and have discussions about supporting this process. This will be published by March 2022.

Recommendation
Within 12 months, the trust should:

- Discuss and agree a continuity plan to support incoming Freedom to Speak Up Guardians and minimise any disruptions to the Freedom to Speak Up arrangements, ensuring this is in line with guidelines from the National Guardian's Office.

Freedom to Speak Up Champions/Ambassadors

Some organisations have Freedom to Speak Up Champions or Ambassadors who work alongside Freedom to Speak Up Guardians to complement their work. These internal Freedom to Speak Up networks seek to raise awareness and promote the value of speaking up, listening up and following up. Many Freedom to Speak Up Guardians rely on these networks to address challenges posed by organisation size, geography and the nature of their work and help them support workers, especially those who may face barriers to speaking up.

At the time of our review, the trust had several Freedom to Speak Up Champions from across the trust representing a range of professional and other backgrounds.

In line with the trust's description of the Freedom to Speak Up Champion role, workers brought cases to Freedom to Speak Up Champions as they did to the Freedom to Speak Up Guardian.

There was variable engagement with and support for the Freedom to Speak Up Champions. A senior leader explained that the Freedom to Speak Up Champions did not have ring-fenced time, and this affected their ability to work effectively. The senior leader added that there had been a lack of support among the trust leadership to make the most of the trust's Freedom to Speak Up Champions.

There was a lack of awareness among the workers we spoke with about the Freedom to Speak Up Champions and their role.

In April 2021, the NGO published guidance to inform the development and support of Freedom to Speak Up Champion/Ambassador networks. The planning and implementation of refreshed arrangements, in line with this guidance, is expected within a year from the publication of this guidance.

Recommendation
Within nine months, the trust should:

- Review the use of the Freedom to Speak Up Champion role, ensuring this is in line with guidelines from the National Guardian's Office.

Leadership

Senior responsibility for Freedom to Speak Up

Working with the National Guardian's Office, NHS Improvement published guidance for NHS and foundation trust boards on Freedom to Speak Up. The guide sets out expectations and details individual responsibilities, including the role of executive lead for Freedom to Speak Up.

The executive lead for Freedom to Speak Up is an important role and sits in different places in different organisations. At this trust, the role sat with the Director of Human Resources and Organisational Development. Freedom to Speak Up is further supported with a non-executive director who has responsibility to support the trust and provide an independent view of the service.

We found that the positioning of the Freedom to Speak Up executive lead role was perceived as a conflict of interest and that concerns were raised about impartiality and conflict. These matters had previously been raised to a trust leader. While it was perceived that action had not been taken, we were told that the matter had been looked into. It had been concluded that similar arrangements were in place in other trusts, and there was not an issue with the current arrangements.

There were differing views among senior leaders with whom we spoke on this matter. Some agreed that the role should not sit within human resources, referring to many of the cases brought to Freedom to Speak Up Guardians that may in some way concern human resources, including cases about bullying and harassment. They explained that this meant there was potential for an actual or perceived conflict of interest.

Others did not perceive an issue with the arrangements. A senior leader stressed that the same arrangements worked effectively in other organisations. They added that the arrangement had the benefit of facilitating partnership working with human resources.

There are organisations where the executive lead role for Freedom to Speak Up sits in human resources, though this may not always be suitable. There may be local reasons why an arrangement that functions well in one setting may not be appropriate in another. Leaders should take appropriate steps to assure themselves that those with senior responsibility for Freedom to Speak Up have the confidence of the workforce.

Recommendation
Within 12 months, the trust should:

- Take appropriate steps to identify and review measures to assure themselves that those with senior responsibility for Freedom to Speak Up have the confidence of the workforce, making improvements as needed.

Self-review toolkit

NHS E/I's guidance for NHS trust and foundation trust boards on Freedom to Speak Up is accompanied by supplementary information and a Freedom to Speak Up self-review tool. It is expected that an assessment using the self-review tool is completed yearly and shared with NHS E/I.

We reviewed the trust's self-assessment. The assessment found that many of the expectations in the guide were not being met, either partially or fully. We also noted that the assessment was not complete.

A senior leader explained that the document had been updated when there were changes to the Freedom to Speak Up arrangements. However, they explained the assessment had not been finalised or presented and signed off by the trust board.

Recommendation
Within six months, the trust should:

- Complete the Freedom to Speak Up review toolkit and share this with NHS England and Improvement, in line with NHS England and Improvement guidelines.

Speaking up strategy

In accordance with NHS E/I's guidance for NHS and foundation trust boards on Freedom to Speak Up, boards should have a clear vision – supported by a strategy – for the speaking up culture in their trust. The strategy should be developed and reviewed annually by the Freedom to Speak Up executive lead.

The trust shared its Freedom to Speak Up strategy, dated January 2020.

A senior leader explained that there was a lack of appropriate ownership of the strategy, which was not in accordance with NHS E/I's guidance for NHS trust and foundation trust boards. They explained that there were multiple attempts to update the strategy, though this did not happen.

Recommendation
Within six months, the trust should:

- Develop and begin the implementation of a strategy to improve the speaking up culture across its workforce, in line with guidelines from NHS England and Improvement. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.

Speaking up communication strategy

Workers we asked knew the previous Freedom to Speak Up Guardian. Those we spoke with mentioned various ways through which the role had been advertised, including a 'road show' during Speak Up Month where the Freedom to Speak Up

Guardian and Champions, alongside trust leaders, visited different parts of the trust to raise awareness.

NHS E/I's guidance for NHS and foundation trust boards on Freedom to Speak Up states that boards should support the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up.[14]

We reviewed the trust's Freedom to Speak Up communication strategy. The strategy did not include a timeline for delivery. Although it had measures for success, it did not have targets or milestones. It also did not allocate responsibility for delivery of the plan.

Like the trust's speaking up policy (discussed below), the strategy used terminology that was not in line with NGO guidance. Furthermore, the strategy was focused on the communication of the trust's Freedom to Speak Up Guardian and Champions, rather than speaking up more generally.

The plan did not contain a release date or version number.

Recommendation
Within six months, the trust should:

- Develop and evaluate its Freedom to Speak Up communication plan in line with guidelines from NHS England and Improvement, ensuring this takes account of workers in the trust's community sites and other groups that may face barriers to speaking up.

Integration with the local care system

A topic that consistently came up during our review was about the trust's integration with the local care system. Common among feedback from workers in this regard were the following perceptions:

- That trust workers did not always have the same opportunities to apply for roles
- That ways of working were being 'imposed' on the trust
- There was a 'them and us' mentality, with concern about whether workers would be treated differently if they spoke up.

Not all workers shared these views though, with some referring to developments as a 'breath of fresh air'. For example, the Big Conversations (referred to above) was a concept from another organisation and was referred to as an example of positive collaboration.

[14] Supplementary information accompanying the guidance also sets out suggestions of how to evaluate the effectiveness of a communication strategy.

Trust leaders were aware of these themes and empathised with workers speaking up. Leaders explained the trust was challenged and that it required support. They added that closer working among providers was happening across the country, encouraged by the government and others in the healthcare system.

"There is commitment at board level [to improve the speaking up culture and arrangements."

Trust leader

Another trust leader stressed that it was not the case that one trust had 'all the answers' and referred to examples of good practice flowing from the trust.

Recommendation
Within six months, the trust should:

- Should develop a plan to ensure that workers can speak up effectively about the impact of integration as its local integrated care system continues to develop and mature.

Policy

A speaking up policy is an important part of an organisation's speaking up arrangements.

The trust's current speaking up policy (called 'Freedom to speak up: raising concerns (whistleblowing) policy') was issued in May 2020.

NHS Improvement expects all NHS organisations in England to adopt its Freedom to speak up: whistleblowing policy for the NHS, published in April 2016, as a minimum standard.

The Advocacy and Learning (Freedom to Speak Up, FTSU) Team at NHS England and Improvement (NHS E/I) reviewed how the trust's policy aligned with the national integrated whistleblowing policy. They found the trust's policy:

- was mostly in line with the national policy
- contained useful links; and
- could benefit from a one-page flow diagram in the beginning of the policy for ease of use.

The team highlighted the following points for improvement for the consideration of trust leaders:

Section	Extract from the trust policy	Advocacy and Learning (FTSU) Team
2	*"This policy applies to all current and ex-employees of Blackpool Teaching Hospital NHS Foundation Trust. It also applies to contractors, volunteers or service providers."*	We consider the policy could be simplified in its description of those to whom it applies.

4.2	*"… you can contact …* • *Our **Freedom to Speak Up Guardian** …* • *our **Freedom to Speak Up Ambassador*** • *our **Freedom to Speak up Champions**"*	We consider the policy would benefit from a brief explanation of the difference between these roles.
	"… you can contact … "	We consider the policy would benefit from the inclusion of the contact details for the following: • FTSU Guardian • FTSU Champions / Ambassadors • Executive and Non-Executive Leads for Speaking Up.
	"If your concern relates to fraud, bribery and/or corruption, then you should immediately contact the Trust's Local Counter Fraud Specialist. In those cases the Local Counter Fraud Specialist (LCFS) will make the decision regarding contact with the Line Manager or Executive Director."	We consider the policy would benefit from clarification. The implication is that individuals should bypass their line manager and others if they have fraud concerns and go straight to Local Counter Fraud Specialist, though this is not clear.
4.2.1	"…. contact the Whistleblowing Helpline for the NHS and social care..."	The hyperlink should be updated to Speak Up Direct.
4.3	*"On receipt the … you will receive an acknowledgement within 14 working days …"*	We consider acknowledgement within 14 working days to be a long time to wait. The policy will benefit from review of this timeframe, considering the experience of the person speaking up and feeling confident something will happen.
4.3.1	*"If you make a disclosure under this policy during the course of disciplinary proceedings against you, we will normally continue with the disciplinary proceedings whilst investigating your disclosures concurrently."*	We consider the policy may benefit from clarification. The policy says 'normally', and so there is a caveat. It is important to allow for situations where an individual(s) alleges the disciplinary action is unfavourable treatment for speaking up.

The National Guardian's Office (NGO) has developed a policy review framework to support Freedom to Speak Up Guardians and others to assess their organisation's speaking up policy. According to the framework, an effective speaking up policy should:

- encourage speaking up
- be clear and accessible for all workers, including those who may face barriers to speak up
- be clear that workers may speak up about things that can be improved, as well as problems, risks or issues
- describe a clear process and offer alternative routes for speaking up
- explain that the confidentiality of those speaking up will be protected as far as possible and provide assurance about protection from unfavourable treatment for speaking up and commit to taking action where this happens; and
- be reviewed regularly with feedback from those who have or may wish to use the policy.

We reviewed the trust's policy using this framework. In this assessment, the trust policy scored variably. We made the following observations:

Section	Extract from the trust policy	Intelligence and Learning Team at the National Guardian's Office
2	*"… raise a concern about risk, malpractice or wrongdoing that you think is harming the service we deliver."*	The best speaking up policies make it clear that workers may speak up about anything, welcome this, and encourage workers to speak up about things that could be improved, as well as problems, risks or issues. They avoid limiting beliefs that only 'concerns' can be raised and avoid confusing and emotive terminology like 'whistleblowing' which may act as a barrier to speaking up.
4.1	*"it does not matter if you turn out to be mistaken as long as you are genuinely troubled".*	Good policies do not discourage speaking up by questioning an individual's motivation. The matters about which they are speaking up could still be true.
4.1.1	*"Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns."*	
4.7	*"Alternatively, you can raise your concern outside the organisation…"*	Good policies encourage speaking up to happen through the normal line management chain but are clear that there are alternatives to this at any point.

4.7.1	*"**Making a 'protected disclosure**"*	The best policies recognise that workers may be engaging with the policy at a difficult time when they may be stressed, upset, and uncertain of what to do. They make their key messages easy to read and understand, and ensure that the information that workers will need to help them make the right first step is presented in an easily accessible way. The best policies make it clear that workers may speak up about anything, welcome this, and encourage workers to speak up about things that could be improved, as well as problems, risks or issues.
4.8	*"**National Freedom to Speak Up Guardian**"*	The description of the NGO's case review process, taken from the national integrated speaking up policy, is not accurate.
4.6	*"We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate."*	Good policies are reviewed regularly and feedback from those who have used the policy, or may wish to, is considered as part of this process. The best policies are clear that they will actively seek feedback from workers, especially from groups who may be faced with barriers to speaking up.
App. 1	*"If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made."*	The best policies are clear that confidentiality will be preserved unless disclosure of information provided in confidence is required by law.

Other observations we made about the policy:

- In line with the national speaking up policy, the trust's policy stated (s 4.6) it will be reviewed at least annually. However, on the version control sheet attached to the policy, it stated the policy would be reviewed three years after its approval (i.e. May 2023)
- There were differing explanations (sections 2 and 4.1.3) as to who came within the remit of the policy
- The policy provided differing instructions about how concerns about fraud should be raised (sections 4.1 and 4.2)

- The terms confidentiality and anonymity were used interchangeably (section 4.3)
- References to other organisations needed to be updated (section 4.7.1).

Recommendation(s):

Within 12 months, the trust should:

- Revise the trust's speaking up policy to take account of the observations made in this report.
- Take steps to ensure all existing and new workers are aware of the contents and meaning of its revised speaking up policy.

Freedom to Speak up: Guidance for NHS trusts (and supplementary resources, including a self-review toolkit)

Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS

NHS England and Improvement are updating both the policy and guidance.

We welcome working with them as part of that to ensure they meet NGO expectations. We invite them to consider the observations in this report and take them into account when devising mechanisms to monitor the implementation of the revised guidance and policy.

Speaking up to national bodies

Some workers said they spoke up outside their trust. Their experience appeared to be variable, but there were examples of what appeared to be less than good practice.

Following the CQC's lead, we are developing the Speak Up Partnership Group to improve the consistency and quality of responses given to workers who speak up to national organisations.

Recommendations

Within three months, the trust should:

1.1 Continue to demonstrate that it values the views of its workers, including consulting staff about changes to their services as appropriate, in line with its policies and procedures and good practice.

1.2 Continue to take appropriate steps to promote a culture of visible and accessible leadership.

1.3 Take appropriate steps so that issues about which workers speak up are responded to in accordance with trust policies and procedures and good practice.

1.4 Take appropriate steps to ensure workers who speak up are meaningfully thanked for doing so, in accordance with trust policies and procedures and good practice.

1.5 Take appropriate steps to ensure its policies and procedures are fair and supportive of all workers in the speaking up process, including those who are the subject of matters that are raised.

1.6 Take appropriate steps to promote effective communication with those speaking up in order to effectively manage expectations.

1.7 Take appropriate steps to assure themselves that speaking up practices ensure that the confidentiality of workers who speak up is appropriately supported – including looking into cases where a breach of confidentiality is reported.

1.8 Take appropriate steps to ensure that workers who speak up can have input into the terms of reference for any subsequent investigations, in accordance with trust policies and procedures and good practice.

1.9 Take appropriate steps to ensure its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent and trained investigators.

1.10 Take appropriate steps to ensure matters arising from cases of speaking up are investigated within reasonable timescales and without undue delay.

1.11 Take appropriate steps to ensure that workers who speak up receive meaningful and timely feedback in accordance with trust policies and procedures and good practice.

1.12 Communicate that detriment for speaking up will not be tolerated, act to prevent detriment occurring, and put in place procedures that would enable cases of detriment to be looked into effectively when they are reported.

1.13 Take appropriate steps so that those who speak up have access to appropriate support and are made aware of and appropriately supported to access this support in a timely way.

1.14 Work with their Freedom to Speak Up Guardian to identify potential groups that face particular barriers to speaking up, and work towards addressing those barriers.

1.15 Provide assurance that all three Freedom to Speak Up Guardians that support workers at the trust are able to meet the requirements of the universal job description.

1.16 Revert to using the term 'Freedom to Speak Up Guardian' for all three guardians. It may, locally, consider how it communicates the primary functions of the individuals in each of the roles though, at all times, the individuals should be able to fulfil the requirements of the universal job description.

1.17 Ensure that that changes to the Freedom to Speak Up arrangements are communicated to workers in a timely way.

1.18 Take appropriate steps to assure themselves that their Freedom to Speak Up Guardian arrangements have the confidence of the workforce.

1.19 Provide the Freedom to Speak Up Guardian(s) with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.

1.20 Take appropriate action to ensure the Freedom to Speak Up Guardian(s) are appropriately supported to carry out their role, in line with guidance from the National Guardian's Office and NHS England and Improvement.

1.21 Take appropriate steps to ensure cases brought to the Freedom to Speak Up Guardian are recorded and reported in accordance with guidelines from the National Guardian's Office.

Within six months, the trust should:

2.1 Continue with and review the effectiveness of its programme of work to challenge unwanted and/or unprofessional behaviours.

2.2 Continue to promote and facilitate the use of mediation where appropriate.

2.3 Continue to improve effectiveness of its governance arrangements, including the communication of information from and to ‘board to ward’.

2.4 Continue to take appropriate steps to ensure human resources policies and processes have the confidence of its workforce, including effective training for workers in human resources.

2.5 Update and implement the trust's equality, diversity and inclusion strategy considering the findings of this review.

2.6 Provide and monitor the uptake of effective speaking up training for all workers, ensuring this meets the expectations set out in guidelines from the National Guardian’s Office.

2.7 Complete the Freedom to Speak Up review toolkit and share this with NHS England and Improvement, in line with NHS England and Improvement guidelines.

2.8 Continue to improve the board reports presented by the Freedom to Speak Up Guardian, ensuring this is in line with guidelines from NHS England and Improvement.

2.9 Develop and begin the implementation of a strategy to improve the speaking up culture across its workforce, in line with guidelines from NHS England and Improvement. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.

2.10 Develop and evaluate its Freedom to Speak Up communication plan in line with guidelines from NHS England and Improvement, ensuring this takes account of workers in the trust’s community sites and other groups that may face barriers to speaking up.

2.11 Develop a plan to ensure that workers can speak up effectively about the impact of integration as its local integrated care system continues to develop and mature.

Within nine months, the trust should:

3.1 Review the use of the Freedom to Speak Up Champion role, ensuring this is in line with guidelines from the National Guardian’s Office.

Within 12 months, the trust should:

4.1 Discuss and agree a continuity plan to support incoming Freedom to Speak Up Guardians and minimise any disruptions to the Freedom to

Speak Up arrangements, ensuring this is in line with guidelines from the National Guardian's Office.

4.2 Take appropriate steps to identify and review measures to assure themselves that those with senior responsibility for Freedom to Speak Up have the confidence of the workforce, making improvements as needed.

4.3 Revise the trust's speaking up policy to take account of the observations made in this report.

4.4 Take steps to ensure all existing and new workers are aware of the contents and meaning of its revised speaking up policy.

Freedom to Speak Up Gap Analysis Tool

Review undertaken by: Tracey Garde, FTSU Guardian & Lisa Gammack, Deputy Director of Organisational Development

Date of review: March 2022

WORKERS

	Existing provision /gaps	Action needed	Authorised action/ date for completion	Review date
Valuing workers' views Workers' views should be valued, including consulting about changes to their services where appropriate.	Bolton Engage survey, NHS national staff survey, staff consultation prior to organisational change processes, staff listening sessions, staff networks, Exec Team walkarounds, Team Brief etc.	FTSU Guardian to promote the FTSU approach at the new staff networks: • LGBTQ+ staff forum • Disability & Health Conditions Staff Network	By June 2022	October 2022
Speaking up culture A suitably independent review of the speaking up culture in the service relating to Blackpool should be undertaken. All necessary steps to implement its findings without undue delay should be taken. Given the evidence of fear of speaking up in this service, the review should take all reasonable steps to protect individuals' confidentiality.	Full review of the Blackpool case review & recommendations. FTSU internal audit completed 2021. All findings addressed and shared with the People Committee.	Review completed by the Guardian & Dep Dir or OD. Staff Experience Steering Group & People Committee to continue receiving FTSU quarterly update reports.	Completed March 2022 Apr '22, July '22, Oct '22 & Jan '23	n/a

Support to speak up Policies and procedures relating to speaking up (including the reporting and handling of incidents) should: refer to the support available for workers to speak up from the Freedom to Speak Up Guardian and Freedom to Speak Up Champions/Ambassador; make clear that all workers can seek support, about any issue, from the Freedom to Speak Up Guardian enable those who speak up to have access to appropriate support. They should be made aware of and appropriately supported to access this support in a timely way ensure that letters to suspended workers accurately state their ability to access their Freedom to Speak Up Guardian or Freedom to Speak Up Champion/Ambassador.	The Trust has a FTSU Policy in line with the national NHSI policy. Letters that are sent to staff identifies support available via Vivup, KESS, occupational health service & the Trust's staff wellness offer. The Trust's Resolution Policy highlights the Freedom to Speak Up service on p7 and p 13.	The standard paragraph in letters to staff involved in incidents or speaking up to be amended to include support available from FTSU Guardians & champions.	Completed March 2022.	n/a
Responding to speaking up The response to issues raised by workers should be in accordance with policies, procedures and good practice. Workers who speak up should be meaningfully thanked. The response to cases of workers speaking up, including decisions relating to the investigation of those cases, should not focus on whether the matters in those cases are qualifying or protected disclosures under the Public Interest Disclosure Act 1998. Effective communication with those speaking up should be promoted in order to manage expectations effectively.	All responses are dealt with in accordance with good practice. All workers are thanked for speaking up, recognising how difficult it can be. FTSUG engages in regular contact with all individuals in open cases until completion.	No further action identified at this stage.	n/a	n/a

Workers who speak up should be treated in accordance with the values of the organisation (where the NGO undertook its review): *openness, care, compassion and respect*. Work should be completed to help workers – particularly those responsible for responding to speaking up matters – develop the skills to handle difficult conversations.				
Groups facing barriers to speaking up Organisations, working in partnership with the Freedom to Speak Up Guardian, should: seek to identify groups potentially facing barriers to speaking up and work towards addressing those barriers Support from the Workforce Race Equality Scheme (WRES) Implementation Team should be considered to help meet the needs of ethnic minority workers. A senior worker should be appointed as equality, diversity and inclusion lead. This role should be appropriately resourced. The cultural ambassador's network should reflect the diversity of the workforce that it supports.	FTSUG is a member of the BAME Staff Network & attends their meetings. FTSUG also feeds into the Trust's EDI Steering Group. The FTSUG has a positive working relationship with the EDI Team and BAME Staff Network Chair. FTSUG working with HEE NW to support junior doctors in training across NW particularly with issues relating to EDI.	No further action identified at this stage.	n/a	n/a
Confidentiality and anonymity Speaking up arrangements, including the support provided by the Freedom to Speak Up Guardian, should appropriately protect workers' confidentiality, and demonstrate understanding and empathy for the needs of individuals.	Confidentiality is always maintained - where it is necessary to share details of the individual this is always with the worker's permission. The FTSU feedback survey asks workers whether they feel they	No further action identified at this stage.	n/a	n/a

Reasonable steps should be taken to respond to the issues raised by those who speak up in confidence. Matters should be investigated as fully as possible, even where the identities of those speaking up are unknown. Alleged breaches of confidentiality should be appropriately investigated.	were treated confidentially and with empathy and the feedback received has been very positive.			
Training – Speak Up, Listen Up and Follow Up Effective speaking up training for all workers should be provided and uptake monitored, ensuring this meets the expectations set out in guidelines from the National Guardian's Office.	The uptake of the online 'Speak up', 'Listen up' and 'Follow up' training is currently low. The FTSUG provides regular training on induction programmes, care certificate training, preceptorship and leadership & management development programmes.	FTSUG to explore whether the 'Speak up', 'Listen up' and 'Follow up' online training can be made mandatory on a 3-yearly basis.	By June 2022	n/a
Disadvantageous and/or demeaning treatment It should be communicated that detriment for speaking up will not be tolerated. Action should be taken to prevent detriment occurring. There should be procedures to allow cases of alleged detriment to be looked into effectively when they are reported. Investigations into the alleged conduct of workers who have previously spoken up should also seek to identify whether the allegations about the worker are	Detriment is covered in FTSU training sessions and that it will not be tolerated. The organisation's responsibility and commitment to deal with detriment is clear outlined within the Trust's FTSU Policy. The Trust's Disciplinary Procedure has recently been updated to reflect this position.	No further action identified at this stage.	n/a	n/a

motivated by a desire to cause them detriment because they spoke up. If evidence of detriment is found, appropriate action should be taken. The disciplinary policy should be amended to require such action.				
Bullying and harassment, poor working relationships and unwanted and/or unprofessional behaviours The programme of work to challenge unwanted and/or unprofessional behaviours should be continued and reviewed for effectiveness. Appropriate measures should be taken to identify the causes of poor working relationships and implement effective actions to remedy those causes, including steps to measure the effective of those actions. An action plan should be developed to address bullying behaviour and develop a working culture that is free from bullying, including providing anti-bullying training for all workers. The bullying and harassment policy and procedure should be consistent with the standards in the bullying and harassment guidance issued by NHS E/I, including implementation and monitoring of the policy and ensuring its contents are shared with workers.	The Trust has introduced the VOICE Behaviour Framework which articulates how all staff should behave at work. The behaviours are a key feature of FABB appraisal and check-in meetings. The A&E Dept have launched the Civility Saves Lives Campaign and the intention is to further develop & roll-out the campaign & resources across the organisation. The Trust is planning to implement a new EDI training programme called the 'Be Inclusive Programme'. Microaggressions will be covered within the programme.	Develop & roll-out the Civility Saves Lives Campaign across the organisation (target date to be agreed). Launch & deliver the new Be Inclusive Training Programme.	Target dates TBA	March 2023
Mediation Mediation should be actively promoted and facilitated, where appropriate, to resolve issues arising from speaking up.	Mediation is actively promoted in the Trust's Resolution Policy under the informal stages.	No further action identified at this stage.	n/a	n/a

Managers and HR workers should be up to date with guidance on explaining the value of mediation to workers.				

FREEDOM TO SPEAK UP GUARDIANS

	Existing provision /gaps	Action needed	Authorised action/ date for completion	Review date
Appointment Freedom to Speak Up Guardians should be appointed through a fair and open process.	The current FTSUG was recruited via a fair and open recruitment process.	The additional FTSUG to be appointed via a fair & open process.	By 31st May 2022	n/a
Confidence in the arrangements Assurance should be obtained that the workforce has confidence in the Freedom to Speak Up Guardian arrangements. Assurance should be provided that the multiple Freedom to Speak Up Guardians supporting the same organisation/s are able to meet the requirements of the universal job description. The term 'Freedom to Speak Up Guardian' should be used for all Freedom to Speak Up Guardians supporting the same organisation/s. Locally, the organisation may consider how it communicates the primary functions of the individuals in each of the roles though, always, the individuals should be able to fulfil the requirements of the universal job description.	Feedback is sought from all individuals who have spoken up via the FTSU process.	No further action identified at this stage.	n/a	n/a

Ring-fenced time Freedom to Speak Up Guardians should be provided with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.	The FTSUG is a substantive post with ring-fenced time of 0.6WTE. Due to the success of the role a further 0.4WTE/0.6 role is being recruited to.	No further action identified at this stage.	n/a	n/a
Support The support required for Freedom to Speak Up Guardians to carry out their role and meet the needs of the workers should be identified and provided, including: • sufficient cover to support their work in their absence; • alternative routes to handle speaking up matters to overcome any possible conflicts; and • appropriate managerial and emotional support.	An additional FTSUG is being recruited to support the current post holder and to maintain continuity, cover for leave and potentially help in succession planning. The FTSUG has monthly 1:1 FABB conversations with her line manager to provide support. The FTSUG also attends the local FTSU Network gaining support from peers.	No further action identified at this stage.	n/a	n/a
Continuity A continuity plan should be agreed to support incoming Freedom to Speak Up Guardians and minimise any disruptions to the Freedom to Speak Up arrangements, ensuring this is in line with guidance from the National Guardian's Office.	Recruiting a further FTSUG will support and minimise any disruptions.	No further action identified at this stage.	n/a	n/a

Recording cases and reporting data In accordance with guidance from the National Guardian's Office: • all instances of speaking up brought to the Freedom to Speak Up Guardian should be recorded, not just those cases where workers state that they are raising a matter 'formally' • non-identifiable information about all these cases should be reported to the National Guardian's Office	All workers who contact the FTSUG are recorded irrespective of whether that worker wants to raise a formal issue or whether they just want support/ advice etc. The FTSUG reports all cases via the data portal to the NGO.	No further action identified at this stage.	n/a	n/a
Freedom to Speak Up Champions/Ambassadors The use of the Freedom to Speak Up Champion/Ambassador role should be reviewed, ensuring it is in line with guidance from the National Guardian's Office. Freedom to Speak Up Champion/Ambassador networks should reflect the diversity of the workforce they support.	The FTSU Champion Network has been reviewed in line with NGO guidance. Champions will be available for support/ signposting and raising awareness only. The FTSU Network is a diverse group which reflects the organisation.	No further action identified at this stage.	n/a	n/a
Network meetings Freedom to Speak Up Guardians should regularly attend regional meetings of their peers to ensure that they have access to guidance and support to undertake their work, including to assist with the writing of board reports, and in order to share learning and good practice.	The FTSUG attends the monthly NW regional meetings and regularly contributes to discussions within the forums.	No further action identified at this stage.	n/a	n/a

Board reports Freedom to Speak Up Guardian reports to the board (or equivalent) should be: • sufficiently detailed and comprehensive to support the development of a positive speaking up culture • in accordance with guidance from NHS E/I and the NGO.	The FTSUG prepares and delivers reports to the board outlining the themes of speak up cases and actions that are taken.	No further action identified at this stage.	n/a	n/a

LEADERSHIP

	Existing provision /gaps	Action needed	Authorised action/ date for completion	Review date
Senior Responsibility for Freedom to Speak Up Assurance should be obtained that those with senior Freedom to Speak Up responsibility have the confidence of the workforce.	Trust Board, Chief Executive & Director of People all have responsibilities for the FTSU approach and actively take action on this important agenda.	No further action identified at this stage.	n/a	n/a
Vision and strategy - Speaking Up In line with guidance from NHS England and Improvement, the board (or equivalent) should articulate a vision of how it intends to support its workers to speak up, which encompasses a strategy containing: • measures to identify the main issues the organisation should address • deliverable objectives within fixed timescales • steps to measure the effectiveness of those actions • under appropriate executive oversight • and to effectively communicate this to trust workers	The Trust's Workforce & OD Strategy sets out our FTSU approach and key actions required to embed the approach. The WOD is due to be refreshed and will now be known as the People & OD Plan.	Develop & implement the Trust's new People & OD Plan and incorporate the FTSU vision within it.	By Oct 2022	Oct 2022

Communications plan - Speaking Up In line with guidance from NHS England and Improvement, a communications plan should be developed and implemented to embed speaking up, including the promotion of the Freedom to Speak Up Guardian role. The effectiveness of the plan should be evaluated, and action taken where learning / gaps are identified. Changes to the Freedom to Speak Up arrangements should be communicated to workers in a timely way.	FTSU communications plan developed & implemented. Constructive working relationship between the FTSUG and the Communications & Engagement Team.	No further action identified at this stage.	n/a	October 2022
Freedom to Speak Up self-review toolkit NHS E/I Freedom to Speak Up self-review toolkit should be completed and shared in accordance with guidance from NHS England and Improvement.	FTSU self-review toolkit completed in 2021.	No further action identified at this stage.	n/a	December 2022
Measuring speaking up culture Measures should be identified and employed to monitor the development of a positive speaking up culture, so that leaders are responsive to the needs of all workers and are developed in accordance with good practice. Incident reporting rates should be regularly reviewed to identify any areas which appear to be under-reporting and action taken to address this.	We currently use various ways to measure our FTSU culture including: • Bolton Engage surveys • NHS national staff survey • FTSU national index	No further action identified at this stage.	n/a	n/a
Case review gap analysis Actions identified through the gap analysis of recommendations made in published case reviews should be implemented.	Gap analysis completed in March 20222.	No further action identified at this stage.	n/a	n/a

Visibility and accessibility Leaders should be visible and accessible to all workers to promote a culture of visible and accessible leadership.	Senior leadership walkarounds, Executive Team buddy visits, staff listening sessions hosted by senior leaders, 'Tea with Fi' sessions and more.	No further action identified at this stage.	n/a	n/a
Engagement A plan should be developed to ensure that workers can speak up effectively about the impact of integration as its local integrated care system continues to develop and mature. The workforce should be informed as soon as is practicable following the decision regarding the future leadership of the organisation.	Separate plan not in place.	The requirement for this plan to be discussed with the Director of Strategy & Transformation, Managing Director of the Bolton ICP and Chief Operating Officer. Devise a set of key actions to develop & implement the required plan.	By July 2022	October 2022
Governance arrangements The effectiveness of governance arrangements should be improved, including the communication of information from 'board to ward' and back.	Governance arrangements are in place.	FTSUG to discuss & review governance arrangements with the new Director of Governance.	By July 2022	October 2022

Conflicts of interest NHS E/I's national guidance relating to the managing of conflicts of interest should be implemented. The organisation's conflicts of interest policy should be implemented so that workers are aware of its purpose and all relevant workers make appropriate declarations, including those relating to conflicting loyalty interests.	The Trust has Conflict of Interest Policy in place.	Policy to be further communicated to the workforce.	By end of June 2022	October 2022
Investigations Workers who speak up should have input into the terms of reference for any subsequent investigations. The response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, should be undertaken by suitably independent and trained investigators. Reasonable consideration should be given to workers' objections relating to the perceived independence of investigators. A clear rationale for any decisions regarding investigators should be given to workers in response to any objections and there should be transparency about the way potential conflicts of interest relating to investigations are managed. Speaking up cases should be investigated within reasonable timeframes and without undue delay.	Independent & trained investigators are appointed. Any objections to the choice of investigators are fully considered by an appropriate senior person. Speaking up cases are investigated in a timely manner without undue delay. Investigation outcomes are communicated to individuals.	Deputy Director of People / Head of Human Resources to review arrangements with regards to FTSU investigations and identify any further action required to comply with the findings of the review.	September 2022	March 2023

Where investigations are undertaken in response to speaking up issues raised by workers, feedback should be provided to those individuals regarding the progress of said investigations.				
Action/Follow up Recommendations from a cultural review should be implemented.	A specific cultural review hasn't been conducted. The Trust's conducts regularly staff engagement survey which highlight any cultural issues and the survey findings are acted upon. The Staff Experience Steering Group monitor the delivery of the Trust's high-level staff engagement action plan and divisional action plans.	No further action identified at this stage.	n/a	n/a
Policy - Speaking Up The speaking up policy should be in accordance with good practice, meet the minimum standards set out in the NHS Improvement speaking up policy for the NHS and reflect guidance on reviewing speaking up policies from the National Guardian's Office. New and existing workers should be made aware of the speak up policy.	The Trust's FTSU Policy is in line with the NHSI's policy. Staff are made aware of the Trust's FTSU Policy at induction and in communications by the FTSUG.	No further action identified at this stage.	n/a	n/a
Alignment with the Freedom to Speak Up Review principles All aspects of the organisation's work should be consistent with the principles of the Freedom to Speak Up review.	Principles are adhered to.	No further action identified at this stage.	n/a	n/a
Other policies and processes	The Trust's Resolution Policy highlights the FTSU service on pages 7 & 13.	Reference to the support available from the FTSUG & champions to be referenced in	September 2022	October 2022

Policies and processes should be supportive of all workers affected by the speaking up process, including those who are the subject of matters raised. Where a worker is going through a disciplinary process that also encompasses potential patient safety issues or similar matters they have raised, the worker should be provided with all appropriate support to speak up about those matters and all appropriate steps should be taken to maintain the worker's confidentiality. On the scheduled review of a policy and/or procedure, steps should be taken so that the policy or procedure in question is in alignment with good practice in relation to freedom to speak up. HR policies and procedures should: have the confidence of the workforce meet the needs of workers who speak up, including effective training for workers in human resources Where the grievance process is used in response to a worker speaking up, the grievance policies and procedures should be correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it. Workers who take periods of sickness leave, including in relation to their speaking up, should be provided	Amendments have been made to the Trust's Disciplinary Policy to highlight the support available from FTSU Guardian and Champions as well as other options of support available.	the Trust's Supporting Staff Policy.		

with support upon returning from that leave that is in accordance with the values, policies, and guidance. Those with responsibility for supporting workers to return to work rom sickness absence should be capable of implementing the relevant policies and guidance to manage this process. The policy for dealing with serious incidents should provide that feedback and any learning is shared with those who speak up regarding an incident.				
Fit and proper person review Fit and Proper Person reviews should be undertaken in accordance with good practice.	The Trust has a Fit and Proper Person Policy in place (this isn't a HR policy) – it's available on the intranet.	No further action identified at this stage.	n/a	n/a

Agenda Item 23

Title:	Audit Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Annette Walker, Director of Finance		Decision	

Summary:	Chair's Report from the Audit Committee meeting held on the 15th of June 2022.

Previously considered by:	

Proposed Resolution	

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:	Audit Committee Chair	**Presented by:**	Audit Committee Chair

Committee/Group Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	15th June 2022	Date of next meeting:	5th of October 15:00
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Alan Stuttard, Martin North, Malcolm Brown, Annette Walker, Sharon Katema, Lesley Wallace, Othmane Rezgui, Karen Finlayson, Imogen Milner, Catherine Hulme, Collette Ryan, Tim Cutler	Quorate (Yes/No):	Yes
		Key Members not present:	Karen Finlayson, Bilkis Ismail

Key Agenda Items:	RAG	Key Points	Action/decision
Head of Internal Audit Opinion		The Internal Auditors, PWC presented the Head of Internal Audit Opinion. PWC have issued eleven reports for the Trust and 2 reports for iFM Bolton Ltd. The opinion for the Trust is generally satisfactory with some improvements required. The opinion for iFM Bolton Ltd is generally satisfactory with some improvements required. These opinions are the second highest in the types of opinion that PWC use. It was noted that the opinion is draft and will be finalised following discussion with the Chief Finance Officer and Corporate Secretary in conjunction with PWC. In terms of the Audit Opinion it was pleasing to note the significant improvement in dealing with the outstanding open actions when compared to the position last year. PWC also advised that they have conducted a full Data Security Protection Tool kit assessment for submission to NHS digital which is reported on separately outside of the Opinion.	Noted Action: CFO and IDCG to liaise with PWC.

	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

KPMG Year End Report 2021/22 (ISA260) and Independent Auditors Report to Council of Governors		The External Auditors, KPMG, presented the Year End Report for 2021/22 (ISA260). The purpose of the report is to summarise the key issues identified during the Audit. KPMG identified that there were still some outstanding items to be signed off in relation to the accounts. These primarily related to the assessment of accruals. However, the majority of substantial testing had been completed. The deadline for submission is the 22nd of June, however KPMG advised that with the additional testing and the need to ensure that all the audit files had been completed it was likely this time scale would not be met. A revised timetable of the 1st of July has been notified to NHSI/E although it was hoped that the submission would be completed before this date. In the event that the testing identified any changes it was agreed that there would be delegated authority to the Chair of Audit and Chief Finance Officer to agree. This would also be subject to Board agreement. With regard to value for money this had previously been reported to the Audit Committee and there were no issues raised. The Audit Committee agreed to recommend the ISA260 to the Board of Directors subject to the caveats regarding the additional testing. The ISA260 would also form the basis of the Independent Auditors Report to the Council of Governors. The Audit Committee thanked KPMG for their work on the audit of the accounts.	Recommended for adoption by the Board subject to the additional testing by the External Auditors.
Letter of Representation		The Audit Committee noted the Letter of Representation which will be signed following completion of the accounts.	Noted.
Audited Annual Accounts		The Chief Finance Officer presented the annual Accounts for 2021/22. It was noted that although the annual accounts show a deficit of £1.1m, the operational position was a surplus of £35k. The operational surplus is that which the Trust is held to account by NHSI/E. The difference is due to a number of technical issues. The year-end cash balance was £56.8m and capital expenditure for the year was £25.8m.	Recommended for adoption by the Board subject to the additional testing by the External Auditors.

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	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

		It was noted that the final position will be subject to the additional testing referred to by the External Auditors, although it was anticipated that there would not be any changes. The Audit Committee thanked the finance team for their work on the accounts and in responding to the audit questions.	
Annual Report including Annual Governance Statement		The Interim Director of Corporate Governance presented the Annual Report including Annual Governance Statement. The IDCG thanked members for their comments in relation to the draft report which had also been reviewed by the External Auditors. The IDCG was thanked for the report particularly in the context of being new to the organisation.	Recommended for adoption by the Board.
Annual Quality Account Report		The Interim Director of Corporate Governance presented the Annual Quality Account Report. This report had also previously been considered by the Quality Assurance Committee.	Recommended for adoption by the Board.
Counter Fraud Annual Report 2021/22		The Local Counter Fraud Specialist presented the Counter Fraud Annual Report for 2021/22. The report referenced the items which had been investigated during the course of the year and the training programme undertaken within the Trust. The LCFS reported that there was a very positive and open approach to reporting matters. The LCFS was thanked for her work over the course of the year.	Noted.
Salary Overpayment Report		The Head of Financial Services presented a report on Salary overpayments. Although there were a number of overpayments in the context of the total number of salary transactions the number was very low. The Audit Committee were assured that action was being taken to recover all the overpayments.	Noted.
Board of Directors Compliance Report		The Interim Director of Corporate Governance presented the Board of Directors Compliance Report. This report covered areas such as Fit and Proper Person Requirements and Declarations of Interest.	Noted.
Risks Escalated There were no matters to be escalated to the Board of Directors.			

	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 24

Title:	Charitable Funds Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28th July 2022		Discussion	
Exec Sponsor	Director of Strategic Transformation		Decision	

Summary:	Chair report from the Charitable Funds Committee on 13th June 2022.

Previously considered by:	

Proposed Resolution	

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:	Sarah Skinner, Charity Manager	**Presented by:**	CFC Chair

Committee/Group Chair's Report
(Version 2.0 August 2018, Review: July 2020)

Name of Committee/Group:	Charitable Fund Committee	Report to:	Board of Directors
Date of Meeting:	13th June 2022	Date of next meeting:	5th September 2022
Chair:	Martin North	Parent Committee:	Board of Directors
Members Present:	Sharon Martin, Francis Andrews, Annette Walker, Alan Stuttard, Catherine Hulme, Rachel Carter and Sarah Skinner In attendance: Rayaz Chel and Suzanne Lomax	Quorate (Yes/No):	Yes
		Key Members not present:	Voting members: Bilkis Ismail Non-voting members: Rachel Noble and Abdul Goni

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Our Bolton NHS Charity Q1 2022/23 Highlight Report		SS	The Q1 2022/23 highlight report was shared with the CFC to provide an overview of activity against key themes: • Fundraising and grants • Corporates and High Net Worth Individuals • Events • Media • NHS Charities Together • Charity-funded schemes	Members of the CFC noted the highlight report and agreed to support Our Bolton NHS Charity with fundraising opportunities and events as set out in the highlight report
Charity Strategy		RN	Due to RN's absence, it was agreed that this item would be withdrawn from the agenda.	Copy of the draft strategy to be circulated to CFC members for comment ahead of the next meeting.

	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

Faith Facilities Update		SS	The Committee received an update on the relocation and refurbishment of the faith facilities, including the interdependency with the Doctors Mess; the contribution from Our Bolton NHS Charity; next steps, and associated timescales. The project will work to the reporting and spend deadlines of March 2023 and this will also provide the opportunity for an opening event as part of Ramadan at the beginning of April 2023 to promote the new faith facilities as a fit for purpose facility for staff and patients. There is an expectation that the Trust will make up the shortfall; however, due to the severe pressure on the availability of capital funding this financial year, the opportunity for Our Bolton NHS Charity to fund the faith facilities in totality was discussed.	The CFC noted the proposal for Our Bolton NHS Charity to grant the funding to the Trust as a contribution towards the scope of work outlined in the paper and the request to attend the extraordinary meeting of the CFC on 14th July 2022 to consider and approve the granting of the funds. Our Bolton NHS Charity to ascertain if funding the faith facilities in their entirety is a viable option.
Riba Donations		SS	The Board received the update on the work around interest (Riba) donations and noted that donations can only be used for specific purposes pertaining to the improvement of toilet/washroom facilities. Due to the complexities of this funding, thorough engagement with the Muslim community will take place and robust due diligence processes will be followed.	The CFC agreed this project presents an ideal opportunity to upgrade facilities so they are appropriate for all faiths and requested a paper is provided to the Executive Team for further discussion.
NHS Charities Together: Development Grant Opportunity		SS	The Board received and noted the paper designed to provide the CFC with an overview of the £30k development grant available from NHS Charities Together, introduce the self-assessment tool, present initial findings from the Development Grant Working Group (DGWG) and outline the key dates and next steps in terms of an application. Members of the DGWG had completed the assessment tool and identified fundraising, influencing and operations as the three weakest areas.	CFC members confirmed their support for the three identified themes and noted the tasks and associated deadlines outlined within the next steps. CFC members also suggested the assessment tool is used as a framework for driving improvements within the charity and requested an action plan against all eight themes.

	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

Finance Report		CH	The CFC received and noted the finance report which provided an update on the income, expenditure and fund balances of Our Bolton NHS Charity. The charity had a net decrease in funds of £18k for the 12 months to 31 March 2022 and fund balances totalled £929k at 31 March 2022. The draft annual accounts will be completed in July 2022 and brought to the next meeting.	It was noted that there is a new Charities Act 2022 with a phased implementation and further details will be brought to this meeting. Historical data within Appendix C should be reviewed with long-standing commitments removed ahead of the next meeting.
Garden of Reflection		SL	The Committee received the statement of case for charitable funding to support the creation of a Garden of Reflection, which will provide a space where those who have given the gift of life can be remembered and celebrated, to remember those who lost their lives during Covid and also allow staff to pay respect to colleagues who have died in service.	The idea was fully supported by the CFC; however, it was suggested the design could be enhanced through exploring opportunities with local horticultural colleges, garden centres and through engagement with local bereavement cafes
Comments Nothing to add.				
Risks escalated There were no risks to be escalated to the Board of Directors.				

	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