BOARD OF DIRECTORS MEETING

Date: 24 November 2022
Time: 09.00-12.00
Venue: Microsoft Teams Link

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 and Staff Story	CN DoP	Verbal	To receive the patient and staff story
09.15	3. Declarations of Interest	Chair	Report	To note declarations of interest in relation to agenda items
	4. Minutes of meeting held on 29 September 2022	Chair	Minutes	To approve the previous minutes
	5. Matters arising and Action Log	Chair	Report	To address any matters arising not covered on the agenda and note progress on agreed actions
09.20	6. Chair's update	Chair	Verbal	To receive an update on current issues
09.25	7. Chief Executive's Report	CEO	Report	To receive the Chief Executive's Report
Risk and Governance				
09.30	8. Board Assurance Framework	DCG	Report	To receive the BAF for assurance
09.40	9. Committee Terms of Reference	DCG	Report	To approve the Committee Terms of Reference
Strategy and Performance				
09:50	10. Strategy and Operations Committee Chair's Report	SOC Chair	Verbal	To receive assurance on work delegated to the Committee
10:00	11. Operational Update	COO	Presentation	To receive and note
10:10	12. Integrated Performance Report a. Operational Performance b. Quality and Safety	Executive Directors	Presentation	To receive and note

	c. Workforce d. Finance			
10:30	13. Digital Strategy	DoSDT	Report	To receive the report
10:40	**BREAK**			
Workforce				
10:50	14. People Committee Chair Report	People Chair	Report	To provide assurance on work delegated to the Committee
11:00	Staffing Reports 15. a) Nursing b) Midwifery Staffing Report	CN	Report	To receive the Nursing and Midwifery Staffing reports for assurance.
11:10	Workforce Updates 16. a) Staff Health and Wellbeing Report b) Industrial Action Update	DoP	Report	To receive the reports
Quality and Safety				
11:25	17. Quality Assurance Committee Chair Report	QAC Chair	Report	To provide assurance on work delegated to the Committee
11:35	18. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Q.2 Update	CN	Report	To receive the report
11:50	19. NHS England Report of independent investigation following East Kent	CN	Report	To receive the report
Finance				
12:00	20. Finance and Investment Committee Chair Report	F&I Chair	Report	To provide assurance on work delegated to the Committee
Consent Agenda				
	21. a) Standing Financial Instructions (SFI) and Financial Scheme of Delegation b) Standing Orders	DoF DCG	Report	To approve the SFIs, Scheme of Delegation and Standing Orders
	22. Annual Reports			To receive the annual reports

	a) Emergency Preparedness, Resilience and Response (EPRR) b) Infection Control c) Safeguarding Report d) National Adult Inpatient Survey Summary	 COO CN CN	Report	
Concluding Business				
12:15	23. Messages from the Board	Chair	Verbal	To agree messages from the Board to be shared with all staff
	24. Any Other Business	Chair	Verbal	To note
	25. To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting			
Resolution to Exclude the Press and Public				
12:30	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: 26 January 2023

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 1 April 2020)	Financial Interest
		Chair PossAbilities learning disability social enterprise	Financial Interest
		CIPFA C Co Ltd (previously CIPFA NEWCO Limited	Financial Interest
		Family member 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
Zada Ali Shah	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 Benevolent Fund	Financial Interest
		Associate Hospital Manager LSCF NHS Trust	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
		EDI Football Advisor Lancashire Football Club	Non-Financial Professional Interest
		National Board Advisor for race discrimination for IOPC (Independent Office of Police Conduct)	Non-Financial Professional Interest
		Coaching Bank for Academic Health and Social Care Network hosted by Liverpool Heart and Chest Hospital	Non-Financial Professional 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
Malcolm Brown	Non-Executive Director	Family member employed by Trust	Non-Financial Personal Interest
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

Name:	Position:	Interest Declared	Type of Interest
		Governor Bolton Sixth Form College and The Valley Community Primary School	Non-Financial Personal Interest
Sharon Katema	Interim Director of Corporate Governance	Nothing to declare	
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	Non-Financial Professional 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
Tyrone Roberts	Chief Nurse	Nothing to declare	

Name:	Position:	Interest Declared	Type of Interest
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	Non-Financial Professional Interest
		BOLTON HOLDCO LIMITED	Non-Financial Professional Interest
		BRAHM FundCo 2 Limited	Non-Financial Professional Interest
		BRAHM FUNDCO 1 LIMITED	Non-Financial Professional Interest
		BRAHM INTERMEDIATE HOLDCO 1 LIMITED	Non-Financial Professional Interest
		BRAHM Intermediate Holdco 2 limited	Non-Financial Professional Interest
		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. Types of Interests:

a) Financial Interest
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making;

b) Non-Financial professional interest
Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making;

c) Non-financial personal interest
Where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of the decisions they are involved in making; and

d) Indirect Interests
Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non- financial personal interest who would stand to benefit from a decision they are involved in making

Meeting:	**Board of Directors (Part 1)**
Date:	**Thursday 29 September 2022**
Time:	**09:00-12.30**
Venue:	**Microsoft Teams**

PRESENT:

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

IN ATTENDANCE:

Sharon Katema	Interim Director of Corporate Governance	SK
Niruban Ratnarajah	Interim Locality Clinical Director, NHS Greater Manchester	NR
Rachel Tanner	Director of Adult Social Services, Bolton Council	RT
Lynn Donkin	Director of Public Health, Bolton Council	LD
Lianne Robinson	Associate Chief Nurse	LR
Rachel Carter	Associate Director of Communications and Engagement	RC
Victoria Crompton	Corporate Governance Manager	VC
Tracey Joynson	Patient Experience Manager (item 2 only)	TJ
Faye Chadwick	Assistant Divisional Nurse Director, Family Care Division	FC
Blandina Mutambirwa	BAME Staff Network Chair (item 15 only)	BM
Catherine Binns	Chair, Disability & Health Conditions Staff Network (item 15 only)	CB
Rahila Ahmed	Equality, Diversity and Inclusion Lead (item 15 only)	RA

1. Welcome and Apologies for Absence

The Chair welcomed everyone to the meeting, and in particular welcomed three observers who were in attendance. Apologies for absence from Tyrone Roberts were noted.

2. Patient and Staff Story

Faye Chadwick, Assistant Divisional Nurse, Family Care Division, delivered a presentation from the 0 -19 Service that sought to outline the engagement undertaken with service users, and how this was completed. The presentation set out the integrated response which was taken and the future steps for the Children's Services Transformation Programme, noting that young people

health champions had been introduced to assist with designing and establishing services going forward.

A short video was played and the Board were provided with some context around the service in that it was commissioned a year ago with a full action plan around developing and working towards an innovative service.

Board members noted the brilliant engagement and indicated this demonstrates a good example of how local communities can be empowered to assist with the transformation and delivery of services.

Resolved: The Board of Directors received the Patient and Staff Story.

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 28 July 2022 were approved as a correct record.

6. Matters arising and Action Log

There were no matters arising to report.

7. Chair's Update

The Chair presented her report and thanked all staff for their hard work throughout the increased pressures being experienced across the organisation.

8. Chief Executive Report

The Chief Executive presented her report and extended thanks to members of staff who had continued to provide urgent and emergency care to patients during the bank holiday following the death of HRH Queen Elizabeth. Special thanks were extended to the Digital Team who had worked hard to ensure patients could watch the funeral whilst in the care of the Trust.

The following key points were noted:

- The Trust has commenced the flu and Covid booster programme for staff, offering colleagues both their seasonal flu vaccine and Covid booster in one appointment.
- The FABB Annual Awards 2022 were scheduled to take place on Friday 7 October, at the Last Drop Village. Over 600 nominations were received for health and care staff across the Bolton system.
- The Trust welcomed Tandal, a five-year-old rescue dog who had been adopted by the Trust's Deputy Head Chaplain, and would be assessed through the charity "Pets as Therapy."
- The Trust continues to work with clinical divisions and corporate teams to identify Cost Improvement Programme (CIP) schemes. Engagement has been positive and a lot of ideas have been generated.
- Work has commenced on the two new theatres, which would provide extra theatre capacity and were part of a large scale investment into healthcare in Greater Manchester.
- Demolition had commenced on the hospital site to support the development of the Bolton College of Medical Sciences.
- Partners from across the Bolton system, including primary and secondary care met to discuss how to collectively work together to manage what is

set to be a very challenging winter. It was beneficial to have a range of different views all working towards the same goal.

Resolved: The Board of Directors received and noted the Chief Executive's Report.

9. Strategy and Operations Committee Chair Report

The chair of the Committee, presented the report from the inaugural meeting which was held on 26 September 2022. The Committee had received the Terms of Reference for the newly established Committee, the purpose of which was to provide assurance to the Board of Directors on the operational performance and strategic planning functions of the Trust along with oversight and assurance on the associated digital and transformation work programmes. Following some comments and suggestions, it was agreed the Terms of Reference would be updated and circulated to committee members outside of the meeting, and submitted to the next meeting for final ratification.

A number of issues highlighted in the meeting were escalated to the Board of Directors, including:

- No Criteria to Reside represents over a third of adult beds
- Urgent Care, 12-hour performance continued to decline
- Cancer performance was predicted to fail the current quarter
- Maternity, regarding CNST compliance and EPR Go Live
- Winter plan level of risk given current BAU pressures
- Feasibility of completing the digital programme in the anticipated timeframe, given its scale.

Resolved: The Board of Directors received and noted the Strategy and Operations Committee Chair Report.

10. Winter Plan

The Chief Operating Officer presented the 2022/23 Winter Plan which had been formulated within the context of what was predicted to be a challenging winter due to the increase in demand for urgent care services, and difficulty in moving patients who no longer required hospital care to their discharge destination.

The plan was informed by a series of organisational, locality and Greater Manchester winter review and planning workshops. It also reflected collaborative working across teams taking into account lessons learnt from the previous winter. It was noted that the modelling indicated that if no actions were taken, the Trust would require all beds to be open including an additional 81 beds in order to manage this winter. Therefore, these plans were focussed on making up this shortfall through reductions in length of stay, reducing bed occupancy and avoiding admissions.

It was confirmed the plans were brought together both within the locality and at the Greater Manchester Urgent Care Board. All trusts would be expected to be agile and able to respond accordingly when required. An escalation process was in place to deal with challenging situations and the GM System Operational Response Taskforce (SORT) would have overview for Greater Manchester.

In response to Jackie Njoroge's query on the preparations in place within social care to deal with the expected winter pressures, Rachel Tanner responded that

there were good systems in place within Bolton with additional flexibility to adapt the system plan if required. Organisations were prepared to work together when pressures escalated within the system. Furthermore, the Trust had a plan ready and was giving consideration to how the funding would be allocated once received through Greater Manchester.

The Medical Director commented the plan was clear and well-articulated and reflected good input from clinicians, but queried whether there would be clear visibility on the risks to patients across the system and whether these will be presented to the Urgent Care Board. The Chief Operating Officer advised that the risks were well understood across the system and would be included on the Risk Register. It was noted that risks across social care would be articulated once some modelling work has been completed, but ascertaining the totally of the risk across the system was still being developed.

The Associate Chief Nurse advised that conversations have commenced with care homes across the locality to give consideration as to how care can be managed differently. The workforce is also being considered in the winter plans to contemplate how staff can be used differently.

Resolved: The Board of Directors received and noted the Winter Plan.

11. Operational Update

The Chief Operating Officer provided an operational update which provided an overview of Covid-19, Urgent and Emergency Care, no criteria to reside, cancer and the elective recovery. The following key points were highlighted:

- Whilst there were no patients testing positive for Covid19 within Critical Care, there were currently 40 in-patients testing positive on general wards.
- A&E attendances in August were 3.6% lower than in August 2021 which averaged at around 350 attendances per day.
- Following the completion of urgent care improvement work the Clinical Assessment Unit, Medical Ambulatory Care and Surgical Ambulatory Care have been reconfigured to create a Same Day Emergency Care (SDEC) unit. This was expected to be pivotal in streaming patients who were unlikely to need an admission, away from the Emergency Department. An urgent treatment centre pilot had also commenced, which would bring together primary and secondary clinicians with a view of stream patients away from the Emergency Department who could be seen elsewhere.
- There was a reduction in the number of patients with No Criteria to Reside (NCTR) in September. However, the number of days delayed had increased and benchmarking highlighted that Bolton had, on average, 3% more occupied beds than the GM average.
- The two week wait standard for cancer performance had improved. However, the 62-day performance was deteriorating and would not be achieved during the quarter. A deep dive of cancer pathways which did not meet the 62-day target had been completed, and diagnostic delays have been highlighted as a major factor and these are being managed on a specialty by specialty basis.
- The elective recovery focus has been on reducing 104 week waits and that work has continued, but the focus now is treating all patients waiting more than 78-week waits by March 2023. The Trust remains on track to complete this noting that significant risks remained.

- A Health Inequalities Group focussing on the differences in access to, and outcomes from services that were experienced by different parts of the population had been established.

In response to a query from Bilkis Ismail, the Chief Operating Officer advised that further analysis was required to understand why Bolton's NCTR figures were higher than the average across GM. All of the actions which were being taken were being shared at the GM System Operational Response Taskforce (SORT) meeting which also provides a good opportunity to see what is working across other localities.

The Medical Director asked when more detail around Key Performance Indicators (KPIs) for the Integrated Care work would be available along with data to show how the service is performing. RT responded that work was underway to bring the strands together and highlighted that this was a complex piece of work as there was a need to demonstrate service impact.

Resolved: The Board of Directors received and noted the Operational update.

12. Integrated Performance Report

The Deputy Chief Executive, led the presentation of the Integrated Performance Report for August which provided an outline of the key points around operational performance, quality, workforce and finance for August. It was noted that due to operational challenges, the Acute Adult Division Integrated Performance Meeting (IPM) had been stepped down. The following key points were highlighted;

- There were two unrelated, complex cases of MRSA bacteraemia reported in September which were being investigated. The Trust had previously gone for 787days since the last reported cases and remains in a positive position in relation to Greater Manchester MRSA bacteraemia performance.
- Two matrons had been recruited to the Division as part of the full workforce review that had been completed in Maternity in response to staffing issues across the Division.
- Clinical correspondence is within target, but there was variation in figures across divisions. In order to progress this work further Business Intelligence were completing daily reports to highlight which areas do not have traction.
- Work had been completed on Sepsis screening, and the timely delivery of antibiotics.
- Serious Incidents and in particular actions undertaken since the review of overdue actions have now resulted in quicker decisions relating to progression of serious incidents.
- The Trust was no longer an outlier for Mortality as both SHMI and HSMR were within range due to improvements in coding.
- Agency spend remained high due to organisational pressures and remain an area of focus with regular monitoring of actions being taken to reduce this spend a subject of discussion at People Committee. In addition, Turnover figures remained high and retention plans also had been discussed in the People Committee.
- Year to date financial deficit was £6.9m off track, due in part to, the unprecedented demand on services and the rising cost of inflation. The Financial Plan would continue to be reviewed through the Finance and Investment Committee.

Rebecca Ganz, queried whether the system used in the community postnatal department for the Friends and Family Test (FFT) could be replicated in other areas, as they have a very good response rate. The Associate Chief Nurse advised community services do generally have a better update of FFT than

hospital services, but work is being completed to see whether it is possible to bring that best practice into the hospital.

In response to a query from Bilkis Ismail, the Medical Director advised that fracture neck of femurs were treated by a relatively small group of experienced clinicians, which could account to why there were delays. However, overall outcomes for hip fracture patients in Bolton remained good. The Trust was also seeing an increase in orthopaedic patients due to the impact of the delay in elective care recovery.

With regards to the 2week wait for breast symptomatic target, the Chief Operating Officer advised that the Trust prioritised two week wait for cancer referrals which is why the symptomatic figures were lower. There were some small signs of improvement and the figures would be reported through the Strategy and Operations Committee. It was confirmed that the Trust was still collaborating with the private sector around cancer treatment.

Malcolm Brown commended the Medical Director on the reduction of the HSMR and SHMI and proposed that consideration be given to the inclusion of caesarean section rate in the future Integrated Performance Reports.

Caesarean section rate to be included in Integrated Performance Report in future.	**TR FT/22/19**

Board members discussed the culture within the Trust and the Director of People gave assurance that systems and processes in place throughout the organisation to ensure staff are listened to and able to raise concerns and acknowledged that there was more work to do to develop these lines of communication. .

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

13. Quality Assurance Committee Chair Report

The Chair of the committee presented the report from the Quality Assurance Committees which were held on 17 August 2022 and 21 September 2022 highlighting the key points discussed.

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

14. People Committee Chair Report

The Committee Chair delivered the report which provided an overview of discussions from the meeting held on 20 September 2022. The Chair commended the Head of Resourcing and Clinical Divisions for the work undertaken in the preparation of, and the level of detail included in their respective reports.

Rebecca Ganz, queried if the Trust should be aiming for a higher response rate than the current target of 40% for the NHS National Staff Survey for 2022. The Director of People advised the 2021 response rate was 37%, so the target had been set as an improvement on the previous year's figures, but the aspiration is always to get as many responses as possible.

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

15. Workforce Race Equality Standard, medical Workforce Race Equality Standard (New) and Workforce Disability Equality Standard 2022 Reports

The Director of People presented the report which highlighted that the Trust had achieved an improved position in relation to the experience of BAME and disabled workforce, however, there was more work to be done to create a truly inclusive culture within the organisation. The WRES and WDES performance data will continue to inform the key EDI priorities.

Blandina Mutambirwa, provided an update and thanked the Board for the support the network receives, in particular from OD, Resourcing and Communications. The feedback from the network is good and those who took part in the BAME Leadership Programme have given positive reflections.

Catherine Binns advised that the group was established in March 2022, and there is a lot of work to be done in this area. The challenge faced related to how staff could be supported within their areas of work to attend forums and networks. It was noted that James Mawrey was the Executive Lead for disabilities and supportive of the work being completed by the network.

Bilkis Ismail thanked the staff network chairs for their work and feedback adding that the BAME Forum has made fantastic progress over the last three years as it was more established.

Noting the concerns highlighted regarding the provision of equipment to staff with a disability, the Director of People proposed a deep dive is conducted on the issues being faced by staff as this was unacceptable and there was a need to ensure the Trust promotes the disability agenda.

The Medical Director commented a different approach is required for appointing people from other ethnic backgrounds into management and leadership positions. Rahila Ahmed responded that the solution lay in communication and engagement with current and prospective staff, refreshing development opportunities, and promoting these to staff. In addition, the Trust was currently rolling out inclusive recruitment training.

It was agreed to bring updates back from the BAME and Disability and Health Conditions Forums back in six months.

Updates from the BAME and Disability and Health Conditions Forums back in six months.	**SK FT/22/20**

Resolved: The Board of Directors received and noted the report.

16. Finance and Investment Committee Chair Report

The Director of Finance provided an update from the Finance and Investment Committee which took place on 28 September 2022. The following key points were highlighted:

- The GM financial position, performance and quality issues remained an area of concern following GM's year to date deficit of £59m, of which Bolton deficit year to date was £6.9m against a planned deficit of £2m.
- The committee approved the funding for the full Theatre development and creation of a Paediatric Hub, subject to TIF funding being received.
- Committee members received an update on the National Cost collection for 2020/21 and 2021/22 as follows:
    - 2020/21 – Bolton received a score of 93, which is more efficient than the average.

    - The 2021/22 return was submitted on 9 August and whilst some questions had been received, there was no request to resubmit the information.
- The committee had commended the Finance Team following their nomination and subsequent Highly Commended Award in the Team of the Year Award. The Team had also achieved Level 3 Towards Excellence Accreditation and a training needs analysis had been completed for the entire finance department.

Resolved: The Board received the Finance and Investment Committee update.

17. Charitable Funds Committee Chair Report

The Chair of the Charitable Funds Committee presented the report from the meeting held on 5 September 2022. It was noted that the Committee had received an update on the provision of faith facilities from the Project Lead. The statement of case for charitable funding for the relocation and refurbishment of multi-faith facilities at the hospital had also been considered. However, feedback received from the Hindu Forum regarding the proposed layout of the Hindu temple meant it was not possible to approve the use of charitable funds at the meeting. The Project Lead would be meeting with colleagues from iFM to ascertain final costs and approval for the use if charitable funds would be sought electronically outside of the meeting or via an extraordinary meeting, if required.

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

18. Message from the Board

It was agreed the key messages from Board should be around:

- 0 -19 work.
- Work completed on equality and diversity.
- Faith facilities.
- Operational pressures – thank you to staff for their continued hard work and dedication.
- Financial challenges.

The communications team will develop a communication to be shared with staff.

19. Any other business

None.

20. To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting

The following question was posed from a member of the public*:*

At the start of 2020 the Covid-19 pandemic started to sweep across the Nation and sadly in March 2020 the first death from Covid at the Royal Bolton Hospital was reported. As the pandemic took hold, Nurses, Doctors and professional service across Bolton NHS FT worked tirelessly to do everything they could to keep our community safe and look after those most in need.

On 23 December 2020 the Bolton FT Covid vaccination programme commenced and by March 2021, 5,500 staff had been vaccinated. Sadly, whilst staff at Bolton FT continued to work in unprecedented situation and put the lives of all others above their own, the Covid-19 vaccine did not prevent some of them too from catching Covid-19 whilst at work, nor did it guarantee 100% protection from falling

victim to what is now known as 'Long Covid'. As staff continued to fight and fall victim to this awful outbreak of a communicable disease at Bolton FT, CEO of Bolton FT Fiona Noden went on record in March 2021 to say that "supporting our staff through and beyond the Covid pandemic needs to remain one of our top priorities".

Can the Board of Directors firstly please advise what measures have been put in place to support staff diagnosed with Long Covid, to quickly access appropriate physiological/respiratory treatment and support them on their recovery from long Covid?

Secondly, can the Board of Directors please advise why Bolton FT took the decision to subject staff who have put their own lives at risk and caught Covid-19 in the line of duty during the pandemic, to the generic Attendance Management Policy thresholds whilst they awaited/undergo treatment following the outbreak of a communicable disease at Bolton FT.

Finally, can the Board of Directors advise how many staff have been diagnosed with Long Covid since 2020 (who contracted Covid at work), and how many of these have been successfully supported by Bolton FT to return to (and remain) in work at Bolton FT to date?

I thank you for your time in answering these questions and would like to pass on my upmost thanks to all at Bolton FT who went (and continue) to go above and beyond for all of us.

The Director of Workforce responded advising the Trust is offering to support with those staff members who have Long Covid. There are 10 members of staff who are currently on the Long Covid pathway with Occupational Health. The Trust has also provided guidance to managers within the organisation.

National guidance was received regarding sickness and pay policies which the trust is following and the guidance has an emphasis on two years to support staff back into the workforce.

As Covid was a communicable disease it is not possible to confirm whether staff acquired the infection whilst at work or in the community.

21. Next meeting

The next Board meeting will take place on 24 November 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/22/15	28/07/2022	Integrated Performance report	TR to investigate implications of not achieving 100% compliance for patient safety alerts	TR	Nov-22	Failure to take actions required under any National Patient Safety Alert may lead to CQC taking regulatory action. Declared compliance with alerts is a key safety indicator, and compliance with NPSA is a focus of CQC inspection. Compliance with alerts is assessby the alert being closed as complete within the timeframes specified. As such, we may have compliance with an alert however a delay in the process means we have not closed this within the set timescales. The Trust has an alerts policy whcih sets out our approach to alert management, however, we are reviewing the alerts management process with divisional teams to ensure a robust process with relevant oversight on escalation.
FT/22/19	29/09/2022	Integrated Performance report	Caesarean section rate to be included in Integrated Performance Report in future.	TR	Nov-22	Complete - DoM met with MB and discussed metrics. Due to recommendations in Ockenden report this metric is no longer reported, however work is ongoing with Family Care Division and BI to review reporting metrics moving forward with regards to adding in additional detail. This is supported by Chief Nurse.
FT/22/13	28/07/2022	Staff Story	Invite LS to a Board of Directors meeting in six months to provide an update	SK	Jan-23	
FT/22/20	29/09/2022	WRES/WDES	Updates from the BAME and Disability and Health Conditions Forums back in six months.	SK	Mar-23	
FT/20/21	29/09/2022	Any other business	Chief Finance Officer to present the Estates Plan at a future Board Development Session.	AW	Mar-23	

Key

complete	agenda item	due	overdue	not due

Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 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, the Trust featured in a Financial Times report about how the NHS is coping with the Winter months, and the impact this is having on our workforce. The report was published in advance of the Autumn Statement and gave an insight into what we are doing in our emergency department, theatres and intermediate care teams to manage the demand and continue to operate in a post-pandemic world.

Over the last four weeks, our teams have been working together on an 'improvement sprint' to make small changes that will make a big difference to our patients and visitors. One focus has been to improve our ward environments by standardising the information we have on display, so our people have a consistent experience, no matter where they are being cared for. The next stage of this work is to install digital boards on every ward to display information, and continue this work across all of our sites.

Our Research Team has recruited the first baby on to a study aiming to protect babies from serious illness due to the respiratory syncytial virus (RSV). The HARMONIE research study is looking at the effectiveness of an antibody that has been developed to significantly reduce the number of babies that are admitted to hospital with the virus. Our team is offering the parents of babies on the Neonatal unit, who are approaching their first winter, the opportunity to get involved and help researchers find out how much protection the antibody provides, to improve care for future generations.

Our South Bolton Community Midwifery Team has been nominated for a Caribbean and African Health Network (CAHN) Award for supporting Bolton's diverse communities by tackling language barriers and improving access to care. More than 70% of people currently accessing community maternity services in South Bolton are not born in the UK, or do not have English as a first language and a particular focus has been to provide information in formats that all women and families are able to understand. The service has also changed their clinic structures to enable women to attend appointments at a location that is convenient for them, rather than asking them to travel.

Ambition 2
To be a great place to work

A recent assessment from Health Education England found that significant improvements have been made in how we support trainee doctors in our Obstetrics and Gynaecology department. Key areas of improvement have included GP training, the handover process and there has been an increase in the number of junior doctors who would recommend a post in Bolton to others.

Our Bolton NHS Charity, chaplaincy and staff experience teams will be running a December Fundraising and Wellbeing Calendar of activity, aligned to the well-known 'Five Ways to Wellbeing' – connect, take notice, be active, learn and give. Activity will include funding festive refreshments and Christmas presents for patients in hospital and intermediate care over Christmas, the development of a garden of reflection and a 'Challenges of Christmas' Schwarz Round for colleagues who find Christmas difficult and would benefit from coming together and sharing experiences.

The support on offer for our workforce who are impacted by the cost of living crisis is being enhanced as we approach what is set to be a difficult few months ahead. A confidential breakfast service is being offered via our Chaplaincy Team, and we will also be visiting community sites with the same offer. Further work is being undertaken to understand what support our staff need so we can put this in place as soon as possible.

Since the last Board of Directors' meeting, there have been some key changes and announcements made in relation to some key posts;

Professor Donna Hall CBE has announced she will step down as the Chair of Bolton NHS Foundation Trust on 1st April 2023. Donna was appointed Chair of the Trust in April 2019, bringing with her extensive experience of working at senior management level, including in local government as Chief Executive of Chorley Council and then later Wigan Council. Donna has made a significant contribution to the Trust and the process to carefully select a new Chair will take place in the coming weeks.

We appointed Sharon Katema as Director of Corporate Governance and Trust Secretary. Sharon joined the Trust in February 2022 to undertake the role on an interim basis, and following a four stage interview process, has taken up her permanent position. With a wealth of experience in corporate governance, Sharon will work to ensure we are well governed and compliant with all statutory and regulatory requirements.

Following the planned departure of Linda Martin, Fiona McDonnell has now started in her role as our new Managing Director for iFM Bolton and is the Estates and Facilities Director for the Trust. We look forward to working with Fiona in her new capacity to ensure that our environments are the best they can possibly be for our patients, visitors and staff.

Ambition 3
To use our resources wisely

There are currently more than 500,000 people waiting for treatment across Greater Manchester and work continues to make sure that we are treating as many people as we possibly can.

We are one of the first 20 trusts in the country to be implementing a new national tool, initially within our Bookings and Scheduling Teams, to help improve elective waiting list management and assist with theatre scheduling. The system, called the Care Co-ordination Solution (CCS), also known as Foundry, enables staff to view waiting lists, re-prioritise patients awaiting treatment, and to optimise theatre utilisation.

Our Electronic Patient Record (EPR) is now live in our Emergency Department, enabling our teams to streamline processes, have more robust documentation about our patients and to help with decision making.

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

Our Ultrasound Department at based at Royal Bolton Hospital has undergone refurbishment to give patients access to the latest technological advancements in

ultrasound. The Ultrasound machines will provide improved quality images and are part of an ongoing rolling equipment replacement programme to ensure all machines are kept up to date with the latest technology.

Work has begun to improve the faith facilities on offer on our hospital site and allow us to provide some much needed and improved prayer spaces for our staff, patients and visitors. The development will be funded by Our Bolton NHS Charity, and we are lucky to have received support from our local communities who have been fundraising to support this important work too. The work is expected to be complete in March 2023.

Ambition 5
To integrate care

Our Health Inequalities Enabling Group took some time out this month with representatives from health and social care, to understand the health inequalities that exist in Bolton and explore how our services can work together to address them.

One of our District Nurses Helen Barnes, has shared her expertise in the British Journal of Community Nursing about how best to support homeless people with end-of-life care. Helen's article sets out how homeless people experience a backdrop of health inequalities and lower life expectancy because of risks such as substance misuse and poor nutrition and sanitation, which can increase pain at the end-of-life. Helen identifies how joint working within community services, including Community Nurses, could provide more opportunities to meet the health needs of homeless people.

A new Early Supported Discharge scheme has launched for patients whose condition is improving and can continue their recovery safely at home. Patients who are eligible for the scheme will have their plans discussed with them by healthcare professionals, and how they can access support once home. When home, each patient will be reviewed by a doctor or a nurse from their local surgery within 48 hours to ensure they are safely home and will keep recovering. Early Supported Discharge is taking place with 22 GPs throughout Bolton.

Ambition 6
To develop partnerships

In Bolton, we have a long history of working in partnership to integrate health and social care services with the shared aim of improving the health and wellbeing of our residents. Developments to date include the creation of an Integrated Care Partnership (ICP) and a Strategic Commissioning Function (SCF), which have brought teams closer together to deliver health and care services. To build on this progress, staff from primary, secondary and social care are invited to an online session this month to explore how we can continue progressing our integration agenda.

The Bolton Health and Care Locality Board approved the decision to align the Bolton Integrated Care Partnership work plan with the Strategy, Planning and Delivery Committee. The newly formed group will come together in December for the first time, bringing together representatives from executive and operational teams across Bolton, to define how the group will form plans to benefit our Bolton communities.

Pupils from a local primary school have been raising money to help children recovering on our hospital children's ward. The year two class at Cherry Tree Primary School in Farnworth have raised more than £690 by playing a charity football tournament. The funds will be used to create 'fruity Fridays', so children who are staying on the ward can come together and enjoy a healthy snack on a Friday afternoon, and to fund some new equipment.

Title:	Board Assurance Framework

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24 November 2022		Discussion	✓
Exec Sponsor	Sharon Katema		Decision	

Summary:	The Purpose of this report is to present the Board Assurance Framework for review and approval of the position for the quarter. 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. This BAF reflects the existing Trust Strategy and whilst it has been subject to review, it will progressively develop through engagement and consultations with the Committee and ultimately the Board of Directors.

Previously considered by:	Executive Directors and Board Committees

Proposed Resolution	The Board is asked to **receive** the Board Assurance Framework.

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	**Presented by:**	Sharon Katema

1. **DEFINITIONS**

- **Strategic risk**: Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors.
- **Linked risks:** The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
- **Controls:** The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the Ambition
- **Gaps in controls:** Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
- **Assurances:**
- The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively.
    - 1st Line functions that own and manage the risks,
    - 2nd line functions that oversee the compliance or management of risk,
    - 3rd line function that provides independent assurance.
- **Gaps in assurance**: Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
- **Risk Treatment**: Actions required to close the gap(s) in controls or assurance, with timescales and identified owners.

2. **INTRODUCTION**

2.1. The Board Assurance Framework (BAF) provides a structured process that is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact the delivery of the strategic objectives.

2.2. During the development and update of the BAF Executives have been through a process of identifying the main sources of risk balanced against the controls and assurances we have in place to enable discussion and scrutiny at the Board level.

2.3. Assurance is fundamentally about arriving at informed conclusions through robust evidence. The most objective assurances are usually obtained from independent/external reviewers supported by internal sources such as self-assessment and management update reports.

3. **BACKGROUND**

3.1. The Board Assurance Framework (BAF) was presented to the Board of Directors in July 2022, and following this a review was undertaken. This review has included updating the format to provide greater clarity and improve the position against strategic risks.

3.2. The Director of Corporate Governance has worked with Executive Directors to build on the previous version of the BAF and ensure a clear updated position. Each strategic risk

is now aligned to one of the six ambitions and each have an Executive and Committee lead that are responsible for the review and monitoring of the risks.

3.3. Each strategic risk will be reviewed by the respective Executive Director and responsible Committee on a quarterly basis. The Lead Executive is responsible for owning the mitigation of each risk and delivery of the Ambition, whilst the Lead Committee is responsible for overseeing progress in delivering the Ambition. This will in turn, align to the review of the enabling strategies

3.4. Updated versions of the BAF were presented at the monthly Finance and Investment Committee, Quality Assurance Committee, People Committee, and the Strategy and Operations Committee.

4. PROGRESS

4.1. At the end of October 2022, none of the strategic risks have seen any improvements in the current risk score. However, this is considered normal at this point in the financial year.

4.2. In addition to receiving the Board Assurance Framework, there is a process to review the alignment with corporate and operational risks through Risk Management Group which will ensure there is internal oversight of the BAF.

4.3. Notable changes to this iteration of the refreshed BAF template include the inclusion of:

- Principal risk against each Ambition
- Gaps in Assurance
- Gaps in Control
- Assurance levels split into the 3 lines of defence
- Overall Assurance Level
- Inclusion of the Inherent and Target risk scores
- Future inclusion of risks from the Corporate Risk Register rated 15 and above which are aligned with each Ambition.

5. RISK SCORE

5.1. The BAF now includes the Inherent, Current, and Target risk scores. The Inherent and target risk score will remain static for as long as the risk is 'live'. The current risk score is reviewed each quarter and updated to reflect changes in the risk environment and improved controls.

5.2. To ensure consistency in approach, all risks have been assessed in line with our Risk Management Policy and have been graded using the system highlighted below to generate a risk score: **Severity (Consequence) x Likelihood = Risk Score**.

Severity		Likelihood		
1	Insignificant	2	Rare	Difficult to believe that this will happen / happen again
2	Minor	2	Unlikely	Do not expect it to happen / happen again but it may.
3	Moderate	3	Possible	It is possible that it may occur/ reoccur.
4	Major	4	Likely	It is likely to occur / recur but is not a persistent issue
5	**Catastrophic**	5	**Certain**	Will almost certainly occur / reoccur and could be a persistent issue

Severity Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	8	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Key

15+	High
8 - 12	Significant
4 - 6	Moderate
1-3	Low

6. RISK APPETITE

6.1. Risk appetite can be broadly defined as the amount of risk that an organisation is willing to take or the total amount of risk an organisation is willing to accept in order to meet its strategic objectives.

6.2. Risk exists in all environments, especially in Healthcare and the Trust recognises that it is impossible to achieve its aims and objectives without taking risks. Whilst the amount of risk that the Trust is willing to accept will vary, this will be captured in each of the strategic risks and may change as we move forward.

6.3. A review of the Risk Appetite statement has been undertaken and there is no proposal to amend this position.

7. CONTROL OF THE RISK.

7.1. This sets out how the Strategic Risk impacts the organisation and how it aligns with the Trust risk appetite.

7.2. Once a risk has been assessed, there are four main responses to managing a risk as outlined in diagram below. It is proposed that the Trust continue to ***Treat*** the risk.

8. CONCLUSION.

The Board is asked to note that the Board Assurance Framework is iterative and will be reviewed at a Strategy Session to be held on 15 December 2022.

The Board is asked to **receive** the BAF, propose any amendments, and confirm if the BAF provides sufficient assurance on the work undertaken to achieve the Trust's Ambitions.

Agenda Item

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;

Ambition 1
Provide safe, high quality care

LEAD DIRECTOR	**Medical Director**	**1.1**
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

Linked Risks

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 2022	4	4	**16**	4	4	**16**	4	3	12

PRINCIPAL RISK: IF THE TRUST DOES NOT GIVE THE BEST CARE EVERY TIME THEN THIS WILL RESULT IN INCREASED MORTALITY IN HOSPITAL

Overall Assurance Level

RISK APPETITE:

1	2	3	4	5
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

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

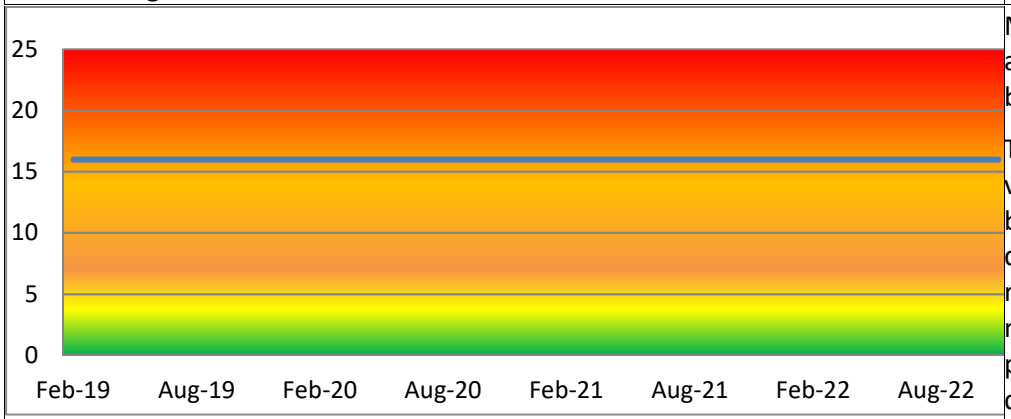
Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• HSMR higher than expected (SHMI within range) • Recording of diagnosis and co-morbidities not accurate • Learning from deaths actions not implemented • NEWS compliance currently under 90% • Documentation of DNACPR • Failure to recognise or respond to a deteriorating patient generates a clinical incident report • Sepsis performance not at 100%	• Monitored quarterly at Trust Mortality Reduction Group (MRG) • Access to Bolton Care Record now fully available for comorbidities • Recording and coding action plan • LfD from death process/policy • Tracking of actions from LfD committee • complaints intelligence (where a death has occurred) is reviewed and reported to the LfD Committee • Medical Examiner will request SJR • Clinical incident reporting and Root cause analysis • Quarterly KPI's include sepsis screening tool • Revised fluid balance charts on EPR • DNA CPR audits • Sepsis performance report to MRG and would sit better under NEWS compliance – move up! • Quarterly cardiac arrest RCA reports • Deteriorating patient lead in post	Divisional Action plans for aiding improvement in NEWS including hydration programme (not part of NEWS) New reporting suite for EPR NEWS Updated DNAR-CPR policy	***1st Line of Defence (Operational Management)*** • Monthly monitoring of co-morbidity recording via HED – monitored by MRG • 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. • Quarterly Audit via Nursing care Indicators reported at MRG. • Cardiac arrest RCA audits • Sepsis quarterly performance • SHMI for sepsis within normal limits • A&E screening on upward trajectory ***2nd Line of Defence (Reports at Board and Committee Level)*** • Quarterly Learning From Deaths reports to QAC and Board alternately. • Quarterly SHMI (2 quarters in arrears) • Tracking template for LfD actions and feedback • Quarterly Quality Account updates to CG&QA committee (on NEWS and antibiotic prescribing compliance) •	Audit of capacity and DNAR-CPR by division quarterly Audit of medical handover monitored for improvement and eventual assurance via CGQA	• 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. • Implementation of recording and coding plan. MRG currently reviewing • Education package developed for medical staff. Overseen by MRG • LfD audit action plan examined for themes with thematic analysis is embedded. • Development of New reporting suite for EPR NEWS • Capacity assessment link now on EPR • Appointment of DNAR-CPR clinical lead • Audit of medical handover monitored for improvement and eventual assurance via CGQA • Design and implement a robust quarterly audit of response using patient track data-needs reactivation • Incorporation of SAFER principle into training

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
	• Sepsis improvement work stream • New healthcare intelligence provider appointed (HED • Harm Free Care Panel – review cases of falls, pressure ulcers, etc •		***3rd Line of Defence (Independent or Semi-independent assurance)*** Internal Audit reviews CQC Inspection Reports Trust HED benchmarking against national acute trusts' data Regional benchmarking and peer review (e.g. Critical Care peer review, Ockenden Insight report) AQuA audits of care (e.g. sepsis, pneumonia) GIRFT reviews into care provision (e.g. cancer services, CIAD) External assessments and accreditation (e.g. RCOA ACSA assessment, RCS reviews) CNST MIS assessment	HED data published nationally in arrears – system does allows some early identification	• Implementation of EPR sepsis bundle

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

Risk tracking



Background

Mortality reduction remains a key strategic and operational ambition for the Trust; delivering high quality evidenced-based healthcare will reduce mortality for our patients.

The mortality indices have been outside the expected range at various points over the last few years. Work has been done to better understand the reasons for this and there are clear data quality issues that are being addressed – there is an under-reporting of comorbidities for our patients, causing a lower number of deaths to be predicted (expected group) for our population than might be realistically expected. Our observed deaths, mirrored by crude mortality, are within the expected range and are frequently below national average.

Date	Comments
05/11/20	Risk narrative updated
29/06/21	Narrative updated
01/11/21	Narrative updated
30/06/22	The narrative has been updated and reviewed. This remains a high risk with no change in risk score.
16/11/22	Narrative reviewed and updated. Risk persists due to the need for continued actions to provide controls.

Ambition 1
Provide safe, high quality care

Lead Director	**Chief Operating Officer**	**1.2**
Lead Committee	**Strategy and Operations Committee** The Scan request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
	4	**5**	**20**	**4**	**4**	**16**	**4**	**3**	12

Linked Risks

Risk ID:
5424
5425

Principal Risk: If the Trust does not treat and discharge patients in a timely way, then it will not achieve its key performance targets and may result in regulatory action.

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
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

RISK MANAGEMENT - Control of the Risk

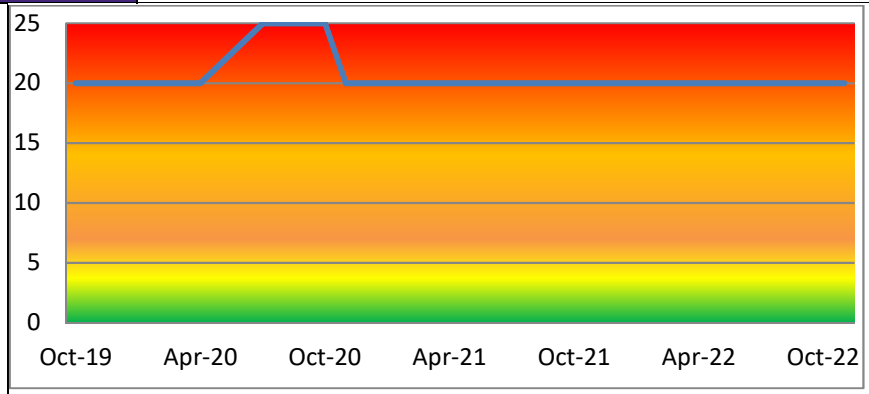
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Failure to admit, treat or discharge patients from the hospital in a timely manner Key causes • Volume of attendances • Late decision to admit from A/E • Failure to discharge patients in a timely manner • Poor in hospital flow • High delayed days for patients with no criteria to reside • Increased length of stay • High levels of bed occupancy in hospital and community	Escalation policy Flow meetings and reports (four a day) SAFER principles Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge Escalation beds opened in hospital and community System Operational Response Taskforce (SORT)		1st Line of Defence (Operational Management) • Regular performance monitoring at Divisional level. • Monthly Integrated Performance Management (IPM) meetings to review performance data • Working with GM to agreed standards • Review of Divisional Risk Registers at Risk Management Group • Tableau reports detailing Urgent Care & Community metrics • Monthly review of all urgent care & community work streams at Performance & Transformation Board reporting to SOC		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

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Impact of COVID 19 on pathways, including risks associated with overcrowding • Insufficient capacity in workforce, diagnostics, beds or theatres • Increase in referrals • Large volumes of patients with delayed follow up • Increased length of stay • High levels of bed occupancy in hospital and community • Impact of COVID 19 on pathways, including risks associated with overcrowding	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 Mutual aid in GM		**2nd Line of Defence (reports and metrics monitored at Board/Cttees** Monthly review of Integrated performance report at SoC. Bi-monthly presentation to SOC and Board: • COO Operational Update • IPR performance dashboard **3rd Line of Defence (Independent Assurance)** • NHSE Single Oversight framework and monitoring arrangements • NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting • Getting it right first time (GIRFT) programme. • Monitoring of delivery and performance of cancer metrics at GM? • Internal Audit • External Audit	GM ICS Performance meetings	Review of OPD and Theatre capacity and transformation Redesign of pathways for COVID compliance Significant increase in digital options for care Clinical review of all long waiters

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



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

20.02.20	Risk updated to reflect challenges to RTT and cancer performance
16 Nov 22	Review of BAF. No change in risk score, Risk remains High at 16.

Ambition 2
To be a great place to work

Lead Director	**Director of People**	**2**
Lead Committee	**People Committee**	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 202	**4**	**5**	**20**	4	4	**16**	4	3	12

Linked Risks

Principal Risk: If the Trust is not a great place to work then it will be unable to recruit, retain and support people to maximise their potential.

Overall Assurance Level

Amber

RISK APPETITE

1	2	3	4	5
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

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

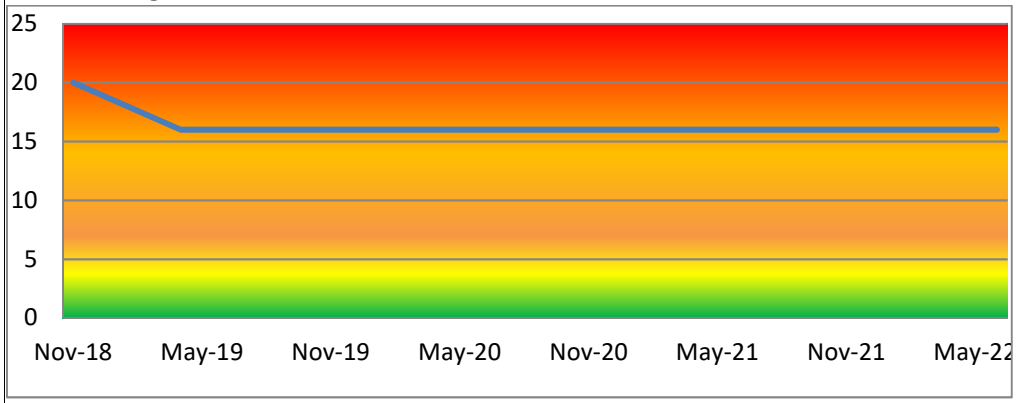
Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
• Health and Wellbeing of workforce – If the Trust does not reduce sickness absence rates there will be a service delivery and financial impact • Increased risk as a result of Covid related absence. • • Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will	• Health and Wellbeing Plan • Workforce & OD Strategy. • Occupational Health Provision • Staff Experience and Inclusion Steering Group • Staff Health and Wellbeing programme • Great Plan to Work Plan • Go Engage Pioneer Programme • Workforce & OD Strategy.	*Workforce and OD Strategy has been rolled forward with a view to align with the Corporate Strategy.* *Nursing job planning*	***1st Line of Defence (Operational Management)*** • Attendance KPI • Staff survey • Friends and Family • Go Engage • Staff Survey • Friends and Family • Divisions' People Committee reports to People Committee • IPM meetings with Divisions • Workforce Digital group reports to PC		• 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 • Extensive actions within the Staff Engagement Action plan

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
be a potential impact on improvement initiatives, discretionary effort and attendance • 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. • 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 • 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 • 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 • Failure to maximise digital HR systems could lead to lost opportunities for increased efficiency and effectiveness • Workforce Transformation – failure to support and enable	• Recruitment & retention Plan • Weekly / Monthly Safe Staffing meeting • Consultants Job planning • Weekly / Monthly Safe Staffing meeting • EDI Strategy • Staff Network groups • Revalidation • Appraisals • Mandatory and Statutory Training • ESR / ERS Benefits realisation plan • Agile Working policy •		***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Report to People Committee and Board. Includes • recruitment and retention • Temporary staffing • Sickness • Staffing report, • HR reports on vacancies • Ward to Board heat map • Staff Story included as a standing item in Board ***3rd Line of Defence (Independent or Semi-independent assurance)*** • WRES, • WDES, • Annual Gender Pay gap report • Annual Quality report • NHS Staff Survey • Local, Regional & national Benchmarking • Internal Audit • Bolton Integrated Partnership locality plan		• Review Workforce and OD strategy Dec People Committee • EDI Action plan with regular updates provided to Subgroups (EDI Steering group) and People Committee • Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
the workforce to adapt, modernise and transform how we do things and embrace a locality Team Bolton culture / approach will impact our ability to address critical health & social care system wide workforce challenges					

2	Ambition - To be a great place to work

Risk tracking



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.

The risk has been reviewed in light of potential industrial action and the cost of living challenge. Whilst there are mitigations in place should this be crystallised, the next iteration will consider whether to increase the score.

Date	Comments
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy
05.11.20	Risk reviewed – no changes made
06.01.21	Risk reviewed, minor changes made to content and to summary
28/06/21	Risk reviewed, minor changes to narrative
30/06/22	Risk reviewed, no proposed changes to score
09/11/22	No change in risk score proposed. General refresh of BAF

Ambition 3 To use our resources wisely	LEAD DIRECTOR	Chief Finance Officer	3
	LEAD COMMITTEE	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT										Linked Risks	
	Inherent Risk Rating			Current risk rating			Target Risk Rating				
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score		
November 22	4	4	16	4	4	16	4	3	12		

Principal Risk: If the Trust does not use its resources effectively, and operate within agreed financial limits, this may impact the sustainability and quality of services

Overall Assurance Level: Amber

RISK APPETITE

1	2	3	4	5
Minimal (As ARP) (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

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

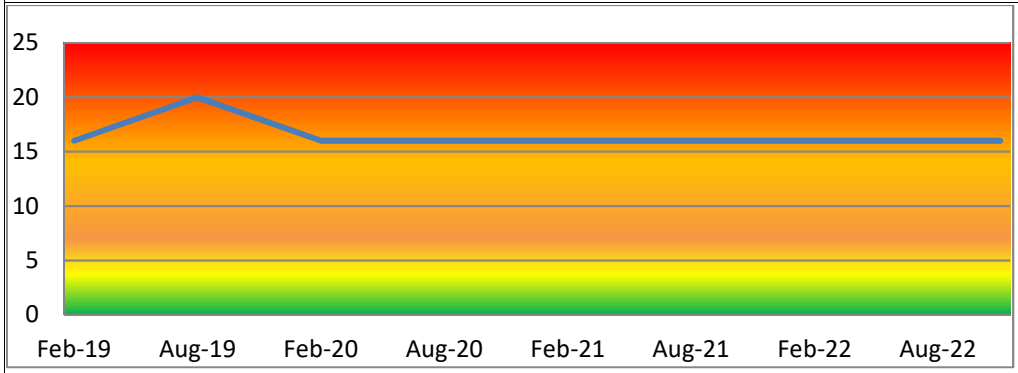
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Delivery of year on year cost improvements. Cost control and managing inflation effects. Shortage of revenue and capital funding	• Executive / CRIG approval of business cases • Improvement and Transformation Team coordination of ICIP • Monthly financial reporting to budget holders • Divisional accountability through IPM	GM ICB overarching strategy and financial strategy.	**1st Line of Defence (Operational Management)** Capital Revenue Investment Group (CRIG) reports Reports to Integrated Performance Management Meetings Monthly cash flow forecast	Model Hospital benchmarking reporting to F&I 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~~ April 2023

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
	• Annual budget setting and planning processes • Finance department annual business planning process • Development of annual procurement savings plans • Monthly accountability reporting to DOF • Standing Financial Instructions • Scheme of Delegation		**2nd Line of Defence** (reports and metrics monitored at Board/Committee) Monthly Finance Report to F&I Trust staffing levels to F&I Committee PLICs reporting and updates to F&I Cost improvement progress reports to F&I Quarterly benchmarking reporting to F&I Committee SFI breach report to Audit committee Procurement report to F&I Committee Monthly Chair's Report from CRIG to F&I **3rd Line of Defence (independent/ semi-independent assurance)** Internal Audit reports External Audit Reports System Reports to Greater Manchester ICS and NHS England Reporting to Finance committee from the system finance group Costing returns National Agency Team reports		5 year financial strategy refresh subject to clarity on financial regime from 22/23 onwards ~~June 21 Dec~~ 22 April 23 Re-establish quarterly benchmarking reporting to finance Committee ~~July 22~~ April 2023 Effective use of Model Hospital to drive our areas of productivity improvement and drive by January 2023

3	Ambition - To use our resources wisely

Risk tracking



Background

The Finance and Investment 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.

The strategic risk and associated linked risks have been reviewed and *this remains a high risk.*

Date	Comments
20.02.20	Full update to risk
May 20	Risk narrative updated
Nov 20	General Update – risk score reduced
Jan 21	Review to focus on strategic risks
Nov 22	Full review and revision of the timescales for completing the actions. There is no change in risk score

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

Lead Director	**Chief Finance Officer**	**4**
Lead Committee	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
November 2022	4	3	12	4	4	16	4	2	8

Linked Risks

Principal Risk: If the Trust does not sufficient capital resource to to deliver a building fit for the future, then this will impact the investment in a sustainable estate.

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
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

RISK MANAGEMENT - Control of the Risk

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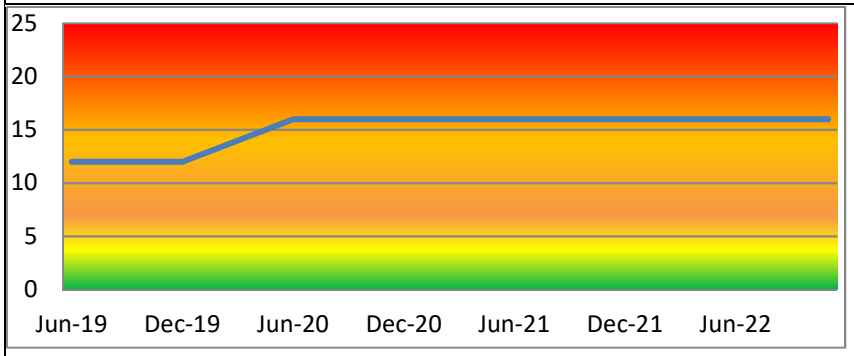
Treat. The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
shortage of capital and revenue funding Changes to capital regime High levels of backlog maintenance Planning, traffic constraints to the site Controllability of community estates not owned by Bolton FT	• 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 • Membership of Bolton Strategic Estates Group	Digital Performance Management Framework being developed	**1st Line of Defence (Operational Management)** Monthly review of business cases at CRIG and Executive Directors. Reports to Strategic Estates Group Monthly IPM meetings to review performance data Reports to the Digital performance and transformation Board which reports into sub-committees of the Board	No current gaps	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 Clinical Strategy, May 2023 Community estates strategy, ~~April22~~ December 22

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
If the Trust does not have a robust digital transformation and delivery plan, the organisation will be unable to function	• Premises Assurance Model • Enterprise Asset Management. • Backtrac system • Agile Working Programme • New Hospital Programme Bid • Refreshed Clinical Strategy • Working with LA and other partners • Traffic surveys • Our Green Plan • Demolition and Disposal Strategy • IFM asset management • Digital plan that maps back to the Trust strategy • NHS Digital IG Toolkit		**2nd Line of Defence (reports and metrics monitored at Board/Cttees** Monthly review of Integrated performance report at F&I. Digital performance and transformation Board which reports into sub-committees of the Board **3rd Line of Defence (Independent Assurance)** • ERIC reports • Model Hospital estates and facilities metrics • Use of resources benchmarking • Locality Board oversight • Management Framework • NHS England IG Toolkit • Cyber Security national assessments		Establishment of Locality Plans **April 2023** Digital Plan in final stages of development and will be complete by ~~September 2022~~ January 2023 Digital Performance Management Framework being developed January 2023 Digital Project Management Officer oversight of all programmes

4	To develop an estate that is fit for the future

Risk Tracking	Background	Date	Comments
		25/02/20	Full page risk description added
		15/05/20	Narrative updated
		16/11/20	Update – risk score increased
		06/01/2021	Review to focus on strategic risks/issues
		30/06/22	Risk reviewed - no changes proposed

Ambition 5
To integrate care

LEAD DIRECTOR	**Director of Strategy, Digital and Transformation**	**5**
LEAD COMMITTEE	**Strategy and Operations Committee** SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

Linked Risks

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 2022	4	3	12	4	3	12	4	2	8

Principal Risk: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
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

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

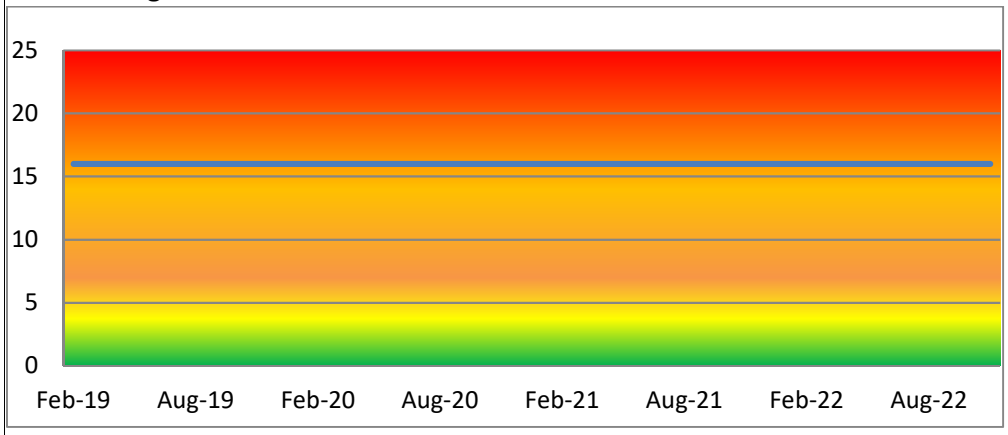
Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
If the organisation does not cooperate with its partners to understand and improve population health, then the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future **Causes** • Not understanding the impact of changes to the Health and Care Act 2022 • Impact of organisations financial Cost Improvement Programmes on the development of the ICP	• 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	• Locality Strategy and delivery plans yet to be developed • Develop the section 75 (under development awaiting guidance) to support the governance of the partnership • System transformation plan to transform services and drive integration • System finance plan	***1st Line of Defence (Operational Management)*** • Transformation programme across neighbourhoods, workforce and communities ICP Organisational Development Programme • **2nd Line of Defence (Reports to board and Committees)** Reports to the Strategy and Operations Committee	• New/immature structures • Lack of agreed plans and approach to delivery	• 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 FT

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development **Consequences** • Changes in the wider health economy may destabilise our organisation • the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future • potential fragment integration and slow development	• Alliance Agreement to support the governance of the partnership • Locality Governance structure • Development of an Alliance Agreement which ensures shared responsibility around delivering organisational Cost Improvement Savings. • 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.	• Delegation from GM yet to be confirmed	3rd Line of Defence (independent and semi-independent assurance) Reports to Joint Bolton Locality Executive Meetings Reports to Bolton Health and Overview Committee		• Work with the ICB to agree the model for delivery under the Place Based Lead • Organisations working together to develop a System Financial recovery Plan • Development of 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 £.

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

Risk tracking



Background

The Strategy and Operations Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition join up services to improve the health of the people of Bolton.

Date	Comments
10/5/20	Risk Narrative Reviewed
16/11/20	Risk Narrative Reviewed
10/08/21	Reviewed
16/11/21	Risk Reviewed
17 May 22	Risk reviewed and updated following changes to national and local policies
16 Nov 22	Risk Reviewed, no change to risk score as Risk remains Significant

Ambition 6
To develop partnerships

Lead Director	**Director of Digital, Strategy and Transformation**	**6**
Lead Committee	**Strategy and Operations Committee** *SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge*	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 2022	4	4	16	4	3	**12**	4	**2**	**8**

Linked Risks

Principal Risk: If the Trust fails to develop partnerships that support the achievement of our strategic ambitions, then this could result in a negative impact to the services we provide, our infrastructure and our financial position.

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
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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Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance

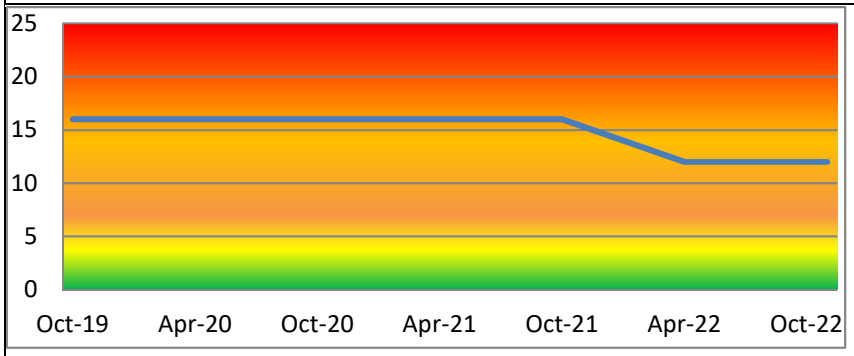
If the Greater Manchester system introduces a new clinical transformation or service reconfiguration programme, then there is a risk that some of our service will fall in scope, which could ultimately result in changes to how our population accesses care
 	
Causes
• Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services
• Develop Provider Collaborative across GM
• Sustainable Workforce Pipeline
• Lack of relationships with neighbouring landowners and developers.
• Missed opportunity for strategic partnerships
 	
Consequences
• Inadequate workforce to deliver safe, effective care.
	• Membership of the Bolton Health and Academic Partnership Board
	• Health Innovation Bolton Partnership
	• Regular meetings with Peel Holdings
	• Membership and attendance at Greater Manchester (GM) Provider Collaborative.
	• Pharmacy transformation programme
		A strong partnership with local academic providers is essential to deliver this
		
		Engagement in the development of service transformation programmes through Directors of Strategy
		
		Development of the clinical strategy is underway
		
		Development of a laboratory information management system (LIMS)
		
		Radiology network agreements remain key to assurance on this programme of work
			1st Line of Defence (Operational Management)
			•
				There is a developing programme of work which currently sits with GM Directors of Strategy, enabling us to contribute to the programme	• Development of a stronger partnerships with local academic providers with a view to develop a workforce pipeline
					• Participation in any working group that is established to ensure that we remain able to shape and influence the developing programme
					• Implementation of GM PACs and Laboratory Information Management System procurements
					• GM network agreements remain unsigned. Bolton continues to engage in this to ensure the agreement reflects our needs
					• Local pathology, radiology and pharmacy clinical service strategies
					• Board approval of Phase 2 of the CDC programme
					• GM provider collaborative delivery being developed linked to GM
					  ○ Financial Plan
					  ○ Digital Plan

			2nd Line of Defence (Reports at Board and Committee Level) •		

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• strategic partnership opportunities will be missed • adjacent land may be developed in a way that negatively impacts the Trust estate, meaning that our ambitions to improve our estate may be limited			***3rd Line of Defence (Independent or Semi-independent assurance)***		• 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 • Production of a shared vision for the site and neighbouring land which meets each partners vision and ambitions

6	To develop partnerships across GM to improve services

Risk Tracking



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.

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

Date	Comments
21/10/19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy
20/02/20	Risk reviewed
05/11/20	Risk reviewed
08/01/21	Risk reviewed
16/11/21	Risk Reviewed
17/05/22	Risk Reviewed and Likelihood reduced to 3
16/11/22	Risk reviewed no change to risk score

Agenda Item 9

Title	Quality Assurance Committee and Strategy and Operations Terms of Reference

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24 November 2022		Discussion	
Exec Sponsor	Sharon Katema		Decision	✓

Summary:	To present the Terms of Reference for the Quality Assurance Committee and the Strategy and Operations Committee, both of which are formal committees of the Board of Directors. A full refresh of the ToR including templates, was undertaken prior to presentation at the Committees. Both sets of ToR were presented for approval prior to presentation at the Board of Directors and were endorsed by the respective committees for ratification The Quality Assurance Committee approved its ToR at the meeting held on 21 September 2022. The Strategy and Operations Committee approved its Committee ToR at the meeting held on 24 October 2022.

Previously considered by:	Quality Assurance Committee and Strategy and Operations Committee

Proposed Resolution	The Board is asked to approve the ToR of the Quality Assurance Committee and the Strategy and Operations Committee.

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

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

Agenda Item 9

Title	Quality Assurance Committee and Strategy and Operations Terms of Reference

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24 November 2022		Discussion	
Exec Sponsor	Sharon Katema		Decision	✓

Summary:	To present the Terms of Reference for the Quality Assurance Committee and the Strategy and Operations Committee, both of which are formal committees of the Board of Directors. A full refresh of the ToR including templates, was undertaken prior to presentation at the Committees. Both sets of ToR were presented for approval prior to presentation at the Board of Directors and were endorsed by the respective committees for ratification The Quality Assurance Committee approved its ToR at the meeting held on 21 September 2022. The Strategy and Operations Committee approved its Committee ToR at the meeting held on 24 October 2022.

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*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 Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

Quality Assurance Committee

Terms of Reference Document Control Sheet

MEETING	Quality Assurance Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
REVIEW:	September 2022
REPORTING GROUPS:	Clinical and Quality Governance Group Professional Forum Risk Management Group Safeguarding Group Mortality Group Health and Safety Group

Terms of Reference of the Quality Assurance Committee

1. Authority

1.1. The Quality Assurance Committee (The Committee) is established as a Committee to the Board of Bolton NHS Foundation Trust and is authorised to investigate any activity within its terms of reference.

1.2. The Committee is authorised by the Board to obtain, within the limits set out in the Trust Scheme of Delegation, outside legal or other independent professional advice on any matter within its terms of reference.

1.3. The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2. Decisions

2.1. The Quality Assurance Committee is a decision-making committee.

2.2. Decisions by the Committee must accord with the requirements of the Standing Orders and the Scheme of Delegation – General Principles and be reported to the next available Board of Directors meeting via the Chair report of the Quality Assurance Committee

3. Reporting Arrangements

3.1. The Quality Assurance Committee will be accountable to the Board of Directors.

3.2. The minutes of Committee meetings shall be formally recorded and approved by the subsequent meeting. The Chair of the Committee shall through the Chair's report, draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.3. The Committee will refer to the other relevant Committees (Audit Committee, People Committee, Finance and Investment Committee, and the Strategy and Operations Committee) matters considered by the Committee deemed relevant for their attention. The Committee will also consider matters referred to it by other Committees.

3.4. The annual work plan of the Committee may be reviewed by the Audit Committee at any given time.

4. Main Duties and Responsibilities

- To promote systems which provide assurance and improve the quality of care, safety and experience of patients, carers, staff and visitors to the Trust.

- The Committee will exercise oversight of the systems of governance and risk management and seek assurance that they are fit-for-purpose, adequately resourced and effectively deployed to concentrate on matters of concern.

- To oversee the effective management of risks as appropriate to the purpose of the committee

- The Committee will seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management.

- Review quality governance and require action to address any non-compliance with key regulatory frameworks and policies

- Review and have oversight of any relevant external reports including those from the CQC and ensure that robust action plans are devised and performance managed to address any identified deficiencies in clinical governance.

- To have an overview of the process to investigate and learn from serious incidents.

- Satisfy itself and the Board that the structures, processes and responsibilities for identifying and managing key risks to patients, staff and the organisation are adequate.

- To ensure that standards and procedures relating to risk are embedded throughout the Trust, with mechanisms through the Committee for detailed scrutiny of high and significant areas, including consultation with appropriate Trust staff.

- Such other relevant matters which the Board may delegate to the Committee

- Such other relevant matters which are referred to the Committee by its sub-committees or the other committees of the Board

- Such other relevant matters as the Committee takes upon itself in line with the broad scope of its main duties and responsibilities.

5. Membership

5.1. The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors and will consist of:

- Three non-executive directors (one of whom will be the Chair of the Committee)
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer

5.2. Each member will have one vote with the Chair having the casting vote, if required. Should a vote be necessary, a decision will be determined by a simple majority.

5.3. The following members will be ordinarily expected to attend meeting.

- Director of Corporate Governance
- Deputy Director of Nursing
- Director of Quality Governance
- Director of Operations
- Divisional Representation
- Greater Manchester ICS Bolton Locality representative

5.4. Other key individuals will be co-opted to the Committee dependent on key work streams to be initiated.

5.5. From time to time the committee may wish to invite individuals to attend the meeting to aid in the understanding of particular items. The Secretary will issue such invitations on behalf of the Chair of the Committee.

5.6. The Deputy Chair or nominated individual will automatically assume the authority of the Chair should the latter be absent.

5.7. Members are responsible for providing feedback to their Divisions/ Teams / committees they represent, and any agreed actions or recommendations as required.

6. Quorum

6.1. A quorum will be no less than 5 members one of whom should be the Chair or their deputy and at least two non-executive directors and two executive directors plus representation from the clinical divisions.

7. Attendance

7.1. It is highly important that members attend the Quality Assurance Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Executive members are expected to nominate a deputy to attend in their absence.

7.2. If a committee member is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

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

8. Agenda & Papers

8.1. An agenda for each meeting, together with relevant papers, will be forwarded to committee members no later than 5 days before the meeting.

8.2. Standard Agenda Items

- Quality Dashboard and ward to Board heat map
- The Committee will receive reports from the following committees:
  - Clinical and Quality Governance Group
  - Professional Forum
  - Risk Management Group
  - Safeguarding Group
  - Mortality Group
  - Health and Safety Group

9. Administration and Frequency of Meetings

9.1. The group will meet no less than 10 times a year.

9.2. The group may establish 'task and finish' groups to deliver specific actions.

9.3. The Committee will be supported by the Director of Corporate Governance and the secretariat whose duties in this respect will include:

- Agreement of the agenda with Chair, Medical Director and Chief Nurse and collation of papers
- Taking the minutes and keeping an action log of matters arising and issues to be carried forward
- Advising the committee on pertinent areas

10. Monitoring Effectiveness

The Committee shall undertake an annual review of its performance and effectiveness against its annual work plan, in order to evaluate the achievement of its duties.

11. Review of Terms of Reference

These Terms of Reference shall be reviewed annually or in light of changes in practice or legislation. Changes to these Terms of Reference must be approved by the Board of Directors

Submitted to:	Quality Assurance Committee
Date of approval:	October 2022
Date for next review:	November 2023

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by**
2022	Full review of ToR document including template. Notable amendments include: ○ s.6.1 quorum to exclude representation from each Division ○ s.8.1 amendment to 5 days (removing working days) ○ s.8.2 Revision of reporting groups	Quality Assurance Committee. [date]	Board of Directors [date]

Strategy and Operations Committee

Terms of Reference Document Control Sheet

MEETING	Strategy and Operations Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Strategy, Digital and Transformation Chief Operating Officer
REVIEW:	October 2022
REPORTING GROUPS:	Performance & Transformation Board Digital Transformation & Performance Board

Strategy and Operations Committee – Terms of Reference

1. Authority

The Strategy and 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, as articulated in the Trust's annual business plan To approve and monitor 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
- To ensure that the Strategic Operational work programme follows the Trust's benefits realisation programme, with project and programmes adding clear and demonstrable value to the Trust
- To encourage and enable risk managed innovation and experimentation as part of achieving our transformation objectives

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
- To recommend approval of Corporate, Clinical and Digital strategies and plan to the Board

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 3-year digital strategy
- Through the Digital Transformation & Performance Board Chair's report, to receive updates on performance and delivery of key digital transformation plans

Transformation

- Through the Performance & Transformation Board Chair's report, to receive updates on performance and delivery of key 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 (one must be present)

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

Two Executive Directors, one of whom must be the Medical Director or the Chief Nurse and two Non-Executive Directors.

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
- Chair's report from the Performance & Transformation Board
- Chair's report from the Digital Performance & Transformation Board
- Quarterly review of strategic objectives and milestones
- Service spotlight sessions

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 in March 2023, and will then move to annual cycle of review.

Quality Assurance Committee

Terms of Reference Document Control Sheet

MEETING	Quality Assurance Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
REVIEW:	September 2022
REPORTING GROUPS:	Clinical and Quality Governance Group Professional Forum Risk Management Group Safeguarding Group Mortality Group Health and Safety Group

Terms of Reference of the Quality Assurance Committee

1. Authority

1.1. The Quality Assurance Committee (The Committee) is established as a Committee to the Board of Bolton NHS Foundation Trust and is authorised to investigate any activity within its terms of reference.

1.2. The Committee is authorised by the Board to obtain, within the limits set out in the Trust Scheme of Delegation, outside legal or other independent professional advice on any matter within its terms of reference.

1.3. The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2. Decisions

2.1. The Quality Assurance Committee is a decision-making committee.

2.2. Decisions by the Committee must accord with the requirements of the Standing Orders and the Scheme of Delegation – General Principles and be reported to the next available Board of Directors meeting via the Chair report of the Quality Assurance Committee

3. Reporting Arrangements

3.1. The Quality Assurance Committee will be accountable to the Board of Directors.

3.2. The minutes of Committee meetings shall be formally recorded and approved by the subsequent meeting. The Chair of the Committee shall through the Chair's report, draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.3. The Committee will refer to the other relevant Committees (Audit Committee, People Committee, Finance and Investment Committee, and the Strategy and Operations Committee) matters considered by the Committee deemed relevant for their attention. The Committee will also consider matters referred to it by other Committees.

3.4. The annual work plan of the Committee may be reviewed by the Audit Committee at any given time.

4. Main Duties and Responsibilities

- To promote systems which provide assurance and improve the quality of care, safety and experience of patients, carers, staff and visitors to the Trust.

- The Committee will exercise oversight of the systems of governance and risk management and seek assurance that they are fit-for-purpose, adequately resourced and effectively deployed to concentrate on matters of concern.

- To oversee the effective management of risks as appropriate to the purpose of the committee

- The Committee will seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management.

- Review quality governance and require action to address any non-compliance with key regulatory frameworks and policies

- Review and have oversight of any relevant external reports including those from the CQC and ensure that robust action plans are devised and performance managed to address any identified deficiencies in clinical governance.

- To have an overview of the process to investigate and learn from serious incidents.

- Satisfy itself and the Board that the structures, processes and responsibilities for identifying and managing key risks to patients, staff and the organisation are adequate.

- To ensure that standards and procedures relating to risk are embedded throughout the Trust, with mechanisms through the Committee for detailed scrutiny of high and significant areas, including consultation with appropriate Trust staff.

- Such other relevant matters which the Board may delegate to the Committee

- Such other relevant matters which are referred to the Committee by its sub-committees or the other committees of the Board

- Such other relevant matters as the Committee takes upon itself in line with the broad scope of its main duties and responsibilities.

5. Membership

5.1. The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors and will consist of:

- Three non-executive directors (one of whom will be the Chair of the Committee)
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer

5.2. Each member will have one vote with the Chair having the casting vote, if required. Should a vote be necessary, a decision will be determined by a simple majority.

5.3. The following members will be ordinarily expected to attend meeting.

- Director of Corporate Governance
- Deputy Director of Nursing
- Director of Quality Governance
- Director of Operations
- Divisional Representation
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5.6. The Deputy Chair or nominated individual will automatically assume the authority of the Chair should the latter be absent.

5.7. Members are responsible for providing feedback to their Divisions/ Teams / committees they represent, and any agreed actions or recommendations as required.

6. Quorum

6.1. A quorum will be no less than 5 members one of whom should be the Chair or their deputy and at least two non-executive directors and two executive directors plus representation from the clinical divisions.

7. Attendance

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9. Administration and Frequency of Meetings

9.1. The group will meet no less than 10 times a year.

9.2. The group may establish 'task and finish' groups to deliver specific actions.

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- Agreement of the agenda with Chair, Medical Director and Chief Nurse and collation of papers
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The Committee shall undertake an annual review of its performance and effectiveness against its annual work plan, in order to evaluate the achievement of its duties.

11. Review of Terms of Reference

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Submitted to:	Quality Assurance Committee
Date of approval:	October 2022
Date for next review:	November 2023

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by**
2022	Full review of ToR document including template. Notable amendments include: ○ s.6.1 quorum to exclude representation from each Division ○ s.8.1 amendment to 5 days (removing working days) ○ s.8.2 Revision of reporting groups	Quality Assurance Committee. [date]	Board of Directors [date]

Strategy and Operations Committee

Terms of Reference Document Control Sheet

MEETING	Strategy and Operations Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Strategy, Digital and Transformation Chief Operating Officer
REVIEW:	October 2022
REPORTING GROUPS:	Performance & Transformation Board Digital Transformation & Performance Board

Strategy and Operations Committee – Terms of Reference

1. Authority

The Strategy and 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

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- 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
- To ensure that the Strategic Operational work programme follows the Trust's benefits realisation programme, with project and programmes adding clear and demonstrable value to the Trust
- To encourage and enable risk managed innovation and experimentation as part of achieving our transformation objectives

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- 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 3-year digital strategy
- Through the Digital Transformation & Performance Board Chair's report, to receive updates on performance and delivery of key digital transformation plans

Transformation

- Through the Performance & Transformation Board Chair's report, to receive updates on performance and delivery of key 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 (one must be present)

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

Two Executive Directors, one of whom must be the Medical Director or the Chief Nurse and two Non-Executive Directors.

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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.

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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

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- Chair's report from the Performance & Transformation Board
- Chair's report from the Digital Performance & Transformation Board
- Quarterly review of strategic objectives and milestones
- Service spotlight sessions

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 in March 2023, and will then move to annual cycle of review.

Agenda Item:
10

Title:	Strategic Operations Committee

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	Sharon Martin, Director of Strategy, Digital and Transformation		Decision	

Summary:	This report provides an update on the September and October Strategic Operations 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:	Rebecca Ganz, Non-Executive Director	**Presented by:**	Rebecca Ganz, Non-Executive Director

Strategic Operations Committee Chairs Report

Name of Committee/Group:	Strategic Operations Committee	Report to:	Board of Directors
Date of Meeting:	26th September 2022	Date of next meeting:	29th September 2022
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Francis Andrews, Sharon Katema, Sharon Martin, James Mawrey, Martin North, Tyrone Roberts, Alan Stuttard, Rae Wheatcroft. In attendance: Sam Ball, Rachel Carter, Faye Chadwick, Rayaz Chel, Tracy Iles, Jake Mairs, Rachel Noble, Julie Ryan, Jo Street, Brett Walmsley, Judith Richardson (minutes)	Quorate (Yes/No):	Yes
		Key Members not present:	Andy Chilton, Rachel Tanner.

Key Agenda Items:	Lead	Key Points	Action/decision
Terms of Reference	R Ganz	• The Committee received the Terms of Reference for this newly established Committee, the purpose of which is to provide assurance to the Board of Directors on the operational performance and strategic planning functions of the Trust along with oversight and assurance of the associated digital and transformational work programmes. • Comments and suggested amendments were received on quoracy, responsibilities, clinical membership, Committee effectiveness review period, along with some slight refinements to wording/language.	• The Committee clarified that SOC would be responsible for Corporate, Digital and Clinical strategies as part its remit • The Chair agreed that the Terms of Reference would be updated with suggested comments and circulated to all attendees outside of the meeting and submitted to the next meeting for final ratification.
Children's Services 'Spotlight'	T Iles	The Committee received the comprehensive presentation from T Iles, Divisional Director of Operations for Family Care and F Chadwick, Assistant Divisional Nurse Director for Family Care. The presentation outlined the current Children's & Young People's Transformation Programme focussing on: – the 0-19 service user engagement response, – SEND agenda, – Family Hubs, – Health Inequalities – Transition to Adult Services. • The 0-19 Transformation Programme has been developed in Local Authority and takes into account national SEND policy and Family Hubs provision. • The Committee welcomed the fantastic work the Division has done engaging with children and families using the voluntary sector to engage with communities the FT would normally not reach. • The Committee discussed the risks for a 3 year contract for this service pose and agreed that such a short term contract poses operational issues and does not support a fully integrated service long term.	• The presentation was well received by the Committee who acknowledged the innovative engagement and co-production approach as an exemplar piece of work to use across the organisation and System working. • The work being done on transition to Adult Services was noted as being at an earlier stage. The Committee looked forward to future updates. • The executive sponsor for the children's transformation programme would be picked up outside of the meeting by the Executive Directors and an update provided to the next meeting. • Executive Directors are currently working with Bolton Council to discuss contract models including a potential longer contract term.

	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

Strategic Operations Committee Chairs Report

Performance and Transformation Board Chairs Report	S Martin	The Committee received and noted the key points from the meeting held on 5th September 2022: • **Elective Programme:** – Cancer Performance remains a challenge across a number of specialities, due to capacity, increased referrals, and annual leave impacting on our pathways. A Cottrell is currently leading on a piece of work to improve overall cancer performance. – Continued work on RTT and waiting list management has provided some achievements but it is still in need of improvement. • **Urgent Care:** – Decline in 12 hours performance and patients who have no criteria to reside – Stroke improvement numbers are declining partly due to bed pressures at Salford and additional admin training, in order to improve SNAP data will help with performance • **Maternity Transformation Group:** – Concerns with CNST achievement for 2023, which is largely around changes in the data required and the Family Care Division are working with EPR to rectify the issues. – Targeted piece on work on the Training Compliance for CNST with positive improvements, however, unable to provide assurance of compliance. • **Finance and Intelligence Group**: – Noted that this is an integral group to the organisation pulling in themes on the operational plan, annual contracting review, model hospital and patient level costings – A T&F Group is being created around the Contracting update to review SLAs and concerns around the pay award	• The Committee reviewed both the Performance and Transformation Board Chair's Report and Month 5 IPM in tandem • NCTR length of stay was discussed as future deep dive 'back door' spotlight for the Committee as the NCTR number of patients continues at materially the same volume, with a focus on reducing the number of NCTR days being a key focus. • Urgent Care performance was noted as declining including in the context of GM Peers and monthly updates including a possible 'front door spotlight' would be appropriate to consider this further. • The interplay between ED, the Urgent Treatment Centre and SDEC were discussed around the need for simplification to help service users navigate their care options. • Division will re-do the Capacity and Demand work going forward and will start by targeting certain areas that are struggling more specifically with Cancer An update from the deep dive work into Audiology and its impact on diagnostic performance will be provided to the next PTB meeting • J Street will work with the Division on where the assurance needs to be provided to with the Training Compliance Action Plan for CNST compliance • PIFU is achieving but need to pick up performance system in the Division against the 104% target

	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

Strategic Operations Committee Chairs Report

Month 5 – Operational IPM	J Street	The Committee received the high level metrics and operational performance across the Trust noting the key points from Month 5: **Access:** • Ambulance handover performance remains the top operational challenge. There have been some recent improvements due to the new escalation process agreed with NWAS and work is on-going with the in-hospital flow programme and 'Warm up to Winter' campaign to improve performance • RTT position - overall the waiting list continues to grow but confident that there is sufficient theatre capacity to meet the recovery milestone before April 2023 • Deterioration in DM01 performance in August mainly due to annual leave. All specialties have plans in place to recover the position in September **Productivity:** • Continued pressures with NC2R which is being experienced across GM. Assurance received that whilst the number is high all the on-going improvement work is having a positive impact in terms of turnover, however, this is not the case with reducing the number overall • Assurance received that a long term locum has been secured in Stroke which is predicted to have a positive impact on TIA and on in-patient stroke metrics. Both Bolton and Salford are experiencing pressures in relation to admission and discharge impacting on flow across the two units and are working jointly to resolve the issues • Re-admission and day case rates remain consistently good. **Cancer:** • The Trust failed the 62-day standard for July and based on the current performance the quarter is predicted to fail. The Trust has undertaken a deep dive into all cancer pathways which do not meet the 62-day target, diagnostic delays are a major factor and these are being managed on a specialty by specialty basis. • The Trust is working with GM to support recovery of the cancer position and will take part in a two-week accelerator initiative, focussing on inpatient diagnostics and surgical first treatments. • Passed the 2 week wait standard in July for the first time since November 2021	• Please see comments relating to the Performance and Transformation Board Chair's Report, as the IPM was reviewed at the same time as the Chair report

	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

		Community: • Additional finances received to support with the anticipated surges through the Winter months including development of home care bridging service and funding to support with discharge to assess at home 7 days a week. • Additional winter schemes to reduce NCR include but are not exclusive: • Initiative to reduce the number of people admitted who reside in care homes – Initiatives to support homeless and vulnerable adults to avoid admission – Work with system partners to ensure vulnerable citizens and staff are supported to have the flu and Covid vaccination – The Bolton Integrated Partnership has commissioned AQuA to work with the Trust to review whole system flow and implement any required new service models. As part of the next phase there is focus on ensuring the MDT functions effectively at ward level, there is timely preparedness of discharge medication and improving the access for the most relevant person to undertake the MCA all of which will contribute to improving flow and preventing avoidable delays to discharge	
Winter Plan Exec Summary	J Street	The Committee received the high level summary of the Trust's Winter Plan for 2022/23, noting the approach to Winter review and planning adopted this year and the financial implications. • The Committee accepted the transformational priorities and operational wider plans and supported the monitoring process for the Winter plan. • The Committee acknowledged that the Plan was not without risks to delivery and was based on bed modelling and intelligence which will be adapted in a worst case scenario and is part of a wider system plan that feeds into GM and the Locality Plan. • The Committee noted that with regards to Workforce and supporting resilience in Winter, less than 1% of staff are utilising Health and Wellbeing resources.	• The Committee noted that in the context of the significant BAU pressures noted in the PTB Chair and IPM reports, the Winter Plan contains substantial risk • JM confirmed that an action plan to increase uptake of Health and Wellbeing resources is being provided to the People Committee in October.

	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

Strategic Operations Committee Chairs Report

Digital Performance and Transformation Board Chairs Report	R Wheatcroft	The Committee received the Chairs report from the meeting held on 12th September noting the following key points: **Digital Programme Group Chair Report:** • The overall programme RAG rating remains red due to the significant level of risks impacting on the delivery of the programme plan relating to challenges in the recruitment of staff; the volume of projects requiring resource; costs in delays in delivery of components and the increase in the rate of business as usual/requests for support. **Community EPR Update:** • The Digital Team are working with the EPR provider to discuss delays to the Community EPR implementation and an update will be provided in the next meeting. **Clinical Coding:** • Clinical Coding are still under pressure and currently reliant on contractor coders. As qualified coders are in such high demand nationwide, applicants for vacancies are interviewed immediately such is the level of competition across trusts • A Facebook campaign for the recruitment of clinical coders is being launched to brand ourselves more competitively with other trusts which will include a full training and remote working package.	• The Committee acknowledged the huge scale and scope of the digital work programme to be carried out and suggested that it would be helpful to understand which projects needed to be achieved and which could be paused. The Chair requested an update to the next meeting of this Committee
Information Governance Annual Report 2021/22	S Martin	The Committee received and approved the IG Annual Report which gave assurance on the IG workplan. It outlined the key activity, achievements and issues for the reporting period 1 April 2021 to 30 June 2022 noting the following highlights: • The Trust achieved the Data Security and Protection Toolkit standard for 2021/22 • Significant amount of FOI requests received • Subject Access Requests increasing and this impacts on the capacity from the Team and Divisions • PWC reviewed the process for compiling the Data Security Protection Toolkit and the evidence available for a sample of 58 requirements. The overall Risk Rating for Bolton NHS Foundation Trust is 'Moderate' and both recommendations have action plans in place.	• The Chair wished to acknowledge the huge scale and scope of the work achieved to date by the IG Team and the Committee approved the report

	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

Strategic Operations Committee Chairs Report

Digital Plan 2022/23 – 2023/24	B Walmsley	The Committee received the 2-year Digital Plan for 2022/23 - 2023/24. The plan is structured around the delivery of 4 strategic objectives; Digital Patient Journey; Integrated Records and Systems; Digital Organisation and Digital Workforce The 2 year plan reflects the current significant changes within the sector such that a longer 5 year plan is not appropriate at this time.	• The Committee requested that: – the language and journey within the report is simplified – it should include a section on the deliverability of the work plan – It should be separated into what has been delivered and what has been approved and what still needs to be approved – how it benefits both staff and end service users • The next draft is due to be submitted to the meeting in October before onward submission to the November Board of Directors meeting.
90-day priorities (Q3) and strategic golden threads	R Noble	The Committee received and approved the proposed approach to identifying, progressing and reporting on priority programmes of work across the organisation for the five priorities agreed with the Board of: • Children & Young People services • Digital and Data • Operational plan and recovery programmes • People • System Transformation	• The Committee clarified that the annual plan will be reviewed quarterly for milestone achievements/outcomes rather than annual 'strategies' • The Committee looked forward to receiving quarterly achievement updates, while also registering concern at the additional work required to deliver this visibility

Items to escalate to the Board:

- NCTR represents over 1/3 of adult beds
- Urgent Care, 12-hour performance is declining
- Cancer, predicted to fail current quarter
- Maternity, regarding CNST compliance and EPR Go Live
- Winter plan level of risk given current BAU pressures
- Feasibility of completing the digital programme in the anticipated timeframe, given its scale

	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

Strategic Operations Committee Chairs Report

Name of Committee/Group:	Strategic Operations Committee	Report to:	Board of Directors
Date of Meeting:	24th October 2022	Date of next meeting:	21st November 2022
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Francis Andrews, Sharon Katema, Sharon Martin, Martin North, Tyrone Roberts, Alan Stuttard, Rae Wheatcroft. In attendance: Sam Ball, Rachel Carter, Jake Mairs, Rachel Noble, Brett Walmsley, Michelle Cox, Michael Clarke, Matthew Greene, Michelle McConvey (minutes)	Quorate (Yes/No):	Yes
		Key Members not present:	James Mawrey, Andy Chilton, Rachel Tanner, Joanne Street.

Key Agenda Items:	Lead	Key Points	Action/decision
Elective Recovery	M Cox	The Committee received the Elective Recovery presentation from M Cox, Divisional Director of Operations for Anaesthetics and Surgical Services, noting recovery from the pandemic will take approximately 10-15 years. The presentation focussed on: • Why we need to recover • NHS Elective Recovery Plan • Progress made so far • RTT Summary Position • 78+ Waiters Forecast • DM01 Summary • Current pressures • Our Challenges: • Plans to Recover: • Non admitted Transformation Programme (October 2022): • Our priorities – Health Inequalities MC confirmed all risks are recorded through the risk register process and majority of the elective recovery sit within ASSD remit. Theatre capacity and bed access are the two greatest risks. Elective procedures will be reduced over the Christmas 3 week period, any longer then additional risks will be added into the system. RW explained how we are working more closely than before with GM colleagues and this is helping us collaboratively. However, this could add to our risks as we may be asked to support other organisations who are in a worse position. Regarding the GP Advice and Guidance and Non Admitted Transformation, S Ball has been meeting with Clinical Leads sharing good news stories to be filtered through the system to drive awareness. The Trust needs to turn around requests within 48 hours for this to have maximum impact. In terms of two areas that could impact the scale and pace of elective recovery, Did Not Attend and Patient Initiated Follow Up were identified as areas of focus. It was confirmed that 2 new theatres will not provide us with additional capacity but as we are bidding for 4 theatres and providing we get all 4 theatres the extra capacity will be used for paediatric capacity as well as supporting GM. The extra theatre space will be used to support our day care unit whilst we refurb our current day care unit as a paediatric hub.	The Elective Recovery spotlight was noted by the Committee. SOC Terms of Reference to include oversight of major risks affecting the top five transformation priorities.

Strategic Operations Committee Chairs Report

90-day priorities (Q3) and strategic golden threads	R Noble	The Committee received the first draft of the workplan which describes known priorities for the next 12 months, with a summary of issues for Q3 and Q4 2022/23. Going forward, the report will contain a highlight report quarterly. • The key risk for the period is that a high volume of consultative work is underway at a time when operational pressures within the organisation will reach their peak. Mitigations are in place, and work programmes will be kept under review with regular reports made to the Committee to highlight any emerging risks. • The aspiration for Q4 is to ready the organisation for a simplified approach to delivery in 2023/24. There will be significant volumes of information to synthesise during Q4 as the clinical and corporate strategies, the digital and people plans take shape, and the operational planning guidance is published.	Received with agreement this will be developed over the coming months. The Committee requested enabling easy triangulation to the top 5 transformation priorities. The Committee confirmed the need to have an outcomes focus together with indicative timeframes, to enable milestone tracking over a 12 month period within the context of a wider multi-year plan.
Corporate Strategy Progress Report	R Noble	The Committee received a verbal update noting the key highlights provided by the Deputy Director of Strategy. • There will be virtual staff sessions around the strategy focusing on the 6 ambitions already in place. This will include 1:1 interviews with Execs, Divisions and staff • The plans will be about the engagement and communication work. • In the background research and evidence will be gathered to provide an opportunity to look at best practice on where to focus differently in the organisation, aligning to national and regional plans.	The NEDs requested regular updates on the discussions between the Execs and the Divisions to sense check and provide assurance to the Board. The Chair will meet with R Wheatcroft, S Martin, R Noble and J Street to confirm how this will happen.
Terms of Reference	R Ganz	The Committee received Version 2 of the Terms of Reference which incorporated the suggested updates to Version 1. A Stuttard noted the Committee had previously agreed for the quorum to have 2 Execs and 2 NED in attendance of whom one member is to be either the Medical Director or Chief Nurse.	The Committee approved the Terms of Reference subject to this final amendment and agreed to review the TORs in 6 months given the early evolution of the Committee
Digital Performance and Transformation Board Chairs Report & Digital Plan update combined	S Martin	The Committee received the Chairs report from the meeting held on 10th October noting the following key points: • Issues identified with information recording - clinical correspondence in A&E. S Irving has confirmed there will be education to ensure ED colleagues are prompted to complete all the data within clinical correspondence. S Martin has asked for assurance for the next meeting. • The EPR Go Live within ED went very well on the 12th October. S Martin expressed her thanks to B Walmsley and everyone involved. • The timescales of Community EPR rollout have changed recently and the Digital team are working through closely with Allscripts to explore what is feasible and relevant timeframes. An update has been requested for the next meeting. • Digital team have been working hard to prioritise all the equipment being rolled out to the wards purchased at the close of 21/22. There is a monthly update to show where this is up to give assurance to the Divisions. • The staffing issues within the Digital Teams continue to be a risk. • The Board received and noted the Service Desk Update Report which provided an overview of the issues and requests reported to the IT Service Desk during September 2022 • Clinical Coding to continue to achieve 100% cases coded in the timescales	RAG Rating for Clinical Coding and Service Desk to be Amber instead of Green due to the staffing. Overview of EPR progress to the next Committee including the timescales for roll out.

Strategic Operations Committee Chairs Report

Miya Business Case	S Martin	The Miya Business Case was noted for information only. This has already been signed off by CRIG	The Committee agreed that it should see strategically significant business cases before they go to CRIG when feasible.
Month 6 – Operational IPM and Performance & Transformation Board Chairs Report combined	R Wheatcroft	The Committee received the high level metrics and operational performance across the Trust from the Chief Operating Officer noting the key points from Month 6 including: • **Urgent Care**: The Trust is currently operating under extreme pressure adjacent to OPEL 4. Actions have been put in place to review again however if we are unable to de-escalate further mitigations will have to be taken. Stockport are in a similar position to Bolton and even though the Urgent Treatment Centre is up and running unfortunately this hasn't reduced numbers. RW confirmed the biggest focus to mitigate pressure is reducing Length of Stay to deal in the context of consistent levels of NCTR. • **Cancer** Bolton is currently the best in the country and have been provided great feedback from NHSE during a recent visit and review of our performance against the Faster Diagnosis Standards. There was a discussion regarding the Maternity targets indicated in the Executive Summary does not reflect the reality in terms of assurance as this is not giving an accurate view of where we actually are. MN explained the outcomes are good for Maternity but they don't represent what is actually happening and the challenges despite the good outcomes evidenced. It was noted that the Director of Midwifery is reviewing Board Assurance in relation to maternity services. The Chief Operating Officer confirmed the details from the Integrated Performance Report relating to Maternity Services are reviewed at Quality Assurance Committee. The Chair of the Committee expressed concern regarding a possible ambulance strike and if this has been factored into any of the scenarios. RW confirmed Core Emergency Services will be provided to support the Trust.	Request for IPM Exec Summary to be reviewed by Exec for accuracy, which will include the areas reported to SOC

Strategic Operations Committee Chairs Report

No Criteria to Reside	R Wheatcroft	The Committee received and noted the key highlights from the No Criteria to Reside update provided by the Chief Operating Officer including:
		
		• The national expectation is 50% people will be discharged with no support (pathway 0). Our Pathway 0 performance currently stands at 55%.
		• Consistently have around the 100-120 patients with no criteria to reside. The delayed days are a key measure and there has been a minor improvement.
		• There is continuous improvement within the following:
		  ○ Neighbourhood Integration Model focusing on ageing well principles, risk stratification and anticipatory care.
		  ○ AQuA Flow Programme to improve discharge.
		  ○ 2 hour crisis response expansion, delivered via Admission Avoidance Team.
		  ○ Discharge to Assess at home pathway expansion including bridging provision.
		  ○ Additional care home discharge 2 Assess beds including dementia high needs care.
		  ○ Domiciliary care provider market stability and incentivisation schemes.
		  ○ Major change to delivery model for Pathway 2 to include complex physical health, mental health and care needs.
		  ○ Radical home care model changes for enhanced admission avoidance.
		  ○ Large scale shift in secondary care provision to integrate with community.
			The Committee noted the report, and that Bolton is performing either better or roughly at nationally required levels in terms of the 'mix' of NCTR patient numbers in pathways 0-4.
			
			The Committee considered the plans underway and highlighted that many initiatives will have an incremental impact ,when we need to identify and agree the 'big' transformation approaches to explore and pursue. As such, It was agreed that further exploration would be undertaken with regards to the Trust considering more 'radical solutions, such as the potential of becoming a home care/intermediate tier provider

Clinical Strategy Chairs Report	F Andrews	The Medical Director provided a quick summary update to the Committee. To date, there have been 2 Clinical Strategy Board meetings. The Team have developed a number of clinics for clinical strategy workshopping around specialities going forward and have engaged with the System Partners. Archus have been visiting all the Directorates to discover what people wish to see going forward and this work is ongoing.	A Clinical Strategy progress update will be provided for the next Strategy Operation Committee meeting with FA having clinical strategy defined for December's meeting The Committee noted the Board is in its early stages and hence a possible risk that December may be an ambitious delivery date for the clinical strategy.

Items to escalate to the Board:

- Risk of increasing the planned 3 week reduction on elective recovery during Winter due to operational pressures given the current status in October
- Risk that collaboration on 90 day priorities and corporate strategy will be impacted by operational pressures
- Recognition that IPM reporting reflects outcomes, which may exclude significant strategic issues which may impact outcomes in the future
- Note that IPM Exec summary doesn't triangulate well with the body of the IPM report to enable simplified assurance
- NCTR requires further focus by SOC on 'big' transformation opportunities to increase the probability of enabling significant change
- Clinical strategy finalisation may also be impacted by Winter pressures

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	24/11/2022		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:	Liza Scanlon (BI)	**Presented by:**	James Mawrey

Bolton NHS Foundation Trust

Integrated Performance Report

October 2022

Guide to Statistical Process Control

NHS Bolton NHS Foundation Trust

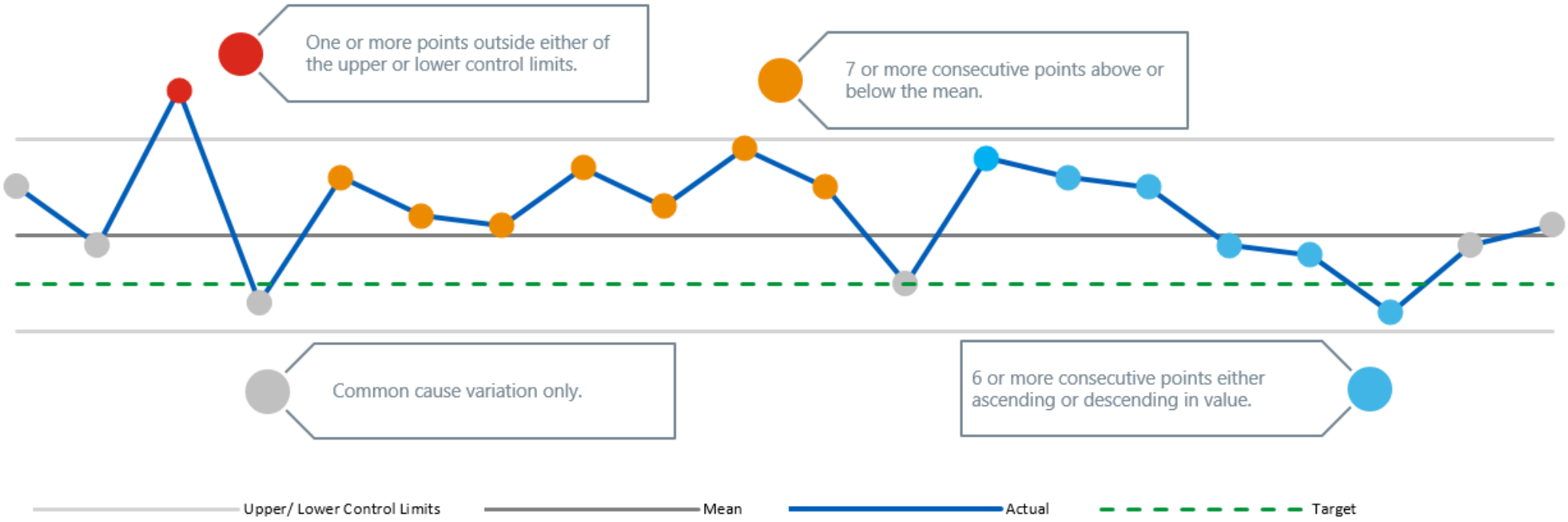
Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail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

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

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

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

Prior to September 2022 the report highlighted runs of 6 or more points above or below the mean. This was changed to 7 points to match the methodology used in Model Hospital



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	15	0	1	1	0	1	2	14
Infection Prevention and Control	8	0	0	2	0	0	0	7
Mortality	3	1	0	0	0	0	0	3
Patient Experience	10	0	0	0	6	2	0	14
Maternity	9	0	0	0	0	1	0	8
Operational Performance								
Access	3	0	0	5	3	0	7	4
Productivity	7	0	1	5	1	2	4	7
Cancer	7	0	0	0	0	0	1	6
Community	0	0	0	1	1	0	0	2
Workforce								
Sickness, Vacancy and Turnover	2	0	0	2	0	0	2	1
Organisational Development	1	0	0	0	3	1	2	1
Agency	0	0	0	3	0	3	0	0
Finance								
Finance	1	1	0	0	1	0	0	3
Appendices								
Heat Maps								

Variation

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

Assurance

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

Quality and Safety

Harm Free Care

Hospital
Special cause variation is noted throughout October with 27 PU reported in total. 20 x category 2, 1 x category 3 and 6 x unstageable. Tissue viability continue to deliver education and training programme to improve recognition of patients at risk and their management. Purpose T training has now been delivered Trust wide with a go live date of 21st November 2022. Quality Improvement pressure ulcer Collaborative commenced October 2022 and locality wide Harm Free Care conference is on the 21st November. These events are to increase awareness, provide education and embed learning.

Community
Common cause variation is noted throughout October with 26 reported in total. 16 x category 2, 1 x category 3 and 9 x unstageable. Key actions: The new risk assessment tool, Purpose T has been embedded in community and has now been extended to intermediate care and the admissions avoidance team. Tissue viability continue to deliver education and training to improve recognition of patients at risk. Community are also participating in the Quality Improvement pressure ulcer collaborative and the locality wide Harm Free Care conference.

Falls
Our YTD performance is currently at 4.27 falls per 1000 bed days. This means we continue to remain under our local target which is 5.3 falls per 1000 bed days. Falls with harm have increased to 4 in October but continue to be within common cause variation. However, all falls with harm are cause for concern. A thematic review of falls with harm has been undertaken and 10 common themes identified for action.
Falls prevention QI initiatives utilising falls sensors and visual displays of falls risk (yellow) begin in December and scoping of digital adjuncts to care is underway.
From 5th December 2022 the Falls Lead will implement a practice review (evolved from Multi Angle Review of Practice or MARP (Field & Reid 2002). Although dated, this tried and tested methodology facilitates the collation of all available information about a patient care area to analyse the care that patients receive in relation to falls. It aims is to gather information about an area and make judgements in relation to how this affects the care that patients receive in terms of safety and essential care needs being met to enable effective outcomes regardless of who delivers the care.

Rambleguard training for the Enhanced Care Team and Laburnum Lodge staff takes place w/c 14th November and falls sensors within Laburnum Lodge are being fitted the following week. Rambelguards will then be introduced as prescribed care for patients identified by the Enhanced Care Team.

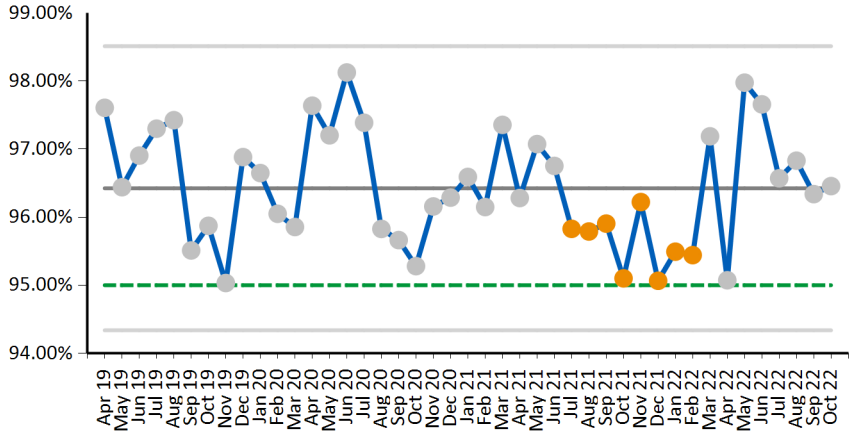
Patient Safety Alerts
In October 2022, Patient Safety Alerts compliance was at 87% against a target of 100%. This is within control limits and does not indicate any special cause variation. There is one alert currently outstanding. The Patient Safety alert policy is currently under review. Oversight of the alerts process is also being reviewed to ensure this is robust.

Report to patient/family within 60 working days of incident declaration
In October 2022, five SI investigation reports were due to be with Patients/families. None of these reports were provided within the 60 day timeframe. Four of the reports have subsequently been completed and signed off. There is no special cause variation noted however control limits ranged between 0 -100% and as such does not provide assurance in this respect.
Past performance has been variable. Process and practices have been strengthened to support improvement in this area. This will continue to be monitored to identify other opportunities to improve performance.

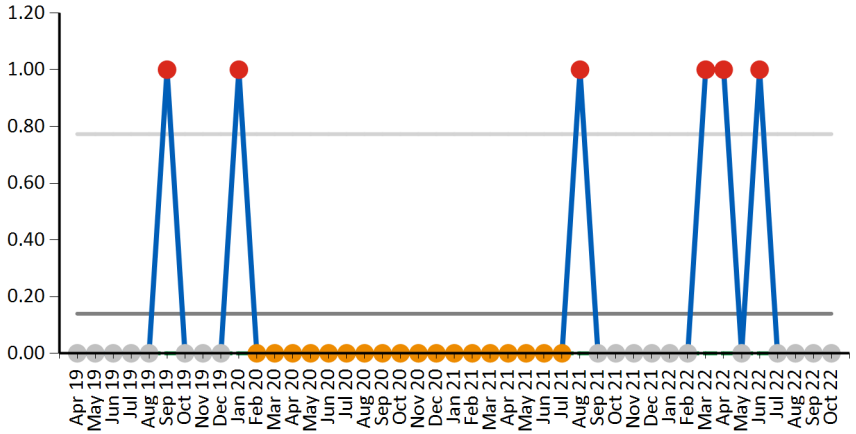
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.5%	Oct-22		>= 95%	96.3%	Sep-22	>= 95%	96.7%	
9 - Never Events	= 0	0	Oct-22		= 0	0	Sep-22	= 0	2	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.27	Oct-22		<= 5.30	4.76	Sep-22	<= 5.30	4.77	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	4	Oct-22		<= 1.6	2	Sep-22	<= 11.2	15	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	20.0	Oct-22	H	<= 6.0	14.0	Sep-22	<= 42.0	79.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	1.0	Oct-22		<= 0.5	1.0	Sep-22	<= 3.5	5.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Oct-22		= 0.0	1.0	Sep-22	= 0.0	1.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		6	Oct-22			2	Sep-22		31	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	15.0	Oct-22		<= 7.0	16.0	Sep-22	<= 49.0	93.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	1.0	Oct-22	L	<= 4.0	0.0	Sep-22	<= 28.0	3.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Oct-22		<= 1.0	0.0	Sep-22	<= 7.0	2.0	
516 - Community patients acquiring pressure damage (unstagable)		9	Oct-22			3	Sep-22		34	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	76.4%	Q2 2022/23		>= 90%	89.5%	Q1 2022/23	>= 90%	83.0%	
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%		Q2 2022/23		>= 90%	100.0%	Q1 2022/23	>= 90%	100.0%	
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	22.0%	Q2 2022/23		>= 90%	38.0%	Q1 2022/23	>= 90%	30.0%	
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q2 2022/23		>= 90%	100.0%	Q1 2022/23	>= 90%	100.0%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	70.6%	Oct-22		>= 95%	74.5%	Sep-22	>= 95%	76.3%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	59.7%	Oct-22		>= 95.0%	58.9%	Sep-22	>= 95.0%	63.5%	F
86 - Patient Safety Alerts	= 100%	85.7%	Oct-22		= 100%	72.7%	Sep-22	= 100%	71.5%	?
88 - Nursing KPI Audits	>= 85%	93.8%	Oct-22		>= 85%	93.0%	Sep-22	>= 85%	93.0%	P
91 - Report to patient/family within 60 working days of incident declaration	= 100%	0.0%	Oct-22		= 100%	50.0%	Sep-22	= 100%	25.0%	?

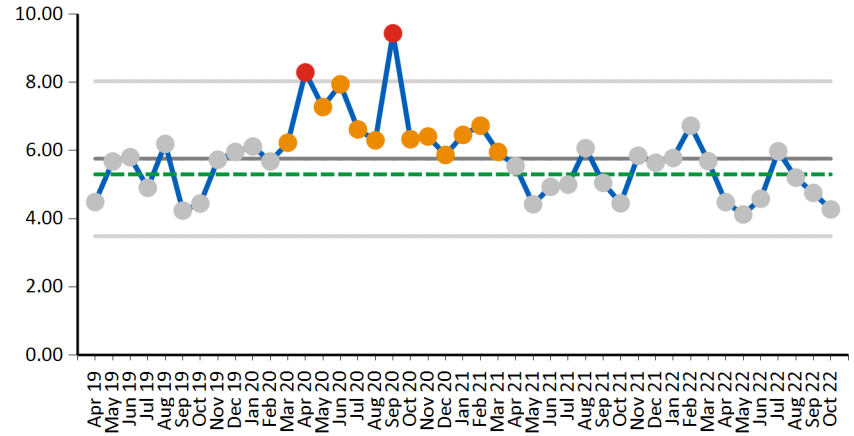
6 - Compliance with preventative measure for VTE



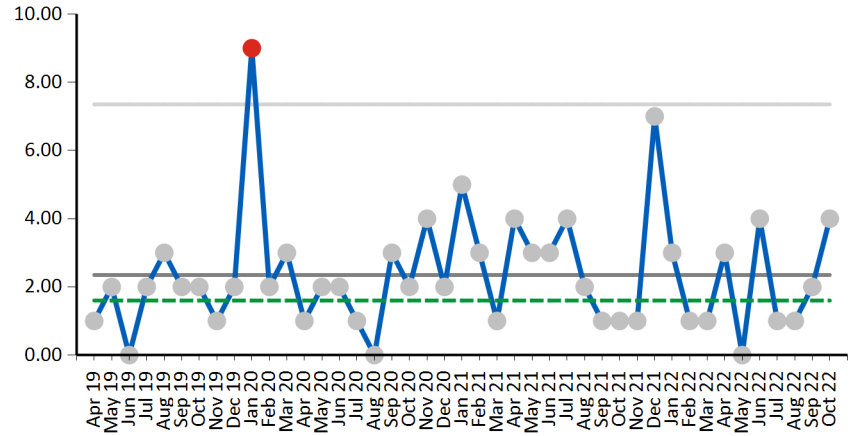
9 - Never Events



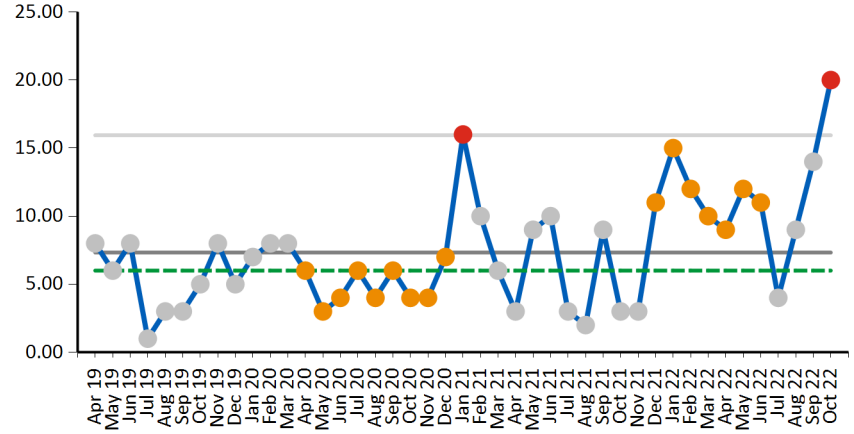
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



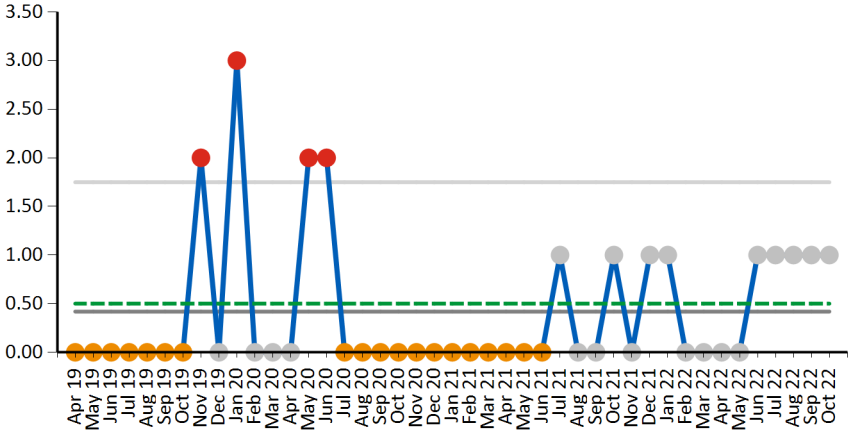
14 - Inpatient falls resulting in Harm (Moderate +)



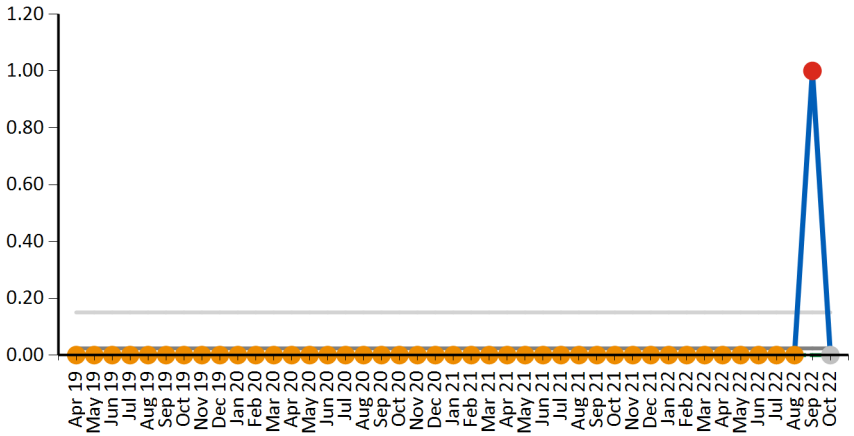
15 - Acute Inpatients acquiring pressure damage (category 2)



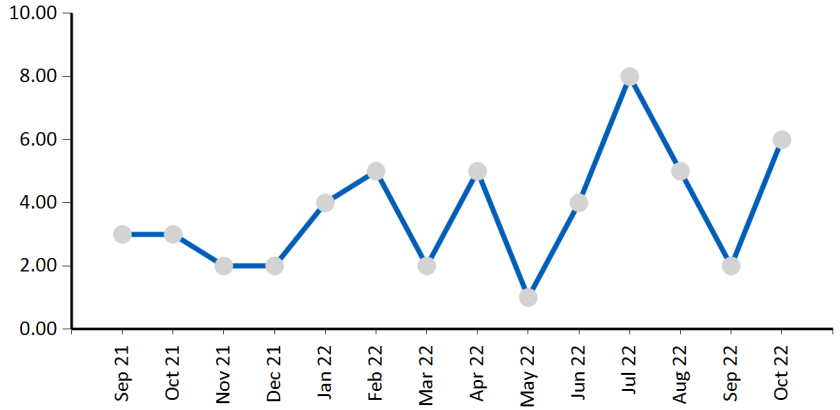
16 - Acute Inpatients acquiring pressure damage (category 3)



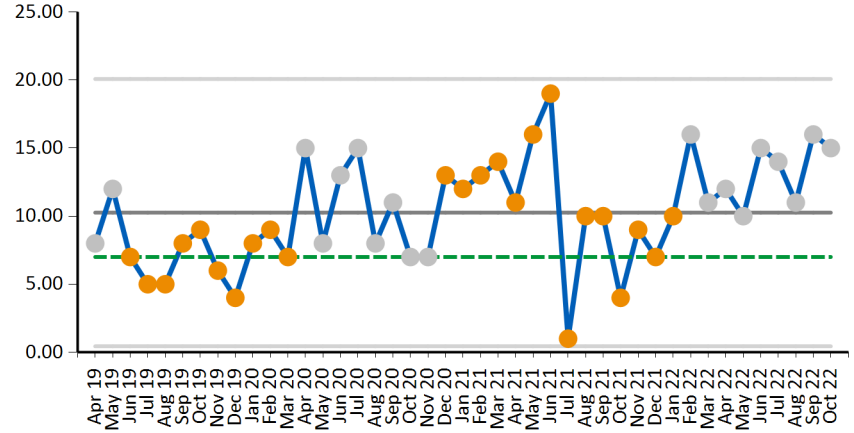
17 - Acute Inpatients acquiring pressure damage (category 4)



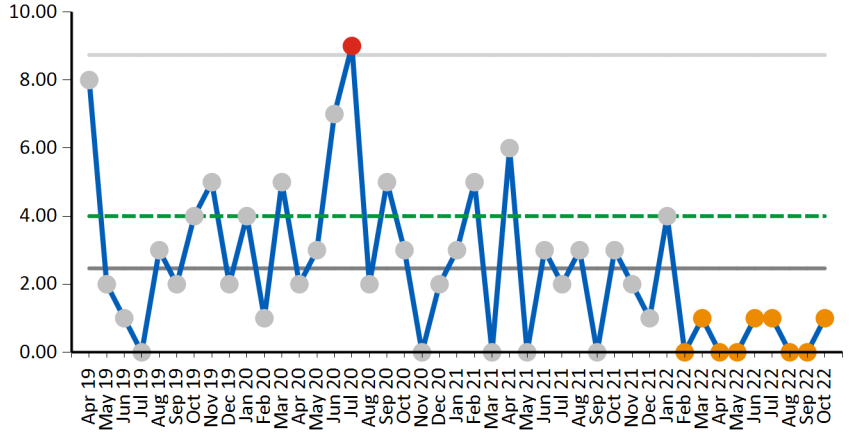
515 - Acute Inpatients acquiring pressure damage (unstagable) - SPC data available after 20 data points



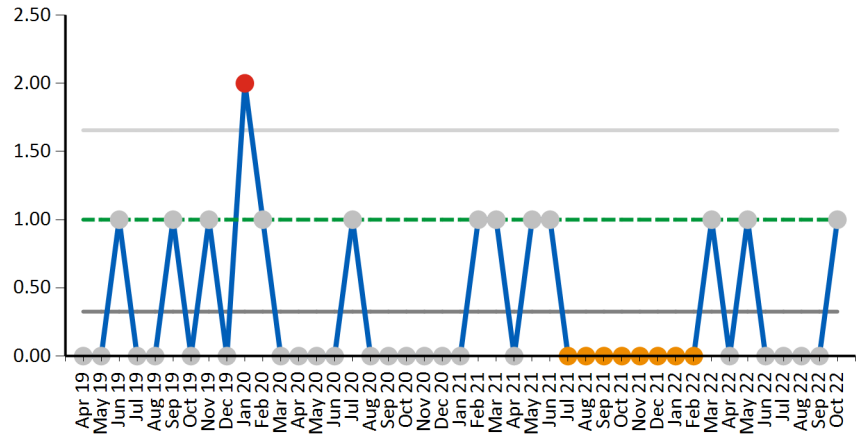
18 - Community patients acquiring pressure damage (category 2)



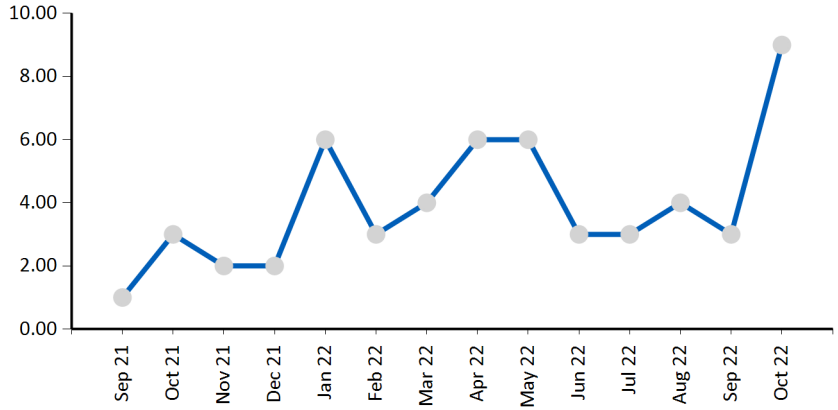
19 - Community patients acquiring pressure damage (category 3)



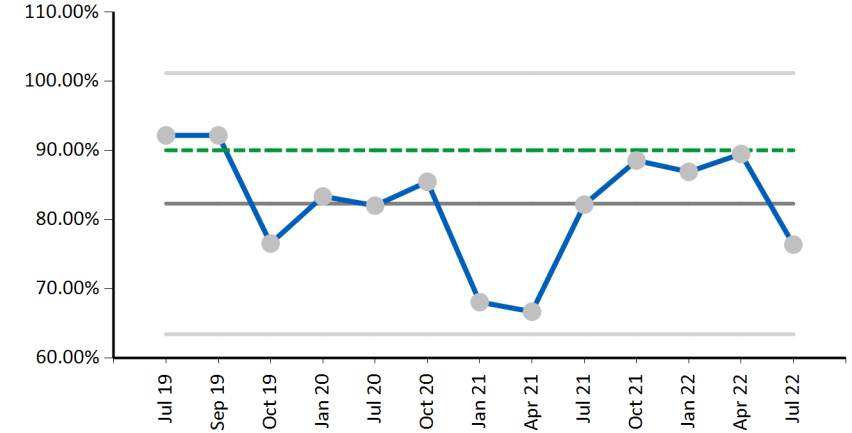
20 - Community patients acquiring pressure damage (category 4)



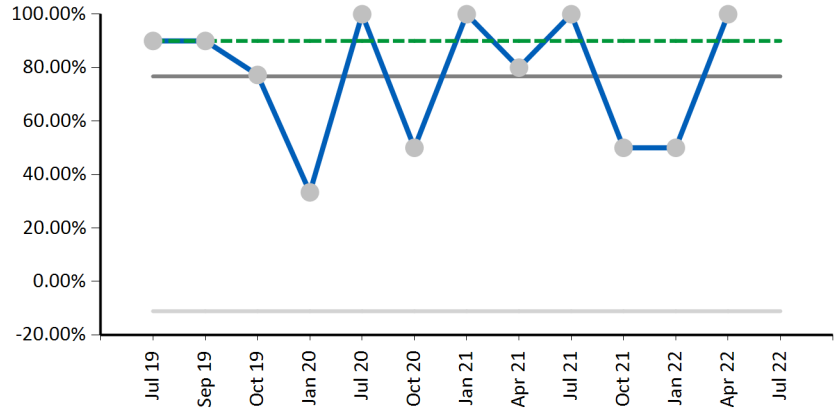
516 - Community patients acquiring pressure damage (unstagable) - SPC data available after 20 data points



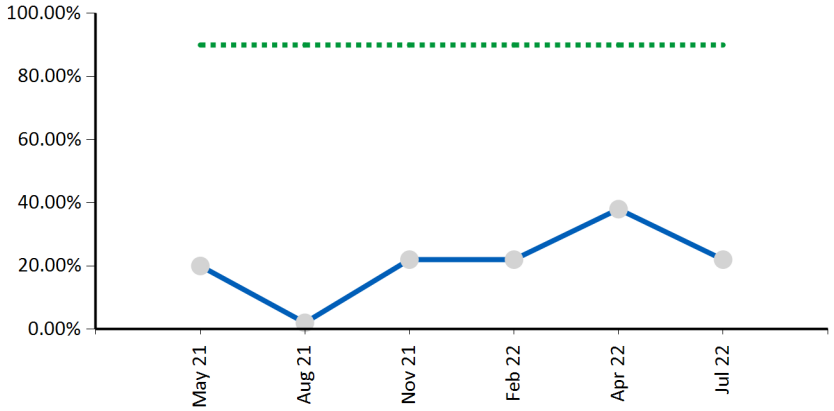
28 - Emergency patients - screened for Sepsis (quarterly)



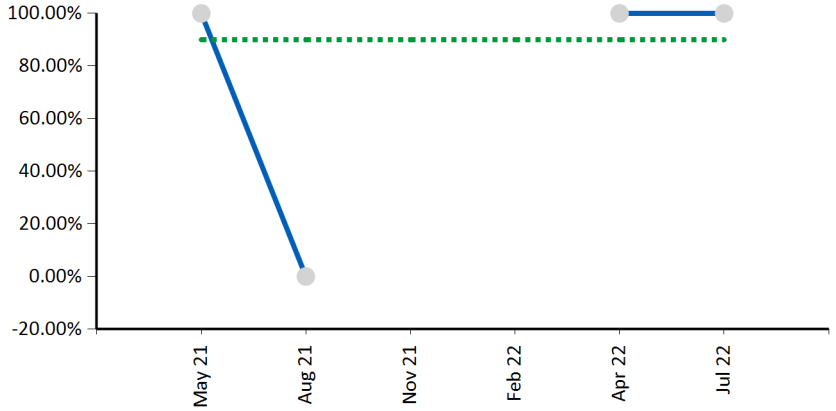
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)



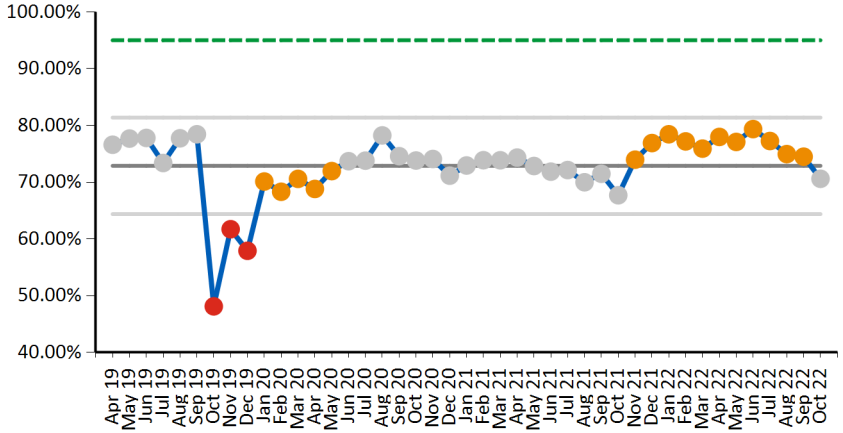
513 - Inpatients - screened for Sepsis (quarterly) - SPC data available after 20 data points



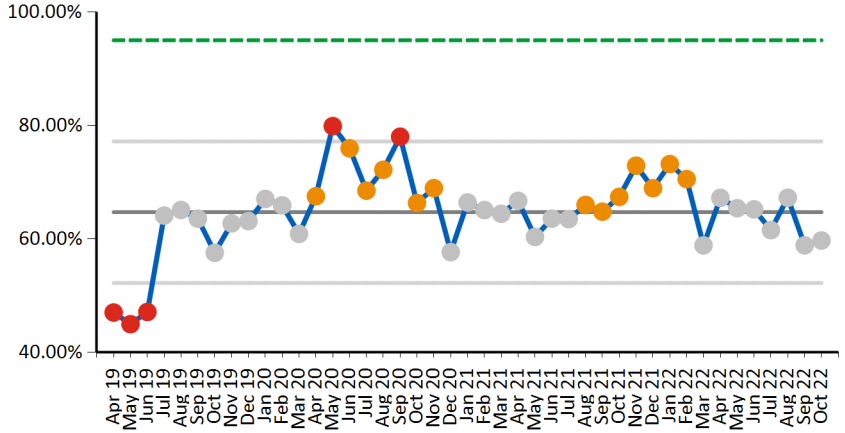
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



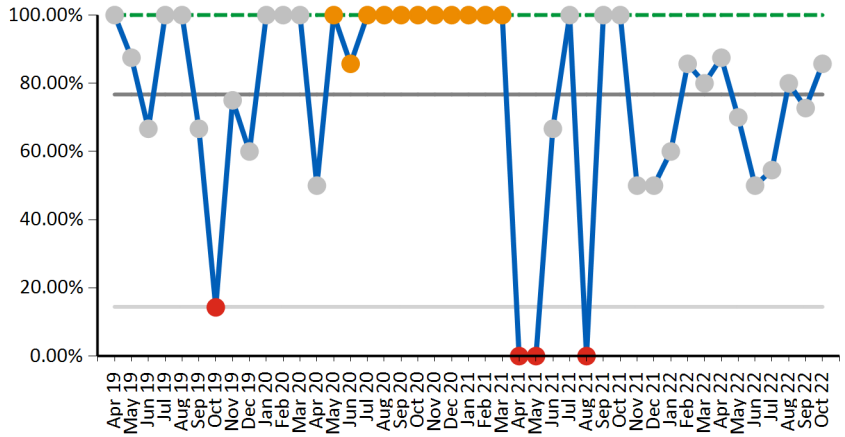
30 - Clinical Correspondence - Inpatients %<1 working day



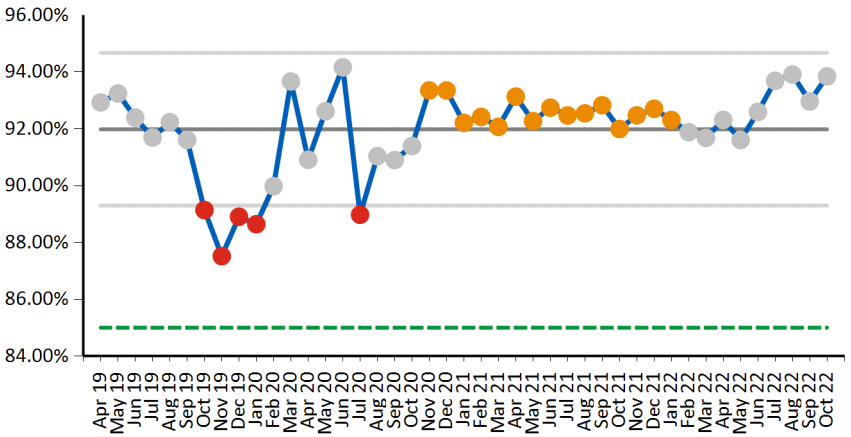
31 - Clinical Correspondence - Outpatients %<5 working days



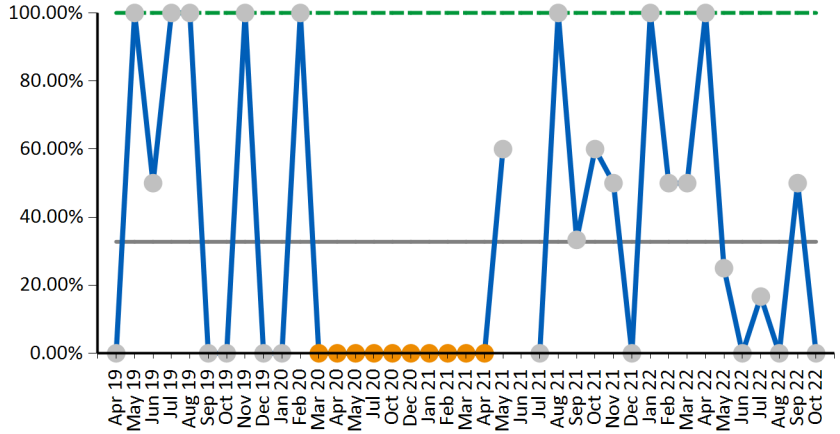
86 - Patient Safety Alerts



88 - Nursing KPI Audits



91 - Report to patient/family within 60 working days of incident declaration



Infection Prevention and Control

Clostridium difficile cases in October remain over objective but numbers have reduced month-on-month for the past four months. Thematic learning is now being acted upon in the relevant divisions and corresponding actions being taken beyond the immediate affected areas. The review process has been reviewed and will change to speed up the process and identify actions earlier and improve assurance. There are daily meetings reviewing single room use to optimise single room use.

The remaining reportable HCAI remain unchanged statistically.

COVID-19 cases rose again in October including nosocomial cases; the IPC team have refreshed staff awareness of risk reduction. Influenza cases have started to rise with 90 flu cases detected by the Bolton lab in October – 75 flu A cases and 15 flu B cases.

IPC statutory training compliance has increased month-on-month

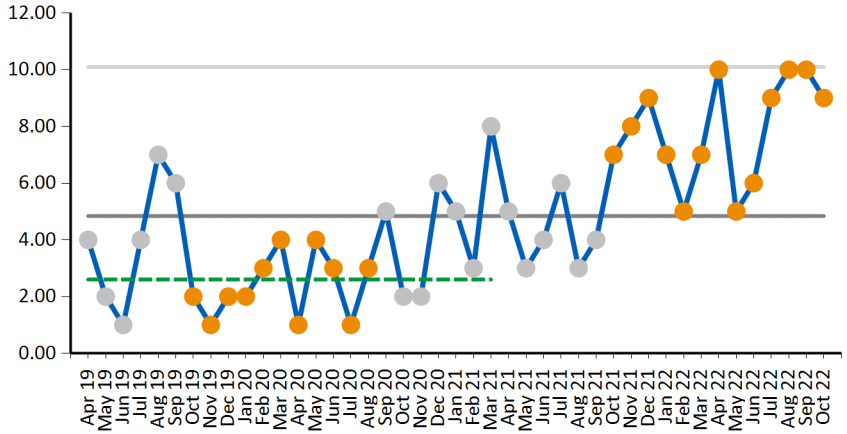
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

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.

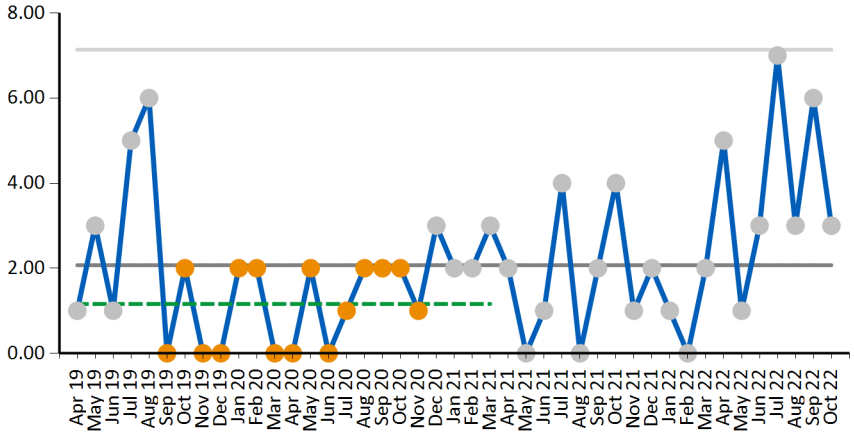
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		9	Oct-22			10	Sep-22		59	
346 - Total Community Onset Hospital Associated C.diff infections		3	Oct-22			6	Sep-22		28	
347 - Total C.diff infections contributing to objective	<= 3	9	Oct-22		<= 3	10	Sep-22	<= 18	78	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Oct-22		= 0	10	Sep-22	= 0	21	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	7	Oct-22		<= 2	3	Sep-22	<= 13	37	
219 - Blood Culture Contaminants (rate)	<= 3%	3.5%	Oct-22		<= 3%	3.7%	Sep-22	<= 3%	3.3%	
199 - Compliance with antibiotic prescribing standards	>= 95%	73.4%	Q1 2022/23		>= 95%	74.8%	Q2 2021/22	>= 95%	73.4%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Oct-22		<= 1.0	2.0	Sep-22	<= 7.0	19.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	3	Oct-22		<= 1	4	Sep-22	<= 4	15	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	2	Oct-22		= 0	2	Sep-22	= 0	5	
491 - Nosocomial COVID-19 cases		53	Oct-22			37	Sep-22		319	

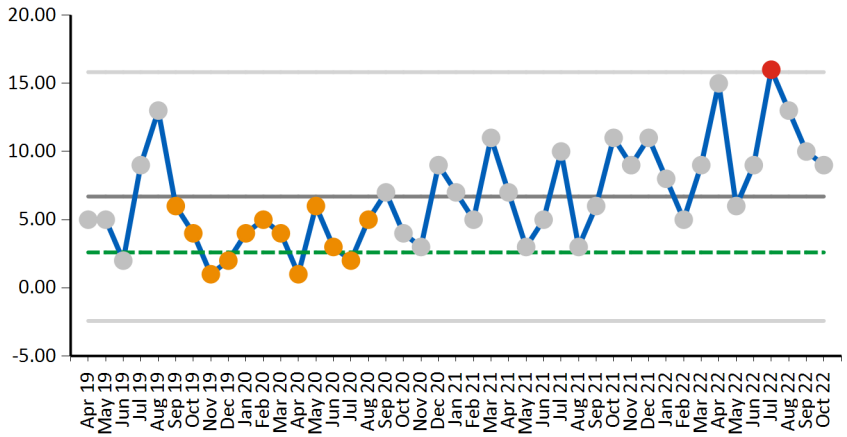
215 - Total Hospital Onset C.diff infections



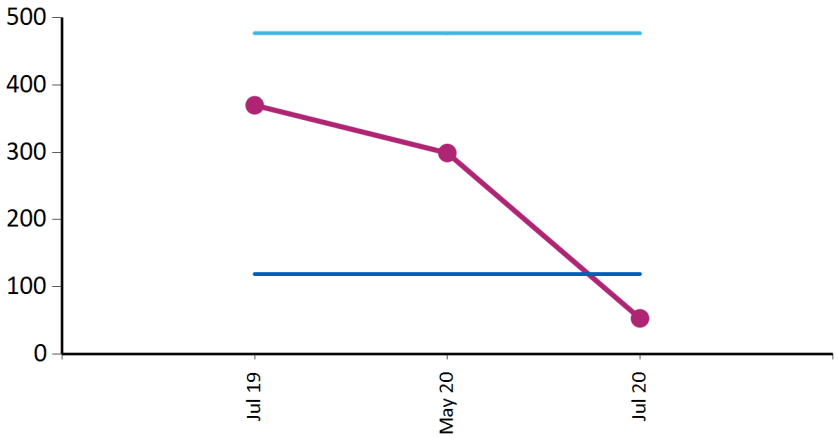
346 - Total Community Onset Hospital Associated C.diff infections



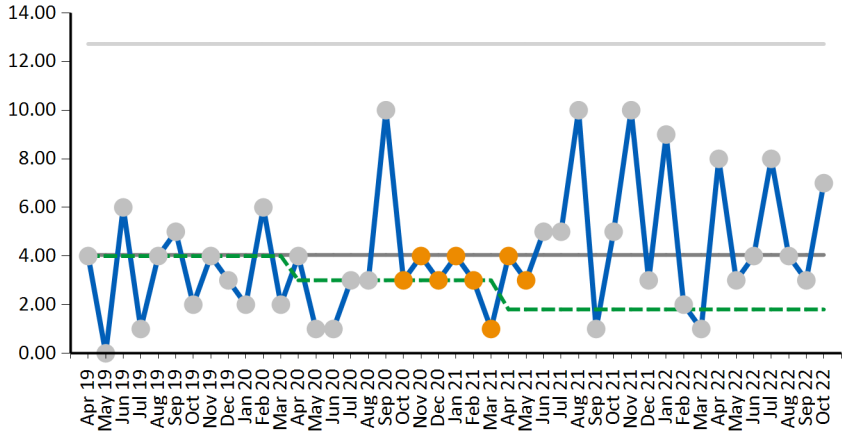
347 - Total C.diff infections contributing to objective



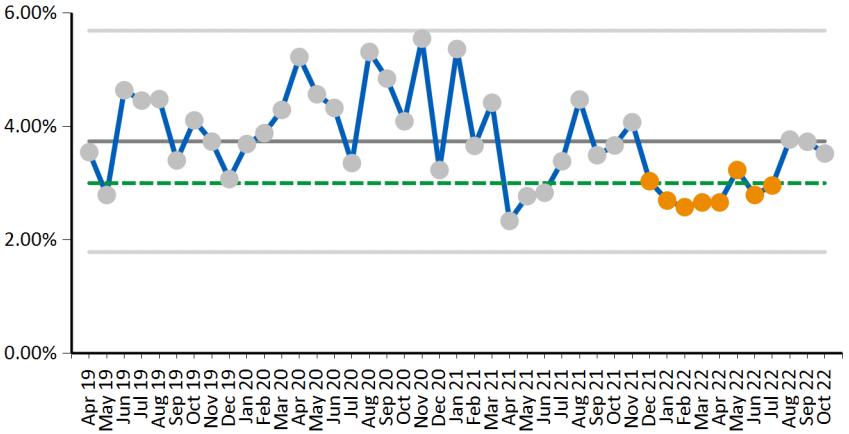
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



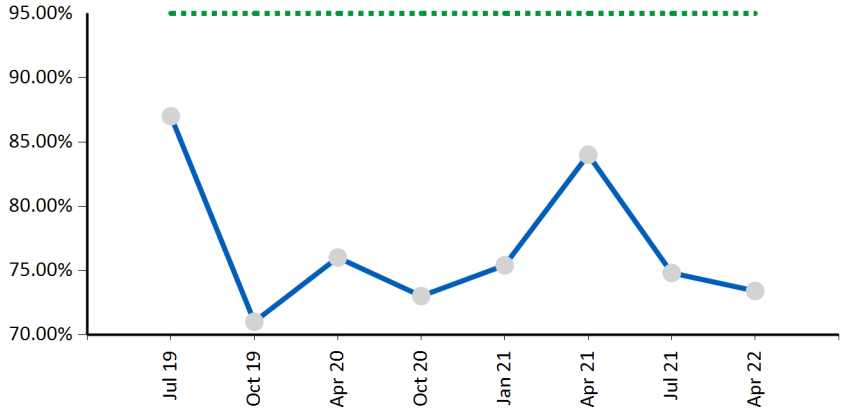
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)



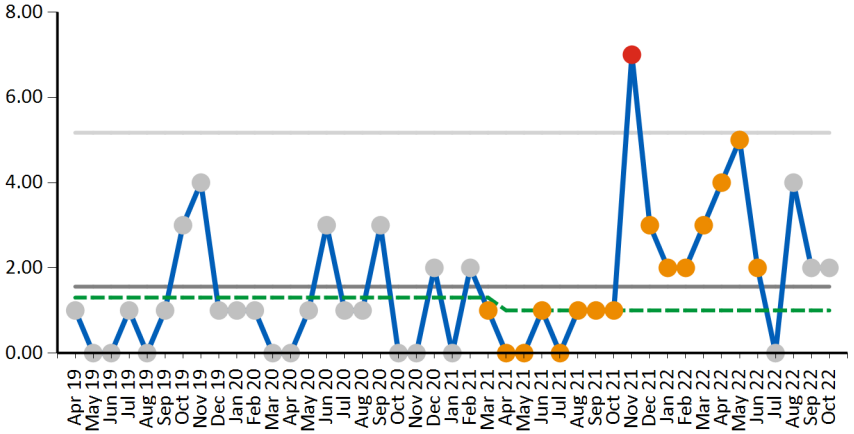
219 - Blood Culture Contaminants (rate)



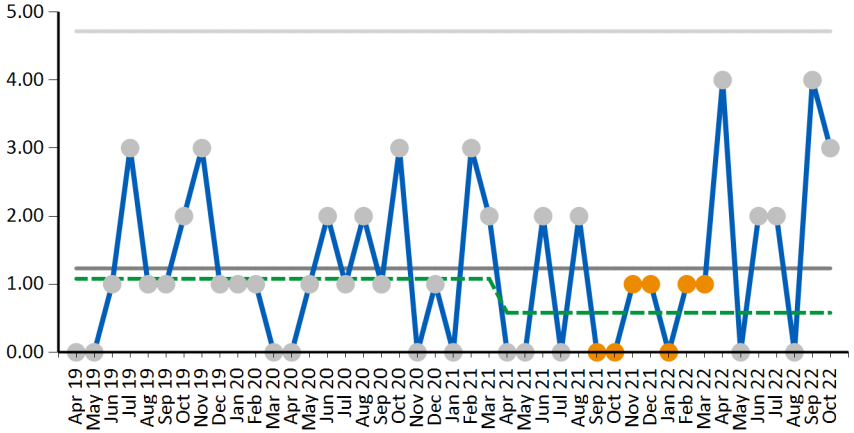
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



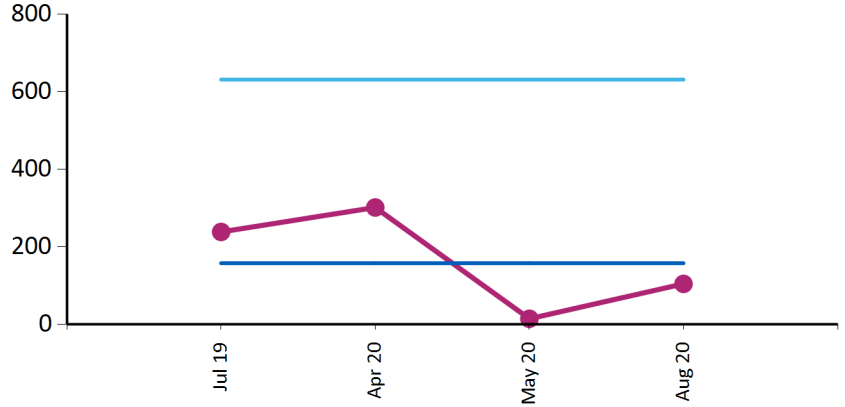
304 - Total Trust apportioned MSSA BSIs



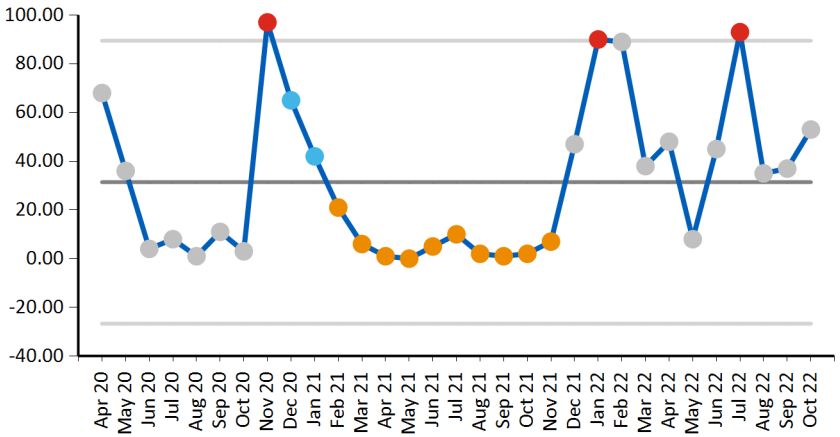
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)



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



491 - Nosocomial COVID-19 cases



Mortality

Crude – in month is below average and target for the time frame.

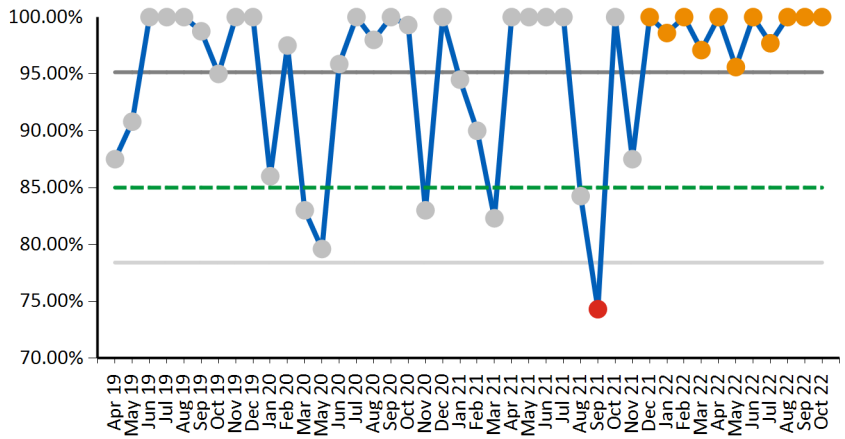
HSMR – in month figure is within control limits but above average for the time frame. The 12 month average to July 2022 is 110.52 showing as an 'Amber' alert.

SHMI – In month figure is above target but in line with the average for the time period. The published rolling average for the period July 2021 to June 2022 is 106.94 'as expected'.

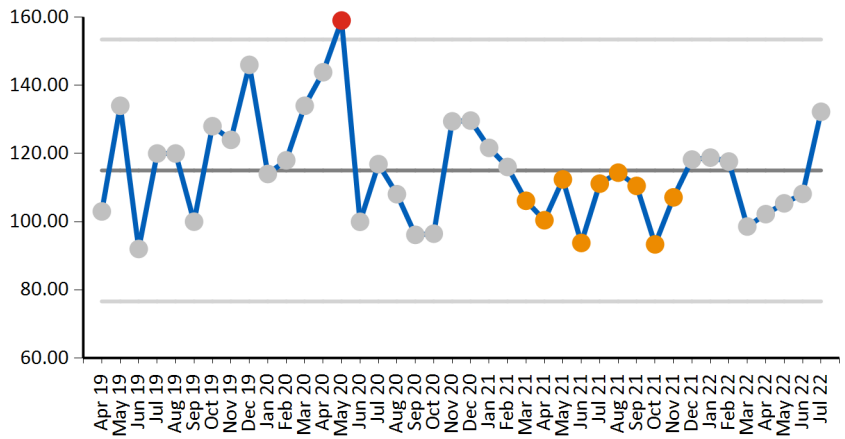
The proportion of coded records at time of the snapshot download is above the target. The proportion of Charlson comorbidities and the Depth of Recording remain similar to previous months

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Oct-22		>= 85%	100.0%	Sep-22	>= 85%	99.0%	
495 - HSMR		132.24	Jul-22			108.16	Jun-22		132.24	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	112.84	May-22		<= 100.00	103.38	Apr-22	<= 100.00	112.84	
12 - Crude Mortality %	<= 2.9%	2.3%	Oct-22		<= 2.9%	2.5%	Sep-22	<= 2.9%	2.3%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Jul-22			4	Jun-22		14	
520 - Depth of recording (First episode of care)		6	Jul-22			6	Jun-22		25	
521 - Proportion of fully coded records (Inpatients)		97.5%	Jul-22			97.4%	Jun-22		97.1%	

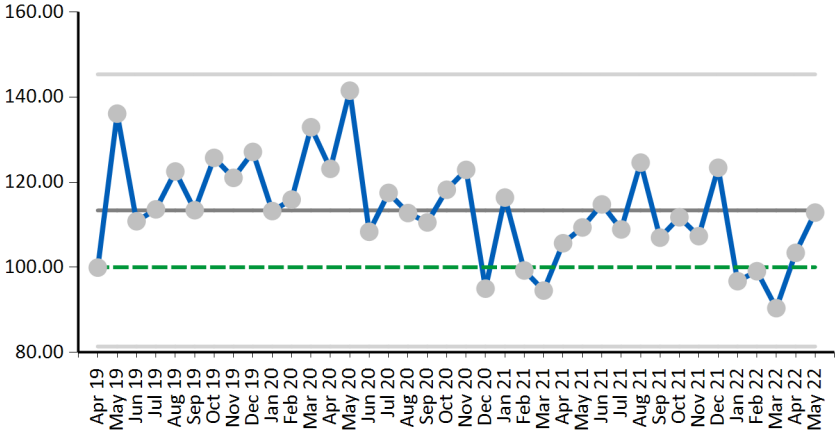
3 - National Early Warning Scores to Gold standard



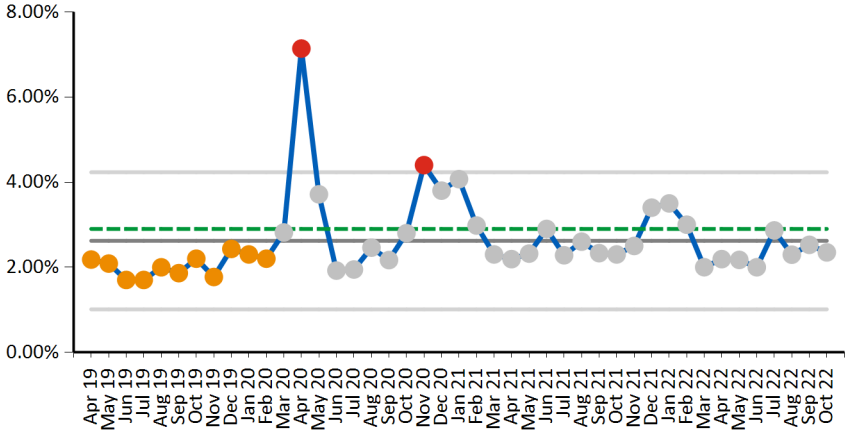
495 - HSMR



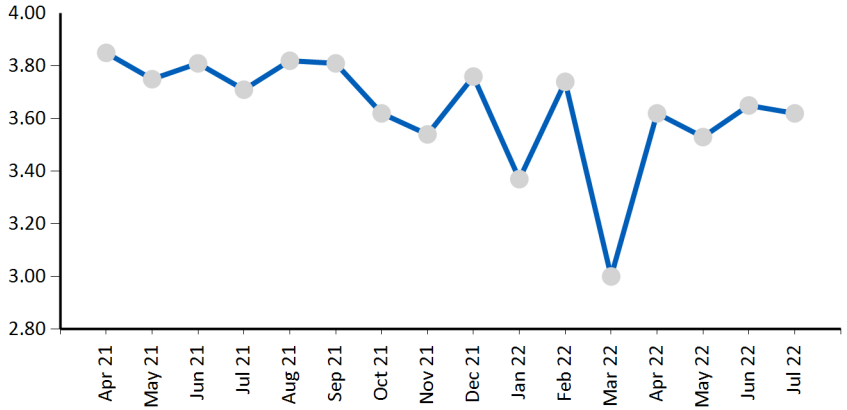
11 - Summary Hospital-level Mortality Indicator (SHMI)



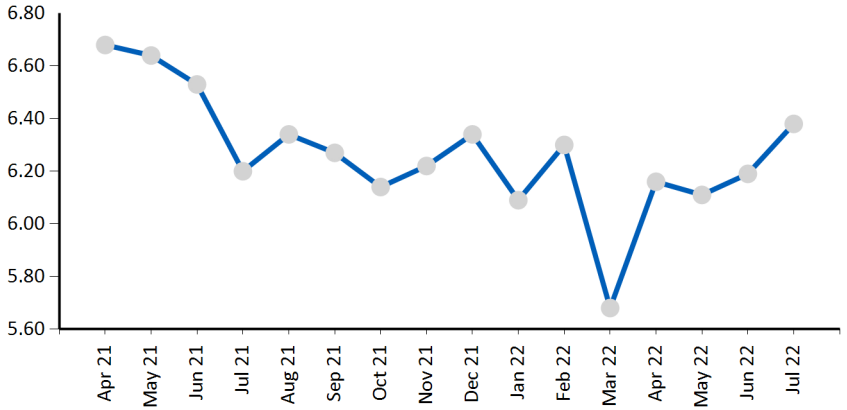
12 - Crude Mortality %



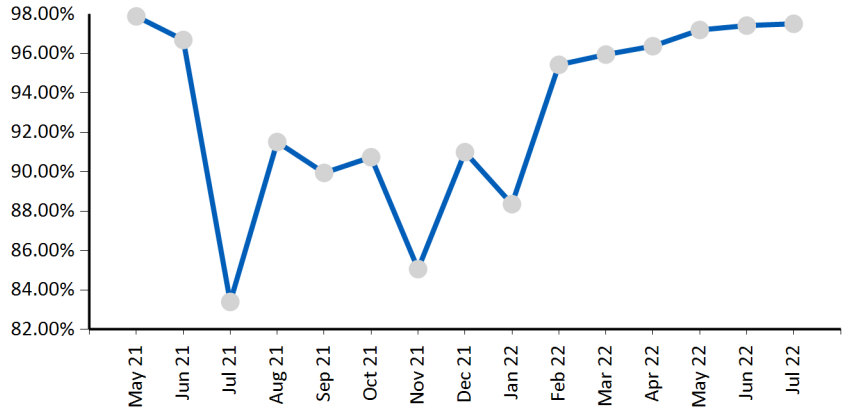
519 - Average Charlson comorbidity Score (First episode of care) - SPC data available after 20 data points



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
Complaints response rates continue to indicate a special cause variation concern with 17% of complaints responded to within timescales against a target of 95%. October 2022 response rates have decreased considerably against an improved picture from previous months and are at the lower limit. A review of each case has been undertaken to establish the cause(s) of the breaches.

The Patient Experience and Divisional teams are working collaboratively to improve the quality of responses which is currently impacting on the timeframes for responses. This includes face to face support for individual cases and the development of improved guidance/standard paragraphs to support the response writing.

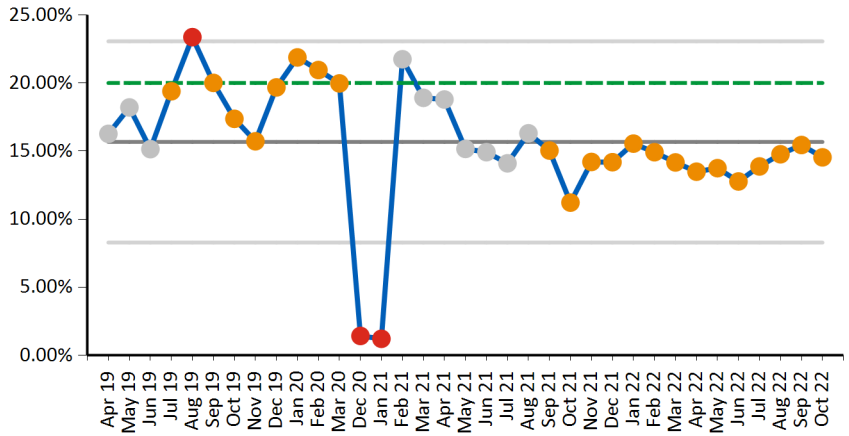
FFT
Response rates for ED, hospital postnatal, and community postnatal are indicating a special cause variation concern however all are within process limits. Satisfaction rates in ED and Antenatal are highlighting a special cause variation with concern.

The Patient Experience Team continue to work with those areas to encourage staff to seek feedback and identify alternative means for patients to provide feedback. Where recommendation rates fell below 90%, Divisional leads are working on the narrative provided within the feedback to identify learning outcomes. The Patient Experience team are currently working with ward managers, departmental managers, matrons and divisional nurse directors to ensure access to the database to enable self-serve to take place with training packages both virtually and in person being offered.

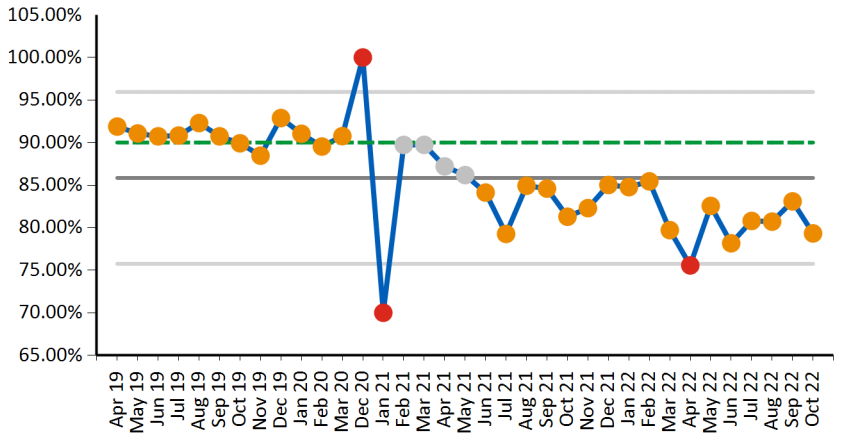
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.5%	Oct-22		>= 20%	15.4%	Sep-22	>= 20%	14.1%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	79.3%	Oct-22		>= 90%	83.1%	Sep-22	>= 90%	80.1%	
80 - Inpatient Friends and Family Response Rate	>= 30%	22.4%	Oct-22		>= 30%	23.9%	Sep-22	>= 30%	23.6%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.0%	Oct-22		>= 90%	96.1%	Sep-22	>= 90%	96.7%	
81 - Maternity Friends and Family Response Rate	>= 15%	16.0%	Oct-22		>= 15%	21.2%	Sep-22	>= 15%	17.9%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	83.2%	Oct-22		>= 90%	83.7%	Sep-22	>= 90%	86.0%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	8.6%	Oct-22		>= 15%	12.2%	Sep-22	>= 15%	9.9%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	81.0%	Oct-22		>= 90%	82.5%	Sep-22	>= 90%	83.9%	
83 - Birth - Friends and Family Response Rate	>= 15%	26.6%	Oct-22		>= 15%	36.4%	Sep-22	>= 15%	31.3%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	84.6%	Oct-22		>= 90%	85.3%	Sep-22	>= 90%	87.8%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	13.5%	Oct-22	L	>= 15%	18.6%	Sep-22	>= 15%	15.9%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	70.6%	Oct-22		>= 90%	78.9%	Sep-22	>= 90%	81.6%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	14.7%	Oct-22	L	>= 15%	14.2%	Sep-22	>= 15%	13.9%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	91.9%	Oct-22		>= 90%	86.0%	Sep-22	>= 90%	88.2%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Oct-22		= 100%	100.0%	Sep-22	= 100%	99.4%	
90 - Complaints responded to within the period	>= 95%	16.7%	Oct-22	L	>= 95%	60.0%	Sep-22	>= 95%	30.9%	

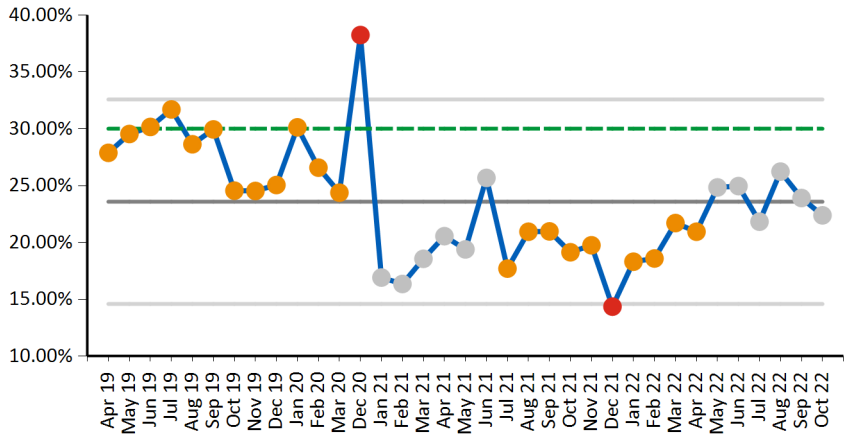
200 - A&E Friends and Family Response Rate



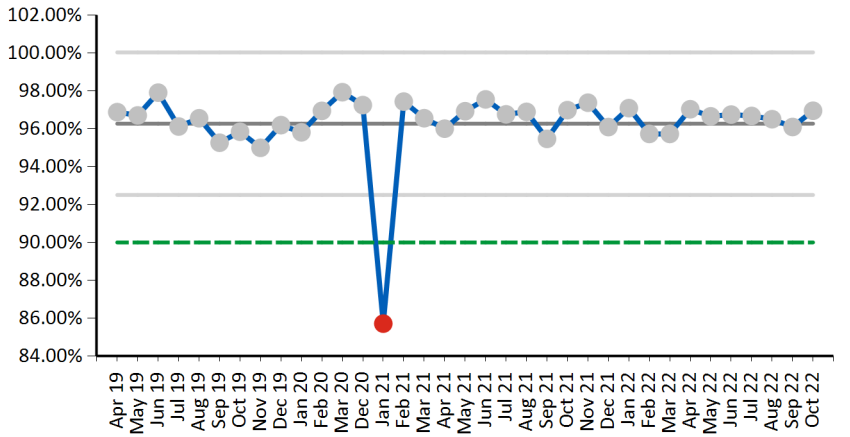
294 - A&E Friends and Family Satisfaction Rates %



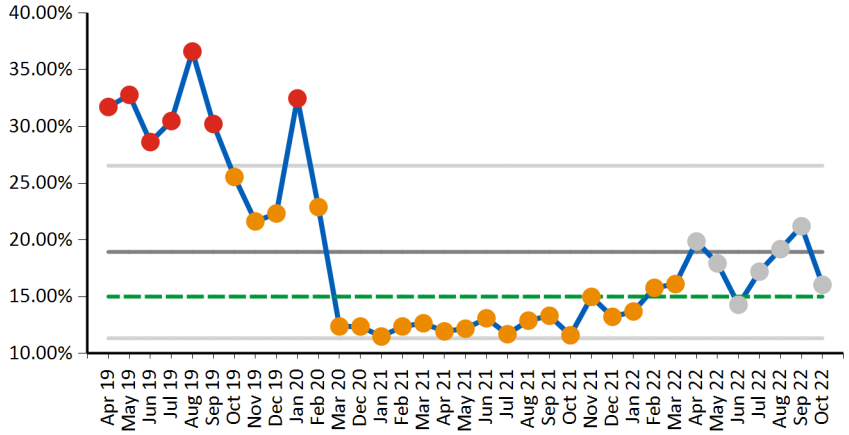
80 - Inpatient Friends and Family Response Rate



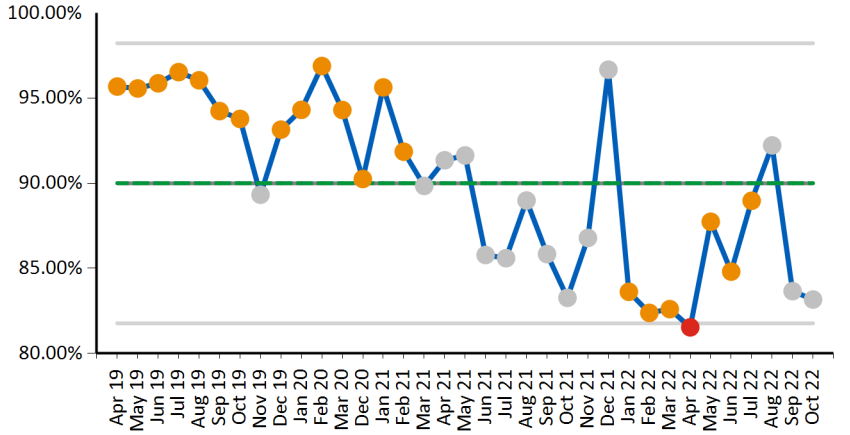
240 - Friends and Family Test (Inpatients) - Satisfaction %



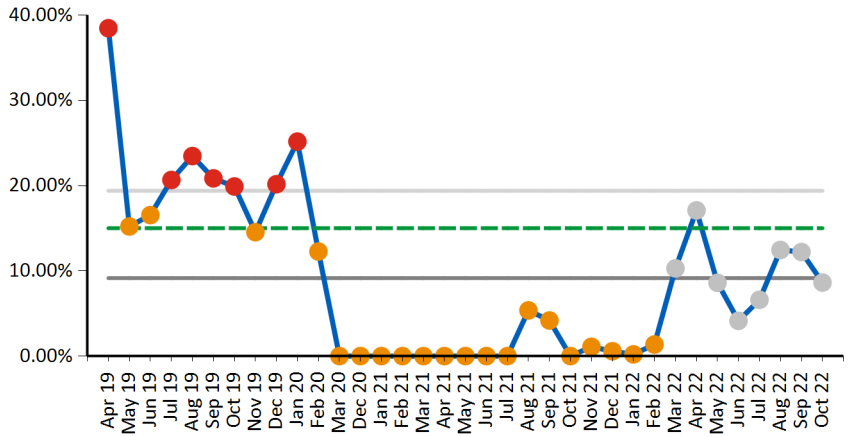
81 - Maternity Friends and Family Response Rate



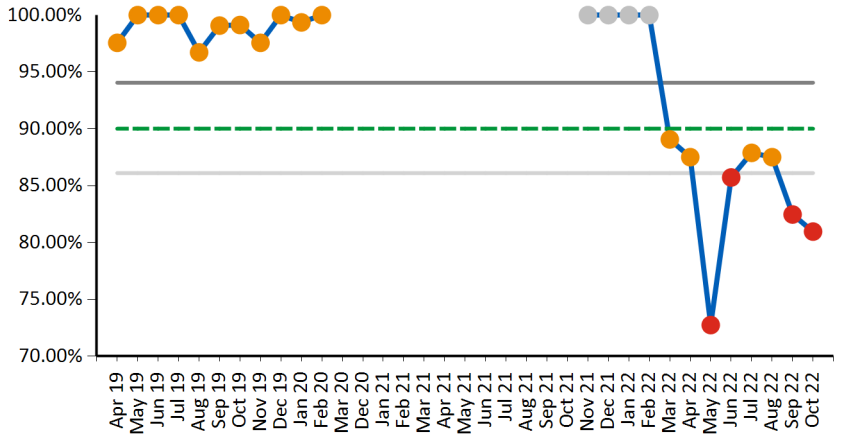
241 - Maternity Friends and Family Test - Satisfaction %



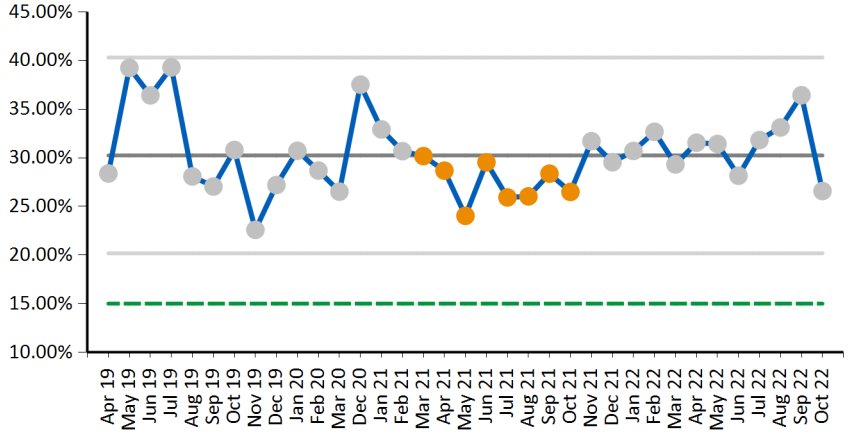
82 - Antenatal - Friends and Family Response Rate



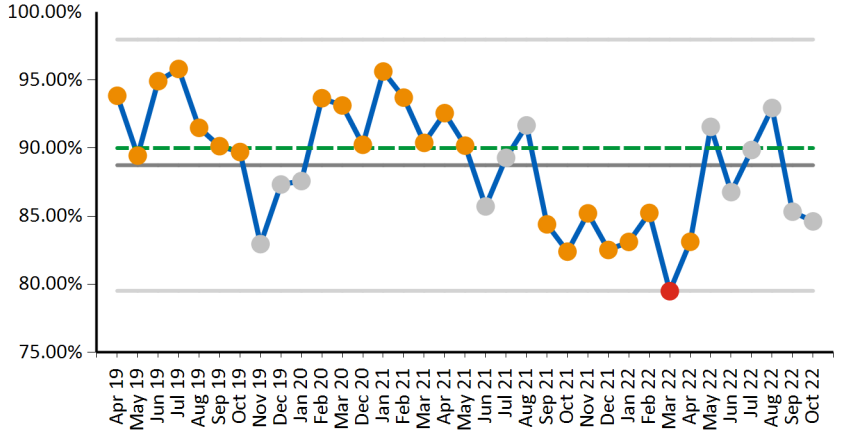
242 - Antenatal Friends and Family Test - Satisfaction %



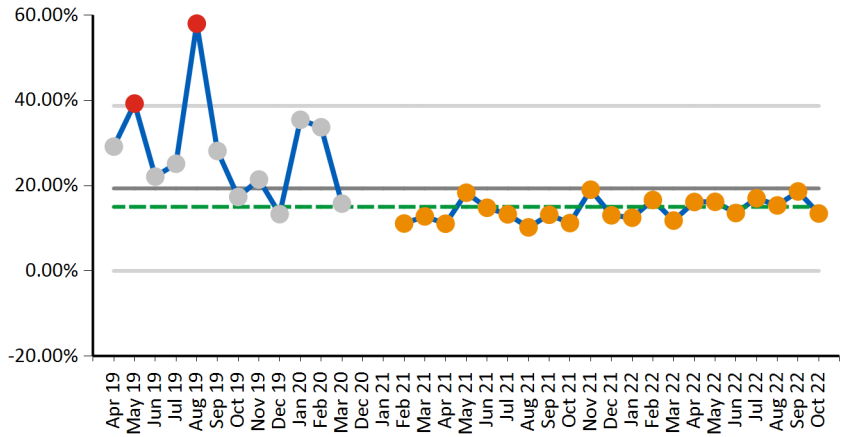
83 - Birth - Friends and Family Response Rate



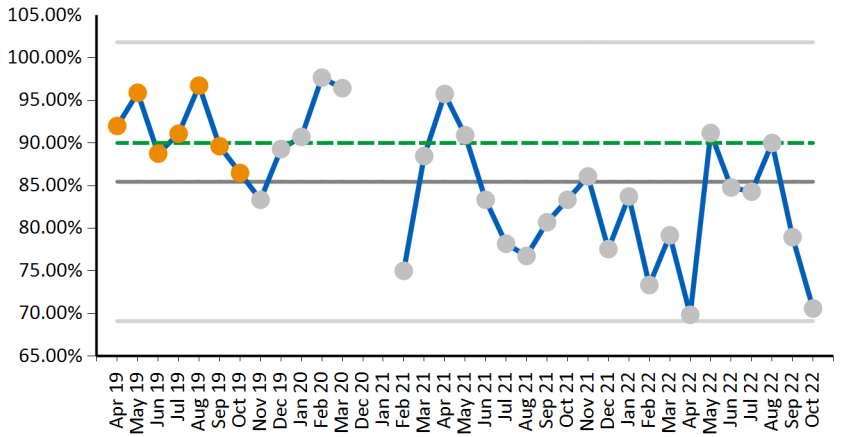
243 - Birth Friends and Family Test - Satisfaction %



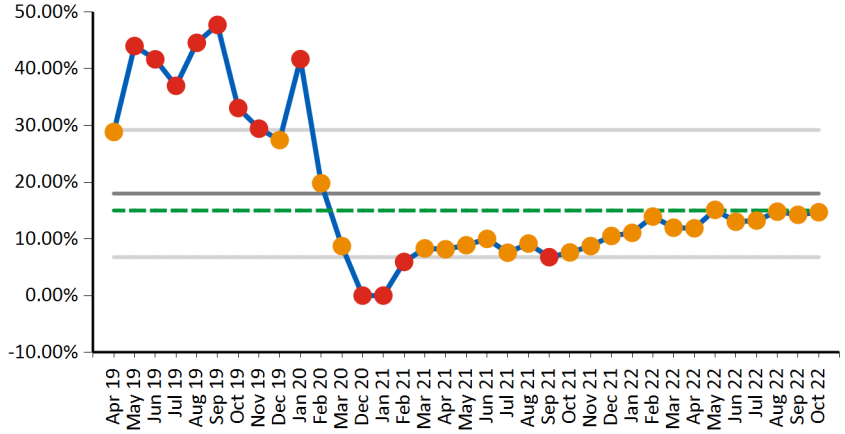
84 - Hospital Postnatal - Friends and Family Response Rate



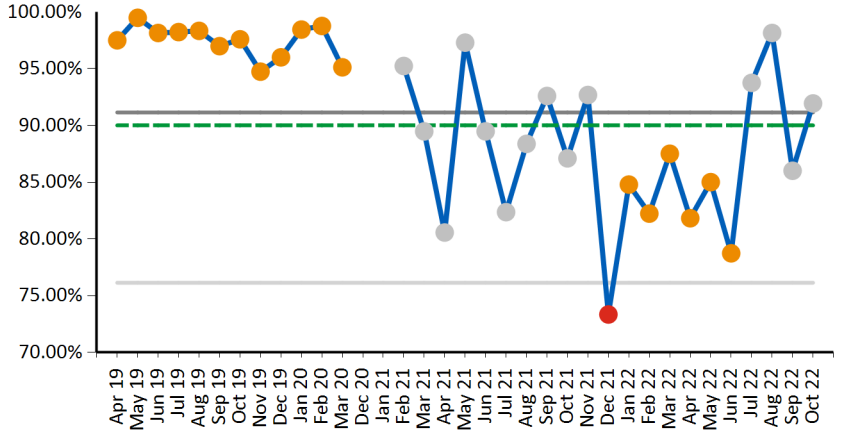
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



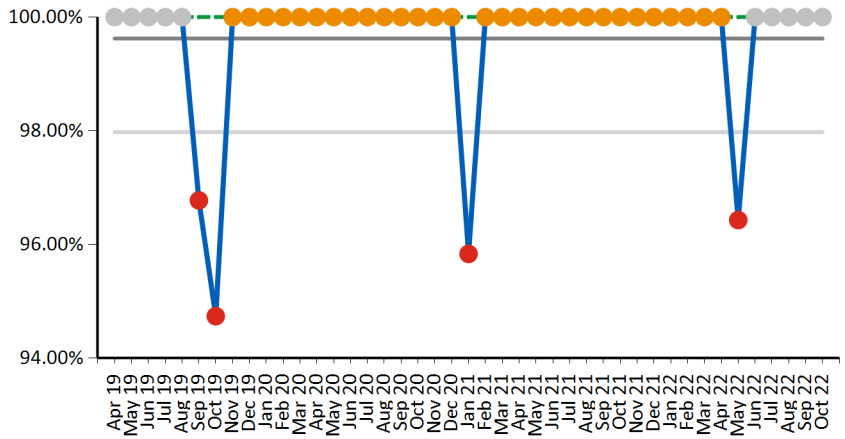
85 - Community Postnatal - Friend and Family Response Rate



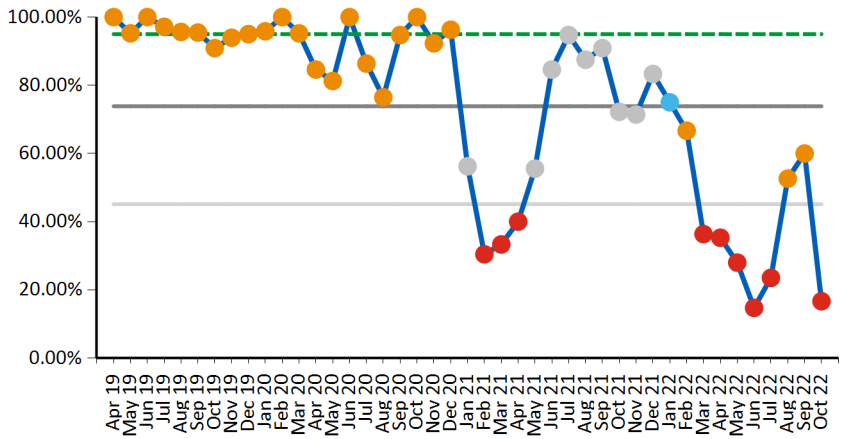
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

202: Midwifery 1:1 care in labour - October 2022 rate 89.73% remains below required level for the Clinical Negligence Scheme for Trusts maternity incentive submission which requires 100% compliance to be reported. Greater Manchester Eastern Cheshire (GMEC) dashboard confirms Bolton rate 89.47% over the past 12 months is less than the regional peer mean 96.59%. Staffing deficit of circa 41WTE the root cause of the current compliance rate. NHS England workforce action plan included in November 2022 Board paper to fulfil Clinical Negligence Scheme for Trust reporting requirements.

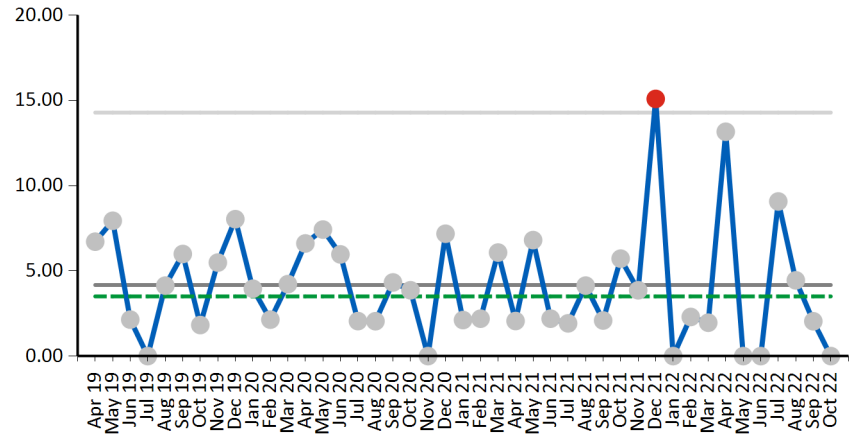
203: Booked by 12+6 – Fluctuating compliance noted. Bolton rolling mean over last twelve months 87.71% aligns with regional mean of 87.71%. Ongoing monitoring to continue and shared best practice still to be sought from other Trust with better performance identified on the GMEC dashboard ie Oldham, Wythenshawe East Cheshire.

210: Breastfeeding initiation – Declining trend continued within Trust 65.05% and low rate noted in other regional providers. Trust performance remains above GMEC mean of 62.65%. Review of activity still to be undertaken by breastfeeding specialists required to ensure focus is retained on Baby Friendly implementation. Increasing demand for tongue tie clinics impacting upon allocation of staffing resource.

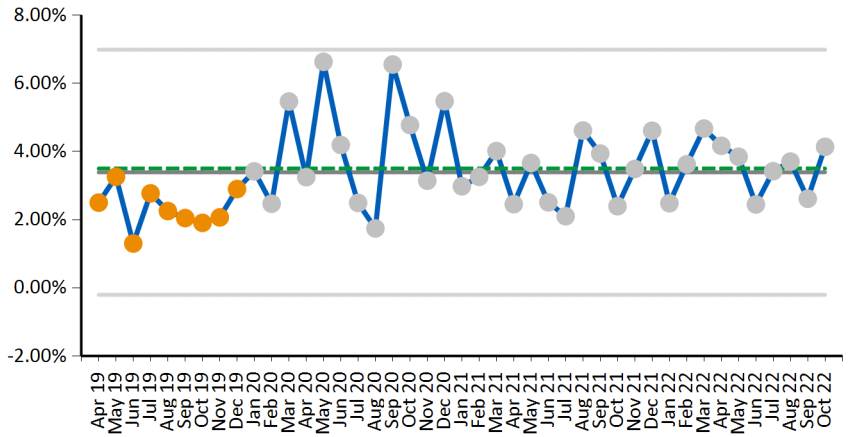
322 – Stillbirths per 1000 – Downward trend. Review of cases in December 2021 and April 2022 undertaken due to increased incidence. Review of July 2022 cases requested and underway to confirm if theme relating to cases of medical terminations where women opt to continue with their pregnancy as such cases are not excluded evident in July 2022 data.

	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	Oct-22		<= 3.50	2.04	Sep-22	<= 3.50	4.02	
23 - Maternity -3rd/4th degree tears	<= 3.5%	4.1%	Oct-22		<= 3.5%	2.6%	Sep-22	<= 3.5%	3.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	96.9%	Oct-22		>= 95.0%	98.7%	Sep-22	>= 95.0%	98.0%	
203 - Booked 12+6	>= 90.0%	87.1%	Oct-22		>= 90.0%	89.6%	Sep-22	>= 90.0%	86.7%	
204 - Inductions of labour	<= 40%	36.1%	Oct-22		<= 40%	35.8%	Sep-22	<= 40%	36.5%	
210 - Initiation breast feeding	>= 65%	61.30%	Oct-22		>= 65%	68.06%	Sep-22	>= 65%	65.27%	
213 - Maternity complaints	<= 5	2	Oct-22		<= 5	6	Sep-22	<= 35	33	
319 - Maternal deaths (direct)	= 0	0	Oct-22		= 0	0	Sep-22	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.4%	Oct-22		<= 6%	7.6%	Sep-22	<= 6%	8.8%	

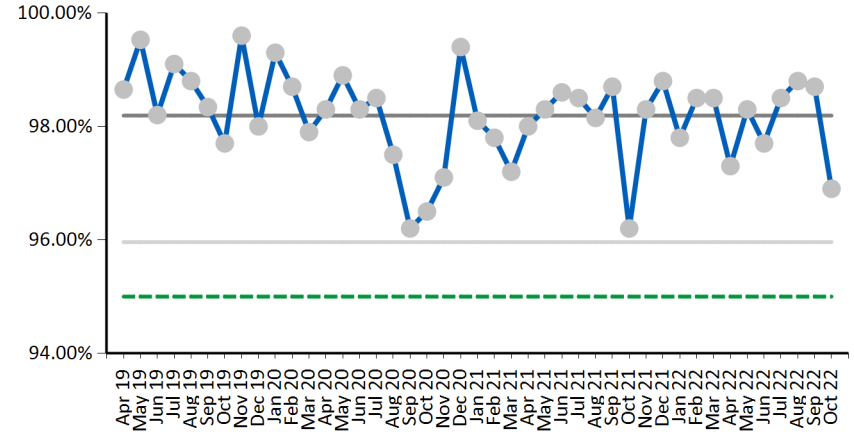
322 - Maternity - Stillbirths per 1000 births



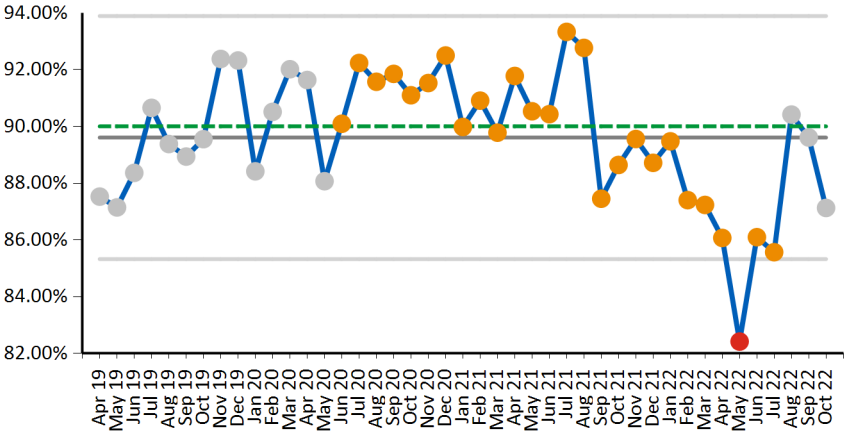
23 - Maternity -3rd/4th degree tears



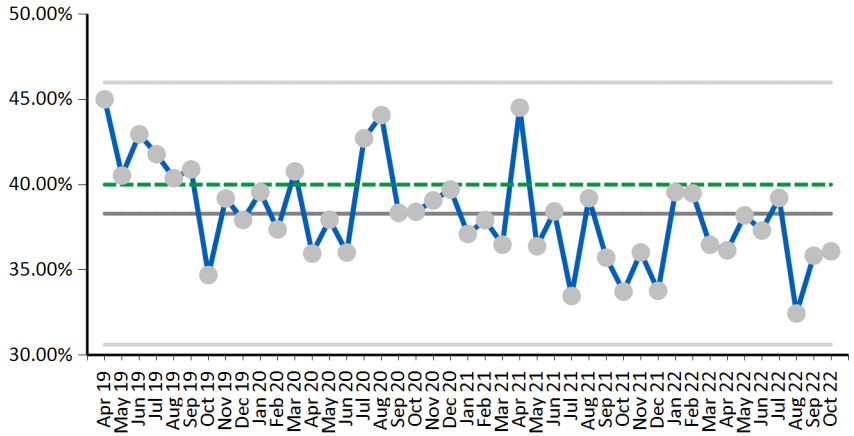
202 - 1:1 Midwifery care in labour



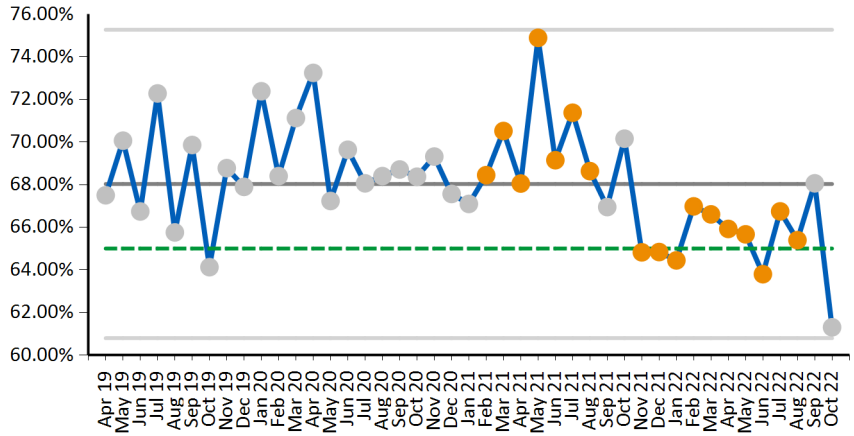
203 - Booked 12+6



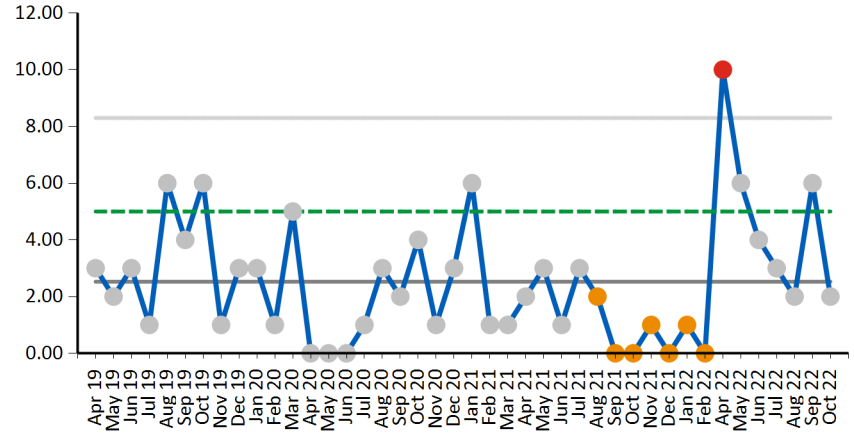
204 - Inductions of labour



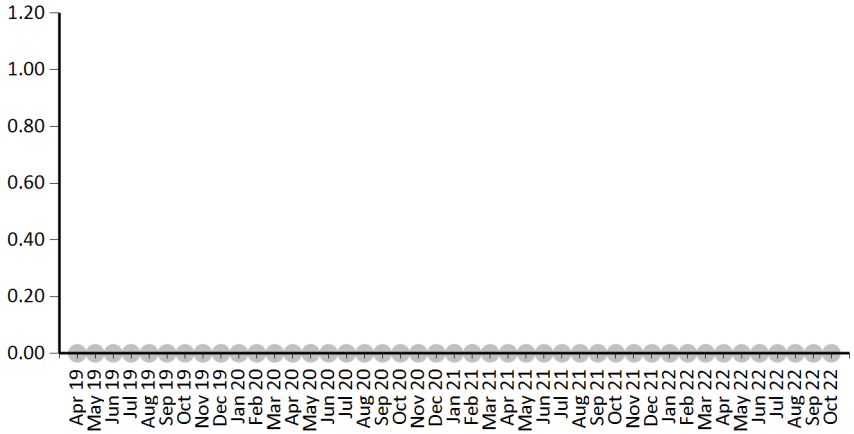
210 - Initiation breast feeding



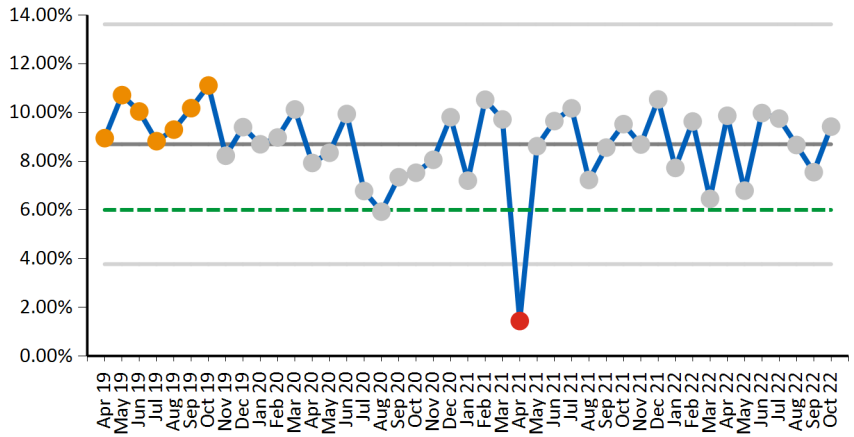
213 - Maternity complaints



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 rates are still high, due to overcrowding in the ED department. The new escalation process agreed with NWAS was implemented in September, and is being supported by ED staffing.

We continue to progress our urgent care transformational priorities which include:

1. The Urgent Treatment Centre (UTC) pilot which began 22nd September '22. After successfully allowing us to stream patients who require support from a primary care physician away from ED, this has been extended

2. Increasing the volume of patients being streamed to the Same Day Emergency Care (SDEC) unit – four new clinical pathways have been agreed by our clinical teams working together and we are working through implementation plans to support this.

3. The launch of virtual ward/early supported discharge initiatives – we aim to either minimise the need for a hospital admission, or reduce length of stay by implementing a range of pathways to support our patients in their own homes or usual place of residence.

We also continue to focus on actions to reduce our patients time away from home, a 'Warm up to Winter' campaign driven by clinical and therapy leads aims has been launched to support SAFER principles and timely discharges across our wards, as we head into winter months.

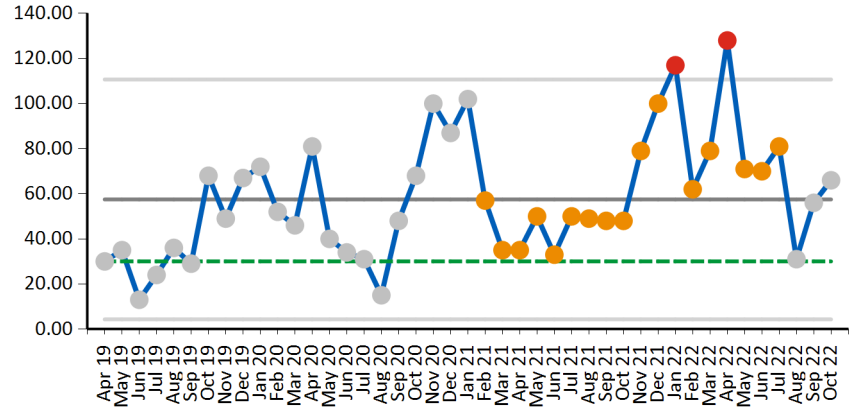
RTT
The number of 78 week waiting patients is continuing to reduce and we continue to be on target to meet the national deadline of zero 78 week waiting patients by 1st April 2023.
We are continuing to focus on increasing capacity and innovating our clinical pathways to reduce patient waiting times.

Diagnostic Waits > 6-weeks
The DM01 position for the Trust improved by 4.5% in October, with the final position standing at 34.0%. The number of breached patients decreased by 333 (1,034 breaches in total).
Endoscopy has improved in month to 3.9% of patients being seen outside of 6 weeks. The majority of breaches were due to an increase in cystoscopy 2ww referrals which impacted on routine capacity. Additional lists have been scheduled to further recover this.
In Imaging all modalities are now compliant to the national target. Ultrasound continues to require support from outsourced capacity however successful recruitment into substantive posts have been made in month, which will positively impact on sustainability of the recovery.
Physiological Measurements has improved in month but remains off track with 62.4% of patients seen outside of 6 weeks. The main pathways which are off track are paediatric audiology, urodynamics and echocardiography.

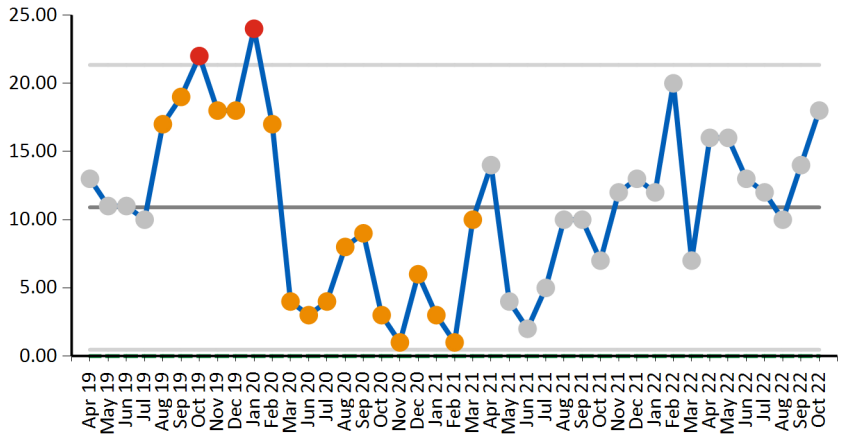
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	66	Oct-22		<= 30	56	Sep-22	<= 210	503	
8 - Same sex accommodation breaches	= 0	18	Oct-22		= 0	14	Sep-22	= 0	99	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	63.2%	Oct-22		>= 75%	60.6%	Sep-22	>= 75%	50.0%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	60.4%	Oct-22		>= 92%	59.6%	Sep-22	>= 92%	63.0%	
42 - RTT 52 week waits (incomplete pathways)	= 0	2,209	Oct-22		= 0	2,193	Sep-22	= 0	13,678	
314 - RTT 18 week waiting list	<= 25,530	38,354	Oct-22		<= 25,530	38,307	Sep-22	<= 25,530	38,354	
53 - A&E 4 hour target	>= 95%	54.8%	Oct-22		>= 95%	61.0%	Sep-22	>= 95%	60.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	19.7%	Oct-22		= 0.0%	13.3%	Sep-22	= 0.0%	15.4%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	18.30%	Oct-22		= 0.00%	16.04%	Sep-22	= 0.00%	15.19%	
72 - Diagnostic Waits >6 weeks %	<= 1%	34.0%	Oct-22		<= 1%	38.5%	Sep-22	<= 1%	34.0%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	80.0%	Oct-22		= 100%	100.0%	Sep-22	= 100%	81.6%	

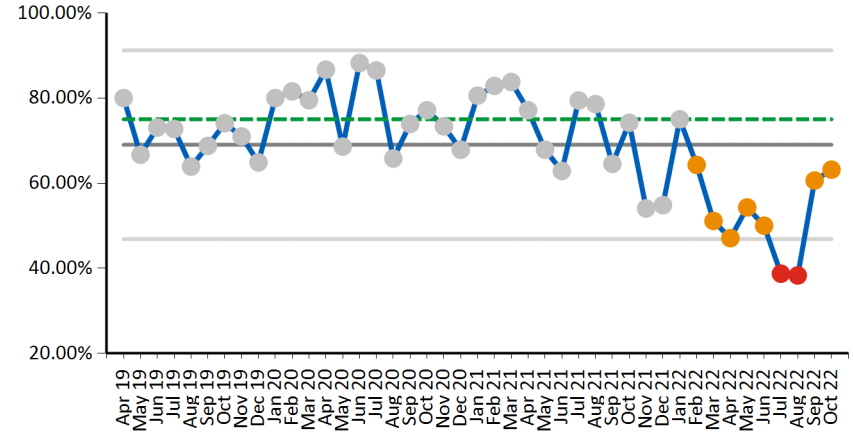
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



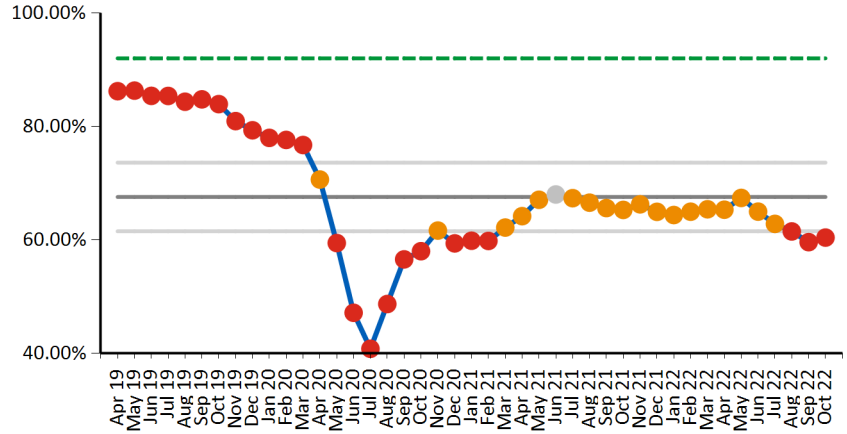
8 - Same sex accommodation breaches



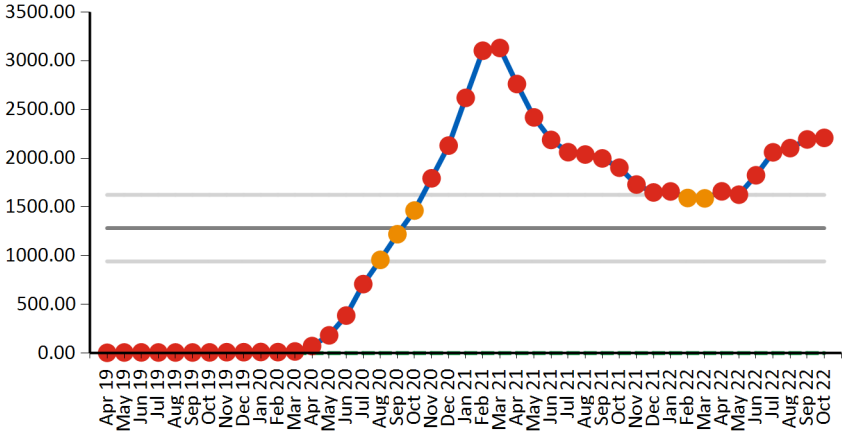
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



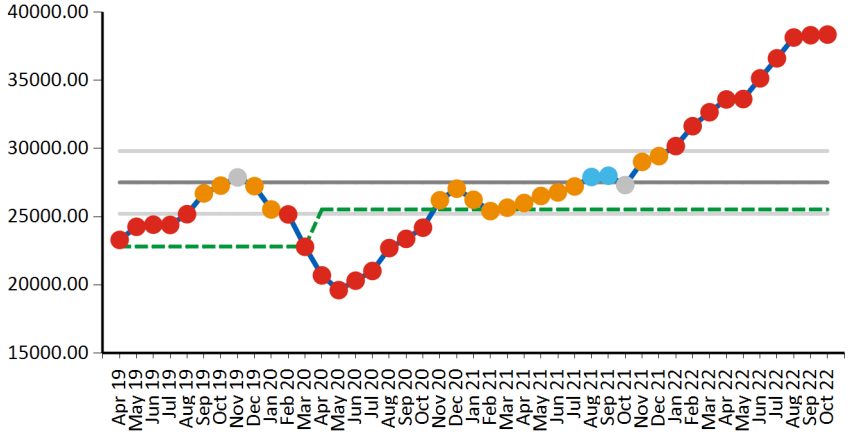
41 - RTT Incomplete pathways within 18 weeks %



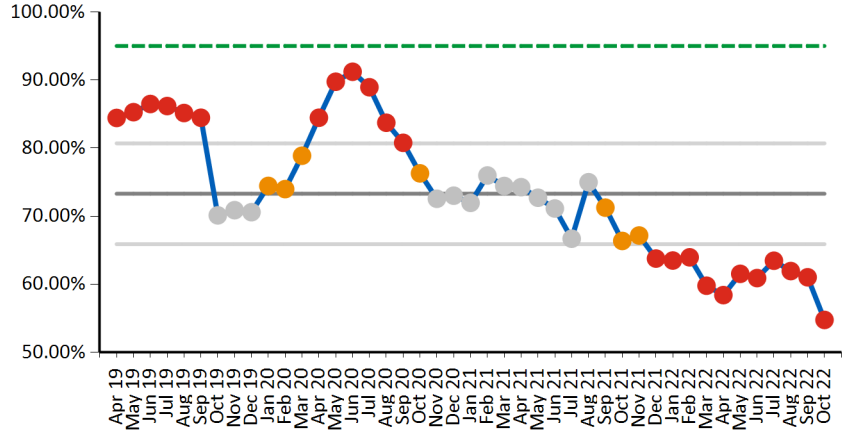
42 - RTT 52 week waits (incomplete pathways)



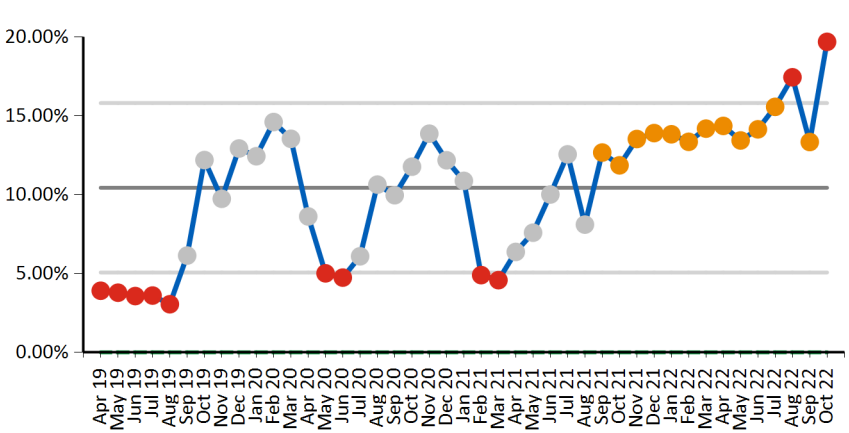
314 - RTT 18 week waiting list



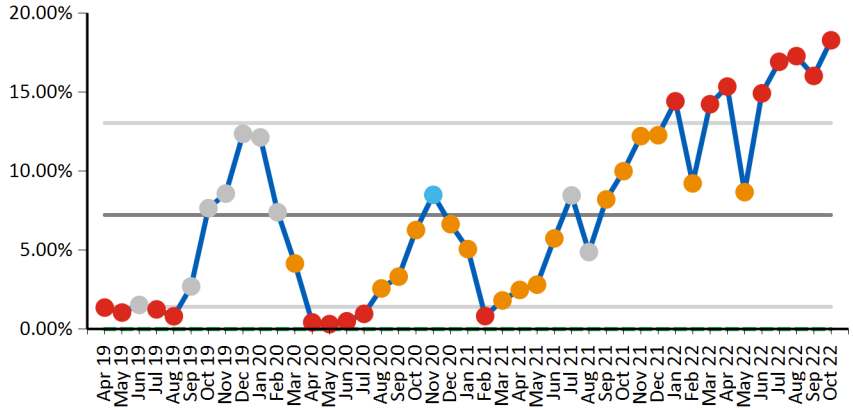
53 - A&E 4 hour target



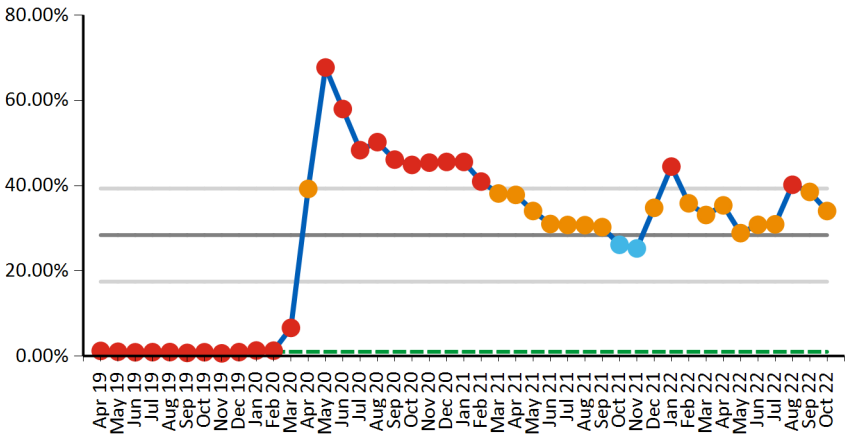
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



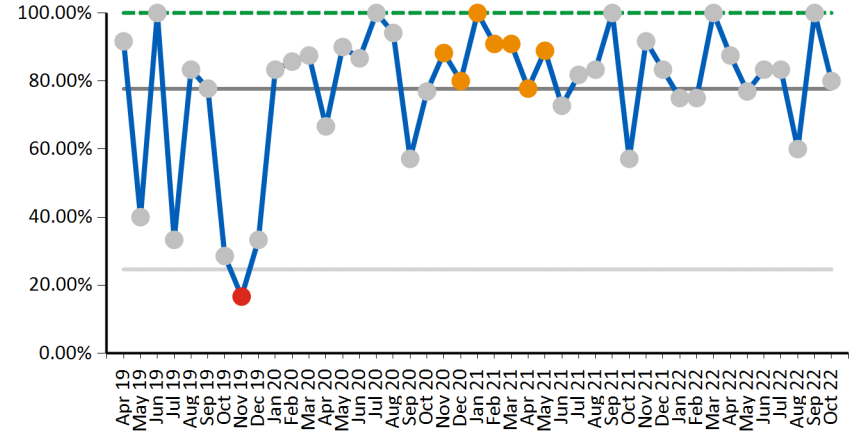
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



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



Productivity

No Criteria To Reside
We continue to experience pressure in relation to reducing the number of patients at any one time with no Criteria to Reside (NCTR); in M7 NCTR occupied bed days is noted to have reduced compared to the previous month and is significantly less than our peak experienced in January 2022. 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 and also system escalation of those patients who have had NCTR for more than 10 days.

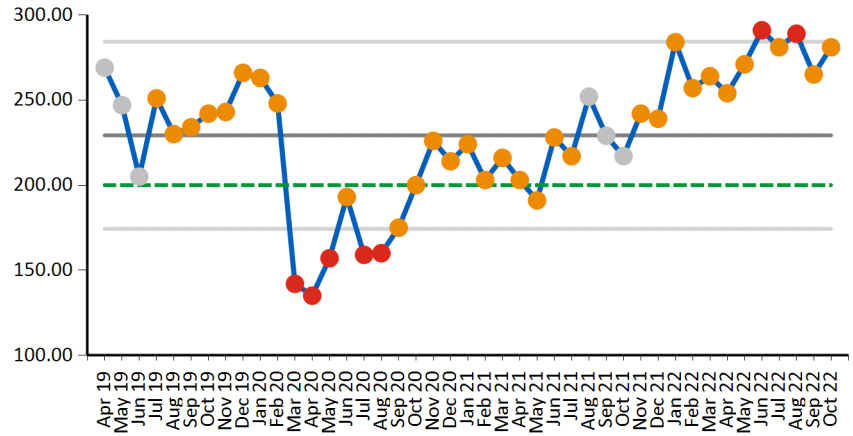
The Bolton Integrated Partnership has commissioned AQuA to work with us to review whole system flow and implement any required new service models and as part of the next phase there is focus on ensuring the MDT functions effectively at ward level, there is timely preparedness of discharge medication and improving the access for the most relevant person to undertake the MCA (not just the social worker; all of which will contribute to improving flow and preventing avoidable delays to discharge.

In preparedness for coming months we are working with systems partners to reduce the impact of NCTR on hospital flow. This includes liaising with local home care providers to implement a local bridging model, increasing the discharge to assess capacity in the care homes sector, wellbeing checks being provided by Age UK, providing proactive and reactive support to those care homes with the admission rates to hospital and also commissioning high care needs dementia beds in Bury.

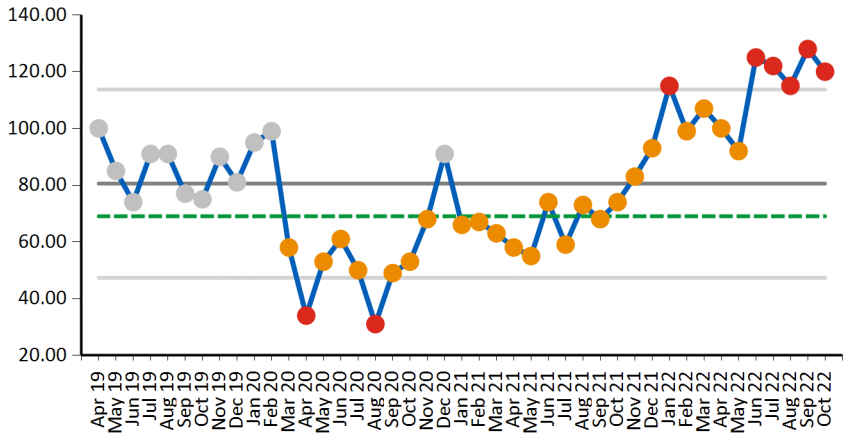
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	281	Oct-22	H	<= 200	265	Sep-22	<= 200	281	?
307 - Stranded Patients - LOS 21 days and over	<= 69	120	Oct-22	H	<= 69	128	Sep-22	<= 69	120	?
57 - Discharges by Midday	>= 30%	23.1%	Oct-22		>= 30%	24.0%	Sep-22	>= 30%	22.2%	F
58 - Discharges by 4pm	>= 70%	59.9%	Oct-22	L	>= 70%	58.7%	Sep-22	>= 70%	58.0%	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.9%	Sep-22	L	<= 13.5%	9.6%	Aug-22	<= 13.5%	9.6%	P
489 - Daycase Rates	>= 80%	90.2%	Oct-22		>= 80%	88.1%	Sep-22	>= 80%	88.9%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.9%	Oct-22		<= 1%	1.7%	Sep-22	<= 1%	1.9%	?
62 - Cancelled operations re-booked within 28 days	= 100%	86.7%	Oct-22		= 100%	85.4%	Sep-22	= 100%	16.8%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.86	Oct-22		<= 2.00	2.97	Sep-22	<= 2.00	2.92	?
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.21	Oct-22		<= 3.70	4.31	Sep-22	<= 3.70	4.34	?

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	73.9%	Sep-22		>= 80%	68.0%	Aug-22	>= 80%	70.8%	
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision	= 0	38	Oct-22		= 0	48	Sep-22	= 0	312	
493 - Average Number of Patients: with no Criteria to Reside	<= 35	108	Oct-22		<= 45	107	Sep-22	<= 335	804	
494 - Average Occupied Days - for no Criteria to Reside		916	Oct-22			1,068	Sep-22		7,136	
496 - Average bed days since patients with LOS >14 days moved onto NCTR list	>= 110	935	Oct-22		>= 160	1,076	Sep-22	>= 1,160	6,680	

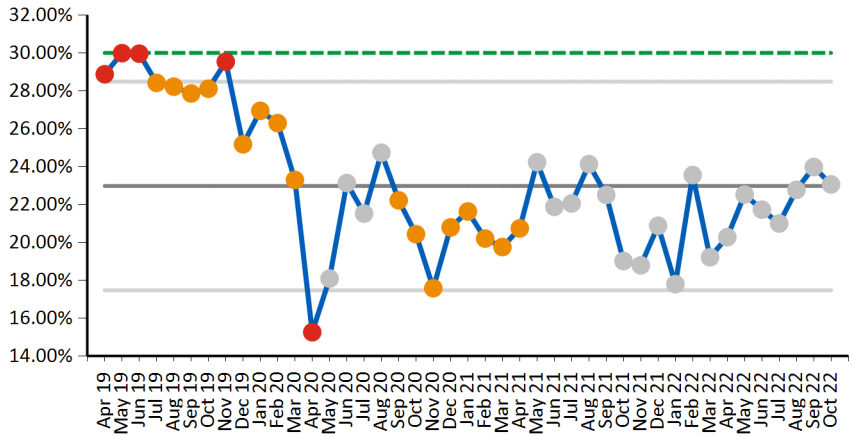
56 - Stranded patients



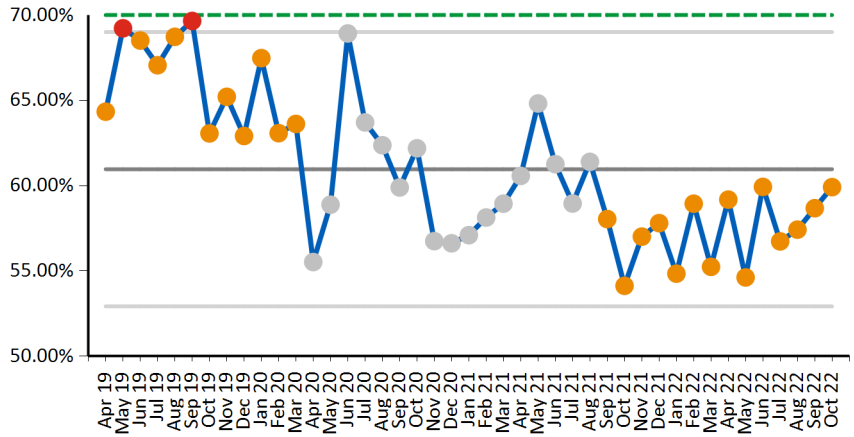
307 - Stranded Patients - LOS 21 days and over



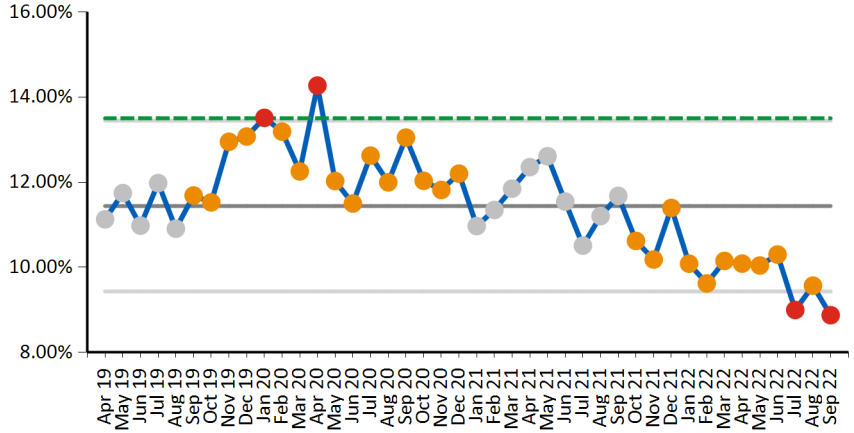
57 - Discharges by Midday



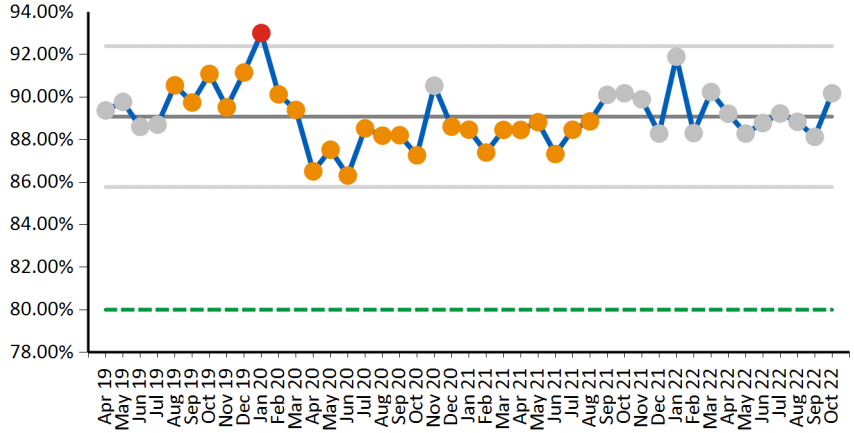
58 - Discharges by 4pm



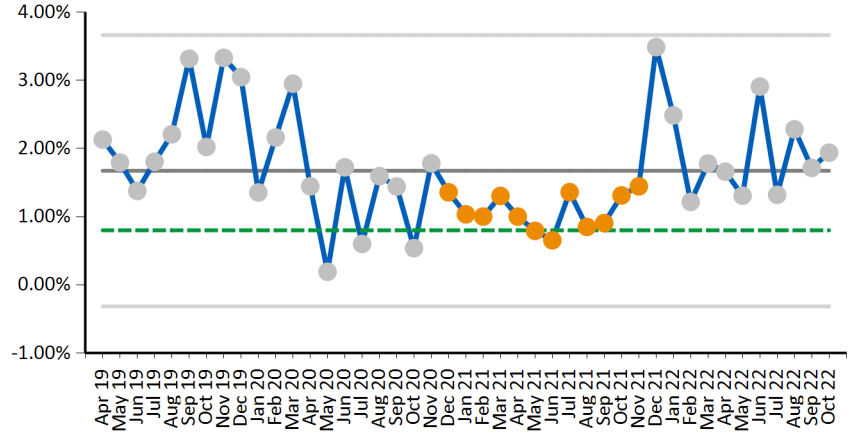
59 - Re-admission within 30 days of discharge (1 mth in arrears)



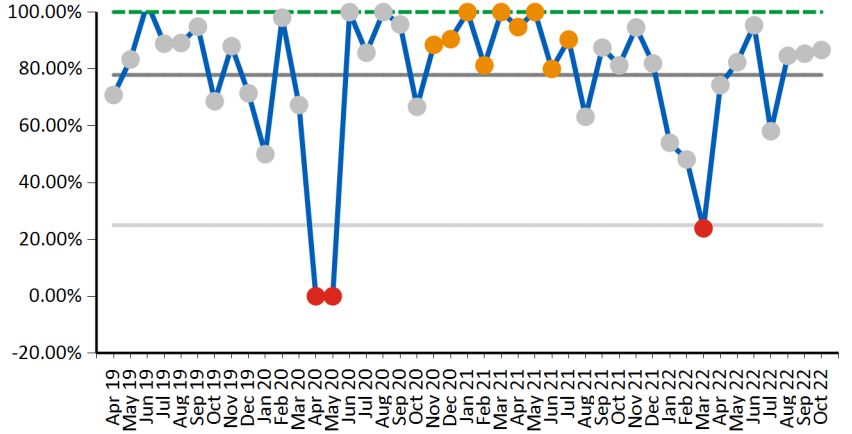
489 - Daycase Rates



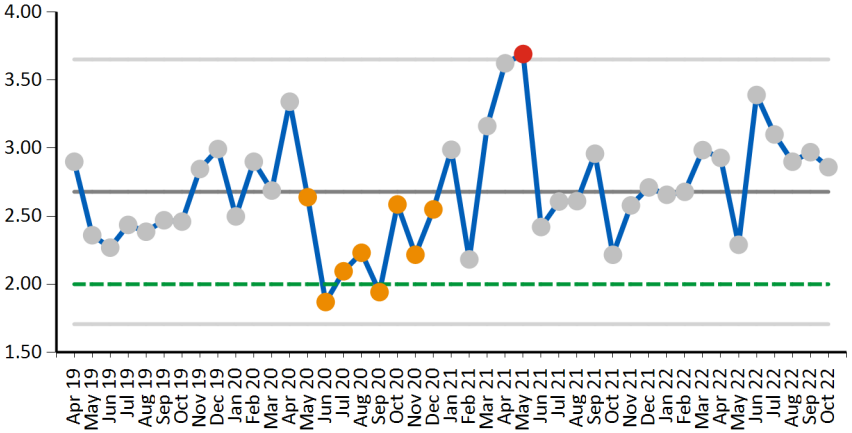
61 - Operations cancelled on the day for non-clinical reasons



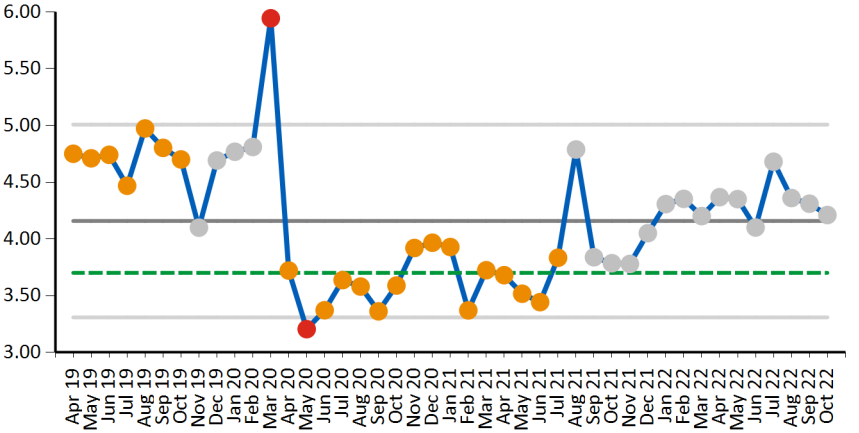
62 - Cancelled operations re-booked within 28 days



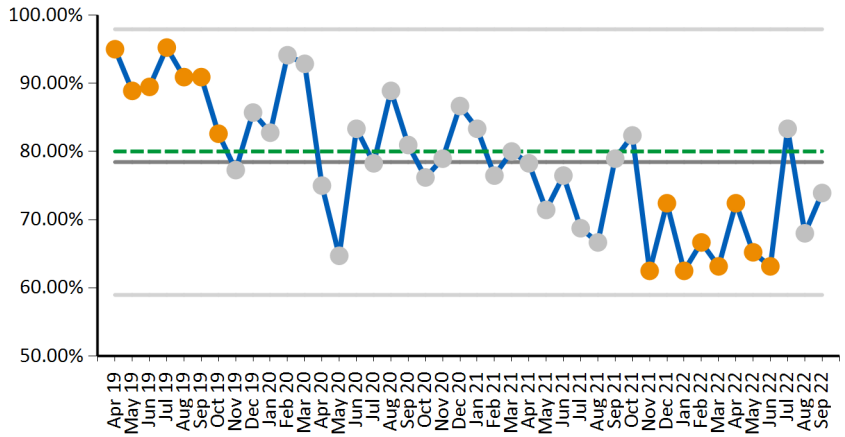
65 - Elective Length of Stay (Discharges in month)



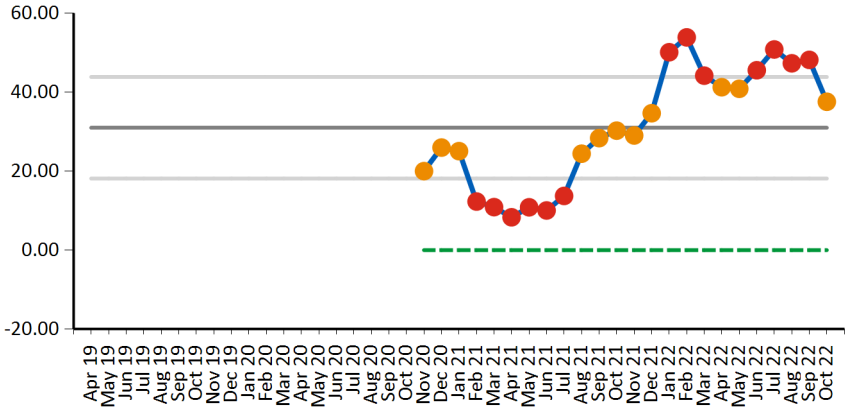
66 - Non Elective Length of Stay (Discharges in month)



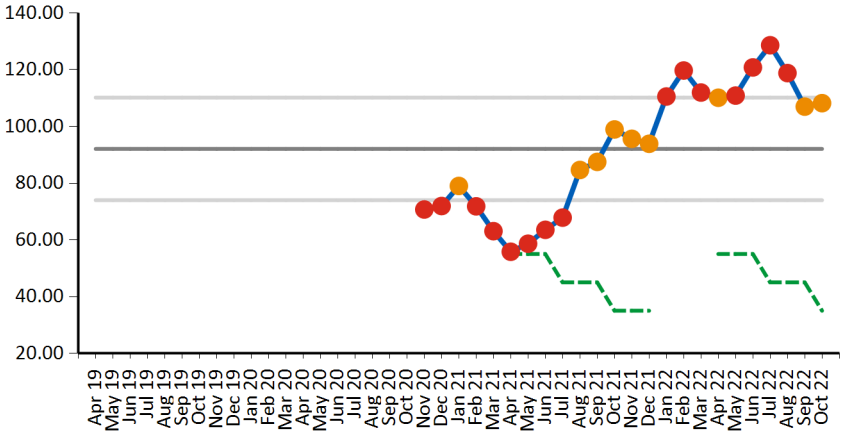
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



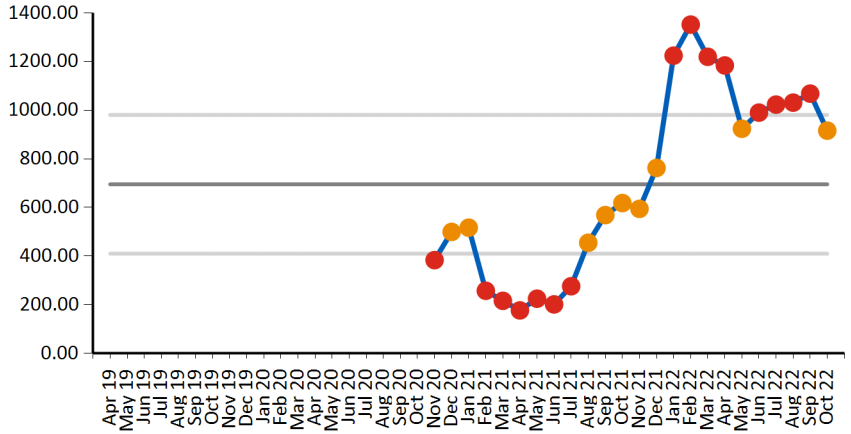
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision



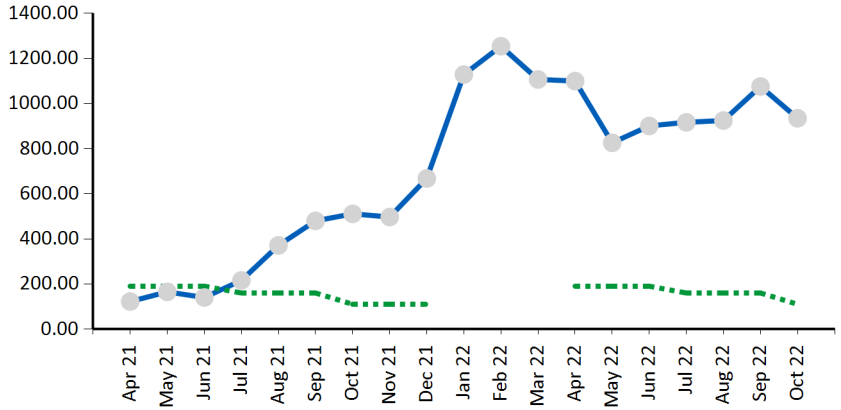
493 - Average Number of Patients: with no Criteria to Reside



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



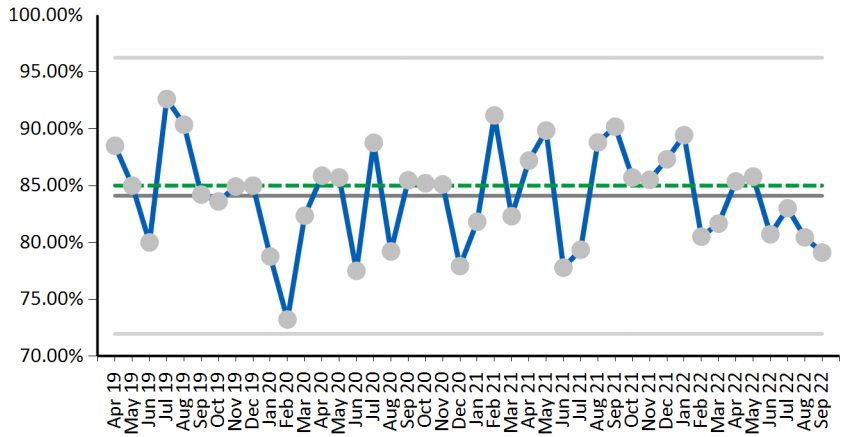
Cancer

Our 2 week wait performance has reduced to 92.6%, we're continuing to focus on the delivery of national best practice milestones and reducing delays at the start of our cancer pathways. This is including work with our primary care colleagues on referral standards and processes in order to allow effective triage and facilitate straight to test pathways where possible.

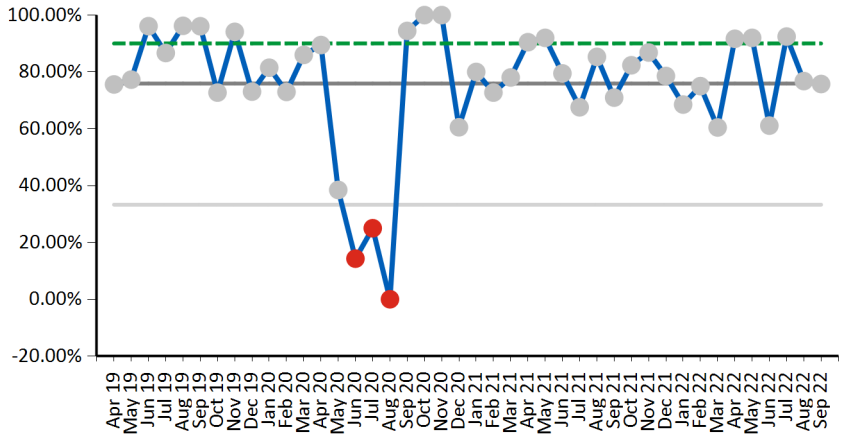
We did not meet the standard for 62 day performance for September and continue with delivery of our trust-wide cancer recovery plan to improve the position. In the last month, this has included meetings with stakeholders for all pathways which are not meeting the standard to refresh each pathway plan. These refreshed plans will be monitored and scrutinised at the cross-Divisional cancer performance meeting.

	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%	79.1%	Sep-22		>= 85%	80.4%	Aug-22	>= 85%	82.5%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	75.8%	Sep-22		>= 90%	76.8%	Aug-22	>= 90%	81.1%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.1%	Sep-22		>= 96%	97.9%	Aug-22	>= 96%	99.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Sep-22		>= 94%	100.0%	Aug-22	>= 94%	89.5%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Sep-22		>= 98%		Aug-22	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	92.6%	Sep-22		>= 93%	96.0%	Aug-22	>= 93%	91.4%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	25.6%	Sep-22		>= 93%	49.4%	Aug-22	>= 93%	35.0%	

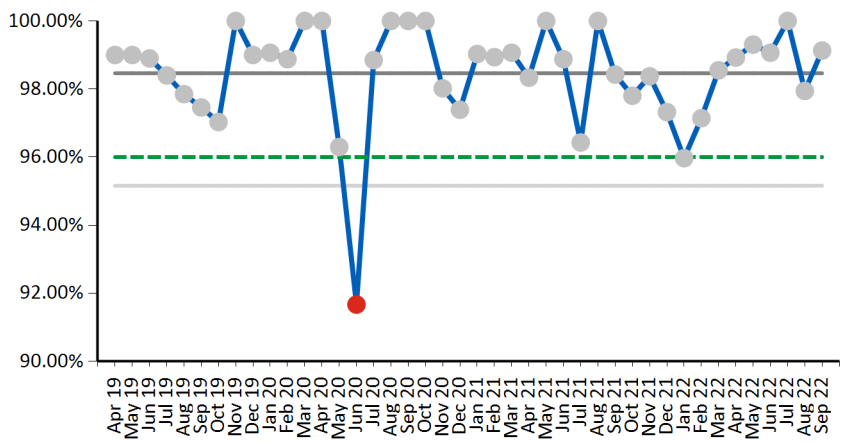
46 - 62 day standard % (1 mth in arrears)



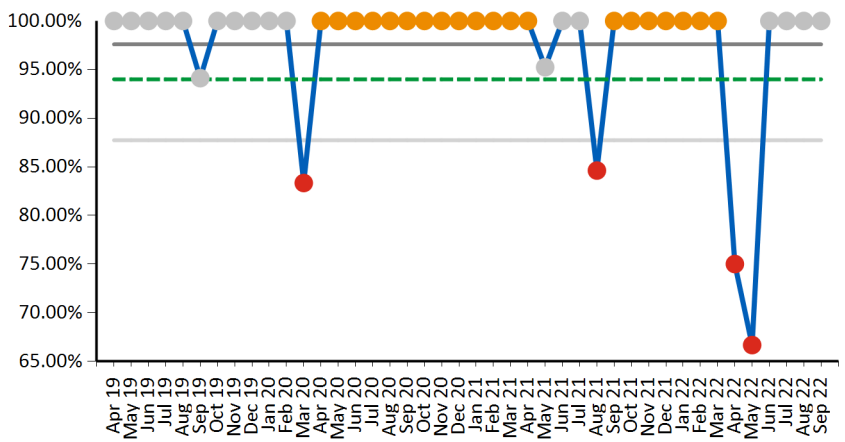
47 - 62 day screening % (1 mth in arrears)



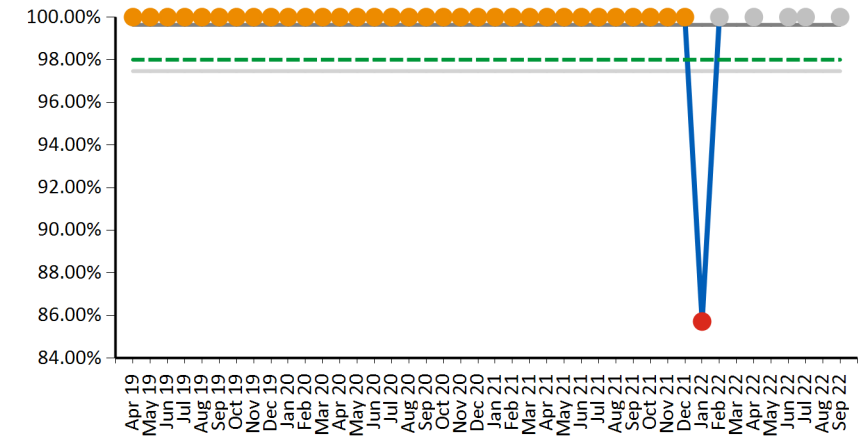
48 - 31 days to first treatment % (1 mth in arrears)



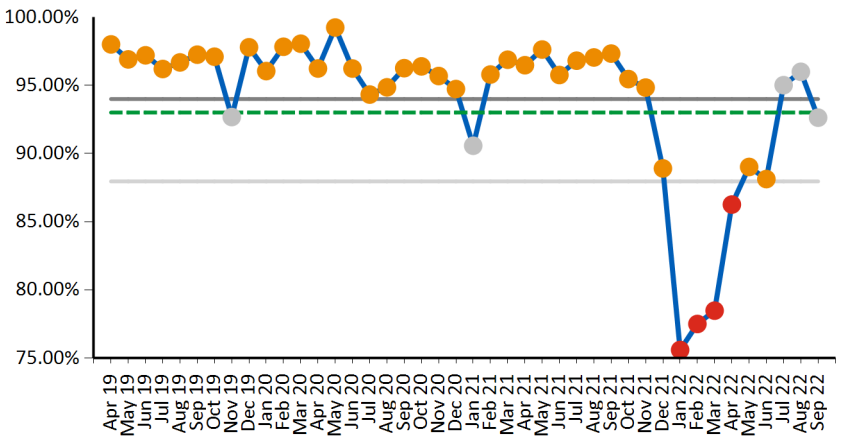
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



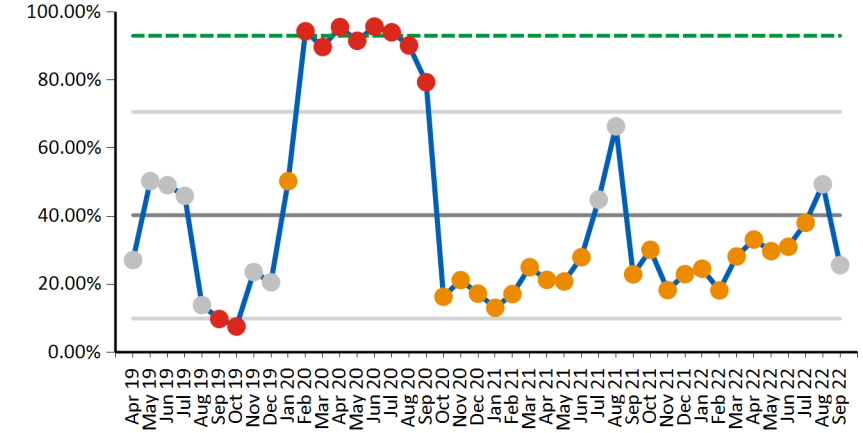
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



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



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

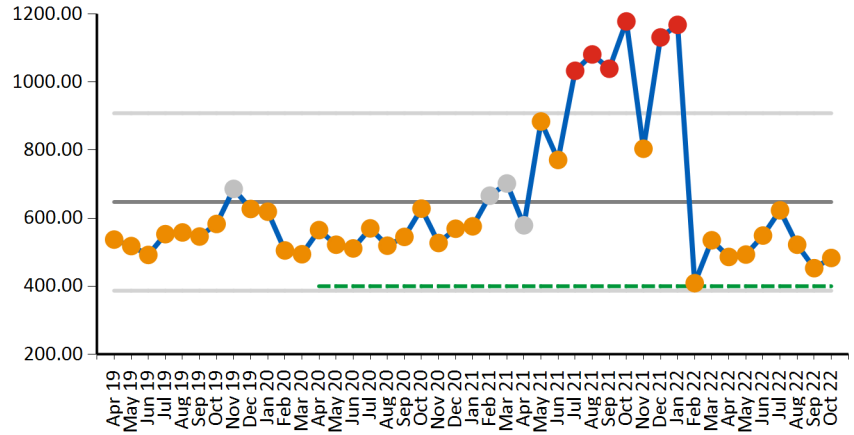


Community

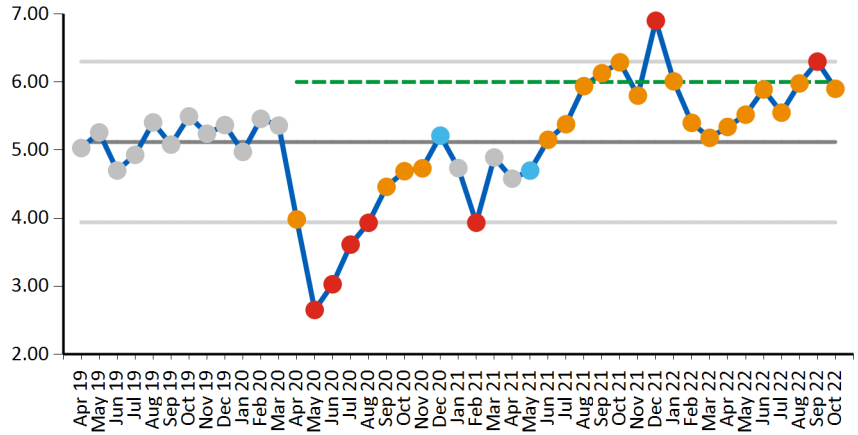
We are meeting our plan for both deflections from ED and also for total length of stay in the intermediate tier. However, it is noted that the intermediate tier length of stay has increased and this is particularly driven by increasing length of stay in our bed bases.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	483	Oct-22	L	>= 400	453	Sep-22	>= 2,800	3,609	?
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.90	Oct-22	H	<= 6.00	6.30	Sep-22	<= 6.00	5.90	?

334 - Total Deflections from ED



335 - Total Intermediate Tier LOS (weeks)



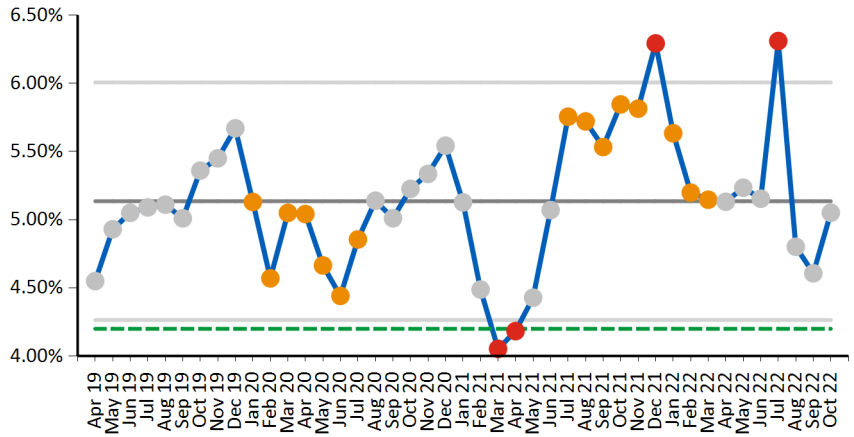
Workforce

Sickness, Vacancy and Turnover

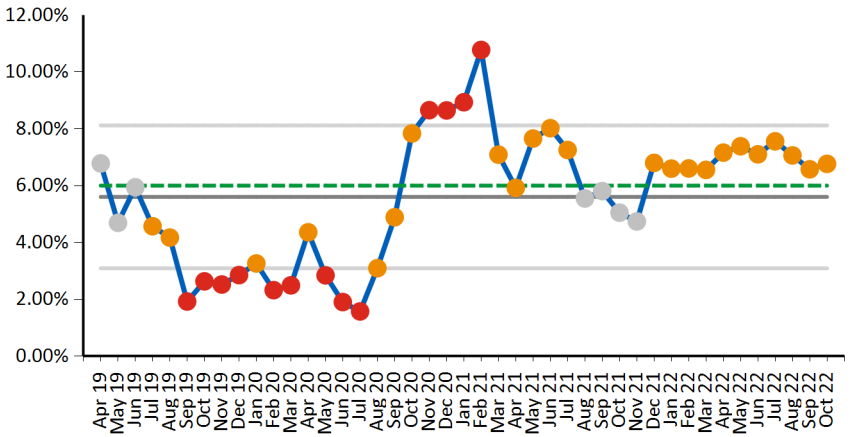
Sickness shows an increased position on last month with an increase from to 4.6% from 5.05% . The Trust continues to benchmark well against peers and detailed work continues in line with the Positive Attendance policy, to support staff and manage sickness closely at individual, team and divisional level. Both vacancy rates and turnover also show a marginally increased position Trust wide compared to last month. The People Committee noted the analysis of turnover by staff group with the trust benchmarking positively against the Regional average with the exception of Nursing and Midwifery staff group which was marginally above.

	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%	5.05%	Oct-22		<= 4.20%	4.61%	Sep-22	<= 4.20%	5.18%	F
120 - Vacancy level - Trust	<= 6%	6.76%	Oct-22	H	<= 6%	6.57%	Sep-22	<= 6%	7.09%	?
121 - Turnover	<= 9.90%	14.66%	Oct-22	H	<= 9.90%	13.98%	Sep-22	<= 9.90%	14.34%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Oct-22			1	Sep-22		15	

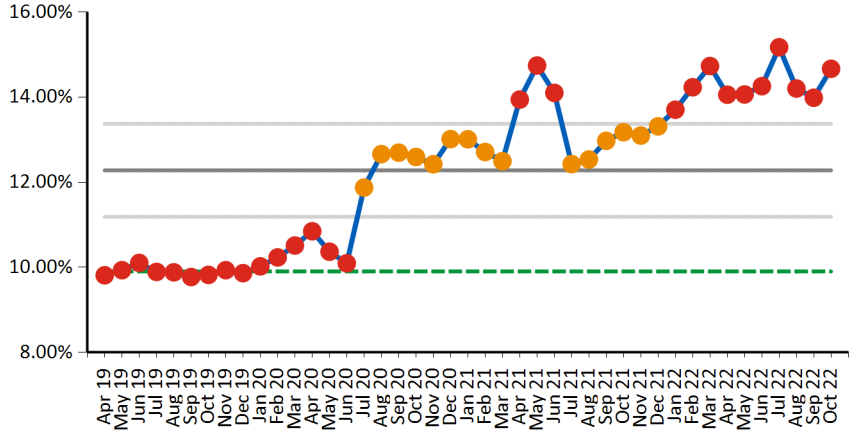
117 - Sickness absence level - Trust



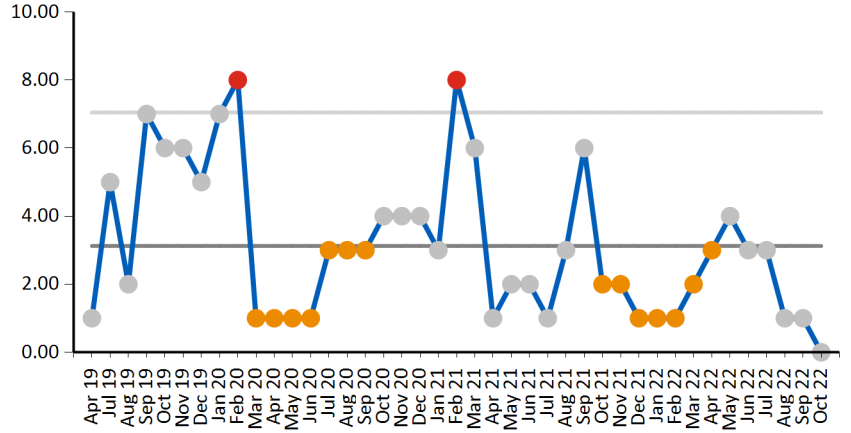
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks

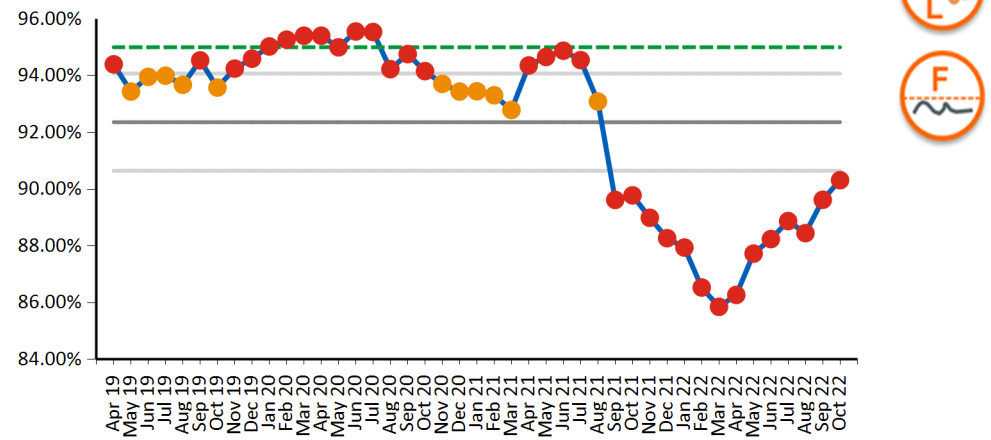


Organisational Development

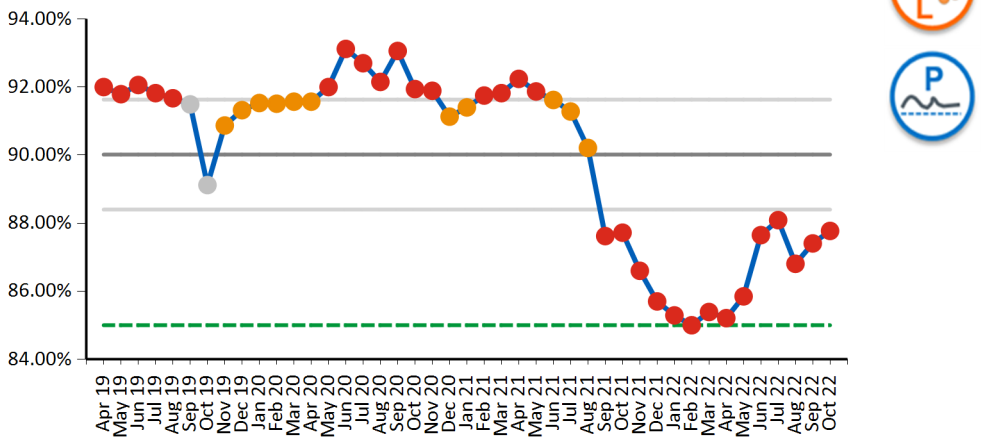
The Trust's overall compliance level for mandatory training was 87.7% (2.7% above our corporate target of 85% and a minor increase since last month) and statutory training was 90.3% (4.7% below our corporate target of 95% and a marginal increase from 89.6% last month). We continue to place great focus on completion and there are agreed targets in place per division; being monitored through the People Development Steering Group. Appraisal compliance has seen an increase this month for the third consecutive month, which shows our activity in this space is working.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	90.3%	Oct-22	L	>= 95%	89.6%	Sep-22	>= 95%	88.5%	F
38 - Staff completing Mandatory Training	>= 85%	87.8%	Oct-22	L	>= 85%	87.4%	Sep-22	>= 85%	87.0%	P
39 - Staff completing Safeguarding Training	>= 95%	91.43%	Oct-22	L	>= 95%	90.86%	Sep-22	>= 95%	89.84%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	82.7%	Oct-22		>= 85%	82.5%	Sep-22	>= 85%	80.0%	F
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	72.8%	Q2 2022/23		>= 66%	65.0%	Q1 2022/23	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	73.3%	Q2 2022/23		>= 80%	60.1%	Q1 2022/23	>= 80%		

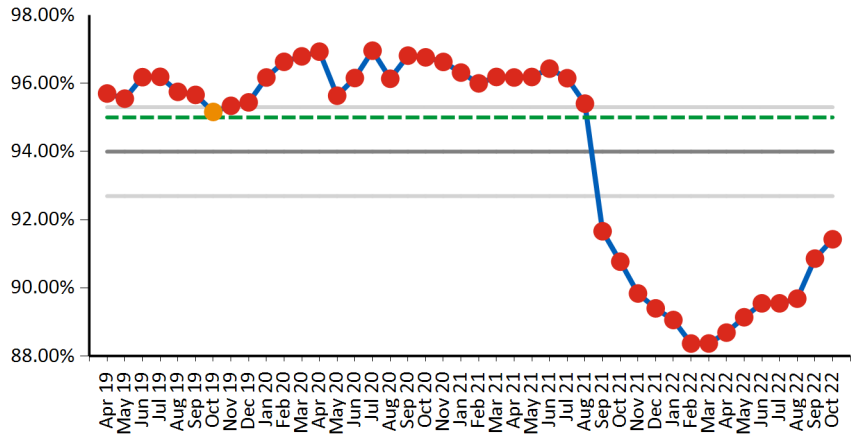
37 - Staff completing Statutory Training



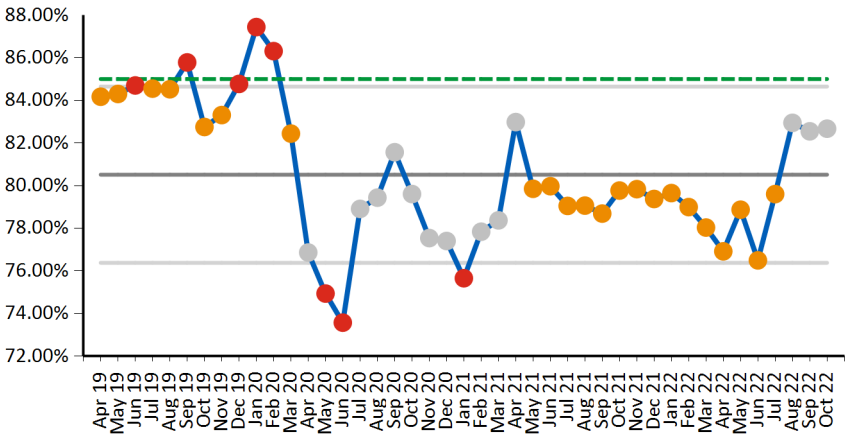
38 - Staff completing Mandatory Training



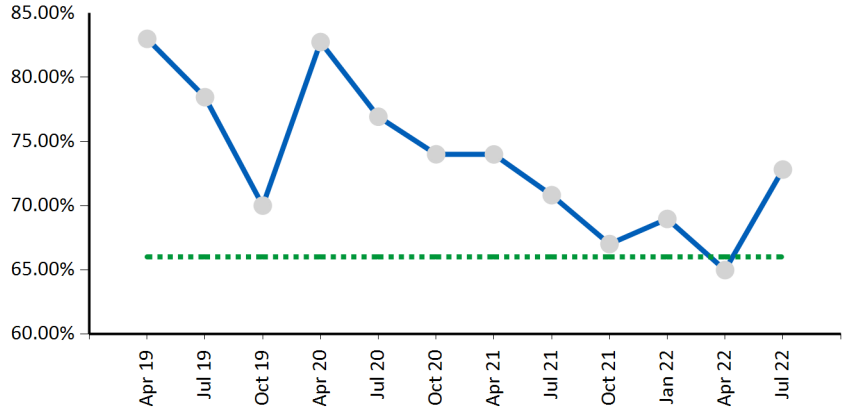
39 - Staff completing Safeguarding Training



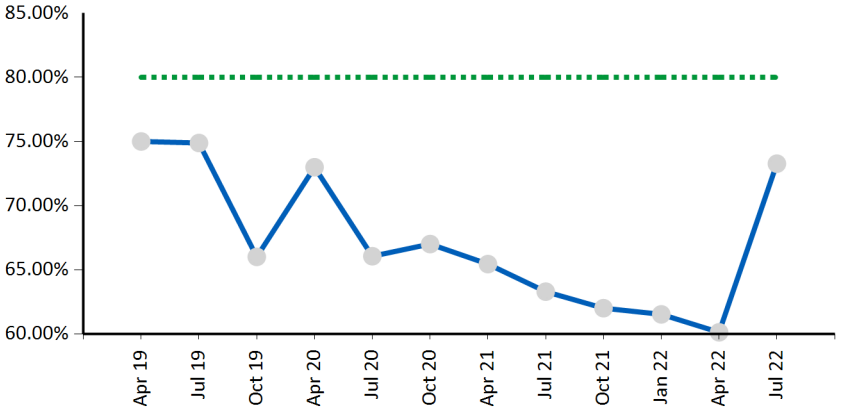
101 - Increased numbers of staff undertaking an appraisal



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

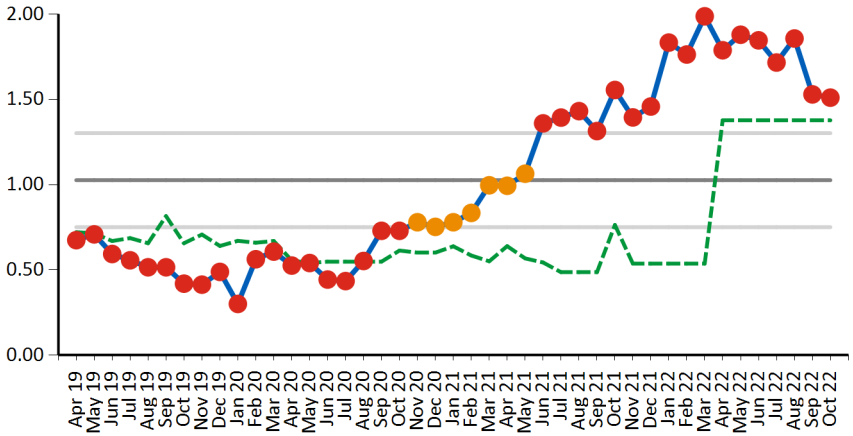


Agency

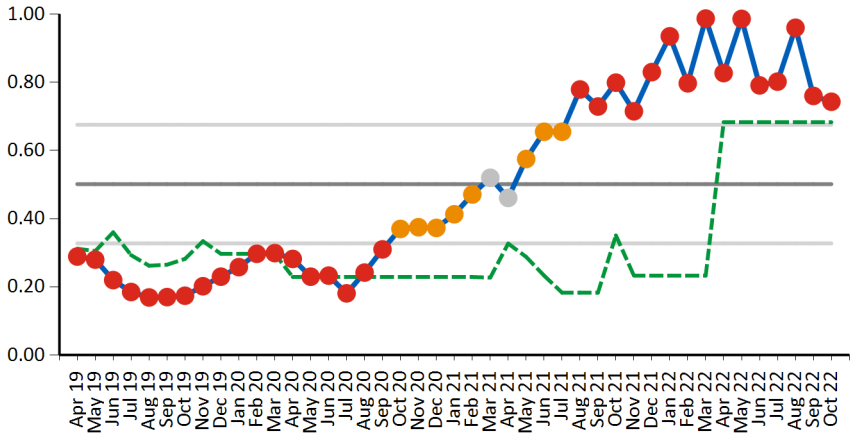
Agency spend overall showed a reduction for Month 7 compared to Month 6 with Nursing and Midwifery showing a reduction of £18k to the lowest agency spend year to date. Medical agency spend was up by £76K in month mainly against Consultant expenditure, which can be tracked against the recruitment pipeline on for Consultant appointments. Members will recall there has been a focus on 'other agency' which has reduced by £78k in month overall.

	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	1.51	Oct-22	H	<= 1.38	1.53	Sep-22	<= 9.64	12.13	P
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.68	0.74	Oct-22	H	<= 0.68	0.76	Sep-22	<= 4.78	5.87	P
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.60	Oct-22	H	<= 0.62	0.53	Sep-22	<= 4.31	4.83	P

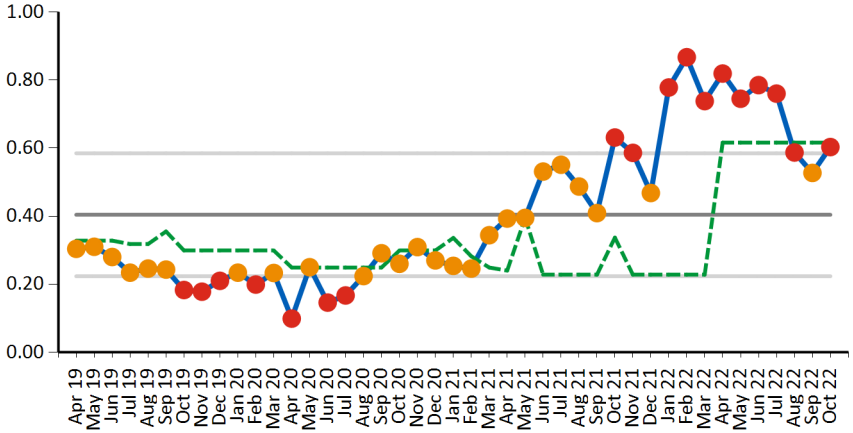
198 - Trust Annual ceiling for agency spend (£m)



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 £9.1m compared with a planned deficit of £3m. The in-month position was a £0.7m deficit.
• Financial Recovery Plan being produced.
• Revenue performance is currently rated red.

Revenue Forecast Outturn
• The forecast scenarios range from a deficit of £26.4m to achieving the planned deficit of £7.2m, with a likely deficit of £16.5m, with an optimistic forecast of £12.1m deficit.
• Forecast Outturn is currently rated red.

Cost Improvement
• The current trackers indicate that £11.1m of savings have been delivered against a target of £12m.
• Non recurrent accounts for £8.6m of the delivery.
• CIP is currently rated red due to the under delivery and reliance on non-recurrent, central CIP.

Variable Pay
• We spent £3.5m on variable pay in month 7 compared to £4.4m in month 6 and have now spent £29.3m YTD
• £0.6m of WLI / extra session accrual release in month.
• Spend on Agency was £1.5m in Month 7, sustaining the improvement seen in month 6.
• Variable pay is rated red as spend is significantly above plan.

Capital Spend
• Year to date spend is £9m; of which £4.4m is on Theatres.
• NHSE have approved the CDC business case and the trust will receive £14.7m over current and next financial year
• Theatres TIF has not as yet been approved, the decision is to be announced 9th December 2022
• Capital is rated red for the risk associated with the plan.

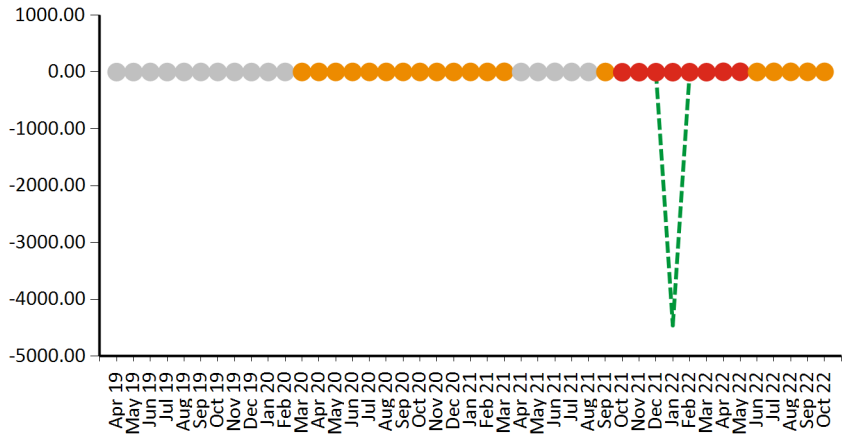
Cash Position
• We had cash of £16.5m at the end of the month.
• Salaries, Tax and NI payments in month of £27.0m
• PRL payments £14.9m in month to support BPPC
• Cash is rated amber.

Loans and PDC
• We have loans of £37.0m.
• Rated green as there are no concerns in this area.

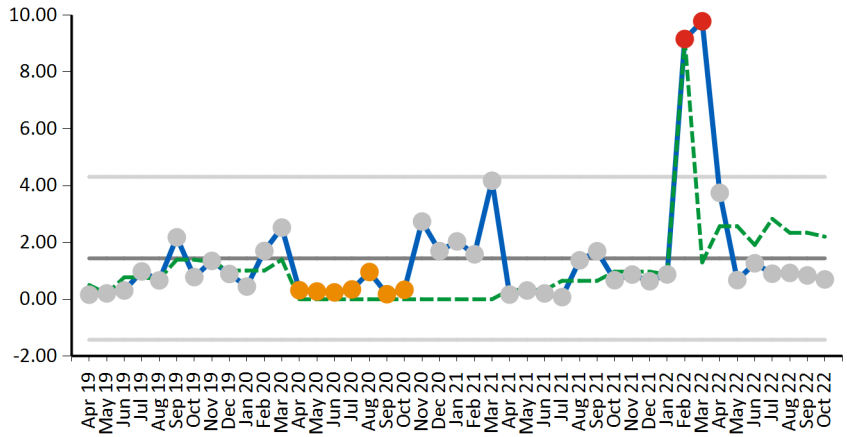
Better Payment Practices Code
• Year to date we have paid 88.3% of our invoices within 30 days.
• Non-NHS performance is 91.8% YTD with 86.3% in month.
• This is below the annual target of 95%, hence rated amber.
• Action to improve performance is underway and showing results

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 0.6	0.7	Oct-22		>= 0.4	1.5	Sep-22	>= 2.9	9.1	
222 - Capital (£ millions)	>= 2.2	0.7	Oct-22		>= 2.3	0.8	Sep-22	>= 16.8	9.1	
223 - Cash (£ millions)	>= 39.4	16.7	Oct-22		>= 40.4	25.3	Sep-22	>= 39.4	16.7	

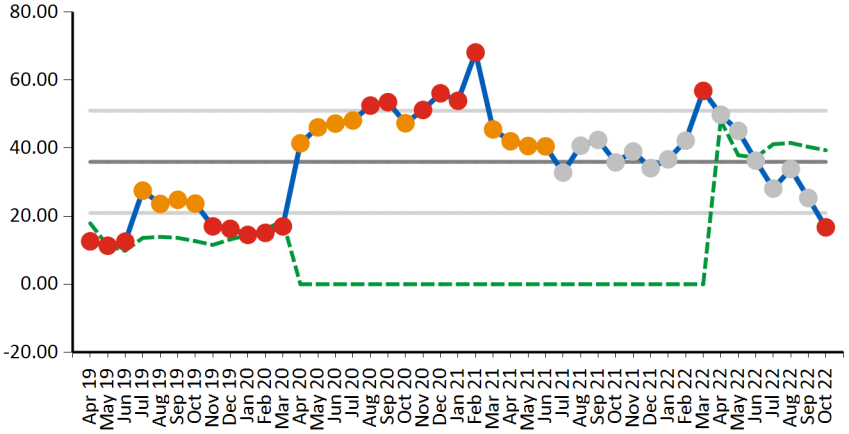
220 - Control Total (£ millions)



222 - Capital (£ millions)



223 - Cash (£ millions)



oard Assurance Heat Map - Hospital

			Council	Acute Division																										Families Division											
	Indicator	Target	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	Inglesid e	M2 (AN)	M3 (Birth)	M4 (PN)	M5 (PN)	M6	NICU	Overall
	Average Beds Available per day	*N/a*	32	N/R	N/R	22		23	26	21	24		25	26	26	23	10	13	6	22	24	27	12	5	22	18	25	25	25	25	22	16	25	25	11	11	4	15	38	9	4	26	5	22	22	17	38	817
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%	80.0%	100.0%	100.0%	N/R	N/R	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	N/R	100.0%	100.0%	90.0%	95.0%	80.0%	100.0%	N/R	100.0%	95.0%	N/R	75.0%	100.0%	85.0%	95.0%	95.0%	100.0%	90.0%	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	96.6%
	C - Diff	*Target = 0*				0	0	0	0	0	0	0	0	2	1	1	0	0	0	0	0	0		0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	7
	MSSA BSIs	*Target = 0*				1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	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	2	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	1	4
	MRSA acquisitions	*Target = 0*				2	0	0	1	0	1	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	5
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	5	4	1	2	0	8	13	6	4		1	2	6	2	0	3	0	2	3	5	1	0	4	0	0	3	0	2	3	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	84
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	0	0	2	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	3
	VTE Assessment Compliance	*Target = 95%*				100.0%	N/R	21.2%		90.0%	33.3%	N/R	100.0%	88.9%	94.0%	100.0%	100.0%	98.5%	99.1%	98.8%	100.0%	97.0%		99.4%	84.2%	100.0%	95.2%	N/R	91.1%	99.3%	71.4%	99.0%	100.0%	100.0%	98.4%	20.0%	72.9%	94.4%			N/R	100.0%	N/R	95.4%	83.3%	97.3%		96.5%
	New pressure Ulcers (Grade 2)	*Target = 0*	0	2	0	0	0	2	0	0	1	0	0	1	5	0	0	0	1	2	2	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	19
	New pressure Ulcers (Grade 3)	*Target = 0*	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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
	New pressure Ulcers (unstageable)	*Target = 0*	0	2	0	0	0	0	0	0	0	0	0	0	3	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	6
Audit	Monthly KPI Audit %	*Target = 95%*	98.8%	89.8%	98.2%	92.9%	N/R	88.8%	74.4%	93.7%	89.0%	N/R	94.4%	84.0%	86.0%	N/R	98.0%	93.9%	98.1%	94.7%	86.2%	90.3%	N/R	100.0%	98.1%	95.4%	95.2%	93.0%	77.9%	92.7%	92.8%	97.8%	99.7%	91.9%	100.0%	100.0%	97.6%	96.6%	99.1%	99.1%	95.0%	97.8%	N/R	97.1%	99.0%	N/R	94.4%	94.0%
	BoSCA Overall Score %	*w=<55,b>55, s*	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%*		18.5%	3.4%	29.0%		36.8%	41.7%	153.3%	28.0%	0.0%	14.8%	60.0%	30.8%	0.0%	50.0%	46.9%	0.0%	9.0%	61.5%	64.4%		25.3%	27.3%	31.6%	31.1%	5.0%	21.6%	13.0%	67.5%	43.0%	26.3%	27.4%	25.0%		26.1%		26.0%	0.2%		8.6%	26.6%	13.5%	14.7%	4.3%	42.1%	22.4%
	FFT Recommended Rate	*Target = 97%*		76.7%	96.4%	100.0%		100.0%	95.0%	100.0%	100.0%		100.0%	96.3%	93.8%		100.0%	98.5%		100.0%	93.8%	97.4%		98.6%	100.0%	100.0%	95.9%	100.0%	100.0%	90.5%	92.4%	100.0%	90.5%	96.2%	98.4%		91.7%		97.3%	100.0%		81.0%	84.6%	70.6%	91.9%	94.1%	100.0%	97.0%
	Number of complaints received	*Target = 0*	0	7	1	0	0	0	1	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	16
Governance	Serious Incidents in Month	*Target = 0*	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Incidents > 14 days, not yet signed off	*Target = 0*	6	62	9	2	0	6	1	5	0	0	2	25	9	21	0	0	1	5	2	1	1	0	1	0	0	9	4	7	5	1	4	2	2	11	0	175	0	0	1	5	7	46	8	8	22	476
	Harm related to Incident (Moderate+)	*Target = 0*	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Staff Development	Appraisals	*Target = 85%*		95.83%			0.0%	53.8%	59.4%	82.6%	90.2%	81.8%	83.3%	91.2%	68.3%	40.0%	74.1%	95.0%	75.0%	87.2%	94.1%	78.9%	75.0%	80.7%	51.4%	87.6%	100.0%	86.5%	88.9%	71.8%	96.0%	88.2%	93.3%	82.5%	71.4%		94.7%	76.1%	88.9%		80.0%	89.5%		80.0%	76.9%		81.5%	79.2%
	Statutory Training	*Target = 95%*		82.77%			98.77%	72.88%	82.04%	87.85%	95.19%	97.4%	82.74%	76.22%	84.79%	83.66%	94.19%	96.30%	87.95%	85.53%	89.40%	84.62%	79.69%	94.03%	70.82%	93.25%	91.57%	87.06%	87.64%	89.66%	95.93%	86.98%	83.21%	81.87%	93.46%		95.39%	74.3%	90.7%		61.9%	86.6%		73.1%	74.2%		84.12%	85.7%
	Mandatory Training	*Target = 85%*		85.57%			90.6%	72.3%	81.8%	86.0%	94.6%	97.4%	73.4%	73.3%	77.2%	82.0%	94.1%	93.3%	85.5%	83.3%	84.0%	86.0%	84.1%	94.9%	62.9%	91.9%	97.2%	83.1%	81.7%	89.1%	90.9%	85.8%	83.8%	72.9%	94.4%		95.4%	79.6%	86.9%		56.0%	88.6%		81.1%	75.0%		90.0%	84.4%
Staffing & Workforce	% Qualified Staff (Day)							97.9%	98.1%	95.3%			95.3%	98.9%	102.7%	3.2%	98.7%				98.7%	97.3%			95.2%	84.3%		99.4%	89.0%		105.1%		101.8%	98.4%				92.5%	90.0%			87.9%		106.3%	45.8%		72.2%	
	% Qualified Staff (Night)							101.6%	103.2%	104.8%			98.4%	107.0%	145.1%	7.0%	100.0%				97.8%	100.0%			100.0%	85.4%		119.8%	124.2%		113.9%		100.2%	103.2%				87.3%	92.9%			95.1%		76.4%	37.7%		79.3%	
	% un-Qualified Staff (Day)							115.3%	188.6%	92.9%			88.4%	105.6%	95.2%	1.6%	104.6%				89.4%	96.8%			99.9%	97.3%		116.3%	81.7%		127.0%		96.9%	105.1%				90.9%	95.2%			92.0%		52.5%	36.8%		99.5%	
	% un-Qualified Staff (Night)							183.8%	275.5%	111.6%			98.9%	121.2%	102.4%	0.8%	100.1%				102.2%	102.1%			108.6%	70.1%		147.3%	113.2%		132.3%		122.5%	116.5%				98.0%	147.7%			83.2%		49.3%	28.4%		111.2%	
	Sickness (%)	*Target < 4.2%*		6.87%			7.97%	7.27%	2.37%	11.98%	5.26%	10.59%	5.61%	10.83%	2.70%	7.79%	2.34%	3.75%	5.82%	6.53%	1.06%	9.75%	0.00%	8.89%	11.94%	6.92%	19.96%	5.60%	21.84%	4.63%	7.16%	7.46%	10.67%	12.06%	6.64%		8.80%	3.32%	3.47%		17.60%	8.58%		10.96%	6.55%		9.22%	7.89%

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		N/R				N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1	0	2	0	5	1	3	0	0		16
	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	1	0	0	0	0	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	1	0	0		1
	Monthly New pressure Ulcers (Unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	1	1	0	1	1	2	0	0		9
Audit	Monthly KPI Audit %	*Target = 95%*	99.1%			98.5%	99.4%	99.7%		95.5%		92.7%	94.0%		94.3%		N/R	99.6%	97.9%	98.8%	98.8%	98.8%	98.5%	99.1%	98.2%	98.1%	98.8%	94.2%	98.0%	98.00%
	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%*	80.0%	0.0%	37.5%	0.0%	20.0%	80.0%	0.0%	5.0%	100.0%	100.0%	2.4%	3.1%	0.0%	0.0%	42.9%	75.0%										0.0%		39.90%
	Friends and Family Recommended Rate %	*Target = 97%*	100.0%		93.3%		100.0%	100.0%		100.0%	100.0%	100.0%	86.0%	87.0%			100.0%	100.0%												99.70%
	Number of Complaints received	*Target = 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%*	16.2%	6.3%	3.7%	0.00%	8.6%	20.7%	4.1%	0.72%	3.9%	6.1%	2.8%	1.9%	3.5%	5.2%	16.4%	13.2%	7.5%	6.1%	2.9%	0.0%	3.9%	1.8%	4.8%	15.4%	2.5%	9.7%		6.70%
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	10.8%	24.1%	31.6%	0.0%	25.0%	14.3%	3.6%	37.2%	5.4%	24.2%	14.5%	13.6%	5.3%	6.0%	11.1%	51.9%	5.7%	0.0%	9.8%	16.0%	7.4%	22.2%	13.3%	8.3%	6.3%	10.5%		14.25%
	12 month Appraisal	*Target = 85%*	93.5%	77.5%	77.8%	87.5%	100.0%	90.0%	86.4%	88.9%	85.7%	93.3%	97.4%	100.0%	82.4%	74.2%	100.0%	100.0%	92.9%	88.2%	89.5%	100.0%	100.0%	92.3%	91.7%	88.9%	97.1%	80.8%		89.90%
	12 month Statutory Training	*Target = 95%*	95.9%	92.9%	100.0%	98.3%	100.0%	100.0%	95.2%	100.0%	96.4%	98.7%	99.2%	93.5%	91.7%	97.5%	100.0%	98.9%	95.8%	97.4%	93.4%	99.0%	98.1%	100.0%	93.8%	97.5%	98.2%	93.8%		96.89%
	12 month Mandatory Training	*Target = 85%*	97.1%	86.8%	100.0%	100.0%	100.0%	97.9%	90.0%	97.3%	93.6%	95.4%	94.7%	96.1%	82.7%	95.7%	100.0%	96.6%	93.2%	96.4%	92.9%	100.0%	98.7%	92.6%	94.1%	100.0%	97.0%	91.6%		95.12%

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 …….

Title:	Our Digital Strategy 2022-2025

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24th November 2022		Discussion	√
Exec Sponsor	Sharon Martin Executive Director of Strategy and Digital Transformation		Decision	√

Summary:	The paper outlines our plans for a digital future as Bolton NHS Foundation Trust over the next 3 years. We want to become a digital trust which means that we use technology to improve the lives of our patients and our staff

Previously considered by:	Strategic Operations Committee Digital Strategy and Performance Committee

Proposed Resolution	For Approval of the proposed approach and development of the supporting resource plan

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:	Brett Walmsley Director of Digital Madeleine Szekely – Deputy Director of Digital	**Presented by:**	Brett Walmsley Director of Digital Madeleine Szekely – Deputy Director of Digital

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Our Digital Strategy

2022-2025

... for a better Bolton

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Our plans for a digital future

We want to become a 'Digital Trust', which means that we use technology to improve the lives of our patients and our staff.

Our main priority areas

Digital integration

Sharing information with patients and across the health and social care system

Digital care

Using transformation to change the way we do things

Digital workforce

Supporting staff to work differently

Digital infrastructure and estate

Getting the basics right, with up to date equipment and excellent connectivity.

What will look and feel different to our staff

- The use of technology will make it easier for our staff to do their jobs
- People will have the right kit for their roles
- There will be more data available to help improve the way we do things
- Our clinical records will be connected to support decision making and free up time to care

How this benefits our patients

- All information about our patients will be in one place meaning they get the right care, sooner
- There will be the option to have more virtual consultations and appointments
- People will have access to information and support about their health conditions and how to manage them
- Patients will have access to their own records

We are committed to:

- Making sure that our digital objectives are reviewed every six months to check they're still right
- Evaluating the benefits of all projects and learning where we can
- Looking outside of the Trust to learn from others

...for a better Bolton

Glossary of Terms

BI	Business Intelligence
CCIO	Chief Clinical Information Officer
CRIG	Capital Revenue Investment Group
COW	Computer on Wheels
E obs	Electronic Clinical Observations
EPR	Electronic Patient Record
EDMS	Electronic Document Management System
FT	Foundation Trust
GMCR	Greater Manchester Care Record
ICB	Integrated Care Board
IDG	Identity Governance Administration
LIMS	Laboratory Information Management System
MDT	Multi-Disciplinary Team
PAS	Patient Administration System
PSFU	Patient Stratified Follow Up
RFID	Radio Frequency Identification
RTT	Referral to Treatment

1. Introduction

Digital technology is all around us and can impact almost every aspect of our lives. For an NHS organisation like ours, 'being a Digital Trust' means that we want to utilise digital technology and the data we collect to improve the care we provide to the people of Bolton. This includes making our services safer, more effective and easier to access – all enhancing the overall experience people have when they use our services.

In addition to patients, we want to make sure that we're using technology to support our staff to work as efficiently and effectively as possible, and ultimately make their working lives easier.

2. Why a 3 Year Strategy

Our previous strategy 'Informatics – 5 year forward view' covered the period 2016-21. Our rationale for a 3-year strategy is that:

- We are establishing the place-based models required for integrated health and care provision
- There will be changes at a Greater Manchester level that are likely to impact our future direction of travel
- Digital technology develops at pace and a longer term plan would quickly become out of date

We will review our objectives annually to make sure they are reflective of the new digital opportunities that will become available to help us improve our clinical and operational services, both internally and with our partners.

3. Our Digital Objectives

Our digital objectives are based on the Bolton locality-level ambitions, as well as national and regional priorities. Our plans are also structured around four of our strategic objectives, as outlined in *Our Strategy…for a better Bolton.* These are:

Digital Integration - We will give patients access to their health records and empower them to self-manage their care using technology – including a greater ability to make and change appointments online or by text, and to access clinical information or expertise online or over the phone (through patient portals, apps and virtual outpatient appointments).

We will share information to support care across the health and social care system. Integrating with existing clinical systems will mean staff can instantly access the up-to-date information they need in one place. In an emergency, high-pressure environment, where quick decision-making is often crucial for the best patient outcomes, staff will be able

to navigate easily and share information between teams; transforming the quality and safety of the care we provide.

Digital Care - We have already begun to implement an electronic patient record (EPR) system, which is a significant step towards creating a safer, more sustainable and efficient working environment. EPRs also have the potential to support care pathways and the way in which we deliver care rather than just acting as a clinical record. It is key that we harness this capability to enable us to improve the quality and safety of care delivered.

Our goal is to transform the organisation's performance through the use of technology. We will explore artificial intelligence and machine-learning across our services, whilst robotics and simulation will be used to support our service delivery and training/development of staff.

Digital Workforce - Supporting staff to deliver treatment and services with appropriate technology is critical to supporting our digital expansion. We will provide staff with access to clinical systems and the training they require to use them effectively. We will provide equipment and solutions to enable staff to work differently and make it easy and seamless to undertake their role.

Digital Infrastructure and Estate - Feedback from our colleagues makes it clear that getting the basics right is a priority. User satisfaction will only be high if the devices we use are built upon resilient, stable and secure foundations, with excellent connectivity. Engagement with our users highlighted the necessity of devices and equipment that are up to date, portable and meet the differing needs of each user. High levels of cyber-security are essential to maintain services and patient safety, whilst comprehensive and fast Wi-Fi across all our sites will ensure colleagues and patients can access the information they need. Our strategic ambitions will only be achievable if our digital infrastructure is fit for purpose.

Sections 4-7 outline the delivery of the strategic objective in more detail.

4. Digital Integration

Connecting digitally with patients can include anything from online appointments to video conferencing and assistive technology that allow patients to manage their conditions at home, supported remotely by professionals. It includes giving people access to their health records and providing clinicians with the information they need to care for the patient in front of them, regardless of where the patient previously received care. We want to enable people to access care in a convenient and coordinated way, promoting independence through the digital tools that people are familiar with in other aspects of their daily lives. As we progress through each layer of the strategy, a fully digitised patient journey with access to all required underpinning systems becomes a realisable aspiration.

We make sure patients have easy access to booking appointments, health advice, records and for their information to be integrated across the health and care system in Bolton. With the Health and Social Care integration bill progressing through its legislative stages the “Bolton place” model will look for digital services to play a key role in enabling improved health and wellbeing for Bolton people by organisations working more closely together. Scoping work is taking place to determine the digital requirements to support the planned transfer of Council social care services to the Integrated Care Partnership. This will define IT infrastructure services with supporting staffing capacity.

The following tables outline the projects we will deliver to enhance Digital Integration:-

Table 1 – Projects in progress

Projects funded and In progress	What will we do	Timescales	Funding source
Virtual Consultation	Patients will have access to online consultation services using Microsoft Teams to support this mode of consultation.	Q2 22/23	Capital business case approved No resourcing included
Greater Manchester Care Record (GMCR)	Give health and care workers access to information from across Greater Manchester ensuring patients receive the treatment. The GM Care Record joins together our Greater Manchester different NHS and care organisations to help hospitals and other care services access individual	Q4 23/24	Trust funded to end of 22/23

Projects funded and In progress	What will we do	Timescales	Funding source
	health and care records quickly and securely.		
Improved Access to systems across Health, Care and Primary Care	We will establish a single technical model extension to our current "standardised digital" operating platforms enabling access to BFT / Primary Care and Social Care systems. We will improve Digital Access for our Health and Social Care staff in the community enabling improved access within six estate sites across the system.	Q4 – 2022/23	Business Case Approved and resource allocated.
Primary Care Digital Strategic Objectives	Bolton CCG was integrated into the GM ICB model from July 2022. It is not planned to change/reassign Bolton CCG digital services at this time. Bolton place model will be the continued technical integration between Primary and FT health & care services. This takes the form of – a. Common access and security layer to clinical and corporate systems. b. Integration of Office 365 tenancy's to support better inter-organisation communications as well as jointly exploiting the O365	Q3-4 22/23	GM ICB funded

Projects funded and In progress	What will we do	Timescales	Funding source
	Apps for common development opportunities. c. In properties with shared tenancy adoption of the new FT WiFi by practices. d. Establishing a Primary Care CCIO to work with peers in determining a digital plan.		
GM ICS and locality / ICP intelligence	Ensure that the NHS intelligence offer in Bolton remains strong and effective after move of the CCG team to the ICB in July 2022, work with GM to ensure that the areas of the BI team which are integrated with the FT remain together. Work with the ICB on new projects and collaborate with other organisations across GM to provide better intelligence for our patients. Active participation in the Bolton Research and Intelligence Network (BRAIN) project locally, working with partners to develop the Research and Intelligence offer across Bolton.	Q4 22/23	Current Budget
Innovation Hub	Bolton is part of a local innovation hub including Bolton Council, the University of Bolton and private businesses who	Q4 2022/23	Current budget

Projects funded and In progress	What will we do	Timescales	Funding source
	want to engage to become partners in co-development and research.		
Digital Menu Ordering	Implementation of an app to enable ordering of food for patients in the hospital.	Q4 2022/2023	Business case developed No resource included

Table 2 – Projects with Business Cases in Development

Business Case In Development	What will we do	Timescales	Funding Source
Patient Entertainment System	To provide a robust patient entertainment platform to support improve patient experience and accessibility.	Q4 2022/2023	Business Case to be developed Approx £0.5m Capital Investment
GM Maternity supporting Longitudinal Care Record	As part of the discovery consultancy work commissioned for GM it was informed that up to 40% of mums traverse Health & Care services across GM. To ensure national Maternity EPR system support the national aims of a shared care record, clinically defined data sets will be extracted from each GM maternity service to upload into the patient GM Care Record. Bolton is providing project direction on delivery of this programme.	Q3-4 22/23.	GM Digital programme not currently funded
Trust Website	New Trust website to support patient and community engagement.	2023/2024	Business case to be developed

Table 3 – New Projects to be commenced

New Project to be commenced	What will we do	Timescales	Funding Source
Patient Apps	Patients will have access to self-help information. People are increasingly turning health apps to help support their physical and mental health and wellbeing. Patients can access the library themselves, choosing health apps that they would like to use to assist them in managing a condition or illness they are experiencing. It also means our team can 'prescribe' apps to patients for different conditions.	A number of specialties to be live by September 2022	The current contract is funded until September 2022 and will then require a further business case No resource included to deploy
Telehealth / Care – Virtual Wards	To provide telehealth and telecare solutions to our patients to support patient empowered care and greater efficiencies in care provision.	New national directive published Q1 23/24.	Business Case to be developed Approx. £2m investment
Digital Exclusion	We must ensure that we do not exclude patients or communities due to digital inaccessibility. Not everyone has access to digital technology and it is vital that we maintain systems and processes which allow people to connect with us using more analogue methods. Through the Bolton Borough-wide Digital	22/23 & 23/24	Working with system partners on solutions Business Case to be developed if required.

	Partnership body we will assess and promote digital inclusion, standardising accessibility and tackling digital exclusion. Alternatives for those not wanting to engage digitally will be explored and options provided to ensure full service user interface activity. This includes developing digital champions and easy to use guides.		

5. Digital Care Delivery

Currently, too much information about a patient's health and care is recorded and stored on paper, or electronically on separate systems that are not interoperable or that require separate logins. Using integrated electronic patient records allows a comprehensive set of information to be shared securely and efficiently between health professionals in support of patient care.

Electronic Patient Records (EPR) are 'digital records of a patient's health and care' and include a broad range of information including 'current treatments, test results, clinical notes, care plans and correspondence between professionals. EPRs also have the potential to support care pathways and the way in which we deliver care rather than just acting as a clinical record. It is key that we harness this capability to enable us to improve the quality and safety of care delivered.

The core functionality of an EPR includes:

- Electronic observations (e-obs)
- Ordering and viewing test results
- Digital correspondence with patients and clinicians
- Electronic prescribing and medication administration
- Digital patient assessments
- Patients notes (captured and viewed electronically)
- Care plans

In delivering EPR, we will be building and expanding upon the digitisation that has already taken place in some areas of the Trust by enabling all patient information (regardless of their location) to be captured and shared digitally.

It is widely accepted that the key driver for projects that implement EPR functionality is to improve patient safety. Whilst digitisation brings wide-ranging safety improvements, this is typically achieved as a result of improved compliance with clinical process and visibility of patient data.

Our approach to delivering EPR will focus on the following principles:

- Clinically-led: Our requirements and procurement decisions will continue to be shaped by our clinicians.
- Real time use: it is vital to have accurate, complete and contemporaneous information available to clinicians wherever they are. This requirement can only be met by equipping our colleagues with mobile devices through which they interact with the EPR. Patient data will be entered at the bedside, information communicated and received in real time with no delay or inaccuracies introduced through reliance on paper or static equipment.
- Interoperability: regardless of which supplier provides which functionality, it is vital that our systems are interoperable and interchangeable.
- Phased and modular: our journey towards a full EPR will involve adopting new EPR functionality in a phased way, module by module, and replacing older systems where appropriate.

The following tables outline the projects we will deliver to enhance Digital Care Delivery:-

Table 4 – Projects in Progress

Projects funded and In progress	What will we do	Timescales	Funding source
Electronic Patient Record	Phase 1A: Upgrade to EPR Infrastructure to support further roll out. Deployment to Community Bedded Units. Deployment to A&E.	2022-2025	Committed/In Progress
Maternity EPR	Phase 1: Implementation of a maternity specific EPR.	2022-2025	Committed/In Progress
Open Eyes EPR	Continue implementation of the OpenEyes EPR to support transformation of ophthalmology services.	2022-2025	Further resource required as original business case funding expired

Replace Patient Flow: (ExtraMed)	We will develop a Business Case to replace the current ExtraMed platform to one which offers the Trust greater interoperability capability as well as more appropriate functionality to support patient flow.	2023/2024	Business Case presented for CRIG Sept 22
Voice Recognition	We will implement Voice Recognition solution allowing clinicians to create the clinical documentation at source which offers direct integration to our EPR platform. The Trust has been asked to become one of three Microsoft national beta sites for this solution. Initial considerations to pilot with Community Paediatrics.	2023/2024	Business Case Approved - UTF 21/22 No resource allocated
GM: Imaging archive	Implementation of a single GM Imaging archive and harnessing the new solution to implement new ways of working within Radiology and wider ologies.	2022-2025	GM Digital programme funded. Limited resource allocated
GM Pathology	A GM strategy for Trusts to standardise on operating Pathology services and functions. Laboratory Information Management System (LIMS) - A GM digital model to establish a consistent Pathology LIMS across Trusts supporting functionality. E.g. test	2022-2024	Funding source: GM Capital 2021/22-2022/23.

	requesting/results, links to PAS / Analysers.		
Digital Pharmacy	Support the implementation of digital pharmacy solutions, including prescription tracking, robot replacement, pixis machines implementation.	2022-2023	Capital Funded but no staffing resource
Digital Pre-Operative Assessment	Digital capture of patient questionnaires to support pre-operative assessment.	2022/2023	Capital Funded but no staffing resource
Medical device integration	Currently our clinicians manually extract key patient vital signs data and input to our e obs platform or onto paper (ICU, HDU, NICU & Theatres). We will provide direct integration of the devices to free up key clinical time.	2023-2025	Phase 1 Capital Funded No staffing resource Phase 2 business case required Approx £1m capital investment required
GM Cancer	Roadmap defined by GM Cancer Alliance to establish three programmes with a common digital set of system/standards – Patient Stratified Follow Up (PSFU). Single Queue Diagnostic MDT. Clinically defined data set for upload to GMCR.	2022-2024	GM Digital programme No Business Case at GM/Local level for the overall programme.
Radio Frequency Identification (RFID)	The introduction of Wi-Fi services across BFT sites supporting Health & Care introduces capability to operate RFID to support clinical and operational services. RFID is a form of	2022-2024	Business Case Approved UTF 21/22 Resource in place for phase 1 only

	wireless communication that incorporates the use of electromagnetic or electrostatic coupling in the radio frequency portion of the electromagnetic spectrum to uniquely identify an object or person.		
Robotics & Artificial Intelligence	Support back-office admin functions and clinical decision making/intelligence through the use of Robotics and AI. Opportunities include write back to PAS/Theatre systems for elective recovery patient prioritisation, patient registration and ADT (see below).	2022-2023	Business case approved

Table 5 – Projects with Business cases in Development

Business case in development	What will we do	Timescales	Funding source
Electronic Patient Record	Phase 2: Deployment to OPD. Deployment to Community Remaining Gaps in paeds & prescribing. Continue to optimise the solution to support improvements in clinical delivery, support new more efficient ways of working and improve record keeping.	2022-2025	Further business case review required as no further capital identified or resourcing Approx. £1.5m capital investment required

Business case in development	What will we do	Timescales	Funding source
Maternity EPR	Phase 2: Implementation of a maternity-specific EPR.	2022-2025	Business case to be developed. Capital and revenue required

Table 6 – New Projects to be commenced

New project to be commenced	What will we do	Timescales	Funding source
PAS/Scheduling Solution	Procure and implement a new PAS/Scheduling solution to meet the modern needs of the organisation and enable effective use of resources.	2022-2025	Business Case to be developed Approx. £3-5m capital investment

6. Digital Workforce

This element of the strategy focuses on using digital technology to enhance, improve and in some cases automate what we do. With investment in smart technology comes long term efficiencies and the capability to remove repetitive, task-based work across many services. This will improve quality, accuracy and even morale.

We want all of our colleagues to have the right tools to do their jobs to the best of their ability. Digital technology has the ability to reduce the administrative burden on our colleagues through automating processes (e.g. pre-populating digital forms), supporting decision-making (e.g. alerts to prevent duplication of medications) and providing clear information (e.g. structured fields and digital text, rather than handwritten notes). In addition to having the right technology, it is vital that people have the right skills to use it. To this end we are committed to supporting our colleagues through training, education and development. Fundamental to the successful delivery of this strategy and any digitisation project is the cultural and behavioral change.

The following tables outline the projects we will deliver to enhance our workforces Digital Skills:-

Table 7 – Projects in Progress

Projects funded and in progress	What will we do	Timescales	Funding source
Agile Working	We will support our staff to work in an agile way, safely. Phase 1. Dowling house: a. corporate office service hub on-site working area. b. Remote working from home: enabling the agile working approach in line with rationalisation of corporate office capacity.	2022-2023	Phase 1 funded Phase 2 subject to business case. Approx. £1m capital investment
IDG & Virtual SmartCards	This further extends our ability to provision a new member of staff with immediate access to clinical and corporate systems.	2022-2023	UTF 21/22 No resource identified to support
New Trust Intranet	New Trust intranet to support sharing of information and communication and act as a digital hub for staff.	2022/2023	Permanent resourcing required
Apps to aid staff	We will use apps where possible to support staff with easy processes. 1st Phase: Room Booking Staff Leave Carry Forward Authorisation.	2022-2023	Further funding required
Informed and Intelligence Analytics Services	Develop analysis to support divisions in elective recovery, particularly	Ongoing	On-going 2022/23 – 2023/24

Projects funded and in progress	What will we do	Timescales	Funding source
	monitoring of the operating plan and highlighting areas of good practice and areas of challenge *(monitoring of ops plan first draft by July 22)*. Develop data flows to support national and local requirements. Ensure robust analysis is available to support health inequalities, and provide actionable insights to help operational teams pinpoint areas of focus. Supporting new system rollouts/upgrade: Provide BI and coding support to new system rollout / upgrade plans to ensure continuation of data supply, data integrity and the ability to report effectively from our system.		
Data Quality & Coding	RTT validation to help manage a growing RTT waiting list and work with operational teams to look at new ways of working. Increase identification of data quality issues and education to staff. Undertake and support data quality initiatives like the Big Clinic Clean Up and Know Your Patient. Run internal initiatives across teams to improve data quality and internal processes (*Identification of*	Ongoing	On-going 2022/23 – 2023/24

Projects funded and in progress	What will we do	Timescales	Funding source
	Community Activity Sprint - July 22). Release our coding information assurance leads to work more closely with specialties and wards to improve clinical data quality and provide targeted help to improve known problem data quality areas.		
Intelligence infrastructure (inc Tableau):	Facilitate further datasets into the Data Warehouse, such as Workforce data. Investigate ways the Data Warehouse can be used for cross organisation working with our partners. Promote, develop and encourage the use of Tableau, including the creation of a "Data Champions" programme. Further democratise our data by encouraging teams to create and explore data within Tableau. Further stabilise the Data Warehouse structure with full roll out of Development areas and SQL standards into the team.	Ongoing	On-going 2022/23 – 2023/24

Business case In development	**What will we do**	**Timescales**	**Funding source**
Equipment to support EPR Rollout for outpatients, community and maternity	Implementation of further equipment to support EPR.	2022-2023	Approx. £1m capital investment

Business case In development	What will we do	Timescales	Funding source
Smart devices	The Digital Team are working on a with iFM to test Smart devices and pagers to support alerting.	2023-2024	UTF 21/22 No resource identified to support WiFi Dependent

Table 8 – Projects to be commenced

New project to be commenced	What will we do	Timescales	Funding source
Clinical Leadership	We will review the CCIO leadership model to ensure divisional representation.	Ongoing	Further funding required
Digital Training & Education	Key enabler to adoption and user acceptance is via the DT&E team. Supporting the rollout of Clinical system upgrades/new investments.	Ongoing	In Progress

7. Digital Infrastructure and Estate

Feedback from our colleagues makes it clear that getting the basics right is a priority. User satisfaction will only be high if the devices we use are built upon resilient, stable and secure foundations, with excellent connectivity.

Engagement with our users highlighted the necessity of devices and equipment that are up to date, portable and meet the differing needs of each user. High levels of cyber-security are essential to maintain services and patient safety, whilst comprehensive and fast Wi-Fi across all our sites will ensure colleagues and patients can access the information they need.

Our strategic ambitions will only be achievable if our digital infrastructure is fit for purpose. We are future-proofing our data centre, and this combined with an anticipated move towards a cloud-first strategy means that we have flexibility to provide the infrastructure that is needed as our requirements change over time. Our infrastructure needs to support the mobility of our colleagues, be that to enable working across sites, out in the community, across partner organisations or at home.

We will adhere to Information Governance standards, including for the availability, security and integrity of information, acknowledging the complexities of access to records, particularly for vulnerable groups. Underpinning our approach is our multi-year capital programme, which will be reviewed and adapted based on changing requirements and the availability of funding.

Delivery: This objective encompasses improving systems, enhancing our support offer and delivering connectivity across our hospital, community and co-located sites with other partners, such as GP practices and Bolton Council. As infrastructure improves, there will be instant benefits to our patients, workforce and systems. This layer of the strategy requires a focus on building for the future, considering new models of investment, such as managed services to enable us to continue to evolve and replace our technology in future, improving our core infrastructure and implementing new wired and wireless solutions to ensure our staff are connected, wherever they are working.

What will be different? Connectivity, cyber-security and I.T. resilience will be improved, meaning that staff can connect wherever they are working on the BFT/GP practice/Council estate. We will take the opportunity to build on our "Standard" Core infrastructure that operates across the BFT and Primary Care sites to establish a seamless service to our customers. Infrastructure will be in place that gives us confidence in our ability to continue to innovate. It will focus on improving digital solutions to support new ways of working, including virtual consultations, virtual conferencing and agile working.

The following tables outline the projects we will deliver to enhance our Digital Infrastructure and Estate:-

Table 9 – Projects in progress

Projects funded and In progress	What will we do	Timescales	Funding source
WiFi	Wi-Fi services to the sites in which staff from Acute/Community & ICP services operate.	Q2 2022/23 – Q3 2023/24	Business Case approved and resource allocated.
Desktop/Laptop devices	We will replace 50% of our desktop devices (circa 3500) across BFT estate. This will provide greater memory and processing capacity necessary to operate the profile of current and future clinical and back-office systems.	Planned timetable for delivery: Q1-4 23/24	Business Case Approved. No Resource allocated

Projects funded and In progress	What will we do	Timescales	Funding source
Computer On Wheel's (COWS):	Feedback from wards from phase 1 EPR deployment highlighted staff satisfaction with provision of COWS to support ward rounds. During 21/22 Trust Capital and UTF funding sourced 97 devices.	Timetable for delivery: Q1-2022/23	Business Case Approved. Resource not allocated
Mobile Phones	Replace/Supply 1200 mobile phones for Families/Community Division for use with the LoneWorkers app.	Planned timetable for delivery: Q2/Q3 – 2022/23 Initial pilot followed by full rollout.	Business Case Approved. Resource not allocated
Mobile Phone Signal Boosters	Roll out of boosters across identified community sites.	Planned timetable for delivery: Q4 – 2022	Business Case Approved.
Server Re-fresh:	Replace Servers / Databases / Storage and licensing to support new/additional application services/upgrades This will enhance performance to end users of clinical systems.	- Q 1 2022 - Complete	Business Case Approved and resource allocated.
Microsoft 365	Roll out and optimise the solution.	Q4 2023	Business Case Approved No resource allocated.
Community Diagnostic Centre	Support the creation of digitally-enabled estate.	Q4 2022/2023	Business Case Approved
Theatre Build and Refurbishment	Support the creation of digitally-enabled estate.	Q4 2022/2023	Business Case Approved

Projects funded and In progress	What will we do	Timescales	Funding source
Cyber Security	Upgrade data filter to provide a more secure basis for internal/external bound traffic.	Q3/Q4 2022	Business Case Approved – CRIG May 22

Table 10 – Projects with Business Cases in development

Business case In development	What will we do	Timescales	Funding source
Service Desk and Server Monitoring	Robust monitoring of the network and server infrastructure to ensure reliable delivery of It service is maintained.	Q4 2022/2023	Business case to be developed Approximately Capital investment of £100k
Mobile Phone Signal Booster FT Site	Provide robust mobile phone signal on the hospital site and act as backup for WiFi in event of failure for mobile devices, pagers etc.	2023/2024	Business case to be developed Approximately Capital investment of £500k

Table 11 – New Projects to be commenced

New project to be commenced	What will we do	Timescales	Funding source
Network Refresh	The Trust's core IT network was refreshed 5 years ago. This requires updating every 7 years to ensure adequate bandwidth if available or it will slow systems down and cause errors to appear.	2024/2025	Business case to be developed Approximately Capital investment of £3-5m

8. Digital Governance

The current approach operated by BFT is to permit Divisions to self-direct digital investments in the absence of a relationship to a defined local digital and clinical strategy.

The following principles should be considered to establish a framework within which digital investment is decided:

- Six monthly review of digital objectives in line with on-going organisational, clinical and operational changes.
- Adoption of NHSD prioritisation matrix for digital investment to support above.
- Annual review of digital maturity assessment following UK guidelines and HIMSS global standards for healthcare digital systems.
- Clear understanding on the role of GM ICS in digital strategy and funding provision following NHSX guidance published in “What good looks like” and “Who pays for what”.
- More joined up digital investment correlation between BFT/Primary Care/Council services to establish a “Bolton” Technology and Analytics framework model.

The Trust is establishing a robust Business Case review and developing a Benefits Realisation process.

The business case template will include a section prompting teams to send draft case to Informatics Programme Group for review by the senior team in Informatics to ensure that all teams are cited and flow and timings can be considered.

The benefits realisation process is in use for new projects moving forwards and a number of projects will be reviewed retrospectively. The process will ensure that the benefits cited in business cases or transformational programme plans are evaluated and progress is reported back to the retrospective committee it was agreed in. This could be CRIG, Trust Performance and Transformation Board or Trust Digital Performance and Transformation Board.

9. Resource Plan

The Digital Strategy outlined is very ambitious but is also essential to the delivery of the wider organisation objectives. Engagement with key stakeholders has made it clear the desire to progress and move forward at pace.

In excess of £20m capital has been invested in equipment, implementation and licensing over the past three years and financial modelling to support the development of this strategy demonstrates a further £15-17m will be required over the next three years.

Alongside capital investment, Bolton NHS FT will undertake a workforce establishment, skills and workload review to support capacity planning and 24/7 Digital cover. This will lead to the development of a three-year capital and revenue financial plan by March 2023. The financial plan will take into account:

https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/#what-does-good-look-like-for-your-organisation

Who Pays for What proposals - Who Pays for What - NHS Transformation Directorate (england.nhs.uk)

10. How we will Measure

	Now	Future	Measure
Digital Integration	Our care pathways are not fully digitised Currently, too much information about a patient's health and care is recorded and stored on paper, or electronically on separate systems that are not interoperable or that require separate logins. This can often be very separate across the healthcare system. We often engage with our patients in very manual ways including paper letters and this interaction is often provider led rather than patient led.	Our service users and staff experience an NHS and social care that acts as one, working in seamless partnership across all care settings through the processes we digitise We will give patients access to their health records and empower them to self-manage their care and engage with health and social care using technology	Measured through systems adoption and service user, carer and staff feedback on the quality of care using patient and staff surveys.
Digital Care	Our care pathways are not fully digitised Currently, too much information about a patient's health and care is recorded and stored on paper, or electronically on separate systems that are not interoperable or that require separate logins. These systems support documentation but often are passive recipients of information rather than an enabler to more effective care pathways	One seamless clinical record is available to all health and social care staff from anywhere. These solutions support safe and effective clinical care reducing clinical risk, promoting best practise and personalised care	Measured through systems adoption and service user, carer and staff feedback on the quality of care using patient and staff surveys. Monitoring of incidents, complaints and clinical audit.
Digital Workforce	Staff often do not have the right equipment or systems in the right place at the right time or have to duplicate input of information into multiple systems leading to reduced productivity and repetition	Staff will have the right tools to do their jobs to the best of their ability. We will provide staff with access to clinical systems, training and equipment to enable staff to work differently and make it easy and seamless to undertake their role.	Measured through systems adoption and staff feedback using patient and staff surveys.
Digital Infrastructure	Our systems are not reliable enough and are reliant on old our outdated infrastructure making it more challenging to connect and engage with our solutions	Connectivity, cyber-security and I.T. resilience will be improved. Staff can connect wherever they are working We will take the opportunity to build on our Core infrastructure that operates across the BFT and Primary Care sites to establish a seamless service to our customers. Infrastructure will be in place that gives us confidence in our ability to continue to innovate.	Measure through service desk metrics, network monitoring systems adoption, penetration tests, digital maturity evaluations, outage reports, Data Security Protection Toolkit and feedback.

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Agenda Item:
14

Title:	People Committee Chair Report October and November 2022

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	James Mawrey, Director of People/Deputy CEO		Decision	

Summary:	This report provides an update on the October and November 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:	James Mawrey, Director of People/Deputy CEO	**Presented by:**	Bilkis Ismail, Non-Executive Director, Chair of People Committee

Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	18th October 2022	Date of next meeting:	14th November 2022
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	Zed Ali, Malcolm Brown, James Mawrey, Sharon Martin, Francis Andrews, Andrew Chilton, Jake Mairs, Carol Sheard, Paul Henshaw, Sharon Katema, Lianne Robinson, Joanne Street, Tracey Garde, Samantha Ball, Lisa Rigby, Rachel Carter	Quorate (Yes/No):	Yes
		Key Members not present:	Fiona Noden, Annette Walker, Tyrone Roberts, Bilkis Ismail

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing		PH presented the Resourcing paper, in relation to turnover he indicated to the Committee that monthly reporting would not give sufficient time to highlight trend activity meaningfully but committed to detailed turnover analysis every two months. With regards to recruitment he indicated pleasing progress with the Trust recruitment pipeline and activity, especially in relation to international nurse recruitment (with 72 arrivals already this year, a further 57 due to arrive between now and the end of the year, and 35 expected to arrive in early 2023), and HCA recruitment (significant reduction in number of vacancies in Acute Adult Care, and A&SS Division at full HCA establishment). Concerns noted about number of HCA leavers in-year (62) and a focussed piece of work is underway on HCA retention. The Terms of Reference and membership for the Resourcing and Talent Planning Steering Group have been reviewed.	• The report was noted • Monthly report remain in place
Agency Update		PH presented the Agency analysis paper. He was pleased to be able to tell the Committee that agency expenditure reduced by £338k in month (September 2022) when compared to August 2022. All agency staff groups showed a spend reduction with nursing reducing by £210k (and at the lowest spend level for that staff group for the financial year), medical reduced by £60k in month (a continuation of a downward spend trend evidenced in August 2022), and 'other' agency reducing by £111k in month. The Trust's total temporary pay bill (bank and agency combined) benchmarks well against other GM Trusts. Despite the positive news we are still tracking above the agency spend forecast submitted to NHSEI at the start of 2022/2023 and significantly tracking above	• The report was noted • Monthly report remain in place

	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

		our internal 'stretch target' for annual agency spend; so it is critically important that focussed work continues on this important item.	
Apprenticeship Update		LR presented an update on our Apprenticeship activity, including progress against our plan and the improvement of apprentices recruited since our last update (note target number of staff undertaking apprenticeships is currently being met – 145 which is 7 above the target of 138).	• Report was noted • Progress to continue to be monitored via People Development Steering Group. • Quarterly update to People Committee.
Health & Wellbeing Update		JK provided an update on our health and wellbeing offering within the Trust, noting that they are currently used by 15% of colleagues with some of our initiatives only used by less 1%. A three phase action plan has been developed to address this, linked with winter planning. Phase one of the plan focuses on specific activity around Cost of Living. A full paper is being provided to the November BoD.	• Highlight report to November People Committee to provide an update on effectiveness of the cost of living initiatives being put in place. • Update to Board of Directors in November.
Freedom to Speak Up Q2 Update		TG shared a quarterly update on freedom to speak up and the increase that has been seen in cases. TG confirmed that this is seen as a positive and there is closer relationship with the OD programmes to ensure themes identified are addressed.	• Report noted
Organisational Development Update		JK presented a paper that highlighted the Organisational Development programmes in-place and being developed across the Trust, specifically in Family Care, Adult Acute, Theatres and Ophthalmology. This was the first paper of this nature and will be presented quarterly moving forward to provide assurance on the cultural, leadership and behavioural improvements taking place where required.	• Report was noted • Quarterly update to People Committee
Workforce & Communities Transformation Update		The intention of this programme of work is to bring together transformational priorities and ambitions across the locality, incorporating existing programmes of work, to include; • Acute and Community Foundation Trust • Integrated Care Partnership (ICP) • Public Health Department • Local Council and Social Care Services The programme builds upon existing innovative and transformational approaches already planned, established or in motion.	• The presentation was noted • Quarterly update to People Committee

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Committee/Group Chair's Report

Industrial Action Update		CS presented a paper updating on the current ballots for industrial action underway by RCN and UNISON. Other health unions were reported to be conducting consultative ballots but the outcomes of these are unknown as yet. Divisional colleagues have been updated and operational planning will need to take place once the outcome of the ballots are known.	• Further updates to be made once the emerging position is clearer.
Steering Group Chair Reports		• Staff Experience & EDI Steering Group • Resource & Talent Planning Steering Group • People Development Steering Group	• Noted
Divisional People Committee Chair Reports		• Acute Adult Care Division • Anaesthetics & Surgical Services Division • Diagnostics & Support Services • Family Care Division • Integrated Care Services Division	• Noted

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

Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	14th November 2022	Date of next meeting:	20th December 2022
Chair:	Bilkis Ismail	Parent Committee:	Board of Directors
Members present/attendees:	Alan Stuttard, Zed Ali, Malcolm Brown, Fiona Noden, James Mawrey, Tyrone Roberts, Francis Andrews, Andrew Chilton, Jake Mairs, Carol Sheard, Paul Henshaw, Sharon Katema, Lianne Robinson, Joanne Street, Lisa Rigby, Francesca Dean, Janet Cotton	Quorate (Yes/No):	Yes
		Key Members not present:	Sharon Martin, Annette Walker

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing		The report included detailed information on turnover broken down by staffing groups and divisions. In terms of the regional and national picture, Paul Henshaw advised that we are benchmarking well in most staff groups, and slightly above in midwifery. The report also outlined key actions that are underway to support retention. The recruitment pipeline remains positive, including additional funding secured for the international nurses programme, and the Committee were sighted on the projected numbers entering the organisation. The Committee welcomed the innovative idea for the Trust to create a Urology CESR training programme across GM.	• The report was noted. • Monthly reporting to remain in place.
Agency Update		Agency expenditure is currently tracking more than the forecast submitted to NHSE, and considerably more than the stretch target set at £16.5 million. Whilst agency spend is showing a downwards trajectory, pressures continue. The paper also outlined actions in place to mitigate and reduce spend.	• The report was noted. • Monthly reporting to remain in place.

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		The Committee was assured that the Trust was not paying the excessive agency rates which were recently reported in the press as being paid by some organisations and that the Trust was working with the NHS Workforce Alliance to standardise agency rates. The Committee was also informed that a tracker was being developed which will show, month on month, the level of newly qualified nurses, international recruits, HCAs etc that we will have recruited, with a view to predicting when agency costs will reduce.	
Mandatory & Statutory Training Update		Lisa Rigby presented a very comprehensive report on the compliance rates for Mandatory and Statutory training at a Trust and Divisional level, as of 31st October 2022. Benchmarking was undertaken and it showed Bolton's position is reflective of other organisations. The plethora of actions being taken were welcomed including the possibility of using MS Teams and in person training in the lecture theatre. It was noted that operational winter pressures may cause difficulties but every effort will be made to focus on improving compliance.	• The report was noted. • Quarterly compliance reports to remain in place.
Cost of Living Update		Jake Mairs presented an update on the Trust's enhanced staff health and wellbeing offer and associated actions to support colleagues with the cost of living crisis. Given the full paper is coming to Board, no further update is provided in this section.	• The report was noted. • Quarterly reports to remain in place.
Bi-annual Safe Staffing Report		Lianne Robinson presented the report. The Committee were assured that minimum staffing levels were in place during this reporting period and that a safe service was being provided. Given the full paper is coming to Board, no further update is provided in this section.	• The report was approved and recommended to the Board.

	No assurance – could have a significant impact on quality, operational or financial performance;
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Bi-annual Maternity Safe Staffing Report		Janet Cotton informed the Committee of the shortfall in Midwifery establishment of 39.11 WTE and the mitigating actions being taken. The Committee noted that the funded midwifery staffing budget reflects the establishment levels as detailed in the staffing establishment reconciliation of September 2022. The Chief Nurse and the Director of Midwifery confirmed minimum staffing levels were in place during this reporting period and that a safe service was being provided. The Committee was also informed that the dashboard indicators reflect a challenged service but that the increased incidence of critical safety indicator outcomes do not appear to be related to staffing levels. Given the full paper is coming to Board, no further update is provided in this section.	• The report was approved subject to amendments and recommended to the Board.
Medical Director's Report – Managing Concerns		The paper updated the Committee on the current formal cases relating to Medical Staff. It provided assurance that cases are being actively managed in line with Trust and national policy (Maintaining High Professional Standards) by outlining the nature of the issue, outcome and whether cases involve doctors with protected characteristics. It was noted that this paper focused on Medical staff and a similar paper would be helpful for all other staff.	• The report was noted. • Future quarterly reports to be brought to the Committee which should include all staffing groups.
AOA Annual Report Action Plan		The Medical Director provided a further update on the measures being taken to support appraisal and revalidation for Medical staff. The Committee felt assured that the necessary measures were in place.	• The report was noted

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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

Committee/Group Chair's Report

Steering Group Chair Reports		• Staff Experience & EDI Steering Group • Resource & Talent Planning Steering Group • People Development Steering Group • Workforce Partnership Forum	
Divisional People Committee Chair Reports		• Acute Adult Care Division • Anaesthetics & Surgical Division • Diagnostics & Support Services Division • Integrated Care Services Division	

	No assurance – could have a significant impact on quality, operational or financial performance;
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Agenda item 15a

Title:	Bi-Annual Staffing Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Summary:	The purpose of this report is to outline the findings of the Bi-annual Nurse staffing review for the period January – June 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators and provides assurance of safe staffing levels for the period January to June 2022 The report also highlights work underway in respect of specialist areas such as; Neonates, theatres, A&E and also Community nursing. It also details work underway with regard to Allied Health professional workforce. Finally, an overview of additional transformational work-streams is included with a focus on the contribution of Nurse associates and also the potential inclusion of digital technology.

Previously considered by:	Chief Nurse People Committee 14th November 2022

Proposed Resolution	Board members were asked to note the assurance provided on staffing for the period January – June 2022.

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

Prepared by:	L Robinson, Deputy Chief Nurse Sonia Griffin, Assistant Nurse Director T Roberts, Chief Nurse	**Presented by:**	T Roberts, Chief Nurse

1. Introduction

1.2 This report details the findings of the Bolton Foundation Trust 2022 bi-annual staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the organisation.

1.3 The report fulfils the requirements outlined in the National Quality Board (NQB 2018) that recommends acute hospitals should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months The review incorporates all national guidance relating to the provision of safe staffing levels, National Institute for Clinical Excellence (NICE) guidance 2016, National Quality Board (NQB) 2018.

1.4 The report provides assurance to the Board of Directors that adult in-patient wards are staffed in line with the national guidance and that where this falls below the standard the relevant mitigation is put in place.

1.5 This report does not cover Maternity staffing, this is covered in detail in a bi-annual Maternity staffing report demonstrating compliance with NQB and CNST requirements.

1.6 This report does not cover in detail staffing in community areas or paediatrics. Bolton FT is currently engaged in the roll out of the Community Nursing Safer Staffing Tool and reporting against these measure will begin in 2023/24

2. Background - Adult in-patient areas

2.1 In January 2018, the National Quality Board (NQB)[1] released updated guidance in respect of adult in-patient areas, defined as wards that provide overnight care for adult patients in acute hospitals.

Table 1; NQB's expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

[1] National Quality Board *Safe, sustainable and productive staffing* an improvement resource for adult inpatient wards in acute hospitals

3. Current situation

3.1 Our approach & assessment to Expectation 1 – Right staff – *adult in-patient areas*

Table 2; Compliance against key recommendations all wards during the months of January- June 2022

Recommendation	Assessment		Variation
RN to Patient ratios not exceeding 1:8 day shifts	All adult in-patient areas achieve a maximum ratio of 1 RN to 8 patients on day shifts	✓	
Evidenced based Tool	The Organisation has deployed the Safer Nursing care tool	x	Lack of validity and reliability due to frequent ward case-mix changes during covid-19 pandemic plus a need for greater validity from enhanced mitigation of the inter-rated reliability
Headroom/uplift	Headroom/uplift is calculated at 23% - compliant	✓	
Skill Mix	Reviewed as part of bi-annual staffing review.	✓	Currently being reviewed as part of safe care roll out.
Professional judgement	All areas were reviewed as a table-top exercise by the Chief Nurse in April 2022 with a focus on RN to Patient ratios and overall shift numbers (budgeted) vs actual	✓	

3.2 The table below provides an example of RN to Patient Ratios throughout the reporting period. An in depth review has been undertaken and there has been no occasions were this ratio has exceeded the 1:8.

Table 3: Example RN to Patient Ratio for day shifts.

Ward	Jan	Feb	Mar	Apr	May	Jun
B1	1:6	1:6	1:7	1:7	1:6	1:6
D1	1:4	1:4	1:4	1:4	1:4	1:4
F3	1:4	1:5	1:5	1:5	1:4	1:5
G3	1:5	1:6	1:6	1:6	1:6	1:6

D1 shows a higher ratio of RN to patient due to being an emergency assessment area.

3.3 Process for review of safe staffing

3.4 A daily review of safeguard by each division and triangulation of data and information with regards to patient harms, complaints, incidents and staff feedback is undertaken to ensure that we capture all emerging risks and can take appropriate action.

3.5 The trust utilises the Safer Nursing Care Tool (SNCT) and SafeCare (web based tools linked to allocate the eroster system) in order to review staffing on a daily basis. This is an evidenced based tool used widely across the NHS to assist organisations when reviewing staffing. This provides the ability to have a full overview of the organisation and the ability to review ward acuity and move staff around to balance and mitigate any risks to patient and staff safety.

3.6 Divisional Nurse Directors or their deputies undertake on a daily basis:

- A full safety walk round across all in patient areas.
- A full review of SafeCare ensuring each area has provided professional judgement with regards to the safe staffing of that ward.
- A divisional staffing review with decisions made to move staff around according to greatest need and level of risk.
- Trust wide staffing meeting at 9:15 am and 1:15pm led by the Assistant Director of Nursing or Associate Chief Nurse, with escalation to the Chief Nurse when there is evidence of potential red flag incidences.
- Matrons are clinically visible in their portfolio.
- Safe Staffing information is reported through the trust bed meetings at 9:00am, 1:00pm. 4:00pm and 7:30pm.

3.7 In addition, there is daily oversight undertaken by the Chief Nurses Senior Nursing Team with twice daily and weekly staffing meetings.

3.8 In instances where the staffing falls below the recommended establishment the following mitigation and actions are put in place utilising all available nursing resource:

- Ward basing specialist nurses where possible.
- Ward managers to be included in staffing numbers.
- Matrons to be released from all none clinical duties to increase their visibility and clinical oversight of their areas.
- Consider use of pharmacy technicians and pharmacists to dispense medications on clinical areas.
- None ward based nurses to be redeployed to suitable ward environment.
- Stepping down none urgent clinical activity.
- Increased use of student nurses and utilisation of synergy model where possible with the oversight of the PEFs and educators.
- Utilising the skills within the full multidisciplinary team such as the skills of the Allied Health Professionals (AHPs)

3.9 In the out of hours' period there is a Late Matron, site manager and hospital at night team who are available for escalation of any staffing issues and are able to be redeployed to the ward to maintain safe staffing levels should they be required.

3.10 Harm data per 1000 bed days

3.11 The organisation has not previously reviewed harm data using per 1000 bed days at ward level and this is currently being scoped with intention to include in safe staffing reports going forward.

3.12 Falls

3.13 The breakdown of falls with moderate or above harm for January to June 2022 is included below. Bolton FT remains below the upper control limit for falls with harm and under the trust target for falls per 1000 bed days. See Table 4 and charts 1 and 2.

Table 4: Falls with Moderate Harm by Division

Month	Number of Falls with Harm	By Division
January	3	ASSD x2, AACD x1
February	1	AACD
March	1	AACD
April	3	AACD
May	0	
June	4	ASSD x1, AACD x2, ICSD x1

Chart 1: Falls with Harm- The trust target is 1.6 falls with harm per month, the mean is 2.

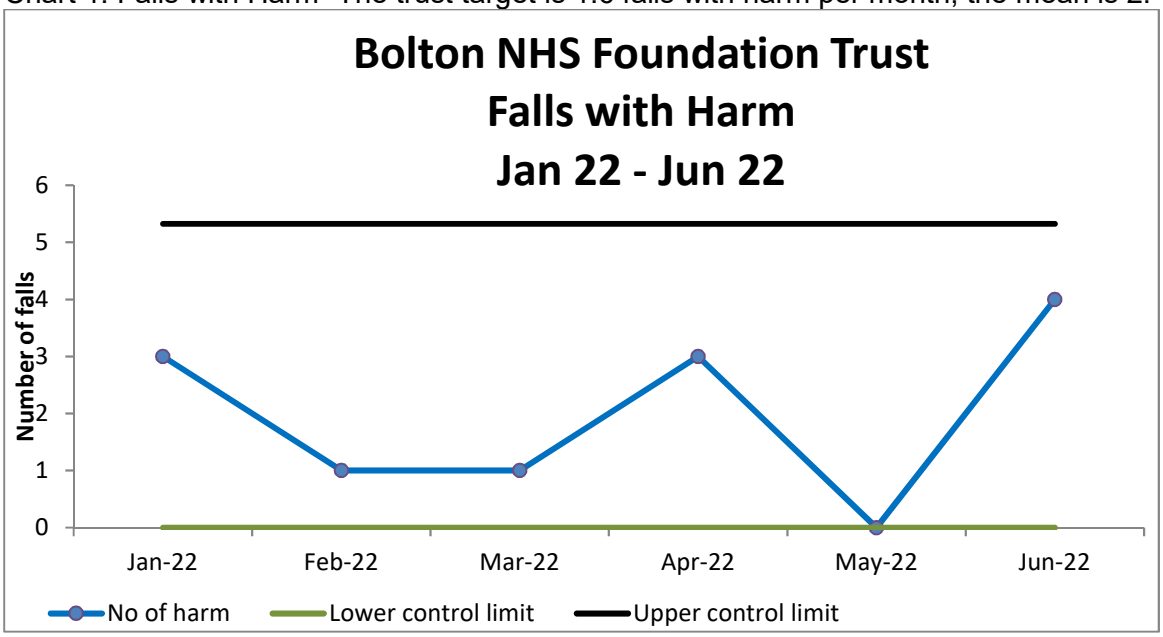
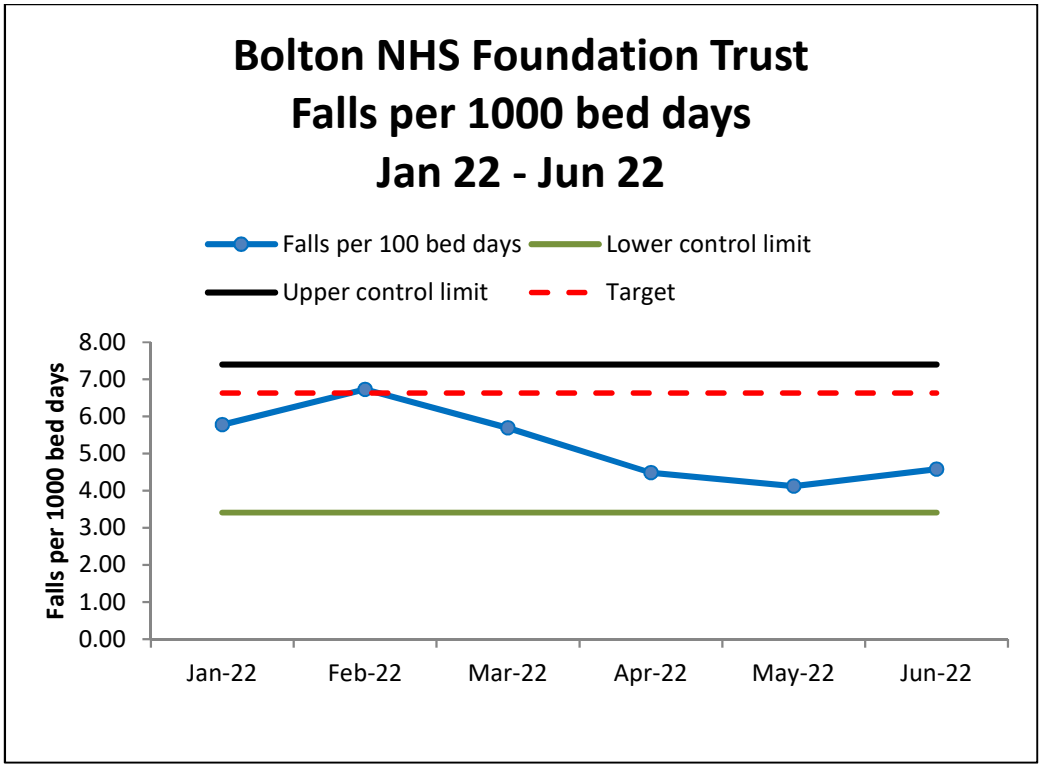


Chart 2: Falls per 1000 bed days.- The mean is 5.21



3.14 All falls with harm are reviewed at a trust wide Harm Free Care panel and key themes and learning are identified.

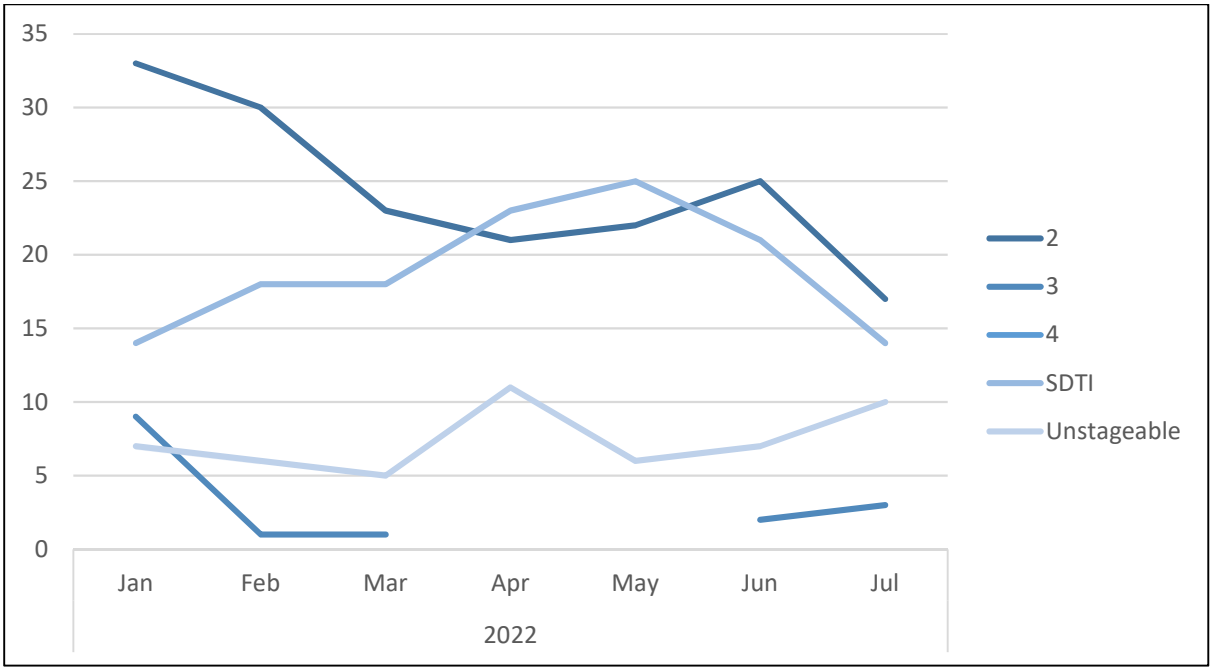
3.15 There have been no falls identified whereby a lack of registered nurses on duty was contributing factor. However, it is recognised that patients that require enhanced care as per trust policy is a contributing factor and are at higher risk. This is being reviewed by the Corporate Nursing teams and a revised approach to the delivery of enhanced care including the use of technology is being scoped.

3.16 Pressure Ulcers

3.17 All pressure ulcers are reviewed at the Trust wide harm free care panel where key themes and learning are identified. There have been no pressure ulcers identified whereby a lack of registered nurses or Health Care Assistants (HCAs) has been a contributing factor.

3.18 SDTI and un-stageable pressure ulcer figures have remained static whereas there has been a downward trajectory of grade 3 and 4 pressure ulcers following peaks in May and June.

Chart 5: Total number of pressure ulcers for Bolton FT



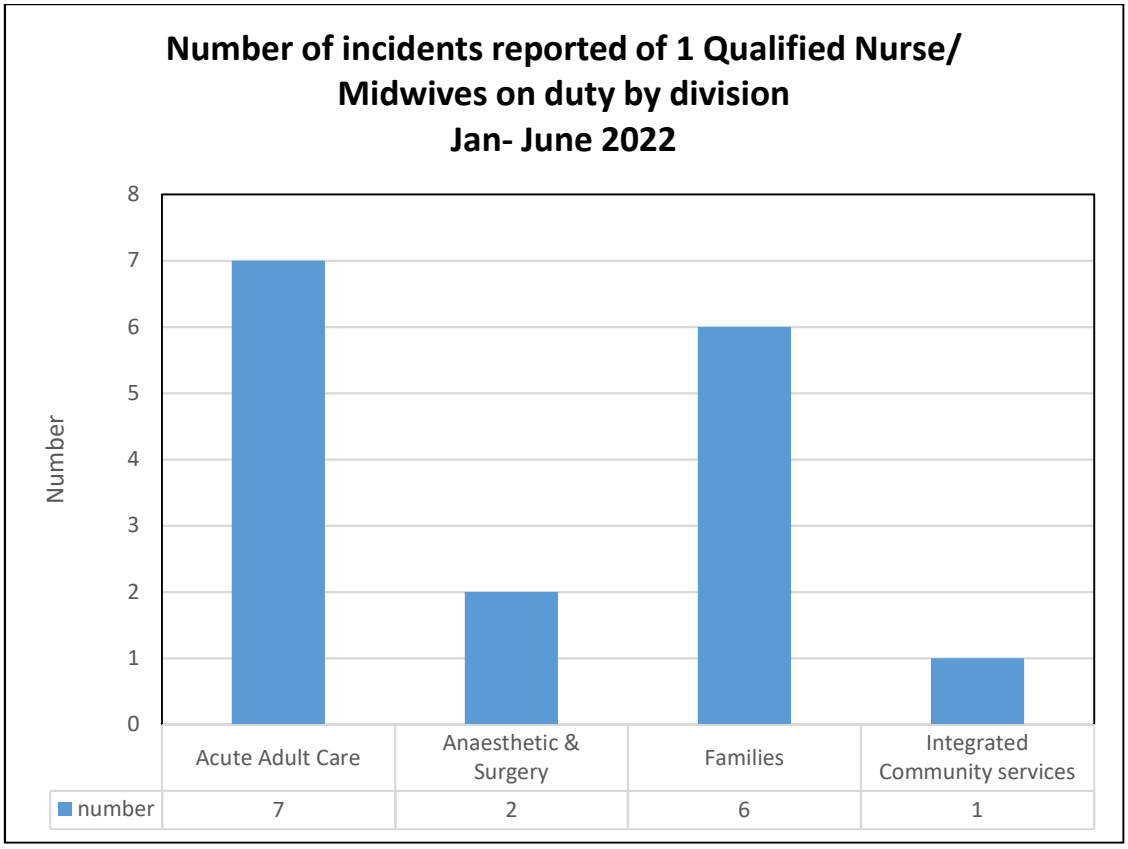
3.19 Red Flags

3.20 In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

- An unplanned omission in providing medications
- A delay in providing pain relief
- An incidence where vital signs have not been assessed or recorded
- Missed intentional rounding
- A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
- Less than two Registered Nurses or Midwives available on a shift.

3.21 Red flags for inpatient services are reported by clinical staff via Ulysses Safeguard system. As part of the SafeCare project there are future plans for these to also be recorded within the SafeCare system.

Chart 6, number of safe staffing incidents



3.23 Appropriate escalation was undertaken for all of the incidents reported and the mitigation taken included the following actions:

- Additonal staff were moved to support from other areas.
- Matron reviews were undertaken and a dynamic risk assessment and professional judgement was used to determine deployment of staffing.
- Unoccupied beds were closed when this could be done safely.

3.24 Themes/trends

3.25 There are 592 incidents between January and June 2022 reported using the staffing cause group and of these 16 incidents detailed only one Qualified Nurse/Midwife.

3.26 Sickness and vacancies are cited as the cause of the areas left with one Qualified Nurse or Midwife in the narrative of the incidents when completed by Managers

3.27 A review was undertaken of the staffing Matron logs and maternity staffing logs for the dates where incidents were reported. All logs documented actions taken to mitigate the areas that had been left with only registered member of staff.

3.28 All incidents detailed appropriate escalation of the lack of Registered staffing. The incidents have been completed with no or low harm as the actual impact. The majority of incidents detail prioritising care to patients during the shifts to manage the situation.

3.29 National Adult Inpatient Survey November 2020 v November 2021

3.30 There are 2 questions in the National Adult In-Patient Survey relating to staffing

Chart 8: National In-patient Survey

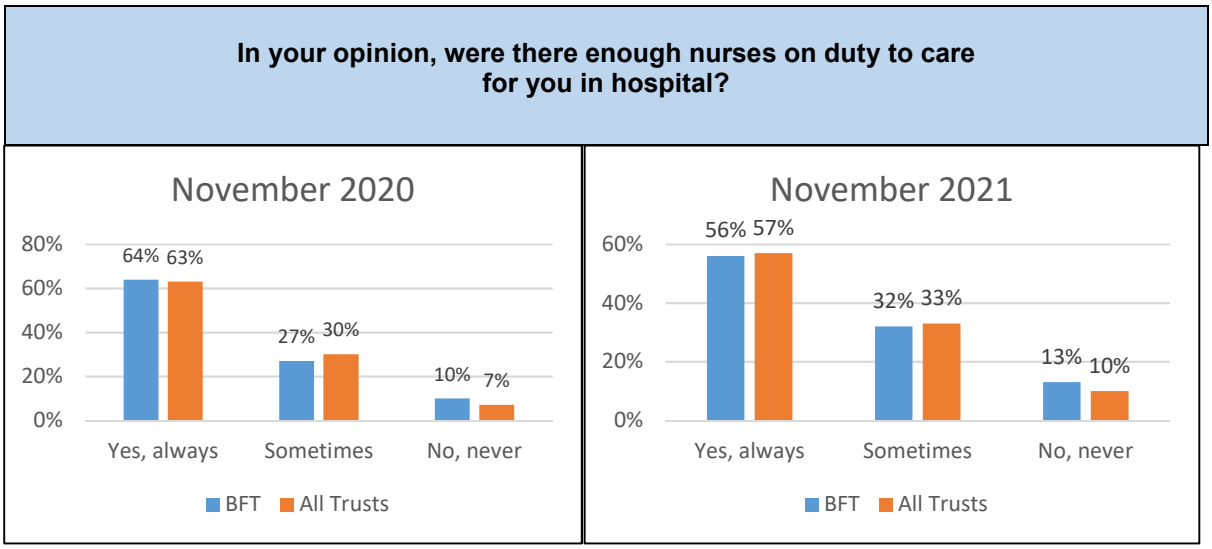
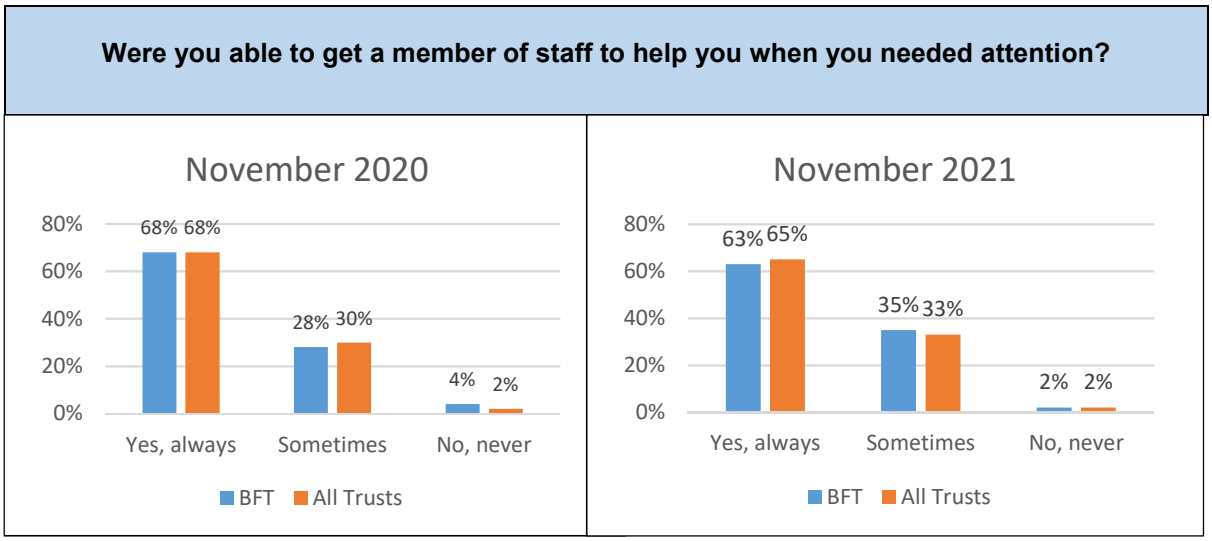
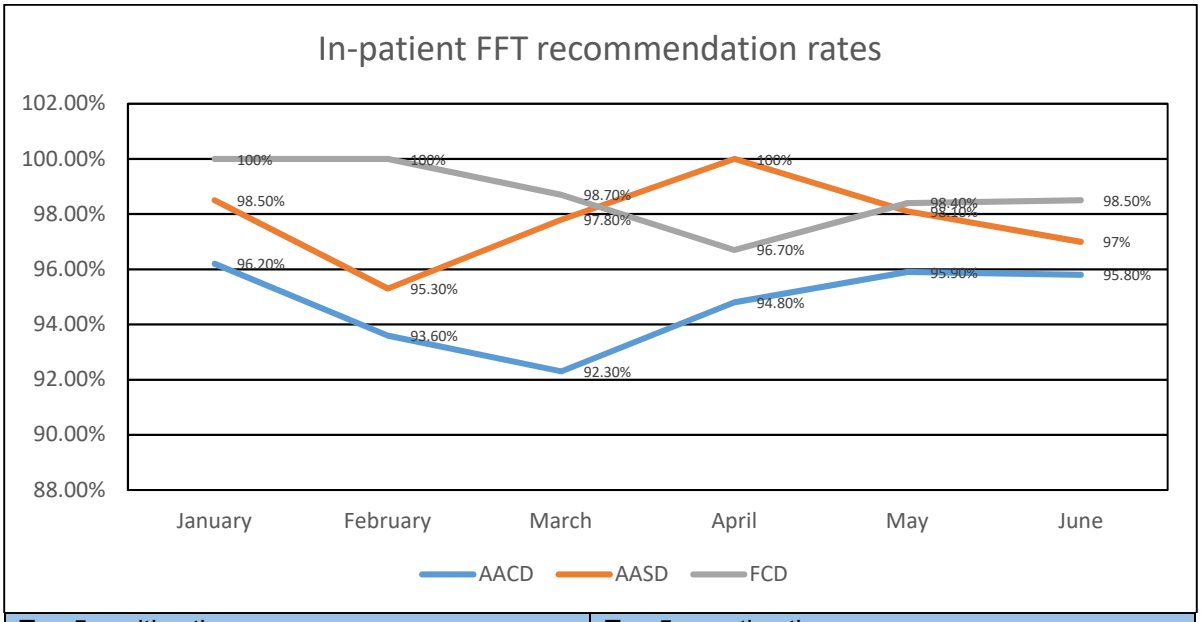


Chart 9: National In-patient Survey



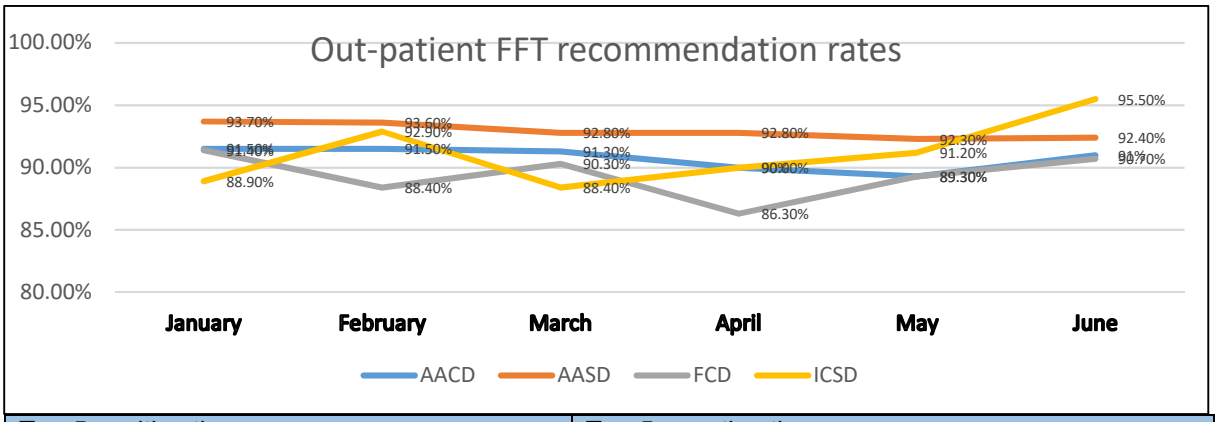
3.31 Friends and Family Test January to June 2022

Chart 10: In-patient FFT recommendation rates



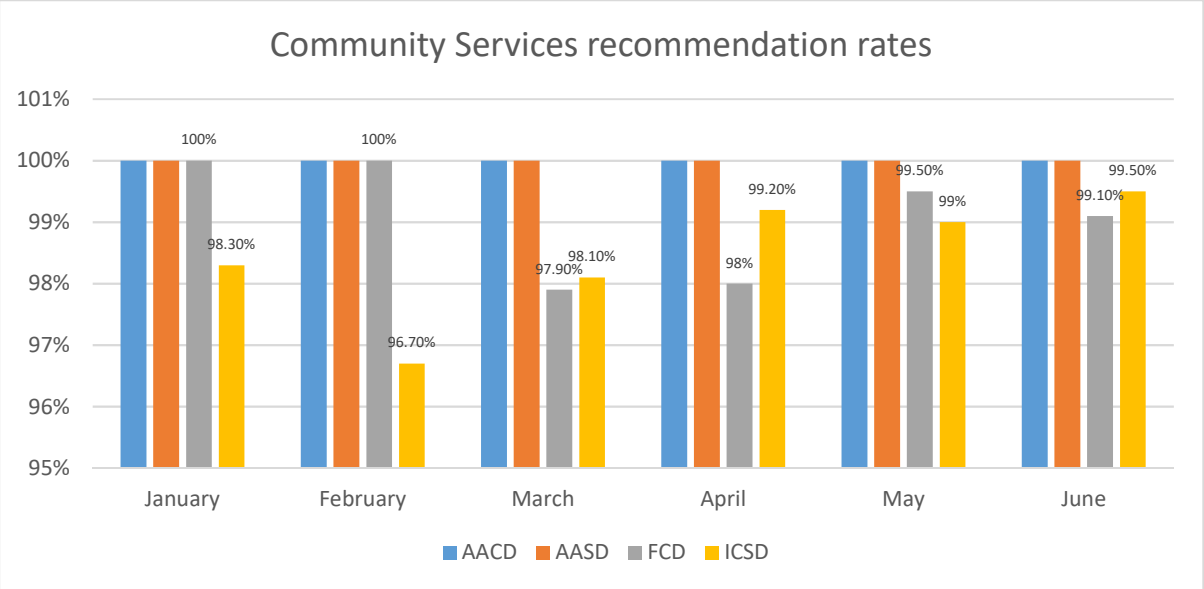
Top 5 positive themes	Top 5 negative themes
• Staff attitude/staff • Implementation of care • Patient mood/feeling • Environment • Communication	• Staff attitude/staff • Patient mood/feeling • Waiting times • Admission • Implementation of care

Chart 11: Out Patient Recommendation rates



Top 5 positive themes	Top 5 negative themes
• Staff attitude/staff • Implementation of care • Waiting • Patient mood/feeling • Admission	• Staff attitude/staff • Waiting • Patient mood/feeling • Communication • Admission

Chart 12: Community Recommendation rates



Top 5 positive themes	Top 5 negative themes
• Staff attitude/staff • Implementation of care • Patient mood/feeling • Communication • Waiting times	• Patient mood/feeling • Staff attitude • Environment • Communication • Food

3.32 PALS and Complaints

3.33 There are no categories captured on our database for PALS and complaints relating to safe staffing. On further analysis of the themes there was no correlation between care provided and staffing levels.

3.34 NHS website reviews

3.35 There were no reviews left on the NHS website in relation to staffing levels and impact on standards of care.

4.0 Expectation 2: Right skills

4.1 Leadership

4.2 As per NQB standards the Anaesthetics and Surgical Services Division have establishment set to enable Ward Managers to be supervisory 5 days per week, this may change to accommodate, sickness, study leave, ward acuity and to provide general staffing support.

4.3 The Adult Acute Care Division set establishments for Ward Managers to have 3 days per week supervisory. This may also be affected by reasons such as sickness, study leave and acuity.

4.4 Across the organisation there is no consistency for supervisory status for ward managers, however all ward managers do have some supervisory time allocated. A review will be included in the next board safe staffing paper.

4.5 Staff measures

4.6 Sickness

4.7 Staff sickness plays a substantial role in shortfalls on the majority of wards and results in temporary shifts being requested or staff redeployment occurring to maintain safety. This has a cumulative effect on the redeploying ward as pressures to maintain patient safety is increased. Sickness is managed by the Ward Manager, with Matron support, Human Resources monitoring and when required, input from Occupational Health. Sickness is managed actively, fairly and consistently balancing the needs of staff with the efficient running of a safe, clean and personal service. The target for sickness 4.2%

4.8 Retention

4.9 NHS Improvement (2019) advises the retention of staff is a key issue for the NHS and it is critical that Organisations focus on securing skilled and sustainable workforce for the future. In addressing the challenges of workforce supply, organisations must focus not only on recruitment but also should ensure new and existing staff are supported and encouraged to remain in the NHS. Turnover within the Organisation is monitored via the People Committee and where high areas of turnover are noted the Divisional Management team and HR Business Partners undertake a deep dive to understand particular issues and agree a support plan. Additionally, all staff are encouraged to undertake exit interviews to aid managers in identifying themes and learning related to why staff are leaving.

4.10 There is a higher rate of all turnover in response to increasing the support required on a temporary basis during Covid – 19, therefore multiple staff were employed on a fixed term contract. In addition, during the pandemic we saw a decline in the number of staff choosing to retire when able and this is now having an impact on our turnover rates.

4.11 The below tables show the HR metrics for each month January to June 2022

Table 7.1: HR metrics

Measure Type	No.	No.	%	%	£	%	%	%	%	%
Period to Measure	In-month	In-month	In-month	12 months	In-month	12 months	12 months	12 months	12 months	In-month
Trust	Headcount (Active)	WTE	Sickness Absence (Non-Covid)	Sickness Absence Rolling (Non-Covid)	Est. Sickness £ (Non-Covid) (in-month)	Labour Turnover %	Appraisal (excluding medical staff)	Statutory Training	Mandatory Training	RTW
Jan-22	5792	5002.50	5.63%	5.24%	£897,862	13.70%	79.65%	87.94%	85.29%	44.54%
Feb-22	5760	4984.66	5.20%	5.21%	£715,861	14.23%	78.99%	86.53%	85.00%	49.82%
Mar-22	5749	4976.19	5.15%	5.30%	£782,939	14.72%	78.03%	85.85%	85.42%	56.04%
Apr-22	5731	4951.56	5.13%	5.34%	£724,670	14.06%	76.92%	86.27%	85.21%	58.35%
May-22	5752	4975.41	5.23%	5.41%	£759,714	14.06%	78.87%	87.73%	85.85%	60.91%
Jun-22	5726	4974.97	5.15%	5.39%	£710,289	14.06%	76.49%	88.24%	87.65%	58.80%

5. Expectation 3 – Right place, right time

5.1 E-Rostering

5.2 E-Rostering and the production of rostering is closely monitored to ensure all rosters are fully optimised. Each division has a monthly meeting with a senior member of the corporate nursing team and workforce support in order to challenge and approve rosters. At this meeting the following KPIs are reviewed prior to rosters being approved:

- Safety: *% of roster unfilled, Charge cover, Skill mix*
- Effectiveness: *Review of unused hours, Additional hours, Wrong grade types*
- Annual Leave: *Ensuring annual leave is within KPI thresholds.*

5.3 A review of rostering KPIs has recently taken place with a roll out of new KPIs planned for January- March 2023.

5.4 Flexible Working Policy

5.5 By ensuring staff have access to an equitable flexible working policy it will hopefully provide staff with the work life balance that is needed and help with preventing sickness and annual leave being used inappropriately. The policy outlines provisions for staff under the following categories:

- Balancing work and personal life
- Special leave provisions
- Caring for children and adults
- Flexible working arrangements

5.6 The policy allows for a partnership approach which is cooperative and which considers both individual and service needs.

5.7 Process for measurement and improvement

5.8 There are plans underway to develop a ward dashboard which will include the following:

- Roster KPIs
- HR Metrics
- Bank & Agency Usage
- Fill Rate.

5.9 This will allow Ward Managers and Senior nursing teams to review and triangulate the data. We envisage that this will be available to report on in the January- June 2023 paper to board.

5.10 Temporary staffing

5.11 Where a staffing shortfall is identified, the escalation process found in the rostering policy should be followed. However, Ward Managers or the Nurse-in-Charge must demonstrate that they have exhausted all potential options via the E-Roster or by using the safer nursing care tool prior to making a request.

5.12 The tables 8 & 9 below demonstrate the month by month breakdown of WTE hours for Registered and Unregistered Bank and Agency staff across the trust from January 2022 to June 2022. This is the culmination of all registered staff employed by the respective divisions including out-patient departments and specialist nursing services.

5.13 When reviewing the data it is important to recognise that a –red position demonstrates that the area is over staffing against the agreed establishment and this is due to sickness and absence, maternity leave, increased acuity and additional escalation areas that are open.

Table 8: Registered bank and agency usage

Qualified	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Funded	1,962	1,964	1,968	1,962	2,011	2,014
Substantive						
Worked	-1,735	-1,739	-1,719	-1,700	-1,695	-1,698
Overtime Worked	-7	-8	-8	-11	-7	-7
Bank Worked	-129	-167	-103	-90	-72	-90
Agency Worked	-152	-123	-170	-132	-144	-125
Sub Total Worked	-2,023	-2,038	-2,001	-1,934	-1,918	-1,920
Funded vs Worked	-61	-74	-33	29	93	94

Table 9: Unregistered bank and agency usage

Unqualified	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Funded	1,169	1,166	1,169	1,173	1,209	1,213
Substantive						
Worked	-1,018	-1,013	-1,030	-1,036	-1,045	-1,048
Overtime Worked	-5	-4	-3	-5	-3	-2
Bank Worked	-216	-247	-203	-202	-184	-201
Agency Worked	-22	-9	-12	-16	-17	-6
Sub Total Worked	-1,261	-1,273	-1,248	-1,259	-1,248	-1,257
Funded vs Worked	-93	-107	-79	-85	-39	-44

5.14 When reviewing staffing, in the absence of the required number of registered staff, additional unregistered staff will be utilised to ensure that patient care needs are met.

5.15 It is evident from the tables above that the number of registered and unregsitered was above establishment in January, February and March and this then starts to turn to a deficit in registered staff. This is in line with the trusts plans to open additional ward areas to deal with winter pressures and increased acuity.

5.16 This information is part of a new data set introduced in August 2022 to provide accurate establishment information. This is monitored monthly and correlated with bank and agency information to ensure that the trust is utilising resources effectively.

5.17 Enhanced care rates (Specialling)

5.18 Inpatients that require enhanced care through direct 1:1, bay tagging or co-horting are managed at ward level on a daily basis. This intervention is not built into existing clinical establishments and as a result we rely on bank staff for additional staffing. Currently, there is a lack of reliability in determining levels of care needed, a view formed following several ad hoc 'in person' checks by the Chief Nurse, and lately reinforced via audits undertaken by colleagues. The following Tables 10 & 11 detail the average number of patients requiring enhanced care provisions per division per month.

Monthly Average Number of Enhanced Care Level 3 Patients by Division
Table 10

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
AACD	42	44.2	34.5	39.4	47.8	40.7
ASSD	17.9	16.3	14.1	13.2	15.1	17.9
FCD	0	0	0	0.3	0	0

Monthly Average Number of Enhanced Care Level 4 Patients by Division
Table 11

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
AACD	28.1	31.3	40.2	41.4	31.9	27.5
ASSD	8.2	6.6	3.8	7.6	9.1	7.1
FCD	0	0	0	0	0.1	0.2

5.20 Enhanced Care level 3: This level of enhanced care observation is required when a patient displays infrequent, unpredictable, unsafe behaviour towards themselves, others and/or the environment or is at avoidable risk of moderate levels of harm. Patients requiring amber (level 3) care will be kept within the line of sight of a clinical team member at all times. There may be a requirement for additional support for these patients above the nursing establishment numbers.

5.21 Enhanced Care level 4: Continuous enhanced observation is required when the patient requires continued regular therapeutic/clinical intervention or if the patient is likely to seriously harm themselves or others. Patients requiring this level of support will display frequent, unpredictable unsafe behaviours towards self, others and/or the environment or is at avoidable risk of significant levels of harm. Nursing establishments within some wards have been uplifted to reflect the increase in requirements for Red Level 4 care, and this should be considered prior to booking further staff.

5.22 Patients requiring Red level 4 care observations will be cared for within in a one to one situation by a clinical team member, by day and by night. The patient will need to be observed at all times, including personal care and toileting. Patients will be cared for on an individual basis.

6.0 Speciality areas

6.1 The ED, Theatres, Critical Care and Neo-Natal units plan and manage their staffing in line with relevant professional guidance. This has not been reviewed as part of this update.

6.2 All areas will have a focused review for the period July 2022- December 2022 and will be reported in the next Bi-annual review and yearly moving forward.

6.3 Community nurse staffing is part of a national roll out of a community safer nursing care acuity model and will be included here in 2023

6.4 A review of allied health professional staffing models have commenced and will be included here in 2023

6.5 All areas are monitored and staffing is reviewed on a daily basis according to patient acuity and dependency. The outcomes of these reviews are then reported through to the daily staffing meetings and are subject to the same controls as earlier reported.

6.6 For the period of January to June 2022 it is noted that the Neo-natal unit experienced staffing pressures related to unfilled vacancies and where vacancies were filled these were by newly qualified nurses who needed longer induction periods. In addition, there were also higher than average sickness and absence levels. This impacted the skill mix in the unit and resulted in a decrease in the availability of supervisory Shift Coordinators. This is monitored on a daily basis and the unit is further supported by Advanced Clinical Nurse Practitioners and appropriate input from the Matron.

6.7 The last review of neonatal nurse staffing levels was undertaken in July 2022 using the British Association of Perinatal Medicine (BAPM) staffing calculation to assess nurse staffing compliance.

6.8 The neonatal unit uses a nursing workforce calculation using the Clinical Reference Group (CRG) work force staffing tool. The last review was conducted on 10 June 2022 with support from the North West Neonatal Operational Delivery Network (NWNODN) using the CRG tool and identified that an additional 11.39WTE Registered Nurse uplift was required to provide direct patient care and an action plan was collated in response. A subsequent regional funding allocation was awarded and the service is now currently funded to the required standard and is currently recruiting to fill vacant funded posts.

6.9 Submission of the action plan will be shared with the Royal College of Nursing, LMNS and Neonatal Operational Delivery network to meet all the required standards**.**

7.0 Next steps

7.1 There are a number key work-streams now in place to drive forward both safe staffing and improve retention these include:

7.2 *Project 1 SNCT*- The embedding of SNCT across the trust on all in-patient ward areas, emergency department and community nursing services. The project also aims to monitor compliance.

7.3 *Project 2 Recruitment*- Deliver on recruitment and retention plans to minimise vacancies in nurse, midwifery and AHP staffing including international recruitment.

7.4 *Project 3 Rota management*- Process, control and reporting for roster and sickness management including the development of KPIs.

7.5 *Project 4 Trainee Nurse Associates*- Utilisation and embed a TNA workforce trust wide with synergy model.

7.7 *Project 5 Bank and Agency*- Process and control for bank and agency spends including fill rate

7.8 *Project 6 leadership*- Complete a full review of the percentage of supervisory time that Ward Managers work against the NQB standards.

7.9 These projects are monitored via the Workforce forum and Talent and Resourcing meetings with assurance via chairs reports to the people committee and Professional Forum (reporting into Quality Assurance Committee).

7.10 Monthly meetings also take place with representatives from finance and HR with the Divisional Nurse Directors and Deputy Chief Nurse to review bank and agency information and establishment control. This process will be further refined over the next reporting period to demonstrate the improvements being made in the use of temporary staffing and monitoring of vacancies.

8.0 Transformation

8.1 Working in collaboration with HR and finance there are a number of transformation schemes currently underway to develop and further strengthen the nursing workforce. These will be reported via the relevant committee meetings and have been identified to support Nurse staffing and also focus on developing the skills, knowledge and ability to undertake leadership and management roles.

8.2 There is an increase in the recruitment of nurse associate via direct entry route with a plan for a minimum of an additional 95+ over the next two years this is being led by Deputy Chief Nurse. The purpose of this is to further strengthen the skill mix and respond to the changes of patient acuity and dependency.

8.3 The Research and Innovation Forum chaired by the Assistant Director of AHPs are currently scoping feasibility of additional technological support to release some aspects of clinical time.

8.4 A review of patient falls will be undertaken with regards to prevention techniques and the use of enhanced care in order to reduce the requirement of one to one care.

8.5 The Chief Nurse co-chairs Greater Manchester workforce oversight group and is seeking opportunities to refresh and renew overall demand and capacity work plans to ensure a consistent direction of travel. There are face to face workshops taking place with regards to this.

8.6 The Chief Nurse has worked with Greater Manchester PMO colleagues to submit a bid to Health education England to pilot an expanded student learner capacity that would see learner placements across primary care and independent sectors to both support integration and expanded capacity

8.7 The Deputy Chief Nurse has commenced a focussed review to pilot digital technology, as appropriate, to support clinical observation of specific patient groups. This is in it's infancy

8.8 Further recognition of the impact and criticality of nursing leadership is noted and an enhanced leadership programme for all Matrons, ward, dept and team managers and their deputies is in development.

9.0 Summary

9.1 This report provides a comprehensive review of the framework used to assess safe staffing levels, both in real-time, and bi-annually. The additional data provided and forensic review supports the recommendation that safe staffing levels were maintained during the periods of January to June 2022.

9.2 The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within Bolton FT.

10.0 Recommendations

10.1 It is recommended that the Board of Directors:

I. Approve the Bi-annual staffing report and recommendations.
II. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

Appendix A – NQB Recommendations

Detailed breakdown.

1.0 Expectation 1 - Right staff

1.1 The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months. The NQB references various tools that can be used.

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

1.4 The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for a maximum of 6-8 patients each during a day shift. There is no specific guidance regarding night duty. This is based on NICE[2] evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward Sr/CN should have supervisory capacity – the extent of which is subject to local Chief Nurse determinant **Headroom / Uplift**

1.5 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

1.6 The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. Current headroom/uplift provided is 23% with national ranges varying between 19% and 25%

1.7 Skill Mix

1.8 This is the ratio of RNs to unregistered staff such as healthcare assistants. Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

1.9 Professional judgement

1.10 The judgement of senior experienced nurses remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements

[2] NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals* July 2014

- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

1.12 NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were stated as specifically affected by the presence (and hence absence) of **registered** nursing staff. These indicators included;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

1.13 The NQB (2018) has highlighted that these indicators can be challenging to monitor consistently and recommends a thorough audit programme be agreed.

1.14 Patient reported outcome measures

1.15 NICE (2014) also recommend monitoring of the following;

- Adequacy of meeting patients' nursing care needs
- Adequacy of provided pain management
- Adequacy of communication with nursing team
- National in-patient survey

1.16 Staffing data & Training and education

- Appraisal, retention, vacancy, sickness
- Mandatory training, clinical training

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Agenda Item 15.B

Title:	Maternity Bi-Annual Staffing Update

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	24 November 2022		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Summary:	The purpose of this report is to outline the findings of the maternity bi-annual review for the period January – June 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. The report highlights that currently the funded registered midwifery staffing establishment meets the requirements of the Birth Rate plus assessment undertaken in 2020 and confirms a further formal assessment is in progress. A detailed reconciliation of the staffing establishment will be undertaken following publication of the revised report. The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with supernumerary status of the Delivery Suite Co-ordinator and one to one care in labour rates remain below the required standard, and remain an area of ongoing focus. Training metrics also highlight poor compliance with the Trust standard and reflect the registered midwifery staffing pressures (circa 39WTE) within the maternity service during the period of review. The report details the actions being taken to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny.

Previously considered by:	Chief Nurse People Committee – 14 November 2022

Proposed Resolution	Board members were asked to note the assurance provided on maternity staffing for the period January – June 2022

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

Prepared by:	J Cotton – Director of Midwifery / Divisional Nurse Director	**Presented by:**	J Cotton – Director of Midwifery / Divisional Nurse Director

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

CNST	Clinical Negligence Scheme for Trusts
NICE	National Institute for Clinical Excellence
NQB	National Quality Board
RCOG	Royal College of Obstetricians and Gynaecologists

1. Introduction

1.1 This report details the findings of the Bolton Foundation Trust 2022 bi-annual maternity staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

1.2 The report fulfils the requirements outlined in the National Quality Board (NQB 2018) and the Clinical Negligence Scheme Trusts guidance (CNST 2022) that recommends maternity services should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months.

1.3 The review incorporates all national guidance relating to the provision of safe staffing levels within maternity services (Royal College of Obstetrician and Gynaecologists (RCOG) 2021), National Institute for Clinical Excellence (NICE) 2016, National Quality Board (NQB) 2018 workforce indicators, clinical outcome and activity measures, outcome measures reported by women, staff reported measures and findings of the formal Birth Rate Plus (BR+) assessment of the midwifery establishment staffing levels undertaken in August 2020.

2. Background

2.1 In January 2018, the National Quality Board (NQB) released updated guidance in respect of nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Table 1: NQB expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

3.0 Expectation 1 - Right staff

3.1 The NQB recommends that there is an annual strategic staffing review, with evidence that it is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months.

3.2 The Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (2022) requires a midwifery staffing oversight report that covers staffing/safety issues to be submitted to the Board every 6 months.

3.3 Process for determining staffing levels

3.4 Birth Rate Plus - Evidence based workforce planning

Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The Birth Rate Plus assessment was last undertaken at the Trust in August 2020 and included case mix data from October to December 2019.

3.5 Findings of the Birth Rate Plus review confirmed that a total clinical staffing establishment of 239.70 WTE was required to deliver a safe midwifery service. This included a clinical midwifery WTE of 219.00 and an additional non clinical establishment. The breakdown as to how the staffing establishment has been calculated by Birth Rate Plus is detailed in Appendix 1.

3.6 The current funded Registered Midwife establishment of 237.98WTE is compliant with the Birth Rate Plus assessment undertaken in 2020 which recommended a total funded establishment of 239.70WTE which should include a clinical midwifery requirement of 219.90WTE in addition to a non-clinical midwifery requirement. The September 2022 funded establishment reconciliation confirms that the funding establishment meets the Birth Rate Plus recommendations (Appendix 2). Birth Rate Plus recommended the service should deploy 19.79WTE additional non clinical staff and the current funded establishment exceeds this requirement. To be noted the staffing deficit of 39.11WTE within the Registered Midwife establishment relates to staff in post (due to vacancy and sickness) and not the funded establishment.

3.7 A formal Birth Rate Plus review is currently underway and is due to be published early in 2023. It is recommended the review is repeated every three years thereafter.

3.8 In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birth Rate Plus or equivalent calculations. The monthly reconciliation as of September 2022 is therefore detailed in Appendix 2.

3.9 Specialist Midwifery Roles

3.10 Specialist midwives support the delivery of the maternity service providing expert guidance and specialist support to the midwifery team. Currently 19.21 WTE specialist midwives are currently employed within the maternity service undertaking a range of roles including infant feeding specialist, digital midwife and pastoral support. The specialist midwives also support the wider workforce by working clinically when required (Appendix 3).

3.11 Birth Rate Plus advises that the additional workforce should equate to no more than 8-10% of the funded clinical midwifery establishment to provide specialist

support for the delivery of a safe service. The current establishment is therefore within the advised requirements for the service.

3.12 Registered Midwife to birth ratio

3.13 A recommended Trust specific ratio for Bolton Foundation Trust of 1.27.5 births to 1WTE was recommended in the last Birth Rate Plus report. This ratio has been calculated using the case mix and acuity data. Table 2 highlights the staffing ratio between March and June does not meet the required standard. Non-compliance with the standard has been exacerbated by the significant staffing gap during this period (circa 39WTE).

3.14 Table 2 highlights the midwife to birth ratio in accordance with funded hours and actual hours worked when staffing levels have been supplemented with additional agency/bank staff to support acuity / activity. A ratio of 1:27 was recommended in the last Birth Rate Plus report and 1:28 was worked in June 2022. Table 2 illustrates the improvement in midwife to birth ratio between actual hours worked due to the supplementation of staffing levels with agency/bank staff,

Table 2: Midwife to birth ratio

Indicator	Goal	Red Flag	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:28.7	1:27.2	1:31.7	1:32.2	1:32.9	1:30.1
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		1:27.2	1:24.6	1:28.6	1:29.5	1:30.5	1:28.6

3.15 Supernumerary Status

3.16 The Delivery Suite Coordinator is a supernumerary member of the team (defined as having no caseload of their own during their shift).

3.17 This indicator is a safety proxy indicator identified within the clinical negligence scheme for trusts guidance to ensure there is oversight of all birth activity within the service at all times.

3.18 Currently non-compliance is recorded on the Birth Rate Plus acuity tool as episodes of care where the Co-ordinator is the named person providing 1:1 care and is thus unable to retain the status of supernumerary co-ordinator.

3.19 CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. The plan to mitigate shortfalls at time of pressure is detailed in section 5.4. An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator is detailed in Appendix 4 for Board approval including a timeline for attainment.

Table 3: Supernumerary status episodes of non-compliance

Indicator	Goal	Red Flag	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
The Co-ordinator is the named person providing 1:1 care	100%	<100%	2	1	3	5	4	1

3.20 Headroom / Uplift

3.21 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

3.22 Current headroom/uplift provided within the Trust is 23% with national ranges varying between 19% and 25%.

3.23 Skill Mix

3.24 Birth Rate Plus advises a registered / non registered skill mix of 90/10 ratio within defined clinical areas such as the postnatal ward to support the delivery of care with unregistered staff. The skill mix calculation is integrated in the overall Birth Rate Plus recommendation and establishment recommendations. The service currently has a 95:5 distribution of clinical to non-clinical ratio in defined settings. An adjustment of the staffing allocations will therefore be undertaken following publication of the upcoming revised Birth Rate Plus report early in 2023.

3.25 Professional judgement

3.26 The judgement of senior experienced midwives remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Acuity requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional

3.27 Safety outcome indicators

3.28 Maternity sensitive staffing metrics are displayed on the integrated performance maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and thus need investigation and prompt action.

3.29 The dashboard reflects an increase in maternity diverts during the period due to sustained staffing pressures within the service during this period.

3.30 The maternity dashboard indicators reflect a challenged service. One to one care in labour compliance rates continue to be below the standard, and remain an area of ongoing focus. A business case for the provision of a second theatre staffing provision was approved in October 2022

3.31 The dashboard figures in Table 4 illustrates compliance with the critical staffing related indicators between January – June 2022. The 1:1 care in labour compliance rate has not attained the optimal standard of 100% and therefore a detailed action plan produced in conjunction with NHSEI is detailed within this report. The service anticipates (subject to recruitment) that full staffing establishment will be demonstrated by September 2023 subject to recruitment to optimise this compliance indicator. Table 4 also highlights the number of times the maternity has been placed on divert due to staffing pressures, which is reflective of the 39.11WTE vacant funded staffing deficit. Assurance can be provided that the increased incidence of critical safety indicator outcomes that have been reviewed such as the stillbirth rate do not appear to be related to staffing levels.

Table 4 - Critical Safety Indicators

Indicator	Target	Red flag	Jan 22	Feb 22	Mar 22	Apr 22	May 22	June 22
Critical Safety Indicators								
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.3	4.3	4.0	4.9	4.3	4.2
HIE Grades 2&3 (Bolton Babies only)	0	1	1	0	0	0	0	0
ICU/ HDU Admissions	Information only		0	0	3	0	0	0
Post-Partum Hysterectomy	0	>1	1	1	0	0	0	1
2nd Maternity theatre requested to be opened but delay or unable to open changed to rag rate Aug 21	0	>=1	0	0		0	0	3
Admissions to Maternity CCU level 2 care	Information only			1	5	5	1	3
% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	11.6%	11.9%	11.8%	9.80%	12.80%	15.45%

3rd /4th Degree Tears (rate in month)	3%	>3.1%	2.47%	3.61%	4.67%	4.17%	3.80%	2.44%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.3%	3.3%	3.4%	3.6%	3.6%	3.6%
Breastfeeding Initiated within 48 Hours	65%	<65%	64.4%	67.0%	66.7%	65.9%	65.7%	64.0%
1:1 care in labour	95%	<90%	97.8%	98.5%	98.5%	97.3%	98.3%	97.7%
% Completed Bookings by 12+6 BI calculation	90%	<90	89.45%	87.53%	87.20%	88.00%	83.20%	86.10%
SUI'S (New only)	0	2	3	0	3	0	0	2
HSIB referrals	Information only		1	0	2	1	1	1
Access Standards								
Unit Closures	0	1	0	1	4	1	1	0

4.0 Expectation 2 – Right Skills

4.1 Mandatory staff training compliance as of June 2022 is highlights the challenge of attaining training compliance with a current vacancy rate of 39.11WTE as compliance with statutory and mandatory training compliance is sub-optimal. Professional specific training has not historically been recorded on the performance dashboard and thus the addition will be made for ongoing oversight and monitoring.

Table 5: Midwifery specific training matrix

Workforce			Jan 22	Feb 22	Mar 22	Apr 22	May 22	June 22
Shifts covered by NLS trained staff	Information only				60%	92%	92%	88%
Medical Device Compliance Training Midwifery	95%	80%	80.00%					
Safeguarding compliance level 3	95%	80%	82.99%	81.59%	81.86%	83.05%	82.63%	84.85%
Safeguarding supervision outreach only	Information only		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
PROMPT training (added Oct 21)	90%	<90%						
Return to work interview percentage completed (number						17.60%	49.00%	

due and completed in comments please)								
Exit Interview percentage completed (number due and completed in comments please)			15%	0%	0%	22%	33%	
Monthly attendance	Information only		92.48%	92.93%	92.74%	92.71%	93.82%	94.55%
Monthly percentage sickness	4%	>=4.75%	7.52%	7.07%	7.26%	7.29%	6.18%	5.45%
Statutory Training	95%	<95%	78.34%	76.25%	72.31%	71.31%	72.56%	76.00%
Mandatory Training	85%	<80%	76.23%	77.20%	73.27%	72.45%	71.71%	77.65%
Completed Staff Appraisals	85%	<=75%	49.10%	56.57%	56.25%	59.74%	65.73%	61.80%

5.0 Expectation 3 – Right place, right time

5.1 Planned versus actual midwifery staffing levels

5.2 The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

5.3 The planned staffing levels outlined in Table 6 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff.

5.4 Table 6 highlights a peak in demand for planned hours in February 2022 that coincides with a peak in bank usage within the service, the commencement of 18 new starters and the introduction of the additional Delivery Suite Co-ordinator each shift.

Table 6: Planned versus actual staffing levels of registered staff (in hours) January – June 2022

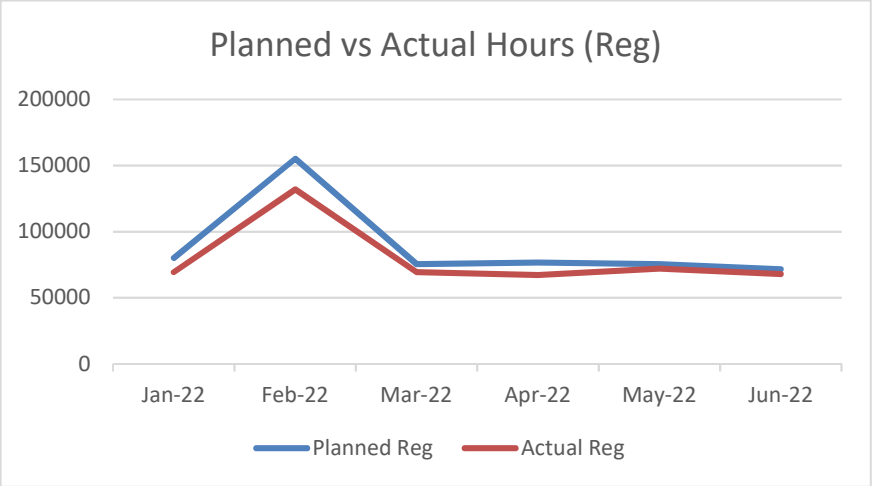
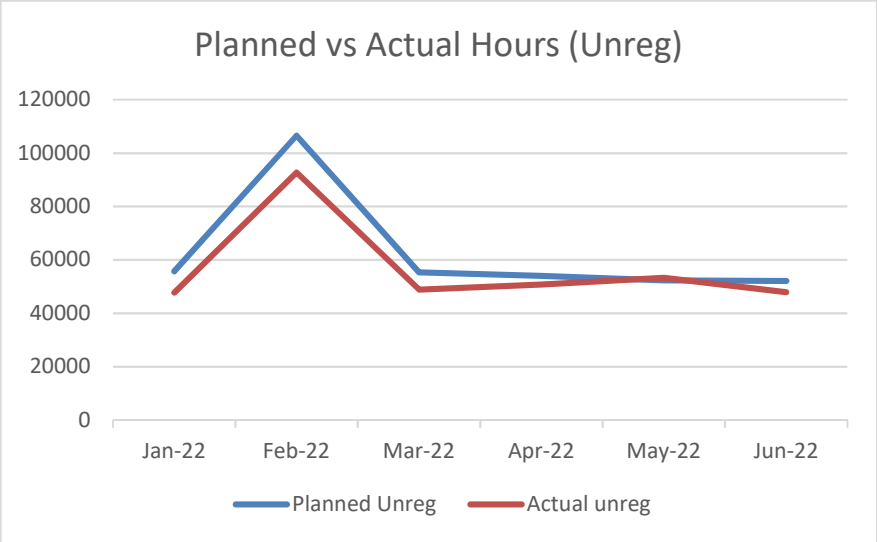


Table 7: Planned versus actual staffing levels of non-registered staff January – June 2022



5.5 Mitigating actions

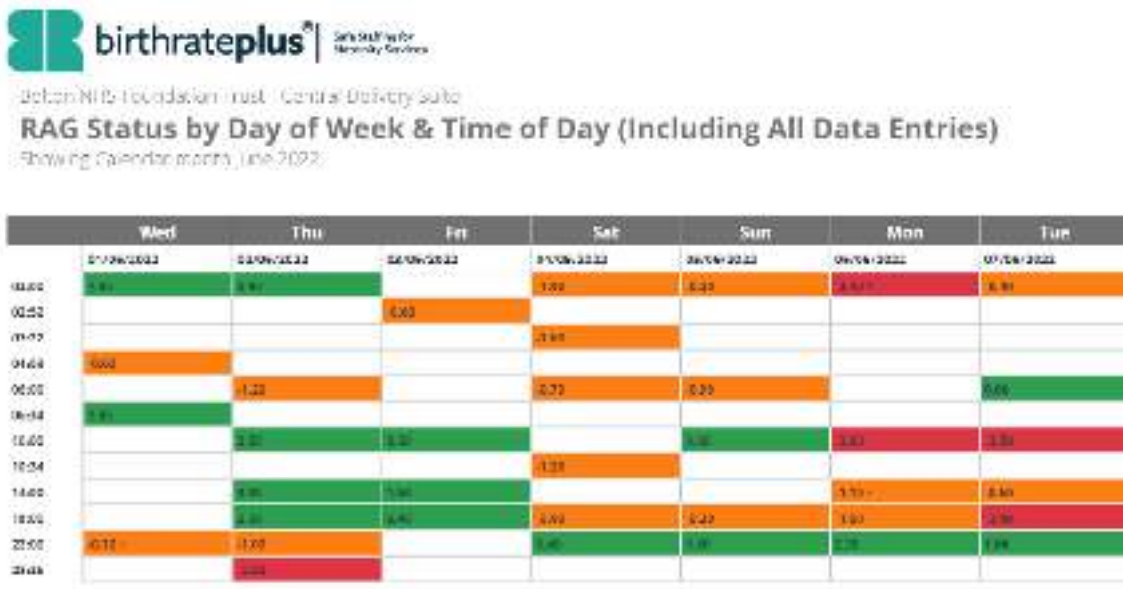
5.6 The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

- Incident reporting system is used to report staffing incidents.
- Regular reviews with ward managers, Matrons and the Director of Midwifery
- Daily operational staffing meetings led by matrons to assess and respond to changes in pressure and demand.
- Midwives move flexibly between delivery suite, maternity ward, birth centres and community to ensure women's needs are met.
- Ward managers work clinically as part of the clinical establishment with matrons, if required, to support patient care.
- Safety huddles occur in maternity twice daily to assess the activity and acuity

- Escalation guidelines are in place and used to respond to elevated demand, to preserve patient safety.
- The publication of rosters in a timely manner so staffing deficits can be safely managed.
- Approval of agency and bank usage to mitigate shortfalls in staffing levels

5.7 For additional oversight and scrutiny on a daily basis staffing figures and the acuity levels within the maternity intrapartum areas are input into an additional electronic Birth Rate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at twice daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. Table 8 details the acuity recorded on the intrapartum acuity tool in June, highlighting the 4hrly review of staffing levels undertaken by the Delivery Suite Co-ordinator and the periods of increased staffing pressure.

Table 8: Birth Rate Plus intrapartum acuity/staffing modelling tool – June 2022



5.8 Midwifery Continuity of Carer

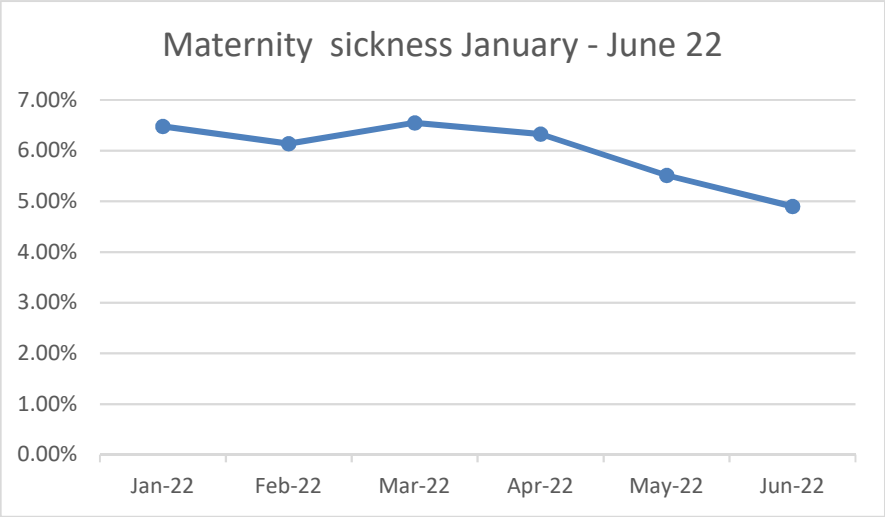
5.9 A detailed Midwifery Continuity of Carer (MCoC) action plan to implement MCoC as a default model of care as a national requirement of NHSEI by March 2024 was submitted to the Board of Directors in July 2022.

5.10 The maternity service received formal notification on 21 September 2022 from NHS England that there is no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders have been advised to focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths.

5.11 Workforce Metrics

5.12 The sickness absence data for the period January - June 2022 shows a decreasing trend in sickness absence reported within the maternity service. Matrons are supported by workforce partners to monitor absence and support staff members during their absence and following their return to work.

Table 9: Sickness absence per WTE January – June 2022



5.13 Red Flags

5.14 Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

5.15 Within the maternity service midwifery red flag events are monitored currently using the Birth Rate Plus acuity tool as detailed in Table 10. Alignment of the red flags with the nationally defined flags as per current NICE guidance is required with ongoing visibility at Trust level. Currently there is a discrepancy with Trust level reported data and the Birth Rate Plus level data and thus alignment of the datasets is required.

5.16 The table highlights a significant number of cases are delayed each month during the induction of labour process. Assurance can be provided that oversight of all induction cases is undertaken if delay is experienced and all cases are prioritised in accordance for need for transfer to Delivery Suite to minimise the risk. An audit of outcomes will be undertaken to provided further assurance.

Table 10: Number of red flag safe staffing incidents between January to June 2022 extracted from the Birth Rate Plus acuity tool.

Red Flags	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Delayed or cancelled time critical activity	0	1	4	2	3	0
Missed or delayed care	0	0	1	0	1	0
Missed medication during an admission to hospital or midwifery led unit	0	0	0	0	0	0
Delay in providing pain relief	0	0	0	0	0	0
Delay between presentation and triage	0	0	0	2	0	0
The Co-ordinator is the named person providing 1:1 care	2	1	3	5	4	1
Delay of 2 hours or more between admission for induction and beginning of process	0	2	7	16	5	0
Delayed recognition or action of abnormal vital signs	0	0	1	0	0	0
Any occasion where 1 midwife is not able to provide continuous 1:1 care and support a woman during established labour	0	2	5	3	1	0
Delay of 24hrs in accessing CDS for continuation of IOL once identified as ready for transfer	51	99	116	130	142	59
Total	53	105	137	158	156	60

6.0 Patient Experience

6.1. The maternity service over the last 12 months has actively sought feedback from service users over the past twelve months. The friends and family test feedback can be evidenced in the maternity survey, feedback sought from the maternity voices partnership and the friends and family response rates illustrated below.

6.2 Further work is required to increase the uptake of responses within the antenatal setting and the use of posters with an accessible code is being trialled to increase the uptake. Table 12 details the satisfaction rates for each clinical area.

Table 11: Friends and Family Response Rates

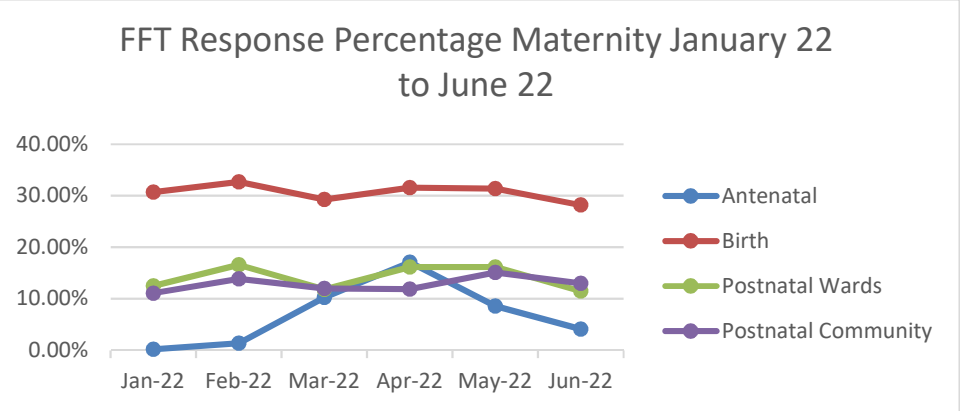
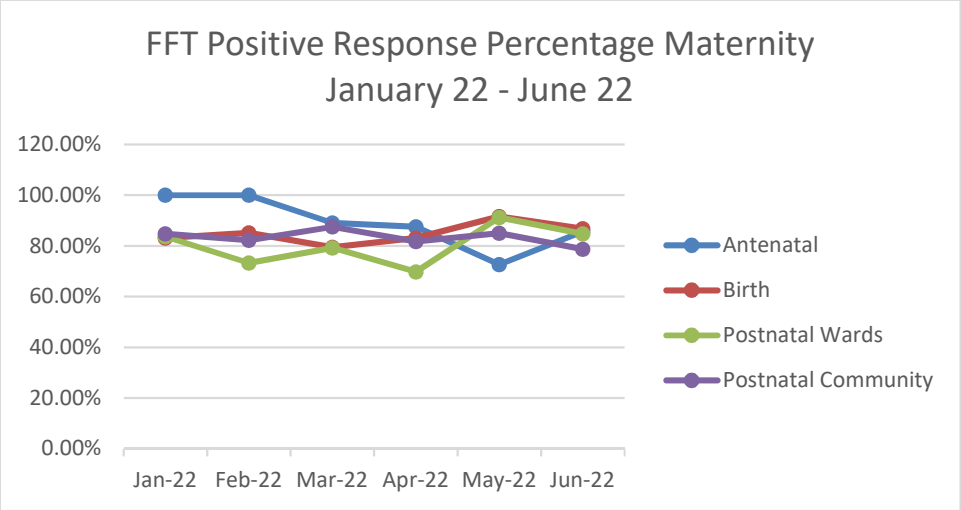


Table 12: Friends and Family Positive Response and themes



7.0 Maternity Survey

7.1 The Women's Experience of Maternity Care Survey was undertaken by IQVIA (in full)between April and August 2022. The survey sample was drawn from women aged 16 or over who had a live birth between the 1st and 28th of February 2022. Eligible women include those who had given birth using any unit managed by the Trust, or at home. Of the 413 surveys distributed, a total of 157were completed (38% response rate).

7.2 The detailed findings of the survey are currently embargoed until published in January 2023, therefore only the overarching positive and negative themes are detailed in Table 13.

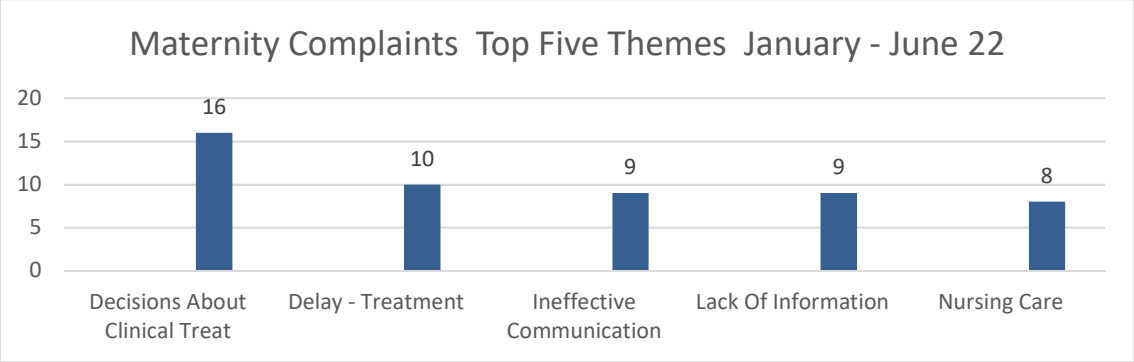
Table 13: Themes from the IQVIA Maternity Care Survey

Top 5 positive themes	Top 5 negative themes
• Staff attitude/staff	• Staff attitude/staff
• Food	• Patient moaning
• Staffing levels	• Clinical treatment
• Waiting times	• Admission
• Pharmacy	• Implementation of care

8.0 Complaints

8.1 Thematic analysis of all complaints is undertaken within the service to identify trends and actions to be undertaken. During the period January – June 2022 - 55 complaints were received within the maternity service. Most of the complaints related to decisions and delays relating to clinical treatment. In order to promote future learning and influence behaviours, themes from complaints are shared with clinical teams and individuals as appropriate. The number of complaints will be included in the maternity dashboard going forward to aid further triangulation of experience against clinical outcome measures.

Table 14: Maternity complaints – top five themes January – June 2022



9.0 Conclusion

9.1 This report details the findings of the Bolton NHS Foundation Trust 2022 bi-annual maternity staffing review in order to provide assurance of safe staffing levels within the maternity service. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

9.2 This report provides assurance that a systematic evidence based process to calculate the staffing establishment has been undertaken by Birth Rate Plus in 2020 and a further review is ongoing due to be published early in 2023. The report provides evidence that the funded midwifery staffing budget reflects the advised establishment as detailed in the staffing establishment reconciliation undertaken in September 2022. The report confirms that the specialist midwifery establishment is within expected parameters.

9.3 The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with supernumerary status of the Delivery Suite Co-ordinator and one to one care in labour rates remain below the required standard, and remain an area of ongoing focus. Training metrics also highlight poor compliance with the Trust standard and reflect the registered midwifery staffing pressures (circa 39WTE) within the maternity service during the period of review.

9.4 The report details the actions required to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny.

10.0 Recommendations

It is recommended that the Board of Directors:

I. Approve the Bi-annual staffing report and recommendations

II. Approve the action plan included within the report

Appendix 1 – Birth Rate Plus summary of establishment – August 2020.

SUMMARY of DATA & REQUIRED WTE for BIRTHRATE PLUS®

Princess Anne Maternity Unit Bolton NHSFT

Second draft 26/08/2020

Data collected April 2019 - March 2020

Total births in service 5984

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

	Annual Nos.	Required WTE	
Delivery Suite			
Delivery Suite Births	6255	61.47	**61.47**
Other DS Activity			
Antenatal Cases	730	4.17	**6.26**
PN Readmissions	36	0.13	
Escorted Transfers OUT	23	0.12	
Non-Viables	106	1.29	
Inductions (10%)	301	0.55	
Triage	7660	11.02	**11.02**
Beehive Birth Suite			
Births & PN Care	476	6.90	**8.01**
Transfers to DS	169	1.11	
Maternity Ward(s)			
Antenatal Care			
Antenatal admissions	360	2.79	**7.87**
Antenatal ward attenders	262	0.17	
Inductions (90%)	2710	4.91	
Postnatal Care			
Postnatal women	6352	47.36	**51.12**
Postnatal Ward Attenders	360	0.24	
Postnatal Re-admissions	29	0.15	
NPE	4350	2.19	
Extra Care Babies	177	1.18	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife booking clinics		1.84	**8.21**
Specialist Midwife clinics		1.69	
Obstetric clinics		1.97	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	11680	4.59	**4.59**
COMMUNITY SERVICES			
Home Births	85	2.51	**56.91**
Community Cases	6103	53.60	
Community Bookings ONLY	595	0.80	
Additional Safeguarding	0	0.00	
INGLESIDE BIRTH & COMMUNITY CENTRE			
Births (Total AN/IP & PN Care)	136	3.96	**4.44**
Transfers to PAH Bolton	61	0.48	

CLINICAL MIDWIFERY WTE REQUIRED 219.90

Additional non-clinical midwifery wte @ 9% 19.79

TOTAL WTE REQUIRED 239.70

Appendix 2 – Birth Rate Plus establishment reconciliation as of September 2022

Midwives		
Row Labels	Funded	WTEC
241 L7 Antenatal Clinic - ANDU [3009]	12.97	10.07
241 L7 Birth Suite - Beehive [3010]	16.44	1.60
241 L7 Central Delivery Suite [3011]	70.56	71.53
241 L7 Community Midwives [3007]	59.73	44.38
241 L7 Divisional Management Family Care Division [2903]	1.00	1.00
241 L7 Ingleside Birth Centre [3020]	2.00	1.76
241 L7 Maternity Smoking Cessation Team [3019]	0.64	0.64
241 L7 Midwifery Management [3003]	3.00	4.00
241 L7 Perinatal Mental Health Team [3018]	4.45	3.40
241 L7 Specialist Midwives [3002]	19.27	19.37
241 L7 Ward M2 - Obstetrics [3004]	15.92	14.00
241 L7 Ward M4 - Post Natal Ward [3005]	16.00	15.38
241 L7 Ward M5 - Post Natal [3006]	16.00	9.82
Grand Total	237.98	196.95

Appendix 3: Specialist Midwife establishment by role type.

ESR Position Title	AFC Band	ESR WTE @ Sep 22	Clinical WTE	Management WTE	Specialist WTE
27842630 Salford Smoking Cessation Midwife - Band 6		0.64	0.64	0.00	0.00
28974234 Specialist Mental Health Midwife - Band 6		1.00	0.00	0.00	1.00
28974234 Specialist Mental Health Midwife - Band 6		0.60	0.00	0.00	0.60
27842620 Perinatal Mental Health Midwife - Band 7		1.00	0.00	0.00	1.00
33793772 Diabetes Specialist Midwife		0.76	0.00	0.00	0.76
12966058 Screening Midwife - Band 6		0.92	0.00	0.00	0.61
33793772 Diabetes Specialist Midwife		1.00	0.00	0.00	1.00
34783443 Specialist Midwife - Infant Feeding - Band 6		0.61	0.00	0.00	0.61
28742728 Specialist Midwife Clinical Standards - Band 7		0.40	0.00	0.00	0.40
12966719 Diabetic Specialist Midwife - Band 7		1.00	0.20	0.00	0.80
12965975 Infant Feeding Co-ordinator - Band 7		0.80	0.00	0.00	0.80
25128594 Practice Educator Midwife - Band 7		1.00	0.00	0.00	1.00
25128594 Practice Educator Midwife - Band 7		0.61	0.00	0.00	0.61
25128594 Practice Educator Midwife - Band 7		0.92	0.00	0.00	0.92
36500840 Saving Babies Lives & Neo Champion - Band 7		0.60	0.00	0.00	0.60
36500840 Saving Babies Lives & Neo Champion - Band 7		0.00	0.00	0.00	0.00
28972167 Antenatal Screening Midwife - Band 7		1.00	0.00	0.00	1.00
25128594 Practice Educator Midwife - Band 7		0.31	0.00	0.00	0.31
Interim Specialist Midwife for Education and Clinical Skills					
12965975 Infant Feeding Co-ordinator - Band 7		0.61	0.00	0.00	0.61
32489294 Bereavement Midwife - Band 7		0.80	0.40	0.00	0.40
31729992 Lead Midwife - Information Systems & EPR - Band 7		1.00	0.00	0.00	1.00
27305731 Lead Midwife for Safeguarding - Band 7		1.00	0.00	0.00	1.00
28742728 Specialist Midwife Clinical Standards - Band 7		0.43	0.00	0.00	0.43
32489294 Bereavement Midwife - Band 7		0.40	0.20	0.00	0.20
12965975 Infant Feeding Co-ordinator - Band 7		1.00	0.00	0.00	1.00
25128594 Practice Educator Midwife - Band 7		0.80	0.00	0.00	0.80

Appendix 4 – NHSEI workforce plan developed to aid recruitment and enhance supernumerary status of coordinators and 1:1 care in labour rates.								
Objective	Activities to achieve this objective	Delivery Lead	Start Date	Due Date	How will you measure progress? How will you measure success?	Challenges/Risks	Solutions/Mitigations	RAG Status Evidence to provide assurance of completed action
Recruitment- To implement effective processes for workforce planning and recruitment	Review / Develop SOP for recruitment processes to ensure standardised approach to recruitment ad interview criteria	Andrea Gillan HR		31.12.22	SOP agreed through governance processes and implemented. Reduction in complaints regarding recruitment processes	NA	NA	
	Engage with communications team to review rolling adverts and refine template to share on social media / NHS jobs	Louise Tucker		15.11.22	Template revised and staff feedback obtained. Increase in the number of applicants	NA	NA	Ongoing
	Review process for student midwife recruitment to include • External students • Bolton students • Recruitment events / interviews- interviews held on the day and allocations agreed • Offer of employment made through TRAC at an early stage and completion of pre-employment checks	Louise Tucker / Sam Smith	25.10.22	30.12.22	Robust process for student midwife recruitment in place in line with GMEC offer. Positive feedback from students regarding application process	Student Midwife engagement	Identified lead for students to support implementation and review of processes	

	Feedback sessions for current student applicants to identify lessons learned and areas for improvements	L Tucker	14.8.22	21.9.22	Identify areas for development and implement changes based on student feedback.	Students may not attend	Offer financial incentive to attend.	Dates of feedback sessions and outcome
	Network with universities to promote employment opportunities	L Tucker	1.7.22	30.11.22	Number of sessions booked at local universities. Increased number of applicants from out of region universities	Time to deliver training off site	Planned in advance in rota.	Sessions booked edge hill Nov 22
	Recruitment to practice educator with focus on student midwife	K Christie	12.9.22	30.10.22	Applicant in post.	NA	NA	
	International Recruitment – work in collaboration with Trust and GMEC/LMNS to support orientation and employment of international midwives Review unique flexible working options to include annual leave periods and long distance traveling	L Tucker		1.12.22	Employment of international midwives	Funding Training and preceptorship needs	Work in collaboration with GMEC / LMNS for support, advice and guidance	
	Offer opportunities for return to practice	Trust education leads / practice education team	12.09.22	30.12.22	Return to practice midwives supported at Bolton	Lack of courses regionally	Work in collaboration with local HEI	Agreed 2 RTP student placements Salford. No allocation as of 23.9.22
	Deliver Quarterly recruitment events promoting Bolton as an employer of choice – (Family Care Division)	Recruitment and retention lead / pastoral midwife	12.9.22	30.12.22	Attendance at recruitment event Feedback following first engagement session	Time and venue	Gain support from Trust recruitment and workforce teams	

	Events evaluated by attendees and used to inform future sessions							
	Engagement during recruitment process- • Current students - fortnightly / monthly check in sessions • Ongoing monthly new starter sessions - meet the team	Recruitment and retention lead / pastoral midwife	12.9.22		Attendance at sessions monitored Evaluation and feedback Number of applicants who continue through to employment	Time to facilitate sessions	Included in job plan	Dates of sessions and attendance
	Recruitment incentives- review incentives offered by other providers in order to offer a competitive offer	Sam Carney		20.12.22	Trust agreed recruitment incentives offer Increased number of applicants and reduction in vacancy rate	Finance	NA	Recruitment paper
	Complete Birth Rate plus assessment Identify leads and complete data collection	BR+ leads Emma Jones Savannah Dallas Cross	15.9.22	30.01.23	Establishment based on current activity	Time for BR+ leads to be released to complete data collection	Agreed bank pay to support	
	Staffing paper based on findings and recommendations made in BR+ assessment to be presented to Trust Board of Directors	Louise Tucker	30.11.22	7.12.22	Business case to recruit to required establishment	Finance		

Appendix 5 – NQB Recommendations
Detailed breakdown

1.0 Expectation 1 - Right staff

1.1 The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months. The NQB references various tools that can be used.

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

1.4 The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for a maximum of 6-8 patients each during a day shift. There is no specific guidance regarding night duty. This is based on NICE[1] evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward Sr/CN should have supervisory capacity – the extent of which is subject to local Chief Nurse determinant **Headroom / Uplift**

1.5 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

1.6 The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. Current headroom/uplift provided is 23% with national ranges varying between 19% and 25%

1.7 Skill Mix

1.8 This is the ratio of RNs to unregistered staff such as healthcare assistants. Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

1.9 Professional judgement

1.10 The judgement of senior experienced nurses remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment

[1] NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals* July 2014

- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

1.12 NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were stated as specifically affected by the presence (and hence absence) of **registered** nursing staff. These indicators included;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

1.13 The NQB (2018) has highlighted that these indicators can be challenging to monitor consistently and recommends a thorough audit programme be agreed.

1.14 Patient reported outcome measures

1.15 NICE (2014) also recommend monitoring of the following;

- Adequacy of meeting patients' nursing care needs
- Adequacy of provided pain management
- Adequacy of communication with nursing team
- National in-patient survey

1.16 Staffing data & Training and education

- Appraisal, retention, vacancy, sickness
- Mandatory training, clinical training

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

"ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Agenda Item: 16A

Title:	Staff Health & Wellbeing Update

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor:	James Mawrey, Director of People		Decision	

Summary:	To provide an update to the Board of Directors on the Trust's enhanced staff health and wellbeing offering and associated actions to support colleagues, in particular with the current cost of living crisis. The People Committee has previously received staff wellness updates, and in particular as a result of the recent staff wellness offer review, it was noted that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions. This, together with the added staffing and workload pressures and the impact that we know the cost of living crisis will be having, are all contributing to a highly pressurised work environment and challenging winter months for colleagues. The Trust is therefore overlaying the brilliant work which has already been undertaken to further enhance its staff health and wellbeing offering at such a critical time.

Previously considered by:	People Committee – 18th October 2022

Proposed Resolution:	To provide assurance that all possible actions are being taken at this difficult time for colleagues and to note the update on progress with the Trust's enhanced staff health and wellbeing offering.

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:	Jake Mairs, Associate Director – Organisational Development & Laura Smoult, Staff Experience Manager	**Presented by:**	James Mawrey, Director of People / Deputy Chief Executive

1. Background

1.1 This paper provides an update to the Board of Directors on the Trust's enhanced staff health and wellbeing offering and associated actions to support colleagues, in particular with the current cost of living crisis.

1.2 Throughout the COVID-19 pandemic, we know the impact on staff health and wellbeing has been immense and we know from listening to colleagues that they continue to feel fatigued and overwhelmed and some struggle to switch off when they finish work. We have significantly stepped up our efforts to enhance our staff wellness offer throughout this time and create a culture that promotes self-care through initiatives such as TRiM, Schwartz Rounds and the rollout of the Civility Saves Lives Campaign.

1.3 The People Committee has previously received staff wellness updates, and in particular as a result of the recent staff wellness offer review, it was noted that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions. This, together with the added staffing and workload pressures and the impact that we know the cost of living crisis will be having, are all contributing to a highly pressurised work environment and challenging winter months for colleagues.

1.4 The Trust is therefore overlaying the brilliant work which has already been undertaken to further enhance its staff health and wellbeing offering at such a critical time. If we can continue to help and support our colleagues to look after themselves, and the things that may be impacting on their health and wellbeing at work, then we can make sure our colleagues are best placed to look after our patients and families at Bolton NHS Foundation Trust.

2. Wellbeing Improvement Action Plan Update

2.1 Following a review of the Trust's staff health and wellbeing offering, the Staff Experience Team (part of our OD service) have introduced a wellbeing improvement action plan. An update on the priority actions in Phase One of this action plan is detailed in **Appendix One**. This action plan ensures that the Trust goes 'back to basics' on colleague wellbeing and will help to ensure that colleagues are aware of the current staff health and wellbeing offering and its benefits.

2.2 In terms of the key updates of the actions in progress, immediate actions are underway relating to improving the working environment for colleagues. An initial walk-around has been undertaken with iFM to review staff break and rest facilities. Priority areas have been identified and an extension to the funding from NHS Charities Together has been agreed to March 2023 to support with ensuring consistency across staff break and rest facilities and the basics being in place.

2.3 Another priority action is to develop a new look and feel of the Trust's staff health and wellbeing offer and an initial meeting has been held with the Communications & Engagement Team to develop this further. It is intended that this new identity / brand for the staff health and wellbeing offer will be launched to coincide with the new Trust Intranet, taking this timely opportunity to update the offer. This will ensure that colleagues feel a connection to the Trust's staff health and wellbeing offer, as whilst lots of great work is being done locally within Divisions to support staff health and wellbeing, colleagues don't always associate this with the Trust's staff health and wellbeing offer and it will help to ensure consistency of approach.

2.4 Closely connected to the new look and feel of the Trust's staff health and wellbeing offer are the actions related to going 'back to basics,' as much of these initiatives and support mechanisms for colleagues need established processes and embedding as part of the staff health and wellbeing offer. These are all initiatives that are unique to Bolton NHS Foundation Trust and these staff support offers need to be better communicated and promoted so that colleagues are aware of the help and support available to them when they need it the most.

2.5 Lastly, some important initiatives have been identified as priority within Phase One of the wellbeing improvement action plan. These include launching the Trust's Menopause Policy / Guidance for colleagues and leaders across the Trust. Work to review the draft policy and guidance has begun and an online menopause training programme for all staff was also launched on World Menopause Day (18th October 2022) via our ESR system.

2.6 The main priority within Phase One of the wellbeing improvement action plan has related to the cost of living actions which are covered in more detail in the update below. It should be noted that the majority of the actions in Phase One of the wellbeing action plan are on-going; however timescales have been impacted with the need to deliver the cost of living actions as an absolute priority.

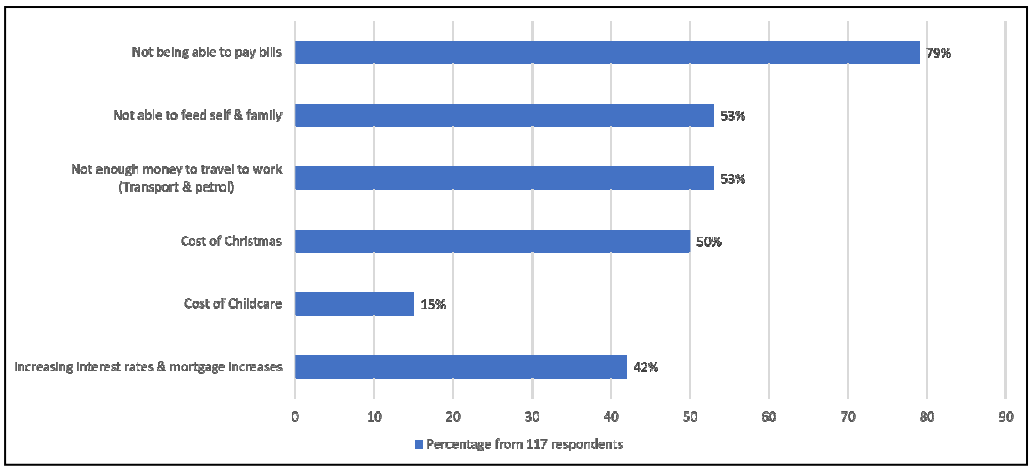
3. Cost of Living Update

3.1 The cost of living actions detailed in Phase One of the wellbeing improvement action plan have been the main priority for the Staff Experience Team throughout October and November 2022.

3.2 Divisions have held listening events at a local level where feedback has been shared about what would be helpful to support colleagues with the cost of living crisis. To sense check the support being provided, during the weeks commencing 17th & 24th October 2022, a cost of living poll was launched via BOB and The Staff Update to ensure that colleague feedback could be incorporated in terms of what colleagues would find most helpful and supportive in response to the cost of living crisis.

3.3 Colleagues have completed a cost of living poll which has informed the priorities in the cost living action plan. **Figure One** below shows how colleagues responded when asked what they were most worried about regarding the cost of living crisis.

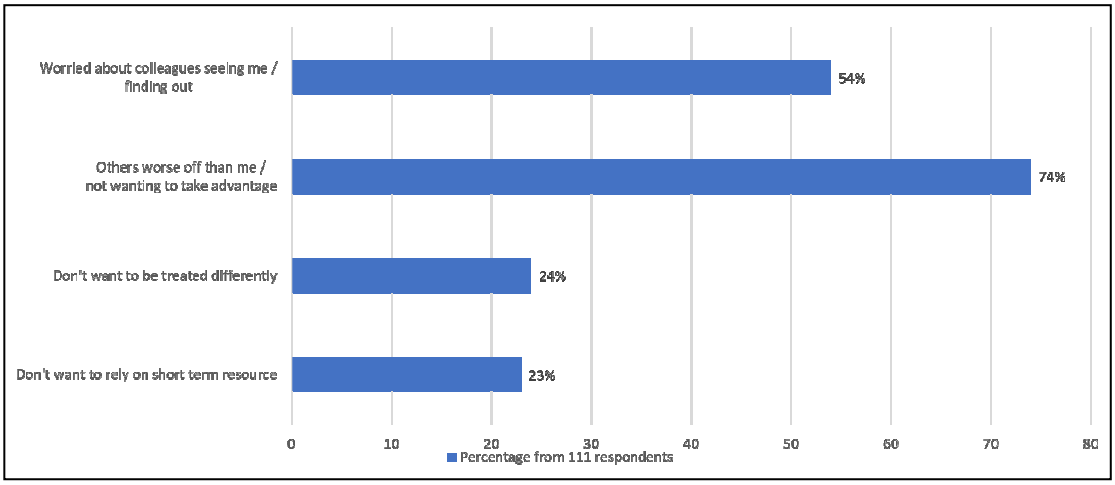
Figure One – cost of living crisis and what colleagues are most worried about



3.4 It can be seen from the above that 79% of respondents were most worried about not being able to pay their bills, around 50% of respondents indicated their fear of being unable to feed themselves/family, not having enough money to travel to work and the cost of Christmas.

3.5 In terms of the biggest barrier to colleagues accessing support relating to the cost of living crisis, **Figure Two** below shows that this was the feeling that others were worse off and not wanting to take advantage (74% of respondents), although 54% of respondents were also worried about being seen by colleagues. Approximately a quarter of respondents didn't want to be treated differently or didn't want to rely on a short term resource.

Figure Two – cost of living crisis and barriers to colleagues accessing support



4. Update on the cost of living actions being taken

4.1 The priority actions include working with the Communications & Engagement Team to develop a cost of living communications toolkit which will include the Trust's current support offers (Vivup Employee Assistance Programme, Occupational Health, Chaplaincy etc.) and will also signpost to other debt advice and resources. We are also working closely with colleagues in iFM to create videos and other resources to include recipe ideas and cleaning tips as in the cost of living poll, 45% of respondents said they would be interested in cheap recipe ideas.

4.2 We have created individual breakfast packs to support colleagues in need which have been made available for colleagues to collect from week commencing 7th November 2022. These can be confidentially accessed from the Chaplaincy Team who can also offer support and a listening ear to colleagues. Colleagues can alternatively confidentially email the Staff Experience Team's Wellness Matters inbox to make arrangements to collect these. For colleagues working in the Community, we have attended various Community sites to deliver breakfast packs and to give colleagues the opportunity to speak with the Staff Experience Team and Chaplaincy colleagues.

4.3 Options are currently being considered regarding having a food bank on the Trust site and in the cost of living poll around a quarter of colleagues were interested in food bank support. There are logistical challenges with this and as there are some community food banks that are in close proximity to the main hospital site, consideration needs to be given to minimise the impact on their footfall and being

conscious of working as a locality. Whilst it therefore might not be the right thing to have a food bank on site, the Staff Experience Team is exploring other options such as having food collection boxes on site and whether these could be circled back to create food boxes to share back with colleagues in need. We are also establishing details of colleagues who are trained to make referrals to food banks.

4.4 In the cost of living poll, 82% of respondents were interested in reasonably priced fruit and veg and we are in the process of finalising arrangements for a fruit and veg stall to be located on the main hospital site. A suitable location has been identified and we are working with a possible provider to arrange for this to be opened on site in the New Year.

4.5 In addition, just over 50% of colleagues said they would be interested in financial support/advice therefore we are looking to arrange these sessions to be delivered by an external provider in November and December 2022. The Trust's Schwartz Round in November 2022 is also focused on supporting colleagues facing the cost of living crisis.

4.6 Lastly, to help increase staff morale, we have received approval to implement a voucher scheme via the Vivup High Five portal, whereby every colleague will receive a £25 voucher. Colleagues can also choose to send the voucher to someone else (a friend, a colleague etc.) who they feel may benefit more or colleagues can also give this money to the Trust's Our Bolton NHS Charity.

4.7 We are aware that the cost of living crisis is an evolving situation that we will continue to closely monitor. The role of leaders is critical in supporting colleagues through the cost of living crisis and the Associate Director of OD is working closely with Divisions on separate OD and culture related activity, which will ensure leaders are aware of their collective and individual responsibility in effective staff health and wellbeing support.

5. Conclusion

5.1 The challenges that colleagues are currently under do not go underestimated and unnoticed and by implementing the actions outlined in Phase One of the wellbeing improvement action plan and the more detailed actions contained in the cost of living action plan, these will help to ensure that colleagues feel supported throughout these difficult times and the cost of living crisis. Continuing to invest in our colleagues' health and wellbeing will ensure that they can in turn provide the best care to our patients.

5.2 Both action plans remain flexible and whilst the immediate priority actions are being delivered, more actions will be added to these throughout the coming months where needed. All of the actions are aligned to our broader activity around retention, ensuring we continue to be a great place to work.

6. Recommendations

6.1 It is hoped that this report provides assurance to the Board of Directors that all possible actions are being taken at this difficult time for colleagues and they are asked to note the update on progress with the Trust's enhanced staff health and wellbeing offering.

Appendix One – Phase One: Wellbeing Improvement Action Plan

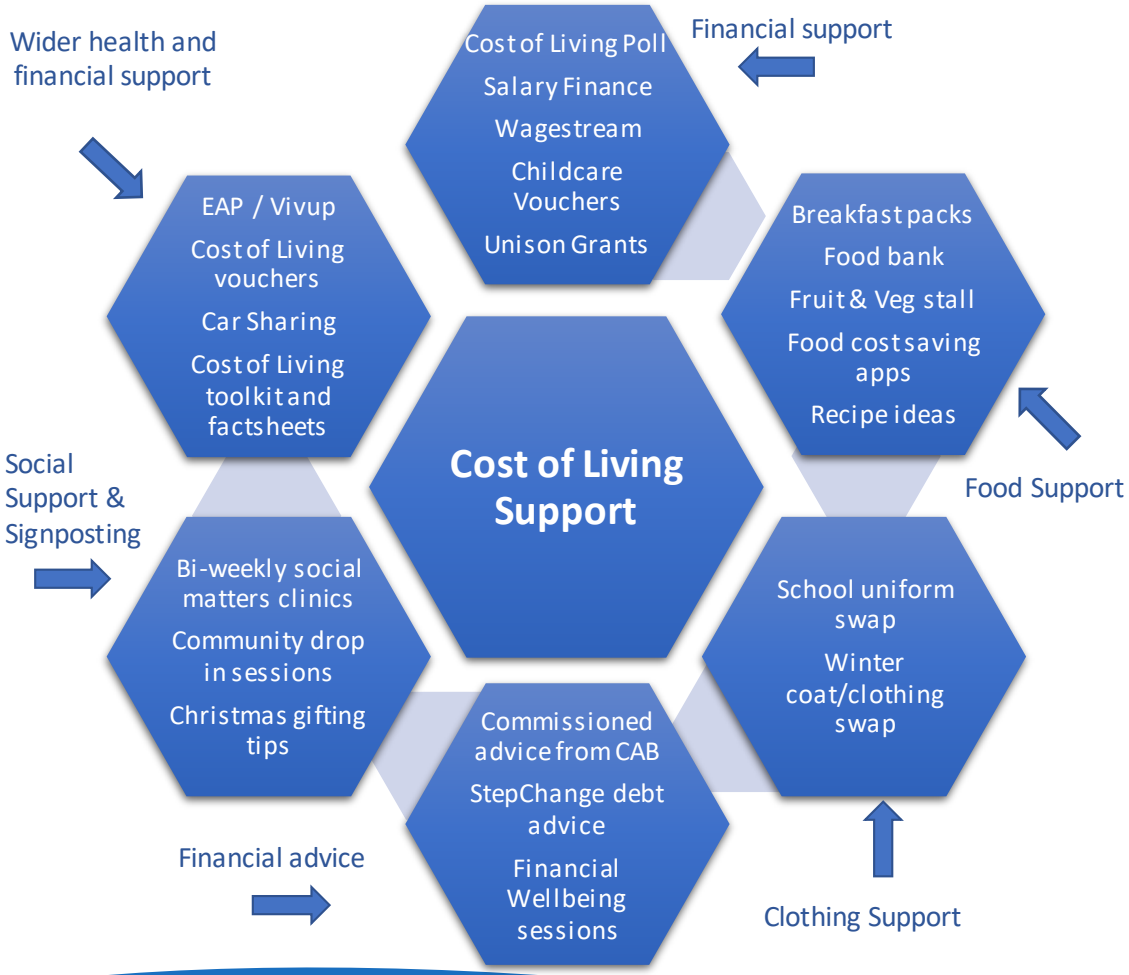
Area	Action	By When	By Who	RAG Status	Update/Comments
Focus on 'Environment' element of NHS H&WB Framework	Review break and rest facilities in each hospital area and collate a list of what they all need – aim for consistency and ensure the basics	Mar 23	Staff Experience Manager & iFM		An initial review and walk-around has been undertaken with iFM. Priority areas have been identified and an extension to the funding from NHS Charities Together has been agreed to March 2023.
	Review outside spaces and wellness walks	Mar 23	Staff Experience Manager & iFM		Same as above.
	Hot meals out-of-hours – discuss with iFM about the hot vending pilot	Oct 22	Associate Director of OD		Completed with positive feedback
	Further enhancement to out-of-hours food offering	Mar 23	Associate Director of OD		Not yet started
	Promotion and enhancement of onsite food offering (incl. subsidy)	Dec 22	Associate Director of OD		In partnership with IFM colleagues
Identity/brand	Develop with Comms & Engagement Team – new look & feel of wellbeing offer (remove COVID-19 focus)	Jan 23	Staff Experience Manager		Initial meeting held with Comms & Engagement Team – this will be developed and launched as part of the new Trust Intranet.
	Joining-up the sickness, special leave and wellbeing offer incl. OH – ensure person Centred flexible wellbeing and attendance management policies	Feb 23	Staff Experience Manager		Not yet started
'Back to basics'	Embed the role of the Wellbeing Guardian	Feb 23	Staff Experience Manager		Not yet started
	TRiM process implementation	Dec 22	Staff Wellbeing Practitioner		Moved priority to December 22.
	Schwartz Rounds process implementation	Nov 22	Staff Wellbeing Practitioner		On-going – initial review underway.
	Refresh EAP promotion and establish processes & reporting	Nov 22	Staff Wellbeing Practitioner		Meeting scheduled 10.11.22 to support with this action.
	Refresh Salary Finance promotion and establish processes & reporting	Nov 22	Staff Wellbeing Practitioner		Meeting scheduled 15.11.22 to support with this action.
	Refresh and relaunch staff H&WB Champions Network	Dec 22	Staff Wellbeing Practitioner		Staff H&WB Champions have been contacted with a view to firstly refreshing membership. First meeting to be arranged December 22.
	Refresh approach – gym, onsite classes etc.	Mar 23	Associate Director of OD & Staff Experience Manager		Not yet started

Appendix One – Phase One: Wellbeing Improvement Action Plan

Initiatives	Push through the menopause policy for sign-off with guidance for colleagues and leaders	Dec 22	Staff Experience Manager		Work to review draft policy has started with support from Staff Wellness Practitioner. An online menopause training programme for all staff was launched on World Menopause Day (18th October 22) via ESR. Menopause support sessions to be scheduled by early December 22.
	Explore a fruit and veg van visiting the site	Jan 23	Staff Engagement Practitioner		On-going – initial meeting has taken place with third party company and iFM however location identified was unsuitable. Second meeting taking place 09.11.22 to discuss an alternative potential location.
	Fatigue Working Group & actions	TBC	Associate Director of OD		On-going – initial meeting has taken place with Medical Director and Working Group has been established.
	Develop programme of support for colleagues returning to practice / workplace following maternity leave or long term sickness absence	Mar 23	Staff Experience Manager & Head of OH		Not yet started
	Financial H&WB / Cost of Living support: - make arrangements for referrals to food banks - availability of breakfast packs to support colleagues - arrange financial wellbeing sessions for colleagues to attend - develop comms toolkit with all information and signposting in one place	 Nov 22 Nov 22 Nov 22 Nov 22	 Chair of Staff Side Head Chaplain & Charity Manager Staff Experience Manager Staff Experience Manager & Comms		On-going – immediate planning to implement this activity is underway.

Key	
	Off-track
	On-track
	Completed
	Not Started

Cost of Living Plans – Summary & Overview



Immediate actions are underway to ensure that we are supporting colleagues in a timely manner		
Cost of living poll	Closes 28/10/22	Staff Wellness Practitioner
Cost of Living comms toolkit (to include current support offers, signposting to debt advice & iFM comms)	Mid Nov 22	Staff Wellness Practitioner & Staff Experience Manager
Breakfast Packs – assembled and distributed to Chaplaincy	04/11/22	Staff Wellness Practitioner
Breakfast Packs – Comms launch & community drop-ins	w/c 07/11/22	Staff Wellness Practitioner
Foodbank – options considered	Early Dec 22	Staff Wellness Practitioner
Fruit & Veg Stall – site identified & agreed with iFM. Awaiting confirmation from provider	Early Dec 22	Staff Wellness Practitioner
Financial Wellbeing sessions (Nov & Dec 22) – to approach providers for cost/check feasibility	w/c 31/10/22	Staff Wellness Practitioner
Cost of Living Vouchers	w/c 28/11/22	Staff Engagement Practitioner

Agenda Item: 16A

Title:	Staff Health & Wellbeing Update

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor:	James Mawrey, Director of People		Decision	

Summary:	To provide an update to the Board of Directors on the Trust's enhanced staff health and wellbeing offering and associated actions to support colleagues, in particular with the current cost of living crisis. The People Committee has previously received staff wellness updates, and in particular as a result of the recent staff wellness offer review, it was noted that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions. This, together with the added staffing and workload pressures and the impact that we know the cost of living crisis will be having, are all contributing to a highly pressurised work environment and challenging winter months for colleagues. The Trust is therefore overlaying the brilliant work which has already been undertaken to further enhance its staff health and wellbeing offering at such a critical time.

Previously considered by:	People Committee – 18th October 2022

Proposed Resolution:	To provide assurance that all possible actions are being taken at this difficult time for colleagues and to note the update on progress with the Trust's enhanced staff health and wellbeing offering.

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:	Jake Mairs, Associate Director – Organisational Development & Laura Smoult, Staff Experience Manager	**Presented by:**	James Mawrey, Director of People / Deputy Chief Executive

1. Background

1.1 This paper provides an update to the Board of Directors on the Trust's enhanced staff health and wellbeing offering and associated actions to support colleagues, in particular with the current cost of living crisis.

1.2 Throughout the COVID-19 pandemic, we know the impact on staff health and wellbeing has been immense and we know from listening to colleagues that they continue to feel fatigued and overwhelmed and some struggle to switch off when they finish work. We have significantly stepped up our efforts to enhance our staff wellness offer throughout this time and create a culture that promotes self-care through initiatives such as TRiM, Schwartz Rounds and the rollout of the Civility Saves Lives Campaign.

1.3 The People Committee has previously received staff wellness updates, and in particular as a result of the recent staff wellness offer review, it was noted that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions. This, together with the added staffing and workload pressures and the impact that we know the cost of living crisis will be having, are all contributing to a highly pressurised work environment and challenging winter months for colleagues.

1.4 The Trust is therefore overlaying the brilliant work which has already been undertaken to further enhance its staff health and wellbeing offering at such a critical time. If we can continue to help and support our colleagues to look after themselves, and the things that may be impacting on their health and wellbeing at work, then we can make sure our colleagues are best placed to look after our patients and families at Bolton NHS Foundation Trust.

2. Wellbeing Improvement Action Plan Update

2.1 Following a review of the Trust's staff health and wellbeing offering, the Staff Experience Team (part of our OD service) have introduced a wellbeing improvement action plan. An update on the priority actions in Phase One of this action plan is detailed in **Appendix One**. This action plan ensures that the Trust goes 'back to basics' on colleague wellbeing and will help to ensure that colleagues are aware of the current staff health and wellbeing offering and its benefits.

2.2 In terms of the key updates of the actions in progress, immediate actions are underway relating to improving the working environment for colleagues. An initial walk-around has been undertaken with iFM to review staff break and rest facilities. Priority areas have been identified and an extension to the funding from NHS Charities Together has been agreed to March 2023 to support with ensuring consistency across staff break and rest facilities and the basics being in place.

2.3 Another priority action is to develop a new look and feel of the Trust's staff health and wellbeing offer and an initial meeting has been held with the Communications & Engagement Team to develop this further. It is intended that this new identity / brand for the staff health and wellbeing offer will be launched to coincide with the new Trust Intranet, taking this timely opportunity to update the offer. This will ensure that colleagues feel a connection to the Trust's staff health and wellbeing offer, as whilst lots of great work is being done locally within Divisions to support staff health and wellbeing, colleagues don't always associate this with the Trust's staff health and wellbeing offer and it will help to ensure consistency of approach.

2.4 Closely connected to the new look and feel of the Trust's staff health and wellbeing offer are the actions related to going 'back to basics,' as much of these initiatives and support mechanisms for colleagues need established processes and embedding as part of the staff health and wellbeing offer. These are all initiatives that are unique to Bolton NHS Foundation Trust and these staff support offers need to be better communicated and promoted so that colleagues are aware of the help and support available to them when they need it the most.

2.5 Lastly, some important initiatives have been identified as priority within Phase One of the wellbeing improvement action plan. These include launching the Trust's Menopause Policy / Guidance for colleagues and leaders across the Trust. Work to review the draft policy and guidance has begun and an online menopause training programme for all staff was also launched on World Menopause Day (18th October 2022) via our ESR system.

2.6 The main priority within Phase One of the wellbeing improvement action plan has related to the cost of living actions which are covered in more detail in the update below. It should be noted that the majority of the actions in Phase One of the wellbeing action plan are on-going; however timescales have been impacted with the need to deliver the cost of living actions as an absolute priority.

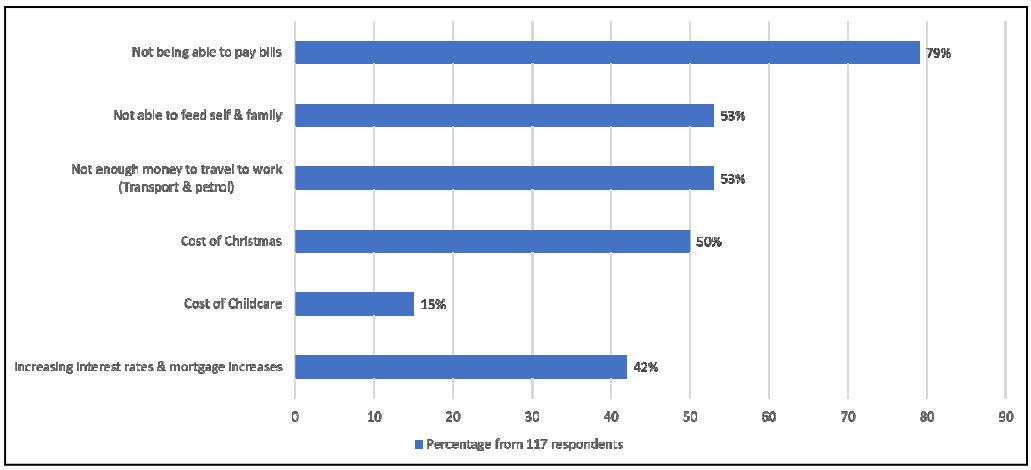
3. Cost of Living Update

3.1 The cost of living actions detailed in Phase One of the wellbeing improvement action plan have been the main priority for the Staff Experience Team throughout October and November 2022.

3.2 Divisions have held listening events at a local level where feedback has been shared about what would be helpful to support colleagues with the cost of living crisis. To sense check the support being provided, during the weeks commencing 17th & 24th October 2022, a cost of living poll was launched via BOB and The Staff Update to ensure that colleague feedback could be incorporated in terms of what colleagues would find most helpful and supportive in response to the cost of living crisis.

3.3 Colleagues have completed a cost of living poll which has informed the priorities in the cost living action plan. **Figure One** below shows how colleagues responded when asked what they were most worried about regarding the cost of living crisis.

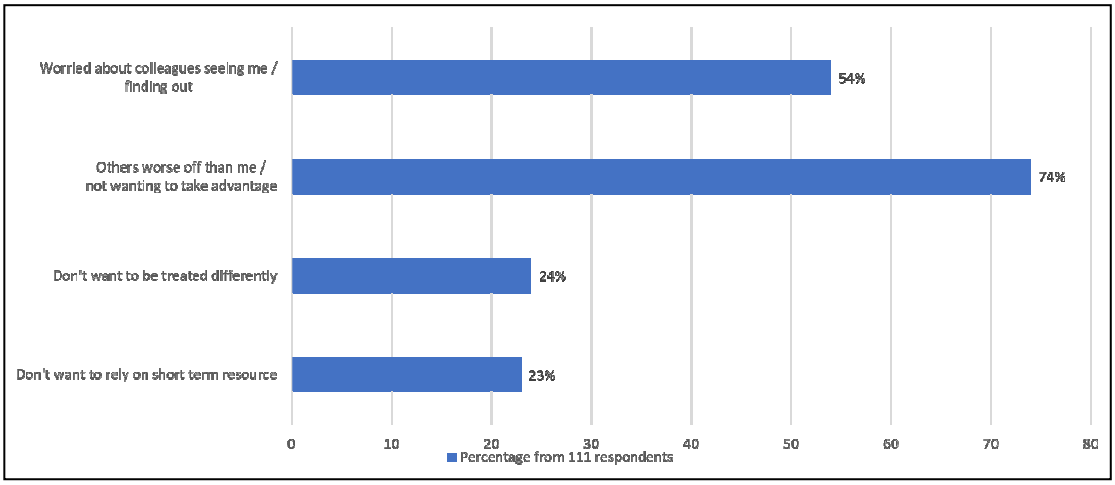
Figure One – cost of living crisis and what colleagues are most worried about



3.4 It can be seen from the above that 79% of respondents were most worried about not being able to pay their bills, around 50% of respondents indicated their fear of being unable to feed themselves/family, not having enough money to travel to work and the cost of Christmas.

3.5 In terms of the biggest barrier to colleagues accessing support relating to the cost of living crisis, **Figure Two** below shows that this was the feeling that others were worse off and not wanting to take advantage (74% of respondents), although 54% of respondents were also worried about being seen by colleagues. Approximately a quarter of respondents didn't want to be treated differently or didn't want to rely on a short term resource.

Figure Two – cost of living crisis and barriers to colleagues accessing support



4. Update on the cost of living actions being taken

4.1 The priority actions include working with the Communications & Engagement Team to develop a cost of living communications toolkit which will include the Trust's current support offers (Vivup Employee Assistance Programme, Occupational Health, Chaplaincy etc.) and will also signpost to other debt advice and resources. We are also working closely with colleagues in iFM to create videos and other resources to include recipe ideas and cleaning tips as in the cost of living poll, 45% of respondents said they would be interested in cheap recipe ideas.

4.2 We have created individual breakfast packs to support colleagues in need which have been made available for colleagues to collect from week commencing 7th November 2022. These can be confidentially accessed from the Chaplaincy Team who can also offer support and a listening ear to colleagues. Colleagues can alternatively confidentially email the Staff Experience Team's Wellness Matters inbox to make arrangements to collect these. For colleagues working in the Community, we have attended various Community sites to deliver breakfast packs and to give colleagues the opportunity to speak with the Staff Experience Team and Chaplaincy colleagues.

4.3 Options are currently being considered regarding having a food bank on the Trust site and in the cost of living poll around a quarter of colleagues were interested in food bank support. There are logistical challenges with this and as there are some community food banks that are in close proximity to the main hospital site, consideration needs to be given to minimise the impact on their footfall and being

conscious of working as a locality. Whilst it therefore might not be the right thing to have a food bank on site, the Staff Experience Team is exploring other options such as having food collection boxes on site and whether these could be circled back to create food boxes to share back with colleagues in need. We are also establishing details of colleagues who are trained to make referrals to food banks.

4.4 In the cost of living poll, 82% of respondents were interested in reasonably priced fruit and veg and we are in the process of finalising arrangements for a fruit and veg stall to be located on the main hospital site. A suitable location has been identified and we are working with a possible provider to arrange for this to be opened on site in the New Year.

4.5 In addition, just over 50% of colleagues said they would be interested in financial support/advice therefore we are looking to arrange these sessions to be delivered by an external provider in November and December 2022. The Trust's Schwartz Round in November 2022 is also focused on supporting colleagues facing the cost of living crisis.

4.6 Lastly, to help increase staff morale, we have received approval to implement a voucher scheme via the Vivup High Five portal, whereby every colleague will receive a £25 voucher. Colleagues can also choose to send the voucher to someone else (a friend, a colleague etc.) who they feel may benefit more or colleagues can also give this money to the Trust's Our Bolton NHS Charity.

4.7 We are aware that the cost of living crisis is an evolving situation that we will continue to closely monitor. The role of leaders is critical in supporting colleagues through the cost of living crisis and the Associate Director of OD is working closely with Divisions on separate OD and culture related activity, which will ensure leaders are aware of their collective and individual responsibility in effective staff health and wellbeing support.

5. Conclusion

5.1 The challenges that colleagues are currently under do not go underestimated and unnoticed and by implementing the actions outlined in Phase One of the wellbeing improvement action plan and the more detailed actions contained in the cost of living action plan, these will help to ensure that colleagues feel supported throughout these difficult times and the cost of living crisis. Continuing to invest in our colleagues' health and wellbeing will ensure that they can in turn provide the best care to our patients.

5.2 Both action plans remain flexible and whilst the immediate priority actions are being delivered, more actions will be added to these throughout the coming months where needed. All of the actions are aligned to our broader activity around retention, ensuring we continue to be a great place to work.

6. Recommendations

6.1 It is hoped that this report provides assurance to the Board of Directors that all possible actions are being taken at this difficult time for colleagues and they are asked to note the update on progress with the Trust's enhanced staff health and wellbeing offering.

Appendix One – Phase One: Wellbeing Improvement Action Plan

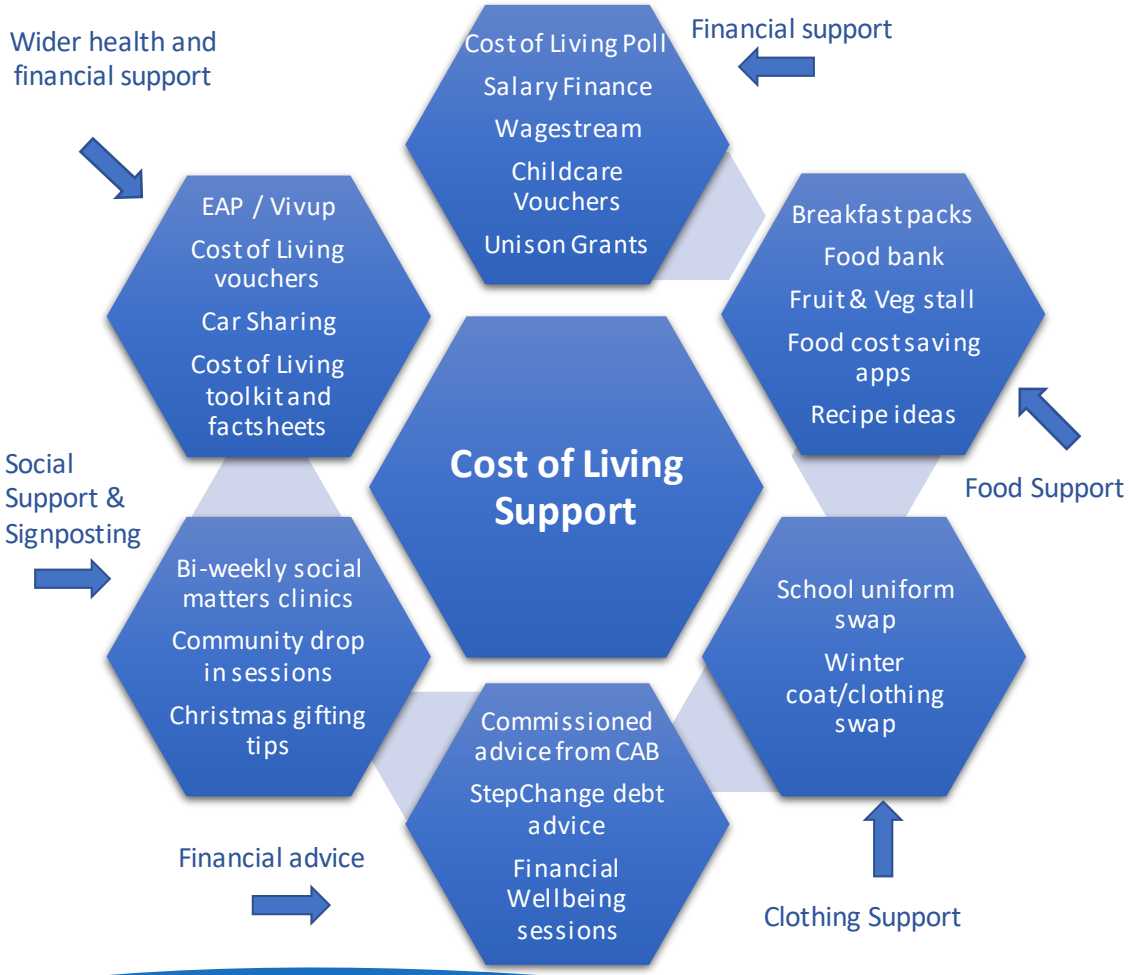
Area	Action	By When	By Who	RAG Status	Update/Comments
Focus on 'Environment' element of NHS H&WB Framework	Review break and rest facilities in each hospital area and collate a list of what they all need – aim for consistency and ensure the basics	Mar 23	Staff Experience Manager & iFM		An initial review and walk-around has been undertaken with iFM. Priority areas have been identified and an extension to the funding from NHS Charities Together has been agreed to March 2023.
	Review outside spaces and wellness walks	Mar 23	Staff Experience Manager & iFM		Same as above.
	Hot meals out-of-hours – discuss with iFM about the hot vending pilot	Oct 22	Associate Director of OD		Completed with positive feedback
	Further enhancement to out-of-hours food offering	Mar 23	Associate Director of OD		Not yet started
	Promotion and enhancement of onsite food offering (incl. subsidy)	Dec 22	Associate Director of OD		In partnership with IFM colleagues
Identity/brand	Develop with Comms & Engagement Team – new look & feel of wellbeing offer (remove COVID-19 focus)	Jan 23	Staff Experience Manager		Initial meeting held with Comms & Engagement Team – this will be developed and launched as part of the new Trust Intranet.
	Joining-up the sickness, special leave and wellbeing offer incl. OH – ensure person Centred flexible wellbeing and attendance management policies	Feb 23	Staff Experience Manager		Not yet started
'Back to basics'	Embed the role of the Wellbeing Guardian	Feb 23	Staff Experience Manager		Not yet started
	TRiM process implementation	Dec 22	Staff Wellbeing Practitioner		Moved priority to December 22.
	Schwartz Rounds process implementation	Nov 22	Staff Wellbeing Practitioner		On-going – initial review underway.
	Refresh EAP promotion and establish processes & reporting	Nov 22	Staff Wellbeing Practitioner		Meeting scheduled 10.11.22 to support with this action.
	Refresh Salary Finance promotion and establish processes & reporting	Nov 22	Staff Wellbeing Practitioner		Meeting scheduled 15.11.22 to support with this action.
	Refresh and relaunch staff H&WB Champions Network	Dec 22	Staff Wellbeing Practitioner		Staff H&WB Champions have been contacted with a view to firstly refreshing membership. First meeting to be arranged December 22.
	Refresh approach – gym, onsite classes etc.	Mar 23	Associate Director of OD & Staff Experience Manager		Not yet started

Appendix One – Phase One: Wellbeing Improvement Action Plan

Initiatives	Push through the menopause policy for sign-off with guidance for colleagues and leaders	Dec 22	Staff Experience Manager		Work to review draft policy has started with support from Staff Wellness Practitioner. An online menopause training programme for all staff was launched on World Menopause Day (18th October 22) via ESR. Menopause support sessions to be scheduled by early December 22.
	Explore a fruit and veg van visiting the site	Jan 23	Staff Engagement Practitioner		On-going – initial meeting has taken place with third party company and iFM however location identified was unsuitable. Second meeting taking place 09.11.22 to discuss an alternative potential location.
	Fatigue Working Group & actions	TBC	Associate Director of OD		On-going – initial meeting has taken place with Medical Director and Working Group has been established.
	Develop programme of support for colleagues returning to practice / workplace following maternity leave or long term sickness absence	Mar 23	Staff Experience Manager & Head of OH		Not yet started
	Financial H&WB / Cost of Living support: - make arrangements for referrals to food banks - availability of breakfast packs to support colleagues - arrange financial wellbeing sessions for colleagues to attend - develop comms toolkit with all information and signposting in one place	 Nov 22 Nov 22 Nov 22 Nov 22	 Chair of Staff Side Head Chaplain & Charity Manager Staff Experience Manager Staff Experience Manager & Comms		On-going – immediate planning to implement this activity is underway.

Key	
	Off-track
	On-track
	Completed
	Not Started

Cost of Living Plans – Summary & Overview



Immediate actions are underway to ensure that we are supporting colleagues in a timely manner		
Cost of living poll	Closes 28/10/22	Staff Wellness Practitioner
Cost of Living comms toolkit (to include current support offers, signposting to debt advice & iFM comms)	Mid Nov 22	Staff Wellness Practitioner & Staff Experience Manager
Breakfast Packs – assembled and distributed to Chaplaincy	04/11/22	Staff Wellness Practitioner
Breakfast Packs – Comms launch & community drop-ins	w/c 07/11/22	Staff Wellness Practitioner
Foodbank – options considered	Early Dec 22	Staff Wellness Practitioner
Fruit & Veg Stall – site identified & agreed with iFM. Awaiting confirmation from provider	Early Dec 22	Staff Wellness Practitioner
Financial Wellbeing sessions (Nov & Dec 22) – to approach providers for cost/check feasibility	w/c 31/10/22	Staff Wellness Practitioner
Cost of Living Vouchers	w/c 28/11/22	Staff Engagement Practitioner

Agenda Item 16B

Title:	Industrial Action Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	James Mawrey		Decision	

Summary:	The pay award to NHS staff is determined nationally. A number of trade unions have indicated that they have/intend to consult their members on taking industrial action in response to the 2022 pay award. Colleagues will have seen that the Royal College of Nursing (RCN) has announced that nursing staff at some of the NHS organisations across the UK have voted to take strike action over pay levels and patient safety concerns. As the 50% turnout threshold was not met at Bolton (47% voted) then there is no mandate for strike action by the RCN at this time in Bolton. This is despite the fact that 93% of those staff who voted did vote for strike action. This paper notes the position of the other recognised Trade Unions, along with the measures that are currently being taken within Bolton.

Previously considered by:	Written and verbal updates have been provided to the People Committee.

Proposed Resolution	The Board are asked to note the report and the actions that are being taken to manage the implications of any potential industrial action.

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:	Carol Sheard, Deputy Director of People	**Presented by:**	James Mawrey, Director of People/Deputy CEO

Introduction / Background

The pay award to NHS staff is determined nationally. A number of trade unions have indicated that they have/intend to consult their members on taking industrial action in response to the 2022 pay award.

At Bolton we want to see a resolution as soon as possible to the strikes, but ultimately pay is a matter for the Government and the trade unions. We value our staff and understand that good pay and conditions are important, not only for individuals and their families but for wider issues such as retention and recruitment, too.

Whilst the pay negotiations have taken place at national level, any potential industrial action needs to be communicated by the Trade Unions to individual NHS employers. Operational planning and a review of business continuity plans needs to be undertaken at local Trust level.

We will of course reassure the public that patients should continue to come forward for emergency services as normal, as the NHS is committed to keeping disruption in these services to a minim.

RCN update as at 15th November 2022

You will have seen today that the RCN has announced that nursing staff at some of the NHS organisations across the UK have voted to take strike action over pay levels and patient safety concerns.

As the 50% turnout threshold was not met (47% voted) then there is no mandate for strike action by the RCN at this time in Bolton. This is despite the fact that 93% of those staff who voted did vote for strike action.

For those organisations impacted then industrial action is expected to begin before the end of this year and the RCN's mandate to organise strikes runs until early May 2023, six months after members finished voting.

Whilst there is no mandate for strike action at Bolton there is for other organisations in Greater Manchester. This may of course have a knock on impact for Bolton (mutual aid).

Other Trade Unions position

Despite RCN not having a mandate to strike at Bolton we are of course minded that there are other Trade Unions balloting staff.

Union	Status	Dates	Notes
BMA (general Practice)	Formal ballot under consideration	NA	
BMA (jr Docs cttee)	Formal ballot announced	Ballot planned for January	
RCN	Formal ballot concluded	Ballot 6/10-2/11	Results announced 9/11
Unison	Formal ballot underway	Ballot 27/10-25/11	Ballot of 350k members in the NHS (mostly non clinical staff)
Royal College of Occupational Therapists/British	Formal ballot underway	Ballot 27/10-25/11	Their members will be represented by UNISON (see above)
Association of Occupational Therapists			
The Chartered Society of Physiotherapy	Formal ballot announced	Ballot 7/11-12/12	
Royal College of Midwives (RCM)	Formal ballot announced	Ballot 11/11-9/12	
GMB (Ambulance Services)	Formal ballot underway	Ballot 24/10-29/11	Ballots in all 10 ambulance services
Unite (Ambulance Services)	Formal ballot underway	Ballot 26/10 – 30/11 and 28/10 – 2/12	Ballots in all 10 ambulance services ballots are running in two rounds)

Concluding comments

Patient safety is always paramount. Unlike workers in many other sectors during a strike, some staff continue their work. This is carefully negotiated between employers and unions beforehand to make sure patients are safe. A way of maintaining safe staffing levels is through derogations (an exemption provided to a member or service from taking part in strike action). We will work with unions to seek derogations. These are based on:

- Safety of delivery of NHS services - Ensuring minimum staff levels are available to deliver emergency, immediate life, limb or organ-saving intervention
- Safety of staff should be protected - For those working during a possible industrial action
- Safety of the public is maintained - Ensuring relevant staff levels are available to deliver care to the public in case of major incident at national or local level
- Professional regulatory advice is provided and followed
- Life preserving services will continue - With the necessary number of professionals
- Derogations agreed locally to reflect local population and service needs

Bolton has produced industrial action FAQ to help our employees understand industrial relations good practice.

Recommendation

The Board are asked to note the report and the infrastructure in place to manage the implications of any potential industrial action.

Agenda Item 14

Title:	Quality Assurance Committee Chair Report October and November 2022

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	Francis Andrews, Medical Director		Decision	

Summary:	This report provides an update on the October and November Quality Assurance 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:	Malcolm Brown, Chair Quality Assurance Committee	**Presented by:**	Malcolm Brown, Chair Quality Assurance Committee

Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	18 October 2022	Date of Next Meeting	16 November 2022
Chair	Malcolm Brown	Quorate (Yes/No)	Yes
Members present	Fiona Noden, James Mawrey, Tyrone Roberts, Francis Andrews, Rae Wheatcroft, Sharon Martin, Martin North, Jackie Njoroge, Lianne Robinson, Sophie Kimber-Craig and Stuart Bates.	Key Members not present:	Rebecca Lennon, Diane Sankey, Michelle Cox and Gareth Hughes.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision

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

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

Committee/Group Chair's Report

Integrated Performance Report (IPR)		Chief Nurse / Deputy Medical Director	The Chief Nurse and Deputy Medical Director provided the update highlighting the key points and exceptions: • Pressure Ulcers – The first collaborative is being launched this week and will be rolled out over 12-18months and regular updates on this will be provided to the Committee. • Serious Incidents being completed and with family within 60 working days – Data is showing as being 80%. Prior recording of this standard was incorrect and so should not be included. Correct recording commenced August 2022. • C-difficile has increased by 19% nationally post covid-19, although the Chief Nurse asserted that this should not defend away the rates in the organisation as our baseline was already higher than Greater Manchester organisations. • FFT recommendation rates will be focussed on in the next month as the rates are too variable to determine improvement and reliability • Maternity – 3rd and 4th degree tears has improved and overall the Trust is working to make sure data collected is reflective of the East Cheshire NHS Trust dashboard to ensure reporting on what the Trust needs to be reporting on. • Clinical Correspondence – Work is still ongoing with a report due to be presented in November to include a trajectory for improvement • Mortality – Progress continues to be made and both SHMI/HSMR are within the ranges needed and there are improvements being made in the Sepsis workstream. Jackie Njoroge queried whether clinical correspondence was a symptom of something else	• The Quality Assurance Committee received and noted the Integrated Performance Report (IPR).

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

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

			not working and how the Trust can gain better control of the situation. The Deputy Medical Director confirmed that a working group had been established and would regularly review the issues with inpatient correspondence and in particular whether staff were able to complete and needing to identify a way of utilising EPR to automatically prepare the letters for efficiency. Jackie Njoroge observed that statutory/ mandatory training on the wards appeared to have declined and asked whether this was being addressed in People Committee. She added that staff turnover used to be seen in the reports and it may be beneficial to reintroduce this. The Director of People confirmed that a deep dive looking at the top 10 areas for staff turnover had been commissioned by the People Committee.	
Clinical Governance & Quality Committee Chair Report		Chief Nurse	The Chief Nurse presented the chairs report, noting the following key items: • Infection Prevention and Control – Visiting has been reopened with robust measures in place and restricted visiting of 2 people per bed. • Nursing KPI Audits – There is a need to triangulate this data as is showing as green but is not always in sync with the BoSCA dashboards. • Patient Safety Incident Report – An overview of incidents is being undertaken looking at specific postcode areas for any inequalities. • NEWS – There is to be a deeper look into historical EPR delayed observations and if there are any significant issues around doing these at the time the observations take place.	• The Quality Assurance Committee received the Clinical Governance and Quality Committee Chair Report.

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

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

Committee/Group Chair's Report

			Martin North queried the c-difficile rates and if the Trust was back in a position to get the basics right to which the Chief Nurse commented that there is regular monitoring of side room availability for those at the end of life, Covid positive or those with c-difficile and so it is constantly being managed.	
Priority Four – Q1 & Q2 – NEWS Improving Response to Escalation		ASSD	The report was presented by the Divisional Nurse Director who informed the Committee of the following progress to date; • Significant improvement is seen in AACD since April 2022 with the biggest improvement in frequency and the escalation of NEWS scores. • ASSD have had progress demonstrated against the timely recording of observations and the sepsis response and escalation. • KPI's now assessed by the ward manager and matron oversight giving more insight into trends and concerns or staffing training required. The Chair discussed the need for nurses to feel empowered enough to escalate any issues. The Divisional Nurse Director confirmed that the RRSAFER work is in place to assist with the escalation and that this will be reporting through Clinical Governance and Quality Committee in due course.	• The Quality Assurance Committee received and noted the report.
Urology SI Assurance Report		ASSD	The Divisional Nurse Director presented the assurance paper to Committee in order to address the issues relating to SI 189914 following an incident related to a patient with a history of bladder cancer who was not booked a follow up appointment by the reception staff.	• The Quality Assurance Committee received and noted the report.

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

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

Committee/Group Chair's Report

			A discussion took place regarding the process being very manual and if there were ways to use EPR in order to support and prevent further issues but it was noted that Urology are not yet at that stage with the EPR system. The Associate Chief Nurse questioned how the learning from this was being used across other divisions and how the division plans to track the learning to see what progress is being made. The Divisional Nurse Director confirmed that there are weekly SMT meetings within the division and the outcomes of these are then shared with the Governance Leads and Operational Business Managers. The Committee noted that whilst there was a need to embed the manual process across all divisions, digitalising the process would improve overall handling of future cases and mitigate against future occurrence.	
Mortality Quarterly Report		Associate Medical Director	The Associate Medical Director presented the Mortality report and drew attention to the following: • Both SHMI and HSMR were within range. Crude mortality was as expected and reflected well on the national average. The crude mortality for Bolton is also good. • Improvements to the EPR would be required with a view of ensuring clinicians would not miss key comorbidities. This would include automatic uploading of comorbidities into the Health Issues section as this will improve the average comorbidity score and the depth of coding.	• The Quality Assurance Committee received and noted the report.

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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

			• A 'Best Practice Guide' for clinicians had been developed to inform doctors on how to ensure data is recorded in the best way for it to be easily coded. JN questioned what could be done to embed this further into EPR. The Associate Medical Director advised that the coding rules were sanctum and the challenges around comorbidities automatically recording would affect audit compliance as it would code something from a previous episode that had not been recorded during the current episode. The Chief Nurse questioned if anything else such as AKI, sepsis, NEWS had triggered to which the Associate Medical Director discussed Oesophageal Cancer but that this was likely due to not expecting to see patients die from this so it does flag when recorded.	
Learning from Deaths Quarterly Report		Associate Medical Director	The Associate Medical Director presented the Learning from Deaths report and highlighted that: • There is a log detailing the secondary reviews that have taken place of which over 1000 have been done and there are currently 13 outstanding. • The outstanding cases would be prioritised in order of date requested. • A dashboard which would be available to all Divisions shortly which is included in the report for the Committee. • Some of the themes identified from these reviews include; oxygen prescribing, referrals by EPR and decision making. • The Learning from Deaths Committee are exploring more consistent ways of sharing the	• The Quality Assurance Committee received and noted the report.

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			learning/ feedback from the reviews as well as ensuring there is reassurance the feedback has been received and actioned where necessary. • The drop off in cases reviewed during Q1 was discussed with the Associate Medical Director confirming that this will be picked up and is due to trained reviewers not having capacity and so trying to train more but it is being monitored. The Chair queried if there was any current triangulation of data at ward level through the BoSCAs, NEWS etc. that could be used. The Associate Medical Director advised this would not be accurate as a patient could move the day prior and this would be the latest data pulled.	
Maternity & Paediatric Sepsis Update		Associate Medical Director	The Associate Medical Director presented the report which detailed that: • The repeated audits in Paediatrics regarding emergency admissions were noted to be really good and that process has now been adopted into Maternity. • There were consistency issues relating to the use of paper but this would improve following the EPR roll out. • Maternity have procured a complete EPR system for maternity; K2 will be implemented across all areas within the unit, which will provide much better flow of information between the various clinical areas. • There were no issues regarding quality of care but there are still areas to address in relation to recording and recognising.	• The Quality Assurance Committee noted the report.
Bluespier Whiteboard and Virtual Fracture Clinic Patient Management System		Medical Director	The Medical Director presented the report that the Committee had requested for assurance regarding	• The Quality Assurance Committee noted the report.

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			the use of multiple systems for patient management. Bluespier was one of the systems used by the Trauma and Orthopaedic team to record their patients and schedule them for surgery, creating lists that could be viewed from any computer and allows for easy transfer. Whilst there is a risk to using systems that are not fully integrated there is an expected standard that no clinical information is held on Bluespier that is not present in EPR.	
Assurance and Quality Governance Report		Dir. of Quality Governance	The Director of Quality Governance presented the report which provide an overview of key findings and recommended changes to the quality governance structures following a review of clinical governance structures. The following changes were noted: • The work plan for Clinical Governance and Quality Committee is now fully aligned with Quality Assurance Committee. • Divisional reports previously received on a regular basis have been stood down as they were replicated in other work. These reports have been replaced with a monthly review of the IPM data for all divisions and would build on this with sources of quality assurance such as the BoSCA framework. This would be complimented with mock CQC inspections held twice a year which will be brought to this Committee.	• The Chair agreed to support the recommendations with a view to review this in six months' time. • It was noted that when the Committee review and receive SI reports any changes/ comments would be shared with the family in an addendum as these reports are shared with the family once the Sign Off panel have approved the report. • The Quality Assurance Committee noted the report.

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Committee/Group Chair's Report

			MN expressed support for the recommendations and queried how the Committee could be assured that they would receive the right level of assurance. In addition, JN questioned how the committee would be assured that there were robust systems in place to ensure that the committee would not only receive select information. Divisional leaders from AACD, ASSD and Family Care all commented on how the process allowed consistency, reduced report writing and the opportunity to address any concerns raised with the time made available. The Chief Nurse confirmed that the only paper had been removed (the quarterly divisional reports) and all other items that previously came to the Committee will remain the same, with an additional 15 sources of intelligence.	
Risk Management Committee Chair Report		Chief Operating Officer	• The Chief Operating Officer presented the Chair's Report taking the item as read and noted the following; • The Committee were challenged to confirm whether they felt it was right to be showing as no risks above a score of 16 and so work is ongoing to review this.	• The Quality Assurance Committee received the Risk Management Committee Chair Report.
Safeguarding Committee		Associate Chief Nurse	The Associate Chief Nurse presented the Chair's Report taking the item as read with no additional comments or escalations to be made.	• The Quality Assurance Committee received the Safeguarding Committee Chair Report.
Group Health & Safety Committee		Dir. of Quality Governance	The Director of Quality Governance presented the Chair's Report taking the item as read and noted the following items;	• The Quality Assurance Committee received the Group Health & Safety Committee Chair Report.

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Committee/Group Chair's Report

			• Fire Safety Surveillance was red due to reports not being received. • Ligature Risks – There was no update received in the actions and so there was no assurance but can confirm the risk assessments have taken place and Shirley Ryan is leading on future action updates.	

For Escalation:

Jackie Njoroge queried the escalation of risks appropriately via the Chairs Reports received and how these are monitored.

The Chief Nurse advised that this would be a large piece of work to undertake similar to an internal audit but the Chief Nurse will feedback to Jackie Njoroge.

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Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	16 November 2022	Date of Next Meeting	21 December 2022
Chair	Malcolm Brown	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Martin North, Francis Andrews, Tyrone Roberts, Carol Sheard, Sam Ball and Sharon Katema.	Key Members not present:	Fiona Noden, James Mawrey, Sharon Martin.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Integrated Performance Report (IPR)		Chief Nurse / Medical Director	The Chief Nurse and Deputy Medical Director provided the update highlighting the key points and exceptions: • Pressure Ulcers – There is an error in the narrative for the hospital saying special cause variation is noted when actually there are two astronomical points; one for stage 2 hospital acquired pressure ulcers and for 1 x stage 4 pressure ulcer (hospital) There has been an increase in stage 2 hospital acquired pressure ulcers 'in month' but a review could not identify any themes in terms of location / cause, however it is thought that this could be due to the launch of the Pressure Ulcer Collaboration that commenced in October 2022, and the subsequent raising of awareness. The Chief Nurse advised there was also a category four inpatient which is the first for several years and this will be discussed at a panel this week. It was noted that there were a number of failings but the Chief Nurse was assured that colleagues had put robust interim measure in place to strongly mitigate this this recurrence. The Chief Nurse confirmed that the identification of a stage 4 pressure ulcer (hospital acquired) is a serious issue and has been given due focus.	• The Quality Assurance Committee received and noted the Integrated Performance Report.

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Committee/Group Chair's Report

			The Committee were also informed that following a review of some other Trusts within Greater Manchester, the Chief Nurse identified that the Trust is potentially reporting in a way that suggests there are more cases of pressure ulcer acquisition in the community due to lapses in our care that is actually the case. The Deputy Chief Nurse and Divisional Nurse for ICSD are leading on the work to address this. • C-Difficile – It was noted that this was heading in a positive direction of travel with now 4 months of decreasing numbers, and the Chief Nurse was tentatively optimistic this will improve further • Patient Experience – There is a deep dive being presented at Clinical Governance & Quality Committee in December to review friends and family free texts • Maternity – The GMEC comparison which has been carried out by the Director of Midwifery has been really helpful and provided helpful context • Sepsis Screening – There is a concern regarding the downward trajectory for ED • Clinical Correspondence – The Medical Director is working with AQuA to understand any issues and continuing to support divisions • Mortality – Both SHMI and HSMR are in the expected range due to the continuing hard work by the Coding Team JN queried the increasing trend of pressure ulcers and how the Trust can be assured that reactions are effective and at what point does the Trust need to try a different approach. The chief nurse confirmed that the PU Collaborative would take 12-18months to become fully embedded, incorporating the 'plan, do, study, act' model for improvement and development of an overall 'change package' that would be implemented. That said, it was highlighted that increased trust-wide awareness and activity relating to pressure ulcer prevention should support improvement generally.	
Clinical Governance & Quality Committee Chair Report		Medical Director	The Medical Director presented the chairs report, noting the following key items: • The Divisional updates were taken as read and noted. • PSIRF -Nine incidents were graded moderate harm and above and fourteen ongoing SI investigations with eleven overdue the 60-day deadline for reports being sent to families/patients.	• It was agreed that the Chief Nurse will agree outside of the meeting when the PSIRF report will be added to the Committees agenda. • The Quality Assurance Committee received and

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Committee/Group Chair's Report

			• Learning from Experience – This was a well-received report and provoked a lot of discussion. • Resuscitation – The report was received and a number of actions were identified, one of which was for the Resuscitation Lead to contact GMMH to make them aware of potential changes. MB discussed the level 5 harm in the Acute Adult report. It was confirmed that this was currently awaiting the results of a post mortem as unable to determine if this was a fall or medical collapse. There was a discussion regarding the SI process and that there are 11 overdue to which the Chief Nurse advised that the new format whereby the Medical Director and Chief Nurse see the report before final sign off has caused some delays due to appropriate queries being raised MB raised a concern that the Committee receive the IPR report the day before the Committee which does not allow for ample reading of the report. It was noted that this is due to Board reporting timelines and following the Committee's previous discussions around receiving the previous months' out of date IPR.	noted the Clinical Governance and Quality Committee Chair Report.
Priority Two – Q2 – Rheumatology		ICSD	The report was presented by the Clinical Lead for Rheumatology who informed the Committee of the following progress to date; • Work has been impacted by some changes that have been taking place within medical capacity, including the lack of SPR. • PIFU has been implemented as a pilot with the lead nurse, which will lead to reduced follow up frequency need. • The Division have begun the implementation self-management strategy in patients with inflammatory arthritis. • Scoping undertaken of alternative Fibromyalgia referral pathway i.e. accessing patient education rather than requirement for consultant assessment. Patients can be directed towards accessible, approved video based education.	• The Quality Assurance Committee received the update on Quality Account Priority Two – Rheumatology.
Board Assurance Framework		Dir. of Corporate Governance	The Director of Corporate Governance presented the Board Assurance Framework to the Committee and noted the following; • The template has had a few changes to that layout but there hasn't been any change to the overall content. • Some of the notable changes includes the inclusion of principal risk which will impact the achievement of the ambition to provide	• The Board Assurance Framework will be presented to the Committee on a quarterly basis going forward.

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			safe, high quality care. There are also gaps in assurance and gaps in controls which had previously been included in the actions column and are now separate to help identify the systems and process that need to be in place. • Assurance levels have been split into three lines of defence which will help assurance mapping and there is also an overall assurance level rather than being broken down into individual sections. • There is no proposal to amend the current risk score of '16' and the risk appetite will also remain at '2'. Feedback from the Committee included; • The use of a glossary for the many acronyms, • A plea to ensure that the control and assurance columns tie together • Dates to be included alongside the control and assurance columns • Clarification regarding ambition one and if this is focused on mortality or the wider risk.	• The Committee receive and noted the Board Assurance Framework.
Infection Control Annual Report		Chief Nurse	The Chief Nurse presented the Annual Infection Control report taking the report as read and drew attention to the following: • There is a stated commitment to preventing all Healthcare Acquired Infections and a zero tolerance to all avoidable infections and the Trust has achieved this objective on most points during April 2021 – March 2022. MB questioned why CPE infections were not included on the table provided on the front sheet. RC confirmed that there is no mandatory report for this but the Trust does have its own internal target and so is included in the body of the report.	• The Quality Assurance Committee received and noted the Annual Infection Control report.
Safeguarding Annual Report		Chief Nurse	The Annual Safeguarding Report was shared by the Chief Nurse who highlighted the following key points; • In 2021/22 there had been no changes to statutory requirements for safeguarding adults and children, however Bolton has seen an increased number of referrals and causes for concern since the start of COVID-19 with lockdowns considerably contributing to the rise in cases • There had been a 22% increase in children referrals in 2021/22 compared to the year previous. • Looked after children are more at risk of health issues and are provided health reviews the data for which is not currently included in the IPM data which may need to be going forward.	• The Quality Assurance Committee received and noted the Annual Safeguarding Report.

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Committee/Group Chair's Report

BCG Vaccination for Babies Service Update		Director of Midwifery	The Director of Midwifery presented the report noting that; • The BCG service was paused earlier this year following the concerns around safe storage of the vaccinations. Communication was sent to the families affected by this. • As at 21 October there were 761 babies still needing vaccination. • The Trust has been holding daily calls to manage the action plan and fortnightly calls with GM to provide assurance. • The service was resumed on 15 November following robust staff training, storage concerns addressed and the appropriate PGD in place. • The current trajectory shows that the Trust will be back on track by 15 December and wre-commenced yesterday, administering 40 vaccinations • Once the backlog has been cleared the service will move to Thoracic Medicine who will continue to provide the vaccinations.	• The Quality Assurance Committee received the update regarding the BCG Vaccination Service.
Maternity Services in East Kent Independent Investigation Report		Director of Midwifery	The Director of Midwifery took the report as read and discussed the following; • The report highlights the outcome of the investigation which relates to the detection of identification of poorly performing units, the need to provide care with compassion and kindness and the need for teams to work with a common purpose and to respond to challenge with honesty. • In response to this publication there is going to be a review of the multiple action plans which Maternity services are having to deliver at this time with a view to implement a single action plan which will include; CNST, East Kent and Ockenden recommendations. Janet C asked the Committee to consider whether the committee was confident that they are able to read the signals that are shared at this meeting and at Board? And could they detect if the Maternity service here at Bolton could be identified if it was at risk of the concerns that were identified in the report. Committee members discussed the assurance provided by both the CNST report and previous reports / updates since April 2022. Whilst these updates shared areas of concern, the committee discussed the open and candid updates presented at both BoD public board in July 2022 and other key committees since.	• Early Warning Dashboard for Cultural Indicators to be presented to the Committee in February 2023. • The Committee received and noted the East Kent Independent Investigation Report.

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Committee/Group Chair's Report

			Following a robust discussion on cultural indicators and soft intelligence, CS spoke to the Committee regarding a data set which looks at 13 cultural indicators and how these are being linked into the CQC KLOE's and this could be used to form an early warning dashboard for cultural issues. JC asked that Families were the first to trial this dashboard and it was agreed that it will be presented back to the Committee.	
Maternity Speciality Themes : Serious Investigations		Director of Midwifery	• The report presented by the Director of Midwifery provided a summary of the themes from the serious incidents and complaints that occurred. • It was noted that there was one serious incident declared during this period and four serious incidents were closed. • There were no generic themes that were identified within the four cases that were declared	• The Quality Assurance Committee received the update on Maternity Specialty Themed Serious Incidents.
CNST Scheme Update		Chief Nurse	The Chief Nurse presented the report to the Committee noting the following key points; • There are two work-streams underway. One of which is around the recovery of as much of the amber safety standards as possible, and this is being supported by the director of Finance as Executive sponsor for overview of the working group. • The other work-stream is focussed on governance and the 'how, when and why' did this happen. This is looking at both Corporate and Divisional Governance with PWC carrying out an internal audit and corporate governance reviewing divisional governance systems and processes • The Trust is currently confident in the delivery of three of the actions with the recovery group focussing on the remaining amber actions and the detailed analysis of evidence to make sure it can stand up to scrutiny if needed. • The aim is to make sure that the Trust manages the oversight of CNST rigorously going forward by establishing a transformation group at which the work-streams and the leads will each contribute to their submitting their evidence and having that push and pull effect with regards to challenge to make sure that our Board oversight and reporting is robust.	• The Quality Assurance Committee received the report providing an update on the CSNT Scheme.

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Committee/Group Chair's Report

Risk Management Committee Chair Report		Chief Operating Officer	The Chief Operating Officer presented the Chair's Report taking the item as read and noted the following; • The buzzer issues will be resolved by 5th December 2022 and the Chief Nurse confirmed that mitigation remained in place with no untoward incidents	• The Quality Assurance Committee noted the Risk Management Committee Chair Report.
Mortality Reduction Group Chair Report		Associate Medical Director	The Chief Operating Officer presented the Chair's Report taking the item as read and noted the following; • The Terms of Reference and report template had been agreed. • Sepsis workstream actions were noted in order to address the shortfall. • Cardiac Arrest workstream will report monthly until further assurance is provided.	• The Quality Assurance Committee noted the Mortality Reduction Group Chair Report.
Safeguarding Committee		Associate Chief Nurse	The Chief Nurse presented the Chair's Report taking the item as read with no additional comments or escalations to be made.	• The Quality Assurance Committee noted the Safeguarding Committee Chair Report.
Professional Forum Chair Report		Chief Nurse	The Chief Nurse presented the Chair's Report taking the item as read with no additional comments or escalations to be made.	• The Quality Assurance Committee noted the Professional Forum Chair Report.
For Escalation:				

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Agenda Item 15

Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q2 Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24 November 2022		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

Summary

The purpose of this report is to provide an update on progress towards the achievement of the ten safety actions contained within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Following the comprehensive review of Ockenden (1) in Q1, the Chief Nurse requested a detailed review of CNST evidence. This was commenced by the interim Head of Midwifery and further progressed by our newly appointed Director of Midwifery who commenced in post September 2022.

In view of early outputs from this review, both September and October 2022 Strategy and Transformation Chair's report have highlighted significant concerns with delivery of year 4. This position has also been shared at November's sub-board Quality Assurance Committee.

For contextual purposes, colleagues should note that this is the fourth year of the MIS which is operated by NHS Resolution, the scheme rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. Full compliance has been recorded in the previous three years of the scheme.

MIS incentivises the implementation of safety actions, which if achieved in full, then entitle Trusts to an annual rebate (circa £1m in 2022/23 for BFT).

Our current assessment of compliance against the ten standards is shown below. This follows a full review being undertaken by the Director of Midwifery.

	Total	Red Not met or evidence not yet found	Amber Seeking evidence	Green Fully met or on track
Safety actions	10	3	4	3

Note that four safety actions remain at risk of non-attainment and a further three safety actions have breached the required timeframes for completion.

Whilst we expect to make significant improvements in the compliance position between now and the final submission date of 2 February 2023, the Board of Directors should note that it is unlikely that we will be able to report compliance with all ten safety actions. This means that the rebate of circa £1m is at risk.

	The following actions are being undertaken to mitigate the associated risks associated; • NHS Resolution were asked to confirm if retrospective submissions of quarterly reports can be considered to improve the overall compliance position. NHS Resolution has confirmed retrospective submission cannot be accepted. • Internal Audit have been asked to provide assurance of systems and processes now in place to achieve the MIS standards year 4. • Leads for each of the 10 safety standards have been re-confirmed and PMO support and additional capacity has been put in place • The corporate governance team is further reviewing evidence and correlating with the safety actions and indicators. • Support has been secured from the Local Maternity and Neonatal System (LMNS) and the Regional Chief Midwife to optimise the submission. • A CNST recovery group comprising the Director of Midwifery and senior leadership within maternity, chaired by the Director of Finance has been formed. • We will explore with NHS Resolution the possibility of a rebate proportionate to the final level of achievement. • It is important to note that whilst achievement of all of the CNST (4) 10 safety standards is at risk, our Maternity services, as evidenced by our key performance indicators, remains safe.

Previously considered by:	Executive Directors have received updates and previous iterations of the paper in October and November 2022. Presented at Quality Assurance Committee 16th November 2022

Proposed Resolution	*It is recommended that the Board of Directors:* *I. Note the current CNST MIS position* *II. Note the actions plans included within the report* *III. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as 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:	J Cotton, Director of Midwifery/ Divisional Nurse Director L Robinson, Deputy Chief Nurse Annette Walker, CFO	**Presented by:**	T Roberts, Chief Nurse J Cotton, Director of Midwifery/ Divisional Nurse Director

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

ATAIN	Avoiding Term Admissions into Neonatal Units
CNST	Clinical Negligence Scheme for Trusts
MIS	Maternity Incentive Scheme
MSDS	Maternity Services Dataset
NWNODN	North West Neonatal Operational Delivery Network
PMRT	Perinatal Mortality Review Tool
PMO	Project Management Office
PROMPT	Practical Obstetric Multi-Professional Training

1. Introduction

1.1 The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten CNST maternity safety actions included in year four of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

1.2 Current MIS compliance has been re-assessed with regard to the revised guidance issued in October 2022.

1.3 The MIS incentivises the implementation of the safety actions, which if achieved in full, then entitle trusts to an annual rebate (circa £1m in 2022/2023 for BFT).

2. Background

2.1 The CNST MIS year 4 scheme was launched on the 6 May 2022 to support the delivery of safer maternity care. The scheme rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The MIS further incentivises in the fourth year, the 10 maternity safety actions from the previous year with some further refinement.

2.2 Each of the 10 safety actions comprises of a number of indicators. Each indicator is required to be met individually in order to achieve the related standard overall. There are currently 46 indicators in total.

2.3 This is the first formal update pertaining to MIS year four attainment of the safety actions to date. The last Board update provided in May 2022 referenced progress with regard to the attainment of the Ockenden standards as the year four CNST scheme had just launched**.**

2.4 This report provides a worst case scenario, based on available evidence to date and whilst not all the current red standards are recoverable there are actions in place to further improve the submission.

2.5 The financial rebate to the trust is currently at risk based on the submission below.

3. Progress Tracker

3.1 A summary of progress to date with regard to the attainment of all MIS ten safety actions is summarised in the table 1 below. To date three of the safety actions are on track and seven of the actions are at risk of non-compliance. The table also shows compliance at indicator level.

Table 1: Brief Overview

	Total	Red Not met or evidence not found	Amber Seeking evidence	Green Fully met or on track
Safety Actions	10	3	4	3
Indicators	46	14	9	23

A detailed narrative relating to the actions being undertaken to improve attainment is detailed in section 4 below.

3.2 Table 2 provides current attainment in more detail against each standard.

Table 2: Progress Tracker

Summary Overview CNST Safety Standard Achievement - November 2022						
Action No.	**Maternity Safety Action**	**RAG**	**Number of Indicators**	**Red**	**Amber**	**Green**
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		5	1	0	4
2	Are you submitting data to the Maternity Services Data Set to the required standard?		8	0	0	8
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?		7	3	0	4
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		4	1	1	2
5	Can you demonstrate an effective system of midwifery workforce		5	1	0	4

	planning to the required standard?					
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?		3	2	1	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?		1	0	1	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?		4	4	0	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?		4	2	1	1
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21		5	0	5	0
Total			46	14	9	23

4.0 Detailed Narrative on Improvement Actions

4.1 An update is provided below on all safety actions with progress and further narrative.

5.0 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? RED

5.1 As of the 18 October 2022, there were 22 eligible cases (Appendix 1) that met the defined threshold for reporting and requirements for surveillance information where required to be completed within one month of the death the Perinatal Mortality Tool (PMRT) in the revised year 4 reporting period. The ongoing actions to be undertaken are detailed in Appendix 1.

5.2 The service has not met the required standard to attain this action due to the lack of quarterly Board reporting of required metrics in Q1 that included the sharing of details of all deaths reviewed and consequent PMRT action plans. The report was required to evidence that the PMRT has been used to review eligible perinatal deaths and that the required reporting standards have been met. Previously the defined cases were included in a quarterly Divisional Perinatal Mortality report which detailed learning from all deaths, and identified themes and trends. There is no evidence of this submission during the year 4 period. A copy of the Q1 PMRT Board report has been generated but was not submitted for consideration of the Board within the relevant time period. A copy of the Q1 report was therefore shared with Safety Champions in October 2022.

Table 3: PMRT compliance table

Safety Action 1 (Standard A)	Compliance score		RAG
i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.	**Notification 22/22**	**100%**	
	Surveillance 16/16	**100%**	
ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death.	**13/13**	**100%**	
Safety Action 1 (Standard B)			
i. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	**6/6**	**100%**	
Safety Action 1 (Standard C)			
i. For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take	**14/14**	**100%**	

	place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.		
Safety Action 1 (Standard D)			
i.	Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**Q1 report not submitted**	
		Q2 report submitted November 2022	

6.0 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? GREEN

6.1 An up to date digital strategy has been collated that reflects the 7 success measures within the What Good Looks Like Framework within the defined timescale.

6.2 The digital strategy was shared with the Local Maternity and Neonatal System in October 2022 prior to approval by the Integrated Care Board.

6.3 The provisional indicative dashboard confirms that the Trust has achieved all data submission expectations relating to the July 2022 assessment data.

6.4 This safety action has been attained.

7.0 Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units programme? RED

7.1 Safety action 3 requires evidence of an action plan being agreed with the maternity and neonatal safety champions, Board level champion and signed off by the Board by 29 July 2022. There is no evidence of Board level sign off of the action plan by 29 July 2022.

7.2 The current action plan is detailed in Appendix 2 for formal sign off.

7.3 Prior to Q2 2022/2023 there is no evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion each quarter. The last action plan dated April 2021 was submitted as part of the year three evidence.

7.4 The quarterly transitional audit recommenced in September 2022 following a revision of the guidance in the year 4 scheme. The year 4 guidance confirms it is acceptable to recommence the reviews using data from quarter 1 of 2022/23 financial year. The Q2 audit was completed in November 2022.

7.5 A quarterly review of Avoiding Term Admissions to Neonatal Units (ATAIN) admissions during quarter one has been undertaken as per recommendations and was shared with Safety Champions in October 2022.

7.6 The ATAIN Q2 audit will be shared in January 2023.

7.7 A formal cycle of business for the maternity safety and quality meeting will be introduced to retain oversight and scrutiny of the required action plans to negate the risk of future non-submission.

8.0 Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? RED

8.1 Obstetric medical workforce

8.2 An audit of compliance with the Royal College of Obstetricians and Gynaecologist workforce document 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service': that included an action plan needed to be signed off at Board level prior to the 29 July 2022. There is no evidence that this audit took place within the required timeframe and monitored monthly thereafter to fulfil the reporting requirements or evidence of written commitment to the principles prior to the 16 June 2022. This action was introduced in the year 4 scheme as from 6 May 2022.

8.3 An audit of compliance from July 2022 – September 2022 was therefore undertaken in October 2022 and the position is detailed in table 3 for oversight and scrutiny.

8.4 The Clinical Director is overseeing ongoing engagement with the RCOG document along with the action plan to ensure non-attendance at the required clinical situations continues to be reviewed at monthly intervals. Oversight will be monitored at the maternity safety and quality meeting and ongoing assurance will need to be provided to Divisional Board for oversight.

8.5 Anaesthetic medical workforce

8.6 Copies of the anaesthetic roster have been provided to confirm compliance with ACSA standard 1.7.21.

8.7 Neonatal medical workforce

8.8 An assessment of compliance with the required neonatal medical standards was undertaken in June 2022. The service was compliant with all the required standards with the exception of Tier 3 presence on the Unit for at least 12 hours per day. An action plan has been collated and a business case is currently being scoped for the additional funded staffing establishment uplift. This evidence will fulfil the requirements for this action.

8.9 Neonatal nursing

8.10 The last review of neonatal nurse staffing levels was undertaken in July 2022 using the British Association of Perinatal Medicine (BAPM) staffing calculation to assess nurse staffing compliance.

8.11 The year 4 revised criteria requires each neonatal unit to perform a nursing workforce calculation using the Clinical Reference Group (CRG) work force staffing tool. The last review was conducted on 10 June 2022 with support from the North West Neonatal Operational Delivery Network (NWNODN) using the CRG tool. This identified that an additional 11.39 WTE Registered Nurse uplift was required to provide direct patient care (Appendix 3) and an action plan was been collated in response (Appendix 4). A subsequent regional funding allocation was awarded and the service is now currently funded to the required standard and is currently recruiting to fill vacant funded posts.

8.12 Submission of the action plan will be shared with the Royal College of Nursing, LMNS and Neonatal Operational Delivery network to meet all the required standards**.**

9.0 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? AMBER

9.1 The bi-annual staffing report was submitted to Board in July 2022 reflecting the period July to December 2021 and thus cannot be considered as relevant for the year four period as the year 4 criteria defines the relevant time period as from 6 May 2022 until 5 December 2022

9.2 A formal Birth Rate Plus systematic evidence-based process to calculate the midwifery staffing establishment is currently ongoing within the service. Data from the last Birth Rate Plus assessment undertaken in August 2020 was therefore used to inform the bi-annual staffing review published in November 2022. This fulfils the requirement that a systematic, evidence-based process to calculate midwifery staffing establishment has been completed.

9.3 The bi-annual staffing report scheduled at Board in November 2022 meets the reporting timeframe requirements and highlights that 100% supernumerary status of the Delivery Suite Co-ordinator could not be evidenced due to acuity and staffing levels and thus the required standard was not met. The service currently has a deficit against establishment of 39.11WTE (due to vacancy and sickness) and thus the staffing position remains challenged. The year 4 scheme requires evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status. The relevant time frame to demonstrate compliance for the submission is between 6 May 2022 until 5 December 2022**.**

9.4 A further review will therefore be undertaken in January 2023 to confirm if supernumerary status has been attained following a re-assessment.

9.5 The service has an ongoing workforce action plan collated in conjunction with NHSEI including a proposed timescale for achieving the appropriate uplift in funded establishment to achieve 100% compliance with 1:1 care in active labour (Appendix 4). Evidence of this action plan will enable the Trust to declare compliance with this sub-requirement.

9.6 Ongoing monitoring of the workforce action plan will take place at Divisional people committee

10.0 Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives (SBL) care bundle version two? AMBER

10.1 The Saving Babies Lives dashboard has not been shared to date with Trust Board in the year 4 reporting period as yet which commenced in May 2022 to outline compliance with the Saving Babies Lives care bundle version 2.

10.2 The Saving Babies Lives Midwifery lead post is currently vacant and the new post holder is due to commence in January 2023. An update will therefore be presented in the January 2023 Board report as the scheme does not define the frequency for this to be presented to the Board.

10.2 The last national Saving Babies Lives survey was submitted in May 2022 reporting full compliance with all elements of the care bundle and a re-submission was successfully undertaken on the 28 October 2022. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board and is thus detailed in Appendix 5

10.3 The Trust is currently unable to evidence 80% compliance with element one that relates to Carbon Monoxide (CO) measurement at booking and 36 weeks gestation using the Maternity Information System (MIS).

10.4 As the issue appears to be related to data inputting compliance a manual audit of 60 cases is currently being undertaken to confirm the current position.

10.5 Element 4: 90% training compliance needs to be demonstrated for the defined metrics such as fetal monitoring, prompt and newborn life support all of which require face to face training. Recovery from the current position of 77% to 90% is feasible within the required timeframe and a recovery plan is in place.

10.6 Trusts are required to evidence their position as of 2 February 2023. Further detail will therefore be presented in the January 2023 Board paper.

11.0 Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of the Maternity Information System (MIS) year 4? AMBER

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Table 4 – Prompt Training Compliance per staff group as of 4 November 2022

Compliance	Total	Total	Compliant	% compliance	Numbers required for 90%	Difference as at 5/10
Midwives		238	198	83%	215	36
Obstetricians		57	32	56%	52	25
Anaesthetists		43	40	93%	0	12
HCAs and MSWs		51	34	67%	46	42

11.1 Ratification of the local Training Needs Analysis (TNA) remains ongoing to align with the core competency framework requirements defined in the Ockenden report. The scheme requires confirmation that a local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in the unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. Approval of the TNA is still awaited within Division and is being expedited to ensure compliance with the CNST standard.

11.2 PROMPT maternity emergency training and newborn life support training compliance remains below the required threshold of 90% within all staff groups. Trusts are required to evidence their position as of 2 February 2023 prior to submission of compliance to NHS Resolution and confirm they have attained 90% compliance within defined staff groups. Our current overall PROMPT training compliance is 77% and 3 sessions are booked in November. A further session is currently being planned to attain the required 90% standard prior to 5 December 2022.

12.0 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? RED

12.1 There is no evidence that Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly. This requirement was an expansion of an action in the year 3 scheme and thus has not been required in previous years. The dashboard needs to include the number of incidents reported as serious harm, themes identified and actions being taken to address any issues to date and staff feedback from frontline champions and engagement sessions, minimum staffing in maternity services and training compliance prior to 16 June 2022 as required. Key highlights taken from the integrated performance dashboard will therefore be included in the CNST update at quarterly intervals going forward and are detailed in Table 3.

12.2 Serious incidents have previously been reported to Quality Assurance Committee as a delegated Committee of Board during this reporting period. NHS Resolution have confirmed that serious incident reports can be submitted to a Quality Assurance Committee if the Committee can evidence that it has delegated authority to the Board of Directors. The Trust is able to evidence this position using the Quality Assurance Committee terms of reference.

12.3 For transparency, the defined indicators identified in the perinatal quality surveillance model will be incorporated into the locally agreed dashboard for oversight of the Board for ongoing monitoring detailed in Table 3.

Table 5 – Safety Champions locally agreed dashboard

Indicator	Goal	Red Flag	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22
Quality & Safety								
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		456	471	461	441	450	490
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			6	0	0	4	2	1
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.9	4.3	4.2	4.7	4.8	4.8
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	0	0	0	0
HIE (2&3) rate (12 month rolling)	<2	2.5	0.7	0.7	0.7	0.4	0.4	0.2
Early Neonatal Deaths (Bolton Births only)	Information only		2	0	2	1	0	4
END rate in month	Information only		4.4	0.0	4.3	2.3	0.0	8.2
END rate (12 month rolling)	2.4	>3.1	1.9	1.7	1.9	1.6	1.6	2.3
Late Neonatal deaths	Information only		0	0	0	0	0	0
Perinatal Mortality rate (12 month rolling)	7.5	8	7.7	6.9	6.7	7.0	6.9	7.6
Serious Untoward Incidents (New only)	0	2	0	0	2	0	0	0
HSIB referrals			1	1	1	0	1	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Workforce								
1:1 Midwifery Care in Labour	95%	<90%	97.3%	98.3%	97.7%	98.5%	98.8%	98.7%
The Co-ordinator is the named person providing 1:1 care		<100%	5	4	1	5	0	2
Fetal monitoring training compliance (overall)								
PROMPT training compliance (overall)	<90%	>90%						49%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:29.5	1:30.5	1:28.6	1:31.4	1:30.3	1:31.5
RCOG benchmarking compliance	Information only					60%	90%	100%
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

12.4 Bi-monthly engagement sessions (e.g. staff feedback meeting, staff walk around sessions etc.) are being undertaken by a member of the Board and outcomes are being shared within the Division to fulfil the action requirement.

12.5 Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter is not evident prior to quarter 2 of 2022/2023. This was a new addition for CNST 4. The initial report is being collated for presentation in November 2022.

13.0 Midwifery Continuity of Carer (MCoC)

13.1 In July 2022 a formal paper detailed the position to date relating to the provision of MCoC and confirmed that until the current midwifery vacancy rate was recruited to establishment, the service would be unable to implement and roll out MCoC safely.

13.2 The maternity service received formal notification on 21 September 2022 thereafter from NHS England that there is no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders have been advised to focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths.

14.0 Next Steps

In order to ensure adequate oversight and scrutiny of future CNST programmes of work the following action are being taken in response:

- Establishment of an oversight Forum to monitor and oversee with regard to future schemes
- Review of CNST year 4 evidence commenced by PWC as part of Trust audit programme
- Internal review of Divisional governance functionality in progress
- CNST reporting requirements are being reviewed to ensure alignment to the Board work plan. This will ensure that the Board or its delegated committees are receiving the appropriate reports in line with regulatory requirements. The Board work plan is scheduled to be presented for approval at the next Board of Directors meeting in November
- Undertake a review to determine additional resource required to support Maternity governance and leadership roles, with a plan to implement by the end of November.

15.0 Risk

15.1 The Trust is at risk of reputational damage in the event of non-compliance with the recommendations of the year four maternity incentive scheme requirements. Full compliance was reported during the year three period and the scheme builds on the requirements each year.

16.0 Financial

16.1 Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small

discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

17.0 Summary

17.1 The report details progress with regard to attainment of the ten maternity safety actions detailed in the year 4 maternity incentive scheme that commenced on the 6 May 2022 following publication of revised guidance in October 2022.

17.2 Three of the safety actions within the year four scheme are on track to be completed within the identified timescales.

17.3 Four of the safety actions have breached and the opportunity to report retrospectively is being explore with NHS Resolution.

17.4 Three of the safety actions require significant focus and a recovery plan is in place.

17.5 Support has been requested from the Local and Maternity and Neonatal System (LMNS) and the Regional Chief Midwife to resolve the issues identified within this report.

17.6 Maternity service delivery remains safe, as evidenced through our key performance indicators

18.0 Recommendations

It is recommended that the Board of Directors:

i. Note the current CNST MIS position

ii. Note the actions plans included within the report

iii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – PMRT reporting requirements and ongoing action plans

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported/no days	1 month surveillance	PMRT started 2 months 100% factual questions	Report to draft 4 months	Report published 6 months	Date parents informed/concerns questions	Comments Assigned to/from/HSIB
81998	NND	23+1	13.6.22	0	5.8.22	13.8.22	13.10.22	13.12.22	28.9.22	TO ST HELEN'S –
81998	NND	23+1	18.6.22	0	5.8.22	18.8.22	18.10.22	18.12.22	28.9.22	TO ST HELEN'S
82113	TOP	21+5	20.6.22	1	N/A	N/A	N/A	N/A	N/A	
82258	NND	27+1	27.6.22	1	6.7.22	7.7.22	29.9.22	29.9.22	7.7.22 18.7.22	
82271	LFL	23+1	28.6.22	1	5.7.22	5.7.22	6.10.22	28.12.22	16.7.22 19.8.22	
82355	LFL	23+5	28.6.22	3	6.7.22	6.7.22	6.10.22	6.10.22	7.7.22	
82374	SB	26+3	4.7.22	2	6.7.22	12.7.22	6.10.22	4.1.23	8.7.22 22.7.22	
82400	TOP	27+6	6.7.22	3	N/A	N/A	N/A	N/A	N/A	
82401	TOP	23+5	7.7.22	2	N/A	N/A	N/A	N/A	N/A	
82632	ENND	20+1	21.7.22	0	21.7.22	N/A	N/A	N/A	N/A	
82721	SB	27+5	26.7.22	1	28.7.22	27.7.22	26.11.22	26.1.23	27.7.22	
82752	LFL	23+1	29.7.22	1	30.7.22	30.7.22	29.11.22	29.1.23	30.7.22 12.8.22	
82813	SB	37+3	31.7.22	2	2.8.22	2.8.22	30.11.22	31.1.23	1.8.22 23.8.22	
81756	NND	25+6	26.5.22	N/A	N/A	N/A	N/A	N/A	N/A	FROM LWH
83051	LFL	23+1	12.8.22	4	16.8.22	16.8.22	12.12.22	12.2.23	12.8.22 19.8.22	
83045	SB	25+6	14.8.22	2	16.8.22	16.8.22	14.12.22	14.2.23	12.8.22 19.8.22	
83224	SB	35	25.8.22	1	29.8.22	31.8.22	25.12.22	25.2.23	26.8.22 10.9.22	
83511	TOP/ NND	21+3	3.9.22	13.9.22	N/A	N/A	N/A	N/A	N/A	
83552	SB	38+5	15.9.22	1	16.9.22	16.9.22	15.1.23	15.3.23	15.9.22 19.9.22	
83641	NND	21	20.9.22	2	26.9.22	N/A	N/A	N/A	N/A	
83695	TOP/NND	23+2	22.9.22	4	N/A	N/A	N/A	N/A	N/A	
83726	NND	25	27.9.22	1	7.10.22	7.10.22	27.1.23	27.3.23	14.10.22	
83900	22+2	7.10.22	0	N/A	N/A	N/A	N/A	N/A	N/A	

NND – Neonatal Death
TOP – Termination of Pregnancy
MISC – Miscarriage
LFL – Late fetal loss
SB - Stillbirth

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
Although indicated this mother was not offered a Kleihauer test	3	Education from bereavement team
		CDS manager to discuss in staff huddles
		CDS manager to discuss in staff huddles
It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital	3	NNU manager to discuss at staff huddles importance of providing and documenting support information
		Bereavement midwife to develop written information
		Education by bereavement team
The opportunity to take their baby home was not offered to the parents as there is no local policy for this	3	Local policy being developed
		Local policy being developed
		Bereavement midwife to finalise SOP and introduce
This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	3	CDS manager to discuss at staff huddles
		CDS manager to discuss in staff huddles
		CDS manager to discuss in staff huddles
At 20 weeks uterine artery dopplers were not undertaken	2	USS manager to meet with staff member to reflect upon case
		Ultrasound manager to meet with staff member to reflect on case
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	2	CDS manager to discuss in staff huddles
		CDS manager to discuss in staff huddles

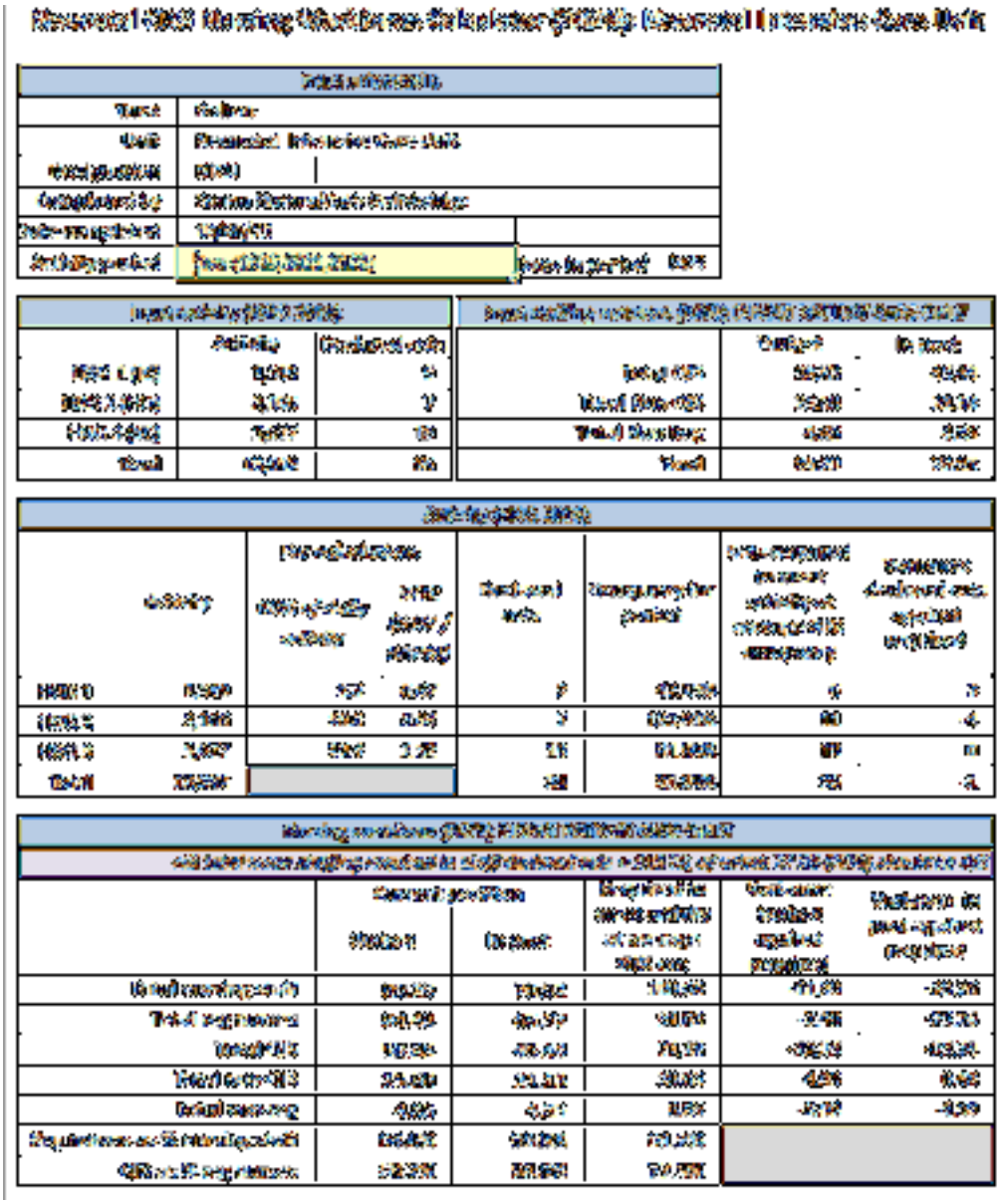
Appendix 2 - ATAIN action plan – ongoing actions

Ref	Standard	Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	ATAIN Collect data for future reporting to meet requirements of CNST 4 safety action 3(e)	Revise current ATAIN spreadsheet	H Rawlinson	30/09/2022	20.09.22 New data requirements added to current ATAIN spreadsheet (located on K drive- - ATAIN)	4
		Work with data analyst to create graphs to display data for future quarterly reports	H Rawlinson	30/12/2022		2
2	ATAIN	Set up new data collection process to enable capture and validation of future data	H Rawlinson/ Business Intelligence	30/09/2022	20.09.22 Weekly meetings commenced with transitional care lead and safety and quality midwife to support the required manual data collection	4
3	ATAIN Quarterly review of the reasons for full term babies being admitted to neonatal unit	Complete a high-level review of the primary reasons for all admissions to neonatal unit should be completed	Maternity Governance Lead	20/09/2022	14.09.2022 Q1 2022-23 report complete	4
		Focus on the main reason(s) for admission			To be included within quarterly	

		through a deep dive to determine relevant themes to be addressed.			review in the future.	
4	ATAIN Quarterly review of the reasons for full term babies being admitted to neonatal unit	Weekly ATAIN reviews ongoing with actions and lessons learnt.	Consultant Obstetrician/ Maternity Governance Lead	31.03.2022 Ongoing	Continue to meet every week and chairs reports to be produced and shared with speciality quality forums.	
5	TC Ensure relevant staff aware of: Importance of keeping mother and baby together both by avoiding admission to NNU and by stepping baby down as soon as possible Criteria for admission to TC particularly that term babies can meet criteria for TC and that babies do not necessarily need admission to NNU for NGT feeding alone	Review and update the Transitional care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.	Neonatal Governance Lead	30/10/2022	Draft guideline shared for comments	
		Share information at neonatal ops meeting system wide	Consultant Neonatologist	30/11/2022		
		Share information at neonatal band 7 coordinators meeting	, Neonatal Governance Lead	30/11/2022		
		Share information at neonatal consultants meeting	Consultant Neonatologist	30/11/2022		
6	TC Ensure babies step down from NNU as soon as criteria for TC are met	Implement process to include discussion on each neonatal ward round whether baby now meets criteria for stepping down to TC	Consultant Neonatologist	30/11/2022		

7	TC Ensure full and transparent understandin g of TC staffing	Ensure staff aware to accurately and consistently complete neonatal bed state to reflect the appropriate work load detailing when the coordinator is unable to provide TC.	Postnatal Ward Manager	30/11/202 2		
8	Respiratory Distress Syndrome (RDS) identified as most frequent reason for admission	Deep dive review of data relating to RDS ongoing	Mat Neo safety champions	30/12/202 2		

Appendix 3: Neonatal nursing workforce compliance as defined by the neonatal clinical reference group nursing calculator.



Assumptions For further detail please refer to the narrative sheet.

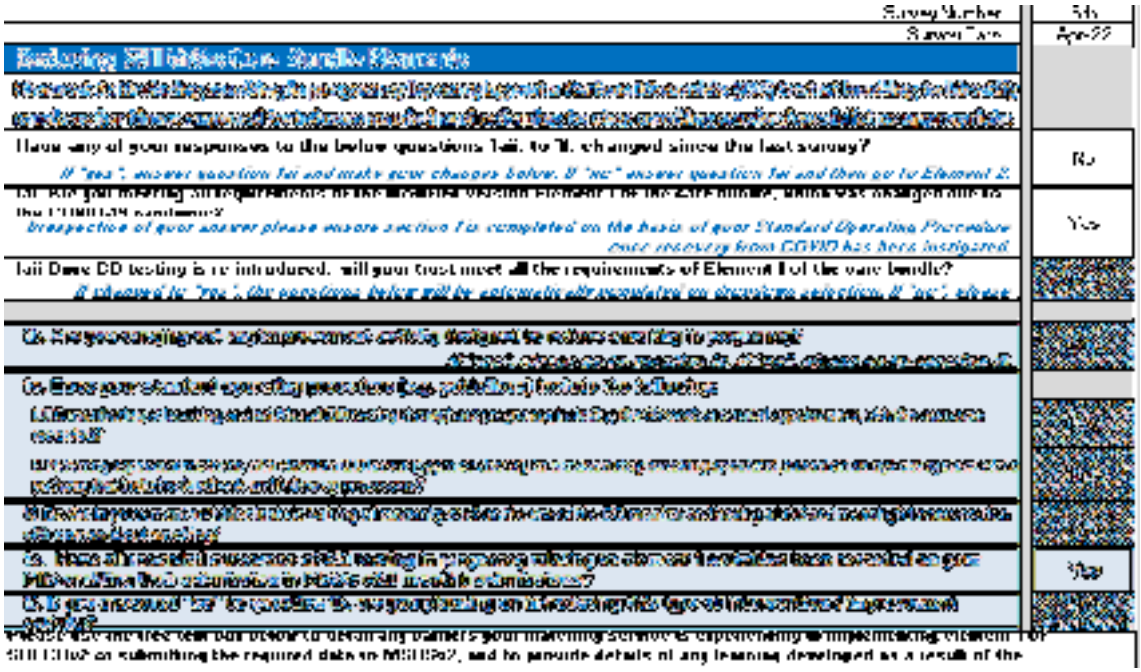
- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Appendix 4 – Neonatal Nurse Staffing action plan

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve neonatal nursing staffing requirements as per Clinical Reference Group workforce tool.	1. Assess compliance with standard	Divisional Nurse Director Neonatal Matron	June 2022	*10.6.22 Establishment deficit 11.39WTE as per Clinical Reference Group workforce tool.*	
		2. Ensure 11.39WTE staffing deficit reported in bi-annual staffing review and escalated to the Chief Nurse.	Divisional Nurse Director Neonatal Matron	October 2022	*27.10.22 Confirmation received following funding allocation funded deficit has been addressed*	
		3. Recruit to funded vacancies	Divisional Nurse Director Neonatal Matron	March 2023		

Appendix 5 SBLV2 care bundle compliance survey



Agenda Item

Title:	Reading the signals – Maternity Services in East Kent – the Report of the Independent Investigation

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	24 November 2022		Discussion	x
Exec Sponsor	Tyrone Roberts		Decision	

Summary:	The purpose of the presentation is to provide an overview of the findings detailed in the publication 'Reading the Signals; Maternity and Neonatal Services in East Kent' – the Report of the Independent Investigation shared on the 19 October 2022. The slides highlight the main findings of the report that relate to: - Failures in team working - Failures of professionalism - Failures of compassion - Failures to listen - Failures after safety incidents - Failure in the Trust's response, including at Trust Board. The report outlines four key areas for action: 1: Monitoring safety performance – finding signals among noise 2: Standards of clinical behaviour – technical care is not enough 3: Flawed team working – pulling in different directions 4: Organisational behaviour – looking good while doing badly Each Board has been asked to review the findings of this report at its next public board meeting and determine how effective assurance mechanisms are at 'reading the signals' and identify any further actions required to improve oversight. The findings of the East Kent publication precedes the publication of single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables. The attached presentation slides provide an overview of current formal and informal assurances.

Previously considered by:	Not Applicable

Proposed Resolution	*It is recommended that the Board of Directors:* *I. Note and approve the report.*

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

Prepared by:	J Cotton Director of Midwifery / Divisional Nurse Director	**Presented by:**	Tyrone Roberts, Chief Nurse

Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

Chapter 1:
Missed opportunities at East Kent - Investigation findings

- The Panel has examined the maternity services in two hospitals
- Timeframe of cases examined were between 2009 and 2020
- 202 cases assessed by the Panel
- 8 missed opportunities found to tackle the situation
- No single shortcoming explains the poor outcomes nor individual error
- Geography / demographics / distance / estate should not explain or justify the poor outcomes
- Several Failures noted including:
  - Failures of professionalism
  - Failures of compassion
  - Failures to listen
  - Failures after safety incidents
  - Failure in the Trust's response, including at Trust Board level

8 Missed opportunities

- Missed Opportunity 1: Internal review and report, 2010
- Missed Opportunity 2: Clinical Commissioning Group reporting to NHS England from spring 2013
- Missed Opportunity 3: Care Quality Commission report and governance issues, 2014
- Missed Opportunity 4: Bullying and inappropriate behaviour within the Trust and maternity services, 2014/15
- Missed Opportunity 5: The Report of the Morecambe Bay Investigation, 2015
- Missed Opportunity 6: Report of the Royal College of Obstetricians and Gynaecologists, 2016
- Missed Opportunity 7: The death of baby Harry Richford
- Missed Opportunity 8: Engagement with the Healthcare Safety Investigation Branch from 2018

4 Key areas for action

- Key Action Area 1: Monitoring safety performance – finding signals among noise
- Key Action Area 2: Standards of clinical behaviour – technical care is not enough
- Key Action Area 3: Flawed teamworking – pulling in different directions
- Key Action Area 4: Organisational behaviour – looking good while doing badly

Chapter 2:
The Panel's assessment of the clinical care provided

202 cases reviewed by the panel

- Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases the Panel assessed (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%).

- In the 25 cases involving injury to babies, 17 involved brain damage. This included hypoxic ischaemic encephalopathy (HIE, and/or cerebral palsy attributable to perinatal hypoxia. Had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

- In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%), had care been given to nationally recognised standards, the outcome could have been different.

Chapter 3:
The wider experience of the families

Key themes

- Not being listened to or consulted with
- Encountering a lack of kindness and compassion
- Being conscious of unprofessional conduct or poor working relationships compromising their care
- Feeling excluded during and immediately after a serious event
- Feeling ignored, marginalised or disparaged after a serious event
- Being forced to live with an incomplete or inaccurate narrative.

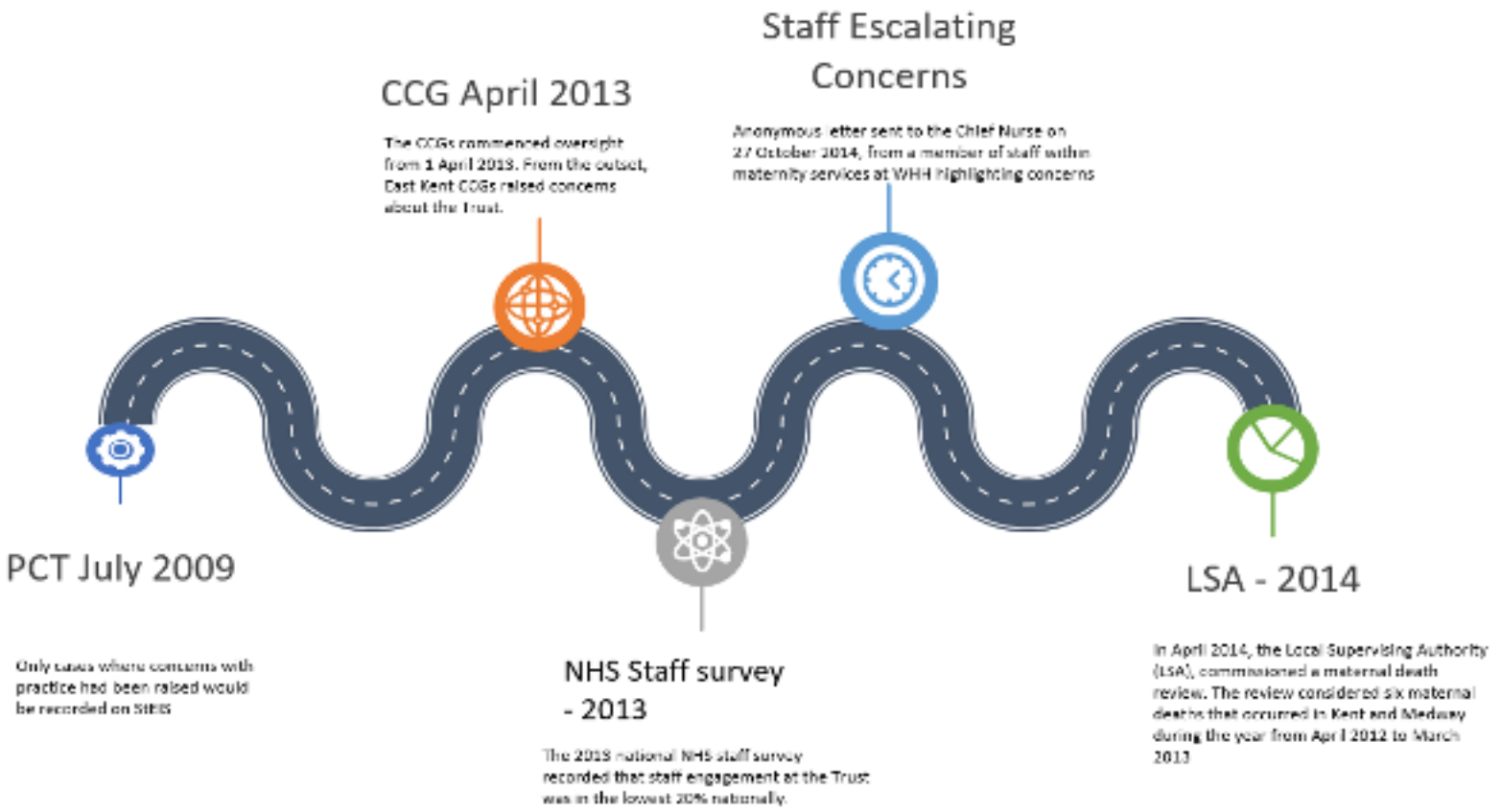
Panel conclusion: *we found evidence that the prevalent culture in the Trust has tolerated and fostered the unkind, uncompassionate and intolerant behaviours sometimes experienced by women and their families*

Chapter 4:
What we have heard from staff and others

History and Structure – The Trust merged in 1999 following a local review of services, “Tomorrows Healthcare” The Trust continued to operate as 3 separate organisations. The following were cited as contributary factors to the culture within the organisation.

- Poor staff morale
- Engagement and leadership
- Staff behaviours
- Bullying, harassment and discrimination
- Challenging poor consultant behaviour
- Poor performance and behaviours left unaddressed
- Organisational issues - culture of denial and resistance to change
- A blame rather than learning culture
- Lack of diversity and racial discrimination
- The separate operation of the WHH and QEQM sites
- Geography
- External factors - facilities and infrastructure
- Changes at Board and senior management level
- Governance & risk management
- Training compliance
- Consultant rotas and availability

Chapter 5: How the Trust acted and the engagement of regulators



Chapter 5: How the Trust acted and the engagement of regulators

RCM

- In March 2015, the Royal College of Midwives' Regional Officer lodged a collective grievance on behalf of midwives at the Trust. 51 staff signed this letter on 11 March 2015.

- On 26 June 2015, at the Trust's Closed Board meeting, the Medical Director (under "Confidential Items") updated the Board on "longstanding cultural issues" in maternity services following concerns raised by staff to the CQC and the subsequent collective grievance. The situation had improved within maternity services, but further work was required.

RCOG

- In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to carry out a review and to report on a number of behavioural and performance issues, which included concerns about relationships between midwives and obstetricians
- On publication, the report was dismissed and described as "a load of rubbish" by some senior obstetricians. A number of staff were also unaware of the report altogether.
- The Trust informed the RCOG report reviewers of 20 areas of perceived factual inaccuracies, and submitted a narrative pointing out the lack of benchmarking around safety issues and a lack of comment about the workforce.
- Upon publication of the RCOG report, the Chief Nurse of the CCGs wrote to the Trust to express concern about the quality of the serious incident investigations. Ahead of a QSG intelligence-sharing call on 22 February 2016, it was made clear that the issues were longstanding and that there was a need for positive action. The CCG sent an email to the Acting Chief Nurse at the Trust.

Chapter 5: How the Trust acted and the engagement of regulators

CQC

- August 2014 CQC overall rating for the Trust was “Inadequate”, in providing safe care and being well led, and that it required improvement to deliver effective and responsive services.
- The findings of the 2014 CQC report identified a significant difference between the Board’s perception of how well the Trust was doing and the experiences of the staff.
- The reaction of the Trust was one of real defensiveness and disbelief.
- The improvement plan for the CQC was reported and discussed at Board level. However, the Board rarely dived into the detail of maternity and neonatal services.
- February 2015, a consultant obstetrician and gynaecologist wrote to the CQC raising concerns.
- March 2015, midwife raised concerns that there was a culture of bullying at the Trust, stating staff were afraid to raise concerns for fear of reprisal, and that such pressures were putting their ability to provide quality care in jeopardy.
- The CQC inspected the Trust in July 2015 and rated it as “Requires Improvement”.
- In August, the South Kent Coast and Thanet CCGs stated that they were undertaking further scrutiny following the receipt of a 72 hour report in relation to a maternity death SUI.

Report to Monitor and review of maternity services

- Monitor was responsible between 2004 and 2016 (when it became part of NHS Improvement (NHSI)) for authorising, monitoring and regulating NHS Foundation Trusts.

Maternity services featured very little in Board discussions, despite the concerns that had been raised. Maternity services also did not feature consistently within governance sessions, and there was rarely detailed discussion about maternity and neonatal services at Board level. Issues became diluted, and their significance was not recognised as they were reported up through the chain and repeatedly summarised

Chapter 6: Areas for action

The report highlights:

- An unacceptable lack of compassion and kindness
- A grossly flawed teamworking
- Internal and external denial

- The report has not sought to identify multiple detailed recommendations
- NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations (of which this report supports)
- Instead four broad areas for action have been identified
- None is susceptible to easy analysis or a “quick fix”

Key Action Area 1:
Monitoring safe performance – finding signals among noise

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Key Action Area 2:
Standards of clinical behaviour - technical care is not enough

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.

- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance

Key Action Area 3:
Flawed teamworking -pulling in different directions

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

Key Action Area 4:
Organisational behaviour -looking good while doing badly

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

Recommendation 5

Recommendation 5 (specifically for East Kent)

- The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Agenda Item:
20

Title:	Finance and Investment Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	Annette Walker, Chief Finance Officer		Decision	

Summary:	This report provides an update on the September and October Finance and Investment 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:	Annette Walker, Chief Finance Officer	**Presented by:**	Jackie Njoroge, Non-Executive Director, Chair of Finance and Investment Committee

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	28th September 2022	Date of next meeting:	28th October 2022
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Rebecca Ganz, Bilkis Ismail, Rae Wheatcroft, Sharon Katema, Andrew Chilton, Lesley Wallace, Rachel Noble, Catherine Hulme, Matthew Greene, Paul Henshaw, Adele Morton, Dawn Killey	Quorate (Yes/No):	Yes
		Key Members not present:	James Mawrey and Fiona Noden

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM Financial Update		A Walker	The committee received an update from the recent GM Oversight Meeting, an overview of the month 5 position and key financial risks across GM. The key points were noted as follows: • There is a significant amount of concern about the GM financial position, performance and quality issues. GM met with the national team at NHSE on 15th September. Actions on revenue run rate and capital were agreed during this meeting. • GM has a year to date deficit of £59m. The Bolton deficit year to date is £6.8m. There is concern as to how to achieve a breakeven position. • A range of risks have been identified in relation to delivering efficiencies given the pressures, including concern over the delivery of the agency cap, increased costs from winter demand and the elective backlog recovery in addition to pressures as a result of the pay award and increasing energy prices. The committee discussed agency spend and NCR patients in detail.	Noted. Information on NCR patients to be quantified.

	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

TIF Theatres Bid Business Case		L Wallace	The committee received this business case seeking approval for the full Theatre development and creation of a Paediatric Hub, subject to TIF funding being received (decision expected by 9th December). It was noted that two of the Theatres were already approved by Trust Board in November 2021, using Trust cash and £1.5m PDC for Healthier Together. The cost of the entire project is £19.6m and it was noted that the Trust would have to fund £2m of this to support inflationary cost pressures. This has been heavily supported by GM for the purposes of elective recovery. There was a discussion on staffing and revenue impacts and some assurance was provided on these concerns.	The business case was approved subject to TIF funding being received.
Month 5 Finance Report		A Chilton	The committee received an update on the month 5 financial position. Key points were noted as follows: • The year to date deficit was £6.9m against a planned deficit of £2m. • The in month deficit was £1.4m. • GM is not currently achieving ERF for quarter 1. • The forecast range is from a deficit of £21m to break-even, with the likely case a £15.2m deficit. • CIP of £14.9m has been identified against the £20.6m target. £7.2m has been delivered year to date. • There are considerable risks in the capital programme.	Noted.

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

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

Committee/Group Chair's Report

Costing Update		A Morton	The committee received an update on the National Cost Collection for 2020/21 and 2021/22 as follows: • 2020/21 - Bolton received a score of 93, which is more efficient than the average. • The 2021/22 return was submitted on 9th August. Some questions have been received on this but there has been no request to resubmit the information. There was a discussion on getting more timely data and the A&E data which suggests that Bolton is efficient.	Noted.
Update on Finance Staff Development		A Morton	The committee received an update on Finance Staff Development. The key points were noted as follows: • The Team were nominated for the Team of the Year Award and were Highly Commended. • Level 3 Towards Excellence Accreditation has been achieved. • Sprint Events have taken place. One of these looked at finance training for non-finance staff. • Staff Engagement and EDI Groups have been established. • A training needs analysis has been done for the entire finance department.	Noted.
Chairs' Reports		A Walker	The Committee noted the Chair's Reports from the following meetings**:** • CRIG – 6th September • System Finance Group – 20th September	Noted.
Comments				
Risks escalated				

	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

(Version 2.0 August 2018, Review: July 2020)

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	26TH October 2022	Date of next meeting:	23rd November 2022
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rebecca Ganz, Rae Wheatcroft, Sharon Katema, Lesley Wallace, Rachel Noble, Catherine Hulme, Matthew Greene, Paul Henshaw	Quorate (Yes/No):	Yes
		Key Members not present:	James Mawrey, Andrew Chilton, Bilkis Ismail

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM Financial Update		A Walker	The Committee received an updated on the GM Financial positon presented to the Provider Federation Board in October. The key points were noted as follows: • GM have a year to date deficit of £76.7m aggregated across providers and £16.7m deficit for the ICB. • GM total position end of month 6 is a deficit of £93.4m with the plan still to break even. • GM is expecting to deliver Capital Plan. • Radical savings ideas will need to be generated to address the financial deficits we are seeing. • Strategic transformation continues to be the main focus of change for Bolton FT.	Noted. Full paper circulated to members for information, in confidence.

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

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

Committee/Group Chair's Report

Month 6 Finance Report		M Greene	The Committee received an updated on the month 6 financial position for Bolton FT. Key points were noted as follows: • Year to date deficit £8.4m compared with a planned deficit of £2.3m. In month deficit of £1.5m. • Underlying position has improved by £500k and a Financial Recovery Group has been set up. • Variable pay spend decreased by £0.2m. • CIP trackers indicating £9.2m of savings against a target of £10.3m. • Capital of £8.4m spent year to date of which £4.4m relates to TIF. • Current Cash position is £25.4m. Cash for pay award not yet received due to timing issue.	Noted.
Financial Recovery Measures		M Greene	The Committee received a presentation on Financial Recovery Measures for 2022/23. The key points were noted as follows: • Current financial position £8.4m with forecast scenarios as discussed. • Financial Recovery Group established chaired by the Operational Director of Finance. • Finance recovery process to be set up with iFM to progress CIP schemes and mirror actions from Bolton FT. • The Commercial Director of Finance is supporting IT to understand impact of 21/22 Capital spend and to drive efficiencies from IT investment.	Noted as Amber for risk but Green for actions taken by the Finance Department. Benefits Realisation on implemented projects be brought to 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

HFMA Checklist		M Greene	The Committee received an update on the HFMA checklist. The key points were noted as follows: • HFMA checklist focuses on financial sustainability and getting the basics right. • Internal Audit feedback and final scores will be available by Friday 4th November. • An action plan will be confirmed and agreed with Internal Audit to comply with the national deadline of 30th November 2022. Delivery of action plan will be linked to Financial Recovery Group.	Noted.
MIYA Business Case		L Wallace	The Committee received the business case previously approved at CRIG. • The Business Case seeks approval to enter into a contract for the Miya Patient Flow System. • The total value of the contract is £1.2m inclusive of VAT and implementation costs. The Miya Patient Flow system will replace Extramed, the current bed management and patient flow system which has limited functionality and requires a software upgrade.	Approved. Update required of the benefits realisation from this business case 6 months and 12 months.
Chairs' Reports		A Walker	The Committee noted the Chair's Reports from the following meetings**:** • CRIG – 4th October • Placed Based Finance & Assurance Committee – 20th September (minutes)	Noted.

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

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

Committee/Group Chair's Report

Comments
Risks escalated

	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 21

Title:	Review of Standing Financial Instructions and Scheme of Delegation

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24 November 2022		Discussion	✓
Exec Sponsor	Annette Walker		Decision	✓

Summary:	The **Standing Financial Instructions** (SFIs) are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. The **Financial Scheme of Delegation** (FSOD) sets out the powers and financial levels of authority or the Board, its Committees and the Executive. The Standing Financial Instructions and Financial Scheme of Delegation combine to form part of the Standing Orders of the organisation and are reviewed periodically. The last set of SFIs and FSOD were updated and formally approved by Board in November 2020. A summary of the changes that have been made are included in the attached paper to assist with reading.
Previously considered by:	The documents have been reviewed by the Director of Finance and the finance team.
Proposed Resolution	The Board is asked to approve the Standing Financial Instructions and Scheme of Delegation.

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:	Catherine Hulme Head of Financial Services	**Presented by:**	Annette Walker Director of Finance

020 Review of Standing Financial Instructions and Scheme of Delegation

The Standing Financial Instructions and Financial Scheme of Delegation form part of the Standing Orders of the Trust and are reviewed periodically. The last full review and approval by the Board was November 2020.

The Charity is covered by the Trust Standing Financial Instructions but has a separate Financial Scheme of Delegation approved by the Charity Committee.

Summary of Changes from the Previous Version

Financial Scheme of Delegation

- Removal of Audit Committee as the approving committee of the Annual Accounts and Annual Report - these are matters reserved to the Board of Directors. Audit Committee can review.
- Formal power for Executives to approve changes to Directorate/Divisional control total.
- Change of job title of the Deputy Director of Finance to Operational Director of Finance, with an increased level of approval of £150k.
- Formal power of approval of £50k for the Deputy Director of Finance.
- Amendment from "Approval of business cases for capital schemes or non-recurrent revenue up to £100k to "Approval of capital or non-recurrent revenue spend up to £100k" in the Chief Executive or Director of Finance section.
- Clarification that the approval of sale or disposal of equipment limit is the NBV (Net Book Value) in the Director of Finance section.
- Inclusion of narrative for the approval of "Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave" for all levels of delegated authorisation.
- Formal power for Non Budget Holding Managers to authorise "Timesheets (not including overtime or internal bank hours) and scheduling of annual leave".
- Clarification that virements are within existing budgets.
- Formal power for the Deputy Director of Operations/Divisional Director of Operations/Deputy Director of Finance to approve changes to Directorate/Divisional control total.
- Other minor wording changes.

Standing Financial Instructions

- Change of Section title from Counter Fraud and Security Management to Counter Fraud, Corruption and Bribery and Security Management.
- Inclusion of narrative in para 2.4.2 – "Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist".
- Updated the narrative regarding security management (paragraphs 2.4.11 – 2.1.13).
- Inclusion of paragraph 6.5.5 regarding losses.
- Updated the narrative in paragraph 7.1.1 to remove the reference to European Law and include reference to contract regulations.
- Updated the narrative in paragraph 7.3.1 to reflect an increased limit of £15k from £10k and to refer to annual expenditure rather than cumulative expenditure

- Updated the narrative in paragraph 17.1.1 to refer to the Managing Conflicts of Interest Policy rather than the Standards of Business Conduct Policy which was the previous Trust policy.

Standing Financial Instructions are for reference purposes. It is not expected or reasonable for every member of staff to know the details intricately. A list of Key SFIs has been drawn up with a corresponding description in simple language. It is reasonable that all staff should know these.

Key SFIs

SFI	Description
3.2.4	Do not use non recurrent monies to fund recurring expenditure
5.1.2	Do not open a bank account in the name of Trust, only the Director of Finance can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Director of Finance
6.5.1	You must seek permission from the Director of Finance to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non-pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Director of Finance has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the Director of Finance
13.2.1	Suspected fraud must be reported to line management, Local Counter Fraud lead or the Director of Finance
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.5	Do not accept personal gifts of cash or vouchers

Recommendation

The Committee is asked to review the revised Standing Financial Instructions and Financial Scheme of Delegation and recommend approval to the Board.

Bolton
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

November 2022

CONTENTS

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1.1 Use and Application

1.1.2 These Standing Financial Instructions are issued by the Board of Bolton NHS Foundation Trust (the Trust). They will have effect as if incorporated in the Standing Orders.

1.1.3 These Standing Financial Instructions detail the financial regulations adopted by the Trust. They are designed to ensure that financial matters are carried out in accordance with the law and relevant Government policy in order to achieve probity, accuracy, and value for money. The Standing Financial Instructions should be used in conjunction with the Financial Scheme of Delegation which sets out powers and financial limits of the Board, its Committees and the Executive.

1.1.4 These Standing Financial Instructions apply to all employees, agency, locum or temporary staff working for the Trust. They also apply to wholly owned subsidiaries, hosted functions and organisations and the Trust Charity unless separate arrangements have been agreed by the Board. Standing Financial Instructions do not provide detailed advice or policies and should therefore be used in conjunction with financial procedure notes.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought.

1.1.6 Wherever the title Chief Executive or Director of Finance is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them.

1.2 Failure to Comply

1.2.1 Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter.

1.2.2 Deliberate failure to comply with Standing Financial Instructions could constitute fraud or theft and result in criminal action being taken.

1.2.3 If for any reason these Standing Financial Instructions are not complied with, full details should be reported to the Director of Finance who will advise on the appropriate course of action. This will include deciding whether to report to the Audit Committee and/or the Board if the breach is significant.

1.2.4 All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.3 The Role of the Board

1.3.1 The Board exercises financial supervision and control by:-

(a) approving the financial strategy;

(b) approving of budgets within overall income;

(c) approving important financial policies and systems;

(d) approving the Financial Scheme of Delegation; and

(e) receiving regular assurance on financial strategy and performance.

1.4 The Role of the Chief Executive

1.4.1 The Chief Executive may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.4.2 By law, the Chief Executive of an NHS Foundation Trust is the Accounting Officer. The responsibilities of the Accounting Officer are contained in guidance issued by the Regulator and include the requirement to ensure that:-

(a) there is a high standard of financial management in the NHS Foundation Trust as a whole;

(b) there is efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation; and

(c) financial considerations are fully taken into account in decisions by the NHS Foundation Trust.

1.4.3 It is a duty of the Chief Executive to ensure that the Board and all employees understand their responsibilities within these Standing Financial Instructions.

1.5 The Role of the Director of Finance

1.5.1 The Director of Finance will carry out duties and responsibilities where delegated by the Chief Executive under these Standing Financial Instructions.

1.5.2 The Director of Finance may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.5.3 The Director of Finance is accountable for:-

(a) design and implementation of financial policies;

(b) maintaining an effective system of internal financial control;

(c) ensuring that sufficient financial records are maintained;

(d) the provision of strategic financial advice to the Board and employees; and

(f) the preparation and maintenance of accounts, certificates, estimates, records and reports as required.

1.6 The Role of the Board and Employees

1.6.1 The Board and employees must act in the interests of the Trust by:-

(a) avoiding loss of property and valuables;

(b) exercising economy and efficiency in the use of resources; and

(c) conforming with the requirements of these Standing Financial Instructions and the Financial Scheme of Delegation.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with the NHS Foundation Trust Code of Governance, the Board will formally establish an Audit Committee of non-executive directors.

2.1.2 The Board will satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 The Audit Committee will have clearly defined terms of reference and follow guidance from the NHS Audit Committee Handbook.

2.1.4 The Audit Committee will meet a minimum of four times a year.

2.2 Internal Audit

2.2.1 The Audit Committee will ensure that there is an effective internal audit function established by management that meets mandatory audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

2.2.2 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(a) an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives; and

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.2.3 The Head of Internal Audit will provide to the Audit Committee:-

(a) a risk-based plan of internal audit work, agreed with management and approved by the Audit Committee;

(b) regular updates on the progress against plan;

(c) reports of management's progress on the implementation of actions agreed as a result of internal audit findings;

(d) an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This opinion is used by the Board to inform the Annual Governance Statement; and

(e) additional reports as requested by the Audit Committee.

2.2.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.2.5 The Head of Internal Audit will be accountable to the Director of Finance.

2.2.6 The Director of Finance is responsible for ensuring that:-

(a) there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the accountable officer;

(c) an annual Internal Audit report is prepared for the consideration of the Audit Committee;

(d) an annual Internal Audit Plan is produced for consideration by the Audit Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year; and

(e) ensuring that a medium-term Internal Audit Plan (usually three years) is prepared for the consideration of the Audit Committee and the Board.

2.3 External Audit

2.3.1 The Audit Committee will review the findings of the external auditor and consider the implications and management responses.

2.3.2 In accordance with the relevant legal requirements the governors of the Trust appoint the External Auditor. The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council of Governors will need to ensure they have the skills and knowledge to choose the right External Auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the External Auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

2.3.3 The Audit Committee should make recommendations to the council of Governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

2.3.4 The Trust and the Council of Governors must ensure compliance with requirements of the relevant Acts as to who may be an auditor for an NHS Foundation Trust.

2.3.5 While the Council of Governors may be supported by the Audit Committee in running the process to appoint the external auditor, the Council of Governors must have ultimate oversight of the appointment process.

2.3.6 In appointing and monitoring the External Auditor, the Council of Governors should ensure that the audit firm and audit engagement leader have an established and demonstrable standing within the healthcare sector and are able to show a high level of experience and expertise.

2.3.7 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practice.

2.4 Counter Fraud, Corruption and Bribery and Security Management

2.4.1 The Audit Committee will satisfy itself that the organisation has adequate arrangements in place for countering fraud. NHS organisations must have appropriate counter fraud arrangements.

2.4.2 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

2.4.3 The Director of Finance will monitor and ensure compliance with the conditions of the NHS Contract Fraud Standards.

2.4.4 The Director of Finance is responsible for deciding at what stage to involve the police in cases of theft, fraud, misappropriation and any other irregularities.

2.4.5 The Director of Finance will appoint a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud, Corruption and Bribery Manual and guidance.

2.4.6 The Local Counter Fraud Specialist will report to the Director of Finance and will work with staff in NHS Protect in accordance with the NHS Fraud, Corruption and Bribery Manual.

2.4.7 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. A Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.4.8 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

2.4.9 The Act:-

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

2.4.10 The Trust will produce an annual statement to satisfy the compliance requirements of the Bribery Act.

2.4.11 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS Security Management.

2.4.12 The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Executive Director with lead responsibility for Security Management and a Local Security Management Specialist (LSMS).

2.4.13 The LSMS shall regularly report progress to each meeting of the Health and Safety Committee and upwards to the Trust Executive Committee at least quarterly.

2.5 Financial Reporting

2.5.1 The Audit Committee will assure the integrity of the annual financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.6 Scrutiny of Waivers and Registers

2.6.1 The Audit Committee will be responsible for:-

(a) scrutinising waivers approved by chief Executive and/or Director of Finance and approving waivers above £1m;

(b) scrutinising regular reports on losses and compensations; and

(c) scrutinising the registers of interests.

2.7 Raising Concerns

2.7.1 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, non-compliance with Standing Financial Instructions, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

2.7.2 The Audit Committee should review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action.

2.8 Access to Records and Information

2.8.1 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:-

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust; and

(d) explanations concerning any matter under investigation.

3. FINANCIAL PLANNING AND MANAGEMENT

3.1 Annual Financial Plans

3.1.1 Prior to the start of the financial year the Director of Finance will prepare and submit an annual financial plan for approval by the Board. The financial plan will:-

(a) reflect the Trust's annual plan in terms of developments, workforce, performance etc.;

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the context of available income;

(d) identify potential financial risks;

(e) include a cash flow forecast;

(f) identify an opening capital plan; and

(g) include details of the required level of cost improvement.

3.1.2 The financial plan will be submitted to the Regulator in the required format.

3.1.3 The Director of Finance will monitor financial performance against the plan and report to the Finance Committee and/or Board and the Regulator.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Delegation to Budget Holders

3.2.1 Budgets will be delegated in accordance with the Financial Scheme of Delegation.

3.2.2 Budget holders must ensure that plans are in place to prevent expenditure budgets from being exceeded.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the control of the Director of Finance unless virement is agreed.

3.2.4 Non-recurrent budgets should not be used to finance recurrent expenditure without the authority in writing of the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:-

(a) monthly financial reports to the Board and/or Finance Committee;

(b) timely and accurate financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from the budget or plan;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers;

(f) determination of budget control totals prior to the start of the financial year; and

(g) a requirement for a monthly report from Divisional Directors to provide an account of their financial performance and forecast outturn.

3.3.2 Budget Holders are responsible for ensuring that:-

(a) any overspending or reduction of income which cannot be met by an approved virement is not incurred;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised;

(c) no permanent employees are appointed without the approval of the Director of Finance other than those provided for within the available resources and manpower establishment as approved by the Board; and

(d) they take responsibility for the delivery of savings targets in accordance with the requirements of the annual plan.

3.4 Capital Planning

3.4.1 The Board will approve the capital plan as part of the overall financial plan prior to the start of the financial year.

3.4.2 The Board may delegate decision making to the Finance Committee and the Capital Revenue & Investment Group (CRIG) in line with the Financial Scheme of Delegation.

3.4.3 The Director of Finance will provide monthly reports to the Finance Committee monitoring progress against the capital plan.

4. ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Trust must prepare annual accounts in accordance with the requirements of the Regulator. The Director of Finance will make arrangements to:-

(a) prepare and submit annual accounts in accordance with the Regulator's requirements, accounting policies and generally accepted accounting practice;

(b) prepare and submit annual accounts to the Board and an audited summary to an annual members meeting convened by the Council of Governors; and

(c) lay a copy of the annual accounts before Parliament.

4.1.2 The annual report should include an Annual Governance Statement in accordance with the relevant requirements.

4.1.3 The annual accounts must be audited by the external auditor and be presented at the annual members' meeting.

4.1.4 The Trust will prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's requirements.

5. BANK AND GBS ACCOUNTS

5.1 Operation of Accounts

5.1.1 The Director of Finance is responsible for:-

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) ensuring separate bank accounts for charitable funds;

(c) ensuring accounts are not overdrawn except where arrangements have been made; and

(d) making arrangements for overdrafts if required.

5.1.2 All accounts will be held in the name of the Trust. No officer other than the Director of Finance will open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.2 Banking Procedures

5.2.1 Monies belonging to the Trust or its Charity must only be deposited in bank accounts authorised by the Director of Finance. All bank accounts must be in the name of the Trust or its Charity.

5.2.2 The Director of Finance will ensure that detailed procedures are in place for the operation of bank and GBS accounts.

5.2.3 The Director of Finance will advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3 Tendering and Review

5.3.1 The Director of Finance will ensure that banking arrangements are reviewed at regular intervals to ensure they reflect best practice and represent best value for money. This will be through local or national competitive tendering exercises.

6. CONTRACTING AND INCOME

6.1 Contracting for Income

6.1.1 The Director of Finance is responsible for negotiating, approving and signing contracts with CCGs and other NHS bodies.

6.1.2 The Trust will contract its services in line with either national tariff arrangements or local price agreements.

6.1.3 The Director of Finance will ensure that the appropriate contractual arrangements and documentation are in place for all services provided.

6.1.4 The Director of Finance will ensure that reports are produced detailing contract performance and income levels.

6.1.5 The Director of Finance will ensure the production of reports to show the profitability of services compared to income generated.

6.2 Income

6.2.1 The Director of Finance is responsible for designing and maintaining systems for recording, invoicing, collection and coding of income due.

6.2.2 Private patient and overseas visitors paying for their treatment, are required as far as possible, to make a pre-payment equal to the estimated cost of treatment prior to admission.

6.3 Fees and Charges

6.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges.

6.3.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is received, the Trust's policy on Standards of Business Conduct and Conflict of Interest must be followed.

6.3.3 All employees must inform the Director of Finance promptly of money due from agreements, including provision of services, leases, private patient undertakings and other transactions.

6.4 Debt Recovery

6.4.1 The Director of Finance is responsible for ensuring arrangements are in place to recover outstanding debt.

6.4.2 Where income is written off, this should be dealt with in accordance with losses procedures and reported to the Audit Committee.

6.4.3 All overpayments (including salary) should be recovered wherever possible.

6.5 Security of Cash, Cheques, Payable Orders

6.5.1 The Director of Finance is responsible for:-

(a) approving all means of officially acknowledging or recording cash, cheques and payable orders received;

(b) controlling stationery used for receipting funds;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash;

(d) authorisation and provision of safes or lockable cash boxes;

(e) ensuring that policies are in place for the operation of safes including key holding;

(f) systems and procedures for handling cash, postal orders and cheques; and

(g) authorising the use of charitable giving platforms such as Just Giving, Amazon Wish Lists etc and ensuring that there is appropriate oversight and monitoring.

6.5.2 Trust cash will not be used to cash private cheques or "I Owe You's" (IOUs).

6.5.3 All cheques, postal orders, cash etc., will be banked promptly and intact. This means that disbursements (payments) will not be made from cash received prior to banking.

6.5.4 The holders of safe keys will not accept unofficial funds or items for depositing in their safes.

6.5.5 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy & Response Plan& Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures. will comply with the requirements of the law and relevant national guidance and European law as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7. TENDERING PROCEDURES

7.1 Compliance

7.1.1 Trust will comply with the requirements of the law and relevant national guidance and contract regulations as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7.2 Formal Tendering

7.2.1 The Trust will ensure that a minimum of three competitive tenders are invited for:-

(a) the supply of goods, materials and manufactured articles;

(b) the receipt of services;

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) health care services supplied by non NHS providers.

7.3 Exceptions Where Formal Tendering Need Not Be Applied

7.3.1 Formal tendering procedures need not be applied:-

(a) where total estimated annual expenditure with a supplier is expected to be below £15k, at least one written quote is needed;

(b) where total estimated annual expenditure with a supplier is not expected to exceed £50k but is above £15k, a minimum of three written or electronic quotations must be obtained; or

(c) where a competitive process or direct award (where permissible) has been undertaken through a public sector framework agreement co-ordinated by the procurement team.

7.3.2 Formal tendering procedures **may be waived** in the following circumstances:-

(a) in very exceptional circumstances formal tendering procedures would not be practical;

(b) where the timescale genuinely precludes a competitive process; or

(c) where specialist goods/services are required and available from only one source.

7.3.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

7.3.4 All waivers with supporting reasons should be fully documented and approved by the Director of Finance or the Chief Executive and reviewed by the Audit Committee at each meeting.

7.3.5 Where contract expenditure subsequently breaches a tender threshold, advice from the procurement team will need to be sought and the matter reported to the Audit Committee.

7.4 Tendering Procedures

7.4.1 All invitations to tender will be compliant with the Trust procurement policies and procedures which ensure a full audit trail is maintained.

7.4.2 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Clarifications may be made regarding qualitative aspects of the tender prior to the award of a contract providing there is a full audit trail of communications and information relevant to all bidders and shared.

7.4.3 Contracts should be awarded based on achieving the best value for money, from both quality and cost perspectives.

7.4.4 Contracts should not be awarded if they exceed the budget allocated.

7.4.5 All tenders should be treated as confidential and should be retained for inspection.

7.4.6 The Director of Finance will ensure that a register of tenders is maintained.

7.5 Financial Standing and Technical Competence

7.5.1 The Director of Finance will ensure that procurement processes include the necessary checks on the financial standing, technical competence, legal and regulatory compliance and suitability of contractors/suppliers.

8. PAY EXPENDITURE

8.1 Remuneration and Nomination Committee

8.1.1 The Board will establish a Remuneration and Nomination Committee, with clearly defined terms of reference, specifying which posts and issues fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will report in writing to the Board the basis for its recommendations. The Board will use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

8.1.3 The Trust will remunerate the Chair and non-executive directors of the Board in accordance with resolutions of the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 Remuneration in terms and conditions of other employees will follow nationally negotiated settlements unless otherwise agreed by the Remuneration Committee.

8.2.3 The funded establishment of any department may not be varied except in accordance with the Financial Scheme of Delegation.

8.3 Staff Appointments

8.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration beyond the limit of their approved budget and funded establishment.

8.4 Payroll

8.4.1 The Director of Finance will arrange the provision of a payroll service and will be responsible for:-

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment;

(e) ensuring internal controls and audit review; and

(f) ensuring separation of duties.

8.4.2 Managers have responsibility for:-

(a) completing and submitting time records, termination forms and other notifications in accordance with agreed timetables; and

(b) notifying payroll if an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.

8.5 Contracts of Employment

8.5.1 The Director of People will have responsibility for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) making arrangements to deal with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis as part of the annual financial plan.

9.1.2 Authority to incur spend and enter into expenditure contracts will be set in accordance with the Financial Scheme of Delegation.

9.2 Requisitioning of Goods and Services

9.2.1 The requisitioner should use electronic catalogues for the procurement of goods or services. Where this is not possible the procurement team should be consulted to advise on the appropriate route to market.

9.3 Payment of Invoices

9.3.1 The Director of Finance will ensure arrangements are in place for prompt payment of invoices and claims. Payment of invoices will be in accordance with contract terms.

9.4 Expenditure contracts

9.4.1 Advice should be sought from the procurement team before signing expenditure contracts of any value. The 'value' of the contract is over its duration rather than per annum. Authority to sign contracts is set out in the Financial Scheme of Delegation.

9.5 Prepayments

9.5.1 Prepayments will only be permitted where this is normal commercial practice or provides a financial advantage to the Trust and the financial standing of the company has been assessed along with the associated financial risk.

9.5.2 In all cases the budget holder is responsible for ensuring that goods and services due under a prepayment contract are received.

9.6 Official Orders

9.6.1 Official orders must be used for all non pay expenditure and contracts unless there is an agreed exception approved by the procurement team. The Trust operates a no purchase order no pay policy. This means that there is no obligation to pay for supplies delivered or work carried out without a purchase order.

9.7 Budget Holders

9.7.1 Budget holders must adhere to the delegated limits specified in the Financial Scheme of Delegation.

9.7.2 Orders should not be issued to any supplier that has made an offer of gifts, reward or benefit to directors or employees, or has in any other way breached the Bribery Act (2010).

9.7.3 Requisitions/orders must not be placed where there is no budget or insufficient budget, unless authorised by the Director of Finance or the Chief Executive.

9.7.4 Verbal orders must only be issued very exceptionally and an official order must be obtained as soon as practically possible.

9.7.5 Orders must not be split to circumvent financial thresholds.

9.7.6 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

9.7.7 Changes to the list of employees and officers authorised to certify invoices will be notified to the Director of Finance.

9.7.8 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Director of Finance.

9.7.9 Petty cash records will be maintained in a form as determined by the Director of Finance.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1 Borrowing and Public Dividend Capital

10.1.1 All loans and overdrafts must be approved by the Board. Any draw-down against working capital facilities must be authorised by the Director of Finance and reported to the Board.

10.1.2 Draw down of Public Dividend Capital should be authorised in accordance with the Financial Scheme of Delegation.

10.1.3 The Trust will pay a dividend on its Public Dividend Capital at a rate determined by the Secretary of State.

10.1.4 The Director of Finance will report on loans, overdrafts and Public Dividend Capital to the Finance Committee.

10.1.5 The Director of Finance will prepare applications for loans and overdrafts for approval by the Finance Committee in accordance with the Regulator's requirements.

10.2 Investments

10.2.1 The Director of Finance will prepare a Treasury Management Policy which sets out the Trust's approach to cash management including investments for approval by the Board.

10.2.2 The Treasury Management Policy will seek to obtain competitive rates of interest with minimal exposure to risk.

10.2.3 Cash balances and investments must only be held by banking institutions approved by the Board as part of the Treasury Management Policy.

10.2.4 The Director of Finance is responsible for advising and reporting to the Finance Committee on any Treasury Management activities.

10.2.5 The Director of Finance will prepare detailed procedural instructions on the operation of Treasury Management activities.

11. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The Director of Finance:-

(a) will ensure that there is an adequate process in place for determining capital expenditure priorities;

(b) is responsible for ensuring that monitoring arrangements are in place for capital schemes and that budgets are adhered to;

(c) will put arrangements in place to manage the capital programme within the overall budget available; and

(d) will ensure that the capital investment is not undertaken without the necessary capital financing and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For all capital expenditure the Director of Finance will ensure that that a business case has been produced and approved in accordance with the Financial Scheme of Delegation.

11.1.3 The Director of Finance will assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.4 The approval of a capital plan will not constitute approval for expenditure on any scheme unless:

(a) the funding has been confirmed in the annual capital budget for the year;

(b) the cost of the scheme remains within the sum allocated whilst still delivering the benefits identified in the business case; and

(c) the supporting Business Case has been approved.

11.1.5 Where the forecast of costs of any scheme rises above the sum allocated in the capital budget, the Director of Finance must immediately be notified and an updated business case prepared for the Capital, Revenue and Investment Group approval.

11.1.6 Contractual commitments should not be entered into unless the scheme is approved.

11.1.7 Business cases requiring Board approval under the Financial Scheme of Delegation will be considered and scrutinised by the Finance Committee.

11.1.8 All business cases will be considered by the Capital, Revenue and Investment Group irrespective of the value and either approved or recommended for approval by the Finance Committee or Board according to the Financial Scheme of Delegation.

11.1.9 The Director of Finance will approve procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Capital Asset Registers

11.2.1 The Chief Executive is responsible for the maintenance of registers of capital assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Chief Executive is also responsible for the maintenance of a register identifying land and/or buildings owned or leased by the Trust.

11.2.3 Capital assets must not be sold, scrapped, or otherwise disposed of without prior approval of the Director of Finance. Their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The Director of Finance will approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.5 Capital assets will be valued and depreciated in accordance with current accounting and reporting standards.

11.3 Security of Capital Assets

11.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.3.2 Capital asset control procedures must be approved by the Director of Finance. This procedure will make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical location of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded; and

(f) identification and reporting of all costs associated with the retention of an asset.

11.3.3 All discrepancies revealed by verification of physical assets to fixed asset register will be notified to the Director of Finance.

11.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and employees in all disciplines to apply appropriate routine security practices in relation to NHS property. Any breach of security practices must be reported in accordance with agreed procedures.

11.3.5 Any theft, loss or damage to premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the Director of Finance.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Assets must not be used for private purposes unless agreed in advance by the Director of Finance.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores should be:

(a) kept to a minimum;

(b) subjected to annual stock take or a program of rolling stock takes and

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 The day-to-day responsibility for stock control is delegated to departmental employees and stores managers/keepers. The control of Pharmaceutical stocks is the responsibility of the Chief Pharmacist.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations will be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The Director of Finance will ensure systems are in place to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 The Director of Finance will ensure there are adequate checks on items in stores at least once a year.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 The Director of Finance will identify those authorised to requisition and accept goods from the store. The authorised person will check receipt against the delivery note and notify any discrepancies to Procurement who will pursue correction of delivery or a credit note.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 Land and buildings may not be sold or otherwise disposed of without the approval of the Board.

13.1.2 The Director of Finance must ensure procedures are in place for the disposal of assets.

13.1.3 When it is proposed to dispose of a Trust asset, the Head of Department or Divisional Director of Operations will liaise with Procurement and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 The method of all asset disposals will be recorded and confirmed by a countersignature authorised by the Director of Finance.

13.2 Losses and Special Payments

13.2.1 Any employee discovering a suspected fraud should report the matter to their line manager, Local NHS Counter Fraud Specialist or Director of Finance in accordance with the Fraud, Corruption and Bribery Policy.

13.2.2 Any employee discovering or suspecting any other loss or theft must immediately inform their head of department, security team and the Director of Finance.

13.2.3 Special payments e.g. payments not under legal obligation (or ex gratia) may only be made in line with the Financial Scheme of Delegation.

13.2.4 The Director of Finance will be authorised to take any necessary steps to safeguard against the impact of bankruptcies and company liquidations.

13.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

13.2.6 The Director of Finance will maintain a Losses and Special Payments Register.

13.2.7 All losses and special payments must be reported to the Audit Committee on a regular basis.

14. INFORMATION TECHNOLOGY

14.1.1 The Trust must comply with relevant legal and regulatory requirements in relation to IT and information.

14.1.2 The Trust will nominate one of the Executive Directors to act as the Senior Information Risk Officer (SIRO) to ensure controls over data entry, processing, storage, transmission and output to achieve security, privacy, accuracy, completeness, and timeliness.

14.1.3 The Senior Information Risk Officer (SIRO) will ensure that risks arising from the use of IT are identified and mitigated. This will include the preparation and testing of disaster recovery plans.

14.1.4 The Director of Finance will ensure that financial systems are implemented, developed and maintained to achieve accuracy and timeliness of data.

14.1.5 The Trust will publish and maintain a Freedom of Information (FOI) Publication Scheme.

14.1.6 The Trust IT strategy will be approved by the Board.

15. PATIENTS' PROPERTY

15.1.1 The Trust has a duty to provide safe keeping of money and other personal property belonging to patients.

15.1.2 The Trust will not accept responsibility or liability for patients' property unless it is handed in for safe keeping and a copy of an official patients' property record is obtained as a receipt.

15.1.3 The Director of Finance will ensure that procedures are in operation for the collection, recording, safekeeping and disposal of patients' property.

15.1.4 Where property of a deceased patient exceeds £5,000, the production of Probate or Letters of Administration will be required before release. Where the total value of the property is less than £5,000, this will be released to the next of kin provided forms of indemnity are obtained.

16. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

16.1 Corporate Trustee Arrangements

16.1.1 The Board is the Corporate Trustee of the Trust Charity which is responsible for the management of funds held on trust.

16.1.2 The Board's discharge of Corporate Trustee responsibilities is distinct from its responsibilities for exchequer funds. There must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

16.1.3 The Corporate Trustee may delegate functions as it determines to a Charitable Funds Committee subject to approved written terms of reference. The Board must receive and adopt the annual accounts of the Charity.

16.1.4 The Corporate Trustee will authorise the Chief Executive to make arrangements for the executive leadership and day to day running of the Charity.

16.1.5 The Director of Finance will approve the financial governance arrangements of the Charity.

16.2 Administration of Charitable Funds

16.2.1 The Director of Finance will oversee the preparation of the annual accounts and the annual audit.

16.3 Accountability to Charity Commission

16.3.1 The Corporate Trustee responsibilities must be discharged separately from the Board and full recognition given accountability to the Charity Commission for charitable funds.

16.4 Applicability of Standing Financial Instructions to Funds Held on Trust

16.4.1 The Charity will apply these Standing Financial Instructions where relevant. Any breaches will be notified to the Director of Finance and reported to the Charity Committee.

17. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT

17.1 Policy

17.1.1 The Director of Finance will ensure that all staff are made aware of the Trust policy on Managing Conflicts of Interest Standards of Business Conduct which includes guidance on a range of issues including gifts, outside employment and managing conflicts of interest. This policy will incorporate best practice guidance issued by the Regulator and will take effect as if incorporated into these Standing Financial Instructions.

17.2 Declaration of Interests

17.2.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes. Staff members will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

17.2.2 If a staff member comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any interest, direct or indirect, they must make a declaration.

17.2.3 If a staff member has any doubt about the relevance of an interest, this should be discussed with their line manager or the Director of Corporate Governance.

17.2.4 Staff should be asked to declare interests at the start of meetings and recorded in the minutes.

17.2.5 During the course of a meeting, if a conflict of interest arises, the staff member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

17.3 Register of Interests

17.3.1 The Director of Corporate Governance will ensure that all staff and governors are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

17.3.2 The Director of Corporate Governance will ensure that a Register of Interests is maintained to record formal declarations of interests of staff in accordance with the Trust policy.

17.3.3 The Register will be available to the public on request.

17.3.4 The Trust operates a zero tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Local Counter Fraud Specialist and/or the Director of Finance.

17.3.5 Gifts of cash and vouchers to staff should always be declined.

18. RETENTION OF RECORDS

18.1.1 The Chief Executive will be responsible for maintaining archives for all paper and digital records required to be retained in accordance with guidelines and the Trust's Record Management Policy.

19. RISK MANAGEMENT AND INSURANCE

19.1 Risk Management

19.1.1 The Chief Executive will ensure that risk management arrangements are in place in accordance with relevant requirements, which must be approved and monitored by the Board.

19.1.2 Risk management arrangements will be reported in the Annual Governance Statement within the Annual Report and Accounts.

19.2 Insurance

19.2.1 The Chief Executive will be responsible for ensuring adequate insurance cover is in place in accordance with risk management policy approved by the Board.

19.2.2 The Director of Finance should be notified of any changes to risks or property which require insurance.

19.2.3 The Director of Finance will ensure that insurance arrangements are regularly reviewed and provide the necessary assurances to the Finance Committee and / or Board.

19.2.4 The Director of Finance will authorise claims to be made and these will be reported to the Finance Committee and / or Board.

19.2.5 The Trust will insure for clinical negligence, employers' and public liability claims through the risk pooling schemes administered by the NHS Resolution.

FINANCIAL SCHEME OF DELEGATION

1. Financial Scheme of Delegation – Reservation of Financial Powers and Limits to Board, Committees and Directors

includes non-recoverable VAT

Trust Board The Board reserves to itself the following powers:-	**Committees** Powers reserved to specific Committees unless delegated:-	**Directors** Powers reserved to specific Directors:-
All financial powers emanate from the Board and are delegated according to this Scheme which is incorporated as part of the Trust's Standing Financial Instructions. This scheme can be amended by the Board as required. <u>Powers</u> Approval of the Standing Financial Instructions and Financial Scheme of Delegation Approval of business cases for capital schemes above **£2m** Approval of business cases for revenue expenditure and income impact above **£2m** per annum Approval of invoices and contract values (total life over the contract) above **£2m** Approval of working capital facilities and loans Approval of Annual Financial Plan Approval of Capital Programme and Annual Capital Budget Approval of sale or acquisition of land or buildings Approval of sale or disposal of items on the capital asset register above **£1m** Approval of demolition of buildings Approval of waiver of competition requirements over **£1m** Approval of ex gratia payments above **£100k** Approval of Annual Accounts / Annual Report The Board will authorise the appropriate Executive Director as signatories to execute its decisions e.g. contracts, invoices, requisitions. The Operational Director of Finance transacts items on behalf of the Board in the ledger system.	<u>Audit Committee</u> Approval of the appointment of Internal Auditor Approval of Internal & External Audit Plans Recommending the External Auditor appointment to the governors Scrutiny of the Annual Accounts / Annual Report Review of waivers of competition Review and scrutiny of losses and ex gratia payment registers Review of SFI breaches <u>Finance Committee</u> Approval of business cases for capital schemes up to **£2m** Approval of business cases for revenue expenditure or income impact up to **£2m** per annum Approval of invoices and contract values (total life over the contract) up to **£2m** Approval of the appointment of Measured Term Contractors Approval of the Treasury Management Policy Approval of ex gratia payments up to **£100k** Approval of waivers of competition requirements above **£250k and up to £1m** The Finance Committee will authorise the Director of Finance or other relevant officer as signatory to execute its decisions as appropriate <u>Executive</u> Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Approval of sale or disposal of equipment on the capital asset register up to **£1m** Approval of requisitions, invoices and contract values (total life over the contract) up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events e.g. alcohol <u>Remuneration Committee</u> Approval of Executive Directors' Pay Awards and other variations to their terms and conditions of employment Approval non-contractual severance payments Approval of Pay and Terms and Conditions of senior managers on local pay arrangements Approval of significant variations to national Terms & Conditions	<u>Chair</u> Approval of Chief Executive travel expenses and study leave <u>Chief Executive/Deputy Chief Executive</u> Approval of travel expenses and study leave of Directors <u>Chief Executive or Director of Finance</u> Approval of capital or non-recurrent revenue spend up to **£100k** Approval of requisitions, invoices and contract values (total life over the contract) within approved budget up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events <u>Director of Finance</u> Final interpretation of Standing Financial Instructions Authorising the opening/closing of bank accounts Approval of financial procedures and financial signatories Authorisation of the use of charitable giving platforms, wish lists etc. Authorisation of the use of safes Approval of pricing strategies, fees and charges in relation to income Deciding when to involve the police in matters of fraud or theft Approval of financial systems and controls including cash handling Approval of sale or disposal of equipment on the capital asset register up to **£100k of the NBV** Approval of financial governance arrangements of charitable funds Approval of changes to the Financial Scheme of Delegation below **£50k** Approval of PDC draw down signatories Approval of insurance claims Access to records to progress financial investigations <u>Deputy Chief Executive</u> Assumes powers and limits in the absence of the Chief Executive <u>Operational Director of Finance</u> Assumes powers and limits in the absence of the Director of Finance <u>Capital Revenue & Investment Group</u> - sub group of Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Review of all capital business cases and capital expenditure

2. Financial Scheme of Delegation – Authorised Powers and Limits to the Executive including non-recoverable VAT

Executive Directors Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Deputy Director of Operations** **Divisional Directors of Operations** **Operational Director of Finance** **Deputy Director of Finance** Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Other Deputy Directors** **General Managers** **Professional Leads** Powers and Approval Limits within Departmental Approved Budget:	**Departmental Managers** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**Matrons** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**"Ward / Unit Managers" or equivalent** Powers and Approval Limits within Ward/Departmental/Unit Approved Budget:	**Non Budget Holding Manager** Powers and Approval Limits within Ward/Department/Unit Approved Budget:
Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets (not including overtime or internal bank hours) and scheduling of annual leave
Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£250k**	Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£50k** (Operational Director of Finance **£150k**)	Revenue or capital requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£10k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£2.5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£1k.**	
Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	
Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	
Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	
Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories		
Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget			
Recruitment to posts within pay budget	Recruitment to posts within pay budget	Recruitment to posts within pay budget				
Ex gratia payments up to **£5k**	Ex gratia payments up to **£5k**	Ex-gratia payments up to **£1k**				
Approval of changes to Directorate/Divisional Control Total	Approval of changes to Directorate/Divisional Control Total	<u>Chief Pharmacist</u> Drugs expenditure up to **£50k**				

3. Financial Scheme of Delegation – Financial Limits by Type of Approval (£) including non recoverable VAT

Type of Approval	Board	Finance Comm	Execs	CRIG	CEO	DoF	ED	DDOs	Other Deputy Directors	Dep't managers	Matrons	Ward managers
Approval of business cases for capital schemes	>2m	<2m	<1m	<1m	<100k	<100k						
Approval of business cases for revenue expenditure and income impact per annum	>2m	<2m	<1m	<1m	<100k Non rec	<100k Non rec						
Approval of invoices and contract values (total life over the contract) within approved budget	>2m	<2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of requisitions or orders within approved budget	>2m	>2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of sale or disposal of items on the capital asset register	>1m		<1m			<100k						
Approval of ex gratia payments	>100k	<100k	<50k		<50k	<50k	<50k	<5k	<1k			
Approval of waiver of competition requirements	>1m	<1m	<250k		<250k	<250k						
Changes to Financial Scheme of Delegation	>50k					<50K						

Key SFIs – breaches are reported to the Audit Committee

1.2.4	If you become aware of a breach of SFIs, then seek advice from the Director of Finance
3.2.4	Do not use one off monies to fund ongoing expenditure
5.1.2	Do not open a bank account in the name of Trust, only the Director of Finance can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Director of Finance
6.5.1	You must seek permission from the Director of Finance to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Director of Finance has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the Director of Finance
13.2.1	Suspected fraud must be reported to line management, Local Counter Fraud lead or the Director of Finance
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.4	Do not accept personal gifts of cash or vouchers

Title:	Standing Orders and Matters Reserved for the Board

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24 November 2022		Discussion	
Exec Sponsor	Sharon Katema		Decision	

Summary:	These documents, together with the Trust's Constitution; the Standing Financial Instructions and the Scheme of Delegation provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents and, where necessary, be familiar with the detailed provisions The Standing Orders will also be scheduled for discussion at the Audit Committee meeting on 7 December 2022. Any further changes proposed as a result of Audit Committee debate will be included as a late addendum to this paper

Previously considered by:	The attached Standing Orders were approved by Board in November 2020.

Proposed Resolution	The Board of Directors is asked to approve the attached Standing Orders and their inclusion in the Trust Constitution.

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	**Presented by:**	Sharon Katema

Bolton
NHS Foundation Trust

STANDING ORDERS

November 2022

FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt a "Schedule of matters reserved" and a "Scheme of Delegation". Which, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

It is acknowledged within these Standing Orders and the Standing Financial Instructions of the Trust that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the Trust Board meets its obligation to perform its functions within the financial resources available.

P*rovisions within the Standing Orders which are not subject to suspension under SO 3.32 are indicated in italics.*

CONTENTS

INTRODUCTION

Statutory Framework

Bolton NHS Foundation Trust (the Trust) is a Public Benefit Corporation which was established under the granting of Authority by the Independent Regulator for NHS Foundation Trusts. The principal place of business of the Trust is:

Royal Bolton Hospital, Minerva Road, Bolton, BL4 0JR

NHS Foundation Trusts are governed by statute, mainly the Health and Social Care (Community Health and Standards) Act 2012 and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the Health and Social Care (Community Health and Standards) Act 2006 as amended by the Health and Social Care Act 2012 and in the Trust's terms of authorisation issued by the Independent Regulator.

As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Independent Regulator. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Health and Social Care (Community Health and Standards) Act 2012 requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Independent Regulator requires NHS Foundation Trusts to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

NHS Framework

In addition to the statutory requirements further guidance has been issued, many of these are contained within the NHS Finance Manual. The manual also contains a list of the main statutes and legislation relevant to NHS Foundation Trusts.

Included in the Manual, are the Codes of Conduct and Accountability for NHS Boards. The Code of Accountability requires boards to draw up a schedule of matters reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of board directors.

Also included in the Corporate Governance Framework Manual (Finance) is the “Code of Practice on Openness in the NHS”, which sets out the requirements for public access to information on the NHS and is considered good practice by the Trust.

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by

virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Schedule of Matters Reserved). That document has effect as if incorporated into the Standing Orders.

Wherever the title Chief Executive, Chief Finance Officer, or other nominated Officer is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them,

1 INTERPRETATION

1.1 Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"ACCOUNTABLE OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust with responsibility for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

“ACT” means the NHS Act 2006 as amended by the Health and Social Care Act 2012 or any future parliamentary act covering the role and function of NHS service provision.

"TRUST" means Bolton NHS Foundation Trust.

"BOARD OF DIRECTORS" shall mean the Chair and non-executive directors, appointed by the Governing Body, and the executive directors appointed by the relevant committee of the Trust.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"CHAIR" is the person appointed by the Governing Body to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chair of the Trust” shall be deemed to include the Senior Independent Director of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the chief officer and accounting officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

“CONSTITUTION” shall be the Constitution of Bolton NHS Foundation Trust.

“DEPUTY CHAIR” shall be the Senior Independent Director of the Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution.

Directors for the purpose of SO/SFI and Scheme of Delegation are those board members reporting directly to the Chief Executive.

"DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

2. THE BOARD OF DIRECTORS

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has the functions conferred on it by the Health and Social Care (Community Health and Standards) Act 2006 as amended by the Health and Social Care Act 2012 and its terms of authorisation issued by the Independent Regulator.

2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Independent Regulator. Accountability for non-charitable funds held on trust is only to the Independent Regulator.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6 **Composition of the Board of Directors** - In accordance with the Health and Social Care (Community Health and Standards) Act 2006 and the constitution, composition of the Board of Directors of the Trust shall be:

The Chair of the Trust

At least 5 non-executive directors

At least 5 executive directors including:

- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

The number of Executive Directors must not be greater than the number of Non-Executive Directors

2.7 **Appointment of the Chair and Directors** - *The Chair and non-executive directors are appointed by the Governing Body and the appointments will be in accordance with the constitution* and *guidance issued by NHS England/Improvement*

The Chair and Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years and may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

2.8 **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair and directors will be in accordance the constitution.

The Chair and Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to annual re-appointment and subject to external competition if recommended by the Board and approved by the Council of Governors.

Any re-appointment after the second term of office (irrespective of tenure duration), for the Chair and Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence.

2.9 **Appointment of Senior Independent Director** – *the appointment of a Senior Independent Director (Deputy Chair) of the Trust is as prescribed in section 22 of the constitution.*

2.10 **Powers of Senior Independent Director** - *Where the Chair of an NHS Foundation Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform their duties, be taken to include references to the Senior Independent Director*

2.11 **Joint Directors** - *Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 2.6 as one person.*

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Admission of the Public and Press** – The public shall be admitted to all formal meetings of the Board, but shall be required to withdraw upon the Board of Directors resolving as follows:

> "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

3.2 The Board may treat the need to receive or consider recommendations or advice from sources other than Directors, Committees or Sub-Committees of the Board as a special reason why publicity would be prejudicial to the public interest.

3.3 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner.

3.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5 *The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented, or if, the Chair does not call a meeting within seven days after such requisition has been presented,* at the Trust's Headquarters*, one third or more directors may forthwith call a meeting.*

3.6 **Notice of Meetings** - *Before each meeting of the Board of Directors, a notice of the meeting, shall be delivered to every director, at least three clear days before the meeting.*

3.8 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.9 Public notice of the time and place of any meeting of the Board (open to the public) will be posted on the Trust's web site at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. Such notice, together with a copy of the agenda, will be supplied, on request to the press.

3.10 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.11 A director desiring a matter to be included on an agenda should make this request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.12 **Chair of Meeting** - *At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they are present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.*

3.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.14 **Annual Public Meeting** - The Trust will publicise and hold an annual public meeting in accordance with the constitution and the Act.

3.15 **Notices of Motion** - A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.8.

3.16 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.17 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if considered appropriate.

3.18 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.19 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.20 **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final.

3.21 **Voting** - *Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.*

3.22 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.23 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.24 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.25 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.26 An officer who has been appointed formally by the Board of Directors to act up for an executive director will have the voting rights of that executive director. An officer attending the Board of Directors to represent an executive director without formal acting up status may not exercise the voting rights of the executive director.

3.27 **Non – Voting Directors** - Non Voting Directors are ones who Board members have determined should attend the Board in order to provide it with particular expertise on a continuing basis. They may be expected to attend some or all Board meeting whether held in public or private.

They will receive all board papers for agenda items against which their contributions are required. They will have the opportunity to participate in all board discussions but may not take part in any voting and may be excluded from any part of a Board meeting at the request of the Chair.

All matters discussed or witnessed by attendees shall be regarded as confidential to the board save for those where actions are agreed otherwise.

In order that they do not become liable for decisions made, the Chair will make clear that they are being invited to comment upon items for debate but not take part in any vote should one occur

3.28 **Minutes** - *The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting.*

3.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

3.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.31 **Joint Directors** - *Where a post of executive director is shared by more than one person:*

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of SO 3.38 (Quorum).

3.32 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least half (normally six) of the Board of Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.33 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.34 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

3.35 No formal business may be transacted while SOs are suspended.

3.36 The Audit Committee shall review every decision to suspend SOs.

3.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall not be revoked, varied or amended except upon:

a) A report to the Board by the Chief Executive or the Director of Corporate Governance acting on their behalf.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the Chair) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.38 **Record of Attendance** - *The names of the directors present at the meeting shall be recorded* in the minutes.

3.39 **Quorum** - *No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.*

3.40 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.41 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.7 and such directions as may be given by the Independent Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or subcommittee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions to perform personally and shall nominate officers to undertake the remaining functions for which the CEO will still retain an accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance and Commissioning or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

5. COMMITTEES

5.1 **Appointment of Committees** - *Subject to SO 2.7 and such directions as may be given by the Independent Regulator, the Board of Directors may and, if directed, shall appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.*

5.2 *A committee appointed under SO 5.1 may, subject to such directions as may be given by the Independent Regulator or the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).*

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

5.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined.

5.7 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Independent Regulator, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the regulations laid down by the Independent Regulator.

5.8 The committees formally established by the Board of Directors are:

Audit and Risk Committee

Quality and Safety Committee

Finance and Investment

People Committee

Nomination and Remuneration

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Pursuant to Section 20 of Schedule 1 of the Health and Social Care (Community Health and Standards Act 2006), a register of Director's and Governor's interests must be kept by the Trust

6.1 **Declaration of Interests** - The Code of Accountability requires board directors (including for the purposes of this document Non-executive Directors) and Governors to declare interests, which are relevant and material. All existing board directors should declare relevant and material interests. Any board directors or governors appointed subsequently should do so on appointment or election.

6.2 All employees of the Trust who have a direct financial interest in a private company of any description which may be engaged in the provision of goods or services to the NHS, must declare that interest in in accordance with the "*Standards of Business Conduct Policy"* at the time of appointment or commencement of any such interest**.**

6.3 Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should include in the register are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.4 If board directors or governors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Governance.

6.5 Any changes in interests should be declared at the next Board of Directors' meeting following the change. It is the obligation of the director or governor to inform the Director of Corporate Governance in writing within seven days of becoming aware of the existence of a relevant or material interest.

6.6 The names of directors holding directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.7 During the course of a Board of Directors meeting or a governor meeting, if a conflict of interest is established, the director or governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the

avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

6.8 **Register of Interests** - The details of directors' and governors' interests recorded in the Register will be reviewed on a quarterly basis by the Audit and Risk Committee.

6.9 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 *Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they will at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

7.2 The Independent Regulator may, subject to such conditions as they may think fit to impose ,remove any disability imposed by this Standing Order in any case in which it appears in the interests of the National Health Service that the disability shall be removed.

7.3 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

7.4 *Any remuneration, compensation or allowances payable to a director by virtue of paragraph 9 of Schedule 2 to the NHS & CC Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.*

7.5 For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) they or a close associate of theirs, is a director of a company or other body, not being public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or*

b) they or a close associate of theirs is a business partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;.*

7.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of membership of a company or other body, with no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.7 *Where a director:*

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class and the total nominal value of shares of any one class does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to the duty to disclose an interest.

7.8 Standing Order 7 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a director of the Trust) as it applies to a director of the Trust.

For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:

- *Married persons and those in Civil partnerships or cohabiting. In which case, the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** – The Trust has adopted a Standards of Business Policy and staff must comply with this guidance and guidance in the 2010 Bribery Act. The following provisions should be read in conjunction with these documents.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare any other employment or business or other relationship of theirs or a close associate as previously defined,, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9 Prior to acceptance of an appointment directors should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

8.11 Any Board member or member of staff who receives or is offered and declines hospitality in excess of £50.00 is required to enter the details of the hospitality in the Trust's Hospitality Register.

8.12 The Board recognise the 2010 Bribery act which introduces new bribery offences:

- to give, promise or offer a bribe,
- to request, agree to receive or accept a bribe either in the UK or overseas
- A corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place in accordance with arrangements approved by the Board.

9.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board of Directors, a Board Committee or where the Board of Directors has delegated its powers.

9.3 On approval by the Board, or by the Chair or the Chief Executive under delegated powers, to a transaction in pursuance of which the Common Seal of the Board is required to be affixed to appropriate documents, shall be deemed also to convey authority for the use of the Common Seal.

9.4 Where approval to the sealing of a document has been given specifically in pursuance of a resolution of the Board or in accordance with Standing Order No.9.3 above, the Seal shall be affixed in the presence of the Chair, or other Officer duly authorised and an Executive Director of the Trust, and shall be attested by them.

9.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

10. SIGNATURE AND INSPECTION OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

10.3 A Director of the Board may for purposes of their duty as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, provided that the Director shall not knowingly inspect ore request a document relating to a matter in which they are professionally interested or in which they have directly or indirectly any pecuniary interest.

This Standing Order shall not preclude the Chief Executive from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

10.4 Nothing in the above paragraphs of this Standing Order 10 shall be interpreted as giving the right to Directors to have access to confidential patient records.

11. MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within the Standing Orders and SFIs.
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11.2 **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Agenda Item 22.A

Title:	2021-22 Emergency Preparedness, Resilience and Response (EPRR) Assurance; Statement of compliance and action plan

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24th November 2022		Discussion	
Exec Sponsor	Rae Wheatcroft, Chief Operating Officer		Decision	

Summary:	NHS England require all health organisations participating in the 2022 EPRR Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period. Bolton Foundation Trust has achieved 94% compliance, which results in an assurance rating of 'Substantial'. An action plan is in place regarding the 4 domains where we are not fully compliant.

Previously considered by:	Compliance statement approved by Chief Operating Officer in role as Accountable Emergency Officer. Strategy and Operations Committee

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

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

Prepared by:	Jimmy Tunn, Emergency Planning Manager	**Presented by:**	Rae Wheatcroft, Chief Operating Officer

Emergency Preparedness, Resilience and Response (EPRR) assurance Statement of Compliance 2022-2023

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

Where areas require further action, NHS Greater Manchester Integrated Care will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Detail of the compliance level is identified in the dashboard below and where areas require further action, this is detailed in appendix A below.

Compliance Dashboard:

Please choose your organisation type

Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	1	1	0	0
Training and exercising	4	4	0	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	10	0	0	1
CBRN	14	13	1	0	0
Total	**64**	**60**	**4**	**0**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	11	1	1	0
Total	**13**	**11**	**1**	**1**	**0**

Percentage Compliance	94%
Overall Assessment	Substantially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY compliant

Notes
Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

Appendix A: EPRR Action Plan:

Ref	Standard name	Standard Detail	Acute Providers	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
12	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	The trust Outbreak plan is in place and was used as a framework to respond to the current Covid-19 Outbreak. This plan will be reviewed and updated following the current outbreak.The trust is also instigating the transfer / upload of FFP3 records to the national ESR system as per the new guidance	Partially Compliant	Will be added to EPRR Work plan for review post Incident / New requirement to upload of FFP3 data to be confirmed when initiated)	EPRR Manager	Oct-23
16	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Each ward has specific evacuation plans in place. Whole site evacuation plan is currently in Draft awaiting further consultation.	Partially Compliant	Currently In Draft form will be added to work plan and circulated for further consultation	EPRR Manager	Jul-23
21	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	All staff who provide the on call manager role are provided with the necessary materials, lesson plan and competencies. In addition, daily logs are maintained and any learning from incidents are discussed via a peer support group. A TNA is in development to comply with the new 2022 requirements for the Principles of Health Command course when made available to Acute Trust commanders.	Partially Compliant	Awaiting training / access to Principles of Health Command course resources from NHS GM / NW	NHS GM / NW	Due Course
63	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Used equipment is destroyed and disposed of as per manufacturer's instructions by the EPRR manager. (Currently in Progress)	Partially Compliant	Add to work plan – Confirm disposal of remainder units	EPRR Manager	Juy 2023

Agenda Item 22.B

Title:	Infection Prevention Control Annual Report 2021-22			
Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24/11/22		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Summary:

The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details Infection Prevention and Control activity from April 2021 to March 2022, outlining our key achievements and an assessment of performance against national targets for the year.

The past year and more has been dominated by the COVID-19 pandemic. Infection prevention had never been of such importance in patients to whom the Trust are responsible or for the population more widely. As such, the delivery of clean, safe care has been the utmost priority for the Trust.

There is a stated commitment to preventing all Healthcare Acquired Infections (HCAI) and a zero tolerance to all avoidable infections and the Trust has achieved this objective on most points.

HCAI	Objective	Performance	Outcome
MRSA (hospital onset)	0	0	**Met**
Clostridium difficile infection (healthcare associated)	58	84	**Not met**
E. coli (healthcare associated)	76	62	**Met**
Klebsiella spp. (healthcare associated)	18	9	**Met**
Pseudomonas aeruginosa	4	2	**Met**
MSSA (hospital onset)	12 (internal)	22	**Not met**

Previously considered by:	Clinical Governance and Quality October 2022 Quality Assurance Committee November 2022
Proposed Resolution	The Board of Directors are asked to receive the Infection Prevention and Control Annual Report for 2021/22 and approve for publication.

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:	Richard Catlin, DND & Deputy Director of Infection Prevention and Control	**Presented by:**	Tyrone Roberts, Chief Nurse, Director of Infection Prevention & Control

Infection Prevention and Control Annual Report

April 2021-22

Our Bolton NHS FT Values

1. Executive Summary

1.1. The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details Infection Prevention and Control activity from April 2021 to March 2022, outlining our key achievements and an assessment of performance against national targets for the year.

1.2. The past year and more has been dominated by the COVID-19 pandemic. Infection prevention had never been of such importance in patients to whom the Trust are responsible or for the population more widely. As such, the delivery of clean, safe care has been the utmost priority for the Trust.

1.3. There is a stated commitment to preventing all Healthcare Acquired Infections (HCAI) and a zero tolerance to all avoidable infections and the Trust has achieved this objective on most points (see **Table 1**).

1.4. After a pause due to the pandemic, there were national targets set for the key healthcare associated infections (HCAI) of note: meticillin resistant *Staphylococcus aureus* (MRSA), *E. coli*, *Klebsiella spp.* and *Pseudomonas aeruginosa* bacteraemia and *Clostridium difficile* infections (CDI). There was no target set for meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia but a local target was set by the Trust IPC Committee (IPCC).

2. Key Achievements and Challenges

2.1. The Chief Nurse is the designated Trust Director of Infection Prevention and Control (DIPC) for the Trust and Chair of the Infection Prevention and Control Committee (IPCC). This role was filled during most of 2021/22 by Karen Meadowcroft until her retirement and was filled on an interim basis by Angela Hansen (Deputy Chief Nurse) until the new Chief Nurse – Tyrone Roberts – commenced in post and became the Trust DIPC.

2.2. The DIPC is supported by Richard Catlin (Deputy DIPC) and Dr Celia Chu (IPC Doctor).

2.3. The Infection Prevention and Control Committee (IPCC) meets on a monthly basis with the divisional triumvirates providing assurance reports to IPCC.

Table 1: Reported HCAI Cases 2021/22

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
Hospital Onset, Hospital Associated (HOHA)[1] MRSA bacteraemia	2	0	-2	0 cases	The numbers of HOHA MRSA bacteraemias remain low and there were no cases reported in 2021/22. The last reported case was 10/07/20 meaning that by the end of March 2021, it had been 628 since the previously reported case. Before this, the longest period between cases had been 377 days.

GM Comparison Hospital Onset (cases)	20/21	21/22	21/22 Rank
Bolton FT	2	0	1
PAT	2	0	1
The Christie	1	0	1
WWL	2	1	4
Stockport	2	2	5
T&G	3	2	5
SRFT	4	5	5
MFT	11	10	8

Bolton FT remained one of the three best performing trusts in GM for 2021/22 with no cases identified in year.

[1] See **Appendix 1**

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
HOHA MSSA bacteraemia	16	22	+6 (37.5%)	NA	There was a continued year on year increase, the reason for which is not fully understood.

GM Comparison Hospital Onset (rates[2])	20/21	21/22	21/22 Rank
T&G	10	5	1
PAT	8	7	2
Stockport	5	8	3
WWL	10	11	4
Bolton FT	9	12	5
SRFT	9	12	6
MFT	14	13	7
The Christie	13	18	8

The Trust performed similarly to half of the provider trusts in GM but was slightly worse than the average (12 cases against an average of 10.75 cases).

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
Healthcare associated *E. coli*[3] bacteraemia	38	63	+35 (66%)	76	There was an increase in cases year-on-year with almost all of the increase coming from patients with *E. coli* bacteraemias on admission but who were inpatients at Bolton in the preceding 28-days making them community onset, healthcare associated (COHA)[4]. This reflects three things:

[2] All rates here described as rate per 100,000 occupied overnight beds
[3] See **Appendix 1**
[4] See **Appendix 1**

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
					1. 2020/21 seems to have had an artificially low number of cases generally 2. The Bolton case rate rise was also observed across England and may have reflected the challenges for general population health and wellbeing during the pandemic where access to care may have been more challenging 3. 2021/22 had a particularly hot summer and *E. coli* bacteraemia are strongly correlated with simple urinary tract infections (i.e. without indwelling urinary catheters) and dehydration

GM Comparison Hospital Onset (rates)	20/21	21/22	21/22 Rank
PAT	1260	694	1
WWL	561	753	2
Stockport	1505	1700	3
Bolton FT	1143	1895	4
T&G	792	1995	5
The Christie	2335	2019	6
MFT	1882	2367	7
SRFT	2821	3284	8

Bolton performed about better than half of the trusts in GM and reported almost the average for the providers across the city.

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
Healthcare associated *Klebsiella spp.* bacteraemia	17	9	-8 (47%)	18	There was a marked improvement in the incidence of *Klebsiella spp.* bacteraemias year-on-year.

GM Comparison Hospital Onset (rates)	20/21	21/22	21/22 Rank
WWL	179	217	1
PAT	619	256	2
Bolton FT	511	271	3
T&G	760	538	4
Stockport	697	557	5
The Christie	820	1388	6
MFT	1307	1416	7
SRFT	1850	1619	8

Bolton was the third best provider in GM and had a substantially better case rate than the average (783 cases).

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
Pseudomonas aeruginosa bacteraemia	6	2	-4 (66%)	4	There was a marked improvement in the incidence of *Pseudomonas aeruginosa* bacteraemias year-on-year.

GM Comparison Hospital Onset (rates)	20/21	21/22	21/22 Rank
WWL	179	26	1

GM Comparison Hospital Onset (rates)	20/21	21/22	21/22 Rank
Bolton FT	181	60	2
Stockport	84	111	3
PAT	117	117	4
SRFT	601	278	5
T&G	222	317	6
MFT	396	466	7
The Christie	631	947	8

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
CDT Cases (HOHA + COHA)	59	82	+23 (39%)	58	CDI became an emerging issue during the second half of 2021/22. There had been significant changes to processes related to the management of COVID-19 which impacted on how patients with suspected or confirmed CDI were managed. Isolation was more difficult, post-CDI cleaning was managed differently and antibiotics were used more frequently as part of the management of COVID-19 infections

GM Comparison Hospital Onset (rates)	20/21	21/22	21/22 Rank
WWL	549	676	1
PAT	865	790	2
T&G	982	1457	3
MFT	1664	2030	4
Stockport	780	2145	5
SRFT	2220	2174	6
The Christie	2398	2398	7

Bolton FT	1775	2467	8

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
CPE Cases	9	3	-6 (66%)	NA	There has been a marked reduction in the number of CPE cases identified.

Measure	2020/21 Cases	2021/22 Cases	Difference	Objective	Narrative
Nosocomial COVID-19 cases	343	230	-113 (67%)	NA	There has been a marked reduction in the number of nosocomial cases identified.

2.4. Due to changes to laboratory testing regulations in response to COVID-19, point of care test (POCT) for influenza was not available in the admission areas as in the previous two flu seasons but given the lack of influenza cases, this had no appreciable impact on patient care, safety or impact. As testing capacity and supply chains for test kits improved during the pandemic, POCT was replaced with rapid polymerase chain reaction (PCR) testing which provided staff with results in about after the sample being received in the laboratory 24-hours/day. This was used primarily for emergency admission samples.

2.5. There were three new Carbapenemase Producing enterobateriaceae (CPE) acquisitions during 2021/22 – a reduction from nine months in 2020/21.

2.6. *Escherichia coli (E. coli)* is the main cause of Gram negative bloodstream infections (GNBSI) with cases having increased nationally over the past decade. Although this in itself is a serious issue, it is of more concern because a growing proportion of these infections are resistant to simple antibiotic treatment. There were 212 cases of *E. coli* bacteraemia reported in 2021/22 for Bolton FT. Of these, 62 (29%) cases were apportioned to the Trust as healthcare associated (as defined in **Appendix** 1) with the remaining being apportioned to the community.

2.7. This represents a 66% increase from the year earlier.

2.8. The primary causes of *E. coli* BSI were identified as urosepsis without an indwelling catheter (40%) and hepatobiliary sepsis (19%) although in 18% of cases a clear cause of the infection was not found.

2.9. There was an increase in cases year-on-year with almost all of the increase coming from patients with E. coli bacteraemias on admission but who were inpatients at Bolton in the preceding 28-days making them community onset, healthcare associated (COHA). This reflects three things:

2.9.1. 2020/21 seems to have had an artificially low number of cases generally

2.9.2. The Bolton case rate rise was also observed across England and may have reflected the challenges for general population health and wellbeing during the pandemic where access to care may have been more challenging

2.9.3. 2021/22 had a particularly hot summer and E. coli bacteraemia are strongly correlated with simple urinary tract infections (i.e. without indwelling urinary catheters) and dehydration

2.10. The Trust Antimicrobial Stewardship Committee included representatives from Bolton Clinical Commissioning Group (CCG) and Primary Care. This group liaised with Primary Care and the Community care teams to advise on the appropriate management of patients with recurrent UTI.

2.11. The Antimicrobial Stewardship Group prioritised on synchronising antibiotic prescribing guidelines and stewardship activities and applying best practice prescribing principles to promote antimicrobial stewardship as outlined in the Public Health England (PHE) Start Smart Then Focus guidance. These include documenting the rationale for starting antimicrobial therapy and regular review.

2.12. The Director of Infection Prevention and Control acknowledges the breadth and depth of work undertaken by the wider IPC Team, members of the Infection Control Committees as well as the day to day contribution of all our staff and clinical leaders working together to reduce the incidence of HCAIs.

Recommendation

The Board of Directors are asked to receive the Infection Prevention and Control Annual Report for 2021/22 and approve for publication.

This report is intended to give a concise overview of key activities in the Trust related to infection prevention and control (IPC), healthcare associated infections (HCAI) and antibiotic stewardship. IPC remains critical to the Trust as it is a core component in the delivery of clean, safe care; failures in IPC can lead to adverse outcomes for patients and a poor patient experience. Antimicrobial stewardship has increasingly been identified as a challenge for the UK and presents a legitimate risk of the widespread dissemination of multi-drug resistant organisms and is therefore reflected in this report and future plans.

The Trust has IPC and HCAI objectives set by NHS England related to *Clostridium difficile* and Gram Negative Bloodstream Infections and meticillin resistant *Staphylococcus aureus* (MRSA).

3. SYSTEMS TO MANAGE AND MONITOR THE PREVENTION AND CONTROL OF INFECTION PREVENTION AND CONTROL (IPC)

3.1. IPC Service Delivery

The IPCT remains largely structurally unchanged from the structure in the previous year although two posts have been added funded by a new Service Level Agreement with Bolton NHS Clinical Commissioning Group.

The IPC functions continue to be split between the acute team who serve the Trust's acute services and the community team who serve the Trust's community functions as well as the Bolton Council. Bolton Council continues to commission Bolton Foundation Trust to provide community IPC services for their areas of accountability and the community services provided by Bolton FT.

The Director of Infection Prevention and Control (DIPC) retains overarching responsibility for IPC and reports directly to the Board. The Deputy DIPC (DepDIPC) oversees the development and implementation of IPC strategy and policies for the acute and community teams, reporting directly to the DIPC. The DepDIPC now has a dual role adding Divisional Nurse Director for Diagnostics and Support Services Division (DSSD) and has now been augmented with a new post – IPC Service Lead/Assistant Divisional Nurse Director for DSSD. These work in conjunction with the IPC doctor and the rest of the IPC team and key staff such as the antimicrobial pharmacists to develop strategy related to IPC and HCAI.

In 2021/22 the post of IPC matron remained vacant following a number of unsuccessful attempts to fill the post. This was re-advertised and a successful appointment made in March 2022 and started in post from April 2022. This post holder now manages the whole IPC service.

Bolton NHS Clinical Commissioning Group has funded two posts to provide an advisory and review services for the services provided in Primary care across Bolton.

3.2. IPC Board Assurance Framework (BAF)

In response to the pandemic, NHS England produced a series of IPC Board Assurance Frameworks for oversight by Trust Boards. These have been completed under the oversight of the IPC Committee and reported to the Board via QAC.

3.3. Microbiology Services

The provision of microbiology services has been increased by one whole time post following a successful business case at CRIG and is now established at 3.6 WTE posts.

The team continue to provide advice by phone; regular antimicrobial ward rounds for the review of patients with complex or prolonged antibiotic treatment and has recently established a weekly ward round to review *Clostridium difficile* toxin positive patients. The team also provide planned and prospective support for the critical care departments such as ICU and NICU.

Out of hours IPC advice continues to be provided by the microbiology service. The microbiology service also provides IPC advice Greater Manchester Mental Health Trust under a service level agreement and a limited service for GPs.

Dedicated antimicrobial pharmacy support to supplement the wider IPC service and to improve the scrutiny and awareness of safer antimicrobial prescribing has been maintained at 1.1 WTE.

The microbiology laboratory continues to provide a seven-day service for the diagnosis of *Clostridium difficile* toxin, Meticillin resistant *Staphylococcus aureus* (MRSA), and Norovirus infections. There is access to COVID-19 testing 24-hours/day and seven days/week.

4. Healthcare Associated Infections (HCAI) performance

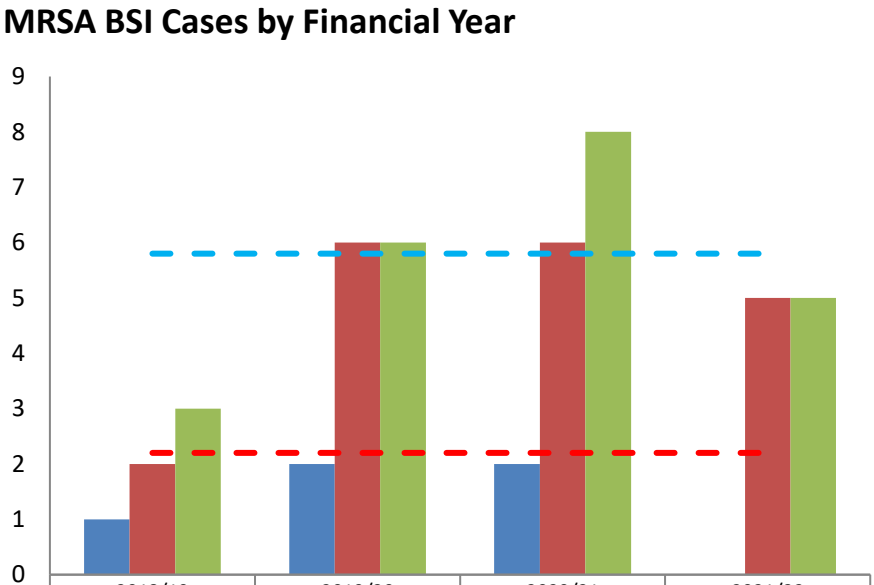
The Trust participates in the mandatory HCAI programmes. The following conditions are reported to the Department of Health (DH) via the Public Health England (PHE) Data Collection System (DCS):

1. MRSA positive blood cultures
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures
4. *E. coli* positive blood cultures
5. *Pseudomonas aeruginosa* blood cultures
6. *Klebsiella spp.* positive blood cultures

4.1. MRSA Bacteraemia

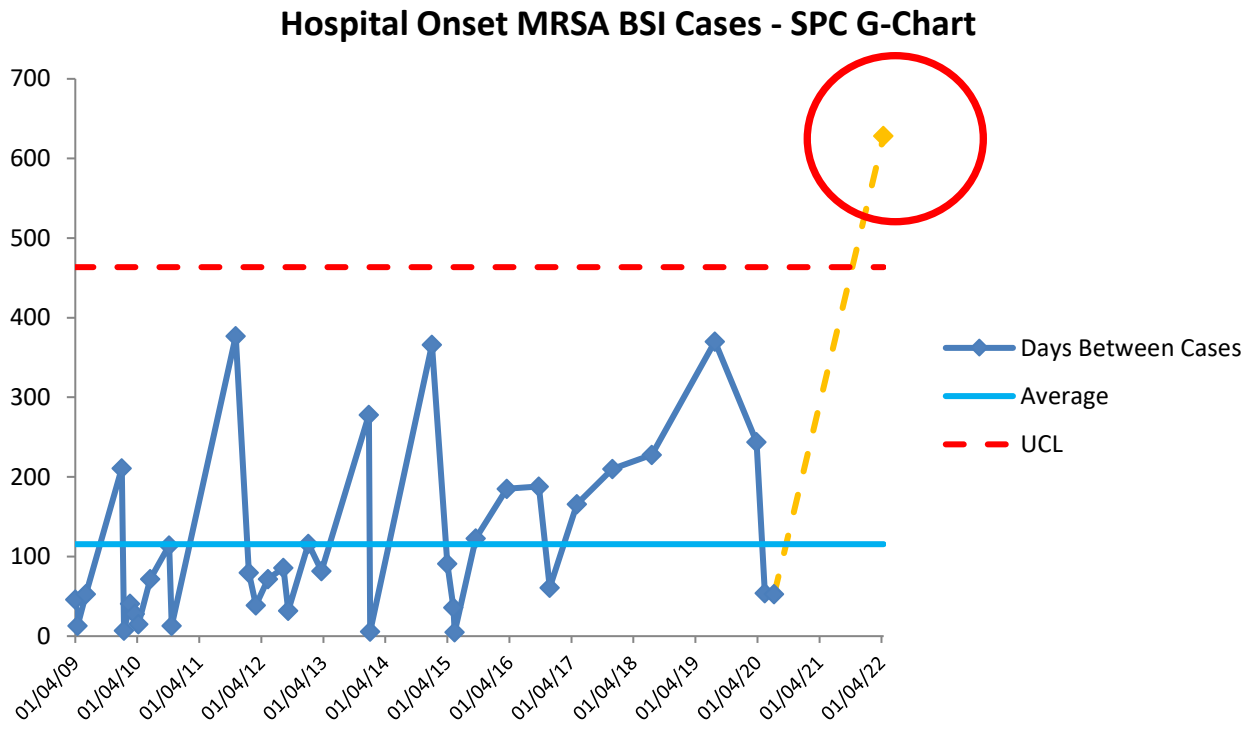
NHS England apportions cases to acute Trusts as outlined in **Appendix 1.**

Fig. 1: MRSA Cases



	2018/19	2019/20	2020/21	2021/22
Hospital Onset	1	2	2	0
Community Onset	2	6	6	5
All Cases	3	6	8	5
Hospital Onset 5-year Average	2.2	2.2	2.2	2.2
Community Onset 5-year Average	5.8	5.8	5.8	5.8

Fig. 2: Hospital Onset MRSA Cases SPC Chart



This chart shows that the period of time between MRSA cases had been increasing for the past two years but the most recent cases in 2020 reduce this time interval. There were no cases in 2021/22 meaning that by the end of the FY, there had been more than 628 days without cases.

4.2. Hospital-Onset, Hospital Associated Cases

There were no cases in 2021/22.

4.3. Non-Trust Apportioned MRSA Cases

There were five community onset cases in 2021/22. These cases have been reviewed using post-infection review (PIR) methodology. In year, the support by Bolton FT for the CCG to undertake these reviews has been strengthened to improve shared learning and will in future all cases will be investigated by the FT IPC service.

There was a repeated theme of patients who acquired systemic MRSA bloodstream infections related to intravenous drug use. The IPC services have worked with the drug and alcohol services to outreach into these communities to provide education, guidance and support.

4.4. MRSA Screening

The Trust has maintained a universal policy to MRSA screening with all elective and non-elective admissions being screened for MRSA on admission to the Trust. Additional

screening is undertaken in the critical care departments of the Trust where patients are screened on admission to the relevant unit and on a weekly basis. Elective patients may also be screened as part of their pre-admission pathway to maximise safety prior to surgery or other invasive procedures.

Patients are re-screened for MRSA weekly once they have been an inpatient for 14 days or more.

Patients who have become colonised with MRSA after admission are now reviewed to determine measures to reduce future likelihood.

4.5. *Clostridium difficile*

NHS England apportions cases as outlined in **Appendix 1.** Every hospital onset hospital associated case is formally reviewed and managed by the Trust HCAI Harm Free Care Panel.

The Trust follows the Department of Health guidelines for *C. difficile* testing[5]. These guidelines stipulate that all stool specimens type 5-7 on the Bristol Stool Chart (BSC) should be tested if there is no other clear cause of diarrhoea. All samples submitted to the lab from the acute services in patients older than two years that meet this definition should always be tested for CDT in the laboratory, additional to any other test request. Any sample in a patient over the age of 65 from community patients should be tested for CDT additional to any other tests requested.

The test should be undertaken using a two-step algorithm with a sensitive screening test; step one using glutamate dehydrogenase enzyme immunoassay (GDH EIA) or *Clostridium difficile* toxin polymerase chain reaction (CDT PCR). Step two using CDT EIA. It is only the CDT EIA positive cases that are mandated for reporting. Bolton FT uses GDH EIA followed by CDT EIA.

Samples that are GDH EIA positive and CDT EIA negative are tested with CDT PCR. If this test is negative, then we can confirm with a high level of certainty that the patient's stool sample does not contain a toxigenic *Clostridium difficile* which means that they cannot develop a *Clostridium difficile* infection (CDI) and are of no clinical risk to other patients. These patients may be taken out of isolation and managed as per their needs. Patients stool with CDT detected by PCR may have had a false negative CDT EIA test or have *Clostridium difficile* but they don't currently have active infection. CDT EIA can only be detected when the bacteria is producing the toxin that causes disease.

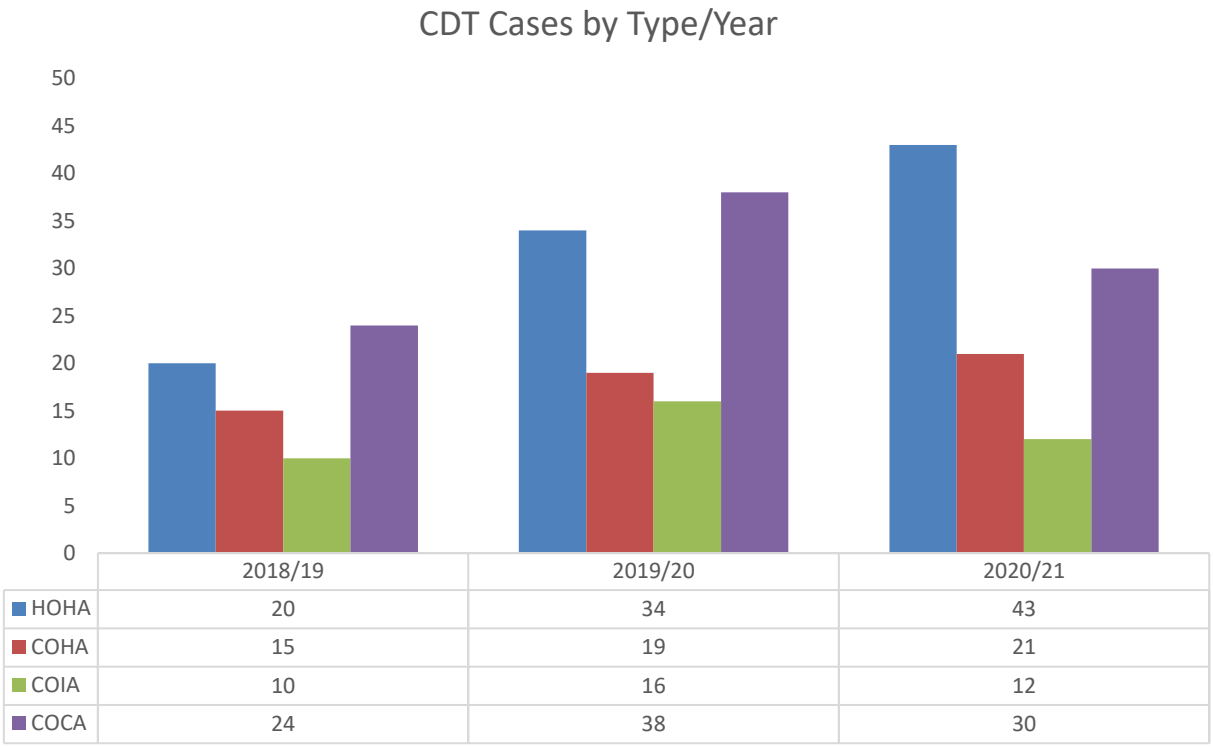
These patients are kept in isolation in line with the trust *Clostridium difficile* policy and may be treated for CDI following discussion with the microbiology team.

4.6. Trust Apportioned Cases

An objective for healthcare associated CDI cases was set by NHS England for 2021/22 of no more than 58 cases. The Trust ended the year with 84 cases in total (65 HOHA cases and 19 COHA cases).

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf

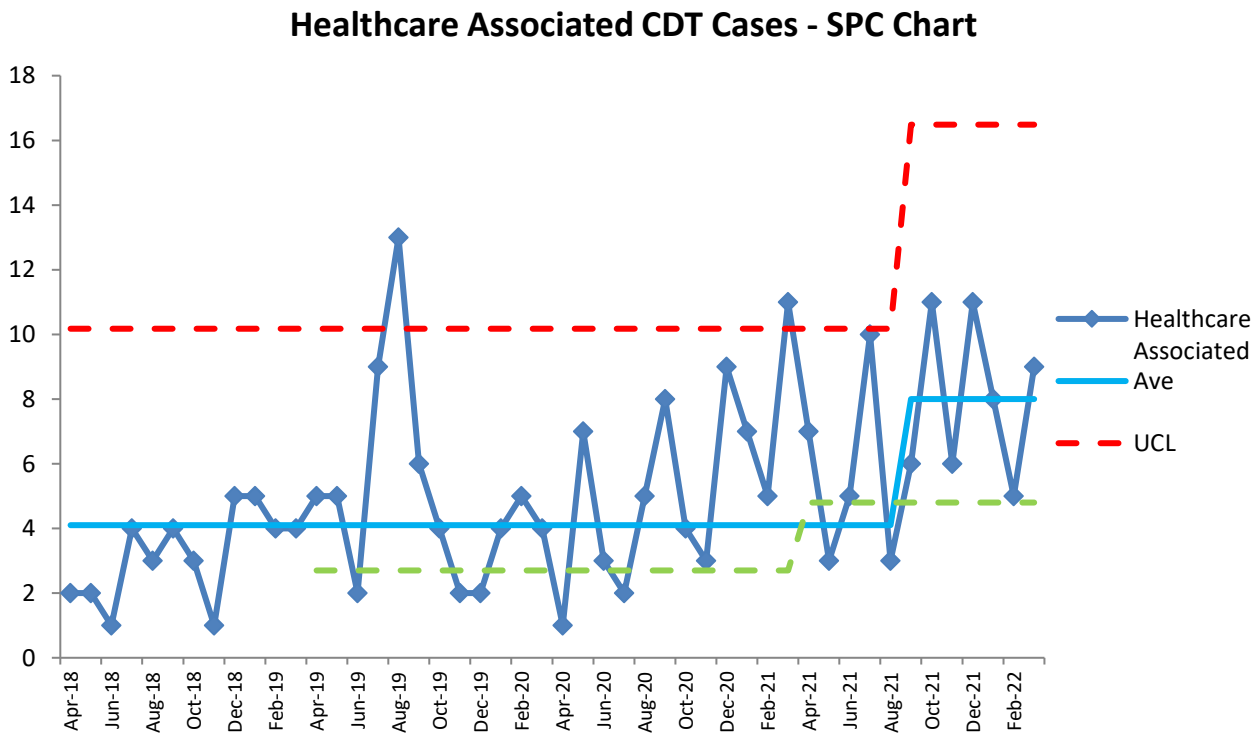
Fig. 3: CDT cases



	2018/19	2019/20	2020/21
HOHA	20	34	43
COHA	15	19	21
COIA	10	16	12
COCA	24	38	30

This table illustrates the increases seen over the past 24-months.

Fig. 4: Hospital Onset CDT Cases SPC Chart



There has been a general sustained increase in the number of healthcare associated cases sufficiently to represent a statistical increase.

There were two confirmed outbreaks which were investigated and managed by an Outbreak Control Team (OCT).

Trust apportioned cases are subject to a review which is undertaken using a guided root cause analysis approach. The purpose of these is to review the care provided and assess whether the care delivered was safe and appropriate. They are reviewed to establish whether care might have contributed to the risk of the patient developing a CDT infection and if this is the case, whether the corresponding policy was followed.

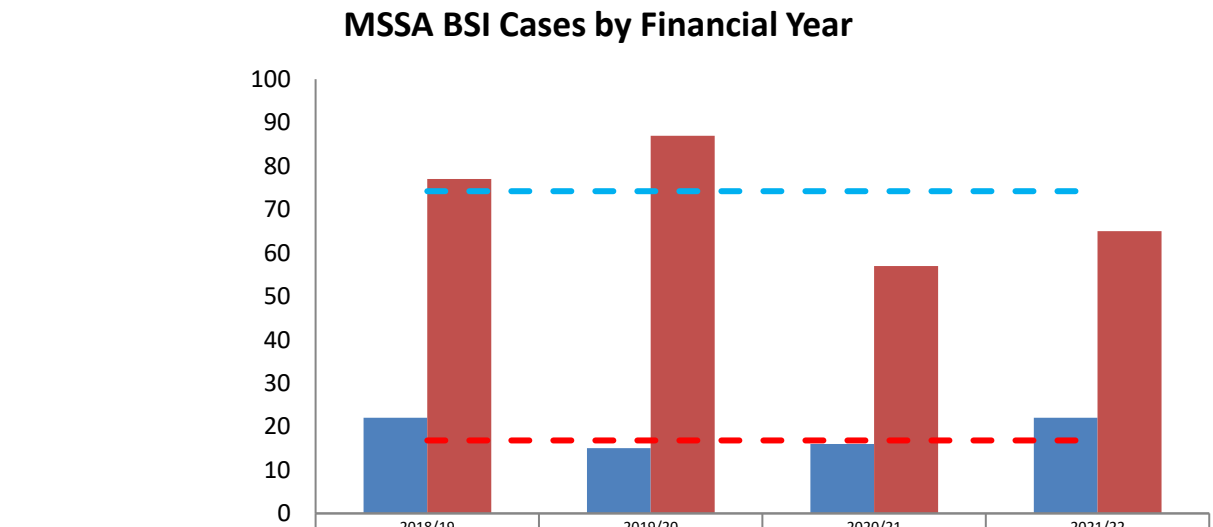
The clinical teams are responsible for the review. On the day of the result, the ward/department management team (patient consultant, ward manager and matron) are notified and given a date for the case to be fed back. The reviews are undertaken by a multidisciplinary team led by the patient's consultant. Feedback is undertaken at a Harm Free Care Panel chaired by the DepDIPC and IPC team, IPC doctor or Consultant Microbiologist and antimicrobial pharmacist. The cases are presented by senior doctor and a senior nurse from the department.

4.7. MSSA Bacteraemia

There are no national targets for MSSA cases. NHS England apportions cases in line with the process in **Appendix 1**. The IPC Committee created an internal stretch target of no more than 12 cases.

There was an increase in MSSA cases in 2021/22 to 22 HOHA cases from 16 in the year earlier.

Fig. 5: MSSA cases



	2018/19	2019/20	2020/21	2021/22
Hospital Onset	22	15	16	22
Community Onset	77	87	57	65
Hospital Onset 5-year Average	16.8	16.8	16.8	16.8
Community Onset 5-year Average	74.2	74.2	74.2	74.2

Gram Negatives

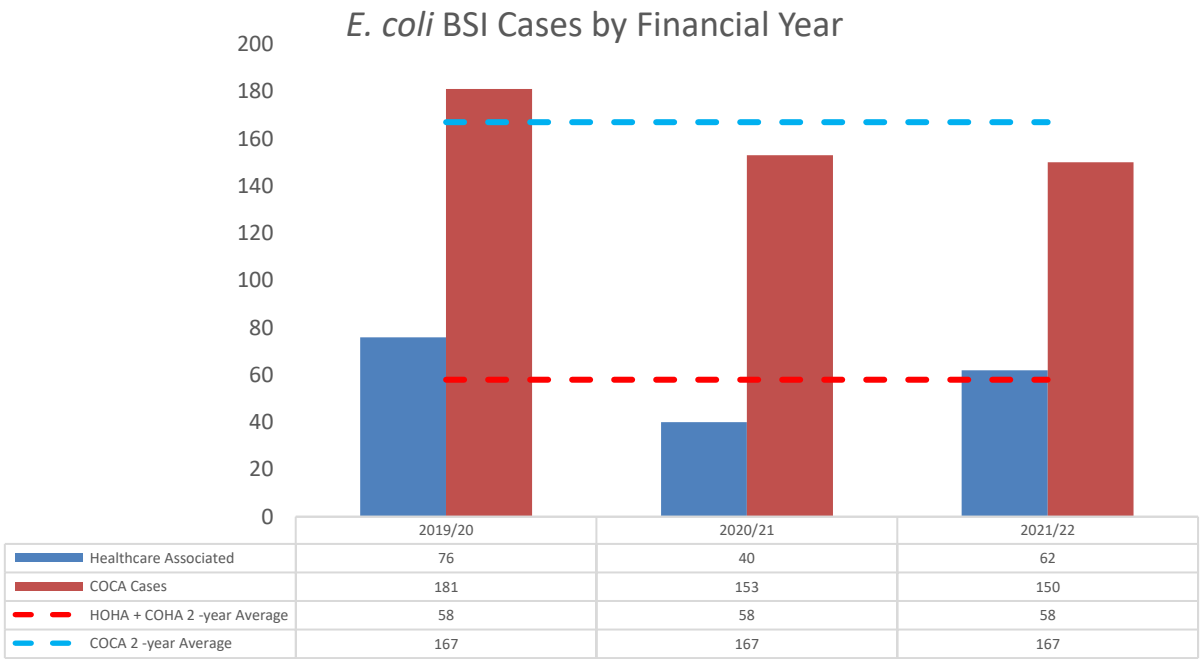
In November 2016, the government announced an intention to reduce all Gram negative bloodstream infections by 50% by the end of 2020/21. As a consequence, two new organisms were added to the mandatory surveillance list: *Klebsiella* species and *Pseudomonas aeruginosa*.

4.8. *E. coli* Bacteraemia

E. coli infections are more complex than MRSA or MSSA infections and much less likely to be attributed only to healthcare provision with personal hygiene and levels of hydration key risk factors for these infections.

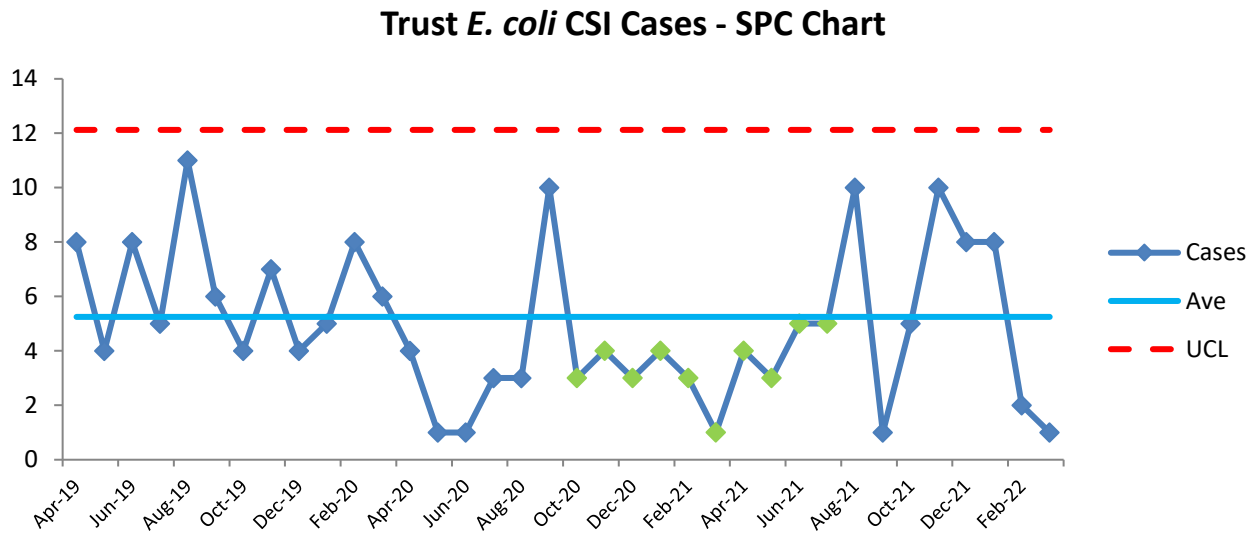
Bolton FT has seen a general reduction of cases over the past few years with an 18.5% decrease between 2019/20 and 2021/22:

Fig. 6: *E. coli* cases



	2019/20	2020/21	2021/22
Healthcare Associated	76	40	62
COCA Cases	181	153	150
HOHA + COHA 2 -year Average	58	58	58
COCA 2 -year Average	167	167	167

Fig. 7: *E. coli* SPC Chart

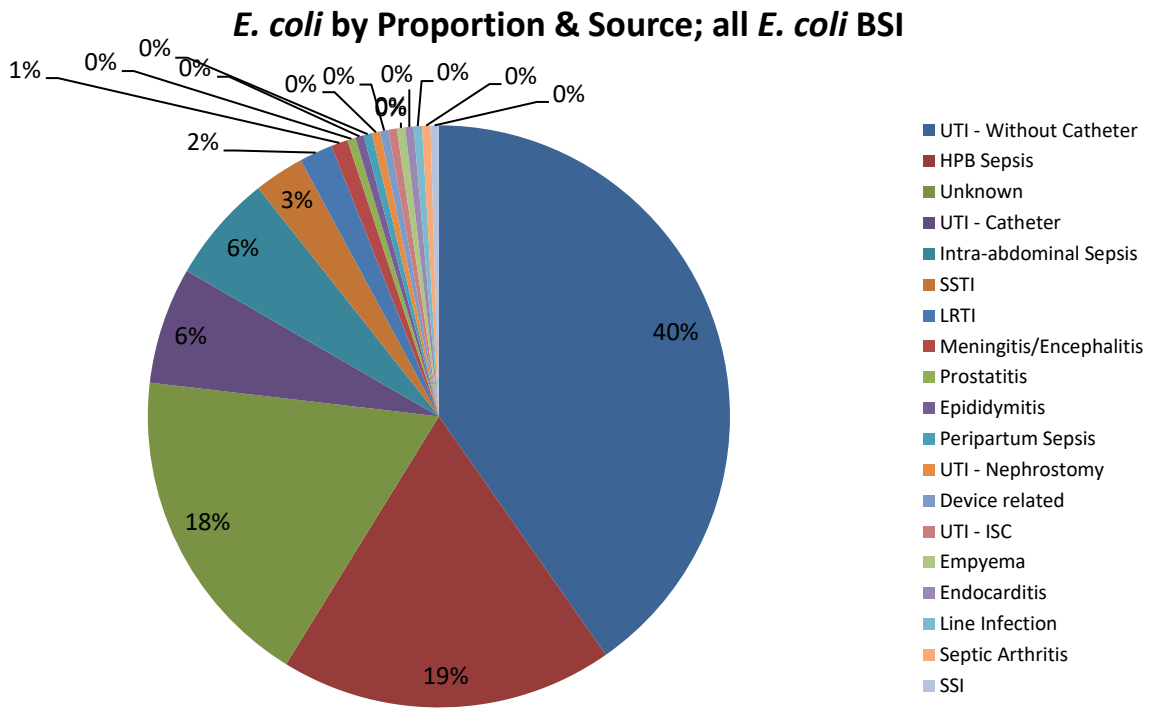


This chart illustrates that overall there has been sustained statistical change in *E. coli* cases although there was a period of 10 consecutive data points below the average between October 2020 and July 2021.

There are *E. coli* cases that are directly related to the provision of healthcare – *E. coli* infections due to urinary tract infections in patients with indwelling urinary catheters – others are less clear although hydration and cleanliness are known to be important.

The IPC Committee now sees a breakdown of *E. coli* cases by cause to better understand the impact of the provision of healthcare on the incidence of *E. coli* bloodstream infections. Shown here are cases for 2019/20:

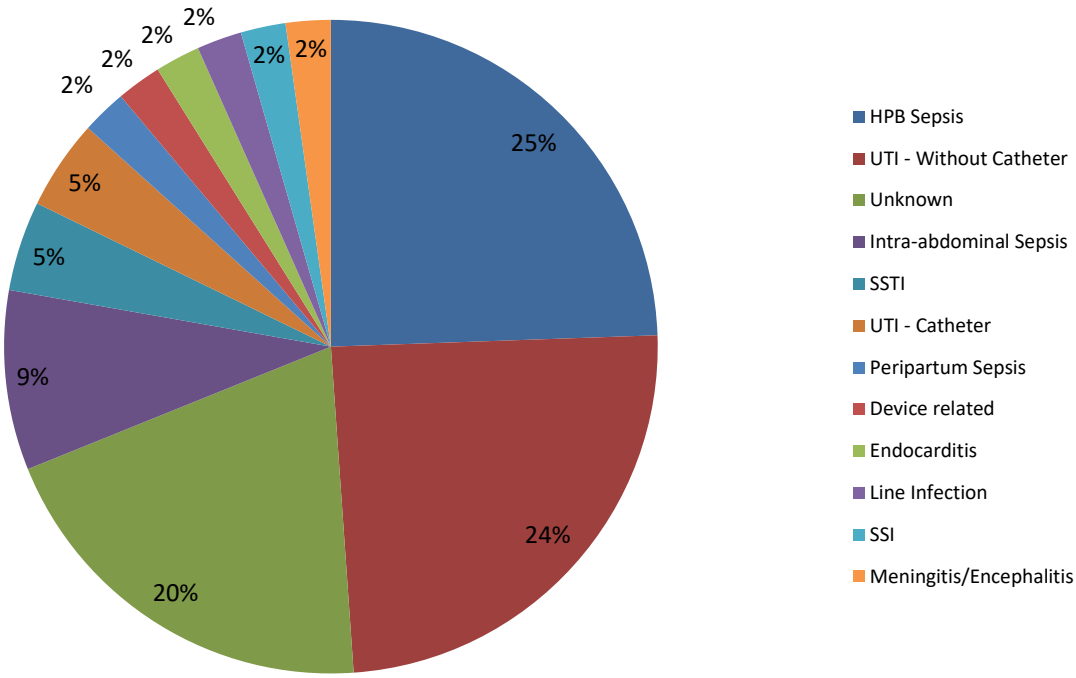
Fig. 8: *E. coli* by Proportion & Source; all *E. coli* BSI



Key to abbreviations	
HPB Sepsis	Hepatobiliary sepsis
LRTI	Lower respiratory tract infection
SSTI	Skin/soft tissue injury
UTI	Urinary tract infection
ISC	Intermittent self-catheterisation
HPB	Hepatobiliary
SSI	Surgical site infection

The most common source was urinary tract infections (with a urinary catheter) followed by hepatobiliary infection and urinary tract infection (without a urinary catheter). No source was identified in 18% of cases.

Fig. 9: *E. coli* by Proportion & Source; Healthcare Associated *E. coli* BSI



No source was identified in 20% cases. Hepatobiliary infection (25%) then UTI with no catheter (24%) were the most commonly identified sources of hospital onset *E. coli* BSI.

4.9. *Klebsiella spp.* Bacteraemia

Mandatory surveillance of bloodstream infections caused by all species of *Klebsiella* started in 2017. There were 39 cases in 2021/22 of which nine were healthcare associated. This compares with 43 cases in the year before of which 16 were healthcare associated.

Fig. 10: *Klebsiella spp* Cases

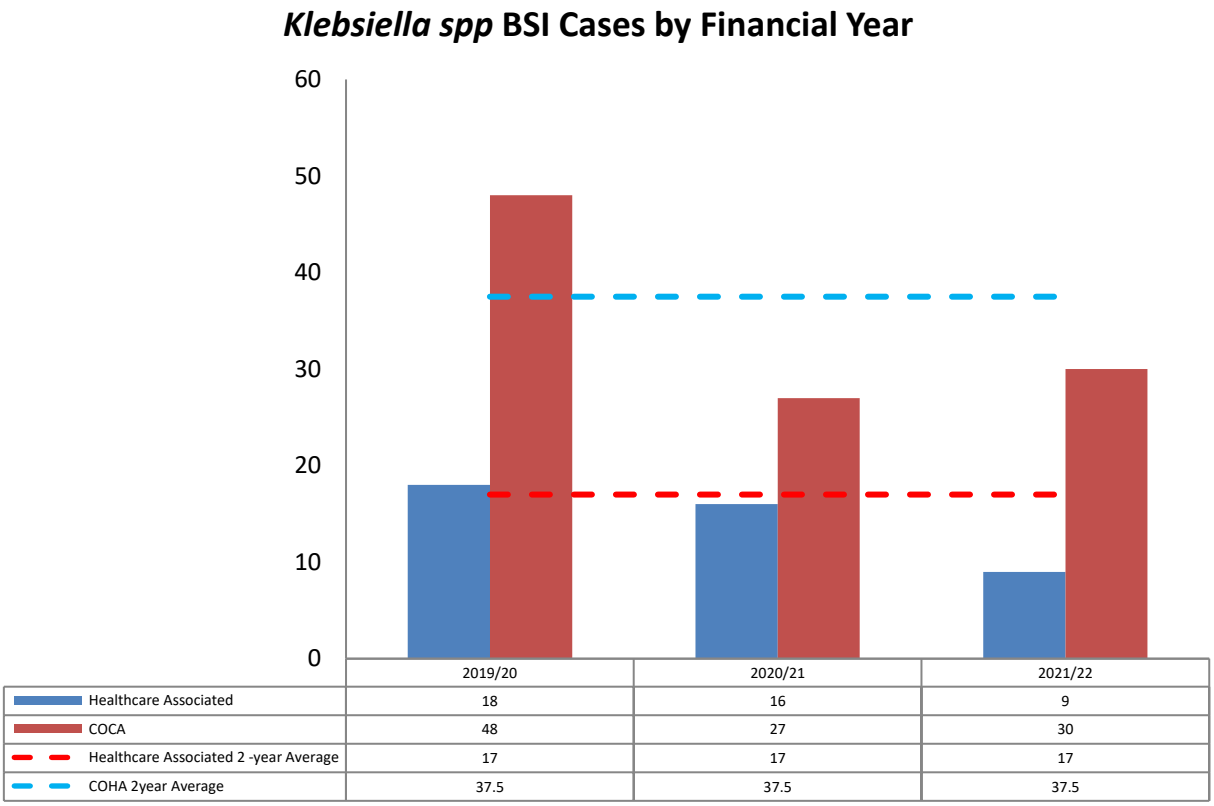
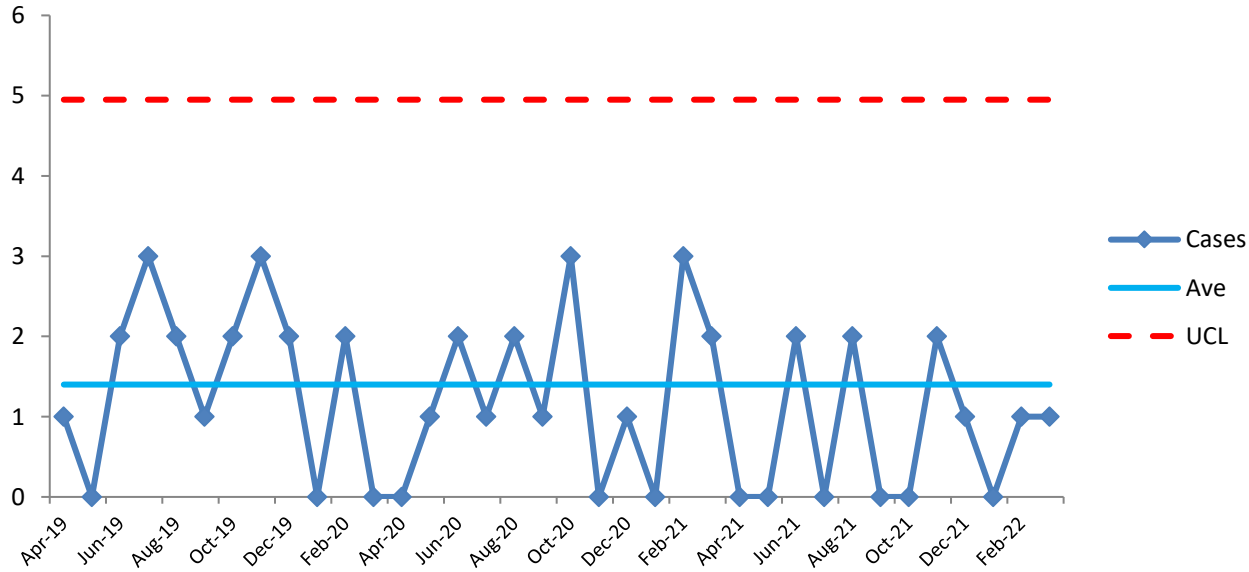


Fig. 11: *Klebsiella spp* SPC Chart

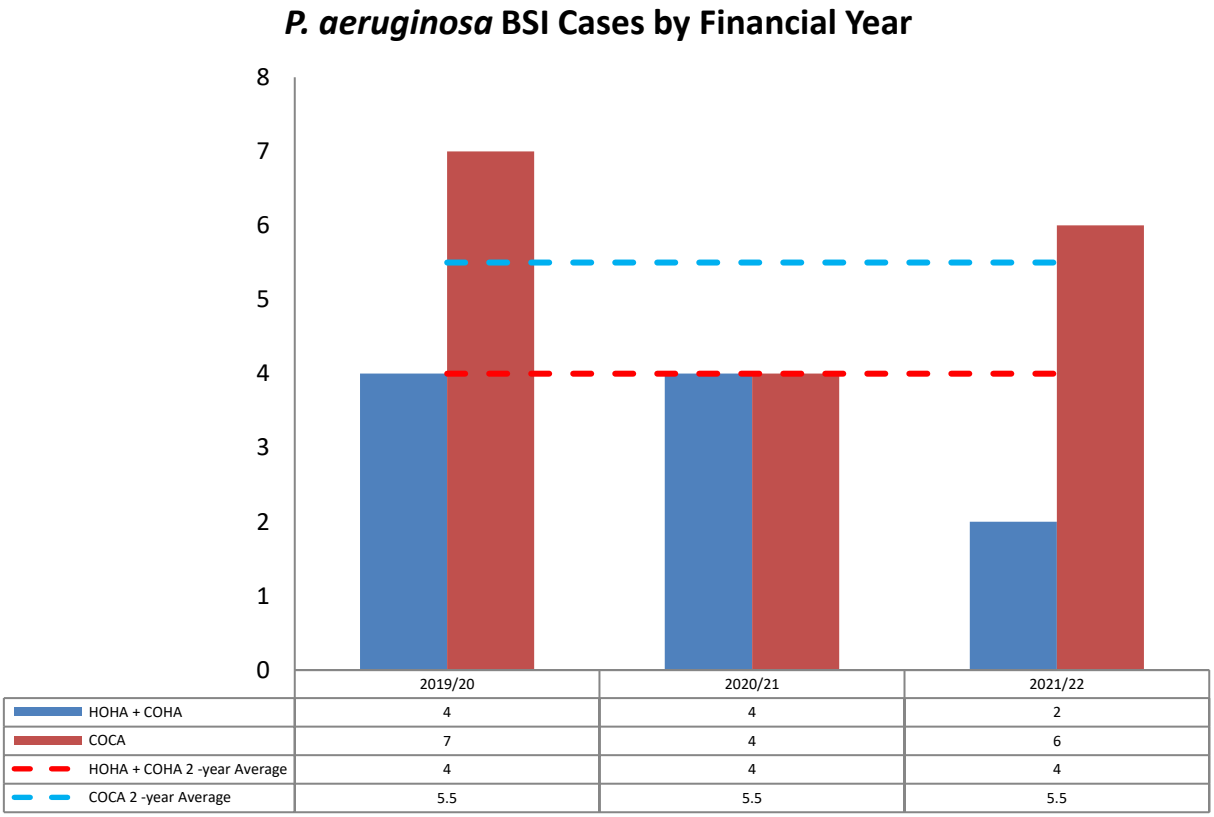


There has been no change in the incidence of *Klebsiella spp.* cases.

4.10. *Pseudomonas aeruginosa* Bacteraemia

Mandatory surveillance of bloodstream infections caused by *Pseudomonas aeruginosa* started in 2017. There was a reduction in the number of cases in 2021/22 – from four to two healthcare associated cases.

Fig. 12: *Pseudomonas aeruginosa* Cases



	2019/20	2020/21	2021/22
HOHA + COHA	4	4	2
COCA	7	4	6
HOHA + COHA 2 -year Average	4	4	4
COCA 2 -year Average	5.5	5.5	5.5

4.11. Additional Surveillance

In addition to these HCAI, the IPC team undertakes active surveillance of other infections or conditions that are important because of the illness they cause and the impact or due to the antibiotic resistance they confer.

5. Infection Prevention and Control Governance

IPC assurance continues to be provided by the IPC Committee.

5.1. Infection Prevention Control Committee (IPCC)

The committee meets monthly and is chaired by the Chief Nurse/DIPC. This committee provides assurance to the DIPC to be reported to the Board where required and provides a strategic direction for the provision of IPC. The committee covers the following on a regular basis plus other topics by exception:

- HCAI surveillance
- Outbreaks/periods of increased incidence
- Antimicrobial stewardship
- Policy approval
- Emerging issues
- Divisional concerns

The revised Terms of Reference are available on request.

5.2. Antibiotic Stewardship Committee (ASC)

The antimicrobial stewardship committee is chaired by the Trust Antimicrobial Stewardship lead – who is a consultant medical microbiology – and includes representation from each of the clinical divisions. The remits of the group are to provide assurance on the following:

- Ensuring the relevant policies are in date and evidence based
- Provide assurance that key antibiotic prescribing policies are audited and that the audits are fed back
- The Trust has a strategy for providing safe and effective care related to antibiotic prescribing and use

The committee oversees the audit of antibiotic prescribing against the standards set out in the DH Start Smart Then Focus[6]. There are five auditable standards:

1. Compliance with Trust Antibiotic Guidelines (*including prescription in line with culture and sensitivity testing and/or microbiology recommendation).*
2. Indication for treatment written in the patient case notes at the point of antibiotic initiation.
3. Indication for treatment written in the antibiotic section of the prescription chart.
4. Stop date or a review clearly documented in the case notes by 48 hrs.
5. Stop or review date clearly documented on the prescription chart by 48 hrs.

Trustwide Compliance with Each Standard:

The set the Trust an objective of at least 85% compliance with all five standards for 2019/20

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

Fig. 13: Antimicrobial Stewardship Compliance Standard 1

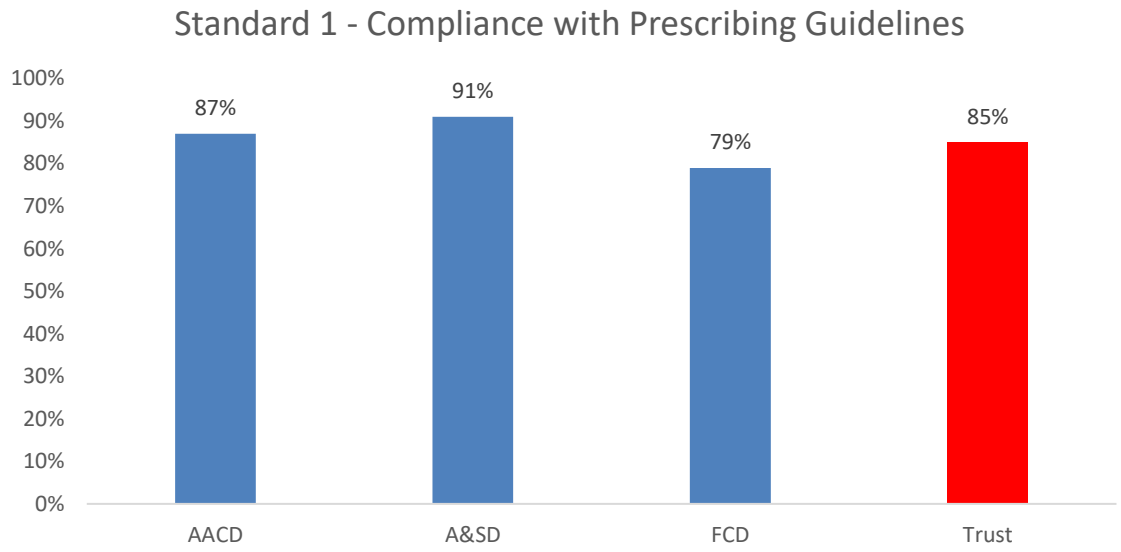


Fig. 14: Antimicrobial Stewardship Compliance Standard 2

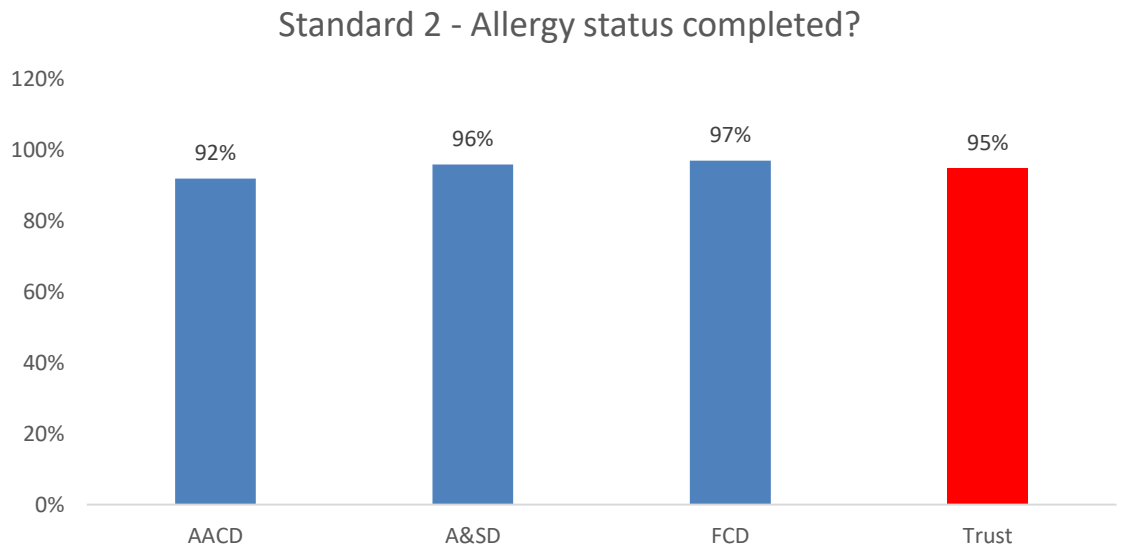


Fig. 15: Antimicrobial Stewardship Compliance Standard 3

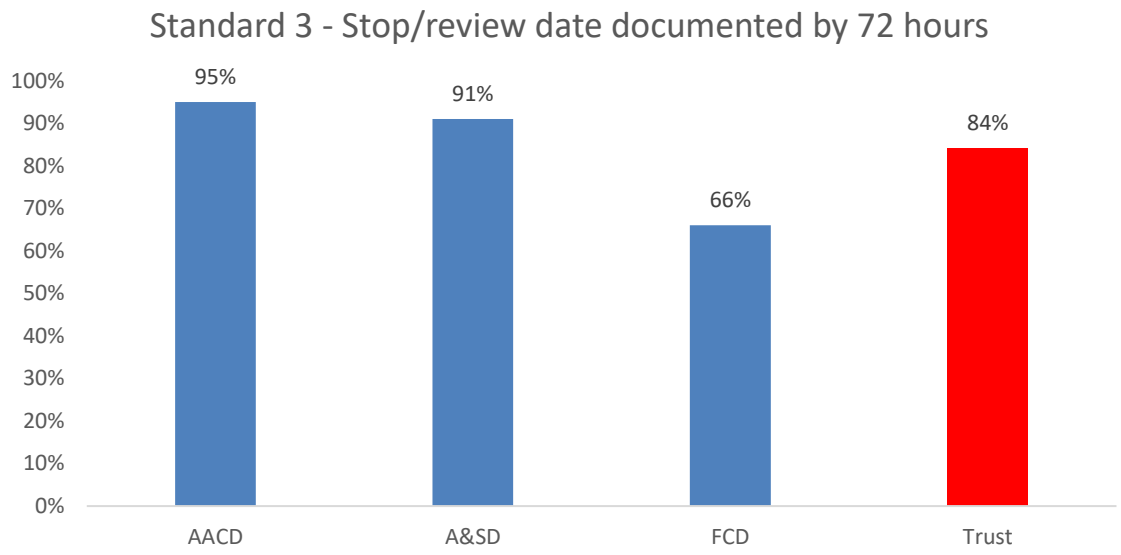


Fig. 16: Antimicrobial Stewardship Compliance Standard 4

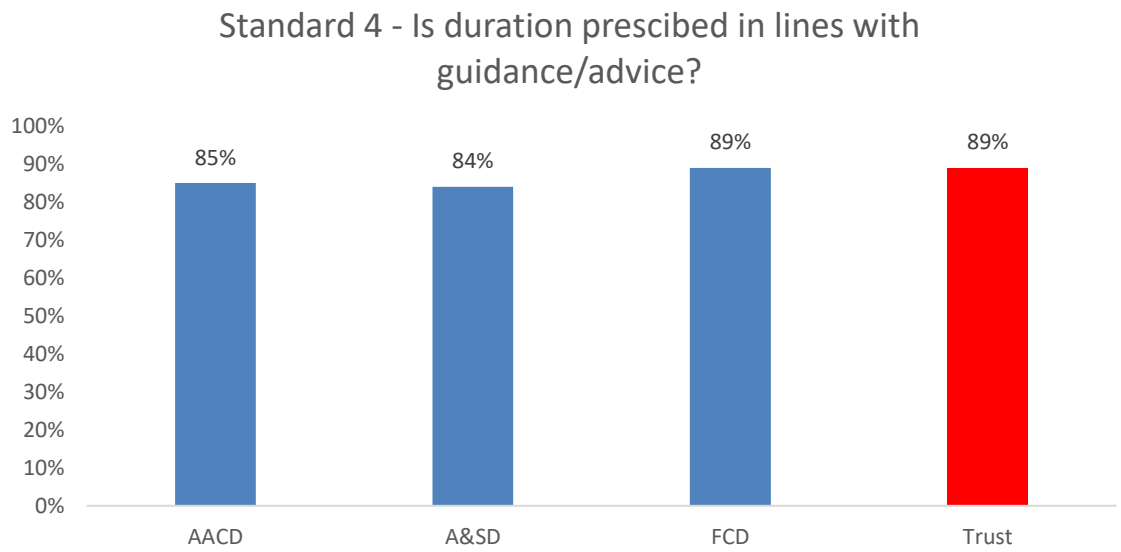
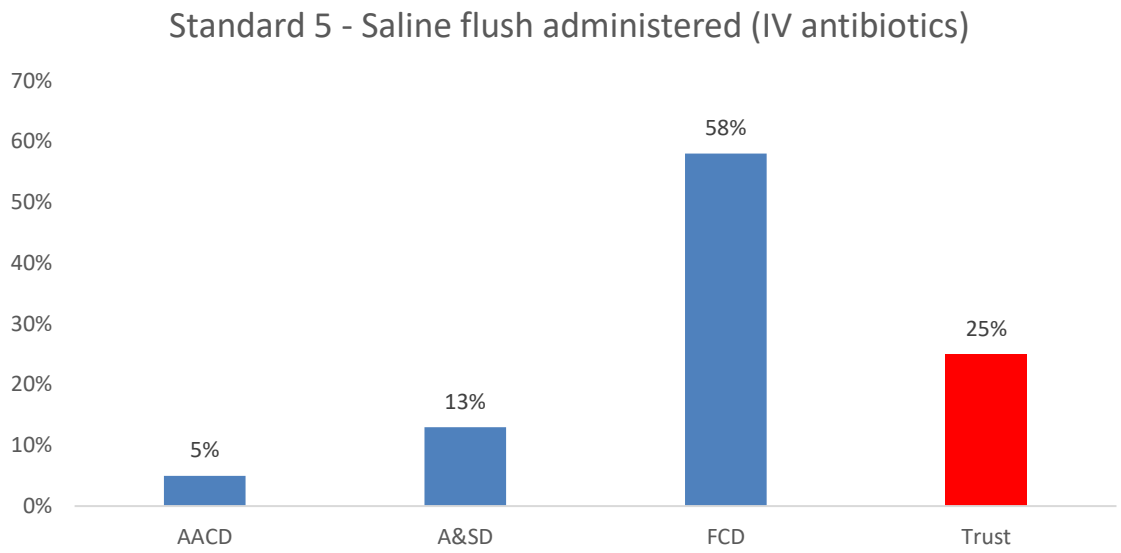


Fig. 17: Antimicrobial Stewardship Compliance Standard 5



This last standard is a new one and improvements are being targeted by the Antimicrobial Stewardship Committee and Drugs and Therapeutic Committee.

5.3. Representation at other Trust wide groups

Members of the IPCT represent the service at a number of Trust wide groups such as the medical devices group and Group Health and Safety Committee and is invited into other Trustwide groups such as building projects as required.

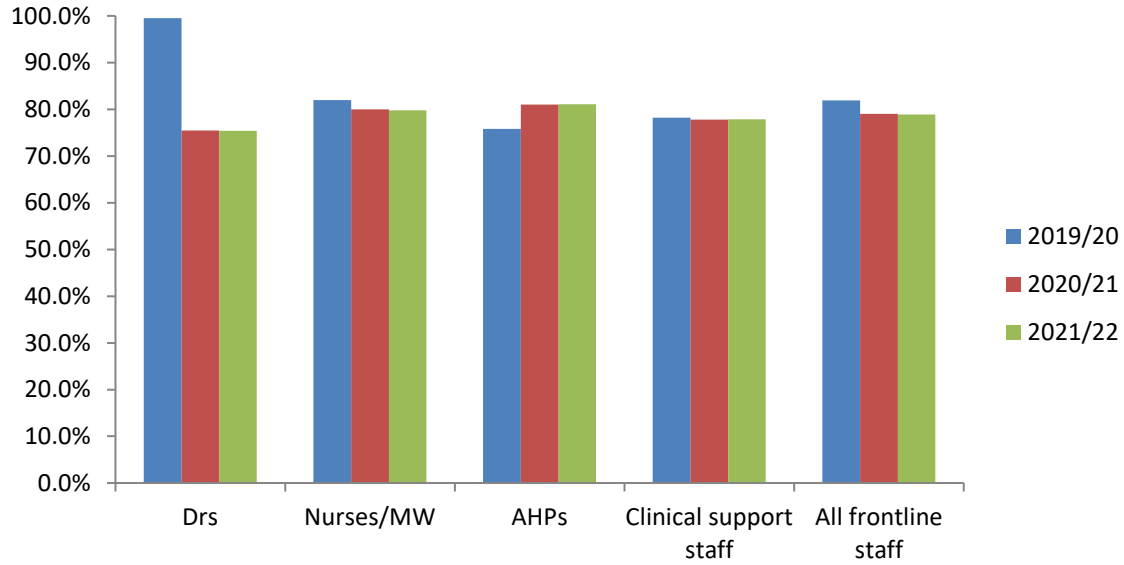
The IPCT also represent the Trust at external meetings including Bolton locality IPC Collaborative, GM IPC Group and North-West IPC Group.

6. Influenza and COVID-19 Vaccines

6.1. Staff Flu Vaccination Campaign

The HR team supported a successful flu vaccination programme for frontline staff in 2020/21 19/20[7]. Uptake in all frontline staff groups increased based on the previous years. Overall uptake for the Trust for frontline healthcare staff was 79%.

Fig. 18: Flu Vaccine Uptake



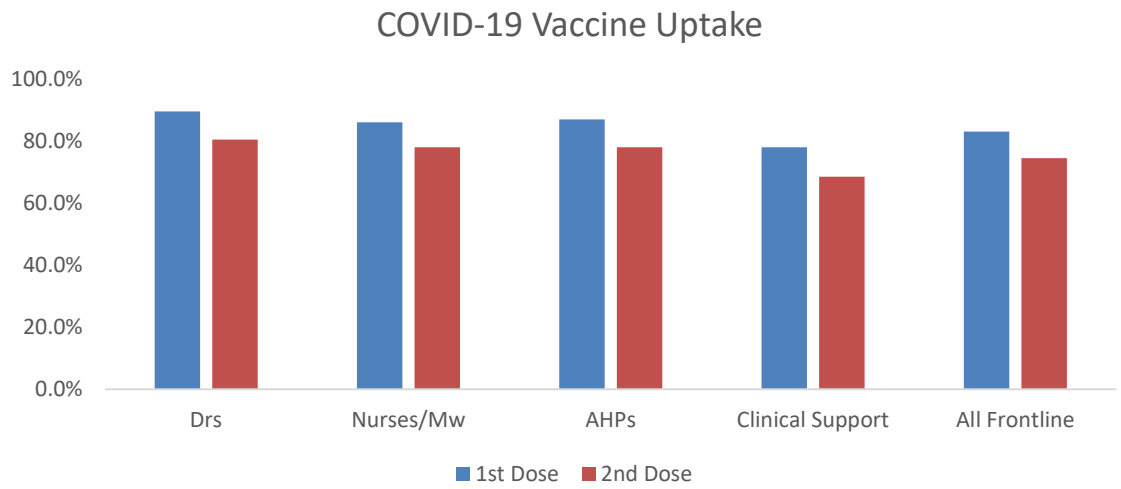
In total 4188 staff were vaccinated of which 3232 were frontline staff.

6.2. Staff COVID-19 Vaccination Campaign

The HR team supported a successful COVID-19 vaccination programme for frontline staff in 2021/22.

Fig. 19: Flu Vaccine Uptake

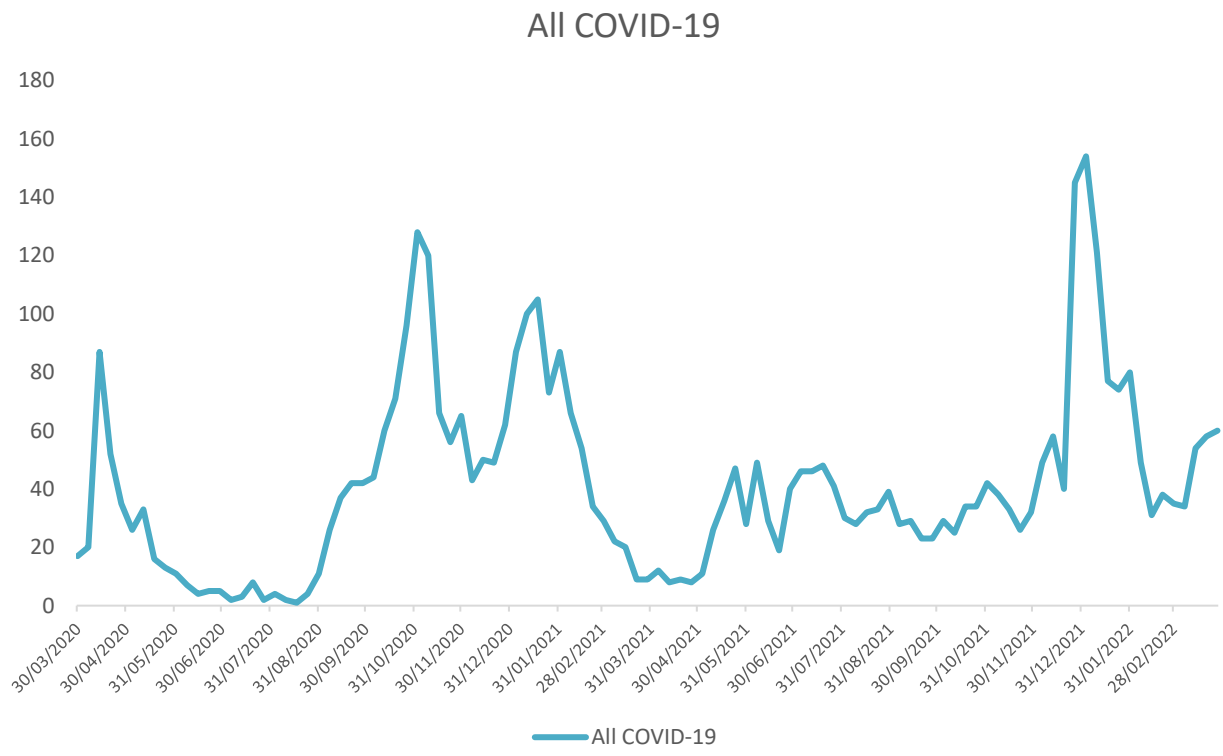
[7] Frontline staff are classified by the DH as: doctors, GPs, qualified nurses/midwives, other registered healthcare professionals and support staff to clinical staff



7. COVID-19

7.1. COVID-19 Numbers in FY 21/22

Fig. 20: Weekly COVID-19 cases



In 2020/21 the Bolton laboratory processed more than 102,003 COVID-19 samples.

7.2. Nosocomial Cases

NHSE/i created consistent definitions to determine where it was likely that an inpatient COVID-19 case was acquired:

HCAI Category	Criteria
Community Onset (CO)	Positive specimen taken date <= 2 days after admission to trust
Hospital-Onset Indeterminate Healthcare-Associated (HOIHA)	Positive specimen taken date 3-7 days after admission to trust
Hospital-Onset Probable Healthcare-Associated (HOPHA)	Positive specimen taken date 8-14 days after admission to trust
Hospital-Onset Definite Healthcare-Associated (HODHA)	Positive specimen taken date 15 or more days after admission to trust

HOPHA and HODHA cases are considered to be nosocomial – or acquired during the provision of healthcare. These definitions are based on the incubation period – the period from exposure to the start of illness – which is up to 14 days but more frequently shorter.

Fig. 21: Proportion of COVID-19 Onset

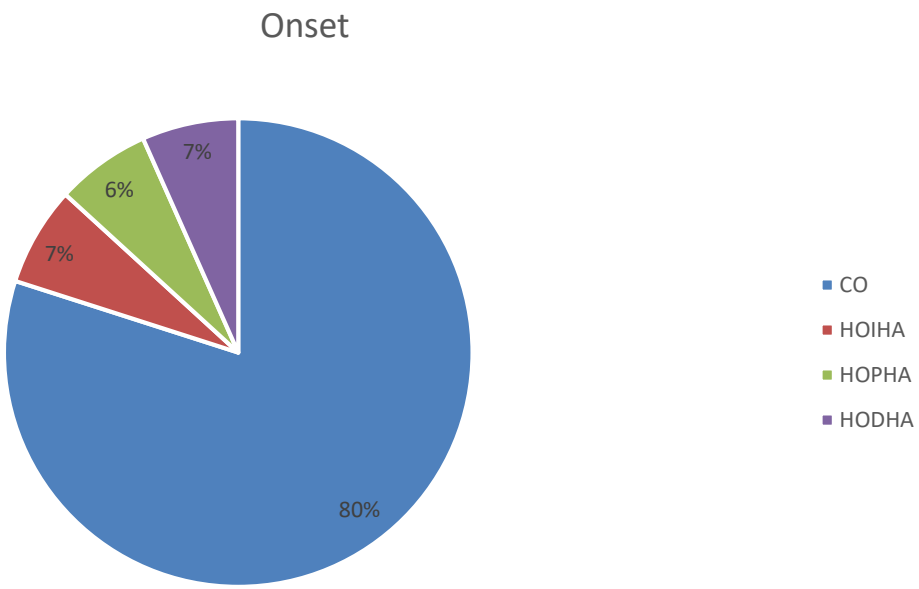
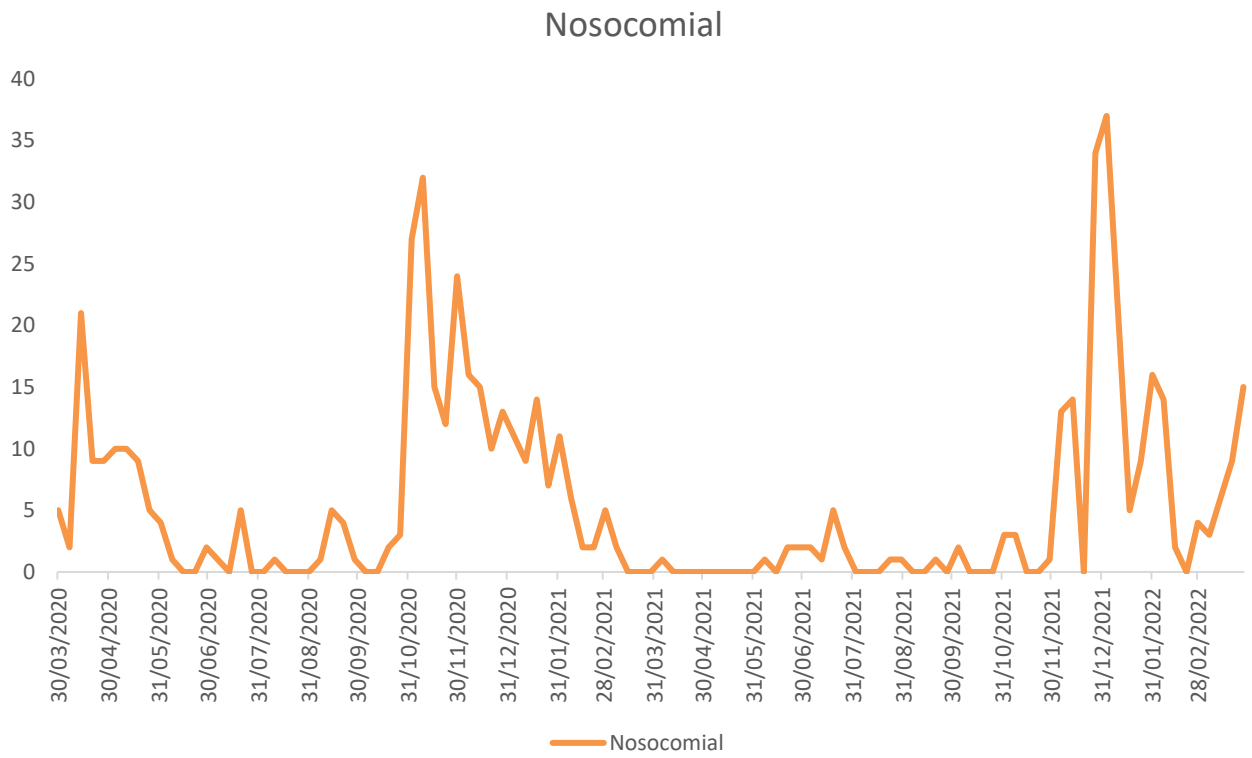


Fig. 22: Weekly Nosocomial COVID-19 Cases



7.3. Patient Deaths

During 2021/22 260 patients died with COVID-19 on their death certificate in line with the national guidance. This does not mean that these patients died of COVID-19 but that they died within 28-days of a confirmed COVID-19 positive test.

7.4. Testing and Testing Progress

The Trust brought in-house COVID-19 testing online in early May 2020 using the BD Max platform. This had the capacity for up to 96 samples/day to be processed, each test taking six hours to report. This was later augmented and then replaced by the Panther platform which has increased capacity to over 400 tests/day, each test taking four hours to report.

These platforms have been augmented by two other platforms that allow for rapid testing:

- Cepheid GeneXpert – this platform takes ~60 minutes to report and allows up to 12 samples to be tested at a time
- Roche Liat – this platform takes ~20 minutes to report but only allows for one sample to be tested at a time

8. Community IPC

The team covers such services as care, homes, Bolton hospice, schools, district nursing, podiatry and community loan stores as examples. The team provide an informative, open, and knowledgeable service working cross organisationally to promote safe and effective infection prevention and control practices.

The team have worked largely with care homes and Bolton Hospice during the pandemic providing training and support for the management of residents and helping these organise navigate the regularly changing landscape of guidance. This has included regular webinars for the care home staff.

The team continue to liaise directly with patients where necessary to ensure they are receiving the correct treatment and have a good understanding of their infection. This may also involve communication and close liaison with other teams - including district nurses, Children's Community, Nursing Team, tissue viability service, podiatry and GPs amongst others.

Thanks to a Service Level Agreement with Bolton NHS Clinical Care Group, an IPC service now offered to Primary Care in Bolton. This includes advice, guidance and training for Primary Care staff and audits of practices.

The team also take queries by phone, completes to RCAs of Trust and non-Trust related infections. The team continue to lead on work in the Bolton population in raising awareness of infections related to injecting drug use such as MRSA and Group A *Streptococcus*.

9. Cleaning and Decontamination

9.1. Decontamination across the Trust

The Infection Prevention and Control team continues to provide decontamination advice throughout the Trust. The IPCT are available to give specialist advice on policies, procedures and the purchase of equipment in relation to decontamination.

The methods, processes and audits have been reviewed in year in response to a spike in CDT cases as described earlier.

9.2. Cleaning Service

Domestic services continue to be delivered by Bolton iFM. Bolton iFM continue to monitor cleaning standards as part of the service contract. Audits are undertaken using national standards. The audits are visual inspections incorporating 41 standards.

Departments are considered to be high-risk (for example, complex care) or very high-risk (for example, ICU). The same standards are monitored, but a successful audit in a high-risk area is 95% compliance with the audit whereas the required compliance in a very high-risk area is 98%.

All cleaning performance is reviewed and discussed at the Trust IPC Committee. Scores are reviewed monthly by the IPC team and area with consistently low scores or scores that generate a specific concern are discussed with the relevant managers.

9.3. Infection Control audits

The IPCT have continued to carry out audits of practice and adherence to key IPC standards on at least an annual basis. High risk areas (listed below) are audited at least twice yearly:

- ICU
- HDU
- A&E Dept
- Ward D1
- Ward D2
- CDU
- NICU
- Main Theatres

The audits are planned in advance and carried out by a member of the IPCT with a member of the ward staff; ideally the ward manager or IPC link nurse.

An action plans are completed by the ward staff and returned to the IPCT and the results are fed through the divisional governance structures.

If the initial audit is unsatisfactory then a re-audit is required and if there are significant concerns, the issue may be escalated to the senior management team for support.

These audits are reported to the IPC Committee via the revised divisional IPC monthly reports for assurance and exceptions are challenged and discussed.

9.4. Hand Hygiene Audits

Hand hygiene audits are completed by nominated departmental staff continue and are inputted into secure applications. All grades of all types of staff are included in the audit and up to five members of staff are observed to check that hand washing before and after patient contact is taking place. Managers are able to generate reports for feed back to their team/department.

Hand hygiene audits are reported to the IPC Committee via the revised divisional IPC monthly reports for assurance and exceptions are challenged and discussed.

10. Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated 2012)		NICE (2011) Quality Improvement Guide for HCAI
Criterion	**The registered Provider is required to demonstrate**	**Quality Improvement Statement**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them	1
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**2**
3	Provide suitable accurate information on infections to service users and their visitors	
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion	**4**
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people	**5**
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	**6**
7	Provide or secure adequate isolation facilities	**7**
8	Secure adequate access to laboratory support appropriate	**8**
9	Have and adhere to polices, designed for the individual's care and provider organisations. That will help to prevent and control infections	**9**
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with provision of health and social care	**10**

NHS England has now established objectives for key HCAI for 2022/23. The nomenclature outlined in **Appendix 1** has now been adopted for all HCAI:

CDT Healthcare Associated Cases	No more than 80 cases
***E. coli* BSI Healthcare Associated Cases**	No more than 53 cases

***Pseudomonas aeruginosa* BSI Healthcare Associated Cases**	No more than 1 case
***Klebsiella spp.* BSI Healthcare Associated Cases**	No more than 11 cases

There are no centrally set objectives for MRSA or MSSA BSI so the following have been adopted:

MRSA BSI HOHA Cases	Zero tolerance for HOHA cases
MSSA BSI HOHA	No more than 15 HOHA cases

Appendix 1: HCAI Nomenclature from 2019/20 (CDI) and 2021/22 (MRSA, MSSA, *E. coli*, *Klebsiella spp.* and *Pseudmonas aeruginosa* Bacteraemias)

Clostridium difficile Cases

- **Community onset community associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA).
- **Community onset indeterminate association:** cases that occur in the community or on the day of admission or the following day **and** the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA).
- **Community onset healthcare associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has been an inpatient in the trust reporting the case in the previous 4 weeks (COHA).
- **Healthcare onset healthcare associated:** cases detected from a sample collected from the third day of admission (admission being day 1 – HOHA).

All Bacteraemias

- **Community onset community associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has not been an inpatient in the trust reporting the case in the previous 4 weeks (COCA).
- **Community onset healthcare associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has been an inpatient in the trust reporting the case in the previous 4 weeks (COHA).
- **Healthcare onset healthcare associated:** cases detected from a sample collected from the third day of admission (admission being day 1 – HOHA).

COVID-19 Apportionment:

- **Community Onset (CO)** includes inpatients who had a positive swab within 2 days from admission (admission counting as day 1). It also includes patients whose first positive swab was day(s) before admission
- **Hospital-Onset Indeterminate Healthcare-Associated (HOIHA)** includes inpatients who had a positive swab between 3 to 7 days from admission (admission counting as day 1)
- **Hospital-Onset Probable Healthcare-Associated (HOPHA)** includes inpatients who had a positive swab between 8 to 14 days from admission (admission counting as day 1)
- **Hospital-Onset Definite Healthcare-Associated (HODHA)** includes inpatients who had a positive swab 15+ days from admission (admission counting as day 1)

Agenda item: 22.C

Title:	Safeguarding Annual Report 2021-2022

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	24 November 2022		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

Summary:	The 2021/22 Safeguarding Annual Report provides an update to the committee on the activity undertaken by the Safeguarding teams at Bolton Foundation Trust. The report provides an overview on how the safeguarding agenda is linked to the objectives set out by Bolton Safeguarding Children's Partnership and Bolton Safeguarding Adults Board. It demonstrates how by working across the local community we are able to better serve and safeguard our vulnerable patients and service users. In 2021/ 2022 there have been no changes to statutory requirements for safeguarding adults and children, however the Domestic Abuse Act was published in 2021 and the report provides an overview of the key requirements. Bolton has seen an increased number of referrals and causes for concern since the start of COVID-19 with lockdowns considerably contributing to the rise in cases. The report provides narrative surrounding the increase in the number of referrals to the service which are in turn causing some challenges with regard to capacity, particularly within the safeguarding adult team. Throughout the year the Trust Safeguarding Committee has refocussed in order to ensure assurance is received from all Divisions in line with CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and the Care Act (2014). The next steps for 2022/23 are focused around: • Further strengthening the governance and reporting arrangements. • Reviewing the training needs of our workforce. • Strengthening our processes with regards to Deprivation of Liberty and Mental Capacity Assessments.
Previously considered by:	Clinical Governance and Quality Committee 2nd November 2022 Quality Assurance Committee 16th November 2022
Proposed Resolution	The Board of Directors are requested to: 1. Note the contents of the report 2. Note the next steps

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

Prepared by:	Bridget Thomas DND, Fiona Farnworth Safeguarding Children Sheila Mooney Safeguarding Adults, Lianne Robinson Deputy Chief Nurse	**Presented by:**	Tyrone Roberts Chief Nurse

Bolton NHS Foundation Trust

Safeguarding Adult, Children

and

Looked After Children Annual Report 2021/22

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Contents

1. Introduction

This 2021/22 Safeguarding Annual Report provides an opportunity to reflect on the achievements of 2021/22 and focus on priorities for 2022/23. This year's Annual Report will focus on the activity of adults, children and Looked After Children during 2021/22 and update on key priorities aligned to statutory and regulatory requirements.

In 2021/22 there has been no significant changes to statutory requirements for safeguarding adults and children, and the Trust continues to work within the same statutory guidance for both children and adults. The Domestic Abuse Act was published in 2021 and the report will provide an overview of the key changes.

We continue to see the impact of Covid-19 on our patients and service users, but we are pleased to provide continued assurance that we prioritise our most vulnerable to ensure they are protected, and their health needs are met.

2021/22 has seen some challenges in both the children and adults safeguarding teams with a period of time when there was no adult safeguarding lead in post following a retirement. This has now been resolved and an experienced safeguarding adult lead has been recruited who is building the safeguarding adult team and benchmarking the needs of the Trust against safeguarding adults' requirements. However, both teams continue to be challenged but work exceptionally hard to ensure the Trust meets is statutory requirements and patients are safeguarded.

The Executive team, safeguarding leads and all managers across the Trust remain committed to ensuring that the safety and protection of our patients and services users and staff remains a key Trust priority. The Trust Safeguarding Committee has refocussed in order to ensure assurance is received from all Divisions in line with CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and the Care Act (2014).

This report will provide an update that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services. This is in line with the Trusts statutory responsibilities and required regulatory and contractual standards.

2. Safeguarding Frameworks

2.1 Legislation

The duties of NHS providers to ensure any person in our care and who use our services are safeguarded is outlined in the NHS England - Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSE August 2019). Whilst safeguarding shares the same responsibilities and principals for adults and children, there are significant differences in the laws and policies that underpin practice. The overarching objective for both is to enable children and adults to live a life free from harm, abuse or neglect. The two key pieces of legislation governing safeguarding adults and children remain –

Children Act 1989/2004 (Children)	Care Act 2014 (Adults)

Trust safeguarding policies, procedures and training are underpinned by this legislation and include definitions and arrangements as to how Bolton NHS FT discharges its statutory safeguarding duties and a comprehensive list of the legislation can be found in **Appendix 1**.

2.2 Local Partnership Arrangements

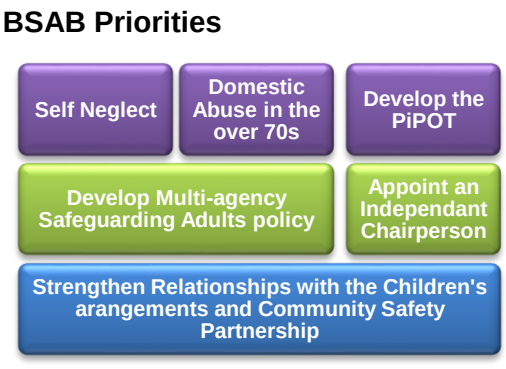
The Children and Adult Safeguarding Teams contribute to the local Safeguarding Partnership arrangements representing the Trust on a range of groups and committees. The team also provide assurance to the Clinical Commissioning Group (CCG) declaring compliance against NHS England Safeguarding Standards (Standard NHS Contract for All Services: Schedule C, Part 7.2). **As this report covers the period from April 2021 – March 2022, the CCG was still in operation.**

2.3 Bolton Safeguarding Adults Board (BSAB)

Diagram 1: Bolton Safeguarding Adults Board

The Trust is represented on Bolton Safeguarding Adults Board (BSAB) by the Associate Chief Nurse who ensures the priorities of the Board are reflected in the Trust safeguarding adult's agenda.

The BSAB coordinates the delivery of Adult Safeguarding across agencies ensuring that local safeguarding arrangements and partners act to protect adults who are at risk of abuse or neglect.

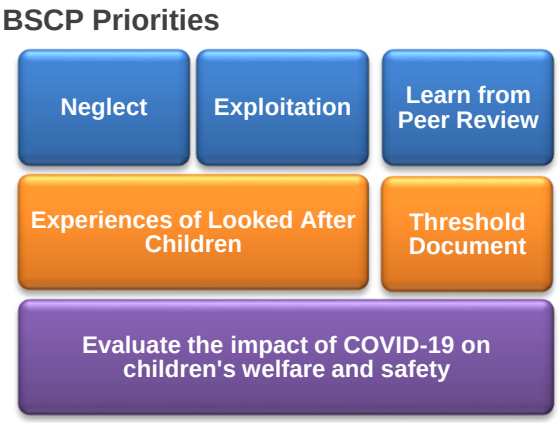


2.4 Bolton Safeguarding Children Partnership's (BSCP)

Diagram 2: Bolton Safeguarding Children Partnership

The Trust is represented on the BSCP by the Chief Nurse. The BSCP vision is to give all our children the best possible start in life, so that they have every chance to succeed, be safe and be happy.

The BSCP is led by the three statutory partners (Bolton Council, Bolton Clinical Commissioning Group and Greater Manchester Police). The partnership, supports and enables local organisations and agencies to work together to safeguard and protect children.



3. Governance Arrangements for Safeguarding

Bolton NHS FT has robust governance processes in place to ensure that culture in which safeguarding children and adults is everyone's responsibility across the Trust and all staff regardless of role who identity concerns, ask for advice and guidance when a safeguarding concern arises.

The Trust Board Executive lead for safeguarding children, Looked After Children and adults at risk is the Chief Nurse. The Trust Safeguarding Teams provide an integrated and consistent approach to safeguarding and the Trust Safeguarding Committee meets monthly to ensure there are robust arrangements in place and these are regularly reviewed.

The Committee provides challenge and assurance on the safeguarding arrangements within the Trust, and monitors compliance and benchmarking against regulatory standards and key clinical effectiveness indicators (including Care Quality Commission (CQC) outcomes). The Committee reports, advises and acts on findings to address any gaps in service. The Safeguarding Committee reports to the Quality Assurance Committee on a quarterly basis which informs the Trust Board.

See Appendix 2 for team structure

2.1 Governance Reporting Structure

Diagram 3: Trust reporting structure

As per statutory and regulatory requirements for Safeguarding there is a clear line of sight from floor to Board. With the Chief Nurse being Executive lead for safeguarding children, looked after children and adult safeguarding.

3.2 Named and Specialist roles

It is a Statutory requirement that there are staff in key safeguarding roles within health organisations. In line with the intercollegiate guidance, Bolton FT has in place named professionals with responsibility for adults, children and LAC.

During 2021/22 the Named Midwife was a combined role with an Enhanced Midwifery Team Leader post. Given the size and acuity of Maternity services, this has been reviewed and supported to become a stand-alone post as per Intercollegiate Guidance.

3.3 Reporting

The Trust Safeguarding Committee has adopted Signs of Safety approach within all assurance and reporting arrangements to the Committee to support a reflective approach to safeguarding across all Divisions and services. Therefore, all reports identify –

What's Working well	What is not working well	What needs to happen

Reports are submitted on a quarterly basis which provide assurance against our responsibilities against CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and the Care Act (2014).

3.4 Risk register

A number of safeguarding risks have been on the Risk Register within the timeframe of this report. These have been reported to the Trust Safeguarding Committee and updated regularly to reflect the actions taken and revised level of risk identified.

The risks include:

Diagram 4: Risks

- Safety of staff visits to a known site following police information
- Vulnerable children not linked to appropriate services or who are unseen
- Managing young people admitted to adult wards (16- and 17-year-olds) where there are mental health concerns.
- Managing complex young people who access Trust services from Specialist Care Placements (eating disorders)
- Workload and capacity of Safeguarding teams
- Identified gaps in working with Domestic Abuse and Complex Safeguarding.
- Knowledge and skills to accurately undertake DoLs and mental capacity assessments.

3.5 Audit

During 2021/22 a number of multi-agency and Trust wide audits were undertaken with findings, learning and recommendations reported to individual staff members and managers and the Trust Safeguarding Committee. Some of the audits are part of GM or local multiagency audits while others are in response to local and national vase reviews or internal reviews. Audits are presented to the safeguarding committee for assurance purposes and to ensure that the relevant learning is disseminated across divisions.

3.5.1 Audit Activity by the Safeguarding Children Team from April 2021 to March 2022

The safeguarding team have undertaken a number of audits in 2021/22. Findings from audits are shared with services involved to improve or change practice.

The table below shows the audits undertaken in 2021/22 by the safeguarding children team

Table 1: Audit activity undertake by safeguarding children team

Observations of Case Conferences	**• For consistency in health attendance & effective contributions and information sharing.**
LAC Health Assessments	**• To audit quality and LAC health plan**
MASSS Heath Referrals	**• To audit approriateness of health referals for child protection**
0-19 Observation of duty team	**• To monitor effectivenees and consistency of safeguarding advice given.**
GM Complex Safeguarding Auidt and Pre-audit	**• Contribution to a wider piece of work across GM**
Routine Enquiry in Maternity	**• To inform the work of the Enhancing Midwifery Team**
Health Referrals to Social Care	**• To monitor quality and appropriateness**
16 and 17 year olds on adult ward	**• To ensure their needs are met under the Children Act**

4. Impact of COVID-19 on Safeguarding

Safeguarding has been 'business as usual' at Bolton FT, throughout COVID-19 with all staff ensuring that safeguarding was prioritised. The safeguarding service has continued to provide advice and support in both acute and community. In 2021/22 the impact of Covid-19 on our patients and services users is ongoing and this included increased vulnerabilities.

The impact of Covid-19 on vulnerable children and adults and has continued into 2021/22 and resulted in increased referrals to Social Care and Police, with a significant increase in incidents of domestic abuse and violence during this period. The need to keep vulnerable adults and children safe is a core priority of our frontline teams however, Covid-19 put huge strain on the workforce and made previous home visiting and monitoring more challenging.

Issues have emerged during the pandemic and lockdown including

Table 2: Emerging issues

Children	Adults
• **Unseen vulnerable children**	• **Increase in domestic abuse by partners/family members**
• **Increased domestic abuse,**	• **Increase in Domestic abuse in over 70s**
• **Increased gang activity and criminal exploitation**	• **Increased Mental Health problems in women compared to men.**
• **Increased cases of neglect and emotional abuse**	• **Older people and disabled experienced depression and anxiety**
• **Child Exploitation/Sexual Exploitation**	• **Over 75s and disabled digitally excluded**
• **High school closures**	• **Increase In A/E attendances with Dementia**
• **Increase in self harm**	• **Increase in S42 Safeguarding adult enquiries for over 85s**
• **Low socio-economic families digitally excluded**	• **Impact on care home residents**

The safeguarding team have revised their training programmes to highlight these themes for frontline staff.

5. Safeguarding Children in Bolton

5.1 Priorities

In 2021/22 four practice areas were identified by the Safeguarding Children Team to be high priority which will continue into 2021/22 in line with GM and Bolton Children's Services strategic objectives.

These include:

1. Domestic Abuse

2. Mental Health presentations of CYP

3. Complex Safeguarding

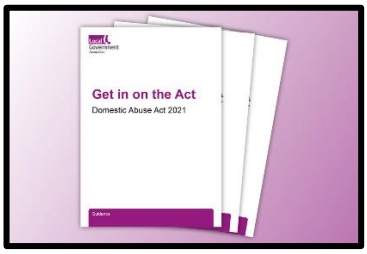
4. CYP - victims and perpetrators of crime

5.1.1 Priority 1 - Domestic Abuse

Diagram 5: Domestic Abuse

There has been increased demand across the region since the start of COVID-19 with lockdowns considerably contributing to the rise in cases.

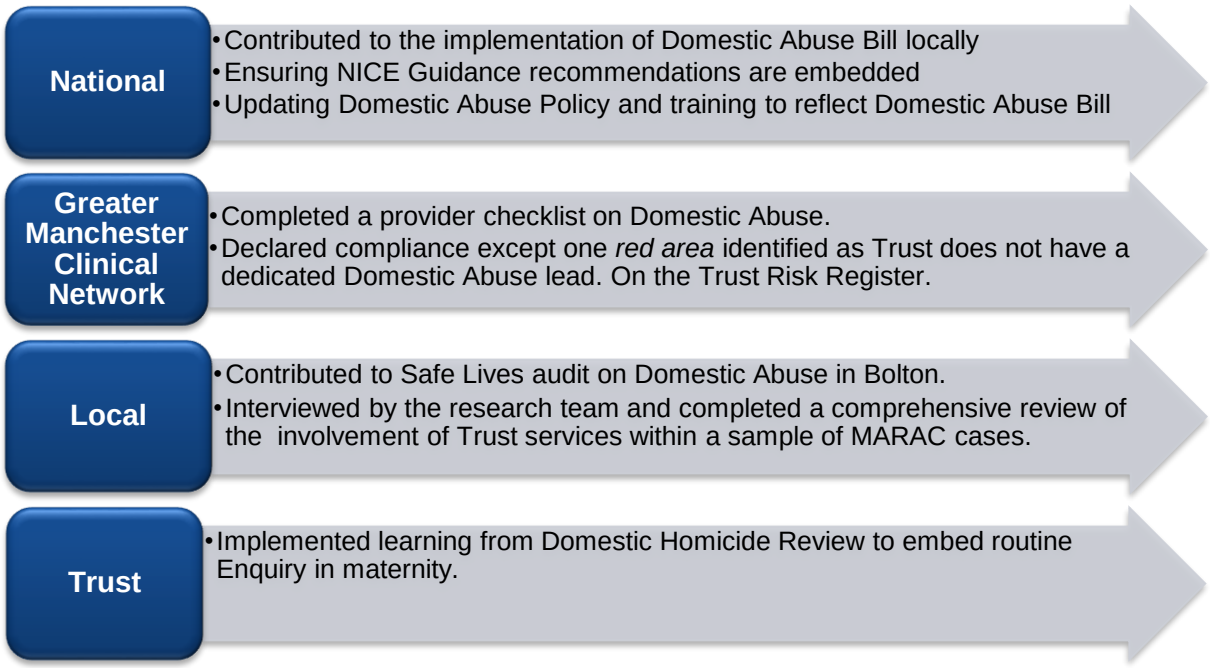
The Government during COVID-19 reported domestic abuse in households as "pressure cooker families" requiring increased vigilance and intervention.



Published in 2021 the Domestic Abuse Act legislation outlined a number of changes in legislation which included -

- Requirement to set up a Domestic Abuse Partnership Board
- Inclusion of new offences
  - Non-fatal strangulation,
  - Revenge porn
  - Threats to share intimate images.
- The definition of coercive control was updated.
- There are plans for Clare's Law to become statutory.

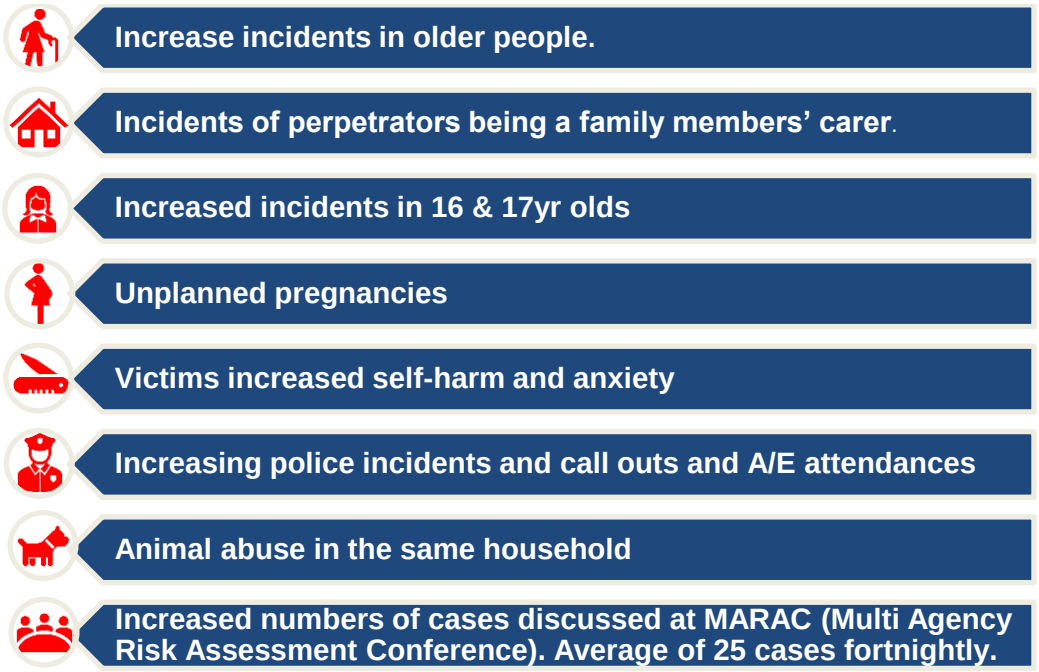
Diagram 6: Overview of work on Domestic Abuse undertaken by Safeguarding Team in 2021/22



Impact of Domestic Abuse

The safeguarding team in Bolton has supported staff across the Trust who have seen increased prevalence in the areas described below across the Trust.

Diagram 7: Impact of abuse



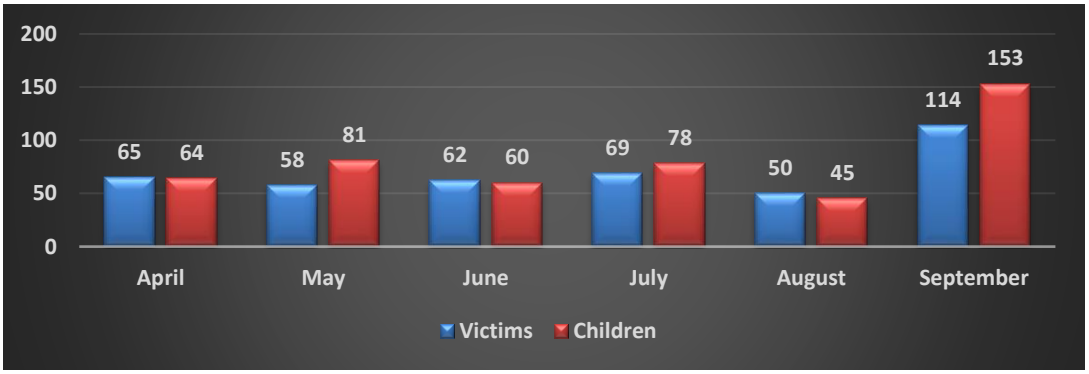
MARAC (Multi Agency Risk Assessment Conference)

The chart below shows the increase in the numbers of MARAC cases discussed in Quarter 1 and 2 (April to September 2021). The data shows the volume of children affected in Bolton in cases heard at MARAC. These are high level Domestic Cases whereby interventions are needed to prevent serious injury or Domestic Homicide.

Safeguarding Children's Nurse represents the Trust at MARAC and has seen meeting frequency increased to fortnightly from monthly due to increase in referrals.

These figures do not include routine callouts by police or individual disclosures to health staff.

Chart 1: MARAC referrals Q1 and Q2



Domestic Abuse Audit

In response to learning from a DHR published in 2021/22 the safeguarding team undertook a maternity records audit was undertaken in July 2021 to support embedding routine enquiry about Domestic Abuse in pregnancy is standard practice across maternity services.

The results were as follows :

68 patients were involved

Table 2: Audit findings

Audit Question	Yes	No	No answer	Total	Findings
Seen alone at booking	**61**	**1**	**6**	**68**	- Women were seen alone to support a discussion about Domestic Abuse at booking. - Direct questions were not used at later in pregnancy or postnatally. - **Questions can't be asked when suspected perpetrator present.** - **Women may not be ready to disclose Domestic Abuse.**
Seen alone further appts	**1**	**0**	**67**	**68**	
Routine enquiry booking	**62**	**0**	**6**	**68**	
Routine enquiry further	**1**	**0**	**67**	**68**	
Domestic Abuse Disclosed	**2**	**59**	**7**	**68**	

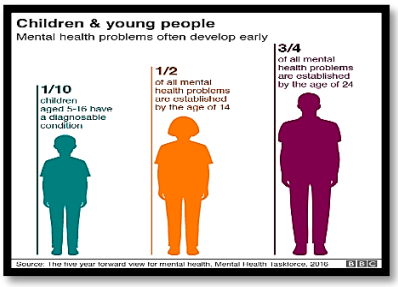
Key messages were shared with maternity services following audit :

- Expectations of NICE Guidance (supporting disclosures of domestic abuse).
- Evidence regarding increasing likelihood of Domestic Abuse escalation in pregnancy to support direct questions being asked.

5.1.2 Priority 2 - Mental Health Presentations of Children and Young People (CYP)

COVID-19 has caused unprecedented disruption in children's lives, affecting emotional, cognitive and social development. Known risk factors have intensified, e.g. socioeconomic, social isolation and bereavement.

Access to sources of support has reduced e.g., friends, schools and activities. There is substantial concern that the pandemic may have long-lasting negative impacts on child mental health.



There has been work across GM to standardise and strengthen the response to children and young people considered to be in crisis.

GM procedures – Child and Young People in crisis support and escalation framework is still being developed but has already been adopted in part in some areas.

Bolton FT

The Safeguarding Children Team and colleagues in Mental Health Services and Children's Social Care all have a part to play in managing risk and providing support to children and their families. In 2021/22 the team have supported an increase in presentation of CYP to A/E the main presentations have been :

Self- harm	Suicidal ideation	Overdose

In addition, in 2021/22 has seen an increase in A/E attendances for young people with eating disorders not previously known to services and requiring medical review or admission has increased. All complex cases require escalation where there are difficulties in arranging discharge from hospital once medically fit.

Learning from Mental Health Local Review

The sad death in 2020 of a 16-year-old patient with mental health issues had a profound effect on the Trust and all the staff involved. As a result, extensive learning and changes in

practice have taken place to ensure that 16 and 17-year-olds with mental health presentations are managed appropriately and safely when admitted.
Although immediate changes were implemented in 2020, additional changes have been implemented during 2021/22 which aligned with the internal Serious Incident recommendations and 4 recommendations out of 28 for Bolton FT from a multi-agency Child Safeguarding Practice Review, these included :

Diagram 8: Learning from reviews

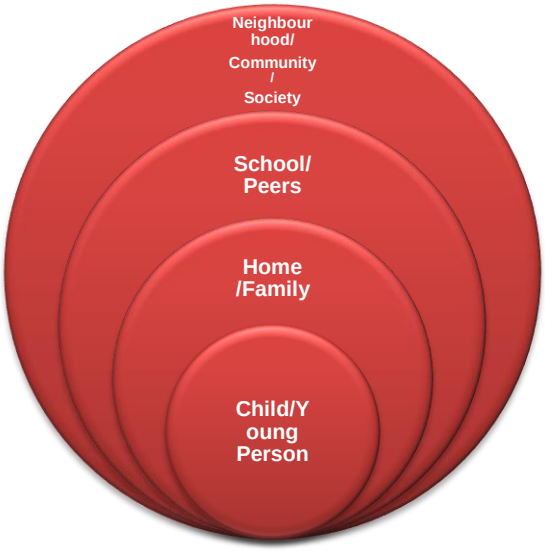
- **SBAR** (Situation, Background, Assessment, Recommendation) for 16- and 17-year-olds admitted to adult wards.
- **Documentation** - Safeguarding team notes available on EPR (Electronic Patient Record).
- **Standard Operating Procedure** (SOP) - For Management of 16- and 17-year-olds.
- **Admission** - Adjusted admission documents to capture needs of 16–17-year-olds on adult wards.
- **Database** - Live database 16- and 17-year-olds available
- **Discharge** - Focus on delayed discharge and external escalation when medically fit for discharge.
- **Audit** - To identify baseline and monitor progress of actions embedded.
- **Training** - We Can Talk and Suicide Awareness training for staff
- **Policy** - Merged Missing Policy for adults and children in to one all age documents.

5.1.3 Priority 3 - Complex and Contextual Safeguarding

In Greater Manchester Complex Safeguarding is used to describe Criminal Activity (often organised), or behaviour associated to criminality, involving vulnerable children/young people, where there is exploitation and/or a clear implied safeguarding concern.

Diagram 9 &10: Complex safeguarding

Complex Safeguarding requires focus on contextual safeguarding which differs to our current traditional model of safeguarding which focuses largely on the risks to the child within the family.



A contextual approach focuses on those external 'contextual risks' that our children also face within the community, schools, public spaces, transport, peer group and online and considers interventions to change the systems and conditions in which this type of abuse occurs.

In 2021/22 the safeguarding team have seen an increase in Complex Safeguarding cases and have worked hard to ensure that frontline practitioners are supported to recognise and responding to the many facets of Complex Safeguarding.

This year training has been updated to ensure it captures emerging themes across Bolton and nationally. The team also represents the Trust at Bolton's CSE and Missing Steering Group (CEAM). As this work is complex and ongoing, the team will continue to prioritise this in 2022/23.

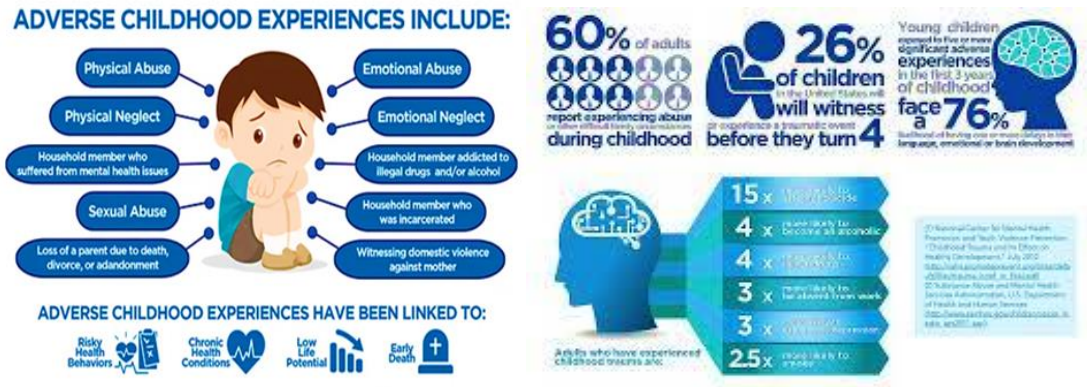
Adverse Childhood Experiences (ACEs)

The continued and growing recognition of ACEs (Adverse Childhood Experiences) and their links to both Complex and Contextual Safeguarding is significant for children and young people in all the practice areas and particularly in CSE and CCE.

In 2021/22 a local prevalence study took place in Bolton to highlight the impact of that ACEs can have on children. This study found that increased ACEs lead to vulnerabilities, exploitation, violent behaviour and abuse.

In 2021/22 the Safeguarding team have continued to embed the recognition of ACEs across all areas of practice, and this will develop further in 2022/23.

Diagram 10: ACEs



Trauma Informed Practice

The focus on Trauma Informed Practice, supports an approach where staff see safeguarding concerns not as isolated problems but as part of a wider picture of causes and needs where support and interventions are required.

Diagram 11: Trauma informed practice

5.1.4 Priority 4 - Child Criminal Exploitation (CCE)

While staff have developed knowledge and skills in working with children and young people at risk of Child Sexual Exploitation (CSE) there has been less working knowledge of Child Criminal Exploitation (CCE).

Diagram 11: Child Exploitation

Known direct targets CYP	
• No strong support networks • No previous criminal record • Unlikely to be stopped by police • Emotional, mental ill-health or learning disabilities • Non-UK citizens or do not have immigration status • Looked after in children's homes or out of area • May be living in poverty	

There is growing evidence that vulnerable children and young adults are specifically targeted for criminal purposes, although any child can be at risk.

Diagram 12: Child Exploitation

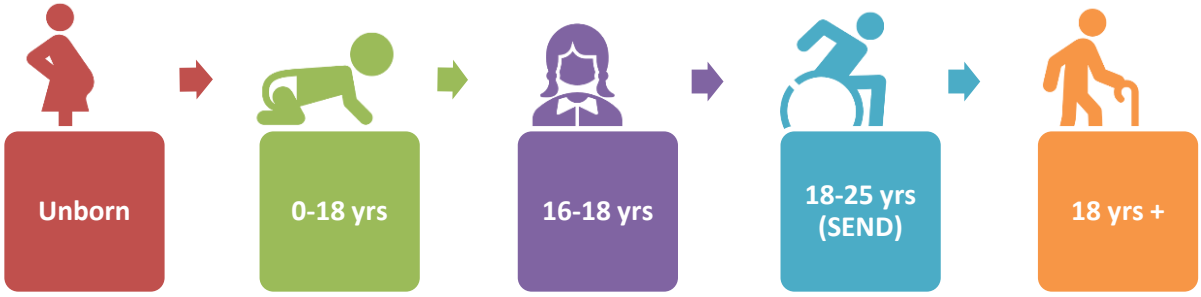
Bolton FT have no dedicated resource for the growing demands of CSE and CCE to provide a health offer to children and young people who are victims. This is included on the Trust Risk Register. To mitigate, the Specialist Safeguarding Nurse in the 0-19 Adolescent service supports the local CEAM meeting (Child Exploitation and Missing meeting). However, this is in addition to the day to day safeguarding work.

Children and young people who are victims or perpetrators of violent crime

This has been recognised across agencies as a concern locally in Bolton. The Tackling Serious Youth Violence project in Bolton includes a number of services and providers including the Navigator project. The Safeguarding Children team work closely with the Navigator project workers to implement processes where children and young people who attend A&E with injuries from violent crime can be referred to the project. The Safeguarding Children Team make referrals to Navigator if these have not been completed in A&E.

6. Safeguarding Activity

Safeguarding remains a complex and changing area of practice. The remit of the Safeguarding Children Team extends beyond children under the age of 18. This includes



Abuse and harm to children and young people can happen in a variety of contexts and can take many forms, some of which are not obvious or easily identified.

In Bolton the Continuum of Help and support is use as a framework for intervention to ensure the correct help at the

right level is available to children and families across Bolton.

6.1 Developments in Bolton Partnership in 2021/22

- **Integrated Front Door**
  - In July 2021 the MASSS (Multi-Agency Safeguarding Screening Service) in Bolton was replaced by the IFD (Integrated Front Door).
  - This provides x a single point of contact to the Social Work assessment team, working alongside the Early Help access point.
  - The Police and a Specialist Safeguarding Nurse who is part of the Trust Safeguarding Children Team, are co-located with the IFD.

- **Framework for Action (FFA)**
  - The threshold document for all agencies across Bolton. was revised and launched in July 2021
  - This ensures that children that require help and support receive this at the appropriate level

6.2 Bolton NHS FT Safeguarding Activity

The Trust safeguarding team undertake a range of safeguarding activities that support staff and improve outcomes for vulnerable children and young people. Advice and guidance is provided by all members of the safeguarding children team on a daily basis and contacts are made by phone or email. There may be a number of discussions about the same child or family.

6.2.1 Daily duty response to referrals from A&E

The Paediatric Emergency Department (PED) see vulnerable children on a daily basis. The Safeguarding team undertake an annual review with PED of cases that require an internal referral to the Safeguarding Children team and criteria are jointly agreed and shared with all staff, this happens bi-monthly and is co-ordinated by an A&E Consultant and Specialist Safeguarding Children Nurse.

The majority of referrals from A&E to the Safeguarding Children team do not result in onward referrals to Children's Social Care, however actions are taken to support the assessment of risk and identify support for the child or family.

In 2021/22 the Safeguarding Children Team received daily referrals for

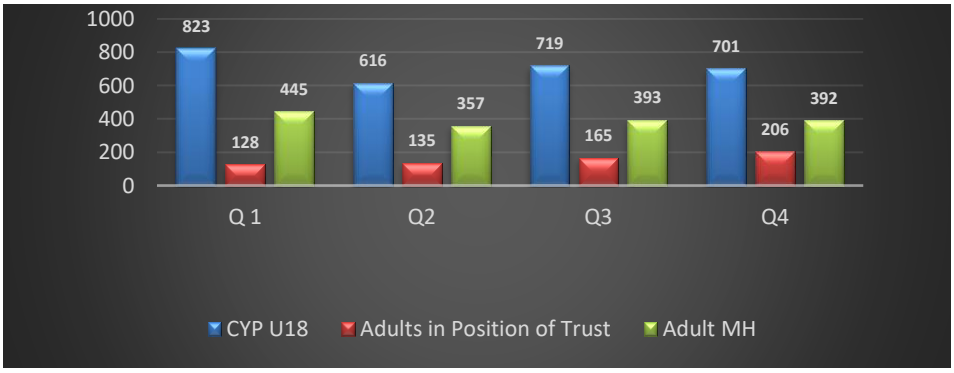
Diagram 13: A&E safeguarding referrals

6.2.2 Safeguarding Team Referral Data 2021/22

Table 3: Safeguarding children referral data

Month	Children (under 18)	Adults who are parents/carers or in a position of trust	Mental Health (adults who are carers and children)
Q1 Total	823	128	445
Q2 Total	616	135	357
Q3 Total	719	165	393
Q4 Total	701	206	392

Chart 2: Safeguarding children referral data



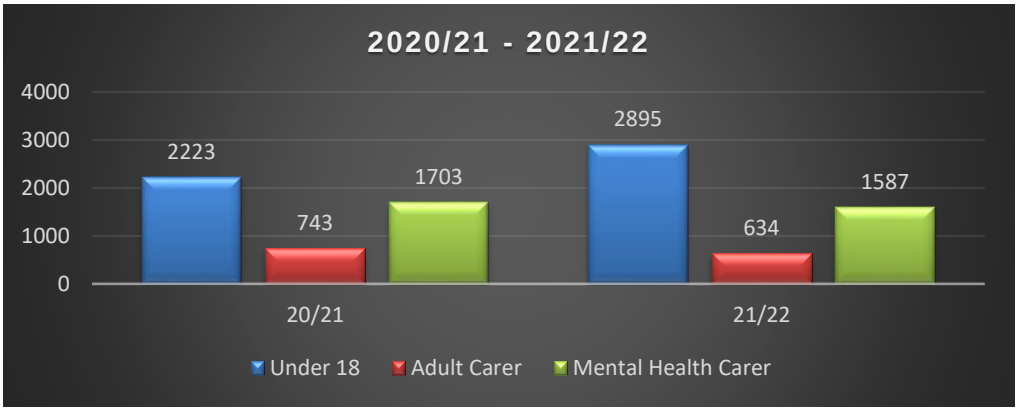
6.2.3 Total Referral in 2021/22 in comparison to 2020/21

The figures below demonstrate a 22% increase in children referrals in 2021/22 compared to the previous year and decrease in the number of referrals regarding persons in a position of trust.

Table 4 : Referral comparison data

23% **increase in all categories of abuse from 2020 - 2021**	**34%** **increase in all categories of abuse from 2019 - 2021**	**31%** **increase in Neglect from 2019 - 21**
38% **increase in Emotional abuse from 2019 – 21**	**27%** **increase in Sexual abuse from 2019 - 2021**	**30%** **increase in Physical abuse from 2019 – 2021**

Chart 3: Referral comparison data



6.2.4 Bolton Child Protection Data

The following chart shows a 3-year comparison of the categories of abuse that children in Bolton are subject to a **Child Protection Plan (CPP)** to protect them.

Table 5: Children subject to CPP

Child Protection Plan at 31st October 2021		Category of Abuse				
Year	**Total CPP**	**Neglect**	**Physical**	**Sexual**	**Emotional**	**Multiple**
2021	494	214	30	33	205	12
2020	381	180	20	28	136	17
2019	325	147	21	24	126	7

There is a year-on-year increase in the number of children subject to a CPP in Bolton as outlined below.

6.2.5 Analysis

- Over 100 more children subject to Child Protection plan in Bolton in 2021 compared with 2020.
- Highest increase in Neglect and emotional abuse which links with increased domestic abuse.
- Significant increase in the number of under 18 referrals to the safeguarding team in 2021/22 compared to 2020/21. New data collection by the safeguarding children team has identified the following themes and trends:
    - Increase in the attendance of children who don't live in Bolton
        - Information sharing for out of area children time consuming and at times problematic. This includes identifying the lead professional for the family and who to escalate concerns to if there are actions required.
    - Further information is often required to identify the level of risk to the child due to limited details on the referral.
        - This includes gathering information on the wider family including parents and siblings. Information given in A/E may not have been gathered or recorded and in some cases incorrect or misleading information has been provided to A/E staff.
    - The Safeguarding Team supports multi-agency meetings to discuss a child or family in more complex cases (for example strategy meetings, discharge planning meetings, Professionals meetings, Best Interest meeting).
        - These are often arranged for the same day/next working day, impacting on the day-to-day work of a small team.
    - The Safeguarding Team is a point of contact for Social Workers on a daily basis to enquire about A/E attendances of children who are subject to a Child Protection Plan or who are Looked after Children who have flagged on the a CP-IS alerts.
    - In a small number of cases concerns identified in A/E have not been shared with Social Care while the child is in A&E, this relies on the duty safeguarding nurse undertaking this, again impacting on the day-to-day work of a small team.
    - Presentation of numbers of younger children with emotional/mental health or significant behavioural concerns impact on the work of the team.

7 Safeguarding Reviews

The safeguarding children team have contributed to a number of statutory reviews within the time frame of the annual report. This includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust services. There is also a requirement to attend panel meetings, practitioner learning events, sign off panels to agree final reports and meetings about publication and publicity arrangements. All reviews include children and families that reside in Bolton and also those who live in other areas but who have accessed Bolton FT services.

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

7.1 Domestic Homicide Reviews (DHR)

A DHR is convened by the Community Safety Partnership as a multi-agency review into the circumstances of the death of a person over the age of 16 as a result of violence, abuse or neglect by a person to whom they were related or who they have been in an intimate relationship with or another family or household member.

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

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

7.2 Rapid Reviews and Child Safeguarding Practice Reviews

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

A number of reviews were in progress within the timeframe of the annual report including reviews for children out of area who had accessed services provided by the Trust.

The following is an overview of the Rapid Reviews and Child Safeguarding Practice Reviews that have taken place in 2021/22. All names and initials anonymised.

In summary in 2021/22 the safeguarding team on befall of the trust has contributed to the following reviews:

Diagram 13: Number of safeguarding reviews

7.2.1 Overview of Reviews

Table 6: Details of reported reviews

Identifier	Type of Review	Overview
AS	**Rapid Review**	**Death of an infant found to be co-sleeping where there were parental risk factors in place.** • Included in the thematic review of 3 infant deaths outlined below. • Specific learning in relation to parental alcohol use.
OE	**Rapid Review**	**Death of an infant of natural causes.** • Subject to an internal SI and included in the review of 3 infant deaths below. • Specific learning in relation to child neglect, un-booked pregnancy and working with resistant families.
Male infant out of area	**Rapid Review**	**Near drowning of a 9-month-old in the family home.** • Child sustained significant long term health condition as a result. • Consideration and implications for this child and sibling.
Female infant out of area	**Rapid Review**	**Death by drowning of a 2-year-old outside the family home.** • Police investigation is on-going. • Considered to be abuse or neglect at the time of death.
"Sarah"	**Child Safeguarding Practice Review**	**Death of 16-year-old from suicide.** • Learning on management of metal health admissions for 16 and 17-year-olds. • Findings from the review were submitted to Ofsted by LA. • Presentation to the Trust Safeguarding Committee to highlight learning and recommendations.
3 Infant deaths	**Thematic Review**	**Completed in September 2021 to review the deaths of 3 infants where vulnerability factors and safe sleeping factors were identified**. • Attended by 0-19 service, Maternity and Trust Safeguarding Children team representatives. • Final report including recommendations from the National Child Safeguarding Practice Panel to be shared with key services.
3 reviews including Child R	**Local Safeguarding Reviews**	**14-year-old who died as a result of a stabbing and two young people were charged with murder.** • Need to understand the child's lived experience, Adverse Childhood Experiences and their impact on learning, behaviour and school absence. • Requirement for robust assessments and plans • Children in families who experience domestic abuse
Family G	**Serious Case Review**	Completed in 2019 but publication delayed due to Coronial Process. • Inquest in January 2021 into the deaths of the 2 children • Local and national media interest. Final report published following conclusion of the Coronial Process.
DHR from a historical case	**Domestic Homicide Review**	Adult male death – the criminal case has concluded. • No recent contact with adults or children in the family by Bolton FT services. • Report provided based on KLOE and historic information.
DHR "Laura"	**Domestic Homicide Review**	Adult female death. Child in the care of the perpetrator at the time of 'Laura's' death. • Report and representation at the Panel provided by the Safeguarding Children Team

7.3 Learning from National Reviews

National reviews into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson in 2020, both murdered as a result of sustained abuse and neglect by their caregivers, was reported nationally and details of the circumstances surrounding their deaths were published in 2021. There is learning for all agencies from both tragic cases as follows:

Table 7: Learning from National Reviews

Professionals and family members had previously thought their parents capable of providing good care to them. History of domestic abuse in both cases.
Lack of information sharing, professional challenge , risk assesment and decision making across agencies.
Escalating concerns from family members to professionals and evidence of physical abuse not acted on.
Understanding the daily lived experience of the child and engagement with reluctant parents

7.4 Achievements of staff in Specialist and Named roles

The Team have maintained a supportive advice and guidance on site service throughout Covid restrictions and the following are achievements in 2021/22. Despite being a small team, the safeguarding children team has provided support across the Trust to all staff, been active and effective at partnership meetings and have aligned with GM procedures.

Table 8: Team achievements

Safeguarding Team Achievements 2021/22	
Effective and continued engagement with partners and for high-risk panels – • MARAC (Multi-Agency Risk Assessment Conference), • MAPPA (Multi-Agency Public Protection Arrangements), • Channel • CEAM (Child Exploitation and Missing)	✓
Effective and timely response to all requests for support including – • Social Workers requesting a Child Protection medical • Initial Health Assessment (IHA) is required because a child has become LAC. • Mental Health admissions for under 18s	✓
Effective joint working with colleagues in MHLT (Mental Health Liaison Team) to ensure processes of escalation and support are in place and understood.	✓

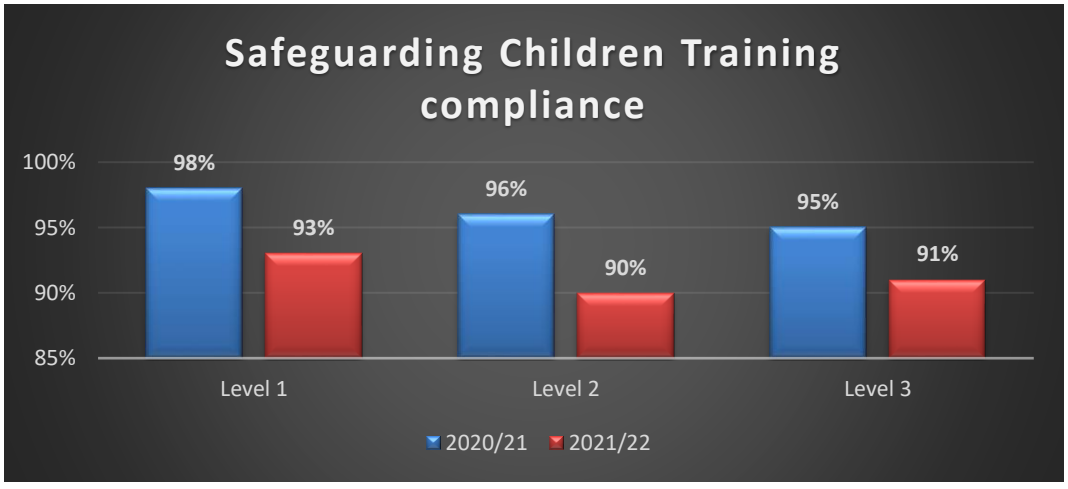
Supported safe discharges from hospital where children and young people are medically fit but have emotional health and wellbeing ongoing concerns.	✓
Effective Peer Review and attendance at A&E Safeguarding meetings as a supportive learning environment	✓
Contribution to the multi-agency Neglect Strategy and group across the Bolton Partnership.	✓
Named Nurse is chair of the Child Safeguarding Practice Review Group	✓
Contributed and represented the Trust on a range of safeguarding reviews.	✓

7.5 Compliance with Safeguarding Children Training

Due to Covid restrictions, all training in 2021/22 was via E-learning. This was as advised by NHS England. Compliance feel in 2021/22 across all levels, however in 2022/23 work will be undertaken across all Divisions to complete a Training Needs analysis to ensure all staff are undertaking training at the correct level to meet the competencies set out in the Intercollegiate Guidance Safeguarding children and young people - roles and competencies The Trust Compliance for Statutory Safeguarding training is 95%.

The chart below shows 201/22 compliance as compared with 2020/21. It should be noted that L3 compliance is based on Family Care Division where all clinical staff band 5 and above will require Level 3 training, these figures include medical staff.

Chart 4: Safeguarding Children compliance



8. Looked after Children (LAC) and Care Leavers

The majority of children and young people who become looked after in Bolton are victims of abuse or neglect. However nationally in recent years there has also been an increase in the number of Unaccompanied Asylum-Seeking Children (UASC), and children who have been trafficked and/or exploited entering the care system.

In Bolton in 2021 **617** children were looked after, a rate of **90 for every 10,000 children**. This is lower than North West region (97 per 10,000) and is higher than England (67 per 10,000).

Looked after children have many of the same health risks and problems as their peers but the extent of those issues is often exacerbated by their experiences of poverty, abuse and neglect.

Table 9: LAC and Care Leavers health risks

Looked After Children (LAC) and Care Leavers	**Emotional and mental health problems is between 45% and 72% compared to 10% in non-LAC peers.**
	Higher levels of teenage pregnancy, drug and alcohol abuse
	Significantly over represented in the criminal justice system.
	Two thirds found to have developmental and physical health issues such as speech and language problems, continence issues, coordination difficulties and sight problems.
	11% have been found to be on the autism spectrum.
	Health and wellbeing of young people leaving care has consistently been found to be poorer than that of young people who have never been in care.
	Special Educational Needs and Disability (SEND), over represented in the care system
	9 times more likely to have an Education and Health Care Plan, (EHC plan) than the general pupil population

8.1 Looked After Children workforce

The Trust arrangements for named professionals for LAC and staff in a specific LAC role is not fully aligned to Intercollegiate Guidance with the Named Nurse for Safeguarding Children undertaking the Named Nurse for LAC role, where a separate role is required to meet

statutory and regulatory requirements. This arrangement is subject to review; however, Bolton is not an outlier with regard to LAC staffing and other organisations across Greater Manchester have similar arrangements. Regular review is based on clinical workload and capacity of those in a specific role to continue to offer detailed oversight of Trust services to Looked after Children.

Named professionals contribute to multi-agency working as medical advisors to the adoption and fostering panels and are linked to the Corporate Parenting Board and Permanency Panel and health economy wide meetings and forums. The Trust LAC group has a distinct action plan based on the safeguarding standards and this feeds into the Trust Safeguarding Committee.

8.2 Looked After Children data

Monthly LAC data is gathered to monitor compliance with timescales for statutory health assessments for children in care which is reviewed within the Trust prior to submission to the Commissioner. The timeliness and quality of statutory health assessments requires scrutiny and prompt action if concerns arise. Compliance data provides evidence of the effectiveness of agreed LAC pathways. On a monthly basis actions are taken where barriers are identified.

Most children who are looked after in Bolton are Bolton residents, however there are children who are placed in Bolton from other areas and responsibility for the provision of health assessments for these children lies with the Trust. The numbers of children who require statutory health assessments varies widely every month depending on the circumstances and number of children entering the care system. The continued fluidity of the LAC population is challenging in practice due to fluctuating numbers which require health assessments this also includes children with complex health needs or at high risks.

8.2.1 Initial Health Assessments (IHA)

These should be completed within 20 days of becoming looked after with an expected compliance of 95%.

Table 10: IHA completion

Total Initial Health Assessments due	**153**
Number completed within 20 working days	**106 (69%)**
Number of additional IHA completed within the month but outside timescales	**47 (31%)**

Reasons for non-completion within time scales

Diagram 14: Reasons for none completion

• 80% due to a delay in Social Care providing statutory paperwork in a timely manner. • Delay in notification by Social Care, • Part A of the statutory paperwork not completed by Social Worker. • Parental consent not available or late.	• Children were not brought to the appointment. • Cancelled by Carer, • Cancelled by young person, • Unable to engage with young person, • Health staffing/capacity/staff sickness.

As a flexible and timely response to support completion of IHA, the Named Doctor for LAC aims to see children within the month that they become LAC for their IHA. This means scheduling additional appointments, however attendance and completion of the IHA is consistently over 90%. This demonstrates a continued priority for administrative and medical staff of the importance of assessment of health needs of children entering care.

8.2.2 Review Health Assessments (RHA)

RHA are completed by community-based nurses (Health Visitors, School Nurses, Special School Nurses, Specialist Nurse LAC) either every 6 months for children under the age of 5 or annually for children over the age of 5. There has been an improved annual compliance with statutory timescales noted with health assessments completed within month providing evidence of the priority and flexible provision to Looked after Children.

Table 11: RHA completion.

Total Review Health Assessments due	**550**
Number completed within timescales (6 monthly Under 5s, annually over 5s)	**461 (84%)**
Number of additional RHA completed within the month but outside timescales	**89 (16%)**
Total % on time /within month	**88%**

The completion of RHAs in 2021.22 were affected by school closures as many RHA are undertaken in schools and nurseries.

8.3 LAC Quality Assurance process and audit

Audit arrangements are in place to monitor the quality of health assessments for LAC. All new staff are required to have 10 RHAs quality assured through annual management reviews. For other staff, dip sample audits are carried out twice a year. The aim of all audit

activity is to show continuous learning and improvement to support better outcomes for children rather than being purely a focus on compliance with timescales.

8.3.1 2021/22 Dip sample audit

Two audits were completed in April 2021 and November 2021. The results highlighted the following -

- Quality of EHA health assessments were good with some excellent examples of holistic health assessments.
- Good practice was evident including
    - The use of appropriate language in completing the health assessments,
    - Enquiring about and recording significant relationships
    - Evidence of excellent communication with a young person who was reluctant to engage but did complete the health assessment.

CCG colleagues were part of the audit team and provided the following comments -

"It was a pleasure to read such quality health assessments and share the child/young person's journey. I was able to understand what life was like for the child. It is testament to the ongoing training, support and quality assurance measures that the Trust have in place and I thank everyone for their valued contribution in making this happen"

8.4 Health Profile Tool

There is a requirement to collect data on the health needs of Looked after Children as part of annual Safeguarding and LAC standards. Building a health profile supports better understanding of the needs of LAC in order to provide responsive services, identify themes and trends, provide data to evidence complexity and to support the tracking of children considered to be high risk.

The Health Profile pro-forma is used for every child who enters care. A RAG rating supports children and young people who require an urgent review or follow up.

The assessment information considered in the health profile included eight domains of concern

Table 12: Domains of concern

1. Physical health including dental	**2. Mental/emotional health or behaviour**	**3. Substance use**	**4. Exploitation / risk**
5. Opportunities for Education / Employment/Training	**6. Age appropriate – development/independent living skills**	**7. Impact of neurodevelopmental disorder or communication issues**	**8. Factors individual to the child e.g. unaccompanied asylum seekers**

8.4.1 Bolton Health Profile

In 2021/22 **153** IHA were completed, and a health profile was completed on all of these reviews which showed the following -

- **41 (27%)** Children had **0-1 domains** - **Low areas of concern requiring action**
- **82 (54%)** Children had **2-4 domains** – **Medium areas of concern requiring action**
- **30 (19%)** Children had **4-8 domains** – **High areas of concern requiring action**

The number of **medium** and **high** variances/areas of concern demonstrates the complex picture and needs of children entering care in Bolton.

Diagram 15: The highest level of variance / areas of concern was found in the following domains

The plan for 2022/23 is to add the health profile on to EPR so that all services can access this information to ensure the best outcome for the child/ young person.

8.5 New care homes and placements.

The CCG and Specialist Nurse for LAC continue to visit all care home placements on an annual basis to safeguarding and senior staff. All cases are managed on an individual basis depending on needs and concerns about the child or young person.

The numbers of private care home placements in Bolton for very complex children and young people has risen, with the majority of residents from out of area so not known locally to Trust services. These placements support children and young people with complex and long-standing issues including eating disorders, mental health and behavioural difficulties.

The safeguarding team will continue to work with partners to support the LAC agenda and ensure a high-quality health service is delivered for our young people to achieve best possible outcomes.

9. Safeguarding Adults

It is every member of staff's responsibility to ensure the safety and protection of all vulnerable adults in our care and who use our services. All organisations have a responsibility to ensure that there is a culture which takes all concerns seriously, ensures transparency and escalates concerns appropriately as outlined in the Care Act 2014. The Care Act is the key legislation that underpins all adult safeguarding work.

9.1 Key Principles of Safeguarding Adults

The Care Act 2014 emphasises six key principles:

9.2 Categories of abuse as described by The Care Act 2014 *(diagram 16)*

9.3 Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) is about having conversations with people on how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

The Care Act advocates a person-centred rather than process-driven approach. This is a key requirement of the Care Act and a priority for the adult safeguarding team in 2022/23 when the new safeguarding lead is in post and has a team to support.

MSP is essential to ensure that any support offered and/or provided is person centred and tailored to the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any Safeguarding process must stay in control of decision making as much as possible.

9.4 Bolton Adult Safeguarding Board

Bolton Safeguarding Adults Board (BSAB) has a statutory responsibility or legal duty to ensure that Bolton has an effective multi-agency response to safeguard our most vulnerable adults that fall into the criteria of the Care Act 2014 and ensure measures are in place to prevent abuse. The board is also legally responsible for carrying out reviews of serious cases to ensure that lessons are learnt and to ensure a more joined up partnership approach to safeguarding issues.

9.4.1 Bolton Safeguarding Adult Board Strategic priorities 2020-2023

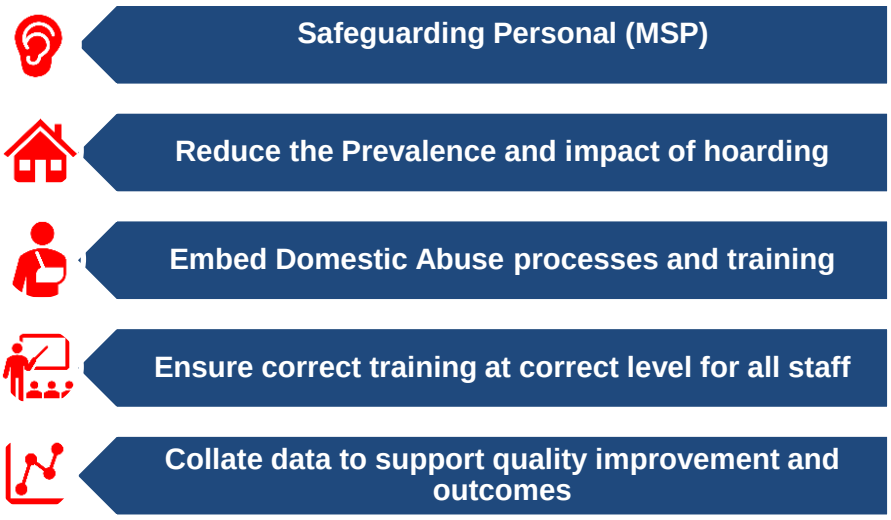
Bolton FT safeguarding adult's agenda reflects the priorities of Bolton Safeguarding Adult Board. While there has been challenges with a limited team in 2021/22, the new team is developing and will align with the BSAB priorities in 2022/23.

In addition, the team will work to ensure that the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is embedded and well understood across the Trust to ensure that patients in our care are not detained illegally.

Another priority will be to work closely with the safeguarding children team on a 'Think Family' approach to safeguarding and in particular in relation to Domestic Abuse.

9.4.2 Bolton Safeguarding Adult Priorities

Diagram 17: BSAB priorities



9.5 Safeguarding Adult Statistics

9.5.1 National data

- In 2021/22 there was an estimated **541,535** concerns of abuse raised, **an increase of 9%** on the previous year.
- **Section 42 enquiries** (safeguarding adult enquiries) **increased by 6% to an estimated 161,925 and involved 129,685 individuals.**
- Other safeguarding enquiries where there may not be reasonable cause to suspect that statutory Section 42 criteria are met but where local authorities use other powers to make enquiries, is reported to be **22,590.**
- The most common type of risk in Section 42 enquiries that concluded in 2021/22 was **Neglect and Acts of Omission, accounting for 31% of risks**,
- The **most common location** of the risk was the **person's own home at 48%.**

9.6 Bolton Safeguarding Adult data

Number of adults in Bolton aged 18 and over - 219,317

Table 13: Age profile

Age profile	Bolton	England
Percentage of population who are adults aged 65+	**17.4%**	**18.5%**
Percentage of population who are adults aged 18-64	**58.7%**	**60.1%**

The following chart provides a comparison with the number of safeguarding adult concerns in Bolton, North West and England before, during and as we emerge from the Covid-19 Pandemic.

9.6.1 Figures show the year on year increase nationally *(Table 14)*

Concerns/S42	2019/20	2020/21	2021/22		
	England	England	England	North West	Bolton
Number of Concerns raised	475,560	498,260	**541,535**	**64,880** (12% of national concerns raised)	**3265** (5% of NW concerns raised)
Number of Section 42 Investigations	161,910	152,270	**161,925**	**21,585** (13% of national S47)	**790** (4% of NW S47)

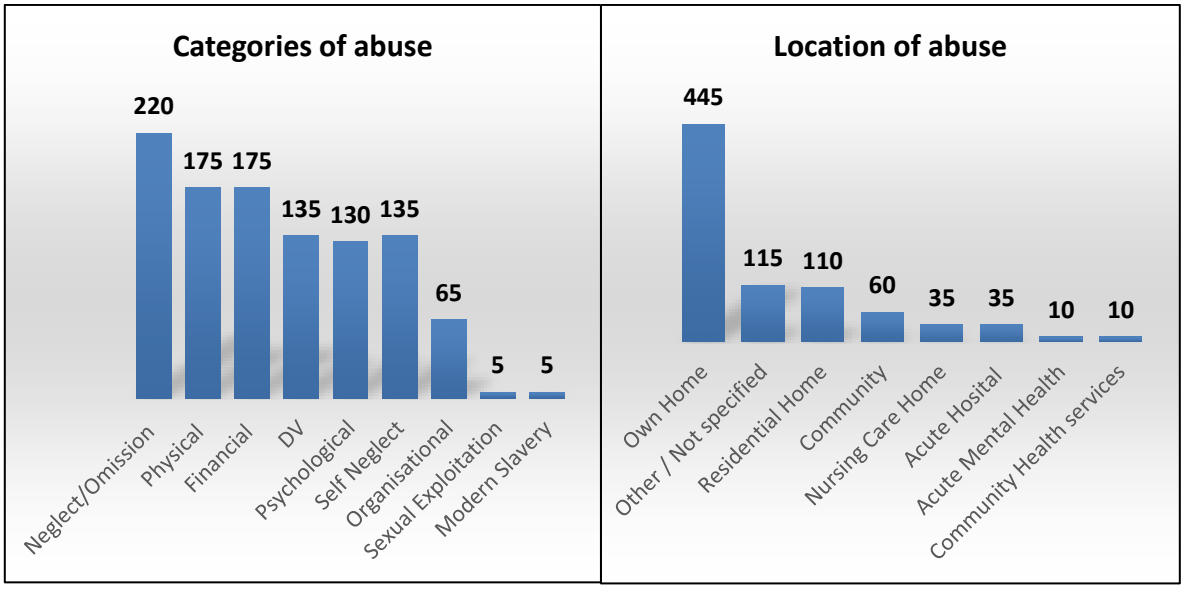
9.6.2 Section 42 Categories of Abuse in Bolton *(Table 15)*

Category of Abuse	Number	Category of Abuse	Number
Neglect / Omission	220	Organisational	65
Physical	175	Domestic Violence	135
Financial	175	Sexual Exploitation	5
Psychological	130	Modern Slavery	5
Self-Neglect	135		

9.6.3 Places where Abuse occurred in Bolton (when documented) *(Table 16)*

Place	Number	Place	Number
Own Home	445	Acute Trust	35
Community	60	Acute Mental Health Unit	10
Nursing Care Home	35	Community Health	10
Residential Home	110	Other	115

Chart 5:Categories and location of abuse



9.6.4 Analysis of data

- Increased referrals year on year also reflected in Bolton
- Increased numbers meeting the criteria for S42 statutory Enquiry
- Most abuse happens in a person's own home although abuse can occur anywhere
- **Top 3 areas of highest concern in Bolton are as follows** –

9.7 Safeguarding Referral data

Through both the first and second wave of the Pandemic, the Trust witnessed a significant increase in safeguarding adult referrals.

In 2021/22 there was an average of **247** referrals per month to the safeguarding adult team compared with **180** per month pre-pandemic, **a 37% increase.**

9.8 Safeguarding Adult Training compliance

The adult Intercollegiate Guidance - Adult Safeguarding: Roles and Competencies for Health Care Staff (2022) is the framework for safeguarding. As with children's training, safeguarding adults training was delivered via eLearning in 2021/22. There has been a gap in Level 3 training as there was issues in embedding the Level 3 eLearning and obtaining data. However, plans to reconvene level 3 face to face training in 2022/23 and refresh the training content will help with compliance.

Chart 6: Adult safeguarding training

9.9 Impact of Covid-19 on Adult Safeguarding

Throughout 2021/22 there were still Covid-19 national restrictions which impacted vulnerable people. As with children's safeguarding, Domestic Violence cases connected to Covid-19 lockdowns feature in the concerns raised. From a safeguarding perspective, regardless of the pandemic, the Trust has continued to provide a Trust wide, safeguarding service, supporting all services in both the community and bed-based services. The Trust has been able to continue to provide face to face support for vulnerable patients especially within the Emergency Department and Community settings.

9.10 Prevent

Prevent safeguards vulnerable people from becoming terrorists or supporting terrorism, by engaging with vulnerable people and protecting those being targeted by terrorist recruiters.

Prevent deals with all forms of terrorism, including Islamist and extreme right wing, and does not focus on any one community.

Prevent is about working in areas where there are risks of radicalisation and offers support predominately through local community partnerships.

Through Prevent, vulnerable individuals who are at risk of radicalisation can be safeguarded and supported.

9.10.1 Prevent duty

The Prevent duty came into force as part of the Counterterrorism and Security Act 2015 and ensures that specified authorities have a duty to prevent people from being drawn into terrorism. It covers schools, colleges, universities, health, local authorities, police, and prisons.

9.10.2 Channel

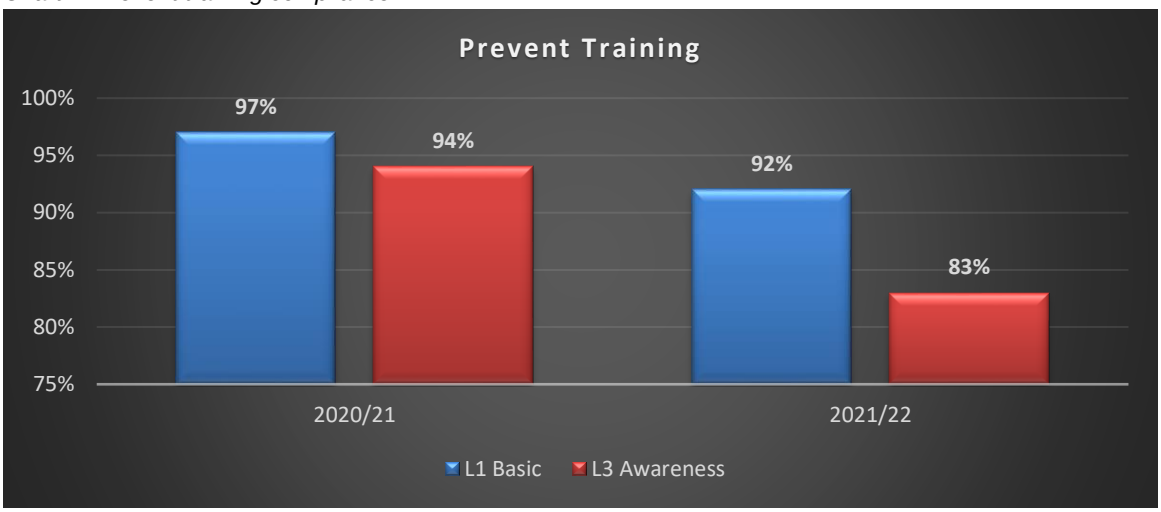
Since 2012, the Channel programme has helped more than 1,500 people who were considered to be vulnerable to exploitation from terrorist influences. It provides tailored support for a person vulnerable to being drawn into terrorism. A referral can come from anyone who is concerned about any person who may be at risk. All referrals are carefully assessed for suitability for Channel. For cases where there is a risk of radicalisation, a multi-agency **Channel Panel** chaired by the local authority will meet to discuss the referral and decide on

what tailored package of support can be offered to the individual. The safeguarding team represent the Trust at Channel Panel.

9.10.3 Bolton FT Prevent Training data

The chart below shows a reduction in both Level 1 and 3 training compliance in 2021/22 compared with 2020/21. Work is underway to review how Prevent training is delivered to ensure compliance increases.

Chart 7: Prevent training compliance



9.10.4 Bolton FT Position on Prevent

- On a quarterly basis, Prevent activity undertaken by the Trust is reported to NHS England.
- The Safeguarding Team provide advice and support for staff reporting Prevent cases and liaising with Counter Terrorist Police to share information for CHANNEL or high-risk cases.
- Bolton FT is represented on the Channel Panel by the safeguarding team
- Home Office Level 1 Prevent training and Prevent Level 2 training across the Trust.

10. Adults - Learning from Reviews

The Safeguarding Adults Board (SAB), under the Care Act 2014, commissions Safeguarding Adult Reviews (SAR) when a person with needs for care and support has died, and it is suspected that the death is a result of abuse or neglect, and there are concerns around how partner agencies worked together to safeguard that person.

In 2021/22 – 0 SAR were commissioned by the SAB.

10.1 Learning from Previous Reviews

Between 2019 and 2021, the safeguarding adult team has contributed to the following reviews –

1 joint Safeguarding Adult Review/Domestic Homicide Review and

1 stand-alone Safeguarding Adult Review.

Recommendations from both reviews include:

Diagram 18: Recommendations from learning reviews

These actions will form key priorities for the Trust safeguarding adult team in 2022/23.

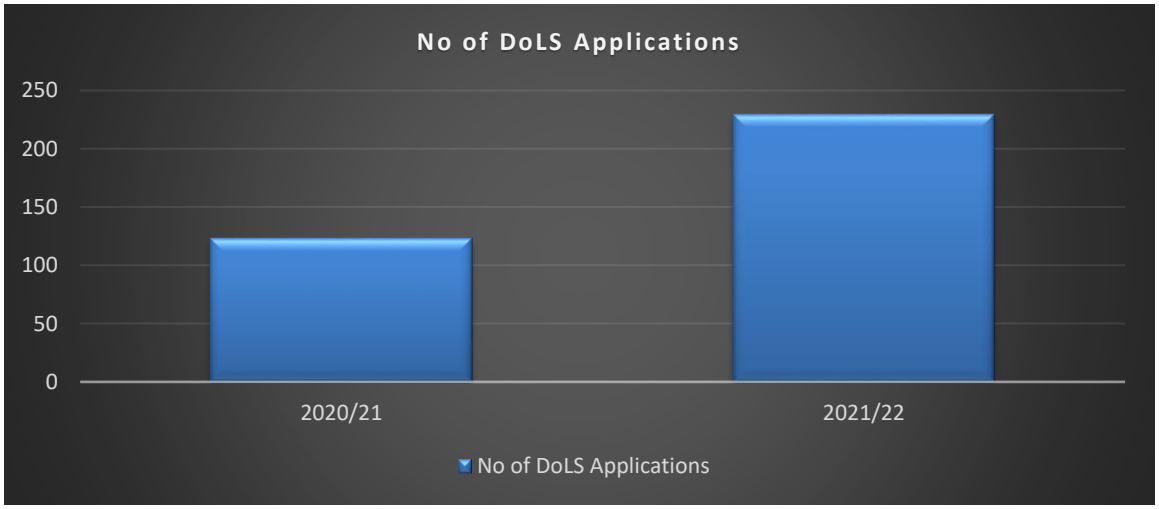
11. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards DoLS

The safeguarding adult team supports the MCA/DoLS agenda as there is no dedicated MCA/DoLS lead for the Trust, this includes providing training and support to staff and ensuring policy reflects statutory requirements. The team support staff in ensuring that correct processes are in place for any patient who lacks capacity to make decisions to ensure they are not illegally detained by the Trust and have a DoLS in place.

11.1 Deprivation of Liberty safeguards (DoLS)

In 2021/22 there has been an increase in the number of DoLS applications made by Bolton FT compared to 2020/21. During COVID, there was very limited capacity within social care to assess DoLS applications due to home working. As COVID restrictions have lifted, the volume of DoLS has increased.

Chart 8: Number of DoLS applications



In 2022/23 The safeguarding team will drive forward this agenda through training, audit and support to increase awareness of staff on their statutory duty and ensure that no patient is illegally detained in the Trust and those that are subject to a DoLS have least restrictive restraint in place.

It is acknowledged that further education and support is required across our workforce to ensure that we are fully compliant with the legislation around DoLS. Over the last 12 months we have redefined our processes to capture the accurate recording of DoLS applications and monitoring these with the local authority. This is an area that still requires further improvement and is a key objective for 2022- 2023.

11.2 Liberty Protection Safeguards (LPS) Update

The LPS were originally due to be implemented in October 2020, but were then delayed to a target of April 2022 because of the pandemic. However, at the end of last year, the government announced a further delay but without specifying a new implementation – a position that still holds. As a Trust we continue to prepare for the implementation of LPS.

12. Conclusion

Safeguarding is often described as a 'golden thread' that weaves through every service and touches every area of practice and practitioner at some stage in a career. This annual report has highlighted the diversity of the adult, children and LAC safeguarding agenda and provides assurance that the Trust is meeting its statutory requirements and that thread is very clearly embedded across the Trust.

The report highlights the impact that the pandemic has had on all aspects of safeguarding and the challenges faced by the teams and wider Trust not just as a result of the pandemic but also due to significant staffing issues in all teams. This has impacted on the ability to further develop safeguarding as the need to be reactive rather than proactive has had to take precedence.

The teams look forward to 2022/23 where they will work more cohesively on a Think Family approach and re-establish face to face training which will greatly impact and support frontline staff.

The wider safeguarding agenda continues to be challenging for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments. However, we recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns.

This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the priorities for 2022/23 align with the partnership strategic objectives to ensure the people of Bolton are afforded the best care and protection when in our care.

13. Next steps 2022-2023

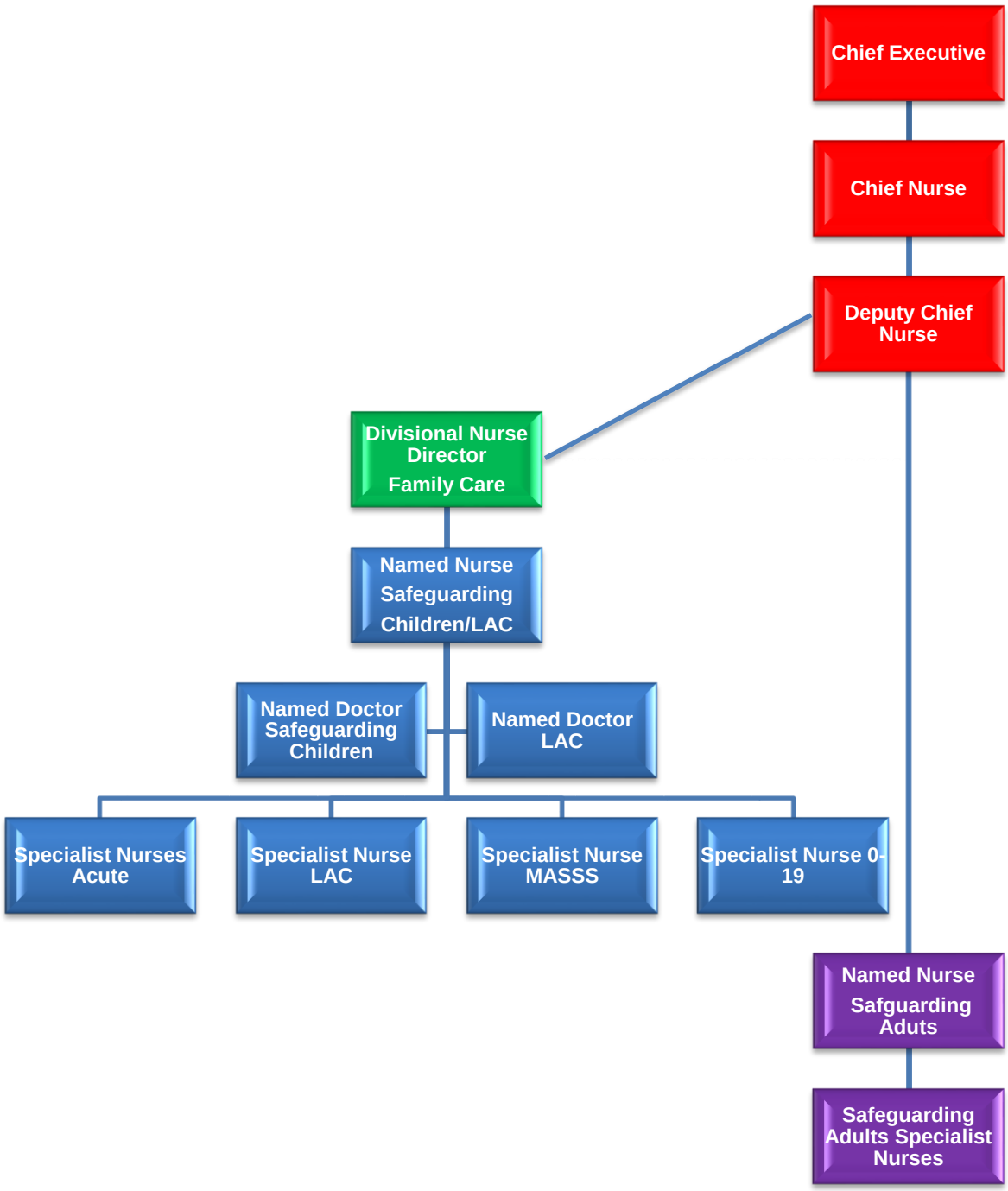
Safeguarding activity and protecting our vulnerable patients and service users remains a key focus for the trust in 2022-2023. In line with the priorities from Bolton Safeguarding Childrens Partnership (SCP) and Bolton Safeguarding Adults Board (SAB) our focus for the next 12 months are:

- Further strengthen and develop reporting through the Trust Committee structures and to SAB and SCP.
- Undertake a full review of the safeguarding teams the service and our processes in line with the guidance in the intercollegiate document.
- Develop further relationships with the local authority and our partners to deliver services that met our populations needs.
- Strengthen our systems and processes for DoLS and MCA working in collaboration with GMMH and the local authority.
- Review safeguarding training across the locality in line with SAB to ensure the training we provide is continually reviewed to meet relevant guidance and also address areas of concern within the local population and area.
- To work towards an integrated safeguarding team enabling smoother transition for patients and a seamless all age service

Appendix 1

Underpinning Legislation /Statutory Guidance
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Promoting the Heath of Looked After Children (2015) Statutory Guidance
• Safeguarding Children and Young People Roles and Competencies for Health Care staff (2019)
• Safeguarding Adults Roles and Competencies for Health Care staff (2019)
• Looked After Children, Skills and Competencies for healthcare Staff (2015)
• Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)
• Lampard Inquiry (2015)
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
• General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018.
• Working Together (2018)
• Children Act 1989/2004
• Working Together (2018) Statutory Guidance
• Female Genital Mutilation Act 2003
• Mental Capacity Act 2005
• Serious Crime Act 2015
• Mental Health Act 2007
• Children and Families Act 2014
• Modern Slavery Act 2015
• The Crime and Disorder Act 1998
• Sexual Offences Act 2003
• Domestic Abuse Act 2021

Appendix 2 – Team Structure



Appendix 3 – Definitions

Child	Having not reached 18 years, up to 19/25 years if SEND (Special Educational Needs and Disability)
Safeguarding Children	Protection from maltreatment, preventing impairment of health or development; growing up with safe, effective care to enable best outcomes.
Child Protection	Part of safeguarding refers specifically to children who are suffering, or at risk of significant harm.
Looked After Child	In the care of the Local Authority for more than 24 hours. Also often referred to as children in care
Adult Safeguarding	Protecting an adult's right to live in safety, free from abuse and neglect, while at the same time making sure that the adult's wellbeing is promoted and having regard to their views, wishes, feelings and beliefs
Deprivation of Liberty Safeguards (DoLS)	DoLS is part of the MCA and is a legal framework for individuals over 18 years who lack the capacity to consent to be accommodated in a hospital or care home in order to receive care and treatment
The Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Agenda Item 22.D

Title:	2021 National Adult Inpatient Survey Summary Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	24 November 2022		Discussion	
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Summary:

This paper summarises the recent National Adult Inpatient Survey 2021 Management Report for Bolton NHS Foundation Trust (BFT by providing an overview of the survey process, findings for BFT and benchmarking against other Trust's surveyed by IQVIA. IQVIA (formerly Quality health) is the organisation commissioned by Bolton FT to provide the survey. Different organisation use different providers. Comparisons are shown by a) those organisations also using IQVIA and b) by reference to CQC data once all providers' results have been collated.

The process involves working backwards from the last day of November 2021 to identify 1250 patients discharged who had a length of stay of at least 1 night. These patients were then surveyed between January and May 2022 with results shared with organisations September 2022, embargoed until release of national CQC data. Regardless of provider used to administrate the survey, all content remains the same. The CQC published the survey results in October 2022, and therefore these are no longer embargoed.

The findings have been considered at both the Clinical Governance and Quality Committee and the Quality Assurance Committee.

A summary of findings is as follows;

- The results for the 2021 survey indicate a broadly stable picture for Bolton NHS Foundation Trust, with the majority of questions sitting in the intermediate - 60% range of organisations surveyed
- Ten questions are in the bottom 20% range which represents a consecutive year on year deterioration for three years
- Two questions are in the top 20% range which represents a consecutive year on year deterioration for four years
- Better performing questions relate to staff discussing health or social care needs after leaving hospital, and for patients saying that they received support from health or social care for their condition
- The overall ratings by the CQC against each of the sections shows a reduction in 8 out of 10 sections for the organisation compared to the previous year
- Analysis of the 2021 survey report has identified the same themes as identified in the previous 2020 survey of;
  - Communication
  - noise at night
  - food
  - cleanliness
  - discharge arrangements

	• Additional themes include; ➢ Pain management ➢ Privacy and dignity ➢ Being asked to give views on the quality of care ➢ Quality of answers to questions about operations and procedures i.e. what to expect before, during and after It is important to note that due to the delay in receiving the survey outcomes from the time period used to select participants, the ability to enact change invariably takes at least two years for impact to be shown unless impact is derived via quality improvement work-streams already underway. The patient experience sub-group is reviewing the progress to date of previously identified actions and is also focussing on the establishment of 'real-time' surveys across all in-patient areas and those residents being cared for in their own homes, on a long-term caseload. Patient and service user experience is one of six priorities identified within the Chief Nurse portfolio.
Previously considered by:	Quality Patient Experience Forum (QPEF) 5th September 2022 Clinical Governance & Quality Committee (CGQC) 7 September 2022 Quality Assurance Committee (QAC) 21 September 2022
Proposed Resolution	The Trust Board are requested to: 1. Note the content of the 2021 National Adult Inpatient Survey 2. Note the recommendations and next steps.

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:	Tracy Joynson Patient Experience Manager & T Roberts, Chief Nurse	**Presented by:**	Tyrone Roberts Chief Nurse

1.0 Background

Bolton NHS Foundation Trust Commissions IQVIA UK&I Healthcare (formerly Quality Health) to undertake the National Inpatient Survey.

The preparation for the survey completion is supported by the Trust's Business Intelligence Unit with regards to data extraction and data cleansing. The survey was undertaken between January and May 2022.

The benchmarking provided is based on those Trusts surveyed by IQVIA. There is also benchmarking data from the Care Quality Commission against providers within the Greater Manchester region.

The survey required a sample of 1250 consecutively discharged inpatients, working back from the last day of November 2021, who had had a stay of at least one night in hospital. There were 33 patients excluded from the survey where they had either died or moved address leaving a sample size of 1217.

405 were completed and returned which provided an overall response rate of 33% compared with 38% in 2020.

The results are also subject to national publication with the key results for each organisation published in October 2022. This was undertaken by the CQC Coordination Centre who published the national results on the NHS Inpatient Survey website.

2.0 Benchmarking

The table below shows the scores for BFT highlighted by IQVIA with comparative data for the previous three years.

	2018 survey	2019 survey	2020 survey	2021 survey
Highest 20%	12 questions	7 questions	4 questions	2 questions
Intermediate 60%	46 questions	53 questions	34 questions	43 questions
Lowest 20%	5 questions	4 questions	8 questions	10 questions

Lowest related questions

10. If you brought medication with you to hospital, were you able to take it when you needed to?
24. To what extent did staff looking after you involve you in decisions about your care and treatment?
25. How much information about your condition or treatment was given to you?
26. Did you feel able to talk to members of hospital staff about your worries and fears?
28. Were you given enough privacy when being examined or treated?
29. Do you think the hospital staff did everything they could to help control your pain?
32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?
39 Before you left hospital, were you give any written information about what you should or should not do after leaving hospital?

40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?
43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Highest related questions

44. Did hospital staff discuss with you whether you might need any further health or social care services after leaving hospital?
46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Bolton NHS Foundation Trust (BFT) was not the lowest or highest scoring Trust against any of the questions contained within the survey.

CQC banding description.

Better
Your trust's results were much better than most trusts for 0 questions.
Your trust's results were better than most trusts for 0 questions.
Your trust's results were somewhat better than most trusts for 1 question *(Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?)*

Worse

Your trust's results were much worse than most trusts for 0 questions.
Your trust's results were worse than most trusts for 0 questions. Your trust's results were somewhat worse than most trusts for 0 questions.

Same

Your trust's results were about the same as other trusts for 46 questions.

The national benchmarking results are available. The Patient Experience team have undertaken analysis of this and reported the findings/position through QPEF and QAC. See banding descriptions above.

CQC section scoring for BFT

Section	2020 score	2021 score	Variance
Section 1. Admission to hospital	7.6	6.9	↓
Section 2. The hospital and ward	8.0	7.7	↓
Section 3. Doctors	8.8	8.7	↓
Section 4. Nurses	8.6	8.4	↓
Section 5. Care and treatment	8.2	7.8	↓
Section 6. Operations and procedures	8.4	8.2	↓
Section 7. Leaving hospital	7.1	7.1	→

Section 8. Feedback on care	7.1	7.1	→
Section 9. Respect and dignity	9.3	9.0	↓
Section 10. Overall experience	8.2	8.0	↓

3.0 Findings from 2021 Survey

Analysis of the 2021 survey report has identified the **same themes** of:

- communication
- noise at night
- food
- cleanliness and discharge arrangements

Additional themes for 2021:

- Pain management
- Privacy and dignity
- Being asked to give views on the quality of care
- Quality of answers to questions about operations and procedures i.e. what to expect before, during and after

4.0 Progress from 2020 National Adult Inpatient Survey

Following analysis of the results of the 2020 survey with triangulation of patient experience feedback from PALS, complaints, friends and family test and NHS website reviews, a number of key work streams were identified to run over a two-year period due to the timing of the reports and subsequent surveys. The aim is to improve the survey results in these areas for patients who are admitted to an in-patient bed during November 2022. These work streams are monitored at the Quality Patient Experience Forum quarterly.

Although there is progress within each of the projects, they have not yet had the desired impact. It is important to note that due to the delay in receiving the survey outcomes from the time period used to select participants, that ability to enact change invariably takes at least two years for impact to be shown unless impact is derived via quality improvement work-streams already underway.

The projects are:

- Communication – This project is being led by Anaesthetics and Surgical Services Division (ASSD) who have introduced a line of communication for patients to speak to someone about their health, worries and fears. This has now been augmented by the initiative to outline to patients their ability to escalate their concerns to a Divisional Nurse Director to discuss patient concerns via a direct and dedicated phone line and then to an executive director in three steps if their issue cannot be resolved.

- Noise at Night – This project is being led by Acute Adult Care Division (AACD) who have interviewed patients across all Divisions to identify the root cause of noise at night. The actions from this are that ear plugs and eye masks are being piloted; the outcome of these

pilots are now being evaluated. A visible decibel meter has been included in these pilots to allow staff to 'see' how much noise is being generated at night. The initial feedback from the pilots is that much of the noise experienced by patients at night is generated by patients and patient activity and the benefits of eye masks and earplugs are being reviewed. This project is ongoing and will continue to feed into the Quality and Patient Experience Forum.

- Cleanliness – This is being led by iFM supported by the Infection Prevention and Control (IPC) service. This has also largely been driven by the implementation of revised national cleaning standards, which includes new and more nuanced ways of auditing cleaning compliance and requires the outcomes of cleaning audits to be displayed publicly; these are now clearly displayed in all areas and will be incorporated into future changes to patient quality information on wards and in departments. In total £600k of new money has been invested in equipment and additional cleaning hours - £300k of which is recurrent. This has also included the introduction of new technologies such as UVC (ultraviolet-C) decontamination to augment the current HPV (Hydrogen Peroxide Vapour) process – this will be faster and more responsive. Audit scores are tabled monthly at the IPC Committee for challenge and assurance and there has been (from a cleaning perspective) favourable PLACE (Patient Led Assessment of the Care Environment) Inspection. This work stream in its current guise has ceased but will be re-visited as and when required.

- Food – This is being led by iFM in respect of the national mealtime standards and the Divisional Nurse Director (DND) for Family Care Division (FCD). This has reviewed the standard of the food provided for patients and the mealtime standards policy respectively. These have ended in their current guise. Food issues were identified as part of the PLACE inspection in terms of heat and presentation which iFM are addressing with the mealtime assistants. The application of the protected mealtime standards is audited monthly as part of the ward KPI process. A revised working group has been established to ensure that the mealtime standards are embedded and to organise the use of mealtime companions for patients co-chaired by the DNDs for ASSD and Diagnostics and Support Services Division (DSSD). This will also agree on a simple metric for the Chief Nurse Improvement Wall.

- Discharge – Integrated Community Services Division (ICSD) is leading this with a number of work streams including: develop roles and responsibility for TTOs on discharge, introduction of a discharge charter and improving roles and responsibilities in relation to discharging patients. The roles and responsibilities for TTOs has now completed and changes have been made to EPR with new mandatory fields when prescribing TTOs. The discharge charter work has been put on hold, as there was duplication of the Trust Discharge Policy and national patient discharge letter. There is now a discharge checklist in EPR and the work now is focused on embedding its consistent use.

5.0. Next steps

The Board is asked to note that work to date will be reviewed via the Patient/service user experience group to form a discussion at Professional forum. The intention is to focus on over-arching 'process' measure interventions that provide reliability over time. For example, Nurse bedside handover between each shift, undertaken professionally and sensitively, can result in many favourable outcomes such as;

- Knowing who is looking after you
- Awareness of the current plan for their care.
- Ability for the 'receiving' nurse to ensure observations, fluid balance. are up to date and pain is controlled
- Enhancing practitioner accountability
- Enabling 'standard' setting for all colleagues, including bank and agency staff who may not have worked on the area previously

Additionally, the refreshed work-plan for the Chief Nurse portfolio includes an ambitious aim to roll out 'real-time' patient/service user surveys, across in-patient areas and to those residents being cared for in their own homes on long-term caseloads during 2022/23. This will focus on two questions which evidence suggests are the cornerstone to subsequent positive experience;

- Were you treated with dignity and respect?
- Were you involved with decision-making and feel able to ask questions?

Finally, communication and mealtime experience / nutrition is a recurrent theme that emerges from our accreditation system (BoSCA) and from complaints. Two key cross-divisional work-streams have therefore been commenced as follows;

- Nurse to nurse shift hand-over with focus on consistency / patient engagement
- Mealtime experience with a focus on registered nurse oversight and leadership

6.0 Recommendations

The Board is asked to;

- Note the content of the 2021 National Adult Inpatient Survey
- Note the next steps